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

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PREVENTION BUREAU
ANTI-RACISM, INCLUSION, SOLIDARITY AND EMPOWERMEN (ARISE) DIVISION
CULTURAL COMPETENCY UNIT

AND

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC) BUREAU
STRATEGIC AND NETWORK DEVELOPMENT DIVISION
EQUITABLE ACCESS AND PROMOTIONS SECTION (EAPS)

2024 CULTURAL COMPETENCE PLAN UPDATE – FY 22-23

Criterion 1

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December 2024

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PREVENTION BUREAU
ANTI-RACISM, INCLUSION, SOLIDARITY AND EMPOWERMENT (ARISE) DIVISION
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2024 CULTURAL COMPETENCE PLAN UPDATE
EXECUTIVE SUMMARY

In alignment with the Culturally and Linguistically Appropriate Services and Healthcare (CLAS) Standards, Cultural Competence Plan Requirements (CCPR), CalAIM's Behavioral Health Administrative Integration priorities, the 2024 Cultural Competence Plan Report, represents an integration of the cultural competence plans across the Los Angeles County Department of Mental Health (LACDMH) and the Department of Public Health's Substance Abuse Prevention and Control (SAPC) Bureau. This dual reporting represents the combined efforts of a workgroup formed by key representatives from LACDMH and SAPC, and the content reflects the cultural and linguistic competence activities as specified throughout the report. The report reflects FY 22-23 updates for LACDMH and FY 23-24 updates for SAPC.

LACDMH updates its Cultural Competence Plan per the California Department of Health Care Services (DHCS) Cultural Competence Plan Requirements (CCPR), 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 ARISE Division - Cultural Competency Unit (CCU) annually updates the Cultural Competence Plan and makes it available to the LACDMH Executive Management, Directly Operated and Contracted/Legal Entity Providers, and Stakeholder groups such as the Cultural Competency Committee, Service Area-based Quality Improvement Committees, and Service Area Leadership Teams. Additionally, Cultural Competence Plan presentations based on annual updates are delivered at various Departmental venues. These presentations aim 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/.

Similarly, SAPC updates its CLAS action plan regularly in compliance with the CLAS provisions. SAPC's plan undergirds efforts to promote, measure, and analyze the progress of its and its providers' service planning, integration, and delivery. The plan serves as a roadmap for reducing disparities, fostering expansion in a diverse portfolio of services that ensures services are culturally and linguistically appropriate and provided in an equitable and inclusive manner.

The report is based on the CCPR set forth by DHCS. These requirements are organized under eight specific criteria, which are 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

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CULTURAL COMPETENCE PLAN UPDATE, FY 22-23

Criterion 1

Commitment to Cultural Competence

December 2024

Criterion 1: Commitment to Cultural Competence

I. Los Angeles County Mental Health and Substance Use Disorder Systems' 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 that 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, community partnerships, integration with social service providers, and openness to sustained learning and on-going improvements. LACDMH believes that wellbeing is possible and that mental health interventions should be person-centered. The Department employs a collaborative approach to assist consumers achieve their personal recovery goals such as finding a safe place to live, use time meaningfully, thrive in healthy relationships, access public assistance, overcome crises successfully, and attain wholesome health.

The Los Angeles County Department of Public Health Substance Abuse Prevention and Control (SAPC) is the largest county-operated substance use system in the nation and leads and facilitates the delivery of a full spectrum of prevention, harm reduction, treatment, and recovery services. SAPC contracts 100% of its services through over 150 community-based organizations.

The 2024 Cultural Competence Plan report, FY 22-23 has two new features:

1) LACDMH has based this year's reporting on its Strategic Plan 2020-2030, Board Motions pertinent to culturally responsive services, and the Los Angeles County Strategic Plan. A brief synopsis and diagram of the domains can be found below. *See Criterion 1 Appendix for the Link to LACDMH Strategic Plan 2020-2030.*

2) SAPC addresses the cultural and linguistic needs of individuals by building knowledge of and respect for the multidimensional and complex ways language and culture (inclusive of race, faith, ethnicity, abilities, gender identity, class, sexual orientation, housing, and education) is experienced individually and impacts personal interactions. It is a critical component of high-quality SUD services and is in alignment with our Strategic Plan 2023-2028. *See Criterion 1 Appendix for the Link to LACDPH SAPC Strategic Plan 2023-2028.*

3) The content of the report was developed by incorporating the expertise of both Departments. To this end, the LACDMH and SAPC Cultural Competence Plan Integration Workgroup was created in March 2023.

This workgroup was comprised of staff from respective cultural competence programs. Its purpose was to develop a cohesive, integrated behavioral health cultural competence report for submission to DHCS. Workgroup members met consecutively from June 2023-December 2024 and accomplished the following:

- As of June 2023, the workgroup developed an action plan for the Cultural Competence Plan report integration.
- As of July 2023, members reviewed and provided input on the DHCS draft "Behavioral Health Equity Plan (BHEP), formerly CC Plan Requirements (CCPR), with an estimated release in August 2023. In December 2023, DHCS suspended BHEP requirements.
- Starting January 2024, the workgroup reorganized to focus on the development of the 2024 Cultural Competence Plan report following the 2010 CCPR.

LACDMH and SAPC Cultural Competence Plan Integration Workgroup members:

- Sandra Chang, Ph.D., LACDMH, Ethnic Services Manager and Cultural Competency Unit Program Manager
- Mirtala Parada Ward, LCSW, LACDMH, ARISE Division Mental Health Clinical Program Manager III
- Robert Byrd, Psy.D., LACDMH, Prevention Division Deputy Director
- Alan Chung Chiu Wu, LACDMH, ARISE Division Health Program Analyst I
- Antonne Moore, M.Ed., Chief, Strategic and Network Development Division
- Cherene Cexil, SAPC, Section Manager, Equitable Access and Promotion Section
- Terri Hudson, SAPC, Staff Analyst, Equitable Access and Promotion Section

A. Policy and Procedures

LACDMH continues to develop, implement, and publicize 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) ○ 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

TYPE	INFRASTRUCTURE DOCUMENTS
	○ SC-6 – Older Adults ○ SC-7 – Assessment for Co-Occurring Cognitive Impairment with Mental Health ○ SC-8 – Treatment for Co-Occurring Cognitive Impairment with Mental Health ○ SC-9 – Access to Care After Discharge from Psychiatric Hospitals and Juvenile Justice Programs
Additional Policies and Procedures Related to Cultural Competence	• Policy No. 200.05 – Request for Change of Provider • Policy No. 200.08 – Access to Care for Veterans and Their Families • Policy No. 200.09 – Culturally and Linguistically Inclusive Services • Policy No. 201.02 – Nondiscrimination of Beneficiaries • Policy No. 305.01 – Mental Health Disorders and Co-Occurring Substance • 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
Board Motions Pertinent to Cultural Diversity enacted CY 2022 and 2023	Listed below are the L A County Board Motions appointing LACDMH as the lead Department or as one of the main contributors for coordination of efforts and reporting (* represents those motions with dual contributions by both Departments). • *Solidifying the Role of Promotoras de Salud in County Services** • *Care with Pride: Establishing a Gender Health Program in Los Angeles County** • *Confronting the Drug Overdose Epidemic** • *Coordinating of Los Angeles County's Response to Incidents of Mass Violence* • *Care with Pride: Supporting Gender Affirming Health Care, Mental Health Services, and Care Management for LGBTQ+ Residents, Including Transgender, Gender** • *Supporting Mental Health for Latino Residents* • *Addressing Physical Safety and Mental Health for Women Fleeing Domestic Violence*

SAPC continually develops, updates, implements and promotes its CLAS policies to build and support its network providers in provide effective services to Los Angeles County residents. Table 1 below provides an outline of current SAPC CLAS policies, procedures, and other infrastructure.

TABLE 2: SAPC POLICIES, PROCEDURES, AND OTHER INFRASTRUCTURE DOCUMENTS RELATED TO CULTURAL COMPETENCE

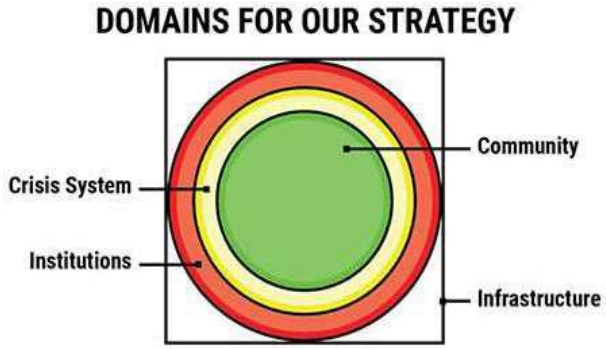
TYPE	INFRASTRUCTURE DOCUMENTS
SAPC Strategic Plan, Overarching Policies, and Practice Parameters	• SAPC Strategic Plan - The Strategic Plan is a culmination of input from the community, providers, and SAPC team, that will guide SAPC's critical work to ensure that we are successfully connecting with and ensuring that Los Angeles County residents have access to needed services provided by a robust, culturally responsive workforce that can carry out SAPC's mission. • BA-101 - Access to SUD Services for Persons with Disabilities • BA 102 - Timely Access • BA-103 - Service Availability • 901-22-R0 - Culturally and Linguistically Appropriate Services
SAPC Additional Policies and Procedures Related to Cultural Competence	• DMC-ODS Substance Use Disorder Treatment Services Provider Manual
Department of Public Health 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
Board Motions Pertinent to	• Reaching the 95% (R95) Board Motion

cultural Diversity	• Funding Allocations Related to Recent National Opioid Settlements *(*Refer to the board motions with asterisk listed in the Department of Mental Health table for a representation of those motions with dual contributions by both Departments).*

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

LACDMH safeguards its commitment to serve LA County communities with equitable, inclusive, as well as culturally and linguistically responsive services by clearly delineating it in all foundational documents. Among them, the departmental Strategic Plan, P&P, provider manuals, contractual agreements, and program-specific mission statements and practices. Simultaneously, these core documents create the Department's blueprint for service planning, delivery, and evaluation.

The LACDMH Strategic Plan 2020-2030 has four deliberate domains which organize departmental focal areas of operations internally and externally. Namely, these domains include Community, Crisis System, Institutions, and Infrastructure. Collectively, they ensure the Department's investment in pursuing the ultimate goal to positively impact the process of recovery and wellbeing of all persons, families, and communities served. A brief synopsis of the domains can be found in the section below followed by corresponding descriptions of LACDMH programs.



- "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, inclusive and connected communities where human needs are met in a responsive, effective, age informed and culturally competent manner across the County." Below are examples of key LACDMH programming that exemplify the Community domain.

1) 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.
2) Promotores de Salud Mental and United Mental Health Promoters (UMHP) Programs	These programs reduce the stigma associated with mental illness among underserved communities by increasing awareness about mental health issues, removing barriers, and improving access to culturally and linguistically appropriate care and resources.
3) Speakers Bureau (SB)	The SB functions as LACDMH's organized public communication and community intervention resource. It is comprised of approximately 75 highly skilled, licensed mental health clinicians who specialize in social media and public speaking delivery. SB members are Subject Matter Experts (SME) representing multiple cultural and linguistic backgrounds.
4) Spanish Support Groups (SSG)	SSG create a safe space where participants share their life experiences and find emotional support, ideas for coping, and information about available resources. These groups allow participants to engage in personal exploration, emotional expression, problem solving and stigma reduction.
5) Stakeholder Groups: *Cultural Competency Committee (CCC)*	The CCC serves as an advisory group for the infusion of cultural competence in LACDMHs operations. The committee advocates for the needs of all cultural groups. The membership includes the cultural and lived experience perspectives of consumers, family members, peers, advocates, mental health providers, and community-based organizations.
6) Stakeholder Groups: *Faith-Based Advocacy Council (FBAC)*	FBAC empowers the Department's collaboration with faith leaders from various religious affiliations. This council operates under the values of caring for the whole person; including spirituality as an aspect of wellbeing, recovery, and resilience; networking with the community; respecting diversity in life experience, worldview, ways of communication, and spirituality; and developing initiatives that integrate spirituality into LACDMH.
7) Stakeholder Groups: *Underserved Cultural Communities (UsCC) subcommittees*	The UsCC subcommunities address the mental health needs and concerns of historically unserved, underserved, and inappropriately served communities. They work closely with community partners and consumers to increase the capacity of the system by developing culturally competent recovery-oriented projects specific to their communities. The seven UsCC subcommittees include: • Access for All • American Indian/Alaska Native (AI/AN) • Asian Pacific Islander (API) • Black and African Heritage (BAH) • Eastern European/Middle Eastern (EE/ME) • Latino • Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, and Two-Spirit (LGBTQIA2-S)

8) Stakeholder Groups: *Service Area Leadership Teams (SALT)*	The SALT convenes regularly to address priorities specific to each Service Area regarding service delivery, optimal utilization of departmental resources, and effectiveness of communication among providers and constituents. The SALT advise the Department on service planning and implementation.
9) Stakeholder Groups: *Community Leadership Team (CLT)*	The CLT is comprised of Co-Chairs from three stakeholder groups: CCC, SALTs and UsCCs. CLT members identify and consolidate stakeholder priorities.
10) Stakeholder Groups: *Mental Health Commission (MHC)*	The MHC reviews and evaluates the community's mental health needs, services, facilities, and special programs in accordance with the Welfare and Institutions Code (WIC) Section 5604.

- "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."

  LACDMH has a strong structure for Crisis Services (ACS) designed to provide alternatives to emergency room care, acute inpatient hospitalization, and institutional care; reduce homelessness; and prevent incarceration. These programs are essential to crisis intervention and stabilization and linkage to community-based programs. The chart below provides a brief description of these programs.

1) Assisted Outpatient Treatment Program (AOT)	AOT serves persons with serious mental illness, history of treatment inconsistency, substantial risk for deterioration, relapse, and/or detention to prevent incidents of grave disability or serious harm to self or others.
2) Crisis Residential Treatment Programs (CRTP)	CRTP are short-term, intensive residential programs that provide recovery-oriented services to individuals who are 18 years and older. CRTP offer an alternative to hospitalization and reduce the duration of psychiatric inpatient stays.
3) Enriched Residential Care Program (ERC)	The ERC program facilitates the placement of consumers who require intensive care and supervision at licensed residential facilities. Services also include medication management, meals, and assistance with daily living activities.
4) 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 include clinical assessments, provision of street psychiatry, and linkage to appropriate resources.

5) Housing and Supportive Services Program (HSSP)	HSSP focuses on providing onsite mental health services for individuals experiencing homelessness and mental illnesses at Permanent Supportive Housing (PSH) locations. Services are individualized and may include group psychotherapy, crisis intervention and medication management.
6) Mental Health – Law Enforcement Teams (MH-LET)	MH-LET offers a co-response resource that pairs a LACDMH clinician with a law enforcement officer. Together, they respond to 911, patrol officer requests, calls involving persons who are mentally ill, experiencing homelessness, or at high-risk for injury to self or others.
7) Outpatient Care Services (OCS) Transition Age Youth (TAY) Drop-In Centers	These Drop-In Centers are an entry point for Seriously Emotionally Disturbed or Severe and Persistently Mentally Ill youth living on the streets or in unstable living situations. Services include basic supports such as showers, meals, clothing as well as linkage and referrals to social service agencies.
8) Preventing Homelessness and Promoting Health	This countywide field-based program provides triage, risk assessment, crisis evaluation and response, coordination of supportive services, brief clinical interventions, and linkage for participants to achieve long-term housing stability and prevent recidivism to homelessness.
9) Psychiatric Mobile Response Teams (PMRT)	PMRT performs evaluations for the involuntary detention of individuals determined to be at risk of harming themselves or others, or who are unable to provide for basic human needs as a result of a mental disorder.
10) School Threat Assessment Response Team (START) Program Expansion	START is a collaborative program comprised of educational institutions and law enforcement agencies with the goal of preventing school violence. The program identifies students at risk and provide an immediate comprehensive response and case management.

- "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." Below are examples of programs that provide services that converge with various L.A. County social service systems.

1) California Work Opportunity and Responsibility for Kids (CalWORKs) and General Relief Opportunities for Work (GROW) Programs	CalWORKs and GROW Programs work together to address the barriers, challenges, and mental health needs experienced by participants as part of their preparation for gainful employment.
2) Urgent Care Centers (UCC)	UCC serve to divert individuals from County and private hospital emergency departments to avoid engagement with law enforcement and potential incarceration. UCC develop individualized plans that are focused on recovery and wellness principles toward successful reintegration into the community.

3) Veteran Peer Access Network (VPAN)	VPAN is a community-driven support network that serves U.S. veterans and their families. Services are based on connections to various county departments, non-profit organizations, the U.S. Department of Veterans Affairs, and LA City programs.
4) Men's Community Re-Entry Program (MCRP)	The mission of MCRP is to reduce recidivism and facilitate community reintegration by treating mental health symptoms of justice-involved men, 18 to 65 years of age, who present with high criminogenic risk factors.
5) Women's Community Reintegration Program (WCRP)	This field-based program assists previously incarcerated women to reintegrate and become successful members of their communities. The program aims to reduce recidivism by addressing criminogenic risk factors and promoting mental health.
6) Wellness Outreach Workers (WOW) Program	The purpose of the WOW program is to promote ongoing peer support to vulnerable adult consumers by facilitating their community reintegration and mental health self-care through culturally sensitive interventions.

- "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." Below are examples of programs that represent foundational columns in LACDMH's infrastructure.

1) Birth to Five Program	The Birth to Five Program provides a comprehensive range of integral support in the operation and provision of mental health services in LA County. It consists of a multi-disciplinary team of subject matter experts who provide services inclusive of specialty trainings to increase and support the Birth to Five workforce, coaching, reflective practice facilitation groups, mentorship, countywide multi-disciplinary provider consultation calls, provider technical assistance site visits and consultation services as they relate to program development and implementation. Through a collaborative approach with County partners, mental health providers, and allied professionals, the Birth to Five Program prioritizes a strength-based relational approach, fundamental in building and maintaining infant and early childhood mental health services.
2) Child Welfare Division (CWD)	The CWD offers a comprehensive range of services, inclusive of Specialized Foster Care (SFC) Co-located Program, Medical Hubs, Wraparound Program, Family Preservation, Intensive Field Capable Clinical Services, Intensive Services Foster Care, Multidisciplinary Assessment Teams, Community Treatment Facility, Qualified Individual, Short Term Residential Therapeutic Program and Specialized Linkages Services Unit.
3) Full-Service Partnerships (FSP)	Adult FSP programs provide comprehensive, intensive, community-based mental health services to adults with severe mental illness. Services aim to help consumers increase their ability to function at optimal levels and decrease

	potential homelessness, incarcerations, and unnecessary medical, psychiatric urgent care, and emergency room visits as well as hospitalizations.
4) Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) Program	GENESIS 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, in-home supportive services, housing retention, and linkage to resources such as Medi-Cal, Medicare, Social Security, and Veteran Administration Benefits.
5) Housing and Job Development (HJDD) Division	The HJDD provides a range of housing services and resources for consumers experiencing homeless such as housing subsidies through the Section 8; financial rental and household goods acquisition assistance; eviction prevention; and temporary shelter.
6) LGBTQIA2-S Champion Network	The LGBTQIA2-S Champion Network is a growing cohort of DMH administrative and clinical staff with meaningful experience, knowledge, and training in affirming clinical practice with LGBTQIA2-S communities. It operates as a public-facing entity to increase the visibility of and access to affirming services for LGBTQIA2-S community members.
7) Maternal Mental Health (MMH) Program/ Parental Perinatal Mental Health Program	This program provides specialized mental health services tailored to address the unique experiences accompanying pregnancy and parenthood. It is designed to support families that may be currently or planning to become pregnant or are post-partum for up to a year after the child's birth.
8) 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 in traditionally underserved, low income, and uninsured communities.
9) Older Adult (OA) Service Extenders (SE) Program	Service Extenders are trained volunteers who provide sensitive and culturally appropriate supportive services to Older Adults. They work with the treatment team and offer added support and advocacy for older adult consumers.
10) Prevention and Early Intervention (Older Adults)	The program's aim is to increase awareness of mental wellness for Older Adults throughout Los Angeles County, particularly among underserved and underrepresented communities.
11) Public Information Office (PIO)	LACDMH's 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 workforce; maintaining the Department's public event calendar; public service announcements; organizational branding; event promotion; graphic design and layout; marketing campaigns; and communication partnerships.
12) Spanish Support Groups (SSG)	SSG provide safe and culturally sound spaces participants to experience emotional support, companionship, and exploration of hidden talents while learning about mental health self-care.
13) Telemental Health Program (TMH)	The TMH Program provides virtual psychiatric medication evaluation and management services for clients affiliated to LACDMH clinics throughout the County of Los Angeles.

14) Therapeutic Transportation Teams (TTT)	The TTT program expands the Department's reach and impact by integrating mental health experts into the emergency response for calls that come to the 911 system, LA City Police Department, or LA City Fire Department.
15) Transition Age Youth (TAY) Navigation Team	This program assists TAY in accessing mental health and other supportive services. Navigators network with community-based organizations to coordinate social services that support the youth's recovery journey utilizing a "no wrong door" approach.

Table 2 below is a more in-depth presentation of the LACDMH Strategic Plan's goals and objectives by domain, which demonstrate the intentionality to create a sustainable cultural, linguistic, and equitable infrastructure. The strategic plan is based on the belief that mental health recovery is possible and that the leveraging of community strengths and resilience with a proactive stance will positively impact mental health outcomes. Fundamental elements of the LACDMH systemwide grounding include service accessibility enhancements, effective levels of intervention inclusive of prevention and early intervention, health integration, culturally sound and linguistically appropriate services, meaningful practices to reduce mental health stigma, removal of barriers to engagement with mental health providers, and an anti-racist as well as equitable service delivery paired by culturally-based data collection, and high-quality workforce training that highlights the past trauma, oppression and discrimination experiences of underserved communities.

See Criterion 1 Appendix for the Link to LACDMH Strategic Plan 2020-2030.

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TABLE 3: CROSSWALK OF LACDMH STRATEGIC PLAN DOMAINS WITH APPLICABLE CULTURAL COMPETENCE PLAN REQUIREMENTS (CCPR) AND CLAS STANDARDS

TABLE 3: CROSSWALK OF LACDMH SELECTED STRATEGIC PLAN OBJECTIVES WITH APPLICABLE CULTURAL COMPETENCE PLAN REQUIREMENTS (CCPR) AND CLAS STANDARDS

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence 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.		1
Community Domain	**Goal 1A Prevention Services** Prevent and/or mitigate mental health challenges by identifying individuals at risk and in need, and getting them timely access to the indicated resources	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.* <u>Strategy 1A.1: Education and Awareness</u> • Expand investments for additional public outreach campaigns ○ Promote mental health education and awareness in our communities, including a focus on school-based programs to reach children and youth and faith-based efforts • Educate communities about local resources ○ Ensure individuals know how to find help for themselves, family, children, friends and colleagues, continuing our ongoing efforts to reduce the stigma around mental illness and promote the concept of mental wellbeing <u>Strategy 1A.2: Early Identification and Engagement</u> Recognize individuals in need and provide early engagement in the community whenever and wherever possible. • Invest in community access platforms as ideal entry points to resources ○ Use homes, clinics, parks, libraries, schools, places of worship, community centers and other gathering points in local communities as platforms for	CR 1, CR 3, and CR 8 CR 1, CR 7, and CR 8 CR 7 and CR 8 CR 2, CR 3, CR 7, and CR 8	1, 9,13, and 15 8,12, and 13 8,9,11 and 15 1, 3, 5, 6, 11, 12, 13 and 15

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**

	Goal 1B **Social Support**	providing access to mental health information for children, youth, families and individuals in comfortable settings
		• 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 mental health issues and can better recognize community members (including children and youth) who may be in need, and engage them and connect them to appropriate resources
		  ○ Improve health equity through better coordinated care and community collaboration
		• 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
		  ○ Equip community access platforms to help address community trauma and promote community healing
		• Train professional staff at LA County and City agencies involved in human services
		  ○ Equip these staff members to recognize and engage children, youth and adults at risk for or experiencing mental health challenges in order to connect them to appropriate resources.
		
		Strategy 1B.1: Housing – "Place"
		Ensure safe and secure places to live and rest.
		
		• Embrace a "housing first" approach
		  ○ Provide access to housing with low barriers to entry and low demands for maintaining residency, including for transition-age youth and families with children who face mental health challenges
		• Expand interim supportive housing and related communities
		  ○ Increase options for safe, clean, organized and coordinated housing with connections to supportive social services to help transition individuals experiencing homelessness
		• Invest in a higher quantity and quality of permanent supportive housing
		  ○ Increase the number of mixed, tenant-based and board-and-care units in all communities, and ensure that all housing options include child friendly amenities
			CR 5 and CR 6
			
			CR 8
			
			CR 5 and CR 6
			
			CR 1, CR 3, and CR 8
				4, 9, 10,11, and 13
				
				9, 10, 11 and 12
				
				4
				
				9, 10, 11, 12, and 13

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
		• Evaluate the service continuum to ensure the appropriate housing supports for crossover youth from the Departments of Children and Family Services and Probation are embedded in programs ○ Pay particular attention to programs serving youth transitioning from other placements into more independent living settings • Provide for the basic human needs required to support personal recovery and community reintegration.	CR 3, CR 7 and CR 8	1, 5, 9, 11, 12, 13
	Goal 1B **Social Support**	In collaboration with other County departments, agencies and a multitude of community partners, we must address the social determinants of health for individuals living with serious mental illness, including children and youth living with a serious emotional disturbance. The basic social determinants include access to affordable and safe community housing, aka "place" (Strategy 1B.1); support from kin (including peers), family, friends, respite care providers and community members at large, aka "people" (Strategy 1B.2); and opportunities to take on meaningful community roles, aka "purpose," such as those provided through employment, education and other developmentally appropriate activities, such as play (Strategy 1B.3). When met, such efforts lay a solid foundation for recovery and wellbeing.	CR 1, CR 3, and CR 8	1, 5, 9, 11, 12, 13
		And finally, we will find ways to make sure treatment plans are completed in a timely manner and continuously updated; that high-quality care is delivered consistently across communities that are age appropriate and in a culturally competent manner. Services will be designed to do everything possible to guard against crisis, isolation, hospitalization, homelessness, prolonged or repeated involvement in the child welfare system and justice involvement.	CR 1, CR 3, and CR 8	1, 9, 10, 11, 12, 13
	Outpatient Mental Health Care Goal 1C:	<u>Strategy 1C.1: Assessment and Care Planning</u> *Identify the services and pathways needed to meet the multifaced needs of individuals.* • Emphasize a whole-person approach to assessment ○ Integrate individual's comprehensive needs including behavioral health, physical health and social support during assessments through the lens of their culture and native language. ○ For children, include developmental and educational needs. • Make care plans comprehensive and interdisciplinary	CR 5, CR 6, CR 7, and CR 8	1, 9, 10, 11, 12, 13, 15

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
		○ Identify appropriate roles for clinicians, peers, family members and individuals themselves. • Ensure that care planning is person-centered ○ Provide culturally competent assessments to ensure the individual's plan is unique to their needs, background and age particularly for children and youth.	CR 1, CR 3, CR 5, and CR 6	2, 3, 4, 7, 9, 10, 11, 12, 13, 14 and 15
		Strategy 1C.3: Outpatient Care *Ensure that our care delivery and resource coordination efforts are effective in helping those who are in need of our care to stay in community and recover from illness.* • Ensure that outpatient care teams adhere to and respect care plans and evaluations ○ Regularly assess and evaluate care plans with individuals through the lens of culture to support recovery, and staff outpatient care teams with the full range of providers, including peers ○ For children, regularly assess and evaluate treatment plans with their parents or caretakers through the lens of culture and appropriate development to support achievement of developmental and educational milestones; staff outpatient care teams with the full range of providers, including parent advocates	CR 1, CR 2, CR 3, CR 7, and CR 8	1, 9,10, 11, 12, and 13
		• Design outpatient services to ensure individuals stay in communities ○ Mitigate the risk of crises, isolation, hospitalization, homelessness, prolonged or repeated involvement in the child welfare system and justice involvement through coordinating services that are community-based and linked	CR 2, CR 3, and CR 8	1, 6, 9, 10, 11, and 13
		• Provide right-sized assertive community treatment (Full-Service Partnership) programs ○ Ensure Full-Service Partnership (FSP) programs, DMH's version of assertive community treatment, are properly staffed to deliver the most comprehensive community-based outpatient services to individuals with the greatest needs	CR 1, CR 3, CR 6, CR 7, and CR 8	9, 10, 11, and 12
		• Conduct culturally and linguistically specific outreach to engage underserved communities in understanding what 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 these communities and provide services to enhance accessibility ○ Support communities in advocating for equity of resources and services	CR 3 and CR 8	1, 9, 10, 11, and 12

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
		• Evaluate the system of care to ensure it meets the needs of the most at-risk children, youth and families engaged with the Departments of Children and Family Services and Probation		
Crisis System Domain	**Goal 2: Intensive Care**	*Create a seamless crisis response and resolution network that helps individuals to stay in community.* A robust and well-coordinated crisis response network is needed to connect with and safely triage individuals with serious mental illness who are at risk, or in the process, of deteriorating and falling out of community. This network must operate as a coherent and functionally contiguous community "guardrail" that prevents individuals of all ages from having any number of adverse outcomes such as illness-related aggression toward self or others, becoming homeless, being removed from their family or entering the criminal justice system. We must reinforce this guardrail, which includes numerous elements such as our emergency outreach and triage division working in collaboration with a bevy of first responders from County, City and other entities, various call centers and behavioral health urgent care centers as well as emergency department and residential services for crises. Aside from needing a broader workforce trained to de-escalate crisis situations and help individuals stabilize, mitigating their departure from community (Strategy 2.1), we need a massive expansion of acute, subacute and residential facilities to provide environments that can be used for intensive care episodes to resolve crises and provide connection back to community (Strategy 2.2). 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 of time, resulting in frequent hospitalization and intensive care. For them, we are building a premier program of co-located care, a network of Restorative Care Villages across LA County campuses that will be designed to deliver a treatment-intensive continuum of care and stop at nothing in providing these individuals with the best possible chance of recovery (Strategy 2.3).	CR 3, CR 5, CR 6, and CR 8	1, 2, 4, 9, 10, 11, and 12

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
		Strategy 2.1: Real-Time Crisis Response *Develop capacity to safely and respectfully resolve mental health crises around the clock in every community.* • Build a real-time, robust, well-coordinated, recovery-oriented, and client- and family-centered crisis response network. ○ Integrate high-quality crisis response services into every community and staff them with well-trained, *culturally competent* and caring first responders who work to resolve crises safely, for both youth and adults, and make every attempt to avoid the need for hospitalization.	CR 1, CR 5, CR 6, CR 7, and CR 8	1, 2, 3, 4, 9, 10, 11, and 13
Institutions Domain	Goal 3: Re-entry initiatives	*Help institutionalized individuals re-enter and re-integrate into the community.* Goals 1 and 2 of this Strategic Plan propose significant investment and fundamental changes to the system of care in LA County that, when fully realized, will dramatically reduce the number of individuals with serious mental illness and youth with a serious emotional disturbance who fall out of their community and into the institutions of deep isolation, the street, prolonged or repeated child welfare involvement, juvenile probation, and jail. Unfortunately, these interventions will take time during which we cannot ever give up on those already living in, or likely to enter, the institutions. Goal 3 is framed around aggressive strategies to safely and humanely get individuals living with serious mental illness, including youth living with a serious emotional disturbance, out of institutions and back into community, which will often require a pit stop in the hospital or other element of the Crisis System. As above, Goal 3 targets individuals who are not connected to community, were missed by the Crisis System and have fallen into deep isolation (Strategy 3.1), homelessness, prolonged or repeated child welfare involvement and/or involvement in the justice system (Strategy 3.2). A portion of these individuals will require involuntary treatment as part of their recovery journey, but we must ensure they do not languish in involuntary settings (Strategy 3.3). Strategy 3.1: Identifying and Connecting with the Deeply Isolated *Reach out to and engage individuals who are living in isolation and cut off from community.*	CR 2, CR 7, and CR 8 CR 1, CR 3, and CR 8	1, 9, 10, 11, 12, 13, and 15 1, 9, 10, 11, 12, 13, 14, and 15

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**

		• Deploy tactics for reaching out to and engaging individuals who are isolated
		  ○ Bring these individuals back into community and give them the chance to flourish, which is key to stability and successful re-entry
		• Evaluate any systemic issues within DMH that may be promoting or enabling the isolation
		  ○ Train front-line and clinical staff in cultural humility and sensitivity in order to better demonstrate empathy for increased cultural competency
		• Identify co-occurring disorders that may be further isolating individuals
		  ○ Train staff to understand the associated stigmas attached to co-occurring disorders and inter-generational trauma within the cultures represented
		  ○ Understand the various healing practices different cultural groups observe and incorporate those into how DMH delivers services
		• Identify and address the systemic issues which put children at risk for being involved in the justice and child welfare systems (e.g., early and repeated suspensions and expulsions)
			CR 1, CR 3, CR 7, and CR 8
			
			CR 5, CR 6, and CR 8
				5,6, 8,9, 10, 11, 12, and 13
				
				1, 3, 4, and 9

Infrastructure Domain	Goal 4: Organizational support	*Build the engine required to develop, implement and sustain needed change in the interest of serving our entire universe of customers including clients and families, staff, contractors and the full range of partners beyond.* Realizing all aspects of Goals 1 through 3 of this Strategic Plan will require an extraordinary amount of change. To be successful, the department must optimize its structural design, streamline its internal processes and its interface with partnering systems and assess its own performance across the board. Goal 4, therefore, frames out the key strategies for building an efficient and effective organizational engine that focuses on entrepreneurial but disciplined financing, right-sized staffing, improved contracting and contract monitoring, better use of technology and proactive approaches to space utilization as well as facilities development while always embracing principles of ongoing organizational learning and improvement – e.g., a department driven by outcomes that leverages training and many other tools to operationalize continuous quality improvement.	CR 1, CR 7, and CR 8	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**

Infrastructure Domain		Strategy 4.2: Process
		Engineer and support the core administrative processes needed to empower both internal and external customer service.
		• Streamline and improve processes for developing contracts, soliciting proposals from the community and supporting new contractors
		  ○ Build an empowered and effective network of community partners
		• Overhaul processes for recruiting and hiring new staff to enable quicker program development and to more competitively attract talented hires
		  ○ Develop improved systems for training, deployment and retention of staff to build out and maintain an effective and high-impact workforce
		• Provide premier customer service to our network of contracted community partners (e.g., legal entities)
		  ○ Recognize and elevate these contracted partners as an asset and a critical resource in our communities
		• Gather and align departmental planning and budgeting processes
		  ○ Blend the many available funding streams to support DMH's mission
		• Develop unified and coordinated processes to monitor providers' quality of service
		  ○ Include fair mechanisms for quality assurance when standards are not met and provide support as needed to proactively sustain high-quality service
			CR 5, CR 6, and CR 8
			
			CR 1, 2, 3, and 7
				4 and 9

		Strategy 4.3: Outcomes *Establish an impact-driven system characterized by listening, learning and continuous improvement.* Actively manage change throughout the Department • Enhance listening among leadership to ensure staff are efficiently, effectively and sustainably achieving strategic goals even as change is underway • Enhance multidirectional communication between DMH and key stakeholders to help inform strategies and change ○ Provide transparency through consistent communications with Service Area Advisory Committees (SAACs), Underserved Cultural Communities (UsCCs), the Faith-Based Advocacy Council (FBAC) and other critical stakeholder networks • Optimize DMH's services from the ground up with the values of a *Just Culture* and continuous quality improvement	CR 1, 3, and 7 CR 8	

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
		○ Identify and leverage outcomes to drive needed change throughout the system to better support our staff to do good work • Process consumer grievances, complaints and appeals through the lens of culture relating to the background of that individual ○ Ensure equity in the reviews to help address racial and ethnic disproportionality in access to and delivery/quality of care • Improve training and professional development to increase the skills and capabilities of departmental staff. ○ Create a true learning organization by building the capacity for staff to manage projects and improve the quality of programs and services. ○ Infuse cultural competency training in every new employee orientation. • Conduct regular and frequent staff trainings to increase their cultural competency, with a focus on staff who directly engage with clients in outpatient and inpatient settings. • Collect and utilize data to analyze service utilization by communities of color to address disparities and inequities in the system of care. ○ Conduct cultural competence assessments to better understand the demographic characteristics of communities. ○ Work to improve data collection to track and specify the cultural composition of DMH consumers beyond broad ethnic category labels, e.g., "Latino," to provide enhanced culturally specific services and valid, relevant outcomes. • Translate key documents for DMH consumers into the top 15 languages spoken in LA County to capture the elements of culture ○ Ensure documents like consent for services, treatment plans and assessments are widely available in-language and capture culturally specific details that will help enhance the delivery of care to the consumer.		
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	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
	Goal IB - Social Support	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.	CR 3, CR 5, CR 6, CR 7, and CR 8	1, 3, 4, 5, 6, 7, 8, 9, and 10
	1C – Outpatient Mental Health Care	Deliver welcoming, enriched and easily accessible services that are responsive to evolving needs to keep individuals living in communities and to sustain recovery. To ensure that we are delivering the highest-quality outpatient mental health care, we will involve our clients, including parents of children, in decision-making and optimize our clinical assessment and interdisciplinary care planning to address the needs of people in a holistic manner (Strategy 1C.1). We will also enhance the coordination of the care being delivered through DMH with other needed services and resources from other agencies in order to build up integrated and personalized foundations for recovery (Strategy 1C.2). And finally, we will find ways to make sure treatment plans are executed in a timely manner and continuously updated; that high-quality care is delivered uniformly across communities for all ages and in a culturally competent manner; and that services are designed to do everything possible to guard against crisis, isolation, hospitalization, homelessness, prolonged or repeated involvement in the child welfare system and justice involvement (Strategy 1C.3).	CR 1, CR 3, CR 7, and CR 8	1, 2, 3, 4, 9, and 10
	Goal 3 – Re-entry Initiatives	Help institutionalized individuals re-enter and re-integrate into the community Goals 1 and 2 of this Strategic Plan propose significant investment and fundamental changes to the system of care in LA County that, when fully realized, will dramatically reduce the number of individuals with serious mental illness and youth with a serious emotional disturbance who fall out of their community and into the institutions of deep isolation, the street, prolonged or repeated child welfare involvement, juvenile probation, and jail. Unfortunately, these interventions will take time during which we cannot ever give up on those already living in, or likely to enter, the institutions. Goal 3 is framed around aggressive strategies to safely and humanely get individuals living with serious mental	CR 1, CR 3, CR 7 and CR 8	1, 5, 6, 9, 10, 11, 12, and 13

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
	Goal 4 – Organizational Support	illness, including youth living with a serious emotional disturbance, out of institutions and back into community, which will often require a pit stop in the hospital or other element of the Crisis System. As above, Goal 3 targets individuals who are not connected to community, were missed by the Crisis System and have fallen into deep isolation (Strategy 3.1), homelessness, prolonged or repeated child welfare involvement and/or involvement in the justice system (Strategy 3.2). A portion of these individuals will require involuntary treatment as part of their recovery journey, but we must ensure they do not languish in involuntary settings (Strategy 3.3). Build the engine required to develop, implement and sustain needed change in the interest of serving our entire universe of customers including clients and families, staff, contractors and the full range of partners beyond. Realizing all aspects of Goals 1 through 3 of this Strategic Plan will require an extraordinary amount of change. To be successful, the department must optimize its structural design, streamline its internal processes and its interface with partnering systems and assess its own performance across the board. Goal 4, therefore, frames out the key strategies for building an efficient and effective organizational engine that focuses on entrepreneurial but disciplined financing, right-sized staffing, improved contracting and contract monitoring, better use of technology and proactive approaches to space utilization as well as facilities development while always embracing principles of ongoing organizational learning and improvement – e.g., a department driven by outcomes that leverages training and many other tools to operationalize continuous quality improvement.	CR 1 and CR 8	1, 2, 3, 4, 9, and 10
Addendum C	Active Tactics Goal 1– – Prevention Services - *Active Tactics* Goal 4 – Organizational	Expanding the Promotores de Salud Mental (Spanish Speaking) and the Mental Health Promoters (Multicultural and Multilingual) Programs: These programs provide specialized mental health prevention services in the community by trained community residents familiar with the language and culture.	CR 3, CR 7, and CR 8	1, 2, 3, 5, 7, 8, 10, 12, 13, and 15

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
	Support – Active Tactics	Build the engine required to develop, implement and sustain needed change in the interest of serving our entire universe of customers including clients and families, staff, contractors and the full range of partners beyond. Realizing all aspects of Goals 1 through 3 of this Strategic Plan will require an extraordinary amount of change. To be successful, the department must optimize its structural design, streamline its internal processes and its interface with partnering systems and assess its own performance across the board. Goal 4, therefore, frames out the key strategies for building an efficient and effective organizational engine that focuses on entrepreneurial but disciplined financing, right-sized staffing, improved contracting and contract monitoring, better use of technology and proactive approaches to space utilization as well as facilities development while always embracing principles of ongoing organizational learning and improvement – e.g., a department driven by outcomes that leverages training and many other tools to operationalize continuous quality improvement.	CR 1, CR 3, CR 6, and CR 8	1, 2, 3, 4, and 9
Addendum D	**Goal 1A - Prevention Services**	Prevent and/or mitigate mental health challenges by identifying individuals at risk and in need and getting them timely access to the indicated resources. Consistently identifying people in need and providing expedient navigation to resources requires a comprehensive approach. We will continue expanding public campaigns to promote greater awareness and understanding of suffering and mental health in communities (Strategy 1A.1). In addition, through focused training across our communities, people experiencing mental health issues and/or suffering in life will be more readily identified so we can help get them to needed resources (Strategy 1A.2). To this end, the navigation, coordination and follow-up across our system must be improved to ensure that individuals of all ages, families and communities get the resources they want and need (Strategy 1A.3). And every strategy will be viewed through the lens of culture to ensure we are providing outreach and engagement that takes into consideration individuals' cultural backgrounds and linguistic needs. Provide for the basic human needs required to support personal recovery and community reintegration.	CR 1, CR 2, CR 3, CR 6, and CR 8	1, 2, 5, 6, 7, 9, 10, 11, 12, 13, and 15

Sections	Goal/Strategy/ Appendix	LACDMH Cultural Competence Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
	Goal 1B – Social Support	In collaboration with other County departments, agencies and a multitude of community partners, we must address the social determinants of health for individuals living with serious mental illness, including children and youth living with a serious emotional disturbance. The basic social determinants include access to affordable and safe community housing, aka "place" (Strategy 1B.1); support from kin (including peers), family, friends, respite care providers and community members at large, aka "people" (Strategy 1B.2); and opportunities to take on meaningful community roles, aka "purpose," such as those provided through employment, education and other developmentally appropriate activities, such as play (Strategy 1B.3). When met, such efforts lay a solid foundation for recovery and wellbeing.		
	Goal 1C – Outpatient Mental Health Care	Deliver welcoming, enriched and easily accessible services that are responsive to evolving needs to keep individuals living in communities and to sustain recovery. To ensure that we are delivering the highest-quality outpatient mental health care, we will involve our clients, including parents of children, in decision-making and optimize our clinical assessment and interdisciplinary care planning to address the needs of people in a holistic manner (Strategy 1C.1). We will also enhance the coordination of the care being delivered through DMH with other needed services and resources from other agencies in order to build up integrated and personalized foundations for recovery (Strategy 1C.2). And finally, we will find ways to make sure treatment plans are executed in a timely manner and continuously updated; that high-quality care is delivered uniformly across communities for all ages and in a culturally competent manner; and that services are designed to do everything possible to guard against crisis, isolation, hospitalization, homelessness, prolonged or repeated involvement in the child welfare system and justice involvement (Strategy 1C.3).	CR 1, CR 2, CR 3, CR 5, CR 6 and CR 8	1, 2,3, 4, 6, 7, 9, 10, 11, 12, 13, 14, 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. Practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities.

Specifications for this section can be found under the heading *"II. County Recognition, Value, and Inclusion of Racial, Ethnic, Cultural and Linguistic Diversity within the System"* in reference to LACDMH's Strategic Plan and descriptions of programs under the Community domain:

- Seven Underserved Cultural Community subcommittees
- Faith-Based Advocacy Council
- Community Ambassador Network (CAN)
- Promotores de Salud Mental and United Mental Health Promoters (UMHP) Programs
- Speakers Bureau
- Spanish Support Groups

B. Involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in LACDMH's planning process for services.

Specifications for this section can be found under the heading *"II. County Recognition, Value, and Inclusion of Racial, Ethnic, Cultural and Linguistic Diversity within the System"* in reference to LACDMH's Strategic Plan and descriptions of programs under the Community domain. Specifically,

- Cultural Competency Committee
- Underserved Cultural Communities Subcommittees
- Mental Health Commission
- Community Leadership Team
- Service Area Leadership Teams

C. New Cultural Inclusive and Responsive Initiatives

LACDMH made significant advances in the areas of service accessibility, inclusiveness of the culturally diverse communities in LA County, provider capacity development, language justice, and revamping its stakeholder platform, partnership establishment with Community-Based Organizations, collaborations with sister health departments and other LA County departments, and actively engaging with the Los Angeles County Board of Supervisors. Collectively, these efforts have bolstered the concerted endeavors of all programs previously described to the stigma and barriers that perpetuate service inequities and mental health disparities. Below is a brief overview of selected systemwide initiatives and activities for FY 22-23:

1. Board-Directed Priorities
   LACDMH has been actively engaged with the LA County Board of Supervisors in advancing, enhancing, and improving the scope, magnitude, and fiscal sustenance of several areas of departmental operations. Board-

directed priorities are communicated via Board Motions, which specify focal areas and reporting expectations. Board Motions also inform future direction, goals, and strategies of the programs related to the priorities. Additionally, these Board Motions facilitated internal and cross departmental collaborations with other LA County Departments.

The Board-Directed Priorities for FY 22-23 concentrated on services to children and family, gender health, gender affirming health care, Latino mental health, and women. *See table 1 for detailed information and the links to each Board Motion.*

2. Gender Impact Assessment (GIA) Project
As a methodology, the GIA Project helped LACDMH improve its understanding of different community needs and experiences, specifically related to gender, race/ethnicity, and age, as well as other social-demographic variables. LACDMH committed to participating in the GIA multi-year plan and identified key programs to join the cohort along with other LA County Departments. The cohort explored current gender imbalances, examined policies and procedures, consumer demographic data collection practices, programming, and the impact of service delivery on the communities served, its workforce and leadership.

Four LACDMH's programs participated in the cohort: Enhanced Emergency Shelter Program (EESP) TAY Navigation Team, EESP contracted TAY Drop-In Centers, Men's Community Reintegration Program (MCRP), and Women's Community Reintegration Program (WCRP). Additionally, the Prevention and Child Wellbeing Administration and ARISE Division management were key participants in the series of meetings to begin the collaborative implementation of most immediate identified actions. The first two priority areas included a comprehensive sexual orientation and gender identity (SOGI) data collection paired with training staff on how to effectively enhance this data collection in a culturally sensitive manner.

As a result, LACDMH has expanded SOGI data to include the following identifiers in consumer demographic data collection: (1) Gender Identity, (2) Sex at Birth, and (3) Sexual Orientation in its Electronic Health Record System known as Integrated Behavioral Health Information System (IBHIS). Training resources made available to staff included:

- SOGI Concepts and Terminology
- How to Ask About SOGI
- SOGI – Pronouns and Why They Matter
- The Ins and Outs of SOGI Data Collection
- SOGI Sexual Orientation Gender ID

3. Enhancements to the Promotores de Salud Mental and the UMHP Programs
These programs exemplify enhancements to the LACDMH workforce by incorporating the voice and talents of natural leaders, and persons with lived experience and/or shared experience. The Promotores de Salud Mental and UMHP Programs aim to address the stigma associated with mental illness in underserved cultural and linguistic communities in Los Angeles County. The most recent additions to the programs' objectives include a specific focus on older adults pertinent to mental health issues, eliminating barriers, and improving access to culturally and linguistically appropriate care and resources.

4. Recruitment and Hiring of New Employees across Multiple Functions
Workforce enhancement and targeted hiring of various staff functions by the Human Resource Bureau in collaboration with programs with vacancies totaling 1,054 employees during FY 22-23. These positions include administrative (e.g., accounting-related, financial workers, procurement aids, safety assistants, staff analysts, health program analysts, warehouse workers); clerical/support (e.g., administrative assistants, secretaries, intermedia typist clerks, supervising typist clerks,); clinical (e.g., mental health clinicians, psychologists and supervising psychologists, nurse practitioners, registered nurses, psychiatric technicians, substance abuse counselor); clinical support (e.g., medical case workers, community health workers, occupational therapists); management (e.g., program managers I, II, III and IV, management analyst); and psychiatrists as a special concentrated effort. Another accomplishment was the filling of executive positions such as the DMH Director and the Chief Peer Services positions.

5. Cal Aim Behavioral Health Initiative
LACDMH implemented the Cal Aim Initiative in support of integrated care; service accessibility; and systemwide improvements for outcomes, reduction of behavioral health disparities, and behavioral health payment reform. The rollout of the Cal Aim multi-year transformation started in July 2022 and it has impacted the Department's conceptualization of medical necessity criteria, documentation redesign, integration of substance use disorders, and removal of barriers by adopting a "no wrong door" in connecting with the Department, and shift from by the minute claims to a reimbursement rate system based on the Current Procedural Terminology coding system.

6. Language Assistance Services (LAS) Unit
The ARISE Division has implemented a LAS Unit to process systemwide requests for language accommodations. This effort is significant to ensure the Department's commitment to meet the linguistic needs of consumers and family members served as well as the inclusion of the community at large in its stakeholder progress. Another impactful LAS Unit operation is

the coordination of American Sign Language (ASL) clinical appointments for directly operated and legal entity/contracted providers. Additionally, the LAS team processed requests for language accommodations for 23 different meetings, including threshold language interpreter, ASL, and Closed Captioning in Real Time (CART) services.

7. Sign Language Interpreter positions in LACDMH Workforce
   To augment LACDMH's capacity to serve the Deaf and Hard of Hearing community, the ARISE Division developed the infrastructure to hire its first Sign Language Specialist in the history of the Department. The position was approved to be under the ARISE Division – CCU and the Language Assistance Team. The addition of this position in the system of care will result in an effective way to address clinical appointments not fulfilled due to vendor unavailability, urgent and emergency ASL-facilitated clinical appointments, and stakeholder group meetings.

8. MHSA Outreach and Engagement (O&E)
   MHSA allocated funding dedicated to unserved, underserved, and inappropriately served ethnic populations who are un-insured or un-insurable across age groups (children, transitional youth, adult, and older adult) consistent with the language and cultural needs and demographics of communities. The funding was provided to the Service Area Leadership Team (SALT) Liaisons, the seven UsCC subcommittees, Outreach Workers (WOW) Program and the Countywide Client Activity Fund (CCAF). Key activities covered by the MHSA O&E included: service area specific mental health information events with over 20,000 participants. Among them are job fairs, veteran events, and community events at local senior centers, colleges, and libraries.

9. Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) Learning Collaborative
   In October 2022, DMH joined the Solano County Department of Health and Social Services – Behavioral Health Division and the University of California – Davis' ICCTM, designed to improve access to quality mental health services and to decrease health disparities and inequities that occur in underserved populations. DMH's ICCTM project engaged the participation of various key stakeholder groups. Among them, the UsCC and the CCC highlighted a small number of communities of focus to receive intensive, targeted interventions. For LA County, the Asian Pacific Islander (API) and Persons with Disabilities communities were identified as the most in need of support during the designated project duration.

10. Crisis Residential Treatment Programs (CRTP) are designed to provide short-term, intensive, and supportive services in a home-like environment through an active social rehabilitation program that is certified by the California Department of Health Services and licensed by the California

Department of Social Services, Community Care Licensing Division. They are designed to improve the lives and adaptive functioning of consumers by providing a vast array of services including self-help skills, peer support, individual and group interventions, social skills, community re-integration, medication support, cooccurring services, pre-vocational/ educational support, and discharge planning.

11. ARISE Leadership Transformation Training
    The ARISE Staff Advisory Council in collaboration with LACDMH's ARISE Division and Training Unit developed the framework for the "Advancing Racial Equity System Change: Leadership Transformation" training series to be rolled out in FY 23-24. The overarching training goal is to train DMH leadership to effectively address anti-Black racism and other forms of oppression in order to cultivate a safer and enriching workplace environment. Sample training content includes the historical foundations of anti-Black and anti-AI/AN racism, practices aimed at dismantling institutional racism, and anti-racist and trauma-informed leadership, supervision, and service provision.

D. Skill development and strengthening of community organizations involved in providing essential services

LACDMH recognizes that service delivery must be informed and enriched by the expertise of Community Based Organizations; innovative programming funded by the MHSA; a systematized approach to circulating information regarding quality assurance as well as training opportunities to equip the workforce from Directly Operated, Legal Entities and Contracted providers with the latest advancements in the mental health field. The section summarizes these specific efforts.

1. Incubation Academy
   The Incubation Academy is a capacity-building project in collaboration with Community Partners. The project provides mentorship, training, technical support, and financial resources for small and mid-sized grassroots community-based organizations (CBOs) interested in providing prevention services to the County's most vulnerable residents. The organizations vary in their programming and target population as the goal is to prepare such organizations to compete for future contracting with DMH. During FY 22-23, a total of 28 organizations participated in the Incubation Academy.

2. 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, which is considered an important complement to the information provided in the 2024 Cultural

Competence Plan Report. See Criterion 1 Appendix for additional information.

3. 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 diversity elements. See Criterion 5 for detailed information.

4. Systematized Quality Assurance Information
   LACDMH's Quality Assurance Unit is responsible for on-going and up-to-date systemwide communication to ensure knowledge and adherence by Directly-Operated and Legal Entities/Contract providers to County, State, and Federal requirements with regards to Medi-Cal certification and credentialing of providers, Specialty Mental Health Services (SMHS) delivery; relevant policies; Network Adequacy and Access-to-Care performance; provider support for accurate documentation and claiming of Medi-Cal SMHS; and clinical records' management.

SAPC Recognition, Value, and Inclusion of Racial, Ethnic, Cultural and Linguistic Diversity within the System

SAPC recognizes and aligns its commitment to the communities, stakeholders and the residents of Los Angeles County with the Strategic Plan which serves as the Bureau's roadmap to developing, navigating and maintaining diverse, equitable, inclusive, and responsive services.

SAPC Vision: All people and communities in Los Angeles County have a chance to pursue their dreams and fulfill their promises without the burden of substance use and addiction.

SAPC Mission: To lead and facilitate the delivery of a comprehensive continuum of innovative, equitable, and quality-focused substance use prevention, harm reduction, treatment, and recovery services that effectively engages and supports individuals and communities.

SAPC Values:

- **Leadership -** We share an inspiring vision and clear priorities, we anticipate future challenges, take action that affects positive change in the lives of individuals and their communities, and in the County.

- **Partnership and Engagement -** We value collaborations with the community, stakeholders, and the public we serve by actively listening to understand needs and how they want to engage.
- **Integrity –** We are dedicated, honest, transparent, and trustworthy in all that we do.
- **Expertise -** We have the knowledge, insight, and expertise to do what we do with utmost quality and professional rigor, and the commitment to continually grow and improve.
- **Program and Service Excellence -** We are respectful, culturally relevant, and effective in the delivery of excellent service with dignity and compassion.
- **Accountability –** We share a responsibility to those we serve to ensure the delivery of effective and responsive care in accordance with recognized standards and continuous quality improvement.
- **Health Equity -** We are committed to ensuring that all people have equitable access to services that increase opportunities for living at optimal health and well-being.

In pursuing its mission and vision, SAPC identified four key priorities and cross cutting strategies (***see figure 1: Key Priorities and Cross-Cutting Strategies***) that support advancement of countywide substance use transformation that is grounded in ensuring diversity, equity and inclusion in all facets of its prevention, harm reductions, treatment, and recovery portfolio.

Figure 1: Key Priorities and Cross Cutting Strategies

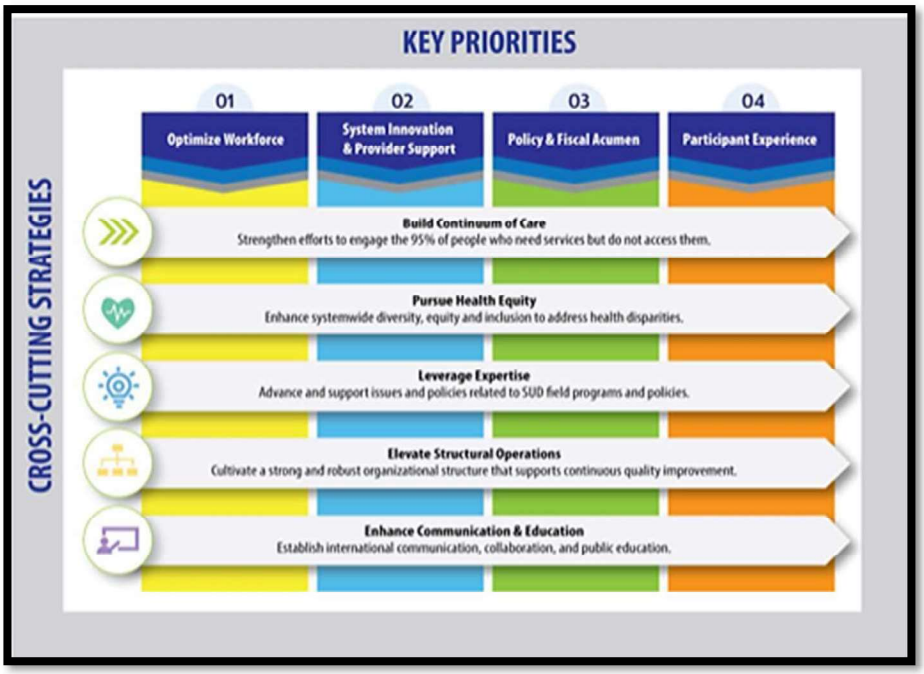


Table 4 below provides a more detailed presentation of the goals and objectives of the SAPC's Strategic Plan by Division, highlighting the intentional effort to create a sustainable cultural, linguistic, and equitable infrastructure. The strategic plan is rooted in

the belief that substance use recovery is possible, and that leveraging community strengths and resilience through a proactive approach will positively influence behavioral health outcomes.

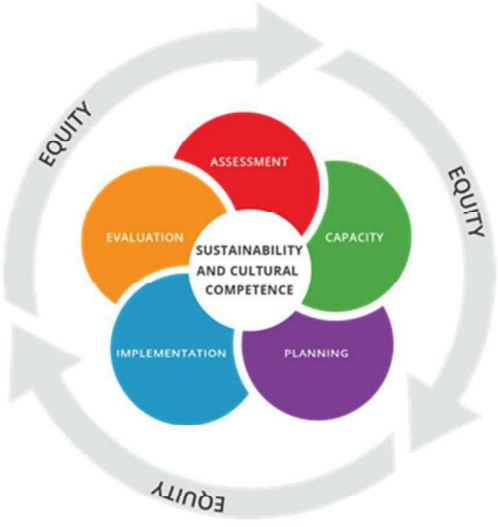
Key components of the SAPC's systemwide framework include: Enhancing service accessibility, providing effective levels of intervention, including prevention and early intervention, integrating health services, offering culturally and linguistically appropriate care, implementing meaningful practices to reduce the stigma surrounding substance use, removing barriers to engaging with behavioral health providers, delivering anti-racist and equitable services, utilizing culturally-based data collection, and offering high-quality workforce training that addresses the trauma, oppression, and discrimination experienced by underserved communities. *See Criterion 1 Appendix for the Link to the SAPC Strategic Plan 2023-2028.*

In addition, SAPC maintains and regularly updates its primary prevention strategic plan. As a requirement of the SUBG Primary Prevention Set-Aside, SAPC Prevention Services Division developed a five-year substance abuse Strategic Prevention Plan (SPP). The purpose of the SPP is to define the steps necessary to achieve SAPC's vision, mission, and goals.

Priority areas are identified in the plan and strategies are selected based on evidence, where applicable, that will best address the priority areas and populations being served. The Fiscal Year 2020-2025 SPP is consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF) process.

The SPF offers practitioners a comprehensive approach to understanding and addressing the substance misuse and related behavioral health problems facing their communities, and to developing and sustaining programs and practices that reduce behavioral health inequities. The SPF includes these five steps:

- Assessment
- Capacity
- Planning
- Implementation
- Evaluation



The SPF is also guided by principles that should be integrated into each of its five steps:

- Cultural competence
- Sustainability

See Criterion 1 Appendix for the Link to the SAPC Strategic Prevention Plan 2020-2025.

TABLE 4: CROSSWALK OF SAPC STRATEGIC PLAN WITH APPLICABLE CULTURAL COMPETENCE PLAN REQUIREMENTS (CCPR) AND CLAS STANDARDS

Priority	Goal	SAPC Cultural Competence Related Content	CCPR Criterion (CR) 1-8	CLAS Standard
Key Priority 1: Optimize Workforce Build and retain a robust, talented, and culturally responsive workforces that is capable of carrying out SAPC's mission	Goal 1.1: Pursue Workforce Excellence	Develop strategies to ensure a diverse and inclusive workforce that is culturally responsive (reflective of population, people with lived experience, language, etc.	CR 1 CR 6 CR 7	1, 3, 4, 7
		Develop strategies to achieve appropriate compensation and increase the quantity, quality, and diversity of SUD counselors and licensed clinicians in the provider network.	CR 1 CR 6 CR 7	1, 2, 3, 4, 9
Key Priority 2: System Innovation & Provider Support Drive Innovation and data driven decision-making to support the SAPC network providers in addressing the needs of community members.	Goal 2.2: Advance data-driven decisions	Improve the collection and reporting of data to better identify disparities and address inequities in services and treatment outcomes.	CR 1 CR 2 CR 3 CR 7	1, 10, 11, 12, 15
		Establish and implement data strategies that inform decisions to ensure equitable access to evidence-based prevention, harm reduction, treatment, and recovery services.	CR 1 CR 3	10, 11, 12, 15
Key Priority 3: Policy and Fiscal Acumen Provide leadership in policy and insight in valued-based care driving fiscal preparedness and accountability.	Goal 3.1: Develop strategies to keep pace with evolving changes in managed care.	Advance upstream risk reduction, harm reduction, and treatment policies	CR 1	1, 13,
		Strengthen relationships with managed care plans and develop and operationalize approaches towards Behavioral Health Administrative Integration that improves care coordination between substance use and mental health systems.	CR1 CR3	1, 2,13
	Goal 3.2: Establish sustainable fiscal strategies that equitably incentivize positive outcomes that benefit people and communities served	Develop and monitor effective fiscal strategies to incentivize high quality care and services.	CR 1	1, 9, 15

Priority	Goal	SAPC Cultural Competence Related Content	CCPR Criterion (CR) 1-8	CLAS Standard
	3.3: Prioritize local and state policies that advance system changes through advocacy, legislation, regulatory review and shaping policy	Explore policies that enhance the scope and reach of existing harm reduction approaches	CR 3	1, 9, 10, 13
		Advance prevention approaches and policies that protect youth, promote public health, advance social equity, and mitigate harms from legalization of commercial cannabis	CR 1, 3, 8	1, 5, 8
	implementation to accelerate SUD prevention, harm reduction, treatment, and recovery needs	Establish policy strategies that advance social, racial, economic, and geographic equity and promote SUD within a behavioral health framework.	CR 1, 3, 8	1, 2, 9. 13
Key Priority 4: Participant Experience Secure and establish a continuum of services that is community and participant centered	Goal 4.1: Improve access to quality prevention, harm reduction, treatment, and recovery services	Ensure coordinated access and availability of evidence-based, culturally responsive, linguistically and developmentally appropriate services.	CR 3 CR 7	1, 5, 6, 9, 12,
		Establish quality improvement processes that enhance operational, administrative, and programmatic processes to support quality service delivery.	CR 4	1, 2, 9
	Goal 4.2: Foster greater understanding and awareness of SUD	Expand awareness of SAPCs prevention, harm reduction, treatment, and recovery service continuum particularly among disproportionately impacted communities and populations.	CR 5 CR 7 CR 4	1, 2, 3, 5, 6, 8, 13, 14
		Mainstream harm reduction and safer use practices to increase adoption and community and provide acceptance and engagement	CR 5 CR 4	1, 13
		Ensures client access to, and a common understanding of, culturally and linguistically appropriate services including availability of translation services and development of new programs specifically designed to meet the needs of patients with limited-English proficiency, physical disabilities, and complex health needs.	CR 7	5, 6, 8, 13

A. Practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with substance use disorder disparities.

- Committee on Cultural Competence and Humility
- Methamphetamine Treatment and Prevention Committee
- Provider Advisory Committee
- Community Opportunities for Recovery and Empowerment

B. Cultural Inclusive and Responsive Initiatives

1. CLAS ACT

   Health inequities in our county are well documented and have been exacerbated over the last two years due to the pandemic and an associated rise in healthcare needs in both physical and behavioral health. Unfortunately, the increased need has not been met with an increase in access. Historically, communities of color are hit the hardest and have poor health outcomes because of healthcare inequities.

   The Culturally and Linguistically Appropriate Services Access to Coaching and Training (CLAS ACT), provides dedicated training and technical assistance to support providers in building the knowledge base and foundation so CLAS can thrive at their agencies and supports development and implementation of SAPCs CLAS action plan.

2. CalAIM Behavioral Health Initiative

   The California Advancing Innovation in Medi-cal (CalAIM) substantially transforms behavioral health systems to support better integrated care, service accessibility; and systemwide improvements for outcomes, reduction of behavioral health disparities, and of behavioral health payment reform. SAPC has been engaged in implementing various CalAIM equity efforts such as this collaboration with LACDMH to integrate the cultural competence plan, partnerships with managed care plans, and establishing payment reform strategies that support equitable access to services.

3. SAPC Outreach and Engagement (O&E)

   SAPC has appointed outreach staff to carry out community outreach and engagement activities focused on substance use disorder. The outreach and engagement staff are well-acquainted with their specific Service SPAs and effectively collaborate with community organizations such as schools, churches, social service agencies, and local groups. They help bridge the gap between SAPC and communities that may not seek SUD services. Leveraging their diverse cultural and linguistic backgrounds, they deliver presentations to reduce stigma and clarify SUD services. Additionally, they organize community events and take part in health fairs. The outreach staff also inform community members about how to access available services from SAPC.

C. Skill development and strengthening of community organizations involved in providing essential services

1. Cultural Competence Trainings
   SAPC provides a wide range of cultural competence training aimed at enhancing the workforce's cultural awareness, understanding, sensitivity, responsiveness, multicultural knowledge, and cross-cultural skills, which are vital for effectively serving our diverse communities. The trainings developed by the Training Unit, CIBHS, and CST include various aspects of cultural competence. Below are some examples:

   - ADA Fundamentals & Service Animals
   - Servicing the Deaf and Hard of Hearing Community
   - Designing Welcoming Spaces for ADA Accessibility
   - Increasing your reach through ADA Accessible websites
   - Navigating the Historical Tapestry of Black Experiences
   - Culturally Responsive Service Design
   - Culturally Responsive Care for Black Men
   - Culturally Responsive Care for Black Children and Youth
   - Culturally Responsive Care for Black Women & Mothers
   - Language Assistance and Oral Interpretation Add-On Rate

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 ARISE Division - 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 ARISE 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 2023:

- Development of new or revisions of departmental policies and procedures (P&P) related to cultural and linguistic competence:
  - P&P 200.02 – Interpreter Services for the Deaf and Hard of Hearing Community
  - P&P 200.03 – Language Translation and Interpreter Services (Revision)
  - P&P 200.09 – Culturally and Linguistically Inclusive Services (Revision)
- Lead for the development of annual LACDMH Cultural Competence Plans
  - Delivery of in-services and providing support for programs featured in the report

    - Feedback on DHCS' draft of new requirements for Behavioral Health Equity Plan report
- Departmental lead for cultural competence during the triennial Medi-Cal Reviews and the annual EQRO Site Reviews
- Development and implementation of two consumer satisfaction forms for Language Assistance Services the ASL Service Satisfaction Survey (SSS) and the Language SSS
- Development and delivery of trainings on cultural competence, cultural humility, and implicit bias, at various departmental venues and the community at large
- Oversight for the conduction of the cultural competence organizational assessments, informing executive management of outcomes, and addressing knowledge gaps in the workforce
- Implementation of initiatives that advance the Department's commitment to anti-racism and cultural diversity-focused work via strategic cultural and linguistic competence within the system of care, inclusive of planning and implementation of the ARISE 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
- Oversight of the coordination, delivery, data collection, and reporting of Language Assistance Services (LAS) 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
- Lead for the LACDMH Speakers Bureau (SB) and overseeing the processing of requests received from the community at large and the system of care
    - Spanish translations for Public Information Office (PIO) media campaign messaging
    - Speaker for LACDMH media campaigns on Spanish TV and radio
    - Subject Matter Expert for the development of mental health content for media campaign for the Latino community
    - Chairing of quarterly SB meetings
- Lead for the Spanish Support Groups
    - Development of the "Manual of Empowerment Tools for Leaders of Spanish Support Leaders"
- Participation in state cultural competence projects with ESMs from other counties in Southern California
- Administrative oversight of the Cultural Competency Committee (CCC) activities
- Lead for anti-racism and cultural diversity-focused community events in collaboration with CCC, stakeholder groups, and SA Chiefs
    - Latino Heritage Month
    - Black History Month
    - May is Mental Health Month

    - Spanish Support Groups End of Year Event 2023
- Participation in Stakeholder Engagement Platform efforts
- Oversight and writing of articles on various informative topics for the CCC's Cultural Traditions and Connections Column featured in the Hello DMH newsletter. The ESM's article contributions include:
    - Latino Heritage Month
    - 2023 Cultural Competence Plan
- Delivery of technical assistance and training to diverse LACDMH programs regarding cultural competence in general, CCPR compliance, and procedures for language translation and interpreter services
- Participation in the Departmental Quality Improvement Council meetings as a standing member to provide updates related to the ARISE-CCU as well as presentations on the CCC projects and activities
- Representation of the ARISE-CCU in various departmental committees such as UsCC and CCC Leadership Group, FBAC and SALT
- Collaboration with LACDMH executive management, LACDMH programs/Units management and stakeholder groups to increase the accessibility of mental health services to underserved communities
- Collaboration with the Southern Region ESMs and representing LACDMH in the County Behavioral Health Directors Association of California Cultural Competency, Equity and Social Justice Committee.

SAPC Cultural Competence staff responsible for cultural competence

Cherene Cexil is the Equitable Access and Promotions Section (EAPS) manager and is the "acting" co-chair for the Committee on Cultural Competence and Humility (C3H). EAPS actively collaborates with other SAPC Divisions, LACDMH, and its provider network to achieve the diversity, equity, and inclusion goals. In her role, Cherene has administrative oversight of the Committee on Cultural Competence and Humility (C3H), language assistance services, progressing the CLAS action plan, and ensuring that CLAS Standards and supporting recommendations to integrate cultural competence into service planning, delivery, and evaluation, including those outlined int SAPCs strategic plan.

IV. LACDMH Budgetary Allocations for Cultural Competence Activities, FY 22-23

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

- $58,000 for Specialized Foster Care trainings
- $36,750 for juvenile justice trainings
- $39,910 for culture-specific trainings focusing on underserved populations
- $80,000 for interpreter trainings

Language Assistance Services

During FY 22-23, LACDMH continued providing and expanding the band of language assistance services as follows:

- $208,217.00 for language interpreter services, which allow consumers, family members, and the community at large to participate in various departmental meetings and conferences
- $5,687.69 for ARISE Division's language translation services provided for consumer, family members and community at large participation in stakeholder meetings
- $24,797.50 for Closed Captioning in Real Time (CART) services
- $41,317.50 for ASL services
- $288,669.56 for countywide translation services
- $15,149,357.00 for Substance Abuse and Mental Health Services Administration (SAMHSA) Community Mental Health Block Grant
- $5,613,871.00 for Community Mental Health Services Block Grant (MHBG) American Rescue Plan Act (ARPA)

MHSA Plan-Specific projected budget allocations

A sizable amount of funding is dedicated to 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 22-23

Programs	Funding
CSS Programs	
1. Full-Service Partnerships	$115,915,000
2. Outpatient Care Services	$192,090,000
3. Alternative Crisis Services	$138,993,000
• *Residential and Bridging Care (RBC) Program*	
• *Psychiatric Urgent Care Centers*	
• *Enriched Residential Services (ERS)*	
• *Crisis Residential Treatment Programs (CRTP)*	
• *Law Enforcement Teams (LET)*	
• *Restorative Care Villages*	
• *Psychiatric Mobile Response Teams (PMRT)*	

Programs	Funding
4. Planning Outreach & Engagement	$4,458,000
5. Linkage Services	$44,479,000
6. Housing Services • *Housing Supportive Services Program* • *Intensive Case Management Services Program* • *Housing for Mental Health* • *Housing Assistance Program* • *Enriched Residential Care Program* • *Interim Housing Program – Adults* • *Enhanced Emergency Shelter Program - TAY**	$45,289,000
Total CSS Program Expenditures	$233,219,000
PEI Programs • *Suicide Prevention* • *Stigma Discrimination Reduction* • *Prevention* • *Early Intervention* • *Call Center Modernization, Phase 2*	 $5,682,000 $21,301,000 $85,010,000 $34,218,000 $3,500,000
Total PEI Program Expenditures	$149,711,000
Total Gross Expenditures INN Programs	$15,600,000
Total Gross Expenditures WET Programs	$17,200,000
Total Gross Expenditures Capital Facilities/Technology Needs • *LAC + USC Crisis Residential Treatment Programs (CRTP)* • *Rancho Los Amigos CRTP* • *Olive View CRTP* • *Olive View Medi-Urgent Care Center* *Olive View Mental Health Wellness Center* • *Martin Luther King Child and Family Center*	$22,800,000
Grand Total MHSA Expenditures across all Plans	$438,530,000

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

V. 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, FY 22-23

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 ARISE Division with inclusion of the CCU, Promotores and UMHP program, Speakers Bureau, and Spanish Self-Help Groups • Comprehensive budget allocations for cultural competence activities • Implementation of the "Sexual and Gender Diversity" Parameter to guide the provision of gender and sexuality affirming services • Culture and language-specific outreach and engagement • Implementation of community-based ARISE events focusing on different aspects of cultural diversity
2. Governance and leadership promoting CLAS	1, 4, 5, and 6	• Revamping of the Stakeholder Engagement Platform • Incorporation of the CLAS standards, CCPR, and departmental Strategic Plan in CC Plan reports • Policies and procedures revisions to 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	• 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 across multiple functions • Development of paid employment opportunities for peers and persons with lived and shared experience • Hiring of LACDMH's first Sign Language Specialist • Hiring of the Chief of Peer Services

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• Implementation of LGBTQIA2-S Champions Network
4. Train governance, leadership, and workforce in CLAS	1 and 5	• Accessible cultural competence trainings • Development of the ARISE Transformation Leadership Training for Management and Supervisors • 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
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 • Implementation of the ARISE Division-LAS Unit for countywide coordination of language accommodations including ASL clinical appointment scheduling for Directly Operated and Legal Entities/Contracted providers • Tri-departmental collaboration to enhance DPH's Language Assistance Services Master Agreement (LASMA) scope
6. Availability of language assistance	7	• Monitoring the LACDMH 24/7 Help Line's language assistance operations • Hiring and retention of bilingual certified staff • Language accommodations (threshold language and ASL interpreters, closed captioning transcription, and translation) for consumers, family members and community members to participate in LACDMH's CCC, UsCC, SALT and other stakeholder meetings • Speakers Bureau readiness to fulfill community and departmental requests for presentations in threshold and non-threshold languages
7. Competence of individuals providing language assistance	6 and 7	• Bilingual certification testing • Offering of trainings for language interpreters • Offering of trainings on medical terminology in several threshold languages
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

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
9. CLAS goals, policies, and management accountability	1	• On-going evaluation of consumer satisfaction outcomes for Language Assistance Services • LA County Board of Supervisors directed priorities concentrating on services to children and family, gender health, gender affirming health care, Latino mental health, and women • ARISE Staff Advisory Council collaborations with the ARISE Division for bidirectional support and accountability
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 • Conduction of program-based needs assessments • Conduction of workforce/discipline – specific needs assessments • Conduction of 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	• Infrastructure developed to collect SOGI data in IBHIS, the Department's electronic health record system • Implementation of LACDMH data dashboards made available to the public
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
13. Partnerships with community	1, 3, and 4	• Multicultural media campaigns to increase access to mental health services and decrease stigma in partnership with departmental stakeholder groups and community-based organizations • Provision of stipends and scholarships for consumers and family members to attend stakeholder meetings and conferences • Partnership with LA County Departments in the multi-year Gender Impact Assessment (GIA) Project • Incubation Academy – Transforming LA efforts to assist small and mid-sized grassroot organizations become LACDMH contracted prevention services providers

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
14. Conflict and grievance resolution processes	8	• Monitoring of beneficiary requests for change of provider • 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 on the departmental CCU's webpage • On-going stakeholder platform and other committee meetings with community members, many of which are held monthly • 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 LACDMH employees to learn about different departmental divisions and receive updates.

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CLAS Standards Implementation: Progress at a Glance

The following chart summarizes SAPC's strategies to apply and maintain CLAS standards.

TABLE 6: CROSSWALK OF LACDMH'S PRACTICES RELATED TO THE CLAS STANDARDS, FY 22-23

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 C3H, CLAS ACT, and PAC • Culture and language specific outreach and engagement
2. Governance and leadership promoting CLAS	1, 4, 5, and 6	• Made the CLAS action plan accessible to internal SAPC staff, providers, various stakeholders, and subcommittees. • Incorporation of the CLAS standards, diversity equity, and inclusion into the Strategic Plan. • Policies and procedures revisions to guide culturally and linguistically competent service provision. • Review and discussions regarding the CLAS standards with departmental leadership • 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 across multiple functions
3. Diverse governance, leadership, and workforce	1, 6, and 7	• 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 across multiple functions • Development of paid employment opportunities for peers and persons with lived and shared experience

CLAS STANDARD	CCPR CRITERION	Examples of CLAS Standards Implementation in Departmental Practices
4. Train governance, leadership, and workforce in CLAS	1 and 5	• Accessible cultural competence trainings • Requirements to complete cultural competence trainings annually. • Inclusion of the CLAS standards in the cultural competence trainings
5. Communication and language assistance	5, 6, 7	• Development of P&Ps for translation and interpretation services, sign language interpretation for the Deaf and Hard of Hearing individuals.
6. Availability of language assistance	6 and 7	• Monitoring the SAPC's 24/7 Substance Abuse Services Helpline language assistance operations. • Established agreements with language assistance vendors to ensure language accommodations for patients and community members
7. Competence of individuals providing language assistance	5, 6 and 7	• Trainings for language interpreters
8. Easy to understand materials and signage	1, 3, and 7	• Ensured translation of critical informing materials, program brochures, media campaigns, and other materials into threshold and preferred languages.
9. CLAS goals, policies, and management accountability	1 and 4	• Developed monitoring tools that support the evaluation of policies and accountability for culturally competent services. • Review of submitted provider network action plans • Regular assessment of CLAS action plan. • On-going evaluation using treatment perception survey to assess patient satisfaction outcomes for culturally and linguistically appropriate services.
10. Organizational assessments	1, 3 and 7	• Monitor the impact of cultural and language-specific outreach and engagement activities • Partner with provider network to identify capacity-building projects for underserved cultural communities • Conduct program-based needs assessments • Monitor and evaluate the strategic plan goals progress. • Conduct outcome evaluations and reporting on service accessibility, and improvements in penetration and retention rates

CLAS STANDARD	CCPR CRITERION	Examples of CLAS Standards Implementation in Departmental Practices
11. Demographic data	2, 4, and 7	• Developed infrastructure around collection of SOGI data into SAPCs electronic health record system. • Implementation of LAC SAPC data dashboards made available to the public.
12. Assessments of community health assets and needs	2, 3 and 8	• Needs assessment completed for prevention and treatment gaps and needs.
13. Partnerships with community	1, 3, and 8	• Establish community coalitions in all Los Angeles County service planning areas. • Collaborate with the community to understand the capacity challenges and gaps within their communities. • Actively involve and collaborate with local community residents, leaders, non-substance use focused businesses, substance use services providers, and other stakeholders on prevention and harm reduction strategies.
14. Conflict and grievance resolution processes	8	• Monitor, investigate, and report on grievances, appeals and requests for State Fair Hearings
15. Progress in implementing and sustaining the CLAS standards	1, 3, and 4	• Monitor and evaluate implementation on strategies in the CLAS action plan and making it accessible to internal SAPC staff, providers, and various stakeholders, and subcommittees. • On-going stakeholder platform and other committee meetings with community members, many of which are held monthly • Include equity and inclusion in SAPC trainings and presentations.

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. Link to LACDPH SAPC Strategic Plan
   http://publichealth.lacounty.gov/sapc/docs/providers/SAPC-Strategic-Plan-2023-2028.pdf?tm

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

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

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PREVENTION BUREAU
ANTI-RACISM, INCLUSION, SOLIDARITY AND EMPOWERMENT (ARISE) DIVISION
CULTURAL COMPETENCY UNIT

AND

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC) BUREAU
STRATEGIC AND NETWORK DEVELOPMENT DIVISION
EQUITABLE ACCESS AND PROMOTIONS SECTION (EAPS)

CULTURAL COMPETENCE PLAN UPDATE - FY 22-23

Criterion 2

Updated Assessment of Services Needs

Lisa Wong, Psy. D.
Director
and
Gary Tsai, MD
Bureau Director

December 2024

Criterion 2: Updated Assessment of Services Needs

Introduction

According to the World Health Organization, four (4) out of ten (10) leading causes of disability are related to mental health among developed countries. The Center for Disease Control and Prevention (CDC) acknowledges that one (1) in five (5) adults in the U.S. has mental illness, and about one (1) in 25 adults live with serious mental health issues. Further, the National Survey on Drug Use and Health conducted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that in 2023, 59% of the U.S. population aged 12 or older used a licit or illicit substance over the past month, with 17.1% of individuals meeting the criteria for a substance use disorder (SUD) over the past year. Persons with mental health and substance use conditions often experience disruptions in daily living accompanied by cognitive and emotional challenges as well as possible exacerbation of their physical ailments, as well as higher rates of homelessness and involvement with the legal system. Despite nationwide initiatives, such as the Affordable Care Act (ACA), underserved communities continue to face discrepancies in access to services, which in turn create mental health disparities. These inequities exist in tandem with a plethora of interrelated problems.

LA County, with a total population of 9,825,708 residents in CY 2023, is considered to be the most populous county in the United States, surpassing the population of 40 individual U.S. states. It is comprised of 88 incorporated cities and many unincorporated areas which more than a quarter of Californians call home. It is not surprising that the Los Angeles County Department of Mental Health (LACDMH) is the largest mental health system in the United States, serving communities that are highly diversified in terms of cultural and linguistic backgrounds. LACDMH's provider network is composed of Directly Operated and Contracted programs that serve Los Angeles residents with extensive mental health services and specialized programs.

The data for individuals who are Medi-Cal eligible or living below 138% of the Federal Poverty Level (FPL) reveals significant disparities across race/ethnicity, age group, gender identity, sexual orientation, and language in all eight Service Areas. These disparities are driven by multiple interconnected factors related to the Social Determinants of Health (SDH), which include inequitable access to critical resources such as environmental conditions, social and community context, educational opportunities, housing, neighborhood characteristics, employment, economic stability, and health insurance coverage. Furthermore, disparities in health care access, affordability, quality of services, and the availability of culturally and linguistically responsive care exacerbate these inequities. These factors, individually and collectively, impact health outcomes, daily functioning, and overall quality of life. Importantly, the influence of SDH disproportionately affects specific cultural groups, deepening inequities and highlighting the unique challenges faced by underserved communities. These culture-specific gaps in access and opportunity create even greater barriers to health and well-being for these populations.

Underserved communities often face common challenges that contribute to disparities in one's mental health trajectory. These include stigma around seeking or receiving mental health care, distrust of government organizations, and a lack of knowledge about or access to mental health services. Additionally, each community has its own unique history and experiences of trauma, rooted in systemic and structural racism, which can make individuals less open to behavioral health services. Some groups may not recognize mental health issues or have the words to describe them. Others may associate mental health disorders with weakness, personal failure, witchcraft, or spiritual punishment for past wrongs.

Mental health disparities are also exacerbated by the interplay of individual, community and system-based factors. Collectively, these factors create complex disparity paradigms that cannot be fully or fairly evaluated without taking into account how these elements interact. Specifically, mental health disorders are often intertwined with substance use; childhood, intergenerational, and migratory trauma, experiences of violence; personal preferences for non-traditional approaches which fall outside of the Western realm; inclination to seek assistance from primary doctors, church leaders, and emergency care centers; lack of knowledge about mental health; economic disadvantages leading to the prioritization basic human survival needs such as food and shelter before health care services.

Another undeniable factor that needs to be considered when looking at disparity data is COVID-19 and its aftermath. It is widely known that, besides a high number of human losses, COVID-19 brought about a negative impact on the mental health of older adults, adults, youth, and children. The effects of the pandemic disproportionate hit communities of color not only with higher rates of infection and mortality, but also increased sources of stress due to the lack of availability of the COVID-19 vaccine and overall economic hardship due to loss of employment or decreased income. Yet another aggravating factor is the impact of hate crimes perpetuated against specific cultural groups, and tragic incidents like the murder of Mr. George Floyd, law enforcement brutality, and the Monterey Park shooting have left a long-lasting mark on these communities.

All the factors previously identified set a realistic background for assessment of data outcomes and interpretation of disparities data presented in this chapter. Thus, a review of the disparity data presented in this chapter needs to be properly contextualized. Furthermore, organizational blind spots and barriers related to funding stream restrictions; deficiencies in workforce training relevant to the mental health needs of marginalized communities; missed opportunities to identify and address racist practices, cross-cultural misinterpretations of symptoms, and implicit bias in diagnostic conceptualizations accentuate disparities for underserved communities.

Cognizant of the disparity paradigms described above and the importance of culturally responsive mental health care, LACDMH has implemented strategic service delivery approaches, community-based interventions, and resource allocations, with a concerted effort to reduce systemic gaps and make mental health services more accessible. These departmental systemwide strategies and programming have allowed for infrastructure

and service delivery enhancements at different points of entry into LACDMH. The overall goal of these interventions is multi-pronged and includes a decrease in culture-based mental health stigma, an increase in mental health service-seeking behaviors, an amplification of the message that recovery is possible, and an improvement of mental health outcomes for underserved communities.

Below is a short listing of recent systemwide efforts to address mental health disparities in addition to the strategies and programming described in CR 1 and CR 3 of this report.

- Implementation of the Anti-Racism, Inclusion, Solidarity and Empowerment Division with key Program/Unit components such as Underserved Cultural Communities, Cultural Competency, and United Mental Health Promotores
- Implementation of a Language Assistant Services (LAS) Unit and dedicated mailboxes for Directly Operated and Legal Entity/Contracted providers to request Sign Language interpreters for clinical sessions, and for the departmental stakeholder platform to offer language supports for consumer and community participation
- Hiring of the first Sign Language Specialist
- Expansion of cultural and linguistic expertise in the United Mental Health Promoters Program
- Community-based delivery of cultural events to honor and commemorate the diversity of Los Angeles County
- Telehealth services to serve community members residing in remote areas of Los Angeles County and to serve clients who have mobility issues
- Implementation of a Speaker's Bureau with clinical experts representing various cultural and linguistic areas of expertise
- Conduction of multimedia mental health campaigns delivering departmental messaging that reflects the cultural and linguistic diversity of the county
- Data collection improvements to identify well-established and emerging cultural groups/communities. For example, tribal affiliation, sexual orientation gender identity and expression (SOGIE), development of public-facing data dashboards presenting key aspects of cultural diversity in client demographics
- Specialized programs to address the mental health needs of school-age students, school threats and community violence
- Specialized program for veterans, currently serving military, and family members
- Specialized programs for persons experiencing homelessness
- An enhanced 24/7 Help Line
- Internal collaborations among departmental programs and the Los Angeles County Board of Supervisors to address community needs
- Hiring approximately 1,500 new employees across a wide range of functions and area of expertise
- Collaboration with other health departments in various workgroups to respond to urgent needs in the community.

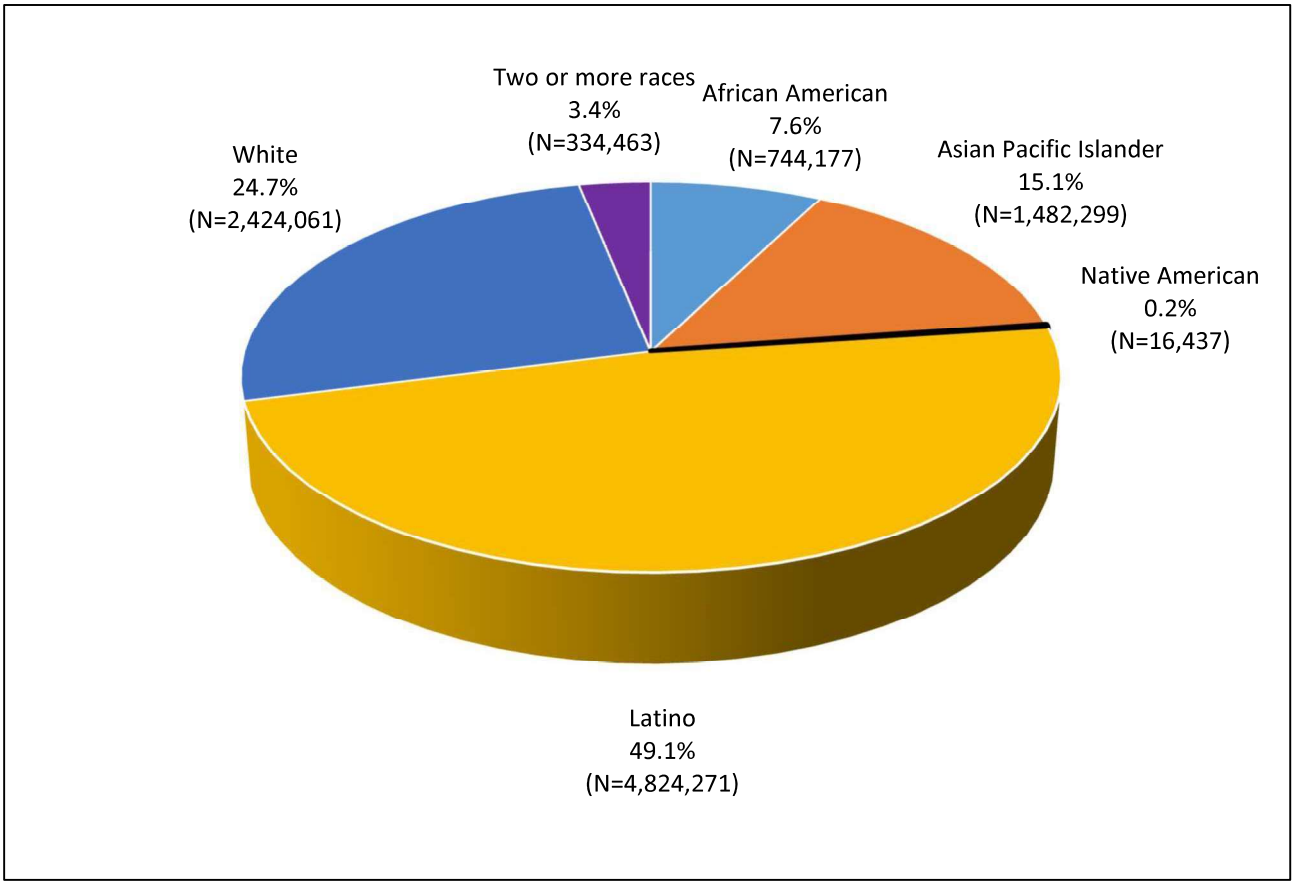
LACDMH believes that using a variety of strategies and programming with an emphasis on cultural and linguistic expertise is the best approach to eliminate mental health disparities. The summative outcomes of such efforts will benefit underserved communities with improved accessibility to mental health services, a higher quality of care, availability of a multicultural workforce, properly trained staff, culturally meaningful engagement with the community at large, demystification and destigmatization of mental health services, and cross-cultural awareness and understanding.

Note: LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs.

I. General Population: Los Angeles County Total Population

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

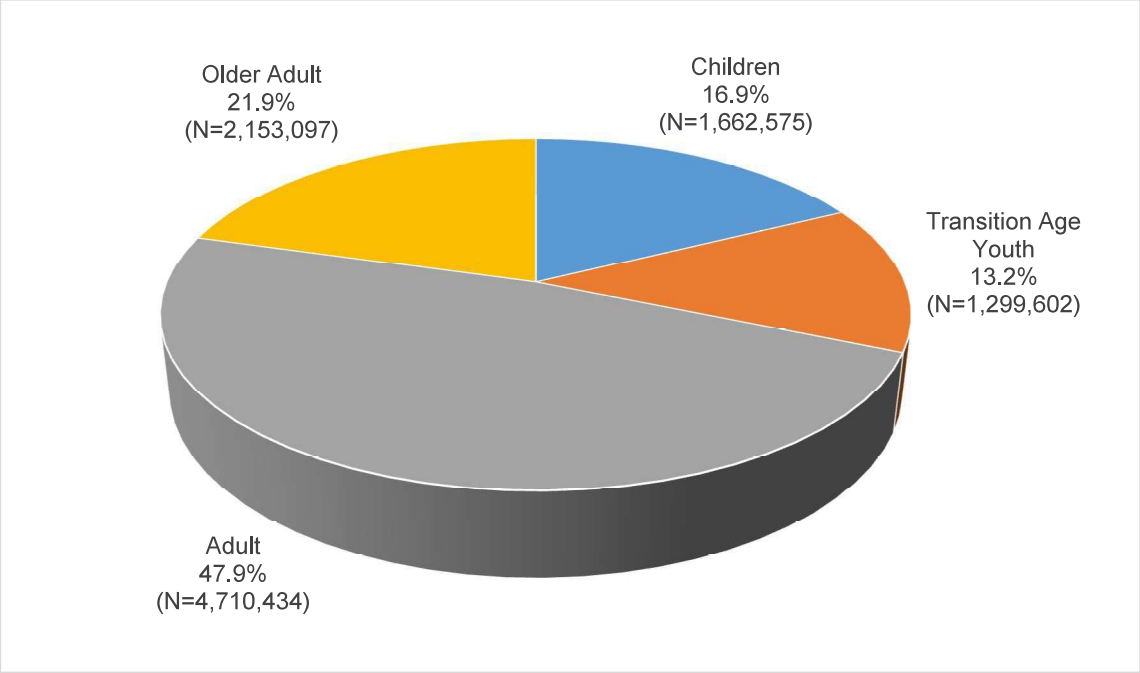
FIGURE 1: GENERAL POPULATION BY RACE/ETHNICITY
CY 2023 (N = 9,825,708)



Data Source: ACS, US Census, Bureau and Hedderson Demographic Services, 2024.

Figure 1 shows the Los Angeles County population by race/ethnicity. Latino is the largest ethnic group at 49.1% compared to Native American being the smallest group at 0.2%.

FIGURE 2: GENERAL POPULATION BY AGE GROUP
CY 2023 (N = 9,825,708)



The four age groups are based on the MHSA age group categories. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2024.

Figure 2 shows the Los Angeles County population by age group. Adults make up the largest age group at 47.9% compared to Transition Age Youth (TAY) which comprises the smallest group at 13.2%.

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TABLE 1: GENERAL POPULATION BY RACE/ETHNICITY AND SERVICE AREA CY 2023

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	61,872	15,853	**223,233**	1,351	**96,065**	16,244	**414,618**
Percent	14.9%	3.8%	**53.8%**	0.33%	**23.2%**	3.9%	100.0%
SA 2	77,627	255,868	**865,630**	3,061	**856,516**	82,681	**2,141,383**
Percent	3.6%	11.9%	**40.4%**	0.14%	**40.0%**	3.9%	100.0%
SA 3	52,334	538,251	813,972	2,741	285,284	44,625	1,737,207
Percent	3.0%	31.0%	46.9%	0.16%	16.4%	2.6%	100.0%
SA 4	59,507	187,993	528,780	1,994	288,515	38,935	1,105,724
Percent	5.4%	17.0%	47.8%	0.18%	26.1%	3.5%	100.0%
SA 5	33,025	93,606	108,032	893	373,099	41,042	649,697
Percent	5.1%	14.4%	16.6%	0.14%	57.4%	6.3%	100.0%
SA 6	221,130	22,553	693,571	1,215	29,619	20,343	988,431
Percent	22.4%	2.3%	70.2%	0.12%	3.0%	2.1%	100.0%
SA 7	36,783	125,538	951,551	2,387	128,019	21,358	1,265,636
Percent	2.9%	9.9%	75.2%	0.19%	10.1%	1.7%	100.0%
SA 8	201,899	242,637	639,502	2,795	366,944	69,235	1,523,012
Percent	13.3%	15.9%	42.0%	0.18%	24.1%	4.5%	100.0%
Total	744,177	1,482,299	4,824,271	16,437	2,424,061	334,463	9,825,708
Percent	7.6%	15.1%	49.1%	0.17%	24.7%	3.4%	100.0%

Bold values represent the highest and lowest populations across all SAs. Orange color values represent the highest ethnicity in the SAs with the highest and lowest population. Blue color values represent the second highest ethnicity in the SAs with the highest and lowest population.
Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2024.

SA 2 had the largest population, with a total of 2,141,383 people. Of this, 40.4% were Latino and 40.0% were White.

SA 1 had the smallest population, totaling 414,618 people. In this area, 53.8% were Latino and 23.2% were White.

TABLE 2: GENERAL POPULATION BY AGE GROUP AND SERVICE AREA, CY 2023

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	**110,392**	13,054	30,652	**178,859**	25,508	56,153	**414,618**
Percent	**26.6%**	3.1%	7.4%	**43.1%**	6.2%	13.5%	100.0%
SA2	**437,399**	53,608	132,874	**1,026,842**	135,111	355,549	**2,141,383**
Percent	**20.4%**	2.5%	6.2%	**48.0%**	6.3%	16.6%	100.0%
SA3	345,339	49,632	114,969	790,600	113,732	322,935	1,737,207
Percent	19.9%	2.9%	6.6%	45.5%	6.5%	18.6%	100.0%
SA4	180,793	22,060	62,902	624,378	58,652	156,939	1,105,724
Percent	16.4%	2.0%	5.7%	56.5%	5.3%	14.2%	100.0%
SA5	103,247	24,467	39,721	330,469	35,278	116,515	649,697
Percent	15.9%	3.8%	6.1%	50.9%	5.4%	17.9%	100.0%
SA6	253,891	31,589	82,006	457,365	51,089	112,491	988,431
Percent	25.7%	3.2%	8.3%	46.3%	5.2%	11.4%	100.0%
SA7	287,284	37,055	91,693	585,248	72,749	191,607	1,265,636
Percent	22.7%	2.9%	7.2%	46.2%	5.7%	15.1%	100.0%
SA8	322,920	39,747	94,883	716,673	97,504	251,285	1,523,012
Percent	21.2%	2.6%	6.2%	47.1%	6.4%	16.5%	100.0%
Total	2,041,265	271,212	649,700	4,710,434	589,623	1,563,474	9,825,708
Percent	20.8%	2.8%	6.6%	47.9%	6.0%	15.9%	100.0%

Note: Age groups are based on the ACA age group categories. Bold values represent the highest and lowest populations across all SAs. Orange color values represent the highest age group in the SAs with the highest and lowest population. Blue color values represent the second highest age group in the SAs with the highest and lowest population. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2024.

SA 2 had the largest population, with a total of 2,141,383 people. Of this, 48% were adults (age 26-59) and 20.4% were children (age 0-18).

SA 1 had the smallest population, totaling 414,618 people. In this area, 43.1% were adults (age 26-59) and 26.6% were children (age 0-18).

TABLE 3: GENERAL POPULATION BY GENDER AND SERVICE AREA CY 2023

Service Area (SA)	Male	Female	Total
SA1	204,135	210,483	**414,618**
Percent	49.2%	50.8%	100.0%
SA2	1,050,129	1,091,254	**2,141,383**
Percent	49.0%	51.0%	100.0%
SA3	841,873	895,334	1,737,207
Percent	48.5%	51.5%	100.0%
SA4	559,403	546,321	1,105,724
Percent	**50.6%**	**49.4%**	100.0%
SA5	313,077	336,620	649,697
Percent	**48.2%**	**51.8%**	100.0%
SA6	479,731	508,700	988,431
Percent	48.5%	51.5%	100.0%
SA7	617,750	647,886	1,265,636
Percent	48.8%	51.2%	100.0%
SA8	740,803	782,209	1,523,012
Percent	48.6%	51.4%	100.0%
Total	4,806,901	5,018,807	9,825,708
Percent	48.9%	51.1%	100.0%

Note: Bold values represent the highest and lowest populations across all SAs. Orange color values represent the SA with the highest male and female population. Blue color values represent the SA with the lowest male and female population. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2024.

SA 2 had the largest population, with 2,141,383 people, while SA 1 had the smallest population, with 414,618 people.

SA 4 had the highest percentage of males at 50.6%, while SA 5 had the lowest at 48.2%.

SA 5 had the highest percentage of females at 51.8%, while SA 4 had the lowest at 49.4%.

B. 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 2023

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	18,063	2,861	57,877	455	18,304	3,039	100,599
Percent	18.0%	2.8%	57.5%	0.45%	18.2%	3.0%	100.0%
SA 2	15,784	37,616	**194,571**	597	**120,237**	9,897	**378,702**
Percent	4.2%	9.9%	**51.4%**	0.16%	**31.7%**	2.6%	100.0%
SA 3	9,150	79,804	155,511	468	33,184	4,349	282,466
Percent	3.2%	28.3%	55.1%	0.17%	11.7%	1.5%	100.0%
SA 4	19,179	48,761	168,111	824	57,261	7,577	301,713
Percent	6.4%	16.2%	55.7%	0.27%	19.0%	2.5%	100.0%
SA 5	4,995	12,791	**17,020**	104	**46,711**	4,699	**86,320**
Percent	5.8%	14.8%	**19.7%**	0.12%	**54.1%**	5.4%	100.0%
SA 6	74,199	8,851	242,296	587	8,979	5,107	340,019
Percent	21.8%	2.6%	71.3%	0.17%	2.6%	1.5%	100.0%
SA 7	6,311	13,568	199,581	443	14,401	1,801	236,105
Percent	2.7%	5.7%	84.5%	0.19%	6.1%	0.8%	100.0%
SA 8	49,707	33,601	149,578	658	39,789	8,408	281,741
Percent	17.6%	11.9%	53.1%	0.23%	14.1%	3.0%	100.0%
Total	197,388	237,853	1,184,545	4,136	338,866	44,877	2,007,665
Percent	9.8%	11.8%	59.0%	0.21%	16.9%	2.2%	100.0%

Note: Bold values represent the highest and lowest populations across all SAs. Orange color values represent the highest ethnicity in the SAs with the highest and lowest population. Blue color values represent the second highest ethnicity in the SAs with the highest and lowest population. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2024.

SA 2 had the highest number of people living at or below 138% of the Federal Poverty Level (FPL). Out of the total population of 378,702 in this category, the two largest ethnic groups were Latino (51.4%) and White (31.7%).

SA 5 had the lowest population living at or below 138% FPL. Of the total population of 86,320 in this category, the two largest ethnic groups were White (54.1%) and Latino (19.7%).

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
SA 1	36,829	2,835	6,582	36,672	4,858	12,823	100,599
Percent	36.6%	2.8%	6.5%	36.5%	4.8%	12.7%	100.0%
SA 2	**101,071**	8,934	23,514	**165,607**	18,938	60,638	**378,702**
Percent	**26.7%**	2.4%	6.2%	**43.7%**	5.0%	16.0%	100.0%
SA 3	75,430	6,933	18,130	113,803	14,335	53,835	282,466
Percent	26.7%	2.5%	6.4%	40.3%	5.1%	19.1%	100.0%
SA 4	69,499	5,508	17,145	150,913	13,641	45,007	301,713
Percent	23.0%	1.8%	5.7%	50.0%	4.5%	14.9%	100.0%
SA 5	13,391	2,846	8,871	**41,937**	3,788	**15,487**	**86,320**
Percent	15.5%	3.3%	10.3%	**48.6%**	4.4%	**17.9%**	100.0%
SA 6	123,062	9,170	26,015	133,377	14,481	33,914	340,019
Percent	36.2%	2.7%	7.7%	39.2%	4.3%	10.0%	100.0%
SA 7	79,047	6,046	15,132	92,778	10,591	32,511	236,105
Percent	33.5%	2.6%	6.4%	39.3%	4.5%	13.8%	100.0%
SA 8	84,502	6,851	17,626	118,190	14,056	40,516	281,741
Percent	30.0%	2.4%	6.3%	41.9%	5.0%	14.4%	100.0%
Total	582,831	49,123	133,015	853,277	94,688	294,731	2,007,665
Percent	29.0%	2.4%	6.6%	42.5%	4.7%	14.7%	100.0%

Age groups are based on the ACA age group categories. Bold values represent the highest and lowest populations living in poverty by SA. Orange color values represent the highest age group in the SAs with the highest and lowest populations living in poverty. Blue color values represent the second highest age group in the SAs with the highest and lowest populations living in poverty. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2024.

SA 2 had the largest population living at or below 138% of the FPL. Out of the total population of 378,702, 43.7% were adults (ages 26-59) and 26.7% were children (ages 0-18).

SA 5 had the smallest population living at or below 138% FPL. Of the total population of 86,320, 48.6% were, adults (ages 26-59) and 17.9% were seniors (ages 65+).

When looking at the highest number of people living at or below 138% FPL in each age group, SA 6 had the most individuals in the 0-18, 19-20, and 21-25 age groups. In contrast, SA 2 had the highest numbers in the 26-59, 60-64, and 65+ age groups. This suggests that SA 6 had the highest proportion of children and transitional age youth (TAY) living in poverty, while SA 2 had the highest proportion of adults and older adults living in poverty.

TABLE 6: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA - CY 2023

Service Area (SA)	Male	Female	Total
SA 1	45,024	55,575	100,599
Percent	44.8%	55.2%	100.0%
SA 2	**168,042**	**210,660**	**378,702**
Percent	**44.4%**	**55.6%**	100.0%
SA 3	125,268	157,198	282,466
Percent	44.3%	55.7%	100.0%
SA 4	138,791	162,922	301,713
Percent	46.0%	54.0%	100.0%
SA 5	**38,360**	**47,960**	**86,320**
Percent	**44.4%**	**55.6%**	100.0%
SA 6	152,341	187,678	340,019
Percent	44.8%	55.2%	100.0%
SA 7	103,978	132,127	236,105
Percent	44.0%	56.0%	100.0%
SA 8	125,603	156,138	281,741
Percent	44.6%	55.4%	100.0%
Total	897,407	1,110,258	2,007,665
Percent	44.7%	55.3%	100.0%

Note: Bold values represent the highest and lowest populations across all SAs. Orange color values represent the SA with the highest male and female population. Blue color values represent the SA with the lowest male and female population. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2024.

SA 2 had the largest total population at 378,702, while SA 5 had the smallest total population at 86,320. Consequently, SA 2 had the highest concentration of males (168,042) and females (210,660) living at or below 138% FPL.

According to Table 6, 55.3% of individuals living at or below 138% of the FPL were female, while 44.7% were male.

Based on population size within each service area, SA 4 had the highest percentage of males living at or below 138% FPL, at 46%, compared to SA 7, which had the lowest percentage at 44%. SA 3 had the highest percentage of females living at or below 138% FPL, at 55.7%, while SA 4 had the lowest percentage at 54%.

TABLE 7: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY PRIMARY LANGUAGE AND SERVICE AREA - CY 2023

Service Area	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Other	Total
SA 1	532	394	186	45	55,093	82	188	98	119	90	38,795	493	248	4,236	100,599
Percent	0.53%	0.39%	0.18%	0.04%	54.76%	0.08%	0.19%	0.10%	0.12%	0.09%	38.56%	0.49%	0.25%	4.21%	100.00%
SA 2	3,354	35,602	366	496	139,441	7,240	4,079	1,566	2,238	6,300	156,611	6,617	3,182	11,610	378,702
Percent	0.89%	9.40%	0.10%	0.13%	36.82%	1.91%	1.08%	0.41%	0.59%	1.66%	41.35%	1.75%	0.84%	3.07%	100.00%
SA 3	1,424	1,733	1,468	12,364	92,664	440	2,771	21,244	24,777	266	106,761	3,758	9,778	3,018	282,466
Percent	0.50%	0.61%	0.52%	4.38%	32.81%	0.16%	0.98%	7.52%	8.77%	0.09%	37.80%	1.33%	3.46%	1.07%	100.00%
SA 4	980	3,671	697	1,971	99,422	1,092	17,066	2,286	6,527	3,233	144,214	5,170	1,380	14,004	301,713
Percent	0.32%	1.22%	0.23%	0.65%	32.95%	0.36%	5.66%	0.76%	2.16%	1.07%	47.80%	1.71%	0.46%	4.64%	100.00%
SA 5	1,042	490	**26**	400	54,039	4,086	1,182	1,760	2,916	1,076	**12,451**	418	545	5,889	86,320
Percent	1.21%	0.57%	**0.03%**	0.46%	62.60%	4.73%	1.37%	2.04%	3.38%	1.25%	**14.42%**	0.48%	0.63%	6.82%	100.00%
SA 6	270	67	182	198	99,648	154	1,467	1,835	1,637	169	227,806	474	328	5,784	340,019
Percent	0.08%	0.02%	0.05%	0.06%	29.31%	0.05%	0.43%	0.54%	0.48%	0.05%	67.00%	0.14%	0.10%	1.70%	100.00%
SA 7	1,208	768	1,168	508	59,958	119	1,963	1,131	1,564	94	**160,087**	2,184	801	4,552	236,105
Percent	0.51%	0.33%	0.49%	0.22%	25.39%	0.05%	0.83%	0.48%	0.66%	0.04%	**67.80%**	0.93%	0.34%	1.93%	100.00%
SA 8	2,112	403	**6,152**	400	124,404	479	3,517	1,228	1,725	505	123,567	4,653	2,458	10,138	281,741
Percent	0.75%	0.14%	**2.18%**	0.14%	44.16%	0.17%	1.25%	0.44%	0.61%	0.18%	43.86%	1.65%	0.87%	3.60%	100.00%
Total	10,922	43,128	10,245	16,382	724,669	13,692	32,233	31,148	41,503	11,733	970,292	23,767	18,720	59,231	2,007,665
Percent	0.54%	2.15%	**0.51%**	0.82%	36.10%	0.68%	1.61%	1.55%	2.07%	0.58%	**48.33%**	1.18%	0.93%	2.95%	100.00%

Note: Bold values represent the highest and lowest primary language across all SAs. For the highest and lowest primary language, the orange color values represent SA with the highest primary language and the blue color values represent SA with the lowest primary language. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2024.

Table 7 shows the estimated population living at or below 138% FPL by primary language and Service Area.

Spanish and English are the highest (84.4%) reported threshold languages among estimated population living at or below 138% FPL in all the SAs. Spanish was the highest (48.3%) reported non-English threshold language among estimated population living at or below 138% FPL compared to other non-English threshold languages (15.6%). SA7 had the highest percentage of Spanish speakers (67.8%) compared to SA5 with the lowest percentage (14.4%).

Cambodian is the lowest (0.51%) reported threshold language among estimated population living at or below 138% FPL in all the SAs. SA8 had the highest percentage (2.18%) of Cambodian speakers compared to SA5 with the lowest percentage (0.03%).

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 2023

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	903	143	2,894	23	915	152	5,030
Percent	18.0%	2.8%	57.5%	0.45%	18.2%	3.0%	100.0%
SA 2	789	1,881	**9,729**	30	**6,012**	495	**18,935**
Percent	4.2%	9.9%	**51.4%**	0.16%	**31.7%**	2.6%	100.0%
SA 3	458	3,990	7,776	23	1,659	217	14,123
Percent	3.2%	28.3%	55.1%	0.17%	11.7%	1.5%	100.0%
SA 4	959	2,438	8,406	41	2,863	379	15,086
Percent	6.4%	16.2%	55.7%	0.27%	19.0%	2.5%	100.0%
SA 5	250	640	**851**	5	**2,336**	235	**4,316**
Percent	5.8%	14.8%	**19.7%**	0.12%	**54.1%**	5.4%	100.0%
SA 6	3,710	443	12,115	29	449	255	17,001
Percent	21.8%	2.6%	71.3%	0.17%	2.6%	1.5%	100.0%
SA 7	316	678	9,979	22	720	90	11,805
Percent	2.7%	5.7%	84.5%	0.2%	6.1%	0.8%	100.0%
SA 8	2,485	1,680	7,479	33	1,989	420	14,087
Percent	17.6%	11.9%	53.1%	0.23%	14.1%	3.0%	100.0%
Total	9,869	11,893	59,227	207	16,943	2,244	100,383
Percent	9.8%	11.8%	59.0%	0.21%	16.9%	2.2%	100.0%

Note: Bold values represent the highest and lowest prevalence of SED/SMI among population living in poverty across all SAs. Orange color values represent the highest ethnicity in the SAs with the highest and lowest prevalence of SED/SMI. Blue color values represent the second highest ethnicity in the SAs with the highest and lowest prevalence of SED/SMI. SED/SMI Prevalence applied for all ethnicity groups = 5%. Some percentages may not total 100% due to rounding.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs.

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

SA 2 had the highest rate of individuals identified with SED or SMI among the population living at or below 138% FPL. Of the total population of 18,935 people with SED or SMI living at or below 138% FPL, 51.4% were Latino and 31.7% were White.

SA 5 had the lowest rate of individuals identified with SED or SMI among the population living at or below 138% FPL. Of the total population of 4,316 with SED or SMI living at or below 138% FPL, 54.1% were White and 19.7% were Latino. Overall,

this data is very consistent with what we would expect based on population data presented in Table 4.

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 2023

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	2,946	227	329	1,834	243	641	6,220
Percent	47.4%	3.6%	5.3%	29.5%	3.9%	10.3%	100.0%
SA 2	**8,086**	715	1,176	**8,280**	947	3,032	**22,235**
Percent	**36.4%**	3.2%	5.3%	**37.2%**	4.3%	13.6%	100.0%
SA 3	6,034	555	907	5,690	717	2,692	16,594
Percent	36.4%	3.3%	5.5%	34.3%	4.3%	16.2%	100.0%
SA 4	5,560	441	857	7,546	682	2,250	17,336
Percent	32.1%	2.5%	4.9%	43.5%	3.9%	13.0%	100.0%
SA 5	**1,071**	228	444	**2,097**	189	774	**4,803**
Percent	**22.3%**	4.7%	9.2%	**43.7%**	3.9%	16.1%	100.0%
SA 6	9,845	734	1,301	6,669	724	1,696	20,968
Percent	47.0%	3.5%	6.2%	31.8%	3.5%	8.1%	100.0%
SA 7	6,324	484	757	4,639	530	1,626	14,358
Percent	44.0%	3.4%	5.3%	32.3%	3.7%	11.3%	100.0%
SA 8	6,760	548	881	5,910	703	2,026	16,828
Percent	40.2%	3.3%	5.2%	35.1%	4.2%	12.0%	100.0%
Total	46,626	3,930	6,651	42,664	4,734	14,737	119,342
Percent	39.1%	3.3%	5.6%	35.7%	4.0%	12.3%	100.0%

Note: Bold values represent the highest and lowest prevalence of SED/SMI among population living in poverty across all SAs. Orange color values represent the highest age group in the SAs with the highest and lowest prevalence of SED/SMI. Blue color values represent the second highest age group in the SAs with the highest and lowest prevalence of SED/SMI. SED/SMI Prevalence for ages 0-20=8%, ages 21 and above=5%.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Some percentages may not total 100% due to rounding.

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

SA 2 had the highest number of SED and SMI estimated population living at or below 138% FPL. Of SA 4's total population of 22,235, 37.2% were adults (age 26-59) and 36.4% were children (age 0-18).

SA 5 had the lowest number of SED and SMI estimated population living at or below 138% FPL. Of SA 5's total population of 4,803, 43.7% were adults (age 26-59) and 22.3% were children (age 0-18).

TABLE 10: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FPL BY GENDER AND SERVICE AREA - CY 2023

Service Area (SA)	Male	Female	Total
SA 1	2,251	2,779	5,030
Percent	44.8%	55.2%	100.0%
SA 2	8,402	10,533	**18,935**
Percent	44.4%	55.6%	100.0%
SA 3	6,263	7,860	14,123
Percent	44.3%	55.7%	100.0%
SA 4	6,940	8,146	15,086
Percent	**46.0%**	**54.0%**	100.0%
SA 5	1,918	2,398	**4,316**
Percent	44.4%	55.6%	100.0%
SA 6	7,617	9,384	17,001
Percent	44.8%	55.2%	100.0%
SA 7	5,199	6,606	11,805
Percent	**44.0%**	**56.0%**	100.0%
SA 8	6,280	7,807	14,087
Percent	44.6%	55.4%	100.0%
Total	44,870	55,513	100,383
Percent	44.7%	55.3%	100.0%

Note: Bold values represent SA with the highest and lowest SED/SMI prevalence. Orange color values represent gender with the highest SED/SMI prevalence by SA. Blue color values represent gender with the lowest SED/SMI prevalence by SA. SED/SMI Prevalence applied for gender = 5%.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Some percentages may not total 100% due to rounding.

Table 10 shows the prevalence of SED/SMI for population living at or below 138% FPL for male and female. Overall, the prevalence of SED/SMI was higher for female (55.3%) than for male (44.7%).

SA 2 had the highest prevalence rate (18,935) of SED and SMI compared to SA 5 with the lowest prevalence (4,316).

SA 4 had the highest rate of prevalence (46%) of SED/SMI among **males** compared to SA 7 with the lowest prevalence (44%).

SA 7 had the highest rate of prevalence (56%) of SED/SMI among **females** compared to SA 4 with the lowest prevalence (54%).

II-A. Los Angeles County Department of Mental Health Medi-Cal Population Service Needs

A. This section summarizes the Medi-Cal population and client utilization data by race/ethnicity, language, age, and gender. All the tables in this section cover Medi-Cal eligibles of all ages.

Table 11: Population of Medi-Cal Eligibles by Race/Ethnicity, CY 2023

CY 2023	African American	Asian	Latino	Native American	White	Not Reported	Total
January - December (monthly average)	436,740	413,293	2,615,305	6,688	585,378	448,691	4,506,095
Percentage	9.7%	9.2%	**58.0%**	**0.1%**	13.0%	10.0%	100.0%

Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded in April 2024.

Differences by Race/Ethnicity

Table 11 presents the Los Angeles County Medi-Cal population by race/ethnicity. In FY 2023, Los Angeles County had 4,506,095 Medi-Cal eligibles. This was an increase of 62,816 from the previous year.

Latino had the highest percentage of Medi-Cal eligibles (58.0%) compared to Native American with the lowest percentage (0.1%).

Table 12: Population of Medi-Cal Eligibles by Age Group, CY 2023

CY 2023	Age Group				
	0-18	19-44	45-64	65+	Total
January - December (monthly average)	1,346,480	1,691,593	960,400	507,621	4,506,095
Percentage	29.9%	**37.5%**	21.3%	**11.3%**	100.0%

Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded in April 2024.

Differences by Age Group

Table 12 presents the Medi-Cal eligible population by age group. The age group 19-44 had the highest percentage of Medi-Cal eligibles (37.5%) compared to the age group 65+ with the lowest percentage (11.3%).

Table 13: Population of Medi-Cal Eligibles by Gender, CY 2023

CY 2023	Gender		
	Male	Female	Total
January - December (monthly average)	2,112,466	2,393,629	4,506,095
Percentage	46.9%	53.1%	100.0%

Note: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded in April 2024.

Differences by Gender

Table 13 presents the Medi-Cal eligibles population by gender for 2023. Female had a higher representation of Medi-Cal eligibles (53.1%) than male (46.9%).

TABLE 14: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ELIGIBLES POPULATION BY RACE/ETHNICITY, CY 2023

CY 2023	African American	Asian/Pacific Islander	Latino	Native American	White	Not Reported	Total
January - December (monthly average)	21,837	20,665	130,765	334	29,269	22,435	225,305
Percentage	9.7%	9.2%	**58.0%**	**0.1%**	13.0%	10.0%	100.0%

Orange color values represent the Medi-Cal population and ethnicity with the highest prevalence of SED/SMI. Blue color values represent the Medi-Cal population and ethnicity with the lowest prevalence of SED/SMI. SED/SMI prevalence applied for all ethnicity groups = 5%.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded in April 2024.

Differences by Race/Ethnicity

Table 14 compares the estimated prevalence of SED/SMI among the Medi-Cal population by race/ethnicity. In FY 2023, Los Angeles County had a total of 225,305 Medi-Cal eligibles with SED/SMI. This was a decrease of 599,983 from the previous year.

The Latino Medi-Cal population had the highest estimated prevalence of SED/SMI (58.0%) compared to Native American Medi-Cal population with the lowest prevalence (0.1%).

TABLE 15: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ELIGIBLES POPULATION BY AGE GROUP, CY 2023

CY 2023	Age Group				
	0-18	19-44	45-64	65+	Total
January - December (monthly average)	107,718	84,580	48,020	25,381	265,699
Percentage	40.5%	31.8%	18.1%	9.6%	100.0%

Note: Orange color value represent the Medi-Cal eligible population and age group with the highest prevalence of SED/SMI. Blue color value represents the Medi-Cal eligible population and age group with the lowest prevalence of SED/SMI. SED/SMI prevalence for ages 0-18=8%, ages 19 and above = 5%.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs.

Differences by Age Group

Table 15 shows the prevalence of SED/SMI in the Medi-Cal population by age group. The age group 0-18 had the highest prevalence of SED/SMI (40.5%) compared to the age group 65+ with the lowest prevalence (9.6%).

TABLE 16: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ELIGIBLES POPULATION BY GENDER, CY 2023

CY 2023	Gender		
	Male	Female	Total
January - December (monthly average)	105,623	119,681	225,305
Percentage	46.9%	53.1%	100.0%

Note: SED/SMI Prevalence applied for all gender = 5%.

DMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA DHCS (Department of Health Care Services), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs.

Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded in April 2024.

Differences by Gender

Table 16 shows the prevalence of SED/SMI among the Medi-Cal eligible population by gender. Female had a higher prevalence of SED/SMI (53.1%) than male (46.9%).

TABLE 17: PRIMARY LANGUAGE OF POPULATION OF MEDI-CAL ELIGIBLES, CY 2023

Language	January to December Average	Average %
English	2,638,861	**59.7%**
Spanish	1,451,889	32.8%
Armenian	91,924	2.1%
Mandarin	53,422	1.2%
Cantonese	43,403	1.0%
Korean	35,915	0.8%
Vietnamese	29,566	0.7%
Farsi	15,931	0.4%
Russian	29,571	0.7%
Tagalog	10,066	0.2%
Cambodian	8,607	0.2%
Arabic	6,229	0.1%
Other non-English	5,425	0.123%
Other Chinese	2,080	**0.05%**
Total	4,422,889	100.0%

Bold values represent the highest and lowest percentages by primary language. Table shows average of monthly Medi-Cal eligible from January 2023 – December 2023. "Missing/Unknown" language data (N = 76,950). SED/SMI Prevalence applied for all languages = 5%. Some percentages may not total 100% due to rounding. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded in April 2024.

Table 17 presents the Medi-Cal eligible population by primary language for 2023. English was the primary language with the highest percentage (59.7%) of Medi-Cal eligibles compared to Other Chinese with the lowest percentage (0.05%).

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II-B. Los Angeles County Department of Public Health
Medi-Cal Population and Substance Use Disorder (SUD) Service Needs

A. This section summarizes the Los Angeles County Medi-Cal population aged 12 and above by race/ethnicity, language, age, and gender. Medi-Cal population by service area (SA), age, gender, race/ethnicity, and primary language were calculated using the 2024 Jan Medi-Cal Eligibility Data System (MEDS) data. All records were geocoded for geographical calculation purposes.

Differences by Race/Ethnicity

TABLE 18: MEDI-CAL POPULATION BY RACE/ETHNICITY FY 23-24

Race/Ethnicity	African American	Asian/ Pacific Islander	Latino	AI/AN*	White	Other**	Total 12+
Medi-Cal Population	355,531	356,109	2,030,158	5,635	504,148	70,094	3,321,674
Percent	10.7%	10.7%	**61.1%**	**0.2%**	15.2%	2.1%	100.0%

Note: Due to rounding, some estimated totals and percents may not total 100%. * AI/AN: American Indian/Alaska Native. **Includes individuals who identify as mixed race, as well as those who self-identify as other.

Table 18 presents the Los Angeles County Medi-Cal Population by race/ethnicity. The Latinos accounted for the highest proportion of Medi-Cal beneficiaries (61.1%), followed by the Whites (15.2%), Asian/ Pacific Islanders (10.7%), African Americans (10.7%), and American Indian/Alaska Natives (0.2%). A small proportion (2.1%) of the beneficiaries identified as either multi-race or other.

Differences by Age Group

TABLE 19: MEDI-CAL POPULATION BY AGE GROUP, FY 23-24

Age Group	Age Group			
	12-17	18-25	26+	Total
Medi-Cal Population	428,592	488,216	2,404,866	3,321,674
Percent	**12.9%**	14.7%	**72.4%**	100%

Note: Due to rounding, some estimated totals and percents may not total 100%.

Table 19 presents the Medi-Cal Population categorized by age group. Individuals aged 26 and above comprised 72.4% of the Medi-Cal beneficiaries, followed by those aged 18 to 25 (14.7%) and aged 12 to 17 (12.9%).

Differences by Gender

TABLE 20: MEDI-CAL POPULATION BY GENDER, FY 23-24

Gender	Gender		
	Male	Female	Total
Medi-Cal Population	1,519,129	1,802,545	3,321,674
Percent	45.7%	54.3%	100.0%

Note: Due to rounding, some estimated totals and percentages may not total 100%.

Table 20 presents the Medi-Cal Population categorized by gender. Females were more represented (54.3%) than males (45.7%).

Differences by Primary Language

TABLE 21: MEDI-CAL POPULATION BY THRESHOLD LANGUAGE, FY 23-24

Threshold Language	Medi-Cal Population	Percent of Medi-Cal Population
English	1,874,649	56.4%
Spanish	1,137,161	34.2%
Chinese (Mandarin/Cantonese/Other Chinese)	83,579	2.5%
Armenian	83,536	2.5%
Korean	31,856	1.0%
Russian	26,486	0.8%
Vietnamese	25,934	0.8%
Farsi	14,711	0.4%
Tagalog	9,295	0.3%
Cambodian	7,703	0.2%
Arabic	5,312	0.2%
Other non-English	21,452	0.6%
Total	**3,321,674**	**100%**

Note: "Threshold language" means a language that has been identified as the primary language, as indicated on the State MEDS File, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. "Mandarin", "Cantonese", and "Other Chinese" were combined into the "Chinese" language.

Table 21 presents the Medi-Cal Population by primary language. The primary language with the highest percentage of Medi-Cal beneficiaries was English (56.4%), followed by Spanish (34.2%), Chinese (2.5%), Armenian (2.5%), Korean (1.0%), Russian (0.8%), Vietnamese (0.8%), Farsi (0.4%), Tagalog (0.3%), Cambodian (0.2%), Arabic (0.2%). The remaining languages represented about 0.6%.

Differences by SA

TABLE 22: MEDI-CAL POPULATION BY SERVICE AREA (SA), FY 23-24

Service Area (SA)	Medi-Cal Population (January 2024)	Percent of Medi-Cal Population
SA1	176,906	5.3%
SA2	691,305	**20.8%**
SA3	524,495	15.8%
SA4	418,512	12.6%
SA5	97,367	**2.9%**
SA6	522,297	15.7%
SA7	439,434	13.2%
SA8	451,358	13.6%
Total	3,321,674	100%

Note: Due to rounding, some estimated totals and percents may not total 100%.

Table 22 presents the Los Angeles County Medi-Cal Population by Service Area (SA). SA2 accounted for the largest portion, with 20.8% of the total Medi-Cal Population. This was followed by SA3 and SA6, which represented 15.8% and 15.7% of the population, respectively. In contrast, SA1 and SA5 represented the smallest percentages, with SA1 at 5.3% and SA5 at 2.9%.

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B. This section summarizes the Los Angeles County Medi-Cal population substance use disorder (SUD) needs by age, gender, race/ethnicity, sexual orientation, and threshold language.

SUD prevalence rates for adolescents (4.55%) and adults (9.23%) were provided by the State. Prevalence rates by other categories were estimated using data retrieved from NSDUH reports and Medi-Cal population calculated by Service Area.

FIGURE 3: ESTIMATED NUMBER AND PREVALENCE RATE OF SUD AMONG MEDI-CAL POPULATION BY AGE GROUP, FY 23-24

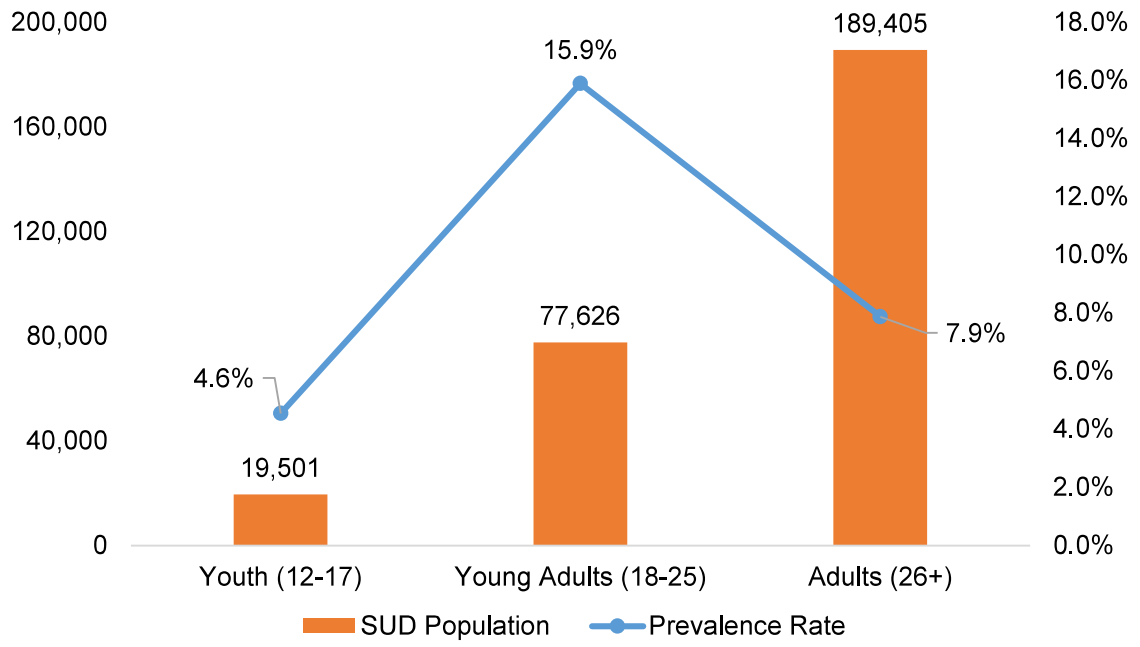

Figure 3 represents the estimated prevalence rate and number of SUD among the Medi-Cal Population, broken down by age group. The majority of the population fell under the adults (26+) group, which had 7.9% estimated SUD prevalence. The highest estimated SUD prevalence was observed in the young adults (18-25) group, with a rate of 15.9%.

FIGURE 4: ESTIMATED NUMBER AND PREVALENCE RATE OF SUD AMONG MEDI-CAL POPULATION BY GENDER, FY 23-24

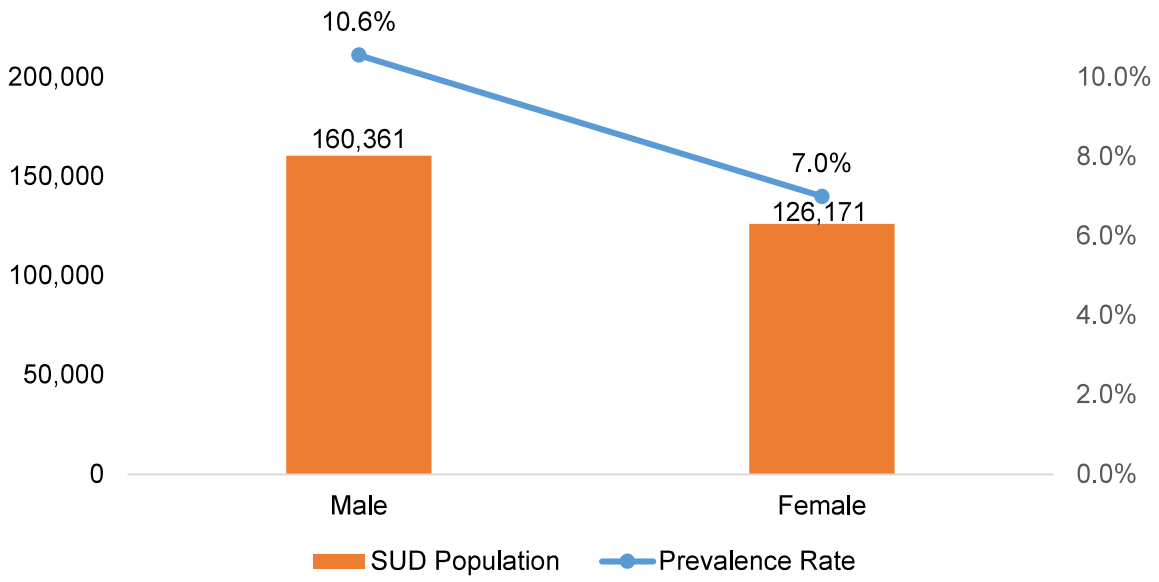

Figure 4 shows that males had a higher estimated prevalence rate (10.6%) compared to females (7.0%).

FIGURE 5: ESTIMATED NUMBER AND PREVALENCE RATE OF SUD AMONG MEDI-CAL POPULATION BY RACE/ETHNICITY, FY 23-24

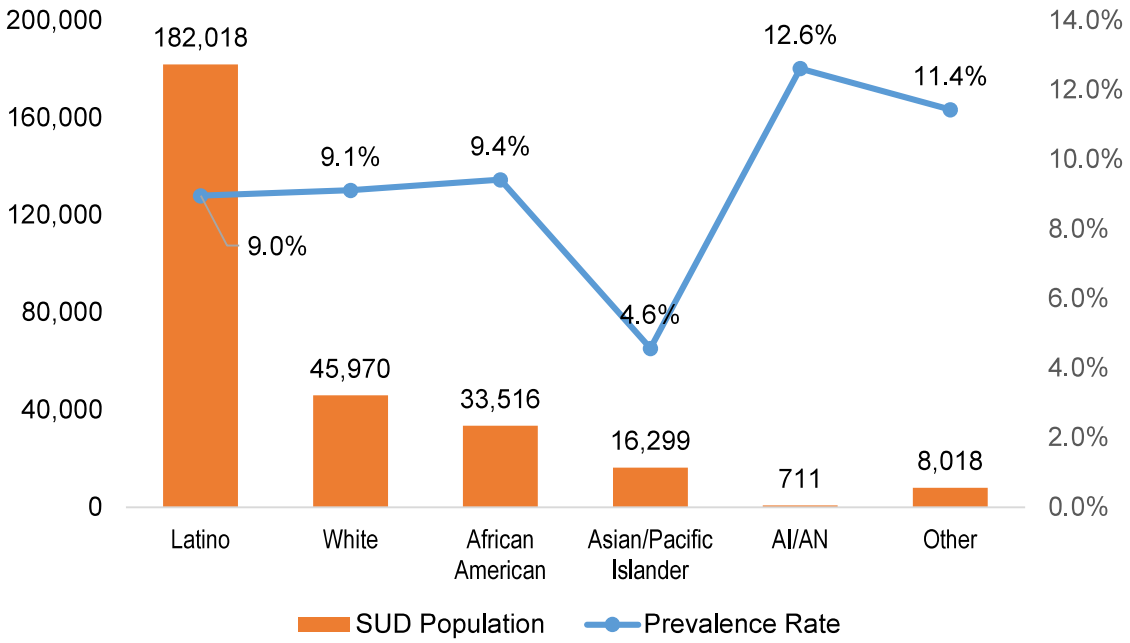

Figure 5 shows that the highest estimated prevalence rate was with the American Indian/Alaska Natives (AI/AN) (12.6%), followed by Other (11.4%), African American (9.4%), White (9.1%), Latino (9.0%), and Asian/Pacific Islander (4.6%).

FIGURE 6: ESTIMATED NUMBER AND PREVALENCE RATE OF SUD AMONG MEDI-CAL POPULATION BY SEXUAL ORIENTATION, FY 23-24

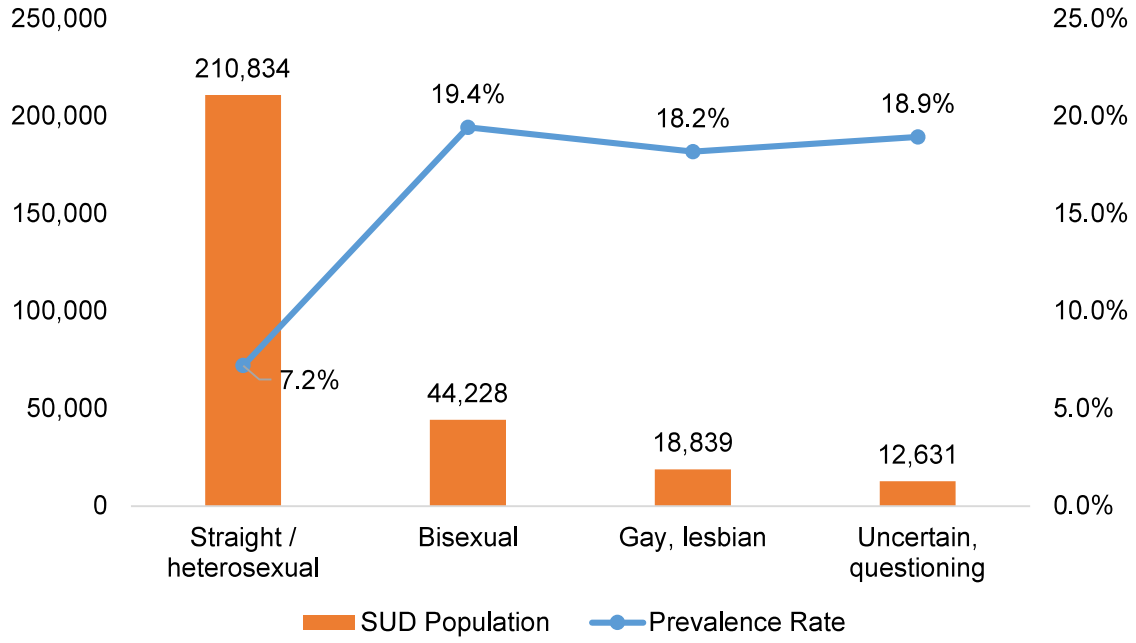

Figure 6 illustrates that the estimated SUD prevalence rates and number within the LGBQ+ population were all above 18%, which was more than double the rate estimated in the straight population, where the prevalence was at 7.2%.

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TABLE 23: ESTIMATED NUMBER AND PREVALENCE RATE OF SUD AMONG MEDI-CAL POPULATION BY THRESHOLD LANGUAGE, FY 23-24

Threshold Language	Estimated SUD Population	Prevalence Rate
English	258,882	13.8%
Spanish	22,286	2.0%
Armenian	2,226	2.7%
Russian	604	2.3%
Farsi	477	3.2%
Chinese (Mandarin/Cantonese/Other Chinese)	216	0.3%
Arabic	188	3.5%
Korean	152	0.5%
Tagalog	108	1.2%
Vietnamese	87	0.3%
Cambodian	8	0.1%

Table 23 presents the estimated SUD prevalence rates and number by threshold language among Medi-Cal Population. The highest estimated prevalence of SUD among the Medi-Cal Population was with the threshold language of English, with 13.8%, followed by Arabic (3.5%), Farsi (3.2%), Armenian (2.7%), and Russian (2.3%). Other languages have an estimated SUD prevalence of 2.0% or below.

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FIGURE 7: ESTIMATED NUMBER AND PREVALENCE RATE OF SUD AMONG MEDI-CAL POPULATION BY SA, FY 23-24

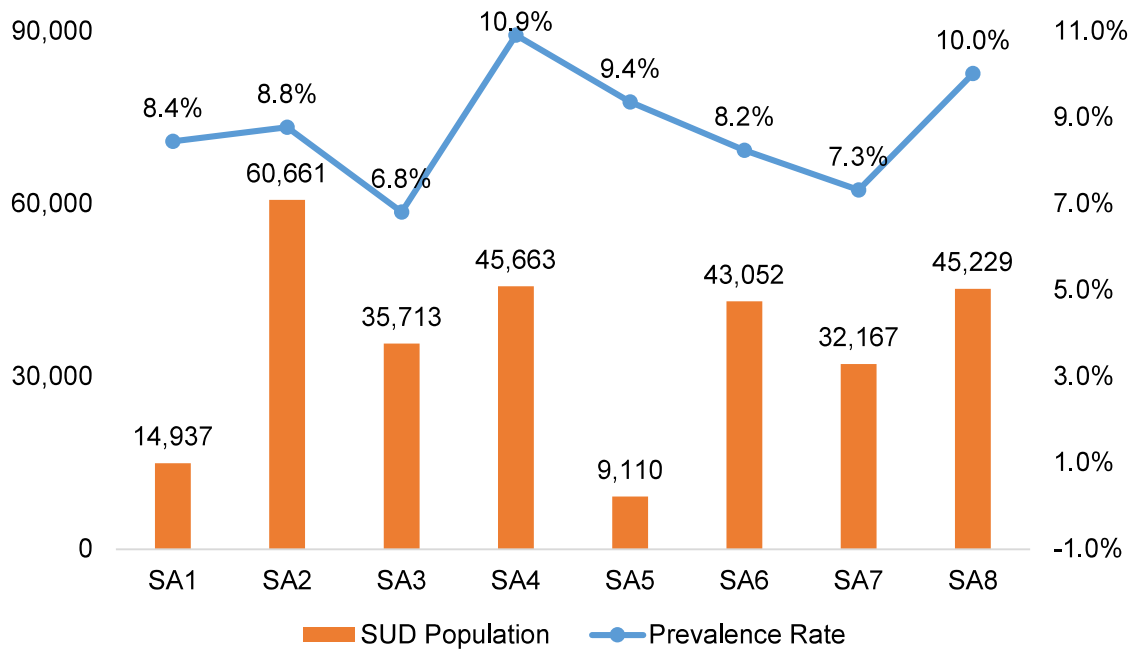

Figure 7 presents the estimated prevalence of SUD among the Medi-Cal Population by SA. Across all SAs, the estimated prevalence rate ranged from 6.8% to 10.9%, with the highest at 10.9% for SA4 and the lowest at 6.8% for SA3.

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III-A. Los Angeles County Department of Mental Health
Consumers Served in Outpatient Programs

TABLE 24: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY RACE/ETHNICITY AND SERVICE AREA, FY 22-23

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Unreported	Other	Total
SA 1	**5,587**	174	**5,182**	80	3,465	895	2,007	452	**17,842**
Percent	**31.3%**	1.0%	**29.0%**	0.45%	19.4%	5.0%	11.2%	2.5%	100.0%
SA 2	4,065	1,523	17,082	112	9,301	1,462	6,831	3,583	43,959
Percent	9.2%	3.5%	38.9%	0.25%	21.2%	3.3%	15.5%	8.2%	100.0%
SA 3	3,597	3,334	13,831	186	5,380	1,468	5,346	9,545	42,687
Percent	8.4%	**7.8%**	32.4%	0.44%	12.6%	3.4%	12.5%	22.4%	100.0%
SA 4	8,126	2,550	19,359	354	6,399	1,170	5,747	2,096	45,801
Percent	17.7%	5.6%	42.3%	0.77%	14.0%	2.6%	12.5%	4.6%	100.0%
SA 5	4,598	608	4,664	95	4,665	664	3,645	1,246	20,185
Percent	22.8%	3.0%	23.1%	0.47%	23.1%	3.3%	18.1%	6.2%	100.0%
SA 6	12,591	309	14,348	207	1,809	750	4,320	1,529	35,863
Percent	35.1%	0.9%	40.0%	0.58%	5.0%	2.1%	12.0%	4.3%	100.0%
SA 7	1,758	685	16,270	232	2,831	1,160	2,729	3,958	29,623
Percent	5.9%	2.3%	54.9%	0.78%	9.6%	3.9%	9.2%	13.4%	100.0%
SA 8	**10,022**	2,377	**17,839**	142	6,199	1,651	5,261	2,798	**46,289**
Percent	**21.7%**	5.1%	**38.5%**	0.31%	13.4%	3.6%	11.4%	6.0%	100.0%
Total	34,993	8,925	76,912	1,085	28,666	6,462	27,324	18,057	202,424
Percent	17.3%	4.4%	38.0%	0.54%	14.2%	3.2%	13.5%	8.9%	100.0%

Bold values represent the highest and lowest consumer population across all SAs. Orange color values represent the highest ethnicity in the SAs with the highest and lowest consumer population. Blue color values represent the second highest ethnicity in the SAs with the highest and lowest consumer population. Total reflects an unduplicated count of consumers served.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data Source: LACDMH-IS-IBHIS, February 2024.

Table 24 presents the unduplicated count of consumers served in outpatient programs by race/ethnicity and Service Area.

SA 8 has the highest number of consumers served. Out of the total consumers served of 46,289, 38.5% were Latino and 21.7% were African American.

SA 1 has the lowest number of consumers served. Out of the total consumers served of 17,842, 31.3% were African American and 29.0% were Latino.

TABLE 25: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY MHSA AGE GROUP AND SERVICE AREA FY 22-23

Service Area (SA)	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	**6,401**	3,250	**6,780**	1,411	**17,842**
Percent	**35.9%**	18.2%	**38.0%**	7.9%	100.0%
SA 2	11,115	8,732	19,170	4,942	43,959
Percent	25.3%	19.9%	43.6%	11.2%	100.0%
SA 3	14,012	10,797	14,255	3,623	42,687
Percent	32.8%	25.3%	33.4%	8.5%	100.0%
SA 4	11,611	8,892	19,501	5,797	45,801
Percent	25.4%	19.4%	42.6%	12.7%	100.0%
SA 5	2,514	2,478	11,291	3,902	20,185
Percent	12.5%	12.3%	55.9%	19.3%	100.0%
SA 6	11,629	6,992	13,676	3,565	35,863
Percent	32.4%	19.5%	38.1%	9.9%	100.0%
SA 7	10,203	7,468	9,882	2,070	29,623
Percent	34.4%	25.2%	33.4%	7.0%	100.0%
SA 8	**14,146**	9,358	**18,027**	4,758	**46,289**
Percent	**30.6%**	20.2%	**38.9%**	10.3%	100.0%
Total	54,773	39,061	83,827	24,762	202,423
Percent	27.1%	19.3%	41.4%	12.2%	100.0%

Bold values represent the highest and lowest number of consumers served across all SAs. Orange color values represent the highest age group in the SAs with the highest and lowest number of consumers served. Blue color values represent the second highest age group in the SAs with the highest and lowest number of consumers served. Number of Unknown Age (N=1). Total reflects unduplicated count of consumers served.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data Source: LACDMH IS-IBHIS, February 2024.

Table 25 shows the unduplicated count of consumers served in outpatient programs by age group and Service Area.

SA 8 had the highest number of clients served. Out of the 46,289 total clients served, 38.9% were adults (age 26-59) and 30.6% were children (age 0-15).

SA 1 had the lowest number of consumers served. Out of the 17,842 total clients served, 38% were adults (age 26-59) and 35.9% were children (age 0-15).

TABLE 26: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA FY 22-23

Service Area (SA)	Gender			
	Male	Female	Unknown	Total
SA 1	8,100	9,740	2	**17,842**
Percent	45.4%	54.6%	0.01%	100.0%
SA 2	20,817	23,129	13	43,959
Percent	47.4%	52.6%	0.03%	100.0%
SA 3	19,996	22,667	24	42,687
Percent	46.8%	53.1%	0.06%	100.0%
SA 4	23,692	22,092	17	45,801
Percent	51.7%	48.2%	0.04%	100.0%
SA 5	11,008	9,169	8	20,185
Percent	54.5%	45.4%	0.04%	100.0%
SA 6	16,575	19,276	12	35,863
Percent	46.2%	53.7%	0.03%	100.0%
SA 7	13,530	16,088	5	29,623
Percent	45.7%	54.3%	0.02%	100.0%
SA 8	21,128	25,145	16	**46,289**
Percent	45.6%	54.3%	0.03%	100.0%
Total	94,485	107,865	74	202,424
Percent	46.7%	53.3%	0.04%	100.0%

Bold values represent the highest and lowest number of consumers served across all SAs. Total reflects an unduplicated count of consumers served.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data Source: LACDMH-IS-IBHIS, February 2024.

Table 26 presents the unduplicated count of consumers served in outpatient programs by gender and SA.

SA 8 had the highest number of consumers served. Out of the total consumers served of 46,289, 54.3% were female and 45.6% were male.

Consistent with population levels by Service Area, SA 1 had the lowest number of consumers served. Out of the total consumers served of 17,842, 54.6% were female and 45.4% were male.

TABLE 27: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY PRIMARY LANGUAGE AND SERVICE AREA FY 22-23

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Other non-English	Russian	Spanish	Tagalog	Vietnamese	Unknown/ Unreported	Total
SA 1	5	14	0	0	16,086	5	3	1	0	2	4	1,090	7	0	491	17,708
Percent	0.03%	0.08%	0.00%	0.00%	**90.84%**	0.03%	0.02%	0.01%	0.00%	0.01%	0.02%	6.16%	0.04%	0.00%	2.77%	100.00%
SA 2	58	885	21	9	34,532	482	64	7	9	8	91	5,069	77	54	589	41,955
Percent	0.14%	2.11%	0.05%	0.02%	82.31%	1.15%	0.15%	0.02%	0.02%	0.02%	0.22%	12.08%	0.18%	0.13%	1.40%	100.00%
SA 3	29	55	95	438	32,824	15	63	557	69	7	4	5,514	37	329	1,516	41,552
Percent	0.07%	0.13%	0.23%	1.05%	78.99%	0.04%	0.15%	1.34%	0.17%	0.02%	0.01%	13.27%	0.09%	0.79%	3.65%	100.00%
SA 4	30	440	40	102	**34,710**	29	614	96	14	7	199	7,110	67	42	527	44,027
Percent	0.07%	1.00%	0.09%	0.23%	**78.84%**	0.07%	1.39%	0.22%	0.03%	0.02%	0.45%	16.15%	0.15%	0.10%	1.20%	100.00%
SA 5	13	21	13	14	16,217	131	31	14	7	8	44	**1,097**	8	7	251	17,876
Percent	0.07%	0.12%	0.07%	0.08%	90.72%	0.73%	0.17%	0.08%	0.04%	0.04%	0.25%	**6.14%**	0.04%	0.04%	1.40%	100.00%
SA 6	4	14	0	7	29,076	4	18	6	1	0	9	5,130	5	13	425	34,712
Percent	0.01%	0.04%	0.00%	0.02%	83.76%	0.01%	0.05%	0.02%	0.00%	0.00%	0.03%	14.78%	0.01%	0.04%	1.22%	100.00%
SA 7	21	3	20	10	23,476	4	34	24	9	0	1	**5,399**	18	8	330	29,357
Percent	0.07%	0.01%	0.07%	0.03%	79.97%	0.01%	0.12%	0.08%	0.03%	0.00%	0.00%	**18.39%**	0.06%	0.03%	1.12%	100.00%
SA 8	19	30	512	25	37,654	55	92	37	5	7	10	5,375	61	125	651	44,658
Percent	0.04%	0.07%	1.15%	0.06%	84.32%	0.12%	0.21%	0.08%	0.01%	0.02%	0.02%	12.04%	0.14%	0.28%	1.46%	100.00%
Total	158	1,187	648	506	157,742	602	728	588	93	30	315	27,430	214	507	2,900	193,648
Percent	0.08%	0.61%	0.33%	0.26%	**81.46%**	0.31%	0.38%	0.30%	0.05%	0.02%	0.16%	**14.16%**	0.11%	0.26%	1.50%	100.00%

Bold values represent the highest and the second highest primary language and consumers served across all SAs. For the highest and the second highest primary language and consumers served orange values represent the SAs with the highest consumers served and blue values represent the SAs with the lowest consumers served. "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 (N= 2,900) consumers served in Outpatient Programs specify primary language as 'Unknown/Not reported', a total of (N=7,722) primary language field had 'No Entry'. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data Source: LACDMH-IS-IBHIS, February 2024.

Table 27 shows the primary language of consumers served in outpatient programs by Service Area.

English was the highest reported primary language (81.5%) among consumers served in outpatient programs in all SAs. SA 1 had the highest percentage (90.8%) of English-speaking consumers, per capita, compared to SA4 with the lowest percentage (78.8%).

Spanish was the highest reported non-English threshold language (14.2%) for consumers served in all SAs. SA 7 had the highest percentage (18.4%) of Spanish-speaking consumers compared to SA5 with the lowest percentage (6.1%)

III-B. Los Angeles County Department of Public Health
Medi-Cal Eligibles Served in SUD Treatment Level of Care (LOC)

In Los Angeles County, patient-centered addiction treatment is delivered across a continuum of services that reflect the severity of the SUD, and the intensity of services required. The list of treatment levels of care includes Outpatient Treatment, Intensive Outpatient Treatment, Residential Services, Withdrawal Management, Opioid Treatment Program, and Recovery Services. This comprehensive continuum of care is necessary to effectively address the treatment needs of each unique individual.

This section summarizes Medi-Cal Eligibles who received SUD treatment from different levels of care provided by the publicly contracted provider network by primary substance use, age, gender, race/ethnicity, and SA in the fiscal year 2022-2023 (FY 22-23).

Table 28. MEDI-CAL ELIGIBLE SUD PATIENTS BY LOC, FY 22-23

Level of Care	Percent
Total Patients	**27,202**
Withdrawal Management	11.2%
Residential Services	29.1%
Intensive Outpatient Program	12.0%
Outpatient Program	22.8%
Opioid Treatment Program	19.4%
Recovery Services	5.6%

Note: Numbers are based on non-missing values. Percentages may not sum to 100% due to rounding.

Table 28 indicates that among the 27,202 Medi-Cal eligibles served, residential services (29.1%) were the most common LOC that patients were admitted to, followed by outpatient treatment (22.8%), opioid treatment program (19.4%), and intensive outpatient treatment (12.0%).

1. Withdrawal Management (N=4,125)

Withdrawal management (WM), also known as detoxification, is a set of treatment interventions aimed at medical and clinical management of acute intoxication and withdrawal from alcohol and other substances. WM services provide the appropriate level of medical and clinical support to allow for patient safety during the withdrawal period, which then allows the patient and treatment team to work together to determine the best ongoing treatment strategy.

This section summarizes Medi-Cal eligibles who received SUD treatment from withdrawal management by age, gender, race/ethnicity, and SA.

FIGURE 8. PRIMARY SUBSTANCE USE AT ADMISSION, FY 22-23

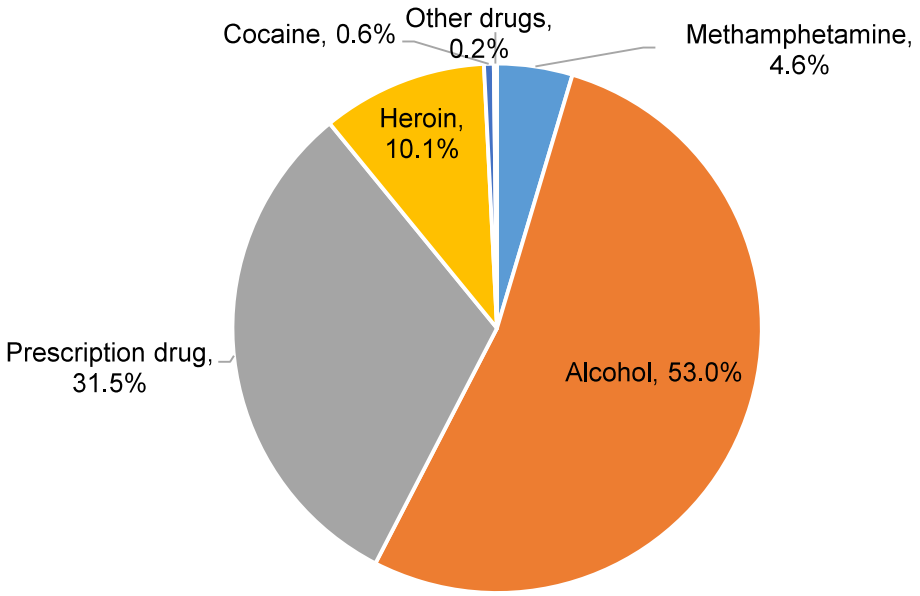

Figure 8 presents that alcohol (53.0%) was the most commonly reported primary substance use among SUD patients in withdrawal management, followed by prescription drug (31.5%) and heroin (10.1%).

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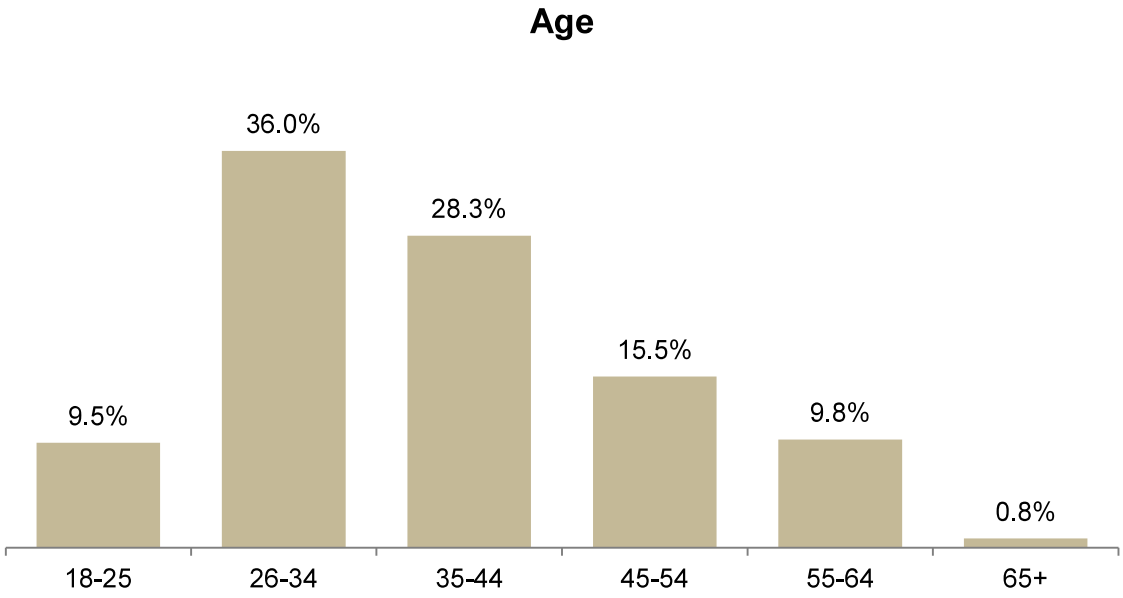
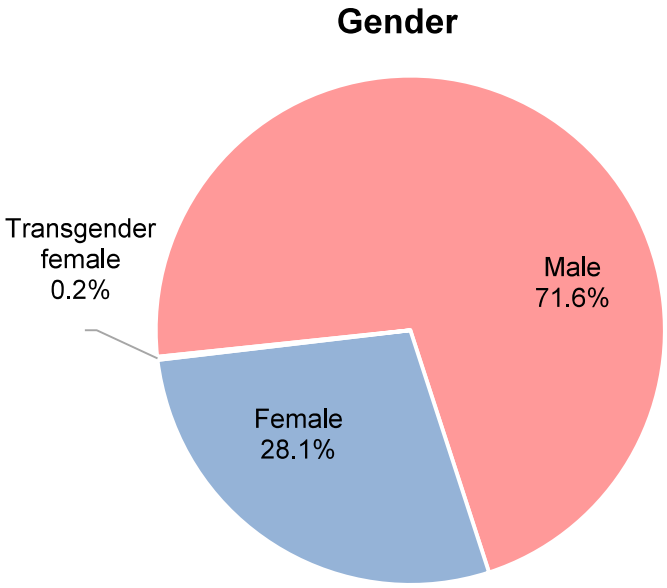
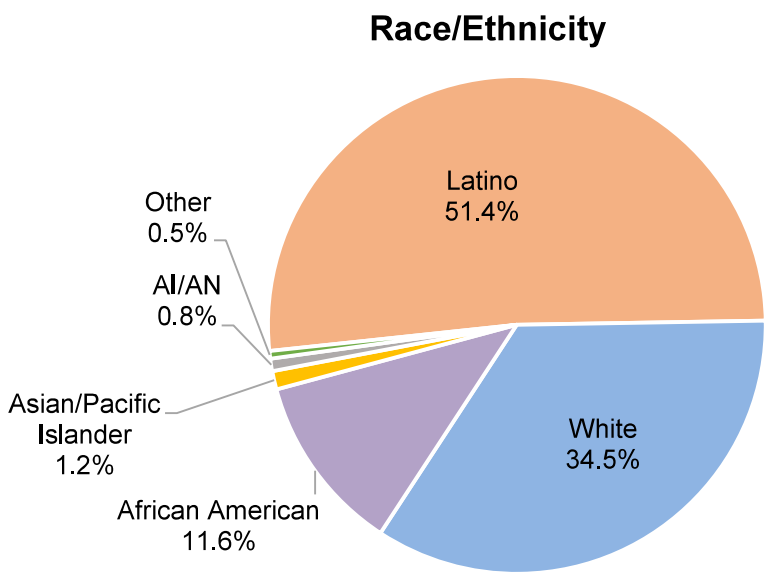
FIGURE 9. MEDI-CAL ELIGIBLE SUD PATIENTS IN WITHDRAWAL MANAGEMENT BY AGE, GENDER, AND RACE/ETHNICITY, FY 22-23







As shown in Figure 9, the majority of patients in withdrawal management were male (71.6%), Latino (51.4%), and ages 26-34 (36.0%).

FIGURE 10. MEDI-CAL ELIGIBLE SUD PATIENTS IN WITHDRAWAL MANAGEMENT BY SA, FY 22-23

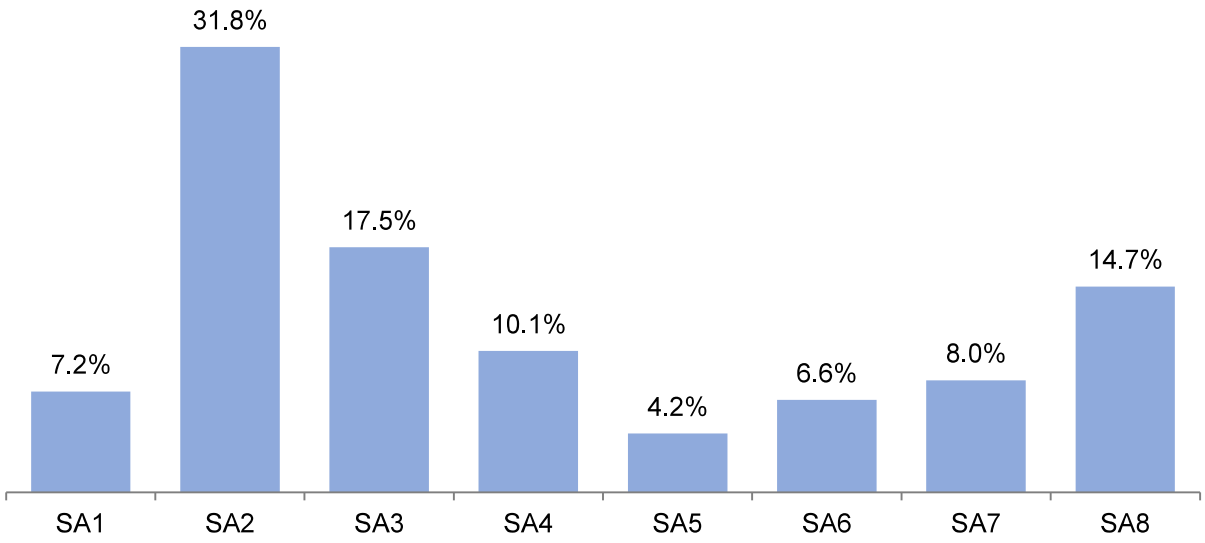


Figure 10 presents the distribution of Medi-Cal eligible SUD patients who received withdrawal management across different SAs. SA2 accounted for the largest portion, representing 31.8% of the patients, while SA5 comprised the smallest share, with only 4.2%.

2. Residential Services (N=10,475)

Residential services are delivered to Medi-Cal eligibles when medically necessary in a short-term residential program corresponding to one of the following levels: Level 3.1 – Clinically Managed Low-Intensity Residential Programs, Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Programs, or Level 3.5 – Clinically Managed Residential Programs (high intensity for adults, medium intensity for adolescents).

This section summarizes Medi-Cal eligibles who received SUD treatment from residential services by age, gender, race/ethnicity, and SA.

FIGURE 11. PRIMARY SUBSTANCE USE AT ADMISSION, FY 22-23

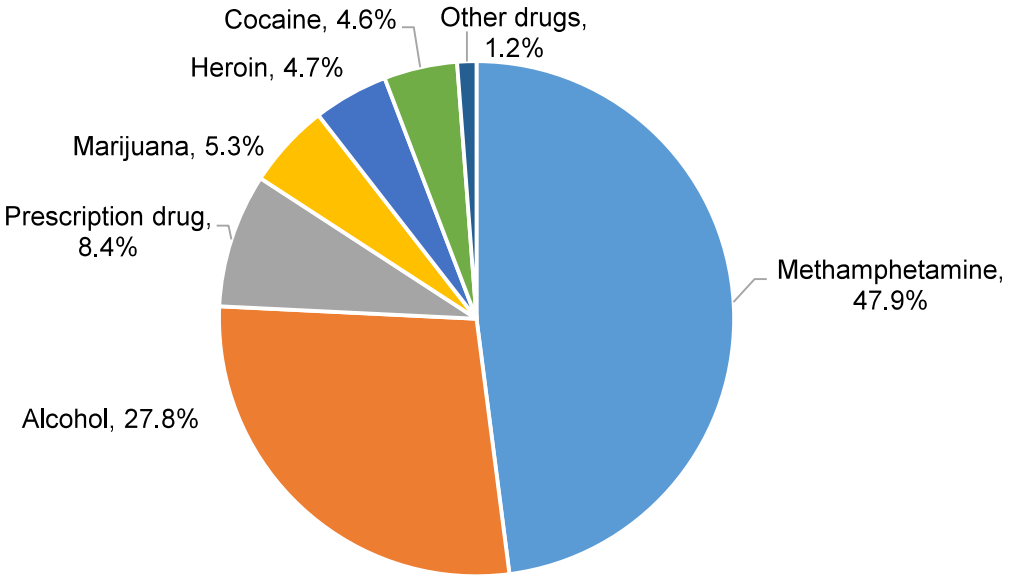


Figure 11 presents that methamphetamine was the most commonly reported primary substance use (47.9%) among patients in residential services, followed by alcohol (27.8%) and prescription drug (8.4%).

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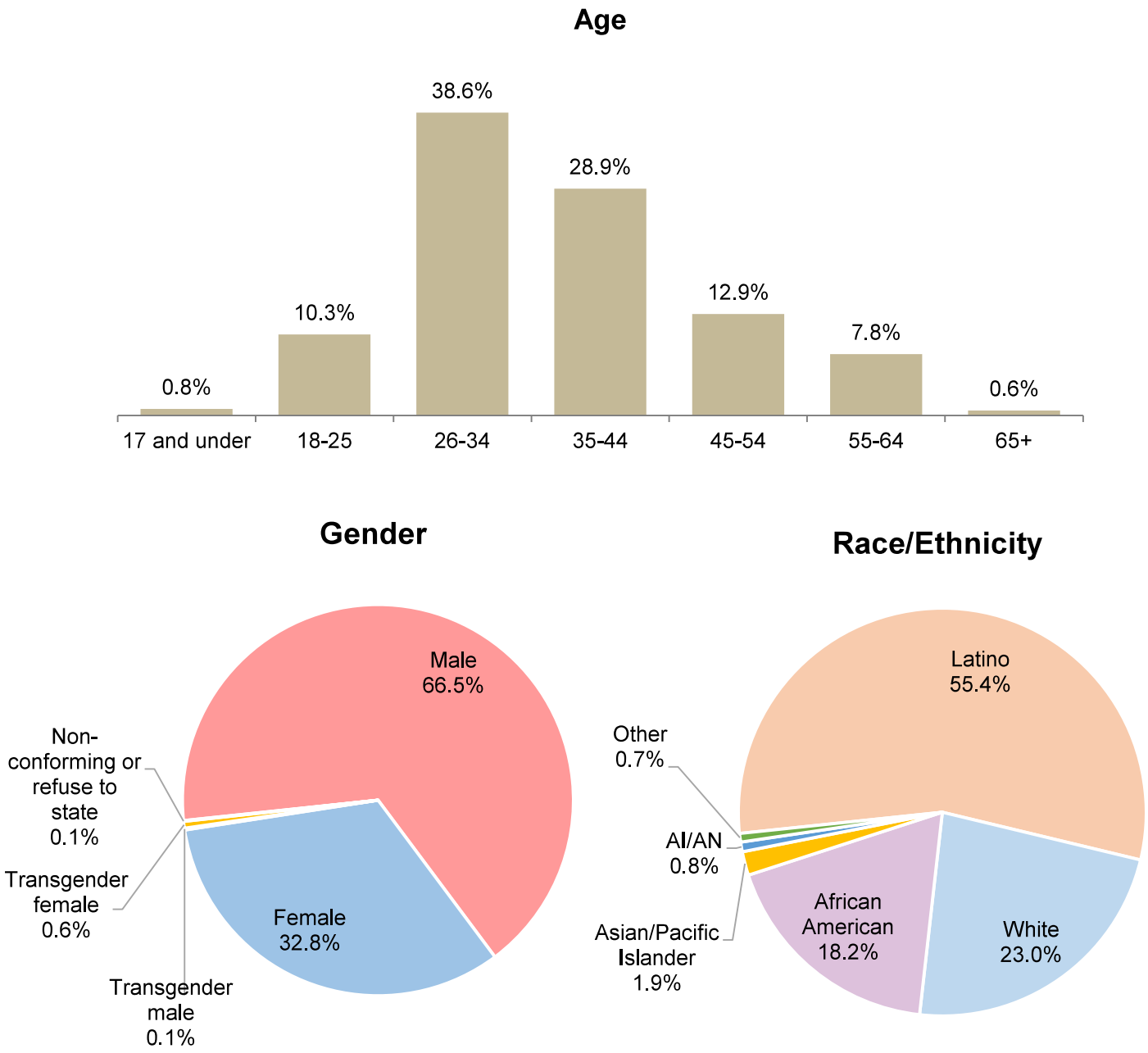
FIGURE 12. MEDI-CAL ELIGIBLE SUD PATIENTS IN RESIDENTIAL SERVICES BY AGE, GENDER, AND RACE/ETHNICITY, FY 22-23



As shown in Figure 12, the majority of patients in the residential services were male (66.5%), Latino (55.4%), and ages 26-34 (38.6%).

FIGURE 13. MEDI-CAL ELIGIBLE SUD PATIENTS IN RESIDENTIAL SERVICES BY SERVICE AREA, FY 22-23

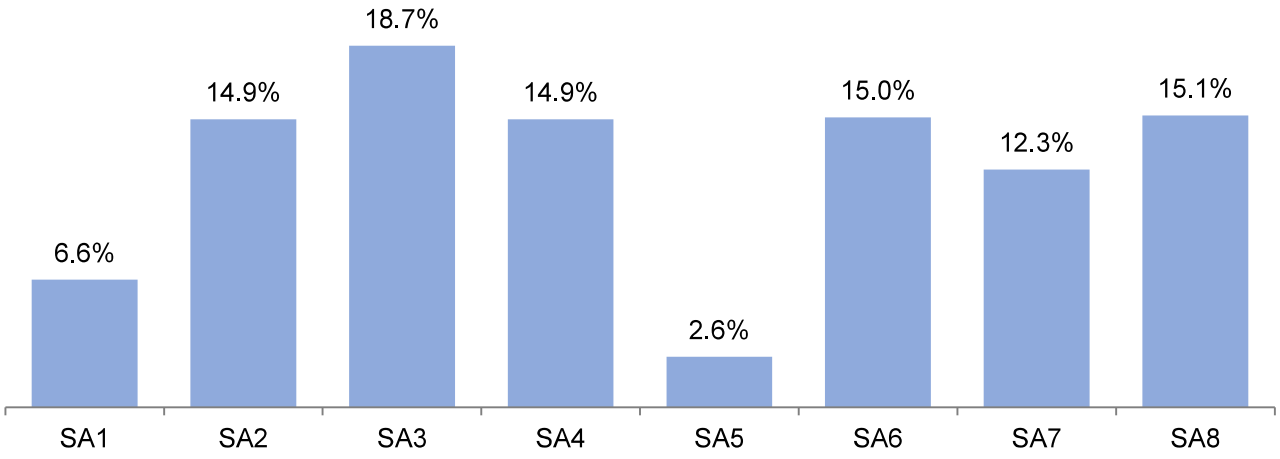


Figure 13 presents the distribution of Medi-Cal eligible SUD patients who received residential treatment across different SAs. SA3 accounted for the largest portion, representing 18.7% of the patients, while SA5 comprised the smallest share, with only 2.6%.

3. **Intensive Outpatient Treatment (N=6,084)**

Intensive outpatient services are appropriate for patients with minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions. It is appropriate for patients who need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting. Services are provided to individuals when medically necessary.

This section summarizes Medi-Cal eligibles who received SUD treatment from the intensive outpatient treatment by age, gender, race/ethnicity, and SA.

FIGURE 14. PRIMARY SUBSTANCE USE AT ADMISSION, FY 22-23

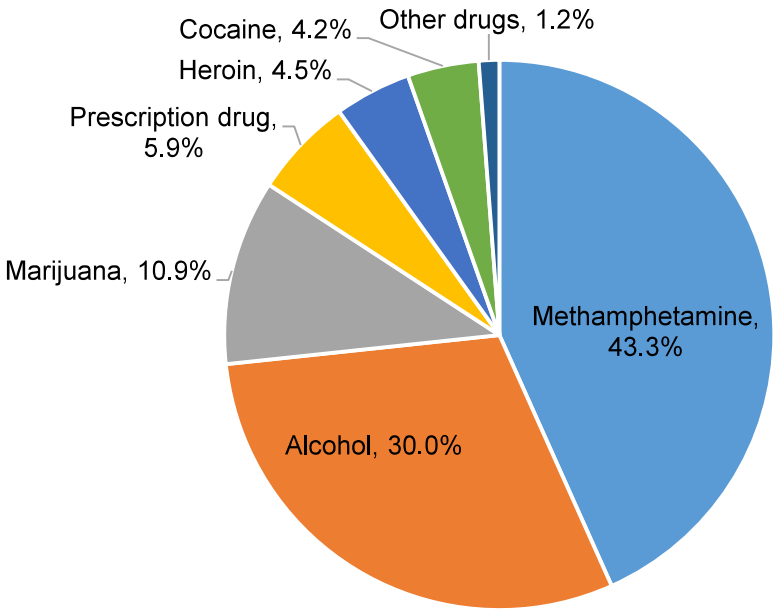


Figure 14 presents that methamphetamine was the most commonly reported primary substance use among patients in intensive outpatient treatment (43.3%), followed by alcohol (30.0%) and marijuana (10.9%).

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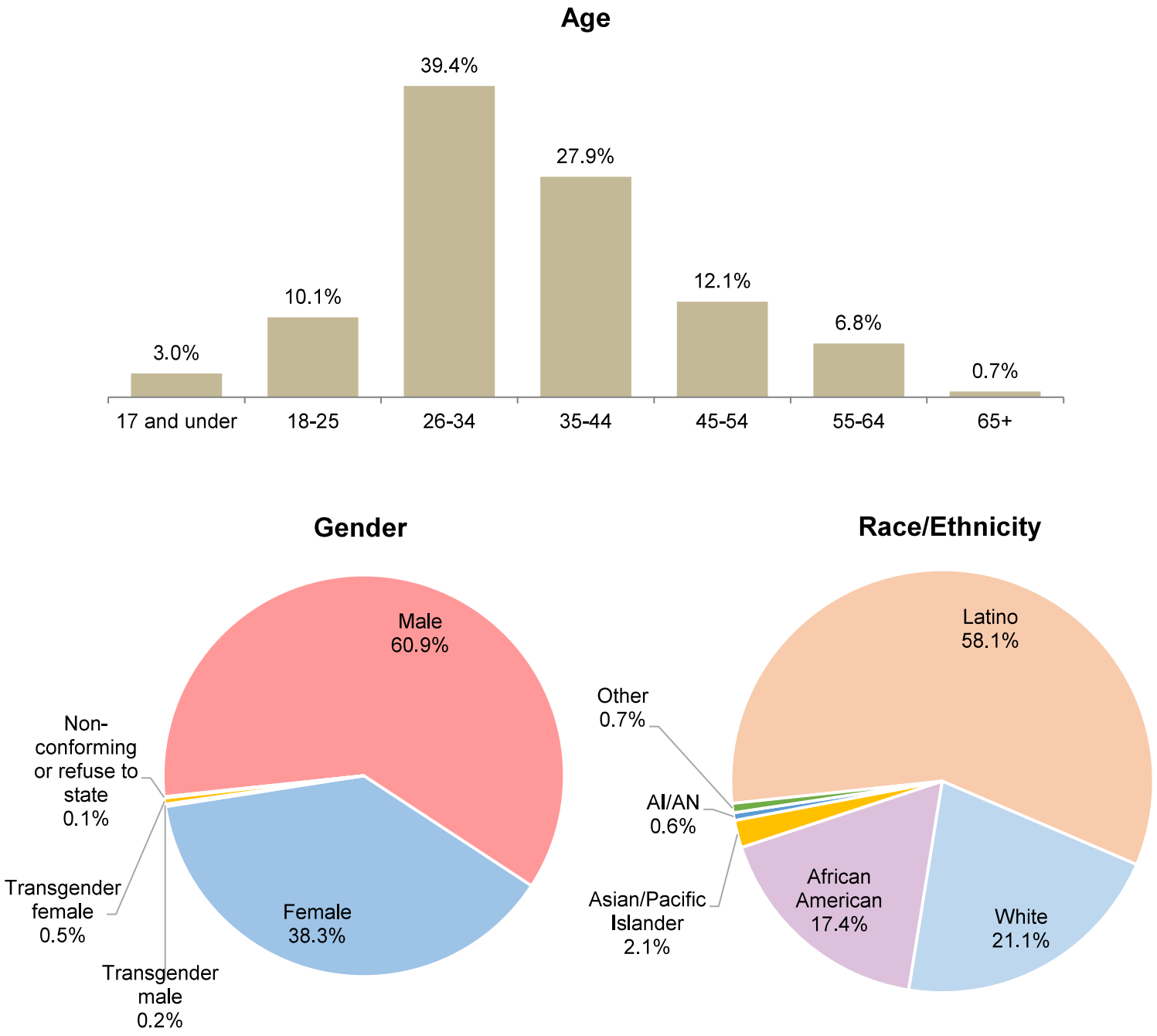
FIGURE 15. MEDI-CAL ELIGIBLE SUD PATIENTS IN INTENSIVE OUTPATIENT PROGRAM BY AGE, GENDER, AND RACE/ETHNICITY, FY 22-23



As shown in Figure 15, the majority of Medi-Cal eligible patients in the intensive outpatient treatment were male (60.9%), Latino (58.1%), and ages 26-34 (39.4%).

FIGURE 16. MEDI-CAL ELIGIBLE SUD PATIENTS IN INTENSIVE OUTPATIENT TREATMENT BY SERVICE AREA, FY 22-23

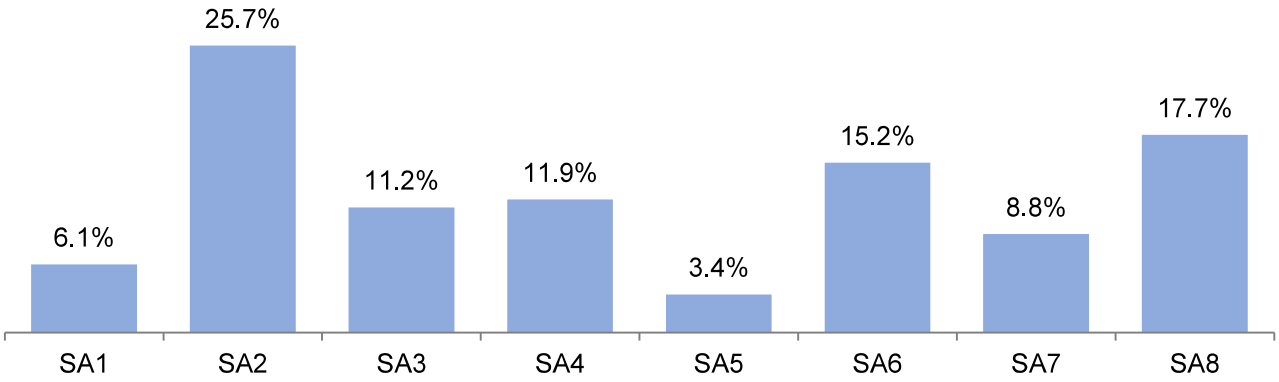


Figure 16 presents the distribution of SUD patients who received intensive outpatient treatment across different SAs. SA2 accounted for the largest portion, representing 25.7% of the patients, while SA5 comprised the smallest share, with only 3.4%.

4. Outpatient Treatment (N=9,042)

Outpatient treatment services are provided in an environment that facilitates recovery, directed towards alleviating and/or preventing alcohol and drug problems. Outpatient is appropriate for patients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.

This section summarizes Medi-Cal eligibles who received SUD treatment from the outpatient treatment by age, gender, race/ethnicity, and SA.

FIGURE 17. PRIMARY SUBSTANCE USE AT ADMISSION, FY 22-23

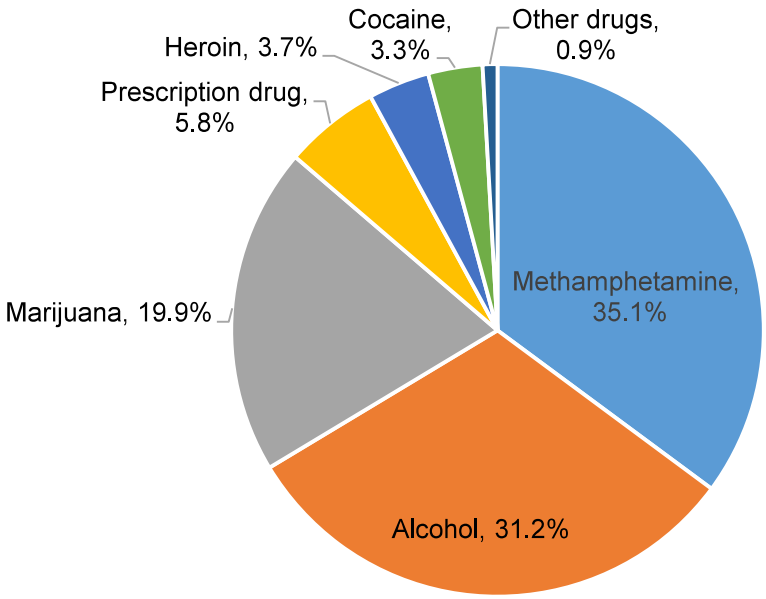
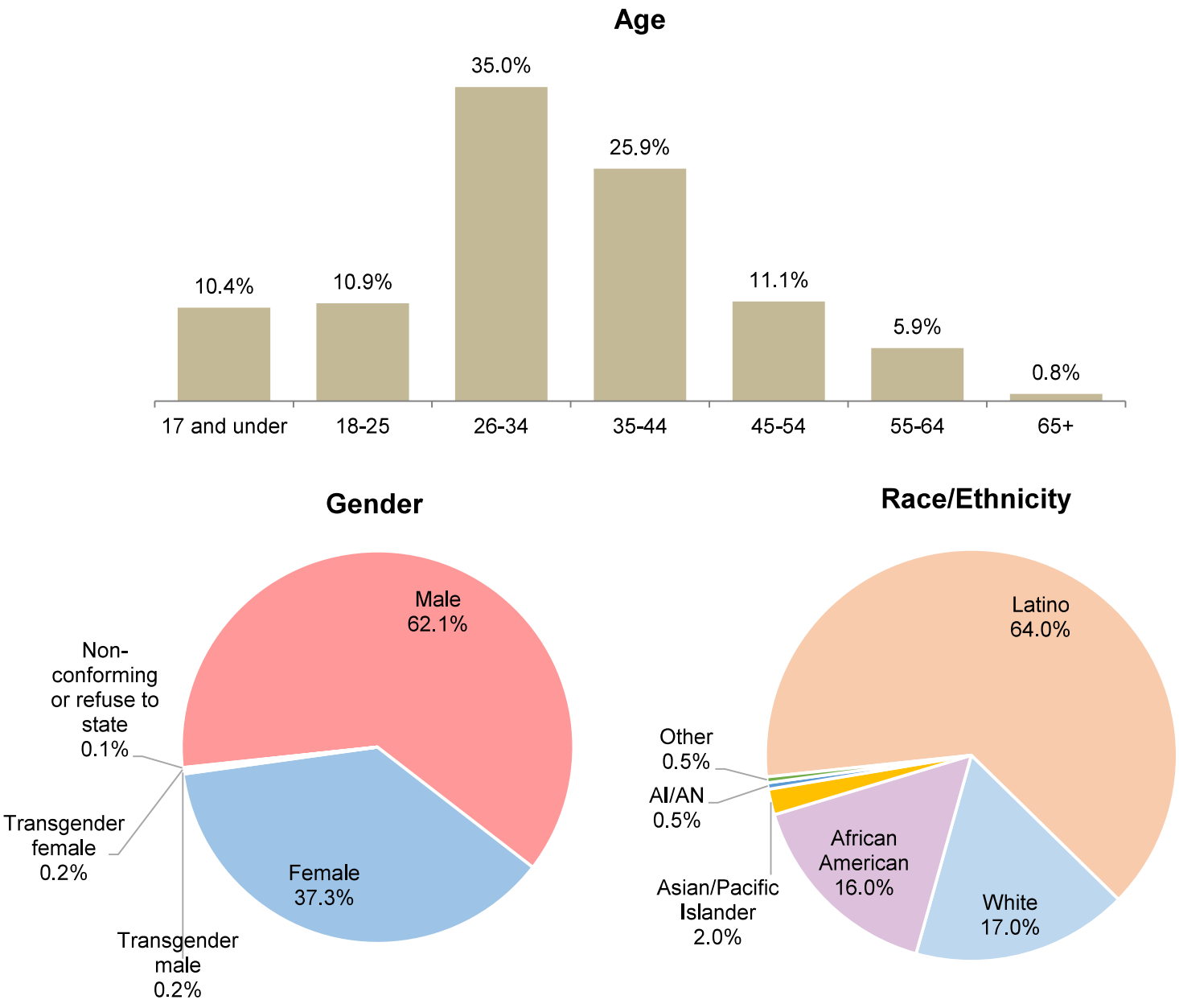


Figure 17 presents that methamphetamine was the most commonly reported primary substance use (35.1%) in outpatient programs, followed by alcohol (31.2%) and marijuana (19.9%).

FIGURE 18. MEDI-CAL ELIGIBLE SUD PATIENTS IN OUTPATIENT TREATMENT BY AGE, GENDER, AND RACE/ETHNICITY, FY 22-23



As shown in Figure 18, the majority of patients in the outpatient treatment were male (62.1%), Latino (64.0%), and ages 26-34 (35.0%).

FIGURE 19. MEDI-CAL ELIGIBLE SUD PATIENTS IN OUTPATIENT TREATMENT BY SERVICE AREA, FY 22-23

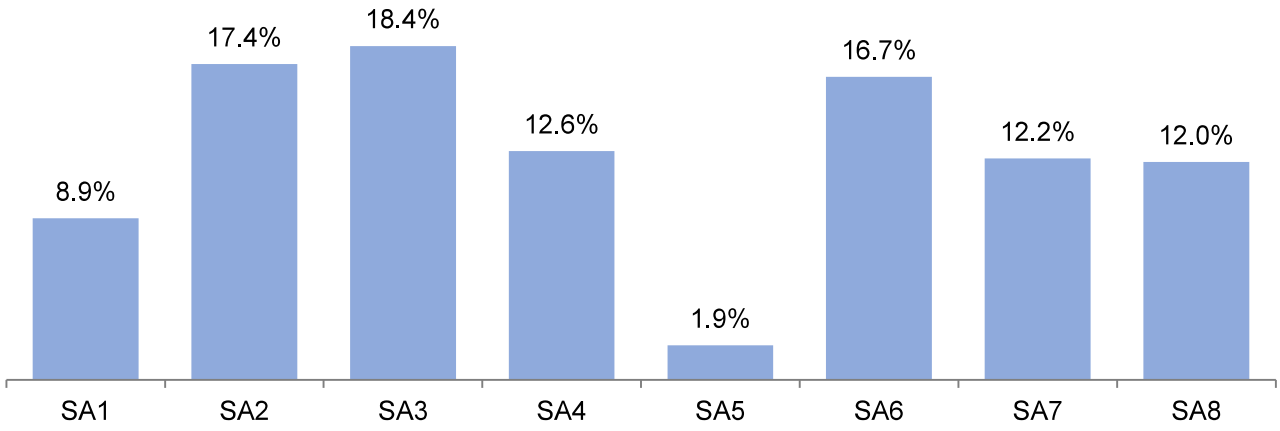


Figure 19 presents the distribution of SUD patients who received outpatient treatment across different SAs. SA3 accounted for the largest portion, representing 18.4% of the patients, while SA5 comprised the smallest share, with only 1.9%.

5. Opioid Treatment Program (N=5,697)

Opioid Treatment Programs (OTPs) are treatment settings that provide MAT, including methadone, buprenorphine, naltrexone, naloxone (for opioid overdose prevention), and disulfiram for individuals with opioid and alcohol use disorders. OTPs may also offer other types of MAT to address co-occurring SUD in addition to opioid use disorder. OTPs also offer a broad range of other services including medical, prenatal, and/or other psychosocial services.

This section summarizes Medi-Cal eligibles who received SUD treatment from the opioid treatment program by age, gender, race/ethnicity, and SA.

FIGURE 20. PRIMARY SUBSTANCE USE AT ADMISSION, FY 22-23

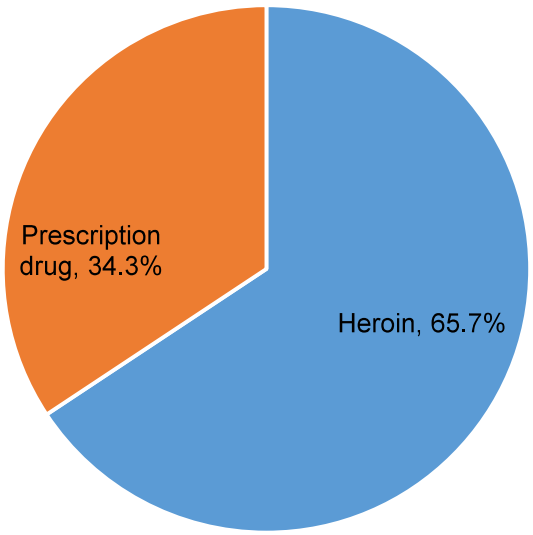
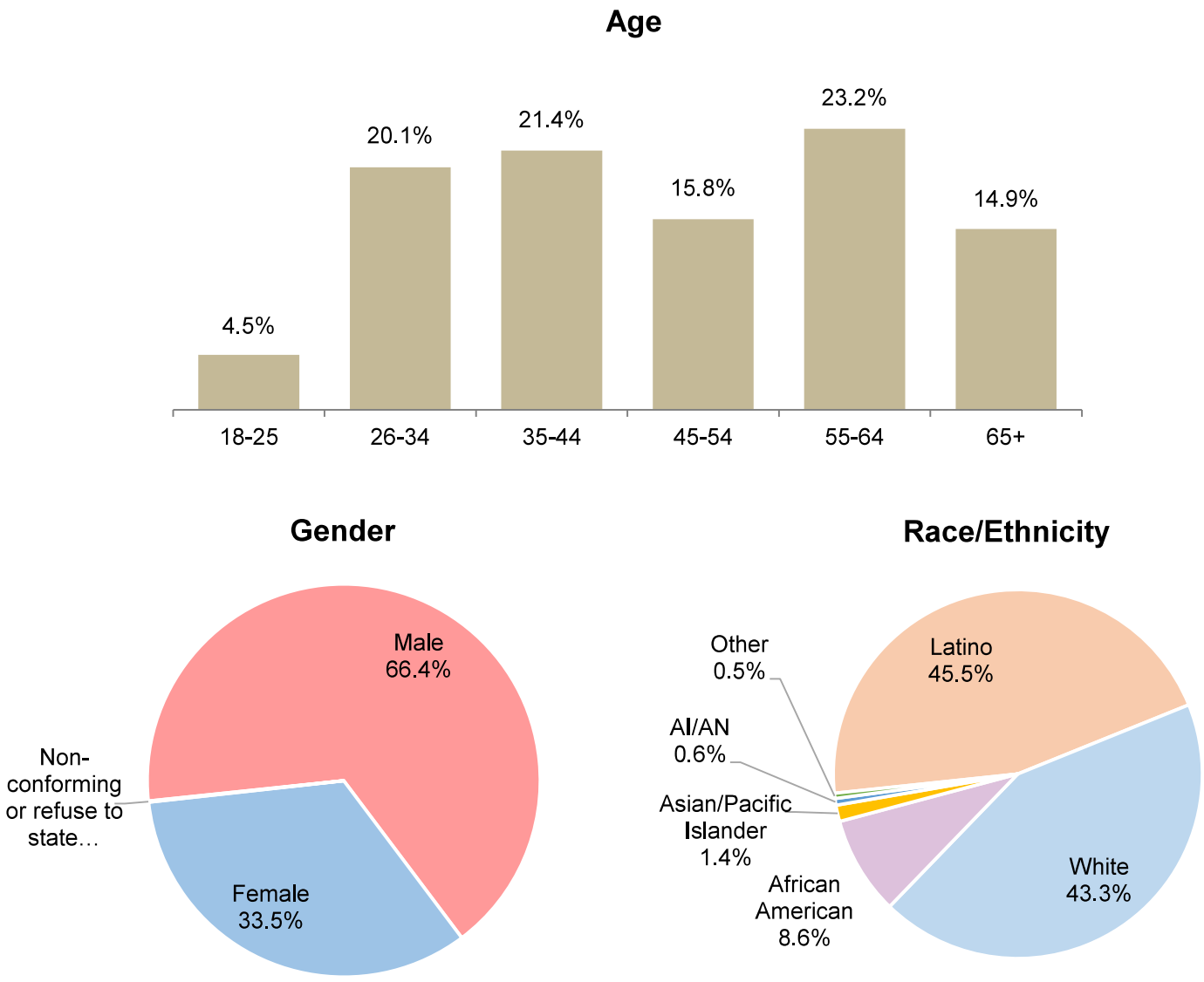


Figure 20 presents that the most commonly reported primary substance use in opioid treatment programs was heroin (65.7%), followed by prescription drug (34.3%).

FIGURE 21. MEDI-CAL ELIGIBLE SUD PATIENTS IN OPIOID TREATMENT PROGRAM BY AGE, GENDER, AND RACE/ETHNICITY, FY 22-23



As shown in Figure 21, the majority of patients in opioid treatment programs were male (66.4%), Latino (45.5%), and ages 55-64 (23.2%).

FIGURE 22. MEDI-CAL ELIGIBLE SUD PATIENTS IN OPIOID TREATMENT PROGRAM BY SERVICE AREA, FY 22-23

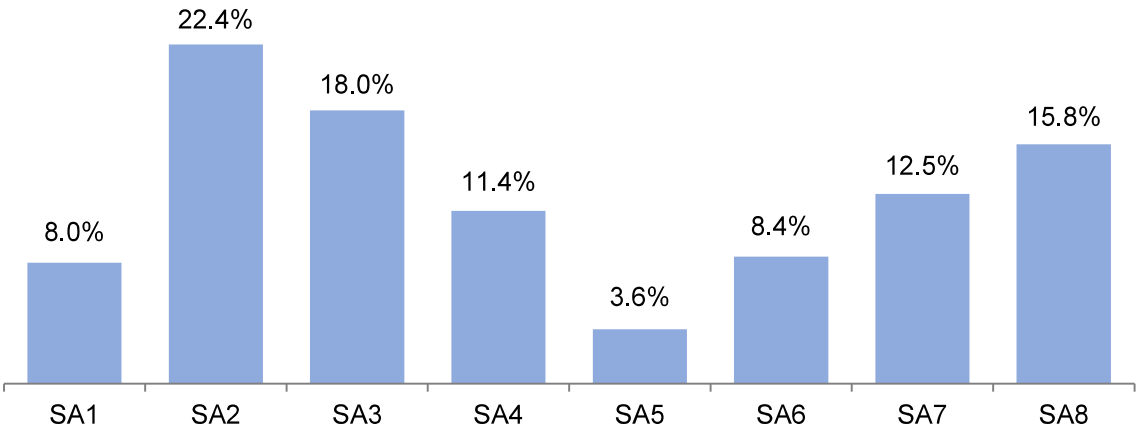


Figure 22 presents the distribution of SUD patients who received opioid treatment program across different SAs. SA2 accounted for the largest portion, representing 22.4% of the patients, while SA5 comprised the smallest share, with only 3.6%

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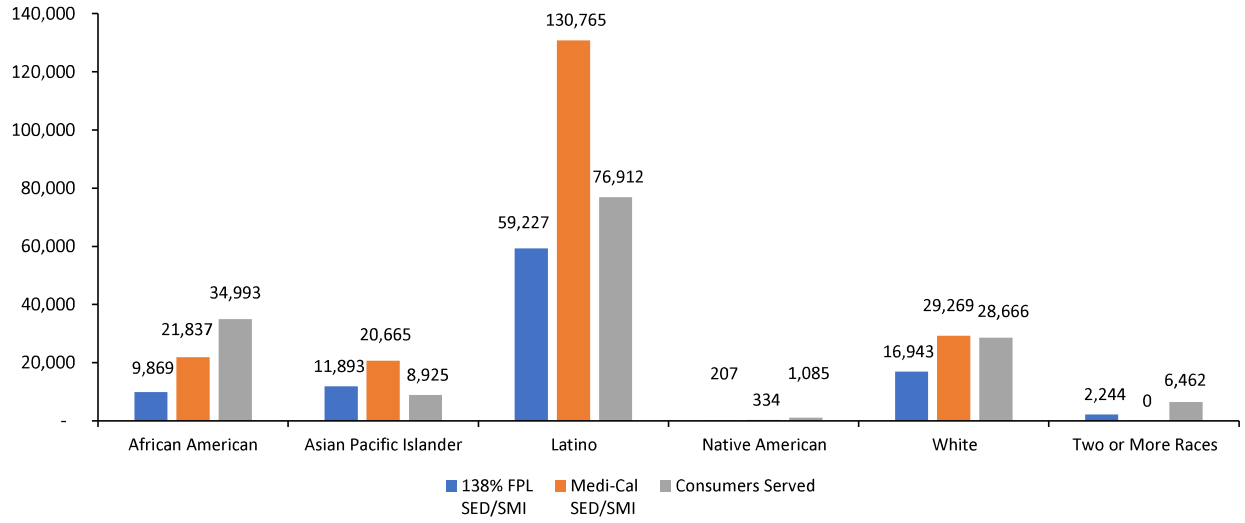
IV-A. Los Angeles County Department of Mental Health
Needs Assessment/Analysis of Disparities

Figure 23 below shows a summary demographic profile that includes the Los Angeles County total population, population living at or below 138% FPL with SED and SMI, Medi-Cal eligible individuals with SED and SMI, and consumers served for each race/ethnicity.

Figure 23: Los Angeles County Population and Demographic Profile CY 2023



LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data Sources: 1. Los Angeles County Population and 138% FPL - American Community Survey, US Census Bureau and Hedderson Demographic Services, 2024; 2. Medi-Cal Data: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility. Downloaded on April 2024; 3. FY 2022-23 Clients Served: LACDMH-IS-IBHIS, February 2024.

Overall, Latino had the highest number of individuals living at or below 138% FPL with SED and SMI (59,227) and the highest number of Medi-Cal eligible individuals with SED and SMI (130,765). They also had the highest number of consumers served (76,912).

Native American had the lowest number of individuals living at or below 138% FPL with SED and SMI (207) and the lowest number of Medi-Cal eligible individuals with SED and SMI (334). They also had the lowest number of consumers served (1,085).

IV-A. Los Angeles County Department of Mental Health Needs Assessment/Analysis of Disparities

The series of tables below (Tables 29-32) highlight disparities by comparing the number of **outpatient consumers served** and the number of **Medi-Cal eligibles with SED and SMI** by race/ethnicity, language, age group, and gender.

Caution must be exercised when looking at the disparities data that compares total consumers served against the number of Medi-Cal eligibles and 138% FPL populations with SED and SMI. The level of disparity or "unmet need" may not reflect the number of individuals that LACDMH is not serving and could be serving. Estimates of unmet need do not mean that each person would seek/receive mental health services from LACDMH. On the contrary, these persons have choices in terms of where they would access mental health services such as their primary care doctor, mental health providers via employment insurance, mental health services from community-based organizations, other Los Angeles County departments, including the Department of Public Health, urgent care centers, shelters, and traditional healers. Therefore, comparisons of consumers served against unmet needs may not be an accurate reflection of the numbers of consumers that LACDMH did not serve and could have served.

Disparity by Race/Ethnicity

TABLE 29: NEEDS ASSESSMENT OF MEDI-CAL ELIGIBLE POPULATION BY RACE/ETHNICITY ESTIMATED WITH SED AND SMI, FY 22-23

	African American	Asian Pacific Islander	Latino	Native American	White	Unreported	Two Or More Races/ Other	Total
Estimated Medi-Cal Population with SED and SMI[1]	21,837	20,665	130,765	334	29,269	22,435	N/A	225,305
Outpatient Consumers Served	34,993	8,925	76,912	1,085	28,666	27,324	6,462	202,424
Total Disparity	13,156	-11,740	-53,853	751	-603	4,889	N/A	-22,881

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. If present on the table, zero "0", indicates "no disparity" and a positive number indicates the number of individuals receiving services beyond the estimated need of services.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data sources: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded on April 2024; FY 2022-23 Clients Served: LACDMH-IS-IBHIS, February 2024.

Table 29 shows the disparities in terms of the unmet need among ethnic groups at the County level. Latino had the highest disparity with an estimated unmet service need for 53,853 Medi-Cal eligible individuals with SED and SMI. The number of unduplicated

Latino consumers served was 76,912 compared with 130,765 Medi-Cal eligible individuals with SED and SMI.

White had the lowest disparity with an estimated unmet service need for 603 Medi-Cal eligible individuals with SED and SMI. The number of unduplicated White consumers served was 28,666 compared with 29,269 Medi-Cal eligible individuals with SED and SMI.

Disparity by Language

TABLE 30: NEEDS ASSESSMENT OF MEDI-CAL ELIGIBLE POPULATION BY LANGUAGE ESTIMATED WITH SED AND SMI, CY 2023

Language	Medi-Cal Population with SED and SMI[1]	Outpatient Consumers Served	Total Disparity
English	131,943	157,742	25,799
Spanish	72,594	27,430	-45,164
Armenian	4,596	1,187	-3,409
Mandarin	2,671	588	-2,083
Cantonese	2,170	506	-1,664
Korean	1,796	728	-1,068
Vietnamese	1,478	507	-971
Farsi	797	602	-195
Russian	1,479	315	-1,164
Tagalog	503	214	-289
Cambodian	430	648	218
Arabic	311	158	-153
Other non-English	271	30	-241
Other Chinese	104	93	-11
Total	**221,144**	**190,748**	**-30,396**

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 positive "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data sources: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded on April 2024; FY 2022-23 Clients Served: LACDMH-IS-IBHIS, February 2024.

Table 30 shows the disparities in terms of the unmet need by language in Los Angeles County. Spanish speaking individuals had the highest disparity with an estimated 45,164 Spanish-speaking individuals in need of services.

Other Chinese had the lowest disparity with an estimated 11 individuals in need of services.
Overall, at the County level, there was an estimated 30,396 individuals in need of services. Out of an estimated total of 221,144 Medi-Cal eligible individuals with SED and SMI, 190,748 unduplicated consumers were served.

Disparity by Age Group

TABLE 31: NEEDS ASSESSMENT OF MEDI-CAL ELIGIBLE POPULATION BY AGE GROUP ESTIMATED WITH SED AND SMI, FY 22–23

	Age Group				
CY 2023	**0-18**	**19-44**	**45-64**	**65+**	**Total**
Medi-Cal Population with SED and SMI[1]	107,718	84,580	48,020	25,381	265,699
Outpatient Consumers Served	74,990	70,080	44,743	12,610	202,423
Total Disparity	-32,728	-14,500	-3,277	-12,771	-63,276

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 positive number indicates the number of individuals receiving services beyond the estimated need of services.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data sources: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded on April 2024; FY 2022-23 Clients Served: LACDMH-IS-IBHIS, February 2024.

Table 31 shows the disparities in terms of the unmet need based on age group at the County level.

The age group 0-18 had the highest disparity with an estimated 32,728 individuals in need of services.

The age group 45-64 had the lowest disparity with an estimated 3,277 individuals in need of services.

Disparity by Gender

TABLE 32: NEEDS ASSESSMENT OF MEDI-CAL ELIGIBLE POPULATION BY GENDER ESTIMATED WITH SED AND SMI, FY 22–23

FY 22-23	Male	Female	Total
Medi-Cal Population with SED and SMI[1]	105,623	119,681	225,304
Outpatient Consumers Served	94,485	107,865	202,350
Total Disparity	-11,138	-11,816	-22,954

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 positive number indicates the number of individuals receiving services beyond the estimated need of services.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data sources: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded on April 2024; FY 2022-23 Clients Served: LACDMH-IS-IBHIS, February 2024.

Table 32 shows the disparities in terms of the unmet need based on gender at the County level. Female had a higher disparity than male with an estimated 11,816 females in need of services compared to an estimated 11,138 males in need of services.

The series of tables below (Tables 33-36) highlight disparities by comparing the number of outpatient consumers served and the number of **individuals living at or below 138% federal poverty level (FPL) with SED and SMI** by race/ethnicity, language, age group, and gender.

Disparity: FPL by Race/Ethnicity

TABLE 33: NEEDS ASSESSMENT OF 138% FEDERAL POVERTY LEVEL (FPL) POPULATION BY RACE/ETHNICITY ESTIMATED WITH SED AND SMI, FY 22-23

	African American	Asian Pacific Islander	Latino	Native American	White	Two or More Races	Unreported	Total
138% FPL Population with SED and SMI[1]	9,869	11,893	59,227	207	16,943	2,244	N/A	100,383
Outpatient Consumers Served	34,993	8,925	76,912	1,085	28,666	6,462	27,324	184,367
Total Disparity	25,124	-2,968	17,685	878	11,723	4,218	N/A	83,984

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. If present on the table, zero "0", indicates "no disparity" and a positive number indicates the number of individuals receiving services beyond the estimated need of services.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data sources: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded on April 2024; FY 2022-23 Clients Served: LACDMH-IS-IBHIS, February 2024.

Table 33 shows the disparities in terms of the unmet need among ethnic groups at the County level. Mental health services need were met for most ethnicities except for Asian Pacific Islanders. They had a disparity with an estimated unmet service need for 2,968 individuals living at or below 138% FPL with SED and SMI. The number of unduplicated Asian Pacific Islander consumers served was 8,925 compared with the estimated 11,893 individuals living at or below 138% FPL with SED and SMI.

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Disparity: FPL by Language

TABLE 34: NEEDS ASSESSMENT OF 138% FEDERAL POVERTY LEVEL (FPL) POPULATION BY LANGUAGE ESTIMATED WITH SED AND SMI, FY 21-22

Language	138% FPL Population with SED and SMI[1]	Outpatient Consumers Served	Total Disparity
English	36,233	157,742	121,509
Spanish	48,515	27,430	-21,085
Armenian	2,156	1,187	-969
Mandarin	1,557	588	-969
Cantonese	819	506	-313
Korean	1,612	728	-884
Vietnamese	936	507	-429
Farsi	685	602	-83
Russian	587	315	-272
Tagalog	1,188	214	-974
Cambodian	512	648	136
Arabic	546	158	-388
Other Chinese	2,075	93	-1,982
Other non-English	2,962	30	-2,932
Unknown/Unreported	N/A	2,900	N/A
Total	**100,383**	**193,648**	93,265

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 positive number indicates the number of individuals receiving services beyond the estimated need of services.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data sources: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded on April 2024; FY 2022-23 Clients Served: LACDMH-IS-IBHIS, February 2024.

Table 34 shows the disparities in terms of the unmet need based on the threshold languages in Los Angeles County.

Spanish had the highest disparity with an estimated 21,805 Spanish-speaking individuals in need of services.

Farsi had the lowest disparity with an estimated 83 individuals in needs of services.

Overall, at the County level, the number of individuals receiving services exceeded the estimated need of services. Out of an estimated total of 100,383 individuals living at or below 138% FPL with SED and SMI, 193,648 unduplicated consumers were served.

Disparity: FPL by Age Group

TABLE 35: NEEDS ASSESSMENT OF 138% FEDERAL POVERTY LEVEL (FPL) POPULATION BY AGE GROUP ESTIMATED WITH SED AND SMI, FY 22–23

	Age Group				
FY 22-23	**0-15**	**16-25**	**29-59**	**60+**	**Total**
138% FPL Population with SED and SMI[1]	38,908	22,289	42,664	19,471	123,332
Outpatient Consumers Served	54,773	39,061	83,827	24,762	202,423
Total Disparity	15,865	16,772	41,163	5,291	79,091

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 positive number indicates the number of individuals receiving services beyond the estimated need of services.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data sources: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded on April 2024; FY 2022-23 Clients Served: LACDMH-IS-IBHIS, February 2024.

Table 35 shows mental health services need were met for all age groups living at or below 138% FPL with SED and SMI.

Disparity: FPL by Gender

TABLE 36: NEEDS ASSESSMENT OF 138% FEDERAL POVERTY LEVEL (FPL) POPULATION BY GENDER ESTIMATED WITH SED AND SMI, FY 22–23

FY 22-23	Male	Female	Total
138% FPL Population with SED and SMI[1]	44,870	55,513	100,383
Outpatient Consumers Served	94,485	107,865	202,350
Total Disparity	49,615	52,352	101,967

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 positive number indicates the number of individuals receiving services beyond the estimated need of services.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data sources: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded on April 2024; FY 2022-23 Clients Served: LACDMH-IS-IBHIS, February 2024.

Table 36 shows mental health services need were met for both genders male and female living at or below 138% FPL with SED and SMI.

IV-B. Los Angeles County Department of Public Health Needs Assessment/Analysis of Disparities Among SUD Medi-Cal Population

The Substance Use Disorder (SUD) penetration rate measures the proportion of Medi-Cal eligibles aged 12 and above who receive SUD services out of the estimated SUD population. This section provides a summary of SUD treatment demands (estimated SUD population), service availability (population receiving treatment), and the penetration rate, broken down by age, gender, race/ethnicity, sexual orientation status, and Service Area (SA). These analyses are essential for assessing disparities in SUD needs across different subgroups.

Disparity by Age

TABLE 37: NEEDS ASSESSMENTS OF MEDI-CAL POPULATION WITH SUD BY AGE, FY 23-24

FY 23-24	Age Group			
	12-17	18-25	26+	LA County
Estimated Medi-Cal Population with SUD	19,501	77,626	189,405	286,532
Medi-Cal Population with SUD served	1,112	2,440	23,650	27,202
Penetration Rates	6%	3%	12%	9%

Table 37 shows significant disparities in SUD penetration rates across different age groups. Compared to the countywide penetration rate of 9%, young adults (18-25) and adolescents (12-17) had a lower penetration rate at just 3% and 6%, respectively. In contrast, adults (26+) had a higher penetration rate at 12%.

Disparity by Gender

TABLE 38: NEEDS ASSESSMENTS OF MEDI-CAL POPULATION WITH SUD BY GENDER, FY 23-24

FY 23-24	Gender		
	Male	Female	LA County
Estimated Medi-Cal Population with SUD	160,361	126,171	286,532
Medi-Cal Population with SUD served	17,512	9,557	27,202
Penetration Rates	11%	8%	9%

Table 38 reveals the disparities in substance use disorder (SUD) penetration rates across different gender groups. Compared to the countywide penetration rate of 9%,

females had a relatively lower penetration rate at 8% and males had a higher penetration rate at 11%.

Disparity by Race/Ethnicity

TABLE 39: NEEDS ASSESSMENTS OF MEDI-CAL POPULATION WITH SUD BY RACE/ETHNICITY, FY 23-24

FY 23-24	Race/Ethnicity						
	African American	Asian/ Pacific Islander	Latino	AI/AN	White	Other*	LA County
Estimated Medi-Cal Population with SUD	33,516	16,299	182,018	711	45,970	8,018	268,532
Medi-Cal Population with SUD served	4,127	500	14,960	171	7,285	159	27,202
Penetration Rates	12%	3%	8%	24%	16%	2%	9%

Table 39 shows significant disparities in SUD penetration rates across different racial and ethnic groups. Compared to the countywide penetration rate of 9%, Asian/Pacific Islander and Latino SUD populations had a lower penetration rate at just 3% and 8% respectively. In contrast, the AI/AN SUD population had the highest penetration rate at 24%, followed by Whites at 16%, and African Americans at 12%.

Disparity by Primary Language

TABLE 40: NEEDS ASSESSMENT OF MEDI-CAL POPULATION WITH SUD BY LANGUAGE

Language	Estimated Medi-Cal Population with SUD	Medi-Cal Population with SUD Served	Penetration Rates
English	258,882	24,369	9%
Spanish	22,286	2,465	11%
Armenian	2,226	200	9%
Russian	604	53	9%
Farsi	477	46	10%
Chinese (Mandarin/Cantonese/Other Chinese)	216	18	8%
Arabic	188	18	10%
Korean	152	13	9%
Tagalog	108	10	9%
Vietnamese	87	9	10%
Cambodian	8	1	13%

LA County	286,532	27,202	9%

Table 40 highlights disparities in SUD penetration rates among Medi-Cal population by primary language, which range from 8% to 13%. Medi-Cal eligibles whose primary language is Chinese had a lower penetration rate of 8%, below the county average of 9%. In contrast, beneficiaries whose primary language is Cambodian had the highest penetration rate at 13%, followed by primary Spanish speakers at 11%, and Farsi and Arabic primary speakers at 10%.

Disparity by Sexual Orientation

TABLE 41: NEEDS ASSESSMENT OF MEDI-CAL POPULATION WITH SUD BY SEXUAL ORIENTATION, FY 23-24

FY 23-24	Sexual Orientation				
	Straight/ Heterosexual	Bisexual	Gay/Lesbian	Uncertain/ questioning	LA County
Estimated Medi-Cal Population with SUD	210,834	44,228	18,839	12,631	286,532
Medi-Cal Population with SUD served	25,286	794	937	185	27,202
Penetration Rates	**12%**	2%	5%	**1%**	9%

Table 41 reveals significant disparities in SUD penetration rates across different sexual orientation groups. Compared to the countywide penetration rate of 9%, Uncertain/questioning, bisexual, gay/lesbian SUD populations had a lower penetration rate at just 1%, 2%, and 5% respectively. In contrast, the straight/heterosexual SUD population had the highest penetration rate at 12%.

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Disparity by Service Area

TABLE 42: NEEDS ASSESSMENT OF MEDI-CAL POPULATION WITH SUD BY SA FY 23-24

FY 23-24	Service Area (SA)								
	SA1	SA2	SA3	SA4	SA5	SA6	SA7	SA8	LA County
Estimated Medi-Cal Population with SUD	14,937	60,661	35,713	45,663	9,110	43,052	32,167	45,229	286,532
Medi-Cal Population with SUD served	2,113	5,136	4,053	3,647	929	4,070	2,999	4,255	27,202
Penetration Rates	14%	8%	11%	8%	10%	9%	9%	9%	9%

Table 42 reveals significant disparities in SUD penetration rates across different SAs. Compared to the countywide penetration rate of 9%, SUD populations from SA2 and SA4 had a relatively lower penetration rate of 8%. In contrast, the SUD population from SA1 had the highest penetration rate of 14%.

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V. 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 43: MHSA CSS CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY RACE/ETHNICITY AND SERVICE AREA, FY 22-23

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Unreported	Other	Total
SA 1	4,161	157	4,067	66	2,720	680	1,054	335	13,240
Percent	31.4%	1.2%	30.7%	0.50%	20.5%	5.1%	8.0%	2.5%	100.0%
SA 2	2,041	1,071	11,273	81	6,451	887	4,091	2,255	28,150
Percent	7.3%	3.8%	40.0%	0.29%	22.9%	3.2%	14.5%	8.0%	100.0%
SA 3	1,770	2,403	9,106	127	3,181	909	2,514	6,073	26,083
Percent	6.8%	9.2%	34.9%	0.49%	12.2%	3.5%	9.6%	23.3%	100.0%
SA 4	5,727	1,982	**12,925**	**259**	4,508	793	2,885	1,564	30,643
Percent	18.7%	6.5%	42.2%	0.85%	14.7%	2.6%	9.4%	5.1%	100.0%
SA 5	2,017	281	2,359	44	2,851	419	1,122	866	9,959
Percent	20.3%	2.8%	23.7%	0.44%	28.6%	4.2%	11.3%	8.7%	100.0%
SA 6	9,642	248	10,386	141	1,344	536	2,375	866	25,538
Percent	37.8%	1.0%	40.7%	0.55%	5.3%	2.1%	9.3%	3.4%	100.0%
SA 7	1,055	517	10,888	**187**	1,966	681	1,436	2,452	19,182
Percent	5.5%	2.7%	56.8%	0.97%	10.2%	3.6%	7.5%	12.8%	100.0%
SA8	6,717	2,021	**12,322**	110	4,639	1,177	2,827	1,785	31,598
Percent	21.3%	6.4%	39.0%	0.35%	14.7%	3.7%	8.9%	5.6%	100.0%
Total	27,344	7,339	59,806	868	22,747	4,994	15,433	13,399	151,930
Percent	18.0%	4.8%	**39.4%**	**0.57%**	15.0%	3.3%	10.2%	8.8%	100.0%

Bold values represent the highest and lowest ethnicity served across all SAs. For the highest and lowest ethnicities served orange color values represent the SA with the highest consumers served and blue values represent the SAs with the second highest consumers served. The body of the table represents count of Consumers use of services across Service Areas. The last row total shows the unique count of Outpatient Consumers served during Fiscal Year 2022-23 Percents may not add up to 100% due to rounding.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data Source: LACDMH-IS-IBHIS, June 2024.

Table 43 presents an unduplicated count of MHSA Community Services and Supports (CSS) consumers served in outpatient programs by ethnicity and Service Area.

Overall, Latino represent the largest consumer (39.4%) in Los Angeles County compared to Native American represent the smallest consumer (0.57%).

TABLE 44: MHSA CSS CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP AND SERVICE AREA, FY 22-23

Service Area (SA)	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	3,277	2,265	6,315	1,383	13,240
Percent	24.8%	17.1%	47.7%	10.4%	100.0%
SA 2	6,687	5,564	12,312	3,587	28,150
Percent	23.8%	19.8%	43.7%	12.7%	100.0%
SA 3	8,225	6,069	9,299	2,490	26,083
Percent	31.5%	23.3%	35.7%	9.5%	100.0%
SA 4	6,037	5,339	**14,353**	**4,914**	30,643
Percent	19.7%	17.4%	46.8%	16.0%	100.0%
SA 5	1,536	1,561	5,133	1,729	9,959
Percent	15.4%	15.7%	51.5%	17.4%	100.0%
SA 6	5,925	4,809	11,494	3,309	25,538
Percent	23.2%	18.8%	45.0%	13.0%	100.0%
SA 7	5,192	4,636	7,617	1,737	19,182
Percent	27.1%	24.2%	39.7%	9.1%	100.0%
SA 8	7,349	5,533	**14,695**	**4,020**	31,598
Percent	23.3%	17.5%	46.5%	12.7%	100.0%
Total	35,381	28,374	67,795	20,378	151,928
Percent	23.3%	18.7%	**44.6%**	**13.4%**	100.0%

Bold values represent the highest and lowest age group served across all SAs. For the highest and lowest age group served orange color values represent the SA with the highest consumers served and blue values represent the SAs with the second highest consumers served. The body of the table represents count of Consumers use of services across SAs. The last row total shows the unique count of Outpatient Consumers served during Fiscal Year 2022-23. Percents may not add up to 100% due to rounding. Number of Unknown Age (N=2). Data Source: LACDMH IS-IBHIS, June 2024.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs.

Table 44 presents the count of MHSA consumers served in outpatient programs by age group and Service Area.

Overall, adults (age 26-59) represent the largest consumer (44.6%) compared to older adults (age 60+) represent the smallest consumer (13.4%).

TABLE 45: MHSA CSS CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA, FY 22-23

Service Area (SA)	Gender			
	Male	Female	Unknown	Total
SA 1	5,782	7,457	1	13,240
Percent	**43.7%**	**56.3%**	0.01%	100.0%
SA 2	12,656	15,490	4	28,150
Percent	45.0%	55.0%	0.01%	100.0%
SA 3	11,774	14,301	8	26,083
Percent	45.1%	54.8%	0.03%	100.0%
SA 4	15,564	15,058	21	30,643
Percent	**50.8%**	**49.1%**	0.07%	100.0%
SA 5	4,802	5,153	4	9,959
Percent	48.2%	51.7%	0.04%	100.0%
SA 6	11,447	14,084	7	25,538
Percent	44.8%	55.1%	0.03%	100.0%
SA 7	8,542	10,635	5	19,182
Percent	44.5%	55.4%	0.03%	100.0%
SA 8	14,069	17,524	5	31,598
Percent	44.5%	55.5%	0.02%	100.0%
Total	69,101	82,786	43	151,930
Percent	45.5%	54.5%	0.03%	100.0%

Note: The body of the table represents count of Consumers use of services across Service Areas. The last row total shows the unique count of Outpatient Consumers served during Fiscal Year 2022-23. Percents may not add up to 100% due to rounding. Bold values represent the highest and lowest percentages within each gender and across all SAs.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data Source: LACDMH-IS-IBHIS, June 2024.

Table 45 presents the count of MHSA consumers served in outpatient programs by gender and Service Area during Fiscal Year 2022-2023.

SA 4 had the **highest** percentage (50.8%) of **male** consumers served in outpatient programs compared to SA 1 with the **lowest** percentage (43.7%).

SA 1 had the **highest** percentage (56.3%) of **female** consumers served in outpatient programs compared to SA 4 with the **lowest** percentage (49.1%).

TABLE 46: MHSA CSS CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY THRESHOLD LANGUAGE AND SERVICE AREA, FY 22-23

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Other non-English	Russian	Spanish	Tagalog	Vietnamese	Unknown/ Unreported	Total
SA 1	4	14	0	0	11,882	5	3	1	0	2	4	837	6	0	410	13,168
Percent	0.03%	0.11%	0.00%	0.00%	90.2%	0.04%	0.02%	0.01%	0.00%	0.02%	0.03%	6.4%	0.05%	0.00%	3.11%	100.00%
SA 2	46	662	18	3	22,250	423	42	5	8	4	77	3,571	67	42	289	27,507
Percent	0.2%	2.4%	0.1%	0.0%	80.9%	1.5%	0.2%	0.0%	0.0%	0.0%	0.3%	13.0%	0.2%	0.2%	1.1%	100.0%
SA 3	20	30	60	315	19,698	6	48	428	52	4	1	3,643	22	199	1,139	25,665
Percent	0.1%	0.1%	0.2%	1.2%	76.8%	0.0%	0.2%	1.7%	0.2%	0.0%	0.0%	14.2%	0.1%	0.8%	4.4%	100.0%
SA 4	26	382	42	79	**23,495**	50	516	65	11	3	80	**4,677**	53	40	303	29,822
Percent	0.1%	1.3%	0.1%	0.3%	78.8%	0.2%	1.7%	0.2%	0.0%	0.0%	0.3%	15.7%	0.2%	0.1%	1.0%	100.0%
SA 5	9	10	2	2	8,755	113	7	2	0	6	42	617	2	2	74	9,643
Percent	0.1%	0.1%	0.0%	0.0%	90.8%	1.2%	0.1%	0.0%	0.0%	0.1%	0.4%	6.4%	0.0%	0.0%	0.8%	100.0%
SA 6	4	13	0	0	21,000	4	15	6	1	0	9	3,769	5	10	167	25,003
Percent	0.02%	0.05%	0.00%	0.00%	83.99%	0.02%	0.06%	0.02%	0.00%	0.00%	0.04%	15.07%	0.02%	0.04%	0.67%	100.00%
SA 7	18	3	16	9	15,375	3	24	18	5	0	1	3,277	16	7	252	19,024
Percent	0.09%	0.02%	0.08%	0.05%	80.82%	0.02%	0.13%	0.09%	0.03%	0.00%	0.01%	17.2%	0.08%	0.04%	1.32%	100.00%
SA 8	14	25	507	13	**25,971**	52	83	22	5	6	9	**3,841**	59	114	114	30,835
Percent	0.05%	0.08%	1.64%	0.04%	84.23%	0.17%	0.27%	0.07%	0.02%	0.02%	0.03%	12.46%	0.19%	0.37%	0.37%	100.00%
Total	129	952	606	384	121,289	565	608	467	76	20	186	20,524	195	375	2,279	148,655
Percent	0.1%	0.6%	0.4%	0.3%	**81.6%**	0.4%	0.4%	0.3%	0.1%	0.0%	0.1%	**13.8%**	0.1%	0.3%	1.5%	100.0%

Note: The body of the table represents count of Consumers use of services across Service Areas. The last row total shows the unique count of Outpatient Consumers served during Fiscal Year 2022-23. Percents may not add up to 100% due to rounding. "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 (N=2,421) in the primary language field were specified as 'No Entry'. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. The body of the table represents count of Consumers use of services across Service Areas, the last row total shows the unique count of Outpatient Consumers served during Fiscal Year 2022-23. Bold values represent the highest and second highest language of consumers served across all SAs. For the highest and second highest language orange values represent the SAs with the highest number of consumers served and blue values represent SAs with the second highest number of consumers served.

LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs. Data Source: LACDMH-IS-IBHIS, June 2024.

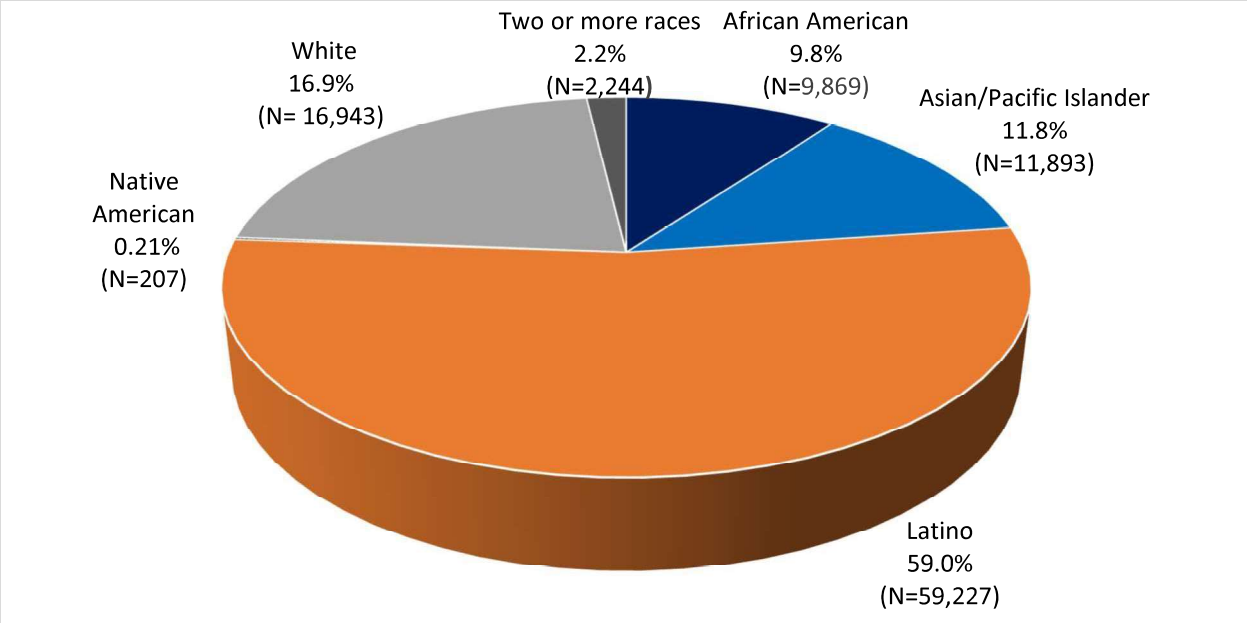
Table 46 shows English and Spanish are the most common languages among MHSA consumers in all of the Service Areas.

English was the highest reported primary language (81.6%) among MHSA consumers served in outpatient programs across all SAs. SA 8 had the highest number (25,971) of English-speaking consumers and SA 4 had the second highest number (23,495) of English-speaking consumers.

Spanish was the highest reported non-English threshold language (13.8%) among MHSA consumers served in outpatient programs across all SAs. SA 4 had the highest number (4,677) of Spanish-speaking consumers and SA 8 had the second highest number (3,841) of Spanish-speaking consumers.

B. LACDMH Analysis of Disparities

FIGURE 24: ESTIMATED POPULATION BELOW OR AT 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE/ETHNICITY, CY 2023



Note: SED/SMI Prevalence applied for all ethnicity groups = 5%.

Figure 24 shows the estimated population below or at 138% FPL in need of services by race/ethnicity.

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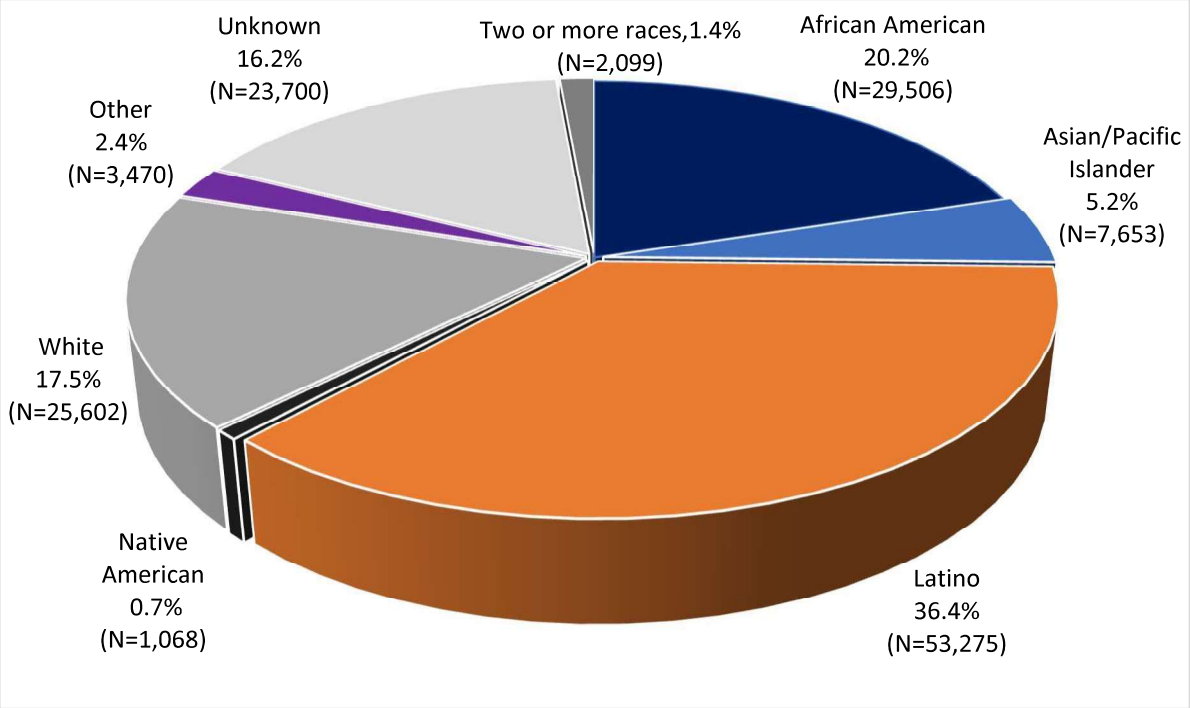
FIGURE 25: CSS CONSUMER POPULATION BY RACE/ETHNICITY FY 23-24



LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs.

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

Figure 25 shows the CSS consumer population by race/ethnicity. Latino is the largest group at 36.4% compared with Native American being the smallest group at 0.7%.

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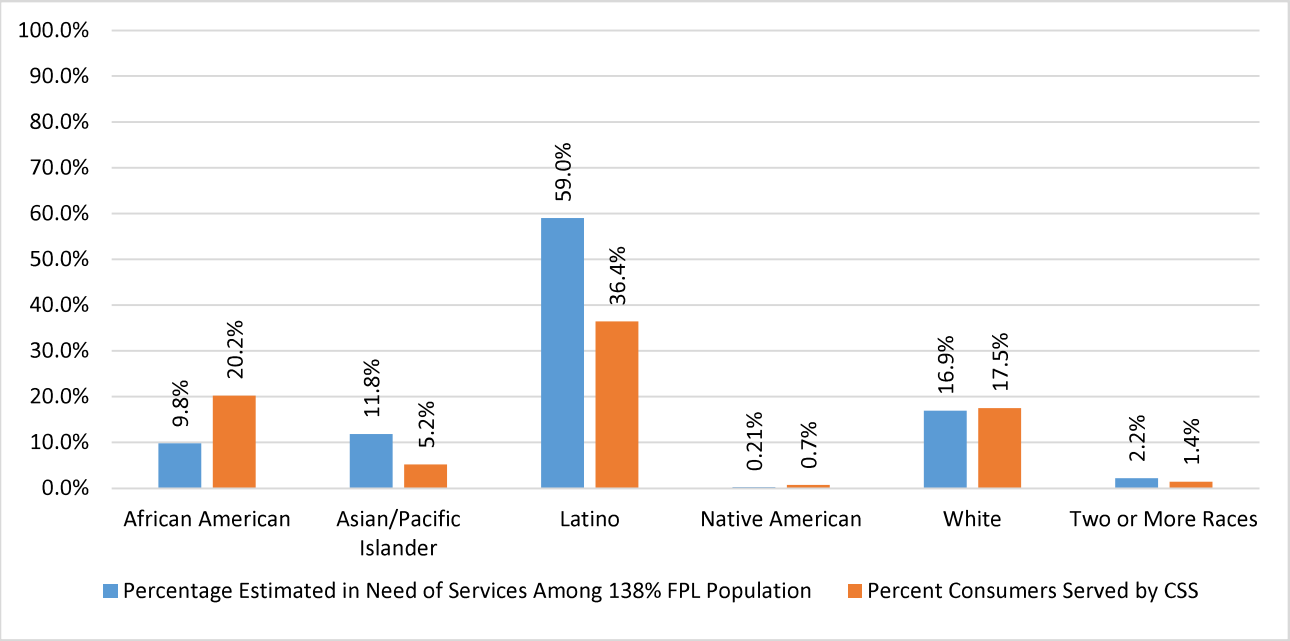
FIGURE 26: NEEDS ASSESSMENT SUMMARY FOR CSS PROGRAMS: PERCENTAGE OF POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES AND CONSUMERS SERVED BY RACE/ETHNICITY, FY 23-24



LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs.

Figure 26 above compares the information in Figures 24 and 25 to analyze the disparities.

The percentage of African Americans receiving CSS services was 20.2% when compared with this population at or below 138% FPL in need of services at 9.8%.

The percentage of Asian/Pacific Islanders receiving CSS services was 5.2% when compared with this population at or below 138% FPL in need of services at 11.8%.

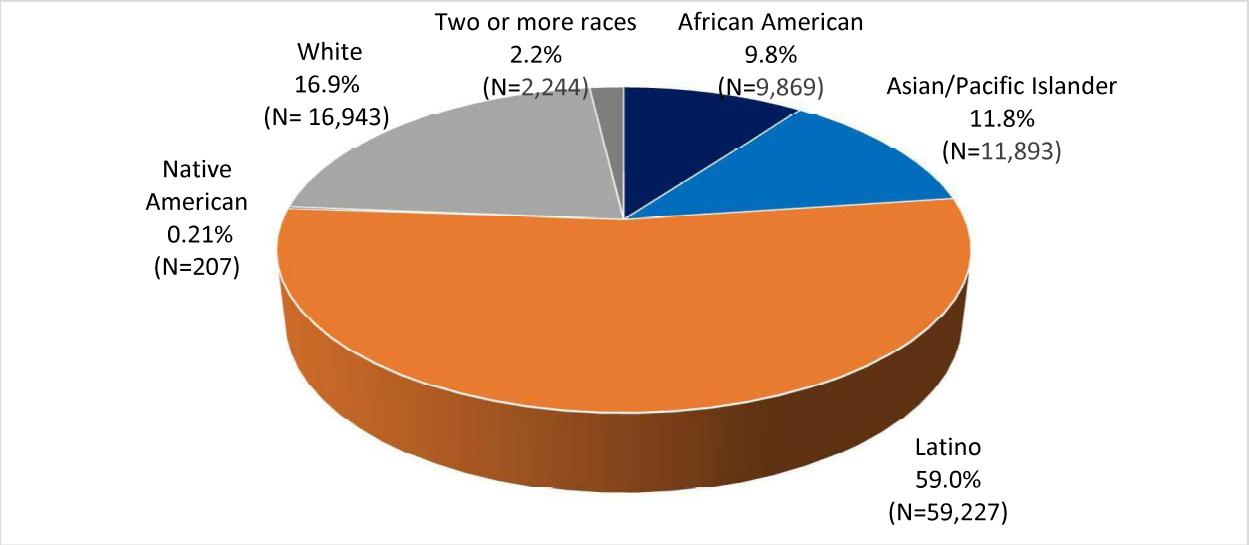
The percentage of Latinos receiving CSS services was 36.4% when compared to this population at or below 138% FPL in need of services at 59.0%.

The percentage of Native Americans receiving CSS services was 0.7% when compared with this population of Native Americans at or below 138% FPL in need of services at 0.21%.

The percentage of Whites receiving CSS services was 17.5% when compared with this population at or below 138% FPL in need of services at 16.9%.

The percentage of Two or More Races receiving CSS services was 1.4% when compared with this population at or below 138%, FPL estimated in need of services at 2.2%.

FIGURE 27: ESTIMATED POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE/ETHNICITY, CY 2023



Note: SED/SMI Prevalence applied for all ethnicity groups = 5%. Some percentages may not total 100% due to rounding.

Figure 27 shows the estimated population at or below or 138% FPL in need of services by race/ethnicity.

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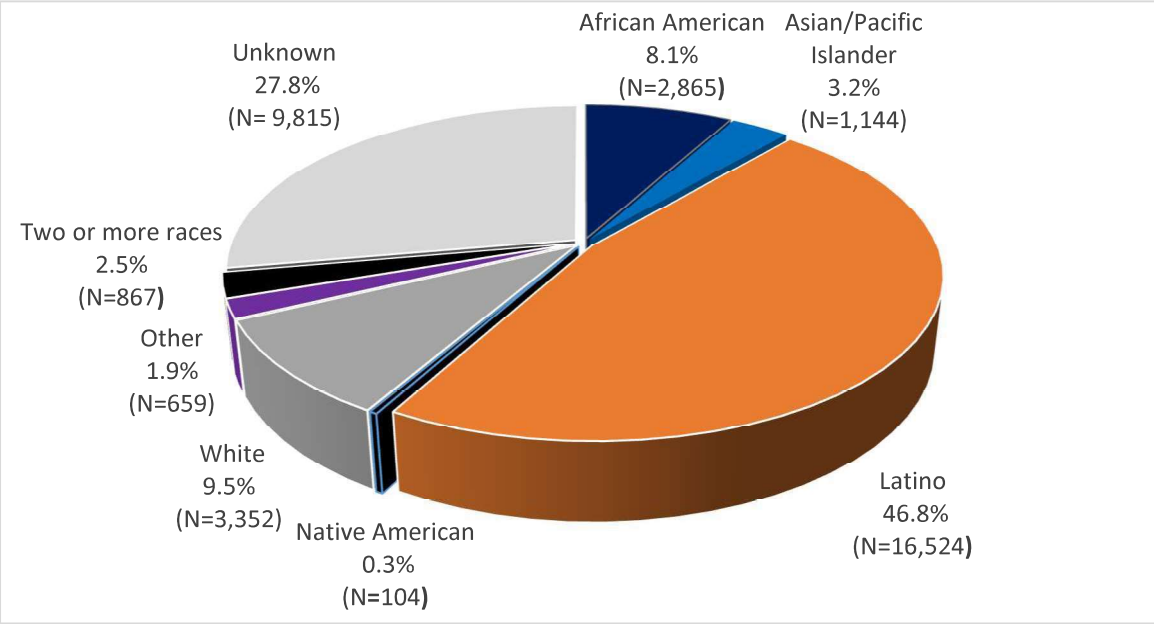
FIGURE 28: PEI CONSUMER POPULATION BY RACE/ETHNICITY FY 22-23



LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs.

Data Source: County of Los Angeles - Department of Mental Health, Mental Health Services Act - Annual Update Summary FY 2023-24.

Figure 28 shows the PEI consumer population by race/ethnicity. Latinos are the largest group at 46.8% compared to Native Americans being the smallest group at 0.3%.

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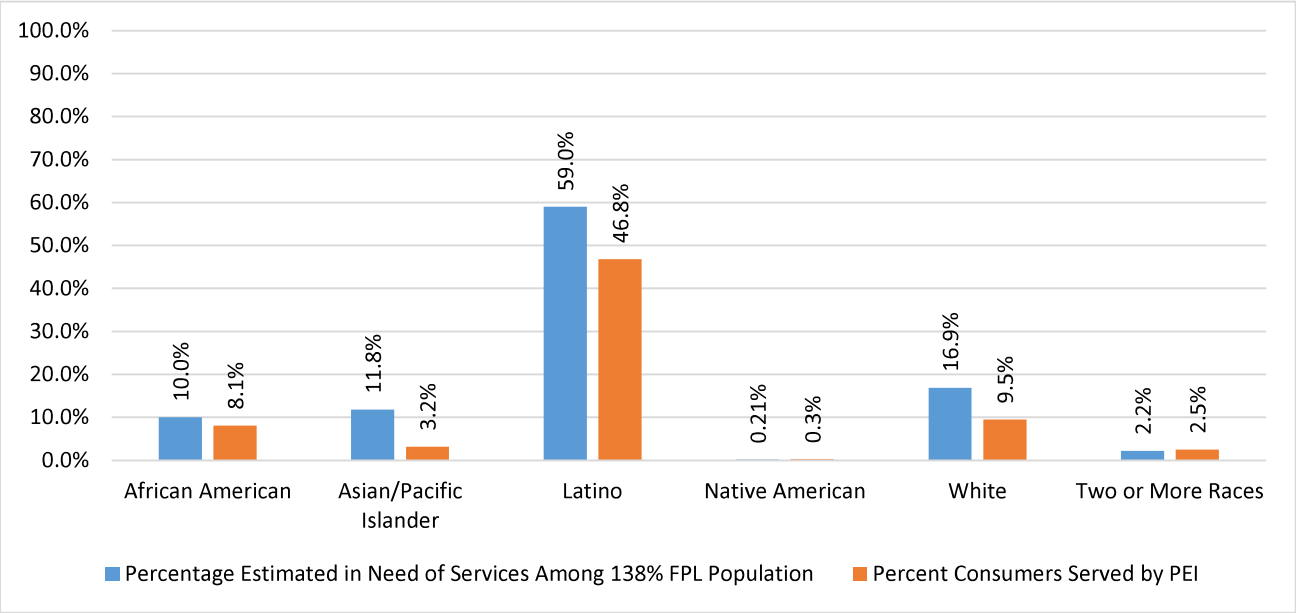
FIGURE 29: NEEDS ASSESSMENT SUMMARY FOR PEI PROGRAM: PERCENTAGE COMPARISON OF THE POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) AND CONSUMERS SERVED BY RACE/ETHNICITY FY 22-23



LACDMH serves the LA County population living at or below 138% Federal Poverty Level who meet the criteria for specialty mental health services (SMHS). According to the CA Department of Health Care Services (DHCS), SMHS are designed for persons who require intensive and specialized care due to complex and severe mental health needs.

Figure 29 above compares the information in Figures 27 and 28 to analyze the disparities.

The percentage of African Americans receiving PEI services was 8.1% when compared with this population at or below 138% FPL in need of services at 10.0%.

The percentage of Asian/Pacific Islanders receiving PEI services was 3.2% when compared with this population at or below 138% FPL in need of services at 11.8%.

The percentage of Latinos receiving PEI services was the highest at 46.8% when compared to this population at or below 138% FPL in need of services at 59.0%.

The percentage of Native Americans receiving PEI services was 0.3% when compared with this population at or below 138% FPL in need of services at 0.21%.

The percentage of Whites receiving PEI services was 9.5% when compared with this population at or below 138% FPL in need of services at 16.9%.

The percentage of Two or More Races receiving PEI services was 2.5% when compared with this population at or below 138% FPL in need of services at 2.2%.

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

A. LACDMH Prevention Early Intervention (PEI) Priority Populations with Disparities

1. *Underserved Cultural Populations*
   - Lesbian/Gay/Bisexual/Transgender/Questioning/Intersex/2-Spirit (LGBTQI2-S)
   - Deaf/Hard of Hearing
   - Blind/Visually impaired
   - AI/AN

2. *Individuals Experiencing Onset of Serious Psychiatric Illness*
   - Young Children (0-5)
   - Children
   - TAY
   - Adults
   - Older Adults

3. *Children/Youth in Stressed Families*
   - Young Children (0-5)
   - Children
   - TAY

4. *Trauma-exposed*
   - Veterans
   - Young Children (0-5)
   - Children
   - TAY
   - Adults
   - Older Adults

5. *Children/Youth at Risk for School Failure*
   - Young Children (0-5)
   - Children
   - TAY

6. *Children/Youth at Risk of or Experiencing Juvenile Justice*
   - Children
   - TAY

B. Process/rationale used by the county in selecting their PEI priority population(s)

These priority populations are designed within the guidelines of the State Mental Health Service Act (MHSA) Prevention and Early Intervention Regulations. Based on community input from stakeholders, including the ad hoc steering committees, LACDMH developed projects that address the needs, priority populations, and special sub-populations. For example, community partners/stakeholders play an active role in

setting the priorities for funding allocations for services funded by MHSA and provide feedback on priority populations and service models to be implemented.

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CR 2 Appendix

1. Definition of disparities

A health disparity is a health difference that adversely affects disadvantaged populations in comparison to a reference population, based on one or more health outcomes. All populations with health disparities are socially disadvantaged due in part to being subject to racist or discriminatory acts and are underserved in health care. Health disparity outcomes can lead to:

- Higher incidence and/or prevalence of disease, including earlier onset or more aggressive progression of disease.
- Premature or excessive mortality from specific health conditions.
- Greater global burden of disease, such as Disability Adjusted Life Years (DALY), as measured by population health metrics.
- Poorer health behaviors and clinical outcomes related to the aforementioned.
- Worse outcomes on validated self-reported measures that reflect daily functioning or symptoms from specific conditions.

Source: National Institute on Minority Health and Health Disparities
Link: Minority Health and Health Disparities Definitions

2. Link to LACDMH data dashboards

LACDMH Dashboard - Mental Health Services Act (MHSA) Client Demographics - Department of Mental Health (lacounty.gov)

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

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PREVENTION BUREAU
ANTI-RACISM, INCLUSION, SOLIDARITY AND EMPOWERMENT (ARISE) DIVISION
CULTURAL COMPETENCY UNIT

and

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC) BUREAU
STRATEGIC AND NETWORK DEVELOPMENT DIVISION
EQUITABLE ACCESS AND PROMOTIONS SECTION (EAPS)

CULTURAL COMPETENCE PLAN UPDATE – FY 22-23

Criterion 3

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

December 2024

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

A new feature of the 2024 Cultural Competence Plan report is the incorporation of content pertinent to the Los Angeles County Department of Mental Health (LACDMH) and the Department of Public Health Bureau of Substance Abuse Prevention and Control (SAPC). CR 3 has been organized in two parts: Part I contains information on the LACDMH strategies and efforts to reduce disparities and Part II describes SAPC's strategies and efforts.

PART 1
Los Angeles County Department of Mental Health

Identified Unserved/Underserved Target Population (with disparities)

I. List of LACDMH Target Populations with Disparities

Based on FY 22-23 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
- American Indian/Alaska Native (AI/AN)
- White
- Unreported

By language

- Arabic
- Armenian
- Cambodian
- Cantonese
- Chinese not listed above
- English
- Farsi
- Korean
- Mandarin
- Non-English languages not listed above
- 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 CCPR Target Populations

A. Community Services and Support (CSS) Plan

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

1. **By ethnicity**
   - African American
   - API
   - Latino
   - AI/AN
   - White
   - Unreported

2. **By language**
   - Arabic
   - Armenian
   - Cambodian
   - Cantonese
   - Chinese not listed above
   - English
   - Farsi
   - Korean
   - Mandarin
   - Non-English languages not listed above
   - Russian
   - Spanish
   - Tagalog
   - Vietnamese

3. **By age group**
   - Age 0-18
   - Age 19-44
   - Age 45-64
   - Age 65+

4. **By gender**
    - Male
    - Female

B. Workforce, Education, and Training (WET)

1. **By ethnicity**
    - African American
    - AI/AN
    - API (Mandarin and Korean)
    - Latino
    - Middle Eastern

2. **By age group**
    - Children
    - Transition Age Youth (TAY)
    - Adults
    - Older Adults

3. **By language**
    - Arabic
    - Armenian
    - Cambodian
    - Cantonese
    - Chinese not listed above
    - Farsi
    - Korean
    - Mandarin
    - Russian
    - Spanish
    - Tagalog
    - Vietnamese
    - American Sign Language

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

1. **Underserved Cultural Populations**
    - Lesbian/Gay/Bisexual/Transgender/Questioning/Intersex/2-Spirit (LGBTQI2-S)
    - Deaf and Hard of Hearing
    - Blind and Visually Impaired
    - AI/AN

2. **Individuals Experiencing Onset of Serious Psychiatric Illness**
    - Young Children (0-5)
    - Children

- TAY
- Adults
- Older Adults

3. **Children/Youth in Stressed Families**
   - Young Children (0-5)
   - Children
   - TAY

4. **Trauma-exposed**
   - Veterans
   - Young Children (0-5)
   - Children
   - TAY
   - Adults
   - Older Adults

5. **Children/Youth at Risk for School Failure**
   - Young Children (0-5)
   - Children
   - TAY

6. **Children/Youth at Risk of or Experiencing Juvenile Justice**
   - Children
   - TAY

III. Identified Strategies: LACDMH Strategies to Reduce Disparities

LACDMH has implemented a robust list of strategies to address the cultural and linguistic needs of LA County's diverse communities and eliminate mental health disparities. Many of these strategies are organic to the programs that spearhead them, while others collectively advance the progress made toward concerted efforts to align service planning, delivery, and evaluation to the departmental Strategic Plan 2020-2030, CLAS Standards, Cultural Competence Plan Requirements and CalAIM regulations. The section below presents the strategies organized as Mental Health Services Act (MHSA)-bound or systemwide.

MHSA

LACDMH recognizes the progressive impact of MHSA legislation on its strategic service models under Community Services and Supports (CSS), Workforce Education and Training, and Prevention and Early Intervention MHSA Plans. During FY 22-23, the MHSA Administration Division revitalized the stakeholder platform to engage the community at large and departmental management around the new Community Planning Process (CPP), which has allowed MHSA stakeholders to gather a broader range of participatory input, focusing on addressing service gaps and the mental health

needs of populations within respective geographies across Los Angeles County. This revitalization has allowed greater inclusion of community stakeholders from various LACDMH Underserved Cultural Communities (UsCCs) such as persons with disabilities, American Indian/Alaska Natives, Asian Pacific Islanders, Black and African American, Eastern European/Middle Eastern, Latino, and LQBTQIA2-S; Client Coalition; Cultural Competency Committee; and community members across all eight Service Areas. Other stakeholders include consumers, family members and caregivers, faith-based organizations, grass-roots organizations, advocates for communities of color, immigrants, racial and health equity, Community-Based Organizations, government entities, and the LACDMH provider network.

The CPP used for developing the MHSA Three Year Program and Expenditure Plan for Fiscal Years 2024-25 and 2025-26 included two interlocking steps:

- Forming a Community Planning Team (CPT) representing a diverse set of stakeholder groups, with particular attention to ensuring robust representation of people with lived experience as consumers, family members, caregivers, and peers.
- Conducting a Community Planning Process offering meaningful engagement opportunities for stakeholder groups to provide input and generate recommendations, while offering equitable supports to ensure participation for all groups.

CPT

The CPT is the diverse, multi-stakeholder entity responsible for reviewing, discussing, and agreeing on recommendations for the MHSA Three-Year Plan, and subsequent annual updates and mid-year adjustments. Consisting of 122 members, the CPT structure embodies three central commitments to a community-driven community planning process:

- Inclusion of a broad range of community and systems stakeholders. For this CPT, 92% (92 out of 100) of the members represent community voices, non-governmental organizations, and service provider networks.
- Robust representation of people with lived experience by establishing a minimum threshold of 20%-to-30% of the total CPT being people with lived experience as consumers, clients, family members, caregivers, and peers. (This threshold is a floor, not a ceiling; the percentage can be higher.)
- Concerted efforts to mirror the demographic and cultural diversity of Los Angeles County.

Based on recommendations from LACDMH stakeholders and management, the CPT included five categories of representatives:

Stakeholder Categories	Representatives
A. Community Leadership Team	30
B. Community Stakeholder Groups	41
C. County Departments	19
D. Education System	5
E. Government/Quasi-Government Agencies	5
Total:	**100**

The following is a breakdown of stakeholder groups and the number of representatives per stakeholder group:

A. Community Leadership Team - comprised of Co-Chairs from the Services Area Leadership Teams (SALTs) and the various Underserved Cultural Communities (UsCCs)

SALT	Representatives
Service Area 1	2
Service Area 2	2
Service Area 3	2
Service Area 4	2
Service Area 5	2
Service Area 6	2
Service Area 7	2
Service Area 8	2
Total	**16**

Underserved Cultural Communities	Representatives
1. Access 4 All	2
2. American Indian/Alaska Native	2
3. Asian Pacific Islander	2
4. Black and African Heritage	2
5. Eastern European/Middle Eastern	2
6. Latino	2
7. Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, and Two-Spirit (LGBTQIA2-S)	2
Total	**14**

B. Community Stakeholders

This group consists of three types of community stakeholders: 1) mental health planning, advisory, and advocacy bodies; 2) service providers supporting different consumer populations; and 3) people working within specific roles in the system (i.e., Peer Specialists and Community Health Workers / Mental Health Promoters).

Community Stakeholder Groups	Representatives
1. Association of Community Human Service Agencies (ACHSA)	1
2. Community Health Workers / Mental Health Promoters	2
3. Cultural Competency Committee	2
4. Faith-Based Advocacy Council	2
5. First 5 Los Angeles	1
6. Health Neighborhoods (1 per Health Neighborhood)	18
7. Housing/Homelessness	1
8. Los Angeles County Mental Health Commission	2
9. National Alliance for Mental Illness (NAMI)	2
10. Peer Advisory Council	2
11. Peer Specialists	2
12. Service Providers (Non-ACHSA)	2
13. Unions Entities/Labor Unions (four count)	4
14. Veterans	2
15. Youth Mental Health Council	2
Total	**45**

C. County Departments

County entities play a critical role in collaborating with LACDMH to deliver services and supports to consumers, clients, family members, and caregivers.

County Departments	Representatives
1. CEO - Anti-Racism, Diversity & Inclusion	1
2. CEO - DOJ Compliance	1
3. CEO – Homeless Initiative	1
4. Department of Aging and Disability	1
5. Department of Children and Family Services	1
6. Department of Fire / First Responders	1
7. Department of Health Services	1
8. Department of Health Services – Housing for Health	1
9. Department of Justice, Care & Opportunities	1

10. Department of Military and Veterans Affairs	1
11. Department of Public Health	1
12. Department of Public Health – Substance Abuse Prevention & Control	1
13. Department of Public Social Services	1
14. Department of Youth Development	1
15. Libraries	1
16. Parks and Recreation	1
17. Probation	1
18. Public Defender	1
19. Sheriff	1
Total	**19**

D. Education System

These K-12 school districts and institutions of higher education are critical partners in the delivery of mental health services and workforce development strategies.

Education	Representatives
1. Los Angeles Unified School District	1
2. Los Angeles County Office of Education	1
3. Los Angeles Community College District	1
4. California State University	1
5. University of California	1
Total	**5**

E. City Governments / Quasi-governmental Agencies

These agencies constitute city governments with their own health Department or quasi-governmental entities that play critical planning, coordination, or resource management functions that impact mental health.

City Government/Quasi-Government	Representatives
Cities with Health Departments	
1. Long Beach	1
2. Pasadena	1
Quasi-Governmental	
1. LA Housing Alliance	1
2. LAHSA	1
3. Los Angeles County Regional Centers	1
Total	**5**

The Community Planning Process (CPP) was implemented in three phases:

- Phase 1 – Stakeholder Input (July, August, September)
- Phase 2 – Stakeholder Recommendations (October, November, December)
- Phase 3 – Consensus and Closing (January, February)

II. Countywide Strategies

LACDMH implemented the following Departmentwide strategies to reduce mental health disparities, eliminate stigma, increase equity in service delivery. and promote hope, wellness, recovery, and resiliency:

1. Collaboration with faith-based and other trusted community entities/groups
2. Development and translation of public-facing materials that address mental health education
3. Co-location with other county departments, e.g., Department of Children and Family Services (DCFS), Department of Public Social Services (DPSS), Department of Health Services (DHS), and Department of Public Health (DPH)
4. Community education to increase mental health awareness and decrease stigma
5. Consultation with 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. 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 closed captioning in real-time (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 to reach community members
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, LACDMH and DPH) on initiatives regarding cultural competence, linguistic appropriateness, and equity
31. Post COVID-19 interventions

LACDMH takes pride in its comprehensive implementation of specialized programs that address various aspects of culture, including race and ethnicity, age group, gender identity, sexual orientation, language, veteran status, experiences of homelessness, and involvement with the justice system, among others. Since the last Cultural Competence Plan report, new programs and innovative practices have been established. Some examples include:

- The Community Assistance, Recovery, and Empowerment (CARE) Court
- CalAIM-related development of Guide to Procedure Codes, training videos, Discipline-Specific Activity Sheets, and modifications to the Integrated Behavioral Information System (IBHIS) for Payment Reform.
- Restorative Care Villages at Olive View and Rancho Los Amigos campuses
- Expansion to seven residential Co-Occurring Integrated Care Network (COIN) provider sites specializing in post-release services based on Assembly Bill 109
- Partnerships with the Los Angeles County Development Authority (LACDA), Los Angeles Homeless Services Authority (LAHSA) and People Assisting the Homeless (PATH) to fast-track persons experiencing homelessness into tenant-based Permanent Supportive Housing (PHS)
- Contractual agreement modifications to include specialty mental health services through the Housing Supportive Services Program
- Development of a "Strike Team" to map existing vacancies, plan coordinated recruitment and marketing efforts, and prioritize hiring approaches
- Implementation of the LGBTQIA2-S Champion Network in all Services Areas
- Implementation of the Maternal Health Champions in all Service Areas
- The ARISE Division's active development of community-based events commemorating different aspects of cultural diversity
- The on-boarding of mental health promoters as full-time positions

- Collaboration in Chief Executive Office's Anti-Racism, Diversity and Inclusion (ARDI) systemwide activities involving executive management, the ARISE Staff Advisory Council, and the ARISE Division
- Successful delivery of the "Take Action for Mental Health L.A. County" campaign comprised of more than 400 events to increase knowledge and reduce stigma around mental health issues. A total of 110 Community-Based Organizations were awarded grants to provide community events including community health fairs, wellness fairs, mental health first aid trainings, wellness picnics, mental health education retreats, media (TV, radio) and social media campaigns, among other activities.
- Launch of the "Do Worthwhile Work" Employee Recruitment Campaign.
- Inaugural LACDMH Faith-Based Conference on May 23 connecting mental health and spirituality experts to promote dialogue and opportunities for partnership
- Completion of an internal data analysis of clients experiencing homelessness while receiving mental health services at Directly Operated clinics and who have not yet been referred for federal housing subsidies.
- Participation in high-profile events such as Los Angeles Dodgers games via coordinating volunteer staffing to address mental health needs during Dodger games. Includes drafting/editing of special in-stadium mental health messaging display translated into various languages by the LACDMH Speakers Bureau.
- Launch of the MHSA client demographics dashboard on the departmental website to provide up-to-date data on consumer demographics and service delivery
- Technological advancements for CalAIM, Netsmart's Telehealth, the Pharmacy Inventory Tracking system (BD Pyxis), the Provider Directory prototype for the Mental Health Resource Locator Navigator (MHRLN), and the DPH-DMH Healthcare Interoperability Data Exchange (HID Ex) Project.
- The School-Based Community Access Platforms (SBCAP)'s workshops and resource events reaching more than 3,500 students, parents/caregivers, and the school community.

Additionally, the Department engaged significantly with the Los Angeles County Board of Supervisors and other County Departments in response to various Board motions. A selected group of Board Motions are described in this chapter based on 1) their emphasis on specific cultural communities in Los Angeles County and 2) LACDMH's response to directives regarding culturally and linguistically inclusive service delivery.

The following chart provides a systemwide overview of LACDMH's programs and strategy profile, based on the list presented above. Programs highlighted in gray are special feature programs in the 2024 Cultural Competence Plan Report.

	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	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 and Substance Use)	24. Specific Ethnic/Language Groups	25. Provider Communication/Support	26. School-based services	27. Trainings/Case Consultation	28. Utilization of Community Knowledge and Feedback	29. Workforce Assessment	30. Health Department Collaboration	31. Post COVID-19 Interventions
1.	ARISE Division	X	X		X	X		X					X	X	X		X	X	X	X		X	X	X	X	X		X	X	X	X	X
2.	Assisted Outpatient Treatment Program				X	X	X		X		X	X		X		X	X	X		X		X	X	X	X			X	X			X
3.	Board of Supervisors Motions*				X			X			X		X	X			X	X	X	X			X	X							X	X
4.	CalWORKs/GROW		X							X	X		X																			
5.	CARE Court	X	X					X						X	X	X	X		X	X		X	X	X					X		X	
6.	Child Welfare Division		X	X	X			X			X				X					X		X				X						
7.	Community Ambassador Network		X								X			X							X	X	X		X	X			X	X		X
8.	Crisis Residential Treatment Program	X	X	X	X			X						X	X		X			X				X	X			X	X		X	X
9.	Enhanced Care Management	X									X						X		X				X								X	
10.	Enriched Residential Care Program				X											X				X						X		X	X			X
11.	Faith-Based Advocacy Council	X	X	X	X								X									X							X			
12.	Full-Service Partnership	X	X			X	X		X		X	X					X	X	X	X		X	X	X		X		X	X			X
13.	GENESIS			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	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 and Substance Use)	24. Specific Ethnic/Language Groups	25. Provider Communication/Support	26. School-based services	27. Trainings/Case Consultation	28. Utilization of Community Knowledge and Feedback	29. Workforce Assessment	30. Health Department Collaboration	31. Post COVID-19 Interventions
14.	Health Neighborhoods	X																				X	X					X			X
15.	Hollywood 2.0	X			X				X		X						X			X											
16.	HOME Teams	X			X						X				X		X		X	X		X	X	X		X		X			X
17.	Housing and Job Development Division				X						X								X	X	X			X		X		X			X	
18.	Housing and Supportive Services				X						X								X	X				X		X		X			X	
19.	Law Enforcement Teams	X		X	X						X						X	X		X		X	X					X				
20.	LGBTQIA2S Champion Network			X	X	X		X					X		X	X	X		X	X		X		X		X		X	X	X	X	
21.	My Health LA (MHLA)	X			X			X									X							X					X			X
22.	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
23.	Men's Community Re-Entry Program		X			X			X		X						X		X	X		X			X		X	X		X		X
24.	Older Adult Service Extenders																					X										
25.	Prevent Homelessness Promote Health					X	X				X						X	X	X	X		X	X	X								X

	PROGRAM NAME	1. Faith-Based Collaboration	2. Development and Translation of public informing materials	3. Co-location of Services	4. Community Education	5. Consultation to Gatekeepers	6. FSP-Countywide Networks	7. Committees & Taskforces	8. FSP-Ethnic Targets	9. EBPs/CDEs for Ethnic Populations	10. Field-Based Services	11. FSP-Enrollment Flexibility	12. CC Enhancement Across Health	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 and Substance Use)	24. Specific Ethnic/Language Groups	25. Provider Communication/Support	26. School-based services	27. Trainings/Case Consultation	28. Utilization of Community Knowledge and Feedback	29. Workforce Assessment	30. Health Department Collaboration	31. Post COVID-19 Interventions
26.	Prevention Early Intervention (Older Adults)-ASD	X			X						X																				
27.	Prevention and Early Intervention Programming	X			X					X				X	X		X			X	X	X	X			X	X	X	X	X	
28.	Prevention Programs	X	X	X	X	X					X			X					X	X			X	X	X	X	X		X		
29.	Promotores de Salud & UMHP	X	X		X	X		X			X		X				X					X	X		X		X	X	X			X
30.	Psychiatric Mobile Response Team & Therapeutic Transportation Team	X		X	X						X						X	X		X		X	X						X			
31.	Public Information Office	X	X		X								X							X				X						X			X
32.	Spanish Support Groups	X																							X					X			X
33.	School Based Community Access Point		X	X	X	X								X						X			X		X	X	X	X	X			
34.	School Threat Assessment Response Team	X		X	X						X						X	X		X		X	X					X				
35.	Speakers Bureau	X	X		X	X		X			X		X				X	X	X	X		X	X		X			X	X			

	PROGRAM NAME	1. Faith-Based Collaboration	2. Development and Translation of public informing materials	3. Co-location of Services	4. Community Education	5. Consultation to Gatekeepers	6. FSP-Countywide Networks	7. Committees & Taskforces	8. FSP-Ethnic Targets	9. EBPs/CDEs for Ethnic Populations	10. Field-Based Services	11. FSP-Enrollment Flexibility	12. CC Enhancement Across Health	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 and Substance Use)	24. Specific Ethnic/Language Groups	25. Provider Communication/Support	26. School-based services	27. Trainings/Case Consultation	28. Utilization of Community Knowledge and Feedback	29. Workforce Assessment	30. Health Department Collaboration	31. Post COVID-19 Interventions
36.	Suicide Prevention	X			X	X		X		X				X	X		X			X	X	X	X	X		X	X	X	X	X	
37.	TAY Drop-in Centers	X			X						X									X		X	X					X		X	X
38.	TAY Navigation Team		X		X						X									X			X								X
39.	Telemental Health Program										X					X	X											X			
40.	Training Unit	X	X	X	X			X		X	X					X						X		X	X						X
41.	Underserved Cultural Communities (UsCC)	X	X		X			X					X	X				X		X			X		X				X		X	X
42.	Urgent Care Centers	X		X	X			X							X		X			X				X	X				X			X
43.	Veteran Peer Access Network			X	X			X			X				X	X	X		X	X	X	X	X	X		X		X	X			X
44.	Wellness Outreach Workers																					X										
45.	Women's Community Re-Entry	X		X	X	X		X			X				X	X				X		X	X	X		X		X		X		X

* Strategies may vary based on the scope of each Board of Supervisors Motion.

The section below highlights five specific LACDMH programs/initiatives selected as special features for Criterion (CR) 3 of the 2024 Cultural Competence Plan report, inclusive of:

1. Community Assistance, Recovery, and Empowerment (CARE) Court
2. Child Welfare
3. Homeless initiative
4. LACDMH ARISE Division's interface with L.A. County Anti-Racism, Diversity and Inclusion (ARDI) initiative commissioned by the Board of Supervisors and under the oversight of the Chief Executive Office
5. Los Angeles County Board Motions in which LACDMH was appointed as the lead Department or main contributor

The information provided for each of the above focuses on the following:

- Description of scope and purpose based in relation to the applicable domain(s) of the departmental strategic plan
- Data on consumers served, FY 22-23
- Strategies and objectives to reduce disparities, timeline, monitoring practices and accomplishments, FY 22-23
- Effect on the cultural and linguistic competence of the system of care

A. **CARE Court**

Many persons in our community experience severe mental illness and may not receive regular help, often resulting in homelessness and substance use. Their loved ones and other caregivers often struggle to find lifesaving support and assistance. The County of Los Angeles launched a new, state-funded program called CARE Court, which helps people with untreated schizophrenia and other associated psychotic disorders receive treatment and services for their health and well-being. Participants receive support services to promote their recovery and well-being, which may include counseling, medication, housing options, social services, and others. Rather than cycling through jails and emergency rooms, CARE Court gives vulnerable individuals and those who care for them another path to access key services that can help keep them safe. Family members, roommates, clinicians, and others can petition the court to seek approval for this program.

The LACDMH CARE Court program planning phase began during FY 22-23 with three (3) specialized workgroups:

- *CEO-Led Workgroup:* The Chief Executive Office led an interdepartmental CARE Court workgroup which met frequently during this period. Numerous county departments and partners came together to plan the Los Angeles County's implementation of CARE Court. These meetings focused on all aspects of cross-functional implementation, including workflow planning and multi-departmental coordination. As part of the planning process, LACDMH developed a three-year funding analysis that outlined the anticipated costs related to implementing CARE Court and identified multiple one-time and ongoing funding sources that would

provide funding for LACDMH and County Counsel's costs to implement CARE Court.

- *DMH-Led Workgroup:* LACDMH convened a CARE Court implementation workgroup. The group included DHS, DPH - Substance Abuse Prevention and Control (SAPC), members of the executive management team, the Chief Information Office, housing partners, and existing field-based programs, among others. The following were the main components addressed during the tenure of this workgroup: service provision model, workflows, exploration of peer support, staffing models/patterns, behavioral health bridge housing, linguistic and culturally competent services, technology platforms, tracking and documentation systems, and marketing and advertising materials.

- *DMH-Led Subcommittees*: As a result of the key areas identified via the LACDMH-Led workgroup, as critical to the planning process, multiple subcommittees were convened to focus on the specific areas identified such as staffing patterns, the incorporation of peer supporters/supporters, and budgeting and finance. There were also additional discussions around the training of staff, which included, but were not limited to, field-based safety training, orientation of mental health staff to the courtroom processes, orientation of court staff on mental health basics, and working with diverse populations.

The components described above represent some of the primary tasks undertaken during the planning phase for the CARE Court program in Los Angeles County. LACDMH worked closely with the CEO to identify the appropriate classifications and structure of the CARE Court program. The program was successfully implemented on December 1, 2023, one year ahead of the initial implementation date.

LACDMH Strategic Plan Domain: Community Services				
Focal population: Persons with untreated schizophrenia and other associated psychotic disorders				
Program Objectives Related to Cultural Competence	**Activities**	**Timeline for Each Activity**	**Monitoring Practices for Each Activity**	**Measurable Accomplishments**
Hiring cultural and language appropriate staffing	Recruit from language specific lists (Spanish). Recruit staff who are bilingual bonus certification eligible	TBD in FY 23-24	Tracking logs	Hiring to begin in FY 23-24
Staff diversity should reflect the community they serve	Recruit staff that represent the community (i.e. African American, Asian, Latino, etc.)	TBD in FY 23-24	Hiring spreadsheet	Hiring to begin in FY 23-24

B. **Child Welfare Division**

Based on the LACDMH strategic plan, the Child Welfare Division services fall under the Community Domain and aim to assist children and families who are at risk of or experiencing challenges in their emotional, social, educational, cultural, spiritual, and well-being aspects of daily living.

The Child Welfare Division is comprised of multiple programs. Among them,

- Family Preservation
- Intensive Field Capable Clinical Services (IFCCS)
- Multidisciplinary Assessment Team (MAT)
- Qualified Individual (QI) Assessment
- Specialized Foster Care (SFC)
- Wraparound Services
- Intensive Services Foster Care (ISFC)
- Short Term Residential Therapeutic Programs (STRTPs)

Applicable LACDMH Strategic Plan Domain: Community Services				
Focal population: Child Welfare				
Program Objectives Related to Cultural Competence	**Activities**	**Timeline for FY 22-23**	**Monitoring Practices**	**Measurable Accomplishments**
1. Co-location with other county departments, e.g., Department of Children and Family Services (DCFS), Department of Health Services (DHS), and Department of Public Health (DPH)	Specialized Foster Care (SFC) and the Countywide Medical Hub programs are both DMH co-located programs that serve children and youth entering the child welfare system. SFC is co-located with DCFS, and the Medical Hubs are co-located with the Department of Health Services (DHS), DCFS, and Department of Public Health (DPH). Services provided for both programs include triage, assessment, crisis intervention, specialty mental health services as needed, and linkage to ongoing treatment.	Ongoing—Services are provided on-site/in-person, field-based, and via telehealth. During the COVID-19 pandemic, most specialty mental health services were provided via telehealth. However, the Department required intensive field-based programs to deliver services to high-risk youth in person in their homes, schools, or community settings.	Both SFC and Medical Hubs procedures are outlined in the guidelines.	For FY 22-23, SFC and the Medical Hubs received approximately 17,441 referrals.
2. Community education to increase	DMH staff and contracted mental health providers were	Information on training and webinars is provided	Training curriculum and informational materials are reviewed	Informational material is available on the following

mental health awareness and decrease stigma	provided with training and webinars. A list of these is in section VI.	quarterly, and material is updated as needed.	and updated as needed.	LACDMH Child Welfare Division (CWD) public-facing website and is reviewed and updated as needed: https://dmh.lacounty.gov/our-services/child-welfare-division/cwd-trainings/
3. Continuous engagement with committees, subcommittees, and task forces that address culturally and linguistically competent service delivery.	CWD workforce engaged with committees that addressed culturally and linguistically competent service delivery, including the ARISE Staff Advisory Council.	The CWD workforce participated in the ARDI Staff Advisory Council, whose mission is to build an intra-departmental community of LACDMH employees connected through a shared commitment to advancing racial equity and shaping LACDMH as an organization grounded in anti-racism, diversity, and inclusion principles.	A statement of work for a Leadership Transformational training series was developed. The series concentrates on efforts to dismantle intersectional oppression through education and leadership accountability. Regular meetings with the CEO ARDI Unit are held to provide updates on LACDMH's efforts toward the ARDI initiative.	During FY 22-23, CWD workforce members participated in 25 ARISE Staff Advisory Council meetings.
4.Field-based services	Specialty Mental Health Services (SMHS) are rendered in the home or community through Specialized Foster Care, Wraparound, Intensive Field-Capable Clinical Services, MAT, and Intensive Services Foster Care.	Specialty mental health services are provided in the field or via telehealth, as clinically indicated and based on safety concerns. Intensive field-based programs continue to deliver services to high-risk youth in person in the youths' homes, schools, or community settings.	The appropriateness of field-based vs. telehealth was monitored case-by-case through consultation.	For FY 22-23, approximately 54% of high-risk children and youth accepted in-person mental health services.
5.Implementation of new technologies to enhance the Department's service delivery.	SFC and the Medical Hubs collaborated with LACDMH to implement VSee to enhance telehealth services. SFC used the Service Request Tracking System (SRTS) 2.0, which allowed staff to transfer referrals to the provider network electronically.	Ongoing – SFC and Medical Hub staff participated in VSee training and developed a workflow. An SFC workflow and guidelines were developed with DMH's Quality Assurance Division.	All newly hired staff were required to participate in the training. DMH Quality Assurance Staff and LACDMH SFC staff developed training for SRTS.	70% of SFC clinical staff used VSee to provide mental health services via telehealth. 90% of referrals to the provider network were made via SRTS 2.0.

6.Interagency Collaboration	CWD continued to collaborate with the Office of Child Protection (OCP), Department of Children & Family Services (DCFS), Department of Health Services (DHS), and Probation to improve mental health services for 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).	CWD staff participated in ongoing meetings with DCFS regarding: • Youth hospital discharge planning meetings. • Crisis response protocols for non-hospitalized youth needing stabilization and ongoing treatment. • Collaborated with DCFS to develop and deliver FURS training to DCFS and LACDMH staff. • System of Care Meeting. • DMH participated in various FURS committees and developed informational material distributed to various community partners/stakeholders.	Sign-in sheets were used to track monthly meetings.	LACDMH Special Linkage Services Unit (SLSU) participated in daily hospital discharge planning meetings for DCFS-involved youth. A total of 717 discharge planning teleconferences were completed. During FY 22-23, 230 children and youth were served via FURS.
7.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.	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.	One training was delivered in Spanish during FY 22-23. A total of 12 participants completed the training.
8. Provider communication and support	Provider meetings were for Wraparound, Intensive Field Capable Clinical Services (IFCCS), MAT, 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),	During FY 22-23 and ongoing program-specific provider meetings 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. Technical Assistance (TA) is offered and tracked to review ongoing progress and utilization.	At a minimum, quarterly provider meetings were hosted by the various programs. During FY 22-23, the 11th Annual MAT Conference was held, followed by Engaging Fathers & Other Adult Males in the Therapeutic Process training. A total of 114 participants completed the training.

	new programmatic policies and procedures, training and coaching information, and additional resources for providers to improve or enhance their service delivery. In addition, ongoing Technical Assistance (TA) was provided to address service delivery concerns, engage youth and families, and to ensure appropriate Safety Planning.			
9.Training/case consultation	CWD continued to deliver training and coaching support to LACDMH staff and contractors. Case consultations, coaching sessions, and training included topics to promote cultural competence, including cultural humility, self-reflection, privilege oppression, and implicit bias. The following trainings were developed and/or acquired through outside vendors: • Core Practice Concepts in Working with LGBTQIA+ Youth • Effective Strategies for Family and Youth Engagement • Fetal Alcohol Spectrum Disorder: Overview, Screening, Diagnosis and Interventions • Fetal Alcohol Spectrum Disorder: Screening, Diagnosis, and Interventions • Grief and Loss: Supporting Children, Youth and Families	DMH staff and contractors could request individualized coaching sessions. Booster training sessions on specific topics addressing cultural competency were developed to meet the specific training needs of LACDMH contractors. Training opportunities were available through virtual platforms to ensure continued access for all LACDMH staff and contractors. Trainings are offered via a virtual platform on a regular basis.	CWD maintains a database to track all training and coaching sessions.	Total number of Coaching Sessions delivered for FY 22-23 were: 414; Total Number of Booster Trainings were: 88. During FY 22-23, LACDMH and contracted provider staff were trained in the following: • **361** staff trained in Core Practice Concepts in Working with LGBTQIA+ Youth • **105** staff trained in Effective Strategies for Family and Youth Engagement • **1,102** staff trained in Fetal Alcohol Spectrum Disorder: Overview, Screening, Diagnosis and Interventions • **343** staff trained in Fetal Alcohol Spectrum Disorder: Screening, Diagnosis and Interventions

	• LGBTQ Survivor Allyship Training • Trauma Informed Strategies for Working with Individuals with ID/DD/ASD (Clinical Staff and Non-Clinical staff) • Fetal Alcohol Spectrum Disorders (FASD) Outside vendor trainings are reviewed to ensure that the content of trainings address cultural humility as well as cultural disparities.			• **523** staff trained in Grief and Loss: Supporting Children, Youth and Families • **175** staff trained in LGBTQ Survivor Allyship Training • **1,876** staff trained in Trauma Informed Strategies for Working with Individuals with ID/DD/ASD (Clinical Staff and Non-Clinical staff) • **458** staff trained in Fetal Alcohol Spectrum Disorders (FASD)

Consumers Served Data, FY 22-23

Program/ Project	Race/ Ethnicity								Gender Identity						Sexual Orientation						Physical Disabilities
	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	
Medi-Cal Minor and Non-Minor Dependents in Foster Care (Some clients identified in more than one category in the FY.)	3,125	41	211	31	6,067	624	1,647	Other Ethnicity: 3,615, Unknown Ethnicity: 79	2,552	2,747	13	7	1	10,144	3	4	119	3	0	15,335	Unreported

C. The Homeless Initiative

LACDMH has adopted a multipronged approach to serving persons experiencing homelessness and contributing to LA County's Homeless Initiative. At the core of these departmental strategies are homeless prevention, outreach in the streets, interim housing, permanent housing, affordable housing, and supportive services. The following section presents a description of the LACDMH programs specializing in homelessness and housing interventions.

1. *Hollywood 2.0*
   The Hollywood 2.0 (H20) project, funded by the LACDMH's MHSA Innovation (INN) Plan, aims to provide comprehensive, community-based care and services to persons experiencing mental illness within the geographic boundaries of the Hollywood community. The service delivery format is based on the world-renowned mental health care model used in Trieste, Italy that uses a human-centered, hospitality-oriented approach to foster autonomy and a sense of purpose to support personal recovery. The Hollywood Mental Health Cooperative provides field-based outreach, engagement, support, and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness. Services are provided by addressing basic needs; conducting clinical assessments; providing street psychiatry; and providing linkage to appropriate services (including mental health services, substance abuse treatment and housing).

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Applicable LACDMH Strategic Plan Domain: Re-entry Initiatives				
Focal Population: Persons with severe mental illness residing in Hollywood, California				
Program Objectives Related to Cultural Competence	**Activities**	**Timeline for Each Activity, FY 22-23**	**Monitoring Practices for each Activity**	**Measurable Accomplishments**
Collaboration with faith-based and other trusted community groups	Hold ongoing H20 stakeholder meetings and larger community meetings with faith-based organizations and community-based providers to strengthen service delivery for persons with Severe Mental Illness (SMI) living in Hollywood.	Ongoing	Meeting dates/notes	Monthly stakeholder meetings (12 total for FY 22-23)
2. Community education to increase mental health awareness and decrease stigma	Held H20 Open Housing Community event to promote awareness around mental health resources and services coming to Hollywood.	Ongoing	Meeting dates/notes	Held one large community event in FY 22-23. Plans to continue in upcoming pilot years.
3.Field-based services	All services performed by this program are in the field.	Completed and ongoing	Outcome data collection	100%
4.Flexibility in FSP enrollment such as allowing "those living with family" to qualify as "at-risk of homelessness"	Developed Care teams to provide "FSP like" services to people that fall into the at-risk category or do not meet FSP focal population but still need field-based services.	Ongoing	Staffed two multi-disciplinary Care teams.	100%
5. Augmentation of mental health service accessibility to underserved populations	The field-based component of the Hollywood Mental Health Cooperative's goal is to provide mental health services in the hardest to reach places and for those who are unable to access or unwilling to access services.	Completed but always in progress to find new and innovative ways to serve.	Monitoring caseloads to ensure clients being served meet focal population	100%
6.Interagency Collaboration	Held ongoing meetings with Hollywood H4WRD, a contracted Community-Based Organization, and other county agencies to discuss potential ideas for services/assets for the department to purse with INN funding.	Completed but also always in progress. Collaboration is ongoing.	Meeting dates/notes	Monthly stakeholder meetings (12 total for FY 22-23)
7. Outreach and Engagement (O&E) activities	Field based teams provide outreach and engagement to clients daily. Outreach and engagement efforts have also been made in the community to gather community	Completed but also ongoing.	Outcome data and meeting dates/notes.	100%. Monthly stakeholder meetings (12 total for FY 22-23)

	participation in H20 stakeholder meetings.			
8. Integration of physical health, mental health, and substance use services	The field teams are comprised of individuals who can provide all these services. When additional support is needed, we link clients to these services within the community and with the lowest barriers possible.	Completed and ongoing.	Ensuring during hiring process and attempts at retention.	100%

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 not listed	Do not know	Decline to respond	
H20	29	1	2		41		68	47	64	35	1	3									

2. *Housing and Job Development Division (HJDD)*
The HJDD provides a range of housing services and resources for consumers experiencing homelessness, including housing subsidies through the Section 8 Housing Choice Voucher Program and Continuum of Care Program; financial assistance for rental assistance, household goods and eviction prevention through the Countywide Housing Assistance Program; and temporary shelter through the Interim Housing Program. In addition, the HJDD provides capital development funding and operating subsidies for the creation of new permanent supportive housing throughout Los Angeles County.

LACDMH Strategic Plan Domain: Infrastructure				
Focal Population: Persons diagnosed with Serious Mental Illness who are experiencing homelessness or at risk of homelessness				
Objectives	**List Activities for Each Objective**	**Timeline for each Activity**	**Monitoring Practices for each Activity**	**Measurable Accomplishments**
1. Equity in distribution of housing resources	Engaged with County ARDI Team to ensure that Community Care Expansion (CCE) funding decisions were made with considerations of equity. This included consideration of geographic location of referrals, locations of existing resources and homeless count to determine where additional new resources should be prioritized. Worked to ensure that resources are available across the county and in areas that represent the highest need.	This activity has been ongoing, and these elements will be integrated into the CCE scoring rubric for preservation resources in FY 23-24.	Monitored new resource development to ensure that it was informed by ARDI principles and addressed equity issues. Monitored distribution of clients utilizing resources to ensure that distribution mirrored demographic needs demonstrated by needs assessment research. Monitored the ongoing racial equity of resource utilization as it aligns with the homeless count demographics and LACDMH client demographics. Monitored the prioritization of equity in awarding contracts and incorporated equity considerations in tools used to score and award contracts.	LACDMH prioritized underserved populations and ensured that resources were targeted to those with the highest levels of need. CES survey score which is a measure of vulnerability was used as an acuity tool for PSH. 5x5 was used to prioritize clients for ERC.
2. Providing integrated, culturally sensitive services in Permanent Supportive Housing (PSH)	LACDMH worked in partnership with the Department of Health Services (DHS) Housing for Health (HFH) program and DPH-SAPC to provide client-tailored integrated services in PSH. LACDMH provided specialty mental health services through the Housing and Supportive Services Program (HSSP), DHS-HFH provided Intensive Case Management Services (ICMS), and DPH-SAPC provided substance abuse services through the	This structure was established in the existing PSH in FY 22-23 and will continue to be implemented as new buildings are developed and come online.	This activity was tracked through contract amendment to HSSP services, service enrollment numbers as well as through billing for each individual service.	In FY 22-23 LACDMH provided HSSP services in 177 PSH apartment buildings.

	Client Engagement and Navigation Services (CENS) Program. Efforts were made to ensure clients were able to access services in their most comfortable language, or that comprehensive translation services were available.			
3.Provided housing that is trauma-informed and culturally sensitive	Ensured that new housing resources consider trauma informed design. Provided staff with training in trauma informed care. Provided staff with training on cultural humility.	Efforts took place throughout the FY Trainings were provided throughout the fiscal year and have continued.	This was tracked by the percentage of providers that have been trained in Trauma Informed Care. For HSSP an annual on-site evaluation is done to ensure contract requirements are met and Corrective Action Plans are required if requirements are not met. For the Interim Housing Program (IHP), trauma informed care is a required training for all IHP staff. Attendance is verified by obtaining training certificates for all staff during the bi-annual interim housing site review.	Trauma informed care trainings for HSSP staff had been implemented in 177 PSH building by the end of FY 22-23. While we do not have exact data for the percentage of staff trained, this training was required for all contracted staff providing HSSP. All IHP staff completed trauma informed care.
4. Assisted LACDMH clients who are homeless to obtain and retain interim and permanent housing	LACDMH clients were provided interim housing and supportive services to assist them in getting off the streets. LACDMH clients were provided financial assistance to help in the transition from homelessness to permanent housing. Mental health services were provided to LACDMH clients who were formerly homeless to promote housing retention.	This goal does not have an end date and took place throughout the year.	This was tracked through: • The number of clients that access LACDMH's interim housing program (IHP) • The number of clients that have transitioned from IHP to PSH • The percentage of clients that have retained their housing once matched to PSH	During FY 22-23 a total of 1,451 clients accessed LACDMH IHP. Of the clients who exited IHP, 29.9% exited to permanent housing placements. Overall housing retention rate: • Capital Investments Program = 95%* • ERC Program = 82%* (*FY 22-23 data was not yet available this number reflects FY 21-22) • For tenant based Federal Housing

				Subsidies was 96.9% in FY 22-23
5. Increased the overall number of interim and permanent supportive housing units and rental subsidies targeting LACDMH clients	Invested in the capital development of PSH for individuals who are homeless and who have serious mental illness or serious emotional disturbance (SMI/SED) in partnership with the Los Angeles County Development Authority. Accessed and effectively utilized appropriate state funding including No Place Like Home to increase overall housing inventory.	This activity was ongoing throughout the year and is dependent on availability of funding.	This was tracked through the number of resources created and then utilized.	By the end of FY 22-23 LACDMH had invested in the capital development of 94 occupied PSH buildings totaling 2,156 units. In FY 22-23, LACDMH funded over 1,000 individuals in Enriched Residential Care (ERC).

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	Other and not reported	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	
DMH-PSH	2659 46.7%	128 2.3%	123 2.2%	44 0.2%	1164 20.5%	0	1142 20.1%	780 13.2%	2555 44.9%	2767 48.6%	1 0.0%	8 0.1%		357 6.3%					100%		
DMH-ERC	370 26.1%	20 1.4%	165 11.7%	11 0.8%	392 27.7%		415 29.3%	129 9.1%	912 64.5%	469 33.1%	0	2 0.1%		32 2.3%					100%		

* Demographic information displayed represents clients housed in LACDMH housing during calendar year 2023. For a given client, each distinct race and ethnicity response is counted separately, so clients may be represented multiple times. 281 clients in PSH and 82 ERC clients had more than one distinct race and ethnicity response.

**HJDD does not yet gather data on sexual orientation. This data will be available in the future as dynamics projects integrate demographic data from IBHIS.

The HJDD provided the following trainings to the LACDMH system of care:

Title of Training	Training Description	Audience Description	Frequency of Training Offering
Resources to Assist Clients to Become Self-Employed-Entrepreneurs	The training provided information regarding community resources to assist consumers to achieve Self-Employment/Entrepreneurial goals. Included in the training were the following: local labor market information, success stories, resources to explore the gig-economy, and other information relevant to self-employment /entrepreneurial assistance.	Los Angeles County directly operated and LACDMH Contractor personnel	10-18-2022
Community Volunteer Resources Training	The training provided information regarding resources to assist consumers to access volunteer opportunities in the community. Included in the training were success stories and other information relevant to accessing volunteer opportunities.	Los Angeles County directly operated and LACDMH Contractor personnel	11-08-2022
Introduction to Employment & Education Resources Training	The training provided introductory information regarding community resources to assist consumers to achieve employment and education goals. Included in the training were the following: accessing Social Security disability benefits resources, how to utilize local labor market information data, success stories and other information relevant to employment assistance.	Los Angeles County directly operated and LACDMH Contractor personnel	01-31-2023
Social Security Work Incentives 101 Training	This training placed emphasis on identifying tools to assess how to best transition from receiving disability benefits for returning to work. There are many myths among the consumer population about disability benefits and employment. This training identified and dispelled these myths. The participants learned how earned income affects disability benefits such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medi-Cal, Medicare, and subsidized housing.	Los Angeles County directly operated and LACDMH Contractor personnel	03-30-2023
Resources to Assist Justice-Impacted Individuals with Employment & Education	The training provided information regarding community resources to assist reentry/justice-involved clients to achieve their employment and/or educational goals. Included in the training were the following: local labor market information, success stories and other information relevant to employment assistance.	Los Angeles County directly operated and LACDMH Contractor personnel	04-25-2023
Resources to Assist People Experiencing Homelessness	The training provided information regarding community resources to assist people experiencing homelessness to achieve their employment and/or educational goals. The	Los Angeles County directly operated and LACDMH Contractor personnel	05-16-2023

Title of Training	Training Description	Audience Description	Frequency of Training Offering
with Employment & Education	training included local labor market information, success stories and other information relevant to employment assistance.		
Resources to Assist Immigrants with Employment	The training provided information regarding community resources to assist immigrant clients to achieve their employment and/or educational goals. Included in the training were the following: local labor market information, success stories and other information relevant to employment assistance.	Los Angeles County directly operated and LACDMH Contractor personnel	06-08-2023
Conservatorship 101	The training provided information about the function and process of conservatorship for clients who are in need of this level of support.	Los Angeles County directly operated and LACDMH Contractor personnel providing services to people currently and formerly experiencing homelessness	10/04/2022
Hoarding Disorder: Practical Interventions for Your Client	This training provided information on hoarding disorders and discussed effective interventions that can be implemented to address hoarding behaviors for clients in housing.	Los Angeles County directly operated and LACDMH Contractor personnel providing services to people currently and formerly experiencing homelessness	01/09/23 -01/10/23 06/05/23 -06/06/23 03/06/23 -03/07/23
Housing First	This training provided information to help providers better understand the “Housing First” approach and best practices to implement Housing First in various housing types including permanent supportive housing.	Los Angeles County directly operated and LACDMH Contractor personnel providing services to persons currently and formerly experiencing homelessness	06/14/23 05/09/23
Housing Specialist Training on Co-Occurring Disorders and Motivational Interviewing	This training introduced providers to Motivational Interviewing (MI) skills that can be used with clients experiencing co-occurring mental health and substance use disorders in housing settings.	Los Angeles County directly operated and LACDMH Contractor personnel providing services to people currently and formerly experiencing homelessness	02/14/23-02/15/23 03/01/23-03/02/23 11/22/22-11/23/22
Life Skills Integrating Activities of Daily	This training provided tools to assist in evaluating the extent to which the clients have knowledge and skills to participate in activities independent of supervision or direction. It provided information	Los Angeles County directly operated and LACDMH Contractor personnel providing	03/14/23-04/18/23

Title of Training	Training Description	Audience Description	Frequency of Training Offering
Living to Improve Quality of Life	on key aspects of ADLs and how to integrate this information into the four areas of functioning for clients.	services to people currently and formerly experiencing homelessness	
Mediating Neurocognitive Impairments on Independent Living Skills to Improve Housing Retention	This training provided participants with an introductory understanding of how neurocognitive disruptions commonly experienced by persons with psychiatric disabilities impact housing success and define the need for supports.	Los Angeles County directly operated and LACDMH Contractor personnel providing services to people currently and formerly experiencing homelessness	07/11/23-07/18/23
Suicide Prevention	This training provided information on best practices for suicide prevention including general risk factors, risk assessment, prevention and strengths- based interventions to manage suicide risk.	Los Angeles County directly operated and LACDMH Contractor personnel providing services to people currently and formerly experiencing homelessness	01/11/23-01/12/23 02/15/23-02/16/23 01/05/23-02/21/23 02/23/2023
Trauma Informed De-Escalation	This training provided information on factors that impact behavioral trauma response and discuss de-escalation techniques that can be applied using a trauma informed approach.	Los Angeles County directly operated and LACDMH Contractor personnel providing services to people currently and formerly experiencing homelessness	03/07/23-03/28/23

3. *Men's Community Re-Entry Program (MCRP)*
   The 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 modifying poor decision-making behaviors that impair a client's ability to meet his needs. Our 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 a maximum of 18-24 months.

   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 are their continual involvement in the justice system, their resistance toward treatment, and their high risk for recidivism.

Applicable LACDMH strategic plan domain: Re-entry initiatives				
Focal Population: Men involved with the justice system				
Objectives	**List Activities for <u>Each Objective</u>**	**Timeline for Each Activity**	**Monitoring Practices**	**Measurable Accomplishments**
1.Designation and tracking ethnic targets for MCRP	MCRP has created an internal system to track the ethnic targets. This helps the program to know the client's ethnic group and attempt to match him with a staff who might be able to meet his cultural needs, and/or consider service array that meets these needs.	This is an ongoing task. It continues to be enhanced depending on the need of the program.	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 clients/ clinical staff: Clients • White - 14% • Latino - 37% • Black and African • American - 31% • Multi-racial - 6% • Unreported - 9% Staff: • Latino and Spanish Speaking - 47% • Black and African American - 29% • White - 0.9% • Asian - 12%
2. Field-based services	MCRP has created an internal system to track the ethnic targets. This helps the program to know the client's ethnic group and attempt to match him with a staff who might be able to meet his cultural needs, and/or consider service array that meets these needs.	This is an ongoing task. MCRP staff worked collaboratively with staff members from Interim Shelters, Residential Programs and Sober Living Facilities to address any disparities related to 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. Formal consultations take place at least once a month to make sure client's needs are addressed.	Questionnaire/Survey are used to report any form of discrimination, disparity, or injustice by an organization, housing program, landlord or service provider. Data: • Reported Discrimination: 25% • Rejection of job/Housing: 59% • Decline of services: 3%

Objectives	List Activities for Each Objective	Timeline for Each Activity	Monitoring Practices	Measurable Accomplishments
3. Interagency Collaboration	Collaborative discussion between forensic programs took place to address the cultural needs of the clients; had panel discussion with experts to better serve the target population.	Collaborative meetings were ongoing and took place three times a month or when needed. Consultation with the following agencies/systems: 1. Probation 2. Public Defender's Office 3. Social Model Recovery Co 4. LACADA Other Justice Involved programs	During these collaborative meetings program procedures and outcomes were discussed to determine the effectiveness of the program.	Based on Risk Assessment conducted every six months: • 53% of the clients were experiencing homelessness. • 89% reported having a substance abuse problem. • 91% experienced financial problems. • 100% were justice-involved. • 12% of JII committed sexual offenses. • 7% of JII committed arson offense. • 6% were Undocumented. • 68% were convicted for robbery/theft Offense 85% reported having Adverse Family Background
4. Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	Program provided trainings to Spanish speaking staff to help them learn and understand the specific clinical terminology when working with Spanish speaking clients. Terminology is used for better expression and cultural sensitivity when assessing clients.	This is an ongoing task: Outreach and Engagement staff are better equipped when assessing clients at jail and/or courthouses. Team has better knowledge of Spanish clinical and case management terminology.	Spanish speaking supervisor met with staff on a regular basis to address any obstacles, training needs or determine their effectiveness in addressing multicultural/multilingual needs. Determined how many staff members had attended trainings in Spanish.	Language needs: 10% of clients are Spanish speaking monolingual. 80% of clients are English speaking. 47% of MCRP are Spanish speaking Staff. Less than 10% have knowledge of Spanish clinical terminology.
5. Partnerships with Health Departments on initiatives regarding cultural competence, linguistic	Partnerships between DHS/DMH/DPH take place to address reentry needs for the justice involved population. Additionally, collaborative work	This is an ongoing task: The aforementioned meetings took place on a monthly or bi-weekly basis. The meetings occurred at the	This task was monitored as follows: • Tracked number of referrals coming from the Collaborative Courts using Microsoft Teams application.	10% of referrals came from Collaborative Court identifying high levels of substance use and moderate to high acuity of MI.

Objectives	List Activities for Each Objective	Timeline for Each Activity	Monitoring Practices	Measurable Accomplishments
appropriateness, and equity	between the Office of the Public Defender, LACDMH and Substance Abuse Treatment providers take place to address the lack of housing and treatment services provided for the most disadvantaged clients who are in need of intensive services.	beginning phase of development.	• Determined how many cases were being provided with co-occurring services both by LACDMH and SA Residential Treatment Providers. • -Determined appropriateness of referral and match with the program and capacity of program to meet the needs.	68% of referrals came from Court Linkage with specific needs such as monolingual speakers, homeless, and special needs. 10% of referrals came from Public Defender's Office- high acuity of mental illness and multiple co-occurring disorders. The rest came from various programs.
6. Augmentation of mental health service accessibility to underserved populations	Formed an In-reach and Engagement Team that specifically worked with Correctional Facilities to identify, assess, process, and prepare JII who are incarcerated to reenter society and begin receiving services.	This in an ongoing task. The In-reach and Engagement Team is in the process of being developed.	Tasks performed by the In-reach and Engagement Team: 1. Process referral. 2. Meet with the inmate while incarcerated to begin the triage assessment. 3. Determine the level of care needed before jail release. 4. Prepare for jail release. 5. Identify housing and case management needs. 6. Provide warm handoff to the treatment team/program.	Outcome measures include: 1. Duration of incarceration 2. Timeframe of case processing from the time referral is received to date of jail release. 3. Number of scheduled appointments in the community. 4. Number of individuals being temporarily housed. 5. Number of intakes conducted and successful enrollments in the reentry program.

Consumers Served, FY 22-23

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	
Men's Community Reentry 7995	76	2	4		91	14	35	21	241	2	1		1		5	5	146	2	85		1

4. *Enhanced Care Management*
   The Enhanced Care Management (ECM) program focuses on addressing the clinical and non-clinical needs of high utilizers of emergency medical services with no appreciable stabilization in health care status. The ECM Program serves adults aged 18 and older with Serious Mental Illness (SMI), including co-occurring substance use disorders, who are frequently hospitalized for chronic/acute medical and psychiatric conditions. ECM accepts referrals from various community sources such as hospitals, emergency departments, urgent cares, outpatient mental health providers operated by LACDMH or its contract agencies, and other community sources including Managed Care Plans (MCP). Members eligible for the program must have full-scope Los Angeles County Medi-Cal and be enrolled in a Managed Care Plan contracted with LA County Department of Mental Health. In addition, the member must have a history of disproportionate use of emergency medical services; and/or demonstrate a need for collaborative care coordination to improve health outcomes as determined by their health care provider(s). Members who agree to participate will be enrolled in the ECM program. ECM services are primarily field-based and provided face-to-face whenever possible. If in-person contact is not possible, outreach and/or follow-up with the member may be performed telephonically or via online video conferencing.

Applicable LACDMH Strategic Plan Domain: Community Services				
Focal Population: Severe Mentally Ill and Substance Abuse				
Program Objectives Related to Cultural Competence	**List Activities for Each Objective**	**Timeline for Each Activity**	**Monitoring Practices**	**Measurable Accomplishments**
1. Collaboration with faith-based and other trusted community entities/groups	ECM sought to build working relationships with community food banks, shelters, transitional living residences to maximize our consumers' success in achieving greater independent functioning. Staff participated in monthly Service Area Leadership Team (SALT) meeting further fostering community relationships with faith-based organizations and community groups, such as NAMI.	Ongoing	ECM collaborates with the Service Area administration Team who represent the community perspective. On a monthly basis, ECM staff and supervisors present at clergy meetings, FSP, and other MH awareness events taking place throughout the service area.	Successfully linked consumers to community resources by closing cases with a Program Completion Questionnaire for clients ready to transition to a lower level of care because they were connected to Mental Health services, Health services, benefit establishment and connected to community or family support.
2. Field-Based Services	ECM staff conducts field-based services for most of their day. That includes visiting prospective client and/or current client at inpatient facilities (hospitals, substance abuse programs). Staff also accompany consumers to medical appointments, grocery stores, etc.	Ongoing	Lead Care Managers and ECM supervisors receive referrals from the different Fee-for- Service Hospitals. The managers and supervisors do outreach follow-ups to the clients while they are hospitalized to enroll them in ECM. ECM Supervisors review cases for change from client in outreach to enrolled.	• June 2022 – Starting with 153 Clients - LA Care, Anthem, Kaiser, and Health Net. • June 2023 – Ending with 276 Clients - LA Care, Anthem, and Health Net. • June 2023 – Closed 446 Clients which services were provided
3. Augmentation of mental health service accessibility to underserved populations	ECM has established relationships with inpatient psychiatric hospitals and facilities to establish relationships with unserved consumers. The goal is to assist them with receiving ongoing mental health treatment through outpatient services or Full-Service Partnership (FSP)	Ongoing	ECM is a field-based program and provides countywide services. Daily ECM staff travel to rural communities in the San Fernando Valley and Antelope Valley to assist underserved populations, sharing information about the availability of appropriate and effective service providers within the area. In addition, ECM staff and supervisors are	ECM does not have outcome data for FY 22-23

			meeting with clients in inpatient psychiatric facilities from underserved and unserved communities offering supporting services.	
4. Integrated Supportive Services	ECM staff meet the consumers where they are. With the support of ECM staff consumers have been able to integrate back into the community such as going back to school, getting a job and utilizing public transportation, libraries, and local community centers, etc.	Ongoing	ECM clients are receiving integrated supportive services in the form of housing assistance, linkage to community supports, or learning to access resources in their community such as libraries and food banks.	ECM does not have outcome data for 2022-2023
5.Outreach and Engagement (O&E) activities	ECM core service is outreach and engagement to its members in person or telephonic. ECM staff conducts outreach to beneficiaries in their homes, shelters, transitional living, substance abuse centers, or benefiters preference.	Ongoing	ECM staff/Lead Care Manager primary duties is to outreach and engage clients in their community and place of residence. The Lead Care Manager conducts the outreach and engagement in person.	ECM does not have outcome data for FY 22-23
6. Integration of physical health, mental health, and substance use services	ECM staff work in collaboration with mental health, medical provider, and substance use providers to address the consumer needs and appropriate services.	Ongoing	Lead Care Managers integrate and collaborate with members of the clients care team. ECM clients are receiving integrated supportive services. For example, they accompany clients to medical appointments, assist the in-home supportive service provider, link clients the general relief benefits, assist with completing intake for substance abuse treatment, or consult with the mental health provider and psychiatrist.	ECM does not have outcome data for FY 22-23

Consumers Served, FY 22-23

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 not listed	Do not know	Decline to respond	
ECM	183	8	6	0	185	22	176	164	540	300	0	1			2	5	51			5	Not reported

D. **The LACDMH ARISE Division's Interface with the LA County's Anti-Racism, Diversity, and Inclusion (ARDI) initiative being led by the Chief Executive Office**

The ARISE Division (previously known as the LACDMH's ARDI Division) was established in 2020 to strengthen the Department's ongoing commitment to addressing anti-black racism and racism in all facets of service delivery and within its workforce. The objectives of the ARISE Division are outlined as follows:

- To combat racism within LACDMH's service delivery systems to effectively serve our diverse communities.
- To promote the cultural well-being of our varied workforce.
- To cultivate an inclusive workplace that accurately reflects the community it serves.
- To implement inclusive and equitable practices for hiring, supervision, and professional development of our workforce.
- To nurture a culture of inclusion, equity, and diversity that informs all organizational levels, including staffing practices, training, policies, and service delivery systems.
- To enhance partnerships and collaborations with other L.A. County Departments, community-based organizations, and stakeholder groups to actively combat racism.
- To improve the responsiveness of executive management and leadership in addressing the needs of our diverse communities and workforce.

The ARISE Division encompasses various programs and units that serve underserved cultural communities. These initiatives aim to enhance access to care for culturally and linguistically isolated individuals while addressing mental health stigma and disparities.

Furthermore, the Division seeks to establish a stakeholder platform that facilitates the collection of direct feedback from members of marginalized communities concerning their mental health needs and challenges. Below is a description of the programs and services within the ARISE Division:

- **Underserved Cultural Communities (UsCC) Unit**
  This is one of DMH's internal platforms for stakeholders, designed to gather feedback on training and provide best practice recommendations for serving underserved and marginalized communities. It implements capacity-building projects that are driven by stakeholders and culturally specific, targeting the following cultural groups: American Indian/Alaska Native (AI/AN), Asian American/Pacific Islander (API), Black/African American, individuals with disabilities (including Blind, Deaf, Hard of Hearing, and persons with intellectual disabilities), East European/Middle Eastern (EE/ME), LGBTQ+, and Latino communities.

- **The United Mental Health Promoters Program (UMHP)**
  The United Mental Health Promoters program serves as a cultural bridge and delivers culturally driven community presentations to underserved communities. The goal is to engage them in service delivery and reduce mental health disparities. In addition, the promoters participate in community outreach activities and events to provide mental health resources and linkages using culturally specific engagement strategies.

- **Cultural Competency Unit (CCU)**
  The CCU completes the Department's annual Cultural Competence Plan and ensures that DMH's service delivery adheres to the cultural and linguistic needs of our community. This includes developing policies and procedures (P&P) in accordance with the CLAS standards and the Cultural Competence Plan Requirements. The CCU also responds to all departmental inquiries and needs pertinent to cultural competence. It also drives the efforts of the Speakers Bureau (SB) in addition to providing trainings and presentations pertinent to cultural competence and cultural humility within the Department and the community at large. The CCU is also responsible for orchestrating ARISE Division cultural events out in the community.

- **Speakers Bureau**
  The SB operates as the departmental centralized public-speaking mechanism to serve the community and LACDMH programs during and beyond COVID-19. It has approximately 75 licensed clinicians representing various departmental programs. SB members provide culturally and linguistically specialized presentations, trainings, public-facing speaking engagements, and media interviews on radio and television in ten languages.

- **Language Assistance Services (LAS) Unit**
  The LAS Unit provides language accommodations for our service delivery as well as for community and administrative meetings as follows:

- American Sign Language (ASL) Interpreter Services for clinical appointments for Directly Operated and Legal Entities/Contracted Providers only.
- Services for LACDMH stakeholder meetings (i.e., SALT, CCC, UsCC, FBAC, MHSA CCP and the Mental Health Commission)
  - ❖ Threshold language interpreter services
  - ❖ ASL
  - ❖ Communication Access Real Time (CART) Translation

- **LGBTQIA2-S Champions Network**
  The LACDMH LGBTQIA2-S Champion Network is a growing cohort of LACDMH administrative and clinical staff with meaningful experience, knowledge, and training in affirming clinical practice with LGBTQIA2-S communities. This body collaborates with other county departments to promote responsive and sustainable systems change and ensures that LACDMH is an affirming and inclusive institution for consumers and employees of all genders and sexualities. It operates as a public-facing entity to increase the visibility of and access to affirming services for LGBTQIA2-S community members. Finally, it serves as an internal-facing community of LACDMH employees who can provide consultation, resources, and other support to county staff with questions, concerns, or learning needs related to best practices with LGBTQIA2-S communities.

LACDMH's ARISE Division also collaborated with LA County Chief Executive Office (CEO) - Anti-Racism, Diversity, and Inclusion (ARDI) in the following initiatives:

- ARISE Division administrative managers participated in the CEO ARDI training series on equity in budgeting and equity in contracting, and the utilization of the Equity Explorer tool to identify communities with the highest need to implement programs and strategies targeting marginalized communities.
- LACDMH is using the CEO ARDI Equity Explorer tool to identify community needs to release solicitations for programs and services that target underserved and oppressed communities.
- The ARISE Division administrative managers participated in CEO ARDI-sponsored workgroups and advisory groups to examine the county's practices related to inclusive and equitable hiring, supervision, and professional advancement processes/procedures for our workforce. To promote a culture of inclusion, equity, and diversity that will guide all levels of the organization, from staffing practices, trainings, P&P, and our service delivery system.
- The ARISE Division coordinated LACDMH's implementation of the Board of Supervisors (BOS) board motion titled, Solidifying the Role of Promotoras de Salud in County Services. On February 15, 2022, the Board of Supervisors instructed the CEO in collaboration with the Department of Health Services, Department of Public Health, Department of Mental Health, and the Alliance for Health Integration to identify funding to sustain Community Health Worker/Promotoras/es programs and provide updates on opportunities to expand the range of services and opportunities to connect more residents to culturally and linguistically accessible care. This motion includes specific directives to the

Department of Mental Health to hire 300 Community Health Workers to work as Promotores de Salud/Health Promoters.

- The ARISE administrative managers collaborated with multiple county departments to implement gender-responsive services through the work of the LGBTQI2-S Champions Network.
- The ARISE Division Program Manager III participated in workgroups to implement the Departmental Language Access Plan.
- The ARISE Division coordinated DMH's implementation of the Care with Pride Board. Motion, which included the following:
    - LACDMH began collecting comprehensive SOGI data within IBHIS, the Department's Electronic Health Record system, on June 16, 2023. Expanded SOGI data categories now include Gender Identity, Sex at Birth, and Sexual Orientation; additionally, clients' personal gender pronouns may now be entered and displayed within the banner bar at the top of their chart.
    - LACDMH published a Sexual and Gender Diversity Clinical Practice Parameter in April 2022. This parameter is both public and internal facing and applies to LACDMH's Directly Operated and contracted programs.
    - LACDMH has created and published three (3) asynchronous web-based trainings for employees at Directly Operated and contracted programs: Sexual Orientation and Gender Identity (SOGI) - Concepts and Terminology, How to Ask About SOGI, and Pronouns and Why They Matter. These trainings are housed within Cornerstone Learning Link (for LACDMH employees) as well as on Granicus for those accessing the trainings outside of County systems.
    - The ARISE Division has been collaborating with the PIO to expand our LGBTQ+ Resources webpage, which will include information and links. The ARISE Division has also created a brochure describing the Department's LGBTQIA2-S services, including information about the LGBTQIA2-S Champion Network and the Gender Affirming Treatment Advocates.

- The ARISE Division coordinated LACDMH's implementation of the Gender Impact Assessment (GIA) Project, which consists of four LACDMH programs, including the Enhanced Emergency Shelter Program (EESP) TAY Navigation Team, EESP contracted TAY Drop-In Centers, Men's Community Reintegration Program (MCRP), and Women's Community Reintegration Program (WCRP). A series of meetings were held from September to November 2023 with these four programs' leadership and staff to provide background, purpose, and requirements of the GIA Project and begin collaboration on the implementation of comprehensive sexual orientation and gender identity (SOGI) data collection. We also stressed the importance of staff training in enhancing data collection and provided the following training resources:

    - How to Ask About SOG
    - SOGI – Pronouns and Why They Matter
    - The Ins and Outs of SOGI Data Collection
    - SOGI Sexual Orientation Gender ID
    - SOGI Concepts and Terminology

The three SOGI data collection metrics include gender identity, sexual orientation, and gender pronouns.

E. LACDMH Involvement with Los Angeles County Board Motions

During FY 22-23, LACDMH played an active role in responding to various Board Motions, often in collaboration with the other Health Departments. Below is a brief description of the most salient Board Motions inclusive of work completed and accomplishments

1. *Solidifying the Role of Promotoras de Salud in County Services*
   The LA County Board of Supervisors (BOS) directed LACDMH to provide 1) An updated report regarding current efforts to retain and expand upon the Promotores de Salud Mental Health program and provide long-term participants of the program with a pathway to full-time employment; 2) Report back on existing allocations pertinent to the Coronavirus Aid, Relief, and Economic Security (CARES) Act and American Rescue Plan Act (ARPA) funding for the Promotores de Salud mental program and plans for its use to preserve and expand upon the program; and 3) Report back on initiatives to include the Promotoras/es and Community Ambassador Network programs in the Department's Anti-Racism, Diversity, and Inclusion initiatives. Additional information can be accessed at: http://file.lacounty.gov/SDSInter/bos/supdocs/166513.pdf.
   Date of enactment: 2/15/2022

   Accomplishments for FY 22-23

   General Overview

   - Onboarded and trained 160 Full time-item Community Health Worker (CHW) Promoters, 25 of whom were hired by different DMH, County and Community programs. The United Mental Health Promoters program includes 146 Promoters across all Service Areas (including 39 vendors). An additional 16 are in the hiring process.
   - The Promoters provided over 5,800 workshops provided across LA County with over 54,000 cumulative participants; 59% of workshops were in-person in February 2023.
   - Collaborated with DPH on several lead abatement projects in primarily Spanish-speaking communities to raise community awareness and provide information identified and resources.
   - LACDMH state funding source outside of the CalAIM initiative to expand CHW/Promotores (P) efforts: The Health Departments are cognizant of the need for stable, long-term funding to support the CHW/P workforce and have been actively involved in the State's efforts to expand Medi-Cal coverage for CHW/P/Peer Support Specialist services, beyond CalAIM. LACDMH and DPH's Substance Abuse and Control Program will both take advantage of increased State funding provided by Senate Bill (SB) 8031 for their respective programs (DPH explains in Attachment III how they will work with their contracted provider network to align with SB 803). This bill is a component of

the State's Medi-Cal reform efforts and operationalizes the integration of CHW/P/Peer Support Specialists that are reimbursable under Medi-Cal in the behavioral health and SUD realm.

- The Health Departments actively monitored and provided comments around the new CHW/P Medi-Cal benefit via the State's proposed CHW State Plan Amendment, slated to also begin in July of 2022.
- To maximize the impact of the January 2022 three-Department letter to the state regarding the CHW State Plan Amendment for Medi-Cal Benefit, the three Health Departments partnered with the CEO Office of the American Rescue Plan for the purpose of funding CHW/P. The Board-approved American Rescue Plan (ARP) Tranche 1 spending plan included $15.0 million for community-based outreach, including activities such as those undertaken by CHW/P.
- Building on the February 2022 CHW landscape analysis and a desire to hear our community partners' vision for a strong CHW/P workforce, the Health Departments launched a 12-month planning process. Key to this planning process is engaging with our community-based contractors to understand what their CHW/P (and their organizations) need to thrive, and how the County can best help build the capacity of our partners and their CHW/P employees.

Update Report Regarding Expansion of the Promotores de Salud Mental Program

- In Fiscal Year 2021-22, LACDMH was allocated 300 temporary staff items, 150 of which were to be used to convert the Promotores de Salud Mental contracted as vendors to County employees to phase out the vendors. The remaining 150 staff items were to be used to expand the Promotores de Salud Mental model to adapt the program to underserved communities prioritized by the Board, including African American, Alaska Native/Native American and Asian Pacific Islander (API). Recruitment efforts were also extended by LACDMH to the other underserved communities, including LGBTQIA2-S, Deaf/Hard of Hearing, different abled or Access for All, and Eastern-European/Middle Eastern underserved communities.
- The Promotores program has demonstrated great capacity to adapt to the challenges of providing, and even expanding, services to the community during the COVID-19 pandemic. It has also reached out to diverse cultures and communities, involving underserved groups in the development of its curriculum. As a result, the program has created culturally competent and linguistically accessible services for these communities, offering workshops in Chinese, Korean, Khmer, and other languages under the United Mental Health Promoters Program (UMHP).
- Despite clear successes, the program has faced challenges in retaining staff, a common issue experienced by many during the pandemic. After completing the onboarding and training process, many promoters leave the program for other LACDMH programs that offer full-time employment and benefits. As a result, onboarding the targeted 300 individuals has been slow, with high attrition rates.
- In response to Board motion, LACDMH is developing a plan to convert temporary staff items to permanent staff items, allowing the staff to fully

participate in the created career pathway. This includes implementation of Promoters as Community Health Workers, Senior Community Health Workers, and Supervising Community Health Workers.

- The Promoters used CARES Act funding to adapt their existing modules into COVID-19 specific modules and created three (3) new workshops providing COVID-19 information to underserved cultural communities. The COVID-19 specific workshops were used to provide factual information on the vaccine, help reduce anxiety related to the vaccination and the pandemic. Outreach efforts were used to link community members to vaccine sites and mental health services. Other COVID-19 specific efforts included increased collaboration with the DPH to augment community participation, and collaboration with the Board offices to deploy Promoters to vaccine sites to provide emotional support, reduce anxiety, and provide linkage.

2. *Care with Pride: Establishing a Gender Health Program in Los Angeles County*
The BOS directed the Department of Health Services (DHS) to work in collaboration with the Department of Children and Family Services (DCFS) and LACDMH to further support the departments' Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+) patients and clients with accessing gender affirming medical services, mental health services and social services. Additional information can be accessed at: http://file.lacounty.gov/SDSInter/bos/supdocs/169998.pdf
Date of enactment: 6/14/2022

Accomplishments for FY 22-23

- LACDMH contributed to the GHP by implementing two programs: 1) The Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual and Two-Spirit (LGBTQIA2-S) Champions Network and 2) the Primary Care and Behavioral Health Integration program to enhance cross-departmental gender affirming healthcare provisions, address health-related inequities, combat stigma, link clients to medical and/or mental health providers, and establish collaborative treatment models within DHS sites. Both programs incorporate the expertise of Gender Affirming Treatment Advocates (GAA).
- The LGBTQIA2-S Champions/GAA clinicians were trained to write support letters for transgender, non-binary, and gender-expansive clients, as well as connect them to mental health services. These trained clinicians are still located in each Service Area. The GAA clinicians conduct specialized clinical and psychosocial assessments and write referral letters for gender-affirming medical care. These services, provided by the LGBTQIA2-S community and allies, improve accessibility, service quality, and treatment outcomes.
- LGBTQIA2-S Champions/GAA services included general mental health support, pre-surgical consultation (in collaboration with DHS psychiatrists), and family-centered mental health services to support teens and transitional aged youth desiring gender-affirming care. LACDMH also fostered linkages to appropriate providers at their clinics after initial assessment within the GHP and Medical Hub sites. Patients can also connect with mental health services through the departmental Help Line and the virtual Provider Network website, which serve as the primary referral hubs.

- Linkages services were facilitated through the LGBTQIA2-S Champions Network once implemented within the ARISE Division. Members of the LGBTQIA2-S Champions Network served as a mechanism to identify, engage, and train clinical providers and allied professionals in affirming service delivery for individuals seeking gender-affirming care. As knowledgeable and experienced LGBTQIA2-S community members, the champions provided a visible LGBTQIA2-S affirming, supportive, and culturally responsive environment for clients and their family members.

Disparity strategies' board motion was a joint effort between LACDMH and LACSAPC.

3. *Confronting the Drug Overdose Epidemic*
The BOS instructed DPH to work in partnership with DHS, LACDMH, Department of Children and Family Services (DCFS), and several other LA County Departments to develop and regularly update a plan of action to address the growing crisis of overdose deaths related to methamphetamine, fentanyl, opioids, and other substances.

SAPC, as designated by DPH, leads and coordinates these efforts, to collectively advance the overdose-related projects. Additional information can be accessed at: http://file.lacounty.gov/SDSInter/bos/supdocs/171257.pdf
Date of enactment: 7/26/2022

Accomplishments for FY 22-23

- SAPC contracts with community-based organizations (CBOs) for Engagement and Overdose Prevention (EOP) Hub services, which include syringe exchange, safer use equipment, Naloxone and fentanyl test strip distribution, linkage to infectious disease testing, and referrals to medical, psychiatric, and substance use disorder (SUD) care. In Fiscal Year (FY) 2022-2023 and continue to implement harm reduction programs and services, directly or in partnership with subcontracted providers in partnership with DPH, DHS and LACDMH.
- SAPC added one EOP Hub for a total of seven across LA County and increased funding by $3.41 million for a total of $4.16 million in County-wide. This investment extended accessibility of harm reduction and overdose prevention services and enabled continued efforts to better serve those disproportionally impacted by overdose, in particular individuals of color, LGBTQ+, justice-involved, and/or PEH.
- SAPC EOP Hubs which conducted 11,944 service encounters, distributed 22,427 units of Naloxone, 15,525 Fentanyl test strips, 688,803 sterile syringes, and 6,299 wound care kits between September 1 and December 31, 2023. EOP Hubs reported 1,328 overdose reversals and 525 referrals to substance use treatment. Eighty-three percent of encounters were with persons experiencing homelessness (PEH) and the majority identified as Black or Latino. More than 30 new outreach sites were also added.

- SAPC, in partnership with DHS, expanded SAMHSA funding to deploy additional services through SAPCs contracted EOP Hubs to purchase clean injection supplies and safer sex supplies, and hire people with lived experience as peer support workers in Service Planning Areas (SPAs) 4 and 6 to work specifically with people experiencing homelessness (PEH) and people who use drugs.
- LACDMH placed Naloxone overdose stations in all 16 directly operated clinics and trained staff on the use of fentanyl test strips and appropriate supplies, made available Naloxone kits for clinic clients, equipped field-based providers with Naloxone kits and Fentanyl test strips, and offered training to prevent and respond to overdoses.
- LACDMH Homeless Outreach and Engagement (HOME) Team, the Men's Community Reentry Program (MCRP), and Full-Service Partnership (FSP) staff responded to a number of overdoses in the field among PEH clients. Clients not served by LACDMH received Naloxone and Fentanyl test strips at the newly created drop-in center, headed by the Skid Row Concierge Outreach Team. This team also provided overdose prevention education and supplies, housing navigation, and mental health services.
- DPH, DHS and LACDMH continued their collaboration on taskforces to 1) streamline navigation to Medications for Addiction Treatment (MAT) for persons being discharged from jail; 2) coordinate overdose prevention in Skid Row; 3) address and coordinate Methamphetamine prevention and treatment approaches; and 4) discuss use of Xylazine test strips and educate patients and staff.
- On September 27, 2022, Governor Newsom signed County-sponsored AB 2473 by Assemblymember Nazarian, which will increase the required minimum training standards for prospective SUD counselor registrants in California, including knowledge of co-occurring substance use and mental health conditions and MAT, among others. The bill will help ensure California has an SUD counselor workforce that is better prepared to enter the SUD treatment field and deliver modern addiction treatment services.
- LACDMH, in collaboration with UCLA and Eisenhower Medical Center, added SUD treatment as a service option for programs housing justice-involved youth.
- LACDMH offered housing services as a key component of justice-involved care at the Men's and Women's Community Re-Entry Programs (MCRP and WCRP) with key programs such as the HOME Team, FSP, the Veteran Peer Access Network (VPAN), Enhanced Emergency Shelters for Transitional Age Youth (TAY, EESP), Interim Housing, Assisted Outpatient Treatment (AOT), and Prevent Homelessness Promote Health $(PH)^2$ programs.
- These LACDMH programs engaged in the planning and implementation of the CalAIM Justice-Involved Initiative for LA County. Together with DPH and DHS-Correctional Health Services, these LACDMH programs have developed workgroups to operationalize the initial screening, create the 90 days prior-to-release assessments, and establish the Adult Behavioral Health Warm Hand-Off and Youth Behavioral Health Warm Hand-Off protocol.
- LACDMH provided specialty mental health services in permanent supportive housing (PSH) through its Housing Supportive Services Program (HSSP), in

collaboration with DHS' Intensive Case Management Services (ICMS) teams and DPH's Client Engagement and Navigation System (CENS) teams with the common goal of providing supports to help residents maintain and retain their housing.

- The three Health Departments continued to expand access to navigation services for people with SUD and co-occurring mental health and/or physical health service needs. Specifically, LACDMH received funding through the new State's Behavioral Health Bridge Housing (BHBH) program to enhance its current non-congregate interim housing and expand to new sites across the County for PEH with serious mental illness, many of whom have co-occurring SUD. SAPC received BHBH funding to expand its recovery housing portfolio, including an additional 300 Recovery Bridge Housing (RBH) beds and a new pilot for 100 Recovery Housing beds to grow the recovery-oriented housing-continuum for individuals in recovery from SUD who voluntarily prefer abstinence-based housing.
- DPH, DHS and LACDMH continue to expand harm reduction efforts. Among them, planning to provide overdose prevention and response training and expand Naloxone and Fentanyl test strip distribution. LACDMH offered trainings to its Interim Housing and Enriched Residential Care licensed residential care facilities on preventing overdoses through the use of Naloxone. LACDMH used Housing First and Harm Reduction models and offered training on these models to case managers. Additionally, LACDMH provided training to psychiatrists, psychiatric nurse practitioners, and clinical pharmacists on the use of low-threshold MAT within its treatment services.
- LACDMH Clinics established co-occurring disorder treatment groups that did not require that clients have their SUD already in remission as a condition of participation based on Cognitive Behavioral Therapy (CBT) and Contingency Management (CM). In doing so, the harm of using substances was reduced as clients moved at their own pace toward recovery.
- The three Health Departments expanded bidirectional referrals for clients with SUD who are at risk of, or diagnosed with, sexually transmitted infections (STI): LACDMH updated its HIV testing policies to use an "opt-out" rather than "opt-in" approach to ensure broad testing among its clients.
- DPH, DHS and LACDMH implemented a variety of prevention, early intervention, and treatment services for young people directly and in collaboration with contracted CBOs, LACDMH psychiatrists closely follow youth taking medications for SUD as well as other mental health disorders for ongoing counseling, evaluation, and treatment planning.
- DHS physicians and SUD counselors worked in partnership with DCFS, LACDMH, and DPH to provide a culturally, developmentally appropriate, trauma-informed medical model for treating youth who use substances; and linked high-risk youth to DHS addiction specialists.
- DPH, DHS and LACDMH continue to implement contingency management strategies for which LACDMH uses CM as a tool in its Integr8Recovery Co-occurring Disorder Treatment Programs, and in Skid Row Concierge services.
- DPH, DHS and LACDMH expanded trauma-informed and culturally responsive harm reduction and overdose prevention trainings. DPH and LACDMH offered Seeking Safety trainings to both the SUD and mental health

treatment network. LACDMH provided training on overdose prevention to all field-based teams and equipped them with Naloxone. The MCRP uses a culturally sensitive and population-specific model when working with individuals with an incarceration history, and advocates for clients who experience discrimination from treatment programs or housing facilities. The MCRP worked collaboratively with DPH's contracted residential substance use programs to serve these populations.

4. *Coordinating of Los Angeles County's Response to Incidents of Mass Violence*
The BOS issued directives requiring LACDMH's active involvement in the following: 1) Collaborate with the Chief Executive Office (CEO), DPH, Aging and Disabilities (ADD), and relevant departments, to coordinate necessary resources and funding to support the Monterey Park shooting victims, and continue targeted culturally and linguistically appropriate outreach to Asian American and Pacific Islander (AAPI) older adults; 2) The identified departments, to work in collaboration with County partners and external subject matter experts in assessing and updating protocols and procedures for the County on providing a seamless response to incidents of mass violence. Additional information can be accessed at:
http://file.lacounty.gov/SDSInter/bos/supdocs/177256.pdf
Date of enactment: 1/24/2023

Accomplishments for FY 22-23

- LACDMH took immediate action to ensure a coordinated response to mass violence incidents. Bilingual certified staff inclusive of the Speakers Bureau proficient in Asian languages were identified and recruited to address the needs of the community.
- LACDMH in collaboration with the CEO, DPH, Aging and Disabilities Department (ADD), and other relevant departments, coordinated necessary resources and funding to support Monterey Park shooting victims and continue targeted outreach to Asian American and Pacific Islander (AAPI) older adults that is linguistically and culturally appropriate.
- The CEO with LACDMH, DPH, and relevant departments assessed and updated protocols and procedures for the County to provide a seamless response to incidents of mass violence in the County.
- LACDMH continued to provide post-incident services as needed and collaborated with Chinatown Services on the planning of a Community Resilience Center for the victim of the incident in Monterey Park.

5. *Care with Pride: Supporting Gender Affirming Health Care, Mental Health Services, and Care Management for LGBTQ+ Residents, Including Transgender, Gender Nonconforming, and Intersex People*
The BOS instructed LACDMH, DHS, DPH, DCFS, and the CEO's Anti-Racism, Diversity, and Inclusion Initiative (ARDI), in collaboration with the Los Angeles County Commission on Human Relations, to report back on the progress of the Gender Health Program (GHP) including data and reporting issues; the status of clinical standards of the GHP; the feasibility of developing and offering educational

webinars relevant to gender-affirming care to workforce members from departments mentioned above; considerations for clinical and administrative staff needed to ensure the continued success of the program; develop a strategy for communication and outreach to raise community awareness of the GHP including traditional and local media, social media, community-based organizations, and community partners; and a plan to create a public-facing County website offering resources and referral links to gender-affirming healthcare services within County departments.
Additional information can be accessed at:
http://file.lacounty.gov/SDSInter/bos/supdocs/181376.pdf
Date of enactment: 6/6/2023

Accomplishments for FY 22-23

- LACDMH implemented two important projects which directly contribute to the GHP efforts: 1) the LGBTQIA2-S Champions Network Program to ensure that clients receive the support needed from highly-trained clinical and administrative staff, and 2) the Primary Care and Behavioral Health Integration program aiming to enhance cross-departmental gender-affirming healthcare provisions, address health-related inequities, combat stigma, link clients to medical and/or mental health providers, and establish collaborative treatment models within DHS sites. Both programs incorporate the expertise of Gender Affirming Treatment Advocates (GAA).
- LACDMH has identified several GAA clinicians and trained them on how to write support letters for transgender, non-binary, and gender-expansive clients and connecting patients to mental health services.
- Additional pertinent details were included above in section B. Care with Pride.

6. *Supporting Mental Health for Latino Residents*
The BOS instructed LACDMH to implement the following strategies: 1. Develop a strategic plan and outreach campaign focusing on the hiring and retention of bilingual and Spanish-speaking clinicians, including partnerships with local universities and Hispanic-Serving Institutions (HSIs) to develop the workforce pipeline; 2. Analyze the feasibility of building upon programs addressing the County's needs to develop more culturally and linguistically appropriate services, such as the Bilingual and Spanish Interdisciplinary Clinical Training (BASIC-T) Pipeline Training Program and Continuing Education Program; 3. Explore models for strengthening the collaboration of these efforts with LACDMH Legal Entities (LE), Training Unit, and LACDMH Underserved Cultural Communities (UsCCs); 4. Collaborate with the CEO in identifying ongoing funding sources to support the above initiatives; and 5. Report back on the implementation of these directives.
Additional information can be accessed at:
http://file.lacounty.gov/SDSInter/bos/supdocs/183269.pdf
Date of enactment: 08/08/2023

Accomplishments for FY 22-23

- LACDMH developed a strategic plan for outreaching, recruiting, hiring, and retaining staff including bilingual and Spanish-speaking clinicians. This plan comprised a multifaceted, multimedia approach to recruitment using videos, social media, and billboard messages showcasing an existing team of culturally diverse LACDMH employees. An important aspect of the hiring campaign was the inclusion of employees representing a range of positions from Community Health Workers to Program Managers.
- The release of a recruitment video featured on LACDMH Night at the Los Angeles Sparks Game on June 25, 2023.
- Increasing the community exposure to the LACDMH recruitment campaign via the "Do Worthwhile Work" website.
- As a result of these targeted recruitment and retainment efforts, LACDMH now maintains a 30 percent bilingual Spanish-speaking workforce.
- LACDMH reached out to current student trainees and will continue ongoing efforts to recruit them into employment with the Department.
- On April 7, 2023, LACDMH held a hiring fair for social work student trainees placed in Directly Operated programs and successfully recruited 20 Psychiatric Social Worker (PSW) I positions.
- LACDMH worked with the Department of Human Resources (DHR) to establish specific hiring lists for graduating social work, psychology, and marriage and family therapy students who have been approved for loan repayment awards while holding employment in the public mental health system.
- LACDMH implemented hiring fairs and the Emergency Appointment (EA) process to expedite the hiring process of Medical Case Workers, Community Health Workers, and current student trainees and interns. Conditional employment offers may be made and LACDMH Human Resources Bureau is available to conduct live scans and other administrative tasks to shorten the hiring process.
- In partnership with DHR, multiple recruitment fairs have been held with various colleges and universities, including the University of Southern California (USC), Alliant International University, and East LA College
- Overall, recruitment efforts have resulted in a total of 50 candidates joining LACDMH through career fair events, including for such impacted classifications as Clinical Psychologists and PSWs
- LACDMH sent a team to recruit psychologists to the American Psychological Association (APA) and the California Psychological Association (CPA) conventions in August and September 2023, respectively, and placed recruitment ads in both APA and CPA publications
- LACDMH engaged with all local social work and psychology graduate programs to hold on-campus recruitment and hiring fairs, as well as to talk in professional development classes about public mental health service opportunities.

- The Department also convened a LACDMH-Psychology Graduate Program Consortium to strengthen working relationships to ensure students placed in LACDMH programs receive the highest quality training.
- The LACDMH Prevention and Child Wellbeing Administration developed a graduate-level practicum project specifically for psychologists, social workers, and art therapy (i.e., marriage and family therapy) students interested in working with children and families. The goal of the project was to establish a natural pipeline to future employment for bilingual English-Spanish students from local universities and colleges listed below:

    - Alliant International University
    - California State University Dominguez Hills
    - California State University Long Beach
    - California State University Los Angeles
    - California State University Northridge
    - California State University Bakersfield
    - Chicago School of Professional Psychology
    - University of California Los Angeles
    - University of Southern California
- LACDMH held continuous partnerships with the University of California, Los Angeles's (UCLA) Hispanic Neuropsychiatric Center of Excellence (HNCE) to expand the Psychologist Trainee Program and a Workforce and Professional Continuing Education Program that addresses the capacity of psychologists to provide culturally competent psychological and neuropsychological assessment pursuant to the Bilingual and Spanish Interdisciplinary Clinical Training Program (BASIC-T) Statement of Work. The investment in training by high-level assessment experts was proposed to ensure that LACDMH would obtain the most effective and evidence-based interventions to decrease the mental health burden of the community, particularly regarding recidivism and re-institutionalization. BASIC-T's initial needs assessment, in coordination with the LACDMH Psychological Assessment Committee, highlighted the imminent need for culturally and linguistically responsive assessment practices that could more efficiently evaluate and target treatment to address the specific and complex mental health needs of the Los Angeles County immigrant and Spanish-speaking community, as well as other underserved communities.
- LACDMH continued supporting the activities of the Latino UsCC Subcommittee, which addressed the Latino community's mental health needs. This subcommittee was open to the general public, consumers/clients/peers, family members, community organizations, community members, and ethnic/cultural special interest groups. The members met once a month to discuss relevant mental health issues and projects pertaining to the Latino community. The Subcommittee was allotted funding ($350,000) annually to develop capacity-building projects to serve the Latino community. The projects aimed to increase knowledge of signs and symptoms of mental illness, increase awareness of mental health resources, encourage early access to services, and decrease stigma. The Latino UsCC capacity-building projects helped LACDMH to better reach, retain, and serve Latino community

members throughout Los Angeles County in a culturally and linguistically appropriate manner.

- Below is a list of the Latino UsCC subcommittee's successful capacity-building projects that were implemented in FY 22-23:

    - Healing Grief and Loss Through Community: This project targeted 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 engaged the Spanish-speaking community in non-stigmatizing conversations around grief, loss, and death and their relation to mental health issues. It also provided linkage and resources.

    - La Cultura Cura - Engaging the Traditional Arts in Healing: The project targeted the Latino community Countywide and focused on individual adults and youth. As documented by a Surgeon General report, only about 20 percent 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 United States (US) perceiving a lower need for mental health care despite common 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. A bilingual Spanish-speaking consultant was hired to partner with Mental Health Promotors from three different Service Areas (SAs) of Los Angeles County to present a mental health workshop series that integrated cultural knowledge and healthy coping skills when facing emotional and mental distress.

    - Empowering Latino Youth as Mental Health Advocates: The primary objectives of this project were to empower Latino youth as experts in developing innovative strategies using media arts to reach other Latino youth throughout Los Angeles County, provide education about the importance of mental health care, destigmatize mental health issues amongst Latino youth, develop culturally sensitive resources/tools, and to increase Latino youth engagement in the Los Angeles County LACDMH stakeholder process. The bilingual Spanish-speaking consultant was hired to recruit 20 Latino youth from three SAs (3, 4, and 6) of Los Angeles County to form a cohort of mental health youth advocates. This project included the outreach and recruitment of Latino youth who created 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 that was created will be produced for distribution throughout Los Angeles County.

- Culture and Mind-Body Medicine Health Education: The Culture and Mind-Body Medicine Health Education Project aims to reduce mental health access barriers for Latino community members by engaging this population in conversations about mental and physical health and their connection to wellness (Bienestar). Focus groups will be used to gather data which will then be utilized to develop wellness forums. The wellness forums will be based on two holistic health modalities: Mind-Body Medicine and Lifestyle Medicine. Both medicines have shown great potential to prevent and manage chronic preventable mental and physical health conditions.

- Latino Breaking Bread - Podcast and YouTube Series: Podcast and YouTube series titled "Breaking Bread" was designed to reach current and former system-involved Latino Transitional-Aged Youth (TAY) ages 16-25 years. The objective of Breaking Bread Podcast and YouTube series project is to outreach and engage members of the Latino TAY population who have experienced system-involvement or other potentially adverse life experiences including homelessness. By providing these platforms for discussions, it will hopefully allow space for discussions around the mental health needs of these youth in a culturally appropriate and non-intrusive manner.

- Finding Balance: Sacred Mayan Ceremonies (aka Healing Circles - The Concept of Oneness): The purpose of Finding Balance: Sacred Mayan Ceremonies project for the Latin American Mayan Peoples is to reduce mental health access barriers for this community by engaging this population in conversations about mental health through a healing space that is culturally responsive and incorporates holistic, indigenous forms of healing. The healing circles will enable this often underserved and marginalized population to enter a space in which the ailments of the body and the spirit are experienced as fundamentally interconnected as Mayan traditional healing is a complex blend of mind, body, religion, ritual, and science.

- Latino Personalismo Advocacy and Latino Mental Health Equity Project: This project aims to strengthen knowledge and advocacy skills to elevate the voices, identify the needs, and increase genuine participation of Latino stakeholders to drive truly equitable transformative change of Los Angeles County's Public Mental Health System (PMHS). It will accomplish this by providing mental health education to the Latino community via culturally responsive interactive trainings. A Peer Train-the-Trainer model will be used to train Community Leaders to also serve as recruiters, peer educators (trainers), and become actively involved in planning, training, and reaching out to other Latino community members.

- Sana Tu Mente Sana Tu Vida: This project will develop a mental health media outreach campaign for the Latin American Indigenous community that resides in Los Angeles County. It will be tailored to resonate with this community, reaching its members by using video-based content with culturally and linguistically appropriate messages distributed in the places where they already seek information and using visuals/design that complement Los Angeles County DMH's current public outreach efforts. This project aims to broadcast 24, 30-60 second Public Service Announcements (PSAs), in Spanish and in the Latin American Indigenous languages of Zapoteco, Chinanteco, and K'iche'.

- Latino Latina Power! Latina Empowerment Groups (18+): The Latino Latina Power! Latinas as Community Leaders program aims to empower Latinas (aged 18 and above) residing in Los Angeles County by promoting awareness of mental health stigma, offering education on life-long mental health skills, and facilitating discussions on harmful cultural norms. This will be done through a 10-week community engagement empowerment and leadership series. The program advocates for the significance of self-love, self-awareness, setting personal goals, developing healthy relationships and boundaries, overcoming fears, and combating depression and suicidal thoughts. • Latinx Outreach Series: The Latino Mental Health Social Media Outreach campaign will produce and promote culturally specific messaging in graphic and media form to promote mental health awareness and education to the Latino community. This messaging will be in both English and Spanish and promoted on Facebook, Instagram, and TikTok, etc., to reach a large audience of different backgrounds and ages that are often missed by traditional outreach methods. The content will be focused on promoting mental health education and monthly topics focused on awareness campaigns such as domestic violence and teen dating in Spring of 2024.

- Latino Student Wellness Leadership Training: The purpose of the Student Mental Wellness Leadership Training Project is for Latino high school-aged, youth ages 15-18, to engage in self-care and further develop the five core Social Emotional Learning skills to confidently converse about mental health and wellness with peers. The goal is to create student mental health wellness leaders that have the knowledge and capacity to recognize and respond to signs of mental health-related issues in their community with empathy and confidence.

- Promotores de Salud Mental/United Mental Health Promoters (UMHP) Program (UMHP): During FY 22-23, the Promotores de Salud Mental/UMHP Program strived to reduce the stigma associated with mental illness among underserved cultural and linguistic communities in Los Angeles County by increasing awareness about mental health issues, removing barriers, and improving timely access to culturally and linguistically appropriate care and resources. The mental health Promoters/Promotoras provided in-person and/or virtual services in the community they reside to bring culturally and linguistically appropriate education and information to their communities

through workshops (13 modules), group discussions, support groups, advocacy, peer support, outreach, and linkages to resources. The UMHP Program was further expanded with greater multi-cultural representation. The Promoters/Promotoras demonstrated a high degree of passion, commitment to helping others, and a profound desire to improve their communities. They served as leaders in peer support networks, health centers, and other community organizations that specifically targeted Spanish-speaking community members. Many of them incorporated their lived experience or have cared for family members with mental health conditions. In doing so, they add a unique level of understanding, experience, and skill set. Combined with the mental health training provided by licensed clinicians on signs and symptoms of mental health, the Promoters were effective in preventing and mitigating mental health disorders among the Latino community.

- LACDMH created employee incentives to increase staff retention, recruitment, and morale. Signing and Retention Bonuses: The LACDMH workgroup identified a proposal regarding amounts, intervals, and programs/staff eligible for the bonuses. CEO has initiated discussions with Labor to implement these bonuses based on funding identified by the Department.

  LACDMH was previously successful in negotiating a field assignment bonus for specialized mobile mental health teams with its Labor partners. The workgroup developed a proposal to increase the previously approved and implemented field bonus. CEO has initiated discussions with Labor to implement these bonuses based on funding identified by DMH.
  - For LACDMH Accelerated Crisis Response (ACR) as of October 17, 2023, financial incentives were approved for hiring additional staff in Psychiatric Mobile Response Teams (PMRTs) as well as Law Enforcement co-response, Therapeutic Transport, and School Threat Assessment Response Teams
  - Up to $10,000 sign-on and retention bonuses for all field-based practitioners on ACR-related programs over the course of 18 months
  - Increase in Field Assignment Bonus from $180 to $280 per month and
  - Increase in existing weekend, evening, and night Shift Differentials by 100 percent.

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7. *Addressing Physical Safety and Mental Health for Women Fleeing Domestic Violence*
   For this motion, LACDMH collaborated with various LA County departments and entities such as DPH, the Department of Public Social Services (DPSS), DHS, Department of Consumer and Business Affairs, executive directors of the Domestic Violence Council, the Women and Girls Initiative, the CEO's Homeless Initiative to work in collaboration with the Los Angeles Homeless Services Authority on the following: 1) Implementation of a mandatory domestic violence training for all domestic violence and homelessness service providers who are contracted with LA County. This would include a description of the intake process utilized to serve persons fleeing from domestic violence; 2) Outline the process for helping unaccompanied women who are fleeing domestic violence, sexual violence, and human trafficking. This would include determining ways to serve women establish public benefits, and cost projections for mental health services as well as hotel/motel-based housing to establish their benefit eligibility. Additional information can be accessed at: http://file.lacounty.gov/SDSInter/bos/supdocs/184620.pdf
   Date of enactment: 10/03/2023

   Accomplishments for FY 22-23

   - Mental health services for unaccompanied victims/survivors: LACDMH provides a wide variety of mental health services across a continuum of care, including prevention, early intervention, outpatient, and intensive services. Unaccompanied women who have experienced domestic violence, sexual violence, and/or human trafficking can receive services. Mental health services may also be provided at locations that are most convenient for the client including shelters, motels/hotels or via telehealth. The cost of the services is dependent on the level and intensity of care needed.
   - LACDMH takes a “no wrong door” approach to access services. Mental health services can be accessed through the LACDMH Helpline at (800) 854-7771, by walking into a LACDMH Directly Operated or Contracted clinic, or through the LACDMH Alternative Crisis Response (ACR) infrastructure, which includes: the 9-8-8 Crisis Call Center (Someone to Call), Field Intervention Teams (FIT) (Someone to Respond), and Crisis Stabilization Facilities & Crisis Residential Treatment Programs (CRTP) (Somewhere to Go). The intake process consists of a mental health intake interview/screening to determine the immediate services needed and linkage to services that address the identified needs.
   - LACDMH provides specialty mental health services through directly operated programs as well as through contracted providers across all eight service areas. LACDMH services are provided at no cost to the resident unless the resident has private insurance and opts to receive services from this Department instead.
   - LACDMH takes a “no wrong door” approach to access services. Mental health services can be accessed through the LACDMH Helpline at (800) 854-7771, by walking into a LACDMH directly operated or contracted clinic, or through the LACDMH Alternative Crisis Response (ACR) infrastructure. ACR infrastructure includes: the 9-8-8 Crisis Call Center (Someone to Call)

launched on July 16, 2022; Field Intervention Teams (FIT) (Someone to Respond); Crisis Stabilization Facilities & Crisis Residential Treatment Programs (CRTP) (Somewhere to Go).

PART 2
Los Angeles Department of Public Health SAPC

Identified Unserved/Underserved Target Population (with disparities)

I. List of SAPC Target Populations with Disparities

The Los Angeles County Department of Public Health Bureau of Substance Abuse Prevention and Control (SAPC) has identified the following target populations as having countywide substance use disorder (SUD) disparities, based on FY 22-23 data.

Medi-Cal Enrolled Population

By ethnicity

- Multi-race or Other
- Latino
- Asian Pacific Islander (API)

By language

- English
- Spanish
- Chinese (combines Mandarin, Cantonese and Other Chinese)
- Armenian
- Korean
- Russian
- Vietnamese
- Farsi
- Tagalog
- Cambodian
- Arabic
- Non-English languages not listed above

By age group

- Age 18-25
- Age 12-17

By gender

- Female

By sexual orientation

- Bisexual (Gay/Lesbian)
- Uncertain/Questioning

By Service Area

- SA2
- SA4

II. Strategies to Reduce SUD Disparities

SAPC addresses the cultural and linguistic disparities through various programs and initiatives to ensure diversity, equity, and inclusion is incorporated in service delivery; reduce stigma, and increase awareness, education and the application of CLAS programs to meet the needs of the diverse communities in Los Angeles County.

1. Development and translation of public-facing materials that provide SUD information and education
2. Co-location of Services with other county entities, e.g., Los Angeles Superior Court, Community Health Centers, Department of Probation, Department of Children and Family Services (DCFS), Department of Public Social Services (DPSS), Department of Health Services (DHS).
3. Community education and multi-media campaigns to increase substance use prevention, harm reduction and treatment services, to decrease SUD treatment stigma and to promote LA County's organized delivery system.
4. Collaborations to enhance the cultural and linguistic competence within and across Departments of Health Services, Mental Health, and Public Health.
5. Field-based services
6. Culture and Language Access-Specific Capacity Building to develop Providers bandwidth and expertise to meet the needs of patients.
7. Policy and procedure development and improvement that steer the quality and timeliness of delivering SUD services.
8. Implementation of new technologies to enhance the Bureau's service delivery*
9. Augmentation of SUD service accessibility to underserved populations.
10. Language Assistance Services to meet the cultural and language needs of non-English speaking communities.
11. Multi-lingual/multi-cultural staff development and support through programs that target specific ethnic and language groups
12. Outreach and Engagement (O&E) efforts*
13. Integration of physical health, mental health, and substance use services
14. Provider communication and support
15. School-based services that provide harm reduction education and Naloxone distribution*
16. Partnerships with other Health Departments (DHS, LACDMH and DPH) on initiatives regarding cultural competence, linguistic appropriateness, and equity

The chart below reflects an overview of the multi-pronged programs and services listed above.

	PROGRAM NAME	1. Development and Translation of Material	2. Co-location of Services	3. Community Education	4. Committees & Taskforces	5. Field-Based Services	6. Culture-Specific Capacity Building Projects	7. Policies & Procedures	8. New Technologies	9. Service Accessibility	10. Language Assistance Services	11. Multi-Cultural Staff Development	12. Outreach and Engagement Activities	13. Integrated Services (Physical, Mental Health and Substance Use)	14. Provider Communication/Support	15. School-based services	16. Utilization of Community Knowledge and Feedback
1.	Equitable Access and Promotion Section (EAPS)	X		X	X		X	X	X	X	X	X	X	X	X	X	
2.	Meth Prevention Task Force	X		X	X				X	X			X		X	X	X
3.	Meth Treatment Task Force	X		X	X				X	X			X		X	X	X
4.	Board of Supervisors Motions*			X	X	X	X			X	X		X	X			
5.	CalWORKs/GROW	X				X											
6.	My Health LA	X		X	X					X			X	X	X		
7.	Training Unit	X	X	X	X	X	X		X			X		X	X		
8.	Clinical Engagement and Navigation Services (CENS)		X	X		X				X	X	X		X	X		
9.	Provider Advisory Committee (PAC)				X			X							X		
10.	Media Campaigns	X		X	X				X	X	X		X		X		X
11.	CLAS-Achieving Coaching and Training				X		X	X		X	X	X		X			
12.	RecoverLA.org	X		X					X	X	X			X			
13.	SBAT	X		X					X	X	X			X			
14.	Martin Luther King, Jr. Behavioral Health Center	X	X						X		X			X			
15.	Student Well Being Centers	X		X		X	X			X			X			X	X
16.	Engagement and Overdose Prevention Hubs	X	X	X							X		X			X	
17.	Naloxone Distribution	X		X							X		X			X	
18.	Tuition Incentive Program	X		X								X				X	

PROGRAM NAME		1. Development and Translation of Material	2. Co-location of Services	3. Community Education	4. Committees & Taskforces	5. Field-Based Services	6. Culture-Specific Capacity Building Projects	7. Policies & Procedures	8. New Technologies	9. Service Accessibility	10. Language Assistance Services	11. Multi-Cultural Staff Development	12. Outreach and Engagement Activities	13. Integrated Services (Physical, Mental Health and Substance Use)	14. Provider Communication/Support	15. School-based services	16. Utilization of Community Knowledge and Feedback
19.	ABC's of SUD Initiative	X		X					X						X		X

The section below highlights four specific SAPC programs/initiatives selected as special features for Criterion (CR) 3:

1. Media Campaigns
2. ABC's of SUD Initiative
3. Student Well Being Centers
4. Connecting to Opportunities for Recovery and Engagement (CORE)

The information provided for the four programs/initiatives above focuses on the following:

- Raising county-wide awareness about SUD and available prevention, harm reduction and treatment services available. Campaigns include social media outreach, public service announcements and printed material, focusing on equity and access to care.
- Collaborating with county school districts to promote harm reduction strategies, life skills and overall fostering a comprehensive and effective continuum of SUD prevention, harm reduction, treatment, and recovery services to meet the diverse needs of Los Angeles County youth.
- Providing linkage to field-based services in co-located, multi-diverse community spaces for LA County residents to get information and resources about how to prevent alcohol and drug use, learn more about substance use disorders and the culturally appropriate options and locations to receive no-cost treatment services.

1. Media Campaigns

Substance Abuse Prevention and Control (SAPC) media campaigns serve an essential purpose in exposing individuals and communities to messaging that promotes risk reduction of substance use and encourages positive behavior change. These media campaigns use data and community-driven strategies to provide effective traditional, social and other marketing approaches that target high-risk geographic areas, incorporating new technologies and other novel public health

approaches to substance abuse and misuse prevention efforts. Below are SAPC's various media campaign efforts - many of which focus on educating youth, young adults, and/or community members about the harms of substance use in Los Angeles County.

a. MethFree LA County
To increase awareness of Methamphetamine (Meth) use and decrease Meth use and deaths in LA County, SAPC partnered with a media contractor in 2021 to further develop the Meth Free LA County public education campaign. The campaign focused on two target audiences: adults who have experimented with meth use or are susceptible to future meth use (i.e., Prevention audience, specifically targeting the LBGQ population and MSM subpopulation) and adults close to someone who uses meth (i.e., Agents of Change).

Based in part on insights from the evaluation of the 2021 launch of this campaign, SAPC implemented a 2022 relaunch to augment the reach to target Latino men who have sex. This campaign launched from September 19 to November 30, 2022, and continued for 10 weeks with billboards, radio, connected TV (streaming), and social media (video and static) on Facebook, Instagram, Twitter, Google search, and YouTube. Social media ads in Spanish drove traffic to the Spanish translated website. Key zip codes in the county were targeted that skew high for individuals identifying as Hispanic were targeted.

b. Fentanyl Frontline (Organic social media soft launch)
. In response to the overdose crisis in Los Angeles County, which saw a 1,280% increase in fentanyl overdose deaths over a five-year period (from 109 deaths in 2016 to 1,504 in 2021) and a 308% increase in emergency room visits due to fentanyl overdoses (from 133 visits in 2016 to 542 in 2020), SAPC launched the Fentanyl Frontline campaign in January 2023 to address this ongoing threat to LA County residents. The campaign was developed to reach a broad audience to share overdose prevention and harm-reduction strategies, and to increase awareness around fentanyl. Ten to fifteen organic social media posts and two assets were created in English and Spanish onto the Los Angeles County Department of Public Health social media platforms (Facebook, Instagram, and X). The organic soft-launch campaign ran for six months and concluded in June of 2023.

c. ABCs of SUD
In an effort to increase awareness of substance use treatment services countywide and to reduce the stigma associated with treatment efforts, SAPC engaged in a destigmatization campaign centered around the stories contained in two educational videos. This initiative targeted people of color, with an emphasis on creating stories that resonated with people who have loved ones with or themselves have a SUD to be viewed at places where they might normally be waiting for other services, such as community-based organizations, faith-based centers, health and mental health clinics, and dental office waiting rooms, lobbies, and reception areas.

The initiative included:

i. Two videos representative of Los Angeles County's diverse population
ii. Out of Home, Point-of-Care, and Connected TV distribution
iii. Community Outreach and Engagement

d. ABCs of SUD Video Descriptions:

- **In Every Corner**: An animated English language video that uses a traffic jam as a conceptual catalyst to show diverse individuals (and their families) how they approach their substance use issues. This video showcases how stigma and lack of knowledge contribute to SUD as a widespread problem in the community by mixing SUD stories with SUD science, with actionable steps people can take. This video contains close captioning in all threshold languages, including English for people who are deaf and hard of hearing.

- **Split Apart:** A Latino-focused live video in Spanish that features a split screen to show the point of view of multiple people struggling with SUDs. The concept shows a diversity of families and individuals to demonstrate how substance use can progress to SUDs and the ways it affects them. Family and community bonds are highlighted by focusing on how they affect both the person struggling with SUD and their family. This video is in Spanish language and closed captioning only.

- To obtain input on the creative concepts developed by SAPC in partnership with its media vendor – Rescue Agency for Behavioral Health, SAPC engaged community stakeholders using multi-media to help frame the purpose and the concept behind the videos. The initial creative development included four different concepts (2 in English and 2 in Spanish). From the results of this engagement, the final selections resulted in the two videos described above. Input and feedback were received at several stages of development. Once the concepts were identified, SAPC returned to the group to share the scripts from the videos to obtain input on content and language, including the use of specific terms in Spanish. reviewing the script to ensure real-life scenarios and the draft of the actual video. Input from these sessions was incorporated into the videos' final development.

2. ABCs of SUD Community Awareness

To increase community awareness about the ABCs of SUD, several promotion opportunities were engaged:

- Out-of-Home
  Posters, in English and Spanish, were in placed in various convenience stores located in the top 100 targeted zip codes. These posters contained a QR code linking to the video located on RecoverLA's SUD 101 page. In addition, print brochures were developed and distributed to the community-based organizations.

- Connected TV (such as Pandora or Hulu)
  More targeted than the use of traditional television, connected television (CTV) are internet enabled whether that connectivity comes from a streaming device like the Amazon Fire Stick or Roku, an internet-enabled gaming console, or a smart TV with built-in connection. Traditional TV is broad, while CTV allows you to target specific audiences.

  For this initiative, CTV ads targeted English and Spanish-speaking adults ages 18-65, who may be struggling with substance use a shorter version of the ABCs of SUD (:30 second ads) were developed to place on media ad placements including video ads on mobile, desktop, tablet, and TV, as well as digital videos served on websites, blogs and other video content platforms across the web. These ads ran for 4 months and were shown on platforms like Hulu©, Pandora and others. The top publishers of the 30 second videos were:

  - In Every Corner (English): Pluto TV, Encore, Fox News
  - Split Apart (Spanish): Univision, ViX, and Pluto TV

- Point-of-Care
  The two full three-minute videos were shown on a loop in waiting rooms at 72 healthcare locations across the County for over six weeks. These locations also had brochures available for people to take, which provided information about substance use disorder (SUD) and how to access RecoverLA.org. Additionally, mobile retargeting was used, so when people in the target group were near one of the 72 locations, they received a banner ad on their mobile devices. This reinforced the message from the video, whether they had seen it or not, helping to increase awareness of SUD resources and strengthen key messages. This mobile retargeting generated over 2, 680 clicks (number of times the ad was selected or clicked), with the Spanish video outperforming the English video.

- Community Outreach and Engagement in ABCs of SUD
  SAPC Member Service team conducted over 15 community meetings and presentations, including Health Neighborhood meetings in all 8 Service Areas, Community Clinic Association of Los Angeles to engage Federally Qualified Health Clinics and other types of clinics, and both DHS and DMH were engaged. The video is promoted in various community meetings and events. For example, Shatterproof– a national nonprofit organization dedicated to transforming SUD treatment and ending stigma -, held an annual" Rise Up Against Addiction 5K event" during which portable TVs were placed in booths for participants to watch videos and obtain information on how to find treatment services. Additionally, other participating community-based and government organizations were engaged to show the video at their facilities.

3. Student Well Being Centers

As part of a Countywide prevention efforts, DPH-SAPC is partnering with local school districts and community-based substance use prevention providers to

conduct Botvin Life Skills Training (LST), an evidence-based program designed to positively impact the lives of youth in elementary, middle, and high school by equipping them with the confidence and the necessary skills to successfully handle challenging situations. Other commonly known evidenced-based programs, such as Project Towards No Drugs (PTND), Strengthening Families, and Project Alert, are also taught by SAPC's Prevention Providers.

SAPC currently operates 40 of 50 planned Student Wellbeing Centers (SWC) across the County that offer a comprehensive health and youth development curriculum in classrooms and within the centers that focus on substance use prevention, mental health, and sexual health. The positive youth development framework enables young people to gain leadership skills and opportunities as peer health advocates in their school communities and their neighborhoods to support life affirming health practices; parent educators offer parent and family engagement opportunities to enhance family communication around adolescent health and wellness; and partnerships with Planned Parenthood and DMH enable access to additional sexual health and mental health services.

In 2023, the SWCs educated the peer health advocates and other students on each campus on the dangers of fentanyl and train them in the administration of Naloxone as well as provided Naloxone to students who demonstrate a need to carry it.

4. **Connecting to Opportunities for Recovery and Engagement (CORE)**
CORE Center is a community space where everyone can come to get information and resources about how to prevent alcohol and drug use, learn more about substance use disorders (also known as addiction) and find out where to go for free or low-cost treatment services. Families and friends can access CORE services in six (6) location: (Antelope Valley Health Center, Hollywood-Wilshire Health Center, Curtis Tucker Health Center, MLK Center for Public Health, Whittier Public Health Center and Pomona Health Center) to build skills to talk about alcohol/drugs with loved ones and learn how to help someone experiencing a drug overdose. The CORE Center strives to eliminate the stigma associated with seeking treatment for a substance use disorder, which is a chronic and relapsing disease, supports opportunities for residents to lead local advocacy efforts to reduce substance use and promotes healing and wellness through community-guided services.

CORE Center staff provide bilingual services through education classes and link people to local support services, including treatment when needed. Additional culturally appropriate services include:

- Information on alcohol and drug prevention, and community advocacy opportunities.
- Workshops such as preventing teen substance use and vaping, understanding health risks of different drugs, understanding substance use disorders and treatment services, and recognizing signs of relapse.
- Peer-to-peer support for families of loved ones using alcohol or drugs.
- Training on how to administer medication (Naloxone) to reverse an opioid overdose.

- Screenings to identify treatment needs.
- Referrals to no-cost treatment services for Medi-Cal and My Health LA clients.

III. The CLAS Action Plan

SAPC's CLAS Action Plan is designed to be a framework to address disparities in SUD and guide implementation of the National Standards for Culturally and Linguistically Appropriate Services. This plan outlines the steps necessary to incorporate these standards, ensuring that substance use disorder (SUD) services provided are equitable, accessible, and culturally aligned. It emphasizes the importance of training, language assistance, and community-specific approaches to improve client-centered health outcomes and foster trust within diverse populations.

SAPCs Cultural Competence and Humility (C3H) Committee worked in partnership with the Provider Advisory Committee (PAC) to prioritize the Plan's action items and gather valuable input. The PAC serves as a model for stakeholder engagement, fostering collaboration and mutual understanding between SAPC and providers. Together, these efforts focus on identifying the needs and developing practical solutions to address them. The ultimate goal is to ensure that services are equitable, culturally aligned, and reflective of the diverse communities served.

Below is an overview of the CLAS Action Plan, which is separated into three primary areas to provide a clear and actionable framework for strategic planning of diversity, equity, and inclusion efforts.

- **Key Performance Area (KPA)** outline the focus areas that are critical to achieving the goals of the Plan. These areas represent the primary aspects of service delivery and organizational operations that must align with CLAS standards.
- **Objectives** are specific, actionable goals set within each Key Performance Area. They detail what needs to be accomplished to successfully integrate CLAS standards.
- **Evaluation metrics** are the tools or criteria used to measure progress and success in meeting the objectives outlined in the action plan.

1. KPA 1. Culturally Reflective Governance, Leadership, and Workforce

Objectives:

- Increase efforts to recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to service populations.
- Provide education and training of governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
- Develop and nourish a climate that supports and promotes a diverse workforce.

Evaluation Metric: Determine the barriers that address the systemic issues in hiring, recruiting and retaining of diverse leadership and workforce.

2. **KPA 2. Communication and Language Assistance**

Objectives:

- Improve timely access to services for people who have limited English proficiency.
- Ensure availability of services in threshold languages including competent bilingual staff and services, and accessible language assistance services.
- Provide easy-to-understand print, multimedia, and signage for critical patient informing materials in threshold and other languages and make them available digitally on the SAPC website.
-

Evaluation Metric: Increased enrollment across the SAPC network for patients who speak a language other than English.

3. **KPA 3. Culturally Reflective Planning and Operations**

Objective:
Ensure the development of culturally and linguistically appropriate goals, policies, and management accountability that are infused throughout the organization's planning and operations.

Evaluation Metric: Evidenced by contract monitor walk-throughs of the provider intake process that exemplify ease of access and engagement for people who are typically marginalized.

4. **KPA 4. Data Collection, Regular Assessments and Accountability**

Objectives:

- Collect and maintain accurate patient population health outcome data.
- Ensure regular assessments of community assets and needs are conducted and used to plan and implement services that respond to the cultural and linguistic diversity of the service population.
- Conducted ongoing assessments of SAPC's CLAS-related activities and integrated them into measurement and continuous quality improvement activities

Evaluation Metric: Reviewed the dashboard at each C3H meeting, discussed data trends and made recommendations for improvement.

5. **KPA 5. Community Engagement and Continuous Improvement**

Objectives:

- Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- Enhance communication for collaboration at all levels of operation.
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

Evaluation Metric: In preparation for CalAIM, conducted 2-3 community stakeholder events with the intention to collaborate with the community to design, implement, and evaluate policies, practices, and services to address CLAS and social determinants of health.

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Criterion 3 APPENDIX

LACDMH Attachments

Attachment 1: 2023 Cultural Competence Plan CR 3 Acronyms

Acronym.pdf

Attachment 2: Mental Health Services Act (MHSA) Annual Update FY 22-23

MHSAAnnualUpdateFY2022-23.pdf

SAPC Attachment

Attachment 1: CLAS Action Plan

CLAS Action Plan-Final.pdf

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

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PREVENTION BUREAU
ANTI-RACISM, INCLUSION, SOLIDARITY AND EMPOWERMENT (ARISE) DIVISION
CULTURAL COMPETENCY UNIT

AND

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC) BUREAU
STRATEGIC AND NETWORK DEVELOPMENT DIVISION
EQUITABLE ACCESS AND PROMOTIONS SECTION (EAPS)

Criterion 4

Cultural Competency Committee

December 2024

Criterion 4: Cultural Competency Committee: Client/Family, Member/Community Committee, and Its Integration of the Committee within the County Mental Health System

A new feature of the 2024 Cultural Competence Plan report is the incorporation of content pertinent to Los Angeles County Department of Mental Health (LACDMH) and the Department of Public Health Bureau of Substance Abuse Prevention and Control (SAPC). CR 4 has been organized into two parts: Part I contains information on the LACDMH Cultural Competence Committee (CCC), and Part II describes SAPC's Committee and Cultural Competence and Humility (C3H).

PART I

I. LACDMH CCC

A. Description, Organizational Chart, and Committee Membership

The 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, Inclusion, Solidarity and Empowerment (ARISE) 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 experiences with mental health conditions. The roles and responsibilities of the Co-Chairs are:

- Facilitate all monthly meetings
- Engagement of members in Committee discussions
- Collaboration with the ARISE 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 and the committee at large. The ESM is also the program manager for the ARISE 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) 2023, 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 including, but not limited to:
    - Age
    - Country of origin, degree of acculturation, generation
    - Educational level

- Family and household composition
- Gender identity and sexual orientation
- Health practices, including the 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 2023, the CCC had a total of eighty-one (81) 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 who agreed to be included in the committee's demographics self-reported and described their racial/ethnic identity exactly as stated below:

- African
- African American
- American Indian/Alaska Native
- Asian
- Black

- Filipino
- Hispanic
- Indígena (indigenous) Latina
- Irish-German
- Japanese
- Jewish
- Korean
- Latino(a)
- Latino Chinese
- Mexican American
- Persian
- Spaniard/Latino/American Indian
- Spanish
- White

Language

The linguistic diversity of the CCC for CY 2023 consisted of the following fourteen (14) languages:

- ASL
- Armenian
- English
- German
- Farsi
- Hebrew
- Ibo
- Korean
- Japanese
- Mayan
- Portuguese
- Spanish
- Swahili
- Tagalog

Gender and Gender Pronouns

Out of 81 members, twenty (20) self-identified as male and sixty-one (61) 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
- Faith-Based Advocacy Council (FBAC)
- 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

- ARISE Division-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
- ARISE Division - Spanish Support Groups
- Latino Coalition
- 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)
- 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)
    - DPH – Substance Abuse Prevention and Control (SAPC)
    - Department of Workforce Development, Aging and Community Services
    - 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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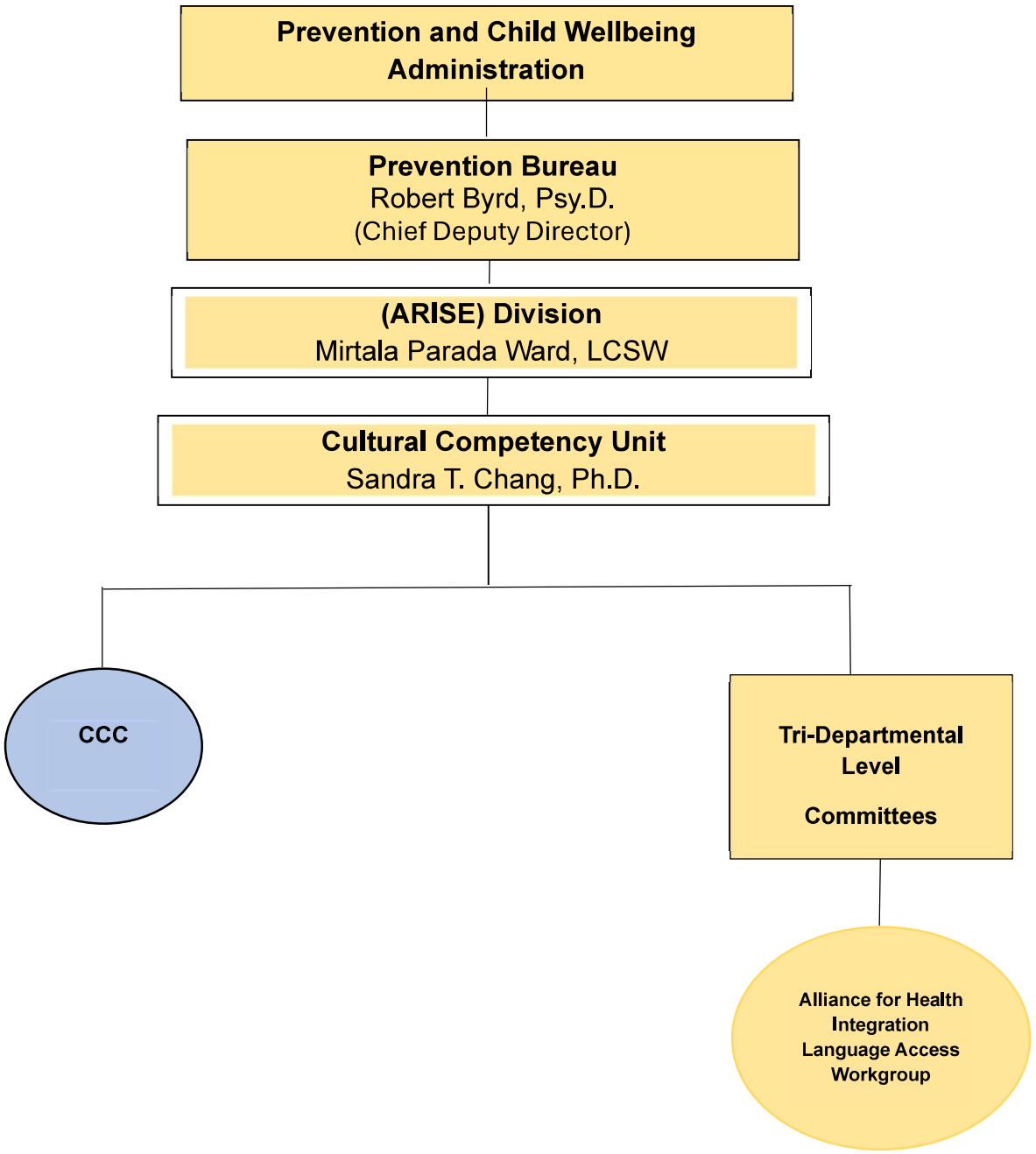
C. Organizational Chart of the CCC, CY 2023



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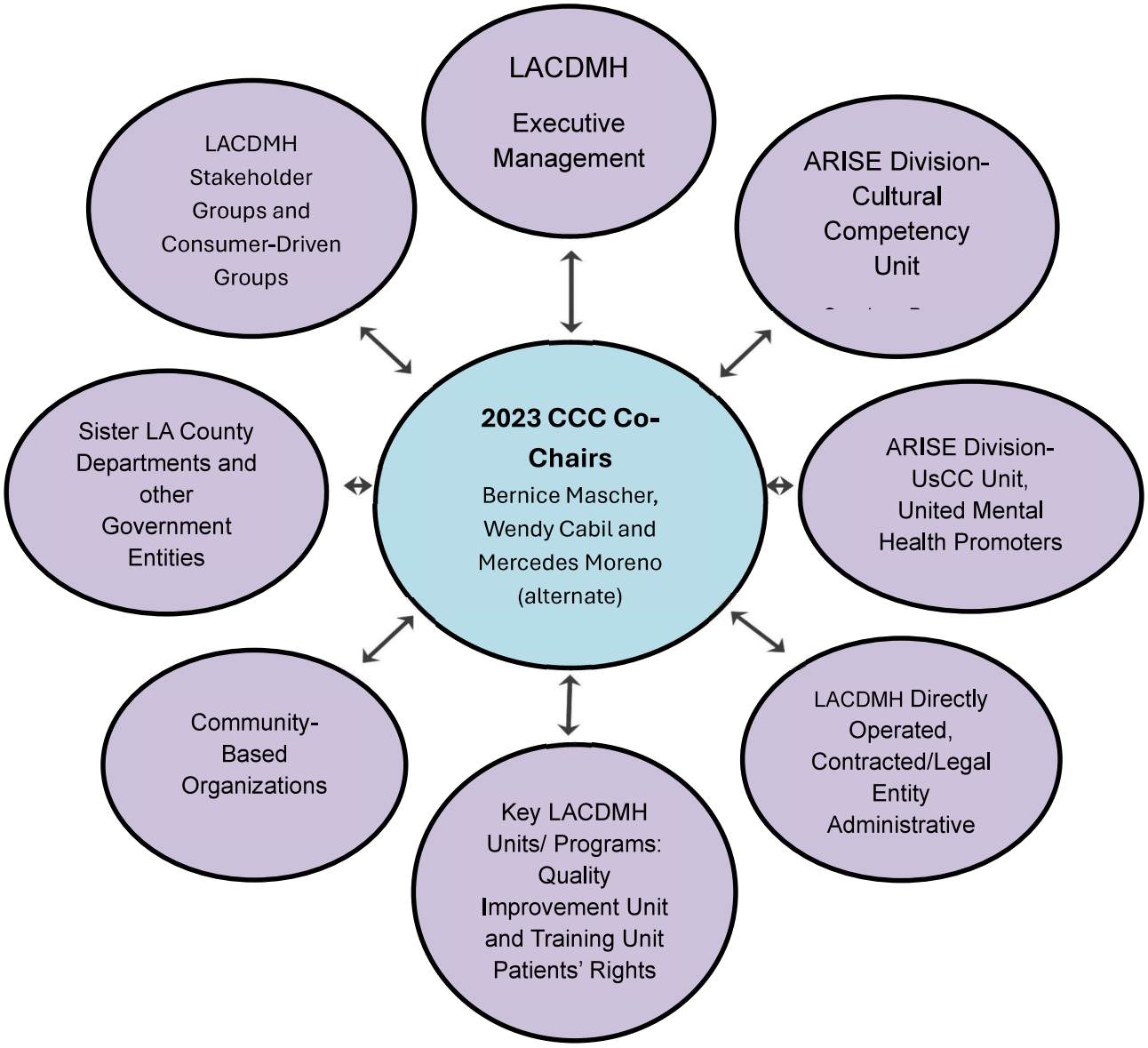
DHS = Department of Health Services
DPH = Department of Public Health

II. CCC Integration in the Mental Health System

CCC Departmental Partnerships and Collaborations, CY 2023



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 ARISE 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 2023, the CCC membership opted for a new workplan model based on monthly presentations that would allow the committee to learn about and provide feedback to LACDMH programs of interest and highlight various aspects of cultural diversity that may not be as widely recognized in society nor formally represented in LACDMH's stakeholder groups. *For details regarding the CCC-CCU Multicultural Diversity Calendar, see attachment 1 in the CR 4 addendum.*

This model positions the CCC to accomplish the following goals:

- Engagement as an advisory body to LACDMH programs via membership recommendations for the planning, implementation, and evaluation of cultural diversity and cultural competence-related efforts.
- Promotion of cultural awareness, sensitivity, and inclusion
- Collaboration with departmental venues (i.e., Speakers Bureau, Promotores de Salud & United Mental Health Promoters Programs) and stakeholder groups

(UsCCs and FBAC) as well as expert community-based organizations to be CCC guest speakers and potential members.

TABLE 1: SUMMARY OF PRESENTATIONS PROVIDED TO AND TOPICS OF DISCUSSIONS HELD BY THE CCC, CY 2023

MONTH	TITLES OF PRESENTATIONS AND DISCUSSIONS
January	1. CCC Annual Report for CY 2022 activities and accomplishments
February	2. Commemoration of National Therapeutic Recreation Month: *The Painted Brain* 3. LACDMH's Mental Health Services Act (MHSA) Administration & Oversight Division Special presentation: *Bolstering Communication with All Service Areas* 4. Commemoration of African American/Black History Month - Special activity: *"I Have a Dream"*
March	5. LACDMH's Quality, Outcomes and Training Division: *Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM)*
April	6. LACDMH's MHSA Data Dashboard for Public Facing in the Departmental website 7. Commemoration of *World* Healing Day: *Intergovernmental Panel on Climate Change*
May	8. Commemoration of May is Mental Health Month - Special presentation: *Conscious Culture Psychology and Take Action for Mental Health LA.*
June	9. LACDMH's Human Resources: *Bilingual Capacity of the System of Care* 10. Commemoration of Post Traumatic Stress Disorder (PTSD) Awareness Month: *The Triple Trauma Paradigm in Unaccompanied Children*
July	11. Commemoration of Muslim American Heritage Month 12. LACDMH's Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Two-Spirit (LGBTQIA2S) *Champion* Network
August	13. Commemoration of various dates in the month of August A. Day of the World's Indigenous People B. National Salvadorian Day C. 60th Anniversary of the March on Washington D. National Grief Awareness Day
September	14. Commemoration of National Recovery Month A. World Alzheimer's Disease Awareness Month: *Living with Alzheimer's Disease* B. Commemoration of Pain Awareness Month: *Older Adults and Living with Pain*
October	15. Commemoration of Global Diversity Awareness Month A. Filipino American History Month B. LGBTQIA2-S History C. German American Heritage Month (postponed to November 2023)
November	16. Commemoration of National Native American, American Indian, and Alaska Native Heritage Month: Honoring Cultural Healing for American Indian/Alaska Native (AI/AN)

MONTH	TITLES OF PRESENTATIONS AND DISCUSSIONS
	17. Commemoration of German American Heritage Month: *German American Experience* 18. Special preparation for the upcoming holiday season: *Holiday Blues*
December	19. Annual Retreat – CCC Annual Report and Reflections on CCC Accomplishments CY 2023

See attachment 2: CCC meeting agendas for additional details on CCC meeting activities.

III. 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's 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 the first six months of CY 2023. 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.

A. CCC Annual Report for CY 2022

In January 2023, the Cultural Competency Committee (CCC) membership welcomed a detailed retrospective presentation on the committee's activities and accomplishments during the previous calendar year. For CY 2023, 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.

B. Commemoration of National Therapeutic Recreation Month: The Painted Brain

In February 2023, the CCC coordinated and hosted multiple presentations in collaboration with community-based organizations such as the Painted Brain and LACDMH's Program to deliver practical information regarding National Therapeutic Recreation Month and current departmental efforts to engage stakeholder groups under the provisions of the MHSA.

The CCC learned that the Painted Brain was partnering with the California Association of Mental Health Peer Run Organizations (CAMHPRO), conducting a series of listening sessions focusing on grass roots community advocacy with the goal of informing the content for the upcoming regional summit in Los Angeles, CA. The speaker explained the advocacy learning curve for communities of color and individuals to advocate for themselves.

CCC Feedback

Members asked whether the sessions would be translated into Spanish or other languages inclusive of American Sign Language (ASL). She also added that for many community members it is difficult to navigate technology. It is difficult for many to be active participants in these and other meetings due to shyness or fear that their image will be captured and could be shared with Immigration authorities.

C. Bolstering Communication with All Service Areas/Communities and Participation in the Stakeholder Process

This presentation informed the membership that these meetings were reinvigorating the stakeholder process, formerly known as "YourDMH," and included the Community Leadership Team (CLT), the Service Area Leadership Teams (SALT), and the UsCC. The meetings served the purpose of obtaining feedback related to MHSA activities, including funding, services, and supports that are being funded. YourDMH was successful in many ways however, they did see that the framework did not necessarily include all stakeholder groups. In expanding the stakeholder process, LACDMH will be adding other groups outside of the CLT, SALT, and the UsCC, such as the Commission, Health Neighborhoods, Peer Advisory Councils, and the CCC. The membership was engaged in a discussion around the following questions:

- What community outreach, engagement and navigation activities are you currently doing in your service area?
- Are those activities working well?
- Are there challenges or gaps?
- What are some activities you would like to engage in to better serve the communities for which you provide outreach?

CCC Feedback

Members had the opportunity to ask clarifying questions regarding the revamping of LACDMH's stakeholder process, many focusing on the differences between Your DMH and the System Leadership Team (SLT) and CLT. The Committee also provided recommendations and calls to action beyond holding listening sessions in order for the stakeholder groups and the community at large to remain engaged with the Department. Another recommendation was for these meetings to be widely announced using social media and to ensure timely distribution of announcements with ample time for the community to find out about meetings several days before these happen. Another recommendation was to focus efforts and resources on solving the housing crisis affecting the communities of Los Angeles County. The Committee was very grateful for the presentation and for the invitation to partner in creating a stronger stakeholder platform.

D. Commemoration of African American/Black History Month -Special Activity for Black History Month

The membership first watched the "I Have a Dream" speech by Dr. Martin Luther King Jr., dated August 28, 1963, and engaged in a discussion about the relevance of the speech to current times. Members spoke of incidents of racism in daily life experienced even by social service agencies such as schools, benefit establishment offices and other types of community-based organizations. Members also reflected on the impact of watching the video, describing it as powerful, touching, and timeless.

E. Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM)

In March 2023, LACDMH's ICCTM team delivered an interesting presentation on the work being done to implement the model at LACDMH. The team is comprised with staff from the ARISE Division-CCU, UsCC Unit and Quality Outcomes and Training Division. The membership learned that the Department participated in this learning project based on Solano County's joining the University of California Davis' five-year MHSA project called ICCTM. The focus and accomplishments of LACDMH's ICCTM team included the following:

- Focus on cultural and linguistic needs to support the Hispanic/Latino Filipino American, and LGBTQ+ community, selected as focal populations due to their historically low penetration rates in the system of care.
- Creation of a training curriculum based on the National Standards for Culturally and Linguistically Appropriate Services (CLAS).
- Development of workgroups of consumers community and organization leaders, advocates, County and contracted behavioral health staff and key community providers.
- Model goals specified increases to timely access to care, increases to ACCESS Help Line use, improvements to customer satisfaction and decreases in crisis services as the first point of contact with the mental health system for Filipino American, Hispanic/Latino, and LGBTQ+ communities

- The presentation acknowledged the many factors that contribute to consumers not being able to attain health equity, such as social determinants of health (socioeconomic status, education level, availability, age, and even access to broadband internet). For their program, they are looking at expanding culturally and linguistically appropriate services and services that are respectful and responsive to the needs of all individuals. This is an area that can be changed and that is why they are excited to work on this project. The data shows the astounding impact of not having culturally and linguistically accessible services, an estimated combined cost of health disparities and deaths due to inadequate and/or inequitable care. The CCC was engaged in discussing the following questions:

    - What comes to mind when transforming the culture of LACDMH?
    - What would that look like to make LACDMH changes as it relates to improving the lives of people of various cultures who have mental illnesses? What recommendations do you have?
    - What are some unmet priority needs needed among the community and across the UsCCs and the CCC?
    - What types of trainings may be needed to increase LACDMH staff understanding and support of the community?
    - What are some good ways to have community stakeholders involved in this ICCTM project?
    - What community activities, interventions, and supports encourage mental wellness?

CCC Feedback

The overall recommendation of the membership was to align the ICCTM work with recovery principles, cultural humility, accountability, as well as MHSA training. Another recommendation was that the project be trauma-informed to avoid future re-traumatization of the community and not to "do things" because the money is there. It was also recommended that all aspects of the project be communicated throughout all levels of the organization, that silo work be removed, and that it includes a complaint policy and process. A request was made for the ICCTM team to focus their efforts on being truly collaborative and innovative by taking risks, being adaptable, and bringing different perspectives to their planning and implementation efforts. The CCC feedback also included recommendations that the departmental staff working on ICCTM implementation are not reassigned in order not to lose momentum and for peers to be involved in the evaluation process. Finally, for the work to be culturally congruent and engage the community through the arts, recreation, music, cultural events, and most importantly, through inclusion.

F. MHSA Data Dashboard for Public Facing in LACDMH's Website

In April 2023, the CCC had the opportunity to review and provide input to the Chief Information Office Bureau (CIOB) on the development of a dashboard that presents cultural competence-related data around the reporting of consumer served information based on race/ethnicity, age groups, preferred language, most prevalent mental health conditions by Service Area and Supervisorial District. The dashboard summarizes consumer demographic data extracted from LACDMH's Integrated Behavioral Information Systems (IBHIS) and the MHSA Community Services and Supports (CSS) Plan, outpatient care services. The goal of the dashboard is to provide consumers, family members, and the community at large with relevant and latest data on the categories previously identified, number of consumers served to date, and the location of services. LACDMH plans to make this information available to the public. Besides the structure of the dashboard, the Committee learned how to access the dashboard content. The workgroup formed for the development of the data dashboard included the Clinical Informatics team in collaboration with the Cultural Competency Unit, Quality Improvement team, Quality Assurance, and Public Information Office among others.

CCC Feedback

The membership demonstrated great interest in the dashboard data and actively asked questions and provided recommendations. The committee recommended disaggregation of data to show a breakdown of consumers from indigenous communities in the Latino group. Another strong recommendation based by more than one member was to focus on decreasing the data reported as "not reported". Regarding future data inclusion in the dashboard, the CCC suggested the following: utilization of the 9-8-8 crisis number, LGBTQIA2-S community service utilization and MHSA funding for activities by SA and Supervisorial District. A final recommendation was made to consider including data on the number of consumers who sought out services at LACDMH but were referred out. Members expressed gratitude and appreciation for the data dashboard development and stated that seeing the number of consumers served was comforting to persons who believe they are alone in their journey of recovering from a mental health condition.

G. Intergovernmental Panel on Climate Change (IPCC)

This presentation focused on identifying ways of managing anxiety related to global warming and climate change. During this second presentation for the April 2023 meeting, the CCC learned about environmental advocacy to prevent and reverse damage to the planet. Based on the information provided, climate change affects the animals in the ocean, and sea levels are rising faster along the East Coast and Gulf of Mexico. In Los Angeles, the sea level has increased 2.5 inches. Temperatures around the world are changing and the earth is getting warmer faster than expected. Increased temperatures will lead to more bacteria in food and water, meaning there will be a shortage of both. The communities most affected by climate change are the elderly, youth, and those living in poverty, often

in areas with high pollution from industrialization, consumerism, and colonization. Climate change has already had a negative impact on both physical and mental health worldwide. It is expected to cause trauma due to environmental destruction, including the loss of livelihoods and culture. There may also be an increase in suicides among people who struggle to adapt to extreme climate and living conditions. Strong cultural, economic, and social connections are crucial for surviving climate challenges and pandemics. Scientists have found that the Earth is healing itself, but new data shows there is only a limited time for us to act and reverse climate change. It's also important for everyone to develop mental health plans to prepare for and adapt to the impacts of climate change.

CCC Feedback

Following the presentation, the members engaged in a brief discussion on simple life changes that can really help and impact the environment and collectively identified ways of helping Mother Earth heal. For example, avoid purchasing unnecessary items, be mindful of the waste we generate, and consider the harmful materials we buy. It's also important to think about the impact on natural ecosystems, such as building homes in areas prone to natural disasters, and dealing with the debris caused by earthquakes, tornadoes, hurricanes, and other destructive events. The discussion also addressed our contributions to the age of invention, the age of industry, and the age of technology pointing out that in less than 200 years we could destroy planet earth. The conclusion reached by the members is that as a society, we forget that the planet is ours and therefore, we must nurture it. We can all make a difference.

H. Conscious Culture Psychology

In May 2023, the CCC dedicated its monthly meeting to the topic of "May is Mental Health Month"/Mental Health Awareness Month and welcomed a presentation on conscious culture psychology as an approach to naturally promote peace, justice, respect for life, harmony and balance. The main topics of this presentation were "Understanding and Healing Historical Trauma: The Perspectives of Native Americans and on the importance of increasing intergenerational communication and relationships. In order to heal from our own historical and current traumas is necessary to break the unspoken generational spiritual contracts in order to exit from cycles of suffering and to include non-traditional practices of healing like Pow Wows. A trauma-informed approach was presented to the CCC, which is based on the four (4) Rs:

- Realizing – trauma has a widespread effect on individuals, families, groups, organizations, and communities and that paths to recovery exist.
- Recognize – the signs and symptoms of trauma in clients, staff, and others in the system
- Respond – integrate trauma knowledge into policies, programs and practices
- Resist – re-traumatization

CCC Feedback

The CCC members congratulated the speakers for the excellence of their work and expressed appreciation for the concept of cultural healing and the implementation of culture-specific community-based organizations in Los Angeles. Other members described the presentation as beautiful and inspiring to advocate for more mental health professionals for American Indian/Alaska Native (AI/AN) and indigenous Latin American communities. General comments and recommendations were made around the importance of intentional trainings to support staff and build a pipeline of future professionals. Other comments focused on the need for more culturally relevant approaches particularly as new projects are developed. The CCC invited speakers to connect with the AI/AN and Latino UsCC to share their expertise and learn about the possibility of presenting their work as potential ideas for future capacity building projects.

I. Bilingual Capacity of the System of Care

In June 2023, LACDMH's Human Resources Bureau (HRB) visited the CCC to deliver a presentation on the bilingual capacity of the Department. This presentation aligns directly with the cultural competence plan requirements and provides information on the internal process of bilingual certification across three distinct skills: reading, writing, and speaking; the range of languages represented in the bilingual certified workforce of the department' and bilingual compensation agreements with Labor Unions. The HRB relies on the departmental management to determine if there is a need for bilingual bonus based on the assignment and the duties that an employee performs. Upon successful testing, the employee is certified. Employees must also possess knowledge of and sensitivity to the culture and needs of the community that utilizes the language of certification. In terms of process, HR sends out canvass letters for language proficiency based on the needs of each area. HR will test employees who respond to canvass letters to ensure they are proficient in the second language. DMH pays bilingual bonus for the following 39 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

CCC Feedback

The CCC membership asked questions to deepen the content of the presentation. One question was: Can a DMH employee be certified as bilingual across multiple languages? And the answer was yes. Another question was about how the Department determines which languages are tested for bilingual proficiency. The

presenter explained languages are determined by management's determination that a bilingual bonus is needed to provide culturally and linguistically appropriate services at their site. The Committee was appreciative of this information and welcomed the HRB to return next year to determine whether the list of languages increases from year to year.

J. Commemoration of Post Traumatic Stress Disorder (PTSD) Awareness Month: *The Triple Trauma Paradigm in Unaccompanied Children*

In June 2023, the CCC had the opportunity to learn about PTSD from a presentation delivered by the LACDMH Cultural Competency Unit. The content of the presentation included background information on PTSD, such as possible causes, most common symptomatology, how it is experienced in daily life, when to get help. The presentation also highlighted the experience of unaccompanied children who are under the age of 18, have no immigration status, and travel to another country without the custody of a parent or guardian. Most unaccompanied children arriving in the United States come from Guatemala, Honduras, El Salvador, Mexico, Colombia, Ecuador, Brazil, Venezuela and the Caribbean (Cuba and Haiti). Unaccompanied children are often children traumatized prior to emigration, during migration, and post-migration. The CCC members were also provided with information on the most common stressors and sources of trauma at each phase of the travel trajectory and how many of these children exhibit conduct behaviors at school, and they can be supported.

CCC Feedback

The membership demonstrated great interest in the presentation and requested copies of the PowerPoint. Members reflected on how these children are exposed to horrific experiences to get to this country only to find themselves "caged" by immigration authorities, how their communities forget what these children have gone through and expressed concern for the future of these children who may never be reunified with their family of origin. LACDMH was praised for its stand in helping these children by allowing clinical staff to volunteer at the sites where the children were being detained. Members talked about an anecdotal book, "Solito", recently published as the account of a little boy who went through the journey. Seeing the amount of personal stories shared by the membership, one of the CCC Co-Chairs invited the membership to share their stories as part of the Cultural Traditions and Connections newsletter or blog, adding that the CCC is always open to hear everyone's voice, stories, now and in the future.

K. Muslim Heritage Month

In July 2023, the CCC engaged in an interfaith exchange by exploring the meaning and traditions of Muslim Heritage Month. This presentation included a brief history of the Muslim community in the United States including the experience of the slave trade. The CCC was also introduced to great leaders, for example, Malcolm X and Muhammed Ali and learned social practices within the Muslim culture such as properly greeting each other to honor the personhood of each person. The common greeting given to others is "Assalamu alaikum", meaning "peace be upon

you" and the response given to the greeting person is "Wa alaikum salaam", meaning "and unto you, peace". The speakers commended the CCC for taking the initiative and therefore, making history in bringing this presentation to its members.

CCC Feedback

The speaker was profusely thanked for his presentation and for sharing about the Muslim culture. The members engaged with the speaker asking about Muslim celebrations throughout the year and traditions attached to them. Members expressed great surprise in hearing that Biblical story of Abraham and his son Issac is solemnly revered as a special celebration by Muslims honoring this prophet. Other celebrations discussed during the Q&A portion included Ramadan and celebrations to honor the Prophet Mohammed.

L. Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Two-Spirit Champion Network

This presentation was delivered by the LACDMH LGBTQIA2S Specialist in collaboration with a member of the LGBTQIA2-S Underserved Cultural Communities subcommittee (UsCC). The LGBTQIA2S is a new initiative within the Department and is comprised of staff from clinical and administrative programs who connect consumers, family members, and staff to LGBTQIA2-S affirming providers who understand and advocate for their needs. The CCC had the opportunity to provide feedback on the LGBTQIA2S mailbox's automated response. The mailbox will serve as a "centralized" location for individuals to send questions, concerns, ideas, and feedback regarding LGBTQIA2-S services and advocacy. It will function as a public-facing resource for the community and internally to support staff seeking information and opportunities for involvement in the Champion Network. The LGBTQIA2-S Champion Network mail communications will:

- Establish and elevate the community of LGBTQIA2-S affirming providers
- Increase access
- Reduce sigma
- Improve outcomes
- The LGBTQIA2-S Champion Network will encourage managers, supervisors, and non-clinical staff to serve as champions and to provide services within job duties and scope of practice.

Once the inbox has been approved and someone sends an email, they will receive an automated response within three (3) business days. The automated response will include resources for community members and county employees. Once active, the inbox will not be able to respond to emergencies but will provide contact information for the Trevor Project, the National 988 hotline, and the LACDMH Helpline. It will be staffed by LGBTQIA2-S champions and leadership. The mailbox will also provide information on trainings; for example, if someone is interested in the Sexual Orientation and Gender Identity (SOGI) training, there will be information in the inbox with a link to access the training.

CCC Feedback

The CCC demonstrated great interest in the LGBTQ IA 2S champion network and the new mailbox. Some members spoke of the CCC work back in 2016 in establishing the first systemwide workgroup to look at the needs of the LGBTQ community, currently known as the LGBTQIA2S UsCC. They also expressed excitement to see enhancements such as the LGBTQIA2S champion network to support consumers, family members and involved staff alike. Questions were raised regarding how these new efforts will be staffed, the qualifications to become a champion, and the training provided to new and existing LGBTQIA2S Champions.

M. Commemoration of Various 2023 Calendar Year Days in August:

1. International Day of the World's Indigenous People

The CCC welcome Mundo Maya Foundation to present on Mayan culture, the issues faced by the Mayan community and the upcoming "Día Del Mundo Maya 2023" event celebration. She invited the membership their day of the Mayan world 2023 celebration. The membership embarked in this learning opportunity through Mayan art. The presenters spoke of the symbolism of the mural painted for the "Día Del Mundo Maya 2023" event: 1) the broken heart representing the genocide and cultural loses due to colonization. 2) The sun with its rays symbolizing indigenous knowledge and the presence of The Creator. 3) Mayan people portraits inspired by the stories shared by the community during the Mayan Heart Circles coordinated by Mundo Maya Foundation. 4) Tears that together into a cascading waterfall symbolizing the suffering of the Mayan people even now in present times. 5) Indigenous iconography for the "Yaxche" or Tree of Life representing a comforting energy and harmony between the world of the living and the world of the dead. 6) "insect messengers" because many Indigenous cultures believe that insects carry messages from the living to the dead. The mural has two sides, a "grief side" painted using neutral and dark colors and a "joy side" to represent their hopes for healing and a better future in bright colors.

CCC Feedback

The presenter was praised for the beautiful artwork and for explaining the Mayan symbolism that it contained in a way that allowed the members to gain knowledge about Mayan iconography and understanding about the historical in current experiences of the Mayan community. Members discussed how art can be utilized as a vehicle for healing and wellbeing. Members expressed great appreciation for the spirituality embedded throughout the presentation and how beautifully the mild culture connects to the spirit of The Creator and ancestors.

2. National Salvadoran Day

This segment was delivered by one of the CCC Co-Chairs who was born, raised and lived in El Salvador for over 50 years. She explained the symbolism of the national flag of El Salvador, the coat of arms and the national motto, "Dios, Union, y Libertad" / "God, Union, and Freedom". Members learned about the name of the country as a homage to Christ being "El Salvador del Mundo"/the Savior of the

World and represented as a statue of Christ standing on top of the world with His arms wide-open. The presentation also included a brief account of the Salvadoran civil war which lasted over 20 years during which the country was devastated by the death of millions of Salvadorans and destruction of buildings, businesses, and way of life.

CCC Feedback
The membership appreciated this presentation and the speaker's personal accounts of the civil war. The Salvadoran community was praised for their courage and members pointed out that the history of multicultural communities must be told as a form of healing and to raise awareness and sensitivity toward human suffering and the traumatic experiences of LA County communities, in this case, the Salvadoran community.

3. 60th Anniversary of the March on Washington

One of the CCC Co-Chairs read facts about the 60th Anniversary of the March on Washington stating that former President Barrack Obama proclaimed August 28th as the official day of commemorating the March on Washington, which took place on August 28, 1963, when more than 200,000 demonstrators gathered to draw attention to continuing challenges and inequalities faced by African Americans. The goals of the protest included a comprehensive civil rights bill, that would eliminate segregation of public accommodations; protection of the right to vote, justice mechanisms for violations of constitutional rights of African Americans, desegregation of all public schools, a massive federal works program to train and place unemployed workers, and a Federal Fair Employment Practices Act barring employment discrimination. In attendance during the March were Sidney Poitier, Charlton Heston, Tony Curtis, and Diane Carroll. The march functioned as a plea for equality and justice and paved the way for the ratification of the 24th Amendment to the U.S. Constitution. The high point of the March on Washington will be remembered for Dr. Martin Luther King's speech "I Have a Dream."

CCC Feedback
The membership applauded the significance and richness of this presentation. The Co-Chair received multiple thanks followed by a brief discussion about the relevance of the march and Dr. Martin Luther King's speech that took place 60 years ago. Members shared personal experiences of discrimination and how the segregation practices also impacted other groups immigrated to the U.S. A member spoke about posted signs in businesses stating, "No Mexicans allowed" and how children who were not Caucasian were served their school meals last. Other historical events were brought into the discussion.

Regarding discrimination such as the case of Mendez vs. Westminster, which desegregated schools in Southern California, thereby allowing children of Mexican descent to attend school along White children. Member also discuss the Brown vs. the Board of Education, which desegregated all schools.

4. National Grief Awareness Day

   This presentation was delivered by a member of the LCDH speakers Bureau who specializes in grief work. This was on common and person-specific experiences of grief as well as coping skills for daily life. Members had an opportunity to hear about the different types of losses experienced in life leading to grief. The presenter introduced the Elizabeth Kubler Ross model and explained the five stages of grief: Shock and denial, Anger, Bargaining, Depression and Acceptance. The presenter engaged the membership in a discussion about grief pointing out that the emotional and behavioral experiences shared by the members were a part of processing losses, especially of loved ones, and there is no right" way to experience a loss.

   CCC Feedback
   The members engaged in a very open discussion about coping with losses. They shared personal experiences, healing practices, and coping ideas. In some cases, members spoke of the loss of family members, being uprooted from their original culture and countries, relationships and pets among others. The discussion also addressed cultural expressions of grief, difference in grief expression across gender identities, stage in life, and age groups. Members highlighted the types of supports that were most helpful, inclusive of mental health services. Members commented presentations had several takeaways such as understanding the grief process, realizing that the process of grief it's difficult for everyone, in that culture-ingrained grieving practices may assist the process of grieving and potential sources of stress for the grieving person based on personal preferences. The message that resonated was the importance of establishing personal and family/group spaces to process loss and grief.

N. Commemoration of National Recovery Month

This commemoration in the month of September included two separate presentations as follows:

1. Living with Alzheimer's Disease

   Highlights of this presentation included basic facts about of Alzheimer's and Dementia, signs and symptoms, differences between these diseases, and risk factors. The presenter dispelled the myths that as a person ages, Alzheimer's sets in. Although Alzheimer's and dementia are often used interchangeably, they are distinctly different. Alzheimer's is a specific disease under the overarching umbrella of dementia. Alzheimer's is unfortunately a fatal disease that progresses over time where a person begins to lose their memory, thinking, judgment, and reasoning abilities. There are many possible causes of dementia, and Alzheimer's is the most common cause. Age and family history are the greatest known risk factor for Alzheimer's disease. After age 65, the risk to develop Alzheimer's disease doubles every five years. Some cultural groups are at higher risk of developing Alzheimer's such as Black Americans, Latino, and women. Resources were provided at the end of the presentation.

CCC Feedback
The CCC was very appreciate of this highly informative presentation and recommended that this presentation be made at senior centers and clinics with high representation of older adults in the clientele. There were also questions as to whether the presentation was available in languages other than English.

2. Older Adults and Living with Pain

   This presentation was an anecdotal account of one of the CCC Co-Chairs with the goal of raising awareness about the process of aging with multiple health problems and chronic pain, the experience of seeking services in another language, coping with lack of medical insurance, needing specialist medical treatment from a neurologist. The Co-Chair sensitized the membership about the mental health needs of older adults when they face serious medical conditions that do not resolve quickly, pointing out that they are prone to experience depression and anxiety. One of the takeaway messages from this presentation was the importance of taking care of one's mental health given the feedback loop and connection between physical health and mental health.

   CCC Feedback
   Members of the CCC thanked the co-chair for speaking openly of her experience, for her strength, endurance, courage, and most of all, her love for life.

O. Commemoration of Global Diversity Awareness Month

1. Filipino American History Month

   The CCC members had the opportunity to learn about historical facts of the Filipino culture dating back to 1,200 years ago, including its multiple kingdoms, religions, scientific advances pertinent to public transportation on the water, pre-Spanish colonization and its impact. With the Spanish colonization came to loss of life as thousands of native people of the Philippines were a murdered, communities went through permanent changes to their way of life, the destruction of 90% of the rainforest, the slavery of Filipino natives from the different islands, and their forced labor as special displays in circuses. After the Spanish reign came the American dominance. During the American colonial period, Filipinos were granted a unique immigration status as non-citizen United States nationals. They were subjects of the United States who could migrate to the United States, but they had no rights. Thus, they could not own land or become full-fledged American citizens. Additionally, they were denied the same rights given to other legal immigrants who filed for visas and immigration status.

2. LGBTQIA2-S History Month

   Highlights of this presentation included the concepts of coming out, inviting in, and living in complete personal authenticity. CCC members gained knowledge about the observance of October 11th as "National coming out day". It was first established in 1988 by two community activists, one of whom was a psychologist. The intention of this day is to celebrate authentic lived experiences as one true self

and to acknowledge how deeply "the personal" side of one's being is at the core of politics. Rather than referring to this date as coming out day, some members of the LGBTQIA2S have renamed it as "inviting in" day. The presenter also focused on the current challenges of the LGBTQIA2S community members currently face in regard to health outcomes. Mental health conditions such as depression and posttraumatic stress, unhealthy substance use, and high rates of suicide are well recognized in the literature. Within the child welfare system, LGBTQIA2S youth are overrepresented. This is due in part to rejection, neglect or violence within their families of origin, within the child welfare system, and society. Presently, 22 states have banned the best practices for medication or surgical care for trans youth. Five states have banned the provision of gender affirming care for young people and criminalize physicians who are offering this care to young people with a felony. There are established groups here in California that is working to put similar bills on our state ballot for next year, for the year 2024 election.

Another important aspect of this presentation was the segment on best practices when working with parents and caregivers of LGBTQ and young people. For many families, this is a tough process and a seeking a strength-based psychotherapy approach can be very beneficial. Parents, LGBTQIA2S youth, families, and caregivers need and deserve a space to process the feelings and emotions that may arise in relation to a child's sexual orientation or gender, such as confusion, sadness, anger, frustration, fear, and/or grief. Parents and youth may require separate spaces and when ready, come together in an appropriate and safe manner for everyone.

3. German American Heritage Month (postponed to November 2023)

CCC Feedback

Members praised both presentations highlighting how their raw historical and honest content had resulted in new insights about the painful trajectory of the Filipino and LBGTQIA2S communities. Members expressed concern about the mental health impact of members of these communities and discussed how the Cultural Traditions and Connections with articles/content covering the knowledge that was shared today would be a powerful way to disseminate it to the community at large in support of youth especially regarding the high rates of suicide and suffering of youth.

P. Commemoration of National Native American, American Indian, and Alaska Native Heritage Month: Honoring Cultural Healing for American Indian/Alaska Native (AI/AN)

The aim of the presentation was to identify past and current stressors and their macro impact on trauma for the Native Americans, American Indians, and Alaska Natives. The presenters shared rich accounts of stressors faced by the AI/AN community pointing out that due to its intensity and chronic presence, it increases the risk for mental illness in native communities. The presenters spoke on the following sources of stress for the AI/AN community, explaining how these have impacted their personal, familial, and communal experiences.

1. Practicing healing with depleted natural resources: Living in both worlds and being in an urban area, AI/AN persons do not have access to natural resources that aid in healing and medication preparation. There is nowhere to go to heal in nature without having a drive far. AI/AN also find healing within their group. However, the community is widely dispersed, on purpose, which makes communal life less accessible. When stressed, the AI/AN way is to connect/ take it to nature as a way of getting centered. However, driving past LA River every day and seeing it dry is no river is sickening for the Tongva people, who can no longer fish in the rivers.

2. The fight for equity: The impact of Colonization continues. The community experiences genocide trauma without societal changes to repair or restore the Native lands and way of life.

3. Identity having to be proved: The government still defines and identifies AI/AN as state recognized versus federally recognized. Having to prove your identity as AI/AN is a stressor. For instance, upon self-identifying as Native American, they are expected to explain how much, show documents, reveal their blood degree. Due to genocide, AI/AN persons and families cannot find records and other types of information.

4. Misappropriation of AI/AN traditions and customs: A lot of people misappropriate of AI/AN culture. The use of traditional regalia was also identified as another way of getting centered. The presenter shared that in order to dance AI/AN just do not just put on regalia. They first have to stand in their place and ways given that to dance in a ceremony for your tribe takes years.

5. Loss of land due to unfair land judgments leading to less than the estimated minimal property payments (e.g., receiving $500 for a house)

6. Tribal identity and way of life: Tongva people live by the ocean, taking their problems to the ocean. Hupa people go to the river and release our energy there. The LA River no longer exists as a result of industrialization and misappropriation of properties.

7. Loss of culture: The impact of being colonized is that daily life has been structured in such a way that it has changed AI/AN practices that had been passed down from one generation to the next. The AI/AN live in fear that their history is going to get lost forever if they do not actively pass it on to younger generations. A related stressor is when youth are not interested in their history or traditions because of generational divide, which exacerbate the fear of history being lost.

Q. Commemoration of German American Heritage Month: *German American Experience*

Highlights of this presentation included October is German-American Heritage Month, and October 6th is German-American Day. It was established in 1989. The influence of the German culture can be appreciated in car manufacturing, arts, language, the Christmas tree and Santa, the hamburger and well-known names like Heinz and Chrysler, Boeing, Firestone, and Trader Joe's. German Heritage Day began back in

1683 when there were 13 German Mennonite families that landed in Philadelphia. There were already about 54 other families there, and they established Germantown, which is still in existence in Philadelphia.
Regarding census data: next to the British, the German population is quite high in the U.S., at least in terms of ancestry reporting, with over 40 million Americans claiming German ancestry and 12% of the population. During the early Industrial Revolution, there was increased immigration of Germans into different parts of the world, including the United States. However, World War 1 and World War 2 caused an even greater migration. Several countries engage in a practice to send German immigrants back to Germany. Farms were open to accommodate the influx of Germans coming back. The speaker shared the perspective of suffering and shame experienced by her relatives as a result of the Jewish genocide simply because of their nationality and identify as German. She added that individual, familial and community stories were very rarely shared while she was growing up, because nobody would talk about it, even in Germany. Partly because the offspring did not want to embarrass the parents and at the same time, parents did not want to add that psychological burden on their offspring. The speaker expressed thankfulness to the CCC for giving her the opportunity to speak on what it was like to grow up as a German youth after the World War II.

R. Special Preparation for the Upcoming Holiday Season: *Holiday Blues*

In preparation for the holiday season, the CCC welcomed a special presentation on how to cope with the stressors and potential sadness, anxiety, guilt, irritability associated with the experience of being separated from one's family. The members heard definitions and common signs and symptoms of the holiday blues, potential causes, and coping strategies. The presenter provided resources and a list of activities that could be of good use when experiencing the holiday blues. Among them:

- Connecting with friends and family members
- Being mindful of one's needs
- Avoid self-imposed pressures
- Practice relaxation and avoid dwell on the past to the point of emotional exhaustion
- Be mindful of money spending
- Find opportunities to enjoy a special activity in the community
- Try to put aside differences between friends and family members
- Keep a positive attitude, have a realistic expectation of the holidays
- Spend time with positive and welcoming people
- Volunteer your time to help others

S. Annual Retreat – Reflections on CCC Accomplishments CY 2023

In December 2023, LACDMH Ethnic Services Manager (ESM) delivered a brief overview of CCC committees' activities and accomplishments for the Year. The CCC's most salient 2023 accomplishments include:

- Implementation of the CCC and CCU multicultural diversity calendar in monthly meetings to highlight commemorations and months of awareness that are less popular.
- Fostering a sense of community with other LACDMH stakeholder groups through their presence in monthly meetings as subject matter expert presenters or participants.
- Feedback and recommendation provision to five different LACDMH programs on projects pertinent to cultural diversity and inclusion.

During FY 22-23, the CCC welcome the participation of SAPC in monthly meetings with the goal of exploring opportunities for collaborative work with the Cultural Competence and Humility Committee.

IV. 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 ARISE 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 ARISE 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.

V. 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 2023. Below is a brief summary of their reflective comments.

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 difference 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 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, and the warm acceptance of our LACDMH liaison and 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 lead to presentations, recommendations for the Department, and developing meaning workgroup and projects. This last year was a healing year in many ways. Coming out of COVID-19 with personal loss, community changes, and new forms resulted in a lot of 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 acknowledgements, labor acknowledgments, Lunar New Year traditions and special holidays such as Juneteenth, the power of peers, the important work of the 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 2023 on a high note and watched each other "shine."

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PART II

I. LAC SAPC Committee on Cultural Competence and Humility (C3H)

A. Description, Organizational Chart, and Leadership

The Committee on Cultural Competence and Humility (or commonly referred to as C3H) was established to support efforts to plan and develop efforts that ensure equity, diversity, and inclusion throughout SAPC's portfolio of services. SAPC C3H structure and SAPC commitment to diversity, equity, and inclusion models some of the structures outlined in the Cultural Competence Plan Requirements (CCPR), Title IX – Section 1810.410 statutes. However, unlike County entities funded under the Mental Health Services Act, SUD systems are not required to meet the same requirements. Nevertheless, SAPCs commitment to ensuring diversity, equity, and inclusion and incorporation of the National Culturally, and Linguistically Appropriate Service Standard in Healthcare is evidenced in the purpose, goals, and activities of C3H.

C3H Purpose Statement

The purpose of the Committee on Cultural Competence and Humility is to cultivate an environment where health equity and accessibility is prioritized and where SAPC and SAPCs provider network engage individuals, in a meaningful way, from a perspective of self-reflection, by building knowledge of and respect for the multidimensional and complex ways language and culture (inclusive of race, faith, ethnicity, abilities, gender, class, sexual orientation, housing and education) is experienced individually and impact personal interactions.

C3H creates a space where diverse representation from SAPC (i.e. level, experience, race/ethnicity, gender, etc.) participate in the implementation and direction of the C3H action/strategic plan, incorporating racial equity principles that align with the county-wide Anti-Racism, Diversity, and Inclusion Initiative (ARDII) which seeks to facilitate discussions and implement strategies that create a more equitable workforce and county community.

C3H serves as the guiding body that assesses, designs, and implements efforts that address the cultural, social, and linguistic needs of communities experiencing harms related to substance use and individual who are at risk of or experiencing substance use disorders. The committee focuses on establishing common standards, policies, and procedures for its provider network, improving data collection, and monitoring cultural competency efforts.

The committee regularly evaluates its progress, reviews the completion of goals, objectives, and deliverables with its members, and collaborates with the Provider Advisory Committee (PAC) to establish priorities.

1. C3H Leadership
   C3H is led by two Co-Chairs, each with specific responsibilities related to supporting the goals and objectives for SAPC's cultural competence efforts are achieved.

   a. EAPS Program Manager is responsibilities include:

      - Facilitate regular meetings
      - Coordinate committee members engagement and participate in other meetings related to cultural competence.
      - Monitor CLAS action plan implementation
      - Serve as a DPH representative on the County's Anti-Racism and Diversity and Inclusion Initiative (ARDII)
      - Partner with other SAPC divisions to assess data and trends.

   b. Provider Capacity/Compliance Lead responsible include:

      - Coordinate committee members and facilitating meetings
      - Facilitate provider adoption of CLAS standards/strategic plan action items
      - Coordinate compliance efforts to ensure adoption.

   c. Under the outlined leadership and structure, C3H advances key priorities and objectives from the action plan to improve racial equity and cultural/linguistic appropriateness in substances use services throughout LA County:

      - Increase efforts to recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce.
      - Ensure availability of services in threshold languages including competent bilingual staff and services, and accessible language assistance services.
      - Ensure development of culturally and linguistically appropriate goals, policies, and management accountability that are infused throughout the organization's planning and operations.
      - Conduct ongoing assessments of SAPC's CLAS-related activities and integrate into measurement and continuous quality improvement activities.
      - Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
      - Implement and evaluate action plan priorities.
      - Organize the collection of CLAS-related data across divisions.
      - Recommends improved strategies to larger SAPC Executive leadership.

See Criterion 4 Appendix, Attachment 4: C3H Structure

B. C3H Membership Structure to Ensure Integration Throughout SAPC

C3H Membership

C3H membership consists of at least one representative from each Division/Section that serves as primary liaison to management. This includes some existing members for continuity.

- Frequency/Duration:
  - Third Wednesdays 3:00pm, unless otherwise scheduled
  - 60 mins

- SAPC Divisions:
  - Strategic and Network Development
  - Quality Improvement & Utilization Management
  - Contracts & Compliance
  - Finance
  - Systems of Care
  - Prevention
  - Health Outcomes & Data Analytics
  - Clinical Standards & Training
  - Other members: CIBHS (SAPC vendor)

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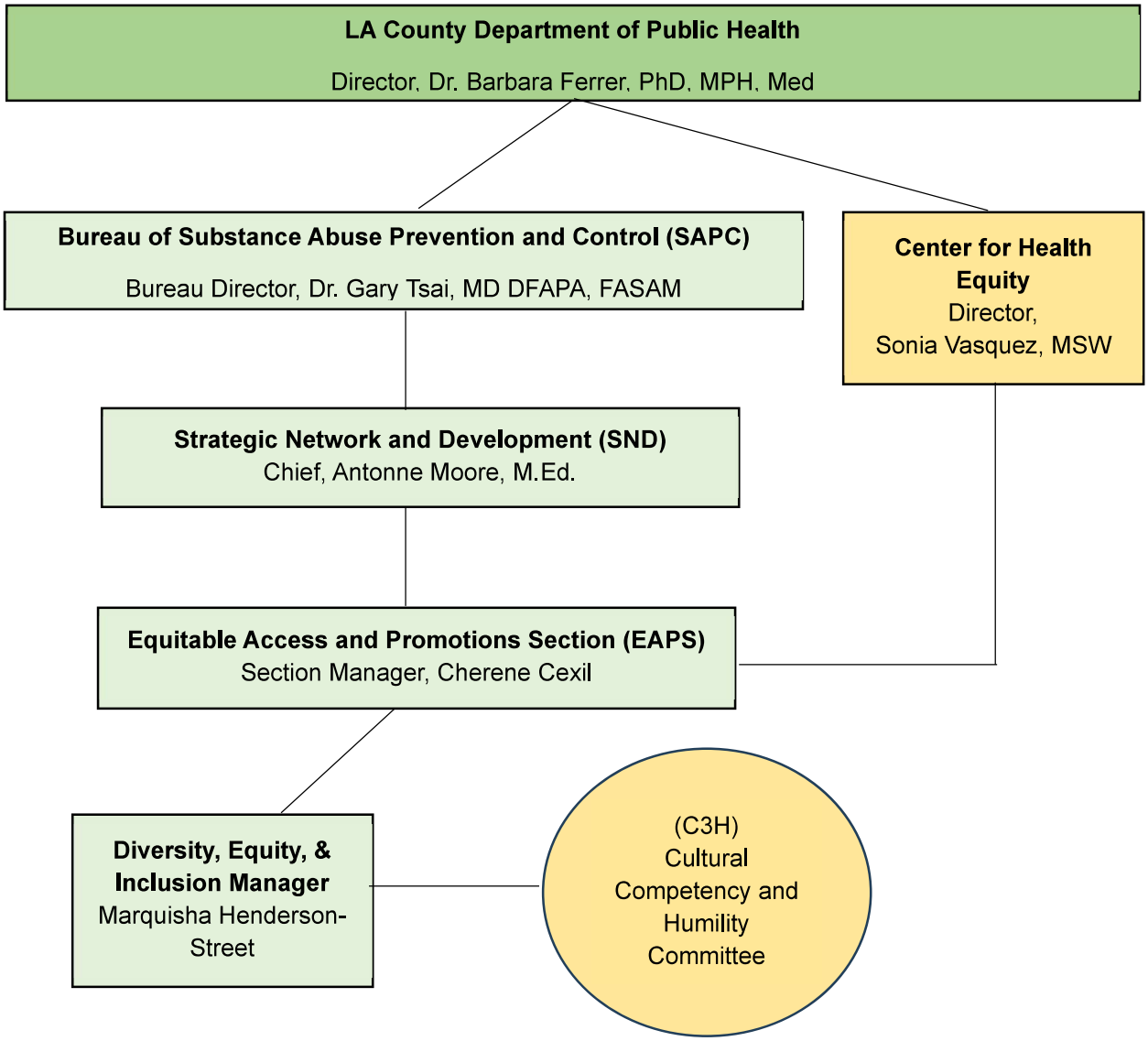
C. SAPC Cultural Competence Organizational Chart, CY 2023



II. C3H Integration in the SAPC

A. Evidence of policies, procedures, and practices that demonstrate the C3H's activities.

The C3H plays a key role in supporting diversity, equity, and inclusion efforts and integrating culturally and linguistically appropriate services within its network or providers. SAPC's Policy and Procedure on Culturally and Linguistically Appropriate Services scope is to govern how SAPC's Strategic and Network Development (SND)

Division, Equitable Access and Promotion Section in collaboration with other SAPC Divisions implements and monitors culturally and linguistically appropriate services, including language assistance services and the provision of critically informing written materials translated into threshold languages. The Cultural Competency Committee acts as an advisory group focused on embedding cultural competence across all SAPC operations. Administratively, the C3H is housed within the Strategic and Network Development Division.

Aligning with federal and State requirements, all counties must have an established committee to address cultural issues and concerns, ensuring representation from diverse cultural groups. The C3H membership reflects the cultural perspectives of staff from various SAPC Divisions, advocating for the needs of all cultural and linguistic groups. Table 2: C3H Presentations and Discussions outlines the activities of the committee during CY 2023. *See Criterion 4 Appendix, Attachment 4: Committee on Cultural Competence and Humility Structure.*

TABLE 2: CY 2023 LIST OF PRESENTATIONS AND DISCUSSIONS

MONTH	TITLES OF PRESENTATIONS AND DISCUSSIONS
January	1. Transgender Training Review 2. Black People Experiencing Homelessness Discussion 3. Action Plan – Walkthrough Template Discussion
February	4. ARDI Survey Discussion 5. Upcoming CLAS Trainings Review 6. Strategies for Strengthening Equity Training Review 7. Action Plan – Walkthrough Template Discussion
April	8. Overview of Demographic Data 9. Action Plan – Action Item Streamlining Discussion
July	10. CLAS Training Discussion
September	11. Strategies for Strengthening Equity in Behavioral Health Training Review
October	12. Upcoming CLAS Trainings Review 13. CLAS Proposal Finalization 14. Providers skilled in working with Black clients Discussion 15. Data Review

Summaries for Presentations and Discussions

1. Transgender Training Review

   C3H discussed the Provider Network's transgender training to enhance cultural competence and sensitivity within its provider network. The trainings focused on understanding the unique needs of transgender individuals, addressing barriers to care, and ensuring inclusive and affirming practices in SUD prevention and treatment. Topics included respectful communication, the impact of stigma, and strategies to create a supportive environment for transgender patients.

2. Black People Experiencing Homelessness Discussion

   C3H recognized the need to train the Provider Network on how to address the unique challenges faced by Black individuals experiencing homelessness, emphasizing the reduction of disparities in accessing substance use disorder (SUD) care. These sessions aimed to equip providers with practical tools for delivering culturally responsive services. Key topics included the intersections of race, homelessness, and SUD, with a focus on addressing systemic inequities, employing trauma-informed approaches, and fostering trust and engagement within Black communities. The training sought to deepen provider understanding of these complex dynamics to enhance care quality and accessibility

3. C3H Action Plan Walk through Template Discussion

   An activity from the C3H action plan was to create a more standardized tool from which to monitor provider network compliance to CLAS as outlined in the Provider Manual and CLAS Bulletin #18-03. Members discussed how the walk-through monitoring tool might best be developed and used by SAPCs Contract Program Auditor, including which documents to review, assessing provider language access, how providers track population trends, and ensuring postings were representative.

4. ARDI Survey Discussion

   The Anti-Racism, Diversity, and Inclusion (ARDI) Initiative in Los Angeles County highlights the critical role of data collection through SAPC's survey participation. This initiative underscores the importance of gathering data to inform and shape actionable equity strategies. The insights gained from the survey contribute to the County's Racial Equity Strategic Plan, helping to establish key priorities and measure progress toward achieving equity goals. This collaborative effort reflects a commitment to addressing systemic disparities and promoting inclusivity across all services and operations.

5. Upcoming CLAS Trainings

   The small group training sessions on transgender topics received detailed review, with attendee feedback highlighting the importance of keeping these sessions specific to Provider Network staff. Participants shared positive perspectives on the

forum, appreciating the opportunity for open dialogue and expressing a strong interest in continuing these discussions to further address and explore these critical topics.

6. Strategies for Strengthening Equity in Behavior Health Training Review (Part 1)

   Attendee participation and feedback from the training were reviewed, focusing on the session's aim to promote equity in the substance use and mental health treatment fields. The training highlighted critical issues, including addressing systemic racism, implicit bias, and structural barriers within behavioral health systems. These elements underscored the importance of creating a more inclusive and equitable environment in behavioral health care. Feedback highlighted the following key points:

   - Usefulness of Allegories: Attendees found the stories and examples shared during the training highly impactful and relatable.
   - Safe Space for Discussion: Participants expressed appreciation for the safe and open environment, allowing candid discussions of sensitive issues.
   - Engagement with Facts: Attendees valued the fact-based approach, which encouraged meaningful dialogue.
   - Large Group Discussions: The group format was well-received, enabling diverse perspectives and fostering a sense of community.
   - Quality of Presentation: The training was noted for its professional delivery and effective facilitation.
   - Overall, the training was positively received, with attendees recognizing its importance in advancing equity and inclusion in behavioral health practices.

7. Action Plan – Walkthrough Template Discussion

   The existing walkthrough template was reviewed with a focus on incorporating and enhancing elements aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). Members provided targeted feedback, highlighting areas for improved clarity and stronger alignment with CLAS principles.

8. Overview of Demographic Trends Data

   Key demographic shifts in Los Angeles County were presented, highlighting populations most impacted by these changes. The discussion emphasized the intersections between demographic trends and vulnerable communities, reinforcing the necessity for SAPC to focus more intentionally on groups disproportionately affected by these shifts. The data specifically suggested prioritizing efforts in Service Planning Area 1 (SPA 1), where resources may currently be insufficient to meet the community's needs.

9. Action Plan – Action Item Streamlining Discussion

   Streamlining CLAS action items was identified as a key strategy to improve focus and ensure smoother implementation, aligning more effectively with committee goals. By prioritizing high-impact items, the approach ensures that progress remains measurable and achievable within the set timelines. This method fosters clarity and enhances the committee's ability to achieve tangible outcomes while maintaining alignment with broader objectives.

10. CLAS Training Discussion

    Members discussed creating a training draft proposal for FY 23/24, reflecting on past training outcomes and incorporating data collected from providers. Feedback from providers highlighted three primary concerns:

    - Reducing no-shows for treatment.
    - Implementing CalAIM initiatives effectively.
    - Ensuring the continuation of treatment services.

    Also, proposed framing future training sessions to emphasize the benefits of delivering culturally and linguistically appropriate services as a strategy to address these concerns. This approach aims to support providers in fostering engagement, improving care outcomes, and aligning with SAPC's broader goals for equity and inclusion.

11. Strategies for Strengthening Equity in Behavioral Health Training Review (Part 2)

    Discussed and received feedback from the membership on part 2 of the training. The feedback was similar to part 1, showing that the session was well-received. Participants appreciated the stories and examples shared, finding them both engaging and relatable, which helped them better understand the material. The training created a safe space where people felt comfortable discussing sensitive topics openly, which encouraged honest conversations. Attendees valued the fact-based approach used in the training, as it led to meaningful discussions. The group setting allowed for a range of perspectives to be shared, fostering a sense of community among participants. The training was praised for its professional delivery and clear facilitation, ensuring that everyone could follow along easily. Overall, participants recognized the importance of the training in promoting equity and inclusion in behavioral health, believing it would help create positive change.

12. Upcoming CLAS Trainings Review

    The C3H discussed upcoming trainings building upon previous sessions to further enhance the knowledge and skills of providers. Toolkits will be made available on SAPCs website for the Provider Network to support the integration of CLAS standards. A new model for transgender panel training will be used for other special community-based training sessions moving forward. Additionally, we discussed that providers will be required to revise their CLAS Provider Network Plans (PNP) to ensure continued alignment with the latest practices and

regulations. In addition, Language Assistance Training will be expanded, with more sessions focusing on language assistance services and the associated LA add-on rates. Health equity training will also be offered to deepen understanding of health disparities and promote more equitable care delivery. Lastly, Best Practices Training, specifically tailored to providing culturally responsive care to Black clients, will be introduced to address unique needs and foster better outcomes for this community.

13. CLAS Proposal Finalization

    Announcement made that the CLAS proposal has been finalized, with key updates and upcoming initiatives outlined.

14. Providers skilled in working with Black clients Discussion

    As part of SAPCs continued efforts to address disparities in mortality among Black men experiencing homelessness, C3H members contributed insights about providers experienced in working with Black clients, a key focus for upcoming trainings and in response to the aimed at fostering culturally responsive care. The committee also recommended reaching out to other divisions to gather additional perspectives and ensure a comprehensive approach to addressing the unique needs of Black patients.

15. Data Review

    Billing in Treatment Data was addressed during a session facilitated by the Health Outcomes and Data Analytics Division. Additionally, collaboration with the Systems of Care Division was highlighted in the discussion surrounding the Annual Report. These sessions emphasized the integration of data-driven insights and collaborative approaches to streamline reporting and enhance program efficiency.

See Criterion 4, Appendix, Attachment 5: C3H CY 2023 Meeting Agendas/Notes.

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III. C3H's Reports to the SAPC's Quality Improvement and Risk Management Committee

EAPS represents the C3H at the bimonthly Quality Improvement and Risk Management (QI & RM) meetings representing SAPC efforts to cultivate - through training, evaluation, and monitoring - an environment where health equity and accessibility are prioritized and where SAPC and SAPCs provider network engage individuals, in a meaningful way, by building knowledge of and respect for the multidimensional and complex ways language and culture influence experience.

EAPS reports on gaps, barriers, and complaints related to discrimination or language access during committee meetings to problem solve impacts to quality improvement overall. Cultural and linguistic competence metrics are included in QI/RM reports including: 1) access to DMC ODS services, inclusive of translation, in the prevalent non-English language, 2) coordination of physical and mental health services at the provider level, and 3) assessment of beneficiaries' experiences including complaints, grievances, and appeals. Finally, EAPS conducts presentation on C3H progress toward its CLAS action plan to promote collaboration with SAPC.

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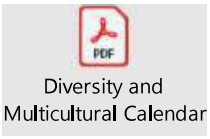
Criterion 4 APPENDIX

LACDMH Attachments

Attachment 1



Attachment 2

CCC Meeting Agendas, CY 2023

CCC 2-8-2023 Agenda FINAL 1.pdf
CCC 3-8-2023 Agenda FINAL 1.pdf
CCC 4-12-2023 Agenda FINAL 1.pdf
CCC 5-10-2023 Agenda FINAL 1.pdf
CCC 6-14-2023 Agenda FINAL 1.pdf
CCC 7-12-2023 Agenda FINAL 1.pdf
CCC 9-13-2023 Agenda FINAL 1.pdf
CCC 10-11-23 Agenda FINAL.pdf
CCC 11-8-23 Agenda FINAL.pdf
CCC 12-13-23 Agenda FINAL.pdf

Attachment 3

CCC Bylaws and CCC Virtual Meeting Code of Conduct

LAC SAPC ATTACHMENTS

Attachment 4
C3H Description of Structure

Committee on
Cultural Competenc

Attachment 5

C3H Meeting Agendas/Notes, CY 2023

C3H Meeting Agenda 1-26-23

C3H Meeting Agenda 2-23-23

C3H Meeting Agenda 4-27-23

C3H Meeting Agenda 7-27-23

C3H Meeting Agenda 9-28-23

C3H Meeting Agenda 10-26-23

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

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PREVENTION BUREAU
ANTI-RACISM, INCLUSION, SOLIDARITY, AND EMPOWERMENT (ARISE) DIVISION
CULTURAL COMPETENCY UNIT

AND

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC) BUREAU
STRATEGIC AND NETWORK DEVELOPMENT DIVISION
EQUITABLE ACCESS AND PROMOTIONS SECTION

CULTURAL COMPETENCE PLAN UPDATE – FY 22-23

Criterion 5

Culturally Competent Training Activities

December 2024

Criterion 5: Culturally Competent Training Activities

A new feature of the 2024 Cultural Competence Plan report is the incorporation of content pertinent to Los Angeles County Department of Mental Health (LACDMH) and the Department of Public Health Bureau of Substance Abuse Prevention and Control (SAPC). CR 5 has been organized in two parts: Part I contains information on the LACDMH Cultural Competence-related trainings and Part II describes SAPC's training efforts.

PART 1

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 provides 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 providing training activities to prepare 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) 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.

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Table 1: LACDMH Three-Year Training Plan, FY 20-21 through FY 22-23

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 22-23.

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
FY 20-21		
Innovative training feature 1 Racial Trauma in the Cambodian Population and Implications for Clinical Work	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
Innovative training feature 2 A Different Look into the African American Community and Mental Health Treatment	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 3 Armenian Genocide-Experience of Collective Trauma: Integrating Loss and Trauma: When More is Too Much	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
Innovative training feature 4 Engaging the Muslim American Community	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
Innovative training feature 5 Racial Equity: Racism and Mental Health	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • 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	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
		• Practitioners providing direct services
Training Alternative 2 Cultural Competence related – SMHS is offered by the Training Unit. Training bulletins available via the Intranet	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
Training Alternative 3 Annual cultural competence related conferences	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
Training Alternative 4 Language Interpreters Series • Introduction to Interpreting in Mental Health Settings • Advanced Mental Health Interpreter Training • Use of Interpreter Services in Mental Health Settings	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
FY 21-22		
Innovative training feature 1	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
A Deeper Look into the African American Community and Mental Health Treatment		• Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
Innovative training feature 2 Unique Issues in Counseling Deaf and Hard of Hearing Mental Health Consumers	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
FY 22-23		
Innovative training feature 1 **America Disabilities Act (ADA) and Disabilities topics:** • ADA Disability Etiquette • Assessment and Intervention of Suicidal Thoughts and Behavior: Special Considerations for Individuals with Intellectual Disability and Autism	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
Innovative training feature 2 **Children: Birth to 5 years of age topics:** • Best Practices in Birth to Five Mental Health • Brain Development, Trauma, and Attachment	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 1 Racial Equity and Racial Trauma topics: • How to Treat Race-Based Stress/Trauma: Clinicians Serving Communities of Color • Intergenerational Treatment Models that Address Trauma in the Black and African American Community	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
Innovative training feature 2 Older adults-related mental health topics: • Addressing and Preventing Social Isolation and loneliness: improving aging network provider capacity • Managing Grief in Older Patients • Sleep Disorders in Older Adults • Effective Techniques in Working with Older Adults with Mild to Moderate Cognitive Impairment	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
Training Alternative 1 Cultural Competence related – SMHS offered by the Training Unit. Training bulletins available via the Intranet	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services
Training Alternative 2 Annual cultural competence related conferences	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training Alternative 3 Language Interpreters Series	LACDMH app for NAPPA	Available to all staff including: • Directly Operated • Legal Entities/Contracted • Administrative • Management • Clerical/support • Staff providing SMHS • Practitioners providing direct services

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Training Plan Specifications
LACDMH can choose a training option described as an "Innovative training feature" or other training alternatives.

A. Innovative Training Features
Refers to any trainings, including conferences that have been provided through the Quality, Outcomes and Training Division - Training Unit.

B. Foundational Cultural Competence Trainings

1. "Cultural Competency (CC) 101"
The ARISE Division-CCU developed a basic cultural competency training in response to the External Quality Review Organization (EQRO) recommendation that system-wide training in cultural humility and cultural sensitivity be provided. The training, "Cultural Competency 101," was originally designed as a train-the-trainer model for the Service Area Quality Improvement Committee (SA QIC) members. This on-line learning has been made available to the entire LACDMH workforce, including Directly Operated, Legal Entities/Contracted Providers, and Administrative Programs.

Part 1: Basic definitions, regulations related to cultural competency, LACDMH strategies to reduce mental health disparities, and LACDMH demographical and client utilization data [Duration: 37 minutes]
http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6638

Part 2: Cultural humility, client culture, stigma, elements of cultural competency in service delivery, and resources [Duration: 30 minutes]
http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6640

Part 3: Cultural competency scenarios and group discussion [Duration: 18.5 minutes]
http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6639

2. **"**Implicit Bias and Cultural Humility"
This virtual training was developed by the ARISE Division-CCU and it 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.

3. "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, as well as 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.

4. "Integration of Cultural Competence in the Mental Health System of Care"
   This training is provided by the ARISE 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 incorporate a multiplicity of cultural elements:
   - Age group diversity (Children, Transition Age Youth, Adults and Older Adults)
   - Persons who are deaf and hard of hearing
   - Persons with justice system involvement
   - Persons experiencing homelessness
   - Persons with intellectual and physical disabilities
   - Language interpreter services
   - Race and ethnicity
   - Racism and Anti-racism
   - Gender identity and Expression
   - 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 the 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 for staff 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 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. This training increases 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.

- *Increasing Spanish Mental Health Clinical Terminology*
  This training is intended to increase cross-cultural knowledge and skills with Spanish-speaking populations, specifically to increase clinician and bilingual staff's vocabulary and use of terms related to providing mental health services, such as assessment, diagnosis, treatment, and crisis intervention. Discussion will include the challenges that present when interpreting/translating and when performing services in Spanish, such as using incorrect or misleading terminology, misunderstanding of translated information, misdiagnosis, inappropriate diagnosis, and other unintended consequences. The training is designed for participants with varying levels of Spanish-language proficiency.

- *Increasing Mandarin Mental Health Clinical Terminology*
  This training is intended to increase cross-cultural knowledge and skills with Mandarin-speaking populations, specifically to increase clinician and bilingual staff's vocabulary and use of terms related to providing mental health services, such as assessment, diagnosis, treatment and crisis intervention. Discussion will include the challenges that present when interpreting/translating and when performing services in Mandarin, such as using incorrect or misleading terminology, misunderstanding of translated information, misdiagnosis,

inappropriate diagnosis, and other unintended consequences. The training is designed for participants with varying levels of Mandarin language proficiency.

- *Increasing Armenian Mental Health Clinical Terminology*
  This training is intended to increase cross-cultural knowledge and skills with Armenian-speaking populations, specifically to increase clinician and bilingual staff's vocabulary and use of terms related to providing mental health services, such as assessment, diagnosis, treatment and crisis intervention. Discussion will include the challenges that present when interpreting/translating, and when performing services in Armenian, such as: using incorrect or misleading terminology, misunderstanding of translated information, misdiagnosis, inappropriate diagnosis, and other unintended consequences. The training is designed for participants with varying levels of Armenian 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. Trainings 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.

- Gender Equity in Workforce Leadership
- ARISE Leadership Transformational Training Series
  During FY 22-23, the ARISE Staff Advisory Council in collaboration with the ARISE Division and the Training Unit developed the training framework. The projected timeline for the training rollout is FY 23-24 for managers (phase I) and FY 24-25 for supervisors (phase II). Designed as a mandatory training series for managers and supervisors, this innovative training is a concerted effort to transform LACDMH's system of care. The overall structure of the ARISE Leadership Transformational Training specifies in-person cohorts of 30 participants. The managers will participate in five (5) mandatory full-day training sessions, three (3) virtual follow-up sessions or "checkpoints", and one (1) booster in-person training.

The training will be delivered as a combination of relevant didactic information and multiple process-oriented discussions in each training session. The underlying message in all training sessions is LACDMH's stance against racism, discrimination, and oppression. The training session will emphasize learning about the foundations and organizational practices that perpetuate of anti-Black racism and other forms of oppression. The goals of this mandatory training series include: 1) To dismantle anti-Black racism, and white supremacy along with other forms of intersectional oppression, through education, 2) To increase leadership accountability, 3) To provide leadership with skills to positively impact staff for the overall health and wellbeing of our communities, and 4) To create a welcoming, affirming, anti-racist, anti-oppressive, multicultural spaces for staff and consumers.

F. Sexual Orientation and Gender Identity (SOGI) Training Series
The ARISE Division-CCU made concerted efforts to expand training opportunities for staff to become familiarized with important information toward the provision of gender and sexuality-affirming services. The expertise of the departmental LGBTQ+ Services Specialist was instrumental in the creation of these insightful videos. Among them,

- SOGI Concepts and Terminology
- How to Ask About SOGI
- SOGI – Pronouns and Why They Matter

Additional trainings were made available to the workforce to instill and deepen staff knowledge and sensitivity around SOGI data collection and the needs of the LGBTQIA2S community.

- The Ins and Outs of SOGI Data Collection
- SOGI Sexual Orientation Gender ID
- Core Practice Concepts in Working with LGBTQIA+ Youth
- LGBTQ+ Survivor Allyship Training
- Affirmative Cognitive Behavioral Therapy to Foster Queer Joy and Gender Euphoria
- Disparities in Suicide-Related Behaviors Across Sexual Orientations by Gender
- Understanding Mental Health Among the Gen Z LGBTQIA2-S+ Communities

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. ***(See Criterion 5 Appendix, Attachment 1: ARISE Division-CCU Annual Cultural Competence Training Attestation form)***

H. 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 1: 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 ARISE 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 functions not specified above

(*See* Attachment *2: 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 ARISE 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, 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 3: Cultural Competence Trainings by Content Category).***

Table 3: Examples of Cultural Competence-Related Specialty Mental Health Trainings Offered by the Training Unit, FY 22-23

America Disabilities Act (ADA) and Disabilities
ADA Disability Etiquette
Assessment and Intervention of Suicidal Thoughts and Behavior: Special Considerations for Individuals with Intellectual Disability and Autism
Adults
Adult Full-Service Partnership (FSP) Nuts and Bolts
African American and Black Culture
Inter-generational Treatment Models that Address Trauma in the Black and African American Community
American Indian/Alaska Native (AI/AN) Culture
Positive Indian Parenting - Train the Trainer
Armenian Culture
Working with the Armenian Family
Children: Birth to 5 (0-5)
Best Practices in Birth to Five Mental Health
Brain Development, Trauma, and Attachment
DC: 0-5 Diagnostic Classification
Fetal Alcohol Spectrum Disorder: Screening, Diagnosis, and Interventions
Introduction to the DMH Infancy, Childhood & Relationship Enrichment (ICARE) Initial Assessment
Perinatal Mental Health 101 Training for California Work Opportunity and Responsibility to Kids (CalWORKs)
Typical and Atypical Development (Birth through Five)
Children/Young Adult
Child/Young Adult (YA) Full-Service Partnership (FSP) Nuts and Bolts
Children and Families
Child and Family Team Facilitator Training
Eating Disorder: Working with Children and their Families
Effective Strategies for Family and Youth Engagement
Fostering Crucial Conversations about Race with Children and Families
Grief and Loss: Supporting Children, Youth and Families

Impact of Intimate Partner Violence on Children and their Development
Mandated Reporting of Reported/Suspected Child Abuse or Neglect- Part 2
Promoting Placement Stability Utilizing the Child and Family Team Process
Role of the Clinician: Participating in the Child and Family Team Process
COVID – 19
Understanding & Addressing Racial Trauma in a POST-COVID Society
Deaf and Hard of Hearing
Unique Issues in Counseling Deaf and Hard of Hearing Mental Health Consumers
Forensic
Assessment and Treatment of Impulse-Control Disorders in Forensic Settings
Forensic Mental Health-Back to Basics
Legal and Ethical Considerations: Working with Forensically Involved Individuals
Risk Assessment for Violence-Forensic Focus

Gangs
Gangs: Evolution, Trends & Updates
Gender Based
Domestic Violence Awareness & Missing and Murdered Indigenous Women and Girls
Engaging Fathers & Other Adult Males in the Therapeutic Process
General Cultural Competency
Cultural Humility: Crucial Reflections
Culturally Responsive Cognitive Behavioral Therapy (CBT)
Grief Support
Grief: Overcoming Isolation through Connection and Support
Understanding Relevant Grief Models: How to Respond through a Culturally Responsive Trauma Informed Lens
Juvenile Justice System
Behavior Chain Analysis in Adapted DBT in Juvenile Justice Settings
Commercial Sexual Exploitation Identification Tool (CSE-IT): User Training for Juvenile Justice Mental Health Program Staff
Trauma-Informed Treatment of Juvenile Justice Youth Part 1: Assessment & Diagnosis

Applying the Risk-Need-Responsivity Principles (RNR) and Level of Service/Case Management Inventor (LS/CMI) In Your Practice
Justice Involved Mental Health (JIMH) - Creating a Culture of Safety
Language Interpreting and Mental Health Terminology
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
Improving Access to Gender Affirming Treatment: Writing Letters of Support for Transgender Clients
LGBTQ Survivor Allyship Training
Latino and Latinx
A Culturally Adapted Introduction to Problem Solving Therapy for the Latino Community
Community Resiliency Model Teacher Training (Spanish-Speaking)
Culturally Adapted Introduction to Problem Solving Therapy for the Latino Community
Racial Trauma in the LatinX Population and Implications for Clinical Work
Trauma Informed Care for Spanish-Speaking Clinicians Working with Monolingual Clients
Older Adults
Addressing and Preventing Social Isolation and Loneliness: Improving Aging Network Provider Capacity
Effective Techniques in Working with Older Adults with Mild to Moderate Cognitive Impairment
Managing Grief in Older Patients
Serving Older Adults: What to Know About Social Isolation, Mental Health & Hoarding Disorder
Sleep Disorders in Older Adults
Strength, Resilience, and Diversity in Psychotic Spectrum Disorders of Late Life
Peer Training
Online Law and Ethics for Peer Professionals
Peer Certification Exam Preparation Training (2-Days)
Racial Equity and Racial Trauma
How to Treat Race Based Stress/Trauma: Clinicians Serving Communities of Color

Racial Trauma and Its Implications on Employment
Recovery
Developing Your Own Wellness Recovery Plan (WRAP)
Recovery Oriented Tools for Trauma Informed Services
Russian Culture
Trauma Informed Care for the Russian-Speaking Community
Service Integration
Intentional Peer Support (IPS) Core Training
QPR (Question, Persuade, Refer)
Understanding Motivational Interviewing Techniques and Applications for the CalWORKs Program
Underlying Needs: A Strengths/Needs-Based Service Crafting Approach
Spirituality
Moral Injury
Suicide Risk Prevention
Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals
Culturally Responsive Suicide Prevention: Integrating Skills for Coping & Resisting with Racism
Suicide Prevention and Intervention for Asian American Adolescents, Transition Age Youth, and Their Families in Our Post-Covid World
Suicide Prevention: Providing Cultural Responsiveness, Anti-Racist and Affirming Clinical Care to 2 Spirit, Questioning, Transgender+ Youth and Families
Suicide Prevention Service Provider Training
Suicide Risk Reduction, Assessment and Treatment in Juvenile Justice Settings - Part 1
Suicide Risk Reduction, Assessment and Treatment in Juvenile Justice Settings - Part 2
Veterans
Military Culture Awareness
Military Sexual Trauma
Total Number of Unique Training Titles: 80

Data source: LACDMH Training Unit

II. 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 to evaluate participant skill acquisition. The 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 4: Examples of trainings with one-month follow-up conducted by Training Unit.***

PART 2

III. LACDPH SAPC Cultural Competence Training

SAPC trainings are designed to enhance its provider network's as well as its own workforce's overall cultural proficiency. This includes increasing cultural awareness, understanding, sensitivity, responsiveness, as well as expanding knowledge of multiculturalism and strengthening cross-cultural competencies. These elements are crucial for ensuring the effective delivery of services to our culturally and linguistically diverse communities.

SAPC supports its provider network in expanding understanding about and developing programming around a broad range of culturally relevant services that meet the needs of the patient population, including race/ethnicity, age group, sexual orientation and gender identification, abilities, etc. y and, lived experience, language interpreter trainings, and culture-specific conferences. Each fiscal year, SAPC engages the California Institute for Behavioral Health Solutions (CIBHS) to implement SAPC-directed annual training plans under our Culturally and Linguistically Appropriate Services Access to Coaching and Training (CLAS ACT) initiative.

In addition, SAPC's Equitable Access and Promotions Section (EAPS) and Committee on Cultural Committee and Humility (C3H) collaborates with the Clinical Standards and Training (CST) and UCLA Integrated Substance Abuse Programs (ISAP) to develop plans for cultural competence training for specialized populations.

Trainings target contracted provider staff and SAPC employees across all sectors including clerical and support staff, financial teams, clinical and direct service providers, as well as administrative and managerial personnel. Providers are contractually required to ensure that their staff complete annual cultural competence training, many of which are provided by SAPC, and this tracked by regularly monitored.

By ensuring consistent and comprehensive training for all staff (SAPC and provider network), SAPCs the plan seeks to promote equitable and culturally competent care for all members of our diverse population, enhancing the effectiveness and inclusivity of service delivery.

CLAS ACT Training Series Descriptions

A. Implicit Bias Leadership Series
This Implicit Bias leadership series was designed to assist existing and potential leaders within SAPC and its provider network to build skills and knowledge to mitigate the negative effects that bias could have on the wellbeing, recovery, and outcomes of the diverse patients served, be more intentional about addressing their own bias, and implement practices and policies that reduce the negative impact of implicit bias.

This four-part series was facilitated by nationally recognized expert Dr. Bryant T. Marks.

i. Session 1: Implicit Bias Awareness: covered the science behind the causes and consequences of implicit bias, including practical strategies to identify, manage, and potentially mitigate implicit bias.
ii. Session 2: Implicit Bias Mitigation presented best practices for reducing and managing bias during the employee life cycle, offering evidence-based knowledge and tools that can be applied in provider organizations immediately to improve diversity, equity, and inclusion.
iii. Session 3: Follow up discussions where Dr. Marks worked with participants to support implementation of bias mitigation concepts and practices.
iv. Session 4: Follow up discussions where Dr. Marks worked with participants to support implementation of bias mitigation concepts and practices.

B. Implicit Bias Awareness (for Clinical and Support Staff)
Implicit biases operate outside of our awareness, affecting our behavior, creating unintended consequences, and posing challenges for all. In this interactive workshop, nationally recognized expert Dr. Bryant T. Marks presented information that addressed:

- The science behind the causes and consequences of implicit bias
- How implicit bias affects individuals and outcomes
- Practical strategies for identifying, managing, and reducing implicit bias

C. ADA Fundamentals and Service Animals: What You Need to Know and How to Prepare
This session was developed to help substance use disorder providers learn about the concepts, guidelines, and requirements of the ADA and to think about inclusive solutions for serving patients with disabilities at their agencies. The training also addressed the ADA essentials for service animals in healthcare settings.

D. Serving the Deaf and Hard of Hearing Community: Improving Access and Quality of Services

The deaf community is diverse. This training reviewed common misconceptions about deaf and hard-of-hearing people, provided an overview of deaf culture and effective communication strategies, and offered resources and strategies to improve accessibility and services for deaf and hard-of-hearing patients. This session included suggestions and considerations for improving access by a SUD provider who provides services to the deaf community lead by representatives from the Greater Los Angeles Agency for Deafness (GLAD).

E. Designing Welcoming Spaces for ADA Accessibility
Providing spaces that are accessible to individuals with disabilities is key to serving your patients effectively. This in-person session provided tools to identify barriers in provider settings clinic and update spaces for improved access. It also provided suggestions for simple and low-cost updates to make environments more inclusive and accessible to meet ADA requirements and included specific scenarios and design questions from providers.

F. Increasing Your Reach Through ADA Accessible Websites
Providing spaces that are accessible to individuals with disabilities is key to serving your patients or clients effectively. This extends beyond physical spaces and includes digital spaces as well. This session will review how health agencies can increase website usability and reduce barriers to SUD services with ADA-compliant and accessible websites.

G. Best Practices in Providing Affirmative and Culturally Responsive Care to Trans Patients
This training provided guidance on appropriate language and terminology to use when working with trans patients, best practices for training staff, suggestions of items and activities that make an environment more inviting, and consideration for when you should enroll a trans person at your agency or refer out to another provider. This training featured SAPC SUD providers who have a wealth of experience serving the transgender community.

H. Discussion Series: Best Practices in Providing Affirmative and Culturally Responsive Care to Trans Patients
As a follow-up to the training, this series of six (6) interactive and experiential sessions offered providers the opportunity to practice skill-building around the assessment and treatment of trans people in efforts to build trust and reduce stigma. During the series, providers discussed best practices for initiating care, sustaining treatment, and preparing for success after treatment.

I. Strategies for Strengthening Equity in Behavioral Health:
This two-session series addressed racism as a roadblock to achieving health equity in the United States. It addressed the staunch denial of its racism continued existence and profoundly negative impacts on the health and well-being of our nation and the world. And even those who acknowledge that racism exists sometimes feel ill-equipped to say the word “racism” out loud or to take action to address it.

Session 1: Naming Racism and Other Systems of Structured Inequity

Session 2: Confronting Racism Denial Moving to Action

Dr. Camara Phyllis Jones – a family physician, epidemiologist, and Past President of the American Public Health Association shared four of her allegories on "race" and racism to illuminate four key messages: racism exists; racism is a system, racism saps the strength of the whole society; and we can act to dismantle racism.

J. Designing and Implementing Inclusive DEI Initiatives with Staff and Community Engagement
Keeping people engaged and sustaining the work of DEI committees long-term is one of the most difficult things to do when starting DEI initiatives. There are key elements that can make your efforts more successful. Effective diversity, equity and inclusion (DEI) efforts require a community-planned and driven process to ensure those most impacted have a voice in the process and system improvement. This webinar focuses on how to develop an engaged DEI planning process that includes both internal and external stakeholder involvement and how to measure success. Successful DEI strategies and action steps including outreach, training, development of committees, and assessment tools will be shared.
(See Criterion 5 Appendix, Attachment 5: CLAS ACT SUMMARY REPORT Fiscal Year 22-23)

Clinical Standards and Training (CST)

A. Embracing & Integrating Cultural Strengths & Differences in Substance Use Treatment Services
The purpose of this virtual live training is to assist SAPC network providers with increasing their understanding of cultural humility and how to apply that knowledge in a substance use treatment setting. This training will define and explore cultural humility and its importance to substance use disorder (SUD) treatment. Participants will be provided examples of at least two (2) SUD treatment approaches that are consistent with cultural humility. The training will then specify how to apply cultural humility in SUD treatment to assist participants in embracing patients' cultural strengths and differences in their SUD recovery journey. The participants will be actively engaged throughout the presentation using breakout sessions, polling, and open discussion.

B. Best Practices in Engaging and Delivering Services to People Experiencing Homelessness
This virtual live training assists SAPC providers with increasing their knowledge and understanding of the unique characteristics and clinical needs of people experiencing homelessness. The training defined homelessness as well as identified the current statistics related to homelessness in Los Angeles County. Discussing the unique needs and considerations of those experiencing homelessness supports participants with assessment and substance use treatment considerations. This training also describes the key elements and steps needed to provide linkage and person-centered care for those experiencing homelessness. Participants are provided with several resources specific to those experiencing homelessness, including the development of a housing plan, that can be used to engage and provide

further assistance to patients. Participants will be actively engaged throughout the presentation using the chat, polling, and open discussion.

C. Substance Use Recovery Oriented Housing: Assisting Our Neighbors Experiencing Homelessness
This virtual live training has a special focus on the development of pragmatic housing plans, resources, and strategies for addressing substance use recovery-oriented housing for those experiencing homelessness. The training focuses on defining homelessness and the impact of substance on those experiencing homelessness. Discussing the unique recovery-oriented housing needs and considerations of those experiencing homelessness, participants have an opportunity to practice developing a housing plan and learn how to work effectively with interdisciplinary teams and the patient to assure patient-centered care.

D. Substance Use Treatment with Justice-Involved Populations
This virtual live training assists SAPC providers with increasing their knowledge and understanding of the unique characteristics and clinical needs of justice involved patients. The training focuses specifically on individuals post-release from jails and prisons who have been identified as being at risk of developing substance use disorders (SUD)or who have SUD. Participants learn how to identify the unique aspects of the individual's care and mitigate potential challenges with the re-integration of individuals into communities. Aspects of engagement and retention as well as assessing for Criminogenic Needs and differing approaches to behavior assist participants with focusing on whole-person care for the individual involved with criminal justice. An overview of special populations also guides participants through considerations needed while those individuals engage in SUD treatment services.

E. Using the PATH Framework to Support Reproductive Autonomy in Substance Use Treatment Services
This training was designed for Program and Clinical Directors, SUD Counselors, and Licensed and Licensed Eligible Practitioners of the Healing Arts and Peers. Participants learn the benefits of including pregnancy intention screening questions for individuals in substance use disorder (SUD) treatment, focusing on utilizing standardized patient-centered questions about reproductive goals with patients. With the use of these questions, reproductive goals counseling addresses health disparity while supporting equity in SUD treatment. Through a variety of activities, including role-play and discussion, participants become comfortable, skilled, and confident when answering questions and providing referrals in order to connect patients to services that will support their recovery and general well-being.

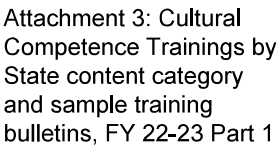
Criterion 5 Appendix

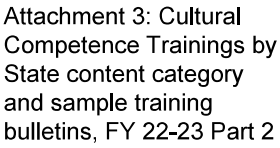
LACDMH Attachments

Attachment 1: Inclusion of Cultural Responsiveness in Trainings

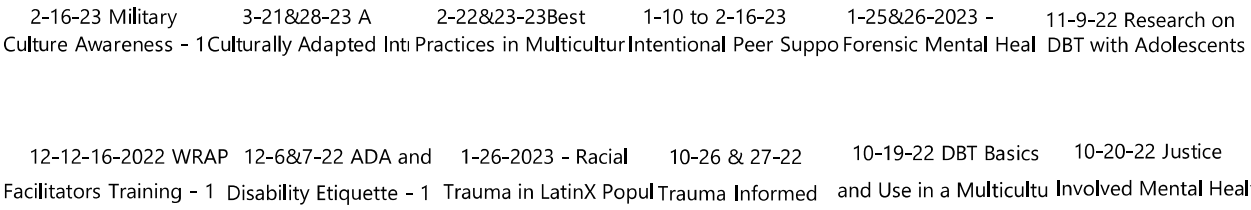
Attachment 2: LACDMH Training Evaluation Form

Attachment 3: Cultural Competence Trainings by State content category and sample training bulletins, FY 22-23





Attachment 4: Examples of trainings with one-month follow-up conducted by Training Unit, FY 22-23



SAPC Attachment

Attachment 5: CLAS ACT Summary Report Fiscal Year 22-23

CLAS ACT Summary Report_FY 22-23.pdf

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

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PREVENTION BUREAU
ANTI-RACISM, INCLUSION, SOLIDARITY, AND EMPOWERMENT (ARISE) DIVISION
CULTURAL COMPETENCY UNIT

AND

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC) BUREAU
STRATEGIC AND NETWORK DEVELOPMENT DIVISION
EQUITABLE ACCESS AND PROMOTIONS SECTION (EAPS)

CULTURAL COMPETENCE PLAN UPDATE – FY 22-23

Criterion 6

County's Commitment to Growing a Multicultural Workforce

December 2024

Criterion 6: County's Commitment to Growing a Multicultural Workforce

I. Recruitment, Hiring, and Retention

A. Los Angeles County Department of Mental Health

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 challenges resulting from the large size and cultural diversity of L.A. County, the Department continues its efforts to recruit, hire, train, and retain culturally and linguistically competent staff through these strategies:

- Provide the workforce with regular training opportunities focused on cultural humility, language access, and the social determinants of health, with an emphasis on understanding and addressing the unique needs of underserved populations
- 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 culturally and linguistically underserved communities via tuition reimbursement and loan forgiveness programs
- Build collaborations with higher education institutions to promote mental health careers. This effort includes the creation of pipelines 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 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

B. Department of Public Health Substance Abuse Prevention and Control

Public Health is committed to fostering an environment in which (1) individuals are appreciated for their differences and treat each other with respect; (2) employees understand and appreciate cultural differences and are responsive to the uniqueness of each individual; (3) employees reach their full potential in pursuit of departmental and organizational objectives.

As part of this commitment, Public Health established the Center for Health Equity (CHE). CHE seeks to build the collective ability of the Public Health workforce and community to achieve health and racial equity.

Key efforts include:

- Implement an Equity Learning Initiative to build the capacity of the Public Health Workforce to apply equity principles during program planning and implementation.
- Improve and expand Public Health's Language Services infrastructure.
- Collaborate with Public Health programs and provide technical assistance to identify and advance equitable policies and practices in areas such as contracting, hiring and retention. data collection and analysis, language access, and accessibility.
- Convene internal Public Health workgroups to identify and develop best practices (i.e. trainings, standards of practice) to address racism, discrimination, gender inclusion and affirmation, and disability accessibility issues.
- Establish and maintain partnerships with community stakeholders and other County agencies to promote Anti-Racist/Anti-Discriminatory practices, improve language access, and lift the voices of impacted communities.
- Develop toolkits and guidance to support the Public Health workforce and community partners with the application of a health equity lens to their work (topics include language access, data collection, analysis, visualization and storytelling).
- Enhance the workforce's ability to apply the equity principles effectively in program planning and implementation.
- Promote and support efforts to ensure language justice. Language justice focuses on ensuring all individuals can communicate and get information in the language with which they are most comfortable.
- Partner with programs to identify and promote policies and practices to ensure fair and just opportunities and resources for all communities.
- Create and support teams to develop best practices to achieve health equity.

SAPC, as a Bureau within the Department of Public Health, promotes a service delivery system that treats individuals within the context of their language, culture, ethnicity, gender identity, age, sexual orientation, developmental stage and any physical, psychiatric, or cognitive disabilities. SAPC ensures that its provider network offers equitable access to and provision of SUD services that are applicable to all its contracted treatment provider sites.

II. Examples of Workforce Development Via the Training Unit

A. Los Angeles County Department of Mental Health

1. Public Mental Health Partnership (PMHP)

The mission of the UCLA-DMH Public Mental Health Partnership (PMHP) is to implement exemplary training and technical assistance activities focused on vulnerable populations with serious mental illness in ways that build excellence in public mental health care across Los Angeles County; 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 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 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 trainings developed for LACDMH, initially presented live, to be produced as videos in both English and Spanish to facilitate broader dissemination of culturally and linguistically responsive content for the Latino community.

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 LACDMH facilities, as well as the University itself and private non-profit facilitates contracted by or in partnership with the County. The first class started in the Academic Year 2018-2019 with trainees ranging from Post Graduate Year Is to IVs. The first class graduated 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 the National Clinician Scholars Program consisted of 1 Adult Psychiatrist/Researcher. 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 through a competitive process with applicants from across the country. LACDMH funds one fellowship slot at a time (new fellows are 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 participating 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. **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.

7. **Learning Net System**
The Department has developed and maintains 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 clinical trainings administratively processed by the system inclusive of posting, registration, and other training logistics important for tracking and reporting purposes.

8. **Intensive Mental Health Recovery Specialist Training Program**
Intensive Mental Health Recovery Specialist 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.

9. **Expanded Employment and Professional Advancement Opportunities for Peers, Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System**
LACDMH 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 22-23, the Department continued 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 learned 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® were 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 interacted in learning activities and demonstrated their own experience with WRAP®. This training is intended for 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 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 would 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.

10. 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, as well as regularly available and offered board required pre-licensure courses.

11. 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, would 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 would 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 the employment start date, the full reimbursement amount must be repaid.

d. Mental Health Student Loan Assistance Program
LACDMH offers a financial incentive towards the outstanding balance of student loans for full-time Mental Health Clinicians and Supervising Mental Health staff who have completed one-year of continuous service at LACDMH and have active, unpaid, graduate student loans. Eligible public mental health employees who have not participated in or have received funds from another financial incentive program, can receive a maximum annual amount of up to $15,000 toward loan repayment.

e. Stipend Program
LACDMH sponsors educational stipends to graduate students each academic year, with a primary goal to increase the public mental health workforce with qualified individuals committed to providing services in high priority areas. Graduate students in the final year of their degree program are eligible in the areas of psychology (PhD/PsyD), social work (MSW), Marriage and Family Therapy (MFT), Psychiatric Technician, and Nurse Practitioner (NP). The Stipend Program objectives include recruiting graduate students who have the linguistic capacity to provide services in one of the thirteen threshold languages in areas identified as high need, have cultural diversity and awareness, and have the capacity to provide culturally appropriate and sensitive services to consumers in areas identified as high need, and would be employed in areas and service programs the County has designated as high need and workforce priority. Awardees would receive an educational stipend of $18,500, with a commitment to gain qualifying full-time employment for one year in a public mental health agency.

B. Department of Public Health Substance Abuse Prevention and Control

As an organization that relies on its contracted provider network to provide substance use prevention, harm reduction, treatment, and recovery services, SAPC is committed to ensuring its contracted provider workforce effectively represents and addresses the needs of the culturally and linguistically diverse communities.

1. SAPC's Clinical Standards Training (CST) Division

This Division supports the Los Angeles County specialty substance use disorder (SUD) prevention and treatment network with a range of training experiences to provide the substance use treatment workforce the necessary skills to provide state-of-the-art, evidenced-based, SUD services. CST also works in collaboration with training partners, including the University of California Los Angeles Integrated Substance Abuse Programs (UCLA-ISAP), Azusa Pacific University (APU), California Institute for Behavioral Health Solutions (CIBHS), and the State of California Department of Health Care

Service (DHCS) to provide additional trainings and organizational support related to SUD service development and delivery.

a. Title: Embracing & Integrating Cultural Strengths & Differences in Substance Use Treatment Services
   Description: The purpose of this virtual live training is to assist SAPC network providers with increasing their understanding of cultural humility and how to apply that knowledge in a substance use treatment setting. This training will define and explore cultural humility and its importance to substance use disorder (SUD) treatment. Participants will be provided examples of at least two (2) SUD treatment approaches that are consistent with cultural humility. The training will then specify how to apply cultural humility in SUD treatment to assist participants in embracing patients' cultural strengths and differences in their SUD recovery journey. The participants will be actively engaged throughout the presentation using breakout sessions, polling, and open discussion.

b. Title: Best Practices in Engaging and Delivering Services to People Experiencing Homelessness
   Description: The purpose of this virtual live training is to assist SAPC providers with increasing their knowledge and understanding of the unique characteristics and clinical needs of people experiencing homelessness. The training will begin with a focus on defining homelessness as well as identifying the current statistics related to homelessness in Los Angeles County. Discussing the unique needs and considerations of those experiencing homelessness will support participants with assessment and substance use treatment considerations. This training will also describe the key elements and steps needed to provide linkage and person-centered care for those experiencing homelessness. Participants will be provided with several resources specific to those experiencing homelessness, including the development of a housing plan that can be used to engage and provide further assistance to patients. Participants will be actively engaged throughout the presentation using the chat, polling, and open discussion.

c. Title: Substance Use Recovery Oriented Housing: Assisting Our Neighbors Experiencing Homelessness
   Description: This virtual live training has a special focus on the development of pragmatic housing plans, resources, and strategies for addressing substance use recovery-oriented housing for those experiencing homelessness. The training will begin with a focus on defining homelessness and the impact of substance on those experiencing homelessness. Discussing the unique recovery-oriented housing needs and considerations of those experiencing homelessness. Participants will have an opportunity to practice developing a housing plan. Participants will also learn how to work effectively with interdisciplinary teams and the patient to ensure patient-centered care.

Participants will be actively engaged throughout the presentation using the chat, polling, and open discussion.

d. Title: Substance Use Treatment with Justice-Involved Populations
Description: The purpose of this virtual live training is to assist SAPC providers in increasing their knowledge and understanding of the unique characteristics and clinical needs of justice-involved patients. The training will focus specifically on individuals post-release from jails and prisons who have been identified as being at risk of developing substance use disorders (SUD)or who have SUD. The focus will be on unique aspects of the individual's care and mitigate potential challenges with re-integration of individuals into communities. Aspects of engagement and retention as well as assessing for Criminogenic Needs and differing approaches to behavior will assist participants with focusing on whole person care for the individual involved with criminal justice. An overview of special populations will guide participants through considerations needed while those individuals engage in SUD treatment services. Using polling, chat and large group discussion participants will be engaged through active participation throughout the presentation.

e. Title: Using the PATH Framework to Support Reproductive Autonomy in Substance Use Treatment Services
Description: This specialized live interactive WebEx Webinar training is designed for Program and Clinical Directors, SUD Counselors, and Licensed and Licensed Eligible Practitioners of the Healing Arts and Peers. Participants will learn the benefits of including pregnancy intention screening questions for individuals in substance use disorder (SUD) treatment. The focus is on utilizing standardized patient-centered questions about reproductive goals with patients. With the use of these questions, reproductive goals counseling begins to address health disparity while supporting equity in Substance Use Treatment (SUT) through a variety of activities, including role play and discussion, participants will become comfortable, skilled, and confident when answering questions and providing referrals in order to connect patients to services that will support their recovery and general well-being. Participants will be engaged in breakout groups, large group discussion, chats, and breakout rooms throughout the training.

f. Title: Can You Hear Me?: Providing Substance Use Telehealth Treatment Services
Description: The purpose of this virtual live training is to assist SAPC providers with increasing their understanding of substance use telehealth treatment services and the best practices when utilizing telehealth services in substance use treatment. The training will begin with identifying the scope, application, and operationalization of telehealth within the Drug Medi-Cal Organized Delivery System (DMC-

ODS). Case examples will be used to illustrate the best practices associated with delivering substance use services through telehealth. Documentation guidelines will be reviewed to assist participants in implementing substance use telehealth treatment services. Participants will be actively engaged throughout the presentation using polling and open discussion.

g. Title: Care Coordination: Maximizing Success in SUD Treatment Through Integration and Coordination of Care
Description: This specialized training will provide a brief review of care coordination service guidelines within the LA County SAPC network and further explore 11 common care coordination needs, such as mental health, housing, and vocational needs. The training will introduce the seven foundational care coordination principles, and participants will practice the application of these principles through a case example. Through discussion and application over a case example, participants will identify and integrate various cultural factors into care coordination practice. Both traditional and new California Advancing and Innovation Medi-Cal (CalAIM) care coordination models will be discussed and applied to special populations that will benefit from these models. This training will end with discussing ways to improve clinical documentation of care coordination and ethical concerns in care coordination delivery.

h. Title: Foundational Principles of Ethical and Confidential Practice in Substance Use Treatment (*For Registered & Certified SUD Counselors)
Description: Healthcare professionals follow a code of ethics that identifies expected behavioral norms, rules, boundaries, standards, and shared ethical principles. A code of conduct for substance use providers offers guidance on how to handle tricky situations and appropriately support patients from across the continuum of substance use prevention, treatment and beyond. This training will introduce those standards and principles of ethics, boundaries, confidentiality, and professionalism important for substance use disorder providers. The training will offer attendees examples of ethical decision-making models as well as practice in utilizing appropriate steps to mitigate breaches of patient rights and confidentiality.

2. California Institute for Behavioral Health Solutions (CIBHS)

CIBHS is contracted to provide training and technical assistance services that encompass a wide range of activities designed to educate and instruct recipients in improving existing treatment, service delivery, and prevention/education methodologies in the field of substance use disorders (SUD). These services include support in developing SUD treatment approaches and implementing administrative systems that align with the standards and procedures established by the County, as well as efforts to adhere to Culturally and Linguistically Appropriate Services (CLAS) standards.

By incorporating CLAS efforts, CIBHS ensures that the services provided are respectful of and responsive to the cultural and linguistic needs of diverse populations, promoting equitable access and quality care for all individuals.

a. Title: ADA Fundamentals and Service Animals
   Description: This session was developed to help substance use disorder providers learn about the concepts, guidelines, and requirements of the ADA and to think about inclusive solutions for serving patients with disabilities at their agencies. The training will also review the ADA essentials for service animals in healthcare settings.

b. Title: Serving the Deaf and Hard of Hearing Community: Improving Access and Quality of Services
   Description: This training reviewed common misconceptions about deaf and hard-of-hearing persons , provided an overview of deaf culture and effective communication strategies, and provided resources and strategies to improve accessibility and services for deaf and hard-of-hearing patients.

   The session included training from The Greater Los Angeles Agency for Deafness (GLAD) and suggestions and considerations for improving access by a SUD provider who provides services to the deaf community.

c. Title: Designing Welcoming Spaces for ADA Accessibility
   Description: Providing spaces that are accessible to individuals with disabilities is key to serving patients effectively. This in-person session provided the tools to identify barriers and update the space for improved access. It also provided suggestions for simple and low-cost updates that can make the environment more inclusive and accessible and address specific scenarios and design questions from providers.

d. Title: Best Practices in Providing Affirmative and Culturally Responsive Care to Trans Patients
   Description: This training provided guidance on appropriate language and terminology to use when working with trans patients, best practices for training staff, suggestions of items and activities that make an environment more inviting, and consideration for when one should enroll a trans person at your agency or refer out to another provider. This training featured SAPC SUD providers who have a wealth of experience serving the transgender community.

e. Title: Discussion Series: Best Practices in Providing Affirmative and Culturally Responsive Care to Trans Patients
   Description: An expert panel reviewed the milestones of treatment for a trans patient. During the series, the panel reviewed best practices for initiating care, sustaining treatment, and preparing for success after treatment. The sessions were interactive and experiential and provided

the opportunity to practice skill-building around the assessment and treatment of trans people that builds trust and reduces stigma.

f. Title: Strategies for Strengthening Equity in Behavioral Health
Description: The trainer shared four of her allegories on "race" and racism to illuminate four key messages:
   - Racism exists
   - Racism is a system
   - Racism saps the strength of the whole society
   - We can act to dismantle racism

g. Title: Designing and Implementing Inclusive DEI Initiatives
Description: Keeping people engaged and sustaining the work of DEI committees long-term is one of the most difficult things to do when starting DEI initiatives. There are key elements that can make efforts more successful. Effective diversity, equity and inclusion (DEI) efforts require a community-planned and driven process to ensure those most impacted have a voice in the process and system improvement. This webinar focuses on how to develop an engaged DEI planning process that includes both internal and external stakeholder involvement and how to measure success. Successful DEI strategies and action steps including outreach, training, development of committees, and assessment tools will be shared.

III. Workforce Augmentation Through Hiring Efforts

In addition to the 11 workforce development programs mentioned above and consistent with the CLAS standards, LACDMH builds its culturally and linguistically competent workforce by filling job vacancies across a variety of positions. During FY 22-23, the LACDMH Human Resources Bureau (HRB) hired an impressive number of new employees across all departmental staff functions inclusive of administrative, clerical support, and clinical positions.

A total of 1,054 new employees were hired by LACDMH during FY 22-23. Table 1 below presents a summary of workforce hiring accomplishments by function.

Table 1: Summary of LACDMH New Hires by Staff Function, FY 22-23

Staff function count	Number hired
Administrative	91
Clerical/Support	352
Clinical	437
Clinical Support	154
Psychiatrist	20
GRAND TOTAL	1,054

Table 2: Specific Listing of LACDMH Positions Hired, FY 22-23

Item	Classification Title
0578	ACCOUNTING CLERK II
0646	ACCOUNTANT I
0647	ACCOUNTANT II
0648	ACCOUNTANT III
0656	ACCOUNTING OFFICER I
0642	ACCOUNTING TECHNICIAN I
0643	ACCOUNTING TECHNICIAN II
0657	ACCOUNTING OFFICER II
1059	ADMINISTRATIVE DEPUTY III(UC)
1002	ADMINISTRATIVE SERVICES MANAGER I
1004	ADMINISTRATIVE SERVICES MANAGER III
0888	ADMINISTRATIVE ASSISTANT II
0889	ADMINISTRATIVE ASSISTANT III
0887	ADMINISTRATIVE ASSISTANT
2521	APPLICATION DEVELOPMENT II
8705	ASSISTANT BEHAVIORAL SCIENTIST
1488	ASSISTANT DIVISION CHIEF, PUBLIC GUARDIAN, MENTAL HEALTH
5276	ASSISTANT COUNSELOR
4595	ASSISTANT STAFF ANALYST, HEALTH SERVICES
4713	CHIEF PEER SERVICES MENTAL HEALTH
5513	CLINICAL PHARMACIST
8695	CLINICAL PSYCHOLOGIST I
8694	CLINICAL PSYCHOLOGIST INTERN
5064	CLINICAL DRIVER
8697	CLINICAL PSYCHOLOGIST II
8103	COMMUNITY HEALTH WORKER
1496	DEPUTY PUBLIC GUARDIAN
1885	DEPARTMENTAL HUMAN RESOURCES MANAGER III
4701	DIRECTOR, MENTAL HEALTH
1495	DEPUTY PUBLIC GUARDIAN TRAINER
2612	DEPARTMENTAL INFORMATION SECURITY OFFICER II
1907	DEPARTMENTAL EMPLOYEE RELATIONS
4108	DEPARTMENTAL FACILITY PLANNER I
1842	DEPARTMENTAL PERSONAL ASSISTANT
4707	DEPUTY DIRECTOR, MENTAL HEALTH URGENT CARE

Item	Classification Title
4625	DEPUTY MANAGEMNET PROGRAM HEALTH SERVICES
4733	EXECUTIVE ASSISTANT, MENTAL HEALTH
2123	EXECUTIVE SECRETARY IV
0749	FINANCIAL SPECIALIST III
0752	FISCAL OFFICER I
4411	GIOGRAPHIC INFORMATION TECHNICIAN II
0672	HEALTH CARE FINANCIAL ANALYST
1417	HEALTH INFORMATION TECHNICIAN
4727	HEALTH PROGRAM ANALYST I
4729	HEALTH PROGRAM ANALYST II
4731	HEALTH PROGRAM ANALYST III
2574	INFORMATION TECHNICIAN MANAGER III
2569	INFORMATION TECHNICIAN SPECIALIST I
2598	INFORMATION TECHNICIAN SUPERVISOR
2590	INFORMATION SYSTEMS ANALYST I
2591	INFORMATION SYSTEMS ANALYST II
2584	INFORMATION TECHNICAL AID
1138	INTERMEDIATE CLERK
2221	INTERMEDIATE SUPERVISING TYPIST
2214	INTERMEDIATE TYPIST CLERK
2545	IT TECHNICAL SUPPORT ANALYST I
2548	IT TECHNICAL SUPPORT ANALYST SUPERVISOR
6022	LIGHT VEHICLE DRIVER
5104	LICENSED VOCATIONAL NURSE I
0904	MANAGEMENT ASSISTANT
9002	MEDICAL CASE WORKER II
9001	MEDICAL CASE WORKER I
9030	MENTAL HEALTH CLINICIAN II
1848	MANAGEMENT ANALYST
2109	MANAGEMENT SECRETARY III
9029	MENTAL HEALTH CLINICIAN I
9038	MENTAL HEALTH CLINICAL SUPERVISOR
5278	MENTAL HEALTH COUNSELOR, REGISTERED NURSE
4740	MENTAL HEALTH PROGRAM MANAGER I
4741	MENTAL HEALTH PROGRAM MANAGER II
4742	MENTAL HEALTH PROGRAM MANAGER III
4738	MENTAL HEALTH PROGRAM MANAGER IV
4735	MENTAL HEALTH PSYCHIATRIST

Item	Classification Title
0998	MANAGEMENT FELLOW
2559	NETWORK SYSTEM ADMINISTRATOR II
5121	NURSE PRACTITIONER
5856	OCCUPATIONAL THERAPIST I
9193	PATIENT FINANCIAL WORKER
9192	PATIENT RESOURCE WORKER
1331	PAYROLL CLERK I
5504	PHARMACY TECHNICIAN
5408	PHYSICIAN, POSTGRADUATE (1ST YEAR)
5411	PHYSICIAN, POSTGRADUATE (YEARS 2-7)
2344	PROCUREMENT ASSISTANT I
2346	PROCUREMENT ASSISTANT II
2343	PROCUREMENT AID
4629	PROGRAM IMPLEMENTATION MANAGER
9035	PSYCHIATRIC SOCIAL WORKER II
9034	PSYCHIATRIC SOCIAL WORKER I
8161	PSYCHIATRIC TECHNICIAN I
8162	PSYCHIATRIC TECHNICIAN II
8163	PSYCHIATRIC TECHNICIAN III
5872	RECREATIONAL THERAPIST II
4736	RELIEF MENTAL HEALTH PSYCHIATRIST
8973	RESEARCH ANALYST III, BEHAVIORAL SCIENCE
5133	REGISTERED NURSE I
3033	SAFETY ASSISTANT
2095	SECRETARY II
2096	SECRETARY III
1140	SENIOR CLERK
8106	SUPERVISING COMMUNITY HEALTH WORKER
0853	SPECIAL SERVICES ASSISTANT IV
5339	SUPERVISING STAFF NURSE II
4737	SUPERVISING MENTAL HEALTH PSYCHIATRIST
9194	SUPERVISING PATIENT FINANCIAL I
0666	SENIOR ACOUNTING SYSTEM TECHNOLOGY
2525	SENIOR APPLICATION DEVELOPER
8105	SENIOR COMMUNITY HEALTH WORKER
1497	SENIOR DEPUTY PUBLIC GUARDIAN
4706	SENIOR DEPUTY DIRECTOR MENTAL HEALTH, UC
1908	SENIOR DEPARTMENTAL EMPLOYEE RELATIONS REPRESENTATIVE

Item	Classification Title
1843	SENIOR DEPARTMENTAL PERSONNEL
2593	SENIOR INFORMATION SYSTEM ANALYST
2585	SENIOR INFORMATION TECHNOLOGY AID
2102	SENIOR SECRETARY III
9207	SENIOR DEPUTY COUNTY COUNSEL
5280	SENIOR MENTAL HEALTH COUNSELOR, REGISTERED NURSE
2216	SENIOR TYPIST CLERK
4593	STAFF ANALYST, HEALTH
0907	STAFF ASSISTANT I
0913	STAFF ASSISTANT II
8243	STUDENT PROFESSIONAL WORKER I
5884	SUBSTANCE ABUSE COUNSELOR
1499	SUPERVISING DEPUTY PUBLIC GUARDIAN
8712	SUPERVISING PSYCHOLOGIST
1865	TRAINING COORDINATOR MENTAL HEALTH
8265	VETERAN INTERN OUTREACH
2331	WAREHOUSE WORKER I

Furthermore, the HRB was responsible for recruiting and hiring staff who were proficient in the languages most commonly spoken by the Los Angeles County communities. The Exams Unit ensured that job descriptions for relevant positions included language proficiency as a requirement, where needed. The unit identified the specific language skills required for roles that involved significant interaction with Limited English Proficient (LEP) consumers and family members. This included not only frontline employees who would interact directly with the public but also translators, interpreters, and other language specialists.

One key area of emphasis was the recruitment of candidates with American Sign Language (ASL) proficiency across all classifications. During FY 22-23, the HRB focused on ASL recruitment as part of standard examinations and emergency appointment recruitment efforts. This concerted effort would result in the identification of viable candidates in various classifications such as Mental Health Promoter, Psychiatric Social Worker I, Psychiatric Technician I, Administrative Services Manager I, Community Health Worker, Health Care Financial Analyst, Assistant Staff Analyst, HS Mental Health Program Manager II, and Senior Staff Analyst.

IV. Workforce Enhancements Involving Mental Health and Substance Use Lived and Shared Experience

A. Los Angeles County Department of Mental Health

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:

United Mental Health Promoters (UMHP) Program

The UMHP Program played a crucial role in workforce development within the Department. Since the program's expansion, there has been increased interest in paraprofessional and clinical jobs. 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.

By the end of FY 22-23, the Promotores/UMHP Program had 134 Promoters, including both part-time and full-time Promoters/CHWs. They represent 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. Continuous recruitment efforts have resulted in the following languages being represented within the Promotores de Salud. Among them are Amharic, Arabic, Chinese, English, Khmer, Korean, and Spanish.

The program has contributed to the expansion of the cultural and linguistic workforce, with 33 part-time CHWs being promoted to full-time county employees, including 21 Spanish-speaking, 6 Black/African American Heritage, 3 Korean, 1 Arabic, 1 Cambodian, and 1 Native American. Additionally, two part-time Korean Promoters have been promoted to full-time employees in mental health clinics, and three Spanish-speaking Promoters have been promoted to full-time county employees in the LACDMH Emergency Outreach and Triage Bureau.

Program activities take place across the eight Service Areas and center around stigma reduction, community-based mental health education, and enhancing mental health service accessibility. In January 2023, the program partnered with the Los Angeles County Department of Economic Opportunity to recruit for open positions at American's Job Centers of California. The program also joined forces with the Workforce Education and Resource Center Inc. (WE-RC) to assist in recruiting in the Antelope Valley region of Los Angeles County, an area of high need. Internally, the Promotores/UMHP program continued to collaborate with LACDMH's Speakers Bureau and actively responded to requests received for participation in health and mental health resource fairs and presentations within the scope of the promoters' expertise and language capabilities. For example, mental health and stigma; general mental health education; emotional wellbeing and stress; mental health resources; immigration, adaptation and resilience; grief and loss; bullying prevention; and common mental health conditions, among others. The promoters also provide a well-recognized logistical support at various culture-specific departmental events implemented for the community at large across all Service Areas.

The breakdown by service area and language is provided in Table 3 below.

Table 3. Promoters by Service Area and Language, FY 22-23

Service Area	Amharic	Arabic	Chinese	English	Khmer	Korean	Spanish	Total
1				1			11	12
2							10	10
3			3	4		3	13	23
4	1			1		4	12	18
5							1	1
6				9			16	25
7				1		1	16	18
8		1		3	2	1	20	27
Total	**1**	**1**	**3**	**19**	**2**	**9**	**99**	**134**

The objectives for the upcoming year are to formalize a partnership with the Los Angeles County Libraries and expand our services to the older adult population. The Program are identifying several high-need libraries countywide where we need to increase our services to unhoused community members. Furthermore, Promotores/UMHP Program plans on broadening the scope of workshop topics to include a focus on older adults, thereby fostering collaborations with senior centers and other community facilities catering to this demographic.

B. Department of Public Health Substance Abuse Prevention and Control

As a department, Public Health continues to sit in countywide spaces such as those led by the County Anti-Racism, Diversity, and Inclusion Initiative and the Center for Health Equity to collaborate with other agencies to reduce inequities and close the gaps while improving health for all.

SAPC, as a Bureau within Public Health that contracts out 100% of its prevention, harm reduction, treatment, and recovery services to community-based organizations, is committed to supporting its provider network's capacity to develop its workforce and increase diversity, equity, and inclusion around recruitment, retention, and professional growth within the substance use disorder treatment workforce.

This includes the following efforts:

Workforce Connect Campaign

SAPC designed, developed, and launched an outreach campaign raising awareness about workforce opportunities in the substance use disorder treatment field specifically for SUD counselors and Licensed Practitioners of

the Healing Arts (clinicians) in Los Angeles County. The campaign highlighted the unique opportunities offered in these fields by emphasizing the fulfilling nature of the work in helping individuals in need of support and treatment. The campaign targeted neighborhoods where the need was the greatest (SPA 1 due to the Opioid Crisis) as well as educational institutions for clinicians and SUD counselors driving people toward the MakeADifferenceLA.org website, where more information on how to become an SUD counselor and organizations that might be seeking workforce.

Campaign Purpose:

- informed the people about the increasing need of SUD counselors and clinicians in LA County and drive them to the website to learn more about these positions and their requirements.
- Effectively reached the most qualified candidates.
- Used a list of current educational institutions to reach people who were getting their certification or degree.
- Messaged to both English and Spanish speaking audiences through media outreach.

Campaign Strategies:

1. **Digital media**
    - Google search captured users who were seeking information about these jobs.
    - Facebook provided significant scale to reach a broader audience in an engaged environment.
    - YouTube, the largest video sharing platform, reached users with video in a highly captivated environment.
    - Programmatic display banners and pre-roll video utilized data to efficiently reach the different audiences across the web.
    - Ads within the NASW-CA Newsletter reached subscribers in a trusted environment.
    - Streaming audio and companion banners on Pandora combined sight and sound in reaching job seekers and complemented outdoor.
2. **Out -of Home Media Ads**
    - 25 Outdoor Posters/Billboard units geo-targeted around the SUD training program locations and across the Antelope Valley
    - 10 bus tails ran on the Antelope Valley Transit Authority busses for 4 to recruit in SPA 1.
3. **Social Media Ads**
    - Messaging ran on Facebook and Instagram
    - Posts efficiently targeted the different audiences in both English and Spanish across mobile, desktop, and tablet devices.

Campaign Outcomes:

The campaign successfully reached the target population with 29,684,590 total impressions (which is the total number of times the ads were shown or displayed throughout LA County). This includes 1.17 million times the video was viewed in

entirety, 15,566 clicks that led a viewer to the website from digital ads, and an additional 8.7 million impressions from ads that remained visible in billboards and in social media that were not removed after the timeframe of exposure expired. The campaign and served as a launching platform for the launch of the Tuition Incentive Program (TIP) initiative to financially support those interested in becoming an SUD clinician or counselor.

Tuition Incentive Program

The Tuition Incentive Program (TIP) is an initiative that helps individuals interested in becoming substance use disorder (SUD) Counselors obtain certification in efforts to expand the workforce with certified-eligible counselors and enhance the provision of quality services. TIP addresses the need for a rapid expansion of the workforce, particularly within the SUD space, by recruiting, training, and developing new SUD counselors to add to the workforce by paying for registration and education costs of becoming a registered counselor. Annually, TIP enrolls and registers around 120 students and is currently in the fourth year.

The War on Drugs (WoD) disproportionately burdened and continues to affect poor, Black, LatinX, justice involved and/or people who use drugs in specific areas of Los Angeles County. The characteristics of patients1 in the DPH-SAPC Network is 64.4% male, 55.8% LatinX, and 71.2% between the ages of 26-54. The demographic make-up of counselors can hinder treatment effectiveness if it is consistently not similar to the patients who receive services (Knudsen et al., 2009). Most counselors in SUD settings across the US are White, female and middle-aged.

TIP engages participants that reside in areas of Los Angeles County hardest hit by WoD, that have lived experience with SUD- either directly and/or experienced through family and/or friends, and are representative of communities being served including Black, LatinX, and LGBTQIA+.

Components of TIP are no-cost to the participant and include:

- Enrollment in Tarzana Treatment Centers College's SUD Counselor Certificate Program, a hybrid style six-month learning experience that consists of virtual classes, supportive learning, and fieldwork experience to ensure field practicum requirements and 255 internship hours are met
- SUD Counselor Registration fee and pre-requisite 9-hour course with one of the three Certifying Organizations (CCAPP, CADTP, CAADE)
- Tuition and materials for the duration of coursework
- Connection to internship (field experience) / employment opportunities within LA County's publicly funded SUD Treatment Network
- Learning Support and resources to support program completion
- Includes resume writing, interviewing skills, time management, conflict resolution, etc.

The eligibility requirements for TIP include:

- Not be currently or previously registered with a Certifying Organization

- Be 18 years or older
- Have a High School Diploma or General Education Development (GED) equivalent or higher degree and show proof of diploma, GED, or degree
- Reside in Los Angeles County
- Possess a valid government issued identification card
- Identify as having lived experience with SUD

AB 2473 approval

Los Angeles County sponsored SUD legislation drafted by SAPC, AB-2473 Chaptered September 2022, related to registered and certified substance use disorder counselors minimum training. AB 2473 increases the minimum training standards for registered and certified counselors working within an alcoholism or drug abuse recovery and treatment program. AB 2743 requires DHCS to implement 12-core competency training requirements, equal to 80 hours, by December 31, 2025. The 12-core competency include:

1. Knowledge of the current Diagnostic and Statistical Manual of Mental Disorders
2. Knowledge of the American Society of Addiction Medicine (ASAM) criteria and continuum of ASAM levels of care, or other similar criteria and standards as approved by the department
3. Cultural competence, including for people with disabilities, and its implication for treatment
4. Case management
5. Utilization of electronic health records systems
6. Knowledge of medications for addiction treatment
7. Clinical documentation
8. Knowledge of cooccurring substance use and mental health conditions
9. Confidentiality
10. Knowledge of relevant law and ethics
11. Understanding and practicing professional boundaries
12. Delivery of services in the behavioral health delivery system

Through AB 2473, individuals who complete the enhanced training requirements will acquire core foundational competencies and advanced awareness of modern SUD treatment approaches to treat clients with substance use disorders, complex traumas, and co-occurring conditions in culturally competent ways. AB 2473 will ensure that SUD counselors entering the SUD field will have a strong foundation to support the behavioral health needs of patients, families, their loved ones, and communities across California.

Payment Reform: Workforce Capacity Building and Incentives

With the continued transformation under the California Advancing and Innovating Medi-Cal (CalAIM) Initiative and the movement towards value-based care under payment reform. To ensure a more strategic and effective transition to CalAIM payment reform, SAPC developed a comprehensive capacity building and incentive efforts that supports providers in transitioning from predominantly cost-based

practices to fee-for-service system, and which incentivizes adaptation to new organizational practices, uses of data in decision-making, and prioritizes service delivery and volume.

Workforce development is one of the three pillars of the Payment Reform Capacity Building and Incentive initiative and supports providers in building and sustaining a robust workforce capable of serving an increasingly more complex SUD population, including populations that historically been marginalized. SAPC offers training and technical assistance in developing long-term workforce sustainability planning and reimbursement for providers that support education costs and/or provide paid time off for their registered SUD counselors to attend classes toward certification. Similar to TIP, this effort helps to ensure individuals with limited resources, people with lived experience and those from historically marginalized communities are able to achieve their professional goals and ensure more representation within SUD treatment facilities.

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.

A. LACDMH Anti-Racism, Inclusion, Solidarity, and Empowerment (ARISE) Staff Advisory Council (SAC), previously known as ARDI SAC

As an advisory body to the Department, the ARISE SAC, reports directly to the LACDMH director. The mission of the ARDI SAC is "to build an intra-departmental community of LACDMH employees who are connected through a shared commitment to advancing racial equity and shaping LACDMH as an organization grounded in principles of anti-racism, diversity, and inclusion." LACDMH continued to meet with a community consultant who specialized in guiding and supporting the work of the council.

The ARISE 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 ARISE 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 ARISE 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 acknowledgment 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 ARISE SAC.
    b. Create a safe work environment to discuss racial issues and concerns.
    c. Strengthen the department's Human Resources system.

3. Increase hiring, supervision, and professional advancement.
    a. Recruit Black clinicians and staff in LACDMH and support their advancement.
    b. Support the equitable advancement of People of Color staff.

4. Expand the service delivery system's capacity to provide anti-racist, culturally congruent and responsive services.
    a. Establish a BIPOC Treatment Task Force.
    b. Develop outreach and education campaigns and expand the health promoters program targeting Black consumers and communities.
    c. Expand outreach and education campaigns and culturally congruent and responsive practitioners and practices.

5. Leverage partnerships and collaborations across Los Angeles County, City Departments and Community Stakeholders.
    a. Improve the County Policy on Equity (CPOE) system.
    b. Strengthen multi-stakeholder community collaboration.
    c. Improve the crisis response system.
    d. Improve collaborative practices with the Department of Children and Family Services.
    e. Increase the number of facilities to co-locate physical health and mental health services.
    f. Use digital technology to expand access to mental health services.
    g. Partner with school districts to improve student mental health outcomes.
6. Build strong commitment, accountability, and responsiveness of Executive Management and everyone in leadership roles.
    a. Executive Management commitment to anti-racism.

Working collaboratively with Countywide CEO ARDI, LACDMH's Executive Director, Dr. Lisa Wong, and LACDMH ARISE Division, a democratic voting process was instituted to select a new name for the Council. Based on a majority of votes, DMH's formerly known ARDI SAC's name has changed to ARISE SAC, and it continues

advising LACDMH executive management on best practices that address systemic racism while creating a sustainable and equitable workplace for employees.

ARISE SAC Membership Demographics

Membership was expanded again this year to 15 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/a 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 continues to seek to identify, reflect, and represent all the needs and identities within the workforce.

LACDMH programs represented by the ARISE SAC membership:

- LACDMH Headquarters
- Human Resources Compliance
- Forensics Administration
- Service Area 1 (SA1) Administration
- East San Gabriel Valley Mental Health Center (SA3)
- 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)
- Human Resources Transformation Team
  Outpatient Care Services (Countywide)

Accomplishments

- Membership expansion to 15 members
- Supported implementation of “Transformational Leadership Training” to expanded management and 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.
- Collaboratively provided recommendations for tangible next steps that create options to sustain and institutionalize values and lessons from the “Transformational Leadership Training”
- Monthly meetings with Executive Management to continue working on building an inclusive and equitable work environment
- Presentations at LACDMH Townhalls regarding the ARISE SAC activities and accomplishments
- Participated in countywide Wellbeing Events to support empowerment, health and safety in the workplace

- 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
- Submitted various articles in the 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, Justice Care Opportunities Department (JCOD), ARDI CEO to expand partnerships
- Participated in CEO ARDI Equity Action Team (EAT) Culture and Climate Workgroup to improve workplace environments

B. 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 safe, welcoming and affirming environments 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 in order 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 particular 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 in order 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 SAC members.

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

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PREVENTION DIVISION
ANTI-RACISM, INCLUSION, SOLIDARITY AND EMPOWERMENT (ARISE) DIVISION
CULTURAL COMPETENCY UNIT

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC) BUREAU
STRATEGIC AND NETWORK DEVELOPMENT DIVISION
EQUITABLE ACCESS AND PROMOTIONS SECTION (EAPS)

CULTURAL COMPETENCE PLAN UPDATE – FY 22-23

CRITERION 7

Language Capacity

December 2024

Criterion 7: Language Capacity

A new feature of the 2024 Cultural Competence Plan report is the incorporation of content pertinent to Los Angeles County Department of Mental Health (LACDMH) and the Department of Public Health Bureau of Substance Abuse Prevention and Control (SAPC). CR 5 features information on the LACDMH Cultural Competence-related trainings labeled A. and SAPC's details labeled B.

LACDMH and SAPC strive 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 (LACDMH) and Contracted Providers (SAPC) 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

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TABLE 1: LOS ANGELES COUNTY MEDI-CAL BENEFICIARIES BY LANGUAGE, CY 2023

Language	Average (January-December)
Arabic	6,229
Armenian	91,924
Cambodian	8,607
Cantonese	43,403
English	2,638,861
Farsi	15,931
Korean	35,915
Mandarin	53,422
Other Chinese	2,080
Other Non-English	5,425
Russian	29,571
Spanish	1,451,889
Tagalog	10,066
Vietnamese	29,566
Total	4,422,889

Note: Medi-Cal data represents monthly data averages from January-December 2023. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility. Downloaded in April 2024.

Threshold language data is updated annually based on beneficiary primary language within Los Angeles County. Medi-Cal criteria for threshold language is 3,000 or five percent (5%) of Medi-Cal beneficiaries whichever is lower within a geographical area. Arabic is not a threshold language for the State but is a threshold language for LA County as there are more than 3,000 beneficiaries countywide who identify Arabic as their primary language.

This is a dataset for all of LA County and is not broken down by Service Area (SA). LACDMH has not received authorization to access beneficiary primary language by Service Area from the MEDS data file for years. Thus, LACDMH is pursuing Medi-Cal beneficiary data by zip code. This will allow the Department to determine threshold languages for each Service Area.

I. Efforts to Increase Bilingual Workforce Capacity

A. LACDMH

According to information provided by the LACDMH Human Resources Bureau (HRB), the Department has over 6,000 employees. Approximately 1,774 of them receive a bonus for speaking, reading, and/or writing in another language. These bilingual-certified employees work in Directly Operated Clinics, and Administrative programs.

The Department pays bilingual bonuses for employees working in Directly Operated (DO) and Administrative Programs who are certified in the following 27 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
- 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 in speaking, reading, and/or writing 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 competence in a language other than English is 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). LACDMH managers request the bilingual bonus listing 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 22-23:

- $58,000 for specialized foster care trainings
- $36,750 for juvenile justice trainings
- $39,910 for culturally specific trainings focusing on underserved populations
- $80,000 for interpreter trainings

A training example offered in FY 22-23 to increase the linguistic competence of staff is *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.

This training is designed to enhance cross-cultural knowledge and skills when working with communities that speak the specific language identified. The content focuses on expanding the vocabulary and understanding of key mental health terms, such as assessment, diagnosis, treatment, and crisis intervention, for clinicians and bilingual staff. 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 $350,000 per FY to implement culturally and linguistically competent projects, totaling $2,4500,000. 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 22-23, LACDMH had

a total of 134 Promotores/UMHP. Table 2 below presents their language expertise by Service Area.

TABLE 2: PROMOTORES/UMHP LANGUAGES BY SERVICE AREA, FY 22-23

Service Area	Amharic	Arabic	Chinese	English	Khmer	Korean	Spanish	Total by SA
1				1			11	12
2							10	10
3			3	4		3	13	23
4	1			1		4	12	18
5							1	1
6				9			16	25
7				1		1	16	18
8		1		3	2	1	20	27
Total by Language	**1**	**1**	**3**	**19**	**2**	**9**	**99**	**134**

The UMHP Program continued its recruitment efforts to hire multicultural Promoters who can address language gaps in LA County communities, specifically in Russian, Tagalog, and Vietnamese. Additionally, the program aims to increase the number of Promoters in languages with low representation.

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 22-23, the ARISE Division - Language Assistance Services Team processed requests for ASL, CART, language interpreters and translation services a follows:

- $208,217 for language interpreter services
- $5,687.69 translation services
- $24,797.50 CART
- $41,317.50 ASL

Additionally, at the departmental level, LAS-related expenditures for FY 22-23 included $288,669.56 for countywide translation services.

B. LAC SAPC

As referenced in other sections of this report, SAPC's SUD prevention, harm reduction, treatment, and recovery services are 100% contracted out to community-based and other organizations. SAPC's contracted providers are required to ensure there is an inherent respect for and inclusion of diverse cultural, ethnic, and linguistic

needs of the primary populations served in programming and operations. This includes but is not limited to:

- Ensure individuals who are LEP, or non-English-speaking receive access to language assistance services (see definition below) that do not significantly restrict, delay, or are of inferior quality at no cost to them when they request services.
- Provide appropriate accommodation in services and effective communication for individuals with disabilities, as necessary, to ensure equal opportunity to participate in or enjoy the benefits of treatment services.
- Provide "critical informing" written materials translated into the patients primary or preferred languages, when requested.
- Participate in community engagement and outreach activities.

SAPC is committed to ensuring its SUD workforce is representative of the rich diversity of the populations served and to ensure its members (i.e., patients or potential patients) have access to communication that allows them to actively participate in treatment services. Among its network of providers, there are 80 providers and 500 bilingual direct service staff offering services in non-English languages. Table 3 below outlines bilingual capacity based on SAPCs treatment provider network sites and practitioners.

TABLE 3: BILINGUAL CAPACILITIES OF SAPC's TREATMENT PROVIDER NETWORK FY 22-23

Language	Number of Provider Sites	Number of Bilingual Practitioners
American Sign Language	2	2
Arabic	2	11
Armenian	10	15
Cambodian	2	2
Cantonese	2	2
Farsi	11	17
Korean	7	9
Mandarin	2	5
Russian	5	6
Spanish	134	407
Tagalog	21	29
Vietnamese	6	5
Total	**206**	**510**

Culturally Competence Trainings

SAPC offers culturally competent trainings to ensure providers deliver equitable, inclusive, and effective care in substance use disorder (SUD) services. These

trainings address cultural humility, implicit bias, and effective communication strategies to meet the diverse needs of Los Angeles County's communities. By fostering understanding and respect for cultural differences, SAPC equips providers to build trust, improve service delivery, and support better health outcomes. These efforts align with SAPC's commitment to reducing disparities and advancing health equity in SUD prevention and treatment programs.

Language Assistance Services

SAPC's language assistance services are designed to ensure equitable access to substance use services for individuals with limited English proficiency (LEP) to remove language-related barriers, foster inclusivity, and improve SUD outcomes for Los Angeles County's diverse communities. These services include on-demand interpretation, document translation, and training for providers on best practices in working with interpreters and culturally diverse populations.

Language capacity plays a critical role in substance use services, enhancing communication and accessibility by:

- **Increased Awareness**: Effective communication in multiple languages helps raise awareness of substance use risks and available prevention resources within diverse communities.
- **Improved Access to Care**: Culturally appropriate language makes it easier for individuals from varied backgrounds to seek help and participate in prevention programs.
- **Building Trust**: Using respectful and culturally sensitive language fosters trust between prevention providers and the communities they serve, strengthening relationships and program effectiveness.
- **Stigma-free language:** Avoiding terms like "addict" or "abuser" and instead use phrases like "person with a substance use disorder" to reduce stigma and promote understanding.
- **Culturally appropriate language:** Tailoring messaging to specific cultural groups by considering idioms, values, and social norms to ensure effective communication.
- **Linguistic accessibility:** Providing information in multiple languages to reach individuals who may not be fluent in the dominant language.
- **Plain language:** Using clear and concise language that is easily understood by the target audience, regardless of their level of education or literacy.
- **Community engagement:** Involving community members in the development of prevention messages to ensure they resonate with local needs and cultural contexts.

II. Services to Persons Who Have Limited English Proficiency (LEP)

A. 2022 LACDMH

Table 4 below summarizes language assistance services coordinated by the ARISE Division, inclusive of the following:

- American Sign Language (ASL)
- Cambodian
- Korean
- Spanish
- Closed Captioning/CART Services
- Translation and translation review services, often in collaboration with the LACDMH Speakers Bureau

During FY 22-23, the ARISE Division- Language Assistance Services (LAS) Team 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. Furthermore, The LAS Team also coordinated language support for other types of events to facilitate community participation. Among them, trainings, focus groups, wellness resource fairs, "Take Action" events for May is Mental Health Awareness Month, and conferences.

TABLE 4: LANGUAGE ASSISTANCE FOR STAKEHOLDERS AND COMMUNITY MEETINGS AND EVENTS, FY 22-23

Name of Meeting/Event	Type of Language Assistance Provided	Frequency
1st Annual Parent and Caregiver Summit (SA-2)	Spanish	Annually
2022 Speakers Bureau Multicultural Community Conference	ASL, CART, Korean, and Spanish	Varies
5th Annual Armenian Genocide Event	Armenian	Annually
Americans with Disabilities Act Disability Etiquette Training	ASL	Varies
CalEQRO System Review – Opening Session	Korean	Varies
Child & Adolescent Needs and Strengths (CANS) Meeting	Spanish	Varies
Community Leadership Team (CLT) Ad Hoc Retreat	ASL, Korean, and Spanish	Varies
CLT Ad Hoc Teams Meeting	ASL, Korean, and Spanish	Varies
CLT and Mental Health Services Act (MHSA) Meeting	ASL, Khmer, Korean, and Spanish	Varies
Community Resiliency Model Training	Spanish	Varies
Cultural Competency Committee (CCC) Meeting	CART and Spanish	Monthly
CCC and Underserved Cultural Communities (UsCC) Leadership Meeting	Korean and Khmer	Monthly
Faith-Based Mental Health (FBAC) Conference	ASL, Korean, and Spanish	Varies
FBAC Meeting	Korean and Spanish	Monthly

Name of Meeting/Event	Type of Language Assistance Provided	Frequency
FBAC Board Meeting	Korean	Monthly
FBAC Executive Board Retreat	Korean	Varies
Fetal Alcohol Spectrum Disorder: Overview, Screening, Diagnosis and Interventions Training	ASL and CART	Varies
Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) Advisory Committee	Korean and Spanish	Varies
In Honor of Women's Contributions in Society: "Historical Moments: Women Telling Our Stories" – Community Event	ASL, CART, Korean, and Spanish	Varies
Innovation (INN) 2 Learning Session (All Service Areas)	Spanish	Varies
Integrated Core Practice Model Training	ASL	Varies
Koreatown Mental Health Center Ribbon Cutting Celebration	Korean	Varies
Learning Session for the INN 2 project	Spanish	Varies
May Mental Health Event	Spanish	Varies
Men's Mental Health Matters presentation	Spanish	Varies
Mental Health Commission – Executive Committee Meeting	ASL and Spanish	Monthly
Mental Health Commission – Full Commission Meeting	ASL, Korean, and Spanish	Monthly
Mental Health Peer Advisory Council Meeting	ASL, CART, and Spanish	Monthly
Mental Health Commission Retreat 2023	ASL, CART, Korean, and Spanish	Varies
Prevention and Early Intervention Learning Session	Spanish	Varies
Prevention is Hope / Suicide Prevention and Awareness	Spanish	Varies
Promoting Placement Stability Training and Engaging Fathers and Oher Adult Males Training	ASL	Varies
SA 3 Parent/Caregiver of Children Focus Group	Spanish	Varies
SA 4 PRC/Koreatown Mental Health Center Asian American Pacific Islander and Mental Health Awareness Celebration	Korean	Varies
Service Area Leadership Team (SALT) 4 - Heroes' event	Korean and Spanish	Varies
SALT 1 Meeting	Spanish	Monthly
SALT 2 Meeting	Spanish	Monthly
SALT 3 Meeting	Spanish	Monthly
SALT 4 Meeting	Korean and Spanish	Monthly
SALT 5 Meeting	Spanish	Monthly

Name of Meeting/Event	Type of Language Assistance Provided	Frequency
SALT 6 Meeting	Spanish	Monthly
SALT 7 Meeting	Spanish	Monthly
SALT 8 Meeting	Spanish	Monthly
SALT Co-Chair Meeting	Korean and Spanish	Monthly
San Gabriel Valley Maternal Mental Health Virtual Meeting (Topic: Parenting Skills)	Mandarin and Spanish	Varies
Stakeholder Ad Hoc Team Meeting	Korean	Varies
Staying Connected and Informed Town Hall Series	Spanish	Monthly
Take Action for Mental Health L.A. County Events Kickoff	ASL	Varies
UsCC – Access for All Meeting	ASL	Monthly
UsCC – API Meeting	Khmer and Korean	Monthly
UsCC – API Subcommittee Agenda Setting	Korean	Varies
UsCC – Latino Meeting	Spanish	Varies
Wonders of Wellbeing Resource Fair	Korean and Spanish	Varies

Data source: ARISE Division - Language Assistance Services Team

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B. LAC SAPC

In general, SAPC provides language assistance for individuals with Limited English Proficiency (LEP) as it relates to direct services to ensure equitable access to substance use disorder care. This is outlined further below, in section III. Provision of bilingual staff and/or interpreters for the threshold languages at all points of contact, and section IV. Document Translation. Table 5 below lists the programs and community meetings in which language services were provided in FY 22-23.

TABLE 5: LANGUAGE ASSISTANCE FOR PROGRAMS AND COMMUNITY MEETINGS, FY 22-23

Name of Programs and Community Meetings	Type of Language Assistance Provided	Frequency
Harm Reduction Community Meeting	ASL, Spanish	Varies
Southern California Drug Alcohol Program (SCDAP) Residential Treatment Services	ASL	Varies

III. Provision of Bilingual Staff and/or Interpreters for the Threshold Languages at All Points of Contact

A. LACDMH

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

TABLE 6: CALLS RECEIVED BY THE LACDMH HELP LINE - ACCESS CENTER BY LANGUAGE, FY 22-23

Languages	Number of Calls
Arabic	15
Armenian	30
Cambodian	9
Cantonese	35
Farsi	34
Hmong	0
Korean	80
Mandarin	95
Other Chinese	0
Russian	36
Spanish	2673
Tagalog	3
Vietnamese	19
American Sign Language (ASL)	0
Other (Bengali)	3
Other (Burmese)	3
Other (Dari)	5
Other (French)	1
Other (Japanese)	3
Other (Nigerian Pidgin English)	1
Other (Pashto)	2
Other (Persian)	1
Other (Portuguese)	2
Other (Portuguese Brazilian)	1
Other (Thai)	2
Other (Tigrinya)	1
Other (Ukrainian)	6
Other (Urdu)	9
Total:	**3,069**

With the implementation of the ARISE Division in the fall of 2021, this function was re-organized under two teams: the Help Line's ACCESS Center and the ARISE Division-CCU. Based on this re-organization, the ARISE 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 7: SUMMARY OF APPOINTMENTS FOR ASL SERVICES FY 18-19 to FY 22-23

Fiscal Year (FY)	Number of Assigned Appointments
FY 18-19	983
FY 19-20	1,027
FY 20-21	629
FY 21-22	622
FY 22-23	707
TOTAL	3,968

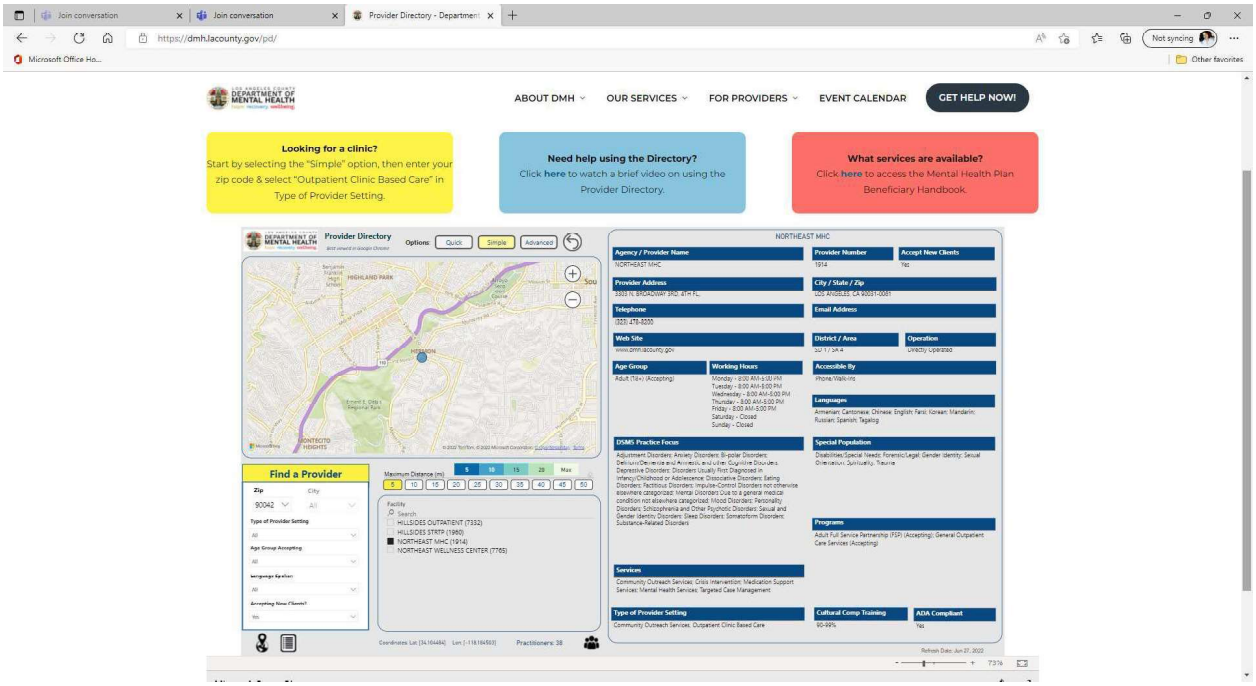
Data Source: DMH ARISE Division – Language Assistance Services Team. Note: Data includes only interpreter services requests assigned to ASL interpreters available to provide service on a given date.

Table 7 presents the number of assigned ASL interpreter services appointments for the five prior FYs. For FY 22-23, the ARISE Division –Language Assistance Services Team processed a total of 707 ASL requests, which was higher than the prior two FYs. The ARISE Division accomplished all steps required for LACDMH to hire its first Sign Language Specialist as a strategic workforce enhancement to assist the Department in maximizing the availability of an ASL expert for clinical ASL appointments.

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 the 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 a 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 accordance with the focus of the client contact and the staff providing the service. Simply translating for the client is not considered an intervention.
    - NOTE: In order to obtain and/or transmit linguistically accurate information from clients who do not speak English as a first language, the Department has translated some of its forms into other languages. Whenever non-English forms are used, the English translation version must be printed on the back of the form. If that is not possible, the English version must be placed immediately adjacent to the non-English version in the clinical record. The English version should note that the document was signed on the non-English version.

- Cultural and/or linguistic considerations
    - When special cultural and/or linguistic needs are present, there must be documentation in the 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 LACDMH P&P 200.05, the Department 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 the 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 the consumer to describe the reason(s) for seeking a change

B. LAC SAPC

The Substance Abuse Services Helpline (SASH)

This is the substance use 24/7 beneficiary helpline used as a resource and primary entry point for callers seeking information, screening, and referrals for substance use disorder treatment services. When requested, callers are referred to culturally and linguistically specific providers and services, within time and distance standards, where feasible.

SASH employs bilingual staff, mostly Spanish, and offers language assistance services in threshold and non-threshold languages as well as ASL interpreter services at the time of first contact. SASH tracks the number of calls received in non-English languages. Table 8 provides the data on the number of calls received by the SASH in which language interpretation services were provided.

TABLE 8: CALLS RECEIVED BY THE DPH SAPC SASH BY LANGUAGE, FY 22-23

SASH Language Assistance Service Utilization	
Languages	**Number of Calls Received**
Arabic	1
Armenian	10
Cambodian	0
Cantonese	0
Farsi	5
Hmong	0
Korean	14
Mandarin	8
Other Chinese	0
Russian	7
Spanish	833
Tagalog	1

SASH Language Assistance Service Utilization	
Languages	**Number of Calls Received**
Vietnamese	1
American Sign Language (ASL)	0
Azerbaijani	1
Thai	1
Hindi	1
Burmese	1

In addition to SASH language assistance services, SAPCs Equitable Access and Promotion Section offers support to its contracted providers in accessing ASL interpretation services for clinical appointments Monday through Friday, from 8:00 am to 5:00 pm. Table 9 below represents the total number of assigned ASL interpreter services appointments from FY 19-20 through FY 22-23.

In addition to offering ASL interpretation, SAPC contracts with an organization to provide specialized SUD residential and outpatient treatment services to Deaf and Hard of Hearing individuals. Between FY20-21 and FY 22-23, a total of nine (9) clients were provided served.

TABLE 9: SUMMARY OF APPOINTMENTS FOR ASL SERVICES FY 19-20 TO FY 22-23

Fiscal Year (FY)	Number of Assigned Appointments
FY 19-20	112
FY 20-21	26
FY 21-22	317
FY 22-23	96
TOTAL	551

Data Source: SAPC EAPS

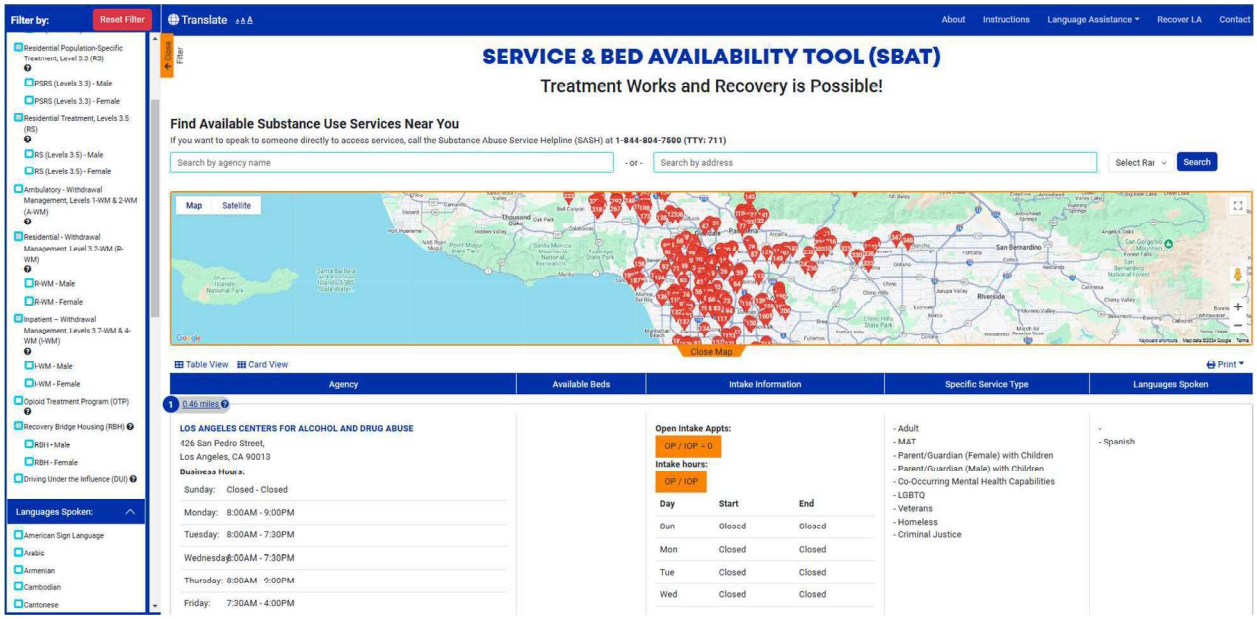
Service and Bed Availability Tool Provider Directory

Designed as a best-in-class provider directory, the Service and Bed Availability Tool (SBAT) makes the search for SUD treatment as easy as searching on Yelp©. The SBAT is SAPC's web-based, filterable provider directory of contracted specialty SUD treatment services, including Outpatient, Intensive Outpatient, various levels of Residential treatment and Withdrawal Management, OTPs, Recovery Bridge Housing (RBH), and Driving Under the Influence (DUI) programs.

The purpose of the SBAT is to simplify the process of identifying appropriate SUD providers by allowing users to refine and filter their search based on the level of care,

languages spoken, and by specialized populations, including youth, those with co-occurring mental health disorders, people experiencing homelessness, and LGBTQA, livered. Users can tailor their search according to their needs to identify intake, bed, and slot availability more quickly. They can refine their search by location to ensure geographic proximity, and each agency data includes contact information, business hours, ADA accessibility, availability for new cases and staff that have completed cultural competence training.

Since all SAPC points of entry will use the SBAT to identify which treatment agency and location to contract for services, network providers are required to update and verify beds/slots availability and intake appointments on a daily basis. 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 www.SUDHelpLA.org.



Language Assistance Services

SAPC ensures that appropriate language assistance services are available for individuals with Limited English Proficiency (LEP) and those requiring American Sign Language (ASL) interpretation seeking or accessing SUD services and resources from its network of contracted providers.

SAPC's Provider Manual for Substance Use Treatment Services and SAPC Bulletin 18-03 directs providers in ensuring they comply with federal and State. Below, is a sample of related content from SAPC's Provider Manual for Substance Use Treatment Services ***(see Criterion 7 Appendix, Attachment 6: SAPC Provider Manual for Substance Use Treatment Services, September 2022)***.To ensure tracking of services, providers must document the use of interpretation services and ensure accessibility across all communication platforms.

Language assistance services include interpretation via approved vendors and virtual options for convenience. In some instances, providers may request support from SAPC to offer individuals interpretation services when based on regular assessments of the network, obtaining interpreters is challenging, such as sign language interpretation for people who are Deaf. The Language Assistance Request Process includes procedures to request emergency and non-emergency sign language interpreter appointments. ***(See Criterion 7 Appendix, Attachment 7: SAPC* Language Assistance Request Process).**

Excerpt from *SAPC Provider Manual for Substance Use Treatment Services (2022), Culturally, Linguistically, and Population-Appropriate Service section page 111.*

Language Assistance Services
SAPC and its contracted providers shall ensure compliance with all requirements for ensuring access to language assistance services (e.g., oral interpretation, sign language, written translation, etc.) for beneficiaries who are monolingual non- English speaking or limited English proficiency (LEP) at no cost, this may include linguistically proficient staff and/or interpreter services.

When a beneficiary requests services in a non-English language, network providers shall (as outlined in SAPC Bulletin 18-03):

- *Input beneficiary self-reported preferred language for treatment services into the EHR-Sage and the relevant data fields in CalOMS.*
- *Use the Care Coordination benefit to refer beneficiaries for treatment in their preferred language if treatment services are not available by linguistically proficient staff.*
- *If a beneficiary refuses interpreter services, document in the chart that free interpreter services were offered and declined.*
- *Family members, friends, etc. are not used as interpreters, unless specifically requested by the beneficiary, and when restricted to intake and screening/assessment activities. Under no circumstances is a minor child used as an interpreter.*

Interpretation services shall be available during all hours the provider is open for business. In some limited circumstances, SAPC may provide assistance to its network provider agencies with identification of oral and sign language interpretation services, contact eapu@ph.lacounty.gov.

IV. Required Translated Documents

A. LACDMH

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 ARISE-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 the 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 ARISE-CCU is actively involved in the leadership and activities of the Speakers Bureau.

TABLE 10: SAMPLE LACDMH FORMS, BROCHURES, AND WEBPAGE RESOURCES TRANSLATED INTO VARIOUS LANGUAGES

Forms, Brochures and Webpage Resources	THRESHOLD AND 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
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	X	X	X	X	X			X	X	X	X	X		X	X

Forms, Brochures and Webpage Resources	THRESHOLD AND NON-THRESHOLD LANGUAGES														
	Arabic	Armenian	Cambodian/ Khmer	English	Farsi	Hindi	Japanese	Korean	Russian	Spanish	Simplified Chinese	Tagalog	Thai	Traditional Chinese	Vietnamese
Stimulation (TMS) Client Satisfaction Survey															
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					
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	

Forms, Brochures and Webpage Resources	THRESHOLD AND NON-THRESHOLD LANGUAGES														
	Arabic	Armenian	Cambodian/ Khmer	English	Farsi	Hindi	Japanese	Korean	Russian	Spanish	Simplified Chinese	Tagalog	Thai	Traditional Chinese	Vietnamese
* Your Wellbeing on Your Terms -Online COVID-19 resource				X						X					
* Maintaining Health and Stability during COVID-19 - Online resource		X						X		X				X	
* Alleviating Fear and Anxiety during Essential Trips in Public - Online COVID-19 resource		X						X		X				X	
* Coping with Stress during Infectious Disease Outbreaks - Online COVID-19 resource	X	X	X				X	X	X		X	X		X	X
* Staying Connected during Physical Distancing - Online COVID-19 resource	X	X	X	X			X	X	X		X	X		X	X
* Coping with the Loss of a Loved One - Online COVID-19 resource	X	X	X	X			X	X	X		X	X		X	X
* 988 FAQs				X						X					
* 988 Comparison Chart				X						X					
* School Based Community Access Point - Tips				X						X					
* Suicide Prevention Questionnaire				X X						X	X			X	
* 2023 Consumer Perception Survey Announcement Flyer	X	X	X	X	X			X	X	X	X	X		X	X
* Various Public Information Office Messaging															
* American Disabilities Act (ADA) Complaint Form					X					X					
* ADA Notice to Employees and Applicants - Spanish translation review					X					X					
* ADA Notices for Posting at Facilities - Spanish translation review					X					X					
* Where Do I Call for Help during a Crisis? poster		X		X	X			X		X	X			X	

Data Sources: Quality Assurance Division and ARISE Division - Cultural Competency Unit.
* Translation or translation reviews for accuracy and cultural meaning completed by LACDMH Speakers Bureau.

B. LAC SAPC

In accordance with Federal and State guidelines, SAPC supports the translation of SAPC-required critical informing documents into the threshold languages. SAPCs Information Notice 18-03: Requirements for Ensuring Culturally and Linguistically Appropriate Services outlines standards regarding language translation and interpreter services to ensure that under no circumstances is a beneficiary denied access to substance use disorder services due to language barriers and that language assistance services be provided at no cost to members.

In some instances when translation in a particular language or for auxiliary aids, SAPC will assist providers needing translation and interpretation services by completing the Language Assistance Request Form. The form is completed, signed, and submitted to EAPU for processing and tracking. ***(See Criterion 7 Appendix for Policies cited in this section and Attachment 8: Language Assistance Request Form)***

SAPC ensures the translation of prevention and community engagement materials. As an example, after four students overdosed due to pills contaminated by fentanyl, SAPC produced a series of materials to educate and warn Los Angeles County residents about the dangers of fentanyl. These materials were translated into the threshold languages to ensure access ***(See Criterion 7 Appendix Attachment 9 for sample Fentanyl in Los Angeles County- Spanish)***.

Documents are translated using vetted vendors. All vendors are provided SAPCs nomenclature document with definitions of SUD-specific terminology to be used in contextualizing written materials, and it require that all documents be back-translated by a different vendor to ensure accuracy.

TABLE 11: SAMPLE SAPC FORMS, BROCHURES, AND WEBPAGE RESOURCES TRANSLATED INTO VARIOUS LANGUAGES

Forms, Brochures and Webpage Resources	THRESHOLD LANGUAGES											
	Arabic	Armenian	Cambodian/ Khmer	English	Farsi	Korean	Russian	Spanish	Simplified Chinese	Tagalog	Traditional Chinese	Vietnamese
SUD Treatment Brochures	X	X	X	X	X	X	X	X	X	X	X	X
Member Handbook	X	X	X	X	X	X	X	X	X	X	X	X
Member Orientation Video	X	X	X	X	X	X	X	X	X	X	X	X
Non-Discrimination Notice	X	X	X	X	X	X	X	X	X	X	X	X
Beneficiary Notification Letter	X	X	X	X	X	X	X	X	X	X	X	X
Confidentiality and Consent	X	X	X	X	X	X	X	X	X	X	X	X
Complaint or Grievance Form	X	X	X	X	X	X	X	X	X	X	X	X
Appeal Form	X	X	X	X	X	X	X	X	X	X	X	X
Release of Information	X	X	X	X	X	X	X	X	X	X	X	X
Treatment Perception Survey Announcement Flyer								X				
Treatment Perception Survey	X	X	X	X	X	X	X	X	X	X	X	X
Community Opportunities for Recovery and Engagement (CORE) Center Connection Cards								X				
Client Engagement and Navigation Services (CENS) Flyer								X				
Overdose Prevention Kit: You Can Save a Life Brochure	X	X	X	X	X	X	X	X	X	X	X	X
Overdose Prevention Kit: Proceed with Caution	X	X	X	X	X	X	X	X	X	X	X	X

Forms, Brochures and Webpage Resources	THRESHOLD LANGUAGES											
	Arabic	Armenian	Cambodian/ Khmer	English	Farsi	Korean	Russian	Spanish	Simplified Chinese	Tagalog	Traditional Chinese	Vietnamese
Overdose Prevention Kit: Good Samaritan Card	X	X	X	X	X	X	X	X	X	X	X	X
Overdose Prevention Kit: Prescription	X	X	X	X	X	X	X	X	X	X	X	X
NOABD: Your Rights	X	X	X	X	X	X	X	X	X	X	X	X
NOABD: Non-Discrimination	X	X	X	X	X	X	X	X	X	X	X	X
NOABD: Termination	X	X	X	X	X	X	X	X	X	X	X	X
NOABD: Grievance Appeal Template	X	X	X	X	X	X	X	X	X	X	X	X
Grievance Form	X	X	X	X	X	X	X	X	X	X	X	X
Notice of Privacy Practices								X				
NOABD: Your Rights	X	X	X	X	X	X	X	X	X	X	X	X
Red Ribbon Banner								X				
Health Alert -Pills Contaminated with Fentanyl												
Fentanyl in LA County	X	X	X	X	X	X	X	X	X	X	X	X
Fentanyl Overdose FAQ	X	X	X	X	X	X	X	X	X	X	X	X
Fentanyl Parent Toolkit	X	X	X	X	X	X	X	X	X	X	X	X
Fentanyl Student Toolkit	X	X	X	X	X	X	X	X	X	X	X	
Fentanyl Teacher Toolkit	X	X	X	X	X	X	X	X	X	X	X	X

Criterion 7 Appendix

LACDMHs Attachments

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

REQUEST FOR INTERPRETATION

LAC SAPCs Attachments

Attachment 6: Provider Manual

SAPC Provider Manual 7.0_Sept 202

Attachment 7: Language Assistance Request Process

Language Assistance Request Process.docx

Attachment 8: Language Assistance Request Form

Language Interp Request Form-Blank_

Attachment 9: Fentanyl in Los Angeles County- Spanish

Fentanilo en el Condado de Los Ánge

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

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PREVENTION BUREAU
ANTI-RACISM, INCLUSION, SOLIDARITY AND EMPOWERMENT (ARISE) DIVISION
CULTURAL COMPETENCY UNIT

AND

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC) BUREAU
STRATEGIC AND NETWORK DEVELOPMENT DIVISION
EQUITABLE ACCESS AND PROMOTIONS SECTION (EAPS)

CULTURAL COMPETENCE PLAN UPDATE – FY 22-23

Criterion 8

Adaptation of Services

December 2024

Criterion 8: Adaptation of Services

A new feature of the 2024 Cultural Competence Plan report is the incorporation of content pertinent to the Los Angeles County Department of Mental Health (LACDMH) and the Department of Public Health Bureau of Substance Abuse Prevention and Control (SAPC). CR 8 has been organized in two parts: Part I contains information on the LACDMH adaptation of services, including customer-driving programs, quality of care: contracted programs, and quality improvement and quality assurance. Part II describes SAPC's quality of care: provider network and quality improvement activities.

Part I
Los Angeles County Department of Mental Health

I. Consumer-Driven/Operated Recovery and Wellbeing Programs

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:

Peer Run Centers (PRCs): LACDMH has five PRCs throughout the county. The PRCs are in Service Areas (SAs) 2, 3, 4, 6, and 7. At the PRCs, our Peers concentrate on forming "heart forward" connections with every visitor. The PRCs are not only a comfortable, safe, and non-judgmental environment for all who enter, but is also a place with intention. The Peer staff and volunteers use their lived experience to help make visitors feel welcomed, accepted, and supported. Every visitor will feel assured that they will leave with the appropriate community referrals they need while also developing a positive connection with LACDMH and the Peers at the Centers.

The Power of Peer Support
The Peer Resource Centers serve as beacons of opportunity for Peers to extend a warm and caring welcome to those seeking mental health information and resources. Through sharing the lived experience and first-hand knowledge of its Peer staff and volunteers, PRCs cultivate hope, recovery, and wellbeing in the surrounding community and throughout Los Angeles County. The PRC vision is "Heart Forward", and the mission is to ensure that "Everybody leaves with something."

Linkage to Services
*Staff and P*eer volunteers are available to offer linkage and warm handoffs to community organizations that can help address visitor needs. Visitors can be linked to resources such as:

- Mental health services
- Physical health services
- Food
- Clothing
- Hygiene facilities
- Transportation
- Temporary shelter

- Housing services
- Benefits establishment
- Legal services
- Education and job training
- Volunteer and employment opportunities
- Collaboration

Each PRC is dedicated to the community and demographic that it serves. PRC staff speak, read, and write in English, Spanish, and Korean to deliver services in the native language of its visitors. Other threshold languages are being explored to better match the linguistic needs of the neighborhood. PRC staff offer an open, welcoming, and safe environment for all community members. The PRCs are strategically located in each service area in close proximity to a LACDMH clinic. PRCs come with Wi-Fi, phones, and charging stations, available for public use. Resource information is available to the community in English, Spanish, Korean, and other key languages in Los Angeles County.

The PRC services are based on the commitment to find effective ways to engage the community. PRC efforts focus on minimizing barriers to service accessibility, particularly mental health stigma. The PRC's physical location, staff composition, outreach and engagement, peer connections, and in-person/online/hybrid groups are designed to encourage visitors to experience the services and resources without any commitment to services. Staff are skilled at building relations with visitors at a pace that is not intrusive and that is person-centered. This approach has encouraged many reluctant individuals to explore available services and has resulted in connecting individuals to actual services.

Some of the PRCs visitors are already connected with LACDMH mental health providers or other county entities. Visitors to the PRCs also utilize the PRCs as an option for Peer Support and to supplement the services they are receiving. Sometimes, individuals may come to the PRCs for advocacy regarding the services they are receiving. PRC staff work closely with service providers to ensure individuals are receiving services to best meet their needs and empower the visitors to advocate for themselves. The PRC staff consistently engage visitors to provide feedback regarding their experiences. PRCs encourage regular visitors to transition from utilizers to participants to advance to the role of peer supporters.

The PRC projects and staffing are based on the diversity in the County. Implemented in different SAs, each PRC addresses the diverse cultural needs of the community served and incorporates culture-specific elements in its operations and special activities. The unique populations served throughout LA County varies by SA and the cultural/linguistic needs of each community is highlighted by the regional cultural awareness events sponsored by the PRC. For example, the SA 2 PRC highlights events such as Cinco de Mayo, the SA 4 PRC highlights Korean commemorations, and the SA 7 PRC implements 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 events.

The PRCs' activities promote cultural awareness, have staff who are involved in Anti-Racism and Diversity committees, and 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 the elimination of disparities is an important pursuit. In the words of PRC staff:

- "We value connection.
- We engage those who walk into the PRC ensuring them that 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, our support, and any tools we have to 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 22-23

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

The Promotores de Salud Mental and the United Mental Health Promoters Program

The Promotores de Salud Mental and the United Mental Health Promoters (UMHP) Program aims to address the stigma associated with mental illness in underserved cultural and linguistic communities in Los Angeles County (LAC). The program's objectives include raising awareness about mental health issues, eliminating barriers, and improving access to culturally and linguistically appropriate care and resources. The Promotores de Salud Mental Program, initiated in 2010-11 within the Latino, Spanish-speaking community, served as the pilot program, while the United Mental Health Promoters Program represents its multicultural expansion, commencing in November 2020. These unified programs combine a community leadership/peer-to-peer approach with support, guidance, and training from DMH-licensed clinicians. Additionally, Senior and Supervising Community Health Workers, who previously served as Promotores and/or peer advocates, provide mentorship and share knowledge and lived experiences to further support Mental Health Promoters.

The Promotores, deeply committed to improving their communities, bring a unique set of skills and experiences to their roles. Many have firsthand experience with mental health conditions, either personally or as caregivers, giving them a deep understanding and empathy. When combined with training provided by licensed clinicians on recognizing signs and symptoms of mental health, they become effective in preventing and managing mental health disorders. Their deep community connections and culturally sensitive approach make them well-suited to support local residents in increasing mental health awareness.

The program's expansion has resulted in an increase in workshops countywide from 7,354 in FY 21-22 to 9,446 in FY 22-23. Correspondingly, workshop attendance rose from 64,097 to 88,657 (accounting for possible duplication, given that the same community member may attend multiple workshop presentations). Local hiring has led to increased trust among community members, resulting in their attendance at workshops covering a variety of topics. Additionally, the program has successfully expanded its partnerships with Korean media, leading to a notable increase in Korean language workshops from 160 to 518.

Figures 1 and 2 below demonstrate the number of workshops completed by the Promotores and UMHP by language and the number of community members they reach.

FIGURE 1: WORKSHOPS BY LANGUAGE

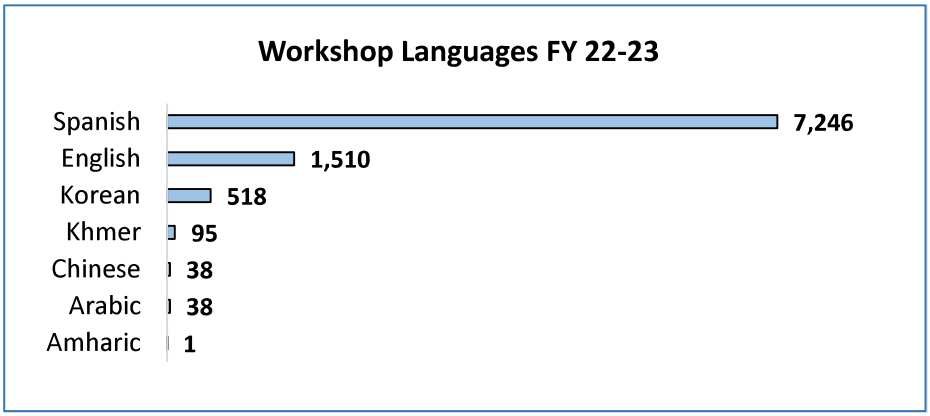
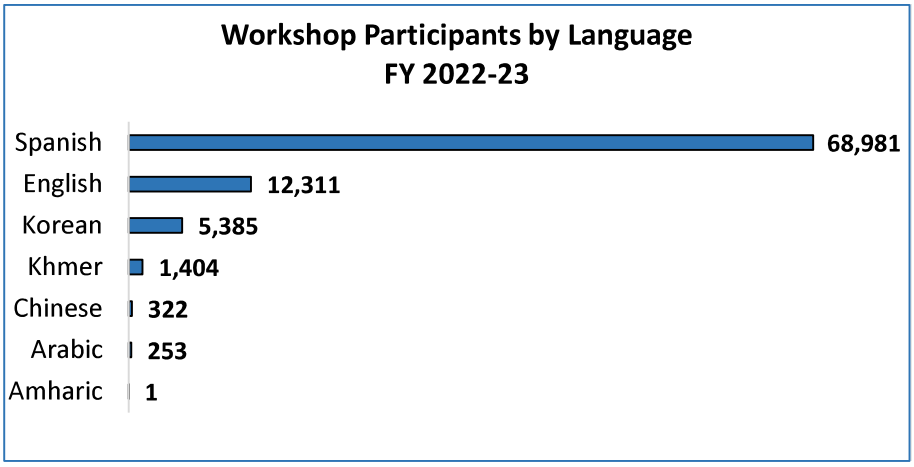


FIGURE 2: WORKSHOP PARTICIPANTS BY LANGUAGE



II. Responsiveness of Mental Health Services

LACDMH actively engages in culturally relevant outreach targeting underserved communities in order 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 to service delivery.

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 2023, 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 in radio and television in ten languages inclusive of Armenian, Cambodian, Cantonese, English, Farsi, Hindi, Korean, Mandarin, Russian and Spanish.

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.

TABLE 4: SAMPLE OF SPEAKERS BUREAU MAIN ACTIVITY TYPES CY 2023

Speakers Bureau Activity	# of Activities	Audience #
Clinical – Group	1	50
Consultation	131	13,773
Contact with an Assigned Organization	1	1
Information on Mental Health Resources	8	326
Interpreter Services	1	1
Material(s) development	45	247,254
Media Interview – Print	3	1,150,000
Media Interview – Radio	7	4,031,000
Media Interview – Television	6	1,794,702
Presentation/Training - Community Event Speaker	13	897
Presentation/Training - Conference/Seminar Keynote	2	330
Presentation/Training - Conference/Seminar Panelist	3	15,100
Presentation/Training - Conference/Seminar Workshop	5	374
Presentation/Training - Standalone Workshop	31	1,102
Translation Review (of departmental document translations)	22	11,647
Translation - Translated materials	2	13
Grand Total	**281**	**7,266,570**

Source: LACDMH ARISE Division, Language Assistance Services Team

TABLE 5: SB ACTIVITIES BY LANGUAGE
CY 2023

Language Used for Activity	# of Activities	Audience #
ASL	1	1
Armenian	2	1,502,000
English	127	16,081
Farsi	2	2
Korean	62	5,000,172
Korean and English	5	950
Mandarin	13	374,933
Russian	2	unreported
Spanish	14	116,508
Spanish and English	1	75
Grand Total	**229**	**7,010,722**

Source: LACDMH ARISE Division, Language Assistance Services Team

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TABLE 6: MOST FREQUENTLY REQUESTED CLINICAL AND NON-CLINICAL TOPICS, CY 2023

Black, Indigenous, and People of Color (BIPOC) Mental Health Issues
Care Court Program
Crisis Intervention, Safety Planning, and De-escalation
Holiday Blues
Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, Two Spirit (LGBTQIA2-S)
Mass Violence Incidents
Mental Health Navigation, Support, and Resources
Mental Health Career Path
Men's Mental Health
Social Media and its Impact on Mental Health
Stress Management
Teen Mental Health and Resources
Wellness
Women's Mental Health

Source: LACDMH ARISE Division, Language Assistance Services Team

Table Notes:

1. Topics are listed in alphabetical order, not by frequency of requests.
2. United Mental Health Promoters, in partnership with the Speakers Bureau, resourced most non-clinical and general topic requests.
3. Whenever applicable, the expertise of specialized LACDMH programs was sought out to fulfill some requests submitted to the Speakers Bureau.
4. Requests, including multiple topics are reported separately.

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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. The 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 with departmental 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 is entered and updated in the Network Adequacy Provider and Practitioner Administration application https://lacdmhnact.dynamics365portals.us/). Each practitioner species completed hours of cultural competence training.

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

   - 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 according to 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 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 the age of 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) Comorbidity (i.e. substance use & Mental Health)

- Domain 4
  - Medical History
  - Current Medications
  - Comorbidity (i.e., medical & Mental Health)

- Domain 5
  - Social and Life Circumstances

- Culture/Religion/Spirituality

- Domain 6
  - Strengths, Risk Behaviors & Safety Factors

- Domain 7
  - Clinical Summary & Recommendations
  - Diagnostic Impression
  - Medical Necessity Determination/Level of Care/Access Criteria

IV. Quality Improvement and Quality Assurance

A. 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.

CPS forms were developed for each age group. The Youth Services Survey (YSS) form is administered to consumers ages 13 to 17 years. The Youth Services Survey for Families (YSS-F) form is administered to families/caregivers of consumers aged 0 to 17 years. The Adult Mental Health Statistics Improvement Program (MHSIP) Consumer Survey form is administered to consumers aged 18 to 59 years. The Older Adult MHSIP Consumer Survey 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

During Spring 2023, CPS was utilized and administered to consumers served in outpatient programs over a period of five days in May. Compared to Spring 2022, more surveys were completed during the Spring 2023 survey period. A total of 12,180 surveys were returned for all age groups, and 9,545 were completed (78.4%). Figure 1 shows the percentages of completed surveys by age group. Most completed surveys were received by Adults, followed by Families, Youth, and Older Adults. Most surveys were completed in English or Spanish, and respondents indicated high satisfaction with language availability.

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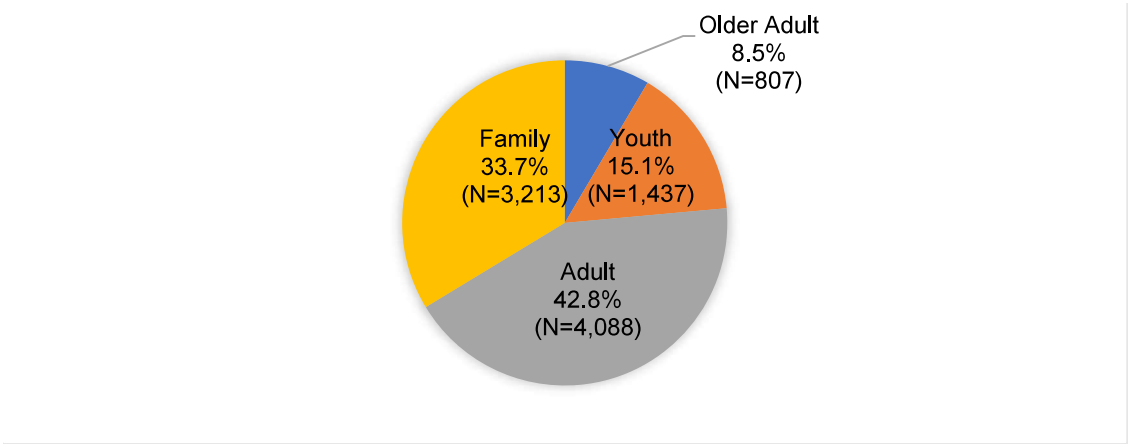
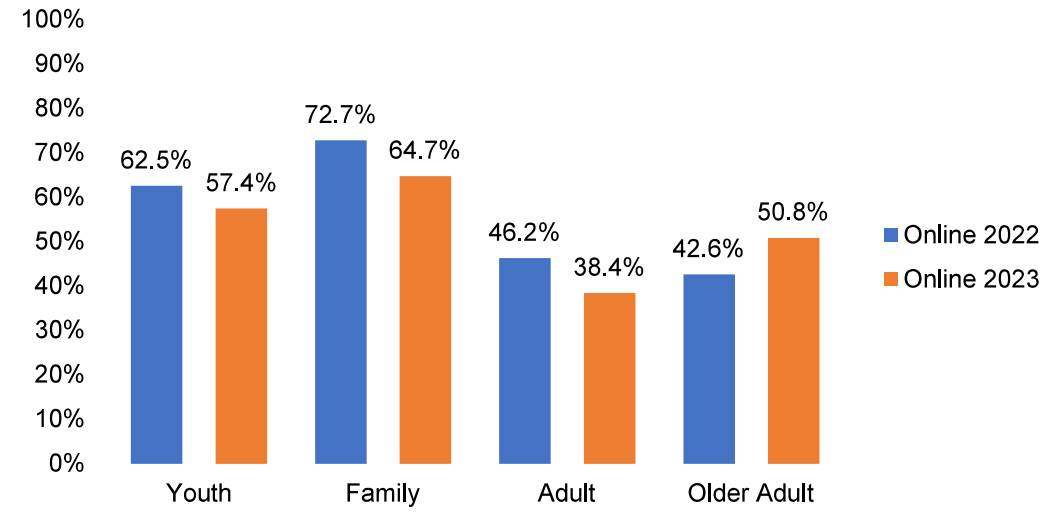
FIGURE 1: COMPLETED SURVEYS BY AGE GROUP



Data Source: Consumer Perception Survey data May 2023.

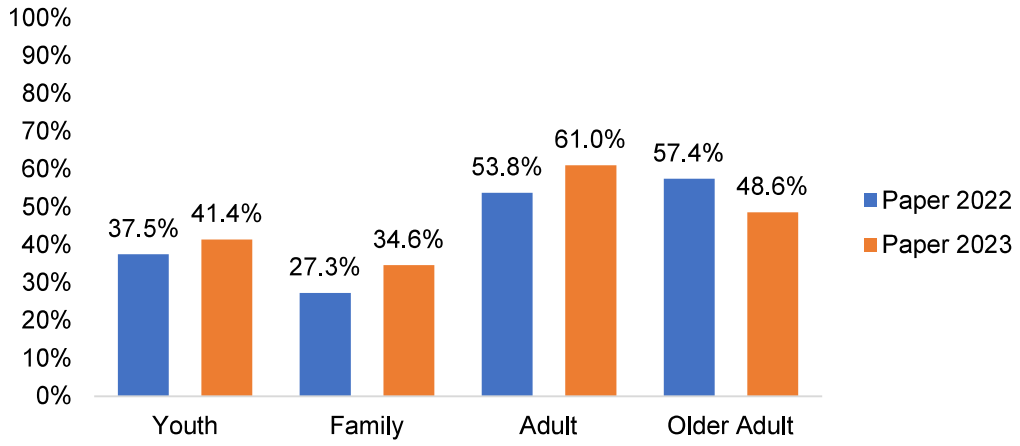
Surveys were available for consumers to complete using different formats. These formats included paper surveys and two online options using LACDMH electronic surveys and UCLA survey links. Figures 2 and 3 show the four age groups showed preferences for completing surveys in different formats. In 2023, use of the online format decreased for all age groups, except Older Adults which increased by 8.2 Percentage Points (PP) since 2022. Youth, Families, and Adults completed more paper surveys in 2023 (Figure 3).

FIGURE 2: COMPLETED SURVEYS BY FORMAT: ONLINE 2022 AND 2023



Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2022 Survey Period, February 2023. UCLA Consumer Perception Survey Los Angeles County Report May 2023 Survey Period, December 2023.

FIGURE 3. COMPLETED SURVEYS BY FORMAT, PAPER 2022 AND 2023



Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2022 Survey Period, February 2023. UCLA Consumer Perception Survey Los Angeles County Report May 2023 Survey Period, December 2023.

For Spring 2023, the percentage of individuals who reported being very satisfied remained high for several domains. Figure 4 summarizes the age group comparison of satisfaction by domain. Youth and Families had the highest scores for the Quality and Cultural Appropriateness domain, with 96.7% and 97.8% of respondents agreeing or strongly agreeing with the items in that domain. Families also had the highest scores in the Social Connectedness domain, the Access domain as well as the Improved Functioning domain. Older Adults had the highest scores in participation in the Treatment Planning domain and the General Satisfaction domain.

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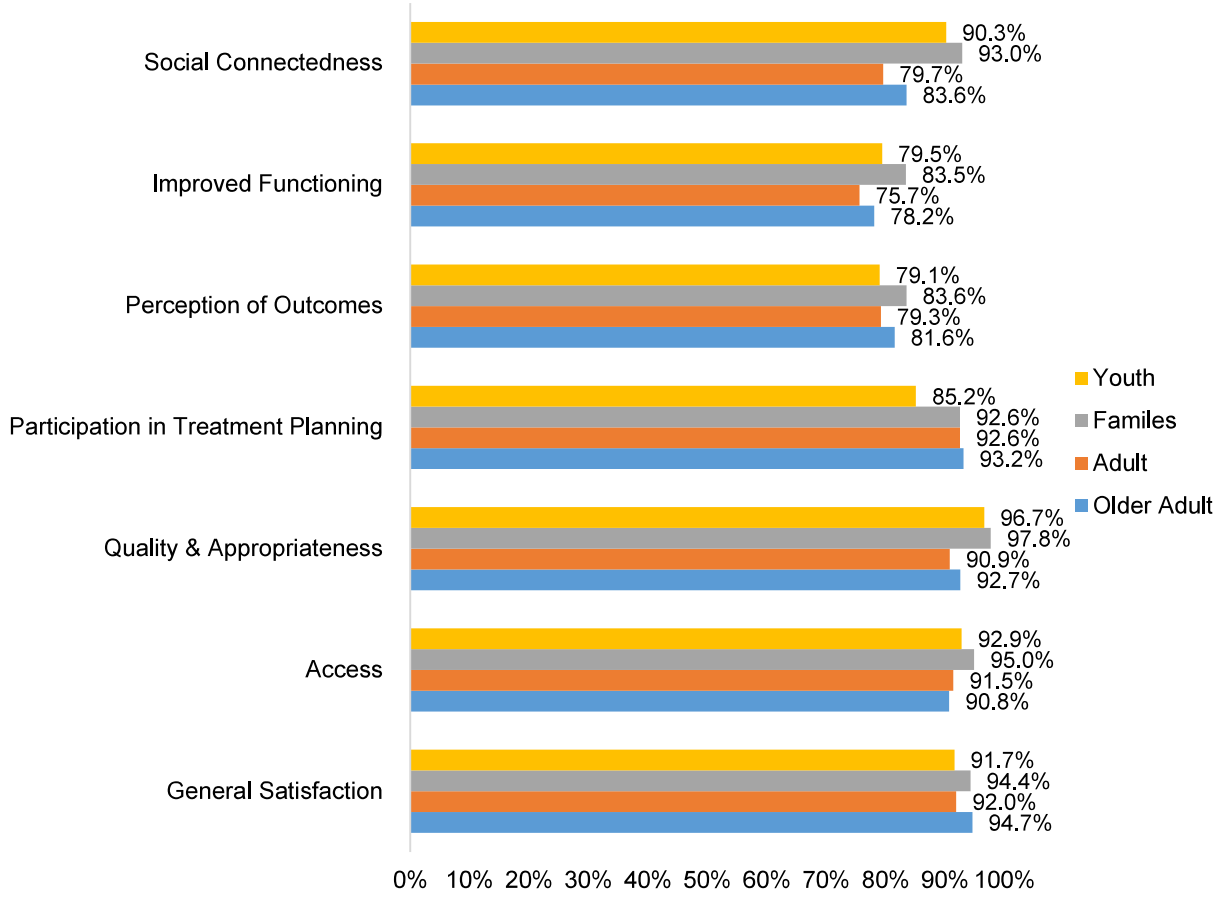
FIGURE 4: AGE GROUP COMPARISON OF SATISFACTION BY DOMAIN



Data Source: Consumer Perception Survey data May 2023.

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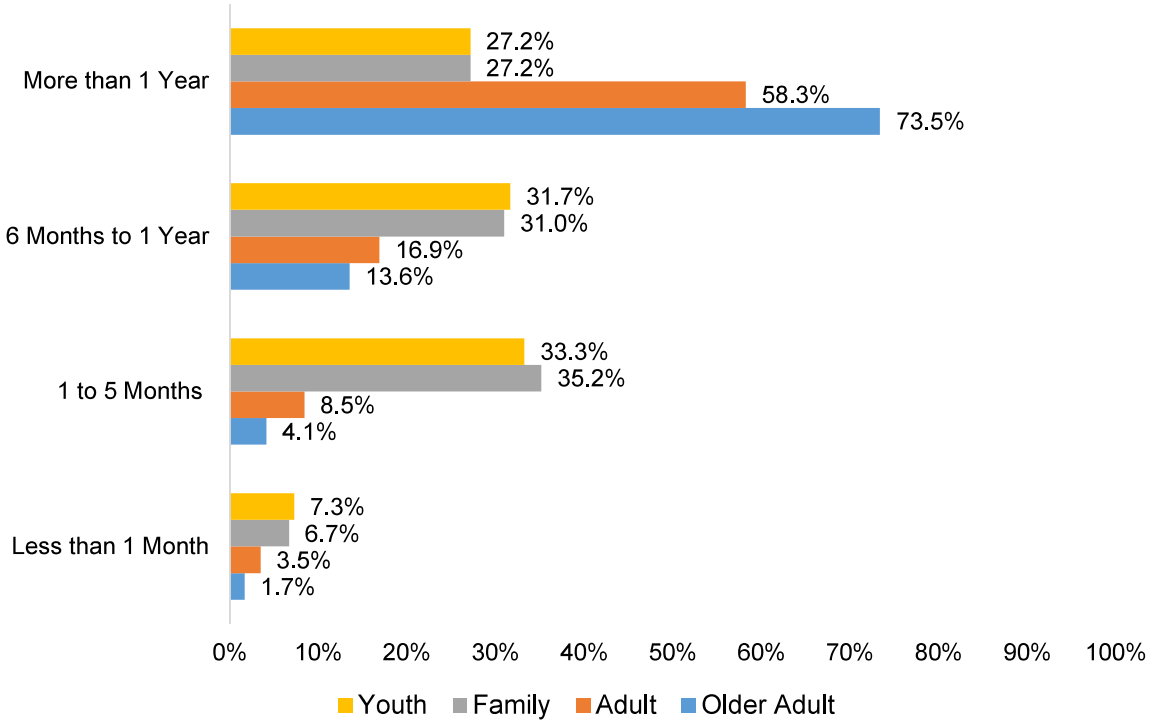
Figure 5 shows that most of the survey respondents had been in services for six months to over a year when they completed the survey. The majority of Older Adult and over half of Adult respondents had been in services over a year. Additionally, most Families and Youth had been in services between 1 month to 1 year at the time of the survey.

FIGURE 5: AGE GROUP COMPARISON OF LENGTH OF ENROLLMENT IN TREATMENT



Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2023 Survey Period, December 2023.

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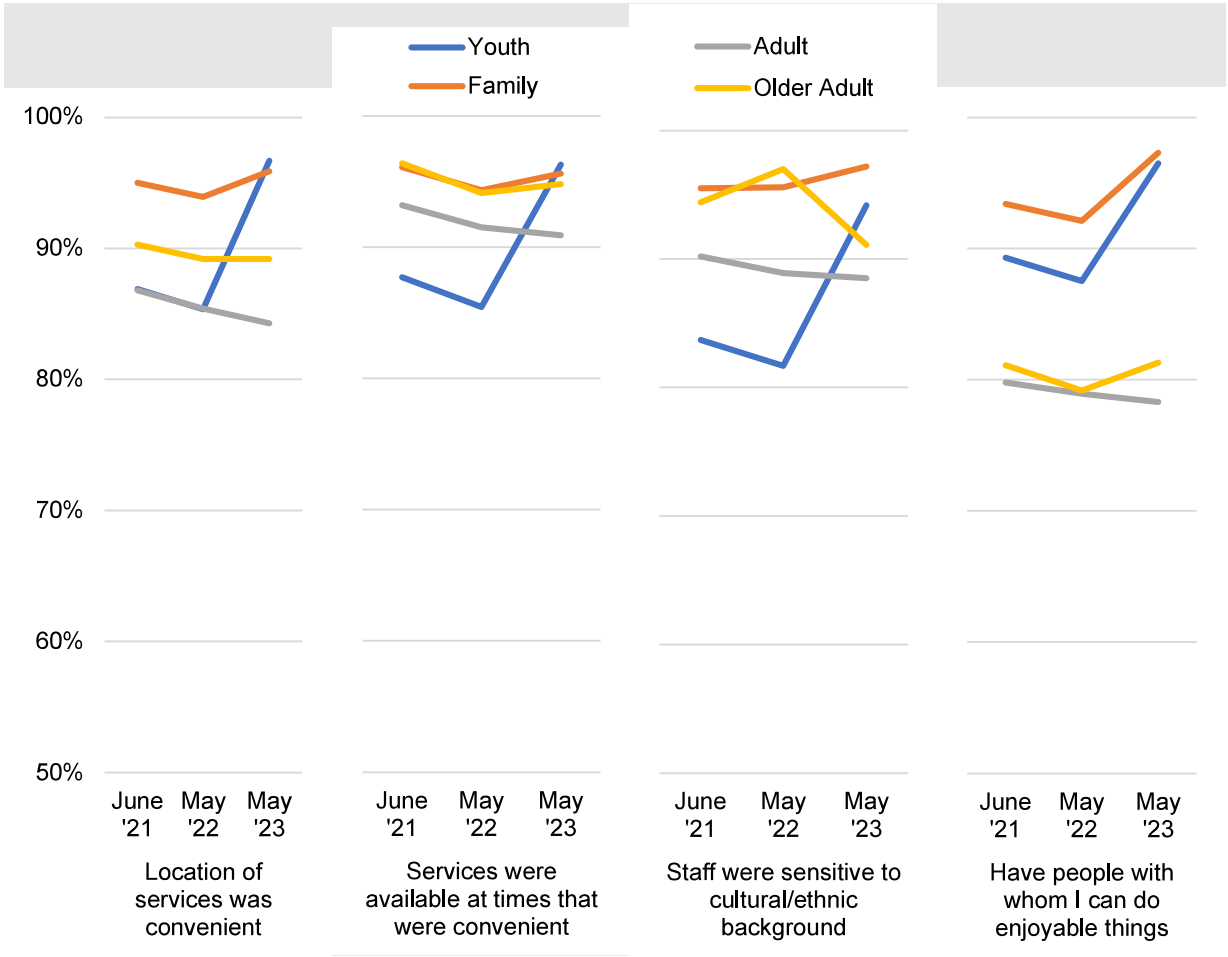
Figure 6 shows four of the CPS items common to the Youth, Families, Adult, and Older Adult surveys from June 2021 to May 2023. The percentages below reflect the number of respondents selecting either Agree or Strongly Agree for each item.

FIGURE 6. AGE GROUP COMPARISON OF ACCESS, CULTURAL SENSITIVITY, AND SOCIAL CONNECTEDNESS COMMON ITEMS ACROSS SURVEYS OVER TIME

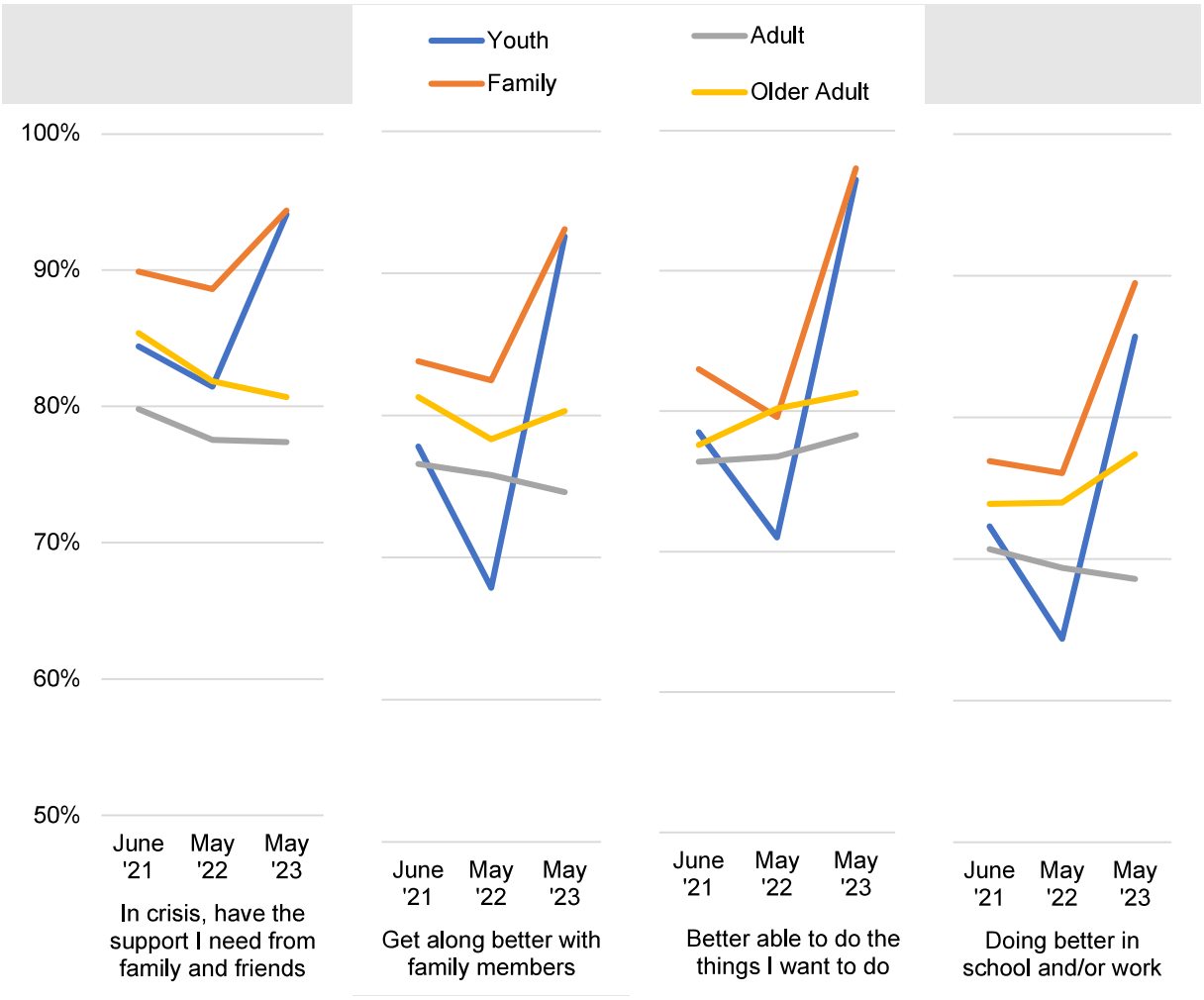


Data Source: Consumer Perception Survey data, June 2021, May 2022, and May 2023.

Families had the highest percentages on "Have people with whom I can do enjoyable things." Youth increased on all four items by nearly 10 Percentage Points (PP) from May 2022 to May 2023. Adults decreased on all four items over the last three survey periods. Older adults had the highest percentages on "Services were available at times that were convenient" and the lowest percentages on "Have people with whom I can do enjoyable things."

Figure 7 shows the other four CPS items common to the Youth, Families, Adult, and Older Adult surveys from June 2021, May 2022, and May 2023. The percentages below reflect the number of respondents selecting either Agree or Strongly Agree for each item.

FIGURE 7. AGE GROUP COMPARISON OF PERCEPTION OF OUTCOMES AND FUNCTIONING AND SOCIAL CONNECTEDNESS COMMON ITEMS ACROSS SURVEYS OVER TIME



Data Source: Consumer Perception Survey data, June 2021, May 2022, May 2023.

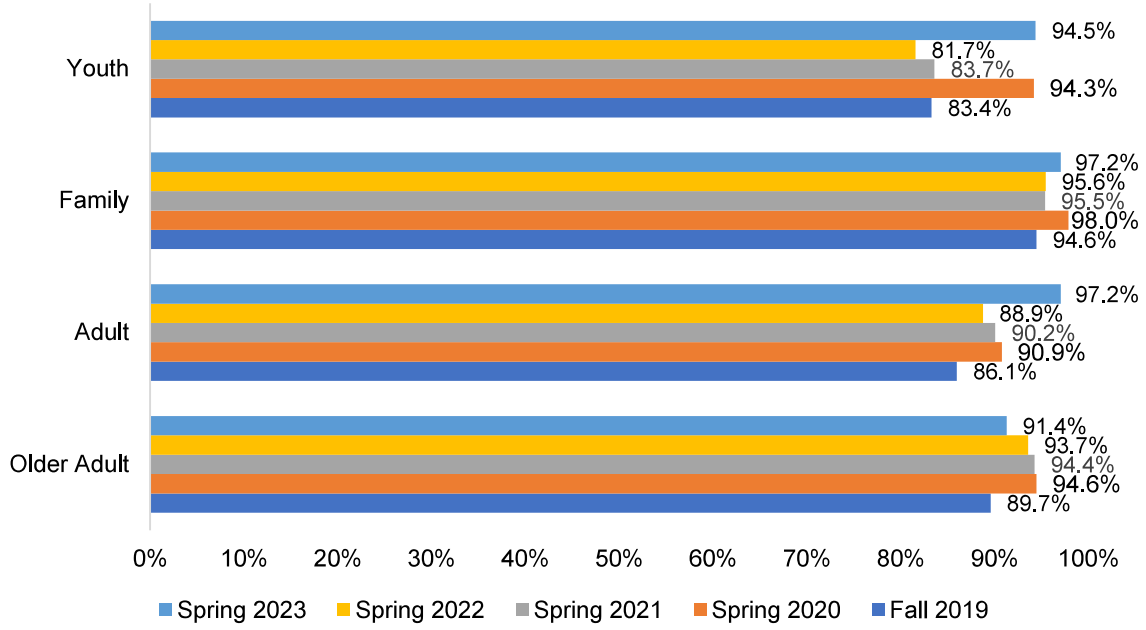
Youth and Families tended to have the highest percentages of agreement with the "In crisis, have support", "Getting along better with family members," "Being better able to do the things I want to do," and "Doing better in school or work items," in May 2023. From May 2022 to May 2023, Youth and Families percentages increased for all items. Family scores tend to be higher than those of Youth, Adults and Older Adults. Adult scores tend to be lower than the other three age groups over the last three survey periods. 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" in

May 2022 but displayed a large increase in 2023. Like the other common items in Figure 7, overall scores increased for most age groups from June 2021 to May 2023 except for Older Adults and Adults who decreased on "In crisis, have support," and Adults showed a decrease in "Doing better at school and work" and "Getting along better with family members."

Trends for the common items across all four survey versions fluctuated across the last three survey periods (June 2021, May 2022, and May 2023). Families tended to have the highest percentage of respondents that agreed or strongly agreed with common items for the last three survey periods. Youth and Families had decreased considerably for May 2022, yet had large increases for May 2023. The percentage of Older Adults was variable from June 2021 to May 2023. Adult scores tended to be lower for most items in June 2021 and continued to show an overall decrease in May 2023. Youth tended to have the lowest percentages in May 2022 on most items with a considerable increase in May 2023. 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.

Figure 8 summarizes the percentage of survey participants who endorsed agree or strongly agree to the item "Staff being sensitive to their cultural ethnic/background" across five CPS data collection periods, from Fall 2019 to Spring 2023. 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%. In Spring 2023, Families and Adults have the highest percentage at 97.2%.

FIGURE 8: TRENDING DATA – PERCENTAGE OF AGREE OR STRONGLY AGREE RESPONSES TO ITEM "STAFF WERE SENSITIVE TO MY CULTURAL BACKGROUND"

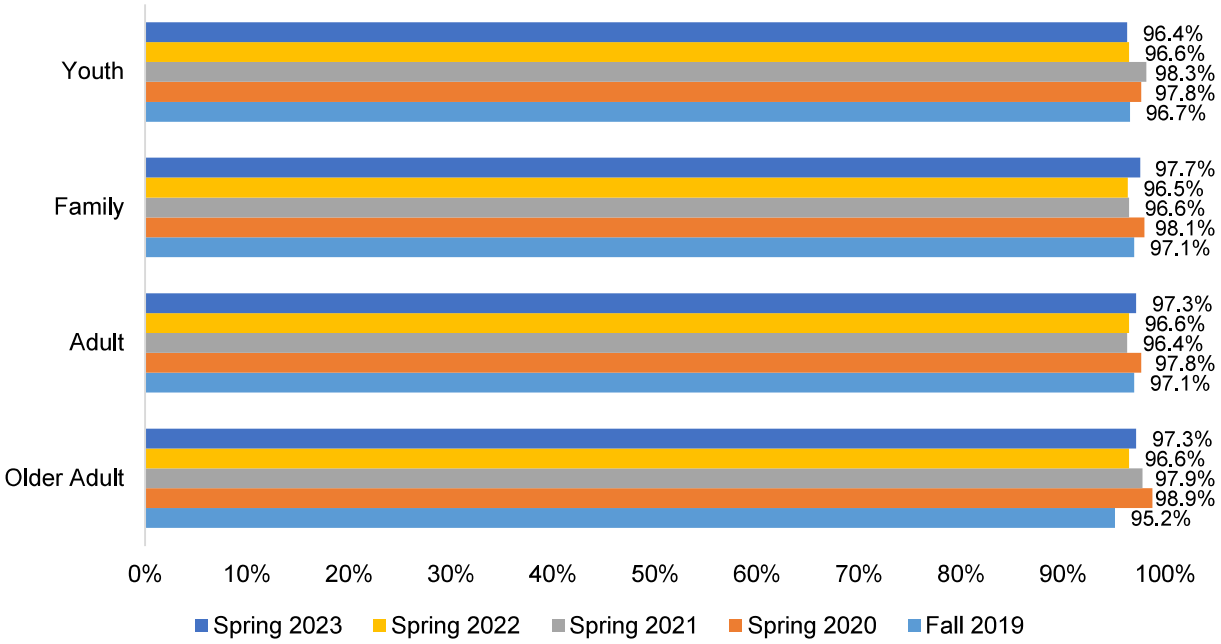


Data Source: Consumer Perception Survey data, Fall 2019, Spring 2020, Spring 2021, Spring 2022, and Spring 2023.

Survey participants also reported on whether services received were provided in a language of preference. The majority of survey participants endorsed "Yes" with Families, Adults, and Older Adults reporting the highest percentage with 99.1%, while Youth reported 91.4%.

Figure 9 summarizes the percentage of survey participants who endorsed agree or strongly agree ratings regarding the availability of written materials in their preferred language. Across the five CPS data collection periods, from Fall 2019 to Spring 2023, 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%.

FIGURE 9: PERCENTAGE OF AGREE OR STRONGLY AGREE RESPONSES TO ITEM "WRITTEN MATERIALS PROVIDED IN MY PREFERRED LANGUAGE"



Data Source: Consumer Perception Survey data, Fall 2019, Spring 2020, Spring 2021, Spring 2022, and Spring 2023.

B.=Open-Ended Comments Collection Survey

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 thematic analysis that parallels their CPS data collection. Thus, an Open-Ended Comments (OEC) Collection survey was developed to guide providers through evaluating the OEC comments received from consumers or caregiver who completed a CPS form(s) in

Spring 2023. CPS forms gathered open-ended comments from LACDMH's youth, families/caregivers, adult, and older adult consumers. A total of 136 OEC Collection surveys were submitted to the Quality Improvement Unit. Once analyzed, an Open-Ended Comments Summary Report was produced to include an overview of providers with completed OEC Collection surveys. Any identifying information of the participants was removed to maintain confidentiality. It is important to note that the organization of comments is subjective, and there may be variances among providers submitting the comments and QI staff reviewing the comments.

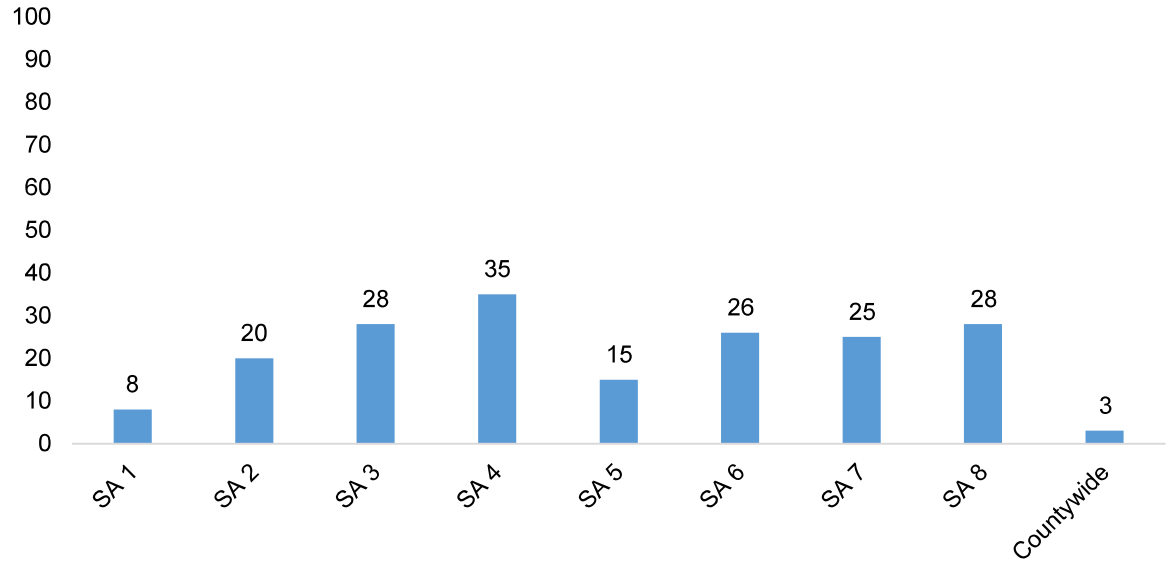
All completed OEC Collection surveys were submitted to the QI Unit through Microsoft Forms Survey software. The OEC Collection surveys were reviewed by internal QI staff and sorted into categories. The Surveys were made available in all LA County threshold languages and in three formats:

- The LACDMH Electronic version that could be emailed or texted to the client or completed in-person or over the telephone
- The UCLA electronic version that can be accessed by the client through a weblink or QR code
- A paper version of the survey

Providers could choose from the available formats and were allowed to choose multiple formats depending on their clients and program's needs.

Figure 10 represents SA participation. Many providers reported having locations in multiple Service Areas (SAs). Of note, SA 4 had the highest number of providers who completed the OEC Collection survey.

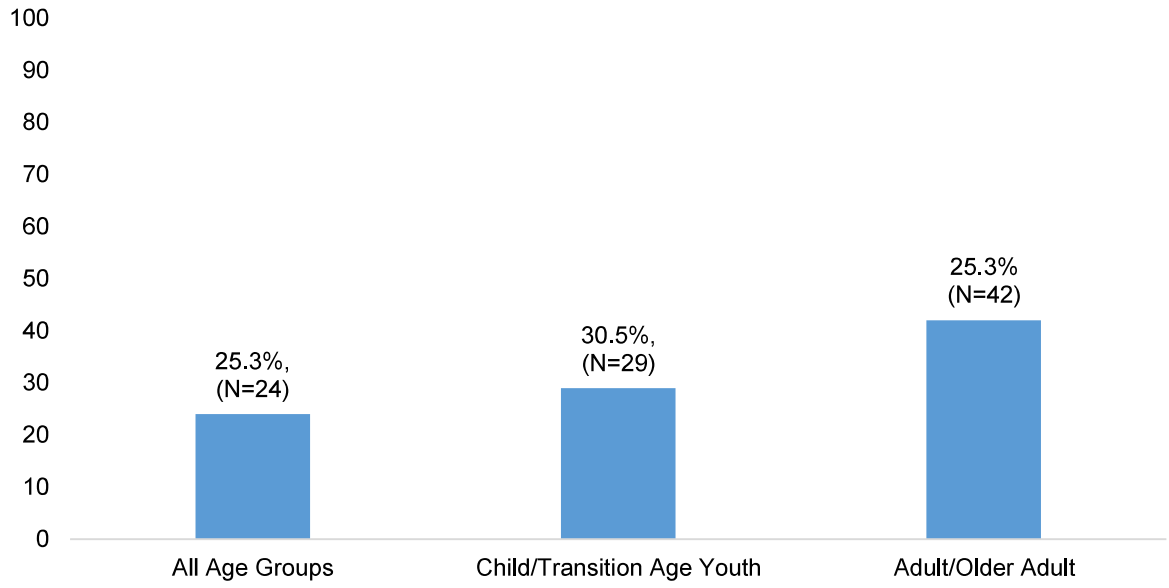
FIGURE 10: NUMBER OF PROVIDERS WITH COMPLETED OEC COLLECTION SURVEYS BY SERVICE AREA



Note: Countywide providers deliver services throughout the county, not just in one designated SA. Data source: Spring 2023 Consumer Perception Survey (CPS) Open-Ended Comments (OEC) Collection survey.

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 11 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.

FIGURE 11: NUMBER OF PROVIDERS WITH COMPLETED OEC SUMMARY COLLECTION SURVEYS BY AGE GROUPS SERVED

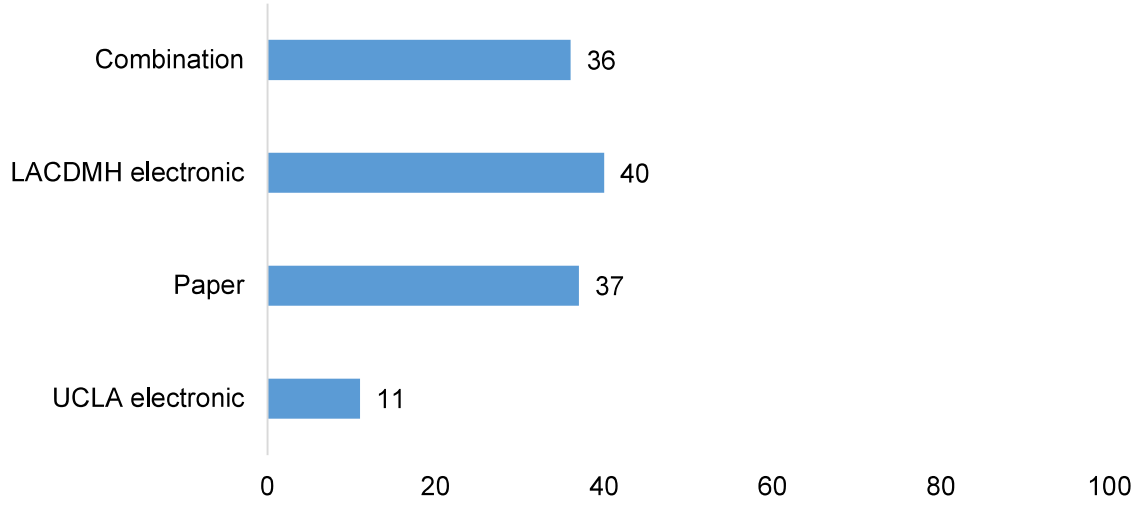


Data source: Spring 2023 CPS OEC Collection survey.

Most providers who completed the OEC Collection survey received comments (88.2%, N=120). Only 11.7% (N=16) reported not receiving comments. The number of comments reported by a single provider ranged from one to 230, with 2,981 comments reported.

In 2023, the CPS survey format most used by providers who participated in the OEC Feedback Analysis survey was the LACDMH electronic version while the UCLA electronic version was the least utilized format (Figure 12). Less than half of providers who completed the OEC Collection survey reported using an electronic version (41.2%, N=56). Some providers utilized both paper and electronic methods (26.5%, N=36) and 31.6% (N=43) utilized the paper method only.

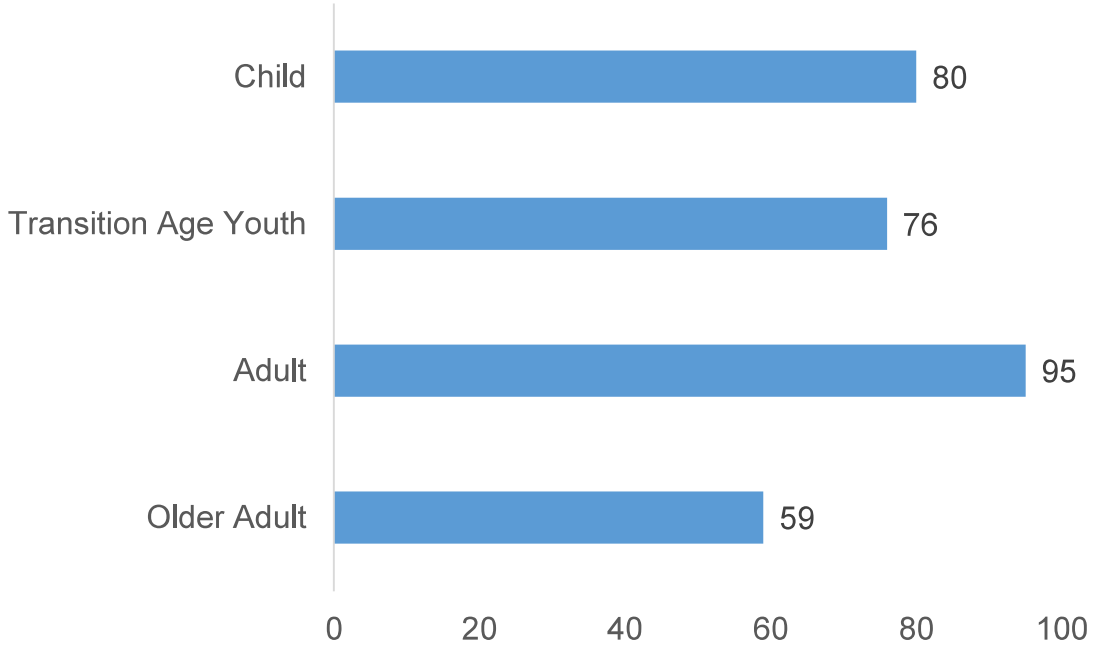
FIGURE 12: NUMBER OF PROVIDERS WITH COMPLETED OEC FEEDBACK ANALYSIS SURVEYS BY SURVEY FORMAT UTILIZED



Data source: 2023 Consumer Perception Survey (CPS) Open-Ended Comments (OEC) Feedback Analysis survey.

Figure 13 shows that Providers who primarily serve the Adult group made up the largest proportion of providers who completed the survey, while Providers specializing in the Older Adult group made up the smallest survey completion.

FIGURE 13: NUMBER OF PROVIDERS WITH COMPLETED OEC FEEDBACK ANALYSIS SURVEYS BY AGE GROUPS SERVED



Note: Providers could report serving more than one age group. Data source: 2023 CPS OEC Feedback Analysis survey.

C. Categories of Provider Reported Comments

Provider reported client/caregiver comments were qualitatively grouped into the following nine thematic categories: General Positive, General Negative, New Programming, Staff-related Issues, General Recommendations, Services, Cultural Competency/ Appropriateness, Access, and Other. The following provides a summary discussion of the categories and client comments reported by providers.

1. *General Positive Comments*
   Many comments received were general statements of gratitude for services, support, and treatment. Parents and caregivers were grateful for the support for their children. Several individuals noted that the services and treatment "saved" their lives. Multiple LACDMH Directly Operated (DO) and Legal Entity (LE)/Contracted sites were identified as providing good, satisfying overall experiences.

2. *General Negative*
   There were few general negative comments as most negative experiences were able to be sorted into other categories. The general negative comments indicated a desire to not attend court-ordered treatment and not wanting to wear masks in the clinics. Difficulty communicating with staff, feeling judged and rushed, experiencing inefficient situations, and feelings of not being helped were noted.

3. *New Programming*
   Clients and caregivers requested more groups and classes for children and parents on topics including homework, anger management, Post-Traumatic Stress Disorder (PTSD), and physical health issues. Parents requested more support with workshops and services focused on mothers. Group activities were desired by TAY and Adult age groups, parents want more activities for children, and many clients and caregivers would appreciate a higher level of community involvement activities. Increased availability of art supplies would benefit some clients.

4. *Recommendations* for treatment included requests for more family therapy, a wider availability of injectable antipsychotic medications, nutritionists, and hypnotherapy. There was also interest in more education about crisis lines and linkage to resources including transportation, housing assistance, Regional Centers, and assessment. Some clients may benefit from services or linkage to a Chaplin or preferred religious support. It was also recommended that case managers and therapists communicate more with schools and parents.

5. *Staff-related Issues*
   Client comments often noted the kindness, care, responsiveness, professionalism, and respect displayed by both clinical and support staff. There were many comments of gratitude for specific providers and staff members.

6. Negative comments tended to focus on customer service and staff turnover. Clients and caregivers noted poor interactions with front office staff, therapists, nurses, and psychiatrists that included unreliable, inattentive, discourteous, and unprofessional behaviors. Some clients reported sessions ending early and starting late. Clients

and caregivers also disliked the low volume of staff and frequent turnover. They perceived some interns and younger therapists as inexperienced.

7. *General Recommendations*
   Clients and caregivers requested faster initial response to requests for services, returning calls, more appointments, more appointment reminders, more in-home and in-person appointments, the receipt of documents in a timely manner, longer appointments, later appointment times, consistent scheduling that does not interfere with school, and treatment over school breaks. There is a need for more financial and legal assistance/resources, parenting literature, assistance with transportation, and improved organization of programs and activities.

8. Clinics would benefit from higher quality furniture and bigger chairs, storage lockers for personal items while receiving services, updated or newer buildings, funding for lab supplies, clean, functional bathrooms, air conditioning, more decoration, and more parking. Clients and caregivers would appreciate water and coffee in waiting rooms, turning on the TV in the waiting area, avoiding the news, background music, snacks and consistently stocked vending machines, lunches, and stress toys.

9. *Services*
   Most client comments identified in the Services category were positive. Clients noted general satisfaction and 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.

10. *Generally*, clients indicated they were pleased with the services offered and appreciated the consistency, attentiveness, respect, flexibility, and collaboration of the treatment teams. They also appreciated check-ins, learning skills, and connection to resources. They identified services that are convenient and personalized, pleased with Full-Service Partnership (FSP) and Wraparound programs as the most helpful. There were requests for more assistance with housing resources, no video sessions with children, a better process for outside referrals for assessment, and more specialized treatment.

11. *Cultural Competency/Appropriateness*
    Most client comments identified by providers remarked on good cultural sensitivity and availability of services in a preferred language and culture. However, there were several requests to increase Spanish, Chinese, and Korean-speaking providers, Black providers, and male providers, and some requests for clinicians of a client's same age group. Clients and caregivers would also benefit from confirmation that written materials and brochures are available in Spanish.

12. *Access*
    Clients and caregivers expressed gratitude for deaf or hard of hearing services and other disability services, flexibility of scheduling, and options for in-person and telehealth services. However, providers reported receiving many accessibility-related comments. Comments focused on improving appointment availability with

requests for later appointments, weekend appointments, appointments after 5:00 PM, and psychiatry appointments after 3:00 PM. Clients and caregivers reported there were long wait lists, long periods of time to be assigned to a therapist, and between therapy and psychiatry appointments, and there were frequent cancellations of appointments.

13. *Additionally*, requests were made for accommodation of school and extracurricular activities when scheduling appointments, more in-person services and home visits, medications to be filled on time, more locations, text reminders, more transportation support, tablets for clients to receive telehealth, and smoother transition when clients leave the system.

Other

Feedback that did not specifically fall into one of the above categories is grouped as Other. These include comments about the design of the CPS and only being in services for a short amount of time.

D. Summary of the OEC Feedback Analysis Survey

The OEC Feedback Analysis survey aimed to facilitate the review of consumer experiences of youth, families, adult, and older adult populations. The OEC Feedback Analysis report was completed to assess qualitative feedback collected from clients/caregivers in overall, positive, negative, and general/recommendation comments. Report findings were distributed to participating providers to assist with further development and improvement of services provided to clients throughout Los Angeles County. Below is a brief summary of the feedback received:

- Most comments received were statements of gratitude for services, support, and treatment for all age groups. Clients would like to see a greater variety of groups and increase community involvement. New treatments and case management resources are needed.
- The kindness, care, responsiveness, professionalism, and respect provided by staff was recognized by clients and caregivers. However, high staff turnover and poor customer service interactions negatively impact clients.
- Clients and caregivers recommended improvements for access to care by decreasing the time to connect with services, expanding clinic hours, more appointment reminders, and consideration of school conflicts when scheduling appointments. Case management activities should be expanded, and clinic environments could use updating.
- Generally, clients and caregivers are pleased with LACDMH providers' cultural competency. However, clients requested more Spanish, Chinese, and Korean-speaking providers, Black providers, and male providers, and more written materials and brochures to be made available in Spanish.

- **Recommendations**
  - The QI Unit will share the OEC Feedback Analysis report findings with the SA District Chiefs and Outpatient Care Services Leadership.
  - Outcomes from the OEC Feedback Analysis report should be reviewed at the provider-level and with each site's leadership team.
  - Outcomes should be reviewed with clinical and support staff for staff education and collective involvement in improving service delivery for clients.
  - Providers to consider surveying their client community to identify and prioritize improvement needs.
  - Providers should review their site's procedures/processes to ensure that information about available resources, community supports, and clinic procedures are easily accessible to clients.
  - Providers should ensure that all staff are aware of the appropriate workflows for communicating client messages to their treating providers, and that they are aware of the expected response times.
  - Providers should ensure that their staff are providing ample notice of scheduled appointments to clients to ensure clients are able to attend the appointment, thereby decreasing no-shows and ensuring clients are not waiting too long for the next available appointment.
  - ACCESS/Helpline, 988, and Warm Line contacts should be made readily available to clients. Providers should ensure clients are aware of these valuable resources.
  - Providers should review the site's staffing needs and create incentives for staff retention.
  - Providers should consider offering customer service training to all staff on a regular basis.
    - LACDMH Talent Works: https://lacounty.csod.com
    - Legal Entity/Contracted Providers: LACDMH QI Customer Service Workshop
  - Providers should consider whether suggestions from the Thematic Content, particularly General Recommendations, would fit for your site and clients.
  - Providers should evaluate/assess if their current staffing, language support, and written materials are meeting their clients' needs.
  - Provider should review their workflows and processes to improve access to care timeliness.

Providers should review practitioner caseloads to identify clients that have been in treatment for an extended period to evaluate if the client is ready to be stepped down to a lower level of care

E. 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.

1. **Non-Clinical Performance Improvement Project (Non-clinical PIP)**
   In the FY 2022-23 non-clinical PIP, Improving Follow-Up After Emergency Department Visit for Mental Illness (FUM) for Beneficiaries that Present with Mental Health Concerns, the QI, Quality Assurance (QA) and Chief Information Office Bureau (CIOB) Units, Enhanced Care Management (ECM) Team, Geriatric Services Intervention Support (GENESIS) program, Health Access Integration (HAI) Unit, and Intensive Care Division (ICD) worked collaboratively to increase mental health linkage opportunities for vulnerable populations in urgent need of care by improving engagement and follow-up with Medi-Cal beneficiaries visiting hospital emergency departments (EDs) for mental illness by initiating outreach and data exchange with facilities serving these beneficiaries to ensure better continuity of care and reduce their emergency room visits. It impacted individuals seeking emergency care at two pilot hospitals, Emanate Inter-community Hospital and St. Francis Medical Center.

   FUM data from the California Department of Healthcare Services (DHCS) from Measurement Year (MY) 2020 and 2021 was reviewed. Data was collected from the Integrated Behavioral Health Information System (IBHIS).

   Objective 1: Gain insight into clients with mental health issues that visit emergency departments to improve post ED follow up for mental health services by creating timely exchange of data between EDs and LACDMH.

   A total of 28 referrals were submitted to ECM during the intervention period. However, two referrals had no known client ID, and no demographic information recorded preventing them from being tracked in the Integrated Behavioral Health Information System (IBHIS). The total number of referrals during this PIP was 26. Of the 26 referrals with demographics, the majority were adults (N=19, 73.1%) and identified as male (N=20, 76.9%). The majority of referrals identified their primary language was English (N=21, 80.7%). No primary language was recorded for the remaining five. Five referrals (19.2%) had an entry of Homelessness on their Problem List. Eight referrals (30.8%) identified race/ethnicity as Hispanic/Latino, six (23.1%) as White, four (15.4%) as Black/African American, two (7.7%) as Asian, one (3.8%) as Other, and five (19.2%) as Unknown.

   From May 2023 to December 2023, ECM education of ED staff increased from 0 to a combined total of 19, which met the goal of increasing the ED staff education by 100% for the 1st Remeasure period of June-September 2023. However, no new educational opportunities were able to occur during the 2nd Remeasure period of October-December 2023 due to both hospital EDs

limiting access of the ECM team. This goal was not met for the 2nd Remeasure period.

Overall, the ECM number of referrals received during the PIP was low. At the completion of the PIP, the number of ECM referrals that enrolled in ECM services were a combined total of 28. Of these 28 referrals, four (14.3%) were enrolled in ECM as a result of the hospital ED referral. An additional four (14.3%) were found to have already been enrolled in ECM at the time of the referral. An additional four (14.3%) referrals declined to participate in ECM. Five referrals (17.9%) did not have Medi-Cal or did not meet ECM criteria in other ways. For eight referrals (28.6%), ECM staff was unable to contact the client or upon contact found the client was not stable enough to engage. One referral did not have this information entered. The goal of increasing the number of ECM referrals enrolled in services by 5% was met.

All ECM referrals were checked in Los Angeles Network for Enhanced Services (LANES) by ECM staff for contact with other hospitals. The goal of checking 100% of the referrals was met.

Objective 2: Connect identified beneficiaries in EDs back to their mental health provider or provide linkage to needed mental health services.

For the FUM measures, it was assumed the ECM date of referral corresponded to the date of discharge from the ED, since this date was not separately recorded. Billing data was used to identify a billable service that was considered a follow-up service for calculating the FUM numerator, since the codes used by ECM staff are specific to ECM and not currently included in the FUM code set. Given those assumptions, for the 1st Remeasure period, a total of 17 discharged patients were tracked with a known client ID and received at least one billable service within the DMH system of care within seven or 30-days. Six (35.3%) discharged patients attended their seven-day follow-up (FUM7) mental health appointments, and nine (52.9%) discharged patients attended their 30-day follow-up (FUM30) mental health appointments. At the 2nd Remeasure period, an additional nine discharged patients were tracked, making a grand total of 26 discharged patients tracked with a known client ID and received at least one billable service within the DMH system of care within seven or 30-days. Eleven (42.3%) attended their FUM7 appointments, and 16 (61.5%) discharged patients attended their FUM30 mental health appointments. FUM7 increased by 7 PP and FUM30 increased by 8.6 PP at the end of the data collection. The goal to increase FUM7 and FUM30 by 5% was met.

For adults, the 1st Remeasure period FUM7 was at 33.3% and FUM30 was at 50.0%. In the 2nd Remeasure for adults, FUM7 increased 14.1 PP to 47.4%. For older adults, the 1st Remeasure period FUM7 was at 40.0% and FUM30 was at 60.0%. In the 2nd Remeasure for older adults, FUM7 decreased 11.4 PP to 28.6%, and FUM30 decreased by 2.9 PP to 57.1%. The goal to increase adult and older adult FUM7 and FUM30 by 5% was met.

However, the rate of FUM7 for older adults appeared lower at the completion of the data collection, indicating that further exploration of barriers is needed.

Findings

Although the pilot project began in May 2023 at Emanate ED and June 2023 at St. Francis ED, hospital staff, patient engagement, and data collection were slow to begin. An unexpected amount of time was needed for the ECM team to develop relationships with hospital ED staff, create buy-in, and facilitate engagement in the interventions. When mental health referrals began, some patients declined referrals, and the ECM had difficulty contacting others due to patients not having phones, limited resources, and unhoused statuses.

At the conclusion of the PIP, it appears that all goals were met despite the low number of referrals. Lessons learned include:

- Hospital ED administration buy-in takes longer due to relationship-building and education needs.
- Hospital ED staff face challenges in implementing new processes due to time limitations of patient encounters.
- Hospital EDs vary in resources, staffing, and openness to revising workflows.
- Health Information Exchanges (HIEs) are limited in the information that is collected and shared.

The MHP plans to continue this project for FY 2023-24 with a focus on connecting the LADCMH GENESIS program to HIE alerts for enrolled beneficiaries. Integration of HIEs such as PointClickCare (PCC) are being considered to assist with data collection and communication. Other data resources are being explored for better quality baseline data and overall data collection. Creation of a training on making referrals and available mental health services provided by LACDMH for CA Bridge Navigators is also being considered. Emanate ED has also discussed including ECM information in their discharge packets and creating hospital emails for ECM staff to directly receive a list of admitted patients.

2. Clinical Performance Improvement Project (Clinical PIP)

The FY 2022-23 clinical PIP, *Improving Treatment Services for Individuals with Eating Disorders*, was sunset in October 2022. The ED Practice Network continues to support providers with meetings every other month. Additionally, the ED Best Practices tool kit is available on the LACDMH website, https://dmh.lacounty.gov/resources/eating-disorder-resources/. The toolkit also provides information, resources, and training opportunities. The ED 101 general overview and CBT specific training continue to be available in addition to a monthly consultation series.

Objective 1: Develop a new clinical PIP

Based on the EQRO recommendations in the FY 2022-23 External Quality Review (EQR), a new clinical PIP was developed with a focus on decreasing the rate of inpatient psychiatric rehospitalizations. The QI Unit joined with the Intensive Care Division (ICD)-Treatment Authorization Requests (TAR) Unit on an ongoing project focused on decreasing inpatient rehospitalization rates. The ICD-TAR Unit collected stakeholder feedback, discussions with and between Service Area (SA) program staff and leaders and contracted and non-contracted hospitals, and data analyses of a sample of providers to determine predictors for readmission, the Readmission Reduction Project pilot was initiated in FY 2021-22. The goal of the pilot project was to reduce rehospitalization rates among LA County consumers. In Phase One, two LACDMH hospitals were chosen to participate in the pilot project, Southern California Hospital at Van Nuys and Los Angeles Downtown Medical Center. The Re-Admission Pilot project was predicated on the implementation of concurrent authorization. The population focus is on those consumers who had 4 hospitalizations within the year or had been hospitalized twice within 30 days. The overall re-hospitalization goal was to reduce rates to no more than the 19% nationwide rate. The aim of the pilot was to reduce those factors that may lead to repetitive hospitalizations by increasing the support of the LAC DMH teams and programs to aid the hospitals as part of the discharge planning process.

For CY 2023, the QI Unit joined the ICD-TAR on Phase Two of the pilot project that focused on decreasing inpatient psychiatric rehospitalization rates among two new hospitals, St. Francis Medical Center and Emanate Inter-community Hospital Parkside West. The interventions selected included in-reach, education, support to consumers by Enhanced Care Management (ECM), early identification of individuals at risk of 30-day readmissions, multidisciplinary consultation and care coordination by LACDMH teams (ICD, ECM, service navigation/hospital liaisons, clinical pharmacy), Hospital clinicians and staff, Managed Care Plans (MCP), and Department of Public Health's (DPH) Substance Abuse Prevention and Control (SAPC), and utilization of a health information exchange, LANES.

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 Managed Care Program Annual Report for the Medi-Cal Behavioral Health Division.

LACDMH monitors grievances and appeals. 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, 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. In the role of MHP, LACDMH shall ensure that a procedure is in place whereby issues identified as a result of grievance, appeal, or expedited appeal processes are transmitted to the MHP's QIC, the MHP's administration, or another appropriate body within the MHP (DHCS, Oversight, and Compliance 2012-2013).

Table 7 and 8 below provide a systemwide summary of grievances and appeals received and processed by the LACDMH Patients' Rights Office for FY 22-23.

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TABLE 7: LACDMH GRIEVANCES AND APPEALS
FY 22-23

GRIEVANCES						
CATEGORY	**PROCESS**		**GRIEVANCE DISPOSITION**			
	Grievance	**Exempt Grievance**	**Grievances Pending, Unresolved as of June 30**	**Resolved**	**Referred**	**Timely Resolution**
ACCESS						
Services not available	7	0	1	6	0	6
Services not accessible	12	0	1	12	0	10
Timeliness of services	4	0	1	3	0	3
24/7 Toll-free access line	0	0	0	0	0	0
Linguistic services	0	0	0	0	0	0
Other access issues	12	0	1	11	0	7
(Access) TOTAL	**34**	**0**	**4**	**32**	**0**	**26**
Percent	**6.4%**	**0.0%**	**11.7%**	**94.1%**	**0.0%**	**76.4%**
QUALITY OF CARE						
Staff behavior concerns	136	1	30	116	0	96
Treatment issues or concerns	114	0	20	84	0	74
Medication concern	25	0	5	20	0	15
Cultural appropriateness	6	0	0	6	0	6
Other quality of care issues	20	0	3	17	0	15
(quality of care) TOTAL	**301**	**1**	**58**	**243**	**0**	**206**
Percent	**56.6%**	**0.3%**	**19.2%**	**80.7%**	**0.0%**	**68.4%**
Change of Provider						
Confidentiality Concern						
Percent	**0.0%**	**0.0%**				
OTHER						
Financial	0	0	0	0	0	0
Lost Property	9	0	4	5	0	4
Operational	13	0	0	13	0	10
Patient's Rights	68	0	11	58	0	50
Peer behaviors	13	0	3	10	0	8
Physical environment	6	0	1	5	0	4
County (Plan) communication	0	0	0	0	0	0

Payment/Billing issues	4	0	1	3	0	3
Suspected Fraud	0	0	0	0	0	0
Abuse, Neglect or Exploitation	18	0	4	14	0	14
Other grievance not listed above	66	0	7	58	0	57
(other) TOTAL	**197**	**0**	**31**	**166**	**0**	**150**
Percent	**36.9%**	**0.0%**	**15.7%**	**84.2%**	**0.0%**	**76.1%**
GRAND TOTAL	**532**	**1**	**93**	**441**	**0**	**382**

TABLE 7: LACDMH APPEALS, FY 22-23

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.

4. California Advancing and Innovating Medi-Cal (CalAIM)

Over the past several years, the LACDMH Quality Assurance Unit has been implementing the CalAIM initiative across Specialty Mental Health Service in Los Angeles County. CalAIM is a multi-year initiative by the State Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, program and payment reforms across the Medi-Cal program. A set of CalAIM behavioral health policies designed to improve access to care, streamline

administrative requirements, and modernize the Medi-Cal payment methodology was rolled out in phases across California and within the Los Angeles County Department of Mental Health (LACDMH). https://file.lacounty.gov/SDSInter/dmh/1117881_QABulletin21-07CalAIM-AnOverview.pdf

A few key initiatives include:

- The Criteria to Access SMHS (previously known as medical necessity criteria) was updated for both adults and beneficiaries under age 21 (except for psychiatric inpatient hospital and psychiatric health facility services), to ensure access to appropriate care and to standardize access to the SMHS delivery system statewide. A mental health diagnosis is no longer a prerequisite for receiving or delivering SMHS and, for those under 21, those who have a condition placing them at a high risk due to trauma are able to access SMHS.
  https://file.lacounty.gov/SDSInter/dmh/1117880_QABulletin21-08UpdatedCriteriatoAccessSMHS.pdf

- Under No Wrong Door, the goal was to make sure that people get the right care no matter where they enter the system - Managed Care Plan (MCP) or Mental Health Plan (MHP) i.e., LACDMH, - and do not face delays or barriers in accessing needed services. Clinically appropriate services rendered during the assessment phase will be reimbursed even if the beneficiary does not end up meeting access criteria. In certain circumstances, beneficiaries can receive unduplicated care in more than one delivery system.
  https://file.lacounty.gov/SDSInter/dmh/1126524_QABulletin22-06NoWrongDoor.pdf

Part II
Los Angeles County Department of Public Health SAPC

I. Quality of Care: Provider Network

A. Contractual Agreement:

As stated in previous sections, SAPC contracts 100% of its prevention, harm reduction, treatment, and recovery services. SAPC uses several mechanisms to ensure that contractors provide quality care that is culturally and linguistically appropriate and monitors for compliance, at minimum, annually: Contract provisions, SAPC bulletins, and the Provider Manual. The below represents sample language from each.

1. *Contraction Provision 18Y of the SAPCs Drug Medi-Cal Organized Delivery System (DMC ODS) provider contract outlines the requirements for ensuring compliance to CLAS standards, and all applicable Federal, State, and local regulations, manuals, guidelines, and directives.*

Contractor shall ensure that all services provided are delivered in a culturally and linguistically appropriate manner, in accordance with 42 C.F.R., part 438, the National CLAS Standards (available at www.thinkculturalhealth.hhs.gov/clas/standards) and as described in SAPC Bulletin 18-03, unless superseded by an updated version, or most current version, and the most current version of the *Provider Manual*.

Contractors shall ensure that, in accordance with all applicable federal, State, and local laws, rules, regulations, directives, guidelines, policies and procedures, patients who have limited English proficiency, who are non-English monolingual, or who have a disability are provided information on the free language assistance services that are available them, including prominent posting of language assistance services. These services include the provision of bilingual staff who are representative of the primary population(s) served by each Contractor facility location where treatment is provided, oral and sign language interpreters, and auxiliary aids and services (e.g. large print documents, braille, TTD/TTY, closed caption, etc.).

Contractor shall ensure its policies, procedures, and practices are consistent with the CLAS standard and language assistance requirement and are incorporated into the organizational structure, as well as day-to-day operations.

2. *SAPC Bulletin #18-03: Culturally and Linguistically Appropriate Service Requirements further outlines the requirements of providers to address cultural competence*.

   On June 29, 2015, Substance Abuse Prevention and Control (SAPC) released an interim bulletin instructing contracted providers on the requirements for compliance with the Federal Department of Health and Human Services (HHS), Office of Minority Health's National Cultural and Linguistic Appropriate Service (CLAS) standards. In June 2016, SAPC's Committee on Cultural Competence and Humility released the Strategic Plan for ensuring equitable access to services for those representing diverse backgrounds.

   This bulletin provides further guidance on these CLAS requirements under the System Transformation to Advance Recovery and Treatment, Los Angeles County's Substance Use Disorder Organized Delivery System (START-ODS). Consistent with prior requirements, SAPC contracted providers must ensure that culturally, developmentally, and linguistically appropriate services are provided as specified in Title 42 of the Code of Federal Regulations, Part 438 (specifically 42 CFR 438.10 and 42 CFR 438.206), including provisions for:
   a. Services provided in Los Angeles County's threshold languages (see "Definitions" below), or in the individual's preferred language, where it is not one of the threshold languages;
   b. Written materials provided in the threshold languages of populations served; and
   c. Culturally relevant and competent services.

3. *SAPC Provider Manual for Substance Use Disorder Treatment Services includes contains numerous references for providers to ensure compliance to cultural competence, the below represents a sample of these:*

- *Recovery Bridge Housing Foundational Principles (page 79)*
  Program policies and operations are consistent with the National Standards for Cultural and Linguistically Appropriate Services (CLAS) and ensure individual rights or privacy, dignity, respect, and safety.

- Services for Persons with Disabilities (page 107)
  Providers must comply with all elements of the Americans with Disabilities Act of 1990 (ADA). This includes access to alternate access technologies (e.g., TTY/TVR, magnification, audio, etc.) and policies for allowing service animals. Providers must accommodate the communication needs of all qualified individuals and be prepared to facilitate alternative format requests for braille, audio format, large print, and accessible electronic formats, such as a data CD, as well as requests for other auxiliary aids and services, as appropriate. SAPC's website provides resources and additional information about implementing culturally competent services. In addition, providers can use the DHCS Alternative Format website (https://afs.dhcs.ca.gov) to identify alternative format selections by beneficiaries.

- Lesbian, Gay, Bisexual, Transgender, Questioning Populations (page 120)
  As with any patient, substance use providers need to screen for physical and mental health conditions in LGBTQ persons due to the risk of co-morbid health conditions. As a result of previously discussed challenges confronted by the LGBTQ community, members of this group do have higher rates of certain mental health conditions and are also at greater risk for certain medical conditions. Comprehensive screening and assessments can assist LGBTQ patients in accessing appropriate care for their physical and mental health concerns.

  The methods of best practice outlined in the counseling competency model apply to all populations, particularly in working with LGBTQ patients. In this model, a counselor:

  - Respects the patient's frame of reference
  - Recognizes the importance of cooperation and collaboration with the patient
  - Maintains professional objectivity
  - Recognizes the need for flexibility and being willing to adjust strategies in accordance with patient characteristics
  - Appreciates the role and power of a counselor as a group facilitator
  - Appreciates the appropriate use of content and processes therapeutic interventions; and is non-judgmental and respectfully accepting of the patient's cultural, behavioral, and value differences

B. Documentation:

SAPC's provider documentation includes a comprehensive set of guidelines, templates, and resources to assist contracted providers in delivering high-quality, equitable substance use disorder (SUD) services.

Key elements include:

- **Provider Manual:** Details policies, procedures, and expectations for providers, ensuring compliance with SAPC standards and state regulations.
- **Clinical Documentation Standards:** Includes templates and examples for assessments, treatment plans, progress notes, and discharge summaries to maintain consistent and effective client records.
- **CLAS Standards Implementation:** Guidance on integrating Culturally and Linguistically Appropriate Services (CLAS) standards into provider practices.
- **Billing and Reporting:** Resources for accurate submission of claims and documentation of services provided.
- **Training Materials:** Includes presentations and toolkits to enhance provider knowledge on topics such as cultural competence, health equity, and evidence-based practices.
- **Compliance Resources:** Ensures adherence to privacy laws, ethical standards, and quality assurance processes.

This documentation supports SAPC's commitment to a unified, culturally responsive, and client-centered system of care across Los Angeles County.

II. Quality Improvement

A. Treatment Perception Survey

SAPC's Health Outcomes and Data Analytics (HODA) Division is responsible for ensuring comprehensive distribution and administration of the Substance Use Disorder Treatment Perception Survey (TPS), working in partnership with SAPC's provider network. The information collected is used to measure adult and youth clients' perceptions of access to services and quality of care. The TPS is also required to fulfill the county External Quality Review Organization (EQRO) requirement related to having a valid client survey. The data may also be used by service providers to evaluate and improve the quality of care and patient experience.

The TPS includes several questions that allow SAPC and its provider network information on satisfaction around cultural and linguistic availability and respect.

It is an anonymous survey that collects information from adult patients in the SUD treatment system of care in 6 domains, 5 domains are required by the State and due to the implementation of telehealth services during COVID-19, SAPC wanted to assess patient satisfaction with telehealth services:

- Access

- Quality of Care
- Care Coordination
- Treatment Outcome
- General Satisfaction
- Telehealth (added by SAPC)

For youth patients in the SUD system of care, the TPS is comprised of 8 domains, 7 of which are required by the State, with the domain related to telehealth added by SAPC.

- Access
- Therapeutic Alliance
- Service Satisfaction
- Staff/Environment
- Care Coordination
- Outcome
- Overall Satisfaction
- Telehealth (added by SAPC)

Benefits of TPS:

- Providers are able to use patient feedback to help identify strengths and areas for growth
- Allows patients a voice
- Offers action planning for improving services
- Supports provider grant applications and ongoing accreditation
- Provides outcome measurement directly from clients themselves"

Survey Administration

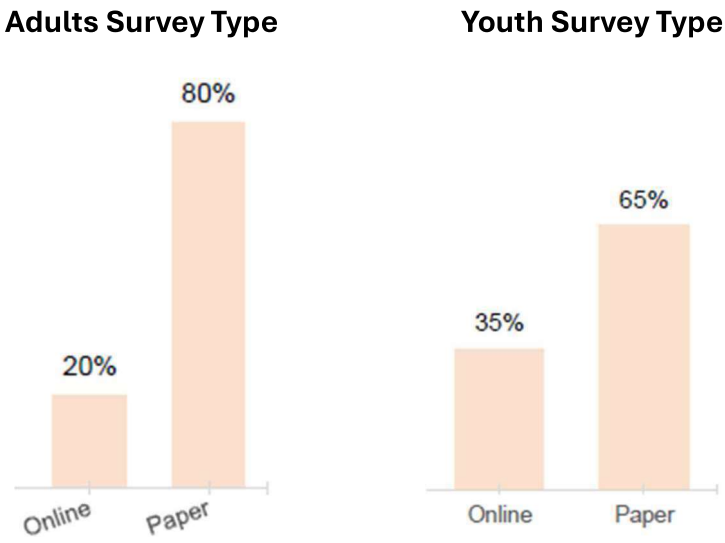
The survey was administered between October 17-21, 2022, to both adults (ages18-65+) and youth (ages 13-17) in outpatient, narcotic treatment programs, residential, and recovery support service settings.

Online Survey

Individuals receiving services from treatment providers whether by telephone or telehealth (e.g., videoconferencing) during the survey period should be given access to the online survey via a web link. Each link is customized for a specific provider, meaning that the CalOMS Provider ID, Reporting Unit and treatment setting have already been pre-filled in hidden fields. The list of unique provider links will be distributed to providers. Both adults and youth can select among 13 languages (English, Spanish, Tagalog, Vietnamese, Russian, Chinese, Arabic, Korean, Armenian East, Armenian West, Cambodian, Hmong, and Farsi) after clicking on the link. Responses entered to the online survey are sent directly to SAPC.

Paper Survey Forms
Individuals receiving services from treatment providers in person during the survey period should be given access to the paper survey or online survey via a web link. Survey forms for both adults and youth are available in 13 languages. Figure 12 below shows the comparison between online and paper surveys.

FIGURE 12: COMPARISON OF ONLINE AND PAPER SURVEYS AMONG ADULTS AND YOUTH



Adult Survey Questions
The TPS comprised of sixteen survey questions. Table 8 below outlines the adult survey questions and which domains they represented. Those highlighted in green and bolded are those that most related to cultural competence and those with (*) were added by SAPC.

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TABLE 8: LIST OF ADULT TPS QUESTIONS BY DOMAINS

	Survey Questions	Domain
1.	The location was convenient (public transportation, distance, parking, etc.)	Access
2.	Services were available when I needed them.	Access
3.	I chose the treatment goals with my provider's help	Quality
4.	Staff gave me enough time in my treatment sessions.	Quality
5.	**Staff treated me with respect.**	**Quality**
6.	**Staff spoke to me in a way I understood.**	**Quality**
7.	**Staff were sensitive to my cultural background (race, religion, language, etc.)**	**Quality**
8.	Staff work with my physical health providers to support my wellness	Care Coordination
9.	**Staff work with my mental health care providers to support my wellness**	**Care Coordination**
10.	As a direct result of the services I am receiving, I am better able to do the things that I want to do.	Outcome
11.	**I felt welcomed here**	**General Satisfaction**
12.	Overall, I am satisfied with the services I received.*	General Satisfaction
13.	I was able to get all the help/services that I needed*	General Satisfaction
14.	I would recommend this agency to a friend or family member.	General Satisfaction
15.	Now thinking about the services you received, how much of it was by telehealth (by telephone or videoconferencing)	Telehealth
16.	Telehealth was as helpful as in-person.	Telehealth

Youth Survey Questions

The youth TPS comprised of twenty survey questions. Table 9 outlines the questions and the associated domains. Those highlighted in green and bolded are those that most related to cultural competence and those with (*) were added by SAPC.

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TABLE 9: LIST OF YOUTH TPS QUESTIONS BY DOMAIN

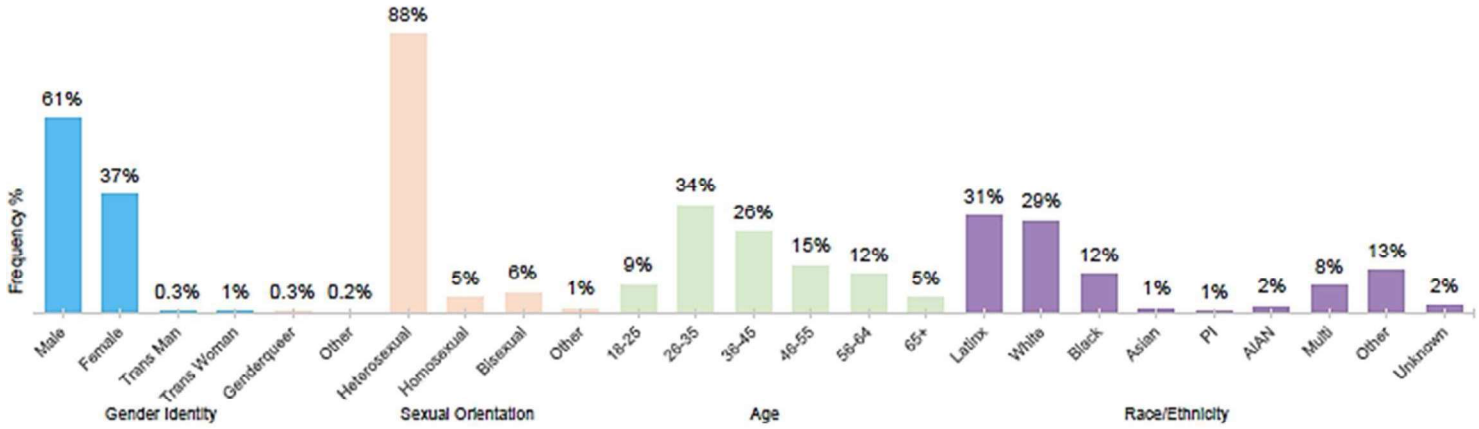
	Survey Questions	Domain
1.	The location was convenient (public transportation, distance, parking, etc.)	Access
2.	Services were available at times that were convenient for me.	Access
3.	I had a good experience enrolling in treatment.	Access
4.	My counselor and I worked on treatment goals together.	Therapeutic Alliance
5.	I received services that were right for me.	Service Satisfaction
6.	**Staff treated me with respect.**	**Staff/Environment**
7.	I feel my counselor took the time to listen to what I had to say.	Therapeutic Alliance
8.	I developed a positive, trusting relationship with my counselor.	Therapeutic Alliance
9.	**Staff were sensitive to my cultural background (race, religion, language, etc.)**	**Staff/Environment**
10.	**I feel my counselor was sincerely interested in me and understood me.**	Therapeutic Alliance
11.	I liked my counselor here	Therapeutic Alliance
12.	My counselor is capable of helping me.	Therapeutic Alliance
13.	**Staff here make sure that my health and emotional health needs are being met (physical exams, depressed mood, etc.)**	**Care Coordination**
14.	Staff here helped me with other issues and concerns I had related to legal/probation, family and educational systems	Care Coordination
15.	My counselor provided necessary services for my family.	Care Coordination
16.	As a result of the services I received, I am better able to do things I want to do.	Outcome
17.	Overall, I am satisfied with the services I received.	Overall Satisfaction
18.	I would recommend the services to a friend who is in need of similar help	Service Satisfaction
19.	Now thinking about the services you received, how much of it was by telehealth (by telephone or videoconferencing) *	Telehealth
20.	Telehealth was as helpful as in-person sessions*.	Telehealth

Percent Distribution of Demographics for Adult and Youth Surveys

A total of 6007 surveys were received from the 2022 TPS distribution. Figure 13 shows the demographics of the survey. Survey respondents were overwhelmingly male (61%) and heterosexual, and Latinx (34%) and white (29%) with the largest respondents being between the ages of 26-35 (34%).

The TPS includes SOGI data, with survey respondents identifying as transgender men (.3%) and women (1%), genderqueer (.3%) and others (.2%). While the required TPS uses the outdated term “homosexual”, SAPC is working to modify this to be culturally appropriate.

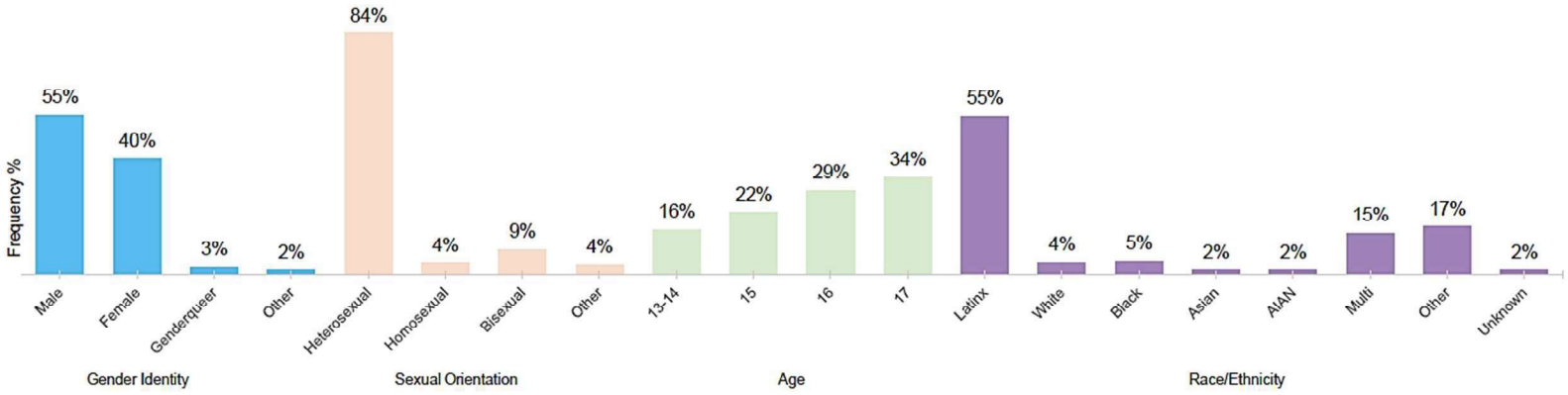
GRAPH 13: ADULT TREATMENT PERCEPTION SURVEY DEMOGRAPHICS



A total of 228 youth surveys were received from the 2022 TPS distribution, of these 204 (89%) were valid analysis. Figure 14 shows the demographics of the youth survey. Survey respondents were predominantly male (55%), heterosexual, and Latinx (55%) with the largest respondents being age 17 (34%).

The TPS includes SOGI data with survey respondents identifying as genderqueer (3%) and others (2%). While the current TPS uses the outdated term “homosexual”, SAPC is working to modify this to be culturally appropriate.

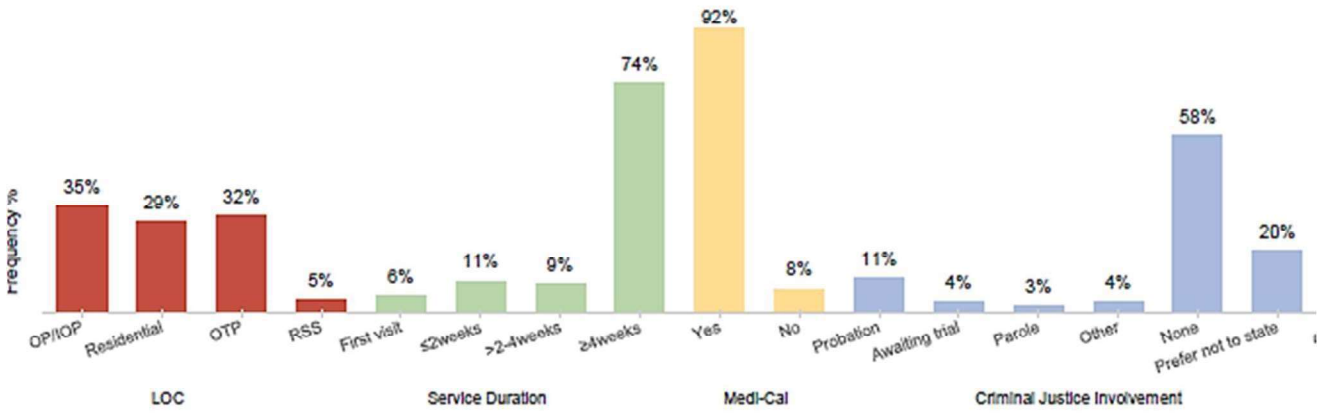
GRAPH 14: YOUTH TREATMENT PERCEPTION SURVEY DEMOGRAPHICS



Levels of Care, Service Duration Criminal Justice Involvement from Adult and Youth Survey Results

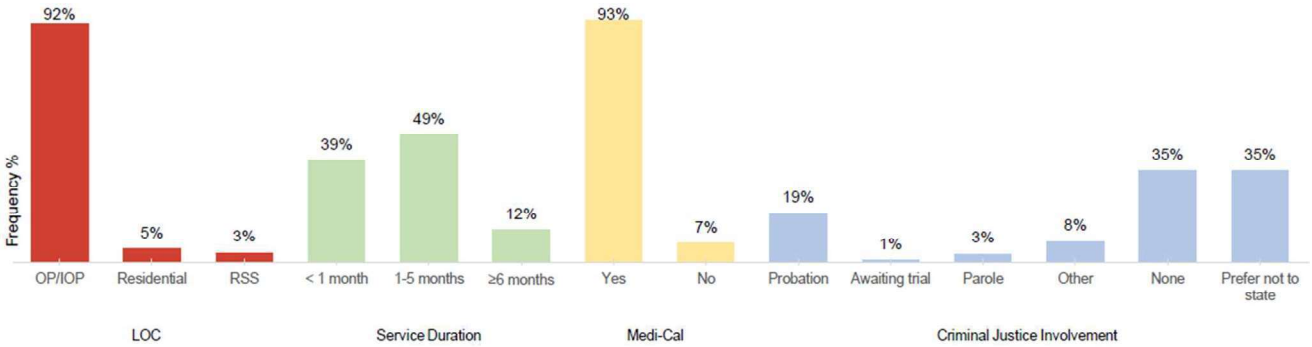
While a greater percent of patients was in OP/IOP (35%) and OTP (32%) programs, the number was fairly well distributed between the primary levels of care. Most respondents had participated in treatment for more than 4 weeks (74%), and reported no criminal justice involvement (58%), as shown in Figure 15, below.

FIGURE 15: PERCENTAGES OF ADULT LEVEL OF CARE, SERVICE DURATION, CRIMINAL JUSTICE INVOLVEMENT



Consistent with data regarding youth services, a greater percent of patients was in OP/IOP programs (92%), participated in treatment for 1-5 months (49%), had Medi-Cal (93%), and reported no criminal justice involvement (35%), though a comparable 35% indicated that they preferred not to state, as shown in Figure 16.

FIGURE 16: PERCENTAGES YOUTH LEVEL OF CARE, SERVICE DURATION, CRIMINAL JUSTICE INVOLVEMENT

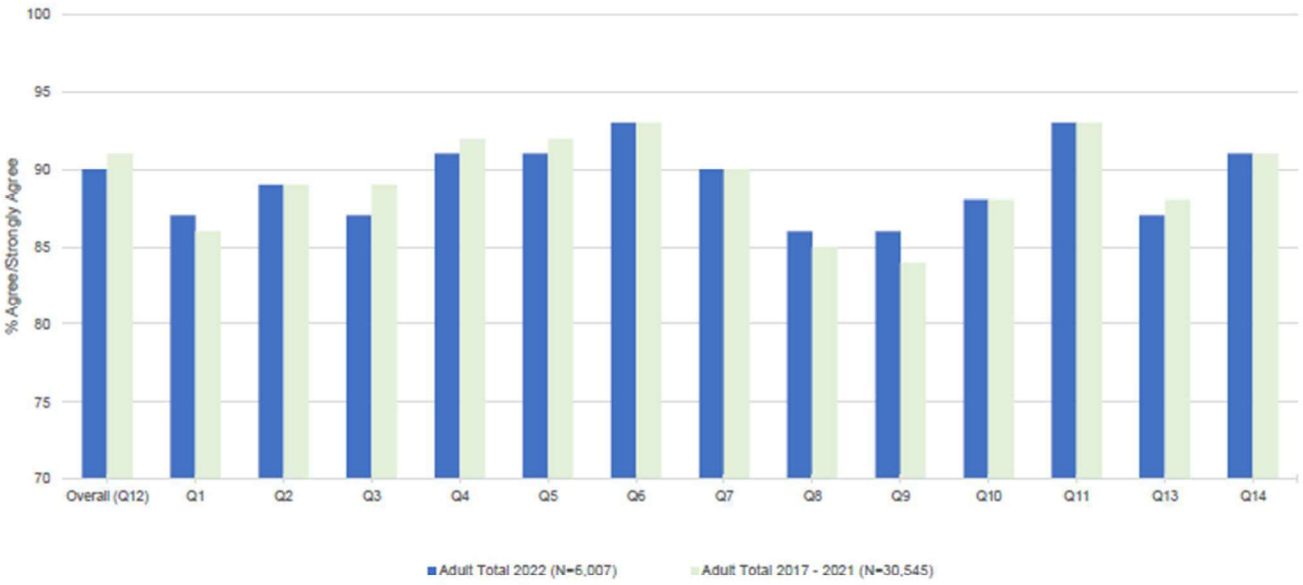


Percent of Adult and Youth Participants in Agreement with TPS Questions

Overall Satisfaction

Figure 17 shows that overall satisfaction for adults was high (90%), although slightly down from the previous five-year average (91%). There were slight increases in positive perception about physical and mental health care coordination and convenient location.

FIGURE 17: ADULT OVERALL SATISFACTION BY QUESTION NUMBER



Among youth TPS respondents, in 2022, there was an increase in overall satisfaction (Q17), along with increased positive perceptions in most domains (access, service satisfaction, staff/environment, care coordination, and outcome) when compared to the previous five-year average. Only one item in the therapeutic alliance (i.e., counselor's capacity to help) decreased in satisfaction from the five-year average.

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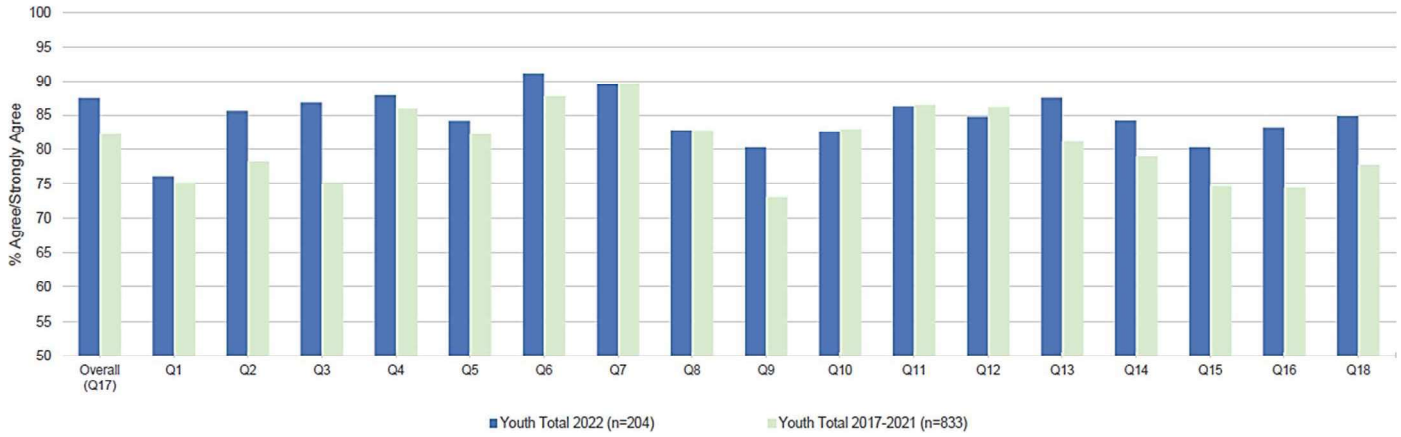
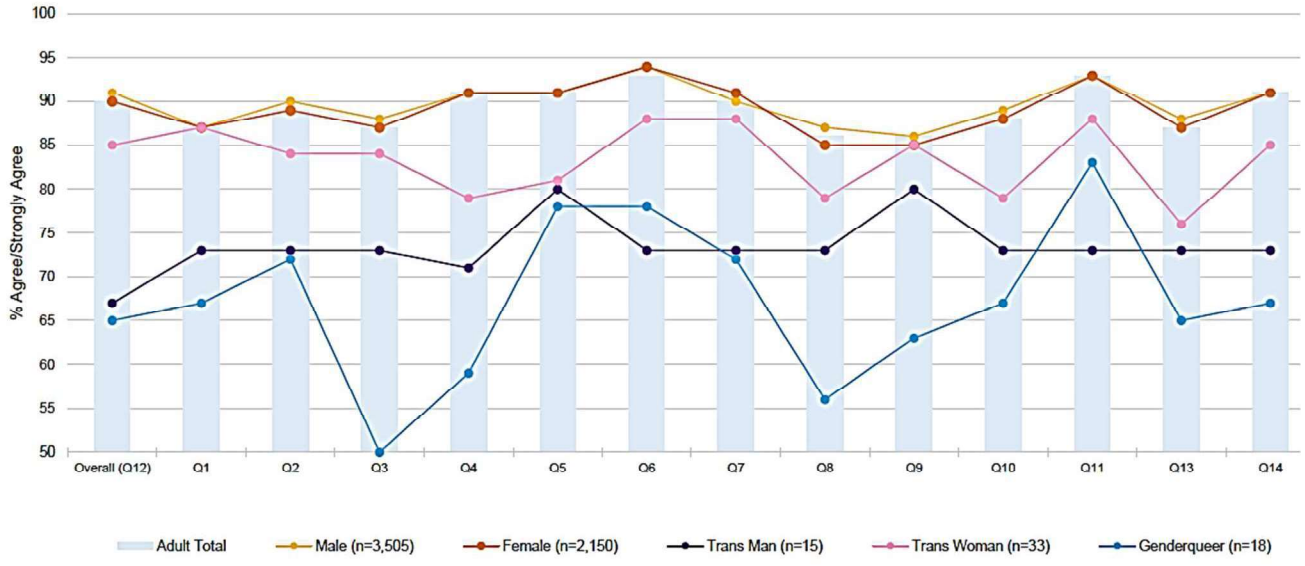
FIGURE 18: YOUTH OVERALL SATISFACTION BY QUESTION NUMBER



Percent of Adult Respondents in Agreement per question by Gender Identify

In general, male and female patients reported higher overall satisfaction and were in higher agreement with other domains (access, quality, care coordination, and general satisfaction); whereas other gender identity groups reported lower satisfaction. Genderqueer in particular report less satisfaction across most domains, though were showed moderate satisfaction regarding sensitivity to cultural background.

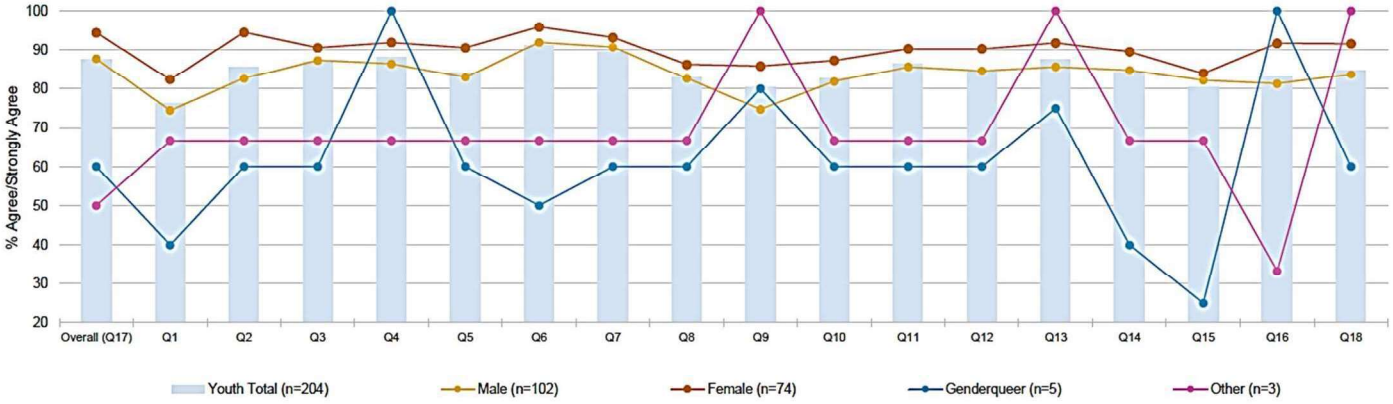
FIGURE 19: ADULT AGREEMENT BY GENDER IDENTITY



Percent of Youth Respondents in Agreement per question by Gender Identify

In general, female and male patients reported higher overall satisfaction and were in agreement with other domains (access, therapeutic alliance, and care coordination); whereas genderqueer and other gender identity groups reported lower satisfaction particularly around care coordination and outcome.

FIGURE 20: YOUTH AGREEMENT BY GENDER IDENTITY



Percent of Adult Respondents in Agreement with Each Question by Sexual Orientation

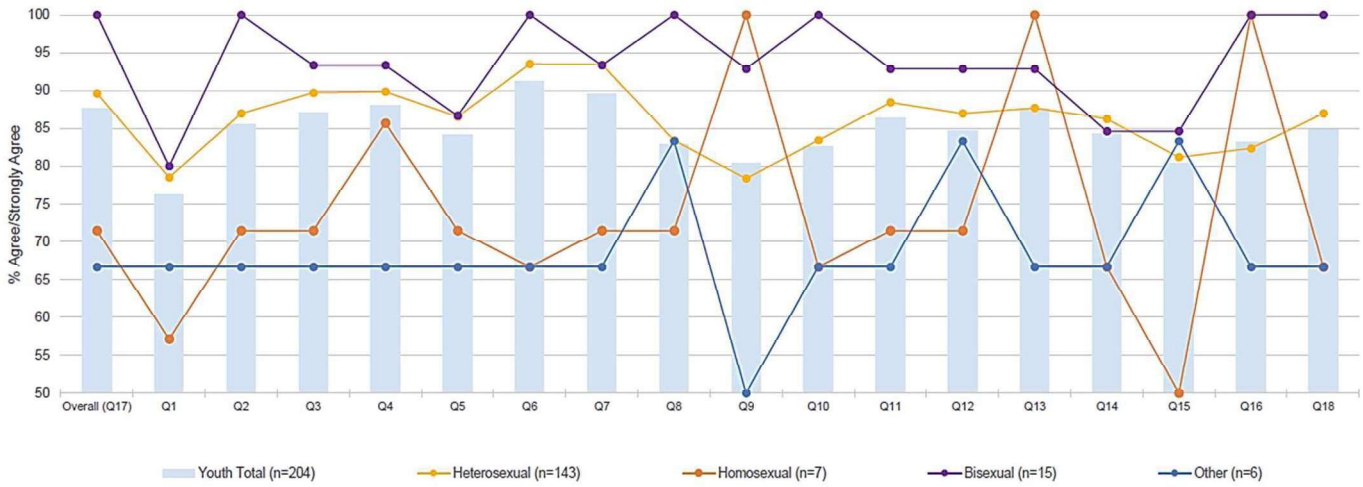
In general, those who identified as lesbian or gay and bisexual patients reported lower overall satisfaction and were less likely to be in agreement in all domains (access, quality, care coordination, general satisfaction). More specifically, respondents who identified as bisexual or other, were less likely to be in agreement with sensitivity to cultural background (Q.8).

FIGURE 21: ADULT AGREEMENT BY SEXUAL ORIENTATION

Percent of Youth Respondents in Agreement with Each Question by Sexual Orientation

In general, heterosexual and bisexual youth patients reported higher overall satisfaction and were more likely to be in agreement in all domains (access, therapeutic alliance, and service satisfaction); whereas gay/lesbian and those who identified as "other" reported lower satisfaction, particularly around sensitivity to cultural background and care coordination.

FIGURE 22: YOUTH AGREEMENT BY SEXUAL ORIENTATION



Percent of Adult Respondents in Agreement with Each Question by Race/Ethnicity

In general, Pacific Islanders were less likely to be satisfied, while AIAN, and Latinx patients were more likely to be satisfied with treatment services in all domains (access, quality, care coordination, outcome, general satisfaction).

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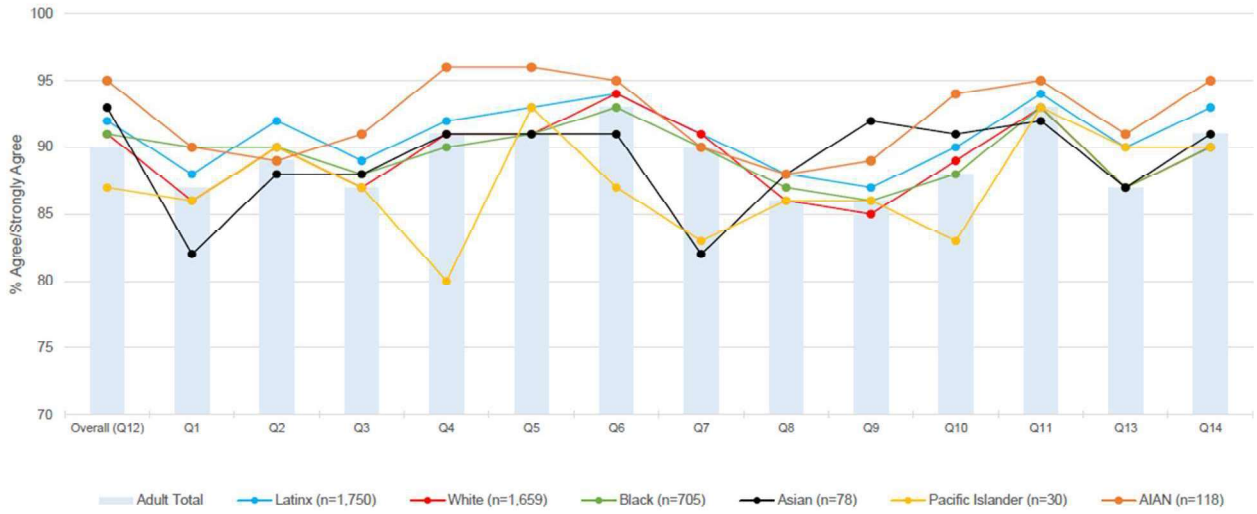
FIGURE 23: ADULT AGREEMENT BY RACE/ETHNICITY

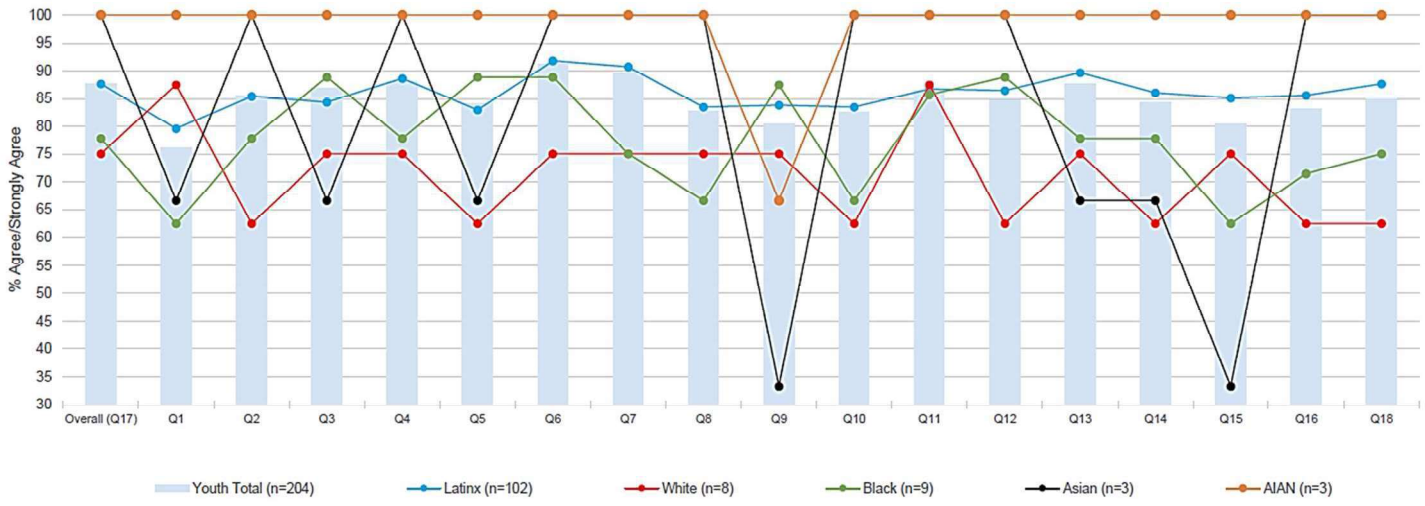


Note: AIAN = American Indian/Alaskan Native; Not all categories presented (e.g., other, unknown and those selecting more than one category).

Percent of Youth Respondents in Agreement with Each Question by Race/Ethnicity

In general, among youth respondents, Latinx patients reported higher overall satisfaction and were more likely to be in agreement with other domains (access, therapeutic alliance, outcome, and care coordination); whereas White patients reported lower satisfaction. NOTE: Due to small sample sizes (n<5), findings and comparisons among Asian and AIAN should be interpreted with caution.

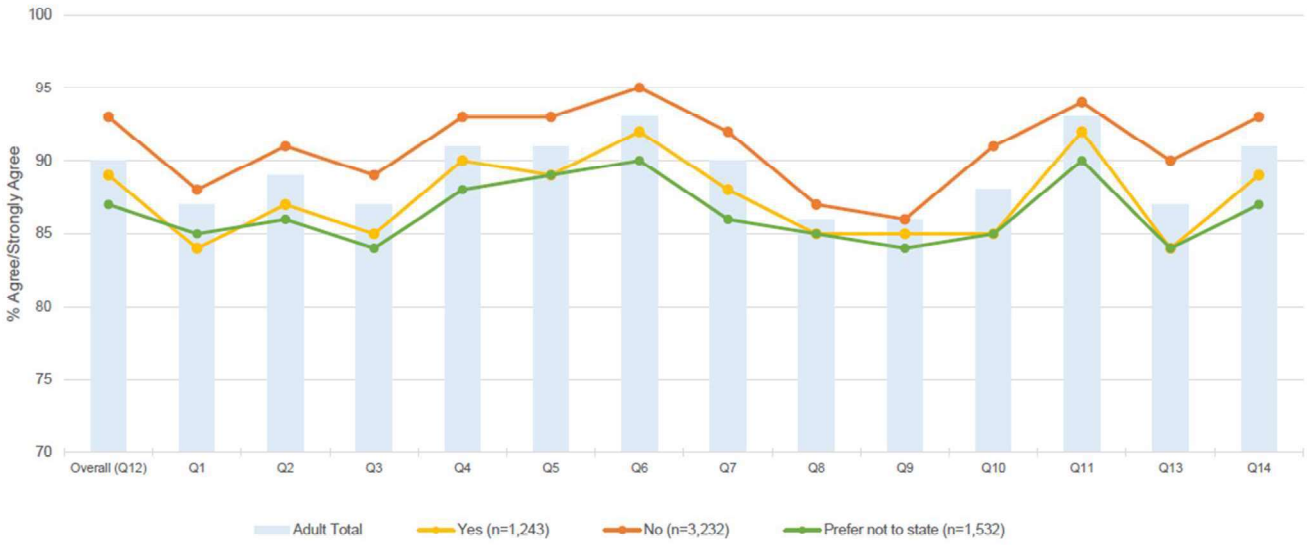
FIGURE 24: YOUTH AGREEMENT BY RACE/ETHNICITY



Percent of Adult Respondents in Agreement with Each Question by Criminal Justice Involvement

Adult patients with no criminal justice involvement reported higher overall satisfaction and higher positive perceptions for other domains (access, quality, care coordination, general satisfaction), while patients with criminal justice involvement (post-release, parole, awaiting trial) reported lower satisfaction in general.

FIGURE 25: ADULT AGREEMENT BY CRIMINAL JUSTICE INVOLVEMENT



Percent of Youth Respondents in Agreement with Each Question by Criminal Justice Involvement

Youth respondents with no criminal justice involvement reported higher overall satisfaction and higher positive perceptions for other domains (access, therapeutic alliance, service satisfaction, staff/environment, outcome), while patients with criminal justice involvement (post-release, parole, awaiting trial) reported lower satisfaction in general.

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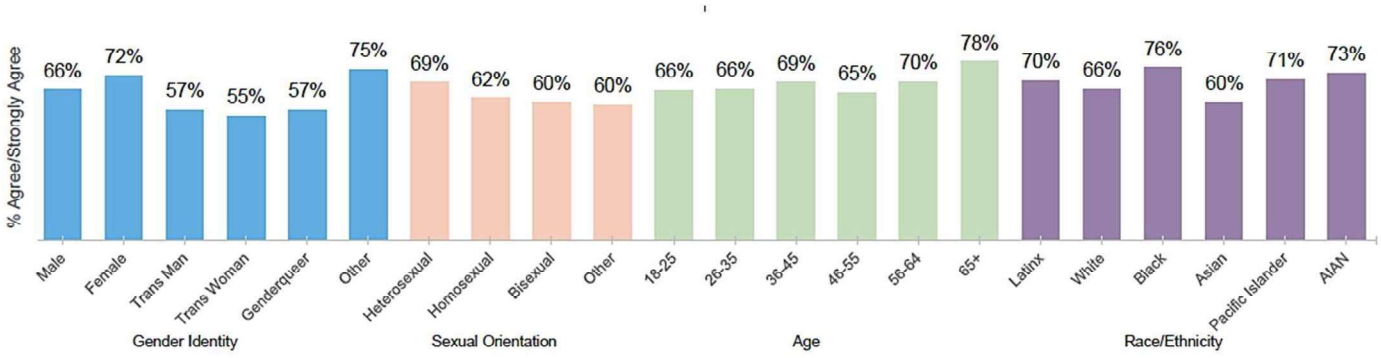
FIGURE 25: YOUTH AGREEMENT BY CRIMINAL JUSTICE INVOLVEMENT

Comparison of Telehealth Satisfaction

Adults

In general, patients who reported greater satisfaction with telehealth services were female, heterosexual, Black, and 65 and above years.



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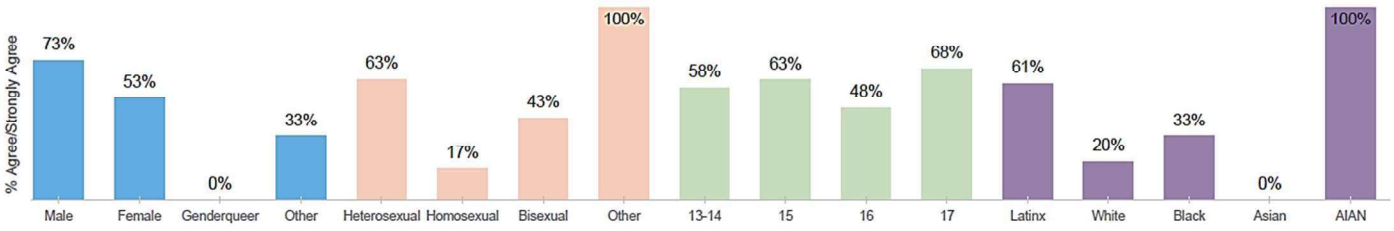
Youth

In general, patients who reported greater satisfaction with telehealth services were male, other sexual orientation, 17 years of age, AIAN.



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B. Performance Improvement Plan

SAPC, as the Drug Medi-Cal Organized Delivery System for Los Angeles County- is required under the External Quality Review Organization (EQRO) and Title 42 C.F.R. § 438.240 to conduct a clinical and non-clinical PIP, which are validated and reviewed by an EQRO annually.

Both the HODA Division and SAPC's Medical Director share responsibilities for coordinating, organizing, and supporting PIPs and includes representation from other Divisions within SAPC. During FY 22-23, SAPC conducted a non-clinical PIP around improving enrollment in Medi-Cal and a clinical PIP to Improve access and utilization of Recovery Services PIPs.

1. Non-Clinical Performance Improvement Plan:

Background

Enrollment in Medi-Cal and other social service programs is associated with the availability of preventive screenings, physical health services, mental health services in additional to SUD prevention and treatment, vital social services (including housing for people experiencing homelessness and support for food for people with food insecurity). Receipt of these services improves health outcomes and addressing these social determinants of health is a key part of SUD treatment and recovery. For these reasons, timely Medi-Cal enrollment for those who are eligible is essential to providing needed services.

SAPC conducted initial data analysis using claims, Medi-Cal Eligibility System (MEDS), authorizations, and financial eligibility data in March 2021 and identified about 800-1,000 patients in our current services who were not enrolled in Medi-Cal or did not transfer their previous Medi-Cal coverage to Los Angeles from a previous county of residence at the time of admission each month. For the majority of patients who were not enrolled in MEDS (57%), providers incorrectly reported patients' Medi-Cal status on admission as "DMC" on the Financial Eligibility Form, instead of "Applying for Medi-Cal".

The lack of accurate identification of patients eligible for, but not currently enrolled in Medi-Cal, and the lack of provider action to enroll Medi-Cal eligible patients in Medi-Cal deprives the eligible patients from the benefits of enrollment. Over 90% of the patients identified in March 2021 did not have their Medi-Cal status updated while they were in treatment.

Purpose:

The purpose of this non-Clinical PIP was to improve Medi-Cal enrollment among eligible but not-yet-enrolled patients served by the SAPC contracted system of care. A secondary aim of this PIP will be to increase client enrollment in other county funding programs (e.g., AB109, GR, Prop 47) which can cover other non-DMC billable expenses (e.g., Room and Board, Recovery Bridge housing services) and/or full-service expenses if Medi-Cal enrollment is denied, or that go beyond Medi-Cal or compliment Medi-Cal as part of the treatment continuum.

Medi-Cal eligible patients representing different cultural backgrounds and those that speak non-English threshold languages benefit from improved enrollment and engagement interventions supported from this PIP, including those with physical and mental wellness concerns.

Description of Methods, Goals, Interventions, and Performance

To achieve these aims, SAPC utilization management (UM) worked with four pilot agencies to identify barriers and/or successful practices for enrolling patients to Medi-Cal and/or other County funding programs and to provide necessary trainings and support. These agencies were selected using the following two criteria: 1) agencies who serve mostly non-DMC patients or 2) agencies with a history of incorrectly reporting non-DMC patients as "DMC" on the Financial Eligibility Form.

To achieve these aims, the PIP had three primary performance goals:

a. Decrease incorrect reporting of Medi-Cal status under Financial Eligibility
b. Increase Medi-Cal enrollment among non-DMC patients after admission
c. Increase enrollment in other County program (e.g., GR, CalWORKS) among low-income patients who are ineligible for Medi-Cal

To ensure appropriate evaluation of these goals, table 9 below outlines the interventions, variables (indicators), performance measures (outcomes) and target for the PIP.

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TABLE 9: NON-CLINICAL PIP GOALS AND PERFORMANCE MEASURES

Goal	Interventions	Variables (Indicators)	Performance Measures (Outcomes)	Target Improvement Rate
Decrease incorrect reporting of Medi-Cal status in the Financial Eligibility	1. Provide information to the provider network about Medi-Cal Enrollment. 2. Verify at the time of authorization review the patient's financial eligibility. 3. Utilize a financial enrollment team that to assist care managers to guide providers about completing Medi-Cal enrollment.	Number of non-DMC patients incorrectly reported as DMC in the Financial Eligibility Form at admission	% of non-DMC patients incorrectly reported as DMC in the Financial Eligibility Form at admission;	Decrease from 63% to 30% by December 2022
Increase Medi-Cal enrollment among non-DMC patients after admission	1. Provide information to the provider network about Medi-Cal Enrollment. 2. Verify at the time of authorization review the patient's financial eligibility. 3. Utilize a financial enrollment team that to assist care managers to guide providers about completing Medi-Cal enrollment.	Number of Medi-Cal enrolled patients after admission	% of non-DMC patients who enrolled in Medi-Cal after admission;	Increase from 31% to 40% by December 2022
Increase enrollment in other County program (e.g., GR, CalWORKS) among low-income patients ineligible for Medi-Cal	Provide information to the provider network about other benefit enrollment for low-income patients who are ineligible for Medi-Cal.	Number of non-DMC patients who enrolled in other programs	% of non-DMC patients who enrolled in other County program after admission	Pending

Results:

Verification of financial eligibility as a UM process at the time-of-service authorization prevents providers from incorrectly labeling Medi-Cal eligible patients as actually being enrolled in Medi-Cal, and creates a clear incentive for providers to enroll patients in Medi-Cal. Technical assistance can increase provider competence at enrolling Medi-Cal eligible patients in Medi-Cal and non-Medi-Cal eligible patients in other available funding sources. The interventions outlined in Table 9 above improvements in incorrectly attributing Medi-Cal enrollment to

patients not-yet-enrolled in Medi-Cal following UM verification of financial eligibility. This financial eligibility, in turn, led to improved physical and mental wellness. These improvements were and the benefits of Medi-Cal enrollment to patients was consistent through the entire PIP period.

2. Clinical Performance Improvement Plan

Background

Medications for opioid use disorder (MOUD) reduce the risk of overdose by over four-fold within the first 28 days of treatment, and improve treatment retention and recovery, but only 9.1% of Medi-Cal beneficiaries in 2020 (vs. 28% NCQA QC Benchmark for 2021) in Los Angeles County (LAC) access this lifesaving medication treatment that continue for at least 180 days.

Black residents are at the highest rate of overdose in LA County, and disproportionately do not access buprenorphine for OUD, consistent with national demographic trends. Additionally, the overdose rates are highest in-Service Planning Area (SPA) 4, emphasizing the need for more MOUD services in this service area. Further, service recipients in SPA 2 have the highest rate of residents who speak a non-English language at home, emphasizing the need for bilingual competencies among MOUD champions in this SPA.

Purpose:

The primary purpose of this clinical PIP is to increase the percentage of beneficiaries with opioid use disorder (OUD) receiving MOUD for 180 consecutive days from 9.1% to 50% of the QC benchmark by December 31, 2027, through improved beneficiary information campaigns and MOUD capacity-building organized through champion working in Medi-Cal funded sites.

Description of Methods, Goals, Interventions, and Performance

SAPC is expanding its proactive outreach, including street-based outreach, for telephone access to MOUD using investments in LA County's operated telephone MAT Consultation line service. LA County community health centers are also participating in the equity-focused Center for Care Innovations Addiction Treatment Starts Here (CCI-ATSH) program through which trusted community partners are resources to increase education and prevention in Los Angeles County's Black communities. We also planned to partner with OTPs to launch additional MOUD services in SPA 4. Lastly, we have patient-facing MAT information and material translated into threshold languages.

SAPC worked with the HealthNet Medi-Cal health plan to identify members with Medi-Cal diagnosed with OUD and develop interventions to improve initiation and engagement to MOUD treatment. The PIP included expansion based on successful strategies to all members with OUD without access to MOUD.

The interventions include a broad training program for providers, care coordinators, and members. Also, other interventions included are expanded NTP/OTP sites and funding for prescribers with incentives at the DMC-ODS

provider sites, particularly residential and outpatient. These data goals include linked measurable data goals for increased patients and visits as well as LOS in MOUD treatment.

To achieve the aim stated above, this clinical PIP has four goals:

a. Train administrators, support staff, and practitioners, counselors, and peers about MOUD and how they can facilitate access to it
b. Increase the number of access points for MOUD available to Medi-Cal beneficiaries, specifically including low-threshold telephone-based MOUD initiation where feasible
c. Partner with health plans to revise beneficiary education materials (e.g., flyers and brochures that can be used in Medi-Cal care settings) to improve acceptability of MOUD
d. Provide enhanced member care coordination (e.g., behavioral health integration, case management, improved communication between behavioral health and MCPs, improved discharge planning practices and support).

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To ensure appropriate evaluation of these goals, Table 10 below outlines the interventions, variables (indicators), performance measures (outcomes) and target for the PIP

TABLE 10: CLINICAL PIP GOALS AND PERFORMANCE MEASURES

Goal	Interventions	Variables (Indicators)	Performance Measures (Outcomes)	Target Improvement Rate
1. Train administrators, support staff, and practitioners, counselors, and peers about MOUD and how they can facilitate access to it.	MOUD Trainings	a. Number of MOUD trainings. b. Breadth of participants in each training	a. Trainings per month b. Number of agencies in attendance	a. >1 month b. 1 representative from each agency
2. Increase the number of access points for MOUD available to Medi-Cal beneficiaries specifically including low-threshold telephone-based MOUD initiation where feasible.	Increase the number of access points	a. Count of access points b. Count of claims for MAT and billing for care coordination to MAT outside of DMC-ODS	a. Increase in the number of access points measured every 6 months b. % of patients with MOUD who have claim codes for MAT and Care Coordination to MAT outside of DMC-ODS	a. addition of one new access point per 6 months b. >15% of patient with MOUD have claim codes for MAT and Care Coordination to MAT outside of DMC-ODS
3. Partner with health plans to revise beneficiary education materials (e.g., flyers and brochures that can be used in Medi-Cal care settings) to improve acceptability of MOUD.	Beneficiary education materials	Number of sites using education materials	Increase in the number of sites using education materials measured every 6 months	a. Addition of one new access point using education materials per 6 months
4. Provide enhanced member care coordination (e.g., behavioral health integration, case management, improved communication between behavioral health and MCPs, improved discharge planning practices and support)	Enhanced member care coordination	a. Count of access points b. Count of claims for MAT and billing for care coordination to MAT outside of DMC-ODS	a. Increase in the number of access points measured every 6 months b. % of patients with MOUD who have claim codes for MAT and Care Coordination to MAT outside of DMC-ODS	a. Addition of one new access point per 6 months b. >15% of patient with MOUD have claim codes for MAT and Care Coordination to MAT outside of DMC-ODS

Results:
This clinical PIP is in the implementation phase. The PIP started on 11/2022 and is anticipated to end on 11/2024.

3. Grievance and Appeals

The complaint/grievance and appeals processes for SUD is similar to that described above for LACDMH. They are available for patients, their authorized representative, or providers acting on behalf of the patient ("involved parties").

A grievance (or complaint) and appeal may be submitted to the SAPC or its network of providers. At the SUD treatment agency level, providers must have clear and transparent policies and procedures for managing complaints, grievances, and appeals. These processes should be integrated into the agency's monitoring and quality improvement efforts and include signage informing patients of their rights to file grievances with SAPC, DHCS Office of Civil Rights, and the United States Health and Human Services Office of Civil Rights.

SAPC's Contracts and Compliance Division in partnership with the Quality Improvement unit tracks, investigates, and monitors grievances and appeals. Table 11 summarizes the number and percentage of inpatient and outpatient grievances and appeals by category and disposition.

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TABLE 11: SAPC GRIEVANCES AND APPEALS
FY 2022-2023

GRIEVANCES						
CATEGORY	PROCESS		GRIEVANCE DISPOSITION			
	Grievance	Exempt Grievance	Grievances Pending, Unresolved as of June 30, 2023	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	0	0	0	0	0	0
24/7 Toll-free access line	0	0	0	0	0	0
Linguistic services	0	0	0	0	0	0
Other access issues	9	0	0	9	0	0
(Access) TOTAL	9	0	0	9	0	0
Percent	**23%**	**0.0%**	**0.0%**	**100%**	**0.0%**	**0.0%**
QUALITY OF CARE		0	0		0	0
Staff behavior concerns	2	0	0	3	0	0
Treatment issues or concerns	1	0	1	0	0	0
Medication concern	0	0	0	0	0	0
Cultural appropriateness	1	0	0	1	0	0
Other quality of care issues	9	0	1	8	0	0
(Quality of Care) TOTAL	**13**	0	**2**	**11**	0	0
Percent	**34%**		**14%**	**85%**	0	0
Change of Provider	0	0	0	0	0	0
Confidentiality Concern	0	0	0	0	0	0
Percent	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
OTHER						
Financial	0	0	0	0	0	0
Case Management	2	0	0	5	0	0
Operational	0	0	0	0	0	0
Patient's Rights	0	0	0	0	0	0
Peer behaviors	0	0	0	0	0	0
Physical environment	0	0	0	0	0	0
Suspected Fraud	0	0	0	0	0	0
Abuse, Neglect or Exploitation	9	0	0	9	0	0
Other grievance not listed above	5	0	0	5	0	0
(Other) TOTAL	**16**	**0**	**0**	**16**	**0**	**0**
Percent	**42%**	**0.0%**	**0.0%**	**100%**	**0.0%**	**0.0%**
GRAND TOTAL	**38**	**0**	**2**	**36**	**0**	**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**

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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