APPENDICES

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17. Summary of Substantive Recommendations and LACDMH Responses

APPENDIX 1

Roster of Participants

A. MHSA Stakeholder Delegates Roster

B. Ad Hoc Plan-to-Plan Advisory Group Roster

C. Ad Hoc Guidelines Advisory Group Roster

D. Ad Hoc Plan Development Advisory Group Roster

MHSA Stakeholder Delegates DIRECTORY

Representation	Delegate or Alternate Name	Entity	Contact Number	Email Address
Commissions/Advisory Councils-C/AC				
Children's Council	Sharon G. Watson	The Children's Council of Los Angeles County	213.893.0421	swatson@laccpc.org
	Alt: Colleen Mooney	The Children's Council of Los Angeles County	310-346-6815	comooney@sbcglobal.net
Commission for Children & Families	Helen Kleinberg	Commission for Children and Families	213.974.1558	hnkkleinberg@sbcglobal.net
	Alt: Trish Curry	Commission for Children and Families	213.974.1558 626.441.5602	trishacurry2@earthlink.net
Co-Occurring Joint Action Council	Jim O'Connell, CEO	COJAC / Social Model Recovery Sys.	626.332.3145	jimo@socialmodel.com
	Alt: Vivian Brown, PhD, Pres./CEO	COJAC / Prototypes	310.641.7795	protoceo@aol.com
First 5 LA	Deanne Tilton, First 5 LA Commissioner	First 5 LA	626.455.4585	tiltod@dcfs.lacounty.gov
	Alt: TBD			
MHSA Housing Advisory Board	La Cheryl Porter	Community Development Commission	323-838-7700	lacheryl.porter@lacdc.org
	Alt: Neil Mc Guffin	Corporation Supportive Housing	213-623-4342 ext. 107	neil.mcguffin@csh.org
Mental Health Commission	Jerry Lubin, Chair	AICP / MH Commission	213.738.4772	jerry917@earthlink.net
	Alt: Larry Gasco, Vice-Chair	MH Commission	213.738.4772	ldgasco@hotmail.com
Narcotics and Dangerous Drugs Commission	Lauraine Barber, 2nd Vice Chair	Narcotics and Dangerous Drugs Commission	562.429.6826	lgrams17@aol.com
	Alt: Jack Kearney, 1st Vice Chair	Narcotics and Dangerous Drugs Commission	562.461.9446	jpk@familyintervention.com
Service Area Advisory Committees (SAAC)	3 delegates and 3 alternates each			
SAAC I	JoEllen Perkins	DMH	661.575.1800	jperkins@dmh.lacounty.gov
	Alt: TBD			
	Natalie Ambrose	Community Resident	661.270.1517	namb@earthlink.net
	Alt: TBD			
SAAC II	Eva Carrera	DMH	213-738-3190	ecarrera@dmh.lacounty.gov
	Alt: Beth Briscoe	DMH	818 598-1944	bbriscoe@dmh.lacounty.gov
	Jim Randall	DMH	818.708.4511	jrandall@dmh.lacounty.gov
	Alt: William Lemley	San Fernando Valley Community MHC	818.989.7475	wlemley@sfvcmhc.org
	Emma Oshagan	Pacific Clinics	626.441.4221 ext. 242	eoshagan@pacificclinics.org
	Alt: Eddie Viramontes	El Centro de Amistad	818.898.0223	ed.v@elcentrodeamistad.org
SAAC III	Alfredo Larios	DMH	213.738.3572	alarios@dmh.lacounty.gov
	Alt: TBD			
	Anne Wrotniewski	SAAC III	323.264.8701	AWROTNIEWSKI@ccharities.org
	Alt: David K. Gaffield	San Gabriel Children's Center	626.859.2089	davidgaffield@sangabrielchild.com
	Bertha Washington	NAMI Pomona	909.593.9995	wash350@msn.com
	Alt: Earsel Laskey	DMH/Arcadia MHC	626.821.5858	elaskey@dmh.lacounty.gov

MHSA Stakeholder Delegates DIRECTORY

Representation	Delegate or Alternate Name	Entity	Contact Number	Email Address
SAAC IV	Ed Vidaurri	DMH	213.738.3765	evidaurri@dmh.lacounty.gov
	Alt: Larry Hurst	DMH	213.430.6732	lhurst@dmh.lacounty.gov
	Elvie Soldevilla	APCTC	213.483.3000 ext.300	esoldevilla@apctc.org
	Alt: Don Edmondson	CA DMH	213.624.1732	dpe70@post.harvard.edu
	Don Parrington	IMCES	213.381.1250	dparrington@earthlink.net
	Alt: K. Albert Thompson	DMH	213.251.6522	athompson@dmh.lacounty.gov
SAAC V	Karen Wiliams	DMH	310.268.2507	kwilliams@dmh.lacounty.gov
	Alt: Patrice Grant	DMH	310.268.2508	pgrant@dmh.lacounty.gov
	Ruth Hollman	SHARE	310-305-8878	ruth@shareselfhelp.org
	Alt: Jason Robison	SHARE	310-305-8878	jason@shareselfhelp.org
	Roland Moses	N/A	310.208.3399	rolandgmoses@msn.com
	Alt: Michi Okano	Pacific Asian Counseling Services	310.337.1550	mokano@pacsla.org
SAAC VI	Yolanda Whittington	DMH	323.298.3715	ywhittington@dmh.lacounty.gov
	Alt: Carol Vernon	DMH	310.668.3962	cvernon@dmh.lacounty.gov
	Ray Hernandez	USC School for Early Childhood Education	213-743-6540	Raymond@usc.edu
	Alt: TBD			
	Eddie Lamon	Community Advocate	310.608.1597	N/A
	Alt: TBD			
SAAC VII	Ana Suarez	DMH	213.738.3499	asuarez@dmh.lacounty.gov
	Alt: Carol Sagusti	DMH	213.738.3468	csagusti@dmh.lacounty.gov
	Dwyane Clements	DMH/Rio Hondo MHC	562.402.0688	dclements@dmh.lacounty.gov
	Alt: Carmen (Fatima) Baldizon	DMH	562.903.5394	Fbaldizon@dmh.lacounty.gov
	Kathy Salazar	MELA Counseling Services Center	323.721.6855	kathy-melacenter@sbcglobal.net
	Alt: Lourdes Caracoza	ALMA Family Services	323.881.3799	lourdesc@almafs.com
SAAC VIII	Lisa Wicker	100 Oceangate suite 550 Long Beach, CA 90802	562-435-2337	lawicker@dmh.lacounty.gov
	Alt: TBD			
	Cathy Williamson	DMH/Long Beach South Bay	562.435.2207	cwilliamson@dmh.lacounty.gov
	Alt: Romanda Harmon	Community Advocate	562.746.7878	ROMANDAMARIE@hotmail.com
	Erika Hainley-Jewell	The Children's Clinic	562.933.0513	ehainley@thechildrensclinic.org
	Alt: Kimberlee Woods	Center for Long Beach	562.434.4455	kimw@centerlb.org

MHSA Stakeholder Delegates DIRECTORY

Representation	Delegate or Alternate Name	Entity	Contact Number	Email Address
Community Advocates - CA				
Advocate for Homeless and Mentally Ill	Michael Castillo, Program Specialist	LA County Chief Executive Office	213.974.4652	mcastillo@ceo.lacounty.gov
	Alt: TBD			
	Tod Lipka, CEO	Step Up on Second	310-394-6889 ext. 26	tod@stepuponsecond.org
	Alt: TBD			
Client Stakeholder Group	Keris Jan Myrick	Project Return, Peer Support Network	323.346.0960 X.222	keris@mhala.org
	Alt: Andrew Posner	Division Director BACUP	213.368.1888 ext. 12	aposner@bacup.net
Client Stakeholder Group (incl. CA Network)	Gaines Lyons, CNMHC Board Director	CA Network of Mental Health Clients	323.346.0960	glyons@mhala.org
	Alt: Ursula Sims	CA Network of Mental Health Clients	213.251.6523	usims@dmh.lacounty.gov
LAC Client Coalition	Audrey Hall	Los Angeles County Client Coalition	310.637.9991	ahall80028@aol.com
	Alt: Ana Swett	Los Angeles County Client Coalition	310.659.3494	annaswett1@aol.com
	Maria Tan	Los Angeles County Client Coalition	310.485.2003	mariaftan@yahoo.com
	Alt: Darla Baker	Los Angeles County Client Coalition	562.857.9419	dbaker@dmh.lacounty.gov
Mental Health Advocacy Services, Inc.	Jim Preis, Executive Director	MHAS, Inc.	213.389.2077 ext. 13	jpreis@mhas-la.org
	Alt: Nancy Shea, Senior Attorney	MHAS, Inc.	213.389.2077 ext. 18	nshea@mhas-la.org
National Alliance on Mental Illness	Stella March	NAMI	310.472.4297	SMARCH@nami.org
	Alt: TBA			
Division of Empowerment and Advocacy	Eduardo Vega, Division Chief	DMH	213.251.6580	evega@dmh.lacounty.gov
	Alt: Gwen Lewis-Reid, Assistant Director, OCA	DMH	213.251.6524	glewisreid@dmh.lacounty.gov
Older Adult	Cynthia Jackson	Heritage Clinic, Center for Aging Resources	626.577.8480	cjackson@cfar1.org
	Alt: Holly Kiger	Wise and Healthy Aging	310.576.2550 ext. 239	hkiger@wiseandhealthyaging.org
	Carey Temple	1306 1/2 N.Sycamore LA, CA 90028	Cell# 323-447-2124	yeraclt@att.net
	Alt:TBD			
Parent Advocate	Carmen Diaz, Board President/UACF	United Advocates for Children and Families	213.351.7788	diaz4carmen@yahoo.com
	Alt: Ruth Tiscareno, Lead Parent Partner/Advocate	United Advocates for Children and Families	213.482.9400	rtiscareno@ccsla.org
TAY Representatives	Ms. Heather Carmichael, LCSW	My Friend's Place	323.908.0011 ext. 106	hcarmichael@myfriendsplace.org
	Alt: Nick Taylor, Health Education Coordinator	My Friend's Place	323.908.0011 ext. 124	ntaylor@myfriendsplace,org
	Ronnie E. Thomas, Medical Case Worker II	DMH	213.923.8020	rthomas@dmh.lacounty.gov
	Alt: Erika M. Herrera	Peer Partner at Pacific Clinic 13001 Ramona Blvd. Irwindale, CA 91706	626-337-3828 cell 626-221-1012	eherrera@pacificclinics.org
Veteran Rep	Steven Peck	Community Development Director, US Veterans	562.388.7810	sjpeck@usvetsinc.org
	Alt: Bill Wallace	Clinical Director, US Veterans	562.388.8108	bwallace@usvetsinc.org

MHSA Stakeholder Delegates DIRECTORY

Representation	Delegate or Alternate Name	Entity	Contact Number	Email Address
Community Based Organizations/Foundations - CBO/F				
Association of Community Human Service Agencies (ACHSA)	Bruce Saltzer, Executive Director	ACHSA	213.250.5030 x103	bsaltzer@achsa.net
	Alt: Thomas Hill	ACHSA	213-250-5030	thill@achsa.net
Faith Community Representative	Calvin Hsi, Director Charity Development Department	Taiwan Buddhist Tzu Chi Foundation, U.S.A.	909-447-7931	Calvin_Hsi@us.tzuchi.org
	Alt: Eugene Taw, M.D.	Taiwan Buddhist Tzu Chi Foundation, U.S.A.	626.281.3383	eugenetaw@roadrunner.com
	Ruthie Grey	Faith Community	323.779.2237	Ruthgr3@aol.com
	Alt: TBD			
	Rev. Paul Lance	Southern California Ecumenical Council	310-375-4441	RevLance@Seasideucc.org
	Alt: TBD			
Foundation Community Representatives	Mary Rainwater	Integrated Behavioral Health Project	323.876.7468	rainwatermary@msn.com
	Alt: Beatriz Solis	The CA Endowment	213.928.8736	bsolis@calendow.org
	Bonnie Armstrong	Casey Family Program	626.229.2338	Barmstrong@casey.org
	Alt: TBD			
Education/Schools - E/S				
Education Coordinating Council (ECC)	Carrie D. Miller, PhD, Program Director	ECC	213.974.5967	cmiller@ceo.lacounty.gov
	Alt: TBD			
Los Angeles County Office of Education	Madeline Hall, Chief Grants Officer	LACOE	562.922.6112	hall_madeline@lacoe.edu
	Alt: Ray Vincent	LACOE	562.922.6301	Vincent_Ray@lacoe.edu
Los Angeles Unified School District	Rene Gonzalez, Assistant Superintendent	LAUSD	213.241.3856	rene.gonzalez@lausd.net
	Alt: John DiCecco, Director	LAUSD	213.241.3872	john.dicecco@lausd.net
Government - GOV				
Alcohol and Drug Admin.	Yolanda Cordero, Prevention Coordinator	LA County Alcohol and Drug Programs Admin.	626.299.4510	ycordero@ph.lacounty.gov
	Alt: Sandy Song, Planner, Planning Division	LA County Alcohol and Drug Programs Admin.	626.299.3234	sasong@ph.lacounty.gov
City of Los Angeles Representative	Paul Freese, Director of Litigation and Advocacy	Public Council	213.385.2977 x109	pfreese@publiccounsel.org
	Alt: Leslie Wise	LA Homeless Services	213-225-6566	leslie.wise@lacity.org
Community and Municipal Services Cluster	Lari Sheehan, Deputy CEO, Chief Executive Office 500 W. Temple Str. Room 723 LA, CA 90012	LA County CEO	213.893.0321	lsheehan@ceo.lacounty.gov
	Alt: TBD			
Los Angeles County Department of Children and Family Services	Harvey Kawasaki, Division Chief	LA County DCFS	213.738.3000	kawash@dcfs.lacounty.gov
	Alt: Michael Rauso, Division Chief	LA County DCFS	213.738.3601	rausom@dcfs.lacounty.gov
Los Angeles County Department of Community & Senior Services	Lorenza Sanchez	LA County DCSS	213.738.4045	lsanchez@css.lacounty.gov
	Alt: Roseann Donnelly	LA County DCSS	213.738.4238	rdonnelly@css.lacounty.gov
Los Angeles County Department of Health Services	Melissa Christian, Mental Health Liason	LA County DHS	213.240.7834	mchristian@dhs.lacounty.gov
	Alt: Karen Bernstein, Director, Special Programs	LA County DHS	213.250.8644	kbernstein@dhs.lacounty.gov

MHSA Stakeholder Delegates DIRECTORY

Representation	Delegate or Alternate Name	Entity	Contact Number	Email Address
Los Angeles County Department of Probation	Andrea Gordon, Director	LA County Probation	323.730.4547	andrea.gordon@probation.lacounty.gov
	Alt: Joseph Delfin, Deputy Probation Officer II	LA County Probation	323.213.0406	joseph.delfin@probation.lacounty.gov
Los Angeles County Department of Public Social Services	Judith Lillard, Program Director	LA County DPSS	562.908.5861	JudithLillard@dpss.lacounty.gov
	Alt: Ken Krantz	LA County DPSS	562.908.6772	KenKrantz@dpss.lacounty.gov
Los Angeles County Sheriff	Director Karen Dalton	LA County Sheriff	213.893.5882	ksdalton@lasd.org
	Alt: Commander Detta Roberts	LA County Sheriff	213.893.5918	blroberts@lasd.org
Los Angeles Police Department	Lt. Lionel Garcia	LAPD	213.485.3300	24050@lapd.lacity.org
	Alt: Det. Charles Dempsy	LAPD	213.485.3395	30036@lapd.lacity.org
Los Angeles County Public Defender's Office	Joanne Rotstein, Special Assistant	LA County Public Def.	213.974.2811	Jrotstein@pubdef.lacounty.gov
	Alt: Robert Fefferman	LA County Public Def.	323.226.8167	Rfefferman@lacopubdef.org
Public Health Representative	Cynthia Harding	Los Angeles County of Public Health	213.639.6400	charding@ph.lacounty.gov
	Alt: Jeanne Smart, Director Nursing Family Partnership	Los Angeles County of Public Health	213.639.6461	jsmart@ph.lacounty.gov
Superior Courts	Tim Dowell	Superior Courts	323.226.2944	tdowell@lasuperiorcourt.org
	Alt: Richard Luckham	Superior Courts	323.226.2913	rluckham@lasuperiorcourt.org
Health Care - HC				
Community Health Clinics	Louise McCarthy, President/CEO	Community Clinic Association of LAC	213.201.6500	lmccarthy@ccalac.org
	Alt: Cynthia Carmona	Community Clinic Association of LAC	213.201.6500	ccarmona@ccalac.org
Hospital Representative	Mara Pelsman, CEO	Gateways Hospital	323.644.2000 ext. 274	mpelsman@gatewayshospital.org
	Alt: TBD			
L.A. CARE	Cheryl Garcia, R.N., UM Liaison	L.A. CARE	213.695.1250 ext. 4136	cgarcia@lacare.org
	Alt: Rus Billimoria, MBBS, MPH	L.A. CARE	213.695.1250 ext. 4274	rbillimoria@lacare.org
Underrepresented Ethnic Communities & Other Underserved Communities - UREP/OC				
Disabled Community Rep	Jennifer Olson	Greater Los Angeles Agency on Deafness, Inc. (GLAD)	323-478-8000	jolson@gladinc.org
	Alt: TBD			
Gay/Lesbian Community Representative	Diane Kubrin	L.A. Gay & Lesbian Center	323-993-7432	dkubrin@lagaycenter.org
	Alt: Susan Holt	L.A. Gay & Lesbian Center	323-993-7645	sholt@lagaycenter.org
UREP Representative (At Large)	Tara Pir	IMCES	213.381.1250 ext. 228	TaraPirIMCES@msn.com
	Alt: Luis Garcia	Pacific Clinics	626.254.5000	lgarcia@pacificclinics.org
African / African American	Ron Hasson	NAACP	323.464.7616	ronhasson@sbcglobal.net
	Alt: Beckelech Woude	Community Advocate	310.927.4074 323.294-2511	N/A

MHSA Stakeholder Delegates DIRECTORY

Representation	Delegate or Alternate Name	Entity	Contact Number	Email Address
American Indian	Benjamin Hale	Community Advocate	N/A	bnavajo@aol.com
	Alt: Mark Parra	AIDS Project Los Angeles, Native American Programs	213.251.6504	mparra@dmh.lacounty.gov
Asian American and Pacific Islander	Mariko Kahn, Executive Director	Pacific Asian Counseling Services	310.337.1550 ext 2018	mkahn@pacsla.org
	Alt: Terry Gock, Director	Asian Pacific Family Center	626.287.2988	tgock@pacificclinics.org
Eastern European / Middle Eastern	Angela Savoian	American Releif Society	818. 314-3906	asavoian@hotmail.com
	Alt: Sherif Toma	IMCES	213-381-1250	sheriftoma@yahoo.com
Latino	Leticia Ximénez	EOB/SA 4	213-738-6193	LXimenez@dmh.lacounty.gov
	Alt: Maria Elana Juarez	The Latino Coalition	213.484.1932	N/A
Workforce - WF				
Academic Partnerships Representative/Universities and Research Representative	Karl Burgoyne, M.D., Professor	Department of Psychiatry, Harbor UCLA	310.222.3137	kburgoyne@dmh.lacounty.gov
	Alt: Mary Read, M.D., Medical Director	Department of Psychiatry, Harbor UCLA	310.222.3344	mread@dmh.lacounty.gov
Academic Partnerships Representative/Universities and Research Representative	Micki Gress, Director, Assistant Dean	USC School of Social Work	213.740.0294	gress@usc.edu
Academic Partnerships Representative/Universities and Research Representative	Alt: Ferol Mennen, Associate Professor	USC School of Social Work	213.740.1295	mennen@usc.edu
AFSCME Union	Teddy McKenna, LCSW	AFSCME	213-252-1382	L2712@afscme36.org
	Alt: Brad Stevens, President	DMH/Harbor UCLA	310.222.5391	bstevens@dmh.lacounty.gov
SEIU Union	Jane Jose	SEIU	213.368.8671	jane.jose@seiu721.org
	Alt: Michael Alba, Clinical Psychologist	SEIU	818.832.2400	malba@dmh.lacounty.gov
Staff Advisory Council	Heidi Rotheim	DMH	213.738.2988	hrotheim@dmh.lacounty.gov
	Alt: Hector Garcia	DMH/West Valley MHC	213.305.3129	hgarcia@dmh.lacounty.gov
Training Workgroup	TBD			
	Alt: TBD			
Other				
At Large	C. Rocco Cheng, Corporate Director	Pacific Clinics	626.960.4020 ext. 208	rcheng@pacificclinics.org
	Alt: Wendy Wang	Pacific Clinics	626-960-4020	wwang@pacificclinics.org
	Richard Van Horn	Mental Health Association in LA County	562.285.1330	rvanhorn@mhala.org
	Deborah Tull	Los Angeles Community College District	310.233.4621	tulld@lahc.edu
	Alt: Bonnie Burstein	Los Angeles Community College District	310.233.4586	bursteb@lahc.edu
	Areta Crowell	Retired Director, County of Los Angeles, DMH	323.463.7535	acrowell13@sbcglobal.net
	Miguel Santana	Deputy Chief Executive Officer, Children & Families Well Being	213.974.4530	msantana@ceo.lacounty.gov
	Garrison Smith, LA County Homeless Coordinator	Shelter Partnership, Inc.	213.974.4673	gsmith@ceo.lacounty.gov
	Catherine Bond	LACCC(Los Angeles County Client Coalition)	559-300-8677	cbond702002@yahoo.com

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU

MHSA PREVENTION AND EARLY INTERVENTION (PEI)
PLAN-TOPLAN ADVISORY GROUP ROSTER

EXECUTIVE MANAGEMENT TEAM REPRESENTATIVES			
BUREAU/DIVISION	**REPRESENTATIVE**	**PHONE NO.**	**E-MAIL ADDRESS**
Office of the Director – Empowerment & Advocacy Division	Eduardo Vega	(213) 251-6580	EVega@dmh.lacounty.gov
Office of the Director – Public & Government Relations Division	Kumar Menon	(213) 639-6757	KMenon@dmh.lacounty.gov
Office of the Chief Deputy Director	Robin Kay	(213) 738-4108	RKay@dmh.lacounty.gov
Office of the Medical Director	William Arroyo	(213) 738-6152	WArroyo@dmh.lacounty.gov
Office of the Administrative Deputy	Lyn Wallensak	(213) 738-2891	KWallensak@dmh.lacounty.gov
Program Support Bureau	Dennis Murata	(213) 738-4978	DMurata@dmh.lacounty.gov
Program Support Bureau – Planning Division	Gladys Lee	(213) 251-6801	GlLee@dmh.lacounty.gov
Program Support Bureau – Training Division	Alfredo Larios	(213) 251-6879	ALarios@dmh.lacounty.gov
Chief Information Office Bureau	Gordon Bunch	(213) 251-6413	gbunch@dmh.lacounty.gov
Emergency Outreach Bureau	Mary Marx	(323) 226-4744	MMarx@dmh.lacounty.gov
Child, Youth & Family Program Administration	Sam Chan	(213) 738-3201	SChan@dmh.lacounty.gov
Specialized Children & Youth Services Bureau	Sandra Thomas	(213) 738-4644	SThomas@dmh.lacounty.gov
Adult Systems of Care	Jacquie Wilcoxen	(562) 435-2337	JWilcoxen@dmh.lacounty.gov

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU

MHSA PREVENTION AND EARLY INTERVENTION (PEI)
PLAN-TO-PLAN ADVISORY GROUP ROSTER

Older Adult System of Care	James Cunningham	(213) 351-7254	JCunningham@dmh.lacounty.gov
Service Area District Chiefs	Carlotta Childs-Seagle Edward Vidaurri	(213) 738-3572 (213) 738-3765	CChildsSeagle@dmh.lacounty.gov EVidaurri@dmh.lacounty.gov

PEI STAFF			
BUREAU/DIVISION	**REPRESENTATIVE**	**PHONE NO.**	**E-MAIL ADDRESS**
Program Support Bureau – Central Administration	Angel Baker	(213) 738-4105	ABaker@dmh.lacounty.gov
Program Support Bureau – PEI Countywide Administration	Lillian Bando	(213) 738-2321	LBando@dmh.lacounty.gov
Program Support Bureau – PEI Countywide Administration	Mary Silvestrini	(213) 738-2336	MSilvestrini@dmh.lacounty.gov
Program Support Bureau – PEI Countywide Administration	Lea VanDenburgh	(213) 351-5206	LVanDenburgh@dmh.lacounty.gov
Program Support Bureau – PEI Countywide Administration	Lisa Wicker	(213) 738-2322	LAWicker@dmh.lacounty.gov
Consultant	Randall Ahn	(213) 738-2329	RAhn@dmh.lacounty.gov
Consultant	Yvette Townsend	(310) 560-5548	YvetteLTownsend@aol.com

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PREVENTION AND EARLY INTERVENTION (PEI) ADMINISTRATION

Ad-Hoc PEI Guidelines Advisory Group Roster

Name	Organization	Sector	Service Area	Email Address	Age	Priority Population
STAKEHOLDER DELEGATES						
Barber, Lauraine Delegate – Narcotics Commission	LAC Narcotics and Dangerous Drugs Commission	Education Consumer/Family Health	8, ALL	lgrams17@aol.com	ALL	1. Experiencing Onset 2. C/Y Stressed Families 3. Trauma-Exposed
Bear, Laurel Delegate – Other School Districts	Alhambra Unified School District	Education	3	Bear_Laurel@alhambra.k12.ca.us	C	1. C/Y School Failure 2. C/Y Stressed Families 3. Juvenile Justice
Bond, Catherine Delegate – Client Stakeholder	Mental Health Association/Project Return	Consumer/Family Underserved	ALL	cbond@mhala.org	A, OA	1. Experiencing Onset 2. Underserved 3. Trauma-Exposed
Carmichael, Heather Delegate – TAY	My Friends Place	Underserved – Homeless youth	4	HCarmichael@myfriendsplace.org	C, TAY	1. Trauma-Exposed 2. Underserved 3. Experiencing Onset
Cheng, Rocco Delegate – At-large	Pacific Clinics	Mental Health Underserved Faith Based	2, 3, 7 ALL	rcheng@pacificclinics.org	ALL	1. Underserved 2. C/Y Stressed Families 3. Experiencing onset
Diaz, Carmen Delegate – Parent Advocate	DMH/United Advocates for Children and Families	Consumer/Family	ALL	CDiaz@dmh.lacounty.gov	C, TAY	ALL, except Experiencing Onset
Garcia, Cheryl Delegate – L.A. Care	LA Care Health Plan	Underserved, Health	ALL	cgarcia@lacare.org	ALL	1. Underserved 2. Experiencing Onset
Gordon, Andrea Delegate - Probation	Probation	Law Enforcement Underserved	ALL	Andrea.gordon@probation.lacounty.gov	C, TAY, A	1. Juvenile Justice 2. C/Y School Failure 3. Trauma-Exposed 4. C/Y Stressed Families 5. Underserved
Hasson, Ron Delegate – UREP/African-American	NAACP	Underserved Health, Mental Health	ALL	ronhasson@sbcglobal.net	ALL	1. Underserved
Hollman, Ruth Delegate – SAAC V	SHARE!	Health	5, ALL	ruth@shareselfhelp.org	A	1. Trauma-Exposed 2. Underserved 3. Experiencing Onset
Jackson, Cynthia Delegate – Older Adults	Heritage Clinic	Mental Health Underserved Consumer/Family	1,2,3,4, 8	Cjackson@cfar1.org	OA	1. Experiencing Onset 2. Underserved 3. Trauma- Exposed
Kawasaki, Harvey Delegate – L.A. County Department of Children and Family Services	DCFS	Social Services	ALL	kawash@dcfs.lacounty.gov	C, TAY	1. C/Y Stressed Families 2. Trauma-Exposed 3. C/Y School Failure 4. Juvenile Justice

Name	Organization	Sector	Service Area	Email Address	Age	Priority Population
STAKEHOLDER DELEGATES - continued						
Kleinberg, Helen Delegate – Commission for Children & Families	LAC Commission on Children & Families	Social Services ALL additional that relate to children/youth	ALL, 2	hnkkleinberg@sbcglobal.net	C, TAY	1. C/Y Stressed Families ALL that relate to children/youth
Lamon, Eddie Delegate – SAAC 6	SAAC 6 Chair	Consumer/Family Underserved	6	No email	ALL	1. Underserved 2. Trauma-Exposed
Peck, Stephen Delegate – Veterans	U.S. Veterans	Underserved – Homeless Social Services – Veterans	5, 6, 8	sjpeck@usvetsinc.org	A, OA	1. Trauma-Exposed 2. Experiencing Onset
Pir, Tara Delegate – UREP	IMCES	Underserved Social Services, Mental Health Community Resource Media	2, 4	TaraPirIMCES@msn.com	A, ALL	1. Underserved 2. C/Y Stressed Families 3. Trauma-Exposed
Rotstein, Joanne Delegate – L.A. County Public Defenders Office	L.A. County Public Defenders Office	Law Enforcement	ALL	jrotstein@pubdef.lacounty.gov	ALL	1. Juvenile Justice 2. Experiencing Onset 3. C/Y School Failure
Temple, Carey Delegate – Older Adults	DMH	Consumer/Family	ALL	CTemple@dmh.lacounty.gov	ALL	ALL
Van Horn, Richard Delegate – At-large	Mental Health Association	Mental Health Education, Underserved	ALL	rvanhorn@mhala.org	ALL	ALL
STAKEHOLDER ALTERNATES						
Alba, Michael Alternate – SEIU Union	DMH/SEIU	Employment Mental Health	2	MAlba@dmh.lacounty.gov	C, TAY	1. C/Y Stressed Families 2. Underserved 3. C/Y School Failure
Burstein, Bonnie Alternate – At-large	LA Community College District	Education Mental Health Underserved	ALL	bursteb@lahc.edu	ALL	1. Underserved 2. Experiencing Onset 3. (Stressed families, trauma exposed, school failure)
Coral, Lilian Alternate – Children's Planning Council	LAC Children's Planning Council	Social Services	ALL	lcoral@laccpc.org	C, TAY	1. Underserved 2. C/Y Stressed Families
McCarthy, Louise Alternate – Community Clinics	Community Clinic Association	Health Mental Health	ALL	LMcCarthy@ccalac.org	ALL	ALL, except Juvenile Justice
Wang, Wendy Alternate - ACHSA	ACHSA	Mental Health	ALL	wwang@achsa.net	ALL	ALL
OTHER REPRESENTATIVES						
Boardman, Bruce SAAC III Co-chair	Social Model Recovery Systems	SAAC Chairperson Rep., Health Mental Health	3, ALL	bruceb@socialmodel.com	A	1. Experiencing Onset 2. Trauma-Exposed 3. Underserved
Rabens, Ilean	Mental Health Commission	ALL–work with Juvenile Halls and Camps	7, 8 & ALL	irabens919@aol.com	C, TAY	ALL, except Experiencing Onset

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PREVENTION AND EARLY INTERVENTION (PEI) ADMINISTRATION

Ad-Hoc PEI Plan Development Advisory Group Roster

Name	Organization	Sector	Service Area	Email Address	Age	Priority Population
STAKEHOLDER DELEGATES						
Carmichael, Heather Delegate – TAY	My Friend's Place	Underserved – Homeless youth	4	HCarmichael@myfriendsplace.org	C, TAY	1. Trauma-Exposed 2. Underserved 3. Experiencing Onset
Cheng, Rocco Delegate – At-large	Pacific Clinics	Mental Health Underserved Faith Based	2, 3, 7 ALL	rcheng@pacificclinics.org	ALL	1. Underserved 2. C/Y Stressed Families 3. Experiencing onset
Diaz, Carmen Delegate – Parent Advocate	DMH/United Advocates for Children and Families	Consumer/Family	ALL	CDiaz@dmh.lacounty.gov	C, TAY	ALL, except Experiencing Onset
Garcia, Cheryl Delegate – L.A. Care	LA Care Health Plan	Underserved, Health	ALL	cgarcia@lacare.org	ALL	1. Underserved 2. Experiencing Onset
Gonzalez, Rene Delegate – Los Angeles Unified School District	LAUSD	Education	ALL	rene.gonzalez@lausd.net	C, TAY	ALL
Gordon, Andrea Delegate - Probation	Probation Department	Law Enforcement Underserved	ALL	Andrea.gordon@probation.lacounty.gov	C, TAY, A	1. Juvenile Justice 2. C/Y School Failure 3. Trauma-Exposed 4. C/Y Stressed Families 5. Underserved
Jackson, Cynthia Delegate – Older Adults	Heritage Clinic	Mental Health Underserved Consumer/Family	1,2,3,4, 8	Cjackson@cfar1.org	OA	1. Experiencing Onset 2. Underserved 3. Trauma- Exposed
Kawasaki, Harvey Delegate – L.A. County Department of Children and Family Services	DCFS	Social Services	ALL	kawash@dcfs.lacounty.gov	C, TAY	1. C/Y Stressed Families 2. Trauma-Exposed 3. C/Y School Failure 4. Juvenile Justice
Kleinberg, Helen Delegate – Commission for Children & Families	LAC Commission on Children & Families	Social Services ALL additional that relate to children/youth	ALL, 2	hnkkleinberg@sbcglobal.net	C, TAY	1. C/Y Stressed Families ALL that relate to children/youth
Lamon, Eddie Delegate – SAAC VI	SAAC VI Chair	Consumer/Family Underserved	6	No email	ALL	1. Underserved 2. Trauma-Exposed
McCarthy, Louise Delegate – Community Clinics	Community Clinic Association	Health Mental Health	ALL	LMcCarthy@ccalac.org	ALL	ALL, except Juvenile Justice

Name	Organization	Sector	Service Area	Email Address	Age	Priority Population
STAKEHOLDER DELEGATES - continued						
Olson, Jennifer Delegate – Disabled Community	Greater Los Angeles Agency on Deafness (GLAD)	Underserved	ALL	jolson@gladinc.org	ALL	1. Underserved 2. C/Y Stressed Families 3. C/Y School Failure
Pir, Tara Delegate – UREP	IMCES	Underserved Social Services, Mental Health Community Resource Media	2, 4	TaraPirIMCES@msn.com	A, ALL	1. Underserved 2. C/Y Stressed Families 3. Trauma-Exposed
Randall, Jim Delegate – SAAC II	DMH	Consumer/Family	2	JRandall@dmh.lacounty.gov	TAY, A, OA	Experiencing Onset
Rotstein, Joanne Delegate – L.A. County Public Defenders Office	L.A. County Public Defenders Office	Law Enforcement	ALL	jrotstein@pubdef.lacounty.gov	ALL	1. Juvenile Justice 2. Experiencing Onset 3. C/Y School Failure
Van Horn, Richard Delegate – At-large	Mental Health Association	Mental Health Education, Underserved	ALL	rvanhorn@mhala.org	ALL	ALL
STAKEHOLDER ALTERNATES						
Alba, Michael Alternate – SEIU Union	DMH/SEIU	Employment Mental Health	2	MAlba@dmh.lacounty.gov	C, TAY	1. C/Y Stressed Families 2. Underserved 3. C/Y School Failure
Burstein, Bonnie Alternate – At-large	LA Community College District	Education Mental Health Underserved	ALL	bursteb@lahc.edu	ALL	1. Underserved 2. Experiencing Onset 3. (Stressed families, trauma exposed, school failure)
Posner, Andrew Alternate – Client Stakeholder Group	BACUP	Consumer/Family	4	aposner@bacup.net	A	1. Underserved 2. Experiencing Onset
OTHER REPRESENTATIVES						
Boardman, Bruce SAAC III Co-chair	Social Model Recovery Systems	SAAC Chairperson Rep., Health Mental Health	3, ALL	bruceb@socialmodel.com	A	1. Experiencing Onset 2. Trauma-Exposed 3. Underserved
Rabens, Ilean	Mental Health Commission	ALL–work with Juvenile Halls and Camps	7, 8 & ALL	irabens919@aol.com	C, TAY	ALL, except Experiencing Onset
Wilcoxen, Jacquelyn Service Area District Chief	DMH	Mental Health	6	JWilcoxen@dmh.lacounty.gov	ALL	ALL

APPENDIX 2

Service Area Ad Hoc Steering Committee Rosters

A. SAAC Co-Chairs Roster
B. Service Area Ad Hoc Steering Committee Rosters

Service Area Advisory Committee (SAAC) Roster (7/14/08)

Service Area	Title	Name	Address	Contact Phone	E-mail	District Chief's Name	Contact Phone	E-mail
SAAC 1	Chair	Natalie Ambrose	39124 Calle De Sota Santa Clarita, CA 91390	661-270-1517 661-270-1358 fax	namb@earthlink.net	Jo Ellen Perkins	661-223-3827	jperkins@dmh.lacounty.gov
SAAC 2	Chair	Dorothy Ross	10434 Jellico Avenue Granada Hills, CA 91344	818-368-1306	aross51390@aol.com	Ron Klein	818-568-6967	rklein@dmh.lacounty.gov
SAAC 2	*alt. for meetings*	Tom Walsh	6420 Franrivers Avenue West Hills, CA 91307	818-887-0374	thwalsh@aol.com			
SAAC 3	Co-Chair	Bruce Boardman	223 E. Rowland Street Covina, CA 91723	626-332-3145	bruceb@socialmodel.com	Alfredo Larios	213-738-3572	alarios@dmh.lacounty.gov
SAAC 3	Co-Chair	Gina Perez	800 S. Santa Anita Ave. Arcadia, CA 91006	626-254-5000	gperez@pacificclinics.org			
SAAC 4	Chair	Suzanne Liss	7703 Skill Hill Drive Los Angeles, CA 90068	323-851-4709	harlansu2@aol.com	Ed Vidaurri	213-738-3765	evidaurri@dmh.lacounty.gov
SAAC 5	Co-Chair	Celinda Jungheim	13219-G Fiji Way Marina Del Rey, CA 90292	310-306-6766	celinda@isp.com	Karen Williams	310-268-2507	kwilliams@dmh.lacounty.gov
SAAC 5	Co-Chair	Judith Holtz	1328 Second Street Santa Monica, CA 90401	310-394-6889	judith@stepuponsecond.org			
SAAC 5	Co-Chair	Joshua Efron-Potter	None listed.	310-936-9679	jpotter@gmail.com			
SAAC 6	Co-Chair	Eddie Lamon	2015 E. 131st Street Compton, CA 90222	310-608-1597	None listed.	Jacquelyn Wilcoxen	323-418-4209	Jwilcoxen@dmh.lacounty.gov
SAAC 6	Co-Chair	Hayward McNeill	5588 W. 63rd Street Los Angeles, CA 90056	310-216-7333	haywardhayward@att.net	Carol Vernon	310-668-3962	Cvernon@dmh.lacounty.gov
SAAC 6						Yolanda Whittington	323-298-3715	ywhittington@dmh.lacounty.gov
SAAC 7	Chair	Julie Johnson	9401 S. Painter Avenue Whittier, CA 90605	562-698-8121 x1253	julie.johnson@wuhsd.k12.ca.us	Ana Suarez	213-738-3499	asuarez@dmh.lacounty.gov
SAAC 8	Co-Chair	Lauraine Barber	3109 Lees Avenue Long Beach, CA 90808	562-429-6826	lgrams17@aol.com	Cathy Warner	562-435-2337	cwarner@dmh.lacounty.gov
SAAC 8	Co-Chair	Martha Long	456 South Elm Avenue Long Beach, CA 90802	562-437-6717	mlong@mhala.org			

Service Area 1- Ad Hoc PEI Steering Committee

Constituency Represented		Name	Agency/Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Required Sectors	Education	Michael Geisser	Palmdale Elementary School District	661-947-7191	msgeisser@psd.k12.ca.us	LGBTQ, Prenatal-5, Children	Michael Geisser, MA, NCSP, LEP, is currently the Director of Psychological Services for the Palmdale Elementary School District. He has worked in public education as a school psychologist for 30 years, 29 of those years in Palmdale. He has also been a part-time instructor in the Psychology and Educational Psychology & Counseling Departments at Cal State University at Northridge for the past 15 years. He is a nationally Certified School Psychologist as well as a California State Licensed Educational Psychologist. His backgrounds in psychology and education as well as his experience w/in the Antelope Valley make him a strong representative for the education sector on the Steering Committee.
		Susan Zaks	Try Again	661 538-1319	sz_tryagain@sbcglobal.net	Children, Transition Age Youth Co-Occurring Disorders	Susan Zaks, M.A. has lived in the Antelope Valley since 1986 (23 years) and worked in the A.V. since 1988. She runs a counseling/ community service program for at-risk youth, most of who are on probation. She also participates on the Antelope Valley Stand Down Committee, the Site Council for R.Rex Parris H.S., works on the Bands for Abuse Prevention, Yes2Kids Battle of the Bands, The A.V. Block Party and the Abuse Awareness Walk (to mention a few). She has been working with this population (aged 12-18) since 1997, 11-1/2 years. She has a Bachelors degree in Child Development, a Masters degree in Counseling Psychology, and is a licensed certified chemical dependency counselor. In her current position, she deals with youngsters who have been expelled from comprehensive high schools as well as those expelled from alternative learning centers. In her 26 years of living and working with youth in the Antelope Valley, she has always pressed the youth to go to school, do the work, and do their best in order to lead productive positive life styles. She has worked on various social services committees and is aware of the services or lack of same in our community.
	Health	Stan Sorenson	Tarzana Treatment Center	661-726-2630 ex 4134	ssorensen@Tarzanatc.org	Co-Occurring Disorders, Transition Age Youth, Adults, Older Adults	Stan Sorenson, LMFT, CPRP, has lived in the AV since 1983 and worked for several years as a child care worker and social worker. He has worked nine years as a counselor in the behavior health unit of old Palmdale Hospital and nine years as LPHA at the Mental Health Association (now Mental Health America). More recently, he has worked for 2-1/2 years at Tarzana Treatment Center as Director of Adult Services. These services include substance abuse treatment and primary care in the AV.
		Janice Woods	DHS- Hub/SCAN Clinic	661-945-8531	jawoods@dhs.lacounty.gov	Children Trauma	Janice Woods, MD, MPH, FAAP, Medical Director of High Desert Health System, Hub/SCAN Clinic in Lancaster since November 2008, performs forensic evaluations on children who have been or are suspected of being sexually or physically abused, and or neglected as well as providing ongoing medical care for children in foster care living in the Antelope Valley. Previously, she was the director of the SCAN clinic at LAC+USC Women and Children's Hospital, Violence Intervention Program for three years, where she performed forensic evaluations on children and adolescents who were or were suspected of being physically or sexually abused. She also performed sexual assault examinations on children, adolescents, and adults who were sexually assaulted. She has worked extensively with the Interagency Council on Child Abuse and Neglect, and served on the Child Death Review, Suicide Death Review, and Medical Evaluation committees. She has practiced pediatrics for the past 14 years, working at several county facilities, including Martin Luther King, Harbor-UCLA, Los Angeles County-USC, and High Desert MACC.
	Law Enforcement	Lt. Cory A. Kennedy	Los Angeles Sheriff's Department	661-272-2400	cakenned@lasd.org	Trauma	Lt. Cory A. Kennedy has worked in AV since 1983 as a member of the Sheriff's Department. He is the Lieutenant in charge of the Detective Bureau at the Palmdale Station. He is an expert in the field of Domestic Violence, training, and investigations. He would very much like to support the committee with whatever assistance he can.
		Kyle Jason Smith	California Department of Corrections and Rehabilitation / Division of Adult Parole Operations	661-729-0530 ex 264 661-951-4135 ex 264	kyle.smith@cdcr.ca.gov	Law Enforcement Parole Agent II - Division of Adult Parole Operations	Kyle Jason Smith lives in Kern County and has been working in the Antelope Valley for approximately one year. For the past year he has been employed by the California Department of Corrections and Rehabilitation / Division of Adult Parole Operations / as a Parole Agent II assigned to the Parole and Community Team (PACT) at the Antelope Valley Parole Complex. He has a Bachelor's of Art Degree in Criminal Justice and has been employed with the California Department of Corrections and Rehabilitation for approximately 18 years. Prior to his current assignment in the Antelope valley, he was assigned as a Parole Agent I in Kern County and was in charge of supervising a caseload of adult parolees who participated in the Parolee Out-Patient Clinic (POC) at the level of Enhanced Out Patient (EOP). He is a good candidate for the PEI Ad Hoc Committee because he sees an increased need for the development of community based mental health services that can assist with the prevention, intervention and stabilization of individuals at risk of mental illness.
	Mental Health Provider	Jill Blanks	The Children's Center of the Antelope Valley	661-949-1206	jblanks@childrenscenter.av.org	Children Trauma	Jill Blanks, MA, LMFT, has been the Family Preservation and Family Support Director at The Children's Center of the Antelope Valley since 2006. She has lived and worked in the Antelope Valley since 1983. She worked at Antelope Valley Hospital Medical Center as a therapist and Director of an Eating Disorders program for five years as well as in the inpatient dual diagnosis unit. In 1989 she was a volunteer therapist with The Children's Center in 1989 and thereafter became a staff therapist for the next four years. She worked in private practice for over 15 years as a LMFT. She trained new therapists at The Children's Center on trauma treatment. She was the lead therapist training intern co-therapists for sexually abused children and adults abused as children in a group setting. In 2000 she returned to The Children's Center as a Clinical Supervisor for the Clinical and Family Preservation Departments. For seven years the Federal Aviation Administration contracted with her as an on-site Employee Assistance Counselor to provide assistance for the stressors facing air traffic controllers and support staff. She was part of a Critical Incident Stress Debriefing team debriefing FAA personnel and their families during airplane crashes.
		Kathleen Slijepcevic	Hathaway-Sycamores	661-942-5749 ex 6530	kathleenslijepcevic@hathaway-sycamores.org	Children	Kathleen Slijepcevic, PhD, LMFT, moved to the Antelope Valley in 1993. She has worked at community mental health clinics and local hospitals as a clinician and social worker for the past 12 years, and in the last year began a private in-home counseling practice providing diagnostics and therapy for children and their families enduring trauma. She also counsels those living with chronic medical illness. She serves as Multidisciplinary Assessment Team (MAT) Assessor for Hathaway-Sycamores Children and Family Services, in collaboration with DCFS and DMH. She has had the privilege of providing psychological assessment, evaluation and therapy to the those individuals in need as a paid professional and as a volunteer for Desert Vineyard Church situated in Lancaster, as well as a volunteer therapist, dietary, and laboratory aid for Lancaster Community and Antelope Valley Hospitals. She is a licensed marriage and and family therapist, holds a doctorate in clinical psychology and is currently pursuing licensure as a psychologist in California. She fervently believes in the importance of exposure, acceptance, assistance, and empowerment for all individuals undergoing a life difficulty.
	Social Services	Janie Hodge	Paving the Way Foundation	661-940-9012	janie@pavingthewayfd.com	Children, Transition Age Youth, Older Adults	Janie Hodge 19 years a resident of the Antelope Valley, including ten years working in the Antelope Valley and five years as a business owner in the community. For three years she has been the Director of Paving the Way Foundation, a non-profit 501c3 organization in the Lancaster community which she founded. She has spent the past several years directly serving the underprivileged, youth and senior population of our community helping to get services and programs, and will bring this experience as a member of the Steering Committee..
		Anna Sandberg	Los Angeles County Dept. of Children and Family Services	661-223-4236	lesina@dcfs.lacounty.gov	All Age Groups Mental Health	Anna Lesinski-Sandberg, PhD, has been affiliated with the Antelope Valley since 1997. She has worked in the social service sector for over 15 years, providing social work and therapeutic services. She has a Masters Degree in Marriage & Family Therapies, Masters Degree in Individual Counseling, Masters Degree in Theology and a PhD in Marriage and Family Focus. She has worked for DCFS for over 11 years and spent numerous years working for other community service organizations, mental health agencies and volunteering. Her present role is the Multidisciplinary Assessment Team Coordinator (MAT) for DCFS, where she helps to identify and provide services to families who have a need for a "significant safety intervention." This intervention involves children detained and placed in out of home care, during which time; families receive a full psychosocial assessment, followed by linkage to community services. Ms. Lesinski-Sandberg is an appropriate selection for the Social Services Prevention and Early Intervention Sector, as she is directly involved in the day-to-day activities of providing service to children and families with limited resources, therefore, having the capacity to identify the ongoing needs of the Antelope Valley community.

Service Area 1- Ad Hoc PEI Steering Committee

Constituency Represented			Name	Agency/Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Required Sectors	Consumers/Families	Consumers	Brett Hooper	Los Angeles County Dept. of Mental Health	661-223-3815	bhooper@dmh.lacounty.gov	Mental Health	Brett Hooper, BA, was born in Lancaster and has spent most of his life living or working in the Antelope Valley. Having a Bachelors degree in Social Science, Mr. Hooper is a strong advocate and consumer of mental health services. Previously, he worked for the Antelope Valley Discovery Center for over four years, before transitioning to his current role with the County of Los Angeles Department of Mental Health. He is not only supportive of mental health consumers in the Antelope Valley community but is close to mental health consumers in his personal life, as his wife and best friend are also consumers of mental health services. His work as a Peer Advocate for the Department of Mental Health continues to provide him with opportunities to support mental health consumers as part of the services offered at the Antelope Valley Wellness Center.
		Family Member	Donna L. Wolfe	Lancaster Health Center	661-723-4649	dowolfe@ph.lacounty.gov	Children, Transition Age Youth, Health	Donna L. Wolfe, RN, BSN, PHN, has lived in the Antelope Valley continuously since 1986; prior to that she lived in the valley from 69-74 and again in 76-77, leaving for either school or a military commitment. She has worked in the valley for the majority of those years. Currently, she holds the position of Public Health Liaison to SPA 1 Antelope Valley. The vision of this job is to optimize the health of individuals, families and the communities in which I am a citizen. Previously, she worked for eight years with DCFS and another ten years with Department of Health Services at High Desert Health Systems. She ran a medical mobile van that serviced the more disadvantaged areas of the community. She is a former foster parent and the grandparent of a child with ADHD for whom it has been extremely difficult to get proper mental health services. Ms. Wolfe is a Registered nurse and has extensive years working with DCFS. In this program she was responsible for consulting with social workers on the medical, dental and mental health needs of children in foster care and children with referrals to DCFS. Finding referrals to mental health professionals was a daunting process. This process made her acutely aware of the lack of mental health services in the Antelope Valley.
		Parent/Caregiver of Child/Youth in MH System	Marina Wallace	DCFS parent	661-220-0484	wallam@dcfs.lacounty.gov	Children	Marina S. Wallace, AA, has a resident of the Antelope Valley since 2003 and recently graduated from the Antelope Valley College with an AA degree in Administration of Justice. She will be attending the bachelor program at CSUB in spring of 2009. She is the mother of three children, one of whom has been diagnosed with a learning disability as well as ADHD (Attention Deficit Hyperactivity Disorder). She has been employed with the MAT Team at the County of Los Angeles Department of Children and Family Services since July 2008. Although she is new with the county, she has learned so much about how the system works, the many resources available, and the many ways that every single individual contributes to helping the children and families of The Antelope Valley. She feels that being a part of the PEI Committee places her in a position to lean more and how to utilize that knowledge.
Underserved Communities		Community # 1 African American/ African	Sonia Hicks	Los Angeles County Dept. of Mental Health	661-266-3172	shicks@dmh.lacounty.gov	Mental Health	Sonia Hicks is a Community Worker with the Department of Mental Health. She is currently doing mental health outreach and engagement activities, representing DMH and providing presentations about Proposition 63 Mental Health Service Act. She has been a resident of the Antelope Valley for over 16 years, half of that time working for DMH. As a representative of the African American Community, Ms. Hick has an acute awareness of the issues facing the underserved African American Population. She advocates for services and support for pregnant African American women, as this underserved sector of the Antelope Valley, faces higher infant mortality rates than any other sector countywide. Through her outreach and engagement activities and work in the community, she often provides resources and information to the African American Community and is directly linked in her work to providing outreach to the underserved African American population.
		Community # 2 Asian/ Pacific Islander	Wendy Emiko Tashiro	Los Angeles County Dept. of Children and Family Services	661-951-4172	tasiw@dcfs.lacounty.gov	Social Services, Education Prenatal-0, Children, Transition Age Youth, Adults	Wendy Emiko Tashiro is a fourth generation Japanese American. She has worked with DCFS for eleven years, starting as a Children's Social worker. Currently, she is a CSA (Children's Services Administrator). She worked in the Adoptions Division as a birth parent worker, children's social worker, applicant social worker, PRU (Placement & Recruitment Unit) worker, and served as the "Wednesday Child Coordinator." Prior to that, she worked with people who were homeless in a small inner city church in Kentucky and at St. Joseph Center in Venice, CA. In 1994, she traveled to Guatemala to stand in solidarity with the Guatemalan people and provide international accompaniment. In 2000, she was part of a group that went to Cambodia to deliver clothes and medical supplies to orphanages in Cambodia. In March 2008, she was part of the Rotary International delegation to Japan to learn about social services in Japan and share (with the help of a translator) work that is being done in LA County in the area of child welfare. She has lived in the Antelope Valley for about seven years and has worked in the AV for about five years.
		Community #3 Middle Eastern/ Eastern European	Navid Daee	Tarzana Treatment Center	661-726-2603 ex 4113	ndaee@tarzanatc.org	Community Family Resource Centers, Transition Age Youth	Navid Daee is an MFT Intern and has been working as the SPA 1 Community Assessment Service Center (CASC) Supervisor at Tarzana Treatment Center for almost three years. He was born and raised in Iran. In his my daily experience at his present position he comes in contact with people from Middle East who feel more comfortable talking to him because of cultural competency. He is also aware of social services that are available to people from that region and is able to help the members of the community more effectively. He am fluent in Farsi and knows basic Arabic.
		Community #4 Latino	Lona Aguirre	Community Member	661-285-8103hm 269-6567 cell	aguirre2hm@yahoo.com	Children, Transition Age Youth	Lana Aguirre is a 43 year-old mother of six children, age's 11, 14, 15, 19, 21, and 25. I has been married 24 years and adopted three of her children, the youngest ones when they were infants. She owns two daycare facilities called Pure & Simple Developmental Center, and just started her own Pure And Simple charities this year. She has been a provider 24 years. She is a college student at Antelope Valley College and I teaches in the spring at the college to students and foster parents. She helps with community events all over Antelope Valley with her husband and forms all the events for children everywhere including Lake LA. Mrs. Aguirre has provided child care services for The Children Center Of Antelope Valley, over 100 children at a time with her staff. In addition, two years ago she was voted as the buddy of the year in Antelope Valley and has been a child advocate for the superior court. Basically, she loves children and is on the Steering Committee for the needy of our valley.
		Community # 5 Lesbian/Gay/ Bisexual/Transgender/ Questioning	Robert Lopez	Tarzana Treatment Center	661-726-2630 ex 4135	rlopez@tarzanatc.org	Children, Transition Age Youth, Health, Education	Robert Lopez has worked in assisting youth to access health services for 15 years. He began working with youth in the San Francisco Bay Area by developing peer influencers in the prevention of HIV/AIDS in Contra Costa County in the early 1990's. He served as Co-chair on the Board of Directors for AGUILAS SF, where he over saw the implementation and sustainability of El Ambiente, and HIV/AIDS prevention project. He currently resides in the Antelope Valley and worked as the Project Supervisor of the SAMSHA HIV/AIDS & Substance Abuse Prevention Project for Tarzana Treatment Centers Inc. at the Antelope Valley Youth Outpatient Services site. He worked with a Health Educator and Art/Drama Therapist and provided education/prevention service, linkage to treatment, and youth leadership for youth incarcerated at Challenger Memorial Youth Detention Facility, Antelope Valley High School & Palmdale High School Cal-SAFE programs. Currently, he is Program Supervisor for the H.O.U.S.E. 2 Home Emergency Youth Shelter for at risk/run-away youth. He has served on the Antelope Valley LGBT Community Center as Co-chair, and has been involved in several LGBT projects in the AV with community base organizations that serve the LGBT community.
		Community # 7 Deaf/ Hard of Hearing	Christina Rajlal	PathPoint	818-773-9570	christina.rajlal@pathpoint.ord	Co-Occurring Disorders, Children, Transition age Youth, Adults	Christina Rajlal is the Program Manager for PathPoint and sits on the Mental Health Committee for North Los Angeles County Regional Center's Vendor Advisory Committee. I represent the following groups or sectors: TAY, Adults, Older Adults, Social Services, Underserved Communities for the Asian/ Pacific Islander, Underserved Communities with stigma and discrimination, Representative of the Hearing Impaired Community, Representative to the Dually Diagnosed Community (Developmentally Disabled and Mentally Ill), At Large Underserved Communities. As the Program Manager of PathPoint's Community Access Program, she works closely with individuals that are hearing impaired and have challenges in communication who are also developmentally disabled. She has both DSP certifications, RSPO certification and Administrator Certificate for ARF. Although not currently providing services directly to Department of Mental Health consumers, Ms. Rajlal has ten years experience working with individuals who have mental illnesses. She personally is a big advocate for people with mental health issues and other populations that aren't always represented. She has working in the Antelope Valley for one year.

Service Area 1- Ad Hoc PEI Steering Committee

Constituency Represented		Name	Agency/Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
At-large	At Large # 1	Vicki Alexander	Los Angeles County Dept. of Children and Family Services	661-223-4260	alexav@dcfs.lacounty.gov	Mental Health, Social Services	Vicki Alexander has lived in the Antelope Valley about 19 years, worked in the Antelope Valley for the last nine years, and owns a small business in Lancaster. She works for DCFS as a community liaison in the Antelope Valley. Since her employment is community based, she feels a strong connection to this sector. As a community worker she understands the concerns the community has and is informed about community politics, the needs of the area, and its concerns. She has worked with many cross sections of the community including families, children, people with mental health issues, the developmentally disabled, disadvantaged youth, and business owners. She is enrolled the Masters in Social Work from a satellite campus of CSUB in the Antelope Valley. Her job with DCFS is to work with the community to identify and/or develop community based services, traditional and non-traditional, to address the needs of children and families and limit the need to have child welfare involved with these families. She has continual contact and feedback from the Annie E. Casey Foundation which assists in building communities to reduce the reliance on child welfare and out of home care.
At-large	At Large # 2	Judy Cooperberg	Mental Health America	661-726-2859	jcooperberg@mhala.ord	Stigma and Discrimination, Transition Age Youth, Adults	Judy Cooperberg, MS, CPRP, has worked in the AV since 1988 and lived here since 1995. She is the Executive Director of Mental Health America of Los Angeles, Antelope Valley Services. She has been creating and managing all of MHA's programs in the Antelope Valley. She also serves on other local Boards of Directors, including the United Way, Valley Oasis (Domestic Violence Council), and Antelope Valley Partners for Health. She is an active member of the AV Chambers of Commerce, Palmdale Chamber of Commerce, AV Board of Trade, Lancaster West Rotary, the Zonta Club of Antelope Valley and several community-based working groups, including the AV Homeless Coalition (founding member) and the AV Human Relations Task Force. She has been creating, administering and providing psychiatric rehabilitation programs for adults and transition age youth (TAY) since 1982 (starting in the San Fernando Valley). For the past year, she has been developing collaborations and events around welcoming and reintegration of returning military, National Guard and reservists and their families. She has a Masters of Science degree in Educational Psychology and is a Certified Psychiatric Rehabilitation Practitioner (CPRP) through USPRA. I59
Age Groups	Prenatal - 5	John Whitaker	Children's Bureau of Southern California	661-951-2191 (cell)	allkids.org	Children 6-15, Trauma, Social Services	John Whitaker, PhD, MFT, is Director of Community Services for the Children's Bureau of Southern California. He is involved with Via Partnership for Families, a First 5 funded child abuse prevention grant. he has developed and implemented a North San Diego County Mental Health social services delivery program to the homeless population, targeting the homeless mentally ill and building networks among community service providers (Welfare, SSI, DCFS, Soup Kitchens, Shelters, Community Service Agencies, Religious Service Groups, Sheriff, etc.) while working together to close gaps in services and to support our shared target population. He provides clinical supervision/consultation to the Foster Care/Adoptions Program associated with Children's Bureau of Southern California as well as to the Family Preservation Program and Family Connection Program delivered by Children's Bureau of Southern California as part of a collaboration of community service agencies. He supervises foster care services for the Children's Bureau in the Palmdale regional office. He serves on the Yes2Kids-Antelope Valley Child Abuse Prevention Council as a Board Member and President and is the LA Children's Council, SPA I Steering Committee Chair and SPA I Co-convener.
Age Groups	Children (6-15)	Karen Gilmore	United We Mentor/AVPH	661-942-4719 ex 309	kgilmore@avph.org	Health, Mental Health	Karen Gilmore, MSW, has worked in the field of Social Work for over 20 years in a variety of capacities. She has mainly worked in Child Abuse Prevention and Treatment and as a therapist providing Mental health services to adults and children. She moved to the Antelope Valley in 1995 and went to work as a Supervisor for Children's Bureau for their Prevention Programs including Family Connection Program and Family Preservation. When Children's Bureau contracted with LA county Mental Health to provide Mental health services she became the Program Manager over Mental Health services and was instrumental in collaborating with local AV schools to provide school based MH services. She acted in that capacity for four years until she and her family moved to Colorado in 2003. In Colorado she worked with Cherry Creek School District as a school based social worker with elementary and preschool aged children. Upon returning to the AV, she began working with Antelope Valley Partners for Health in November 2007 as the Program Director for the United We Mentor program which is a grant funded through the Department of Education to provide 4th-7th grade youth with volunteer mentors.
Age Groups	Transition-Age Youth (16-250	Farah DePalm	Los Angeles County Dept. of Mental Health	661 223 3816	FDePalmGreen@dmh.lacounty.gov	Mental Health	Farah DePalm, MA, MBA, has lived in the Antelope Valley area for more than ten years to date. She worked with various agencies such as North Los Angeles County Regional center where she was a Case Coordinator as well as Quality Assurance Specialist for more than 5 years. She became an expert in obtaining community contacts such as referral sources and collaborative agency information. She has served many population, especially TAY groups as well as adult groups. She has experience with 0-5 groups that was obtained by working with Children's' Bureau Partnership for Families grant program. Currently , she is employed by the Department of Mental health as a Mental Health Services Coordinator, with a position working as a Children's and TAY Navigator. She holds a Master Degree in Human Services as well as a Masters Degree in Business. Ms. DePalm is well versed, well known in the community for my social work experience and very experienced with working with the TAY population.
Age Groups	Adults (26-59)	Angela Coleman	Los Angeles County Dept. of Mental Health	661-223-3813	AColeman@dmh.lacounty.gov	Mental Health, Social Services	Angela Coleman, M.S., has lived in the AV for six years. She has a Master of Science degree in MFT from Cal. State Dominguez Hill and is a MFT-Intern. She has completed one year in a Clinical Psychology doctorate program at California School of Professional Psychology. She has been a therapist at Penny Lane Centers, Walden Foster Family agency, and The Children's Center. Previously, she was a CSW II for DCFS and worked as a Counselor at the Regional Center. At the Children's Center she worked in the Family Preservation Program as a in-home Therapist. Ms. Coleman has worked with many parents/adults diagnosed with mental disorders who also suffered from substance abuse/dependency. As a volunteer at Sacred Heart Catholic Church she provided services to the elderly population who resided in Convalescent Homes. She currently works for the Department of Mental Health as an Adult Navigator. In addition to other duties, she provides on-going assessments of FSP referrals, presentations, and linkage to mental health services for adults seeking assistance with mental health as well as related issues in the AV area.
Age Groups	Older Adults (60+)	Donald Robbins	Heritage Clinic	661-575-9365	drobbins@cfar1.org	Mental Health	Donald Robbins provides mental and dementia services for older persons and their families. He has worked for Heritage Clinic for five months. He is presently a mental health clinician for Heritage Clinic. For two and one half years he was an MFT intern for the County of Los Angeles Senior Center. He specialized in senior adults while in private practice in San Fernando Valley. Mr. Robbins has a strong interest in mental health service for older adults. He has lived in the Antelope Valley for three years.
SAAC Chair		Natalie Ambrose	Community Member	661-270-1517	namb@earthlink.net	Older Adults Mental Health	Natalie Ambrose is the current chair of the Service Area Advisory Committee for Service Area 1 and has served in that capacity for several years. Her active involvement in the Antelope Valley Community as an advocate, consultant and planner for children, adult and older adult populations, has been a strong presence in the Antelope Valley. Ms. Ambrose is well respected, bringing years of professionalism and dedication, as she diligently works to advocate for the Antelope Valley residents and rural communities.
District Chief		JoEllen Perkins	Los Angeles County Dept. of Mental Health	661-223-3800	JPerkins@dmh.lacounty.gov	All Ages Mental Health	JoEllen Perkins, LCSW, is the DMH District Chief for Service Area I. She has extensive experience providing direct service to children, youth, adults, and older adults, and currently has administrative oversight responsibility for contract and directly-operated services in the Antelope Valley. JoEllen Perkins, LCSW Have worked in the Valley on two occasions – in l984 with the Department of Children and Family Services, and most recently since 2000 with the Department of Mental Health as the District Chief. She is also an adjunct professor of Social Work at California State University, Bakersfield – Antelope Valley campus.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION (PEI)

Service Area 2 - Ad Hoc PEI Steering Committee

	Constituency Represented	Name	Agency/Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Required Sectors	Education	Rosemary Rubin	LAUSD	818.755.5408	rosemary.rubin@lausd.net	Children, Health, TAY	Rosemary Rubin has had a variety of roles during her 30 plus years with the Los Angeles Unified School District (LAUSD). As a classroom teacher and then a secondary school counselor, Rosemary worked primarily in San Fernando Valley schools and frequently encountered children with behavioral problems. For 10 years, she coordinated the LAUSD Suicide Prevention Unit for over 800 schools. In addition to training teachers and a variety of other personnel, she made numerous presentations to parents and students. Most recently, Rosemary has served as an Organization Facilitator. She works with student health and human services both within and outside of LAUSD, and is involved with community agencies and businesses that express interest in working with schools. She iserves as the chair of the Local District 2 Crisis Team, having been involved both in the local and district-wide crisis teams for 17 years as a presenter and planner.
		Sandy Terranova	Phillips Graduate Institute	818.386.5612	sandyt@pgi.edu	Children, TAY, Mental Health	Sandy Terranova is the Vice President of Professional Training and Services at Phillips Graduate Institute, a nonprofit graduate school offering masters and doctoral degrees in psychology, school counseling, school psychology and organizational consulting. She is also the Executive Director of the school's counseling center, California Family Counseling Center. Her experience spans both academic/didactic aspects as well as the more applied/experiential training aspects of the educational process. Sandy developed and implemented a specialized training program for pre-licensed therapists that offers mental health counseling services to children, families and groups in ove 25 LAUSD schools as well as Head Start programs. She is a licensed therapist with a teaching degree and has worked at a nonpublic school setting in the past.
	Health	Heidi Lennartz	Mission Community Hospital	818.904.3652	hlennartz@mchonline.org	Adults, Social Services, Mental Health, Health	Heidi Lennartz, LCSW, has been in healthcare for over fifteen years, beginning as a volunteer with one of LA Free Clinic's Hotlines. Ms. Lennartz achieved her Master's of Social Work at the University of Southern California specializing in Community Organizing/Public Administration. Pursuant to that, Ms. Lennartz worked as a Social Worker in Physical Medicine/Rehabilitation in New York City. In the early 1990's, she worked in Los Angeles with the AIDS community at Midway Hospital's Immune Suppression Unit, and served on the Board of Directors for The Shanti Foundation. For the next six years, Ms. Lennartz served as Program Administrator for Behavioral Health Services on the San Fernando Campus of Mission Community Hospital. In the spring of 2001, she became Manager of Case Management & Social Service at USC University Hospital. However, she remained with Mission Community Hospital as a member of the Board of Directors. In August 2002, Ms. Lennartz returned to a management role at Mission Community Hospital and was appointed as its CEO in August, 2006.
		Connie Kruzan	Valley Community Clinic	818.301.6319	connie@teen411.com	Children, TAY	Connie Kruzan is the Director of Adolescent Services at Valley Community Clinic. Connie began the program in 1992, the Teen Clinic's peer provider model was chosen by the CA Wellness Foundation for replication throughout the state of California with oversight provided by the California Family Health Council. Since that time Valley Community Clinic's Teen Clinic has evolved from a teen pregnancy, STI, HIV prevention program to a comprehensive adolescent medical program. Teens are seen by an Adolescent Medicine certified doctor, have their own lobby, exam rooms and have peers working as support staff in the department.
	Law Enforcement	Commander Harlan Ward	LAPD	818.644.8080	harlan.ward@lapd.lacity.org	Mental Health	Commander Harlan L. Ward is currently assigned as one of the two assistant commanding officers of the Los Angeles Police Department's Operations-Valley Bureau. He has more than 35 years of law enforcement experience and has managed a variety of patrol and investigative functions. One of his former assignments included oversight of the Department's Mental Health Crisis Response Program, and he was involved in the development of specialized mental health services in downtown Los Angeles in recent years. Commander Ward has an excellent understanding of mental health issues, the relationship of these issues with law enforcement and the potential for early intervention and prevention.
		Paul Vinetz	Los Angeles County Probation Department	818.373.8110	paul.vinetz@probation.lacounty.gov	Children, TAY	Paul Vinetz has worked as a Probation Officer with Los Angeles County for 23 years. He notes that one of the constant conditions he has encountered throughout his career is the impact of mental illness on the criminal and juvenile justice systems. As both the director of Juvenile Justice Cluster Three programs and an officer in the California Probation Parole and Correctional Association, Paul recognizes the importance of early intervention and prevention to help individuals of all ages avoid entanglement with the justice system.
	Mental Health Provider	Dominique Eugene '	Pacific Asian Counseling Services '	818.989.9214	deugene@pacsla.org	Underserved Cultural Populations	Dominique Eugene is a Licensed Marriage and Family Therapist, a registered Play Therapist and Supervisor, and a Nutritional Therapist Practitioner. Due to her strong interest in social, cultural and health psychology, Dominique moved to Japan where she worked as an Assistant Language Teacher in the countryside of Gunma prefecture. Her experience in Japan and extensive travel throughout Asia provided her with significant cultural sensitivity. Dominique has worked in various community settings from the New York City school system as a bilingual guidance counselor to South Los Angeles in an acute psychiatric hospital. Subsequently, she is well acquainted with the broad variety of mental health services in various locations and cultures. At present, she is a Clinical Site Manager at a predominantly Asian agency.She is fluent in Haitian-Creole and has conversational skills in Spanish and Japanese.
		Larry Schallert	Child and Family Center (Santa Clarita)	661.259.9439	larry.schallert@childfamilycenter.org	Children, Youth, Education	Larry Schallert, LCSW has over 35 years of experience working with children and families, including work in schools as an aide and a counselor, and in mental health clinics as a therapist, clinical director, and director of a variety of programs. He has received local, state and national recognition for his leadership in developing school-based mental health programming, has published articles in professional journals and been a guest presenter at national conferences about school mental health-related issues. Mr. Schallert is currently the Director of Adult Education and Community Services for the Child and Family Center in Santa Clarita.

Service Area 2 - Ad Hoc PEI Steering Committee

Constituency Represented		Name	Agency/Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Required Sectors	Social Services	Jamie Cantor	Los Angeles County Department of Children and Family Services	661.233.5823	cantoJ@dcfs.lacounty.gov	Children, TAY	Jamie Cantor is a Children's Services Administrator I for the Department of Children and Family Services (DCFS). She has experience working with all age populations and cultures of children, youth and teens during her 20 years of employment with DCFS. Most of her working experience has been in Service Area II, giving her knowledge of trends and changes with these population groups over time. Jamie has developed collaborative working relationships with a variety of Service Area II organizations including DMH, Regional Center, schools, and other community-based organizations.
	Social Services	Rita Baer	Valley Trauma Center	818.772.9981	rbaer@valleytrauma.org	Children, TAY, Trauma, Health, Law Enforcement	Rita Baer is an MFTI with extensive experience working with children 0-18 and their families through the Family Preservation, Family Support, CAPIT, and the Adoption Support Services programs. As the Executive Director of Valley Trauma Center, Rita has worked extensively with women and children who have suffered sexual trauma. She is well aware of the trauma that children from foster homes and those involved in the DCFS system experience as a result of having personally lived in a group home as a teen and a variety of experiences as an adult. Rita has an adult daughter who came to live with her at age 12, having lived in 14 different foster homes. Her youngest daughter adopted a 10 year-old child from the foster care system who is age 18 today.
	Consumers/Families: Consumer	William Lemley	SFVCMHC, Inc. Client Run Center		wlemley@sfvcmhc.org	Underserved Cultural Populations	William Lemley is a mental health consumer and activist residing in the San Fernando Valley. William is currently employed with San Fernando Community Mental Health Center, Inc. in their Client Run Center as a key staff member. He is well-respected by his peers and co workers in the agency. William is an active member of SAAC II and frequently represents the concerns of mental health clients in a variety of forums. As a recipient of services, William brings a unique perspective to the committee.
	Consumers/Families: Family Member	Deborah Brown	Parent	818.906.2206	reaching_dreams@hotmail.com	Children, Youth, Education	Deb Brown is the mother of a 15 year old boy who is mentally ill. Because of his illness, her son has had a variety of difficulties both in school and at home, necessitating Deb's involvement with a broad variety of treatment and other resources. She has spent countless hours navigating the special education system as well as dealing with insurers. She is an advocate for parent education and support based on her first-hand knowledge of the stress that parents often endure simply because they lack critical information.
	Consumers/Families: Parent/Caregiver of Child/Youth in MH System	Madelyn Gordon	Grandparents as Parents	818.264.0880	madelyn@grandparentsasparents.org	Older Adults, Trauma	Madelyn Gordon is the Executive Director of Grandparents as Parents, Inc. (GAP) This organization, founded in Los Angeles County, serves urgent and ongoing needs of grandparents and other relatives raising at risk children and youth. GAP estimates that 95% of its clientele took primary responsibility for one or more children due to neglect, physical or sexual abuse and/or parental substance abuse. The remaining 5%of these children leave their family of origin due to mental and physical illness, crime, abandonment, teen pregnancy, or the death of one or both parents.
Underserved Communities	Co-occurring Disorders	Stan Galperson	Tarzana Treatment Center	818.654.3811	sgalperson@tarzanatc.org	TAY, Adults, Social Services, Health	Stan Galperson has been employed in the field of Chemical Dependency/Mental Health for 23 years. With a Doctorate in Clinical Psychology, Dr. Galperson has served as the Patient Care Director for Tarzana Treatment Centers (TTC) for the past 13 years. As a result of his work in the Service Area II based organization, he has gained broad experience in working with youth and adults, and a diverse population representing many different cultures.
	Lesbian/Gay/Bi-Sexual/Transgender/ Questioning	Kelly Jones	LAUSD	818.997.2640	kelly.jones@lausd.net	Mental Health, Social Services, Education, Family Members	Kelly Jones has worked in education and as a mental health provider for 26 years, serving both as a classroom teacher and then a psychiatric social worker. He is presently the administrator for mental health services for Districts 1 and 2 which include the entire San Fernando Valley. In addition, he has experience working in inpatient and outpatient mental health services at LAC/USC County Medical Center. Kelly has a personal connection to mental health through the Bipolar illness of a close family member. He has personal knowledge of the GLBTQ community and is well-qualified to represent this group with connections to a variety of resources.
	Stigma and Discrimination	Irena Szewiola	Community Member	818.892-0279	818.892.5531 - Fax number	Education, Underserved Cultural Populations	Irena Szewiola is a community activist in her SFV neighborhood after retiring from a 44 year career with LAUSD as a teacher, school psychometrist, counselor and administrator. She has advocated for over 60 years for proper resettlement and assistance to Polish refugees and immigrants. Irena has written grants for a variety of purposes to enhance the community - from a "student to student" program to a telephone translation line. During the past 10 years, she has served on the North Hills West Neighborhood Council; Community Police Advisory Board; and Advisory Council for Board Member for LAUSD District 1 and 2. She brings a wealth of knowledge about stigma and discrimination to the group.
	African American	James Coomes	Department of Mental Health	818.366.0625	jcoomes@dmh.lacounty.gov	Mental Health, Children, Youth, Family Members	James Coomes, LCSW is currently the manager of the DMH Urgent Community Services Project which serves residents of Service Area II and collaborates with Olive View Medical Center's Psychiatric Emergency Room (PER) to provide community-based services in lieu of hospital or PER care. He has 12 years of experience with child and adult public mental health coupled with extensive experience in addressing issues of cultural sensitivity and competency. James identifies as a multiracial person of color (African American and Caucasian descent) and has been actively involved both personally and professionally in issues of racial identity and cultural concerns. In addition to his professional experience in the mental health field, James has deep compassion and understanding for family members as he is the caregiver of a family member with severe mental illness.

Service Area 2 - Ad Hoc PEI Steering Committee

Constituency Represented		Name	Agency/Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Underserved	Asian/Pacific Islander	Hosun Kwon	Asian Pacific Counseling and Treatment Centers	818.267.1114	hkwon@apctc.org	Mental Health	Hosun Kwon, LMFT, has worked with the Asian Pacific Islander population since 2000. During the early years of her career, Hosun gained detailed knowledge and a true appreciation of the stigma about mental illness in API communities. She provided services to adults, children and their families and helped them master tools for successfully navigating new environments. More recently, she has translated the knowledge about individuals to help her conduct targeted outreach and education to her community. Hosun routinely provides parenting classes and works with clergy to reduce stigma and help API families learn about and use mental health resources.
	Latino	Ed Viramontes	El Centro de Amistad	818.347.8565	ed.v@elcentrodeamistad.org	Mental Health	Mr. Viramontes is currently the Executive Director of El Centro de Amistad and has over 35 years of service in the human services field in the Los Angeles area. He is an active advocate for provision of mental health services to the Latino population. He is active in San Fernando Valley communities both personally and through El Centro.
At-large	American Indian	Pamela Villasenor	FTBMI	818.515.5165	pevillasenor@gmail.com	Health	Pamela Villasenor is a health care consultant with special knowledge and skills related to the care of American Indians. She is actively involved with the American Indian community in Los Angeles, advocating for the special needs of this population.
	Middle Eastern/ Eastern European	Olga Zysman	The HELP Group	818.267.2752	ozysman@thehelpgroup.org	Mental Health, Children, Youth, TAY	Olga Zysman is a Director of Outpatient Services at The Help Group Child and Family Center, a non-profit and family focused, child mental health provider offering comprehensive services and programs to the children and families in San Fernando Valley area. Olga has been with The Help Group for almost 9 years and promotes her agency mission and commitment to helping young people fulfill their potential to lead positive, productive, and rewarding lives. She is also a Licensed Marriage and Family therapist and has worked in private practice for over 12 years, specializing in treatment of children with Autism and Asperser's Disorders as well as specializing in working with recent immigrant families from the former Soviet Union regions. Because of her unique position of being able to represent mental health issues of ethnic minorities as well as having an extensive experience in working in mental health as a clinician and administrator, Olga is a great advocate for reduction of barriers of stigma of mental health in ethnic minority populations as well as increase accessibility of services in programs across all cultures and socioeconomic backgrounds.
	Middle Eastern/ Eastern European	Emma Oshagan	Pacific Clinics	626.744.5230 ext 242	eoshagan@pacificclinics.org	Mental Health, Underserved Cultural Populations	Emma Oshagan, originally from Beirut, Lebanon, is an active member of the Armenian community in the Los Angeles area. Through her own life experiences as an Armenian, Emma is involved and knowledgeable about current issues for this population. She is employed by Pacific Clinics to develop programs designed to address the mental health needs of Armenians. Emma developed and started the first children's school-based mental health program for Armenian students in L.A. County which is located in Glendale. She is involved in DMH planning, having served as a stakeholder delegate for Service Area 2 for the past 4 years, and participating in the Stakeholder's Under-represented Ethnic Populations (UREP) committee since its inception. She is regularly invited for interviews on Armenian television and for public speaking engagements. Emma founded the Armenian American Mental Health Association approximately two years ago. She is the President of this rapidly growing organization that has more than 90 members.
Age Groups	Prenatal - 5	Lorna Milman	The Village Ready for School	818.702.1255	lorna.milman@lausd.net	Education	Lorna Milman is a 22 year employee of LAUSD and has worked as a parent educator, middle school counselor and currently as a family resource center director. She is also a part-time adjunct faculty member of the Pierce College counseling department. At the family resource center, a collaborative of First 5, LAUSD and community-based agencies, Lorna oversees services geared toward children 0-5 and their siblings and caregivers. As a San Fernando Valley resident for 28 years who works here and has raised a family in the area, Lorna brings professional expertise regarding the 0-5 age group as well as an understanding of the area and compassion for parents and children
	Children (6-15)	Mike Alba	San Fernando Mental Health Center (DMH)	818.832.2400	malba@dmh.lacounty.org	TAY, Mental Health	Mike Alba has worked with children and families from all socioeconomic groups for 14 years in both DMH directly-operated and contract service providers. He works on the "front lines" with juvenile justice programs, schools and the Department of Children and Family Services. In addition, San Fernando Mental Health Center where Mike works, sees a large number of children and families from the San Fernando Valley that are uninsured and/or undocumented.
	TAY (16-25)	Stewart Sokol	Tarzana Treatment Center	818.654.3950	ssokol@tarzanatc.org	Health, Co-Occurring Disorders	Stewart Sokol is the Tarzana Treatment Center's (TTC) Director of Youth Services since 2004. Prior to this role, Stewart was the Deputy Director of TTC's Community Programs and Services (1999-2004). Dr. Sokol has also done extensive work in the area of HIV/AIDS, including international prevention efforts and conducting consultations and lectures for hospital medical staff and students in London, Paris, New York and Los Angeles. He has also worked as a teacher of school-aged children with AIDS and was involved in forming a local adolescent consortium. Most recently, he has become known for work in the area of prevention and early intervention for substance abuse among transition age youth.

Service Area 2 - Ad Hoc PEI Steering Committee

Constituency Represented		Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Age Groups	Adults (26-59)	James Randall	DMH	818.610.6732	jrandall@dmh.lacounty.gov	Mental Health, Family Members,	James Randall has multiple family members with chronic and severe mental illnesses. As a result, he has had extensive experience working with a broad variety of adult mental health programs who have provided services to his family members. He is also active in the National Alliance for the Mentally Ill (NAMI), having served as president of the local affiliate, president of the Los Angeles County Council of NAMI presidents, and numerous other roles. Mr. Randall is also employed by DMH as an Outreach Coordinator for Service Area II and organizes many events that address stigma and educate various cultural and ethnic groups. He is a San Fernando Valley resident and is currently pursuing a graduate degree in Social Work.
	Older Adults (60+)	Eva McCraven	Hillview Mental Health Center	818.896.1161	emmcraven@hillviewmhc.org	Mental Health, Underserved Cultural Populations	Eva McCraven, Ph.D. has been a resident of the San Fernando Valley since age 11, giving her a broad understanding of the geographic and cultural diversity of this area. She has worked extensively in the Hispanic and African American communities and committed her professional efforts to serving communities in the East Valley with high rates of poverty. Eva has over 20 years of experience in health education. During her tenure at Hillview Mental Health Center as Director of Consultation and Education, Assistant Executive Director, Executive Director and currently as CEO, Eva has directed a variety of mental health prevention and education programs that she designed and implemented. At present, Hillview Mental Health Center provides a broad range of mental health programs including services focused on Older Adults.
SAAC Chair		Dorothy Ross	Service Area Advisory Committee	818.368.1306	aross51390@aol.com	Older Adults, Health, Mental Health	Dorothy Ross, LMFT is the current chair of the Service Area II SAAC. She worked in long term and residential care facilities that serve older adults as a social worker from 1970 until 1989. She also worked as a social worker in conjunction with a physician and conducted home visits to older adults to assess the problems of caretakers and make recommendations for supportive and ancillary care. Ms. Ross has been in solo practice since 1984 in the San Fernando Valley.
District Chief		Eva Carrera	Department of Mental Health	213.738.3190	ecarrera@dmh.lacounty.gov	Children, Youth, Mental Health	Eva Carrera, LCSW is one of two DMH District Chiefs for Service Area II. She has extensive experience providing direct service to children and youth, and currently has administrative oversight responsibility for contract and directly-operated services in the San Fernando Valley.

Service Area 3 - Ad Hoc PEI Steering Committee Roster

	Contituency Represented	Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
Required Sectors	Education	Jay Bechtol	Hillsides Eduction Center	(323) 254-2274	jbechtol@hillsides.org	Children, TAY	Mr. Jay Bechtol has been working with children and families for the past 20 years. He is currently the Director of Hillsides Education Center a Non-Public School in Pasadena serving students with special needs. Mr. Bechtol began his career when he was the director of a recreational and day rehab program for children living in residential placement. After earning a Master's Degree in Social Work he then coordinated an out patient program overseeing a variety mental health programs including Therapeutic Behavioral Specialists and School Mental Health services
		Natalie Macchia	San Gabriel unified School District	(626) 292-2431 x 250	macchia_N@sgusd.k12.ca.us	CFRC, Asian/Pacific Islander, Latino, 0-5, Children, TAY, Adults, Older Adults	Mrs. Natalie Macchia has a Masters in Educational Counseling, a PPS and a BSW. She is currently the Counseling Coordinator at San Gabriel Unified School District's Family Resource Center (DFRC). She is responsible for the coordination of counseling and implementation of the district's Elementary School Counseling grant. She also manages the Marriage and Family Therapist trainee program, oversees all case management activities at the DFRC and acts as the liaison between the schools, clinical supervisor and community counseling agencies. She has experience providing direct, comprehensive services to students and families in her previous work as a school counselor at a continuation high school in the Los Angeles Unified School District and a middle school in San Gabriel. Her work experience also includes working for the Department of Children and Family Services
	Health	Alicia Mardini	East Valley Community Health Center	(626) 919-4333 x2220	amardini@evchc.org	0-5, Children, TAY, Adults, Older Adults, Latino	Ms. Alicia Mardini has been the Chief Executive Officer of East Valley Community Health Center since 1981. East Valley provides comprehensive healthcare services including medical, dental and mental health to the underserved and uninsured populations within the East San Gabriel and Pomona areas. Seventy-five percent of patients/clients receiving services at East Valley are Latino. East Valley also provides outreach education and prevention services within the communities it serves, in the areas of HIV and teen pregnancy prevention. Ms. Mardini's experience ranges from development, implementation and evaluation of program and service models that address the needs of East Valley's target populations in an effective and culturally sensitive manner to executive and financial management. Most recently, under the direction of Ms. Mardini, East Valley implemented a Primary Care/ Mental Health Integration pilot project which focuses on the early identification and treatment of depression, anxiety and PSTD among patients receiving medical services at East Valley.
		Diana Liu	Los Angeles County Department of Public Health - MCAH Program	(213) 639-6468	diana1127@sbcglobal.net	CFRC, Asian/Pacific Islander, 0-5, Children, TAY	Ms. Diana Liu has worked as an epidemiologist in various capacities in local public health departments for over 13 years. She was a public health epidemiologist serving as the Head of Surveillance and Interim Head of Health Education in San Bernardino County Dept. of Public Health, AIDS/STD Programs. She is presently working in the areas of research, evaluation and planning in the Los Angeles Dept. of Public Health, Maternal, Child and Adolescent Health Programs. While serving as a member for the ICAN Data Sharing Committee, she received the ICAN Outstanding Services to Children Award, and the Certificate of Commendation from Supervisor Yvonne Burke, Second District in February 2001, in recognition of outstanding and dedicated service to the affairs of the community and for the civic pride demonstrated by numerous contributions for the benefit of all people of Los Angeles County. Outside of her work, Ms. Liu is an active member of her community. She is the Disaster Action Team Co-chair for the American Red Cross Arcadia Chapter, and a Master Gardener from the Common Ground Community Garden Program.

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	Contituency Represented	Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
Required Sectors	Law Enforcement	Jim Smith	Monterey Park P.D.	(626) 307-1402	jsmith@montereypark.ca.gov	0-5, Children, TAY, Adults, Older Adults	Captain Jim Smith is a Police Captain for the Monterey Park Police Department. He has over 16 years of law enforcement experience. Captain Smith has served for the past seven years as a steering committee member of the Mental Illness and Law Enforcement Systems (M.I.L.E.S.) a partnership of the San Gabriel Valley Police Chief's Association, Los Angeles County Sheriff's Department, and Pacific Clinics. Captain Smith is also a graduate of the 214th Session of the Federal Bureau of Investigation's National Law Enforcement Academy and is the Vice President of the San Gabriel Valley Peace Officers Association.
		Kelly Perdue	CA Department of Corrections and Rehab (Juvenile Parole)	(818) 551-2090	kelly.perdue@cdcr.ca.gov	TAY	Mr. Kelly Perdue is an LCSW with 18 years experience in the field of social work and mental health services. He has worked in the field of corrections for almost 14 years. He has worked for the Department of Corrections & Rehabilitation for most of that time and has been responsible for cases on parole that were diagnosed with mental health disorders. Mr. Perdue works with parole staff to secure services for the transition age youth population (TAY) which is becoming more challenging. The TAY population is often excluded from programs due to their criminal history or by virtue of being on parole. He is currently working with victims of crime, a population that is often ignored in the process of investigation and litigation and recognizes that this population often develops mental health disorders that may have been avoided or the symptoms greatly reduced if they had received treatment.
	Mental Health Provider	Janet Yang	Center for Aging Resources - Heritage	(626) 577-8480	jyang@cfar1.org	African American, Asian/Pacific Islander, Middle Easern/Eastern European, Latino, Disabled, Older Adults	Dr. Yang, a licensed clinical psychologist, has been working with older adults for 30 years. She is the Clinical Director at the Center for Aging Resources, a mental health clinic and adult day care center serving older adults in Service Area 3, and training graduate students in mental health fields. She has been co-chair of the Los Angeles County Department of Mental Health Older Adult System of Care for 3 years, co-chair of the West San Gabriel Valley Elder Abuse Task Force, Multi Disciplinary Team for 5 years, and Commissioner on the Pasadena Senior Commission for 8 years. Dr. Yang has written and published articles on psychotherapy with older adults, mental health outreach to older adults, reminiscence and neuropsychology.
		Elizabeth Gross	Acradia Mental Health	(626) 821-5844	egross@dmh.lacounty.gov	TAY, Adults, Older Adults	Dr. Elizabeth Gross is currently Clinical Program Head for Arcadia Mental Health Center and Arcadia FSP Program. She joined the Los Angeles County Department of Mental health in 2001 as a clinical psychologist with Arcadia Mental Health Center and later moved to DMH CalWORKs Program Administration where she served as Program Head for over two years. Prior to joining DMH, she completed a post-doctoral fellowship at the USC Keck School of Medicine in the Department of Psychiatry and the Behavioral Sciences. She currently holds a Volunteer Faculty appointment at the rank of Clinical Associate Professor.
	Social Services	Anne Wrotniewski	Catholic Charities	(323) 264-8701	awrotniewski@ccharities.org	Education, Mental Health Provider, CFRC, 0-5, Children, TAY, Adults, Older Adults	Ms. Anne Wrotniewski has been working with homeless and low-income individuals in Los Angeles County SPAs 3 and 4 for over 2 ½ years. She began as an Americorps Volunteer through the Sisters of Notre Dame Mission Volunteers and has been a case worker with Catholic Charities since Fall of 2007. She has been attending SA 3 SAAC meetings since October of 2007 and has been attending Stakeholder meetings as a representative of SPA 3 since April of 2008. She has performed research regarding care for mental illness in minority communities through the MSW Program she is currently pursuing at California State University at Los Angeles. This degree will supplement her BA in Anthropology with minors in Spanish and Psychology.

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Contituency Represented			Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
Required Sectors	Social Services		Theresa Barajas	Bienvenidos Family Services	(626) 430-9114	tbarajas@bienvenidos.org	Immigrant, 0-5, Children, TAY, Adults, Older Adults	Ms. Theresa Barajas is currently the Program Assistant for Bienvenidos Family Services in the City of Covina. She has worked for Bienvenidos Family Services for ten years and has been involved with several programs such as, Foster Family Agency, The Institute for Women's Health, and Respite Daycare. Ms. Barajas attended Rio Hondo College, Whittier, CA. and earned a certificate in Early Childhood Education. While at Rio Hondo College, one of her Early Childhood Education assignments was to mentor an at risk child. The mentoring assignment was a commitment for a period of one year.
	Consumers/Families	Consumer	Christopher Carlson	Arcadia Mental Health - Peer Advocate	(626) 821-4635	ccarlson@dmh.lacounty.gov	TAY, Adults, Older Adults, Individuals with Serious Mental Illness and/or their familes	Mr. Christopher Carlson is currently a Peer Advocate in Arcadia Mental Health Center's Wellness program. He worked as a graphic artist and commercial illustrator for over 20 years. He participated in the Jump Start program, the MHSA funded workforce development fellowship to train recovery based case managers, prior to joining Arcadia's staff as a peer advocate. He has helped to develop many of Arcadia's Wellness Center groups.
		Family Member	Rose La Presto	Community - (NAMI Glendora)	(626) 339-2474	lapresto1@verizon.net	Consumer, Parent/Caregiver of Child/Youth in Mental Health System, Latino, Older Adults	Ms. Rose La Presto is a retired Administrative Analyst with a B.A degree in Psychology. She had a 15-year career with a large corporation where she held several positions, including supervisory responsibilities, reports/procedures writer, director of business recovery after a crisis, and director of health and safety for a department of over 800 employees with responsibility for ensuring adherence to Cal OSHA regulations. Ms. La Presto has extensive personal experience dealing with problems of the mentally ill. She has two mentally ill family members, and a brother who was a substance abuser. She also served as caregiver for an elderly terminally ill family member for four years. Ms. La Presto has been an Executive Committee Member with SAAC 3 for two years and a NAMI board member for two and a half years
		Parent/Caregiver of Child/Youth in MH System	Amy Ley Sanchez	Hillsides	(323) 496-5222	aley-sanchez@hillsides.org	Mental Health Provider, Consumer, Family, Asian/Pacific Islander, Latino,	Mrs. Amy Ley Sanchez is a constituent and parent of a consumer for mental health based services in Service Planning Area 3. She has three children, ages 10, 5, and 3 and serves as a board member for the West San Gabriel Valley SELPA committee. Her youngest child, Sofia, was diagnosed with autism in April 2008 and is currently accessing a wide range of mental health and adjunctive services through Regional Center and her local school district.
Underserved Communities	Community #1 African-American		Joyce Hill	Joyce Hill		momsis8076@sbcglobal.net	0-5, Children, TAY, Adults, Older Adults	Ms. Joyce Hill has been a Registered Nurse for over 25 years. She recently retired from the Los Angeles County Medical Center. She was Nurse Manager for an Infectious Disease Ward and an Aids/HIV Ward for over 11 years. For the first 10 years of her career she was Nurse Manager for Ante Partum and Post Partum/Newborn Nursery Wards. She has worked in her church for 12 years as a youth director and with New Revelation Missionary Baptist Church. She is Currently working with the Christian Education at the Bethel Missionary Baptist Church of Pasadena. Ms. Hill has personal and professional experience with the African American community.
	Community #2 Asian/Pacific Islander		Glenn Masuda	Pacific Clinics	(626) 287-2988	gmasuda@pacificclinics.org	Children, TAY, Adults, Older Adults, Provider of Mental Health Services, API, Immigrant, Refugee	Dr. Glenn I. Masuda is a native of Los Angeles, CA. He has an undergraduate degree in Psychology from USC and Masters and Doctorate degrees from the University of Washington in Seattle, Washington. He is a licensed Psychologist in the state of California and is currently Associate Director, Clinical at the Asian Pacific Family Center in Rosemead, a division of Pacific Clinics where he has been since it's opening in 1986. He is Program Director of the Child, Youth and Family Services. His specialty areas are adolescent psychology, family therapy, community interventions, as well as diversity competency training. In addition, Dr. Masuda is currently a part-time Associate Professor in the Multi-Cultural Community Psychology at Alliant International University, Los Angeles Campus. He has taught classes since 1990 in Professional Development, Ethnic Minority Mental Health, Community Psychology, an advanced seminar in working with adolescents and the Intercultural Laboratory

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	Contituency Represented	Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
Underserved Communities	Community #3 Latino	Jaime Renteria	DMH	(213) 738-3476	jrenteria@dmh.lacounty.gov	0-5, Children, TAY, Adults, Older Adults	Mr. Jaime Renteria is currently a Mental Health Services Coordinator with DMH. He has over 22 years of experience in the social service arena which includes working at state prisons, juvenile halls, California Youth Authority, school districts, probation department. and with mental health providers. He has bachelor degree in Behavioral Sciences, is bi-cultural and fluent in Spanish. He is a member of the Latino Underrepresented Ethnic Populations sub-committee. As the Outreach & Engagement Coordinator for SA 3, he is very familiar with the San Gabriel Valley and it's demographics and resources. Mr. Renteria is first generation Latino of Mexican descent and the father of four wonderful children.
	Community #4 Co-occuring Disorders	Dawn Dades	Social Model Recovery Systems	(626) 974-8122	dawnd@socialmodel.com	TAY, Adults	Ms. Dawn N. Dades is the Program Manager for River Community Covina, a program of Social Model Recovery Systems, Inc. that provides Day Rehabilitation and Outpatient services for adults who have been diagnosed with co-occurring disorders. She is a Licensed Marriage and Family Therapist and has over twenty five years of experience working with adolescents and adults in inpatient, residential, community based, and outpatient settings. Ms. Dades has represented Social Model Recovery Systems as both a trainer and a trainee at various venues in Service Area 3 and throughout California. In addition to her clinical and administrative duties, Ms. Dades provides supervision and training to undergraduate, graduate, and post graduate students seeking hours towards MFT and CSW licensure
	Community #5 American Indian	Julia Bogany	Gabrieleno-Tongva Tribe San Gabriel Valley		JuliaBogany@aol.com	Children, TAY	Ms. Julia Bogany is a member of the Gabrieleno-Tongva tribe in the San Gabriel Valley and is their Cultural Consultant. She is a member of the California Indian Basketweavers Association and serves on several committees and organizations that include, Chaffy College Equity Council, Pomona Human Relations Board Member, Riverside School District Native American Consultant, and California Indian Education Association. Ms. Bogany is also president of Residential Motivators, her consulting firm. Ms. Bogany has years of training in Child Development, Indian Child Welfare, and Native American Studies. She is fluent in English and Spanish and has been a preschool director and after-school middle school coordinator. She has also been an instructor of child development for home daycare. She assists the Gabrieleno-Tongva tribe and the Fontana Native American Indian Center with grants. She represents her Gabrieleno-Tongva tribe at many events and activities and has worked over twenty years for her community and her tribe and is a strong advocate for ICWA and FASD.
	Community #6 Deaf	Amy Kay	Five Acres	(626) 798-6793 x 3165	akay@5acres.org	0-5, Children, TAY, African American, Latino	Ms. Amy Kay is currently the Deaf Services and Community Based supervisor at Five Acres. She has over 12 years experience working in the mental health field, which includes parent education, direct therapeutic services to Deaf and Hard of Hearing families County wide and in service area 3. In addition to providing clinical supervision, Ms. Kay oversees the School-Based Program at Marlton School, Five Acres Pasadena Community and School Based program, and the Perinatal Program, which provides in-home service to Deaf women who are pregnant or have recently given birth. She is also involved in strengthening community partnerships with the Department of Children and Family Services, Greater Los Angeles Council on Deafness and linking the Five Acres Therapeutic Behavioral Services Program to the Deaf community. Ms. Kay is an active member of the Advocacy Council on Deaf Abused Children. In addition to her agency work, Ms. Kay has a Private Practice in Sherman Oaks.

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Contituency Represented		Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
Underserved	Community #7 Developmental Disability	Michael A. Segovia	Alma Family Services	(323) 881-3799	michaels@almafs.com	Health, Mental Health Provider, 0-5, Children, TAY, Adults, Older Adults	Mr. Michael Segovia, LCSW is a Regional Director for Alma Family Services overseeing the Walnut mental health clinic. He has over 12 years of clinical and administrative experience in providing Mental Health services to diverse communities. He is a member of the SPA 3 Mental Health Provider Panel (MHPP) committee which meets monthly with San Gabriel Pomona Regional Center to link Regional Center consumers to Mental Health and supportive services. As part of his responsibilities in Service Area 3, he oversees Alma's Juvenile Justice Programs at Camp Rockey and Camp Afflerbaugh in the cities of San Dimas and La Verne, in addition to directing the outpatient mental health services and Therapeutic Behavioral Service programs out of Alma's Walnut office.
At-large	Asian/Pacific Islander	Lydia S. Ko	Asian Pacific Family Center-East	(626) 839-0300 x23	lydiasko@yahoo.com	Adults	Mrs. Lydia S. Ko has been an active Community Advocate in the East San Gabriel Valley for over 12 years. Upon completing one of the parenting programs offered by the Asian Pacific Family Center-East (APFC-E) in 1997, Mrs. Ko became more involved in the community; organizing API parent support groups, serving as PTA president, and advocating on the Community Council to the local school district. Mrs. Ko is currently the Team Coordinator of parenting programs at APFC-East, where she has served thousands of API parents and families. She also continues to organize and mobilize the community, encouraging many immigrant parents to venture out and volunteer in their local community. In March 2008, Mrs. Ko received the "Service in Action Award" at the Cultural Competence and Mental Health Summit XV, honoring her efforts and accomplishments in the community.
Age Groups	Prenatal - 5	Gloria Daniels	Children's Bureau	(626) 337-8811 x 203	gloriadaniels@all4kids.org	0-5, Mental Health Provider	Ms.Gloria Daniels is Ph.D, LMFT and is currently Program Supervisor II for Children's Bureau in Baldwin Park, CA. She has over fifteen years experience in the mental health arena. She has provided therapy to all ages, and most recently is supervising marriage and family therapist interns who provide therapy to children ages 0-5 and their parents. Her past work experience includes clinical services and management, in addition to her delivery of therapeutic services; Director of Social Services, STARS, Inc.; Clinical Director, EMQ Wraparound Start Up; Manager of Aegis Medical Systems Methadone Clinic.
Age Groups	Children (6-15)	Maricruz Trevino	Glendora DCFS	626-691-1478	trevim@dcfs.lacounty.gov	0-5, Children, TAY, Social Services,	Maricruz Treviño has been working for the Department of Children and Family services for almost 19 years. She is currently the Assistant Regional Administrator for Service Bureau 3, supervising the Emergency Response units in both the Glendora and El Monte Offices, as well as one unit of Dependency Investigations. She has worked the line as an Emergency Response Worker, as well as a Family Reunification and Maintenance Services Worker, but most of her line experience was working as an Investigator for Dependency Court. She supervised a Dependency Investigations Unit for many years before being promoted to management. In addition, Ms. Treviño was one of the founding members of the Children's Advocacy Center (CAC) in Pomona, a non-profit agency affiliated with Project SISTER, devoted to forensic interviewing children victims of sexual abuse and severe physical abuse.

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Contituency Represented		Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
Age Groups	Transition-age Youth (TAY) (16-25)	Vincent Castro	Maryvale	(626) 280-6510	vcastro@maryvale-ca.org	Education, Mental Health Provider, African American, Latino, 0-5, Children, Adults	Dr. Vincent Castro is currently serving as the Director of Operations and the Director of Mental Health Services at Maryvale. Maryvale is the oldest Human Service Organization in California providing comprehensive care to children and their families for over 152 years. Throughout his 22 years of service, Dr. Castro has developed several innovative programs for transitional age youth with the most recent experience related to providing services for youth who emancipate from the foster care system. He has over 22 years of experience as a provider of mental health services as well as providing leadership through various administrative level positions. Dr. Castro has provided service in hospital and other community based settings. He has developed and implemented quality mental health services that serve to promote healthy and productive communities.
	Adults (26-59)	Chuck Lennon	DMH - SA 3 PMRT	(626) 455-4615	clennon@dmh.lacounty.gov	Mental Health Provider, 0-5, Children, TAY, Older Adults	Mr. Chuck Lennon is a Licensed Clinical Social Worker, with over 11years of service in Los Angeles County Department of Mental Health. He began his career with DMH at Edelman Westside Mental Health Center. As the lead social worker for the Santa Monica Dual Diagnosis Project, he worked with homeless, substance abusing, mentally ill adults. In 2001, under the DMH Mental Health Law Enforcement Program, he began working with the Los Angeles Police Department Systemwide Mental Assessment Response Team (SMART). Primary services, in this program, are emergency psychiatric evaluations provided for all age groups; children thru older adults. For the past five years, he has been the supervisor of SA3 PMRT, providing these same community wide, psychiatric emergency services. Mr. Lennon has also provided disaster response services with the Red Cross and the International Association of Fire Fighters.
	Older Adults (60+)	Faye Ashby	Pacific Clinics	(626) 404-9147	fashby@pacificclinics.org	Mental Health Provider	Ms. Faye Ashby has been the Corporate Director of Older Adult Services for Pacific Clinics since 2001. She has a Masters Degree in Social Work and over 30 years experience in development and management of services for older adults. She manages outpatient and field-based mental health services for Pacific Clinics Older Adult Program in Pasadena and also consults with and provides leadership for Pacific Clinics' seven MHSA-funded older adult programs in Service Areas 3, 4, 6 and 7. She coordinates and provides trainings on older adult topics at Pacific Clinics Institute and serves on the Steering Committee of the Geriatric Social Work Education Consortium (GSWEC), a collaboration of five Los Angeles area graduate schools of Social Work and nine field placement Centers of Excellence. She served as Co-Chair of Los Angeles County Older Adult System of Care Committee for more than 3 years. Her prior experience includes being an independent consultant and trainer, instructor of Geriatric Case Management at California State University, Fullerton, director of Extended Home Care at SCAN Health Plan, and director of adult day programs and phy
SAAC Chair		Gina Perez	Pacific Clinics	(626) 254-5000	gperez@pacificclinics.org	0-5, Children, TAY	Dr. Perez has over fifteen years of administrative and clinical experience. At Cedars Sinai Medical Center she acquired training as a Early Childhood Development Specialist with an emphasis on the Pre-natal to Five population. Dr. Perez worked in parent/toddler group modalities, center based intensive dyadic therapy, and with private practice clientele. Dr. Perez was later Director of Community Outreach Programs at Cedars with clinical and administrative oversight of LA Free Clinic, Thai Immigrant Project, and LA Tech Teen Mentor Project. Following her work at Cedars, Dr. Perez worked as Clinical Director for The Jeffrey Foundation in Los Angeles, CA, a therapeutic day school and comprehensive parenting program for children birth to thirteen with special needs. Dr. Perez joined Pacific Clinics in 2001 and serves as Corporate Director of Birth to Five and Transition Age Services.

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Contituency Represented		Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
District Chief		Alfredo Larios	DMH	(213) 739-5455	alarios@dmh.lacounty.gov		Mr. Alfredo Larios is an LCSW and is currently the Acting District Chief for Service Area 3 in the Los Angeles County Department of Mental Health. Mr. Larios has over 25 years in the mental health system both as a department employee and contactor, 18 of these involve providing services to Service Area 3 communities. Mr. Larios has been a member of the Service Area 3 SAAC for over 13 years and served as its original delegate to the Stakeholder process for 3 years. Additionally, Mr. Larios has had longstanding memberships with Trabajadores de la Raza (TR) and the Los Angeles County Latino Mental Health Council (LATCO), serving as the President for the latter for 4 years.
Alternates	Asian/Pacific Islander	Lance Asamura	DMH	(213) 944-8940	lasamura@dmh.lacounty.gov	0-5, Children, TAY, Adults, Older Adults	Mr. Lance Asamura has worked for DMH for the past year and a half. His past experience has been in community involvement. He has conducted presentations and performances for church youth groups and youth advocate groups, in particular, on Asian culture throughout the API communities in Los Angeles and Orange County. He has also been involved in an Asian empowerment group that began back in the 1970's called Yellow Brotherhood. The reason for his undying support for this group comes from his family history. Mr. Asamura's father was an original member and co-founder. Today many models of Asian empowerment exist but one model that was patterned after the Yellow Brotherhood that some people may know is AADAP (Asian American Drug Abuse Program). He believes that his experience in community involvement and his ability to communicate and relate to API youth serve him well in representing the Asian community.
	Mental Health Provider	Urmi Patel	DMH		upatel@dmh.lacounty.gov	Adults	Dr. Urmi Patel recently joined the administrative team for the Los Angeles County Department of Mental Health Service Area 3 as the Supervisor for Full Service Partnership Adult Programs. She has over six years of clinical experience as well as almost two years of administrative experience. The majority of her clinical experience has been with the severely/chronically mentally ill adult population in the outpatient, day treatment, residential, and hospital setting throughout Service Area 3. Dr. Patel worked as the clinical psychologist and supervisor of the AB2034, later Full Service Partnership program, at La Puente Valley Mental Health Center. Following this, Dr. Patel worked as the Program Director of FSP at Prototypes, I-CAN in Pasadena, California, where she oversaw the REACH FSP program and Wellness Center.
	African American	Helen Liddell				Adults, Older Adults, Law Enforcement,	Ms. Liddell is a retired State of California employee of 29 years. She is currently involved in prison ministry at Folsom County Jail with the Mental Health Department. She works primarily with African American inmates with mental health needs. She frequently visits and writes the inmates and their families. She allows the families to call her and she offers support and comfort.
	Asian/Pacific Islander	Rocco Cheng	Pacific Clinics	(626) 960-4020 x28	rcheng@pacificclinics.org	Mental Health Provider, CFRC, 0-5, Children, TAY, Adults, Older Adults	Dr. Cheng is a licensed psychologist. He is the Corporate Director of Prevention and Early Intervention Services at Pacific Clinics. He has been implementing prevention programs since 1995 and oversaw 8 SAMHSA demonstration projects. These projects include mentoring, parenting, leadership development, violence prevention, and gang affiliation prevention programs. He is familiar with prevention and early intervention issues and is interested in issues related to immigrants. He serves on several state advisory committees, including the Mental Health Service Oversight and Accountability Commission's (MHSOAC) Cultural and Linguistic Competence Committee (CLCC), OAC's County PEI plan review team, cultural expert pool providing consultation to State DMH, and California Mental Health Stigma and Discrimination Reduction Advisory Committee. Dr. Cheng is also interested in the spiritual dimension of mental health and serves on the statewide Mental Health and Spirituality Workgroup. In LA County, he is a delegate attending the Stakeholder group and member of PEI ad hoc Advisory Group.

Service Area 4 Ad Hoc PEI Steering Committee

	Constituency Represented	Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Required Sectors	Education	Gloria Granados Avila	LAUSD School Mental Health	323-869-1352	gxg6596@lausd.net	Mental Health Provider, Latino, Immigrant, 0-5, 6-15, TAY	Ms. Granados Avila is a licensed clinical social worker and an administrator with LAUSD School Mental Health Services. She has been in the field for over twenty years, initially working with severely mentally ill adults. She has fifteen years of experience working with children, particularly with high school students. Early intervention is a priority for her, having witnessed what happens to children when they don't receive the help that they need in a timely manner.
		Suzanne Silverstein	Psychological Trauma Center, Cedar-Sinai Medical Center	310-423-3541	silversteins@cshs.org	0-5, 6-15, TAY, Mental Health Provider	Ms. Silverstein is the Supervisor of the Family and Child Program within the Department of Psychiatry and Behavioral Neurosciences at Cedars-Sinai Medical Center where she has been employed for over 31 years. She serves as the Coordinator of the Clinical Art Therapy Program and serves on the Medical Centers Community Benefits Committee. Ms. Silverstein is the Co-Founder and President of the Psychological Trauma Center a non-profit school based organization that is affiliated with Cedars-Sinai Medical Center.
	Health	Gail Myers	Eisner Pediatric & Family Medical Center	213-746-5582 x3444	Gmyers@pedcenter.org	Mental Health Provider, Children, Adults	Ms. Myers has been a licensed Marriage, Family Therapist since 1996. During tha time she has worked primarily in community mental health settings managing childrens' programs. Currently she is the Director of Mental Health at Eisner Pediatric and Family Medical Center, a federally qualified health center, where she is engaged in a project focusing on the integration of behavioral health services.
		Maria N. Tan	LA County Client Coalition	310-476-8765	mariaftan@yahoo.com	Consumer, Asian/Pacific Islander	Ms. Tan is a Volunteer at CORE- Consumer Office of Recovery & Empowerment. She has served as an MHSA Stakeholder Delegate since 2005. Her expertise in the Health sector comes from working as a Registered Nurse for more than 30 years. Ms. Tan is also Chair of the Los Angeles County Client Coalition Training Committee.
	Law Enforcement	David Howell	LAPD	213-485-3300	35898@lapd.lacity.org		Officer Howell is a 9 year veteran of the Los Angeles Police Department. Currently he is assigned to the Mental Evaluation Unit , also known as the S.M.A.R.T. Team. He is a graduate from George Washington University.
		Ronald Leflore	LA County Probation	323-226-8963	ronald.leflore@ probation.lacounty.gov		Mr. Leflore has 35 years of experience working in the delinquency system. Currently, he serves as the Probation Director for N.E.J.J.C. He earned is Bachelor's Degress from Cal State Dominguez Hills and his MPA from Pepperdine University.
	Mental Health Provider	Martin Ribeiro	Children's Bureau	323-953-7356	martinribeiro@all4kids.org	Latino, 0-5, 6-15	Mr. Ribeiro has over twenty years experience working with severely emotionally disturbed children and their families. He has also worked with Spanish speaking children and families for close to twenty years. Presently, he is the Program Supervisor for Children's Bureau Oakwood office. Children's Bureau services children, including 0-5, and their families and our clients are 90% Spanish speaking.
		Angelica Otero	DMH - Northeast MHC	323-478-8200	aotero@dmh.lacounty.gov	Families of Consumers, Latino, TAY, Adults	Ms. Otero immigrated to SPA 4 at the age of three from Puerto Rico. Angelica is Puerto Rican and Honduran, has family members who have chronic mental illness and has provided mental health services within SPA 4 to high-risk adolescent and adult populations since 1998. She is the first high school and college graduate from her immediate family: Masters of Social Work, California State University, Long Beach. Currently, Angelica has joined the Department of Mental Health as a Psychiatric Social Worker and provides specialty mental health services to the elderly population.

Service Area 4 Ad Hoc PEI Steering Committee

Constituency Represented			Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Required Sectors	Social Services		Louis Suncín	DMH - Skid Row Management Team	213-804-5038	lsuncin@dmh.lacounty.gov	All ages, Mental Health Provider, Homeless	Mr. Suncín, Jr. MSW has worked for the County of Los Angeles since 1986 in three different departments, the Department of Social Services, the Department of Health Services, and, most recently, the Department of Mental Health since 1991. He is currently working as a Mental Health Analyst II for the Skid Row Management Team, Los Angeles County Department of Mental Health. His clinica and administrative experience has provided Mr. Suncín with a sensitive and broad understanding of the challenges that social services face in an environment of increasing need and diminishing resources.
			Jim Borgardt		310-633-0221	jim@bordardt.com	TAY, LGBTQ	Mr. Borgardt has been working in social services and psychotherapy for the past 8 years. He has worked with the homeless, learning disabled young adults, and currently with gay and lesbian adolescents. He is committed to connecting people in need with the most effective services that address their needs.
	Consumers/Families	Consumer	Mitchell Eisenberg	LA County Client Coalition	323-666-9644	none available	Older Adults	Mr. Eisenberg's experience began as a young, teenage "consumer" and has continued throughout his life. He was actively involved in the development of the mental health patients civil rights movement of the 1970's. Mr. Eisenberg is also an active member of the Los Angeles County Client Coalition.
		Family Member	Laura Balverde Sanchez	El Dorado Community Service Centers	323-660-4509	elreybrand@sbcglobal.net	Education, Latino, Immigrant	Ms. Balverde Sanchez graduated from UCLA with a BA in Psycology, is working towards a Master's in Public Administration at USC. She taught English as a Second Language and Citizenship classes for LAUSD to adult immigrant population for over 20 years. Her personal experience includes the initial diagnosis of an autistic family member and participation in the prescribed program for over 14 years. She has experience navigating a very complex and frustrating diagnosis process and a very cumbersome resource system. She is an advocate for underserved communities with respect to medical and mental health access. She is bi-cultural and bi-lingual in Mexican culture and the Spanish language of Mexico.
		Parent/Caregiver of child/youth in MH system	Sheila Medrano	Amanecer Community Counseling Services	213-819-5227	smedrano@ccsla.org	0-5, Children, TAY, Law Enforcement, Education, Social Services	Ms. Medrano has a 16 year-old daughter and has experienced first-hand the challenges of navigating the mental health system. She also works with families a Amanecer Community Counseling. There she helps families receive support through AB3632 have are involved with DCFS. In this capacity, Ms. Medrano works closely with schools and mental health professionals.
Underserved Communities	Community #1 Latino		Leticia Ximenez	DMH	213-738-6193	lximenez@dmh.lacounty.gov	Mental Health Provider, Education, 0-5	Leticia Ximénez, Psy. D., is the Birth-To-Five and School-Based Mental Health Program Coordinator for the Los Angeles County, Department of Mental Health, Service Planning Area 4 (SPA4). Dr. Ximénez is an active member of the Under-Represented Ethnic Populations (UREP) Latino Workgroup and the UREP Leadership Committee. She also serves as an MHSA Stakeholder Delegate. She is also a Representative at the SPA4 General Council and at the County-Wide Cultural Competency Subcommittee. She has designed, implemented, and assessed programs, represented agencies in countywide and statewide meetings and committees, and has provided in-service and consultation in a variety of settings. Dr. Ximénez has conducted trauma recovery, crisis intervention, psychological assessment, psychotherapy, rehabilitation services, and case management to individuals, couples, families, and groups in outpatient, school, da treatment, and juvenile detention settings. Dr. Ximénez is committed to maintaining a mental health, multidisciplinary, and multi-cultural perspective. She is a leader in community education, organization, and empowerment.

Service Area 4 Ad Hoc PEI Steering Committee

Constituency Represented		Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Underserved Communities	Community #2 Homeless	Marsha Temple (Committee Co-Chair)	Integrated Recovery Network	213-346-3239	marstemp@earthlink.net	Social Services, Law Enforcement, CFRC	Ms. Temple is the Executive Director of the Integrated Recovery Network, which provides comprehensive services for people who are homeless and disabled, that would otherwise be facing incarceration. Ms. Temple is the President of the Board of Directors of Homeless Health Care Los Angeles. She also serves on the Board of Governors of Centinela Freeman Health Systems and the Board of Directors of the Venice Family Clinic. Additionally, she is a Commissioner serving on the Narcotics and Dangerous Drug Commission of the County of Los Angeles. Ms. Temple is also an attorney who, for twenty years, has represented hospital clients in a variety of liability actions including medical and psychiatric malpractice, breach of contract and related business torts, and defended allegations of elder abuse. Prior to preparation for a career in law, she served on the administrative staff of several hospitals, including the UCLA Medical Center where she was Supervisor and Administrative Director of the UCLA Medical Group. Ms. Temple is a cum laude graduate of UCLA, and an alumna of Loyola Law School.
	Community #3 Asian/Pacific Islander	Karen Cheng-Lim	Asian Pacific Counseling and Treatment Center	213-252-2112	kchenglim@apctc.org	All ages, Mental Health Provider, Immigrant	Dr. Lim is a licensed Clinical Psychologist and the Program Director of the Child and Family Services at SSG/Asian Pacific Counseling and Treatment Centers (APCTC) in SPA-4. APCTC is one of the largest community mental health centers serving the Asian/Pacific Islander community since 1977. Dr. Lim directs the Child Outpatient Clinic and School-based Mental Health Programs, and the Child and TAY FSP Programs. She has worked in the mental health field for 13 years, and her experience includes direct mental health services to API children, TAY and adults, clinical supervision, and program development. She was born in the Philippines, of Chinese descent, and moved to Los Angeles in 1994.
	Community #4 LGBTQ/COD	Peter Cashorali	Pacific Clinics/Portals Division	213-639-2634	pcashorali@pacificclinics.org		Mr. Cashorali, LMFT, directs four programs (Field Capable Clinical Services, clubhouse, wellness and dual-diagnosed residential) for Pacific Clinics-Portals. His background includes providing direct mental health and case management services to members of the HIV-infected/affected, homeless, recovery, chronically mentally ill, African American and LGBT communities, among others. His interests in the present project include discovering what common needs link different communities and how membership in multiple communities impacts individuals.
	Community #5 African American	Charles Porter	United Coalition East Prevention Project	213-622-1621	charlesp@socialmodel.com	Homeless, COD	Mr. Porter is the Prevention Coordinator for United Coalition East Prevention Project, a drug prevention program targeting the skid row area of downtown Los Angeles. He has more than 16 years experience working to prevent violence and drug-related problems in inner-city neighborhoods across the country. He is the chair of Social Model Recovery Systems, Inc.'s Cultural Competency Committee, and co-chair of the Downtown Mental Health Community Advisory Board. For the past 9 years, he has worked to organize community members to and address problems in skid row. He is also responsible for fostering culturally relevant alterative activities to discourage problem behaviors.

Service Area 4 Ad Hoc PEI Steering Committee

Constituency Represented		Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Underserved Communities	Community #6 Middle Eastern/Eastern European	Tara Pir (Alternate Co-Chair)	IMCES	213-381-1250	tarapirimces@msn.com	Mental Health Provider, Social Services	Dr. Tara Pir is a Clinical Psychologist who personally comes from a multicultural family and has professionally maintained a multicultural practice with the focus on Eastern European and Middle Eastern population, in addition to serving as a professor, clinical director, and many leadership positions within the community for over 25 years. She founded and has directed the community clinic IMCES, the Institute for Multicultural Counseling and Education Services with multicultural resources/staff to carry on her commitment to the needs of the target population which are significantly under serviced. Her major work has been dedicated to prevention/early intervention through school based services, human rights, discrimination issues, and cultural competency training, among others.
	Community #7 Latino/Immigrant	Mary Gonzales Veleta	DMH - Northeast MHC	323-428-8200	mgonzalezveleta@dmh.lacounty.gov	Education, Mental Health Provider, African American, Asian/Pacific Islander, TAY, Adults	Ms. Gonzalez Veleta was born in Chihuahua, Mexico and moved to California at age 10. It was at that time that she was first introduced to the educational system, not only learning to read and write, but learning a new language and culture. She graduated from UCLA with an MSW and feels that perhaps starting school at age 10 has given her the freedom to think outside the box, to take risks and be attracted to innovation. She has 30 years of experience working with underserved communities in the areas of equality, mental health, empowerment, race relations, higher education and prevention programs. She is an ally and understands the strengths and barriers of Asian Pacific, African American, Latino and Native American communities. Currently, she has had the privilege of contributing to the planning and implementation of the DMH Northeast Wellness Center.
At-large	At-large #1	Rachel Braude	LAUSD	213-241-4713	rachel.braude@lausd.net	0-5, Education	Ms. Braude has a Bachelor's Degree in Elementary Education with a minor in Spanish and a Masters Degree in Social Work. For the last nine years she has worked as a Psychiatric Social Worker for the Los Angeles Unified School District. For the first four years she worked at a K-12 school providing services to general education students and their families, including individual, group, & family therapy, parenting groups, PSTD intervention, etc. For the last 5 years she has worked under the Division of Special Education in the Infant Preschool Support Services offices. The Division of Special Education assesses preschool age children & develops Individual Education Plans (IEP's) in order for them to receive special education services.
	At-large #2	Barbara Engleman	Hollywood MHC	323-769-6183	bengleman@dmh.lacounty.gov	MH Providers	Ms. Engleman, LCSW has worked in Service Area IV for the last 20 years and has operated "countywide" programs. However, in 2006, she became the manager of the Los Angeles County - Hollywood Mental Health Center in 2006. This full service Mental Health center and one of the largest in the County and provides services to adults in the Hollywood area. Ms. Engleman's area of expertise is in the area of adult services, trauma and disaster work in the community.

Service Area 4 Ad Hoc PEI Steering Committee

Constituency Represented		Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Age Groups	Prenatal - 5	Natasha Wheeler	Hathway Sycamores	323-257-9600 x7136	natashawheeler@hathaway-sycamores.org	Education, Mental Health Provider, CFRC, Latino, 6-15, TAY	Ms. Wheeler is a parent of two children (ages 1 and 3 years), has had an interest in the 0-5 population, and has been working with this population most of her professional life. Prior to beginning Graduate School Training in Clinical Psychology, she volunteered at Thalians at Cedar Sinai working on the Warm line, and as a childcare provider in their Mommy and Me groups. She also worked as an Early Child Teacher at the Neuropsychiatric Institute at UCLA. Her current agency, Hathway Sycamores, was selected to be a pioneer provider in the field of 0-5 and she received additional training in working with the 0-5 population there. Currently, she works as a Director of Community Programs, overseeing a School Readiness Program through First 5 and overseeing outpatient, school based, and full service partnership child services at the Family Resource Center. One of her areas of interest is integrating 0-5 services from prevention, early intervention, to the intervention phases.
	Children (6-15)	Harkmore Lee	Center for the Pacific Asian Family	323-653-4045 x210	harkmorel@cpaf.info	API, Domestic Violence/Sexual Assult Survivors, Social Services, 0-5, TAY, Adults, Older Adults	Mr. Lee, MSW, is the Associate Director of the Center for the Pacific Asian Family, Inc. (CPAF), a leading non-profit agency in California and the U.S. focused on supporting and empowering adult and youth survivors of domestic violence and sexual assault, primarily in the Asian Pacific Islander community. During the past eleven years, Mr. Lee has served in both direct service and management capacities at various organizations aimed at healing and improving the physical, emotional and social health of children who have experienced trauma, neglect and/or barriers to receiving critical resources. He has worked at L.A. County's Department of Children and Family Services, St. Jude Children's Research Hospital, the YMCA, and now CPAF.
	TAY (16-25)	Alyssa Bray	Optimist Youth Homes	323-443-3152	abray@oyhfs.org	Mental Health Provider, 6-15	Ms. Bray is an LMFT and has been working with at-risk children and their families for 15 years. Over the last seven years, she has supervised a number of different programs including a Transitional Day Treatment Program for teenagers on probation, a Community Mental Health Program, and an Aftercare Program which provided outpatient mental health services to children ages 5 through 18, a TAY FSP Program serving the chronically mentally ill and homeless TAY population, and a Transitional Housing Program providing services to transitional age youth aging out of the various systems in Orange County and Riverside County. While supervising these programs, she has also been providing therapy to teenagers ages 13 to 19 in a Non-Public School.
	Adults (26-60)	Ann English	People Assisting the Homeless	323-960-3333	anne@path.org	CFRC, TAY, Older Adults, Homeless	Ann English is the Hollywood and West Los Angeles Area Director for People Assisting the Homeless (PATH) and has a long history working with chronically homeless populations in Santa Monica, Skid Row and Hollywood. As AD for PATH, she oversees multiple facilities and programs for PATH and develops strategies to enhance services and to educate communities about homelessness. Ms.English is the Co-Chair for Project Y!MBY (Yes, In My Backyard) a community collaborative that has generated unprecedented engagement in the Hollywood community towards ending Homelessness.

Service Area 4 Ad Hoc PEI Steering Committee

Constituency Represented		Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Age Groups	Older Adults (60+)	Vivian Sauer	Jewish Family Service of LA	323-761-8800	vsauer@jfsla.org	Mental Health Provider, Social Services, Middle Eastern/Eastern European, Latino	Ms. Sauer, LCSW, is the Associate Executive Director of Jewish Family Service of Los Angeles, the oldest and one of the largest social service agencies in LA County. Her area of expertise includes services to older adults and program development for older adults. She has been director of one of the JFS comprehensive senior centers, as well as their adult day health care center, and now supervises all senior service programs in the agency, which serve the entire continuum of older adults, from the healthy senior to the most frail elderly.
SAAC Chair		Suzanne Liss	Co-Chair Service Area Advisory Committee	323-851-4709	harlansu2@aol.com		Ms. Liss was a client of HMHC for many years, and took the position of SAAC co-chair many years ago. She was a member of the first graduating class of Dr. Verda Bradley's Peer Advocates program started in 1997. Ms. Liss received her law degree when I was 45 years old from a private Los Angeles area law school. She have been a widow for five years now, but blessed with six married children and 1 grandchildren.
District Chief		Ed Vidaurri (Committee Co-Chair)	Service Area 4 District Chief Department of Mental Health	213-738-3765	EVidaurri@dmh.lacounty.gov		Mr. Vidaurri is a licensed clinical social worker who, as the Mental Health Clinical District Chief for Service Area 4, is responsible for a large geographic area with diverse and intense mental health needs and includes Skid Row and Hollywood. Mr. Vidaurri has worked for the Department of Mental Health for nearly 20 years in a variety of roles. He began his career as a psychiatric social worker at MacLaren Children's Center. He went on to supervise the AB 3632 Residential Placement Unit and to lead the development of the Department's Healthy Families Program before joining Service Area 7 administration as a mental health Clinical Program Head. He served as a District Chief for Service Area 7 before assuming similar responsibilities for Service Area 4 in 2005.
Alt.	Law Enforcement	Richard Askew	LAPD	213-485-3300	35720@lapd.lacity.org		Officer Askew is a 9 year veteran of the Los Angeles Police Department. Currently he is assigned to the Mental Evaluation Unit , also known as the S.M.A.R.T. Team Prior to joining the department he was a teacher in a non-traditional school setting for two hears. Officer Askew is a graduate from Occidental College.

Service Area 5 Ad Hoc PEI Steering Committee

Constituency Represented		Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Required Sectors	Education	Kezia Miller	LAUSD School Mental Health	213-694-0045 x24	kezia.miller@lausd.net	Mental Health Provider, Children	Ms. Miller is a Licensed Clinical Social Worker who has worked with children and families for over 20 years, primarily in educational settings. She is currently employed by the Los Angeles Unified School District's School Mental Health Services unit, where she has worked for 14 years. Ms. Miller has lived in Service Area 5 for approximately 17 years.
		Nora Alvarez	The Help Group	310-751-1177	nalvarez@thehelpgroup.org	Mental Health Provider, 0-5, Children, TAY	Ms. Alvarez is an intake coordinator at the Help Group in Culvery City, assisting children and families in the community locate services both in and outside of their schools. She also has 10 years experience working with children with special needs in accessing eeducational supportive services in order to access their education in the least restrictive environment. Ma. Alvarez also assists school professionals in locating and securing the supportive services their school may need in order to collaborate effectively with parents and ensure families feel motivated and empowered to participate in their child's education.
	Health	Mimi Lind	Venice Family Clinic	310-664-7524	mlind@mednet.ucla.edu	Mental Health Provider, TAY	Ms. Lind, LCSW has worked in medical settings since 1988 as a clinical social worker. She has worked in the in-patient wards, as an emergency room social worker, and most recently in an out-patient setting. She specializes in domestic violence and the integration of behavioral health in health care settings.
		LeeAnn Skorohod	Exodus Recovery	310-945-3350	lskorohod@exodusrecovery.com	COD, Mental Health Provider, LGBTQ, TAY, Adults, Older Adults	Ms. Skorohod, CHC, Senior Vice President, Operations for Exodus Recovery, Inc. is a Certified Healthcare Compliance professional with over 20 years administrative experience including health care (both inpatient and outpatient services) and information systems in both the public and private sectors and over 15 years of quality assurance, quality improvement and utilization review experience. Clients served have included adults and older adults with mental illness, addiction, HIV/AIDS and co-occurring disorders.
	Law Enforcement	Doug Theus	Santa Monica PD	310-458-8493	Doug.Theus@SMGOV.NET	Homeless	Lt. Theus is a member of the Special Enforcement Division of the Santa Monica Police Department. He serves as the Lieutenant in charge of the Santa Monica HLP team.
		Channing Lang	Los Angeles Police Department (Mental Evaluation Unit)	213-485-3300	35542@lapd.lacity.org	Suicide-risk	Officer Lang is a nine year veteran of the LAPD. Her background includes working Skid Row for four years as an LAPD Officer. For the past four years, she has been a part of the Mental Evaluation Unit, handling crisis negotiation and suicide calls. Officer Lang is presently persuing her Bachelor's degree, and intends to continue her graduate education in Psychology in the future.

Constituency Represented		Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Required Sectors	Mental Health Provider	Rebecca Gaba	Didi Hirsch Community MHC	310-390-6612 x 352	rgaba@didihirsch.org	Health, Social Services, Consumers, Families of Consumers, African American, Latino, LGBTQ, Immigrant, 0-5, Children, TAY, Adults, Older Adults	Dr. Gaba, Vice President of Clinical Operations, joined Didi Hirsch Community Mental Health Center in 2008. She has earned a Doctorate in Clinical Psychology and a Master's degree in Counseling Psychology. Dr. Gaba is an LMFT with nearly 25 years of experience. She is an nationally recognized presenter and trainer, specializing in trauma related mental health issues. Prio to joining Didi Hirsch CMHC, Dr. Gaba was Chief Operating Officer for the Center for Multicultural Human Services in Virginia, and was Senior Director of Programs for the Children's Institute Inc. A long time advocate for services to children, youth, and families, Dr. Gaba is a strong proponent for a systems approach to community mental health. She has participated in a broad spectrum of State, County, and City workgroups and organizations, supporting greater collaboration among service delivery sectors.
		Mindy Meyer	Well Baby Community Center	310-962-7614	mmeyer@pacbell.net	0-5, Parents/Caregivers	Ms. Meyer, MA is an Outreach Consultant for the Well Baby Community Center, an organization that focuses on Infant/Parent Mental Health. Well Baby Community center strives to support families from the very beginning – to help parents be curious and understanding about their child's behavior and to help children become flexible in the face of life's many challenges, by fostering in them creativity, confidence, and resilience. Ms. Meyer has been a strong advocate for children and their families in SPA 5 for over a dozen years. She is has been keeping abreast of cutting edge research that sheds light upon the types of prevention intervention practices that are impactful in mental health settings. As a resident of SPA 5 for more than 30 years, she is familiar with the needs and challenges that face the service area.
	Social Services	Nick Maiorino	St. Joseph's Center	310-396-6556 x307	nmaiorino@stjosephctr.org	Mental Health Provider, COD, Homeless, Suicide Risk, Adults, Older Adults	Mr. Maiorino is a program director for St. Joseph Center, a multi-social service agency serving low-income individuals and families, the homeless, and persons impacted by disabilities. Although he has knowledge of a wide range of populations, he is particularly attuned to the needs of the homeless and adults with persistent mental illness. Mr. Maiorino has also been a resident of the Westside for ten years.
		Bethany Maher	St. John's Child & Family Development Center	310-829-8047	Bethany.Maher@stjohns.org	Mental Health Provider, 0-5	Ms. Maher, MSW, is a staff therapist and program consultant at Saint John's Child and Family Development Center. She has experience working with the Birth to 5 population, as well as older children, families and adults with severe mental illness. Ms. Maher is currently developing and implementing an early childhood consultation program in Service Area 5 and will be a graduate of the Infant-Parent Mental Health Post-Graduate Certificate Program through the University of Massachusetts, Boston and the Parent-Infant and Child Institute in Napa, CA in April 2009.

Constituency Represented		Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Consumers/Families	Consumer	Kate McCauley	Project Return	323-346-0960	kmmcauley@mhala.org		Ms. McCauley has 15+ years as a volunteer and professional in mental health services in Los Angeles County. She has a BA in teaching from University of Illinois and brings her skills, experience and hope to clinical trainings, IMD recovery groups and advocacy committees. Ms. McCauley is a member of NAMI and Peer Support Specialists. She is also a 20 year resident of Santa Monica.
	Family Member	Roberta Howard	NAMI Westside LA	310-472-0675	rlhowd@aol.com	Education, Stigma, Adults, Older Adults	Ms. Howard is a leader for NAMI Westside LA, an organization that offers self-help support and education dedicated to improving the lives of people with mental illness and their families. She works regularly with the families and friends of individuals with mental illness through NAMI's family to family education classes.
	Parent/Caregiver of child/youth in MH system	Veronica Sanchez	Daniel's Place	310-392-5855	veronica@stepuponsecond.org	Mental Health Provider, Social Services, Consumer, Families of Consumers, COD, Homeless	Ms. Sanchez is the parent of two young children that receive mental health services, a 10 year-old enrolled in FSP and a 4 year-old in therapeutic preschool. She is also a consumer of mental health services herself and was, at one time, homeless in Service Area 5. Today she work as a peer advocate with TAY and their parents at Daniel's Place in Santa Monica. She also serves on the Parent Advisory Committee for St. John's Partnership for Families program where she helps new parents who may qualify for DMH services.
Underserved Communities	Community #1 Deaf/Hard of Hearing	Susan Hajiani	St. John's Child & Family Development Center	310-829-8534	Susan.Hajiani@stjohns.org	Mental Health Provider, Children, TAY, Adults, Older Adults	Ms. Hajiani is a licensed clinical social worker and the program coordinator of Mental Health Services for Deaf and Hard of Hearing People at Saint John's CFDC. She has been professionally involved with Deaf Mental Health for 15 years and has also been active as an advocate for accessibility and better services for over 20 years in both Minnesota and California. Susan is Deaf and lives in Service area 5.
	Community #2 Latino	Nilsa Gallardo	Edelman Children's Program (DMH)	310-966-6603	Ngallardo@dmh.lacounty.gov	Mental Health Provider, African American, Middle Easten/Eastern European, Children, TAY	Dr. Gallardo is currently the Program Head of the Edelman Westside Mental Health Center Children and Families Service, with the Los Angeles County Department of Mental Health (LACDMH). Prior to taking this position she served as a supervisor at the LACDMH Hollywood Mental Health Center. Dr. Gallardo has focused her career on working with underserved and ethnically diverse populations in both the pubic and private sectors.
	Community #3 African American	Russana Rowles	LAUSD School Mental Health	323-750-5167	russana.rowles@lausd.net	Education, 0-5, Children, TAY	Ms. Rowles, LCSW is a Coordinator for LAUSD-School Mental Health Services. Additionally, she hs experience as a private practitionar working with youth in foster care and transition-age youth and as a medical social worked with the West LA V.A. She has experience working with diverse populations and an understanding of the social emotional challenges in the African American community in particular. Russane Rowles chose to serve on the steering committee because of her longstanding commitment to prevention and early intervention secondary to her awareness of the benefits of intervening early to minimize protracted social emotional challenges, and improve healthy outcomes. She also has a fervent commitment to ensuring that the voices and needs of underserved populations (such as African Americans & others) are a part of the dialogue/considerations which directs the PEI proposal in SAAC 5.
	Community #4 Stigma	Stella March	NAMI Westside LA	310-472-4297	smarch@nami.org		Ms. March has been involved with NAMI for more than 30 years. She has also been an active voice in various LA County DMH planning committees since the 1980s, and, more recently, the MHSA Stakeholder Delegates groups and the SLT. Ms. March is the National Coordinator for the NAMI StigmaBusters program.

	Constituency Represented	Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Underserved Communities	Community #5 Immigrants	Leticia Garcia Greenman	St. Joseph's Center	310-396-6468 x317	LGreenman@stjosephctr.org	Social Services, African American, Asian/Pacific Islander, Latino, Immigrant, Refugee, 0-5, Children, Adults, Older Adults	Ms. García Greenman immigrated to the United States from Mexico as a child. She received two undergraduate degrees from Yale University and later went on to receive a Master's degree in Clinical Psychology. Ms. García Greenman has lived and worked in the West Los Angeles area for over 20 years and has been with St. Joseph Center for the past 12 years.
	Community #6 Asian/Pacific Islander	Michi Okano	Pacific Asian Counseling Services	310-337-1550	mokano@pacsla.org	Health, Mental Health, Immirgrants, Refugees, 0-5, Children, Adults, Older Adults	Ms. Okano is the Acting Clinical Director for Pacific Asian Counseling Services an agency specializing in the mental health treatment of Asian and Pacific Islanders of all ages who are low income, immigrants, and often having experienced tremendous trauma. She has worked for the agency for over 15 years, has been in the mental health profession for over 30 years. Prior to working at Pacific Asian Counseling Services, Ms. Okako worked for Assistance League of Southern California as Clinical Director providing services to primarily Hispanic individuals and families. She also has experience working at the Regional Center for the Developmentally Disabled and the Department of Children and Family Services. She is a resident of SA 5, having lived there her entire life.
	Community #7 Veterans	Michelle Wildy	VA Greater Los Angeles	310-478-3711 x48343	Michelle.Wildy@med.va.gov	Adults, Homeless	Ms. Wildy is Licensed Clinical Social Worker and the Assistant Chief of Community Care of the West Los Angeles VA. As Assistant Chief, Ms Wildly oversees all of the homeless programs and outreach programs for the area. Additionally, she oversees the screening clinic which serves as the gateway to both mental health services and homeless services.
At-large	At-large #1 Employment	Fay Craton		310-645-6762	faycraton@yahoo.com		Ms. Craton, MA, SPHR, LMFT, brings to her work and to those around her a unique perspective resulting from experience in the very diverse arenas of psychology, business and spirituality; holding credentials in psychology as a Licensed Marriage and Family Therapist (LMFT) and in business as a Senior Human Resources Professional (SPHR). In the world of business, Fay has been a part of management teams of diverse organizations and sizes; including serving on an interim managing committee with full accountability of the effort of a manufacturer with sales of more than $18 million. It is this combination of experience that make her particularly qualified to represent the employment sector during PEI planning.
	At-large #2 TAY	David Leon	CAPPS UCLA	310-206-0122	DLeon@CAPPS.UCLA.edu	Mental Health Provider	Mr. Leon, LCSW has worked in the social service field for twelve years in multiple US cities and with a wide variety of populations. He received his MSW at USC in 2003 and began working at Didi Hirsch soon after. In his five years at Didi Hirsch, Mr. Leon developed and ran a young adult-focused treatment program combining individual, group and family therapy, event and activities organization, and advocacy. Mr. Leon received his license in social work in 2007 and currently works with college and graduate students at UCLA's student counseling center.

Constituency Represented		Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Age Groups	Prenatal - 5	Paula Kaplan	Vista Del Mar	323-934-7979	paulakaplan@vistadelmar.org	Children, Social Serviecs, Education, Mental Health Providers	Ms. Kaplan, MA, MSW, LCSW, is a Licensed Clinical Social Worker who also has a Masters Degree in Child Development and more than 30 years experience as a researcher, clinician and administrator providing services to young children and their parents and with low income families of diverse ethnic and cultural groups. As a Research Associate for the UCLA Infant Studies Project, she conducted developmental assessments of over 150 infants and toddlers and assisted with data analysis. She has worked at Home-SAFE/Vista Del Mar since 1984, where she developed and supervised the home based prevention and early intervention services using the infant mental health mode pioneered by Selma Freiberg. Services included counseling, child developmen guidance, parent education and case management and child development services. She was became Program Director in 1993, and then Director of Community Based Services for Vista Del Mar in 1996. In addition to her direct clinical experience, Paula has many years experience supervising staff and developing and implementing a variety of programs founded on principles of pr
	Children (6-15)	Natalie Levine	Family Service Santa Monica/ Vista Del Mar	310-451-9747	natalielevine@vistadelmar.org	Education, Mental Health Provider, 0-5, TAY, Adults	Ms. Levine, LCSW has lived in Service Area 5 for the past 34 years. She has a Master's in Social Work with a specialization in Community Mental Health. In addition, Ms. Levine has a California State Credential (PPS) in Child Welfare and School Social Work. She has been affiliated with non-profit, community based mental health agencies for the her whole career (32 years) where she has worked in child/adolescent mental health and school-based social services/mental health. She has mental health practice experience working with all ages, birth through older adults. For the past 20 years, she has worked at Family Service of Santa Monica, where she is the Clinical Director. Ms. Levine looks forward to working in a collaborative process looking at models that address community mental health needs and practices.
	TAY (16-25)	Marissa Lee	ACHSA, CA Youth Empowerment Network	213-250-5030 x107	mlee@achsa.net	Asian Americans, Consumers	Ms. Lee is a transition-aged youth, Asian American, and a mental health consumer. A 2008 UCLA graduate, she has been involved in public health advocacy for the past four years and currently serves on the steering committee for the California Youth Empowerment Network (CA-YEN), a program of the Mental Health Association in California. Marissa is the Mental Health Policy Assistant at the Association of Community Human Service Agencies (ACHSA) in Los Angeles.
	Adults (26-59)	Penny Mehra	Alcott Center for Mental Health Services	310-785-2121	pmehra@alcottcenter.org	Mental Health, Families of Consumers, TAY, Older Adults	Ms. Mehra has served as Executive Director of Alcott Center for Mental Health Services for the past twenty years. Alcott Center provides outpatient and residential services to adults with mental illness. During that time Ms. Mehra as served on many local and county and state-wide planning organizations including SAAC, Network, ACHSA, CCCMHA, and other DMH bodies. Ms. Mehra has fostered advocacy among consumers and collaboration among Westside community service providers. She lives in Santa Monica.

Constituency Represented		Name	Agency/Organization	Phone	E-mail	Additional Constituencies	Statement of Qualifications
Age Groups	Older Adults (60+)	Holly Kiger	WISE & Healthy Aging	310-394-9871 x239	hkiger@wiseandhealthyaging.org	Health, Mental Health, Latino, Homeless, Suicide Risk	Ms. Kiger has worked in a variety of settings over her long nursing career, including hospitals, schools of nursing, public health facilities and community based organizations. For the last twenty years, she has focused on developing and implementing specialized physical and mental health programs designed to serve the needs of older adult and multicultural communities at a community based organization in Santa Monica. Her work has positively affected health care nationally through her many conference presentations, published articles, teaching positions at a variety of universities in Kentucky, Illinois and California and serving on many local, state and national boards and committees, including American Society on Aging's Mental Health and Aging Steering Committee, the California Mental Health Advocates for Older Adults Board of Directors, and the Los Angeles County Department of Mental Health Older Adult System of Care Committee.
SAAC Chair		Celinda Jungheim	Service Area Advisory Committee	310-306-6766	Celinda@isp.com	Consumers, Families of Consumers, Older Adults	Ms. Jungheim is a consumer and former DMH client. She has been a Co-Chair of SAAC 5 for a number of years. A strong advocate for self-help and the recovery model. She currently falls in the older adults age range and lives in Marina del Rey.
District Chief		Karen Williams, Ph.D.	Department of Mental Health	310-268-2507	kwilliams@dmh.lacounty.gov		Dr. Williams works for the DMH and is the District Chief for SA 5. She is licensed as a clinical social worker and a psychologist and has extensive experience in the provision of mental health services to culturally diverse child, TAY, and adult populations. Dr. Williams also has administrative expertise in the areas of program development and management and has taught students at the graduate school level in both social work and psychology programs. She is a resident of SA 5.

Service Area 6 - Ad Hoc PEI Steering Committee Roster

Contituency Represented		Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
Required Sectors	Education	Kay Scott	Compton Unified School District, Centennial High School	(310) 635-2715 x 66216	mascott@compton.k12.ca.us	TAY	Ms. Kay Scott is currently a Guidance Counselor at Centennial High School in Compton. She has had extensive experience with students at the secondary level as well as with teachers, administrators and classified staff, in addition to a variety of collaborative endeavors within the school communities. She has enjoyed many years of professional experience working with adolescents and young adults in the areas of personal and academic guidance and counseling, career education and vocational skills training, as well as the development and implementation of programs and grant-related projects focusing upon student success and retention, and providing opportunities for career exploration and preparation. She has supervised Enrollment Management, Registration, Counseling and Retention, Student Records, Work-Based Learning Coordination, orientation and training of instructors, and liaison activities with school district and campus personnel.
		Jan Nolan	Los Angeles Unified School District	(323) 754-2856	jan.nolan@lausd.net	African American, Latino, 0-5, Children, TAY	Ms. Jan Nolan currently works as an administrator for the Los Angeles Unified School District (LAUSD). She is an LCSW and has worked in SA 6 in public education for 21 years. Prior to working for LAUSD, Ms. Nolan worked for the Department of Mental Health and provided school-based services. She also piloted the first Children's Program at Compton Mental Health. In addition, Ms. Nolan worked at MacLaren Children Center for approximately seven years.
	Health	Lynn Goodloe, M.D.	NAMI Urban Los Angeles	(323) 294-7814	lgoodloe@ca.rr.com	0-5, Children, TAY, Adults, Older Adults	Dr. Goodloe is a surgeon in the area of head and neck surgery. Her passion for providing health care carries over into her personal life. She performs volunteer work with NAMI, the Denise Roberts Breast Cancer Foundation, and her local church. Dr. Goodloe is a founding member of the NAMI (National Alliance for the Mentally Ill), Urban Los Angeles chapter (2003) and is a NAMI Family to Family teacher. She is also a NAMI family member. Her volunteer work with the Denise Roberts Breast Cancer Foundation for Minority Women (Association of Black Women) includes free mammogram screenings at churches. Dr. Goodloe is also a member of the health ministry for her church where she conducts monthly meetings. She provides advice, contributes to the health journal in the church newsletter, and organizes health fairs at the church. She has helped teach a Rites of Passage class for girls aged 11-19 where the girls discussed life lessons, coping skills, and preparation planning for college and jobs. Dr. Goodloe recently received a health degree from the American Board of Integrated Holistic Medicine (ABIHM).
		Janis Jones	Kedren CMHC	(323) 733-3886	J_jones@kedrenmentalhealth.org	0-5, Children, TAY, Adults, Older Adults	Ms. Janis Bush Jones has been a registered nurse and mental health clinician for the past 39 years. She has been employed with Kedren Community Mental Health since 1970. During her tenure, she has served all aged groups and has performed management duties for Adult Day Treatment, Crisis, Acute Psychiatric Hospital, and Adult Out-Patient Services. Ms. Jones is currently Clinic Director for Kedren's Adam I satellite office and is Program Director for Cal WORKS services at Kedren. She has devoted her career to serving the under privileged in SA 6 and maintains her pledge to deliver the best possible service to her community.
	Law Enforcement	Joseph Delfin	Probation	(323) 213-0406	joseph.delfin@probation.lacounty.gov	Children, TAY, Adults	Mr. Joseph Delfin is a Deputy Probation Officer for the Los Angeles County Probation Department. For the past six years he has worked with both youth and adults. Prior to his career with the Probation Department, he worked for the Department of Mental Health in Los Angeles for nearly three years as a Psychiatric Social Worker for Service Area 5. He holds a Masters Degree in Social Work from the University of Southern California and a Bachelors in Social Work from California State University of Los Angeles. Mr. Delfin is licensed by the California Board of Behavioral Sciences since 2007 to practice independently.
		Maureen Pacheco	Los Angeles County Public Defender's Office	(818) 374-2777	mpacheco@pubdef.lacounty.gov	Children, TAY, Juvenile Justice	Ms. Maureen Pacheco is the Juvenile Justice Legislative/Policy Advisor to the Los Angeles County Public Defender. As a public defender for 21 years, Ms. Pacheco represented clients in juvenile, misdemeanor and felony criminal proceedings. She worked for nine years in the Mental Health Court, and spent six years as a juvenile appellate attorney. Ms. Pacheco is on the Board of the Pacific Juvenile Defender Center, and represents the Public Defender's Office on numerous juvenile committees. Ms. Pacheco is past co-chair of the National Association of Criminal Defense Lawyers' Mental Health Committee, and currently serves on NACDL's State Legislative Committee. She is a frequent presenter at local, state and national conferences on the topics of juvenile justice and mental health issues.

Service Area 6 - Ad Hoc PEI Steering Committee Roster

Contituency Represented			Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
Required Sectors	Mental Health Provider		Romalis Taylor	Star View	(323) 999-2404 x 138	rtaylor@starsinc.com	African American, Latino, Co-occurring Disorders, Homeless, Immigrant, 0-5, Children, TAY	Mr. Romalis Taylor has worked in the mental health community for several years. He worked with the Department of Children and Families Services (DCFS) for over 12 years. While at DCFS, Mr. Taylor held the following positions: Regional Administrator, Division Chief Bureau of Children and Family Services, Division Chief Support Services, and Division Chief Family Preservation Service. Mr. Taylor has also worked as a Center Director with primary oversight of mental health services provided directly to children, adolescents and their families through the Compton Star View Community Services Center. As the Center Director he supervised staff for the Full Service Partnership program (FRP); Intensive In Home Mental Health Services (IIHMS); Community Base Mental Health Services (CBMHS); and other evidence-based initiatives being advanced by passage of the Mental Health Services Act (MHSA). He is currently the Director of Government and Community Relations working with programmatic and administrative Directors of DMH programs located in Service Areas 6,4, and 8.
			Angelica Vergara	West Central Mental Health	(323) 298-3677	avergara@lacdmh.org	TAY, Adults	Ms. Angelica Vergara has been providing mental health services for approximately six years to children, TAY and adults. She received her BA in sociology from UCLA and her masters in social welfare from UC Berkeley. Ms. Vergara has a passion for working in the mental health field . She continues to learn and grow from the individuals she serves and from seeing their progress and on-going motivation to achieve their mental health life goals.
	Social Services		Steve Sanders	DCFS	(323) 290-8500	sandes@dcfs.lacounty.gov	0-5, Children, TAY, Adult, Older Adult	Dr. Steve Sanders has a PhD in social work from the University of Southern California. He is currently the Regional Administrator for the Los Angeles County Department of Children and Family Services (DCFS), Wateridge office. Dr. Sanders has provided services to children for over 33 years and has been with DCFS from its inception. He is responsible for providing child welfare services to approximately 4,000 children in South Los Angeles.
			Brenda Shockley	Community Build, Inc.	(323 290-6560	bshock8402@aol.com	Children, TAY	Ms. Brenda Shockley is president of Community Build, Inc., a non-profit community development corporation that provides services to youth, young adults and their families by providing education, training, employment placement, college advisement and supportive services to youth in SPA 6. Community Build has a long history of working with the Department of Mental Health, and serving foster youth residing in SPA 6; through programs with the City of Los Angeles and national demonstration efforts with the U.S. Department of Labor and the Casey Family Programs, Seattle, Washington. Most recently, Community Build was selected by the City of Los Angeles' Mayor's Office of Gang Reduction and Youth Development to implement gang prevention services to youth between the ages of 10-15, residing in Baldwin Village, Crenshaw Corridor and Leimert Park.
	Consumers/Families	Consumer	Audrey Hall	Los Angeles County Client Coalition	(310) 637-9991	ahall80028@aol.com	African American, Adult, Older Adult, Seriously Mentally Ill	Ms. Audrey Hall has been a consumer of mental health services for over 20 years. She is president of the Los Angeles County Client Coalition. She speaks to various consumer groups about advocacy, motivation and empowerment. Ms. Hall has a B.S. in Health Care Management.
		Family Member	Nancy Carter	NAMI Urban Los Angeles		nancy@namiurbanla.org	Education, Consumer, 0-5, Children, TAY, Adults, Older Adults	Ms. Nancy Carter is executive director and co-founder of the Urban Los Angeles affiliate chapter of NAMI (National Alliance on Mental Illness). She is a board member of the NAMI National organization and a Los Angeles County Commissioner for Children's Policy. Ms. Carter is one of the country's leading advocates for mental health in communities of color. In 2007 she received the NAMI California Consumer of the Year award of excellence for her contributions to mental health consumers. She has been a recipient of volunteer awards in mental health from the County of Los Angeles and from the LA County Board of Supervisors. She serves on several local, state and, national committees for mental health planning, crisis intervention, criminal justice and multi-cultural outreach. She is a certified Family to Family teacher for NAMI. She conducts support groups, workshops and gives presentations for the public at local churches, schools and county agencies. She has developed and taught workshops in the areas of foster parenting, probation, cultural competency and spirituality & faith in the African American community
		Parent/Caregiver of Child/Youth in MH System	Luz Gomez		(323) 298-3677		Children, TAY, Adults, Consumer	Ms. Luz Gomez is the mother of two children who are currently receiving mental health services at a county mental health clinic. Ms. Gomez also receives mental health services for herself. The treatment she has received has helped her to overcome her diagnosis and to recognize the constant effort that it takes to help herself and her children.
Und.	Community #1 African-American		Nancy Jefferson	Los Angeles Unified School District	(323) 754-2856	nancy.jefferson@lausd.net	Education, Latino, 0-5, Children, TAY	Ms. Nancy Jefferson has lived in the predominately black sections of Greater Los Angeles for more than five decades. As an African American woman, she has been actively involved in volunteer and social action organizations. She has promoted and assisted African American interests, such as, Association of Black Social Workers of Greater Los Angeles, Minority AIDS Project and the Coalition of Mental Health Professions. Ms. Jefferson has also served on the Advisory Board of KCET Television where she represented the interests of African Americans in Southern California.

Service Area 6 - Ad Hoc PEI Steering Committee Roster

Contituency Represented		Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
Underserved Communities	Community #2 Co-occurring	Angelica Garcia	Pearl Ella Johnson Wellness Center Project		agarcia@mhala.org	Consumer, African American, Co-occurring, Adults, Older Adults	Angelica Garcia is Director of Center Programs of Project Return Peer Support Network. She works with Pearl Ella Johnson Wellness Center and has participated in the start up of El Centrito de Apoyo. She recruits, hires and supervises assigned staff and also leads or delegates leadership of day-to-day operations of the department as needed. Her Passion is carrying the message of hope and advocacy to people who suffer from mental illness. She also networks with peers in other community agencies to share ideas and resources.
	Community #3 Latino	Paco Retana	Los Angeles Child Guidance Clinic	(310) 849-7480	pretana@lacgc.org	Children	Mr. Paco Retana is a Licensed Clinical Social Worker (LCSW) who has been providing community mental health services for approximately 21 years. He specializes in children and families who are experiencing mental health issues. Mr. Retana's passion is working with the underserved, marginalized, populations, and in particular, with the Latino community. Mr. Retana has participated in the School Attendance Review Board, Race and Discipline Task Force, Community Crisis Team and others. He has presented at UCLA, USC and most recently, at the Latino Behavioral Health Conference. Mr. Retana is the recipient of a Humanitarian Award from the National Conference for Community Social Justice.
	Community #4 Immigrant	Berta E. Ortiz	Kedren CMHC		b_ortiz@kedrenmentalhealth.org	Mental Health Provider, African American, Latino, 0-5, Children, TAY, Adults, Older Adults	Dr. Berta E. Ortiz earned a Ph.D. in Counseling Psychology from Texas A&M University in 1982. She has over 20 years experience working with the Latino immigrant population in Los Angeles County. Dr. Ortiz provides psychological services at Kedren Acute Psychiatric Hospital and Community Mental Health Center in Service Area 6, and has a private practice in Montebello and Los Angeles. Dr. Ortiz's deep understanding of the Latino population comes from her personal experience as an immigrant.
	Community #5 LGBTQ	Rhumel Grady	Compton Mental Health	(310) 668-6894	rgrady@dmh.lacounty.gov	Children, TAY, Adults, Older Adults, Individuals With Seriouis Mental Illness and/or Their families, CalWORKs, Substance Abuse	Ms. Rhumel Grady is a University of Southern California graduate, with her LCSW. She has worked for the County of Los Angeles Department of Mental Health for over nine years. She has worked and volunteered with several prominent community-based organizations such as, Suicide Prevention Center, Avalon Carver Community Center Minority Aids Project and The Community Coalition for Substance Abuse and Prevention. Ms. Grady functioned as the HIV/AIDS coordinator for Avalon Carter for over three years. Her strong social services commitment to underserved populations can be recognized by her accomplishments as film producer and co-author of a published journal article on the subject of African American drug use intervention therapy.
	Community #6 Blind	Lisa Rueda	Junior Blind of America	(323) 295-4555	lrueda@juniorblind.org	0-5, Children, TAY, Adults, Older Adults, Education	Ms. Lisa Rueda is currently employed with Junior Blind of America as Director of Program Development. She has worked with this population for approximately one year and a half. She has a background in mental health and holds a doctoral degree in clinical psychology. Ms. Rueda's experience includes working for DMH contracted agencies that specialize in serving children and adults with disabilities. In addition, she is a part-time instructor at California State University, Los Angeles where she teaches courses in Psychopharmacology and Counseling theory. Ms. Rueda feels that she can provide insight with regard to the mental health needs of the visually impaired as well as for individuals with disabilities in general.
	Community #7 Homeless	Dorothy Banks		(323) 298-3727		Adults	Ms. Dorothy Banks was homeless for approximately two and a half years. She lived in six different shelters and homes. During that time she experienced the mental, psychological and spiritual effects that homelessness has on an individual. With the help of West Central Mental Health, her church and her family, she was able to make it through. Ms. Banks now has a place of her own with the help of Section 8. She believes that her experience in being homeless will help her to advocate for those currently homeless and expects to have an impact on their lives by sharing her experiences with them.
At-large	At-large #1 CFRC	Robert Rubin	Vermont Village CDC	(323) 758-3777 x 4175	rerubin@Faithdome.org	Adults, Older Adults	Mr. Robert Rubin is a Graduate of Cal State University Dominguez Hills, with a B. A. in Communications and an AA from Los Angeles Southwest College. He has worked in the Vermont/Manchester community for the last 23 years. Mr. Rubin currently works for Vermont Village Community Development Corporation (VV CDC) that is attempting to revive efforts to rebuild the Vermont/Manchester community through the development of more affordable housing, commercial developments and home ownership. Through these projects, and others like it the VV CDC has generated employment opportunities and much needed social services for the community. Mr. Rubin, also sits on the Community Advisory Committee for the area and the Vermont Village Community Advisory Committee for the Department of Children and Family Services that has over 60 members that represent the neighborhood diversity.

Service Area 6 - Ad Hoc PEI Steering Committee Roster

Contituency Represented		Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
At-large	At-large #2 Faith-based organizations	Belanie Brown	Crenshaw Christian Center	(323) 298-3727	belbless@aol.com	Consumer, African American, Stigma and Discrimination, 0-5, Children, TAY, Adults, Older Adults	Ms. Belanie Brown is a valuable asset and voice throughout the faith-based and community at large. Ms. Brown is a certified missionary from Crenshaw Christian Center, a DMH advocate, a SAAC 6 member, a DMH Commissioner Representative and a DMH countywide clergy member. Ms. Brown earned her bachelor's in Christian Ministry from Azusa Pacific University. Her thesis focused on supporting the mentally ill in the church and community and has been a blueprint to integrating spirituality into the mental health treatment plan at large.
Age Groups	Prenatal - 5	La Faune Gordon	Children's Collective, Inc.	(310) 281-7359	lgordonphd@aol.com	Social Services, CFRC,	Dr. La Faune Gordon is a licensed clinical psychologist who is a certified infant mental health specialist and infant massage instructor. She has many years of clinical experience in working with high-risk children (birth to five), adolescents, and families in the South Los Angeles area. Dr. Gordon's clinical work includes conducting developmental, psychological and psychosocial evaluations, providing individual, group and family therapy, and presenting specialized trainings to clinicians, psychology interns and teaching staff working with underprivileged children and families. She is a former LAC-DMH Mental Health Clinical Program Head for the Enhanced Specialized Foster Care Program in Service Area 6. At present, Dr. Gordon is a clinical consultant for the Children's Collective, Inc. and will soon begin clinical work with the UCLA Infant Mental Health/Ties for Adoption Program.
	Children (6-15)	Rosiland Aubrey-Lee	Department of Children and Family Services	(323) 965-7060	aubrer@dcfs.lacounty.gov	0-5, Children, TAY	Ms. Rosiland Aubrey-Lee has been a social worker with the Department of Children and Family Services (DCFS) for the past nine years. She has also served families through various church organizations for over 30 years. Ms. Aubrey-Lee was a pre-school teacher for 10 years. She received her Bachelor of Arts in Child Development from Cal State Los Angeles University and her Master's of Social Work from the University of Southern California. Ms. Aubrey-Lee is married and has two adult children.
	Transition-age Youth (TAY) (16-25)	Bruce Wheatley	Inner-City Industry	(310) 558-2271	brucew@innercityindustry.org	TAY, African American	Mr. Bruce Wheatley is Chairman/CEO of Inner City Industry. He has worked with transitional age youth in South Los Angeles for eight years. Mr. Wheatley created Inner City Industry's Systemic Transformation Model to address school reform and to implement mental health in schools to address barriers to learning. Mr. Wheatley's passion is focused on the social and emotional development of youth.
	Adults (26-59)	Staci Atkins	West Central Mental Health	(323) 298-3722	satkins@lacdmh.org	Adults	Ms. Staci Atkins has two B.A. degrees from the University of California Los Angeles in Psychology and Sociology and an MSW degree from the University of Southern California. She has provided mental health services to the adult population for the past four years. She currently provides therapeutic services at West Central Mental Heath in an individual and group setting. Ms. Atkins is active in the community by providing emergency outreach with the Psychiatric Mobil Response Team to adults in crisis. In addition, Ms. Atkins is an adjunct professor at Southwest Community College. Ms. Atkins continues to advocate and assist adults in living their best lives.
	Older Adults (60+)	Ruthie Gray	United Women in Transition	(323) 298-3727	ruthgr3@aol.com	Adults, Older Adults	Ms. Ruthie Gray has 20 years of compassionate experience in working with older adults. Ms. Gray has personal experience caring for elderly family members and is very interested in motivating older adults toward healthy mental, physical and spiritual life styles. Ms. Gray also has experience working with adult women with co-occurring disorders, women who are homeless and women in the criminal justice system.
SAAC Chair		Eddie M. Lamon	SAAC 6	(323) 298-3727		Education, African American, Latino, Homeless, Older Adults	Ms. Eddie Lamon is the co-chair of the Service Area 6 Advisory Council for the Department of Mental Health. She has served on numerous mental health advisory councils for over 30 years. Ms. Lamon has over 50 years of community service including the Compton's Unified School District Advisory Council. Ms. Lamon is the mother of 12 children. She has 26 grandchildren and 16 great grandchildren.
District Chief		Yolanda Whittington	West Central Mental Health	(323) 298-3715	ywhittington@dmh.lacounty.gov	Mental Health Provider	Ms. Yolanda Whittington is currently the Mental Health Clinical District Chief for the County of Los Angeles Department of Mental Health. She has administrative and clinical area-wide managerial responsibility for Service Planning Area 6 in South Los Angeles. Ms. Whittington has over 20 years of community service including mental health advocacy and policy planning, analysis and implementation.

Service Area 6 - Ad Hoc PEI Steering Committee Roster

	Contituency Represented	Name	Agency/Organization	Contact Phone	E-mail	Additional Contituencies	Statement of Qualifications
Alternates	Education	Darlene Wooten	Los Angeles Southwest College	(323) 241-5481	wootendm@lasc.edu	TAY, Adults, Older Adults	Ms. Darlene M. Wooten has served for over twenty-five years in education, counseling and management positions at several colleges, agencies and school systems. Currently, she serves as coordinator for disabled students at Los Angeles Southwest College. Previously, she has been: coordinator for special education students at a middle school; guidance counselor & substance abuse advisor for a school system; director of a family resource center; a clinical therapist in private practice; program director for a juvenile sex offenders residential treatment center; family counselor supervisor for a therapeutic foster care program; director of counseling and instructor for a four-year college; a children's social worker; and a children's treatment counselor for the Department of Children & Family Services. She is a member of the Association of California Community College Administrators; and the American Association for Marital & Family Therapy. She has trainer certification in diversity issues, is an LMFT in the state of Tennessee and has a Pupil Personnel Credential in School Counseling in California.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION (PEI)

Service Area 7 - Ad Hoc PEI Steering Committee Roster

Constituency Represented		Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Required Sectors	Education	Terri Villa-McDowell	ABC Unified School District	(562) 926-5566 ext. 21150	terri.villa-mcdowell@abcusd.k12.ca.us	Mental Health Provider, COD, TAY, Adults	Ms. Villa-McDowell is ABCUSD's Safe Schools/Healthy Students Program Coordinator. The program provides school-based mental health counseling, human relations programs, after-school programs, crisis response counseling, and other intervention programs for at-risk students. She also works as the district's Conflict Resolution Facilitator. This new program offers alternate dispute resolution services to ABC district staff and parents. Ms. Villa-McDowell was most recently with the L.A. County Human Relations Commission as Assistant Executive Director for Programs. She developed and supervised community conflict resolution programs and public education initiatives for this agency. She worked over 15 years as a social justice attorney for families and children. She has worked in many areas of the law, including public interest, access to health, nutrition and education for low income children and families, immigrant rights, corporate and criminal law.
		George Muriel	Montebello Unified School District	(323) 887-7900 ext. 2249 (323) 314-2842 (Cell)	muriel_george@montebello.k12.ca.us	Latino, 0-5, Children, TAY, Adults	Mr. Muriel has been with the Montebello Unified School District for 20 years, where he has worked as a teacher, counselor/outreach advisor, Drug, Alcohol, Tobacco Education (D.A.T.E.) Coordinator, Elementary and Intermediate Principal and presently the District Coordinator for Health/Mental Health & Community Services. Before coming to Montebello Unified, Mr. Muriel worked three years as an Outreach Consultant focused on "at risk" students for Norwalk-La Mirada USD and a teacher for Los Angeles USD. Mr. Muriel holds a B.A. in Political Science, a M.Ed. in Bilingual/X Cultural Ed., and a M.S. in School Counseling, all from the University of California, Los Angeles, as well as numerous credentials. In collaboration with Cal State University, Los Angeles and the Montebello Family Support Center, Mr. Muriel has taught the Individual Counseling Practicum, as well as assisted in coordinating and accessing individual counseling services to over 125 Montebello students in the last three years. This collaboration effort has helped to develop and expand counseling resources in the Montebello community.
	Health	Frank Cook	Brand New Day (Universal Care)	(800) 635-6668 ext. 6201 (714) 268-5109 (Pager)	fcook@universalcare.com	Mental Health Provider, Parent/Caregiver of Child/Youth in MH System, Faith-based, Adults, Older Adults	Mr. Cook is a nurse employed in the psychiatric field (ages 18+). He graduated from an ROP medical assisting program in 1979 and has been consistently employed in the nursing field and healthcare industry for the past 30 years. After attending Fullerton College, Mr. Cook joined the US Army, attended their nursing schools, and left as a LPN/LVN. After being honorably discharged from the military, he has been employed with Universal Care Medical Group and Brand New Day of Bellflower (18 years). Mr. Cook currently "starts up" full medical and psychiatric services clinics and maintains outpatient programs for adults with Serious and Persistent Mental Illness (SPMI). He is the parent of a 12 year old boy with high functioing Autism and Asperger's Syndrome, so he has seen the "mental health care system" from both sides; consumer and provider. Mr. Cook feels he as the qualities and experience needed to represent this population within a committee due to his many years of treating them as a nurse, health educator and staff and facility administrator.
		Clara D'Agostino	East Whittier City School District	(562) 907-5945 (562) 233-0695 (Cell)	cdagostino@ewcsd.org	Education, Children	Ms. D'Agostino is interested in representing education on the PEI Steering Committee because of her extensive background in both mental health and the public school setting. She has a Master's Degree from USC in Social Work, with a concentration in Mental Health, and has been licensed as a Clinical Social Worker for thirteen years. Ms. D'Agostino has worked in a clinical mental health outpatient setting in the past and is currently the Project Director for Safe Schools Healthy Students in East Whittier City School District. She has collaborated with multiple groups and agencies to accomplish positive outcomes for students and families. Ms. D'Agostino co-chaired the Substance Abuse Violence Education Task Force in the Whittier area for six years. In the past, she served on the SPA7 Committee for Health as an employee of Presbyterian Intercommunity Hospital. Ms. D'Agostino wants to advocate for expanding prevention services to the school setting.

Service Area 7 - Ad Hoc PEI Steering Committee Roster

Constituency Represented		Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Required Sectors	Law Enforcement	Alex Mata	P.R.I.D.E. Program (Pico Rivera Sheriff's Station)	(562) 260-1408	losmata@verizon.net	Education, Mental Health Provider, Community Family Resource Center, Latino, Faith-based Organizations, Children	Mr. Mata is the Executive Director of the P.R.I.D.E. Program at the Pico Rivera Sheriff's Station. The program is for at-risk youth ages 12-16. It is a 9-week PEI mandatory program per parent.
		Dena Plotkin	Circle of Help	(213) 864-6406	dmplotkin@gmail.com	Mental Health Provider, COD, TAY, Adults	Ms. Plotkin is a LMFT and has worked within the mental health sector for over 20 years. She has served on her local neighborhood council and is a community builder and organizer familiar with a collaborative model. Ms. Plotkin is committed to building stronger communities that can be effective in creating positive change for their members.
	Mental Health Provider	Aurelio Enriquez, Jr.	California Hispanic Commission on Alcohol & Drug Abuse (CHCADA)	(323) 222-4591 ext. 13	aenriquez@chcada.org	Health, Underserved Communities, Children, TAY	Mr. Enriquez is the Project Director for the California Hispanic Commission on Alcohol and Drug Abuse (CHCADA). CHCADA prides itself on its dedication to providing comprehensive DD treatment for the youth and adults they serve, primarily minorities. Mr. Enriquez's personal goal is that CHCADA stray away from having one large central location and remain in the path of developing smaller clinics within the communities they serve and communities in need of service. Mr. Enriquez is originally from southern New Mexico where he served as a State Police Officer for 14+ years. He earned his MSW from New Mexico State University, is currently licensed in California, and recently graduated with his doctorate degree in Clinical Psychology. Mr. Enriquez has learned a great deal about the needs of the populations CHCADA serves in the last five years that he has been in California and truly feels that he will be a profound contributor to this process.
		Rose Temblador	Intercommunity Child Guidance Center	(562) 692-0383	rtemblador@intercommunity.org	0-5	Dr. Temblador is a Clinical Psychologist with over 15 years of experience providing community-based prevention and intervention services to children and families. Her area of specialization is children 0-5. She has worked with this population as a preschool teacher, therapist, and supervisor/administrator. Dr. Temblador has also worked collaboratively with other service providers in the area to provide comprehensive services to families and has experience with evidence-based interventions. Dr. Temblador believes strongly in the power of prevention and early intervention. The 0-5 population has been historically underserved so she would like to participate on the committee to make sure that the unique needs and challenges providers serving this age group face are represented/considered.
	Social Services	Cynthia Diaz	MELA Counseling Services Center	(323) 728-0100 ext. 20 (323) 490-5016 (Cell)	Cynthia@MELACOUNSELING.org	COD, Latino, TAY, Older Adults	Ms. Diaz is the Deputy Director at MELA with 16 years senior management experience in the social services, non profit management & extensive community advocate work in the Latino Community. She currently sits on several committees including the Executive Steering Committee for the state's CDCR/Corrections Standard Authority Parenting Program & Co-Chair Mental Health Committee for Congresswoman Grace Napolitano. MELA provides substance abuse outpatient & social services for families in the ELA area and surrounding communities. TAY Adolescent services include outpatient substance abuse, teen parenting, teen anger management, day care and teen mentoring. Services are provided on site and in 3 local school districts.
		Kevin Rice	Helpline Youth Counseling	(562) 864-3722	krice@vfnet.com	Mental Health Provider, COD, Underserved Communities, 0-5, Children, TAY	Mr. Rice is Clinical Director at Helpline Youth Counseling; he has previous experience in community mental health with all age groups (16 years in the field). Mr. Rice wishes to be a contributor to improving and developing effective service delivery systems, particularly with underserved populations.
umers/Families	Consumer	Dwayne Clements	Rio Hondo Mental Health Center (DMH)	(562) 402-0688	Dclements@dmh.lacounty.gov	COD, Adults, Older Adults	Mr. Clements has been a mental health consumer since 2002. He is a client with COD and is involved with the Rio Hondo MHC COD program.
	Family Member	Rita Murray	National Alliance on Mental Illness (NAMI) Whittier	(562) 692-8006	amiwhttr@aol.com	Adults, Older Adults	Ms. Murray is the President of NAMI Whittier. She is a former SAAC 7 chairperson. Ms. Murray has a B.A. in Psychology. She is a former NAMI California Board member and is a Family-to-Family teacher. Ms. Murray has family members who have a mental illness. She helps other family members learn about mental illness, how to cope with it and how to navigate the system.

Service Area 7 - Ad Hoc PEI Steering Committee Roster

Constituency Represented		Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Cons	Parent/Caregiver of Child/Youth in MH System	F. Carmen Baldizon	Service Area 7 Administration (DMH)	(213) 792-4832	FBaldizon@dmh.lacounty.gov	Family Member of Consumer, Latino, Children, TAY	Parent of child/youth in mental health system.
Underserved Communities	Community #1 American Indian	Paul Sacco	American Indian Counseling Center (DMH)	(562) 402-0677	psacco@dmh.lacounty.gov	Mental Health Provider, 0-5, Children, TAY, Adults, Older Adults	Mr. Sacco is the Program Head at the American Indian Counseling Center. He is an enrolled member of his tribe, Laguna Pueblo. He has worked for the Department of Mental Health for 16 years and has worked in a variety of settings that served children, families, adults and detained youth. Mr. Sacco is an LCSW.
	Community #2 Asian/Pacific Islander	Derek Hsieh	Service Area 7 Psychiatric Mobile Response Team (DMH)	(562) 467-0209 (213) 448-8517 (Cell)	DHsieh@dmh.lacounty.gov	Suicide Risk, Children	Mr. Hsieh supervises the psychiatric mobile response team for Service Area 7. He also comes from an Asian background and is familiar with some of the Asian cultural and mental health issues and needs. In responding to psychiatric emergency calls in the community, Mr. Hsieh has been exposed to many issues and needs in the community, particularly in relation to suicide risk prevention and early intervention. He is also interested to help better meet the needs of the Asian/Pacific Islander community.
	Community #3 Latino	Lourdes Caracoza	ALMA Family Services	(562) 754-9760 or (323) 881-3799	lourdesc@almafs.com	Mental Health Provider, Social Services, Family Member of Consumer, Community Family Resource Center, 0-5, Children, TAY, Adults, Older Adults	Ms. Caracoza is Director of Program Operations and Community Relations, has worked with the Hispanic community in the area of education and advocacy, as well as developing community groups. These past couple of years she has been excited to see the development of new programs and services through MHSA funding. Ms. Caracoza believes PEI is another opportunity that we will have to serve and assist our communities.
	Community #4 Latino	Leticia Guzman-Soydan	Rio Hondo Mental Health Center (DMH)	(562) 402-0688	lguzmansoydan@dmh.lacounty.gov	Monolingual Spanish, Adults, Older Adults	Ms. Guzman-Soydan has worked as a psychiatric social worker and manager in Service Area 7 for 18 years (11/84-9/96 at El Centro MHC, 9/96-4/97 at Telecare Corp., and 2003 to present as manager of Rio Hondo MHC). Between 5/97 and 5/03 worked at the Latino MHC in Service Area 6, a directly-operated countywide program with Spanish-speaking adults and older adults.
	Community #5 Latino	Natalie Kusturic	Plaza Community Services	(323) 268-3219 ext. 217	nkusturic@plazacc.org	TAY, Adults	Ms. Kusturic is a licensed marriage and family therapist with extensive experience as a service provider, as well as administrator. She specializes in children's mental health. She has been working with the immigrant Latino population since 1995. Ms. Kusturic has been a key player in program development and implementation. Ms. Kusturic has always been a strong advocate for children and the Latino community. She has a strong knowledge of mental health and the needs of children, adults and families in the Latino community. She is committed to utilizing her skills to assist in the PEI planning process to insure the underserved needs are addressed.
	Community #6 Latino	Jesus Ramirez	Service Area 7 Administration (DMH)	(213) 738-3313	jeramirez@dmh.lacounty.gov	Mental Health Provider, 0-5, Children, TAY	Mr. Ramirez is a Mental Health Coordinator II who has been with the County for eight years. He is currently the FSP Coordinator for Children and Transitional Age Youth. In the past he has provided Quality Parenting classes for mostly Spanish-speaking parents and has been an ASIST (Applied Suicide Intervention Skills Training) trainer for the Department of Mental Health. Mr. Ramirez has spent most of his eight years working with school aged children and their parents.
	Community #7 Immigrant	Feliza Perez	Un Paso Mas (Mental Health America)	(323) 346-0960 ext. 235 (323) 578-2022 (Cell)	fperez@mhala.org	Family Member of Consumer, Latino, Monolingual Spanish, Adults	Ms. Perez is a Latina immigrant with many years of experience helping other immigrants assimilate to American culture. In 1960, she moved from Mexico to the United States when she married an American from Los Angeles. They had four children and learned from one another how to be a bilingual, bicultural family. Early on, Ms. Perez and her husband gathered groups of immigrants in their home and held discussions regarding immigrant problems and solutions; eventually it was named "Family Movement". Ms. Perez has been working 24 years for Mental Health America of Los Angeles and has been a liaison to the Latino community for the last 8 years. She has reached into the "7 Cities" area, which is comprised of 99% immigrants that have had no previous support. Her accomplishments include: developing the first Mental Health Fair in the 7 cities; producing a series of Mental Health workshops for L.A.U.S.D. Community Reps.; developing and maintaining over 14 education/support groups for 8 years; and developing C.O.R.E., a support/resource group consisting of community leaders representing the seven-city area.

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Constituency Represented		Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
	Community #8 Latino	Ricardo Gonsalves	Bienvenidos	(909) 525-9343	rgonsalves@bienvenidos.org	Health, Mental Health Provider, 0-5, Children, TAY	Dr. Gonsalves holds a Doctorate in Human Development and Psychology from Harvard University. He is co-founder of the California Latino Psychological Association; Associate Researcher-Spanish Speaking Mental Health Research Center-UCLA; faculty member-California Graduate Institute of Psychology; and clinic manager for Bienvenidos Mental Health Services-Pomona. Dr. Gonsalves wants to increase and improve mental health services for the Latino community, particularly for young adults and children; to strengthen the link between psychological and medical services; and to attend to the preventive mental health needs of infants, young children and families.
At-large	At-large #1 Media	Gabriel Buelna	Plaza Community Services	(323) 267-9749	gbuelna@plazacs.org	Employment, Latino, 0-5, Children, TAY, Adults, Older Adults	For many years Dr. Buelna has served the people of Los Angeles, beginning with his work at the L.A. County Department of Children and Family Services to his current role as Executive Director of Plaza Community Services. Dr. Buelna began his career as a children's social worker with DCFS and went on to become a foster care agency Administrator. He worked with abused and neglected children, their families, law enforcement and the courts. Dr. Buelna earned a Bachelor's degree from California State University Northridge (CSUN) and a Master's in Social Work from San Diego State University. Dr. Buelna earned his Ph.D. from the School of Politics and Economics at the Claremont Graduate University. In 1999, he joined CSUN as a faculty member where he continues to teach history and politics. Dr. Buelna is a frequent political commentator on the television network, Univision. As a professor of Latino studies at CSUN, he can offer up-to-date information regarding the Latino community. In addition, Dr. Buelna can assist in navigating the complexity of collaborating with the media.
At-large	At-large #2 Co-occurring Disorders (COD)	Brenda Wiewel	Los Angeles Centers for Alcohol & Drug Abuse (LACADA)	(562) 906-2686 ext.103	bwiewel@lacada.com	Health, Latino, HIV+, Domestic Violence, 0-5, Children, TAY, Adults	Ms. Wiewel has been with LACADA for 20 years; 10 years as Executive Director and 10 years as Clinical Director. She also has 7 years of experience with L.A. County DMH at El Camino Mental Health Center and TRC. She is a MFT/LCSW; USC School of Social Work grad 1980; Field Instructor for USC; President NASW Women's Council for 25 years. Ms. Wiewel's desire is to ensure that comprehensive community services that integrate health, mental health, and substance abuse treatment and prevention for individuals and their families are available to the Latino community for low income persons. Her particular concern is about trauma as a source of, or exacerbating, co-occurring disorders and the need to fill gaps in care.
Age Groups	Prenatal - 5	Steven Hendrickson	Roybal Family Mental Health Center (DMH)	(323) 267-3400	shendrickson@dmh.lacounty.gov	Mental Health Provider, Children, TAY, Adults, Older Adults	A former jounalist, Mr. Hendrickson became a social worker in mid-life. He has worked as a clinician with teenagers on probation, as well as with adults. He is Program Head at Roybal Family MHC in East Los Angeles. Both from family experience and from undergraduate coursework in biopsychology, Mr. Hendrickson has long believed that the first years are critical toward an individual's ability to form a meaningful life.
Age Groups	Children (6-15)	Hillary Sherman-Wicks	Community Family Guidance Center	(562) 865-6444	hshermanwicks@cfgcenter.com	Mental Health Provider, 0-5, TAY	Ms. Sherman-Wicks is a LCSW and has experience as a therapist, program coordinator, and, currently, as Associate Clnical Director. Her experience is with all ages, but primarily with children, teens and families. She has been with Community Family Guidance in Service Area 7 for almost 11 years. She also attended several of the county's trainings for 0-5. Her agency provides services for ages 0-5 through FSP and in their general outpatient program. Their agency also provides outpatient services to several local schools, so she is familiar and has experience with collaborations.
Age Groups	Transition-age Youth (TAY) (16-25)	Sylvia Leyba	Southern California Alcohol & Drug Programs	(562) 864-7724 or (562) 708-0267	sgleyba@yahoo.com	Education, Health, Underserved Communities, 0-5, Children, Adults, Older Adults	Ms. Leyba has a B.A. in Human Services and an M.A. in Counseling. She is currently at Cider House (Program) vocational counseling for up to 70+ men who are residents. She has been the program director for Casa Libre in Bell Gardens that serves both youth and adults who have drug and alcohol addictions. The program offers addiction and family counseling. Ms. Leyba is also active in the community with SPA 7.
Age Groups	Adults (26-59)	Maria Morales	Un Paso Mas (Mental Health America)		Maria9569@sbcglobal.net	Latino, Immigrant	Ms. Morales volunteered for two years at the Mental Health Family Advocate office. As a family member, she helps people find resources in mental health clinics. She works with two support groups in Service Area 7. She has worked for MHA since 2007. Ms. Morales is a community leader and knows the needs of this community.

Service Area 7 - Ad Hoc PEI Steering Committee Roster

	Constituency Represented	Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
	Older Adults (60+)	Irene Redondo-Churchward	SPIRITT Family Services	(562) 903-7000 ext. 23	irenerc@spiritt.org	Social Services, Health, Latino, 0-5, Children, TAY, Adults	Ms. Redondo-Churchward has been the executive director of SPIRITT Family Services since 1982. SPIRITT is a social service agency with five centers. She has been instrumental in the development of all the agency's programs which range from Prevention and Early Intervention to Treatment and Recovery services for child abuse, domestic violence, substance abuse, to youth programs that range from mental health services to empowerment models that include school-based services that culminate in three annual youth conferences.
	SAAC Chair	Julie Johnson	Whittier Union High School District	(562) 698-8121 ext. 1253	Julie.Johnson@wuhsd.k12.ca.us	Education	Ms. Johnson has worked for the Whittier Union High School District for 15 years. She has worked in the classroom with Special Education students, primarily with ED (emotionally disturbed – high school label) students for 10 of those years. Currently, Ms. Johnson works in a special "Social Security program" in the district, working with students receiving SSI or SSDI wanting to work. A great majority of those students are labeled ED.
	District Chief	Ana Suarez	Service Area 7 (DMH)	(213) 738-3499	asuarez@dmh.lacounty.gov	Mental Health Provider	A graduate of UCLA School of Social Work in 1982 with an MSW, Ms. Suarez has served for 25 years in the mental health field in Los Angeles County, working in several service areas and with multiple, contracted providers. Ms. Suarez has held numerous clinical and administrative positions with the Providers in L.A. County, including Executive Director of one agency for a period of 4 years. Ana Suarez has been a District Chief within the L.A. County Department of Mental Health since 2005. During this time, she has primarily been stationed in Service Area 7.
Alternates	Underserved Communities: Latino	Perla Cabrera	Service Area 7 Administration (DMH)	(323) 584-3745	PCabrera@dmh.lacounty.gov	0-5, Children	Ms. Cabrera was born, raised and educated in Mexico City. She went to college in California and obtained a Bachelor in Psychology. As a first generation immigrant, Ms. Cabrera embraces the best of the American and Mexican cultures. Once working in mental health services, she realized that traditional treatment services were not effective due to the rigid training of professionals; need for culturally sensitive treatment and services; misdirection of consumers, stereotypes/stigma from professionals and family members toward consumers; consumers' escalating frustration and, as a result, consumers discontinuing their treatments. Ms. Cabrera would like to empower consumers and professionals for more effective treatment to accomplish consumers' better quality of life. She has work experience in Health Services and Mental Health Services as an administrator, coordinator and triage acute crisis intervention coordinator for Children and Adults.
	Law Enforcement	Violet Hernandez	Los Angeles County Probation Department	(562) 908-3119	Violet.Hernandez@probation.lacounty.gov		Ms. Hernandez is a Supervising Deputy Probation Officer with 20 years of experience and currently manages partnership programs with schools and city police departments with contracts with Probation involving both juvenile and adult probationers. Additional areas of expertise include gang prevention services, juvenile hall and camp supervision experience. Ms. Hernandez also specialized in Suitable Placement (foster care) operations obtaining the most appropriate program placement for youth with special needs. Ms. Hernandez also supervised the Children's System of Care and Wraparound programs for Probation, services that are jointly operated by Probation, Children's Services and the Department of Mental Health for those youth and their families with mental health needs. Previously, Ms. Hernandez worked as psychiatric nurse. She also served for 5 years as a reserve police officer. Ms. Hernandez's educational experience includes a Bachelor's of Science in Nursing with an emphasis in psychiatric nursing. Ms. Hernandez completed post graduate work in Public Administration.
	Underserved Communities: Latino	Alicia Rodriguez	Rio Hondo Mental Health Center (DMH)	(562) 402-0688	ARodriguez@dmh.lacounty.gov	Consumer, Adults	Ms. Rodriguez is employed as a Peer Advocate in the Wellness Center. She has been a consumer and actively involved in various community organizations doing volunteer work serving adults. Ms. Rodriguez has volunteered for: Office of Consumer Affairs, Project Return, Neighborhoods United Coalition, Los Angeles County Latino Client Coalition and La Alianza Metropolitana.

Service Area 8 - Ad Hoc PEI Steering Committee Roster

Constituency Represented	Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Education	Bonnie Burstein	Los Angeles Harbor College	(310) 233-4586	bursteb@lahc.edu	Consumer, Asian/Pacific Islander, Middle Eastern/Eastern European, Latino, TAY, Adults, Older Adults	Dr. Burstein is a licensed Clinical Psychologist and is currently the Clinical Director of the Los Angeles Harbor College Life Skills Center, the Mental Health service site on campus. She has extensive experience working with troubled students and is intimately aware of the psychological challenges facing the T.A.Y. population at the college, 40% of whom are Hispanic and among which suicide is the 2nd leading cause of death. Dr. Burstein has been involved in higher education for 35 years, since 1973, when she started as a college instructor, and a psychologist and therapist at UCLA, where she got her PhD in Clinical and Community Psychology in 1982 and worked for 16 years. For the last 8 years, Dr. Burstein has worked at Los Angeles Harbor College where she teaches Personal Development classes to undergraduates, as well as counsels college students and supervises psychology interns. She also has administrative experience at the University level; she was Chair of the Psychology Department, Extension Division, at the University of Judaism and is responsible for many administrative aspects of the Life Skills Center.
	Suh Chen Hsiao	Los Angeles Unified School District	(310) 832-7545	Suhchen.hsiao@lausd.net	Mental Health Provider, Social Services, 0-5, Children, TAY	A first generation immigrant from Taiwan, Ms. Hsiao completed her Masters of Social Work at the University of Southern California in 1990 and became a Licensed Clinical Social Worker in 1994. She has worked as a social worker in a private hospital setting and with Edelman Children's System of Care with the L.A. County Department of Mental Health providing direct services, community outreach to various age/ethnic groups, conducting needs assessment, program planning/development and administrative work. Ms. Hsiao obtained her Pupil Service Credential for School Counseling in 2003 and Administrative Credential with a Masters in Education in 2006. She has been working as a Psychiatric Social Worker with School Mental Health under the Health & Human Services Division of the L.A. Unified School District since October 2000 servicing Local District 8 schools (Gardena, Carson, Harbor City, Lomita, Wilmington and San Pedro). Ms. Hsiao hopes to use her experience to collaborate/coordinate with community partners to ensure Children & Families have equal access to linguistically/culturally competent mental health services.
Health	Erika Hainley-Jewell	The Children's Clinic	(562) 492-6703	ehainley@thechildrensclinic.org	Social Services, Underserved Communities, 0-5, Children, TAY, Adults, Older Adults	Ms. Hainley-Jewell, LCSW, has been working as a social worker in the health field for the last 8 years. Since 2003 she has worked at The Children's Clinic, Serving Children and Their Families (TCC), a federally-qualified community health center that provides primary care services to 17,000 low income and uninsured patients of all ages at six sites in Long Beach. Ms. Hainley-Jewell received her BA in Psychology from UC Irvine and Masters in Social Welfare from UCLA. Ms. Hainley-Jewell also works as a medical social worker at Long Beach Memorial Medical Center and serves on various local committees including the LB Mental Health Coalition, End Abuse LB Board, Women's Advisory Group to LBPD, DCFS Community Partners Group, to name a few. Though her primary sector is health, Ms. Hainley-Jewell's experience provides her with expertise on Latinos, immigrants, all age categories, homeless (TCC has a clinic at the Multi-Service Center), and social services.
	Lauren Nakano	Beach Cities Health District	(310) 374-3426 ext. 115	Lauren.Nakano@bchd.org	Education, Mental Health Provider, Community Family Resource Center, Latino, Uninsured, 0-5, Children, TAY, Adults, Older Adults	Ms. Nakano has an educational background in health science with an emphasis in community health and 20+ years in the public health field in Service Area 8. In her 14 years with Beach Cities Health District (BCHD), a primary prevention public health agency serving the South Bay, she has had direct experience working with programs that focus on improving access to health services for all ages, school based interventions including counseling, chronic disease prevention and screening, and facilitating partnerships and collaboratives to address health issues such as mental health access, homelessness, substance abuse and parenting. Through BCHD collaboratives and grant funding Ms. Nakano has a wide array of affiliations including but not limited to their regional FQHC for primary health care, mental health non-profit service providers, Torrance Health Center, substance abuse treatment providers, local and County homeless service providers, HIV/AIDS organizations, LA Health Care Collaborative, and Harbor Regional Center.

Service Area 8 - Ad Hoc PEI Steering Committee Roster

Constituency Represented		Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Required Sectors	Law Enforcement	Tyrone Hatfield	Long Beach Police Department	(562) 570-1458 or (562) 577-5820	Tyrone_Hatfield@longbeach.gov	Education, Children, TAY	Lieutenant Hatfield is a 25-year veteran of the Long Beach Police Department. For the last six years, he has been in charge of the Youth Services Division handling juvenile crime investigations, school police, missing persons, runaways, and formerly the Police Athletic League and DARE. Lieutenant Hatfield serves on the boards of the Long Beach Youth Activities & DARE Board and Operation Jumpstart, which mentors disadvantaged youth to reach college. Lieutenant Hatfield has his B.S. in Criminal Justice from California State University of Long Beach. He has also taught parenting classes for the last nine years and has created his own 18-hour parenting course called, "Parenting From The Heart."
		Stephanie Martin	Manhattan Beach Police Department	(310) 802-5130	smartin@citymb.info	Education, 0-5, Children, TAY	Ms. Martin has been a police officer with the City of Manhattan Beach for over 18 years. The vast majority of her career has been focused on dealing with youth: DARE Officer, Community Relations (3 yrs), Juvenile Detective (4 yrs) and School Resource Officer (8 yrs: 5 years at Mira Costa High School and 3 years at the Middle and Elementary levels). In addition, Ms. Martin has volunteered for Youth groups (Youth to Youth and Manhattan Beach Leo's) and was a member/past president of the Manhattan Beach Lions Club (10 yrs). She is currently a Chairperson for the local SARB 16 (Selected as California's Model SARB 2008) and has been on the board for 8 years. Ms. Martin is also on an advisory board to the National Institute of Justice for School Safety and Active Shooter issues. She holds a Liberal Arts Degree from El Camino College and a Bachelor of Arts Degree in Social Science from Chapman University.
	Mental Health Provider	Youngsook Kim-Sasaki	Long Beach Mental Health Center (DMH)	(562) 218-4044	YKimSasaki@dmh.lacounty.gov	Underserved Communities, Adults	Ms. Kim-Sasaki is currently a clinic manager at Long Beach Mental Health Center that serves persistently mentally ill adults in an outpatient setting. This experience over the past two years has provided her with a good understanding of the community's unmet mental health needs, especially for the underserved communities and client populations with special service needs, (e.g., people with HIV, COD, monolingual Spanish-speaking, TAY and older adults). Ms. Sasaki has been an active member of SAAC 8 for over 15 years and was involved in the MHSA Stakeholders process for a year as a nominated member to represent SAAC 8. Ms. Sasaki's past experience as a clinician, supervisor, and manager at Long Beach Asian Pacific Mental Health also provided her with a good understanding of the underserved API communities in SA 8. She believes her personal experience as a Korean immigrant and her involvement with Asian Pacific Policy and Planning (APPPCON) to address advocacy issues of APIs qualifies her to represent underserved ethnic minority groups in the service area.
		Wendy Puzarne	Jewish Family and Children's Service	(562) 427-7916 ext. 234	wpuzarne@jfcslongbeach.org	Social Services, Underserved Communities, 0-5, Children, TAY, Adults, Older Adults	Ms. Puzarne is a LCSW and is the Executive Director of Jewish Family and Children's Service – Long Beach. As a Long Beach community mental health agency working with a diverse population from early childhood through older adults JFCS is closely tied to schools and universities, religious affiliations, as well as public agencies who refer directly to us and utilize our services. JFCS is a supervised training location for local universities who provide interns to serve our clients as well as having licensed therapists. JFCS serves a wide range of mental health needs including, but certainly not limited to: problems of mood, problems of behavior (in schools or in relationships/families), referrals from DCFS for domestic violence counseling and anger management, family dysfunction, and personal growth.

Service Area 8 - Ad Hoc PEI Steering Committee Roster

Constituency Represented		Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Social Services		Michael Ballue	National Council on Alcohol & Drug Dependence (South Bay)	(310) 328-1460 ext. 241	Michael@ncaddsb.com	Health, COD, 0-5, Children, TAY, Adults, Older Adults	Mr. Ballue, CADC II, BSBA, entered the field as a Patient Care Assistant for an Adolescent Dual Diagnosis Locked Unit at Coldwater Canyon Hospital in 1989. He has worked on both Adult and Adolescent Psychiatric Units, Adult and Adolescent Chemical Dependency Units, as a Prevention Specialist in schools, as a Parent and Teen Counselor for Tough Love and Action Community Groups and has served as a Community Outreach Coordinator and Program Director for Chemical Dependency programs treating those with Co-Occurring disorders. He is currently the Executive Director for National Council on Alcoholism and Drug Dependence of the South Bay. NCADD/South Bay provides social services through its Family Preservation and Partnership for Families programs, Prevention services in local schools and through Community Organizing, Project Fatherhood under sub-contract from Children's Institute, Outpatient, Residential and Transitional Living Services, Community, Spanish Speaking and Parenting for Teens Education, Tobacco Control Advocacy and DUI classes.
Social Services		TuLynn Smylie	WomenShelter of Long Beach	(562) 437-7233 ext. 24	tsmylie@womenshelterlb.com	African-American, Asian/Pacific Islander, Latino, Immigrant, Domestic Violence, 0-5, Children, TAY, Adults, Older Adults	Ms. Smylie is the executive director of WomenShelter of Long Beach, an organization committed to helping end the cycle of domestic violence through education, intervention and prevention. She is responsible for all operations including development and fundraising, program planning and development, personnel and financial management. The agency serves children and adults, males and females, and people of all ethnic and cultural backgrounds. Since 2006, Ms. Smylie has served as First Vice Chair of the Los Angeles County Domestic Violence Council. She also serves as the co-vice chair of the Long Beach Police Department's Women's Advisory Group, which informs the Police Chief on community safety and law enforcement issues that impact women. Ms. Smylie is a member of the Board of the ACLU-Southern California. Ms. Smylie holds a law degree from the University of California at Los Angeles Law School and a bachelor's degree in political science from Columbia University in New York.
Consumers/Families	Consumer	Darla Baker	L.A. County Client Coalition/CORE	(562) 857-9419	dbaker@dmh.lacounty.gov	Mental Health Provider, Family, Adults	Ms. Baker is currently Steering Chair, Information Specialist and Advocacy Chair, and was recently Steering Vice-Chair and Corresponding Secretary of the Los Angeles County Client Coalition. She has been active for four years. Ms. Baker has experience from taking part as both a Delegate and Alternate for three years at MHSA Stakeholders, volunteering for the Client Office of Recovery and Empowerment (CORE), is a member of SAAC 8, and advocated at the Capitol for Mental Health several times in Sacramento. Ms. Baker is a high school graduate.
Consumers/Families	Family Member	Cathy Williamson	Service Area 8 Administration (DMH)	(562) 435-2207	cwilliamson@dmh.lacounty.gov	Mental Health Provider, Community Family Resource Center, 0-5, Children, TAY, Adults, Older Adults	Ms. Williamson is the parent of child with a mental illness. She is a National Alliance on Mental Illness (NAMI) Board Member, a Parent Advocate for the Los Angeles County Department of Mental Health, and a Support Group Facilitator for caregivers of persons with mental illness.
Consumers/Families	Parent/Caregiver of Child/Youth in MH System	Jeanmarie Beard	N/A	(562) 420-3612	jpbeard2@verizon.net	Underserved Communities, 0-5, Children	Ms. Beard is the parent of a fifteen year old adopted son who is currently served by D.M.H. under AB 3632. She is involved with NAMI, The Child and Adolescent Bipolar Foundation, D.M.H. and Parkcrest Church ministries. Ms. Beard has received training and educational classes with these groups and lead small groups for education and support. She is currently teaching part time. Her other areas of involvement are with homeless, preschoolers, and parents.
Community #1 African-American		Floyd McGregor	CONNECTING - it works!	(323) 309-7708	drfamcgregor@aol.com	Mental Health Provider, Employment, Asian-Pacific Islander, Latino, COD, 0-5, Children, TAY, Adults, Older Adults	Dr. McGregor is an African American Licensed Clinical Psychologist. He is a Substance Abuse Professional, Certified Anger Management Facilitator and Certified Domestic Violence treatment provider. Dr. McGregor has served on the School Safety Committee for the Inglewood Unified School District for the past 8 years. He has implemented the "Chill Out Anger Management Program" district wide that has received 11 awards by the State of California. Dr. McGregor specializes in working with "at risk" students from all ethnic backgrounds. His primary service delivery for the past 15 years has been with African American and Latino students. Dr. McGregor is the founder of CONNECTING it works!, Inc.; a mental health agency that specializes in connecting mental health to education. The agency is located in Redondo Beach.

Service Area 8 - Ad Hoc PEI Steering Committee Roster

Constituency Represented		Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Underserved Communities	Community #2 Asian/Pacific Islander	Kimthai Kuoch	Cambodian Association of America	(562) 988-1863 ext. 281	kkuoch@cambodian.com	Immigrant, Refugee, Children, TAY, Adults, Older Adults	Mr. Kuoch is the Executive Director and the key leader of the Cambodian Association of America in Long Beach. Mr. Kuoch received a Masters Degree in Public Policy and Administration and a Graduate Certificate in Public Financial Management from California State University, Long Beach. He earned his Bachelor of Science in Business Administration with a triple major concentration in Accounting, Finance, and Banking from San Francisco State University in 1995. As a victim of the "Killing Field" and as a refugee himself, Mr. Kuoch has extensive experience working with Cambodian refugees for over 18 years since he was living in the refugee camps on the Khmer-Thai border. In addition, Mr. Kuoch also has been involved in both non-profit and private management for twelve years. He earned his certificate in Nonprofit Management in 1999, and his educational background provides unique qualifications for managing a linguistically and culturally appropriate social service agency and evaluation project.
	Community #3 Latino	Tiburcio Maldonado	Service Area 8 Administration (DMH)	(562) 435-2097	TMaldonado@dmh.lacounty.gov	Family Member of Consumer, Children, TAY, Adults	Mr. Maldonado's experience is working with the Latino/Spanish population. He is a Spanish teacher for the National Alliance on Mental Illness (NAMI); he facilitates Spanish Parent Support Groups. Mr. Maldonado has been working for the Los Angeles County Department of Mental Health as a Parent Advocate since 2001. He is the parent of a child with mental illness who is also mentally delayed. Mr. Maldonado has more than 20 years' experience working with adults and children in Service Area 8.
	Community #4 Lesbian/Gay/Bisexual/ Transgender (LGBT)	Kim Woods	The Center Long Beach	(562) 434-4455 ext. 233	kimw@centerlb.org	Social Services, African-American, American Indian, Latino, Children, TAY, Adults, Older Adults	Ms. Woods has a BA in Psychology, a MA in Education, and MDiv in Liberation Theology and an EdD in Educational Psychology. Her dissertation is on Identity development amongst LGBTQ college students; she is also a reverend. Ms. Woods is the Executive Director of the Gay and Lesbian Center of Greater Long Beach, which sees over 21,000 people per year who have a variety of issues. Services The Center provides are: mental health counseling, youth program, over 24 support groups, HIV Education and risk reductions, HIV and STD testing, workshops, and mammogram screenings. The Center also has a cyber center and a library and holds various events throughout the year (some of these events include a bike ride and film festival). Ms. Woods has been an educator for over 20 years, working with youth and college students predominantly.
	Community #5 Co-occurring Disorders	Sean Zullo	Choices Recovery Services	(562) 590-9010	seanzullo@yahoo.com	Health, Mental Health Provider, Community Family Resource Center, Employment, American Indian, LGBT, TAY, Adults, Older Adults	Mr. Zullo is nationally and State Certified/Licensed in Psychiatric Rehabilitation, Addiction Counseling, Forensic Counseling. He is also an Accredited Public Accountant and State Licensed Corporate Tax Preparer, business manager and experienced with merger and acquisitions. Mr. Zullo has a BS in Economics from UCLA. He is the Founder and Executive Director of Choices Recovery Services, which is an innovative residential (158 Beds) and outpatient "Special Needs" treatment and rehabilitation program for those with mental health/substance use recovery challenges. The program is headquartered in Long Beach.
	Community #6 Homeless	Sarah Tower	The Village - Homeless Assistance Program (Mental Health America)	(562) 437-6717 ext. 224	stower@mhala.org	Mental Health, Adults, Older Adults	Ms. Tower graduated with her MSW from USC in 2005 and is within a few months of earning her LCSW. She has worked with individuals experiencing mental illness and homelessness for the past 6 years, first with MHA Orange County and with the MHA Village Homeless Assistance Program for the last 3 ½ years. Ms. Tower is the Director of Homeless Outreach and Engagement at the Village, and is an active participant in the Long Beach Continuum of Care Advisory Board and Long Beach Homeless Coalition.
	Community #7 Suicide Risk	Rachelle Ang	California State University at Long Beach (CSULB)	(562) 985-2513 or (562) 985-5436	rang2@csulb.edu	Education, TAY, Adults, Older Adults	Ms. Ang works as a case manager at California State University, Long Beach in the Counseling and Psychological Services office and Disabled Student Services. She is a LCSW and has been working in the field of social work for 11 years. Currently, she is working with high-risk college students seeking psychiatric and psychological assistance. Many of these students have limited resources and no insurance coverage. She helps connect students to outside resources and monitors them to ensure they are receiving assistance to keep them in school and stable with counseling and medication. Ms. Ang also participates in the suicide prevention program that CSULB recently received SAMSHA money to implement on campus. Ms. Ang would be honored to serve on this committee to represent the needs of college students with mental health needs.

Service Area 8 - Ad Hoc PEI Steering Committee Roster

Constituency Represented		Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
At-large	At-large #1 Developmental Disability	Denise Godfrey-Pinn	Harbor Regional Center	(310) 543-7953	Denise.Godfrey-Pinn@harborrc.org	Health, Underserved Communities, 0-5, Children, TAY, Adults, Older Adults	Dr. Godfrey-Pinn currently works as a consulting psychologist for Harbor Regional Center, as well as Clinical Director for the Southern CA Integrated Health & Living Project (a collaborative of 10 Regional Centers). She has also worked as a Clinical Supervisor & bilingual therapist at Altamed HIV Program; Deputy Director/Acting Executive Director for Caring for Babies with AIDS; Program Director for in-home service provision for 0-3 at Children's Institute International; Directer of Research (child sexual abuse) at Drew-King; and maintained a private practice specializing in child trauma and other forensic family issues from 1981-2003. Dr. Godfrey-Pinn has a B.A. in Psychology, and a M.S. and Ph.D. in Clinical Psychology. She continues to expand her involvement with dually-diagnosed Regional Center clients; she provides clinical training/consultation to case management staff, as well as consultation to client families, individuals, and service providers to insure clinically-appropriate programming. Dr. Godfrey-Pinn is interested in service/program development for TAY and young adults with intellectual disabilities.
	At-large #2 Faith-based Organizations	Neena Paltanwala	Service Area 8 Administration (DMH)	(562) 435-2078	NPaltanwala@dmh.lacounty.gov	Mental Health Provider, Family Member of Consumer, Asian/Pacific Islander, Older Adults	Ms. Paltanwala has over 20 years experience working with children, adults and older adults. She works closely with various community programs and providers as a navigator for adults. On a regular basis she works closely with in-patient hospitals, Institutes of Mental Disease (IMD), and directly-operated and contracted outpatient providers. Ms. Paltanwala is highly involved with the National Alliance on Mental Illness (NAMI) and represents DMH by providing resources and linkage for the family members of the clients. She oversees and assures clients needing Assertive Community Treatment (ACT), FSP, and Older Adult FSP Services are appropriately referred and entered into available programs in Service Area 8. Ms. Paltanwala holds a Master's Degree in Social Work from Cal State University, Long Beach; Bachelor's Degrees in Chemistry and Education from the University of Bombay; and a Certificate in Older Adults Mental Health Services.
Age Groups	Prenatal - 5	Karen Rathburn	South Bay TIES for Adoption (DMH)	(310) 533-6611	krathburn@dmh.lacounty.gov	Mental Health Provider, Social Services, African-American, Latino, 0-5, Children	Dr. Rathburn is a Licensed Psychologist, an Assistant Clinical Professor at Harbor-UCLA Medical Center, and the Program Manager for South Bay TIES for Adoption in Torrance. She received her education at the University of Southern California (M.S. & Ph.D.). Dr. Rathburn had internships at Children's Hospital Los Angeles (University Affiliated Program) and Cedars-Sinai Medical Center: Thalians Community Mental Health Center (Child and Family Guidance/Department of Psychiatry). She did her Postdoctoral Fellowship at Harbor-UCLA Medical Center (Department of Pediatrics and Psychiatry). Dr. Rathburn's specialty is Child and Family with a Sub-Specialty of Prenatal to 5. She teaches the Harbor psychiatry fellows, externs post-docs course in Prenatal to 5 Development, Assessment & Treatment and supervises TIES staff, psychology/pediatric externs and postdoctoral fellows. Dr. Rathburn has 20 years' work experience with high risk populations of infants, toddlers and children with prenatal drug exposure (former psychologist in the Infants of Substance Abusing Mother's Clinic – Harbor Peds Dept.), foster children and medically fragile children.
	Children (6-15)	Dan Thorne	Sunbridge Harbor View	(562) 981-9392 ext. 208	dan.thorne@sunh.com	Mental Health Provider, Consumer, TAY	Mr. Thorne has been a licensed Marriage and Family Therapist for over 20 years. He has served since 2001 as the Director of SunBridge Harbor View Community Services Center in Long Beach, an outpatient field-based mental health program which provides school based mental health services, therapeutic behavioral services (TBS), and Full Service Partnership (FSP) services for children ages 5-21. He currently serves on the DMH Performance Based Contracting committee, and has been a past co-chair of the Service Area 8 Quality Improvement Committee. Finally, Mr. Thorne has three children, now in their 20's, who have mental illness; thus, he feels that he is qualified to represent Mental Health Provider for Children and TAY and Family of Consumers on this steering committee.
	Transition-age Youth (TAY) (16-25)	Bowen Chung	Harbor-UCLA Medical Center (DMH)	(310) 222-1801	bchung@mednet.ucla.edu	Mental Health Provider, Children	Dr. Chung is a child and adolescent psychiatrist at Harbor–UCLA Medical Center. He was trained in psychiatry at the UCLA Neuropsychiatric Hospital and is a researcher with a particular interest in health services research and community partnered research. Since Dr. Chung completed his clinical training 5 years ago, he has been seeing patients in DMH contract clinics in Los Angeles – mostly low income, minority youth. His goal in participating in the PEI process is to contribute to improve the quality of services provided by providing input into the MHSA program planning process.

Service Area 8 - Ad Hoc PEI Steering Committee Roster

Constituency Represented	Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Adults (26-59)	Patti LaPlace	City of Long Beach	(562) 570-4119	Patti.LaPlace@longbeach.gov	Underserved Communities, Social Services, TAY, Older Adults	Ms. LaPlace has over 30 years experience working in the mental health field. She began her professional experience as a Recreation Therapist in an inpatient psychiatric facility. As a certified therapeutic recreation specialist, she provided specialized mental health interventions with all age groups. Currently she holds the title of Director of Programs with Memorial Counseling Associates. She also functions as a community liaison with various mental health agencies, community advocacy groups and senior specialty programs. Ms. LaPlace received her Bachelor of Arts Degree in Recreation Administration from CSU, Long Beach in 1981 and a Masters in Public Administration (MPA) from CSU, Dominguez Hills in 1992. She is on staff as a part-time lecturer at both universities. Ms. LaPlace's committee work includes: Long Beach (L.B.) Police Department Mental Health Advisory Committee; L.B. Mental Health Community Coalition; L.B. Area National Alliance on Mental Illness; L.B. Elder Abuse Prevention Team; and L.A. County Department of Mental Health Service Area Advisory Committee for Service Areas 7 & 8.
Older Adults (60+)	Marilyn Rafkin	Beach Cities Health District	(310) 374-3426 ext. 113	Marilyn.Rafkin@bchd.org	Health, Mental Health Provider, Social Services, Community Family Resource Center	Ms. Rafkin is the Director of Community Care Services (older adult and adult disabled services) for the Beach Cities Health District. She earned a MSW from Fordham University in New York. Ms. Rafkin has worked with older adults since 1973, both in direct service and in administration. She has been with BCHD for 15 years and manages the services for older adults, including care management, peer counseling, support groups, and advocacy. She is a former board member of the Alzheimer's Association and is currently the Treasurer of the CA Council, the state wide public policy arm of the Alzheimer's Association.
SAAC Chair	Martha Long	The Village (Mental Health America)	(562) 285-1330 ext. 236	mlong@mhala.org	Consumer, TAY, Adults	Ms. Long has been the Co-chairman of SAAC 8 since the early 90's and participated in the original Stakeholder process for Services and Supports under the Mental Health Services Act. She has been Director of the MHA Village since 1990 and has a good understanding of the values and principles of Recovery as applied to serious mental illness. Ms. Long helped develop the Transitional Age Youth program that was established by the Village and also was a family member of an individual with mental illness.
District Chief	Cathy Warner	Service Area 8 (DMH)	(562) 435-2337	cwarner@dmh.lacounty.gov	Mental Health Provider, Adults, Older Adults	Ms. Warner is a LCSW and has worked in the mental health community for some twenty-five years. She has been with Los Angeles County Department of Mental Health (DMH) since 1986. Some of the positions Ms. Warner has held include: working as an LCSW providing direct services to children, adults and families and as a supervisor; coordinating the provision of treatment and supportive services to consumers residing in residential care facilities (RCF) through efforts such as the Supplemental Rates Program (SRP) and transformation of RCF settings into DMH contracted providers; countywide program development with Adult Targeted Case Management; County-wide HIV Mental Health Services; Assertive Community Treatment; and other initiatives being advanced by passage of the Mental Health Services Act (MHSA). Ms. Warner has held positions of an Educational Consultant, Mental Health Analyst, and Mental Health Clinical Program Head responsible for Rio Hondo Community Mental Health Center, South Bay MHC and Long Beach Adult programs. She is currently the District Chief overseeing the programmatic and administrative responsibilities for DMH programs located in Service Area 8

Service Area 8 - Ad Hoc PEI Steering Committee Roster

	Constituency Represented	Name	Agency / Organization	Contact Phone	E-mail	Additional Constituencies	Statement of Qualifications
Alternates	Mental Health Provider	Therese Haviland	CONNECTING - it works!	(310) 316-1610	winningpair@yahoo.com	Employment, African-American, Asian-Pacific Islander, Latino, COD, 0-5, Children, TAY, Adults, Older Adults	Ms. Haviland has a Master's Degree in Marriage & Family Therapy, has been licensed for 4 years, holds a Pupil Personnel Services credential in School Psychology, is certified in Domestic Violence (for both victims & perpetrators) and in Anger Management, and is a Substance Abuse Professional (SAP) in the state of CA. Since Fall 1999, Ms. Haviland has serviced South Central's, LA's, and Long Beach's low SES, including high populations of African-American and Latinos, in schools, churches, shelters, rehabilitation facilities, etc. CONNECTING's associated agencies/streams of funding, etc., have been school districts, Department of Corrections, Lifestar, NSAPN, churches, private insurance companies, public insurance (Medi-Cal), Victims of Violent Crime, California Children's Services, DCFS referrals, ChildNet, Switzer Learning Center, CAPSES, Choices Recovery, The Center Long Beach, South Bay Children's Health Center, and Beach Cities.
	Education	Pat Kanakis	ChildNet Youth & Family Services	(562) 490-7619 or (562) 533-4828 (cell)	PKanakis@childnet.net	Mental Health Provider, African-American, Latino, 0-5, Children, TAY	Ms. Kanakis works for ChildNet Youth and Family Services as the Community Liaison for the Behavioral Health Division. This position allows her to collaborate with other agencies for resources and referrals including the City of Long Beach. Ms. Kanakis has been employed for 8 years with ChildNet in various capacities including being a clinician and supervising a team of 10 therapists. She has a Masters Degree in Marriage Family Therapy, is a licensed MFT, and has counseled children from 2 to 21 years of age and their families.
	Mental Health Provider	Ann Lee	Service Area 8 Administration (DMH)	(562) 435-3027	alee@dmh.lacounty.gov	Asian/Pacific Islander, 0-5, Children, TAY, Adults, Older Adults	Dr. Lee works for the Los Angeles County Department of Mental Health in the administrative office for Service Area 8 (Long Beach/South Bay). She serves as Contract Liaison for a number of adult and Asian programs in the service area. Dr. Lee is a member of DMH's cross-cultural competency subcommittee and dedicated to cross-cultural issues related to PEI and underrepresented ethnic populations (UREP). Her employment history includes working for the Los Alamitos Unified School District as a consulting psychologist; working with Los Angeles County adolescents in residential treatment; working with ADHD children at The Guidance Center outpatient program; applied behavioral analysis with Developmentally Disabled individuals of all ages; and providing home-based parent training with a private agency. Dr. Lee obtained a PhD from California School of Professional Psychology and is a Licensed Clinical Psychologist. She has experience working with Children, TAY, & Adult mentally ill individuals; individuals with developmental disabilities; and API experience. Dr. Lee has worked in Long Beach for the past 8 years.
	Health	Lillian Lew	Families in Good Health (St. Mary Medical Center)	(562) 491-9100	llew@chw.edu	Social Services, Asian/Pacific Islander, 0-5, Adults, Older Adults	Ms. Lew has been the Director of Families in Good Health (FIGH) at St. Mary Medical Center in Long Beach for 21 years. For the purpose of PEI, FIGH is partnering with Centro Hispanic Association and Guam Communications Network. Ms. Lew has a Master's degree in Educational Foundations from the University of Hawaii and was a East-West Center grantee in the Cultural Learning Institute. Ms. Lew developed and implemented home-based prevention and education programs for high-risk children aged 0-5 and their famlies, starting in the prenatal stage. She has also developed home visitation services for isolated older adults. Because of stigma in the underserved ethnic communities and previous funding requirements for mental health services, FIGH has a large client base of individuals and families who are considered high-risk and have borderline mental health problems in their prevention programs.
	Health	Michael Tredinnick	Harbor Regional Center	(310) 543-7917	Michael.tredinnick@harborrc.org	Developmental Disability, 0-5, Children, TAY, Adults, Older Adults	Dr. Tredinnick is the Director of Children's Services at Harbor Regional Center (HRC), with offices in Torrance and Long Beach. HRC funds and advocates for services throughout most of Service Area 8 and some of Service Area 7. HRC is one of 21 regional centers serving developmentally disabled clients, across the life span, diagnosed with intellectual disabilities, autism, cerebral palsy and epilepsy. A significant proportion have a co-occuring mental health disorder. Dr. Tredinnick is a licensed psychologist and has worked directly or indirectly with this population for over ten years.

APPENDIX 3

PEI Road Map

The Roadmap is intended as a fluid guide to the PEI planning process. Several steps in the Roadmap will occur concurrently and will change as needed.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT (MHSA) - PREVENTION & EARLY INTERVENTION (PEI)

LOS ANGELES COUNTY PEI PLANNING ROADMAP

Key
See reverse side for an explanation of the terms, abbreviations, planning stages and key participants

MHSOAC

PEI Mission

SDMH
PEI Guidelines & Resource Materials

Ad Hoc Guidelines Advisory Group

SAACs/ Service Area Planning

Key PEI Guiding Principles

L.A. County DMH
PEI Planning Guidelines

SAACS

Mental Health Commission

MHSA Stakeholder Delegates

Stakeholders

MHSOAC

Prevention Services

State of California Department of Mental Health (SDMH)

1. Informational Meetings

Stakeholders

SAACs
BOS Forums
PEI Sectors

2. Key Individual Interviews

3. Focus Groups

4. Service Area Community Forums

5. PEI Countywide Forums

6. EBP & PP Teach-Ins

7. Proposal Checklist & Menu of Options

8. DRAFT PEI Plan

9. State Approval

10. L.A. County PEI Plan

L.A. County Department of Mental Health (DMH)

Ad Hoc Plan-to-Plan Advisory Group

Glossary of Acronyms & Definitions

CSS/PEI Needs Assessment

Community Survey

District Chiefs

EMT

PEI Service Area Data Reports

Technical Consultants

Existing EBP & PP Programs Resource List

District Chiefs

EMT

Board of Supervisors

SDMH

Early Intervention Services

Revised 02/17/09

APPENDIX 4

PowerPoint:
Prevention and Early Intervention:
The Mental Health Services Act in Los Angeles County

Prevention and Early Intervention

The Mental Health Services Act in Los Angeles County



County of Los Angeles Department of Mental Health

Prevention and Early Intervention Administration

Overview



- MHSA Background and Description
- What is Prevention and Early Intervention?
- Priority Populations
- Risk and Protective Factors
- Selecting Practices/Strategies
- Local Planning

Broadening our Vision



The public mental health system has historically focused its limited resources on individuals with serious mental illness. Prevention and Early Intervention is an opportunity for the mental health community to address mental health issues before they become severe.

Dedicated Funding Source



- The MHSA established a new 1% tax in California on personal income over $1 million.
- Funds collected starting on January 1, 2005. Allocated to counties based on formulas developed by the California Department of Mental Health.
- Requires that MHSA funds create new, or complement existing, services and resources, not replace funding for current programs.

Components of MHSA Funds



- Community Services and Supports (CSS)
  LA County DMH CSS Plan approved in February 2006 and new programs started in December 2006
- Workforce Education and Training (WET)
  Final Planning Guidelines released July 2007
- Prevention and Early Intervention (PEI)
  Final Planning Guidelines released September 2007
- Capital Facilities and Information Technology
  Final Planning Guidelines released March 2008
- Innovation - Guidelines not yet released

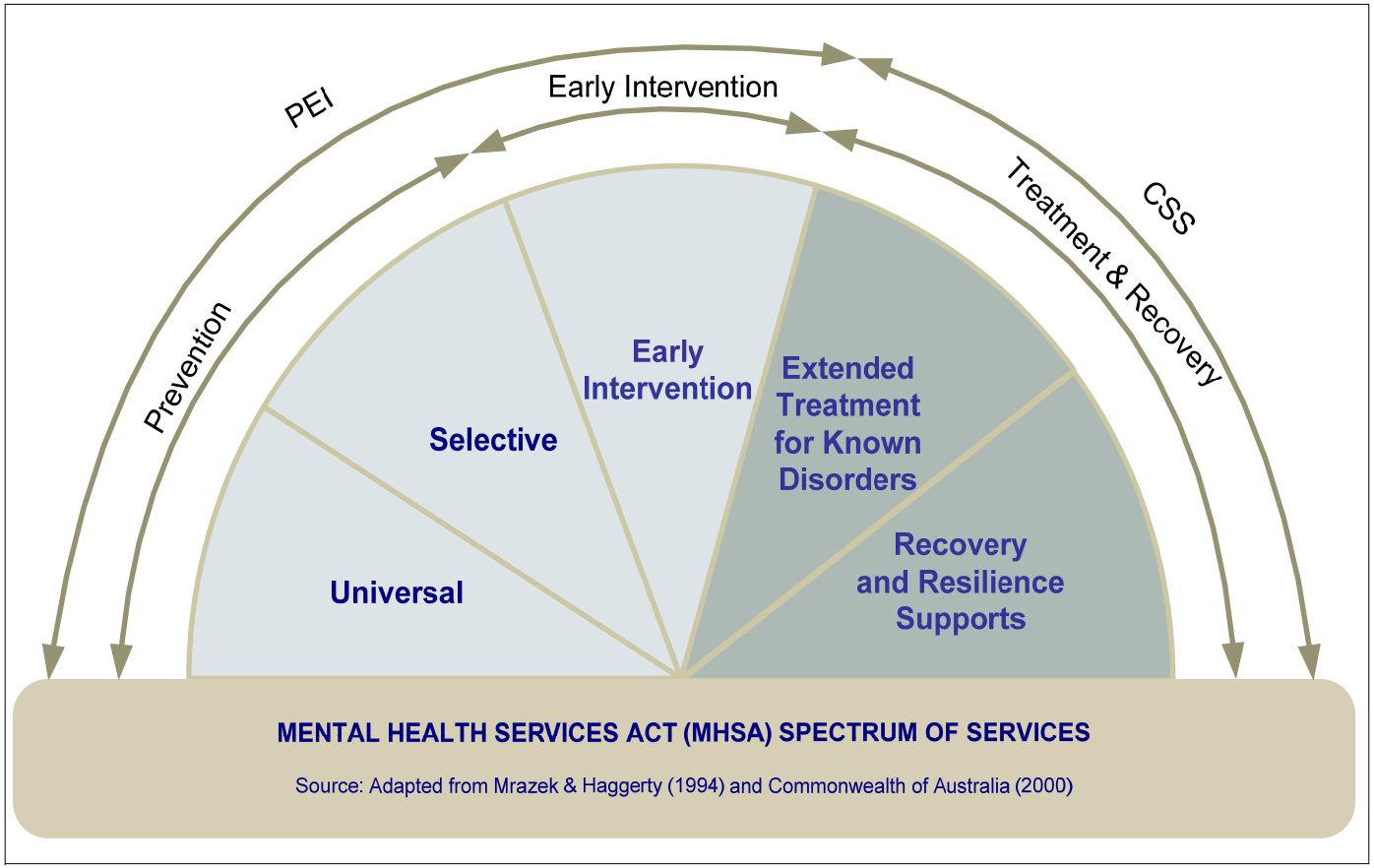
PEI Requirements

ffrom the Mental Health Services Act



- Prevent mental illness from becoming severe and disabling
- Recognize the early signs of potentially severe and disabling mental illnesses
- Increase access and linkage to medically necessary mental health care
- Reduce stigma related to mental illness
- Reduce discrimination related to mental illness

MHSA Spectrum of Services



Definition of Prevention



- Services provided to individuals who *do not have any signs of a mental illness*
  - Universal: Provided to the general public or a whole population group that has not been identified on the basis of individual risk.
  - Selective: Provided to individuals or subgroups whose risk of developing mental illness is significantly higher than average.
- Prevents the development of mental illness
- Promotes and supports emotional well-being
- No time limits imposed

Definition of Early Intervention



- Services for individuals with *minimal signs of mental illness*
- Short duration (less than 1 year*) and low intensity

  * *except services for treatment of early signs of severe mental illness*
- Avoids need for more costly services
- Prevents mental health condition from worsening
- Supports return to well-being

Risk Factors in PEI



- Risk factors predispose individuals toward developing a disease or disorder, (e.g., genetic factors)
- Some risk factors, such as lifestyle behaviors, can be altered with interventions, (e.g., exposure to violence)
- Other risk factors are unchangeable, (e.g., age and ethnicity)
- PEI programs target risk factors to attenuate their harmful effects through prevention and early intervention

Protective Factors in PEI

- Protective factors help us cope with stressors and stave off disease or mental illness
- Some protective factors, such emotional coping skills, sociability, and family support can be altered with interventions, (e.g., cognitive behavioral therapy)
- PEI programs target protective factors to increase stress resistance and promote an individual's wellness and social functioning

PEI Service Characteristics



- Delivered in natural community settings, (e.g., pre-school/school, primary care clinic, tribal center, faith center, etc.)
- Link individuals to more intensive mental health services when needed
- Not for filling gaps in treatment and recovery services for individual who have been diagnosed with a serious mental illness
- Distinct from *Community Services and Supports* component of MHSA

State PEI Key Community Needs

- Disparities in access to mental health services
- Psycho-social impact of trauma
- At-risk children, youth, and young adults
- Stigma and discrimination
- Suicide risk



State PEI Priority Populations



- Underserved cultural/ethnic populations
- Individuals with early signs of severe mental illness
- Children/youth in stressed families
- Trauma-exposed
- Children/youth at risk for school failure
- Children/youth at risk of or experiencing juvenile justice involvement

Program or Practice Standards



- Evidence-based Practice
  - Has been or is undergoing evaluation
  - Quantitative and qualitative data showing positive outcomes
  - Expert/peer reviewed showing effectiveness
  - Replication
- Promising Practice
  - Minimal quantitative data showing positive outcomes
  - Not yet replicated
  - Minimal effectiveness data
- Community-defined Evidence Practice
  - Identified by local unserved/underserved communities
  - Demonstrated effectiveness in local communities
  - Generally, does not have quantitative data in peer-reviewed literature

Selecting a
PEI Practice, Strategy or Program



- Use local data to determine need
  The data will suggest who is most *at risk* in your community, (e.g., age, gender, ethnicity, type of maltreatment, etc.)
- Focus on a PEI priority population
- What *problem* are you trying to solve?
- Where should you focus your efforts: Universal, selected, or early intervention programs?
- Look for programs that target specific risk and protective factors
- Choose interventions, programs, strategies with evidence in their behalf

Selecting a
PEI Practice, Strategy or Program



Service Delivery Site

Where might a prevention or early intervention program be offered?

- Well-baby clinic
- Family resource center
- Community center
- Senior Center
- Church
- School
- Day labor center
- YMCA/YWCA
- Ethnic-specific counseling/mental health agency

MHSA and PEI Funding



MHSA Statewide:

- MHSA FY 07-08: $1.6 billion
- CSS = 55%
- PEI = 20%

PEI Los Angeles County:

- PEI planning: $14 million (approx)
- PEI FY 07-08: $34 million (includes planning)
- PEI annually: $69 million (approx)

L.A. County's PEI Planning Process



- Informational meetings
- Data profiles
- Key individual interviews
- Focus groups
- Ad hoc advisory groups
- Community forums
  - Service area stakeholders groups
  - Countywide stakeholders groups
- Expert panel



Age Distribution of Funds

- 65% of funding for children and youth ages birth to 25 years and their families
- 17.5% for adults ages 26 to 59 years
- 17.5% for older adults ages 60+





Sectors/Partner Organizations

Required

- Underserved communities
- Education
- Individuals with mental illness and/or their families
- Providers of mental health services
- Health
- Social services
- Law enforcement

Recommended

- Community family resource centers
- Employment
- Media

State-administered Projects



- Four-year funding period only
- Suicide prevention
- Stigma and discrimination reduction
- Ethnically- and culturally-specific programs and interventions
- Training and technical assistance
- Student Mental Health Initiative (K-college)
- Statewide evaluation

Web Links & Contact Information

California Department of Mental Health

- Proposed Guidelines
  http://www.dmh.ca.gov/DMHDocs/docs/notices07/07_19_Enclosure1.pdf
- Resource Materials
  http://www.dmh.ca.gov/DMHDocs/docs/notices07/07_19_Enclosure6.pdf

County of Los Angeles Department of Mental Health

- Information, Planning, and other Resources
  http://dmh.lacounty.info/mhsa/plans/pei.html
  email: mhsapei@dmh.lacounty.gov

APPENDIX 1APPENDIX 5

PEI Informational Brochure

مقاطعة لوس أنجلوس
إدارة
الصحة النفسية

قانون خدمات
الصحة النفسية (MHSA)

Prevention & Early Intervention

خطة برنامج الوقاية والتدخل المبكر

Prevention and Early Intervention (PEI) Plan

خطة برنامج الوقاية والتدخل المبكر (PEI)

Director Marvin J. Southard, D.S.W.
المدير

مقاطعة لوس أنجلوس
مجلس المشرفين

Gloria Molina
المنطقة الأولى

Yvonne B. Burke
المنطقة الثانية

Zev Yaroslavsky
المنطقة الثالثة

Don Knabe
المنطقة الرابعة

Michael D. Antonovich
المنطقة الخامسة

William T Fujioka
المدير التنفيذي

County of Los Angeles
Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI)
Administration
550 S. Vermont Avenue, Ste. 605
Los Angeles, CA 90020
هاتف: (213) 738-2331
فاكس: (213) 351-2026
البريد الإلكتروني : mhsapei@dmh.lacounty.gov
موقع الويب: www.dmh.lacounty.gov

المشاركة المجتمعية في تخطيط برنامج الوقاية والتدخل المبكر

س: من الذي ينبغي أن يشارك في تطوير خطة برنامج الوقاية والتدخل المبكر؟
أي شخص مهتم بخدمات الصحة النفسية. الأشخاص المهتمون بالكيفية التي سيتم بها تقديم خدمات برنامج الوقاية والتدخل المبكر المتعلقة بالصحة النفسية في مقاطعة لوس أنجلوس.

س كيف يمكنني المشاركة في التخطيط لبرنامج الوقاية والتدخل المبكر في مناطق الخدمة؟
قم بالمشاركة في اللجان الاستشارية المحلية بمنطقة الخدمة (SAAC)المختصة بالصحة النفسية. اتصل بمدير منطقة خدمة إدارة الصحة النفسية (DMH)للحصول على جداول الاجتماعات ويمكنك مراجعة موقع ويب إدارة الصحة النفسية www.dmh.lacounty.gov أو إرسال رسالة بريد إلكتروني إلى mhsapei@dmh.lacounty.gov.

س: ما هي الفرص الأخرى المتاحة للمساهمة في خطة برنامج الوقاية والتدخل المبكر؟
يمكن دعوة الأفراد للمشاركة في **المقابلات الرئيسية لمقدم المعلومات** و**مجموعات الدراسة** والتي ستجري في أوائل عام 2008. وسيتم عقد **ندوات محلية** بدء في ربيع عام 2008 حيث سيتم سؤال المشاركين المساهمة في تحديد استراتيجيات برنامج الوقاية والتدخل المبكر لمناطق الخدمة التابعة لهم.

س: كيف يمكنني الحصول على معلومات بخصوص المشاركة؟
قم بإرسال رسالة بريد إلكتروني إلى **mhsapei@dmh.lacounty.gov** أو الاتصال على هاتف رقم **(213) 738-2331** لتلقي المعلومات حول الفعاليات المجتمعية المستقبلية والمشاركة في تخطيط برامج الوقاية والتدخل المبكر.

س: ماذا أفعل في حالة عدم فهمي بعض المصطلحات المستخدمة في هذا الكتيب أو كان لدي رغبة في معرفة المزيد حول برنامج الوقاية والتدخل المبكر؟
تتوفر إرشادات برنامج الوقاية والتدخل المبكر ووثائق الموارد ومسرد على موقع الويب الخاص بإدارة الصحة النفسية بالولاية: http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

هل ترغب في المشاركة في اجتماعات برنامج الوقاية والتدخل المبكر (PEI)القادمة؟

إذا كنت ترغب في أن يتم الاتصال بك للمشاركة في أنشطة التخطيط المستقبلية لخطة الوقاية والتدخل المبكر بمقاطعة لوس أنجلوس، فالرجاء إكمال هذا النموذج الموجود على الجانب الآخر وقص النموذج وإرساله بالبريد إلى العنوان التالي:

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Administration
550 S. Vermont Avenue
Los Angeles, CA 90020

*يمكنك كذلك إرسال رسالة بريد إلكتروني إلى mhsapei@dmh.lacounty.gov

Prevention & Early Intervention

تأخذ إدارة الصحة النفسية بمقاطعة لوس أنجلوس (DMH)على عاتقها أسلوباً مكثفاً وشاملاً ومتعدد الجوانب لتطوير خطة برنامج الوقاية والتدخل المبكر بالمقاطعة، وهي تمثل واحدة من خمس خطط معتمدة بموجب قانون خدمات الصحة النفسية (MHSA)الذي أقره ناخبو كاليفورنيا في عام 2004.

وتشمل **الوقاية** في الصحة النفسية الحد من عوامل الخطر أو عوامل الضغط وبناء عوامل ومهارات الوقاية وزيادة الدعم. وترقى الوقاية بالتطور الإدراكي والاجتماعي والعاطفي الإيجابي وتساعد على خلق أقصى حالة من الشعور بالراحة النفسية والتي تتيح للفرد العمل على خير وجه عند مواجهة تغير الظروف في حياتهم والتي تتسم بالتحدي أحياناً.

يركز **التدخل المبكر** على الأفراد والعائلات الذين يناسبهم العلاج قصير المدة (أقل من عام واحد في الغالب) ومنخفض الكثافة نسبياً لتحسين معالجة أي مشاكل بالصحة النفسية أو القلق مبكراً عند ظهور أي منها بصور قابلة للقياس، ومن ثم تجنب الحاجة لمزيد من خدمات أو معالجات الصحة العقلية النفسية أو الحيلولة دون تدهور مشكلة الصحة النفسية إلى الأسوأ.

مفهوم منطقة الخدمة. المحور الأساسي لعملية تطوير وتوفير خطة برنامج الوقاية والتدخل المبكر بمقاطعة لوس أنجلوس هو مستوى منطقة الخدمة – حيث يتم الاستفادة من الاجتماعات التي توفر معلومات والمقابلات الرئيسية مع مقدم المعلومات ومجموعات الدراسة والندوات المحلية. وسيتم تطوير ملفات لمناطق الخدمة تحتوي على البيانات الديموغرافية الاجتماعية والاقتصادية وإحصائيات الصحة النفسية وكذلك البيانات المتعلقة بالصحة والتعليم والخدمات الاجتماعية والسلامة العامة للمساعدة في عملية التخطيط.

تستهدف إدارة الصحة النفسية بالولاية تستهدف إدارة الصحة العقلية بالولاية (SDMH) 5 احتياجات مجتمعية للصحة النفسية وستة شرائح مجتمعية ذات أولوية من السكان وستة جهود على نطاق الولاية لبرنامج الوقاية والتدخل المبكر.

احتياجات الصحة النفسية المجتمعية الرئيسية

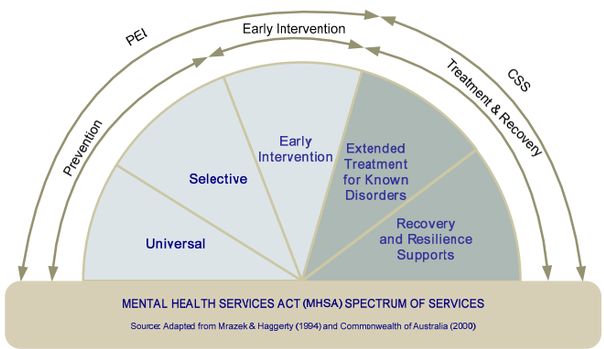
- التفاوت في الوصول إلى خدمات الصحة النفسية
- التأثير الاجتماعي والنفسي للصدمة النفسية
- البالغين والشباب والأطفال المعرضين للمخاطر
- الوصمة السلبية (Stigma)والتمييز
- خطر محاولة الانتحار

شرائح المجتمع التي لها الأولوية

- الأشخاص الذين يعانون من الحرمان الثقافي
- الأشخاص الذين تنتابهم حالة نفسية من الشعور بالخطر (ARMS)أو بداية مرض نفسي خطير
- الأطفال/الشباب الذين يعيشون في عائلات يسود فيها الضغط
- التعرض لصدمة نفسية
- الأطفال/الشباب الذين يعانون من خطر التعرض للفشل الدراسي
- الأطفال/الشباب الذين يعانون من خطر التعرض للدخول إلى أو في نظام مقاضاة الأحداث

المشاريع التي تديرها الولاية

- الوقاية من الانتحار
- الحد من الوصمة السلبية (Stigma)والتمييز
- خدمات للوقاية تتمشى مع المعتقدات والعادات الاجتماعية والثقافية لساكني منطقة الخدمة
- التدريب والمساعدة الفنية وبناء الأهلية
- مبادرة الصحة النفسية للطلاب
- التقييم على مستوى الولاية



شراكات القطاع. على كل منطقة خدمة أن تشرك 7 قطاعات لتطوير خطة برنامج الوقاية والتدخل المبكر. تدعو الحاجة لتوفر المشاركة في كل منطقة خدمة وتفعيل الموارد فيما يلي:

- المجتمعات المحرومة
- التعليم
- الأفراد الذين يعانون من مرض نفسي خطير و/أو عائلاتهم
- مقدمو خدمات الصحة النفسية
- الصحة
- الخدمات الاجتماعية
- هيئات القانون

أوصت إدارة الصحة النفسية بالولاية كذلك بإنشاء قطاعات إضافية، بما في ذلك مراكز موارد العائلات والتوظيف ووسائل الإعلام بالمجتمع.

التمويل. يورد المخطط التالي مبالغ التمويل المقدرة لمقاطعة لوس أنجلوس من الفترة 2007-2009.

السنة المالية	التمويل المقدر لبرنامج الوقاية والتدخل المبكر لإدارة الصحة النفسية بمقاطعة لوس أنجلوس
2007-2008	$34,001,800 * *يتضمن $7,074,500 في الموارد المالية الخاصة بالتخطيط
2008-2009	$57,161,000
الإجمالي:	**$91,162,800**

يجب تخصيص حد أدنى 51% من إجمالي ميزانية خطة برنامج الوقاية والتدخل المبكر بالمقاطعة للأطفال (ممن تتراوح أعمارهم بين 0-15) والشباب في الفترات العمرية الانتقالية (ممن تتراوح أعمارهم بين 16-25).

الرجاء إرسال المعلومات المتعلقة باجتماعات برنامج الوقاية والتدخل المبكر المستقبلية لي _____ .أرغب في المشاركة في أي مجموعة دراسة للتخطيط لبرنامج الوقاية والتدخل المبكر

الاسم: _____

المؤسسة: _____

الوظيفة: _____

العنوان: _____

المدينة، الولاية، الرمز البريدي: _____

البريد الإلكتروني: _____

رقم التليفون: _____

الرجاء وضع علامة أمام الفئة أو القطاع الملائم لك أكثر:

_____ مريض صحة نفسية
_____ عضو عائلة/أم مريض صحة نفسية
_____ مقدم علاج صحة نفسية
_____ مؤسسة دينية
_____ أخرى

الصحة _____ التعليم _____
الخدمات الاجتماعية _____ إنفاذ القانون _____
التوظيف _____ وسائل الإعلام _____
العضو المجتمعي _____ وكالة حكومية أخرى _____

ԻՆՉ ՄԱՍԻՆ ԿԱՐԴԱԼ PEI-Ի ԾՐԱԳՐԵՐԸ

Եթե ցանկանալ եք ձեզ տեղեկացնել որևէ մասնավոր Շրջանի Ներքին Վարչության Ընդհանուր Ծրագրի ներկայացման մասին, կարող եք հարցում կատարել հետևյալ հասցեով, եւ որևէ մեկը կապ կհաստատի ձեզ հետ.

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
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550 S. Vermont Avenue, Ste. 605
Los Angeles, CA 90020

*Ձեր տեղեկութիւնները կարող եք ուղարկել նաեւ էլեկտրոնիկ փոստով՝ mhsapei@dmh.lacounty.gov

ԼՈՍ ԱՆՋԵԼԷՍ ՇՐՋԱՆԻ ՎԵՐԱՀՍԿՈՂՈՒԹԻՒՆ ԿԱԶՄԸ

Gloria Molina
Առաջին Շրջան

Yvonne B. Burke
Երկրորդ Շրջան

Zev Yaroslavsky
Երրորդ Շրջան

Don Knabe
Չորրորդ Շրջան

Michael D. Antonovich
Հինգերորդ Շրջան

William T Fujioka
Գործադիր Կառավարիչ

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Հեռապատճէն : (213) 351-2026
Էլեկտրոնիկ փոստ :
mhsapei@dmh.lacounty.gov
Կայքէջ : www.dmh.lacounty.gov

Prevention and Early Intervention (PEI) Plan

Կանխարգելման եւ Վաղաժամ Միջամտութեան Պլան (PEI)

Ղեկավար՝ Marvin J. Southard, D.S.W.

ԼՈՍ ԱՆՋԵԼԷՍ ՇՐՋԱՆԻ ՏՍՏԱՅԻՆ ԱՌՈՂՋՈՒԹԵԱՆ ԲԱԺԻՆ

ՏՍՏԱՅԻՆ ԱՌՈՂՋՈՒԹԵԱՆ ՍՊԱՍԱՐԿՈՒԹԵԱՆ ՕՐԷՆՔ (MHSA)

Prevention & Early Intervention

Հասարակութեան մասնակցութիւնը PEI-ի ծրագրաւորման մէջ

Ո՞վ պիտի մասնակցի PEI պլանի ընդարձակման գործին
Բոլոր նրանք ովքեր հետաքրքրուած են մտայինառողջութեան մարզի սպասարկութիւններով: Նրանք, որոնց համար կարեւոր է թէ մտայինառողջութեան գծով կանխարգելումի եւ վաղաժամ միջամտումի պատասխանները ինչ ձեւով կը տրամադրուեն Լոս Անջելըս Շրջանում:

Ինչպէ՞ս եմ կարող մասնակցութիւն ունենալ PEI ծրագրաւորումին
Մասնակցեք ձեր տեղական մտայինառողջութեան **Սպասարկութեան Շրջանի Խորհրդատու Կոմիտէներին (SAACs)**. Կապուեք DMH Սպասարկութիւնների Շրջանի Բաժնի Ղեկավարի հետ ստանալու հանդիպումների ժամանակացոյցը, այցելեք DMH կայքէջը **www.dmh.lacounty.gov** կամ էլէկտրոնիկ փոստով **mhsapei@dmh.lacounty.gov**

Ուրի՞ց կարող եմ ստանալ PEI ծրագրաւորման մէջ ներգրաւում ունենալու համար.
Ամիսներ կը հրաւիրեն **հիմնական տեղեկատու հարցազրոյցների** եւ **Կենտրոնացած խմբակների**, որ կը լինի 2008 թուականի սկզբին: Դասակարգային հաւաքները, որտեղ մասնակիցներից կը պահանջի ընտրել PEI-ի որոշակի ստրատեգիաներ հետեւեալ Սպասարկութեան Շրջանի համար, կը լինի 2008 թ. գարնանից:

Ի՞նչպէս կը տեղեկանամ մասնակցութեան ունենալու մասին.
Դիմեք Էլեկտրոնային փոստով՝ **mhsapei@dmh.lacounty.gov** կամ հեռախօսեք **(213) 738-2331** համարին համակարգային յառաջիկայ հաւաքների մասին եւ մասնակցելու PEI Պլանի ծրագրաւորման մէջ:

Ի՞նչ եթէ գոհացնի որոշ արտայայտութիւններ հնձ համար անհամակարծիք լինի եւ կամ ցանկութիւն ունենամ յատելեալ բաներ իմանալ PEI-ի մասին.
PEI-ի ուղեցոյցը, սկզբնադիւրները, եւ յատուկ բառարանը կարելի է ձեռք բերել Պետական DMH կայքէջից. **http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp**

Prevention & Early Intervention

Լոս Անջելըսի Շրջանի Մտային Առողջութեան Բաժինը (DMH) յանձնառու է մի ընդարձակ, բացառիկ, եւ բազմակողմանի մօտեցում ունենալու, գործադնելու համար Շրջանի Կանխարգելման եւ Վաղաժամ Միջամտումի պլանը, մէկը այն հինգ ծրագրաւորումներից որ արտօնուած է Մտային Առողջութեան Սպասաւորութիւնների օրէնքով (MHSA), որ հր հաստատուած է գտել 2004 թուականի Քալիֆորնիայի բեւեռկողների միջոցով:

Կանխարգելումը մտային առողջութեան հարցում հետեւում է ռիսկի ֆակտորների կամ ռիսկը շեշտաւորողների նպատեցման, պաշտպանող ֆակտորների եւ հմտութիւնների առեղծումին եւ պաշտպանութեան յատնումի հոգեբին: Կանխարգելումը բաղկացած է զգացական գարգացումը եւ խրախուսում լաւ զգալու իրավիճակ որ թոյլ է տալիս անհատին յաջողել՝ փոփոխական եւ դրուշ դէպքերում մարտահրաւէրների պայմաններում:

Վաղաժամ Միջամտումը ուղղած է այն անհատներին եւ ընտանիքներին որոնց համար մի կարճ ժամանակամիջոց (սովորաբար մէկ տարուց պակաս) եւ համեմատաբար ցածր-ինտեսիւնացուած միջամտութիւն կը բաւարարի նկատելի չափով բարելաւելու համար մտային առողջութեան հետ կապած մի դժբաղութիւն կամ մտահոգութիւն, դրա դրսեւորման հետ վազելական շրջանում, դրանով զերծ մնալով աւելի ընդարձակ մտային բուժումների կամ միջոցների աւելի ծանր կարիքներից, եւ կամ խոչընդոտելով մտային առողջութեան հետ կապուած դժբաղութեան զարգացում:

Սպասաւորութիւնների Շրջանի Մօտեցումները. Կիզակէտը՝ Լոս Անջելըս Շրջանի PEI պլանի գործադրման համար, գտնւում է Սպասաւորութիւնների Շրջանի ամպարդակով, որի համար օգտագործում է տեղեկատու հանդիպումների, գիտաժոյո տեղեկատու հարցազրոյցների, կենդրոնացած խմբակների, եւ համայնքային Ֆորումների միջոցներ: Սպասաւորութիւնների Շրջանը ուսագծում է ճշդողներ՝ սոցիալ-մշակութային դէմոգրաֆիկ տուեալներ եւ մտային առողջութեան վերաբերեալ վիճակագրութիւններ, նաեւ տուեալներ՝ առողջապահութեան, կրթութեան, սոցիալ տպասաւորութիւնների եւ համապատասխան պետական եւ տեղական կ'ընդդրկուէ՝ դարձ տալու համար մտային ողջութեան:

Մտային Առողջութեան Պետական Դիմարկը (SDMH) նպատակադրած է ճշտել համայնքային մտային առողջութեան 5 կարիքներ, առաջնահերթ 6 ընակչութիւն, եւ երկրի տարածքով 6 միջոցառումներ՝ Կանխարգելման եւ Վաղաժամ Միջամտման ծրագրի համար:

Համայնքային Մտային Առողջութեան Գլխաւոր Կարիքները
- Դժբաղութիւն՝ Մտային Առողջութեան Սպասաւորութիւններ Ձեռք բերելու համար
- Հիւանդութեան հոգեհասարակական ազդեցութիւնը
- Վտանգի ենթակայ Երեխաներ, պատանիներ եւ երիտասարդներ
- Մասնաւորոյց եւ խտրականութիւն
- Ինքնասպանութեան Վտանգ

Առաջահերթ Բնակչութիւն
- Սպասաւորութիւններից Շուրջ Մշակութային Ընակչութիւններ
- Անհատներ որոնք ապրում են Վտանգի Ենթակայ Մտային Վիճակ (ARMS) կամ Դեպքանական Հարց Հիւանդութեան Սկզբնաւորում
- Երեխաներ/Պատանիներ Ստրես ունեցող Ընտանիքներում
- Դոգեկան Վնասի վտանգին ենթակայ
- Վտանգի ենթակայ Երեխաներ/ Պատանիներ Դպրոցական Անյա- չողութեան Պատճառով
- Վտանգի Ենթակայ Երեխաներ/ Պատանիներ որոնք կամ ենթակայ են Անչափահասների Կողմարդութեան Համակարգ-ցուսի (Juvenile Justice System) կամ այնտեղ են գտնում

Դեռատիկան Դավակշրջի Ծրագրաւորումներ
- Ինքնասպանութիւնների կանխարգելում
- Սառնացոցի եւ խորհրդատուութեան նպատեցում
- Ցեղային եւ մշակութային ինքնուրոյն ծրագիրներ եւ միջամտութիւններ
- Վարժութիւն, թեքնիք օգնութիւն, եւ կարողութեան կուտակում
- Ռասայորակ մտային առողջութեան նախաձեռնութիւններ
- Երկրի տարածքով արժեւորում

Նպազգոյնը %51 Շրջանի PEI Պլանի բիւրջէից պիտի յատկացուի երեխայ (0-15 տարեկան) եւ անցման տարիքի պատռանի (TAY16-25 տարիքի) բնակչութեանը.

Տնտեսական Տարի	LA-ի Շրջանի DMH PEI ՊԼԱՆԻ ՆԱԽԱՏԵՍՈՒԹԻՒՆ ՊՊԱՏՍՏՈՒՈՒՄ
2007-2008	$34,001,800 * ** ներառում է նաեւ $7.074.500 միլիոն ծրագրատրման գումարները*
2008-2009	$57,161,000
ԳՈՒՄԱՐ	**$91,162,800**

Խնդրում եմ ուղարկել ինձ PEI պատգամ հանդիպումների ծրագիրը
Ցանկանում եմ մասնակցել PEI-ի ծրագրատրութիւնների փետրուարեայ խորհրդի.

Անուն. _____

Կազմակերպութիւն. _____

Պաշտօն/հոգուս. _____

Հասցէ. _____

Քաղաք, նահանգ, փոստային կոդ. _____

Էլեկտրոնային հասցէ _____

Հեռախօս՝ _____

Խնդրում է նշանակել այն կատեգորիան որ արձնգ շատ է վերաբերում ձեզ.

- Մտային առողջութեան սպասաւ
- Ընտանիքի անդամը / Մտային Առողջութեան Ծնողը
- Մտային առողջութեան հայթայթող
- Կրօնական ղեկավարներ եւ համայնքի առաջնորդներ
- Ոստիկանութիւն եւ Արդարադատութիւն
- Դաստիարակչական Կազմակերպութիւններ
- Առողջապահական Ծառայութիւններ
- Սոցիալական Ծառայութիւններ
- Ընտանեկան Ծառայութիւններ
- Օրէնքի Գործադրում
- Երիտասարդ
- Ընտանիքի Ծառայութիւններ
- Այլ _____

តើលោកអ្នកចង់ចូលរួមនៅក្នុងការប្រជុំ PEI នៅពេលអនាគត ឬទេ ?

លើលោកអ្នកចង់ជានពត៌មានដើម្បីចូលរួមនៅក្នុងសកម្មភាពរៀបចំគម្រោងការណ៍នៅអនាគត សម្រាប់ការការពារ និងគម្រោងអន្តរាគមន៍ជំបូងនៃទោនធីឡូសអេនជីលេស

សូមមត្តាបំពេញក្រដាសនេះនៅទំព័រខាងក្រោយ, និងផ្ញើទៅអាសយដ្ឋានខាងក្រោម ៖

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Administration
550 S. Vermont Avenue
Los Angeles, CA 90020

*លោកអ្នកក៏អាចផ្ញើអ៊ីម៉ែលព័ត៌មានទៅ mhsapei@dmh.lacounty.gov

ការចូលរួមពីសហគមន៍នៅក្នុងគម្រោងការណ៍ PEI

Q. តើអ្នកណាខ្លះដែលត្រូវចូលរួមក្នុងការបង្កើតគម្រោង PEI ?

អ្នកដែលយកចិត្តទុកដាក់ទៅលើសេវាសុខភាពផ្លូវចិត្ត ។ អ្នកដែលយកចិត្តទុកដាក់អំពីវិធី ការពារសុខភាពផ្លូវចិត្ត និងសេវាអន្តរាគមន៍ជំបូង ដែលនឹងអនុវត្តនៅក្នុងទោនធីឡូសអេនជីលេស ។

Q. តើខ្ញុំអាចចូលរួមនៅក្នុងគម្រោងការណ៍ PEI ក្នុងតំបន់សេវាតាមរបៀបណាដែរ ?

ចូលរួមជាមួយនឹង **គណៈកម្មការទីប្រឹក្សាតំបន់សាវ (SAACs)** នៃសុខភាពផ្លូវចិត្តក្នុងតំបន់ ។ សូមទាក់ទងប្រធានសង្កាត់ តំបន់សេវា DMH ដើម្បីទទួលកំណត់ពេលប្រជុំ, មើលវ៉ិបសាយ DMH www.dmh.lacounty.gov ឬអ៊ីម៉ែល mhsapei@dmh.lacounty.gov

Q. តើមានឧកាសអ្វីខ្លះ សម្រាប់ការផ្តល់យោបល់ដល់គម្រោង PEI ?

ជនទីមួយៗអាចបានទទួលការអញ្ជើញឲ្យចូលរួមក្នុង ការសម្ភាសន៍នៃអ្នកឲ្យការណ៍សំខាន់ និងក្រុមផ្តល់យោបល់, ដែលនឹងប្រព្រឹត្តទៅនៅដើមឆ្នាំ ២០០៨ ។ នានិទាយរដូវឆ្នាំ ២០០៨ នៅក្នុងវេទិកាសហគមន៍ នឹងមានការស្នើសុំឲ្យអ្នកចូលរួម ជ្រើសរើសវិធីសាស្ត្រ PEI ជាក់ច្បាស់មួយសម្រាប់តំបន់សេវា ។

Q. តើខ្ញុំអាចទទួលព័ត៌មានស្តីអំពីការចូលរួម តាមរបៀបណាដែរ ?

អ៊ីម៉ែល mhsapei@dmh.lacounty.gov ឬទូរស័ព្ទ (213) 738-2331 ដើម្បីទទួលព័ត៌មានស្តីអំពីពិធីនានាដែលនឹងប្រព្រឹត្តទៅនៅក្នុងសហគមន៍និងការចូលរួមនៅក្នុងគម្រោងការណ៍សម្រាប់កម្មវិធី PEI។

Q. ចុះបើសិនជាខ្ញុំមិនយល់នូវពាក្យខ្លះដែលមានប្រើនៅក្នុងទិត្តប័ណ្ណនេះ ឬខ្ញុំចង់ដឹងពី PEI បន្ថែមទៀត ?

សូមអានការណែនាំ PEI, ធនធានឯកសារនានា, និងសន្ទានុក្រមដែលមាននៅវ៉ិបសាយ DMH រដ្ឋ http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

ទោនធីឡូសអេនជីលេស

ទីប្រឹក្សានៃអ្នកគ្រប់គ្រង

Gloria Molina
សង្កាត់លេខ ១

Yvonne B. Burke
សង្កាត់លេខ ២

Zev Yaroslavsky
សង្កាត់លេខ ៣

Don Knabe
សង្កាត់លេខ ៤

Michael D. Antonovich
សង្កាត់លេខ ៥

William T Fujioka
នាយកប្រតិបត្តិ

County of Los Angeles
Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI)
Administration
550 S. Vermont Avenue, Ste. 605
Los Angeles, CA 90020
ទូរស័ព្ទ : (213) 738-2331
ទូរសារ : (213) 351-2026
អ៊ីម៉ែល : mhsapei@dmh.lacounty.gov
វ៉ិបសាយ : www.dmh.lacounty.gov

ទោនធីឡូសអេនជីលេស ក្រសួងសុខភាពផ្លូវចិត្ត

ច្បាប់នៃសេវាសុខភាពផ្លូវចិត្ត (MHSA)

Prevention & Early Intervention

គម្រោងនៃការការពារ និងអន្តរាគមន៍ជំបូង (PEI)

Marvin J. Southard, D.S.W.
នាយក

Prevention & Early Intervention

ក្រសួងសុខភាពផ្លូវចិត្តនៃខោនធីឡុសអេនជឺលេសកំពុងតែធ្វើការបង្កើតនូវគម្រោងការពារ និងការធ្វើអន្តរាគមន៍ដំបូង (PEI) ដែលមានភាពល្អិតល្អន់, ទូលំទូលាយ, និងមានការដោះស្រាយគ្រប់ជ្រុងជ្រាយ ។ គម្រោងនេះគឺជាគម្រោងមួយក្នុងចំណោមគម្រោងទាំងឡាយដែលមានការអនុញ្ញាតដោយច្បាប់នៃសេវាសុខភាពផ្លូវចិត្ត (MHSA) ដែលបានសម្រេចដោយអ្នកបោះឆ្នោតនៅ រដ្ឋកាលីហ្វ័ញ៉ា នៅឆ្នាំ ២០០៤ ។

ការការពារ នៅក្នុងសុខភាពផ្លូវចិត្តរួមមានការកាត់បន្ថយនូវកត្តាគ្រោះថ្នាក់ ឬកត្តាដែលធ្វើឲ្យមានភាពតានតឹង, ការបង្កើតកត្តាការពារ និងជំនាញ, និងបង្កើនការគាំទ្រគ្នា។ ការការពារនៅឲ្យមានការជឿនយល់ជាវិជ្ជមាន, ការអភិវឌ្ឍន៍ផ្នែកសង្គម និងសតិអារម្មណ៍ និងលើកទឹកចិត្តឲ្យមានសុខភាពល្អ ដែលអនុញ្ញាតឲ្យមនុស្សម្នាក់ៗអាចដោះស្រាយបញ្ហានៅចំពោះមុខបានយ៉ាងល្អ នៅពេលមានការផ្លាស់ប្តូរ និងជួនកាល ក្នុងកាលៈទេសៈលំបាក ។

ការធ្វើអន្តរាគមន៍ដំបូង គឺសំដៅទៅលើជនទីមួយៗ និងគ្រួសារ។ ចំពោះអ្នកទាំងនេះ មានការធ្វើអន្តរាគមន៍ដែលមានរយៈពេលខ្លី (តាមធម្មតាតិចជាងមួយឆ្នាំ) ហើយមានកម្រិតស្រាល ដែលសមរម្យ ដើម្បីធ្វើឲ្យមានភាពរីកចម្រើនច្បាស់លាស់ក្នុងការព្យាបាលសុខភាពផ្លូវចិត្ត ឬ ការបាត់ បង់ នៅពេលដែលបញ្ហាសុខភាពផ្លូវចិត្ត ឬការបាត់បង់នេះ ទើបតែនឹងកើតឡើង ក្នុងគោលដៅជៀសវាងការត្រូវការសេវា ឬ ការព្យាបាលសុខភាពផ្លូវចិត្តដែលមានសភាពធ្ងន់ធ្ងរ; ឬការការពារកុំឲ្យបញ្ហាសុខភាពផ្លូវចិត្តកាន់តែមានភាពធ្ងន់ឡើងៗ

របៀបដោះស្រាយតាមរយៈតំបន់សេវា គោលបំណងនៃការបង្កើតគម្រោង L.A. ខោនធី PEI នេះគឺស្ថិតនៅតាមកម្រិតតំបន់សេវា-ដោយប្រើប្រាស់ការប្រជុំផ្តល់ព័ត៌មាន, ការសម្ភាសន៍អ្នកឲ្យការណ៍សំខាន់, ក្រុមផ្តល់យោបល់, និងវេទិការសហគមន៍ ។ តំបន់សេវា មានគម្រោងស្វែងរកទិន្នន័យផ្នែកសង្គម-សេដ្ឋកិច្ច ប្រជាសាស្ត្រ និងស្ថិតិនៃសុខភាពផ្លូវចិត្ត, រួមទាំងការបង្កើតទិន្នន័យទាក់ទងទៅនឹងសុខភាព, ការអប់រំ, សេវា សង្គមកិច្ច, និងសុវត្ថិភាពសាធារណៈ: ដើម្បីនឹងជួយដល់ការបង្កើតគម្រោងនេះ ។

ក្រសួងសុខភាពផ្លូវចិត្តរដ្ឋ (SDMH) បានយកចិត្តទុកដាក់ទៅលើសេចក្តីត្រូវការផ្នែកសុខភាពផ្លូវចិត្តនៃសហគមន៍ ចំនួន ៥, ក្រុមប្រជាជនដែលមានអាទិភាព ចំនួន ៦, និងការទិតទំនៅជុំវិញរដ្ឋ ចំនួន ៦ សម្រាប់កម្មវិធីការពារ និងធ្វើអន្តរាគមន៍ដំបូង ៖

សេចក្តីត្រូវការសំខាន់ៗផ្នែកសុខភាពផ្លូវចិត្តនៃសហគមន៍

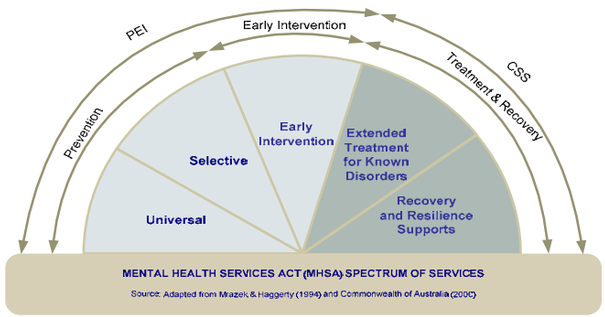
- ភាពខុសគ្នា ក្នុងការទទួលបាននូវសេវាសុខភាពផ្លូវចិត្ត
- ឥទ្ធិពលលើចិត្ត-សង្គម ដោយបណ្តូសផ្លូវចិត្ត
- កុមារដែលកំពុងតែប្រឈមមុខនឹងគ្រោះថ្នាក់, យុវជន យុវនារី និងប្រជាជនដែលមានវ័យក្មេង
- ស្ថាកស្នាមទុយ៉ិស និងការរើសអើង
- គ្រោះថ្នាក់ដែលអាចនាំទៅដល់ការសម្លាប់ខ្លួន

ប្រជាជនដែលជាអាទិភាព

- ប្រជាជនវប្បធម៌ផ្សេង ដែលមិនបានទទួលការបម្រើគ្រប់គ្រាន់
- អ្នកដែលកំពុងតែមានសតិអារម្មណ៍ដែលប្រឈមមុខនឹងគ្រោះថ្នាក់ (ARMS) ឬដែលទើបតែនឹងចាប់ផ្តើមមានជំងឺសតិអារម្មណ៍ធ្ងន់ធ្ងរ ។
- កុមារ/យុវជនយុវនារី រស់នៅក្នុងគ្រួសារដែលមានភាពតានតឹង
- ការជួបប្រទះនឹងរបួសផ្លូវចិត្ត
- កុមារ/យុវជន យុវនារីដែលប្រឈមមុខនឹងគ្រោះថ្នាក់នៃការរៀនថ្នាក់ថ្នាក់
- កុមារ/យុវជន យុវនារីដែលប្រឈមមុខនឹងគ្រោះថ្នាក់ដោយសារការថ្នាក់ចូលទៅក្នុង ឬកំពុងនៅក្នុងប្រព័ន្ធយុត្តិធម៌យុវភាព

កម្មវិធីនានាដែលគ្រប់គ្រងដោយរដ្ឋ

- ការការពារនូវការសម្លាប់ខ្លួន
- ស្ថាកស្នាមទុយ៉ិស និងការកាត់បន្ថយការរើសអើង
- កម្មវិធីពិសេសនិងអន្តរាគមន៍សំរាប់ជាតិពន្ធ ឬវប្បធម៌ផ្សេង
- ការហ្វឹកហាត់, ជំនួយផ្នែកបច្ចេកទេស និងការសាងសង់សមត្ថភាព
- ការផ្តើមគំនិតផ្នែកសុខភាពផ្លូវចិត្តរបស់សិស្ស
- ការប្រមាណមើលទូទាំងរដ្ឋ



ការរួមសហការជាមួយអង្គភាពនានា SDMH បានរកអង្គភាពចំនួន ៧ ដែលខោនធីត្រូវតែសហការជាមួយក្នុងការបង្កើតគម្រោង PEI របស់ខ្លួន ។ មានការតម្រូវឲ្យមានការរួមសហការជាមួយសហគមន៍ និងតម្រូវឲ្យមានអានុភាពធនធានជាមួយ ៖

- សហគមន៍ដែលមិនបានទទួលការបម្រើគ្រប់គ្រាន់
- ការអប់រំ
- អ្នកដែលមានជំងឺផ្លូវចិត្តធ្ងន់ធ្ងរ និង/ឬ គ្រួសាររបស់គេ
- អ្នកផ្តល់សេវាសុខភាពផ្លូវចិត្ត
- សុខភាព
- សេវាសង្គមកិច្ច
- ក្រសួងប៉ូលិស

SDMH ក៏បានធ្វើអនុសាសន៍ដល់អង្គភាពបន្ថែមទៀត, រួមមានមជ្ឈមណ្ឌលធនធានគ្រួសារក្នុងសហគមន៍នានា, ការងារ, និងគ្រឹះផ្សាយព័ត៌មាន ។

ថវិកា តារាងខាងក្រោមនេះមានរាយនូវចំនួនគំរោងថវិកាស្មានសម្រាប់ខោនធីឡុសអេនជឺលេស ពី ២០០៧-២០០៩ ។

ឆ្នាំសារពើពន្ធ	DMH នៃ L.A. ខោនធី ថវិកាស្មាន សម្រាប់ PEI
២០០៧-២០០៨	៧៤.០០១.៨០០ ដុល្លារ * *រួមមាន ៧.០៧៤.៥០០ ដុល្លារក្នុងគម្រោងថវិកា
២០០៨-២០០៩	៥៧.១៦១.០០០ ដុល្លារ
សរុប៖	**៩១.១៦២.៨០០ ដុល្លារ**

ថវិកាចំនួនយ៉ាងតិចណាស់ ៥១% នៃចំនួនថវិកាសរុបសម្រាប់គម្រោង PEI ខោនធី ត្រូវតែប្រើប្រាស់សម្រាប់កុមារ (អាយុពី ០ ដល់ ១៥ ឆ្នាំ) និងយុវជនយុវនារីពេញវ័យ (TAY អាយុពី ១៦ ដល់ ២៥ ឆ្នាំ) ។

សូមធ្វើការដាក់ចំនួនព័ត៌មានបន្ថែមទៀតអំពីការប្រើប្រាស់ ទំព័រចិត្តប្រឹក្សាផ្នែកផ្លូវចិត្ត PEI នៅពេលអនាគត ។

លេខ៖ _____

អត្ថិភាព ៖ _____

ទីតាំង ៖ _____

អាសយដ្ឋាន ៖ _____

ទីក្រុង, ក្នុង, ហាងតំបន់ ៖ _____

អ៊ីម៉ែល ៖ _____

ទូរស័ព្ទ ៖ _____

សូមជ្រើសរើសប្រភេទនៃអង្គភាពដែលអ្នកចង់ឲ្យមានការទាក់ទងទៅ ៖

_____ អតិថិជនសុខភាពផ្លូវចិត្ត

_____ សមាជិកគ្រួសារ/មាតាបិតារបស់អតិថិជនសុខភាពផ្លូវចិត្ត

_____ អ្នកផ្តល់សេវាសុខភាពផ្លូវចិត្ត

_____ អគ្គីភាពដែលទាក់ទងទៅនឹងសាសនា

_____ ដៃគូទៀត

_____ ការអប់រំ

_____ ក្រសួងប៉ូលិស

_____ ក្រុមផ្សាយព័ត៌មាន

_____ ក្រសួងផ្នែកច្បាប់ដទៃទៀត

有意參與日後預防及早期介入 PEI 會議嗎？

您若願意獲悉並參與洛杉磯縣日後預防及早期介入計畫之活動，請填妥背頁表格，並寄回下址：

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Administration
550 S. Vermont Avenue
Los Angeles, CA 90020

*您亦可以把資料以電郵方式送至本署的網址：mhsapei@dmh.lacounty.gov

社區人士參與預防及早期介入之計劃

問：誰應參與 PEI 計畫的發展?

任何關心精神健康服務的人士。重視精神健康預防及早期介入服務將如何在洛杉磯縣推行的人士。

問：我如何在服務分區內參與 PEI 的計畫?

您可參與所屬區內的精神健康**服務區域咨詢委員會(SAACs)**。有關會議日期，可向各精神健康署服務分區主任查詢；亦可參閱精神健康署之網址：www.dmh.lacounty.gov 或電郵連絡：mhsapei@dmh.lacounty.gov

問：還有其他途徑就 PEI 計畫提出建議嗎?

個別人士可獲邀參與 2008 年初舉行的**重點人士專訪會**和**專案小組**。2008 春開始，將有**社區論壇**讓與會人士可就區內 PEI 服務的具體策略表達其取向 。

問：我可從何獲取有關如何參與的資料?

如欲得悉即將進行的各項社區活動，和參與 PEI 服務的策劃，請以電郵方式連絡 mhsapei@dmh.lacounty.gov 或致電 (213) 738-2331

問：若有對本冊子的詞彙不明白或欲更認識 PEI 時，怎麼辦?

PEI 指引、資源文件及詞彙總覽均有刊登在州政府的精神健康署網址上: http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

洛杉磯縣
監理會

Gloria Molina
第一區

Yvonne B. Burke
第二區

Zev Yaroslavsky
第三區

Don Knabe
第四區

Michael D. Antonovich
第五區

William T Fujioka
執行首長

County of Los Angeles
Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI)
Administration
550 S. Vermont Avenue, Ste. 605
Los Angeles, CA 90020
電話: (213) 738-2331
傳真: (213) 351-2026
電郵: mhsapei@dmh.lacounty.gov
網址: www.dmh.lacounty.gov

洛杉磯縣

精神健康署

精神健康服務法案

Prevention & Early Intervention

預防及早期介入計畫

總監： Marvin J. Southard, D.S.W.

洛杉磯縣精神健康署(DMH)正以一項徹底、廣泛而多元化的方案來發展本縣的預防及早期介入服務(PEI)。這為加州於 2004 年經投票後訂定的精神健康法(MHSA)中 5 項計畫之一。

預防性服務在精神健康而言，包含減低危機因素或壓力來源，建立保護性因素和技能及增強支持系統。預防工作可加強個人在認知、社交、情感處理等能力上的正面培育，並強化良好的精神健康狀態，好讓個人能在面對變動和遇上困境時仍能妥善地生活。

早期介入服務是指當一精神健康困境或隱憂剛萌生於個人或及家庭時，儘早提供短期(一般指少於一年) 和輕度的干預，使情況有所改善，不用更進一步的精神健康療法或服務；以及防止該精神健康問題的惡化。

分區性的服務模式：在發展洛杉磯縣預防及早期介入服務時，重點為服務分區化 - 這模式將會透過服務說明會、 重點人士專訪會、專案小組及社區論壇等進行。將按區內社會經濟人口分佈及精神健康狀態的統計資料，並搜集有關健康、教育、社會服務、及公共治安資料，作為計畫時的依據。

州政府精神健康署為預防及早期介入服務制訂了 **5** 項社區性的精神健康境況、**6** 組優先接受服務的人士、和 **6** 項全州性的企劃行動：

社區精神健康的關鍵性的境況

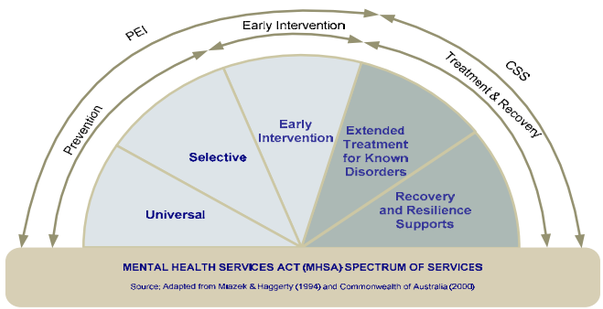
- 精神健康服務資源的缺乏
- 挫傷導致的心理性及社會性影響
- 瀕臨危機的兒童、青少年及青成人社群
- 羞辱和歧視
- 自殺危機

優先接受服務人士

- 被忽略的文化族群
- 正瀕臨精神健康狀態(ARMS) 危機或正罹患嚴重精神病的人士
- 身處重大家庭壓力的兒童或青少年
- 身受重大創傷的人士
- 瀕臨學業危機的兒童或青少年
- 面對或身處青少年司法管治危機的兒童或青少年

全州性推行之企劃

- 自殺防預
- 減少羞辱和歧視
- 配合各族裔和文化背景所專設的服務和介入
- 培訓、技能輔助及和建立才能
- 學生精神健康之倡導
- 全州性的服務評估



合作夥伴　州政府精神健康署指定 7 個社群為合作夥伴，共同拓展其 PEI 服務。與下列社群的夥伴關係和資源的調配是不可或缺的：

- ▶ 被忽略的社群
- ▶ 教育界
- ▶ 患嚴重精神病人士及 / 或其家人
- ▶ 精神健康服務界
- ▶ 醫療衛生界
- ▶ 社會服務界
- ▶ 執法人員

州政府精神健康署同時建議可有更多合作的夥伴，包括社區內的家庭資源中心、就業界和媒體的參與。

經費　洛杉磯縣 2007-2009 年度預算所需經費詳列於下：

財政年度	洛杉磯縣精神健康署 PEI 預算經費
2007-2008	$34,001,800 * **包含 $7,074,500 的籌劃經費*
2008-2009	$57,161,000
總額:	**$91,162,800**

洛縣 PEI 計畫預算總額中，不少於 51%的經費必須用於兒童(0-15 歲者) 及過度年齡之青少年(16-25 歲者)的服務 。

_____ 請寄來有關 PEI 會議的資料.　_____我願意參與PEI 策劃的專案小組.

姓名:_____

所屬單位:_____

職位 / 稱銜:_____

地址:_____

城市、州、郵遞區號:_____

電郵:_____

電話:_____

請勾選下列最適用於您的項目：

_____ 精神健康服務使用者
_____ 精神健康服務使用者的家人或家長
_____ 精神健康服務提供者
_____ 宗教團體
_____ 其他：（請註明）_____
_____ 教育界
_____ 執法人員
_____ 媒體
_____ 其他政府機關
_____ 醫療衛生界
_____ 社會服務界
_____ 就業界
_____ 社區人士

Interested in participating in future PEI meetings?

If you would like to be contacted to participate in future planning activities for the Los Angeles County Prevention and Early Intervention Plan, please complete this form on the other side, tear off the form, and mail it to the address below:

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Administration
550 S. Vermont Avenue, 6th Floor, Room 605
Los Angeles, CA 90020

*You may also e-mail the information to mhsapei@dmh.lacounty.gov

Community Involvement in PEI Planning

Q. Who should get involved in developing the PEI plan?
Anyone who has an interest in mental health services. People who care about how mental health prevention and early intervention services will be delivered in Los Angeles County.

Q. How can I get involved in PEI planning in the Service Areas?
Participate in your local mental health **Service Area Advisory Committees (SAACs)**. Contact the DMH Service Area District Chief for meeting schedules, check the DMH website **www.dmh.lacounty.info/stp/pei.html** or e-mail **mhsapei@dmh.lacounty.gov**

Q. What are other opportunities to provide input to the PEI Plan?
Individuals may be invited to participate in **key informant interviews** and **focus groups**, which will occur in early 2008. **Community forums**, where participants will be asked to select specific PEI strategies for their Service Areas, will be held starting in spring 2008.

Q. How do I get information about getting involved?
Email **mhsapei@dmh.lacounty.gov** or call **(213) 738-2331** to receive information about upcoming community events and participation in planning for PEI programs.

Q. What if I don't understand some of the terms used in this booklet or want to learn more about PEI?
PEI guidelines, resource documents, and a glossary are available on the State DMH website: http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

LOS ANGELES COUNTY BOARD OF SUPERVISORS

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Chief Executive Officer

County of Los Angeles
Department of Mental Health
Program Support Bureau
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Prevention and Early Intervention (PEI)
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Phone: (213) 738-2331
Fax: (213) 351-2026
E-mail: mhsapei@dmh.lacounty.gov
Website:
www.dmh.lacounty.info/stp/pei.html

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH SERVICES ACT (MHSA)

Prevention & Early Intervention

Prevention and Early Intervention (PEI) Plan

Director Marvin J. Southard, D.S.W.

The Los Angeles County Department of Mental Health (DMH) is undertaking an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan, one of five plans authorized by the Mental Health Services Act (MHSA) enacted by California voters in 2004.

Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills, and increasing support. Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances.

Early Intervention is directed toward individuals and families for whom a short duration (usually less than one year) and relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services; or preventing a mental health problem from getting worse.

Service Area Approach. The focus for developing the L.A. County PEI Plan is at the Service Area level—utilizing informational meetings, key informant interviews, focus groups, and community forums. Service Area profiles identifying socio-economic demographic data and mental health statistics, as well as data related to health, education, social services, and public safety will be developed to aid the planning process.

The State Department of Mental Health (SDMH) has targeted 5 community mental health needs, 6 priority populations, and 6 statewide efforts for the Prevention and Early Intervention program:

Key Community Mental Health Needs

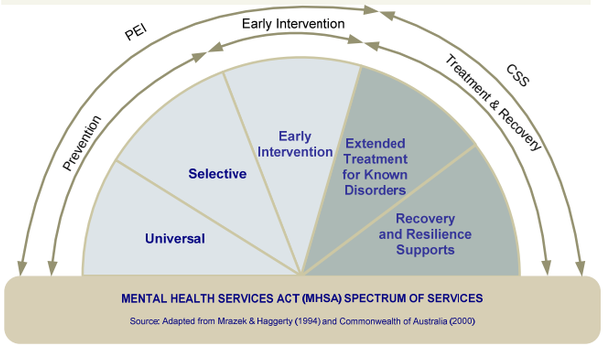
- Disparities in Access to Mental Health Services
- Psycho-Social Impact of Trauma
- At-Risk Children, Youth and Young Adult Populations
- Stigma and Discrimination
- Suicide Risk

Priority Populations

- Underserved Cultural Populations
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Children/Youth in Stressed Families
- Trauma-Exposed
- Children/Youth at Risk for School Failure
- Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

State-Administered Projects

- Suicide Prevention
- Stigma and Discrimination Reduction
- Ethnically and Culturally Specific Programs and Interventions
- Training, Technical Assistance and Capacity Building
- Student Mental Health Initiative
- Statewide Evaluation



Sector Partnerships. SDMH has identified 7 sectors that counties must partner with to develop their PEI Plan. Community partnerships and resource leveraging are required with:

- ▶ Underserved Communities
- ▶ Education
- ▶ Individuals with Serious Mental Illness and/or Their Families
- ▶ Providers of Mental Health Services
- ▶ Health
- ▶ Social Services
- ▶ Law Enforcement

SDMH also recommended additional sectors, including community family resource centers, employment, and media.

Funding. The following chart lists the estimated funding amounts for Los Angeles County from 2007-2009.

FISCAL YEAR	LA COUNTY DMH PEI ESTIMATED FUNDING
2007-2008	$34,001,800 * *includes $7,074,500 million in planning funds
2008-2009	$57,161,000
TOTAL:	**$91,162,800**

A minimum of 51% of the overall County PEI Plan budget must be dedicated to the child (ages 0-15) and transition-age youth (TAY ages 16-25) populations.

___ Please send me information on future PEI meetings. ___ I would be willing to participate in a focus group for PEI planning.

Name: _____

Organization: _____

Position/Title: _____

Address: _____

City, State, Zip Code: _____

Email: _____

Phone: _____

Please check the category or sector that is most applicable to you:

___ Mental Health Consumer
___ Family Member/Parent of Mental Health Consumer
___ Mental Health Provider
___ Faith-Based Organization
___ Other _____
___ Education
___ Law Enforcement
___ Media
___ Other Government Agency
___ Health
___ Social Services
___ Employment
___ Community Member

کانتی لس آنجلس

بخش بهداشت روانی

امور خدمات

بهداشت روانی (MHSA)

Prevention and Early Intervention (PEI) Plan

طرح اقدام زودهنگام و پیشگیری (PEI)

Director Marvin J. Southard, D.S.W.

کانتی لس آنجلس

هیئت سرپرستان

Gloria Molina
ناحیه اول

Yvonne B. Burke
ناحیه دوم

Zev Yaroslavsky
ناحیه سوم

Don Knabe
ناحیه چهارم

Michael D. Antonovich
ناحیه پنجم

William T Fujioka
سر افسر اجرائی

County of Los Angeles
Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI)
Administration
550 S. Vermont Avenue, Ste. 605
Los Angeles, CA 90020
تلفن: (213) 738-2331
فاکس: (213) 351-2026
ایمیل: mhsapei@dmh.lacounty.gov
وب سایت: www.dmh.lacounty.gov

مشارکت مردم در طرح پی ای آی PEI

س. چه کسی باید در برنامه ریزی های پی ای آی PEI مشارکت کند؟
هر کس که به خدمات بهداشت روانی علاقه مند است و به نحوه اجرای خدمات اقدام زودهنگام و پیشگیری از بیماریهای روانی در کانتی لس آنجلس اهمیت می دهد.

س. من چگونه می توانم در محدوده های خدماتی طرح پی ای آی PEI شرکت کنم؟
در **کمیته مشاوره خدمات ناحیه ای بهداشت روانی** محل تان شرکت کنید. (SAACs) با رئیس دفتر ناحیه ای خدمات DMHتماس بگیرید و از زمانبندی ها مطلع شوید و یا وب سایت DMHرا به آدرس www.dmh.lacounty.gov چک کنید ویا به mhsapei@dmh.lacounty.gov ایمیل بزنید.

س. امکانات دیگر کمک رسانی به طرح پی ای آی PEI چیست؟
اوایل سال 2008 ممکن است از اشخاص دعوت کنند که به **مصاحبه های اطلاعات کلیدی افراد** بیایند و یا **گروه های شاهد** تشکیل دهند. **جلسات مباحثه گروهی** که طی آن ها از افراد خواسته می شود سیاستگذاری های ناحیه خدماتی خود را انتخاب کنند، از بهار 2008 برگزار خواهند شد.

س. چگونه اطلاعات مربوط به مشارکت را به دست بیاورم؟
به mhsapei@dmh.lacounty.gov ایمیل بزنید یا با شماره **(213) 738-2331** تماس بگیرید و اطلاعات مربوط به گردهمایی های گروهی آینده و مشارکت در برنامه های پی ای آی PEI را دریافت کنید.

س. اگر بعضی از اصطلاحات این کتابچه را نفهمیدم یا خواستم بیشتر در مورد آن ها بدانم، چه بکنم؟
راهنماهای پی ای آی PEI و منابع مطالعه بیشتر و یک لغتنامه در وب سایت ایالتی DMH گذاشته شده است.
http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

آیا علاقه مند هستید در جلسات آینده پی ای آی PEI شرکت کنید؟

اگر مایلید که با شما تماس بگیرند تا در برنامه ریزی های آتی طرح پیشگیری و اقدام زودهنگام کانتی لس آنجلس شرکت کنید، لطفاً پشت این فرم را پر کنید، آن را از کاغذ جدا کنید و به آدرس زیر پست کنید:

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Administration
550 S. Vermont Avenue
Los Angeles, CA 90020

*شما همچنین می توانید اطلاعات خود را به mhsapei@dmh.lacounty.gov ایمیل کنید.

Prevention & Early Intervention

بخش بهداشت روانی کانتی لس آنجلس (DMH) مشغول بررسی کامل و جامع و همه جانبه ای برای توسعه طرح اقدام زودهنگام و پیشگیری (PEI) است. این طرح یکی از پنج طرح تصویب شده امور خدمات بهداشت روانی (MHSA) است که توسط رای دهندگان کالیفرنیایی در سال 2004 به مرحله اجرا رسیده است.

پیشگیری در بهداشت روانی عبارت است از کاهش عوامل ریسک یا عوامل استرس و ساختن مهارت ها و عوامل حمایت کننده و بالابردن میزان پشتیبانی. پیشگیری باعث بهبود رشد مثبت شناختی، اجتماعی، و عاطفی می شود و سلامت را به نحوی تقویت می کند که شخص می تواند در برابر تغییرات و گاهی شرایط دشوار به خوبی عمل کند.

اقدام زود هنگام برای آن دسته از اشخاص یا خانواده هایی در نظر گرفته شده که برای آن ها اقدامات بهداشت روانی به مدت کوتاه (معمولاً کمتر از یک سال) و به صورت آرام می تواند مشکل یا مسئله و نگرانی روانی آن ها را به طور محسوسی در مراحل اولیه پیدایش بهبود بخشد، و به این ترتیب نیاز به خدمات یا درمان های بهداشت روانی بعدی و پیشرفته تر را از بین ببرد و یا از وخیم تر شدن یک مشکل روانی جلوگیری کند.

رویکرد ناحیه خدمات. در توسعه طرح پی ای آی PEI در کانتی لس آنجلس اصل بر ایجاد خدمات در سطح ناحیه ای می باشد که از طریق جلسات ارائه اطلاعات و مصاحبه های آگاهی دهنده و گروه های شاهد و

گردهمایی های گروهی صورت می پذیرد. یک طرح ناحیه ای مشخص کنندهٔ شرایط اقتصادی-اجتماعی ناحیه ای و آمارهای بهداشت روانی و همچنین بهداشت، آموزش، خدمات اجتماعی و مسائل ایمنی عمومی بوجود خواهد آمد که برای برنامه ریزی مورد استفاده قرار گیرد.

بخش ایالتی بهداشت روانی (SDMH) پنج مبحث بهداشت روانی برای مردم را هدف قرار داده است و 6 جمعیت اولیه را در نظر گرفته و 6 برنامه را برای طرح اقدام زودهنگام و پیشگیری در سطح ایالت مشخص کرده است:

نیازهای کلیدی بهداشت روانی جامعه

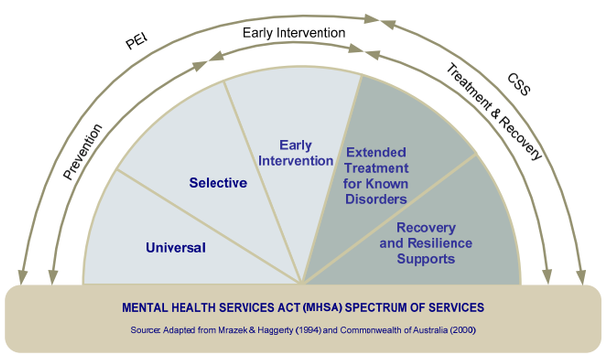
- مسائل دسترسی به خدمات بهداشت روانی
- تأثیر روحی-اجتماعی ضربات روحی
- کودکان، نوجوانان و جوانان در معرض خطر
- مسائل تبعیض و تحقیر
- خطر خودکشی

جمعیت های دارای اولویت

- جمعیت هایی که از لحاظ فرهنگی تقویت نشده اند
- اشخاصی که در معرض خطر مسائل روانی (ARMS) قرار دارند یا ممکن است بیماری روانی جدی پیدا کنند
- کودکان/جوانان خانواده های دچار استرس
- کسانی که ضربات روحی را تجربه کرده اند
- کودکان/جوانانی که در معرض خطر شکست تحصیلی هستند
- کودکان/جوانانی که در معرض خطر سرکار یافتن با دستگاه قضایی هستند یا با آن درگیر شده اند

پروژه های تحت نظر ایالت

- پیشگیری از خودکشی
- کاهش تبعیض ها و تحقیرها
- برنامه ها و اقدامات خاص قومی و فرهنگی
- کمک های آموزشی و تکنیکی و تقویت ظرفیت ها
- برنامه های بهداشت روانی دانشجویان
- ارزیابی در سطح ایالت



همکاری بخشها. سازمان ایالتی SDMH 7 بخش را تعیین کرده است که کانتی ها باید برای برنامه ریزی های خود با آن ها همکاری کنند. همکاری های جامعه و مشارکت منابع اطلاعاتی برای این موارد است:

- گروه های رسیدگی نشده
- آموزش
- اشخاص دچار بیماری های شدید روانی و/یا خانواده آن ها
- ارائه کنندگان خدمات بهداشت روانی
- بهداشت
- خدمات اجتماعی
- اجرای قانون

سازمان SDMH همکاری با بخش های دیگری را نیز پیشنهاد می کند که از جمله مراکز خدمات خانواده جامعه، خدمات کاریابی و رسانه های گروهی را می توان نام برد.

سرمایه گذاری. جدول زیر مبالغ تخمینی سرمایه های لازم برای کانتی لس آنجلس را برای 2007-2009 نشان می دهد.

سال مالی	سرمایه گذاری تخمین زده شده برای PEI توسط DMHکانتی لس آنجلس
2007-2008	$34,001,800 * * شامل 7074500 $ سرمایه در برنامه ریزی ها
2008-2009	$57,161,000
در جمع:	**$91,162,800**

حداقل 51% بودجه کل طرح PEIکانتی باید به کودکان (سنین 0 تا 15) و جوانان دوره گذار (سنین 16 تا 25) اختصاص داده شود.

لطفاً برای من اطلاعات مربوط به جلسات آینده PEIرا ارسال کنید ____ . من مایل هستم در گروه های شاهد برای طرح PEIشرکت کنم.

نام: _____

سازمان: _____

عنوان/مقام: _____

درس: _____

شهر، ایالت، کدپستی: _____

ایمیل: _____

تلفن: _____

لطفاً مقوله یا بخشی که از همه بیشتر به شما مربوط می شود، علامت بزنید:

____ متقاضی بهداشت روانی
____ متقاضی بهداشت روانی که عضو خانواده/پدر یا مادر است
____ ارائه کننده خدمات بهداشت روانی
____ سازمان های مذهبی
____ دیگر

____ آموزشی
____ اجرای قانون
____ رسانه گروهی
____ دیگر سازمان های دولتی

____ بهداشت
____ خدمات اجتماعی
____ کاریابی
____ عضو گروه خاص

로스엔젤레스 카운티 정신 건강국 [The Los Angeles County Department of Mental Health (DMH)]은 2004 년 캘리포니아 주민 선거에 의하여 법률화된 정신 건강 서비스 법 [Mental Health Services Act (MHSA)]에서 승인된 5 가지 플랜의 하나인 카운티의 예방 및 조기 중재[Prevention and Early Intervention (PEI)] 플랜을 개발하기 위해집중적이며,총괄적,그리고 다면적인 접근방법으로 착수하고 있습니다.

예방은 정신 건강에 있어서 위험 요인 및 스트레스 요인을 줄이며, 보호 요소와 기능 구축, 그리고 지원을 증가시키는 것을 포함합니다. 예방은 긍정적인 사고력, 사회성과 정서적인 개발을 승진시키며, 개인이 변화와 도전적인 상황에 처한 경우 기능을 잘 할수 있도록 웰빙 상태를 장려합니다.

초기 중재는 단기적 (보통 1 년 이하) 이며 정신 건강 문제를 비교적 낮은-집중적인 방식으로 중재하는것이 정신 건강 문제를 적절히 향상시키는데 적격한 개인 및 가족들을 위한 것이며, 그리하여 광범위한 정신 건강 치료나 서비스의 필요성을 피하며; 또는 정신 건강 문제가 악화되는 것을 예방하는 것입니다.

서비스 지역 접근. L.A. 카운티의 PEI 플랜을 개발하기 위한 촛점은 서비스 지역 수준에 있습니다 - 정보성이 있는 회의, 주요 정보인과 인터뷰, 포커스 그룹, 커뮤니티 회의를 활용하는 것입니다. 서비스 지역 분석은 사회경제 인구통계학 자료 및 정신 건강 통계를 확인할뿐 아니라 기획 진행을 보조하기 위한 건강, 교육, 복지 서비스, 그리고 공공 안전을 개발할 것입니다.

주 정신건강국 (SDMH)에서는 예방과 조기 중재 프로그램을 위해 5 가지 커뮤니티 정신 건강을 위한 필요사항, 6 우선 순위 인구, 그리고 6 가지 주전체를 통한 협력에 목표를 두고 있습니다:

주 커뮤니티 정신 건강 필요 사항

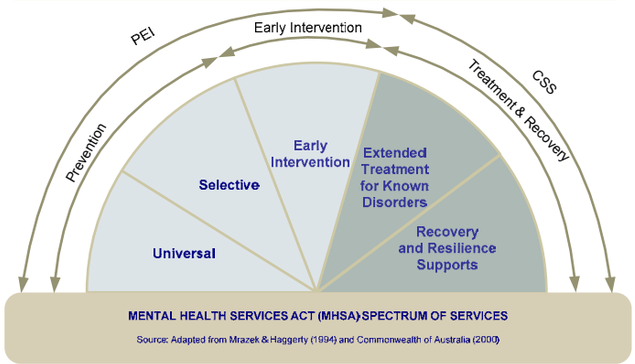
- 정신 건강 서비스 이용에 대한 불균형
- 충격에 의한 심리-사회적 영향
- 위험아동, 청소년 및 어린 성인 인구
- 낙인 및 차별 대우
- 자살 위험성

우선 순위 인구

- 서비스를 충분하게 받지 못하는 문화 인구
- 위험에 처한 정신 상태 (ARMS)를 경험하는 개인 또는 심각한 정신 질환 발병에 처한 사람
- 스트레스가 심한 가정내의 아동/청소년
- 정신적 충격에 노출
- 학습 실패에 위험성 있는 아동/청소년
- 청소년 사법 시스템에 입소 또는 유치의 위험성이 있는 아동/청소년

주-행정 프로젝트

- 자살 방지
- 낙인 및 차별대우 감소
- 민족적 및 문화적으로 특정한 프로그램과 중재
- 교육, 기술 보조 및 능력 육성
- 학생 정신 건강 창안
- 주전체 평가



파트너쉽: SDMH 는 PEI 플랜을 개발하기 위해 카운티가 협력해야할 7 가지의 분야를 식별하였습니다:

- ▶ 충분한 서비스를 받지 못하는 커뮤니티
- ▶ 교육
- ▶ 심각한 정신 질환을 가진 개인 그리고/또는 그들의 가족
- ▶ 정신 건강 서비스 제공자
- ▶ 건강
- ▶ 복지 서비스
- ▶ 치안

SDMH 는 또한 커뮤니티 가족 자원 센터, 고용 및 미디어를 포함한 추가 분야를 권장하였습니다.

기금: 아래의 도표는 로스엔젤레스 카운티의 2007 년-2009 년 예산 기금을 열거한 것입니다.

회계 연도	LA 카운티 DMH PEI 예산 기금
2007-2008	$34,001,800 * **기획 기금 $7,074,500 million 포함*
2008-2009	$57,161,000
합계:	**$91,162,800**

카운티 전체의 PEI 플랜 예산중 최소한 51%는 아동 (연령 0-15 세) 과 과도기 연령 청소년 (TAY 나이 16-25 세) 인구에 전용되어야 합니다.

_____차후의 PEI 회의에 관한 정보를보내주십시오. ____PEI 기획을 위한 포커스 그룹에 참여하기를 원합니다.

이름:_____
단체:_____
지위/직명:_____
주소:_____
도시,주,우편번호:_____
이메일:_____
전화:_____

귀하에게 가장 적격하게 해당되는 부나 분야에 표시를 하십시오:

___ 정신 건강 소비자
___ 정신 건강 소비자의 가족 멤버/부모
___ 정신 건강 서비스 제공자
___ 종교 -바탕의 단체
___ 기타_____
___ 교육
___ 치안
___ 미디어
___ 기타 정부 기관

차후의 PEI 회의에 참여하시는 것에 관심이 있으십니까?

로스엔젤레스 카운티 예방 및 조기 중재 계획을 위한 차후의 기획 활동에 참여하기 위해 연락을 받고 싶으시면, 이 양식의 뒷면을 작성하신다음, 양식을 잘라내신 후, 아래의 주소로 보내주십시오:

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Administration
550 S. Vermont Avenue
Los Angeles, CA 90020

*이메일로 정보를 보내주실 수도 있습니다: mhsapei@dmh.lacounty.gov

PEI 계획에 대한 커뮤니티의 참여

Q. PEI 계획 개발에 누가 관련하여야 하나?
누구나 정신 건강 서비스에 관심이 있는 사람. 로스엔젤레스 카운티에서 정신 건강 예방 및 조기 중재 서비스가 어떠한 식으로 인도되는지에 관심이 있는 사람.

Q. 서비스 지역내의 PEI 계획에 어떠한 방법으로 참여할 수 있나?
귀하의 지역 정신 건강 서비스 지역 고문 위원회[Service Area Advisory Committees (SAACs)] 에 참여하십시오. 회의 스케줄을 받기 원하시면 DMH 서비스 지역 지구장에게 연락하시거나, DMH 웹사이트 www.dmh.lacounty.gov 를 방문, 또는 mhsapei@dmh.lacounty.gov 로 이메일을 보내주십시오.

Q. PEI 계획에 대해 제안 을 제공할 수 있는 다른 기회에는 어떤것이 있나?
개인들은 2008 년 초에 있을 **주 정보인 인터뷰와 포커스 그룹** 에 참여할 초청을 받을 수 있습니다. 참여인들이 그들의 서비스 지역에 대한 특정한 PEI 정책을 선택할 수 있는 커뮤니티 포럼은 2008 년 봄에 열립니다.

Q. 참여하기 위해 필요한 정보는 어떻게 받나?
다가 오는 커뮤니티 행사 및 PEI 프로그램 계획에 참여할 수 있는 정보를 받으시려면, 이메일 **mhsapei@dmh.lacounty.gov** 또는 **(213) 738-2331** 로 전화하십시오.

Q. 이 책자에 사용된 용어를 이해할수 없거나 PEI 에 대해 더 알고 싶으면 어떻게 하나?
PEI , 자료 문서 및 용어는 주 DMH 웹사이트에 있습니다: http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

로스엔젤레스 카운티
감독 위원회

Gloria Molina
제 1 구역

Yvonne B. Burke
제 2 구역

Zev Yaroslavsky
제 3 구역

Don Knabe
제 4 구역

Michael D. Antonovich
제 5 구역

William T Fujioka
대표 이사

County of Los Angeles
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550 S. Vermont Avenue, Ste. 605
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Fax: (213) 351-2026
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웹사이트: www.dmh.lacounty.gov

로스엔젤레스 카운티
정신 건강국

정신 건강 서비스 법 (MHSA)

Prevention & Early Intervention

예방 및 조기 중재 (PEI) 플랜

이사 Marvin J. Southard, D.S.W.

Вы хотите принять участие в будущих собраниях по вопросам плана PEI?

Если вы хотите, чтобы с вами связались по поводу участия в будущих мероприятиях по разработке плана PEI округа Лос-Анджелес, заполните, пожалуйста, форму с другой стороны, оторвите и отправьте ее по почте по указанному ниже адресу:

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Administration
550 S. Vermont Avenue
Los Angeles, CA 90020

*Вы также можете отправить информацию по электронной почте mhsapei@dmh.lacounty.gov

Участие населения в разработке плана PEI

Вопрос: Кто должен принимать участие в разработке плана PEI?
Любой человек, заинтересованный в психиатрических услугах. Люди, которых волнует, как будут предоставляться услуги по профилактике психических расстройств и раннему вмешательству в округе Лос-Анджелес.

Вопрос: Как я могу участвовать в разработке плана PEI в районах обслуживания?
Примите участие в работе местного **консультативного комитета** по охране психического здоровья **в районе обслуживания (Service Area Advisory Committee, SAAC)**. Свяжитесь с руководителем района обслуживания Департамента охраны психического здоровья (Department of Mental Health, DMH), чтобы узнать расписание собраний, посетите веб-сайт департамента DMH **www.dmh.lacounty.gov** или обратитесь по электронной почте по адресу **mhsapei@dmh.lacounty.gov.**

Вопрос: Каким еще образом я могу сделать вклад в разработку плана PEI?
Вы можете принять участие в **опросах основных информантов**, а также в **тематических групповых опросах**, которые будут проводиться в начале 2008 г.. **Общественные собрания**, на которых участникам предстоит выбрать конкретные стратегии в рамках плана PEI для своих районов обслуживания, будут проводиться, начиная с весны 2008 г.

Вопрос: Как я могу получить информацию об участии?
Напишите по адресу электронной почты **mhsapei@dmh.lacounty.gov** или позвоните по телефону **(213) 738-2331,** чтобы получить информацию о предстоящих общественных мероприятиях и участии в планировании программ PEI.

Вопрос: Что делать, если я не понимаю некоторые термины, используемые в данном буклете, или хочу узнать больше о плане PEI?
Руководство PEI, справочные документы и терминологический словарь можно найти на веб-сайте департамента DMH штата: **http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp**

Наблюдательный совет ОКРУГА Лос-Анджелес

Gloria Molina
Первый район

Yvonne B. Burke
Второй район

Zev Yaroslavsky
Третий район

Don Knabe
Четвертый район

Michael D. Antonovich
Пятый район

William T Fujioka
Председатель совета

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Веб-сайт : www.dmh.lacounty.gov

ДЕПАРТАМЕНТ ПСИХИЧЕСКОГО ЗДОРОВЬЯ ОКРУГА ЛОС-АНДЖЕЛЕС

ЗАКОН О ПСИХИАТРИЧЕСКОЙ ПОМОЩИ (MENTAL HEALTH SERVICES ACT (MHSA)

Prevention and Early Intervention (PEI) Plan

План профилактики и раннего вмешательства (PEI)

Директор Marvin J. Southard, доктор наук в области социальной работы

Департамент психического здоровья округа Лос-Анджелес (Los Angeles County Department of Mental Health, DMH) применяет интенсивный, комплексный и многогранный подход к развитию в округе плана профилактики и раннего вмешательства (Prevention and Early Intervention, PEI), одного из пяти планов, легализованных Законом о психиатрической помощи (Mental Health Services Act, MHSA), который был принят избирателями штата Калифорния в 2004 г..

Профилактика в психиатрии означает сокращение факторов риска и факторов, вызывающих стресс, создание защитных факторов и навыков, а также усиление поддержки. Профилактика способствует позитивному когнитивному, социальному и эмоциональному развитию и поощряет здоровый образ жизни, который позволяет человеку выстоять перед лицом изменяющихся, а иногда бросающих вызов обстоятельств.

Раннее вмешательство предназначено для лиц и семей, для которых достаточно вмешательства короткой продолжительности (обычно менее одного года) и относительно низкой интенсивности, чтобы значительно улучшить психическое здоровье или устранить расстройство на ранней стадии проявления, то есть избежать необходимости в более экстенсивном психиатрическом лечении или услугах; либо предотвратить обострение психического расстройства.

Метод районного обслуживания.
Развитие плана PEI округа Лос-Анджелес сосредоточено на уровне районов обслуживания — использование информационных собраний, опросов основных информантов, тематических групповых опросов и общественных собраний. Чтобы рационализировать процесс планирования, будут составлены характеристики районов обслуживания, отражающие социально-экономические демографические данные, статистику психического здоровья, а также информацию, касающуюся здоровья, образования, социальных услуг и общественной безопасности.

Департамент психического здоровья штата (State Department of Mental Health, SDMH) ориентируется на 5 социальных проблем, связанных с психическим здоровьем, 6 приоритетных групп населения и 6 проектов в масштабе штата для осуществления программы PEI:

Основные социальные проблемы, связанные с психическим здоровьем

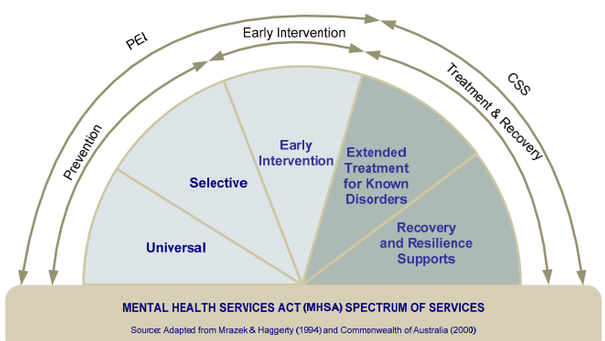
- Неравенство в доступе к психиатрическим услугам
- Психо-социальное влияние травмы
- Дети, подростки и молодежь, находящиеся в группе риска
- Предрассудки и дискриминация
- Риск суицида

Приоритетные группы населения

- Культурные слои населения, получающие недостаточное обслуживание
- Лица с пограничным психическим состоянием (At-Risk Mental State, ARMS) или проявившимися симптомами серьезного психического заболевания
- Дети и молодежь в неблагополучных семьях
- Лица, подверженные травмам
- Дети и молодежь, не успевающие в школе
- Дети и молодежь, которые могут быть поставлены на учет или состоят на учете в органах по делам несовершеннолетних

Проекты штата

- Профилактика суицида
- Борьба с предрассудками и дискриминацией
- Программы и услуги вмешательства для отдельных этнических и культурных групп населения
- Обучение, техническая поддержка и развитие способностей
- Охрана психического здоровья учащихся
- Оценка в масштабе штата



Сферы взаимодействия. Департамент SDMH определил 7 сфер, в которых округа должны сотрудничать для развития плана PEI. Взаимодействие и взаимопомощь районов необходимы в следующих сферах:

- политика в отношении групп населения, получающих недостаточное обслуживание
- образование
- политика в отношении лиц с серьезным психическим заболеванием и/или их семей
- политика в отношении поставщиков психиатрических услуг
- здоровье
- социальные услуги
- правоприменение

Департамент SDMH также рекомендует дополнительные сферы, включая организацию общественных семейных центров помощи, занятость и средства массовой информации.

Финансирование. Следующая таблица показывает установленные суммы финансирования для округа Лос-Анджелес на 2007-2009 г.г..

ФИНАНСОВЫЙ ГОД	УСТАНОВЛЕННЫЕ ДЕПАРТАМЕНТОМ DMH ОКРУГА ЛОС-АНДЖЕЛЕС СУММЫ ФИНАНСИРОВАНИЯ ПЛАНА PEI
2007-2008	$34,001,800 * **включает $7,074,500 в фондах планирования*
2008-2009	$57,161,000
ОБЩАЯ СУММА:	**$91,162,800**

Как минимум 51 % общего бюджета плана PEI округа должен предназначаться детям (в возрасте от рождения до 15 лет) и молодежи переходного возраста (transition-age youth, TAY) (16–25 лет).

Пожалуйста, отправьте мне информацию о будущих собраниях по вопросам плана PEI.
Я хочу принять участие в тематическом групповом опросе для разработки плана PEI.

Имя, фамилия: _____
Организация: _____
Должность/звание: _____
Дом. улица: _____
Город, штат, почтовый индекс: _____
Адрес электронной почты: _____
Телефон: _____

Пожалуйста, поставьте галочку напротив категории или сферы, которые наиболее применимы к вам:

Потребитель психиатрических услуг
Родственник/родитель потребителя психиатрических услуг
Поставщик психиатрических услуг
Религиозная организация
Другое _____
Здравоохранение
Социальные услуги
Занятость
Член сообщества
Образование
Правоохранительный орган
Средства массовой информации
Другая правительственная организация

是否有兴趣参加未来 PEI 会议？

如果您希望参加洛杉矶县防预与早期干预计划的未来规划活动，请填写完成背面的表格，之后撕下表格并邮寄至以下地址：

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Administration
550 S. Vermont Avenue
Los Angeles, CA 90020

*您还可以将信息通过电子邮件发送给 mhsapei@dmh.lacounty.gov

PEI 计划的社区参加

问. 哪些人应该参加制定 PEI 计划？

任何对心理健康服务感兴趣的人士。那些关心心理健康防预与早期干预服务如何在洛杉矶县实施的人士。

问. 我将如何参加服务领域的 PEI 计划？

请参加您当地心理健康**服务领域咨询委员会（SAAC）**。请联系负责会议日程安排的 DMH 服务领域行政区主任，登录 DMH 网站 **www.dmh.lacounty.gov** 或发送电子邮件至 **mhsapei@dmh.lacounty.gov**

问. 还有什么机会可以向 PEI 计划提出意见？

可能会邀请个人参加将于 2008 年初开展的**关键信息访谈**与**工作小组**。**社区论坛**将于 2008 年春季全面开始，论坛上将要求参加者为其服务领域选择特定的 PEI 策略。

问. 我将如何获得有关参与的信息？

要获得即将举行的社区活动与参加 PEI 项目计划的有关详情，请发送电子邮件至 **mhsapei@dmh.lacounty.gov** 或请致电 **(213) 738-2331**。

问. 如果不理解本手册中的部分条款或希望了解更多有关 PEI 的信息，我该如何？

要查看 PEI 准则、资源文件和词汇表，可登录州 DMH 网站：**http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp**

洛杉矶县
监督委员会

Gloria Molina
第 1 行政区

Yvonne B. Burke
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Zev Yaroslavsky
第 3 行政区

Don Knabe
第 4 行政区

Michael D. Antonovich
第 5 行政区

William T Fujioka
首席执行管

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Department of Mental Health
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网站： www.dmh.lacounty.gov

洛杉矶县
心理健康部门

心理健康
服务法 (MHSA)

Prevention & Early Intervention

Prevention and Early Intervention (PEI) Plan

预防与早期干预（PEI）计划

Marvin J. Southard, D.S.W. 主任

洛杉矶县心理健康部门（DMH）正紧锣密鼓地采取高度加强、内容丰富且涵盖各面的方法来制定县预防与早期干预（PEI）计划，这是 2004 年由加州选民颁布的心理健康服务法（MHSA）授权了 5 个计划中的一个。

心理健康**预防**涉及减少风险因素或紧张性刺激，建立保护性因素和技能，并增加支持。预防促进正面的认识、社会与情感发展，并鼓励一种健康良好的状态，它可让个人在面对不断变化和偶尔的困境时能够应对自如。

早期预防是针对个人和家庭所采取的短期（通常少于 1 年），相对强度较低的干预，用于大幅改善心理健康问题或在问题出现的早期及时引起关注与重视，从而避免了更大的心理健康治疗或服务；或防止心理健康问题日趋严重。

服务领域方法 制定洛杉矶县 PEI 计划的重心在于充分利用说明性会议、关键信息访谈、工作小组和社区论坛来达到服务领域水平。服务领域概况档案可找出社会经济人口统计数据和心理健康统计，以及与卫生、教育、社会服务和公共安全的相关数据，该档案将用于协助规划流程。

针对 5 个社区的心理健康需要、6 类重点人群和 6 项全州的工作，州心理健康部门（SDMH）制定了预防与早期干预计划：

关键社区心理健康需求

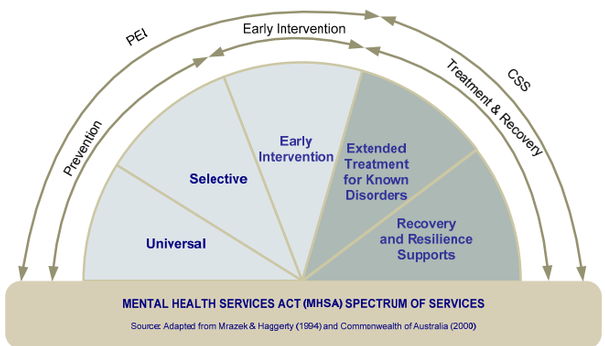
- 接受心理健康服务的不同人群
- 受心理社会创伤影响的人群
- 处于危险中的儿童、青少年与年轻成年人群
- 遭受耻辱和歧视的人群
- 有自杀风险的人群

重点人群

- 缺乏服务的文化群体
- 经历过危险心理状态（ARMS）或严重精神疾病发作的个人
- 遭受家庭压力的儿童/青年
- 心灵受到过创伤的人群
- 学校表现不佳的儿童/青少年
- 有可能或已进少管所接受调教的儿童/青少年

州监管的项目

- 预防自杀
- 减少遭受耻辱和歧视
- 种族和文化上的特定计划和干预
- 培训、技术协助和能力培养
- 学生心理健康倡议
- 遍及全州的评估



部门间的合作关系 SDMH 已确定将与各县合作制定 PEI 计划的 7 个部门。社区合作和资源利用需要以下各项：

- 缺乏服务的社区
- 教育
- 患严重心理疾病的个人和/或其家属
- 心理健康服务的提供商
- 卫生
- 社会服务
- 执法

SDMH
还推荐了其他部门，包括社区家庭资源中心、就业中心和媒体。

资金 下图列出洛杉矶县 2007 至 2009 年预计的资金数额。

财年	洛杉矶县 DMH PEI 的预计资金
2007-2008	$34,001,800 * **包括 7,074,500 百万美元的计划资金*
2008-2009	$57,161,000
总计：	**$91,162,800**

洛杉矶县 PEI 计划总预算中，至少有 51% 的预算资金必须用于儿童（0 至 15 周岁）和过渡期适龄青年（TAY 16 至 25 周岁）人群。

____ 请将有关未来 PEI 会议的信息发送给我。 ____ 我将愿意参加 PEI 计划的工作小组。

姓名：_____

公司：_____

职位/头衔：_____

地址：_____

市、州、邮编：_____

电话：_____

电子邮件：_____

请选择最适合您的类别或部门：

____ 心理健康消费者
____ 心理健康消费者的家庭成员/父母
____ 心理健康提供商
____ 基于信仰的机构
____ 其他 _____
____ 卫生
____ 社会服务
____ 就业中心
____ 社区成员
____ 教育
____ 执法
____ 媒体
____ 其他政府机构

¿Le interesa participar en próximas juntas de PEI?

Si le gustaría que se comunicaran con usted o desea participar en actividades futuras del Plan de Prevención e Intervención Temprana, favor de llenar el reverso de esta forma, desprender y enviar a la siguiente dirección:

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Administration
550 S. Vermont Avenue, 6th Floor, Room 605
Los Angeles, CA 90020

* También puede enviar la información a mhsapei@dmh.lacounty.gov

Participación de la Comunidad en la Planificación de PEI

Q. ¿Quién debería involucrarse en el desarrollo del plan PEI?
Cualquier persona con interés en los servicios de salud mental. Personas a quienes les interese saber la forma en que se procurarán los servicios de prevención e intervención temprana en el Condado de Los Ángeles.

Q. ¿Cómo puedo participar en la planeación de PEI en las Áreas de Servicio?
Participe en su **Comité Consultivo de Área de Servicio** en salud mental local **(SAACs).** Comuníquese con el Jefe de Área Distrital del Departamento de Salud Mental para horarios de juntas, y visite el sitio de Internet de DMH www.dmh.lacounty.gov o envíe un e-mail a mhsapei@dmh.lacounty.gov

Q. ¿Qué otras oportunidades existen de aportar al Plan PEI?
Podría invitarse al público a **las entrevistas clave de informantes** y de **los grupos de enfoque** que se llevarán a cabo a principios de 2008. **Los foros comunitarios,** en los cuales se solicitará a los participantes seleccionar estrategias específicas PEI para sus Áreas de Servicio, darán comienzo en la primavera de 2008.

Q. ¿Cómo consigo información sobre cómo involucrarme?
Envíe un e-mail a mhsapei@dmh.lacounty.gov o llame al **(213) 738-2331** para recibir información sobre próximos eventos de la comunidad y participación en la planeación de los programas PEI.

Q. ¿Qué sucede si no entiendo algunos de los términos utilizados en este folleto, o si quiero saber más de PEI?
Usted puede encontrar los lineamientos de PEI, material de lectura y un glosario en el sitio de Internet de DMH del Estado.
http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

CONDADO DE LOS ANGELES
CONSEJO DE SUPERVISORES

Gloria Molina
Primer Distrito

Yvonne B. Burke
Segundo Distrito

Zev Yaroslavsky
Tercer Distrito

Don Knabe
Cuarto Distrito

Michael D. Antonovich
Quinto Distrito

William T Fujioka
Director Ejecutivo

Departamento de Salud Mental del
Condado de Los Angeles
Oficina de Programas de Apoyo
Ley de Servicios Mentales (MHSA)
Administración de
Prevención e Intervención Temprana (PEI)

550 S. Vermont Avenue
Los Angeles, CA 90020
Teléfono: (213) 738-2331
Fax: (213) 351-2026
E-mail: mhsapei@dmh.lacounty.gov
Sitio de Internet: www.dmh.lacounty.gov

DEPARTAMENTO DE SALUD MENTAL DEL CONDADO DE LOS ANGELES

LEY DE SERVICIOS DE SALUD MENTAL (MHSA)

Plan de Prevención e Intervención Temprana

Prevención e Intervención Temprana

Director Marvin J. Southard, D.S.W.

Prevención e Intervención Temprana

El Departamento de Salud Mental del Condado de Los Ángeles (DMH) está tomando un enfoque muy intenso, incluyente y multifacético para desarrollar el Plan de Prevención e Intervención Temprana (PEI) del Condado, uno de cinco planes autorizados por la Ley de Servicios de Salud Mental (MHSA) promulgado por los votantes de California en 2004.

La Prevención en la salud mental incluye el reducir los factores de riesgo o de estrés, implementar factores y aptitudes de protección, y aumentar los apoyos. La prevención promueve el desarrollo cognitivo positivo, social y emocional y fomenta un estado de bienestar que le permite al individuo funcionar bien frente a circunstancias cambiantes y a veces desafiantes.

La Intervención Temprana está dirigida a individuos y familias para quienes una intervención corta (normalmente, menos de un año) y de relativa baja intensidad, es adecuada para mejorar significativamente un problema o un asunto preocupante de salud mental en sus primeras etapas, evitando de esta manera la necesidad de un tratamiento o servicios de salud mental más extensos; o prevenir que un problema de salud mental empeore.

Enfoque de las Áreas de Servicio. El enfoque para desarrollar el Plan PEI del Condado de Los Ángeles se encuentra a nivel de Área de Servicio—a través de juntas informativas, entrevistas con informantes clave, grupos de enfoque y foros comunitarios. Los intereses de las Áreas de Servicio son la identificación de información demográfica socioeconómica y estadísticas de salud mental, así como el desarrollo de información relacionada a la salud, educación, servicios sociales y seguridad pública para ayudar en el proceso de planificación.

El Departamento de Salud Mental del Estado (SDMH) ha enfocado su atención en las necesidades de 5 comunidades de salud mental, 6 poblaciones prioritarias, y 6 esfuerzos estatales para el programa de Prevención e Intervención Temprana:

Necesidades de Salud Mental de Comunidades Clave

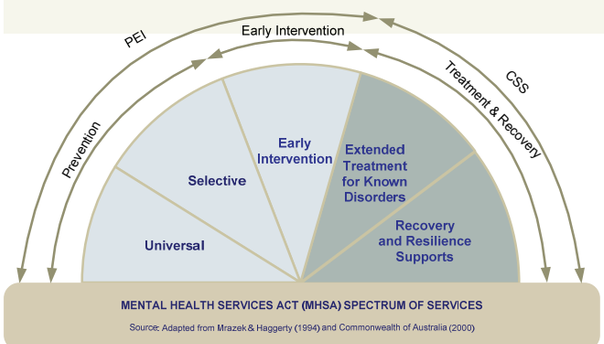
- Disparidades en el Acceso a los Servicios de Salud Mental
- Impacto Psico-Social de Traumas
- Poblaciones de Niños, Jóvenes y Adultos Jóvenes en Riesgo
- Estigma y Discriminación
- Riesgo de Suicidio

Poblaciones Prioritarias

- Poblaciones Culturalmente Subatendidas
- Individuos Presentando Síntomas de Salud Mental en Peligro o Inicio de una Enfermedad Mental Grave
- Niños/Adultos de Familias con Altos Factores de Estrés
- Individuos expuestos a traumas
- Niños/Jóvenes en Riesgo por Fracaso Escolar
- Niños/Jóvenes en Riesgo por su Ingreso o Estancia en el Sistema Juvenil de Justicia

Proyectos Administrados por el Estado

- Prevención de Suicidio
- Disminución del Estigma y la Discriminación
- Programas e Intervenciones Étnicas
- Capacitación, Asistencia Técnica y Fortalecimiento de la Capacidad
- Iniciativa estudiantil para la Salud Mental
- Evaluación Estatal



Asociaciones por Sectores. SDMH ha identificado 7 sectores con los cuales los condados deben asociarse para desarrollar el Plan PEI. Se requieren asociaciones de comunidades y aprovechamiento de los recursos con:

- Comunidades Mal Atendidas
- Educación
- Individuos con una Enfermedad Mental Grave y/o Sus Familias
- Proveedores de Servicios de Salud Mental
- Salud
- Servicios Sociales
- Aplicación de la Ley

El SDMH también recomendó sectores adicionales, incluyendo centros de recursos de familias en comunidad, empleos y prensa.

Financiamiento. La siguiente gráfica muestra las cifras de financiamiento estimadas para el Condado de Los Angeles de 2007-2009.

AÑO FISCAL	DMH DEL CONDADO DE LA FINANCIEMIENTO ESTIMADO DE PEI
2007-2008	$34,001,800 * **incluye $7,074,500 millones en fondos para planeación*
2008-2009	$57,161,000
TOTAL:	**$91,162,800**

Un mínimo de 51% del total del presupuesto para el Plan PEI del Condado debe asignarse a las poblaciones de niños (en edades de 0-15) y a los jóvenes en edad transitoria (TAY - en edades de 16-25).

____ Favor de enviarme información de próximas juntas de PEI ____ Me gustaría participar en un grupo de enfoque para la planeación de PEI

Nombre:_____
Organización:_____
Posición/Título:_____
Dirección:_____
Ciudad, Estado, Código Postal:_____
Correo electrónico:_____
Teléfono:_____

Verifique la categoría o sector que más se asemeja a su interés:

____ Consumidor de los servicios de Salud Mental
____ Miembro de la Familia/Padre Consumidor de los servicios de Salud Mental
____ Proveedor de Servicios de Salud Mental
____ Organización practicante de una fe
____ Otro_____
____ Salud
____ Servicios Sociales
____ Empleo
____ Miembro de una Comunidad
____ Educación
____ Cumplimiento de la Ley
____ Medios de Comunicacion
____ Otras Agencias
____ Gubernamentales

Interesado ba Kayong Lumahok sa mga darating na mga Pulong ng PEI?

Kung nais ninyong matawagan upang lumahok sa mga darating na gawaing pagpaplano ng Plano sa Pag-iwas at Maagang Pamamagitan (Prevention and Early Intervention Plan) ng County ng Los Angeles, paki sagot ang pormang nasa likod, pilasin ang porma, at ipadala sa address sa ibaba:

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Administration
550 S. Vermont Avenue
Los Angeles, CA 90020

*Maaari nyo ring i-e-mail ang impormasyon sa mhsapei@dmh.lacounty.gov

Pakikilahok ng Komunidad sa Pagpaplano ng PEI

Q. Sino ang kailangang makilahok sa pagpaplano ng PEI?
Ang sinumang interesado sa mga serbisyong pangkalusugan ng isip. Ang mga taong may pag-aalala tungkol sa kung papaanong makararating sa County ng Los Angeles ang mga serbisyo ng pag-iwas at maagang pamamagitan para sa kalusugang pang-isip.

Q. Paaano akong makikilahok sa pagpaplanong PEI sa mga lugar ng serbisyo?
Lumahok sa inyong lokal na pangkalusugang mga **Komite ng Serbisyo ng Pagpapayo sa Purok (Service Area Advisory Committees [SAACs])**. Makipag-alam sa Hepe ng Distrito ng Serbisyo ng DMH (Service Area District Chief) para sa mga nakatakdang mga pagpupulong, tingnan ang website ng DMH sa www.dmh.lacounty.gov o mag-e-mail sa **mhsapei@dmh.lacounty.gov**

Q. Anu-ano pang mga oportunidad ang makapagbibigay ng nasasa-isip tungkol sa Plano ng PEI?
Maaaring anyayahang lumahok ang mga tao sa **pakikipagpanayam sa pinunong tagabigay-impormasyon** at **mga grupo ng tampulan**, na maigaganap sa maagang bahagi ng 2008. Ang mga **Pagpupulong na pangkomunidad**, kung saan hihilingan ang mga kalahok na pumili ng mga natatanging pamamaraan ng PEI, ay magaganap simula sa tagsibol ng taong 2008.

Q. Paano ako makakakuha ng impormasyon tungkol sa pakikilahok?
Mag-email sa **mhsapei@dmh.lacounty.gov** o tumawag sa **(213) 738-2331** upang makatanggap ng impormasyon tungkol sa darating na mga pangyayari sa komunidad at pakikilahok sa mga programang pagpaplano ng PEI.

Q. Paano kung hindi ko maintindihan ang ilan sa mga terminolohiya na ginamit sa libretang ito o nais na mas makaalam pa tungkol sa PEI?
Ang mga gabay para sa PEI, mga mapagkukuhanang dokumento, at isang glosaryo ay mahahanap sa website ng DMH ng Estado sa: http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

COUNTY ng LOS ANGELES
LUPON NG MGA TAGAPAMAHALA

Gloria Molina
Unang Distrito

Yvonne B. Burke
Pangalawang Distrito

Zev Yaroslavsky
Pangatlong Distrito

Don Knabe
Pang-apat na Distrito

Michael D. Antonovich
Panglimang Distrito

William T Fujioka
Pangunahing Pinunong Tagapagpaganap

County of Los Angeles
Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI)
Administration
550 S. Vermont Avenue, Ste. 605
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Fax: (213) 351-2026
E-mail: mhsapei@dmh.lacounty.gov
Website: www.dmh.lacounty.gov

COUNTY NG LOS ANGELES
KAGAWARAN NG KALUSUGANG PANG-ISIP

KILUSANG MGA SERBISYO PARA SA KALUSUGANG PANG-UTAK(MHSA)

Prevention & Early Intervention

Prevention and Early Intervention (PEI) Plan

(Pag-iwas at Maagang Pamamagitan)

Direktor Marvin J. Southard, D.S.W.

Prevention & Early Intervention

Ang Kagawaran ng Kalusugang Pang-isip (Department of Mental Health [DMH]) ng County ng Los Angeles ay nagsasagawa ng masusing, ipinagsama-samang, maraming anyong hakbang sa pagpapalago ng Plano para sa Pag-iwas at Maagang Pamamagitan (PEI) ng County, isa sa limang planong inawtorisa ng Mental Health Services Act (MHSA) na pinatupad ng mga botante ng California noong taong 2004.

Ang Pag-iwas sa kalusugang pang-isip ay ibinibilang ang pagbawas ng mga sanhi ng peligro o dahilanan ng alinsangan, pagtataguyod ng mga sanhi at kaalamang tumatanggol, at pagdami ng suporta. Ang pag-iwas ay nagdudulot ng positibong pag-unlad na pag-uugnay, sosyal at pangdamdamin at humihikayat ng kalagayang malusog na nagpapahintulot sa taong kumilos ng mabuti sa harap ng mga pangyayaring pabagu-bago at minsa'y nakasusubok.

Ang Maagang Pamamagitan ay tinutukoy para sa mga tao at pamilya para kung kanino naaangkop ang maiksi (kadalasang maikli sa isang taon) at di-matinding pamamagitan upang mapabuti ang problema o suliranin ng kalusugan ng isip ng maaga sa kanyang pagpapakita, samakatuwid naiiwasan ang pangangailangan ng mas matinding mga paggamot o serbisyo ng kalusugan ng pag-iisip; o ang pag-iwas na lumala ang problemang pangkalusugang pag-iisip.

Pamamaraang Lugar ng Serbisyo. Ang pokus ng pagtataguyod ng Plano ng PEI ng County ng L.A. ay nasa palapag ng Lugar ng Serbisyo—ang paggamit ng mga pagpupulong na nagpapa-alam, pakikipagpanayam sa mga punong tagabigay-alam, mga grupong tumatalakay, at mga porum ng komunidad. Binibigyang-anyo ng mga Lugar ng Serbisyo ang nagsasalarawang datos na pang-sosyo-ekonomiya at demograpiya at mga estadistika ng kalusugang pang-isip, pati na rin ang mga datos na kaugnay sa kalusugan, edukasyon, mga serbisyong panlipunan, at kaligtasang pampubliko ay itataguyod upang tumulong sa hakbang ng pagpaplano

Ang Kagawarang ng Kalusugang Pang-isip ng Estado (The State Department of Mental Health [SDMH]) ay tinugon ang 5 pangangailangang pangkalusugang pang-isip, 6 na pinunong populasyon, at 6 na pang-buong-estadong kilos para sa programa ng Pag-iwas at Maagang Pamamagitan:

Pinunong Pangangailangan ng Kalusugang Pang-isip ng Komunidad

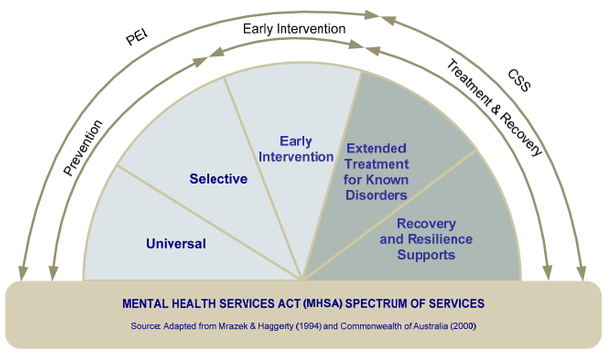
- Pagkakaiba sa Tanggapan sa mga Serbisyo ng Kalusugang Pang-isip
- Dulot ng Tromang Sayko-sosyal
- Mga populasyong bata, kabataan at nakababatang nasa-gulang na nasa-peligro
- Dungis sa Karangalan at Deskriminasyon
- Peligro ng Pagpapakamatay

Pinunong mga Populasyon

- Mga Populasyong ng mga Kulturang Di-naaasikaso ng Mabuti
- Mga Taong Nakararanas ng Kalagayan ng Pag-iisip na Nasa-Peligro (At-Risk Mental State [ARMS]) o Panimulain ng Malubhang Sakit sa Utak
- Mga Bata/Kabataang nasa Maalinsangang mga Pamilya
- Nakalantad sa Troma
- Mga Bata/Kabataang Nasa-Peligro ng Pagbagsak sa Paaralan
- Mga Bata/Kabataang Nasa-Peligro ng Pagpasok sa Systema ng Hustisyang Pangkabataan

Mga Proyektong Pinatatakbo ng Estado

- Pag-iwas sa Pagpapakamatay
- Pagbawas ng Dungis sa Karangalan at Deskriminasyon
- Mga Programa at Pamamagitang Natatangi para sa Lahi at Kultura
- Pagtaguyod ng mga Pagtatasa, Pagtulong na Teknikal at Kakayahan
- Pangunguna para sa Estudyante ng Kalusugang Pang-isip
- Pagtatasang Pangbuong-estado



Mga Pagsosyong Sektoral. Ang SDMH ay nagbanggit ng 7 mga sektor na kailangan ng mga county na makasosyo upang makapagtaguyod ng kanilang Planong PEI. Ang mga pagsosyong pangkomunidad at paggamit ng mga gamit-yaman ay kinakailangan sa:

- Mga Komunidad na Di-naaasikaso ng Mabuti
- Edukasyon
- Mga Taong may Malubhang Sakit sa Pag-isip/o Kanilang mga Pamilya
- Tagabigay ng mga Serbisyo ng Kalusugang Pang-isip
- Kalusugan
- Serbisyong Panlipunan
- Pagpapatupad ng Batas

Ang SDMH ay nagrekomenda rin ng karagdagang mga sektor, kasama na ang mga sentro ng gamit-yaman ng pamilya ng komunidad, pantrabaho, at pangmedya.

Pagpondo. Ang sumusunod na talaan ay naglilista ng mga iniestimang halaga ng pondo para sa County ng Los Angeles mula 2007-2009.

TAONG PISKAL	INESTIMANG PAGPONDO NG DMH PEI NG COUNTY NG LA
2007-2008	$34,001,800 * **kasama na ang $7,074,500 milyon sa pondo para sa pagpaplano*
2008-2009	$57,161,000
TOTAL:	**$91,162,800**

May minimo na 51% ng kabuuan ng badyet ng Plano ng PEI ng County ang kinakailangang ibukod para sa mga populasyon ng bata (edad 0-15) at kabataan na nasa gulang ng pagbabago (TAY ages 16-25).

Paki padalhan ako ng impormasyon sa mga darating na pagpupulong ng PEI. .
____ ____ Nais kong lumahok sa mga grupong tumatalakay ng pagpaplano ng PEI.

Pangalan :_____

Organisasyon :_____

Posisyon/Titulo :_____

Adres:_____

Siudad, Estado, Zip Code :_____

Email:_____

Numero ng Telepono :_____

Paki-tatakan ang kategorya o sektor na pinaka-naaangkop sa inyo :

____ Tagapagtangkilik ng Kalusugang Pang-isip
____ Kapamilya/Magulang ng Tagapagtangkilik ng Kalusugang Pang-isip
____ Tagabigay ng Serbisyo ng Kalusugang Pang-isip
____ Organisasyong Base sa Pananampalataya
____ Iba pa _____
____ Kalusugan
____ Serbisyong Panlipunan
____ Pantrabaho
____ Miyembro ng Komunidad
____ Edukasyon
____ Pagpapatupad ng Batas
____ Medya
____ Iba pang Ahensya ng Gobyerno

Sở Đặc Trách Sức Khỏe Tâm Thần của Quận Los Angeles (DMH) đang thực hiện một công tác cao cấp, toàn bộ, và đa dạng trong việc phát triển Kế Hoạch Phòng Ngừa và Điều Trị Sớm (PEI) của Quận, một trong năm kế hoạch được ủy quyền bởi Đạo Luật về Dịch Vụ Sức Khỏe Tâm Thần (MHSA) được cử tri của California chấp hành vào năm 2004.

Việc Phòng Ngừa trong lãnh vực sức khỏe tâm thần bao gồm việc giảm thiểu nguy cơ mắc bệnh hoặc nguyên nhân đưa đến căng thẳng thần kinh, tạo nên yếu tố và khả năng bảo vệ cùng với sự tăng gia hậu thuẫn. Việc phòng ngừa khuyến khích sự nhận thức và phát triển về giao tiếp cũng như cảm xúc một cách lạc quan và khuyến khích một tình trạng khỏe mạnh về tâm thần khiến một người có thể đương đầu với những hoàn cảnh đổi thay và thách thức trong cuộc sống.

Sự Điều Trị Sớm nhắm vào những cá nhân và gia đình họ trong một thời gian ngắn (thường dưới một năm) với sự can thiệp ít để có thể giúp vấn đề sức khỏe tâm thần hoặc sự quan tâm trở nên khả quan hơn khi nó xảy đến, nhờ đó tránh việc cần phải điều trị nhiều hoặc dùng những dịch vụ rộng lớn hơn; hoặc ngăn ngừa không cho vấn đề sức khỏe tâm thần trở nên nặng hơn.

Đường Lối Dịch Vụ Theo Khu Vực. Trọng tâm của việc phát triển Kế Hoạch PEI Quận L.A. là ở từng khu vực—dùng những buổi họp thông tin, phỏng vấn người cung cấp tin tức, những nhóm tập trung, và diễn đàn cộng đồng. Dịch Vụ Theo Khu Vực đưa ra những dữ kiện nhân khẩu học được nhận dạng về xã hội-kinh tế và thống kê về sức khỏe tâm thần cũng như dữ kiện liên hệ đến sức khỏe, học vấn, dịch vụ xã hội, an ninh trong cộng đồng sẽ được phát triển để hậu thuẫn cho tiến trình hoạch định.

Bộ Đặc Trách Sức Khỏe Tâm Thần Tiểu Bang (SDMH) đã đặt mục tiêu vào 5 nhu cầu sức khỏe tâm thần trong cộng đồng, 6 nhóm dân ưu tiên, và 6 nỗ lực toàn bang cho chương trình Phòng Ngừa và Điều Trị Sớm:

Nhu Cầu Sức Khỏe Tâm Thần Chính trong Cộng Đồng

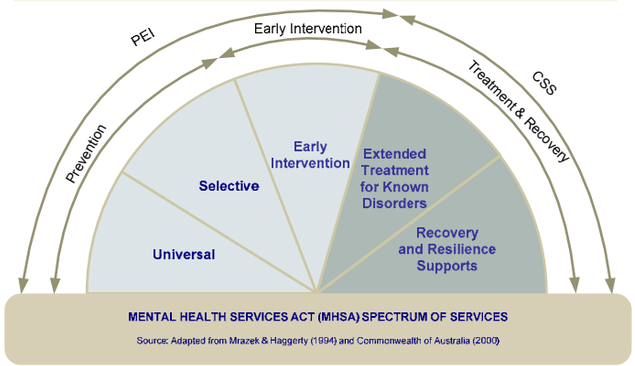
- Chênh Lệch về Sự Tiếp Nhận Dịch Vụ Sức Khỏe Tâm Thần
- Ảnh Hưởng Tâm Lý-Xã Hội của Sự Khủng Hoảng Tinh Thần
- Nhóm Trẻ Em và Thanh Thiếu Niên Có Nguy Cơ
- Bêu Xấu và Kỳ Thị
- Nguy Cơ Tự Tử

Các Nhóm Dân Ưu Tiên

- Các Nhóm Văn Hóa Thiếu Chăm Sóc
- Cá Nhân Có Nguy Cơ Tình Trạng Tâm Thần (ARMS) hoặc Bắt Đầu Bệnh Tâm Thần Nặng
- Trẻ Em/Thiếu Niên Trong Gia Đình Có Căng Thẳng Tinh Thần
- Đương Đầu với Khủng Hoảng Tinh Thần
- Trẻ Em/Thiếu Niên Có Nguy Cơ Thất Bại về Học Vấn
- Trẻ Em/Thiếu Niên Có Nguy Cơ Sẽ Vào Hoặc Đang Ở Trong Trại Giam Cho Trẻ Dưới Vị Thành Niên

Dự Án Thực Hiện Toàn Tiểu Bang

- Ngăn Ngừa Tự Tử
- Giảm Thiểu Sự Bêu Xấu và Kỳ Thị
- Các Chương Trình Đặc Biệt về Chủng Tộc và Văn Hóa và Chương Trình Can Thiệp
- Huấn Luyện, Trợ Giúp Kỹ Thuật, và Xây Dựng Khả Năng Nhận Thức
- Giải Tỏa Khó Khăn về Sức Khỏe Tâm Thần của Học Sinh
- Lượng Định Toàn Tiểu Bang



Khu Hợp Tác. SDMH đã nhận diện 7 khu mà các quận phải hợp tác để phát triển Kế Hoạch PEI của họ. Hợp tác cộng đồng và ảnh hưởng sức mạnh tài nguyên chung được đòi hỏi với:

- Các Cộng Đồng Thiếu Được Chăm Sóc
- Giáo Dục
- Cá Nhân Với Bệnh Tâm Thần Nặng và/hoặc Gia Đình Họ
- Các Cơ Quan Cung Cấp Dịch Vụ Sức Khỏe Tâm Thần
- Sức Khỏe
- Các Dịch Vụ Xã Hội
- Pháp Luật

SDMH cũng đề nghị các khu khác, gồm các trung tâm tài nguyên cộng đồng, các sở tìm việc, và hệ thống thông tin đại chúng.

Tài Trợ. Biểu đồ sau đây trình bày các ngân quỹ ước lượng cho Quận Los Angeles từ 2007-2009.

NĂM TÀI CHÍNH	DMH QUẬN LA NGÂN QUỸ ƯỚC TÍNH CỦA PEI
2007-2008	$34,001,800 * **bao gồm $7,074,500 cho ngân quỹ hoạch định*
2008-2009	$57,161,000
TỔNG CỘNG:	**$91,162,800**

Ít nhất 51% của tổng số ngân quỹ Kế Hoạch PEI của Quận phải được dành cho các nhóm trẻ em (0-15 tuổi) và thanh thiếu niên tuổi chuyển tiếp (16-25 tuổi).

_____Xin gởi tôi tin tức về những buổi họp PEI tới. _____Tôi muốn tham dự vào nhóm tập trung về việc hoạch định cho PEI.

Tên: _____

Tổ Chức: _____

Chức Vụ/Tước Hiệu: _____

Địa Chỉ: _____

Thành Phố, Tiểu Bang, Mã Số Bưu Điện: _____

Điện Tho: _____

Điện Thoại: _____

Xin đánh dấu vào phần hoặc khu nào dưới đây đúng nhất cho quý vị:

_____ Người Dùng Dịch Vụ Sức Khỏe Tâm Thần
_____ Gia Đình/Phụ Huynh của Bệnh Nhân
_____ Cơ Quan Cung Cấp Dịch Vụ Sức Khỏe Tâm Thần
_____ Tổ Chức Tôn Giáo
_____ Tổ Chức Khác _____
_____ Sức Khỏe
_____ Dịch Vụ Xã Hội
_____ Cơ Quan Tìm Việc
_____ Thành Viên Cộng Đồng
_____ Giáo Dục
_____ Pháp Luật
_____ Truyền Thông Đại Chúng
_____ Cơ Quan Chính Phủ Khác

Quý vị có muốn tham dự vào những buổi họp tới của PEI không?

Nếu quý vị muốn được thông báo về những hoạt động sắp tới để hoạch định chương trình cho Kế Hoạch Phòng Ngừa và Điều Trị Sớm của Quận Los Angeles, xin điền vào mẫu đơn ở mặt giấy bên kia, tách rời mẫu đơn, và gởi về địa chỉ sau:

County of Los Angeles Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Administration
550 S. Vermont Avenue
Los Angeles, CA 90020

*Quý vị cũng có thể gởi tin tức qua điện thư về mhsapei@dmh.lacounty.gov

Tham Dự Cộng Đồng Trong Việc Hoạch Định PEI

Hỏi. Ai nên tham dự vào việc hoạch định kế hoạch PEI?
Bất cứ ai quan tâm về dịch vụ sức khỏe tâm thần. Những người quan tâm đến cách thức mà các dịch vụ phòng ngừa và điều trị sớm được cung cấp trong Quận Los Angeles.

Hỏi. Làm sao tôi có thể tham dự vào việc hoạch định PEI theo Dịch Vụ Từng Khu Vực?
Tham dự vào **Ủy Ban Cố Vấn Dịch Vụ Từng Khu Vực (SAAC)** trong địa phương của quý vị. Liên lạc với Trưởng Khu Dịch Vụ Khu Vực DMH về lịch trình họp, vào địa chỉ Internet của DMH **www.dmh.lacounty.gov** hoặc điện thư **mhsapei@dmh.lacounty.gov**

Hỏi. Có những cơ hội khác cho tôi góp ý kiến vào Kế Hoạch PEI không?
Một số người có thể được mời tham dự vào những cuộc **phỏng vấn người cung cấp tin tức** và **các nhóm tập trung**, sẽ xảy ra vào đầu năm 2008. **Diễn đàn cộng đồng**, nơi các tham dự viên được yêu cầu chọn một số chiến lược đặc biệt của PEI trong khu vực dịch vụ của họ, sẽ được khởi xướng vào mùa xuân năm 2008.

Hỏi. Làm sao để tôi có tin tức về việc muốn tham dự?
Điện thư **mhsapei@dmh.lacounty.gov** hoặc gọi **(213) 738-2331** để nhận được tin tức về những hoạt động cộng đồng sắp đến và về việc tham dự để hoạch định các chương trình PEI.

Hỏi. Trong trường hợp tôi không hiểu một số từ ngữ của tập sách nhỏ này và muốn biết thêm về PEI thì sao?
Những chỉ dẫn về PEI, tài liệu giúp đỡ, và tập giải thích từ ngữ được tìm thấy ở địa chỉ Internet của tiểu bang về DMH:
http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

BAN QUẢN TRỊ
QUẬN LOS ANGELES

Gloria Molina
Khu Một

Yvonne B. Burke
Khu Hai

Zev Yaroslavsky
Khu Ba

Don Knabe
Khu Bốn

Michael D. Antonovich
Khu Năm

William T Fujioka
Giám Đốc Điều Hành

County of Los Angeles
Department of Mental Health
Program Support Bureau
Mental Health Services Act (MHSA)
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Administration
550 S. Vermont Avenue, Ste. 605
Los Angeles, CA 90020
Điện Thoại: (213) 738-2331
Fax: (213) 351-2026
Điện Thư: mhsapei@dmh.lacounty.gov
Địa Chỉ Internet: www.dmh.lacounty.gov

SỞ SỨC KHỎE TÂM THẦN
QUẬN LOS ANGELES

ĐẠO LUẬT DỊCH VỤ SỨC KHỎE TÂM THẦN (MHSA)

Prevention & Early Intervention

Kế Hoạch Phòng Ngừa và Điều Trị Sớm (PEI)

Giám Đốc Marvin J. Southard, D.S.W.

APPENDIX 6

PEI Orientation Brochure

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH SERVICES ACT (MHSA)

PREVENTION AND EARLY INTERVENTION (PEI)

ORIENTATION TO PLANNING PROCESS

Revised 6-3-08

OVERVIEW OF THE MENTAL HEALTH SERVICES ACT

The Los Angeles County Department of Mental Health (LACDMH) is undertaking an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan, one of five plans authorized by the Mental Health Services Act (MHSA) enacted by California voters in 2004. The California State Department of Mental Health (SDMH) has responsibility for developing guidelines for the Plans authorized by MHSA and the funding of the statewide and county programs. In February 2006, SDMH approved the LACDMH's Community Services and Supports (CSS) Plan, the first of the MHSA Plans to be released. Implementation of the programs funded under the CSS Plan was initiated in 2007. Subsequently, SDMH released guidelines for other MHSA Plans and, on September 25, 2007, released the final Prevention and Early Intervention (PEI) guidelines. For a summary of the differences between the CSS and PEI Plans, see the chart on the following page.

Timeline for MHSA Plans

Community Services and Supports (CSS)	Workforce Education and Training (WET)	Capital Facilities and Technology (CFT)	Prevention and Early Intervention (PEI)	Innovative Programs (IP)
Develops mental health and supportive services to provide an array of recovery-based services to critical populations of children, transition-age youth, adults and older adults whose needs are not currently being met under other funding sources.	Builds and trains California's mental health workforce for a sustainable and promising future of high-quality care.	Improves the infrastructure of California's mental health system. Provides new funding for housing, new buildings and information technology systems.	An effort to conduct outreach to critical populations, reduce stigma, and reduce negative mental health outcomes, such as suicide, homelessness and incarceration.	Improves access to mental health programs in ground-breaking ways.
Guidelines Issued: August 2005 **LA County Plan Submitted:** October 2005 **LA County Plan Approved:** February 2006	**Guidelines Issued:** May 2007 **Target Date for County Plan Submission:** Spring 2008 **Target Date for County Funding Availability:** Summer 2008	**Final guidelines not yet released.** Draft guidelines issued April 2007.	**Guidelines Issued:** September 2007 **Target Date for County Plan Submission:** Fall 2008 **Target Date for County Funding Availability:** Winter 2008-2009	**Guidelines not yet released.**

Differences Between CSS and PEI

CSS Community Services & Supports Plan	*DIFFERENCES*	PEI Prevention and Early Intervention Plan
• Adults and older adults with severe and persistent mental illnesses • Children, youth, and young adults suffering from severe emotional disturbances	*Target Groups*	• Underserved cultural populations • Individuals experiencing onset of serious psychiatric illness • Children and youth in stressed families • Trauma-exposed • Children and youth at risk for school failure • Children and youth at risk of or experiencing juvenile justice involvement
• Recovery from mental illness and sustained individual wellness • Community collaboration and integrated mental health services (Full Service Partnerships) • Age-appropriate strategies to address severe diagnoses • Peer support • Outreach and engagement to unserved, underserved, and inappropriately served populations • Substance abuse and other co-occurring disorders • Accountability to outcomes • Reduction in involuntary services, institutionalization and out-of home placements for children	*Community Mental Health Needs Addressed*	• Disparities in access to mental health services • Psycho-social impact of trauma • At-risk children, youth, and young adult populations • Stigma and discrimination • Suicide risk
• Full Service Partnerships • Peer support, peer counseling & peer mentoring • Housing and residential services • Counseling, assessment and other traditional mental health services • Alternative crisis services • Bridging and support services	*Types of Services*	*Evidence-based practices, promising practices, and community-defined evidence focusing on:* • Mental health promotion • Mental health education • Screening • Short-term early intervention treatment
• To reduce barriers to services for individuals who would otherwise qualify for CSS mental health services, i.e., persons with serious mental illness or children/youth with serious emotional disturbances.	*Intent of Outreach and Engagement Strategies*	• To engage persons prior to the development of serious mental illness or serious emotional disturbances or, in the case of early intervention, alleviate the need for additional mental health treatment and/or to transition to extended mental health treatment.
• Mental health providers; mental health client/consumer organizations; organizations with experience and background in traditional mental health services	*Providers*	• Non-traditional mental health providers, including partners from health, education, social services, law enforcement, and underserved communities
• 55% of total MHSA Budget • $276,561,824 million for FYs 05-06, 06-07, & 07-08; plus an additional $30 million through the Growth Plan • At least 51% of County's overall CSS funding must be used for Full Service Partnerships.	*Funding*	• 20% of total statewide MHSA budget • Estimated $90 million for FYs 07-08 & 08-09; $57 million annually • At least 51% of overall County PEI budget must be used for children and youth between birth and 25 years of age.
• Full Service Partnerships – funds to provide "*whatever it takes"* for initial populations • General System Development – funds to improve programs, services and supports for the identified initial full service populations and other clients consistent with the priority populations • Outreach and Engagement – funds for outreach and engagement of those populations that are currently receiving no or little service	*Types of Funding Available*	• Funding for programs and interventions that meet the PEI operational definitions and the necessary costs to implement and evaluate those programs and interventions.

PREVENTION AND EARLY INTERVENTION

Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills, and increasing support. Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances.

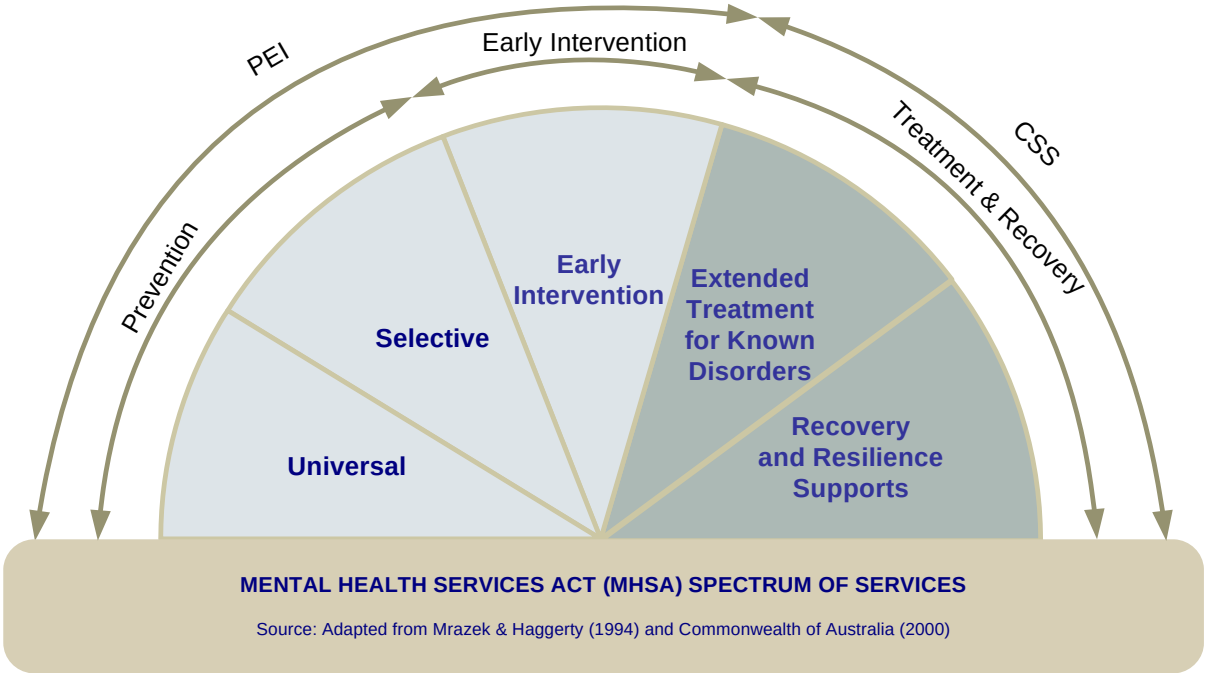
Early Intervention is directed toward individuals and families for whom a short duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.

In Los Angeles County, the focus for developing the PEI Plan is at the Service Area level utilizing informational meetings, key informant interviews, focus groups, and community forums. Informational meetings are currently being held with the Service Area Advisory Committees (SAACs) to provide an overview of the State PEI guidelines and LACDMH PEI planning process, as well as promote participation through the progression of Service Area meetings. Service Area profiles identifying socio-economic demographic data and mental health statistics, as well as data related to health, education, social services, and public safety will be developed to aid the planning process.

Purpose of the PEI Planning Process

1. To identify and select Key Community Mental Health Needs and related PEI Priority Populations for the PEI programs and interventions in L.A. County
2. To assess community capacity and strengths
3. To select PEI programs to achieve desired outcomes
4. To develop PEI projects with specific timeframes, staffing and budgets
5. To implement accountability, evaluation and program improvement activities

Evidence-Based Practices and Promising Practices. In order to maximize the MHSA goals of outcomes and accountability, as well as to foster a cooperative learning environment among stakeholders and advance the state of the art in mental health, SDMH has required counties to select from a limited set of SDMH-recommended Evidence-Based and Promising Practices. Alternative strategies may be proposed with sufficient justification and supporting documentation.



Sector Partnerships. The State requires counties to partner with seven sectors for PEI planning and has identified organizations it recommends be involved. LACDMH has begun meeting with organizations on this list to provide information about PEI, obtain data, learn about existing evidence-based practices, and encourage participation at the Service Area level. See the "PEI Planning Required Sectors" chart on page 10 for a listing of the sectors and organizations.

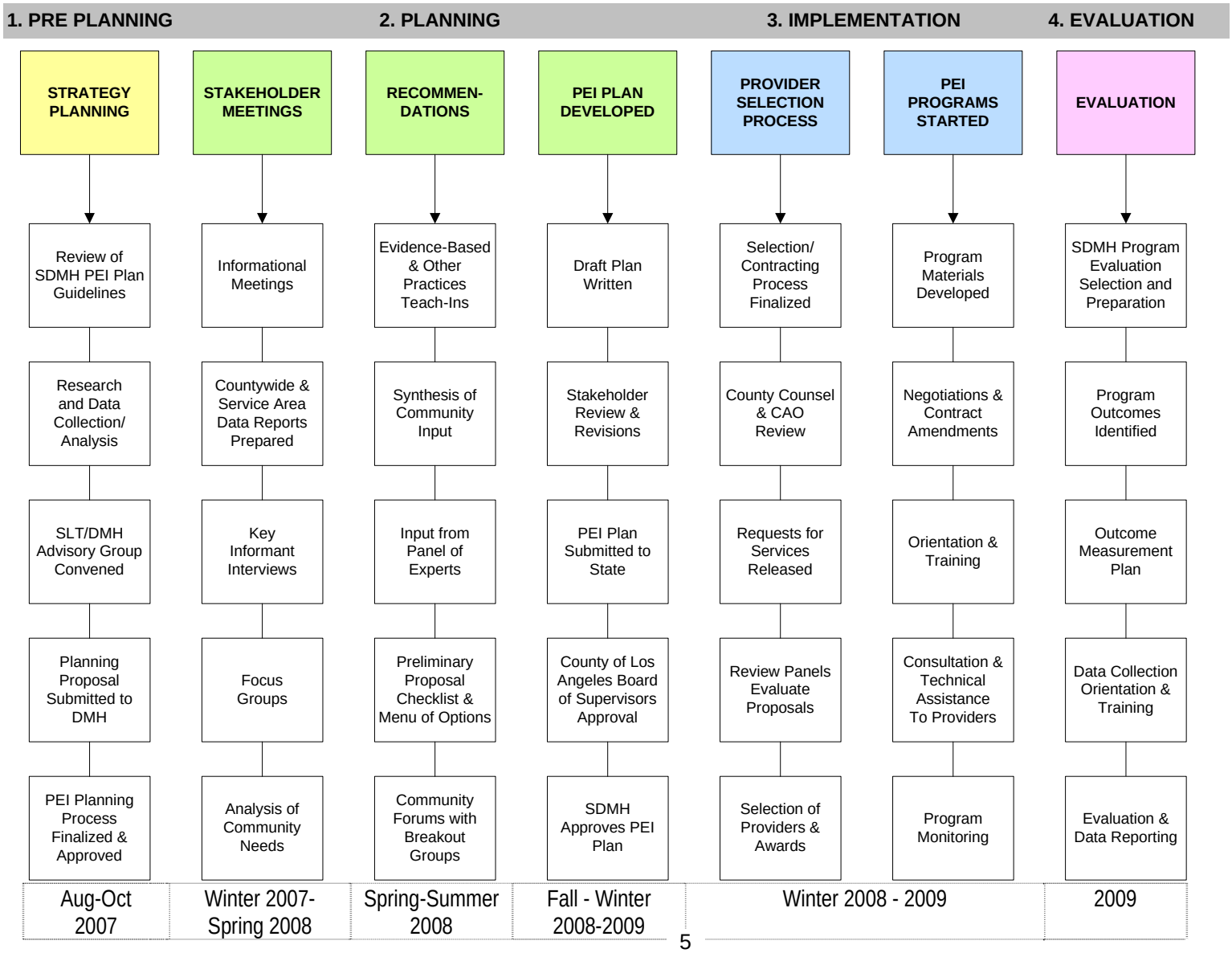
Funding. The chart on the right lists the estimated funding amounts for Los Angeles County from 2007-2009. A minimum of 51% of the overall County PEI Plan budget must be dedicated to the child (ages 0-15) and transition-age youth (TAY ages 16-25) populations.

FISCAL YEAR	LA COUNTY DMH PEI ESTIMATED FUNDING
2007-2008	$34,001,800
2008-2009	$57,161,000
TOTAL:	$91,162,800

State-Administered Projects. *To complement counties' efforts, the SDMH will oversee six statewide projects dedicated to:*

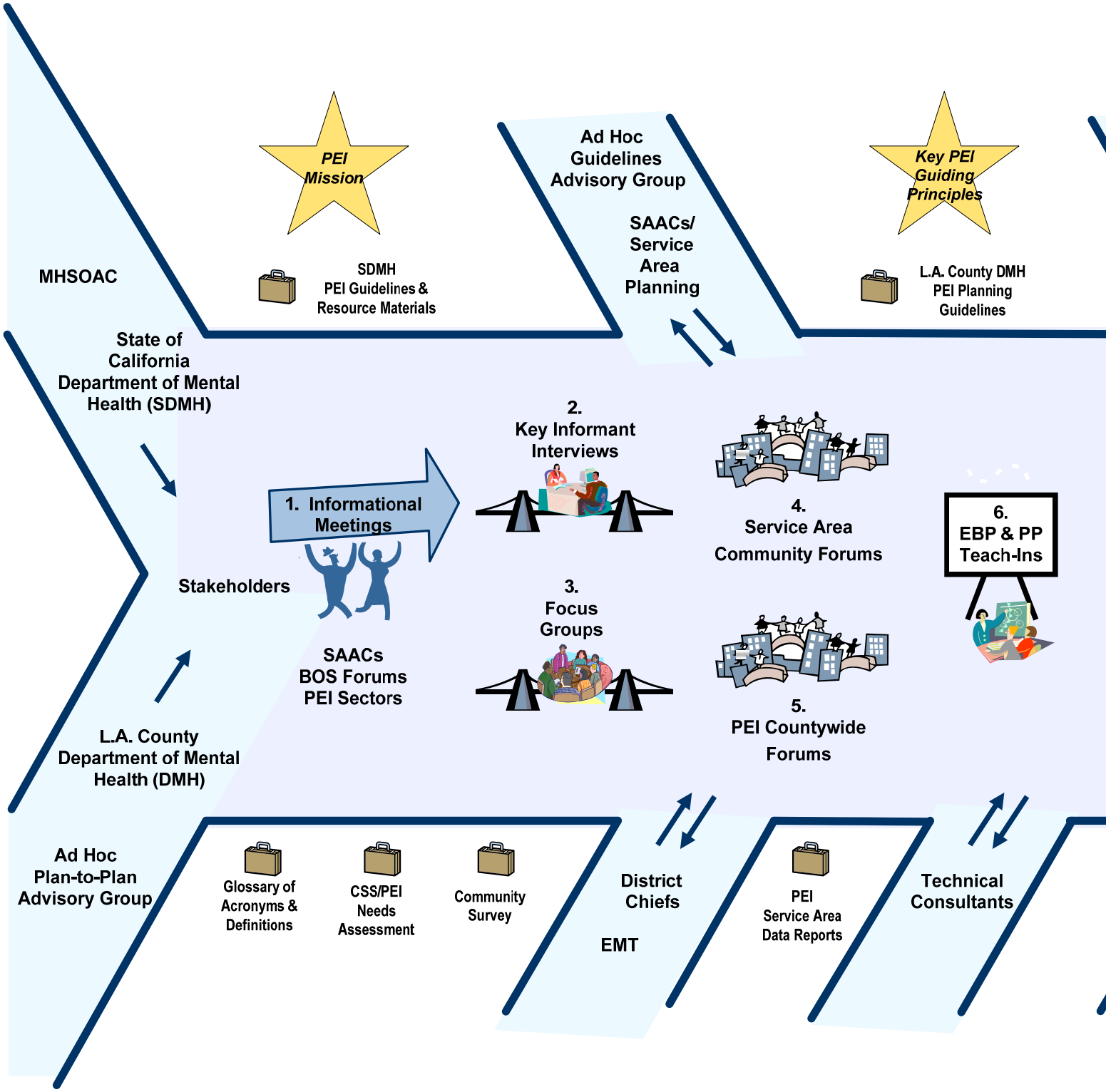
- Suicide Prevention
- Stigma and Discrimination Reduction
- Ethnically and Culturally Specific Programs and Interventions
- Training, Technical Assistance and Capacity Building
- Student Mental Health Initiative
- Statewide Evaluation

Projected Timeline. In order to ensure that the Plan is submitted on a timely basis, target dates for critical planning activities have been identified. The timeline below provides an overview of the planning stages to be undertaken in developing the PEI Plan.



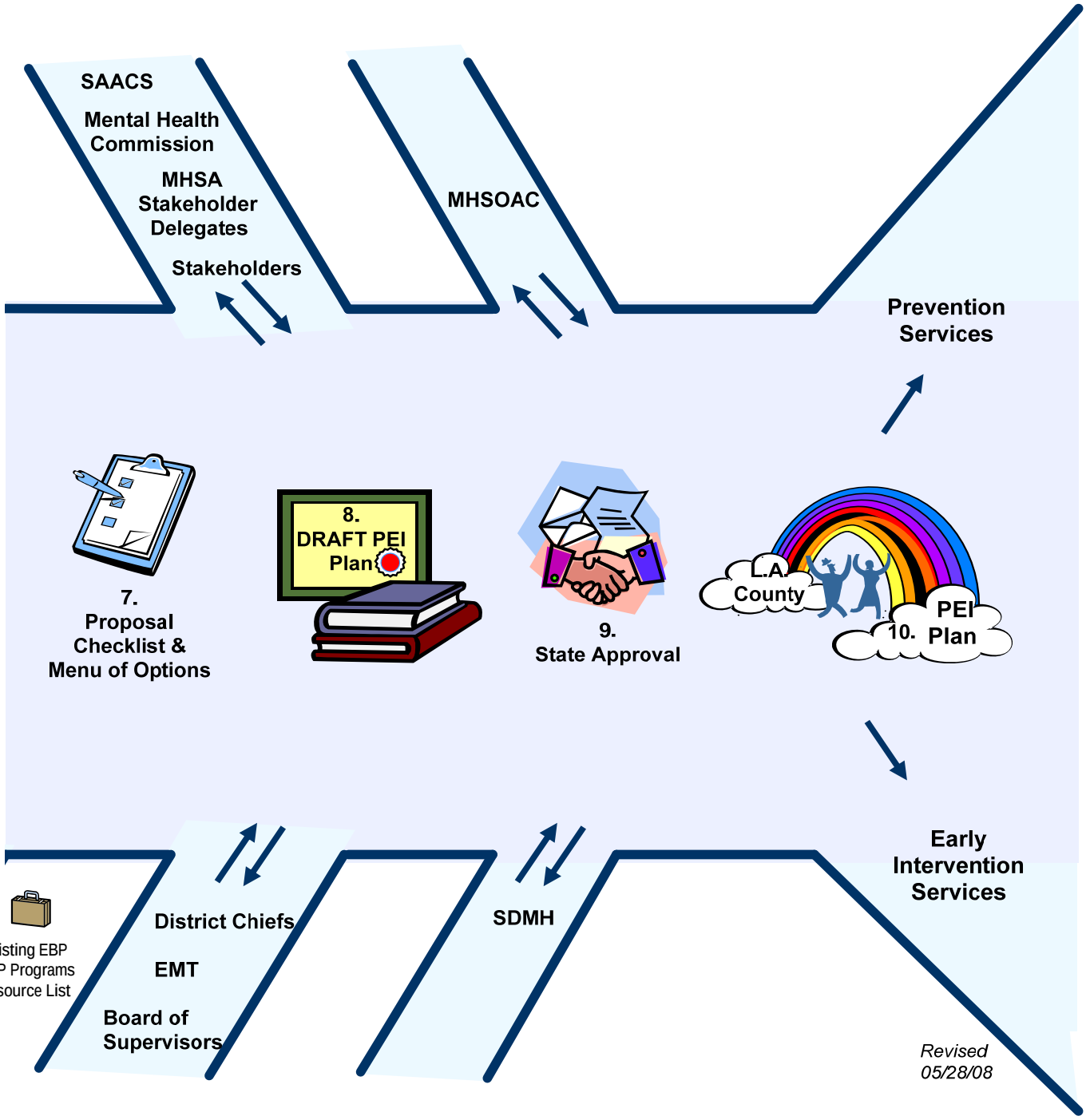
COMMUNITY PARTICIPATION

Active involvement by community stakeholders – consumers, parents, caregivers, family members, sector members, and other concerned individuals – in the PEI planning process is critical to developing effective, representative and culturally-appropriate PEI services. The road map provides an overview of the planning stages. In particular, community involvement is encouraged in the key informant interviews, focus groups, and community forums.



COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT (MHSA) – PREVENTION & EARLY INTERVENTION (PEI)

LOS ANGELES COUNTY PEI PLANNING ROADMAP



STAGES OF THE PLANNING PROCESS

The numbered stages in the road map identify the major steps in developing an approved PEI Plan for Los Angeles County. Although these steps are identified in chronological order, several will occur concurrently.



1. Informational Meetings, which provide an overview of the PEI requirements and planning process, are held in the Service Areas, in conjunction with SAACS, at the BOS Community Forums, PEI sector meetings, and community meetings.



2. Key Informant Interviews will be conducted in English and the other threshold languages with community leaders, gatekeepers, and other individuals who are knowledgeable about their constituency and the key community mental health needs.



3. Focus Groups, composed of 6-10 individuals, explore a specific mental health need and/or priority population to learn the members' concerns, issues, and recommendations for developing strategies for PEI services. Focus Groups will be conducted in English and the threshold languages at the countywide and Service Area levels.



4. The Service Area Community Forums request that stakeholders select PEI strategies that address the needs specific to their Service Area. The forums include breakout sessions to allow greater discussion.



5. The Countywide Community Forums request input on specific PEI strategies from collaborating partners in underserved communities, education, client and family member organizations, providers of mental health services, health, social services, and law enforcement.



6. The EBP/PP Teach-Ins are a series of Service Area workshops with a panel of experts presenting information on Evidence-based Practices and Promising Practices relevant to the PEI Plan.



7. The Proposal Checklist & Menu of Options will synthesize the findings from the key informant interviews, focus groups, and community forums to identify the community mental health needs and priority populations. It will also include a list of potential EBPs and PPs from the State DMH Resource Guide, as well as community-defined programs that may be appropriate for the Service Areas, based on their identified needs.



8. The Draft PEI Plan will be presented to a broad range of stakeholders, including diverse and underserved communities, for their review and approval, which includes a 30-day public review period and hearing. This is a critical checkpoint for validating broad, meaningful stakeholder involvement in the PEI planning process.



9. L.A. County's draft PEI Plan requires State Approval by the MHSOAC.



10. The Los Angeles County Approved PEI Plan is the funded plan that has been approved by the MHSOAC.

ABBREVIATIONS

BOS ..... Board of Supervisors
CSS ..... Community Services & Supports
DMH ..... L.A. County Department of Mental Health
EBP ..... Evidence-Based Practices
EMT ..... Executive Management Team
MHSA ..... Mental Health Services Act
MHSOAC .... Mental Health Services Oversight and Accountability Commission
PEI ..... Prevention and Early Intervention
PP ..... Promising Practices
SAACs ..... Service Area Advisory Committees
SDMH ..... California State Department of Mental Health
SLT ..... System Leadership Team



KEY PARTICIPANTS IN PLANNING

Everyone who has an interest in mental health services is encouraged to participate in this process, especially individuals who care about how mental health mental prevention and early intervention services are delivered in Los Angeles County.

- The Ad Hoc PEI Plan-to-Plan Advisory Group, comprised of SLT members, Sector representatives, and DMH staff, met from August to October 2007 to provide input to the proposed strategies and planning process for the PEI Plan.
- The Ad Hoc PEI Guidelines Advisory Group, comprised of Stakeholder Delegates, Sector representatives, other community members, and DMH staff will develop guidelines for the PEI planning process.
- The County of Los Angeles Board of Supervisors (BOS) must approve the PEI Plan developed by the stakeholders.
- The L.A. County Department of Mental Health (DMH) is responsible for developing the county's PEI Plan and ensuring that stakeholders play an integral role in this process.
- The DMH District Chiefs have responsibility for mental health services in specific Service Areas, programs, and age groups.
- The DMH Executive Management Team (EMT) is comprised of the Director of Mental Health and the executive leadership.
- The Mental Health Commission advises the Board of Supervisors and the Director of Mental Health on various aspects of local mental health programs.
- The Mental Health Services Oversight and Accountability Commission (MHSOAC) has responsibility for input to and review of the State DMH's PEI guidelines, as well as approval of the counties' PEI Plans.
- The MHSA Stakeholder Delegates is comprised of 100+ community representatives from various L.A. County departments, community organizations, racial and ethnic groups, and special needs population groups.
- The Panel of PEI Experts includes researchers, faculty, and providers knowledgeable and experienced with EBPs & PPs.
- Sectors refers to underserved communities, health, individuals with serious mental illness and/or their families, providers of mental health services, education, social services, community family resource centers, employment, and media.
- The Service Area Advisory Committees (SAACs) have a key role in spearheading the Service Area planning efforts.
- Stakeholders encompass consumers and their parents and/or family members, other persons concerned about mental health, and mental health and other community-based organizations.
- The California State Department of Mental Health (SDMH) is responsible for determining the MHSA PEI guidelines and assisting counties in the PEI planning process.



RESOURCES FOR PEI PLANNING



Resources are written materials that the State DMH or L.A. County DMH have prepared to assist counties and stakeholders in their planning decisions.

State DMH PEI Guidelines and Resource Materials, released on September 25, 2007, define the requirements that each county must follow in preparing its local PEI Plan.

L.A. County DMH PEI Planning Guidelines were developed to ensure that the process was inclusive of the diverse stakeholders and underserved communities, as well as promoting collaborative partnerships with the required and recommended Sectors.

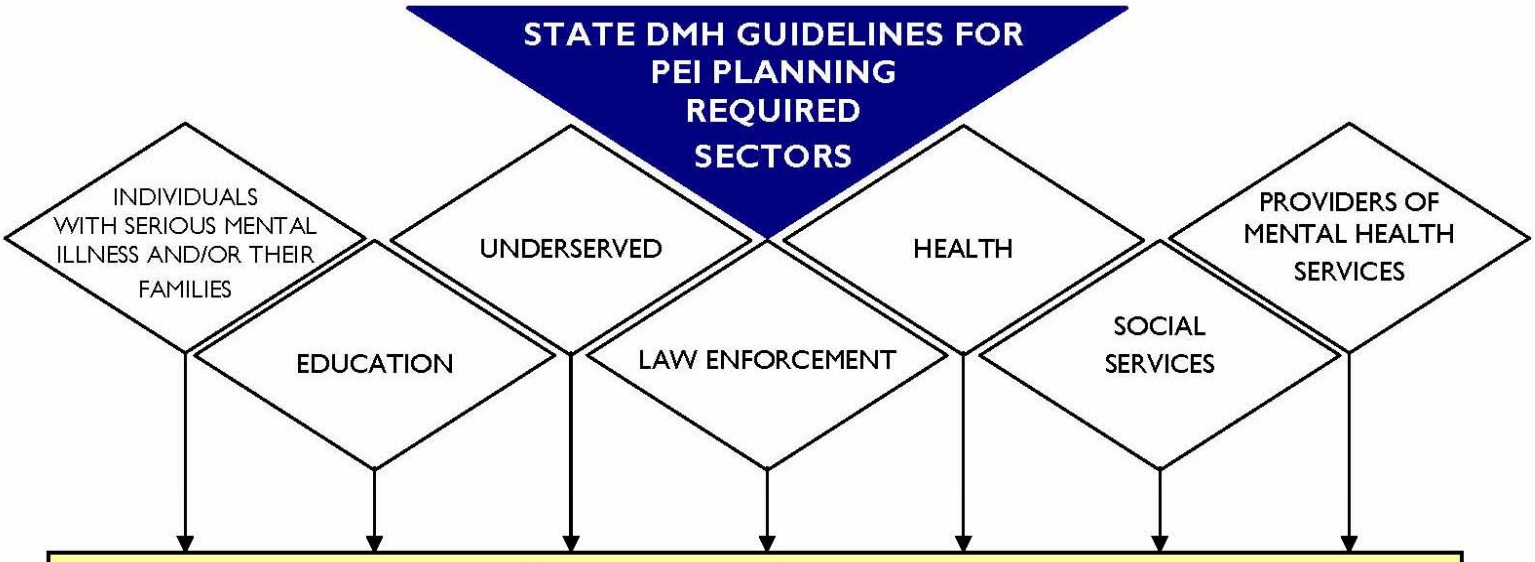
Glossary of Acronyms and Definitions provides an explanation of common PEI terms and abbreviations used in the L.A. County PEI planning process.

The CSS SAAC PEI Needs Assessment summarizes the recommendations from the SAAC and Workgroups needs assessment reports developed for the CSS Plan.

The Community Survey asks participants to rank the key community mental health needs, priority populations, and age groups for their community.

PEI Service Area Data Reports provide socio-economic demographic data and mental health statistics, as well as data related to health, education, social services, and public safety for each Service Area.

The Existing EBP & PP Programs Resource List describes current PEI-related EBP and PP programs in L.A. County.



State DMH Recommended Partner Organizations

• Client and family member organizations	• County offices of education • School districts • Parent/Teacher Associations • Special Education Local Plan Areas (SELPAs) • School-based health centers • Universities/ Colleges • Community colleges • Adult education • First 5 Commissions • Education organizations and settings	*Community based organizations representing:* • Native American • African American • Hispanic/Latino • Asian/Pacific Islander • Refugee • Immigrant • Lesbian/Gay/ Bisexual/ Transgender/ Questioning/ Individuals • Other underserved/ unserved communities	• County criminal justice • Courts • Juvenile and adult probation offices • Judges and public defenders • Sheriff/ police	• Community clinics and health centers • School-based health centers • Primary health care clinics • Specialist mental health services • Specialist older adult care health services • Native American Health Centers • Alcohol and drug treatment centers • Developmental Disabilities Regional centers • Emergency services • Maternal child and adolescent health services	• Child and family welfare services • CalWORKs • Child protective services • Home and community care • Disability services • Adult protective services	• Mental health provider organizations

State DMH Recommended Additional Sectors

Community Family Resource Centers

- Multipurpose family resource centers
- Spiritual/Faith centers
- Arts, Sports, Youth clubs/centers
- Parks and Recreation
- Homeless shelters
- Senior Centers
- Refugee and Immigrant Assistance Centers

Employment

- Public and Private sector workplaces
- Employee unions
- Occupational rehabilitation settings
- Employment centers
- Work Force Investment Boards

Media

- Radio
- Television
- Internet sites
- Print and newspaper offices
- Ethnic media

KEY DEFINITIONS

"Evidence-based practice" means the range of treatment and services of well-documented effectiveness. An evidence-based practice has been, or is being evaluated, and meets the following criteria:

- Has some quantitative and qualitative data showing positive outcomes, but does not yet have enough research or replication to support generalized positive public health outcomes.
- Has been subject to expert/peer review that has determined that a particular approach or strategy has a significant level of evidence of effectiveness in public health research literature.

"Priority population" means a specific group of individuals defined by the Oversight and Accountability Commission as a population who should receive priority consideration by counties when determining who will receive PEI services.

"Promising practice" means programs and strategies that have some quantitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes. It has an evaluation component/plan in place to move towards demonstration of effectiveness; however, it does not yet have evaluation data available to demonstrate positive outcomes.

"Psycho-social" means psychological and social factors that influence a person's mental health, such as, life experiences and maladjusted cognitive and behavioral processes.

"Selective prevention" targets individuals or subgroups whose risk of developing mental disorders is significantly higher than average.

"Trauma-exposed" means those who are exposed to traumatic events or prolonged traumatic conditions, including grief, loss and isolation and are unlikely to seek help from any traditional mental health service.

"Underserved" means members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers, such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services; and those in rural areas, Native American Rancherias and/or reservations who are not receiving sufficient services.

"Universal prevention" targets the general public or whole population.

FREQUENTLY ASKED QUESTIONS

Q. Who should get involved in developing the PEI Plan?

Anyone who has an interest in mental health services. People who care about how mental health prevention and early intervention services will be delivered in Los Angeles County.

Q. How can I get involved in the PEI planning at the Service Areas?

Participate in your local mental health **Service Area Advisory Committees (SAACs)**. Contact the DMH Service Area District Chief for meeting schedules or e-mail **mhsapei@dmh.lacounty.gov**

Q. What are other opportunities to provide input to the PEI Plan?

Some individuals will participate in **key informant interviews** and **focus groups**, which are currently being held. **Community forums**, where participants will be asked to make recommendations on PEI strategies for their Service Areas, are targeted for summer 2008.

Q. How do I get information about getting involved?

Email **mhsapei@dmh.lacounty.gov** to receive information about upcoming community events and participation in planning for PEI programs.

Q. What if I don't understand some of the terms used in this booklet or want to learn more about PEI?

PEI guidelines, resource documents, and a glossary are available on the State DMH website: **www.dmh.cahwnet.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp**



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County of Los Angeles - Department of Mental Health
Program Support Bureau
Prevention and Early Intervention Administration
550 S. Vermont Avenue
Los Angeles, CA 90020
Phone: (213) 738-2331
Fax: (213) 351-2026
E-mail: mhsapei@dmh.lacounty.gov
LA County DMH PEI Website: http://dmh.lacounty.info/mhsa/plans/pei.html
State Website:
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APPENDIX 7

Recommendations Related to
Prevention and Early Intervention from the
2005 Los Angeles County Mental Health Services Act
Community Services and Supports Needs Assessment

Recommendations Related to Prevention and Early Intervention



FROM THE

2005 Los Angeles County Mental Health Services Act Community Services and Supports Needs Assessment

Prevention & Early Intervention

INTRODUCTION

The Los Angeles County Department of Mental Health (DMH) is currently in the process of developing its Prevention and Early Intervention (PEI) Plan, one of five Plans mandated under the Mental Health Services Act. An extensive, Service Area-focused stakeholder process is being implemented to obtain community input and recommendations for prevention and early intervention services.

In early 2004, the DMH faced a substantial shortfall in funding for fiscal year 2004-2005. In response to this budget crisis, the Department initiated stakeholder planning to identify ways to absorb the projected shortfall and more critically, to determine the fundamental direction for the mental health system's evolution. In fall 2004, following the passage of Proposition 63, known as the Mental Health Services Act (MHSA), stakeholders in the Service Areas conducted a needs assessment designed to evaluate the capacity and ability of the current mental health system in Los Angeles County to help children, adults and older adults meet their desired outcomes. DMH developed a Countywide Population Needs Assessment template to provide a systematic assessment and framework for prioritizing the needs of targeted populations. Participants included clients, family members, providers, and representatives of community-based organizations and government entities. The data from these efforts assisted the DMH in planning for its fiscal year 2005-2006 budget, as well in developing its three-year Community Supports and Services (CSS) Plan for the MHSA.

Presented in this report are the recommendations specifically related to **prevention and early intervention** from the 29 MHSA-CSS countywide work groups and the eight Service Area Advisory Committees' (SAACs) final reports. These reports, and the pertinent PEI recommendations, provide a starting point for a critical analysis and discussion relating to prevention and early intervention needs, strategies, implementation, and outcomes. Although the assessments were conducted in 2004 and the reports generated in 2004-2005, the needs that were identified then still exist, as funding for prevention and early intervention services was not yet available. The development of the MHSA PEI Plan and availability of SDMH funding for Los Angeles County offer opportunities to acknowledge and incorporate the recommendations from these earlier planning processes.

Countywide Work Groups

1. Association of Community Human Service Agencies (ACHSA) Children's Mental Health - ACHSA Children's Mental Health
2. ACHSA Children's Mental Health - Co-Occurring Disorders
3. ACHSA Children's Mental Health - Foster Care/Post-Adoption
4. ACHSA Children's Mental Health - Intensive Community-Based Services/Crisis Beds/TBS
5. ACHSA Children's Mental Health - Juvenile Justice
6. ACHSA Children's Mental Health - School-Based Services/ AB3632
7. ACHSA Children's Mental Health - Transition-Age Youth
8. ACHSA Adult Mental Health - AB2034
9. ACHSA Adult Mental Health - Co-Occurring Disorders
10. ACHSA Adult Mental Health - Emergency Response/Crisis Beds
11. ACHSA Adult Mental Health - Uninsured/Underinsured
12. ACHSA Adult Mental Health - Wellness Centers/Self-Help
13. African-American Community Stakeholders
14. American Indian Community Stakeholders
15. Asian/Pacific Islander Needs Assessment SA 2-8
16. Asian-Pacific Policy & Planning Council
17. Children in Foster Care
18. Children with Special Needs
19. Clinica Msr. Oscar Romero (Federally Qualified Health Center)
20. Co-Occurring Disorders
21. Homeless Youth
22. Juvenile Justice/Probation Youth
23. Older Adult Collaborative Report
24. Persons Diagnosed with Developmental Disabilities and Psychiatric Disorders
25. Prenatal to Five
26. School-based Mental Health Services for Children/Teens
27. Suicide Prevention
28. Trauma
29. Transition Aged Youth

RECOMMENDATIONS FROM THE COUNTYWIDE WORK GROUPS

Each Work Group developed a set of priorities for the expansion of services designed to address the needs of underserved populations or to enhance essential services. The Work Groups specified target populations, desired outcomes for these populations, current services they wanted to maintain or expand, and new services and supports they wanted to develop to ensure the achievement of these outcomes. The recommendations have been categorized according to the **key community mental health needs** specified in the SDMH PEI guidelines.

Disparities in Access to Mental Health Services

Outreach

- Outreach to community providers, including: medical providers, such as pediatricians, prenatal clinics, general practitioners, and OB/GYNs; day care providers; preschool, Head Start, and LAUSD early education; Regional Centers; teen pregnancy programs; WIC; DPSS; churches; police departments; groceries and Laundromats, etc.; DCFS; homeless shelters; and domestic violence shelters.
- Outreach and advocacy for developmentally disabled individuals with HMO's on how to access services.
- Increase awareness of service options for developmentally disabled individuals through outreach to pediatricians and schools.

Collaboration and Coordination

- Mobile medical units will operate in collaboration with DHS and community clinics.
- County will collaborate with various community resources.
- Coordination between the child welfare system, services for transition-age youth, and the adult and older adult systems will be improved so as to avoid people falling through the cracks.
- All agencies that are working on a particular school site will coordinate their services by convening multi-agency meetings before services begin and on a regular basis once services are established.

Screening

- Everyone will have access to screening, educational/resource materials, and parental support and education. Every family screened will receive educational developmental materials and resource phone numbers.
- Screening by trained screeners will occur in a timely way and be made accessible to family members, (e.g., in home or community setting).
- Advertise screening services in modes that reach all cultural and linguistic groups in communities.
- Develop a screening tool (in multiple languages).
- An 800 number will be available that is specific to children aged 0-5 and connects families to mental health services and developmental screening in their geographic area.

(Continued on page 4)

"Early identification and screening will be available through a variety of systems (mental health, schools, hospitals, juvenile justice). There will be multiple ways to enter the system."

– ACHSA Children's Mental Health Co-Occurring Disorders Workgroup

"Develop model 'parents as partners' programs wherein parents would be employed to support access and outreach to ethnic minority and other underserved populations."

- Prenatal to Five Workgroup

Disparities in Access to Mental Health Services *Continued*

(Continued from page 3)

"An organized and integrated school-based mental health system is an in-house resource to overburdened school district personnel and addresses cultural factors, general fears, embarrassment, stigma, lack of parental support, lack of transportation and oppositional behaviors that may contribute to the problem of a student not engaging in therapy off campus."

- School-based Services for Children/Teens Workgroup

Education

- Provide education to the community and market the availability of services.
- Increase community education and involvement while addressing and aiding the uninsured and underinsured populations.

Consultation

- Attorneys and courts in the juvenile justice system should have mental health consultation and referral services similar to those provided by the adult Mental Health Court programs.

Connections with Health Providers

- Co-location of primary care physician with mental health services offered at same facility, with comprehensive geriatric and medical assessments.
- That programs which focus attention on medical issues that may affect mental health be provided funds to investigate and treat individuals and families at high risk for those problems.

Other

- System will focus more on prevention and less on crisis.
- Streamline enrollment process for mental health services and/or increase Community Outreach Services funding, especially for prevention, early intervention and groups.
- A broader definition of mental health services, to include bio/psycho/social services, will be used, which will promote easier access to services.
- Augment existing warm lines like NexCare and alternative programs with mental health prevention/early intervention capacity.

At-Risk Children, Youth and Young Adults

Collaboration and Coordination

- Collaboration with pre-school childcare providers to identify children with mental health needs.
- School districts will work as partners and actively cooperate.
- There will be better integration with school systems.
- Coordinate relevant DMH and DCFS initiatives, programs, and resources to ensure that abused children ages 0-3 are referred to IDEA Part C funded services as a result of recent Child Abuse Prevention and Treatment Act (CAPTA) requirements.
- Work in conjunction with staff from early education centers, Head Start programs, and other pre-school settings (which are "capture points" for children who exhibit early behavioral/emotional problems) to support early identification and intervention with children who are aggressive, highly impulsive, exhibit inability to attend and/or who may be very withdrawn and/or poorly socialized.

(Continued on page 5)

At-Risk Children, Youth and Young Adults *Continued*

Screening and Assessment

- 90% of families referred to DCFS with a child aged 0-5 will receive a mental health screening and linkage to appropriate mental health services.
- Mental health screening will be available to all children aged 0-5.
- Identify at-risk parents, who will be offered early intervention and prevention services, beginning during prenatal stage.
- Children will receive comprehensive early assessment, including psychiatric evaluations.
- Developmental Disability, Learning Disability and Mental Health are frequently misdiagnosed or go undiagnosed until client needs extensive intervention and a relatively higher level of care.
- Access to high quality developmental/behavioral screenings (specified as a percentage of children within a given system, e.g., 100% of children ages 0-5 detained by DCFS would be screened and assessed for mental health needs).
- All children ages 0-5 whose parents have an open case in the DMH system will be screened and followed with a specialized focus on prevention and early intervention models. A screening tool like the Pediatric Symptom Checklist, Mental Health Screening tool (0-5 years), or a more comprehensive mental health/developmental screening tool should be administered.

Education and Training

- Parenting education will be provided to transition-age youth and others.
- In-service school personnel will be trained to specialize in best practices related to identifying children in need of services.
- The number of in-home trained professionals able to provide support, prevention and treatment services (especially for children aged 0-3) will increase.
- Children in the API population have more acculturation issues. There is a need for more prevention or earlier intervention programs that educate.
- Expand the Nurse-Family Partnership program, which is designed to help low-income, at-risk pregnant women bearing their first child improve their prenatal health pregnancy outcomes; improve the care provided to infants and toddlers in an effort to enhance the children's health and development; and improve women's own personal development with particular attention to the planning of future pregnancies, women's educational achievement, and participation in the work force.
- Work closely with special education systems serving pre-school age children to increase opportunities for earlier identification and intervention

Services

- Mental health prevention services will be provided to 75% of at-risk parents.
- A full continuum of services for students and their families at all developmental and age levels will be available (e.g., prevention, early intervention, mental health services).
- Explore the possibility of a parent growth center in each community (Family Resource Centers).
- Programs for adolescent sex offenders are limited.

"There are three goals identified for this category: (1) increase the education of "healthy" mental health; (2) reduce the negative stigma within cultural groups of obtaining mental health services; and (3) encourage the development of natural systems and helpers. Mental health promotion should be prevention based, thus identifying and preventing the issues that result in the need for foster care intervention in the first place. Examples of educational concepts may include mental health "healthy development", child abuse prevention at schools, coping with depression, MH promotion for community or professionals."

- Children's Foster Care Workgroup

(Continued on page 6)

At-Risk Children, Youth and Young Adults *Continued*

(Continued from page 5)

- Prevention and intervention services in the community for families are needed for families and their minors who are at risk of involvement in Mental Health and Probation systems.
- DMH should establish countywide, as well as SPA-based, "systems navigators" who specialize in the prenatal to five population and/or have the capacity to successfully address the needs of children across all age levels.
- Providers are repeatedly asked to conduct curriculum based groups for non-SED children such as anger management, parent education, and social skills groups, or to briefly see students who have been abused and traumatized, or who are anxious or depressed but may not reach the medical necessity threshold.
- An expansion of Specialty Services, Mental Health Services, and Self-Help Services that are effective with the “at risk” and juvenile justice population should be a priority. Prevention and intervention services in the community for families are needed for families and their minors who are at risk of involvement in Mental Health and Probation systems.

“Regarding children with special needs, accessing services in the early stages of the problem can be difficult because the client's condition is not severe enough to qualify for tight dollars. This leads to problems becoming significantly more severe before they meet the threshold for qualification.”

- Children with Special Needs Workgroup

Early Intervention and Identification

- Maintain and expand 0-5 early intervention/identification and prevention services for African-American children.
- Maintain/expand early intervention/identification and prevention services in school-based mental health services for African-American families.
- Early intervention with children who are confronted with psycho-social stressors for preliminary "at risk" children that would inevitably result in problems at school and in the home.
- Early Intervention for TAY: by age 14, all foster, Probation and SED youth will be identified and assigned "transition facilitators" that will coordinate treatment and "exposures" to living options and potential careers prior to emancipation.
- Early intervention, while not the highest and most essential priority, is nevertheless an important ingredient of school-based mental health services.
- Intervention earlier with families [with youth involved in juvenile justice]. Interventions are important at intake and visitation.

Other

- It was discussed that emotionally healthy American Indian youth need a "positive self-esteem". In the data that was collected from the community, many youth participants discussed that participation with their culture was an important factor in being emotionally healthy for youth.
- High-risk special populations: children who have been prenatally drug-exposed and/or reside in substance-abusing families or households; children exposed to domestic violence; children of incarcerated parents; children of teenage mothers, as well as young children in the care of elderly grandparents or family caretakers experiencing poverty and limited access to needed resources.
- Conduct longer-term studies which follow children who receive MHSA-funded prevention/early intervention and other prenatal-to-five services to ensure that they are reading at grade level by the end of third grade. This academic milestone is highly predictive of at-risk children's reduced need for expensive public services.
- …all students who are in need must have access to a continuum of services from early intervention, identification and assessment for "at risk" and "after onset" students.

Stigma and Discrimination

Collaboration and Coordination

- Wellness Centers will have a developed community relations component that is active in stigma reduction, advocacy, and wellness education.
- Promote the collaboration of health and mental health services.

Consultation

- Mental health consultation and related services, as appropriate, should be provided in Early Start/Head Start programs and other early education/pre-school sites (including those supported through First 5 Universal Pre-school initiatives), primary care settings, WIC offices, and other "natural community-based service environments" absent the stigma that they be encountered in more traditional mental health clinics.

Education and Training

- Provide education about older adult mental health issues to physicians and other care providers and decrease ageism.
- Community Outreach and Mental Health Education: In this area, mental health education and community outreach programs are necessary to help reduce the stigma for seeking mental health services by API consumers with CMI and for their families (including intensive service engagement activities to help them be linked with the needed mental health intervention programs).
- …culturally competent preventive education and community outreach efforts that are crucial for promoting mental well-being, reducing stigma, and avoiding psychiatric relapses are also quite lacking in this SAAC (3).
- More public health education on how early intervention helps outcomes.
- Education will be available on co-occurring disorders - both in schools (from elementary school through college) and in jails.

Mental Health Promotion

- There is a need in the American Indian community for mental health promotion.
- Mental Health Promotion to fight NIMBYism community opposition to new housing programs.
- Raise public and professional awareness of the importance of early social and emotional development.

Identification and Stigma

- It is more difficult to get parental involvement for API kids. Many parents do no want their child to be assessed as having a mental illness. They would rather they be identified as having a disciplinary problem, even going to jail than have the stigma of mental illness.
- In API communities, there is shame and social stigma related to service utilization and related to socialization of individuals identified with mental illness.
- Remove stigma for families involved in juvenile justice/Probation.
- Provide general outreach and education to reduce stigma and increase the success of consumers in the work place.
- Decreased stigma related to suicide, mental illness and substance abuse.

"There was tremendous passion around the area of stigma for the persons diagnosed with developmental disabilities and psychiatric disorders work group. The feelings expressed in the group were that the community (including businesses, employers, educators, public transit operators, access staff and mental health staff) must see our population as human beings with dignity and rights. There was a sense that everything else flows from that starting point and that it has primary importance even though it is not currently a high priority for mental health funding. This group feels our population ranks as the lowest priority in the mental health system currently which compounds the impact of being a population struggling against stigma."

- Persons Diagnosed with Developmental Disabilities and Mental Disorders Work Group

(Continued on page 8)

Stigma and Discrimination *Continued*

(Continued from page 7)

Other

- The client will not have to be diagnosed and there will be no stigma to attend.
- Overcome stigma that prevents parents from accessing services by increasing community knowledge, awareness, and acceptance of mental health services.

Psycho-Social Impact of Trauma

"Trauma training needs to be provided for all staff, administrative and support personnel, so that trauma is recognized and survivors are not re-traumatized or stigmatized with labels such as, unmotivated, treatment resistant, uncooperative, etc."

- Trauma Workgroup

Services

- That agencies which have mental health programs and also treat clients with STDs and other sexually transmitted concerns be provided funds to services this type of client.
- That programs serving patients with HIV, hepatitis A/B/C be provided funds to meet the psychological services required by this population.
- Trauma-informed treatment services must be culturally competent and understand the trauma survivor in the context of their own cultural background, age, religious beliefs, and gender.
- Treatment should be evidence-based and follow a basic treatment protocol that is trauma specific.
- Elder abuse prevention and intervention is a priority.
- There is a need for early intervention programs for those who may not yet meet the medical necessity criteria.

Suicide Risk

"Increased awareness that suicide is preventable (teach risks, warning signs, interventions, and resources)."

- Suicide Prevention Workgroup

Services

- Reduced rates in populations identified as high-risk (because of high or increasing rates) through development of specialized suicide prevention and intervention strategies.
- Increased resilience among individuals who lose someone to suicide and are at risk.
- Increased knowledge about suicide and suicide attempts in Los Angeles County through collection of surveillance and outcome data that is sufficient to illuminate issues related to specific groups, trends over time, intervention outcome results, etc.
- 24-hour suicide prevention crisis line needs more publicity to increase access, and it needs more counselors who speak languages other than English and more overnight staff.
- Limited suicide screening campaign, (e.g. Teen Screen or Elder Screen).
- Early Suicide and Depression Detection and Intervention targeted at reducing the high level among older adults.

Support for Evidence-Based Practices

In addition to the categories of key mental health needs, several recommendations referred to the need for evidence-based practices. These recommendations are presentation in a separate section.

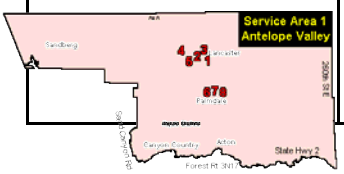
- System will be evidence-based, with results that are measurable based on best practices that have been empirically and behaviorally defined. –*Juvenile Justice/Probation Workgroup*
- Prevention, early identification and intervention as evidenced by identifying the unmet needs and provide appropriate services and provide early intervention when the psycho-social network is challenged. – *African-American Stakeholders Workgroup*
- Prevention services should be developed and implemented consistent with identified and emerging, promising best practices including, but not limited to, those identified by SAMHSA for universal, selective and indicated prevention strategies. Prevention of COD in youth should be one of the major components. – *Co-Occurring Disorders Workgroup*
- Evidence-based, coordinated and accessible prevention and intervention programs in the community. – *Juvenile Justice Workgroup*
- … there is also a demand to significantly expand the use of appropriate evidence-based programs and practices that are aligned with the needs of children and families. – *Prenatal to Five Workgroup*

RECOMMENDATIONS FROM THE SERVICE AREA ADVISORY COMMITTEES (SAACs)

In October 2004, the eight SAACs began an extensive strengths and needs assessment process for their respective regions. Most of the SAACs created at least three work groups to map and assess the current system of supports and services, one each for children, adults, and older adults. The SAACs identified their target population, expanded and increased the desired outcomes for their target populations, identified services and supports essential to the achievement of these outcomes, assessed availability of services, evaluated the quality of mental health services, identified special or minority populations that needed greater access to mental health services, and prioritized service needs.

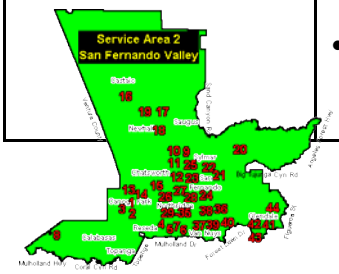
Service Area 1: Antelope Valley

"Service Area 1 is the fastest growing community in Southern California, yet has very few community resources to address the growing demands. Before planning for specialized services, it is first essential to address basic community needs…mental health and school collaborations are in place and effective in this service area. With this growing relationship, however, come more referrals, earlier interventions and more requests for adult services – which cannot be managed with the existing delivery system." - *SAAC1 Final Report*

RECOMMENDATIONS	
	• Maintain/increase capacity for school-based mental health services • Maintain/increase outreach/early intervention services • Co-located services in natural gathering points, including medical offices, senior centers, etc.

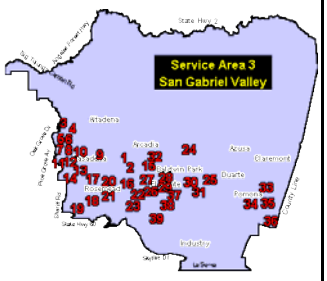
Service Area 2: San Fernando/Santa Clarita

"The need for providing early mental health services to young children is no longer a question for debate. In addition to pervasive development disabilities, some children exhibit emotional and behavioral problems that could both hamper a child's normal development, and may carry on through adulthood. Behavioral and emotional problems in early childhood have been correlated with future mood and anxiety disorders…funding for the expansion of the identification, diagnosis and treatment of services of early childhood problems is clearly a sound investment in the future of our community. It is imperative that an infrastructure be created to support this need." *- SAAC 2 Final Report*

RECOMMENDATIONS	
	• Early intervention/prevention • Screening – A standardized screening process is essential for outreach and identification of clients in our underserved communities. An infrastructure must be created to enhance services and foster the engagement of ethnic communities.

Service Area 3: San Gabriel Valley

"Develop infrastructure for early identification of mental illness by providing cross-training with agencies who work with mental health consumers ,such as primary care physicians, child development specialists, child care providers, DCFS, teachers, judges, Probation, police, organized foster parent organizations and legal guardians to increase awareness, and to facilitate access to mental health treatment services. Also, establish educational forums for family members [and the community] to reduce stigma, increase understanding and acceptance of mental illness." *- SAAC 3 Final Report*

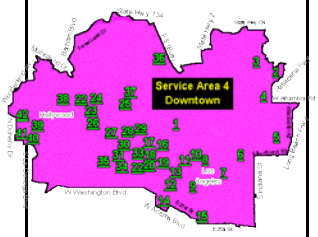
RECOMMENDATIONS	
	• Partner with community agencies to establish stable, family-oriented environment • Reduce mental health stigma by promoting increased public awareness/education in the community. • Increase early prevention programs by developing partnerships with community-based programs. • For older adults, develop infrastructure for early identification of mental illness by providing cross-training with agencies who work with mental health consumers, such as geriatric physicians, skilled nursing facilities, adult protective services, faith-based organizations, senior centers, and the Public Guardian's office to increase awareness and acceptance of mental illness.

Service Area 4: Central Los Angeles

"Funds should be allocated to directly address the need for improved collaboration between Mental Health and other public entities. In order to effectively meet the needs of the children and families in Service Area Four there needs to be a collective commitment to teamwork. Collaborative efforts should begin with the following identified agencies: Regional Center, Department for Children and Family Services, Department of Public and Social Services, Schools, Department of Probation." *- SAAC 4 Final Report*

Service Area 4: Central Los Angeles *Continued*

RECOMMENDATIONS



- Countywide preventative treatment, particularly for youthful offenders
- Increased collaboration between DMH and the criminal justice system.
- Education for criminal justice personnel.
- Increase in number of early intervention and prevention programs.
- Improved assessment for at-risk individuals.
- The service needs for prevention/early intervention are listed in priority order, as follows:

1. Transitional programs for children being discharged from residential or Juvenile Justice placements
2. Non-traditional services to improve mental health, (e.g., recreation, social, yoga)
3. Pre-Medical Necessity
4. Outreach
5. Promotion
6. Home visitation for assessment, in-home services, prevention
7. Sexual, physical abuse
8. Learning Assessment-Interdisciplinary

Service Area 5: Santa Monica/West Los Angeles

"…Consultation and education regarding behavioral strategies effective with acting-out children might prevent mental health problems from becoming worse. Such strategies might also enable early identification and intervention with children who are experiencing the early onset of more persistent mental illness, possibly changing the course of the illness without lost developmental opportunities." - *SAAC 5 Final Report*

RECOMMENDATIONS

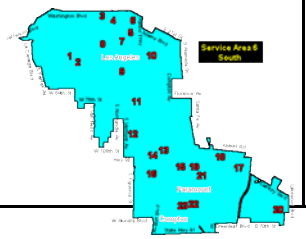


- Enhance early identification and prevention services for children. Identify opportunities to work with children birth to five, and with childcare providers (pre-schools, after-school and recreation programs) to ensure early identification of children at risk, and prompt assessment and treatment. Train childcare providers to identify children at risk and to conduct behavioral interventions that will ensure children remain in their schools, social and recreational settings.
- Identify opportunities to provide consultation and education for childcare providers including pre-schools, staff of the Parks and Recreation Department and staff of after-school programs.
- Collaboration with primary care providers to ensure early identification of older adults with mental health problems and improved coordination of care.
- Develop COS/gatekeeper programs. Many older adults with mental health issues "fall through the cracks" as they are not identified until they are in need of institutional care – and unable to meet any desired outcomes. Gatekeeper programs allow early identification and intervention with individuals who are beginning to deteriorate, In addition, the mental health issues of many older adults go unrecognized by primary are providers and others.

Service Area 6: South Central Los Angeles

"Outreach services to educate and outreach to families regarding the symptoms of emotional disturbance in children and its impact on a child's ability to succeed. Outreach services are particularly important for populations who typically under-utilize mental health services." *- SAAC 6 Final Report*

RECOMMENDATIONS

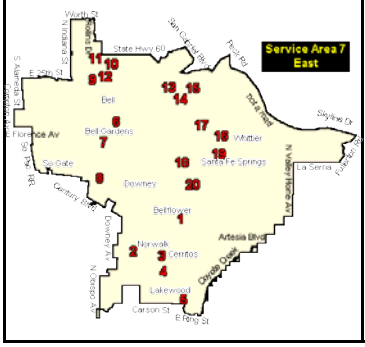


- Maintain and expand mental health promotion and community outreach to increase greater mental health system access and utilization.
- Provide public education to decrease stigma regarding mental health services. Provide education about older adult mental health issues to physicians and other care providers and decrease ageism.
- Maintain and expand evidence-based mental health services, including school-based services for children and families…

Service Area 7: South East Los Angeles

"Implement a program of mental health promotion, community outreach services, early intervention, and prevention to the community at large to increase awareness of mental health concerns for children and of mental health services and resources to address them." *- SAAC 7 Final Report*

RECOMMENDATIONS

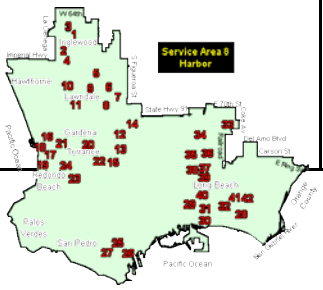


- Early intervention services need to be implemented for clients at all ages and stages of development. Such early intervention must include outreach to educate primary care physicians on the signs and symptoms to look for and the means for referral to appropriate services.
- SAAC 7 sees Early Intervention as having three main dimensions: through mental health promotion, through self-help activities like Project Return, and through clinician outreach services in non-traditional ways. The innovative, non-traditional clinic approach would be for people with prodromal symptoms and be modeled upon the work now being done in Australia's mental health system. Such early intervention outreach must be built upon a sound conceptualized through outcome studies to validate its effectiveness.

Service Area 8: South Bay/Long Beach

"Providing short term mental health services to children who do not yet meet medical necessity criteria but would benefit from those services and ultimately not need longer term services. This relates to the early intervention component of the MHSA." *- SAAC 8 Final Report*

RECOMMENDATIONS



- An early intervention program that provides education, outreach and treatment services to individuals in the community who experienced a first break or who are deemed at significant risk for developing a serious and persistent mental illness. Services would include psychotherapy, psychoeducation, medication as needed, linkage and family work since many of the clients would likely still be living with family.

APPENDIX 8

Summary of Community Survey Results

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU

MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMUNITY SURVEY RESULTS

Following the release in September 2007 of the California State Department of Mental Health's final proposed guidelines for the Mental Health Services Act (MHSA) Prevention and Early Intervention Plan (PEI), the Los Angeles County Department of Mental Health (LACDMH) began an intensive planning process. An initial step undertaken by LACDMH was to distribute a community survey requesting input to the planning for PEI programs in local communities. The survey was used to gather initial feedback regarding priorities on three components of PEI planning in Los Angeles County: (1) key PEI community mental health needs, (2) PEI priority populations, and (3) PEI age groups.

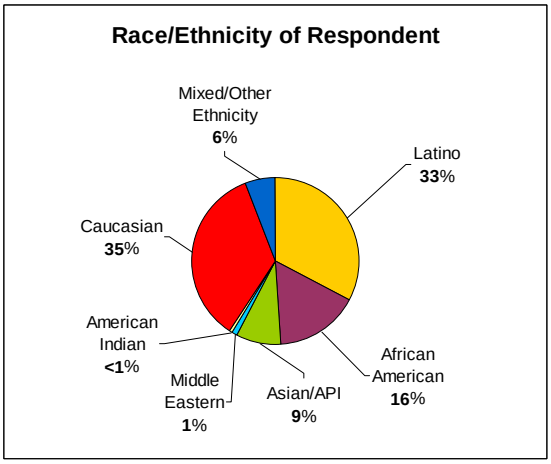
The PEI community survey was administered in English and Spanish to individuals who attended a PEI informational presentation between October 2007 and April 2008. LACDMH staff gave informational presentations at all eight Service Area Advisory Committee (SAAC) meetings and the Board of Supervisors' community forums, as well as at other PEI sector, service area, and countywide meetings. The surveys were handed out at over 90 meetings, and over 1,500 surveys were completed and tabulated.

I. Demographic Characteristics of Survey Respondents

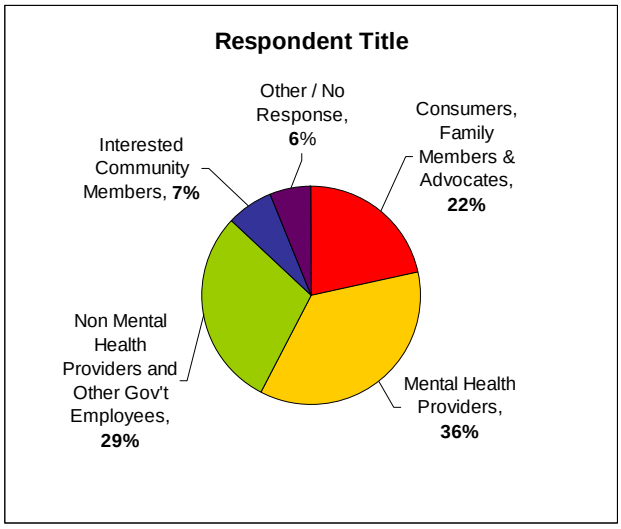
Individuals were asked to report on several attributes in order to assist LACDMH in identifying the characteristics of the survey respondents. Survey respondents self-reported the following attributes:

Gender	
Male	*Female*
27%	73%

Age		
15-25	*26-59*	*60+*
6%	82%	12%



The respondents also represented a broad range of interests and organizations. More than one-third of the respondents were mental health services providers, about one-third were non-mental health providers, and consumers, family members and mental health advocates comprised 22% of the respondents.

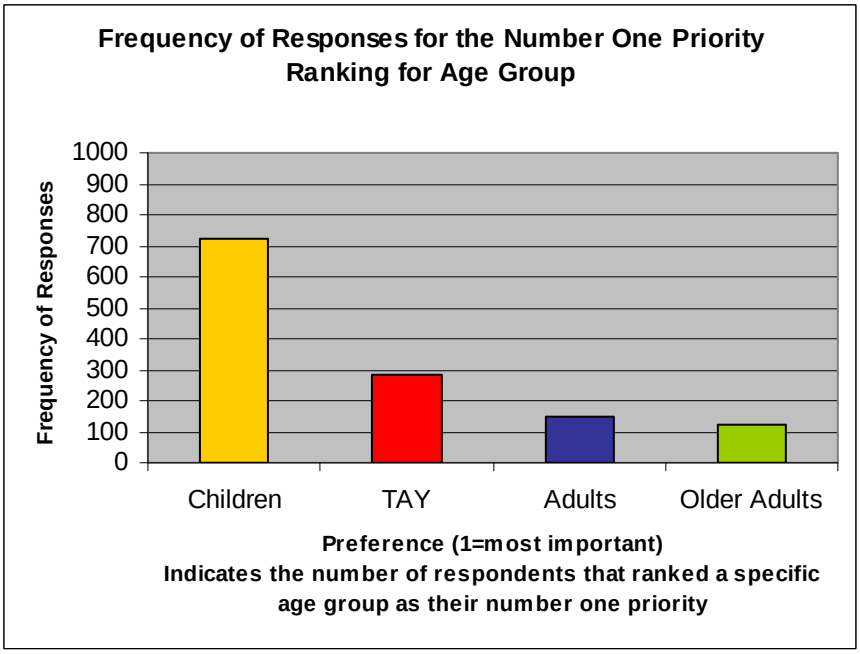


Organization/Affiliation	Percent
None	2.99
Consumer/Family	9.34
Mental Health	33.42
Health	6.29
Education	16.35
Social Services	15.90
Law Enforcement	8.50
Los Angeles County Department	2.21
Other Government Agency	1.23
Other	14.34

Total will not equal 100% as respondents were not limited to only one selection.

II. Age Group Rankings

When asked to select an age group as their top priority to receive PEI services in communities, the majority ranked children as their most important priority group. The community survey results indicate that children ages 0-15 were ranked as the number one priority age group, followed by transition-age youth (TAY) ages 16-25. A rank of "1" was considered the "most important" age group for PEI services in the respondent's community and a rank of "4" was considered the "least important".

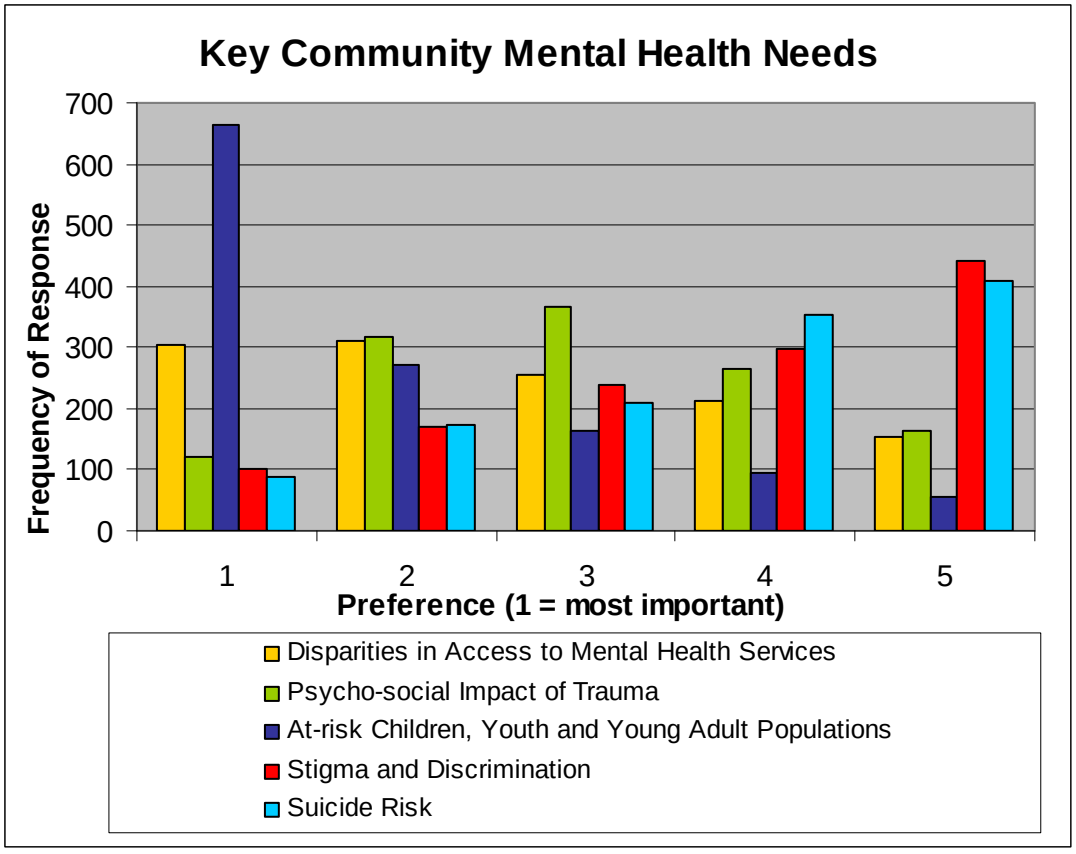


Ranking	Age Group
1	Children
2	TAY
3	Adults
4	Older Adults

III. Key Community Mental Health Needs

Respondents consistently ranked as their key PEI community mental health needs the categories of At-risk Children, Youth and Young Adults and Disparities in Access to Mental Health Services. A rank of "1" was considered the "most important" key PEI mental health need in the respondent's community and a rank of "5" was considered the "least important".

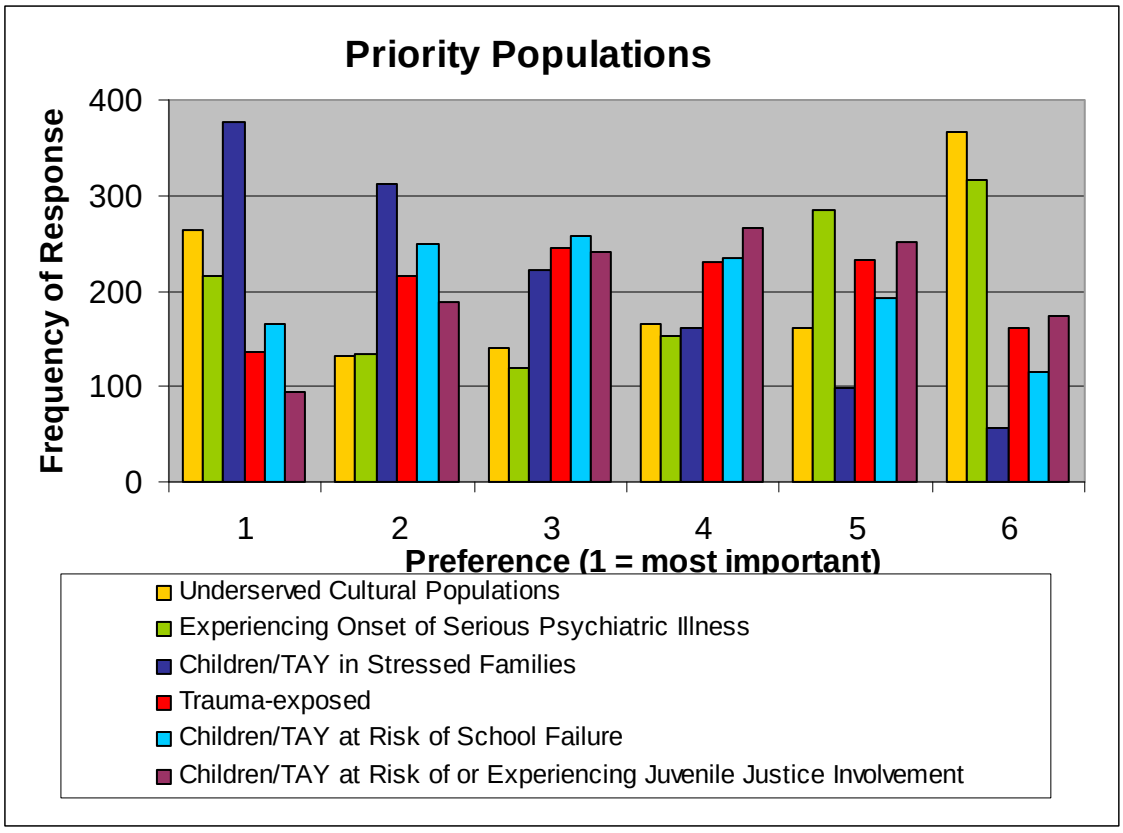
Rank (Median)	Key Community Mental Health Needs	
1	At-risk Children, Youth, and Young Adult Populations	
2	Disparities in Access to Mental Health Services	
3	Psycho-social Impact of Trauma	
4	Stigma and Discrimination	Stigma and Discrimination and Suicide Risk were consistently ranked as "least important" by the survey respondents
	Suicide Risk	



IV. PEI Priority Populations

Respondents were asked to rank the various PEI priority populations in order of importance. Respondents indicated a clear preference for services directed toward Children and Youth in Stressed Families, but no other priority populations had consistent highly-ranked results. A rank of "1" was considered the "most important" PEI priority population in the respondent's community and a rank of "6" was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, there were two populations which received a rank of "2" and "3". These results indicate that survey respondents have little agreement on which PEI priority populations should be served, other than a slight preference for Children/Youth in Stressed Families followed by Children/Youth at Risk for School Failure.

Rank (Median)	Priority Populations	
2	Children/Youth in Stressed Families	Note: The results of these categories are unable to be properly "ranked" due to the wide variance in the results. Regardless, Children/Youth in Stressed Families was clearly the first priority and Children/Youth at Risk for School Failure was the second priority.
3	Children/Youth at Risk for School Failure	
4	Trauma-exposed	
4	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	
4	Individuals Experiencing Onset of Serious Psychiatric Illness	
4	Underserved Cultural Populations	



COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU

MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMUNITY SURVEY RESULTS
MULTI-SERVICE AREA RESPONDENTS

Following the release in September 2007 of the California State Department of Mental Health's final proposed guidelines for the Mental Health Services Act (MHSA) Prevention and Early Intervention Plan (PEI), the Los Angeles County Department of Mental Health (LACDMH) began an intensive planning process. An initial step undertaken by LACDMH was to distribute a community survey requesting input to the planning for PEI programs in local communities. The survey was used to gather initial feedback regarding priorities on three components of PEI planning in Los Angeles County: (1) key PEI community mental health needs, (2) PEI priority populations, and (3) PEI age groups.

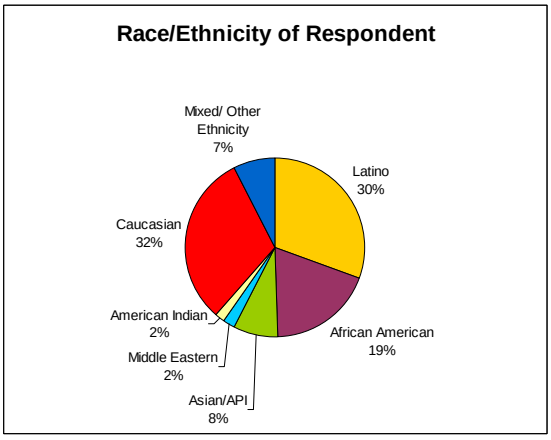
The PEI community survey was administered in English and Spanish to individuals who attended a PEI informational presentation between October 2007 and April 2008. LACDMH staff gave informational presentations at all eight Service Area Advisory Committee (SAAC) meetings and the Board of Supervisors' community forums, as well as at other PEI sector, service area, and countywide meetings. The surveys were handed out at over 50 meetings. Over 1,500 surveys were completed and tabulated, 351 of which were tabulated as multi-service area responses (where respondents indicated more than one service area on their survey).

I. Demographic Characteristics of Survey Respondents

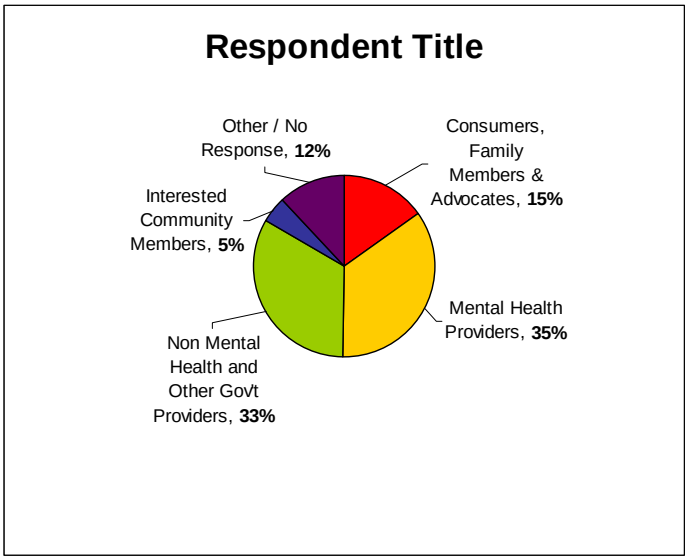
Individuals were asked to report on several attributes in order to assist LACDMH in identifying the characteristics of the survey respondents. Survey respondents self-reported the following attributes:

Gender	
Male	*Female*
22%	78%

Age		
15-25	*26-59*	*60+*
4%	83%	13%



The respondents also represented a broad range of interests and organizations. More than one-third of the respondents were mental health providers, one-third were non-mental health providers, and consumers, family members and mental health advocates comprised approximately 15% of the respondents.

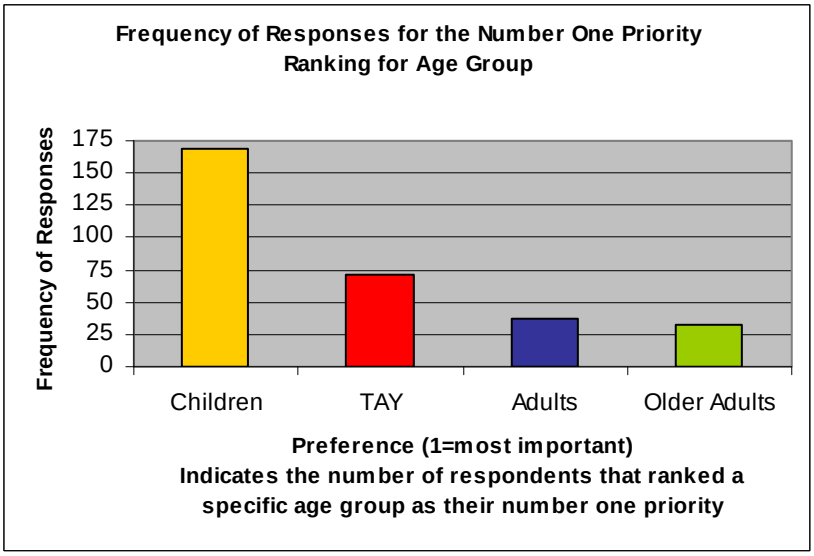


Organization/Affiliation	Percent
None	.28
Consumer/Family	4.27
Mental Health	29.91
Health	7.41
Education	15.67
Social Service	17.95
Law Enforcement	12.54
Los Angeles County Department	3.99
Other Government Agency	.57
Other	19.66

Total will not equal 100% as respondents were not limited to only one selection.

II. Age Group Rankings

When asked to select an age group as their top priority to receive PEI services in communities, the majority (55%) ranked children as their most important priority group. The community survey results indicate that children ages 0-15 was ranked as the number one priority age group, followed by transition-age youth (TAY) ages 16-25. A rank of "1" was considered the "most important" age group for PEI services in the respondent's community and a rank of "4" was considered the "least important".

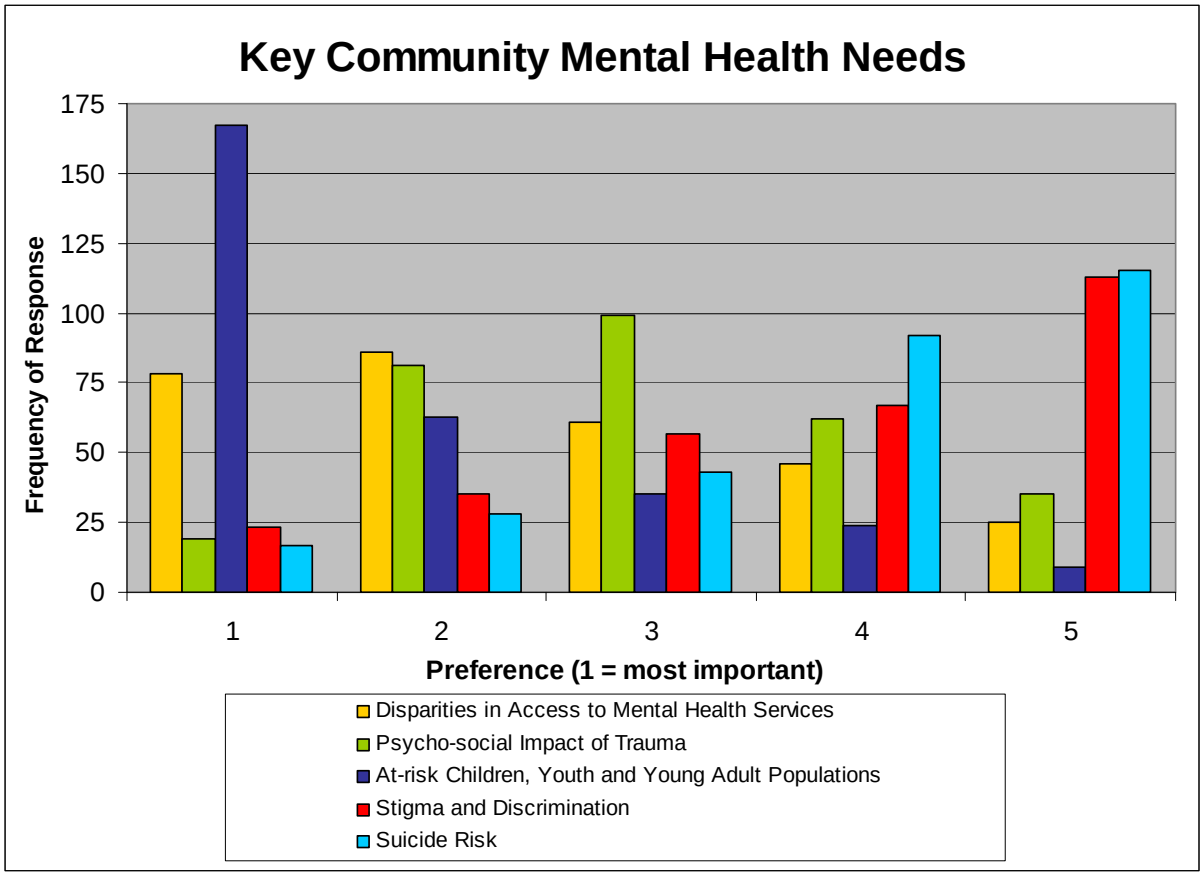


Ranking	Age Group
1	Children
2	TAY
3	Adults
4	Older Adults

III. Key Community Mental Health Needs

The majority (56%) of Multi-Service Area respondents ranked their top key PEI community mental health need as At-risk Children, Youth and Young Adults. The categories of Disparities in Access to Mental Health Services and Trauma-Exposed followed the top ranking, while Suicide Risk and Stigma and Discrimination were ranked least important. A rank of "1" was considered the "most important" PEI key mental health need in the respondent's community and a rank of "5" was considered the "least important".

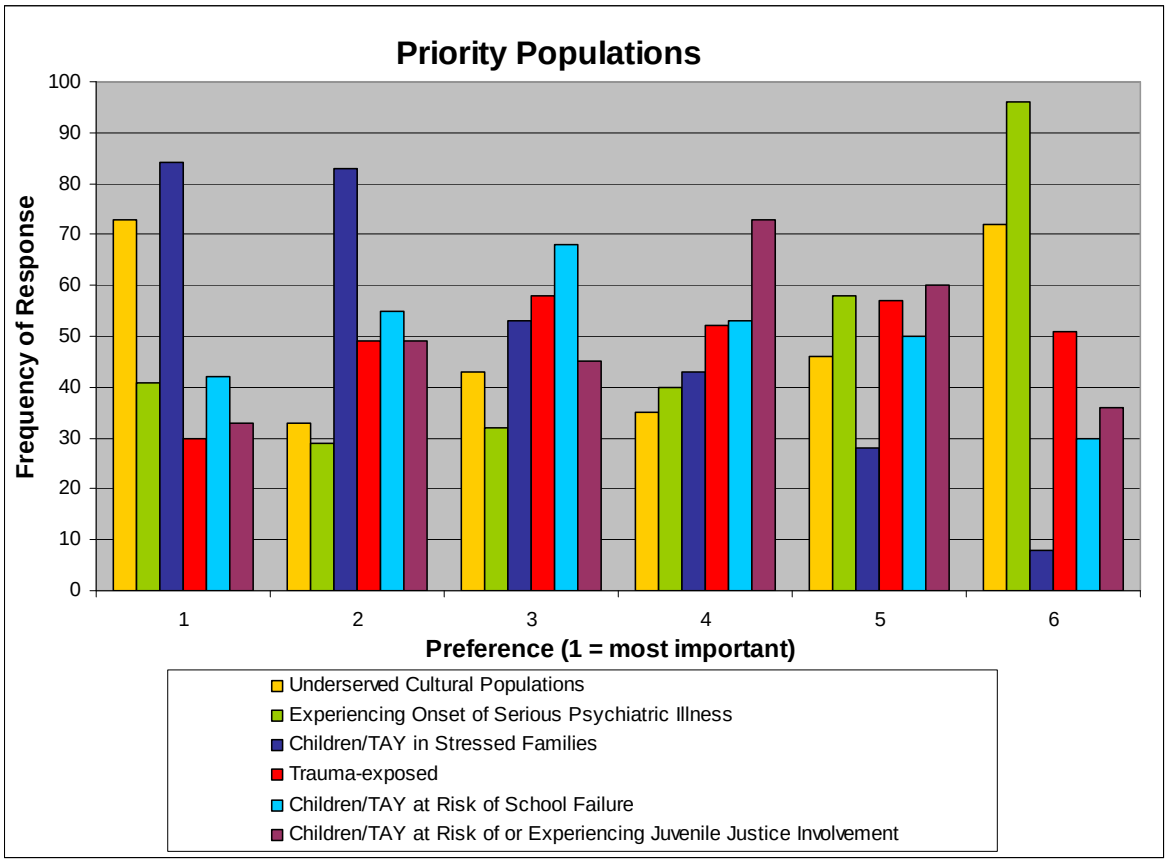
Rank (Median)	Key Community Mental Health Needs	
1	At-risk Children, Youth, and Young Adult Populations	At-risk Children, Youth and Young Adult Populations ranked as the "most important" PEI key mental health needs across multi-service area respondents.
2	Disparities in Access to Mental Health Services	
3	Psycho-Social Impact of Trauma	
4	Suicide Risk	Suicide Risk and Stigma and Discrimination were ranked "least important".
4	Stigma and Discrimination	



IV. PEI Priority Populations

Respondents were asked to rank the various PEI priority populations in order of importance. Respondents indicated a clear preference for services directed toward Children and Youth in Stressed Families, but no other priority populations had consistent highly-ranked results. A rank of "1" was considered the "most important" PEI priority population in the respondent's community and a rank of "6" was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, there were two populations which received a rank of "2" and "3". These results indicate that Multi-Service Area survey respondents have little agreement on which PEI priority populations should be served other than a slight preference for Children/Youth in Stressed Families.

Rank (Median)	Priority Populations	
2	Children/Youth in Stressed Families	Note: The results of these categories are unable to be properly "ranked" due to the wide variance in the results. Regardless, Children/Youth in Stressed Families was clearly the first priority and Children/Youth at Risk for School Failure was the next highest priority.
3	Children/Youth at Risk for School Failure	
4	Trauma-exposed	
4	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	
4	Underserved Cultural Populations	
5	Individuals Experiencing Onset of Serious Psychiatric Illness	



COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU

MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMUNITY SURVEY RESULTS
SERVICE AREA 1

Following the release in September 2007 of the California State Department of Mental Health's final proposed guidelines for the Mental Health Services Act (MHSA) Prevention and Early Intervention Plan (PEI), the Los Angeles County Department of Mental Health (LACDMH) began an intensive planning process. An initial step undertaken by LACDMH was to distribute a community survey requesting input to the planning for PEI programs in local communities. The survey was used to gather initial feedback regarding priorities on three components of PEI planning in Los Angeles County: (1) key PEI community mental health needs, (2) PEI priority populations, and (3) PEI age groups.

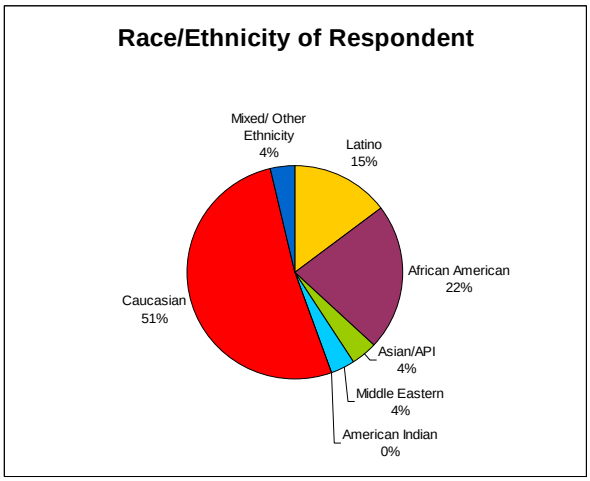
The PEI community survey was administered in English and Spanish to individuals who attended a PEI informational presentation between October 2007 and April 2008. LACDMH staff gave informational presentations at all eight Service Area Advisory Committee (SAAC) meetings and the Board of Supervisors' community forums, as well as at other PEI sector, service area, and countywide meetings. The surveys were handed out at over 90 meetings. Over 1,500 surveys were completed and tabulated, 45 of which were tabulated specifically for Service Area 1.

I. Demographic Characteristics of Survey Respondents

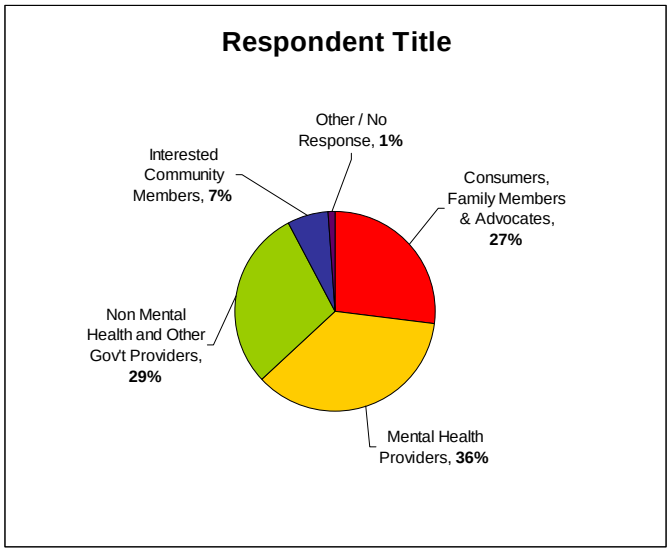
Individuals were asked to report on several attributes in order to assist LACDMH in identifying the characteristics of the survey respondents. Survey respondents self-reported the following attributes:

Gender	
Male	*Female*
24%	76%

Age		
15-25	*26-59*	*60+*
0%	85%	15%



The respondents also represented a broad range of interests and organizations. More than one-third of the respondents were mental health providers, less than one-third were non-mental health providers, and consumers, family members and mental health advocates comprised 27% of the respondents.

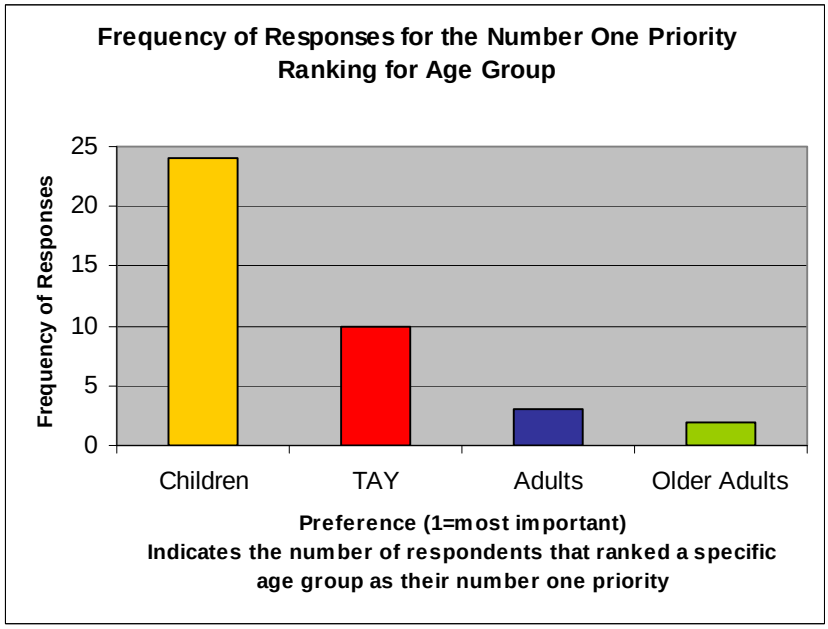


Organization/Affiliation	Percent
None	6.67
Consumer/Family	15.56
Mental Health	37.78
Health	4.44
Education	22.22
Social Service	6.67
Law Enforcement	2.22
Los Angeles County Department	0
Other Government Agency	0
Other	13.33

Total will not equal 100% as respondents were not limited to only one selection.

II. Age Group Rankings

When asked to select an age group as their top priority to receive PEI services in communities, the majority (61%) ranked children as their most important priority group. The community survey results indicate that children ages 0-15 was ranked as the number one priority age group, followed by transition-age youth (TAY) ages 16-25. A rank of "1" was considered the "most important" age group for PEI services in the respondent's community and a rank of "4" was considered the "least important".

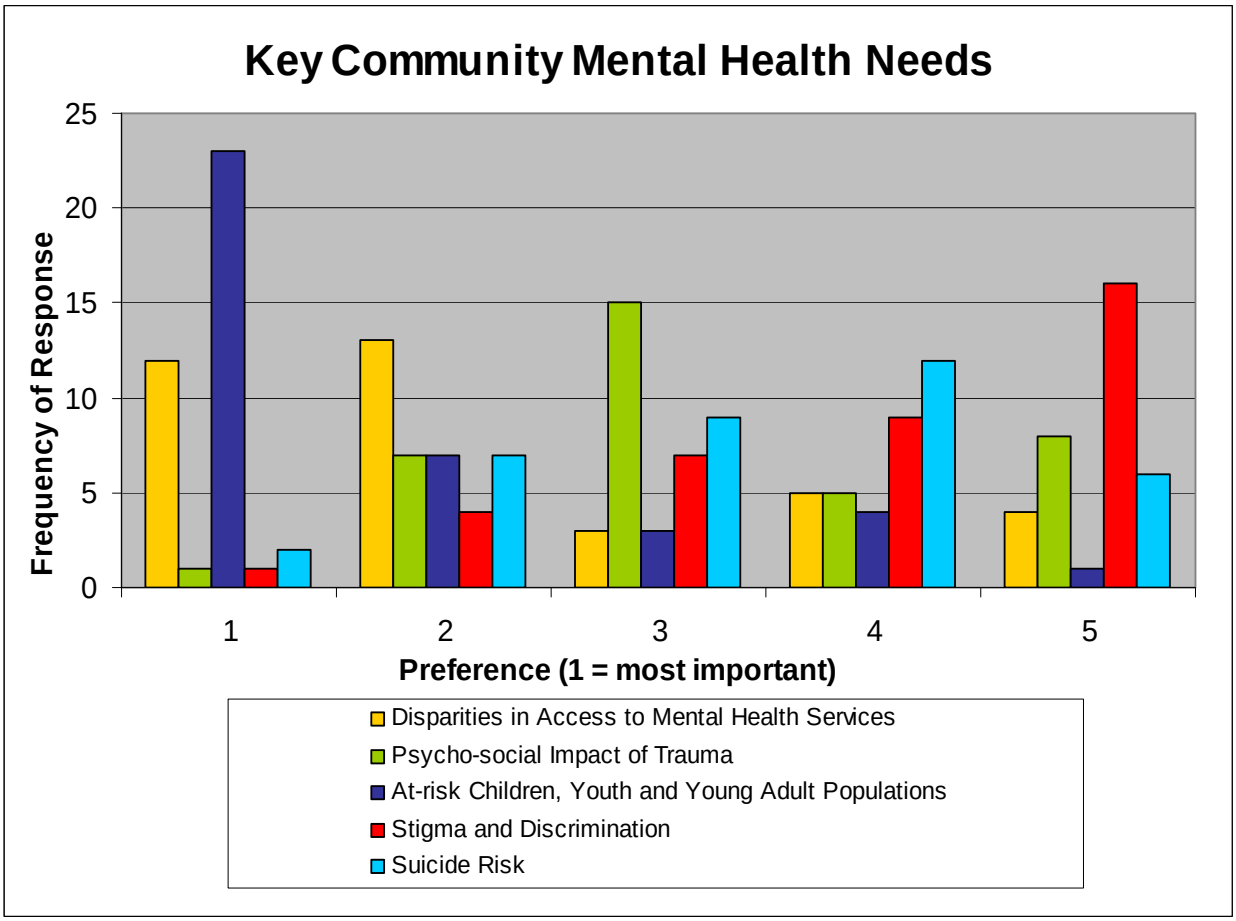


Ranking	Age Group
1	Children
2	TAY
3	Adults
4	Older Adults

III. Key Community Mental Health Needs

Service Area 1 respondents consistently ranked their key PEI community mental health needs as the categories of At-risk Children, Youth and Young Adults and Disparities in Access to Mental Health Services. A rank of "1" was considered the "most important" PEI key mental health need in the respondent's community and a rank of "5" was considered the "least important".

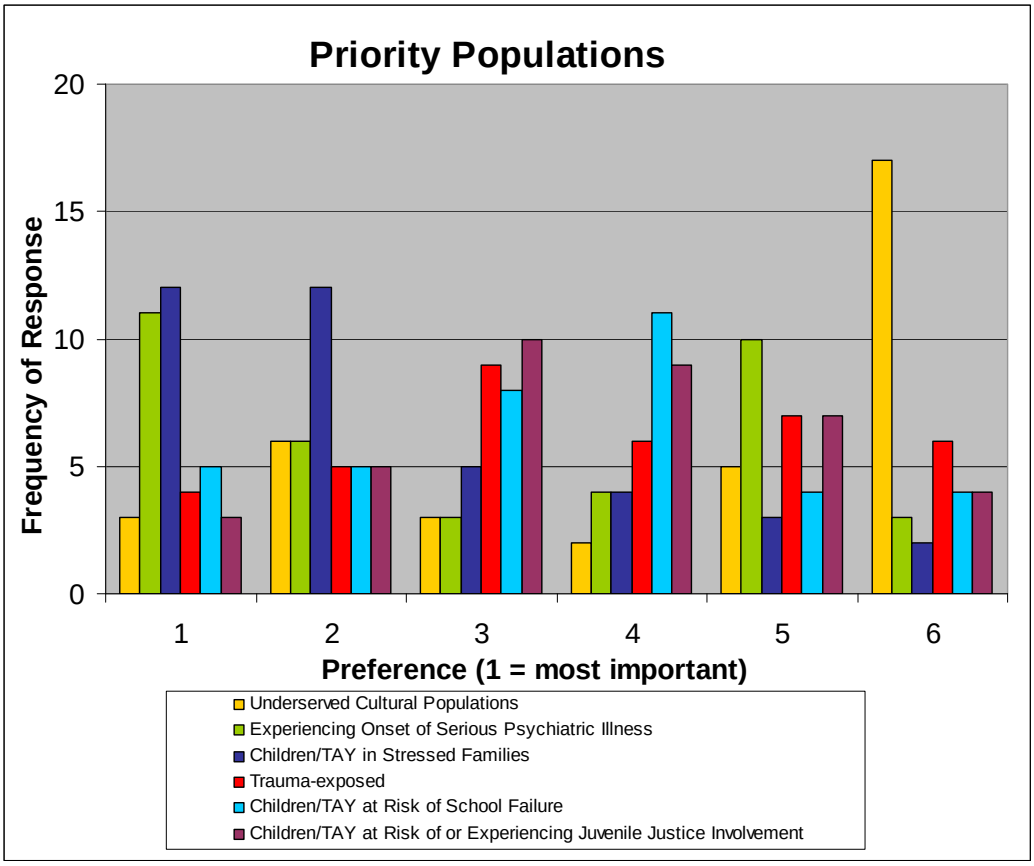
Rank (Median)	Key Community Mental Health Needs	
1	At -risk Children, Youth, and Young Adult Populations	
2	Disparities in Access to Mental Health Services	
3	Psycho-Social Impact of Trauma	
4	Stigma and Discrimination	Stigma and Discrimination and Suicide Risk were consistently ranked as "least important" by Service Area 1 respondents.
	Suicide Risk	



IV. PEI Priority Populations

Respondents were asked to rank the various PEI priority populations in order of importance. Respondents indicated a clear preference for services directed toward Children and Youth in Stressed Families, but no other priority populations had consistent highly-ranked results. A rank of "1" was considered the "most important" PEI priority population in the respondent's community and a rank of "6" was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, there were two populations which received a rank of "2" and "3". These results indicate that Service Area 1 survey respondents have little agreement on which PEI priority populations should be served other than a slight preference for Children/Youth in Stressed Families followed by Children/Youth at Risk for School Failure.

Rank (Median)	Priority Populations	
2	Children/Youth in Stressed Families	Note: The results of these categories are unable to be properly "ranked" due to the wide variance in the results. Regardless, Children/Youth in Stressed Families was clearly the first priority and Children/Youth at Risk for School Failure was the second priority. Underserved Cultural Populations was ranked as the lowest priority in Service Area 1.
3	Children/Youth at Risk for School Failure	
4	Trauma-exposed	
4	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	
4	Individuals Experiencing Onset of Serious Psychiatric Illness	
5	Underserved Cultural Populations	



SUMMARY OF COMMUNITY SURVEY RESULTS
SERVICE AREA 2

Following the release in September 2007 of the California State Department of Mental Health's final proposed guidelines for the Mental Health Services Act (MHSA) Prevention and Early Intervention Plan (PEI), the Los Angeles County Department of Mental Health (LACDMH) began an intensive planning process. An initial step undertaken by LACDMH was to distribute a community survey requesting input to the planning for PEI programs in local communities. The survey was used to gather initial feedback regarding priorities on three components of PEI planning in Los Angeles County: (1) key PEI community mental health needs, (2) PEI priority populations, and (3) PEI age groups.

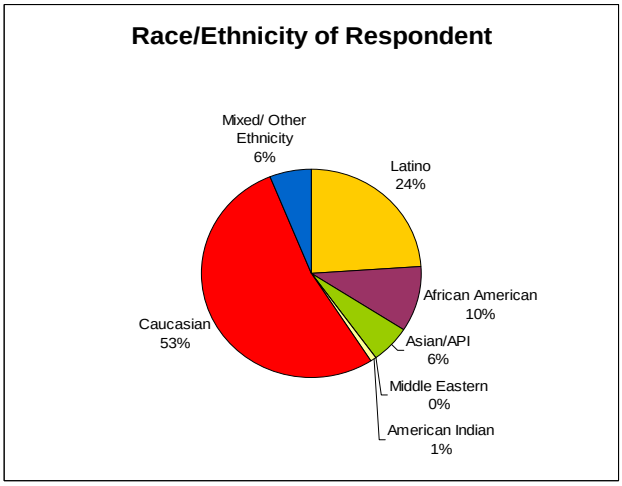
The PEI community survey was administered in English and Spanish to individuals who attended a PEI informational presentation between October 2007 and April 2008. LACDMH staff gave informational presentations at all eight Service Area Advisory Committee (SAAC) meetings and the Board of Supervisors' community forums, as well as at other PEI sector, service area, and countywide meetings. The surveys were handed out at over 90 meetings. Over 1,500 surveys were completed and tabulated, 223 of which were tabulated specifically for Service Area 2.

I. Demographic Characteristics of Survey Respondents

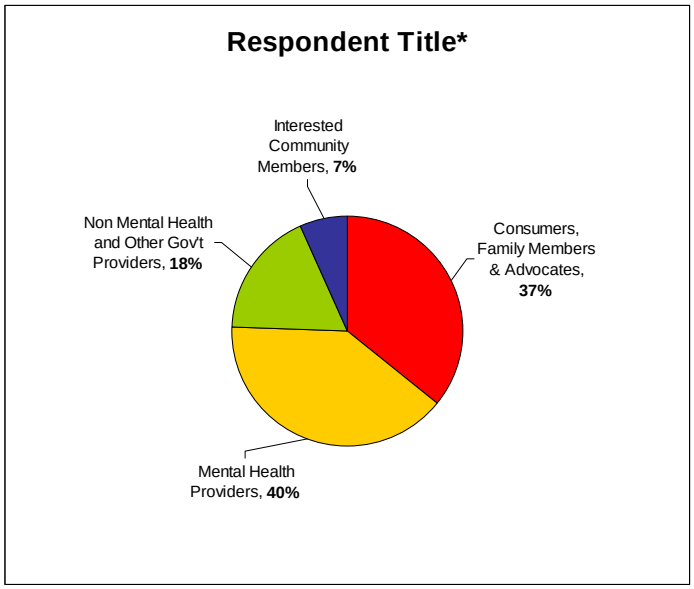
Individuals were asked to report on several attributes in order to assist LACDMH in identifying the characteristics of the survey respondents. Survey respondents self-reported the following attributes:

Gender	
Male	*Female*
30%	70%

Age		
15-25	*26-59*	*60+*
3%	79%	18%



The respondents also represented a broad range of interests and organizations. More that one-third of the respondents were mental health providers, less than one-fourth were non-mental health providers, and consumers, family members and mental health advocates comprised 37% of the respondents.



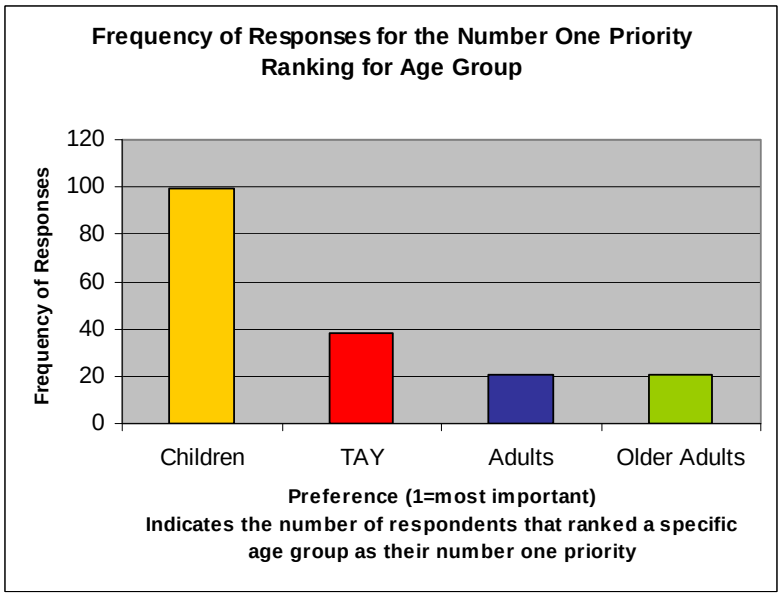
Organization/Affiliation	Percent
None	3.14
Consumer/Family	16.14
Mental Health	45.29
Health	6.73
Education	13.45
Social Service	3.14
Law Enforcement	3.14
Los Angeles County Department	0
Other Government Agency	0.45
Other	11.66

Total will not equal 100% as respondents were not limited to only one selection.

* Total will not equal 100% as respondents were not limited to only one selection.

II. Age Group Rankings

When asked to select an age group as their top priority to receive PEI services in communities, the majority (55%) ranked children as their most important priority group. The community survey results indicate that children ages 0-15 was ranked as the number one priority age group, followed by transition-age youth (TAY) ages 16-25. A rank of "1" was considered the "most important" age group for PEI services in the respondent's community and a rank of "4" was considered the "least important".

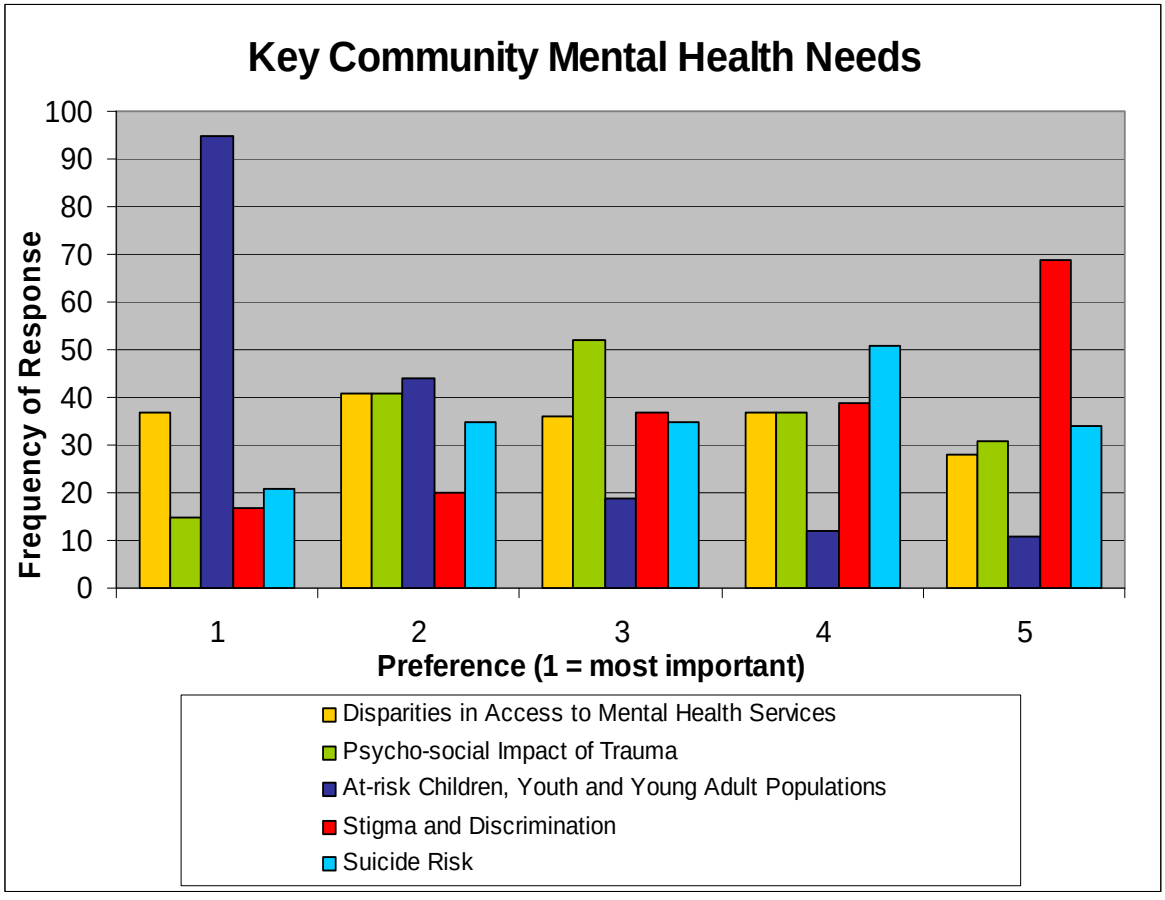


Ranking	Age Group
1	Children
2	TAY
3	Adults
4	Older Adults

III. Key Community Mental Health Needs

The majority (52%) of Service Area 2 respondents consistently ranked their top key PEI community mental health need as At-risk Children, Youth and Young Adults. The categories of Trauma-Exposed and Disparities in Access to Mental Health Services were the next priorities, while Suicide Risk and Stigma and Discrimination were ranked least important. A rank of "1" was considered the "most important" PEI key mental health need in the respondent's community and a rank of "5" was considered the "least important".

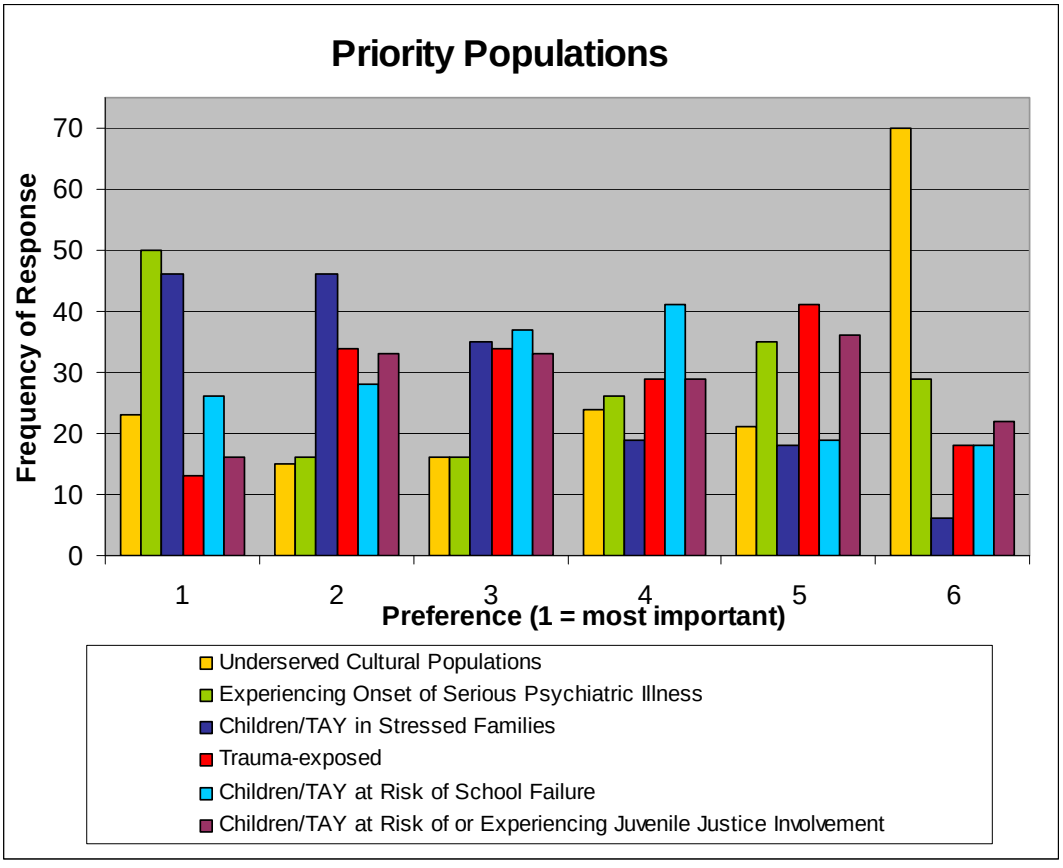
Rank (Median)	Key Community Mental Health Needs	
1	At-risk Children, Youth, and Young Adult Populations	At-risk Children, Youth and Young Adult Populations was ranked the "most important" PEI key mental health need in Service Area 2.
3	Disparities in Access to Mental Health Services	
3	Psycho-Social Impact of Trauma	
3	Suicide Risk	
4	Stigma and Discrimination	Stigma and Discrimination was ranked "least important" by the Service Area 2 respondents.



IV. PEI Priority Populations

Respondents were asked to rank the various PEI priority populations in order of importance. Respondents indicated a clear preference for services directed toward Children and Youth in Stressed Families, but no other priority populations had consistent highly-ranked results. A rank of "1" was considered the "most important" PEI priority population in the respondent's community and a rank of 6 was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, there were two populations which received a rank of "2" and "3". These results indicate that Service Area 2 survey respondents have little agreement on which PEI priority populations should be served other than a slight preference for Children/Youth in Stressed Families followed by Children/Youth at Risk for School Failure.

Rank (Median)	Priority Populations	
2	Children/Youth in Stressed Families	Note: The results of these categories are unable to be properly "ranked" due to the wide variance in the results. Regardless, Children/Youth in Stressed Families was clearly the first priority and Children/Youth at Risk for School Failure was the second priority. Underserved Cultural Populations were ranked as the lowest priority in Service Area 2.
3	Children/Youth at Risk for School Failure	
4	Trauma-exposed	
4	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	
4	Individuals Experiencing Onset of Serious Psychiatric Illness	
5	Underserved Cultural Populations	



COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU

MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMUNITY SURVEY RESULTS
SERVICE AREA 3

Following the release in September 2007 of the California State Department of Mental Health's final proposed guidelines for the Mental Health Services Act (MHSA) Prevention and Early Intervention Plan (PEI), the Los Angeles County Department of Mental Health (LACDMH) began an intensive planning process. An initial step undertaken by LACDMH was to distribute a community survey requesting input to the planning for PEI programs in local communities. The survey was used to gather initial feedback regarding priorities on three components of PEI planning in Los Angeles County: (1) key PEI community mental health needs, (2) PEI priority populations, and (3) PEI age groups.

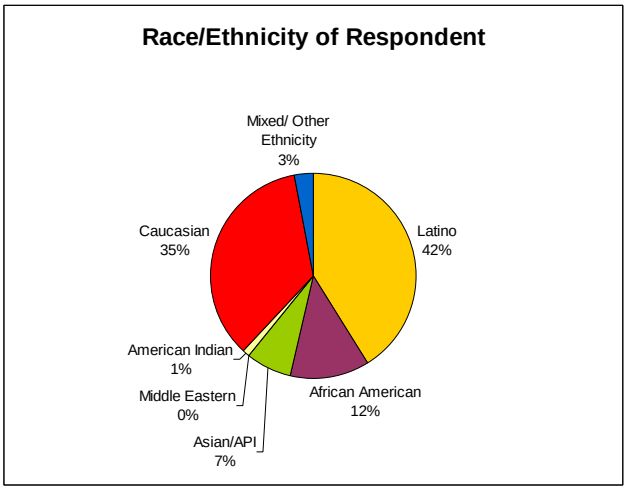
The PEI community survey was administered in English and Spanish to individuals who attended a PEI informational presentation between October 2007 and April 2008. LACDMH staff gave informational presentations at all eight Service Area Advisory Committee (SAAC) meetings and the Board of Supervisors' community forums, as well as at other PEI sector, service area, and countywide meetings. The surveys were handed out at over 90 meetings. Over 1,500 surveys were completed and tabulated, 136 of which were tabulated specifically for Service Area 3.

I. Demographic Characteristics of Survey Respondents

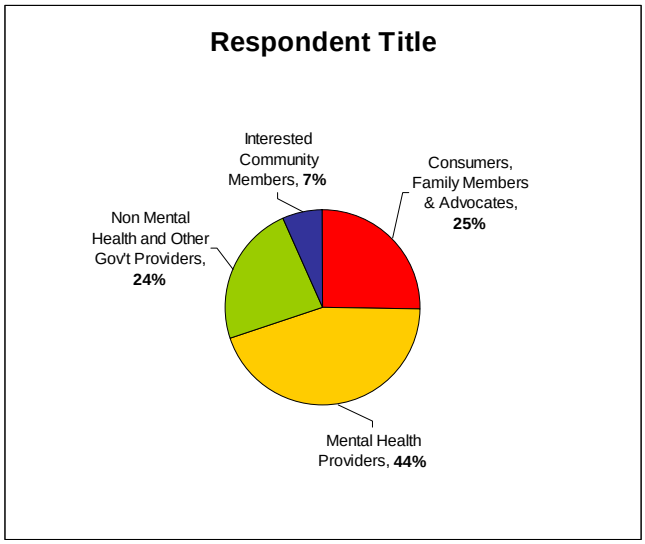
Individuals were asked to report on several attributes in order to assist LACDMH in identifying the characteristics of the survey respondents. Survey respondents self-reported the following attributes:

Gender	
Male	*Female*
35%	65%

Age		
15-25	*26-59*	*60+*
7%	88%	5%



The respondents also represented a broad range of interests and organizations. More than one-third of the respondents were mental health providers, less than one-fourth were non-mental health providers, and consumers, family members and mental health advocates comprised 25% of the respondents.

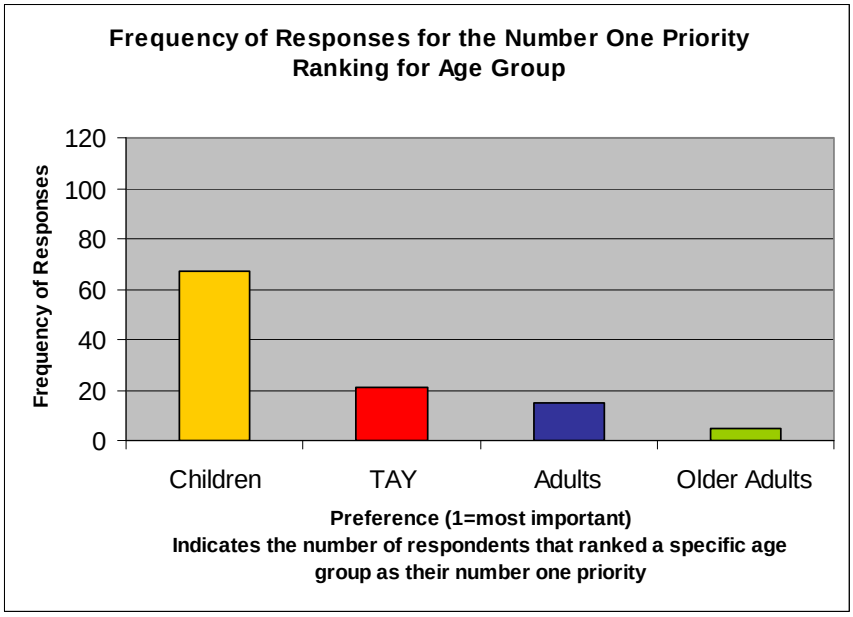


Organization/Affiliation	Percent
None	1.47
Consumer/Family	5.15
Mental Health	38.9
Health	5.15
Education	17.65
Social Service	11.03
Law Enforcement	11.03
Los Angeles County Department	.74
Other Government Agency	.74
Other	14.71

Total will not equal 100% as respondents were not limited to only one selection.

II. Age Group Rankings

When asked to select an age group as their top priority to receive PEI services in communities, the majority (62%) ranked children as their most important priority group. The community survey results indicate that children ages 0-15 was ranked as the number one priority age group, followed by transition-age youth (TAY) ages 16-25. A rank of "1" was considered the "most important" age group for PEI services in the respondent's community and a rank of "4" was considered the "least important".

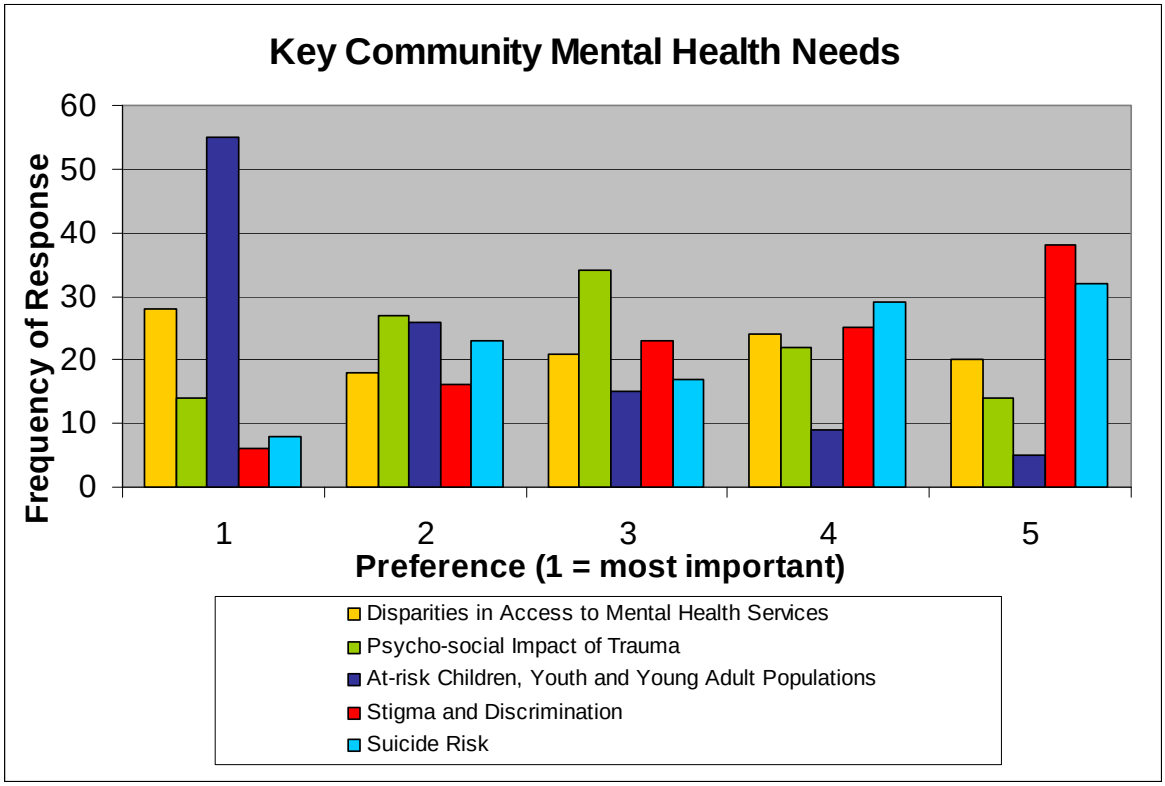


Ranking	Age Group
1	Children
2	TAY
3	Adults
4	Older Adults

III. Key Community Mental Health Needs

The majority (50%) of Service Area 3 respondents consistently ranked their top key PEI community mental health need as At-risk Children, Youth and Young Adults. The categories of Trauma-Exposed and Disparities in Access to Mental Health Services were the next priorities, while Suicide Risk and Stigma and Discrimination were ranked least important. A rank of "1" was considered the "most important" PEI key mental health need in the respondent's community and a rank of "5" was considered the "least important".

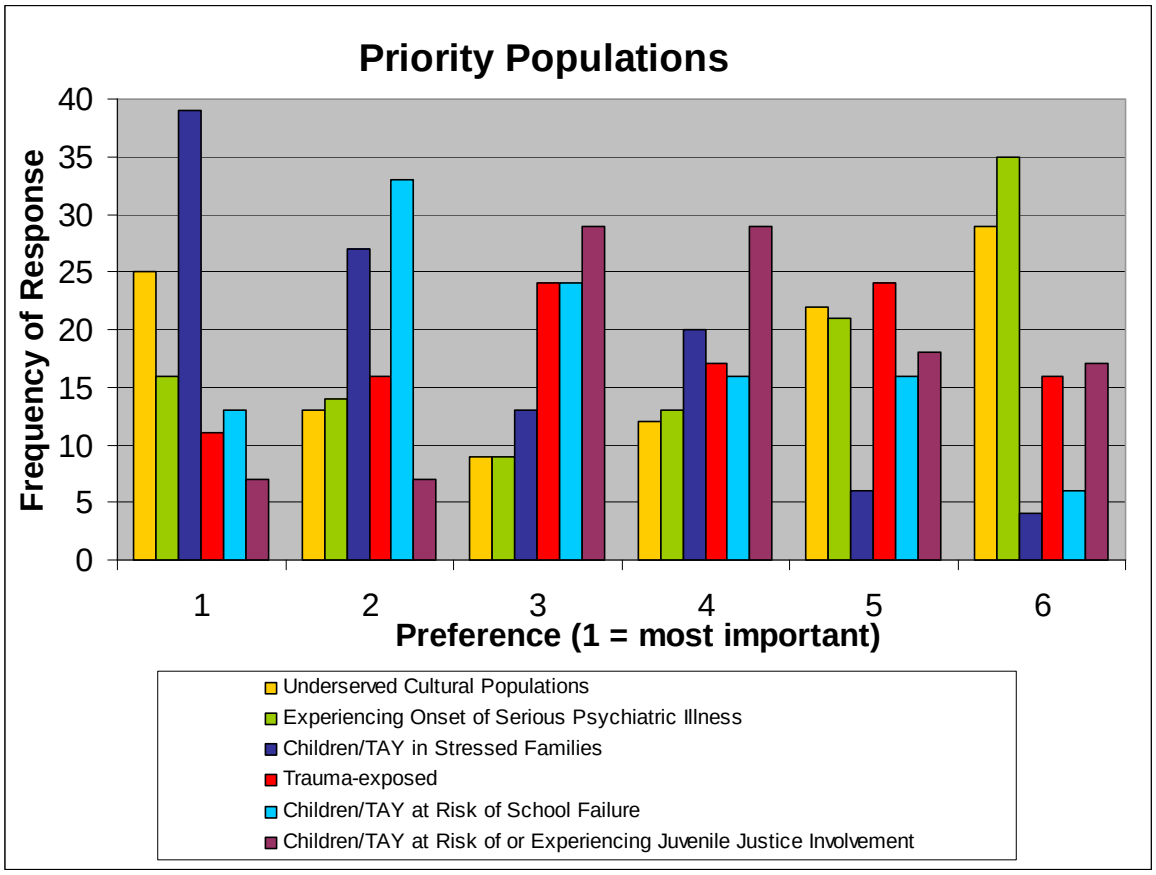
Rank (Median)	Key Community Mental Health Needs	
1	At-risk Children, Youth, and Young Adult Populations	At-risk Children, Youth and Young Adult Populations was ranked the "most important" PEI key mental health need in Service Area 3.
3	Disparities in Access to Mental Health Services	
3	Psycho-Social Impact of Trauma	
4	Suicide Risk	Suicide Risk and Stigma and Discrimination were ranked "least important" by Service Area 3 respondents.
4	Stigma and Discrimination	



IV. PEI Priority Populations

Respondents were asked to rank the various PEI priority populations in order of importance. Respondents indicated a clear preference for services directed toward Children and Youth in Stressed Families, but no other priority populations had consistent highly-ranked results. A rank of "1" was considered the "most important" PEI priority population in the respondent's community and a rank of "6" was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, there were two populations which received a rank of "2" and "3". These results indicate that Service Area 3 survey respondents have little agreement on which PEI priority populations should be served other than a slight preference for Children/Youth in Stressed Families followed by Trauma-Exposed.

Rank (Median)	Priority Populations	
2	Children/Youth in Stressed Families	Note: The results of these categories are unable to be properly "ranked" due to the wide variance in the results. Regardless, Children/Youth in Stressed Families was clearly the first priority and Trauma-exposed was the second priority.
3	Trauma-exposed	
4	Children/Youth at Risk for School Failure	
4	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	
4	Individuals Experiencing Onset of Serious Psychiatric Illness	
4	Underserved Cultural Populations	


Priority Populations
Frequency of Response
40
35
30
25
20
15
10
5
0
1
2
3
4
5
6
Preference (1 = most important)
Underserved Cultural Populations
Experiencing Onset of Serious Psychiatric Illness
Children/TAY in Stressed Families
Trauma-exposed
Children/TAY at Risk of School Failure
Children/TAY at Risk of or Experiencing Juvenile Justice Involvement

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU

MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMUNITY SURVEY RESULTS
SERVICE AREA 4

Following the release in September 2007 of the California State Department of Mental Health's final proposed guidelines for the Mental Health Services Act (MHSA) Prevention and Early Intervention Plan (PEI), the Los Angeles County Department of Mental Health (LACDMH) began an intensive planning process. An initial step undertaken by LACDMH was to distribute a community survey requesting input to the planning for PEI programs in local communities. The survey was used to gather initial feedback regarding priorities on three components of PEI planning in Los Angeles County: (1) key PEI community mental health needs, (2) PEI priority populations, and (3) PEI age groups.

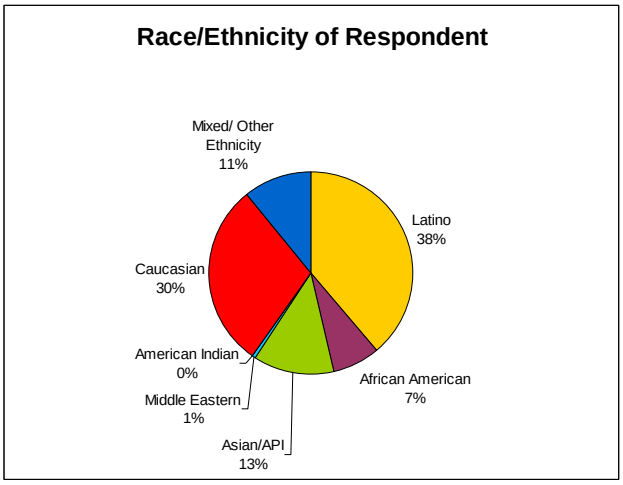
The PEI community survey was administered in English and Spanish to individuals who attended a PEI informational presentation between October 2007 and April 2008. LACDMH staff gave informational presentations at all eight Service Area Advisory Committee (SAAC) meetings and the Board of Supervisors' community forums, as well as at other PEI sector, service area, and countywide meetings. The surveys were handed out at over 90 meetings. Over 1,500 surveys were completed and tabulated, 220 of which were tabulated specifically for Service Area 4.

I. Demographic Characteristics of Survey Respondents

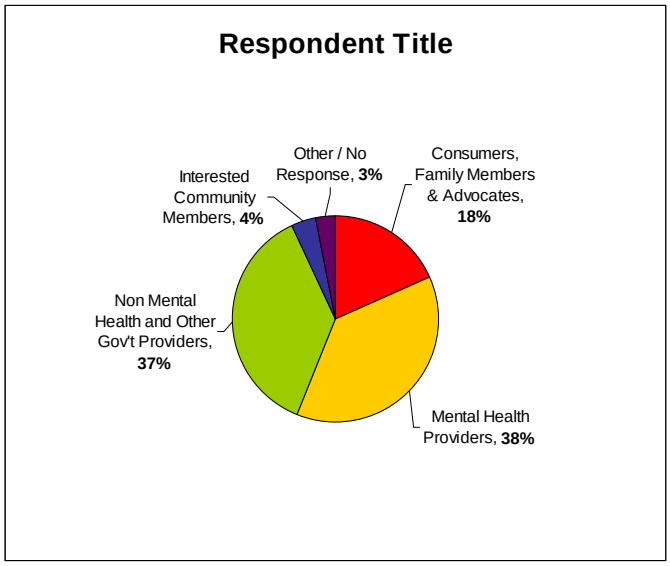
Individuals were asked to report on several attributes in order to assist LACDMH in identifying the characteristics of the survey respondents. Survey respondents self-reported the following attributes:

Gender	
Male	*Female*
38%	62%

Age		
15-25	*26-59*	*60+*
9%	80%	11%



The respondents also represented a broad range of interests and organizations. An almost an equal number of the respondents were mental health providers and non-mental health providers, while consumers, family members and mental health advocates comprised 18% of the respondents.

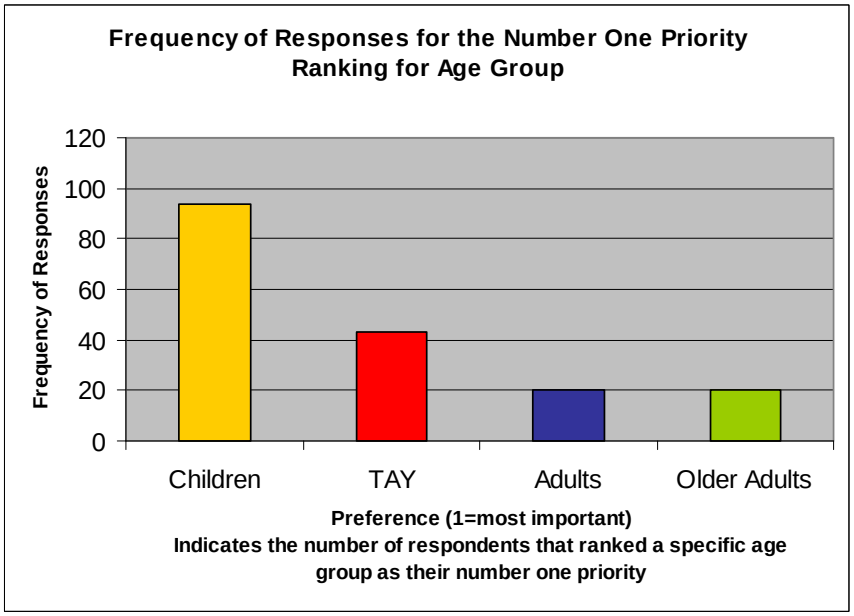


Organization/Affiliation	Percent
None	1.94
Consumer/Family	9.71
Mental Health	28.64
Health	7.28
Education	8.25
Social Service	33.50
Law Enforcement	3.88
Los Angeles County Department	0
Other Government Agency	0.49
Other	14.56

Total will not equal 100% as respondents were not limited to only one selection.

II. Age Group Rankings

When asked to select an age group as their top priority to receive PEI services in communities, the majority (53%) ranked children as their most important priority group. The community survey results indicate that children ages 0-15 was ranked as the number one priority age group, followed by transition-age youth (TAY) ages 16-25. A rank of "1" was considered the "most important" age group for PEI services in the respondent's community and a rank of "4" was considered the "least important".

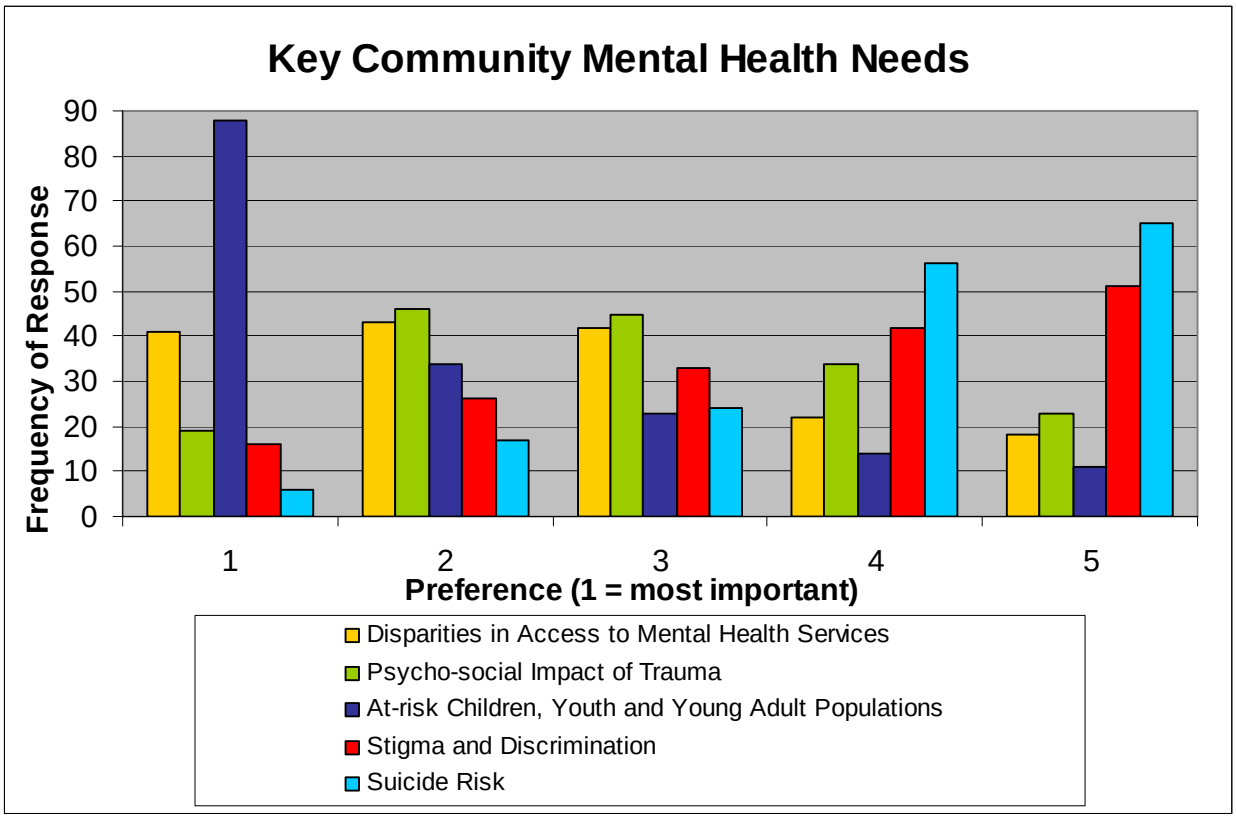


Ranking	Age Group
1	Children
2	TAY
3	Adults
4	Older Adults

III. Key Community Mental Health Needs

The majority (52%) of Service Area 4 respondents consistently ranked their top key PEI community mental health need as At-risk Children, Youth and Young Adults. The categories of Trauma-Exposed and Disparities in Access to Mental Health Services were the next priorities, while Suicide Risk and Stigma and Discrimination were ranked least important. A rank of "1" was considered the "most important" PEI key mental health need in the respondent's community and a rank of "5" was considered the "least important".

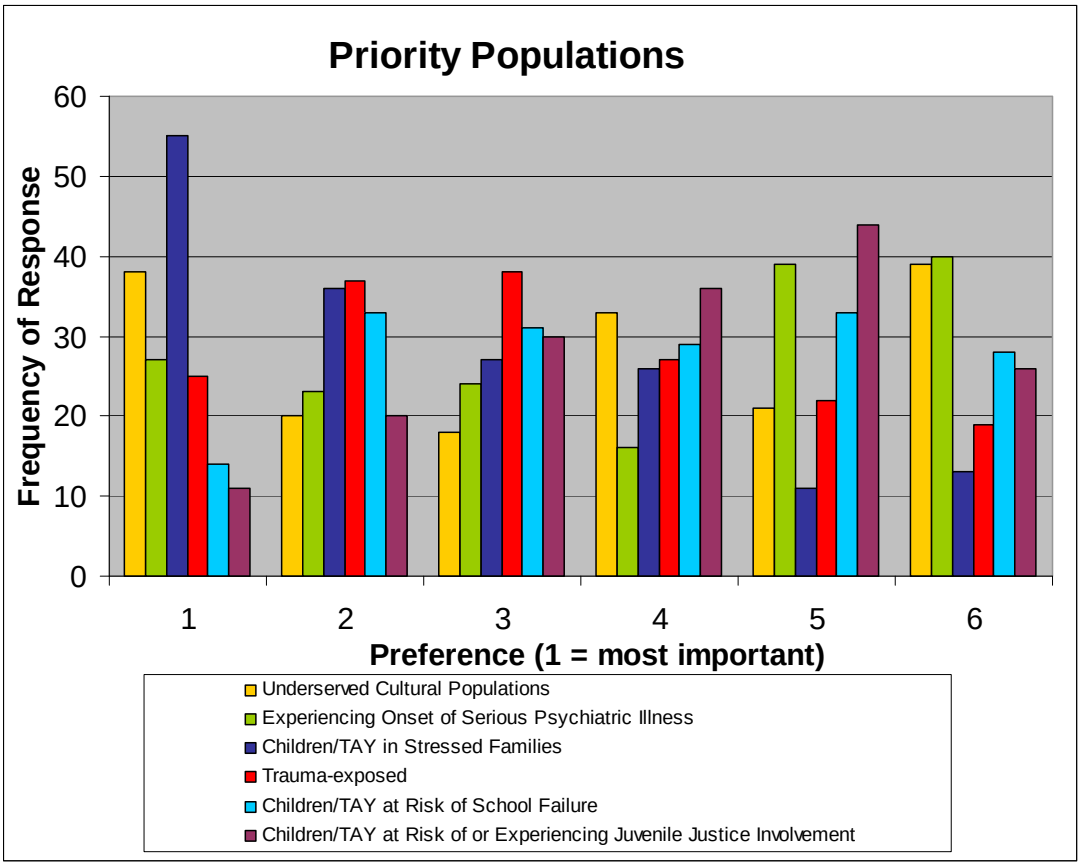
Rank (Median)	Key Community Mental Health Needs	
1	At-risk Children, Youth, and Young Adult Populations	At-risk Children, Youth and Young Adult Populations was ranked the "most important" PEI key mental health need in Service Area 4.
3	Disparities in Access to Mental Health Services	
3	Psycho-Social Impact of Trauma	
4	Suicide Risk	Suicide Risk and Stigma and Discrimination were ranked "least important" by the survey respondents
4	Stigma and Discrimination	



IV. PEI Priority Populations

Respondents were asked to rank the various PEI priority populations in order of importance. Respondents indicated a clear preference for services directed toward Children and Youth in Stressed Families, but no other priority populations had consistent highly-ranked results. A rank of "1" was considered the "most important" PEI priority population in the respondent's community and a rank of "6" was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, there were two populations which received a rank of "2" and "3". These results indicate that Service Area 4 survey respondents have little agreement on which PEI priority populations should be served other than a slight preference for Children/Youth in Stressed Families followed by Children/Youth at Risk for School Failure.

Rank (Median)	Priority Populations	
2	Children/Youth in Stressed Families	Note: The results of these categories are unable to be properly "ranked" due to the wide variance in the results. Regardless, Children/Youth in Stressed Families was clearly the first priority and Children/Youth at Risk for School Failure was the second priority.
3	Children/Youth at Risk for School Failure	
4	Trauma-exposed	
4	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	
4	Individuals Experiencing Onset of Serious Psychiatric Illness	
4	Underserved Cultural Populations	



SUMMARY OF COMMUNITY SURVEY RESULTS
SERVICE AREA 5

Following the release in September 2007 of the California State Department of Mental Health's final proposed guidelines for the Mental Health Services Act (MHSA) Prevention and Early Intervention Plan (PEI), the Los Angeles County Department of Mental Health (LACDMH) began an intensive planning process. An initial step undertaken by LACDMH was to distribute a community survey requesting input to the planning for PEI programs in local communities. The survey was used to gather initial feedback regarding priorities on three components of PEI planning in Los Angeles County: (1) key PEI community mental health needs, (2) PEI priority populations, and (3) PEI age groups.

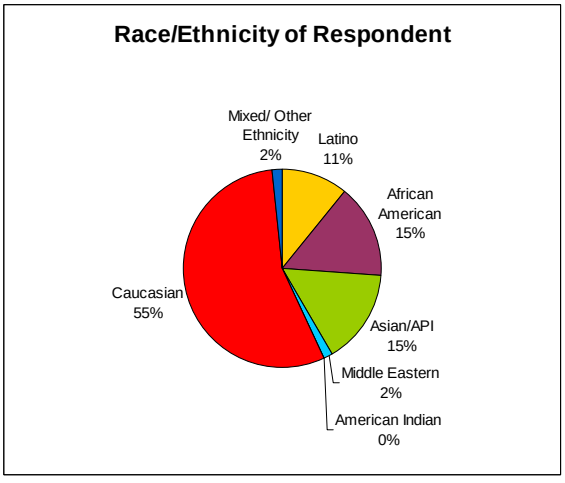
The PEI community survey was administered in English and Spanish to individuals who attended a PEI informational presentation between October 2007 and April 2008. LACDMH staff gave informational presentations at all eight Service Area Advisory Committee (SAAC) meetings and the Board of Supervisors' community forums, as well as at other PEI sector, service area, and countywide meetings. The surveys were handed out at over 90 meetings. Over 1,500 surveys were completed and tabulated, 87 of which were tabulated specifically for Service Area 5.

I. Demographic Characteristics of Survey Respondents

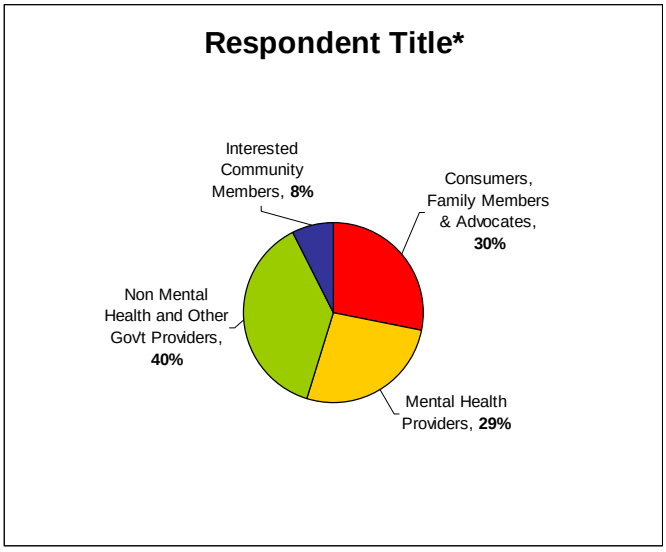
Individuals were asked to report on several attributes in order to assist LACDMH in identifying the characteristics of the survey respondents. Survey respondents self-reported the following attributes:

Gender	
Male	*Female*
25%	75%

Age		
15-25	*26-59*	*60+*
3%	77%	20%



The respondents also represented a broad range of interests and organizations. More than one-fourth of the respondents were mental health providers, more than one-third were non-mental health providers, and consumers, family members and mental health advocates comprised 30% of the respondents.



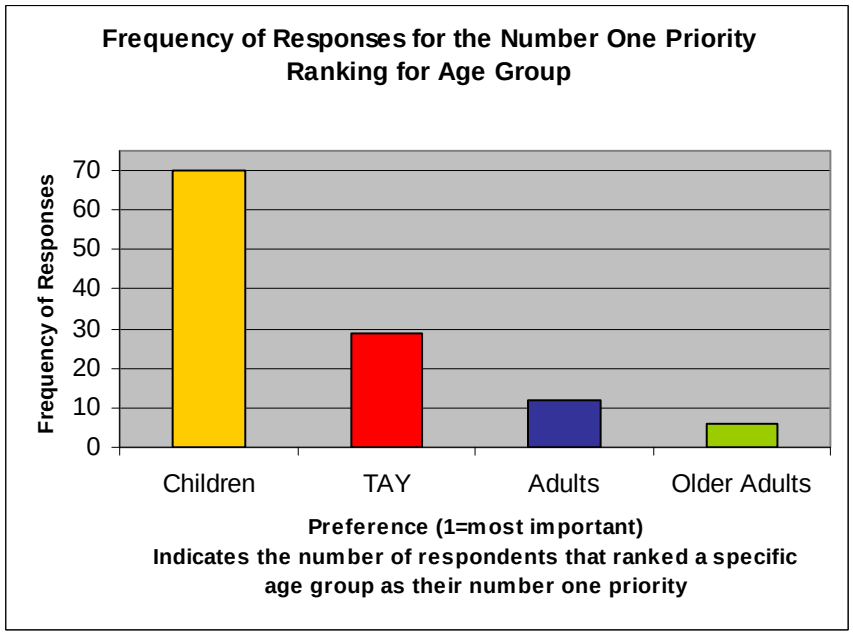
Organization/Affiliation	Percent
None	1.15
Consumer/Family	14.94
Mental Health	34.46
Health	8.05
Education	10.34
Social Service	17.24
Law Enforcement	2.30
Los Angeles County Department	8.05
Other Government Agency	4.60
Other	12.64

Total will not equal 100% as respondents were not limited to only one selection.

* Total will not equal 100% as respondents were not limited to only one selection.

II. Age Group Rankings

When asked to select an age group as their top priority to receive PEI services in communities, the majority (52%) ranked children as their most important priority group. The community survey results indicate that children ages 0-15 was ranked as the number one priority age group, followed by transition-age youth (TAY) ages 16-25. A rank of "1" was considered the "most important" age group for PEI services in the respondent's community and a rank of "4" was considered the "least important".

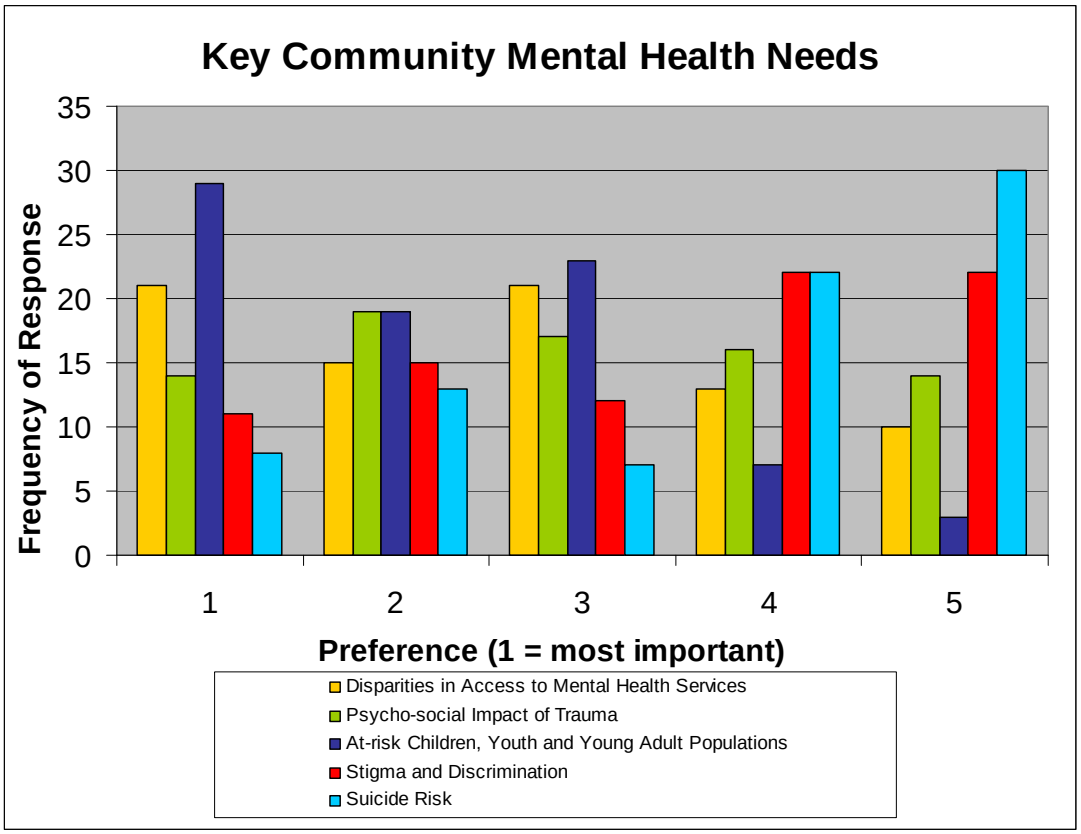


Ranking	Age Group
1	Children
2	TAY
3	Adults
4	Older Adults

III. Key Community Mental Health Needs

Service Area 5 respondents consistently ranked as their key PEI community mental health needs the categories of At-risk Children, Youth and Young Adults, Psycho-Social Impact of Trauma and Disparities in Access to Mental Health Services. A rank of "1" was considered the "most important" PEI key mental health need in the respondent's community and a rank of "5" was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, it was still clear that that At-risk Children, Youth and Young Adult Populations are the highest priority for this service area.

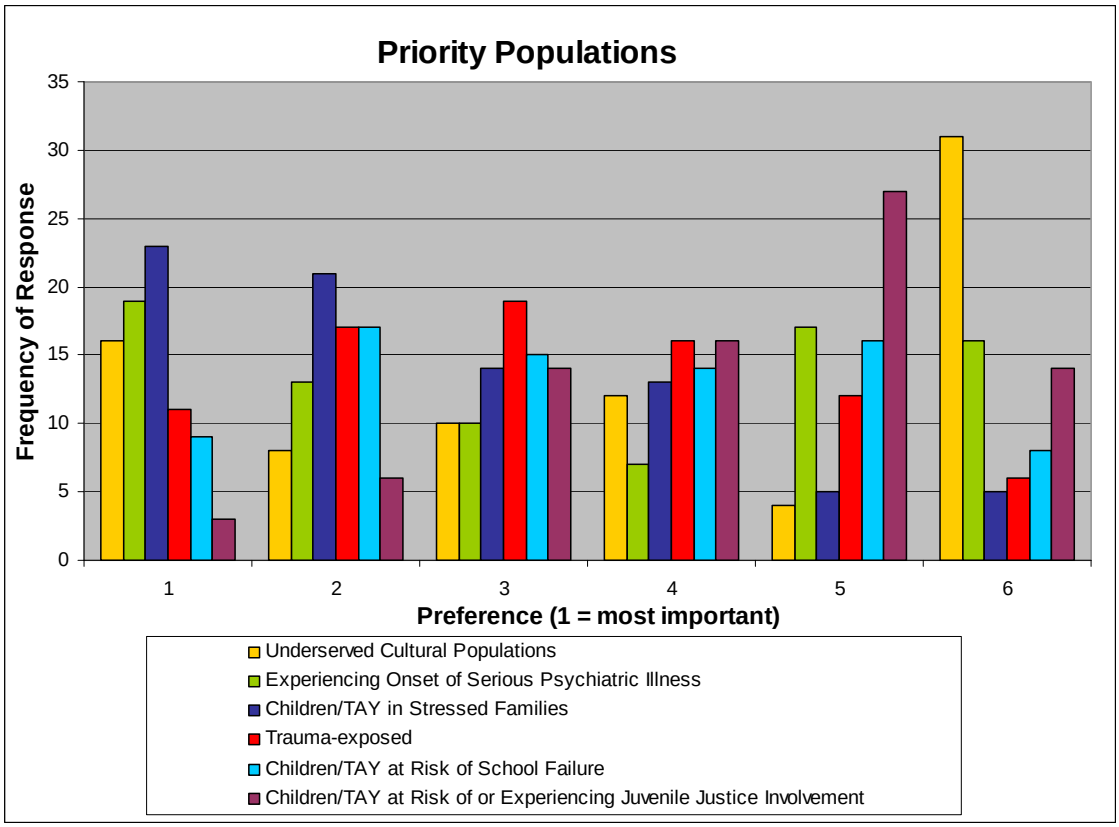
Rank (Median)	Key Community Mental Health Needs	
2	At-risk Children, Youth, and Young Adult Populations	At-risk Children, Youth and Young Adult Populations was ranked the "most important" PEI key mental health need in Service Area 5.
3	Disparities in Access to Mental Health Services	
3	Psycho-Social Impact of Trauma	
4	Suicide Risk	Suicide Risk and Stigma and Discrimination were ranked "least important" by the survey respondents
4	Stigma and Discrimination	



IV. PEI Priority Populations

Respondents were asked to rank the various PEI priority populations in order of importance. Respondents indicated a clear preference for services directed toward Children and Youth in Stressed Families, but no other priority populations had consistent highly-ranked results. A rank of "1" was considered the "most important" PEI priority population in the respondent's community and a rank of "6" was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, there were multiple populations which received a rank of "2" and "3". These results indicate that Service Area 5 survey respondents have little agreement on which PEI priority populations should be served other than a slight preference for Children/Youth in Stressed Families followed by Individuals Experiencing Onset of Serious Psychiatric Illness, Trauma-Exposed and Children/Youth at Risk for School Failure.

Rank (Median)	Priority Populations	
2	Children/Youth in Stressed Families	Note: The results of these categories are unable to be properly "ranked" due to the wide variance in the results. Regardless, in Service Area 5 Children/Youth in Stressed Families was clearly the first priority and Individuals Experiencing Onset of Serious Psychiatric Illness, Trauma-exposed and Children/Youth at Risk for School Failure all tied as the second priority.
3	Individuals Experiencing Onset of Serious Psychiatric Illness	
3	Trauma-exposed	
3	Children/Youth at Risk for School Failure	
4	Underserved Cultural Populations	
5	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	



COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU

MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMUNITY SURVEY RESULTS
SERVICE AREA 6

Following the release in September 2007 of the California State Department of Mental Health's final proposed guidelines for the Mental Health Services Act (MHSA) Prevention and Early Intervention Plan (PEI), the Los Angeles County Department of Mental Health (LACDMH) began an intensive planning process. An initial step undertaken by LACDMH was to distribute a community survey requesting input to the planning for PEI programs in local communities. The survey was used to gather initial feedback regarding priorities on three components of PEI planning in Los Angeles County: (1) key PEI community mental health needs, (2) PEI priority populations, and (3) PEI age groups.

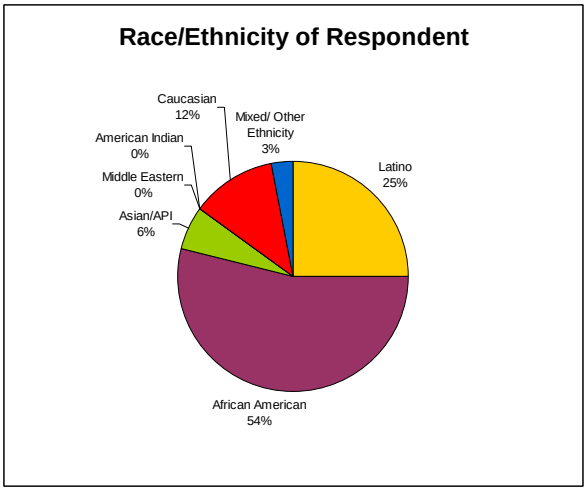
The PEI community survey was administered in English and Spanish to individuals who attended a PEI informational presentation between October 2007 and April 2008. LACDMH staff gave informational presentations at all eight Service Area Advisory Committee (SAAC) meetings and the Board of Supervisors' community forums, as well as at other PEI sector, service area, and countywide meetings. The surveys were handed out at over 90 meetings. Over 1,500 surveys were completed and tabulated, 144 of which were tabulated specifically for Service Area 6.

I. Demographic Characteristics of Survey Respondents

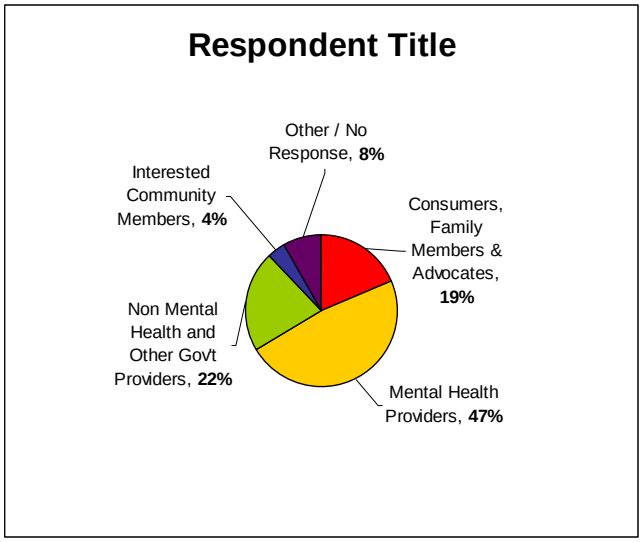
Individuals were asked to report on several attributes in order to assist LACDMH in identifying the characteristics of the survey respondents. Survey respondents self-reported the following attributes:

Gender	
Male	*Female*
23%	77%

Age		
15-25	*26-59*	*60+*
7%	80%	13%



The respondents also represented a broad range of interests and organizations. Nearly one-half of the respondents were mental health providers, about one-fourth were non-mental health providers, and consumers, family members and mental health advocates comprised approximately 19% of the respondents.

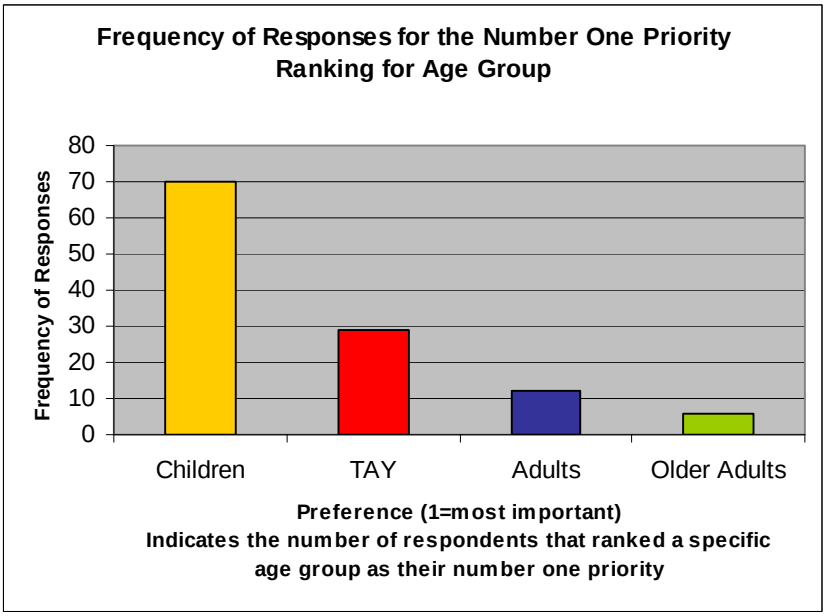


Organization/Affiliation	Percent
None	1.39
Consumer/Family	10.42
Mental Health	43.75
Health	4.88
Education	11.81
Social Service	16.67
Law Enforcement	13.19
Los Angeles County Department	.69
Other Government Agency	.69
Other	10.42

Total will not equal 100% as respondents were not limited to only one selection.

II. Age Group Rankings

When asked to select an age group as their top priority to receive PEI services in communities, the majority (60%) ranked children as their most important priority group. The community survey results indicate that children ages 0-15 was ranked as the number one priority age group, followed by transition-age youth (TAY) ages 16-25. A rank of 1"" was considered the "most important" age group for PEI services in the respondent's community and a rank of "4" was considered the "least important".

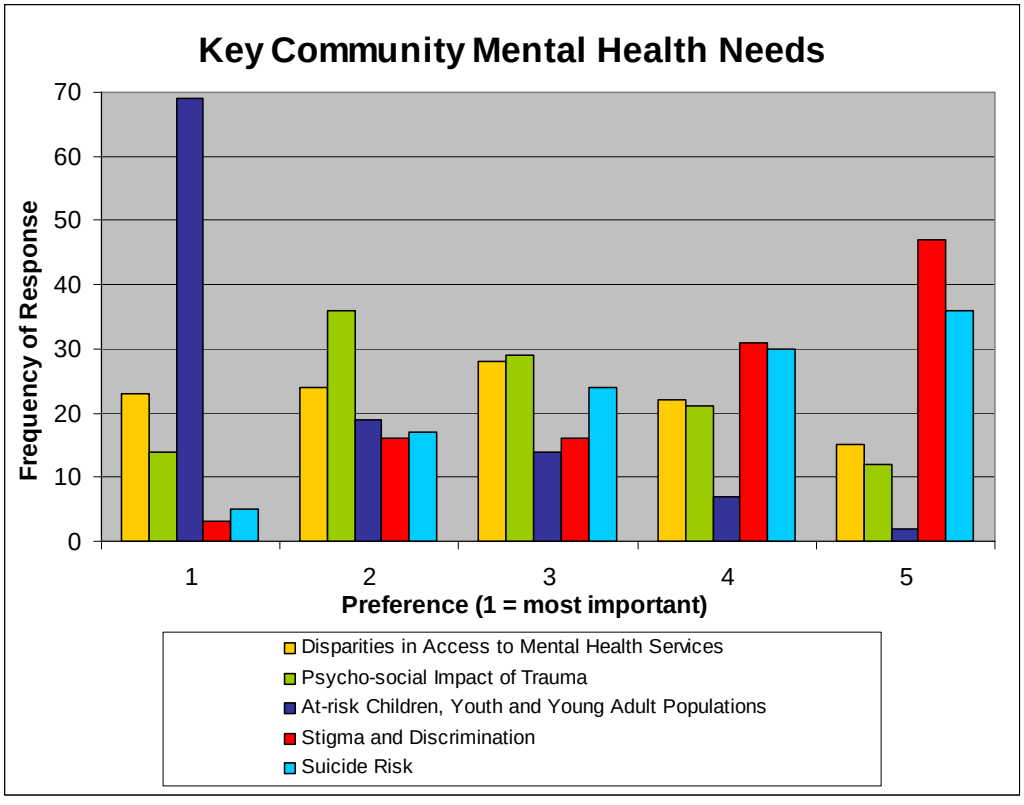


Ranking	Age Group
1	Children
2	TAY
3	Adults
4	Older Adults

III. Key Community Mental Health Needs

The majority (62%) of Service Area 6 respondents consistently ranked their top key PEI community mental health need as At-risk Children, Youth and Young Adults. The categories of Trauma-Exposed and Disparities in Access to Mental Health Services were the next priorities, while Suicide Risk and Stigma and Discrimination were ranked least important. A rank of "1" was considered the "most important" PEI key mental health need in the respondent's community and a rank of "5" was considered the "least important".

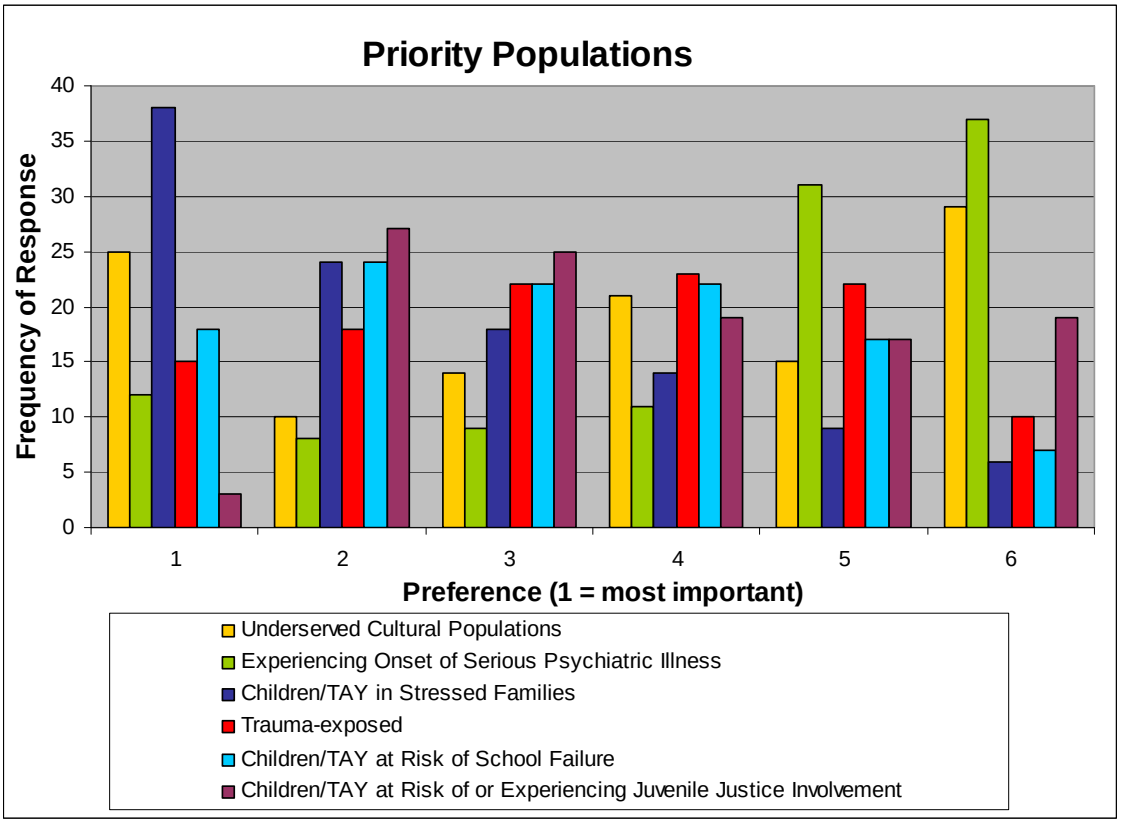
Rank (Median)	Key Community Mental Health Needs	
1	At-risk Children, Youth, and Young Adult Populations	At-risk Children, Youth and Young Adult Populations was ranked the "most important" PEI key mental health need in Service Area 6.
3	Disparities in Access to Mental Health Services	
3	Psycho-Social Impact of Trauma	
4	Suicide Risk	Suicide Risk and Stigma and Discrimination were ranked "least important" by the survey respondents
4	Stigma and Discrimination	



IV. PEI Priority Populations

Respondents were asked to rank the various PEI priority populations in order of importance. Respondents indicated a clear preference for services directed toward Children and Youth in Stressed Families, but no other priority populations had consistent highly-ranked results. A rank of "1" was considered the "most important" PEI priority population in the respondent's community and a rank of "6" was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, there were multiple populations which received a rank of "2" and "3". These results indicate that Service Area 6 survey respondents have little agreement on which PEI priority populations should be served other than a slight preference for Children/Youth in Stressed Families followed by Individuals Experiencing Onset of Serious Psychiatric Illness, Trauma-Exposed and Children/Youth at Risk for School Failure.

Rank (Median)	Priority Populations	
2	Children/Youth in Stressed Families	Note: The results of these categories are unable to be properly "ranked" due to the wide variance in the results. Regardless, Children/Youth in Stressed Families was clearly the first priority and Individuals Experiencing Onset of Serious Psychiatric Illness, Trauma-exposed and Children/Youth at Risk for School Failure all tied as the second priority.
3	Individuals Experiencing Onset of Serious Psychiatric Illness	
3	Trauma-exposed	
3	Children/Youth at Risk for School Failure	
4	Underserved Cultural Populations	
5	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	



COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU

MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMUNITY SURVEY RESULTS
SERVICE AREA 7

Following the release in September 2007 of the California State Department of Mental Health's final proposed guidelines for the Mental Health Services Act (MHSA) Prevention and Early Intervention Plan (PEI), the Los Angeles County Department of Mental Health (LACDMH) began an intensive planning process. An initial step undertaken by LACDMH was to distribute a community survey requesting input to the planning for PEI programs in local communities. The survey was used to gather initial feedback regarding priorities on three components of PEI planning in Los Angeles County: (1) key PEI community mental health needs, (2) PEI priority populations, and (3) PEI age groups.

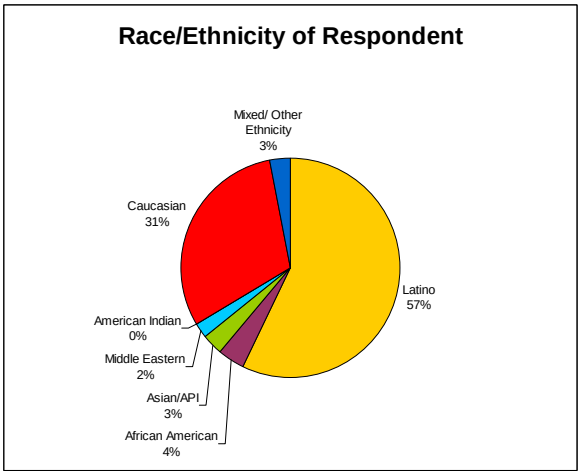
The PEI community survey was administered in English and Spanish to individuals who attended a PEI informational presentation between October 2007 and April 2008. LACDMH staff gave informational presentations at all eight Service Area Advisory Committee (SAAC) meetings and the Board of Supervisors' community forums, as well as at other PEI sector, service area, and countywide meetings. The surveys were handed out at over 90 meetings. Over 1,500 surveys were completed and tabulated, 162 of which were tabulated specifically for Service Area 7.

I. Demographic Characteristics of Survey Respondents

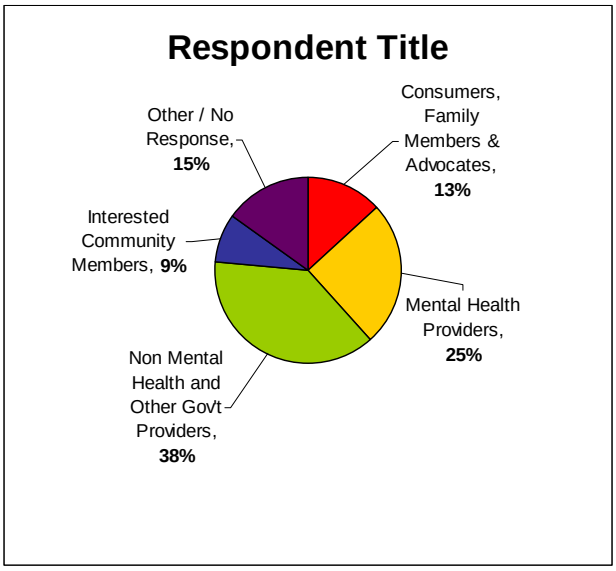
Individuals were asked to report on several attributes in order to assist LACDMH in identifying the characteristics of the survey respondents. Survey respondents self-reported the following attributes:

Gender	
Male	*Female*
24%	76%

Age		
15-25	*26-59*	*60+*
8%	86%	6%



The respondents also represented a broad range of interests and organizations. One-fourth of the respondents were mental health providers, more than one-third were non-mental health providers, and consumers, family members and mental health advocates comprised approximately 13% of the respondents.

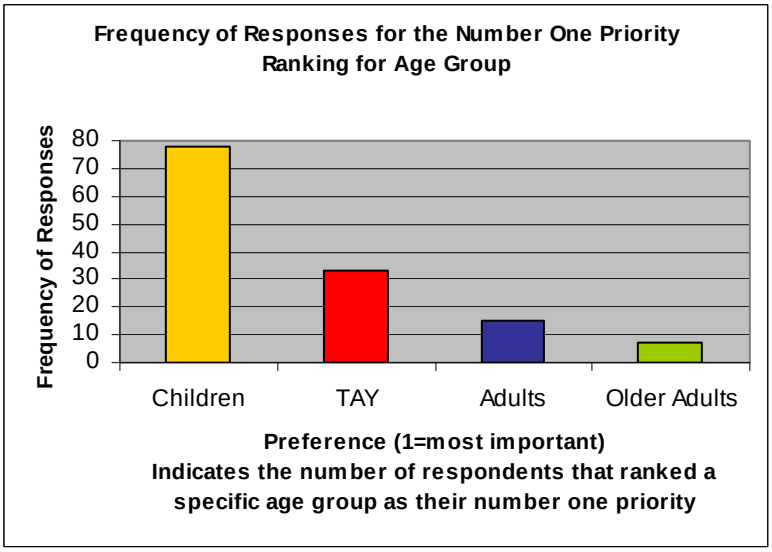


Organization/Affiliation	Percent
None	2.08
Consumer/Family	7.64
Mental Health	25.00
Health	1.39
Education	38.19
Social Service	17.36
Law Enforcement	9.03
Los Angeles County Department	2.78
Other Government Agency	4.17
Other	17.36

Total will not equal 100% as respondents were not limited to only one selection.

II. Age Group Rankings

When asked to select an age group as their top priority to receive PEI services in communities, the majority (59%) ranked children as their most important priority group. The community survey results indicate that children ages 0-15 was ranked as the number one priority age group, followed by transition-age youth (TAY) ages 16-25. A rank of "1" was considered the "most important" age group for PEI services in the respondent's community and a rank of "4" was considered the "least important".

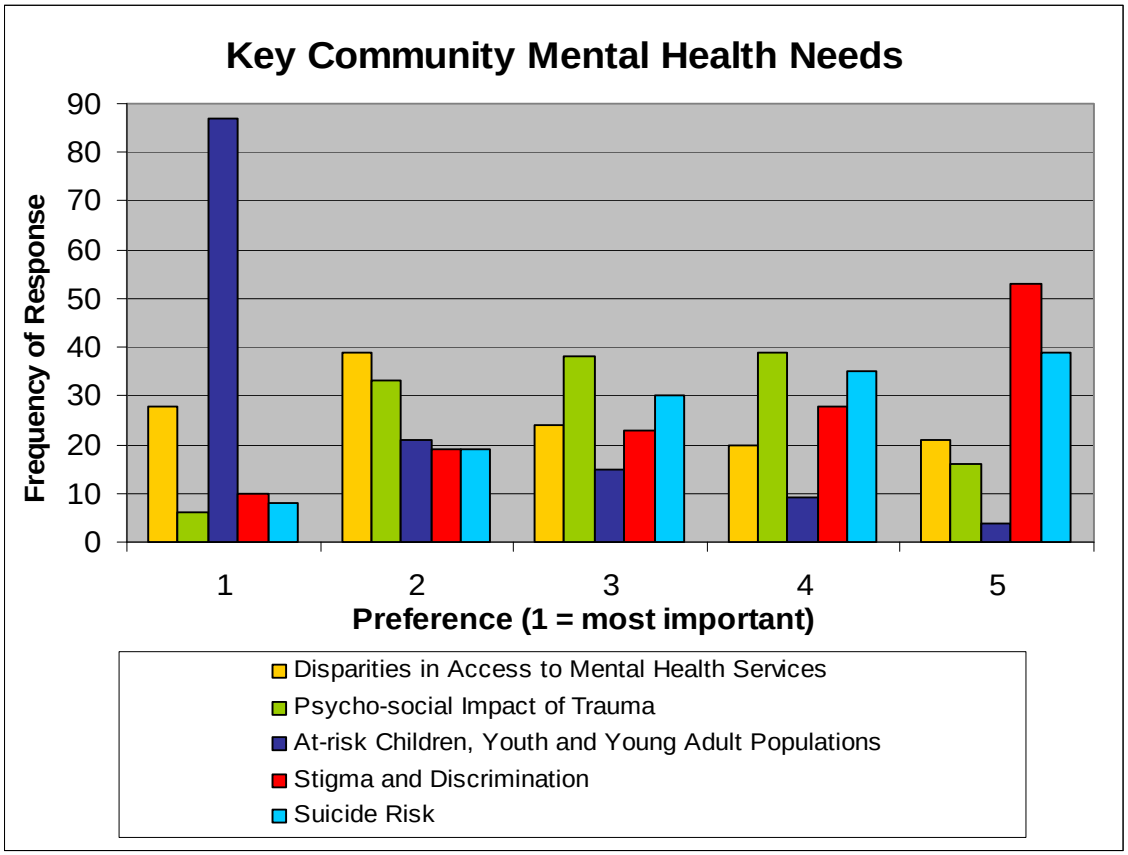


Ranking	Age Group
1	Children
2	TAY
3	Adults
4	Older Adults

III. Key Community Mental Health Needs

The majority (64%) of Service Area 7 respondents consistently ranked their top key PEI community mental health need as At-risk Children, Youth and Young Adults. The categories of Trauma-Exposed and Disparities in Access to Mental Health Services were the next priorities, while Suicide Risk and Stigma and Discrimination were ranked least important. A rank of "1" was considered the "most important" PEI key mental health need in the respondent's community and a rank of "5" was considered the "least important".

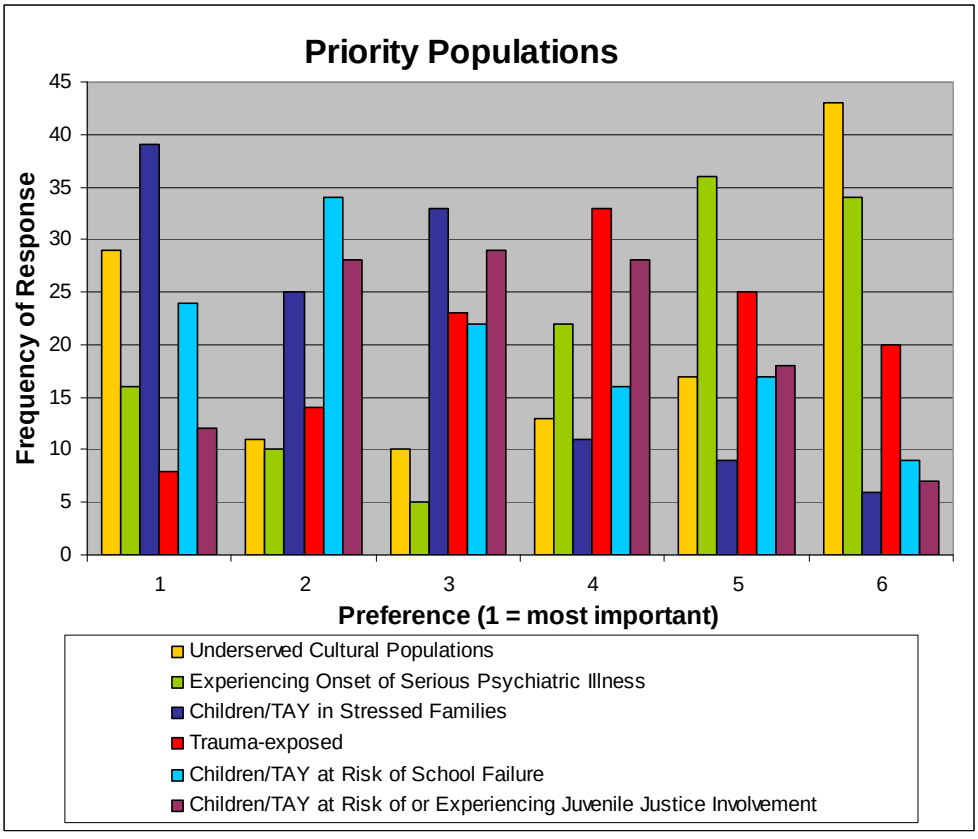
Rank (Median)	Key Community Mental Health Needs	
1	At-risk Children, Youth, and Young Adult Populations	At-risk Children, Youth and Young Adult Populations was ranked the "most important" PEI key mental health need in Service Area 7.
2	Disparities in Access to Mental Health Services	
3	Psycho-Social Impact of Trauma	
4	Suicide Risk	Suicide Risk and Stigma and Discrimination were ranked "least important" by the survey respondents
4	Stigma and Discrimination	



IV. PEI Priority Populations

Respondents were asked to rank the various PEI priority populations in order of importance. Respondents indicated a clear preference for services directed toward Children and Youth in Stressed Families, but no other priority populations had consistent highly-ranked results. A rank of "1" was considered the "most important" PEI priority population in the respondent's community and a rank of "6" was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, there were multiple populations which received a rank of "2" and "3". These results indicate that Service Area 7 survey respondents have little agreement on which PEI priority populations should be served other than a slight preference for Children/Youth in Stressed Families followed by Children/Youth at Risk of or Experiencing Juvenile Justice Involvement and Children/Youth at Risk for School Failure.

Rank (Median)	Priority Populations	
2	Children/Youth in Stressed Families	Note: The results of these categories are unable to be properly "ranked" due to the wide variance in the results. Regardless, Children/Youth in Stressed Families was clearly the first priority and Children/Youth at Risk of or Experiencing Juvenile Justice Involvement and Children/Youth at Risk for School Failure tied as the second priority.
3	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	
3	Children/Youth at Risk for School Failure	
4	Trauma-exposed	
4	Underserved Cultural Populations	
5	Individuals Experiencing Onset of Serious Psychiatric Illness	



SUMMARY OF COMMUNITY SURVEY RESULTS
SERVICE AREA 8

Following the release in September 2007 of the California State Department of Mental Health's final proposed guidelines for the Mental Health Services Act (MHSA) Prevention and Early Intervention Plan (PEI), the Los Angeles County Department of Mental Health (LACDMH) began an intensive planning process. An initial step undertaken by LACDMH was to distribute a community survey requesting input to the planning for PEI programs in local communities. The survey was used to gather initial feedback regarding priorities on three components of PEI planning in Los Angeles County: (1) key PEI community mental health needs, (2) PEI priority populations, and (3) PEI age groups.

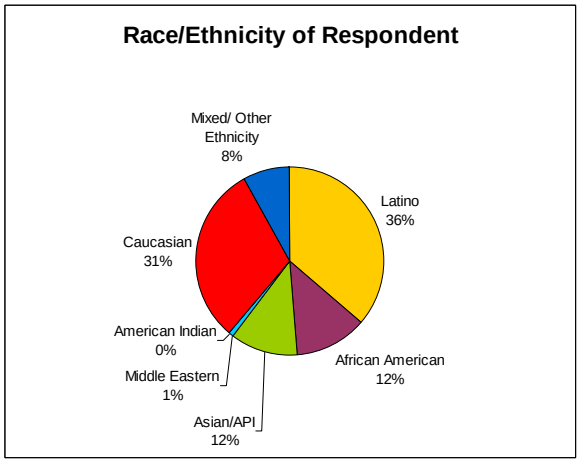
The PEI community survey was administered in English and Spanish to individuals who attended a PEI informational presentation between October 2007 and April 2008. LACDMH staff gave informational presentations at all eight Service Area Advisory Committee (SAAC) meetings and the Board of Supervisors' community forums, as well as at other PEI sector, service area, and countywide meetings. The surveys were handed out at over 90 meetings. Over 1,500 surveys were completed and tabulated, 148 of which were tabulated specifically for Service Area 8.

I. Demographic Characteristics of Survey Respondents

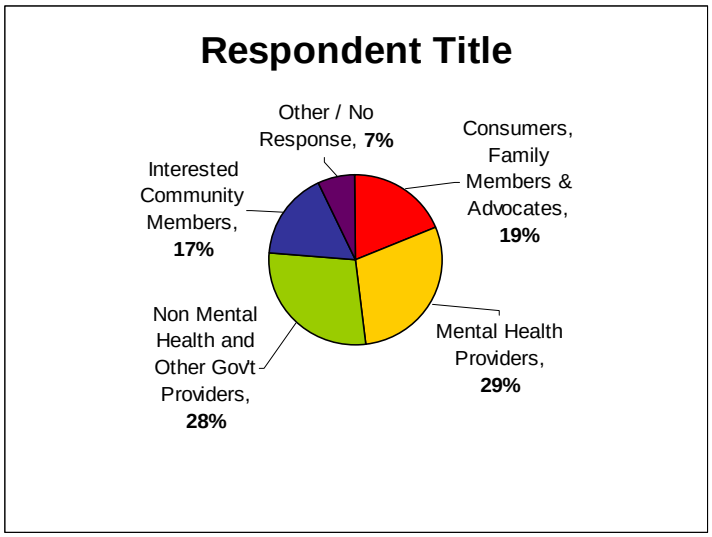
Individuals were asked to report on several attributes in order to assist LACDMH in identifying the characteristics of the survey respondents. Survey respondents self-reported the following attributes:

Gender	
Male	*Female*
24%	76%

Age		
15-25	*26-59*	*60+*
4%	91%	5%



The respondents also represented a broad range of interests and organizations. More than one-fourth of the respondents were mental health providers, one-fourth were non-mental health providers, and consumers, family members and mental health advocates comprised approximately 19% of the respondents.

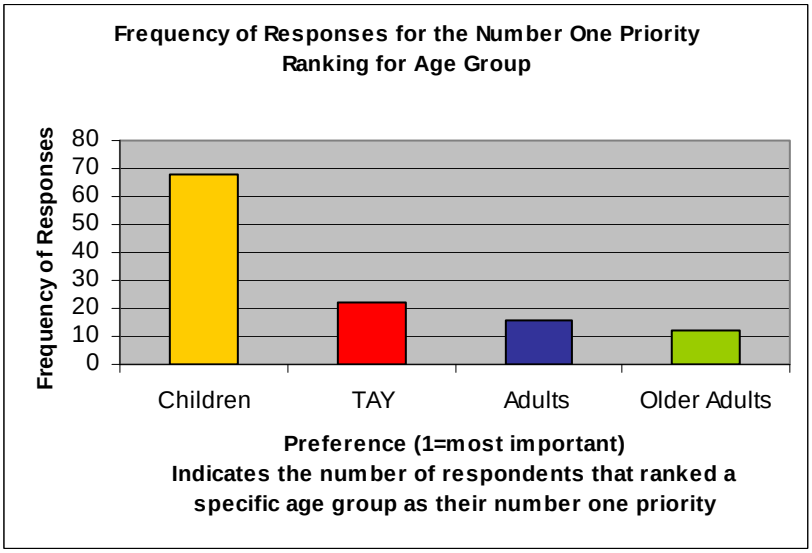


Organization/Affiliation	Percent
None	1.85
Consumer/Family	6.79
Mental Health	22.22
Health	1.23
Education	33.95
Social Service	15.43
Law Enforcement	8.02
Los Angeles County Department	2.47
Other Government Agency	3.70
Other	15.43

Total will not equal 100% as respondents were not limited to only one selection.

II. Age Group Rankings

When asked to select an age group as their top priority to receive PEI services in communities, the majority (58%) ranked children as their most important priority group. The community survey results indicate that children ages 0-15 was ranked as the number one priority age group, followed by transition-age youth (TAY) ages 16-25. A rank of "1" was considered the "most important" age group for PEI services in the respondent's community and a rank of "4" was considered the "least important".

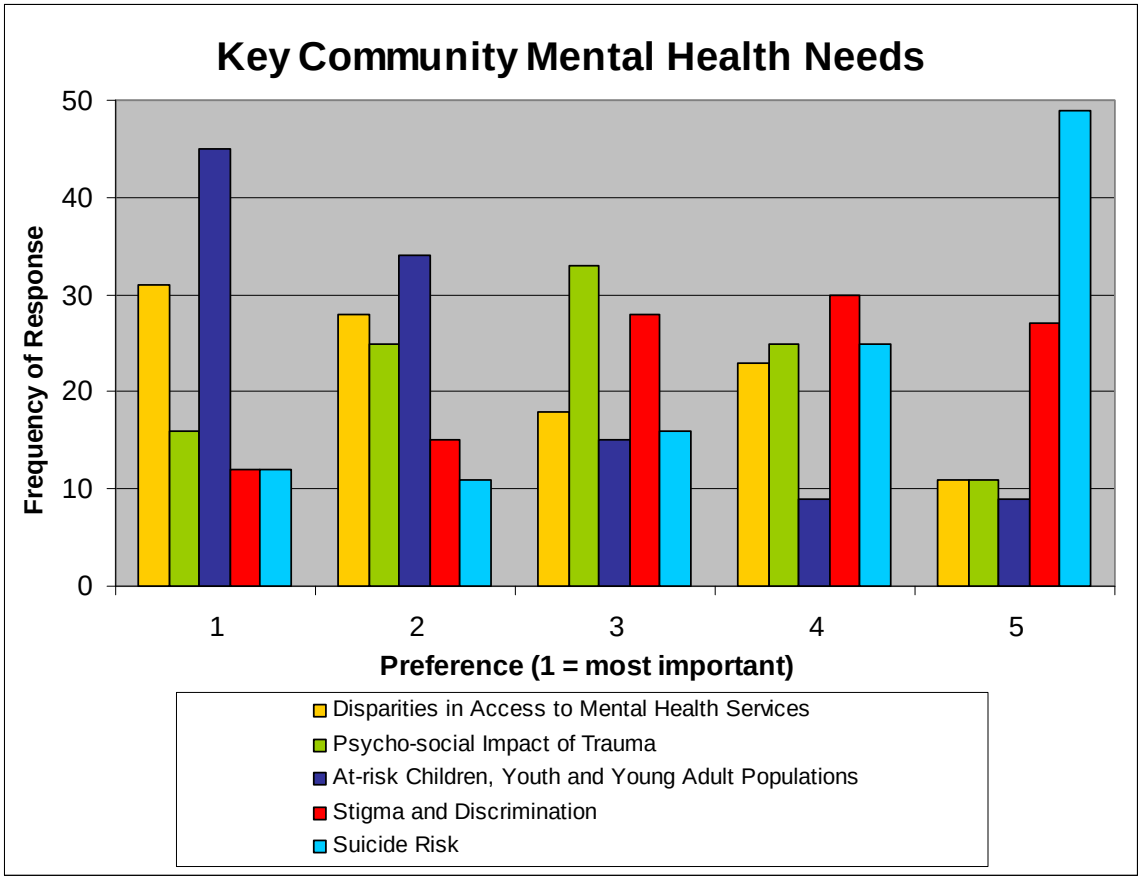


Ranking	Age Group
1	Children
2	TAY
3	Adults
4	Older Adults

III. Key Community Mental Health Needs

Service Area 8 respondents consistently ranked as their key PEI community mental health needs the categories of At-risk Children, Youth and Young Adults, and Disparities in Access to Mental Health Services. A rank of "1" was considered the "most important" PEI key mental health need in the respondent's community and a rank of "5" was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, it was still clear that that At-risk Children, Youth and Young Adult Populations and Disparities in Access to Mental Health Services are the highest priority for this service area.

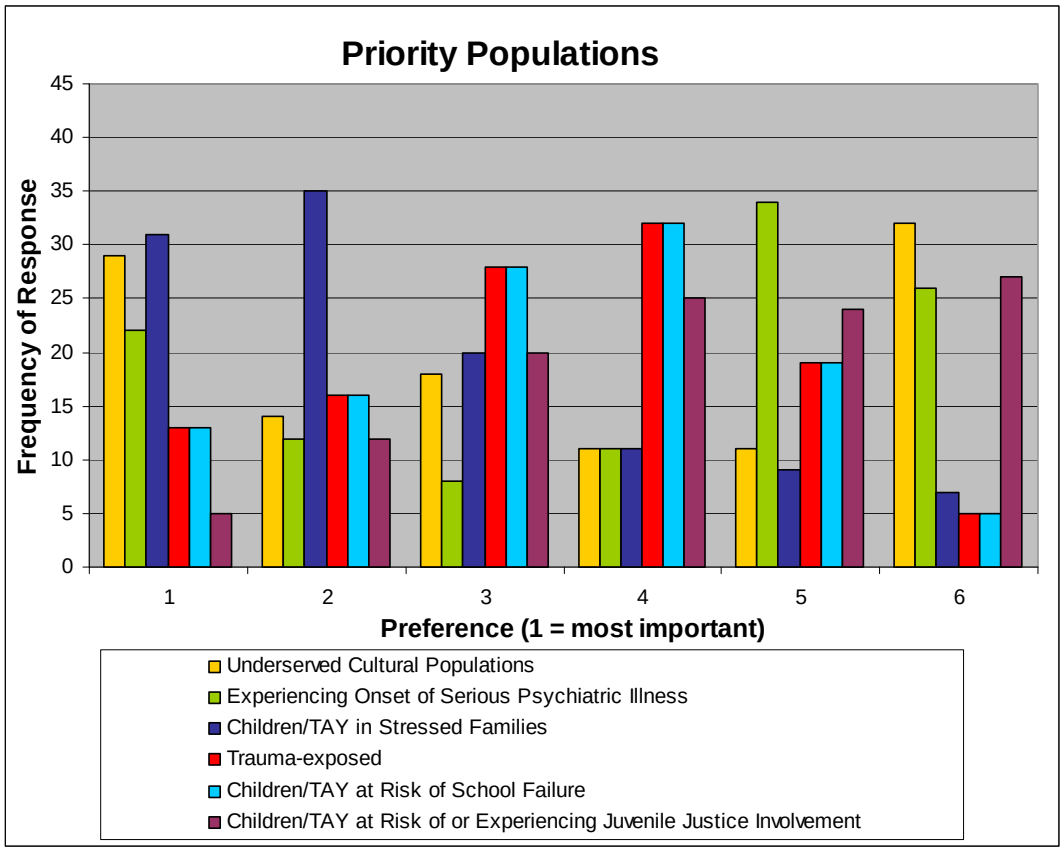
Rank (Median)	Key Community Mental Health Needs	
2	At-risk Children, Youth, and Young Adult Populations	At-risk Children, Youth and Young Adult Populations and Disparities in Access to Mental Health Services ranked as the "most important" PEI key mental health needs in Service Area 8.
2	Disparities in Access to Mental Health Services	
3	Psycho-Social Impact of Trauma	
4	Suicide Risk	Suicide Risk and Stigma and Discrimination were ranked "least important" by the survey respondents
4	Stigma and Discrimination	



IV. PEI Priority Populations

Respondents were asked to rank the various PEI priority populations in order of importance. Respondents indicated a clear preference for services directed toward Children and Youth in Stressed Families, but no other priority populations had consistent highly-ranked results. A rank of "1" was considered the "most important" PEI priority population in the respondent's community and a rank of 6 was considered the "least important". For this particular category, there was such variance that no one priority population received a rank of "1". However, there were multiple populations which received a rank of "2" and "3". These results indicate that Service Area 8 survey respondents have little agreement on which PEI priority populations should be served other than a slight preference for Children/Youth in Stressed Families.

Rank (Median)	Priority Populations	
2	Children/Youth in Stressed Families	Note: The results of these categories are unable to be properly "ranked" due to the wide variance in the results. Regardless, Children/Youth in Stressed Families was clearly the first priority and Trauma-exposed, Children/Youth at Risk for School Failure and Underserved Cultural Populations all tied as the next highest priority.
3	Trauma-exposed	
3	Children/Youth at Risk for School Failure	
3	Underserved Cultural Populations	
4	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	
5	Individuals Experiencing Onset of Serious Psychiatric Illness	



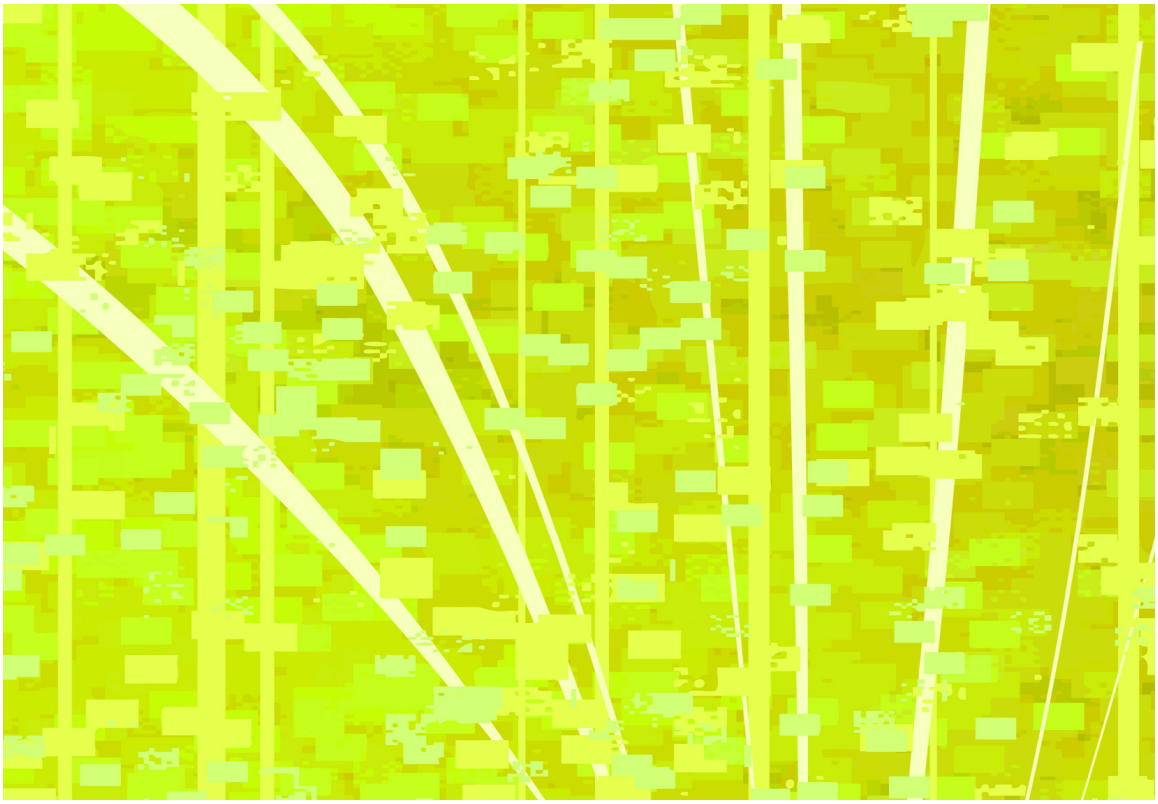
APPENDIX 9

Vulnerable Communities in Los Angeles Count:
Key Indicators of Mental Health

Vulnerable Communities in Los Angeles County:

Key Indicators of Mental Health

Fall 2008



County of Los Angeles Department of Mental Health 550 South Vermont Avenue, Los Angeles CA 90020

Prevention and Early Intervention, Mental Health Services Act

COUNTY of LOS ANGELES

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Program Support Bureau
MHSA PEI Administration Unit

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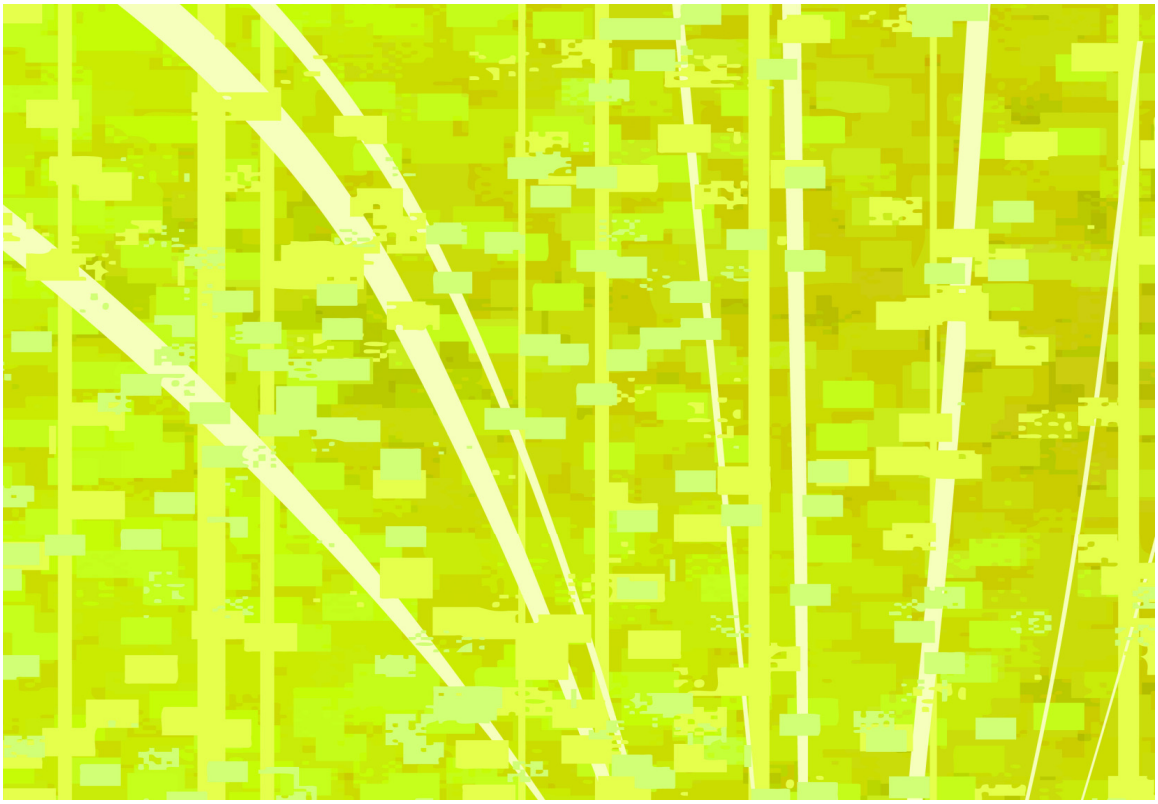
Vulnerable Communities in Los Angeles County:

Key Indicators of Mental Health

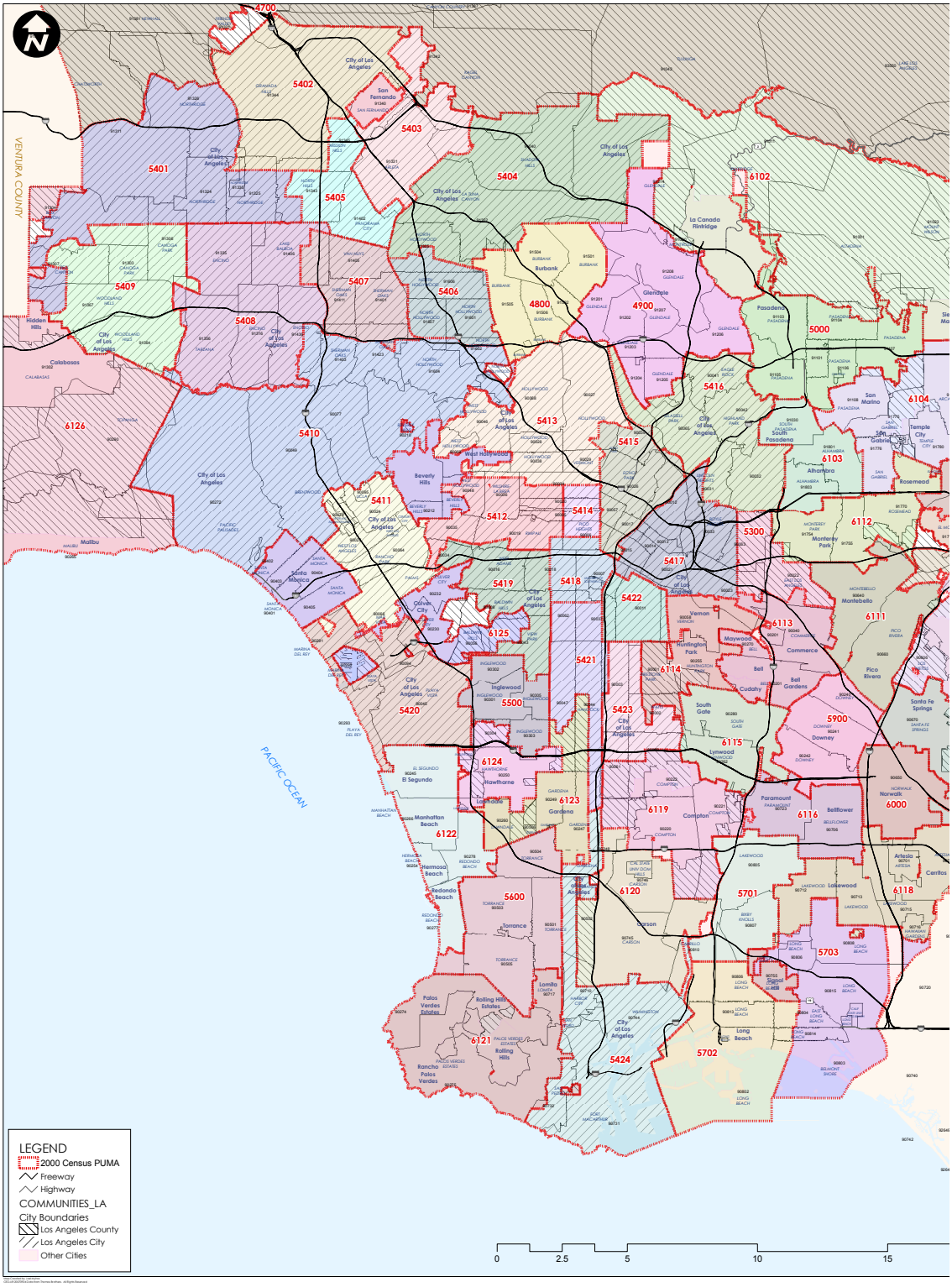
Fall 2008

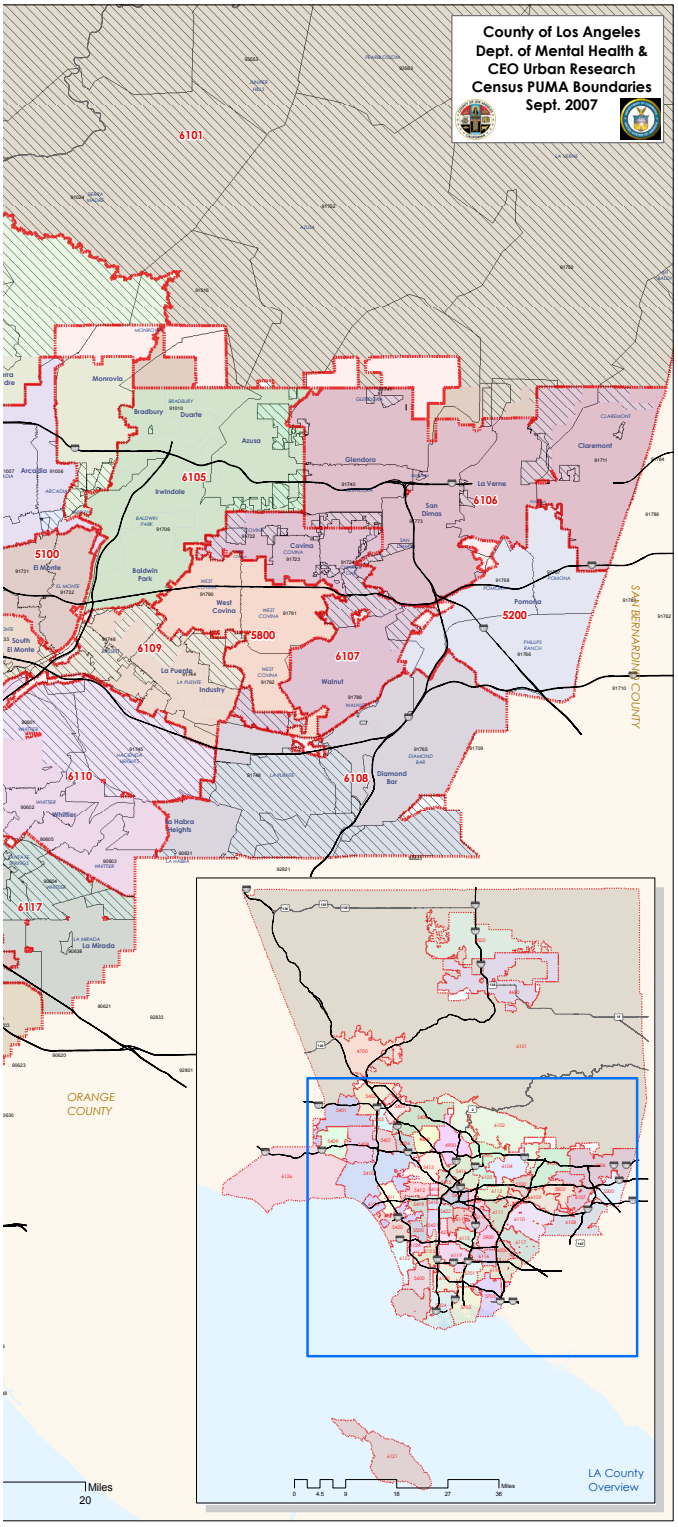


County of Los Angeles Department of Mental Health 550 South Vermont Avenue, Los Angeles CA 90020

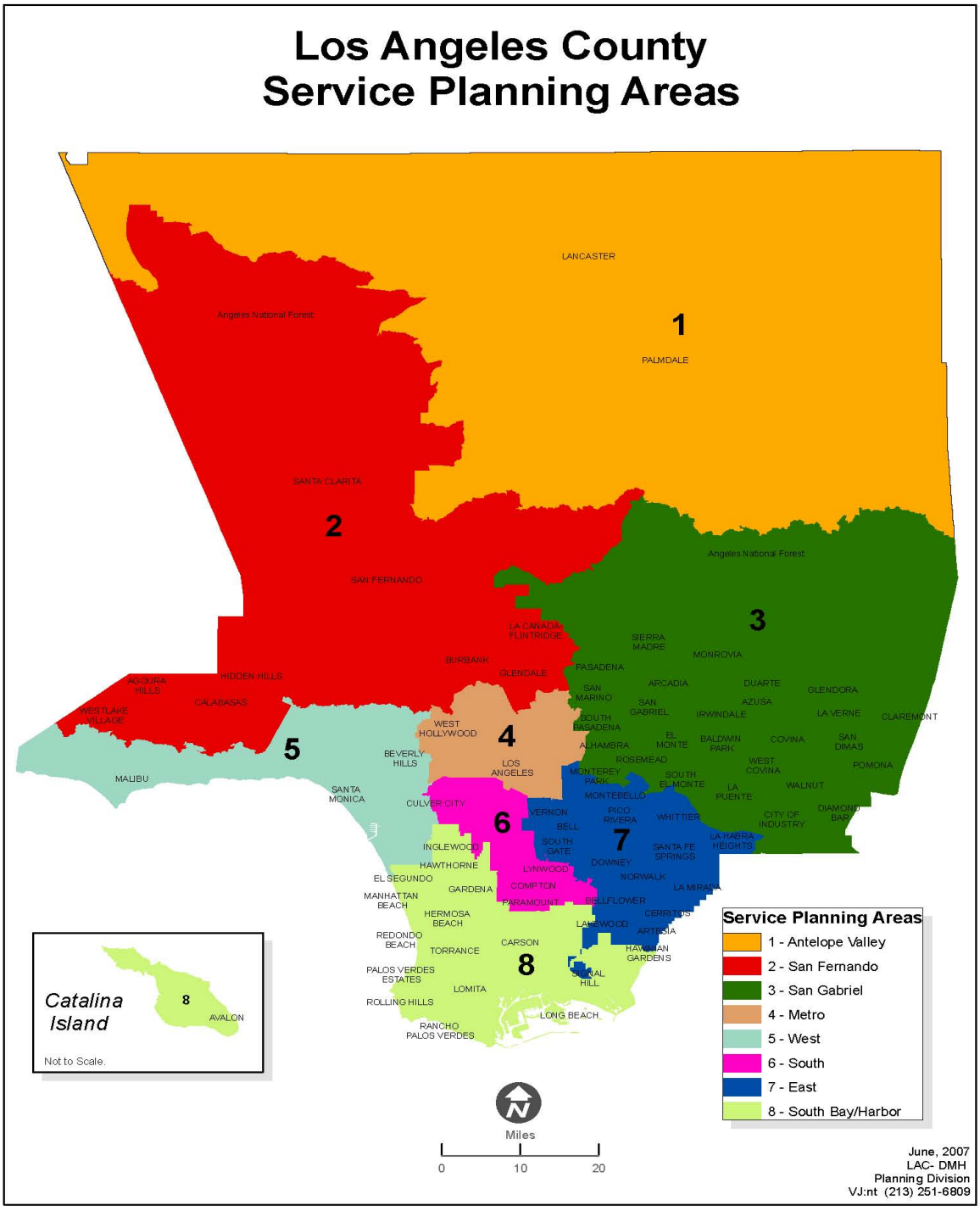
Prevention and Early Intervention, Mental Health Services Act

Community Reference Map





PUMA	Service Area	Community
4500	1	Lancaster
4600	1	Palmdale
4700	2	Santa Clarita
4800	2	Burbank
4900	2	Glendale
5000	3	Pasadena
5100	3	El Monte
5200	3	Pomona
5300	7	East LA
5401	2	Northridge
5402	2	Granada Hills
5403	2	Pacoima-Arleta
5404	2	La Tuna Cyn.
5405	2	Panorama City
5406	2	North Hollywood
5407	2	Sherman Oaks
5408	2	Encino
5409	2	Woodland Hills
5410	2	Brentwood N.
5410	5	Brentwood S.
5411	5	West LA
5412	4	Wilshire La Brea E.
5412	5	Wilshire La Brea W.
5413	4	Hollywood
5414	4	Pico Heights
5415	4	Echo Park
5416	4	Highland Park
5417	4	Downtown
5418	4	USC N.
5418	6	USC S.
5419	4	West Adams
5419	5	Baldwin Hills W.
5419	6	Baldwin Hills S.
5420	5	Playa Vista
5421	6	Hancock N.
5421	8	Hancock S.
5422	6	USC E.
5423	6	Watts
5424	8	Wilmington
5500	8	Inglewood
5600	8	Torrance
5701	8	Long Beach N.
5702	8	Long Beach S.
5703	8	Long Beach E.
5800	3	West Covina
5900	7	Downey
6000	7	Norwalk
6101	1	North County E.
6101	2	North County W.
6102	2	La Canada-Flintridge
6102	3	Altadena-Monrovia-Sierra Madre
6103	3	Alhambra-S. Pasadena
6104	3	Arcadia-San Gabriel-Temple City-San Marino
6105	3	Baldwin Park-Azusa-Duarte
6106	3	Glendora-Claremont-San Dimas-La Verne
6107	3	Covina-Walnut
6108	3	Diamond Bar
6109	3	La Puente-S. El Monte
6110	3	Hacienda Heights
6110	7	Whittier
6111	7	Montebello
6112	3	Monterey Park-Rosemead
6113	7	Bell Gardens-Bell-Maywood-Cudahy-Commerce
6114	6	Florence-Firestone
6114	7	Huntington Park
6115	6	Lynwood
6115	7	South Gate
6116	6	Paramount
6116	7	Bellflower
6117	7	La Mirada-Santa Fe Springs
6118	7	Lakewood-Cerritos-Artesia-Hawaiian Gardens
6119	6	Compton
6120	8	Carson
6121	7	Signal Hill
6121	8	Palos Verdes-Lomita
6122	8	Redondo-Manhattan-Hermosa-El Segundo
6123	8	Gardena-Lawndale
6124	8	Hawthorne
6125	4	West Hollywood
6125	5	Santa Monica-Culver City-Beverly Hills
6126	2	San Fernando-Calabasas-Agoura
6126	5	Malibu


Los Angeles County
Service Planning Areas
LANCASTER
Angeles National Forest
1
PALMDALE
SANTA CLARITA
2
SAN FERNANDO
Angeles National Forest
3
LA CANADA FLINTRIDGE
SIERRA MADRE
MONROVIA
BURBANK
PASADENA
GLENDALE
AGOURA HILLS
HIDDEN HILLS
CALABASAS
WESTLAKE VILLAGE
ARCADIA
DUARTE
GLENDORA
SAN MARINO
AZUSA
SAN GABRIEL
IRWINDALE
LA VERNE
CLAREMONT
SOUTH PASADENA
WEST HOLLYWOOD
4
ALHAMBRA
EL MONTE
BALDWIN PARK
COVINA
SAN DIMAS
5
BEVERLY HILLS
LOS ANGELES
ROSEMEAD
WEST COVINA
POMONA
MALIBU
MONTEREY PARK
SOUTH EL MONTE
LA PUENTE
WALNUT
SANTA MONICA
CULVER CITY
MONTEBELLO
6
VERNON
PICO RIVERA
WHITTIER
CITY OF INDUSTRY
DIAMOND BAR
BELL
7
SOUTH GATE
LA HABRA HEIGHTS
INGLEWOOD
SANTA FE SPRINGS
HAWTHORNE
DOWNEY
LYNWOOD
NORWALK
EL SEGUNDO
GARDENA
COMPTON
LA MIRADA
MANHATTAN BEACH
PARAMOUNT
BELLFLOWER
HERMOSA BEACH
LAKEWOOD
CERRITOS
ARTESIA
REDONDO BEACH
CARSON
TORRANCE
8
HAWAIIAN GARDENS
PALOS VERDES ESTATES
SIGNAL HILL
LOMITA
ROLLING HILLS
LONG BEACH
RANCHO PALOS VERDES
Catalina Island
8
AVALON
Not to Scale
Service Planning Areas
1 - Antelope Valley
2 - San Fernando
3 - San Gabriel
4 - Metro
5 - West
6 - South
7 - East
8 - South Bay/Harbor
Miles
0
10
20
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LAC- DMH
Planning Division
VJ:nt (213) 251-6809

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Abbreviations

ACS	American Communities Survey
APA	American Psychiatric Association
	American Psychological Association
APS	Adult Protective Services
CCR	California Code of Regulations
COD	Co-occurring Disorder
DALY	Disability Adjusted Life Years
DCFS	Department of Children and Family Services
DF	Disrupted Families
DHHS	Department of Health and Human Services (United States)
DMH	Department of Mental Health
DSM IV-TR	Diagnostic and Statistical Manual IV – Text Revision
EDD	Employment Development Division (California State)
FBI	Federal Bureau of Investigations
FPL	Federal Poverty Level
IOM	Institute of Medicine
LAC	Los Angeles County
LAHSA	Los Angeles Homeless Services Authority
LAO	Legislative Analyst's Office (California State)
LAPD	Los Angeles Police Department
MEDS	Medi-Cal Eligibility System
MHE-Rate	Mental Health Emergency Rate
MHSA	Mental Health Services Act
PEI	Prevention and Early Intervention
PMRT	Psychiatric Mobile Response Team
PTSD	Posttraumatic Stress Disorder
PUMA	Public Use Microdata Area
SA	Service Area
SCAN	Suspected Child Abuse and Neglect

Abbreviations continued

SES	Socio-economic Status
SMI	Serious Mental Illness
SPA	Service Planning Area
USC	University of Southern California
YLD	Years Lived with a Disability

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Preface

This report contains information on the population of Los Angeles County across a selected list of demographic, mental health, and other social indicators. It has been prepared as a resource for the Mental Health Services Act (MHSA) Prevention and Early Intervention planning process. One of the intentions of the MHSA is to transform traditional mental health services into a system that is better able to address an individual's needs in the context of their social ecology. With regard to the Prevention and Early Intervention component of the MHSA, this means that planners must take into consideration a broad range of factors that prior to the MHSA were often left out of discussions. The MHSA compels planners to adopt a more holistic and systemic approach in creating a PEI plan, one that involves a variety of sectors, aside from mental health, such as health, education, juvenile justice, child welfare, and community members. As a result of this, the coverage of this report is correspondingly broad and spans several sectors of society beyond what is typically encountered in mental health planning documents. Consequently, although it has been prepared for the PEI planning process, because of its breadth and depth, the present report may be of interest to others with a need for community level data in these areas.

Besides the quantitative information found in this report, PEI planning also involves qualitative sources of information gleaned from key individual interviews and focus group discussions. Together, these very different sources can reveal a community's social and mental health needs. A good needs assessment provides a solid foundation upon which planners can envision the PEI programs most beneficial to their community.

To assist the local planner, this report contains information on communities within each of the county's eight service planning areas. Previously unseen in county planning documents, this level of geographic detail represents an advance our ability to understand the demographic composition and variation within service areas. With such granular data available, it is likely

that planners located in different parts of the county or, representing different segments of society, may arrive at different conclusions regarding the relative importance of a particular statistic and/or a relative need. Such is one the many hurdles facing PEI planners.

Indeed, with its geographic differences, racial and ethnic diversity, cultural richness, age spans, and life experiences, Los Angeles County challenges planners at each step along the roadmap as they formulate services for the individuals and families to be served by the PEI Plan.

As PEI planners, your dedication to this task does not go unnoticed and your input as stakeholders in the MHSA process is indispensable and greatly appreciated.

Prevention and Early Intervention Administration

Fall 2008

Introduction

Data-driven Decisions

As the experience from the Los Angeles County Mental Health Services Act Community Services and Supports planning process in 2005-2006 demonstrated, stakeholders as well as administrators, need access to a wide variety of data sources in order to develop strategies to serve the diverse communities throughout the county. The Los Angeles County Department of Mental Health (LACDMH) is currently engaged in a broad-based community effort utilizing a variety of needs assessment approaches to develop the county's Prevention and Early Intervention (PEI) Plan. Because a key tenet for the MHSA PEI Plan is that decisions should be based on available objective data, it was deemed necessary that this report should include an overview of the demographic characteristics of Los Angeles County, as well as key indicators of risk in the community. This is accomplished through the reporting of descriptive statistics across and within the county's eight service areas. Another key tenet, that the planning process be stakeholder-driven, means that this report must be accessible to the broadest section of the community as possible. It is anticipated that this report will be read by a varied audience and it has been prepared with these role differences in mind.

The Mental Health Services Act

In 2004, California voters approved Proposition 63 which became state law in January 2005 as the Mental Health Services Act (MHSA). The MHSA is thought by many to be the most significant mental health legislation in California over the last 20-30 years because it aims to support new and innovative mental health services that are evidence-based and individualized based upon a community's culture, needs, and stakeholder input. The Act calls for a 1% tax on individuals with adjusted gross incomes over $1,000,000 (affecting about 30,000 individuals) and has resulted in tax revenues that have exceeded initial expectations. In 2004, for example, the Legislative Analyst's Office (LAO) estimated

that the initiative would raise about $800 million in state revenues annually; but, by fiscal year 2006-07, tax revenues were closer to $1.5 billion. Current projections show this figure to increase in the coming years. As funds become available throughout the State of California, it is important for each county to decide which programs will be offered in their area.

The California Department of Mental Health has defined five components to the MHSA:

- Community Services and Supports
- Prevention and Early Intervention
- Workforce Education and Training
- Capital Facilities and Technology
- Innovative Programs

Prevention and Early Intervention

The Prevention and Early Intervention (PEI) component of the MHSA covers services which address risk factors prior to developing mental illness and early symptoms of mental illness when it does develop. As such, some PEI programs may focus on preventing disorders while others may seek to inhibit the progression of a disorder as soon as possible.

The state guidelines designated priority populations for the PEI component that have been identified as being particularly vulnerable to mental illness and/or at risk of not receiving mental health services due to social, economic, or cultural barriers:

- Underserved Cultural Populations
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Children/Youth in Stressed Families
- Trauma-exposed
- Children/Youth at Risk for School Failure
- Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

Additionally, the state has highlighted five key community mental health needs for the state:

- Disparities in Access to Mental Health Services
- Psycho-social Impact of Trauma
- At-risk Children, Youth, and Young Adult Populations
- Stigma and Discrimination
- Suicide Risk

Finally, it should be noted that in order to assist PEI planning activities, the state has specified broad community sectors crucial to the planning process. Integrating and representing stakeholders with specialized knowledge and a breadth of experiences from all of these sectors is an organizing principle in creating an inclusive community mental health plan:

Required Sectors:

- Underserved Communities
- Education
- Individuals with Serious Mental Illness and/or their Families
- Providers of Mental Health Services
- Health
- Social Services
- Law Enforcement

Recommended Sectors:

- Community Family Resource Centers
- Employment
- Media

Organization of the Report

With the enormous amounts of data available today, it was not a trivial task to retrieve, organize, analyze, and disseminate statistical information in a way that is readily understandable. Every effort has been made to accomplish this task and numerous individuals and county departments have contributed to the effort. Data-gathering included collecting and tabulating information from the American Community Survey (ACS) (2005, 2006, 2007) for basic demographic information at the community level. Aggregate reports from different county departments were also gathered in order to shed light on to various sectors of the community, such as, mental health, health and welfare, education, and law enforcement and juvenile justice. Data culled from these sectors are reported so that readers can get a cross-sectional view of Los Angeles County from different perspectives with an explanation for why such data are important to the PEI component.

Part I includes an overview of the data-driven approach to PEI planning, an explanation of the reporting geography in the current report, and a description of the key indicators of risk for behavioral and social problems for each of the six PEI priority populations and two community needs. The indicators have been selected on a theoretical basis and, when possible, where research has shown that a given indicator has the ability to predict mental illness and/or maladaptive behaviors. Only two community needs are covered (Stigma and Discrimination associated with mental illness, and Suicide Risk), as the remaining needs (Disparities in Access to Mental Health Services, Psycho-social Response to Trauma, and At-risk Children, Youth, and Adult populations) overlap conceptually with the priority populations, (e.g., Underserved Cultural Populations, Trauma-exposed, and Children/Youth in Stressed Families) and the reader is directed to those sections of the document for that information.

Part II presents basic demographic information so that a reader may obtain an overview of the population characteristics of Los Angeles County and their respective service area of interest. Additionally, summaries of the key indicators are available for each service area. Each section devoted to a particular service area provides a cross-sectional perspective of the indicators.

Part III contains the 24 key indicators with all data tables, figures, and maps. Additionally, the reader will find a countywide analyses for each indicator as well as the service area findings reported above. Part III provides the reader with a more complete picture of how an indicator varies across the county.

We hope you find the document useful in your work and know that it cannot possibly answer all of the questions that one could pose. It should be used to supplement other PEI planning materials, such as the PEI key individual interviews, focus group interviews, and community forum reports.

Part I

Approach to Data for Prevention and Early Intervention

PEI Data-driven Approach

Communities in Los Angeles County

Key Indicators of Mental Health

PEI Data-driven Approach

MENTAL HEALTH PLANNING for Prevention and Early Intervention is no easy task because it inevitably involves making difficult decisions about where limited funds should be placed. Typically, planners are charged with prioritizing levels of risk, assessing needs, and then projecting these elements against future concerns and resources. Funding certain programs over other promising programs, or placing funds in certain geographic areas over other deserving locations, is an unavoidable and potentially contentious task. The fact is, not everyone can or will receive an equal slice of pie. But to be fair-minded about rationing funds, planners can ensure that everyone, at the very least, can have a say in how the pie is divided. Clearly, the legislators who created the Mental Health Services Act (MHSA) meant for planners to engage in the thoughtful and difficult process of resource allocation so that issues of inclusion and representation are in evidence without becoming an end unto themselves.

This report contains information on the population of Los Angeles County across a selected list of demographic, mental health, and other social indicators. It is a distillation of many data sources into a collection of tables containing numerical information meant for local planners as they craft a Prevention and Early Intervention (PEI) Plan for the county. With all of the columns and rows of numbers in the document, one might be tempted to approach the planning task as a purely actuarial one or to wrongly construe that the county has a grand equation in mind that will determine, through number crunching and statistical wizardry, a perfect plan. Additionally, it is easy enough to get lost in a matrix of numbers or to assume the numbers carry more weight and finality than they do, especially when they are uncertain. So, the prudent planner will use these numbers as a basis for decision-making, not as a single-minded strategy excluding other sources of information.

That said, many of the numbers in this report are quite compelling indictors of risk for a variety of problems in the community. Without examining the numbers for, say, child abuse statistics or older adult suicide rates, planners would need to rely upon opinions and other sources of unreliable and potentially biased information. Who is most at risk for developing a mental illness, or for dropping out of school, or for committing a crime? It is difficult to find the exact set of numbers to answer these kinds of questions, and, for this reason, the reader may find omissions in the figures reported here or there, or object to the presentation of still other figures. In order to provide you with a timely document that was brief and accessible to most people, not every statistic being counted could be reported here. We apologize for any glaring omissions and urge you as a planner to use your other sources of data accordingly.

counts of individuals with a particular mental health disorder, ethnicity, or some other category of interest. You can imagine a pollster asking a group of people, "How many of you have a safe place nearby where your kids can play?" and then counting hands. That is the level of most of the data.

So, this document is not so much of a data book as it is an annotated list of important hand-counts. How many people have graduated high school? Or, how many people are unemployed? Or, what language does one speak at home are the kinds of questions that are answered here. Additionally, when an answer is given, it is with an explanation for why the question was posed in the first place. We have tried to provide a context for the numbers, a context that is decidedly concerned with prevention and early intervention of a variety of problems in the community. Without this context, the document could have easily become a data book, an exhaustive list of numbers, (e.g., Statistical Abstract of the United States); as interesting as this may be, it is essentially a lot of numbers with little to no explanation. While data books are excellent reference material for the researcher, planners need a different sort of text, one that can infuse the numbers with more meaning for the task at-hand.

There are lies, damned lies, and then there are statistics.

Statistics can be misleading and, in order to avoid leading you astray, no inferential statistics are presented in the current document, only those that are purely descriptive. In some cases, where the implication of a particular number is not apparent, a simple arithmetic calculation may be presented such as a sum, ratio, average, or percentage. Because the best data are often those tangible sources that you can count on your fingers, many of these figures are just that, frequency

A preliminary task for the planner – examining the variables, the social indicators that have most relevance for the process of select-

ing and funding mental health related programs in the county – is an important first step in formulating a plan of action. Here, no particular emphasis is placed on any given indicator reported, as all have appeared in the research literature regarding some aspect concerning prevention or early intervention. It is up to the reader to assign a relative ranking of importance to the numbers or conjure a model of risk that makes sense to them, and proceed with their planning tasks as such. In this sense, the present document has a heuristic value that should stimulate discussions beyond the simple reporting of numbers, toward the goal of developing an effective and fair-minded strategy for the Prevention and Early Intervention Plan in Los Angeles County.

Communities in Los Angeles County

PEI Service Area-driven Approach and Focus on Communities

The PEI planning process in Los Angeles County is also a service area-driven approach that focuses on local communities within each service area. Identification of needs and prioritization of populations for the PEI Plan is intended to be grounded in the service area and, more specifically, for at-risk communities and populations in the service area. Toward this end, the data in this report are organized by service areas and, whenever possible, local communities delineated by Public Use Microdata Areas (PUMAs) as described below.

Service Areas

The Los Angeles County Department of Mental Health divides the county into eight service areas for the purpose of planning and service delivery:

- Service Area 1 – Antelope Valley
- Service Area 2 – San Fernando
- Service Area 3 – San Gabriel
- Service Area 4 – Metro
- Service Area 5 – West
- Service Area 6 – South
- Service Area 7 – East
- Service Area 8 – South Bay

The service areas vary widely in geographic size and climate, as well as a variety of demographic and socio-economic factors, such as density of population, racial/ethnic diversity, poverty levels, etc.

PUMAs Cited in Los Angeles

The scope of the present document is Los Angeles County and the challenge of profiling a large population involves striking a balance between brevity and summation while providing enough detail for the local planner to use. Sometimes, too many numbers can obscure information. For instance, demographic and other population data are typically reported by ZIP codes or census tracts, common units of measure found in data book publications. This is useful if you are interested in a particular ZIP code or cen-



sus tract (4000-8000 people), but quickly becomes unwieldy if you are interested in one of the eight county service areas or even the county as a whole. So how is one to proceed?

There are several hundred census tracts covering Los Angeles – too large to examine in detail, busy as you are. Fortunately, in recognizing the plight of planners, the US Census Bureau has created Public Use Microdata Areas (PUMAs), which are communities of aggregated census tracts. In this document, we use 92 PUMAs (including PUMA fragments) covering the entire county as our unit of analysis, a much more manageable number of cases to examine than the hundreds and hundreds of ZIP codes and census tracts.

PUMAs are not entirely without issues. It is important, for example, to make note of the PUMA naming conventions and all of the geography contained within them. PUMAs, more often than not, contain multiple neighborhoods, cities, and unincorporated areas of Los Angeles. The Northridge PUMA, for example, does contain the Northridge neighborhood, but also other neighborhoods of the San Fernando Valley. Another issue involves PUMAs that cross service area boundaries. In these cases, PUMAs were split by apportioning data according to population size for each of the containing geographic sub-areas.

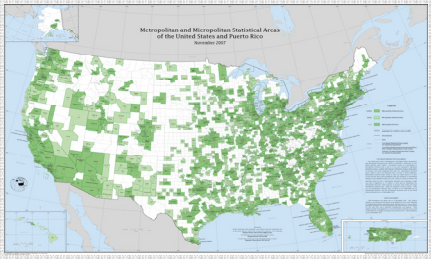
US Census Bureau PUMA Description

A public use microdata area (PUMA) is an area with a decennial census population of 100,000 or more people for which the U.S. Census Bureau provides specially selected extracts of raw data from a small sample of long-form census records screened to protect confidentiality. These extracts are referred to as "public use microdata sample (PUMS)" files. Data users can use these files to create their own statistical tabulations and data summaries. For Census 2000, there are state-level and national PUMS files. The U.S. Census Bureau first provided PUMS information in conjunction with the 1960 census data tabulations.

For Census 2000, state, District of Columbia, Puerto Rico, and Island Area participants, following U.S. Census Bureau criteria, delineated two types of PUMAs within their states. PUMAs of one type comprise areas that contain at least 100,000 people. The PUMS files for these PUMAs contain a 5-percent sample of the long-form records. The other type of PUMAs, super-PUMAs, comprise areas of at least 400,000 people. The sample size is 1 percent for the PUMS files for super-PUMAs.

PUMAs cannot be in more than one state or statistically equivalent entity. The larger 1-percent PUMAs are aggregations of the smaller 5-percent PUMAs. PUMAs of both types, wherever the population size criteria permit, comprise areas that are entirely within or outside metropolitan areas or the central cities of metropolitan areas. Each PUMA is identified by a five-digit numeric census code.

Source: http://www.census.gov/geo/www/cob/pu_metadata.html



Title:	Census 2000 Public Use Microdata Areas 1 Percent
Location:	http://www.census.gov/geo/www/cob/pu1_2000.html
Geography:	Each State, District of Columbia, Puerto Rico
Vintage:	January 1, 2000
Formats:	ARC/INFO Export (.e00), Arcview Shapefile, and ARC/INFO Ungenerate (ASCII)
Projection:	Geographic (Lat/Lon)

Figure 1.0 US Census Bureau PUMA Description

Key Indicators of Mental Health

Indicators

In order to provide planners with an overview of where high-risk communities were located, a collection of bio-psycho-social and demographic variables was assembled which had relevance to the PEI mission. In particular, 24 key indicators were chosen to provide measures of important aspects of the six PEI priority populations (Underserved Cultural Populations, Individuals Experiencing Onset of Serious Psychiatric Illness, Children/Youth in Stressed Families, Trauma-exposed Individuals, Children/Youth at Risk for School Failure, and Children/Youth at Risk of or Experiencing Juvenile Justice Involvement) and two PEI key community needs (Stigma and Discrimination and Suicide Risk).

Each indicator was selected on the basis of its face validity and/or its appearance in the research literature linking it with a PEI population or community need. For this reason, the indicators, along with the underlying reporting geography, can identify vulnerable populations and/or specific areas at high risk for contributing to behavioral and social problems.

Data gathering and processing was quite extensive and included a long period of acquiring raw data from numerous sources, geocoding, allocating and aggregating, and performing lightweight analyses. When possible, these data were reported in terms of PEI age groups, ethnicity, and service area communities. Generally, the numbers reflected actual frequency counts or population percentages, but when necessary, additional calculations were performed on the data to render them interpretable to the planner.

Key Indicators

PEI Priority Populations

Underserved Cultural Populations

- Ethnicity
- Primary Language
- Linguistic Isolation

Individuals Experiencing Onset of Serious Psychiatric Illness

- Mental Health Treatment Penetration Rate
- Depressive Disorders
- Co-occurring Disorders (COD)

Children/Youth in Stressed Families

- Poverty
- Unemployment Rate
- Disrupted Families
- A Safe Play to Play

Trauma-exposed Individuals

- Child Abuse
- Elder and Dependent Adult Abuse
- Homelessness
- Posttraumatic Stress Disorder (PTSD) Rates

Children/Youth at Risk for School Failure

- 4-year Dropout Rates
- High School Graduation Rates
- English Fluency
- 3rd Grade Reading Level

Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

- School Discipline
- Juvenile Felony Arrests
- Youth on Probation

Key PEI Community Mental Health Needs

Stigma and Discrimination

- Language Capacity of Mental Health Providers

Suicide Risk

- Deaths by Suicide
- Mental Health Emergency Statistics

Part II

Service Area Data Profiles

Los Angeles County

Service Area 1: Antelope Valley

Service Area 2: San Fernando

Service Area 3: San Gabriel

Service Area 4: Metro

Service Area 5: West

Service Area 6: South

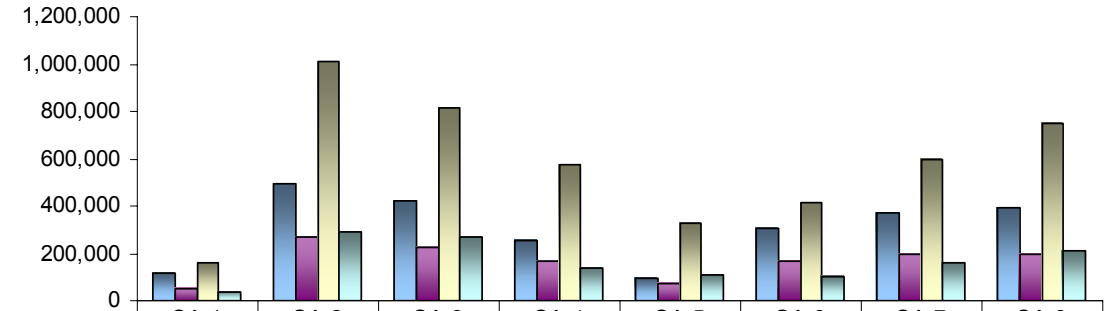
Service Area 7: East

Service Area 8: South Bay

Demographic Profile of Los Angeles County

ENCOMPASSING 4,084 SQUARE MILES, Los Angeles County is one of the nation's largest counties in area. Approximately 27 percent of California's residents live in Los Angeles County. There are 88 cities within the county, each with its own city council. All of the cities, in varying degrees, contract with the county to provide municipal services. Thirty-seven contract for nearly all of their municipal services. More than 65 percent of the county is unincorporated. For the one million people living in those areas, the Board of Supervisors is their "city council" and county departments provide the municipal services. The county, with 102,383.8 budgeted positions, is the largest employer in the five-county region. Of these budgeted positions, 31,627 are in law and justice, 29,098.8 are in health services, and 22,224.5 are in social services.

Figure 2.1
Population by PEI Age Groups



	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8
0-15	115,187	496,419	420,352	257,284	94,315	303,547	371,476	393,230
16-25	53,377	271,839	227,038	164,944	70,175	165,096	198,326	197,122
26-59	158,087	1,012,906	817,969	575,795	324,856	415,321	594,155	750,827
60 & Over	37,904	292,630	268,995	138,539	107,122	99,672	161,757	213,526

Population

In 2005, Los Angeles County had a total population of 9.8 million – 4.9 million (51 percent) females and 4.8 million (49 percent) males. This was the largest population of any county in the nation, and is exceeded by only eight states. The median age was 33.7 years, which made it one of the most youthful areas in the country. Twenty-eight percent of the population was under 18 years and 10 percent was 65 years and older. Across the county, Service Areas 2 and 3 contain almost 40% of the entire population. Correspondingly, they have the largest numbers of children and older adults in the county.

Ethnicity

Ethnically, the county is composed of a population that literally spans the globe. In this report, we attempt to provide you with as much detail as possible in terms of ethnic populations. Because various data sources are consulted, the reader must be clear on any categorical differences involving ethnic counts before making comparisons across groups. For example, a gross summary of the county's ethnic populations is commonly reported as in Table 2.1:

Table 2.0

PEI Age Groups Across Los Angeles County (percent of population)

	0-15	16-25	26-59	60+	Total
Within Service Areas1					
Service Area 1	31.6	14.6	43.4	10.4	100.0
Service Area 2	23.9	13.1	48.8	14.1	100.0
Service Area 3	24.2	13.1	47.2	15.5	100.0
Service Area 4	22.6	14.5	50.7	12.2	100.0
Service Area 5	15.8	11.8	54.5	18.0	100.0
Service Area 6	30.9	16.8	42.2	10.1	100.0
Service Area 7	28.0	15.0	44.8	12.2	100.0
Service Area 8	25.3	12.7	48.3	13.7	100.0
Total	25.1	13.8	47.6	13.5	100.0

	0-15	16-25	26-59	60+	Total
Between Service Areas2					
Service Area 1	4.7	4.0	3.4	2.9	3.7
Service Area 2	20.2	20.2	21.8	22.2	21.2
Service Area 3	17.1	16.8	17.6	20.4	17.8
Service Area 4	10.5	12.2	12.4	10.5	11.6
Service Area 5	3.8	5.2	7.0	8.1	6.1
Service Area 6	12.4	12.2	8.9	7.6	10.1
Service Area 7	15.2	14.7	12.8	12.3	13.6
Service Area 8	16.0	14.6	16.1	16.2	15.9
Total	100.0	100.0	100.0	100.0	100.0

Table 2.1
Ethnicity Across Los Angeles County—
Abbreviated Summary

⌘ Hispanic	47%
⌘ White non-Hispanic	30%
⌘ Asian	13%
⌘ African-American	9%
⌘ American Indian and Alaskan Native	1%
⌘ Native Hawaiian/Pacific Islander	< 0.5%

Table 2.2 provides a more detailed breakdown of the county's population, in some cases by categorizing ethnicities more specifically. Notice that the numbers from both tables are consistent, but not exactly so, owing to the differences in reporting.

In terms of heritage, 36% of the people living in Los Angeles County in 2005 were foreign-born. 64% were native-born, including 47 percent who were born in California. Among people at least five years old in Los Angeles County in 2005, 60.1% spoke a language other than English at home. Of these, 61.8% spoke Spanish.

Households

In 2005, across the county, there were 3.2 million households with an average household size of 2.6 people. Of these, families made up 67% of the all households and married-couple families accounted for almost half of all households (45%). Non-family households (33%) mostly involved people living alone, but some were composed of people living in households in which no one was related to the householder.

Figure 2.3
Types of Households in Los Angeles County

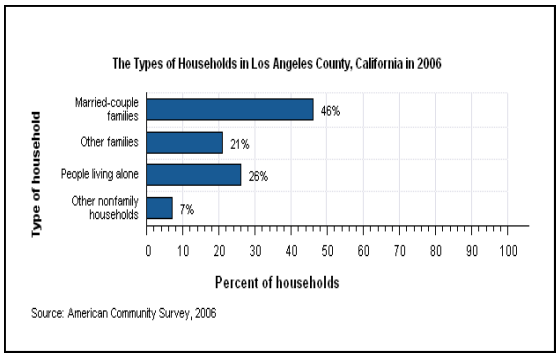


Figure 2.2
Numbers of Spanish Speakers by Census Tract

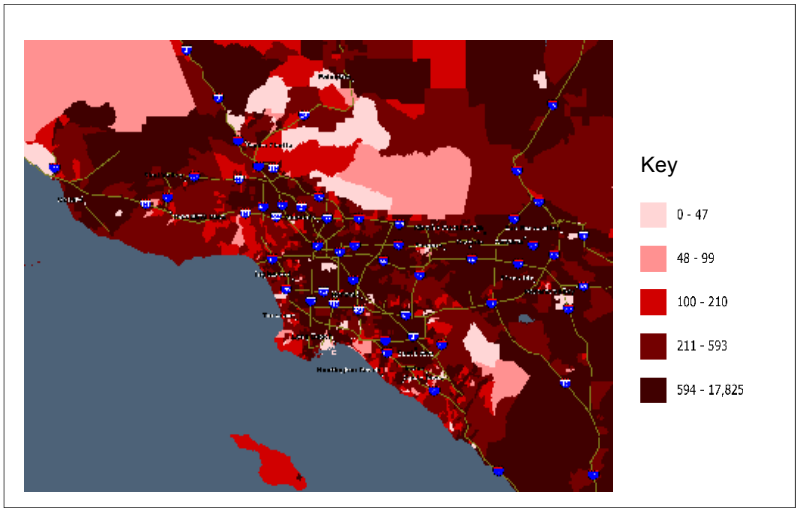


Table 2.2
Ethnicity Across Los Angeles County

	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	Countywide	Percent
African-American	44,897	78,129	78,233	56,874	47,143	273,235	37,489	233,612	**849,612**	8.7
American Indian	1,042	5,758	2,514	3,505	624	1,106	1,622	3,393	**19,564**	0.2
Armenian	1,147	125,339	10,177	15,592	1,776	57	3,346	3,378	**160,812**	1.6
Asian	14,404	172,433	399,619	186,780	66,249	15,177	118,224	215,998	**1,188,884**	12.2
Iranian	575	35,694	4,412	8,061	17,982	1,243	273	3,173	**71,413**	0.7
Latino	143,518	772,157	759,238	600,103	83,453	639,752	918,284	560,625	**4,477,132**	45.8
Pacific Islander	1,830	1,887	1,902	2,712	749	1,406	1,811	8,995	**21,293**	0.2
Russian	1,573	51,627	6,426	17,183	30,692	1,517	2,987	8,465	**120,471**	1.2
South Asian	541	28,379	12,505	11,776	8,439	2,201	12,134	13,586	**89,561**	0.9
Western European White	136,510	710,497	394,309	191,272	308,391	27,296	191,241	439,903	**2,399,418**	24.6
Other	931	7,706	6,787	6,727	2,122	5,950	1,674	4,920	**36,816**	0.4
Other Middle Eastern	2,726	32,650	13,497	10,211	13,440	1,404	6,166	6,131	**86,225**	0.9
Two or More Races	14,862	51,537	44,735	25,763	15,408	13,292	30,463	52,524	**248,586**	2.5
Total	**364,556**	**2,073,793**	**1,734,354**	**1,136,559**	**596,468**	**983,636**	**1,325,714**	**1,554,703**	**9,769,783**	
Percent	3.7	21.2	17.8	11.6	6.1	10.1	13.6	15.9	100.0	100.0

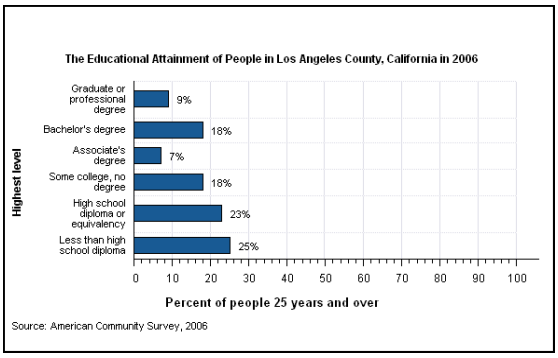
Table 2.3
Primary Language Across Los Angeles County

	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	Countywide	Percent
English	210,319	887,052	668,870	294,986	385,414	304,021	382,503	767,467	**3,900,632**	39.9
Spanish	102,021	650,752	549,444	524,439	68,231	557,391	716,291	445,951	**3,614,519**	37.0
Armenian	525	113,773	8,261	14,175	943	86	1,324	1,730	**140,817**	1.4
Farsi	632	36,294	2,709	7,585	18,008	1,521	379	2,359	**69,488**	0.7
Arabic	1,970	14,665	9,546	1,835	3,567	763	4,595	6,179	**43,120**	0.4
Russian	205	22,518	1,834	8,504	8,505	471	623	2,475	**45,134**	0.5
Cantonese	17	1,219	34,894	7,931	1,358	194	2,005	1,779	**49,397**	0.5
Chinese	432	6,508	108,955	13,873	6,361	2,293	14,489	13,174	**166,085**	1.7
Formosan	78	847	13,532	514	1,319	91	3,118	2,327	**21,826**	0.2
Mandarin	34	1,257	27,796	967	2,024	316	3,642	2,089	**38,126**	0.4
Cambodian	18	1,583	3,180	2,134	166	876	2,876	17,912	**28,745**	0.3
Korean	1,836	36,068	33,100	56,877	10,363	1,938	19,206	23,903	**183,291**	1.9
Vietnamese	1,367	15,312	44,583	3,909	3,425	529	5,592	12,425	**87,142**	0.9
Filipino	3,955	45,572	38,460	53,175	4,720	3,330	25,987	42,281	**217,479**	2.2
N/A or blank	35,372	139,440	129,708	88,683	30,417	96,709	107,435	130,843	**758,607**	7.8
All Other	5,774	100,934	59,483	56,975	51,646	13,107	35,650	81,811	**405,379**	4.1
Total	**364,555**	**2,073,794**	**1,734,354**	**1,136,561**	**596,468**	**983,636**	**1,325,714**	**1,554,705**	**9,769,787**	100.0

Education

In 2005, 74% of people 25 years and over had graduated from high school and 28% had a bachelor's degree or higher. 26% of this population were counted as dropouts; that is, they were not enrolled in school and had not graduated from high school. The total school enrollment in Los Angeles County was 2.9 million. Nursery school and kindergarten enrollment was 321,000 and elementary or high school enrollment was 1.9 million children. College or graduate school enrollment was 713,000.

Figure 2.4
Educational Attainment of People in Los Angeles County



Disability

Among people at least five years old, 12% reported having a disability. The numbers of those having a disability increased by age as shown in the table below:

Table 2.4
Percent of Age Groups Having a Disability

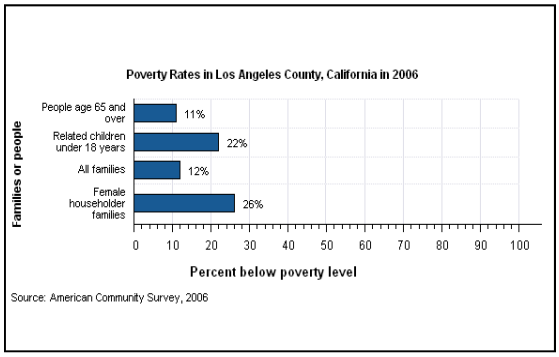
Age Group	%
5—15 years	4
16—64 years	10
65+	44

The ACS has one measure of mental disability involving memory problems; 4.6% of the county's population reported having difficulty in remembering things.

Income and Poverty

The median household income in Los Angeles County was $48,284 (Mean = $63,244). 84% of the households received earnings; 21% of the households received Social Security; and 12% received retirement income other than Social Security. The average income from Social Security was $12,856. These income sources were not mutually exclusive; that is, some households received income from more than one source.

Figure 2.5
Poverty Rates in Los Angeles County



Across the county, large percentages of the population were living below the Federal Poverty Level (FPL). Figure 2.5 depicts these percentages for age groups and family status. Children NOW (2007) ranked Los Angeles County 39th (out of 58 California counties) in terms of Family Economic Well-Being.

PUMA REFERENCE MAP
DEMOGRAPHIC PROFILE
KEY INDICATORS SUMMARY

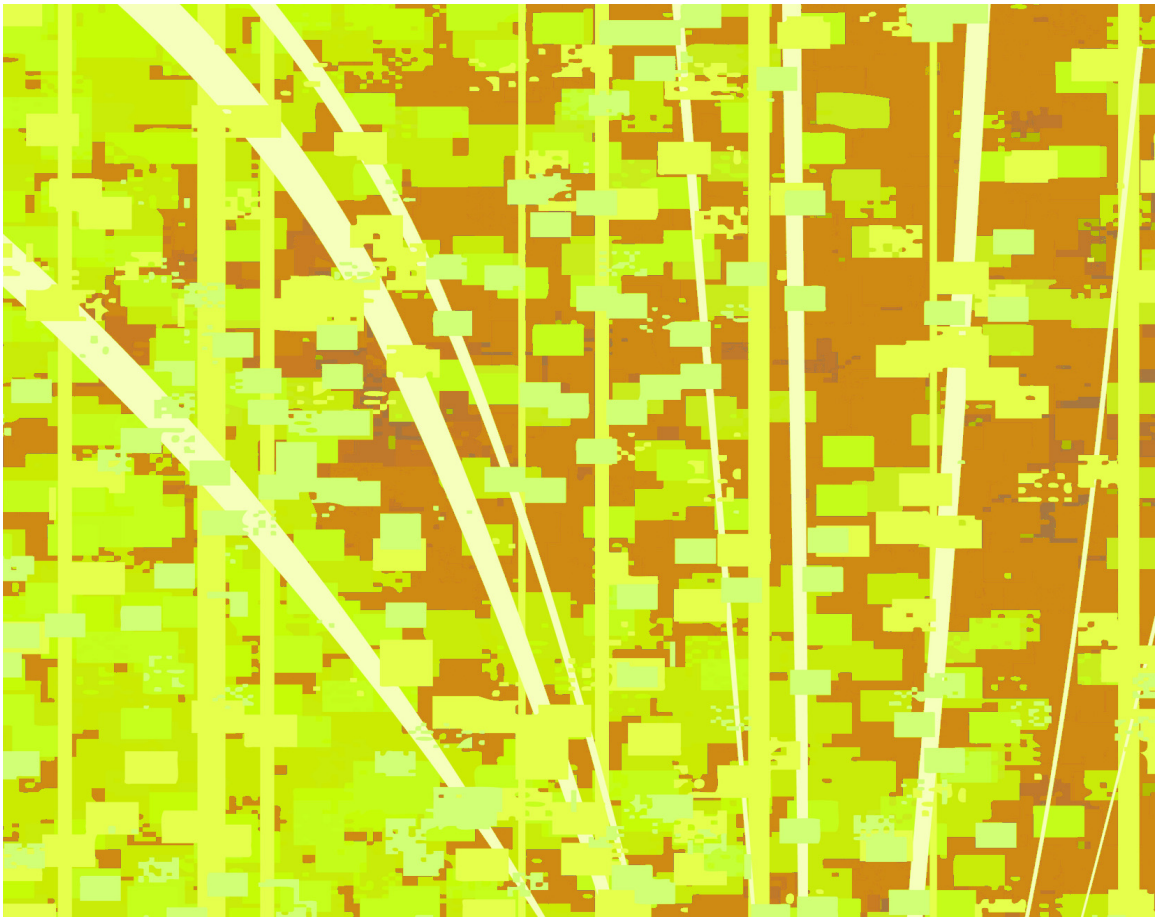
1

SERVICE AREA

VULNERABLE COMMUNITIES IN LOS ANGELES COUNTY
PREVENTION AND EARLY INTERVENTION

SERVICE AREA EXECUTIVE SUMMARY

Antelope Valley



Service Area 1: Antelope Valley

Communities

Lancaster
Palmdale
North County E.

ZIP Codes

93243	93534	93539	93550	93553	93586	93591
93510	93535	93543	93551	93563	93590	93599
93532	93536	93544	93552	93584		

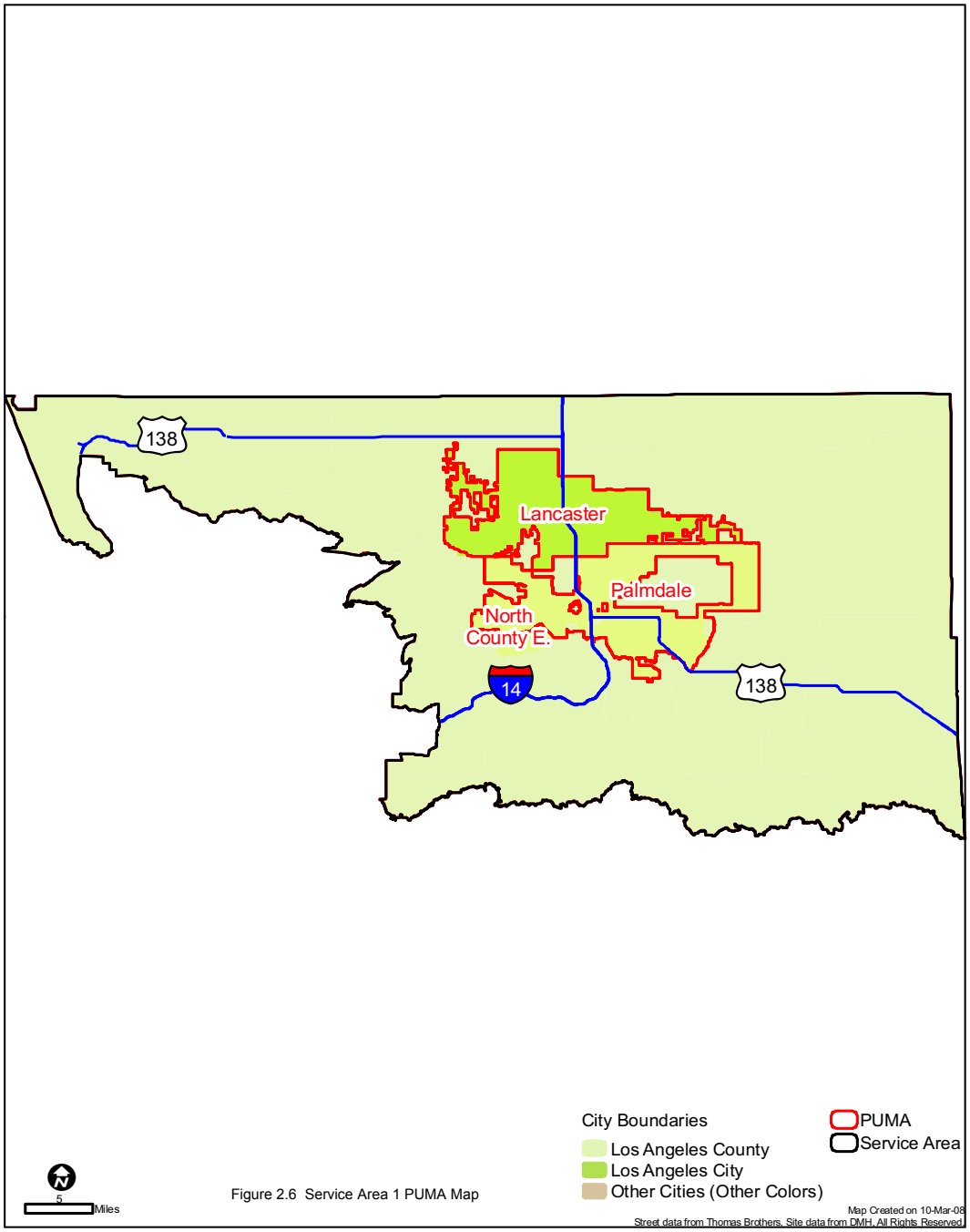


Figure 2.6 Service Area 1 PUMA Map

Demographic Profile

Ethnic Diversity: English Speakers

Service Area 1 (SA1) contains three PUMAs, Palmdale, Lancaster, and North County East. While it is the largest service area geographically, it has the smallest population and is home to only two cities: Palmdale and Lancaster. Overall, the service area has an almost equal number of people who identified themselves as Latinos and Whites. Examining the two urban areas reveals a somewhat different ethnic distribution. In the Lancaster area, no ethnic group has a majority. The Western European White population is more numerous than the Latino. Additionally, African-Americans account for 20% of the population in the area. In the Palmdale area, on the other hand, Latinos are the majority ethnic group, followed by Western European Whites and African-Americans who constitute 10% of the local area population. English is the primary language for 57.7% of the population, which is much higher than the County average of 44%. However, by national standards, language diversity in the service area is still high. Spanish is the second most common language and is reportedly spoken in 28% of homes. No other language group exceeds 5% of all households in the service area.

Age Distribution: Raising Young Families

SA1 has a younger population than other service areas as 31.6% of the population are children aged 0-15 years; the county average for this age group is 25%. At the other end of the spectrum, SA1 has fewer older adults than the county average; 10% of the SA1 population is 60 years and older, whereas 14% of the countywide population fall in this age category.

Economic Diversity:
Median Incomes and Affordable Housing

The median household income for the service area was $48,513 (Mean = $57,751) compared with the county median of $48,282. Average household income in the urban areas of Palmdale and Lancaster were fairly uniform ($50,320 and $51,081, respectively). The surrounding North County E. area had an average income of about $78,693, substan-

tially higher than other parts of the service area and the county. The median is a good statistic as it is not skewed by extremes in numbers. So, in this case, it provides a more realistic description of an household's income than the mean. However, the mean is important because it allows us to make better comparisons with other parts of the service area and county. Comparing mean incomes across the county indicated that service area 1 is below the county average income of $63,244. Five service areas have higher average household incomes than Service Area 1.

In terms of household size, the Palmdale area tended to be larger than other parts of the service area. Service Area 1 has the highest home ownership rate (68.6%) across the county, almost 20 percentage points above the county average of 48.9%. North County E., and Palmdale in particular, had two of the highest home ownership areas in the county. Lancaster's home ownership rate of 58.9%, while considerably lower than other parts of the service area, is still above the county average.

Memory and Educational Attainment: High Memory Problems, Low Educational Attainment

In terms of memory problems measured by the ACS, 6.8% of individuals in Service Area 1 reported memory problems, much higher than the countywide average of 4.6%. In terms of educational attainment, Service Area 1 had a college graduation rate of 16.2% (in adults 25+), far lower than the countywide average of 27.8%.

Key Indicators: Summary and Excerpts

Underserved Cultural Populations

Ethnicity

Within Service Area 1, Hispanics (41.1%) and Western European Whites (38.0%) account for nearly 80% of the total population. Hispanics are a majority in the Palmdale area while Western European Whites are more numerous in the Lancaster area and surrounding North County E. area. Additionally, the Lancaster area is home to relatively large communities of African-Americans, Multi-racial individuals, American Indians/ Alaskan Natives, and Pacific Islanders. However, in terms of actual numbers, Multi-racial individuals, Pacific Islanders and American Indians/Alaska Natives, together account for less than 5% of the service area's population. African-Americans comprise 12.5% of the population in the service area and in terms of actual numbers, the Lancaster area has one of the largest African-American populations in the county.

Primary Language

The majority of the population in Service Area 1 lists English as their Primary Language (57.7%), followed by Spanish, 28.0%. Only one other language, Tagalog (1.1%), is spoken by more than 1% of the population in the service area. Although English is the ma-

jority Primary Language, in actual numbers (and due to the relatively small population in Service Area 1), it has the smallest proportion of English speakers across the entire county (5.4%). Several Asian languages and Russian are similarly represented in low relative proportions. Drilling down and examining the composite service area communities indicates that English speakers are the majority in the Lancaster and North County E. areas but not in the Palmdale area. Small numbers of Korean speakers and Tagalog speakers (over 1%) are found in the surrounding North County E area.

Linguistic Isolation

All Service Area 1 communities had Linguistic Isolation scores that were all below the county's average of 7.8%. Of these, the North County E. area, which surrounds the two urban areas of Palmdale and Lancaster, reported the lowest percentage of individuals who were Linguistically Isolated (2.5%). This figure is consistent with finding that the majority of residents within the service area designated English as their primary language.

Individuals Experiencing Onset of Serious Psychiatric Illness

Serious Mental Illness Penetration Rate

The overall Penetration Rate for Service Area 1 was 0.32, and along with Service Area 6, this was the highest rate seen across the county. Relatively speaking, this indicates that treatment services may be reaching the SMI population here to a greater degree than found in other parts of the county. Examining penetration rates across ethnicities indicated that Asians (0.08) were the least served by county mental health services. Penetration rates for the other major ethnic groups were as follows: the Latino population (0.21), the White population (0.25), the Native American population (0.30) and the African-American population (0.82).

Depressive Disorders

Age Groups

Service Area 1 clients accounted for 4.8% of depressed clients in the county. Each of the service area's communities had a different age group that accounted for the largest proportion of depressed clients in their respective area. In the North County E. area, for example, the Child group accounted for 45% of the depressed population. In the Lancaster area, 40.4% of the depressed population came from the TAY group. And in the Palmdale area, the Adult group constituted 50.3% of the depressed population for the community. Across the service area, the Lancaster area had the majority of depressed clients (56.6%), including 74.0% of the depressed TAY group.

Ethnicity

No one ethnic group constituted a majority of depressed clients served in Service Area 1. Across all ethnicities, African-Americans made up the largest proportion of clients, 32.3%, followed by Latino clients, 29.5%; and White clients, 28.9%. Asian, Native American, and Pacific Islander groups each accounted for less than 1% of the depressed clients served in the service area.

Co-occurring Disorders (COD)

Age Groups

Service Area 1 clients accounted for 3.4% of

individuals with COD treated in the county's mental health system. Overall, 66.8% of the clients with COD in the service area were adults. In the two urban areas, adults were a majority of COD cases, and in the surrounding North County E. area this figure was 48.0%. Across the service area, the Lancaster area had the majority of clients with CODs (61.5%) even though it had only 36% of the service area population. The Lancaster area also included 74.4% of the TAY COD group, 52.8% of the child group, 57.7% of the adult group, and 69.2% of the older adult group.

Ethnicity

White clients accounted for 42.7% of the COD population treated in Service Area 1. This was followed by African-American clients (27.4%), Latino clients (21.8%), Native American clients (1.3%) and Asian clients (1.0%). When compared with population estimates for these groups, it appeared that African-American (12.8%) and Native American (0.3%) clients were overrepresented in the COD client counts, whereas, Latino (41.1%) and Asian (4.3%) clients were underrepresented.

Children/Youth in Stressed Families

Poverty

The overall poverty rate in Service Area 1 of 41.2% was higher than the county average of 38.7%. Examining ethnic groups indicated that in all communities, over 50% of African-Americans were living beneath the 200% FPL. This was more pronounced in the two urban areas of Lancaster and Palmdale where over 60% of African-Americans were below this level. Similarly, the Hispanic population had over 50% of its population in the urban areas living beneath the 200% FPL. The only other group who had a majority of its members living beneath the 200% FPL were American Indians living in the Palmdale area.. Overall, Hispanics account for 56% of the entire poverty population in the service area.

Unemployment Rate

Service Area 1 had a self-reported unemployment rate of 9.2%, which was higher than the countywide average of 7.4%. Of the three communities in the service area, the Palmdale area had the highest unemployment rate reported, 11%. The Lancaster area reported an unemployment rate of 9.9%, also high by county standards. The area surrounding the two urban areas, North County E., had a much lower unemployment rate (5.5%) than either city area.

Disrupted Families

Service Area 1 had an overall DF ratio of 2.0, indicating that there were two intact families for every single-parent family in the service area. This figure was slightly lower than the countywide figure of 2.2. The Palmdale area had the lowest DF ratio (1.6) in the service area while the surrounding North County E. area had the greatest DF ratio of 3.0, or three intact families for each single-parent family.

Safe Place to Play (Countywide Summary Only)

Age Groups

Across the three age groups reported, there appeared to be a trend in parent-report. Par-

ents were more likely to report that a safe place to play was less available for older children than for younger ones.

Ethnicity

There did not appear to be any significant difference between parent reports across ethnicities.

Trauma-exposed Individuals

Child Abuse

Child Abuse and Neglect Base Rates

Service Area 1 had the highest CAN Rate (1.98) found across the county. This indicated that approximately 2 out of 100 children in the service area suffered from some form of abuse or neglect during the 2006 calendar year. Within the service area, both urban centers had relatively high CAN rates with the Palmdale area having some of the highest numbers of substantiated abuse cases seen in the county (28.6%).

Triage Response Acuity

Service Area 1 had the highest Acuity score (0.25) in the county and all of its communities had Acuity scores above the countywide score of 0.15. The Lancaster area (0.31) had the second highest Acuity score seen across the county signifying an area with particularly high needs for immediate response by DCFS staff. The Palmdale area also had a relatively high Acuity scores (0.24) which was greater than 84% of the county's communities, (i.e., PUMAs).

Ethnicity

Across Service Area 1, 93% of SCAN Reports involved three ethnic groups: African-American, White, and Hispanic. This pattern was essentially the same in all of the service area communities. Overall, African-American children accounted for 35.7% of SCAN Reports, White children, 27.8% and Hispanic children, 29.5%. Within the Lancaster area, African-American children (43.4%) were more frequently victimized than other ethnicities. In the Palmdale area, Hispanic children (36.0%) were more frequently victimized than other ethnicities. And in the surrounding North County E. area, White children (41.9%) were more frequently victimized than other ethnicities.

Elder and Dependent Adult Abuse

Service Area 1 had an APS Rate[1] of 3.2, which was the second highest rate seen in the county across all service areas. Within the service area, the Lancaster community had the highest rate of APS cases using two different base rates calculations. This would suggest that the Lancaster area was particularly at risk for Elder and Dependent Adult abuse.

Posttraumatic Stress Disorder (PTSD)

Age Groups

Service Area 1 clients accounted for 7.9% of individuals with PTSD treated in the county's mental health system. The majority of clients with PTSD in the service area were children (51.5%). Examining the composite communities revealed that about half of all cases fell within the Child age group. The TAY group accounted for about a quarter of all cases in the Lancaster area and more than a third of all cases in the surrounding North County E. area. In the Palmdale area, Adults

accounted for more than a third of PTSD cases. Across the service area, the Palmdale area accounted for a majority of all PTSD cases.

Ethnicity

African-American clients accounted for 34.0% of the PTSD population treated in Service Area 1. This was followed by Latino clients (32.7%) and White clients (26.9%). Native American, Asian, and Pacific Islander clients each accounted for less than 1% of the PTSD cases in the area. When compared with population estimates for these groups, it appeared that African-American (12.8%) and Native American (0.3%) clients were overrepresented in the PTSD client counts, while Latino (41.1%), White (39%), and Asian (4.3%) clients were underrepresented.

Homelessness

Age Groups

In Service Area 1, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (68.5%) of the homeless population. This was followed by the Under 18 Age Group at 13.6%, the 18-24 Age Group at 10.1%, and the 56+ Age Group at 7.8%.

Ethnicity

Within Service Area 1, Black/African-Americans accounted for 40.8% of the homeless population. Hispanic or Latinos accounted for 14.3%, Whites, 40.1%, and Multi-Racial and Others accounted for 4.8% of the homeless population.

Sub-populations

In Service Area 1, 50.4% of the homeless population reported that they had a mental illness. This was the highest proportion of mentally ill homeless individuals seen within the county. 26.7% of homeless individuals reported they were substance abusers; and, 7.7% reported they were victims of domestic violence.

Children/Youth at Risk for School Failure

4-year Dropout Rate (Countywide Summary Only)

State figures indicated that over a quarter of all students in Los Angeles County drop out of high school over a four-year period. Examining ethnic categories indicated that African-American students were most at risk for not finishing high school, followed by Pacific Islander, American Indian/Alaska Native, and Hispanic or Latino Students. 15.5% of White students drop out of high school. Two ethnic groups had dropout rates below this: Asian, 7.4% and Filipino, 12.8%.

High School Graduation Rates

Across the county, the Antelope Valley had the highest graduation rate of all service areas, 89.1%. No population saw graduation rates below 50%. The American Indian/ Alaskan Native population in the Palmdale area had the lowest graduation rate in the area, 66.7%.

English Fluency

Across the county, Service Area 1 had the highest fluency rate, 81.3%, within its school population. Examining the composite communities indicated that all communities had a fluency rate that exceeded the county average of 68.7%. Only the Palmdale area (76.5) had a fluency rate below 80%.

3rd Grade Reading Level

Overall, Service Area 1 saw 32.7% of its third

graders score at or above the 50th percentile in a standardized reading test. This figure was above the countywide figure of 22.4%. For the three ethnic groups for whom we do have data in this area (we do not have complete data for this indicator for Asian populations), African-American students had the lowest reading scores (17.9%), followed by Latino students (25.9%) and White students (53.5%). The overall high school graduation rates in the Antelope Valley mirror these reading scores with African-Americans having the lowest rate, followed by Hispanic students, and then White students.

Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

School Discipline

Service Area 1 had the highest suspension rate seen across the county with 8.9% of its students excluded from school at some point in time during the year. The Lancaster area had the highest suspension rate in the county at 11.1%, or one out of ten students. Service Area 1 also had the highest expulsion rate throughout the county with 0.6% of its students permanently denied access to their school. In particular, the Lancaster area had the highest expulsion rate in the county with 0.9%, or about one out of one hundred students receiving this action.

Juvenile Felony Arrests (Countywide Summary Only)

Of the 23,787 youths arrested on felony charges during the reporting period, 84.2% were males, 15.8%, females. Ethnically, Hispanic youths were involved in the majority of felony arrests (57.2%), followed by Black/African-American youths (30.3%) and Whites (9.1%). All other ethnicities combined accounted for less than 4% of the juvenile felony arrests.

Youths on Probation

Camp Population

Both the Lancaster and Palmdale areas have relatively large numbers of youths sent to camp. Service Area 1 had twice as many African-American youth in camp as Hispanic youth. African-American youths accounted for 58.2% of the camp population, Hispanics (29.1%), and Whites (12.1%).

Supervised Youths

Similar to the Camp census, African-American youths under supervision (618) were greater in number than Hispanic youths (469) in the service area. Both of the urban areas within the service area had over 500 youths under supervision.

Key Indicators of Stigma and Discrimination

Language Capacity of Mental Health Providers

Across the service area, staffing ratios for English speakers (29) was over three times the ratio for Spanish speakers (8) and over four times that for Vietnamese speakers (7). For populations numbering over 1000 individuals, only Korean speakers (38) saw a staffing ratio that exceeded that for English speakers.

Key Indicators of Suicide Risk

Deaths by Suicide

Service Area 1 data indicated that males had higher suicide rates than females in all communities. Across ethnicities, Whites had the highest suicide rates in all communities. In the Lancaster area, for example, the suicide rate for Whites was five times that for Latinos. Across age groups, Older Adults were at higher risk than all other groups. The Lancaster area (40.2) had one of the highest suicide rates in the county for Older Adults. Additionally, there was a relatively high rate seen for the TAY population (29.4) in the surrounding North County E. area.

Mental Health Emergency Statistics

Overall, Service Area 1 had the highest MHE-Rate (9.4) for all service areas. The Lancaster area not only had one of the highest call counts in the county, but also the second-highest MHE-Rate, 12.4.

PUMA REFERENCE MAP
DEMOGRAPHIC PROFILE
KEY INDICATORS SUMMARY

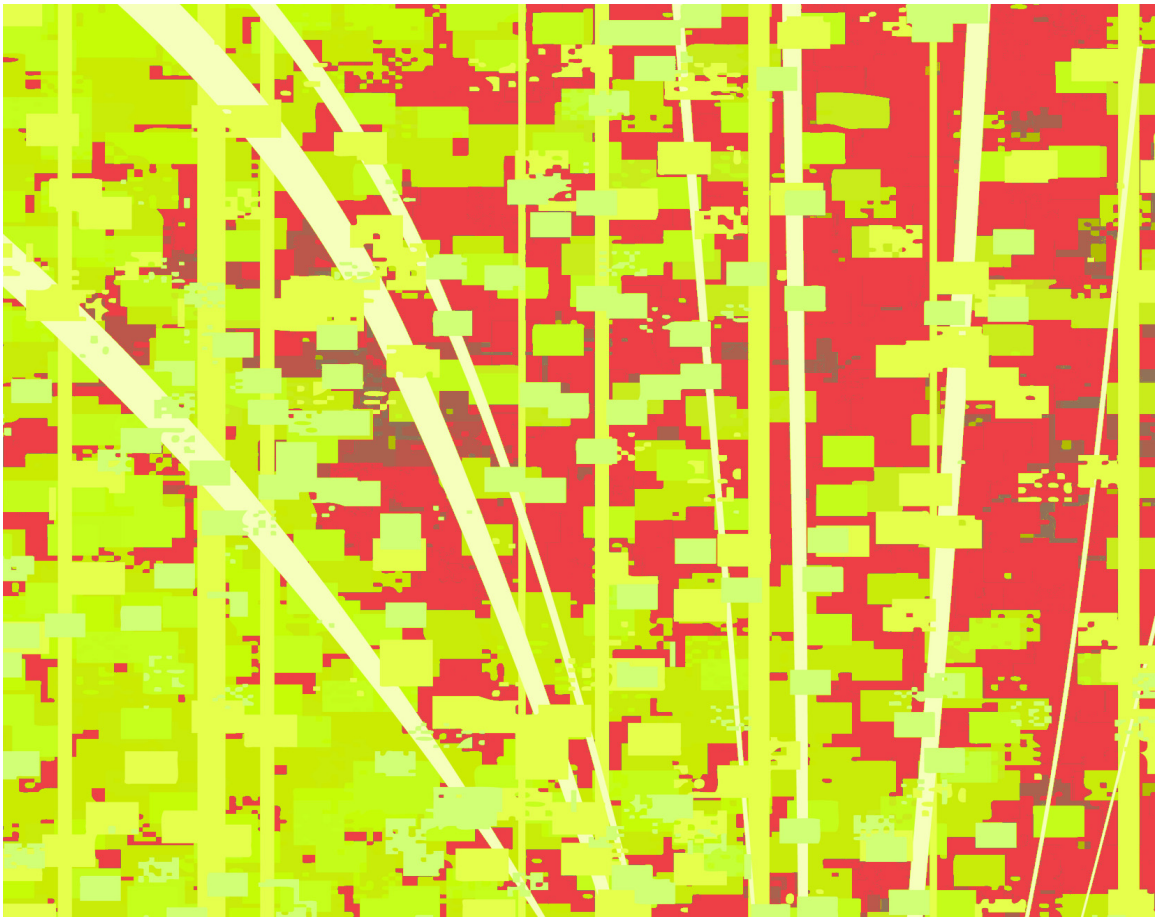
2

SERVICE AREA

VULNERABLE COMMUNITIES IN LOS ANGELES COUNTY
PREVENTION AND EARLY INTERVENTION

SERVICE AREA EXECUTIVE SUMMARY

San Fernando



Service Area 2: San Fernando

Communities

Santa Clarita
Burbank
Glendale
Northridge
Granada Hills
Pacoima-Arleta
La Tuna Cyn.
Panorama City
North Hollywood
Sherman Oaks
Encino
Woodland Hills
Brentwood N.
North County W.
La Canada -Flintridge
San Fernando -Calabasas-Agoura

ZIP Codes

90290	91203	91302	91324	91343	91364	91394	91412	91504
91011	91204	91303	91325	91344	91365	91395	91413	91505
91012	91205	91304	91326	91345	91367	91396	91416	91506
91020	91206	91305	91327	91346	91371	91399	91423	91507
91021	91207	91306	91328	91350	91372	91401	91426	91508
91023	91208	91307	91329	91351	91376	91402	91436	91510
91040	91209	91308	91330	91352	91380	91403	91470	91521
91041	91210	91309	91331	91353	91381	91404	91482	91522
91042	91214	91310	91333	91354	91383	91405	91495	91523
91043	91221	91311	91334	91355	91384	91406	91496	91526
91046	91222	91312	91335	91356	91385	91407	91497	91601
91050	91224	91313	91337	91357	91386	91408	91499	91602
91051	91225	91316	91340	91361	91388	91409	91501	91603
91201	91226	91321	91341	91362	91392	91410	91502	91604
91202	91301	91322	91342	91363	91393	91411	91503	91605

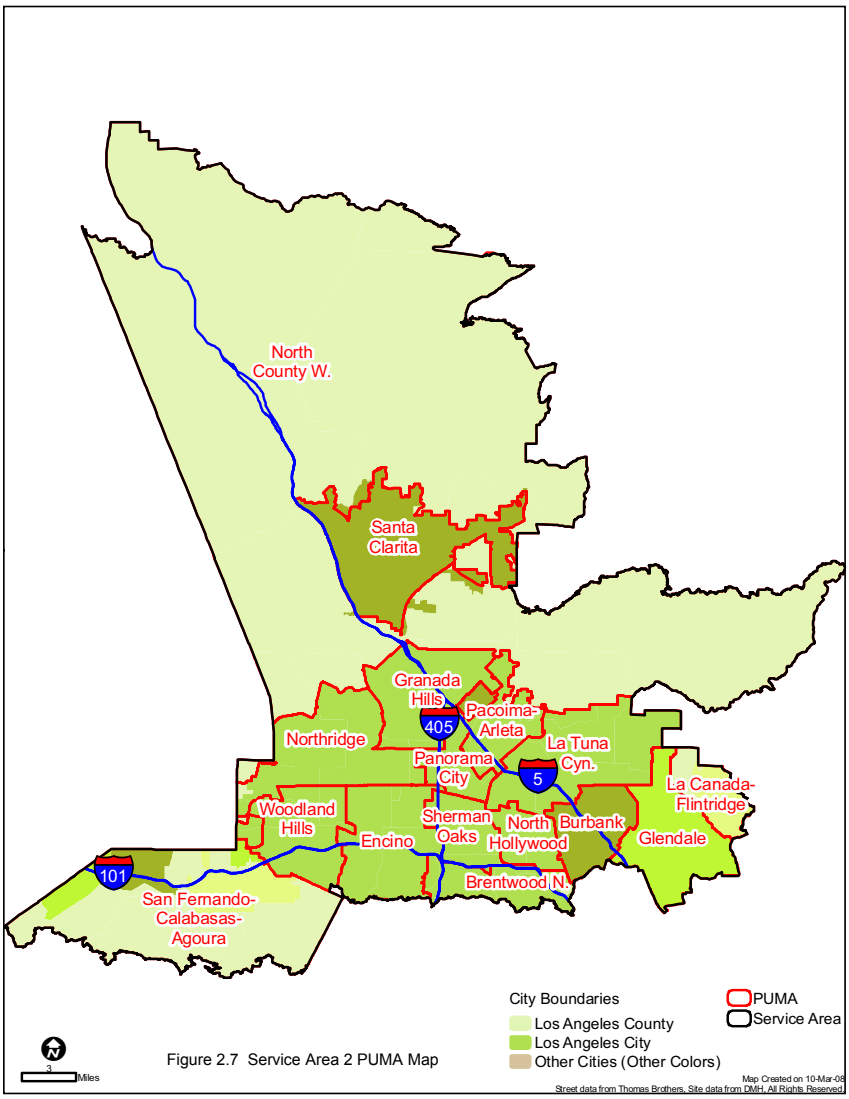


Figure 2.7 Service Area 2 PUMA Map

Demographic Profile

Ethnic Diversity:

Large Population and Language Diversity

Service Area 2 (SA2) is the most populous service area in Los Angeles County; it is comprised of the San Fernando Valley, the cities of Santa Clarita, Burbank, Glendale, and northern parts of the City of Los Angeles. Latinos account for 38.4% of the population, followed by Western European Whites (35.4%), Asians (8.6%), Armenians (5.6%), and African-Americans (3.9%). Across the service area, it is possible to identify areas where ethnic minorities have settled in large numbers. The Pacoima-Arleta community, for example, is populated predominately by Latinos (86.8%); the Glendale community is home to almost half of all Armenians (49%) within the service area; Western European Whites predominately populate the Santa Clarita community; and Asians are most numerous in Northridge.

English and Spanish are the predominate languages spoken at home in 42.8% and 31.4% of households, respectively. This means that a full quarter of the remaining population speak other languages. Armenian is spoken in 5.5 % of households and Tagalog in 2.2% of homes. Like other parts of the county, ethnic groups tend to form communities where their native language is spoken. The Glendale area is a good example of this where 28.9% of the residents speak Armenian and 4.7% speak Korean. Farsi is spoken by 6.1% of the population in the Encino area. Spanish is predominately spoken in the areas of Pacoima-Arleta and Panorama City, which also has a large number of Tagalog speakers (6.5%)

Age Distribution:

Large Numbers in Proportion to County

The percentage of children ages 0-15 living in SA2 (23.9%) is about county average (25%), but because of the population size, SA2 has more children in this age category than the other service areas. SA2, for example, has over 400,000 more children in this age category than SA5. The percentage of persons ages 60 and older in SA2 (14%) is identical to the county average (14%). Again, due to differences in population size, SA2 has more

older adults than any other service area. For example, SA2 has over a quarter million more older adults than SA1.

Economic Diversity:
Higher Incomes than Average

Average median household income in the service area of $55,036 was higher than the county median of $48,282. Similarly, the mean household income of $71,839 was higher than the county mean of $63,244. It is important to consider both median and mean statistics when examining incomes. The median, or mid-point, gives a better indication of the typical level of income reported by individuals within the service area. The mean or arithmetic average, however, is a better statistic to compare different geographical areas, such as between and across service areas. Examining the composite communities revealed that there was a great discrepancy between them in terms of two indicators of wealth: income and home ownership. Mean household incomes ranged from the low $40,000s in a number of communities to over $120,000 in the San Fernando-Calabasas-Agoura area. Similarly, parts of the service area were marked by a high number of rental properties, such as in the North Hollywood and Sherman Oaks areas; home ownership in Santa Clarita at 74.1% was quite a bit above the county average of 48.9%.

In terms of household size, the Pacoima-Arleta area had households that tended to be larger than other parts of the service area (3.7 individuals/household).

Memory Problems and Educational Attainment: Gaps in Education across Service Area

In terms of memory problems as measured by the ACS, 4.7% of individuals in Service Area 2 reported memory problems, identical to the countywide average of 4.6%. As in the other demographic measures, the service area was marked by diverse figures. The West Valley area of San Fernando-Calabasas-Agoura had one of the lowest rates of self-reported memory problems (2.5%) while the areas of Glendale (6.7%), Granada Hills (6.4%), and La Tuna Canyon (6.2%) had much higher rates. Educationally, Service Area 2 had a college graduation rate of 30.7% (in adults 25+), exceeding the countywide average of 27.8%. The community of Brentwood N. had the highest number of college graduates in the service area (59.5%) while the Pacoima-Arleta area had the fewest college graduates (6.5%).

Key Indicators: Summary and Excerpts

Underserved Cultural Populations

Ethnicity

As the largest service area, it is not surprising to see that several ethnic groups have large populations throughout the San Fernando Valley area. Western European Whites have the highest proportion of its population in the San Fernando Valley as do Armenians, Russians, South Asians, and American Indians/Alaskan Natives. The San Fernando Valley is home for the majority of Armenians residing in the county with 69.7% of its overall population contained within its boundaries. Nine of the ten largest Armenian communities are located within the San Fernando Valley; together they account for 5.6% of the service area's population. Similar to this, Russians, Iranians and South Asians have 42.9%, 50%, and 31.7% of their respective populations living in the San Fernando Valley area. American Indians/Alaskan Natives have close to 30% of their population living within the San Fernando Valley. It should be noted that although non-White/non-Hispanic groups are *relatively* numerous, they make up a fraction of the total population in the service area. Within the service area, a handful of communities are noteworthy in their ethnic diversity. The Glendale and Encino areas, for instance, have six different ethnic groups with relatively large numbers residing within its boundaries; the communities of Northridge, Sherman Oaks, and Woodland Hills have five.

Primary Language

Five language groups (English, Armenian, Farsi, Arabic, and Russian) have their largest proportion of speakers residing in the San Fernando Valley. Across the service area, English is the most common Primary Language (42.8%), followed by Spanish (31.4%), Armenian (5.5%), Tagalog (2.2%), Farsi (1.8%), Korean (1.7%), and Russian (1.1%). Drilling down into the service areas composite communities indicates that seven communities are predominately English-speaking; two are Spanish-speaking, and seven others have no clear majority of speakers. Large communities of Armenian speakers are found in the Burbank, Glendale, La Tuna Cyn., and North Hollywood areas. In the Encino area, 6.1% of the residents report Farsi as their Primary Language and in Panorama City, 6.5% of the population are Tagalog speakers.

Linguistic Isolation

Service Area 2 had an overall Linguistic Isolation score of 6.9%, which was lower than the countywide figure of 7.8%. Examining the composite communities with the San Fernando Valley area indicated that there was a great deal of variability in isolated households. The Brentwood N. area, for example, had an isolation score of 1.2%, whereas the Pacoima-Arleta area (11.5%) and the Panorama City area (18.2%) had isolation scores much higher. Because the Pacoima-Arleta area reported a primary language of Spanish in over 72.9% of the population, it seems

likely that most isolated households are primarily monolingual Spanish-speaking. This would also seem to hold for the Panorama City area, as well, with 80.2% of its population reporting Spanish as their primary language. Additionally, in the Panorama City area, there were large numbers of Koreans and Filipinos who spoke their heritage language at home and undoubtedly these households also contributed to the high isolation score for the service area. The Glendale area (9.7%) had nearly 10% of its households reporting Linguistic Isolation, as well. One might be tempted to attribute this to the large population of Armenians living in the area who report Armenian as their primary language (28.9%), but a more careful inspection of the primary language table indicates that several other ethnic groups may contribute to this figure, as well, (e.g., Spanish, Arabic, Farsi, Korean, Russian, and Tagalog speakers account for well over 10% of the community's population).

Individuals Experiencing Onset of Serious Psychiatric Illness

Serious Mental Illness Penetration Rate

The overall Penetration Rate for Service Area 2 was 0.18 and was well below the county-wide rate of 0.34. Such a figure suggested that the local mental health resources may have a smaller reach into the SMI population than other parts of the county. Across ethnicities, Asians (0.05) were the least-served by county mental health services. Following this, in order of Penetration Rates, were the White population (0.14), the Latino population (0.18), the Native American population (0.27) and the African-American population (0.62).

Depressive Disorders

Age Groups

Service Area 2 clients accounted for 18.5% of depressed clients in the county. In general, composite communities saw either the majority of depressed clients coming from either the Child (0-15) group, (the Burbank, Northridge, Encino, San Fernando-Calabasas-Agoura areas), or the Adult (26-59) Group, (the Santa Clarita, Granada Hills, North Hollywood, Woodland Hills areas). Similar to the county numbers, 50% of all depressed clients in the service area were in the Adult group. Across the service area, the largest proportion of clients (25.9%) were served in the Granada Hills area.

Ethnicity

No one ethnic group constituted a majority of depressed clients served in Service Area 2. Across all ethnicities, Latinos comprised the largest proportion of depressed clients, 41.9%, followed by White clients, 29.2%, African-American clients, 10.7%, and Asian clients, 1.8%. Native American and Pacific Islander clients each accounted for less than 1% of the depressed clients served in the service area. Examining the composite communities revealed that in six areas, Latinos were the majority of clients served (the Burbank, Northridge, Pacoima-Arleta, Panorama City, Encino, and San Fernando-Calabasas-Agoura areas). Whites were a majority of depressed clients served in the Santa Clarita area.. No other ethnic group constituted a majority of depressed clients in any other Service Area 2 community.

Co-occurring Disorders (COD)

Age Groups

Service Area 2 clients accounted for 18.9% of individuals with COD treated in the county's mental health system. Within the service area, and similar to the county as a whole, the majority of clients with a COD were adults (26-59). However, examining the composite communities revealed that certain areas treated a majority of other age groups for CODs. Two communities, the Burbank and San Fernando-Calabasas-Agoura areas, for example, treated a majority of children (0-15) for CODs. Two other areas focused on a majority of TAY (16-25) clients with a COD, the Panorama City and Encino areas. Finally, seven communities provided treatment to a majority of adults with CODs (the Santa Clarita, Glendale, Pacoima-Arleta, North Hollywood, Sherman Oaks, Woodland Hills, and La Canada-Flintridge areas). Across the service area, 39.9% of clients with a COD were treated in the Granada Hills area. This was followed by the Woodland Hills area (14.9%), the Pacoima-Arleta area (11.9%), the Sherman Oaks area (9.6%), and the Santa Clarita area (9.0%).

Ethnicity

White clients accounted for 39.1% of the COD population treated in Service Area 2. This was followed by Latino clients (35.0%), African-American clients (14.1%), and Asian clients (1.4%). Native American and Pacific Islander groups each accounted for less than 1% of the COD population in the county's mental health system. When compared with population estimates for these groups, Latino and White groups appeared to be represented close to their population counts. African-American clients appeared to be over-represented when compared to their population share of 3.9%. Examining the service area composite communities revealed two areas where White clients were a majority of the COD population, the Santa Clarita and Woodland Hills areas. Three areas saw a majority of Latino clients with a COD (the Burbank, Encino, and San Fernando-Calabasas-Agoura areas). No other ethnic group constituted a majority of COD cases in the Service area.

Children/Youth in Stressed Families

Poverty

The overall poverty rate in Service Area 2, 30.8%, was below the county average of 38.7%. Overall, the Panorama City area had the highest rate of individuals living beneath the 200% FPL, 52.9%. Examining the ethnic groups within the service area indicated that the Hispanic population were a majority of the poverty population (60.6%). Over 50% of the Hispanic population in six communities in the San Fernando Valley were living below the 200% FPL: the Pacoima-Arleta area (52.2%), the La Tuna Cyn. area (50.0%), the Panorama City area (63.1%), the North Hollywood area (54.4%), the Encino area (51.3%), and the Woodland Hills area (54.4%). In two communities, over 50% of African-Americans were living under 200% FPL, the North Hollywood area (66.9%) and the North County W. area (51.6%). In one community, the Panorama City area, 55.8% of the American Indian population was living below this level. It should be noted that, in actual num-

bers, the African-American and American Indians living in poverty accounted for only 1.2% of the service area's total population.

Unemployment Rate

Service Area 2 had a self-reported unemployment rate of 6.9%, which was below the countywide average of 7.4%. Two communities, the Pacoima-Arleta (10.2%) and the North Hollywood (11.1%) areas, had rates in excess of 10%. Two other communities, the La Tuna Cyn. (9.8%) and the Panorama City (9.6%) areas were close to the 10% mark, as well. The Granada Hills area saw the lowest unemployment rate in the service area (5.1%).

Disrupted Families

Service Area 2 had an overall DF ratio of 2.3 similar to the countywide average of 2.2. Across the service area, there was a broad range of scores with some areas, such as Panorama City (1.3) having close to a 1:1 ratio of two-parent to single-parents households. Four other communities saw DF ratios below 2.0: the Granada Hills area (1.6), the Sherman Oaks area (1.6), the La Canada-Flintridge area (1.8), and the San Fernando-Calabasas-Agoura area (1.7). On the other end of scale, the Brentwood N. area had a DF ratio of 5.6, indicating over a 5:1 ratio of two-parent to single-parents households.

Safe Place to Play (Countywide Summary Only)

Age Groups

Across the three age groups reported, there appeared to be a trend in parent-report. Parents were more likely to report that a safe place to play was less available for older children than for younger ones.

Ethnicity

There did not appear to be any significant difference between parent reports across ethnicities.

Trauma-exposed Individuals

Child Abuse

Child Abuse and Neglect Base Rates

Service Area 2 had an overall CAN Rate of 0.75, which was below the county rate of 0.96. Within the service area, the North Hollywood area (1.26) and the Pacoima-Arleta area (1.22) had the highest CAN Rates. Overall, 17.3% of all SCAN reports were eventually substantiated.

Triage Response Acuity

Service Area 2 had an overall Acuity score of 0.12, which was below the countywide score of 0.15. Five communities had Acuity scores which were at or above this figure: the Pacoima-Arleta area (0.18), the La Tuna Cyn area (0.15), the Panorama City area (0.17), the North Hollywood area (0.18), and the Sherman Oaks area (0.15).

Ethnicity

Across Service Area 2, 90.8% of SCAN Reports involved four ethnic groups: African-American, White, Hispanic, and Mexican. Overall, African-American children accounted for 8.3% of SCAN Reports, White children, 21.7%, Hispanic children, 55.2%, and Mexican children, 5.6%. Hispanic children were a majority of victims in eight communities: the Granada Hills area, the Pacoima-Arleta area, the La Tuna Cyn area, the Panorama City area, the North Hollywood area, the Sherman Oaks area, the Encino area, and the San Fernando-Calabasas-

Agoura area. White children were the majority of victims in three communities: the Brentwood N. area, the North County W. area, and the La Canada-Flintridge area.

Elder and Dependent Adult Abuse

Service Area 2 had an APS Rate[1] of 2.3, which was below the countywide rate. Within the service area, the Sherman Oaks area (3.0), the Panorama City area (2.7), and the North Hollywood area (3.0) had the highest APS Rate[1] scores.

Posttraumatic Stress Disorder (PTSD)

Age Groups

15.5% of the county's PTSD cases came from Service Area 2. Though no age group constituted an overall majority of PTSD cases in the Service Area 2, the Child group (0-15) accounted for the largest proportion of cases (45. 9%). However, drilling down into the composite communities did show that the Child group were a majority in seven areas (the Burbank, Northridge, Pacoima-Arleta, Encino, North County W., La Canada-Flintridge, and San Fernando-Calabasas-Agoura areas). Only one community, the Granada Hills area, saw a majority of TAY clients (16-25) with PTSD and only one community, the Santa Clarita area, saw a majority of Adult clients (26-59). Across the service area, about half of all PTSD cases were treated in the Glendale, Granada Hills, and Sherman Oaks areas. The Sherman Oaks area saw about a quarter of all PTSD cases in the San Fernando Valley.

Ethnicity

Latino clients (50.7%) accounted for a majority of the PTSD population treated in Service Area 2. This was followed by White clients (18.2%), African-American clients (16.7%), and Asian clients (4.6%). Native American and Pacific Islander groups each accounted for less than 1% of the PTSD population in the county's mental health system. When compared with population estimates for these groups, Latino, Asian, and White groups appeared to be underrepresented relative to their population counts. African-American clients appeared to be overrepresented when compared to their population share of 3.9%. Examining the service area composite communities revealed seven communities where Latino clients were a majority of PTSD cases (the Burbank, Northridge, Pacoima-Arleta, Panorama City, North Hollywood, Encino, and La Canada-Flintridge areas). In one community, the Santa Clarita area, White clients constituted a majority of the PTSD population. No other ethnic group constituted a majority of PTSD cases in the Service area.

Homelessness

Age Groups

In Service Area 2, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (69.9%) of the homeless population. This was followed by the Under 18 Age Group at 15.7%, the 56+ Age Group at 9.9%, and the 18-24 Age Group at 4.6%.

Ethnicity

Within Service Area 2, Black/African-Americans accounted for 26.2% of the homeless population. Hispanic or Latinos accounted for 25.0%, Whites, 42.7%, and Multi-Racial or Others accounted for 6.1% of the homeless population.

Sub-populations
In Service Area 2, 38.6% of the homeless population reported that they had a mental illness; 33.3% of homeless individuals reported they were substance abusers; and 10.4% reported they were victims of domestic violence.

Children/Youth at Risk for School Failure

4-year Dropout Rate
(Countywide Summary Only)
State figures indicated that over a quarter of all students in Los Angeles County drop out of high school over a four-year period. Examining ethnic categories indicated that African-American students were most at risk for not finishing high school, followed by Pacific Islander, American Indian/Alaska Native, and Hispanic or Latino Students. 15.5% of White students drop out of high school. Two ethnic groups had dropout rates below this: Asian, 7.4%, and Filipino, 12.8%.

High School Graduation Rates
Across the service area, two ethnic groups, African-Americans and Hispanic students, had the lowest graduation rates seen with both under 70%. Examining the service area's composite communities indicated that the Burbank area had the lowest overall graduation rate in the service area, 57.7%. Additionally, several ethnic groups had especially low rates in particular communities. For example, Hispanic students in the Burbank and La Canada-Flintridge areas were more likely to drop out than graduate. African-American students in the North Hollywood area and La Canada-Flintridge areas were similarly at risk for not graduating. American Indians/ Alaskan Natives in the Burbank and La Tuna Cyn areas were also more likely to not graduate than graduate from high school.

English Fluency
Service Area 2 had an overall fluency rate of 70.2% within its student population, slightly above the county average of 68.3%. Two communities, the Pacoima-Arleta area (49.6%) and the Panorama City area (42.5%) dipped below 50% indicating that one of two students had difficulty with speaking English. Spanish was the most common primary language spoken at home in both of these communities.

3rd Grade Reading Level
Overall, 35.9% of Service Area 2 third graders were reading at or above the 50th percentile. This mark was still higher than the countywide figure of 22.4%. The Panorama City area (18.4%), followed closely by the Pacoima-Arleta area (18.9%), had the lowest reading rates in the service area. This appeared to be associated with the language barrier identified above. Both areas had the lowest English Fluency rates in the service area, as well. Although third grade is a long way from high school graduation, these data indicated that the Panorama City area, with the lowest reading scores in third grade, also had the lowest high school graduation rate in the service area.

Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

School Discipline
Service Area 2 had an overall suspension rate

of 2.7, which was below the countywide rate of 3.7%. Only one community, the North County W. (8.5%), area saw a suspension rate above 5% -- this particular area was also marked by the highest expulsion rate for the service area, (0.5%, or one out of every two hundred students).

Juvenile Felony Arrests (Countywide Summary Only)

Of the 23,787 youths arrested on felony charges during the reporting period, 84.2% were males, 15.8%, females. Ethnically, Hispanic youths were involved in the majority of felony arrests (57.2%), followed by Black/ African-American youths (30.3%) and Whites (9.1%). All other ethnicities combined accounted for less than 4% of the juvenile felony arrests.

Youths on Probation

Camp Population

Service Area 2 had 196 youths in camp. A large majority of these were Hispanic youth, who accounted for 73% of the population, followed by Whites (14.8%), and African-Americans (10.2%).

Supervised Youths

Across the service area, the Santa Clarita and Panorama City areas had the largest numbers of youths under supervision. Within the service area, 63.3% of youths under supervision were Hispanic, 23.2% were White, and 9.1% were African-American. The San Fernando Valley had the largest group of White youths under supervision across the county.

Key Indicators of Stigma and Discrimination

Language Capacity of Mental Health Providers

Across the service area, overall staffing ratios indicated that Armenian (4), Arabic (4), and Chinese speakers had the least resources available to them. Staffing ratios for Spanish speakers were low in the Panorama City area (3), Encino area (3) and North County W. area (0). Staffing ratios for Armenian speakers were low in virtually all communities where sizeable numbers of Armenian speakers resided with the exception of the Granada Hills and Woodland Hills areas. Staffing ratios for Farsi speakers were 0 in the Burbank, La Tuna Cyn., Brentwood N., and San Fernando-Calabasas-Agoura areas where there were over 1000 Farsi speakers in each of these areas. Staffing ratios for Arabic speakers was 0 in the Burbank and Granada Hills areas. Staffing ratios for Russian speakers were lowest in the Burbank area (3), North Hollywood area (4), and the Encino area (3). Chinese speakers in the Northridge and Encino communities had a staffing ratio of 0. Staffing ratios for Korean speakers was 0 in the Santa Clarita, Burbank, Panorama City, Encino, and North County W. areas. Staffing ratios for Vietnamese speakers was 0 in the North Hollywood and Woodland Hills areas. Staffing ratios for Tagalog speakers were 0 in the Panorama City, North Hollywood, Encino, and Woodland Hills areas.

Key Indicators of Suicide Risk

Deaths by Suicide

Service Area 2 had an overall suicide rate of 7.7, which was above the countywide rate of

7.0. Summary tables indicate that Whites, Males, Adults, and Older Adults are at most risk for committing suicide. The suicide rates were particularly high for Whites residing in the Panorama City. Other ethnic groups with elevated suicide rates include African-Americans residing within the Brentwood N. area and Asians residing within the La Canada-Flintridge area.

Mental Health Emergency Statistics

Service Area 2 had the largest number of psychiatric emergency calls placed throughout the county (consistent with its largest population size). However, its MHE-Rate was 5.4, which was below the countywide figure of 5.9. Within the service area, the North Hollywood (1,008) and Sherman Oaks (1,279) areas had the most calls placed and also had the highest MHE-Rates, 7.5 and 7.7, respectively.

PUMA REFERENCE MAP
DEMOGRAPHIC PROFILE
KEY INDICATORS SUMMARY

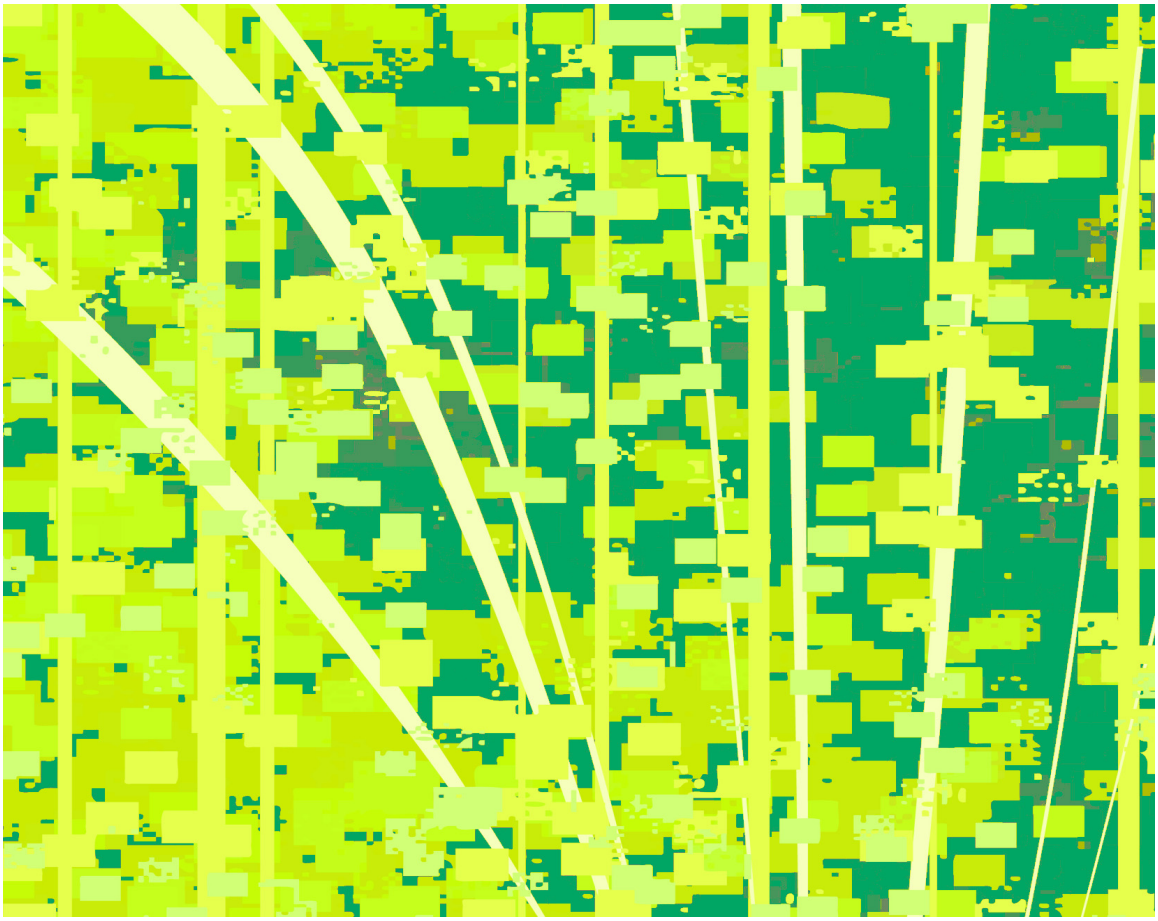
3

SERVICE AREA

VULNERABLE COMMUNITIES IN LOS ANGELES COUNTY
PREVENTION AND EARLY INTERVENTION

SERVICE AREA EXECUTIVE SUMMARY

San Gabriel



Service Area 3: San Gabriel

Communities

Pasadena
El Monte
Pomona
West Covina
Altadena-Monrovia-Sierra Madre
Alhambra-S. Pasadena
Arcadia-San Gabriel-Temple City-San Marino
Baldwin Park-Azusa-Duarte
Glendora-Claremont-San Dimas-La Verne
Covina-Walnut
Diamond Bar
La Puente-S. El Monte
Hacienda Heights
Monterey Park-Rosemead

ZIP Codes

91715	91732	91744	91750	91767	91773	91789	91797
91716	91733	91745	91754	91768	91775	91790	91801
91722	91734	91746	91755	91769	91776	91791	91802
91723	91735	91747	91756	91770	91778	91792	91803
91724	91740	91748	91765	91771	91780	91793	91804
91731	91741	91749	91766	91772	91788	91795	91841
							91896

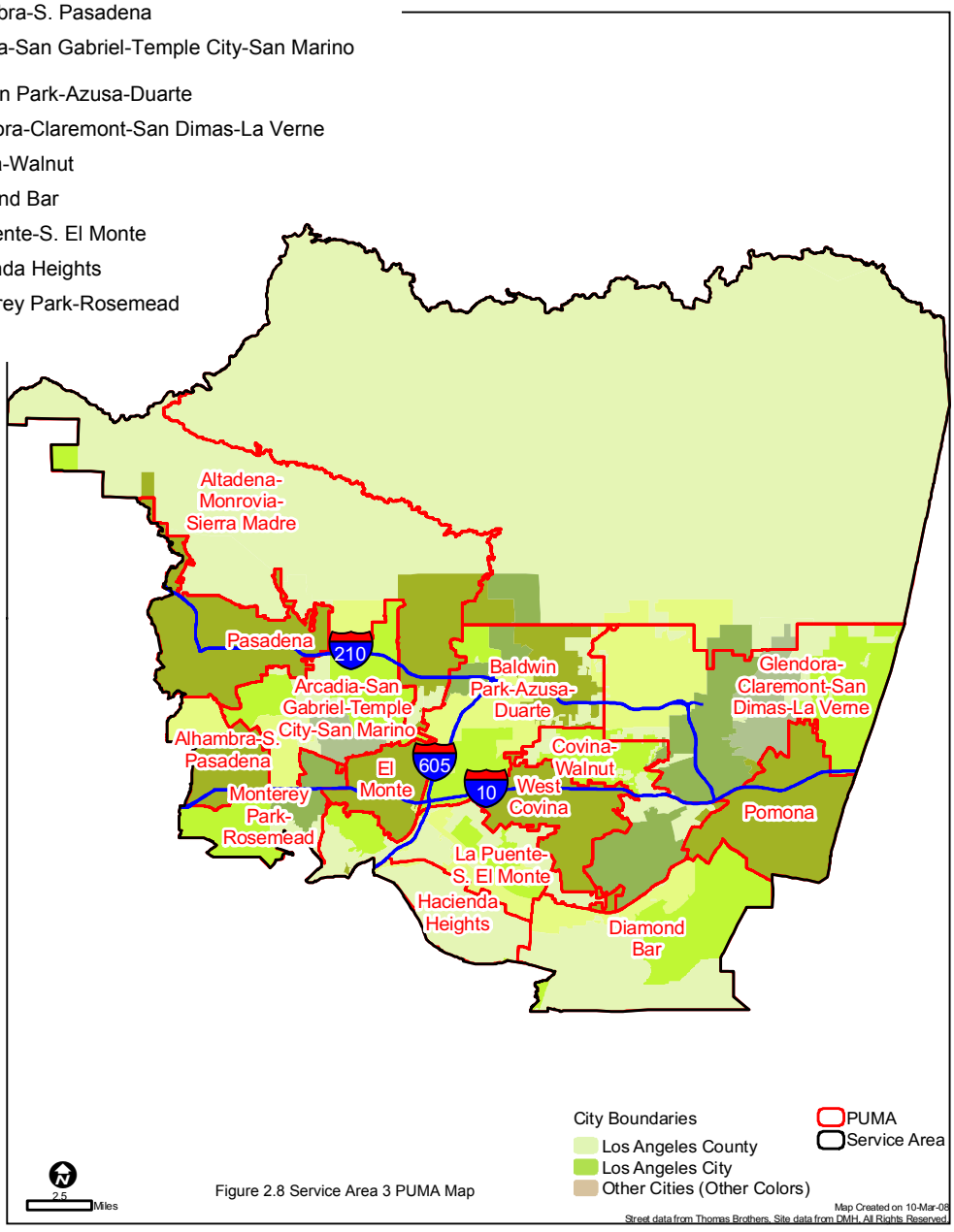


Figure 2.8 Service Area 3 PUMA Map

Demographic Profile

Ethnic Diversity: Distinct Ethnic Communities

Service Area 3 (SA3) includes a large number of cities: Pasadena, El Monte, Pomona, West Covina, Alhambra, South Pasadena, Arcadia, San Gabriel, Temple City, Baldwin Park, Azusa, Duarte, Glendora, Claremont, San Dimas, Covina, Walnut, Diamond Bar, La Puente, South El Monte, Monterey Park, and Rosemead. The total population of SA3 is 1.6 million. Latinos are the largest ethnic group in the area and account for 45% of the population. This is followed by Asians (23.7%), Western European Whites (23.3%), and African-American (3.9%). Russian, Iranian, Armenian, Other Middle Eastern, South Asian, American Indian, Pacific Islander, and Multi-ethnic Individuals are other ancestry groups numbering over 1,000 individuals. As in other service areas, it is possible to identify areas where large numbers of ethnic groups have chosen to settle.

Latinos are a majority of the population in the following communities:

- El Monte (64.9%)
- Pomona (70.4%)
- West Covina (52.5%)
- Baldwin Park-Azusa-Duarte (73.3%)
- La Puente-South El Monte (83.9%)

Western European Whites are a majority in the community of Glendora-Claremont-San Dimas-La Verne (57.7%).

Asians are a majority in Monterey Park-Rosemead (58.4%) and over 40% of the population in the following areas:

- Alhambra-South Pasadena (47.5%)
- Arcadia-San Gabriel-Temple City-San Marino (47.5%)
- Diamond Bar (50.2%)

This is also reflected in the primary language spoken at home. About 39% of all households in the service area speak English; 32% speak Spanish at home. In general, in areas populated by Latinos, Spanish is reported as the language spoken at home. For the most part, the remaining non-English/non-

Spanish-speaking households have an Asian language as their language spoken at home. The largest of these areas are found in the Diamond Bar area, where 10.4% speak Korean at home; in El Monte, where 11.3% of families speak Vietnamese at home; and in the Alhambra-S. Pasadena area, where 17.1% of residents speak Chinese at home.

Age Distribution:
Slightly Older Population

Age-wise, the service area closely resembles the countywide distribution of age groups, though there are, perhaps, slightly more older adults in this area than the county average. The largest number of young children live in the Baldwin Park-Azusa-Duarte area both in terms of actual numbers and relative percentage of the population. The Arcadia-San Gabriel-Temple City-San Marino area is home to the largest numbers of older adults also in terms of actual numbers and relative percentage of the population.

Economic Diversity:
Above-average Incomes

The median household income in the service area of $53,263 was higher than the county median of $48,282. Mean incomes were also higher than the county mean income. It is important to consider both median and mean statistics when examining incomes. The median or mid-point gives a better indication of the typical level of income reported by individuals within the service area. The mean or arithmetic average, however, is a better statistic to compare different geographical areas, such as between and across service areas. Mean incomes ranged from the low of $45,644 in the La Puente-S. El Monte area to $90,186 in the Glendora-Claremont-San Dimas-La Verne area. Home ownership of 61.3% was above the county average of 48.9%. The Diamond Bar, Covina-Walnut, and Glendora-Claremont-San Dimas-La Verne areas had home ownership rates approaching 80%.

In terms of household size, the El Monte, Pomona, Baldwin Park-Azusa-Duarte, and La Puente-S El Monte areas had households that were larger than other parts of the service area.

Memory and Educational Attainment:
Lower Memory Problems, More College Graduates

In terms of mental disability as measured by the ACS, 4.3% of individuals in Service Area 3 reported memory problems, lower than the countywide average of 4.6%. The Glendora-Claremont-San Dimas-La Verne area had the lowest rates of memory problems reported at 2.6%, while the Pasadena community reported the highest levels of memory problems (5.9%). Educationally, Service Area 3 had a college graduation rate of 29.0% (in adults 25+), slightly exceeding the countywide average of 27.8%. The community of Pasadena had the highest number of college graduates in the service area (49.1%), while the La Puente-S. El Monte area had the fewest college graduates (6.9%).

Key Indicators: Summary and Excerpts

Underserved Cultural Populations

Ethnicity

Within Service Area 3, Hispanics are the most populous ethnic group and comprise 45.0% of the area's population; Asians and Western European Whites each account for 23% of the overall population. No other group has over 5% of the total service area population. Within the service area communities, Pomona and the aggregate of Baldwin Park-Azusa-Duarte, are among the largest Hispanic communities in the county. The San Gabriel Valley is home to the largest proportion of Asians within the county with 33.6% of their entire population residing within its boundaries. Looking closer reveals four of the largest Asian communities are found within Service Area 3. The largest community of Western European Whites may be found in the aggregate of Glendora-Claremont-San Dimas-La Verne. Three other communities are home to relatively large groups of American Indians/Alaskan Natives and Pacific Islanders though these individuals make up less than 10% of their respective community populations (Glendora-Claremont-San Dimas-La Verne, Arcadia-San Gabriel-Temple City-San Marino, and La Puente-S. El Monte areas).

Primary Language

English (38.6%) is the most commonly listed Primary Language for the San Gabriel Valley followed by Spanish (31.7%) and Chinese (6.3%). The Service area has four language groups whose largest proportion of speakers throughout the county resides there: Cantonese, Chinese, Mandarin, and Vietnamese. This is most evident when examining the service area composite communities of Alhambra-S. Pasadena, Arcadia-San Gabriel-Temple City-San Marino, Covina-Walnut, Diamond Bar, and Monterey Park-Rosemead. English speakers are the majority in two communities, Altadena-Monrovia-Sierra Madre and Glendora-Claremont-San Dimas-La Verne, while Spanish speakers are the majority in three: Pomona, Baldwin Park-Azusa-Duarte, and La Puente-S. El Monte. Other Asian language groups have relatively large communities, such as Korean speakers in the Diamond Bar area, Vietnamese speakers in Monterey Park-Rosemead area, and Tagalog speakers in the West Covina area.

Linguistic Isolation

In terms of Linguistic Isolation, the San Gabriel Valley had an overall isolation score of 7.0%, which was a slightly below the county score of 7.8%. Drilling down into the composite communities of the service area indicated that three areas had Linguistic Isolation scores in excess of 10%: the Alhambra-S. Pasadena area (10.9%), largely Spanish and Chinese-speaking; the Monterey Park-Rosemead area (15.2%), largely Spanish, Chinese, and Vietnamese-speaking; and the El Monte area (17%), largely Spanish, Chinese, and Vietnamese-speaking. It is especially important to review the community level data for the San Gabriel Valley because like the San Fernando Valley, the difference in neighborhoods is quite dramatic. One might

be tempted to think that because the service area percentage is actually below the county percentage that isolated households are less commonly encountered there. Instead, the numbers clearly indicate that for these three communities, large numbers of Linguistically Isolated households do exist.

Individuals Experiencing Onset of Serious Psychiatric Illness

Serious Mental Illness Penetration Rate

The overall Penetration Rate for Service Area 3 was 0.17, below the countywide rate of 0.34. Such a figure suggested that the local mental health resources may have a smaller reach into the SMI population than other parts of the county. Across ethnicities, Asians (0.04) were the least-served by county mental health services. Following this, in order of Penetration Rates, were the White population (0.12), the Latino population (0.16), the Native American population (0.38) and the African-American population (0.52).

Depressive Disorders

Age Groups

Service Area 3 clients accounted for 11.4% of depressed clients in the county. No age group had a majority of depressed clients in the service area. Examining the relative differences within each community indicated that some areas predominantly treated either children (0-15) or adults (26-59). Five areas, for example, had children as the majority of clients (the West Covina, Alhambra-S. Pasadena, Baldwin Park-Azusa-Duarte, Covina-Walnut, and Hacienda Heights areas). Three communities treated a majority of adults (the Arcadia-San Gabriel-Temple City-San Marino, La Puente-S. El Monte, and Monterey Park-Rosemead areas). Across the service area, the largest proportion of clients (26.8%) were served in the Pasadena area.

Ethnicity

Latinos were a majority of depressed clients served in Service Area 3 (53.3%). This was followed by White clients, 16.7%; African-American clients; 12.0%, and Asian clients, 7.0%. Native American and Pacific Islander clients each accounted for less than 1% of the population served in the service area. Examining the composite communities in further detail showed that in nine communities, Latinos were a majority of depressed clients served (the El Monte, Pomona, West Covina, Alhambra-S. Pasadena, Baldwin Park-Azusa-Duarte, Glendora-Claremont-San Dimas-La Verne, La Puente-S. El Monte, and Hacienda Heights areas). Asians were the majority of depressed clients served in one area, Monterey Park-Rosemead. No other ethnic group constituted a majority of depressed clients in the service area.

Co-occurring Disorders (COD)

Age Groups

Service Area 3 clients accounted for 8.1% of individuals with COD treated in the county's mental health system. The majority of clients with a COD were adults (57.5%), followed by the TAY group (25.7%), children (14.4%), and older adults (2.5%). While most communities followed the countywide trend in treating a majority of adults, there were three exceptions to this. Two communities, the Alhambra-S. Pasadena area and the Hacienda Heights area ,treated a majority of clients with COD who were children. One community, the Baldwin Park-Azusa-Duarte area,

saw that a majority of their COD cases were youths from the TAY group. Eight communities saw the majority of their COD cases from the adult group (the El Monte, Pomona, West Covina, Altadena-Monrovia-Sierra Madre, Acadia-San Gabriel-Temple City-San Marino, Covina-Walnut, La Puente-S. El Monte, and Monterey Park-Rosemead areas). Across the service area, 31.5% of clients with a COD were treated in the Pasadena area. This was followed by the Arcadia-San Gabriel-Temple City-San Marino area (24.0%) and the La Puente-S. El Monte area (10.4%).

Ethnicity

Latino clients accounted for 45.7% of the COD population treated in Service Area 3. This was followed by White clients (26.7%), African-American clients (14.1%), and Asian clients (2.7%). Native American and Pacific Islander groups each accounted for less than 1% of the COD population in the service area. When compared with population estimates for these groups, COD percentages were similar to population counts for Latinos and Whites. However, it was clear that African-Americans (4.6%) were overrepresented in the COD client counts, while Asians (24.4%) were underrepresented. In six communities, Latinos were a majority of clients with a COD: the Alhambra-S. Pasadena, Baldwin Park-Azusa-Duarte, Glendora-Claremont-San Dimas-La Verne, Covina-Walnut, La Puente-S. El Monte, and Hacienda Heights areas. In one community, the Monterey Park-Rosemead area, Asians were a majority of COD clients, but this particular area only accounted for 1.3% of the total COD population for the service area.

Children/Youth in Stressed Families

Poverty

The overall poverty rate in Service Area 3, 34.4%, was below the county figure of 38.7%. Across the service area, the El Monte (56.3%) and La Puente-S. El Monte areas (50.4%) had the highest rates of individuals living beneath the 200% FPL. Examining the ethnic groups within the service area indicated that the Hispanic population were a majority of the poverty population (61.6%). Over 50% of the Hispanic population in four communities in the San Gabriel Valley were living below the 200% FPL: the El Monte area (58.0%), the Pomona area (56.2%), the Baldwin Park-Azusa-Duarte area (57.1%), and the La Puente-S. El Monte area (56.3%). In the El Monte community, 53.5% of the Asian population were living below the 200% FPL. In four communities, over 50% of African-Americans were living under this level, the Pasadena area (55.3%), the El Monte area (53.1%), the La Puente-S. El Monte area (75.8%), and the Monterey Park-Rosemead area (89.9%); in three communities, over 50% of the American Indian population were living below this level, the El Monte area (100%), the Baldwin Park-Azusa-Duarte area (51.5%), and the La Puente-S. El Monte area (100%). It should be noted that, in actual numbers, African-Americans and American Indians living in poverty accounted for only 1.9% of the service area's total population.

Unemployment Rate

Service Area 3 had an overall self-reported unemployment rate of 6.2, which was below the countywide average of 7.4%. Only one

community had an unemployment rate above 10%, the El Monte area (12.1%). Three communities had relatively low unemployment rates, the West Covina area (3.3%), the Alhambra-S. Pasadena area (4.8%), and the aggregate Arcadia-San Gabriel-Temple City-San Marino area (3.8%).

Disrupted Families

Service Area 3 had an overall DF ratio of 2.7, which was higher than the countywide average of 2.7. Communities across the service area ranged widely in their DF scores. The West Covina area yielded the lowest DF ratio in the county (0.9) along with the West LA area in Service Area 5. A DF ratio less than 1 indicated that there were more single parent families in a given area than two parent families. Two other communities saw DF ratios below 2.0: the Pasadena area (1.3) and the Altadena-Monrovia-Sierra Madre area (1.8). On the other end of the spectrum, two communities, the Glendora-Claremont-San Dimas-La Verne area and the Monterey Park-Rosemead area, had a DF ratio equal to 5.0, or a 5:1 ratio of intact families to single-parent families.

Safe Place to Play (Countywide Summary Only)

Age Groups

Across the three age groups reported, there appeared to be a trend in parent-report. Parents were more likely to report that a safe place to play was less available for older children than for younger ones.

Ethnicity

There did not appear to be any significant difference between parent reports across ethnicities.

Trauma-exposed Individuals

Child Abuse

Child Abuse and Neglect Base Rates

Service Area 3 had an overall CAN Rate of 1.01, which was slightly above the county rate. Across the service area, 23.1% of all SCAN reports were eventually substantiated. Two areas, Pomona (1.60) and El Monte (1.57), had CAN Rates greater than 84% or more of the county's communities, (i.e., rates were in excess of one standard deviation from the mean).

Triage Response Acuity

Service Area 3 had an overall Acuity score of 0.13, which was below the countywide score of 0.15. Four communities had Acuity scores that were at or above this figure: the El Monte area (0.19), the Pomona area (0.19), the Baldwin Park-Azusa-Duarte area (0.17), and the La Puente- S. El Monte area (0.15).

Ethnicity

Across Service Area 3, 85.6% of SCAN Reports involved three ethnic groups: African-American, White, and Hispanic. Overall, African-American children accounted for 8.4% of SCAN Reports, White children, 14.0%, and Hispanic children, 63.2%. Only two other ethnic groups accounted for more than 1% of victimized children: Chinese, 2.3%, and Mexican, 2.3%. Hispanic children accounted for a majority of abuse reports in eleven communities: the Pasadena area, the El Monte area, the Pomona area, the West Covina area, the Alhambra-S. Pasadena area, the Baldwin Park-Azusa-Duarte area, the Covina-Walnut area, the Diamond Bar area, the La Puente-S. El Monte area, the Hacienda Heights area, and the Monterey Park-Rosemead area.

Elder and Dependent Adult Abuse

Service Area 3 had an APS Rate[1] of 2.0, which was below the countywide rate. Within the service area, the Altadena-Monrovia-Sierra Madre aggregate (2.9) had the highest APS Rate[1] followed by the Pomona Area (2.7).

Posttraumatic Stress Disorder (PTSD)

Age Groups

Service Area 3 accounted for 13.1% of the county's PTSD cases. In terms of age groups, children (0-15) accounted for a majority of PTSD cases treated in the service area (68.7%). This strong majority was seen in all but a few composite communities. Only the Arcadia-San Gabriel-Temple City-San Marino area and the La Puente-S. El Monte areas, which had majorities of Adult (26-59) cases, were exceptions to this trend. Across the service area, the Pasadena area accounted for 29.1% of the total PTSD cases seen in the San Gabriel Valley. This was followed by the Glendora-Claremont-San Dimas area, 14.1%; the remainder of cases was distributed fairly evenly across the remaining communities.

Ethnicity

Latino clients accounted for 60.0% of the PTSD population treated in Service Area 3. This was followed by African-American clients (15.2%), White clients (13.2%), and Asian clients (3.2%). Native American and Pacific Islander groups each accounted for less than 1% of the PTSD population in the service area. When compared with population estimates for these groups, African-Americans (4.6%) were over represented in the PTSD client counts, while Asians (24.4%), Latinos (45.0%), and Whites (24%) were underrepresented. In ten communities, Latinos were a majority of clients diagnosed with PTSD: the El Monte, Pomona, West Covina, Alhambra-S. Pasadena, Altadena-Monvovia-Sierra Madre, Baldwin Park-Azusa-Duarte, Glendora-Claremont-San Dimas-La Verne, Covina-Walnut, La Puente-S. El Monte, and Hacienda Heights areas. No other ethnic group accounted for a majority of PTSD cases within the composite communities besides Latinos.

Homelessness

Age Groups

In Service Area 3, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (65.2%) of the homeless population. This was followed by the Under 18 Age Group at 15.1%, the 56+ Age Group at 11.1%, and the 18-24 Age Group at 8.7%.

Ethnicity

Within Service Area 3, Hispanic or Latinos accounted for a majority of the homeless population (58.9%). Black/African-Americans accounted for 20.5% of the homeless population; Whites, 16.6%, and Multi-Racial or Others accounted for 4.0% of the homeless population.

Sub-populations

In Service Area 3, 31.1% of the homeless population reported that they had a mental illness; 31.3% of homeless individuals reported they were substance abusers; and 9.6% reported they were victims of domestic violence.

Children/Youth at Risk for School Failure

4-year Dropout Rate (Countywide Summary Only)

State figures indicated that over a quarter of all students in Los Angeles County drop out from high school over a four-year period. Examining ethnic categories indicated that African-American students were most at risk for not finishing high school followed by Pacific Islander, American Indian/Alaska Native, and Hispanic or Latino Students. 15.5% of White students drop out from high school. Two ethnic groups had dropout rates below this: Asian, 7.4%, and Filipino, 12.8%.

High School Graduation Rates

The San Gabriel Valley had the second highest graduation rate in the county, 86.8%. Across the service area, the Altadena-Monrovia-Sierra Madre aggregate had the lowest overall graduation rate of all communities, 66.3%. Three ethnic groups had very low graduation rates within this community: Pacific Islanders, Hispanics, and African-Americans. Overall, across service area ethnic groups, American Indian or Alaskan Natives had the lowest graduation rate (66.1%). In two communities, the Pasadena and Baldwin Park-Azusa-Duarte areas, this figure was less than 50%, or less than one out of every two students.

English Fluency

Service Area 3 had an overall fluency rate of 74.2% in its student population, which was above the countywide figure of 68.3%. Although two communities, the El Monte area (57.6%) and the Pomona area (53.3%), had relatively low fluency rates, this did not appear to impact the high school graduation rates noted above, which were relatively high. A majority of residents in the these two areas spoke Spanish as their primary language.

3rd Grade Reading Level

Overall, 36.5% of Service Area 3 third graders scored at or above the 50th percentile in standardized reading tests. The two lowest scores were found in the El Monte area (23.9%) and the Pomona area (20.8%) where English Fluency was low. Across ethnic groups, 13.9% of African-American students scored at or above the 50th percentile (and this was the lowest score for African-American students across all service areas). Filipino (9.0%), Korean (9.6%), and Vietnamese (16.4%) student reading scores were very low in the third grade. Over 50% of White and Chinese third graders scored above the 50th percentile in reading. Examining high school graduation rates for Asian groups (though aggregated differently from the third grade data) appeared to be quite high. (This may either be due to these groups overcoming their language barrier or the impact of aggregating the lower performing Asian groups with the more populous and higher performing Chinese group.)

Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

School Discipline

Service Area 3 had an overall suspension rate of 3.8%, which was close to the countywide rate of 3.7%. The Pomona area (5.9%) had the highest suspension rate throughout the ser-

vice area., though this did not translate into the highest expulsion rates. That distinction was held jointly by the Alhambra-Monrovia-Sierra Madre and Glendora-Claremont-San Dimas-La Verne areas at 0.5%, or one out of every two hundred students.

Juvenile Felony Arrests (Countywide Summary Only)

Of the 23,787 youths arrested on felony charges during the reporting period, 84.2% were males, 15.8%, females. Ethnically, Hispanic youths were involved in the majority of felony arrests (57.2%), followed by Black/African-American youths (30.3%), and Whites (9.1%). All other ethnicities combined accounted for less than 4% of the juvenile felony arrests.

Youths on Probation

Camp Population

Service Area 3 had a total of 278 youths sent to camp with the Pomona and Baldwin Park-Azusa-Duarte areas consigning the most numbers. Of these, 69.3% were Hispanic, 17.6% were African-American, and 8.4% were White.

Supervised Youths

Service Area 3 had over 3,000 youths under supervision and a majority of these were Hispanic (71.7%). This was followed by African-American youth (12.2%) and White youth (9.9%). The largest Asian group, Chinese youth, accounted for 1% of the youths under supervision. Within the service area, the Baldwin Park-Azusa-Duarte area had the most numbers of youth under supervision, followed by the Pomona and El Monte areas.

Key Indicators of Stigma and Discrimination

Language Capacity of Mental Health Providers

Across the service area, Chinese (1), Tagalog (6), and Vietnamese (5) speakers had the fewest staffing resources available to them. Staffing ratios for English speakers (42) was exceeded only by the staffing ratio for Russian speakers (82) in populations over 1,000 individuals. Within the service area communities, Spanish speakers saw low staffing ratios in the Pomona area (4), the Baldwin Park-Azusa-Duarte area (2), the Diamond Bar area (0), and the Hacienda Heights area (0). Cantonese speakers saw low staffing ratios in the communities of Covina-Walnut (0) and Diamond Bar (0). Chinese speakers saw low staffing ratios (below 5) in all communities with the exception of the Pasadena area. Mandarin speakers saw similarly low staffing ratios in the Alhambra-S. Pasadena area (3) and the Diamond Bar area (0). Korean speakers saw staffing ratios below 5 in the Pomona area (0), the Arcadia-San Gabriel-Temple City-San Marino area (2), the Covina-Walnut area (4), the Diamond Bar area (0), and the Hacienda Heights area (0). Vietnamese speakers saw staffing ratios below 5 in all large communities, (i.e., over 1,000 individuals), with the exception of the Monterey Park-Rosemead area (7). Tagalog speakers saw low staffing ratios in the Pomona area (4), the West Covina area (2), the Arcadia-San Gabriel-Temple City-San Marino area (0), the Baldwin Park-Azusa-Duarte area (0), the Diamond Bar area (0), and the Hacienda Heights area (0).

Key Indicators of Suicide Risk

Deaths by Suicide

Overall, Service Area 3 had a suicide rate of 5.4, which was below the countywide rate of 7.0. Mirroring countywide trends, summary statistics indicated that Whites, Males, and Older Adults were at most risk for committing suicide. Whites (52.6) residing in the La Puente-S. El Monte area had the highest rates in the service area. Whites also had a relatively high rate in the Monterey Park-Rosemead area (29.8). African-Americans (26.7) were at risk in the Glendora-Claremont-San Dimas-La Verne area. Adults and Older adults were at risk throughout the service area; seven areas had rates above 10/100,000 for either or both of these groups: the Alhambra-S. Pasadena, Arcadia-San Gabriel-Temple City-San Marino, Baldwin Park-Azusa-Duarte, Glendora-Claremont-San Dimas-La Verne, Covina-Walnut, and La Puente-S. El Monte areas.

Mental Health Emergency Statistics

Overall, Service Area 3 had a MHE-Rate of 5.0, which was below the countywide rate of 5.9. Only one community, the aggregate of Glendora-Claremont-San Dimas-La Verne, saw the number of psychiatric emergency calls placed exceed 1,000. Otherwise, based upon population, the highest MHE-Rates were found in the El Monte area (7.2), the Altadena-Monrovia-Sierra Madre area (7.0), and the Glendora-Claremont-San Dimas-La Verne (6.6) area.

PUMA REFERENCE MAP
DEMOGRAPHIC PROFILE
KEY INDICATORS SUMMARY

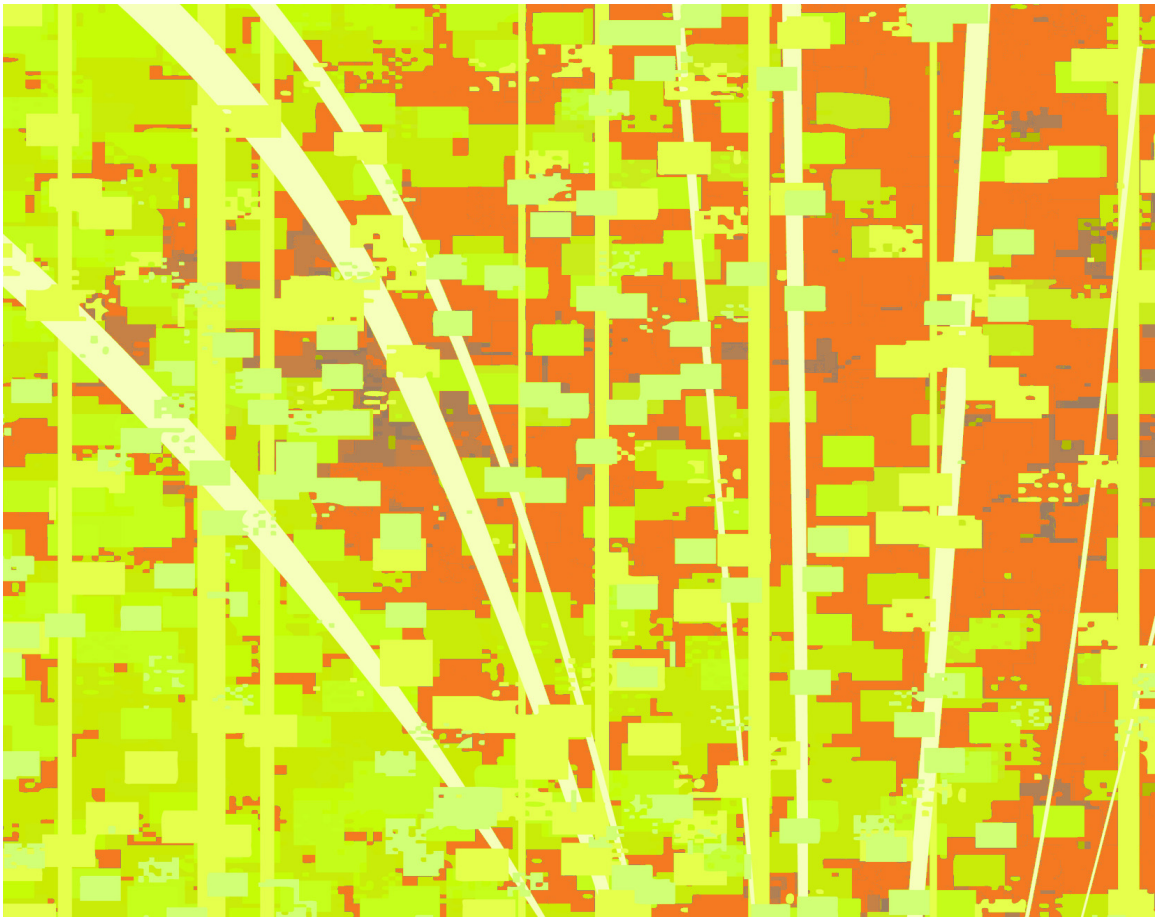
4

SERVICE AREA

VULNERABLE COMMUNITIES IN LOS ANGELES COUNTY
PREVENTION AND EARLY INTERVENTION

SERVICE AREA EXECUTIVE SUMMARY

Metro



Service Area 4: Metro

Communities

Wilshire La Brea E.
Hollywood
Pico Heights
Echo Park
Highland Park
Downtown
USC N.
West Adams
West Hollywood

ZIP Codes

90004	90014	90023	90031	90041	90053	90068	90075	90086
90005	90015	90026	90032	90042	90054	90069	90076	90087
90006	90017	90027	90033	90046	90055	90070	90078	90088
90010	90019	90028	90036	90048	90057	90071	90079	90093
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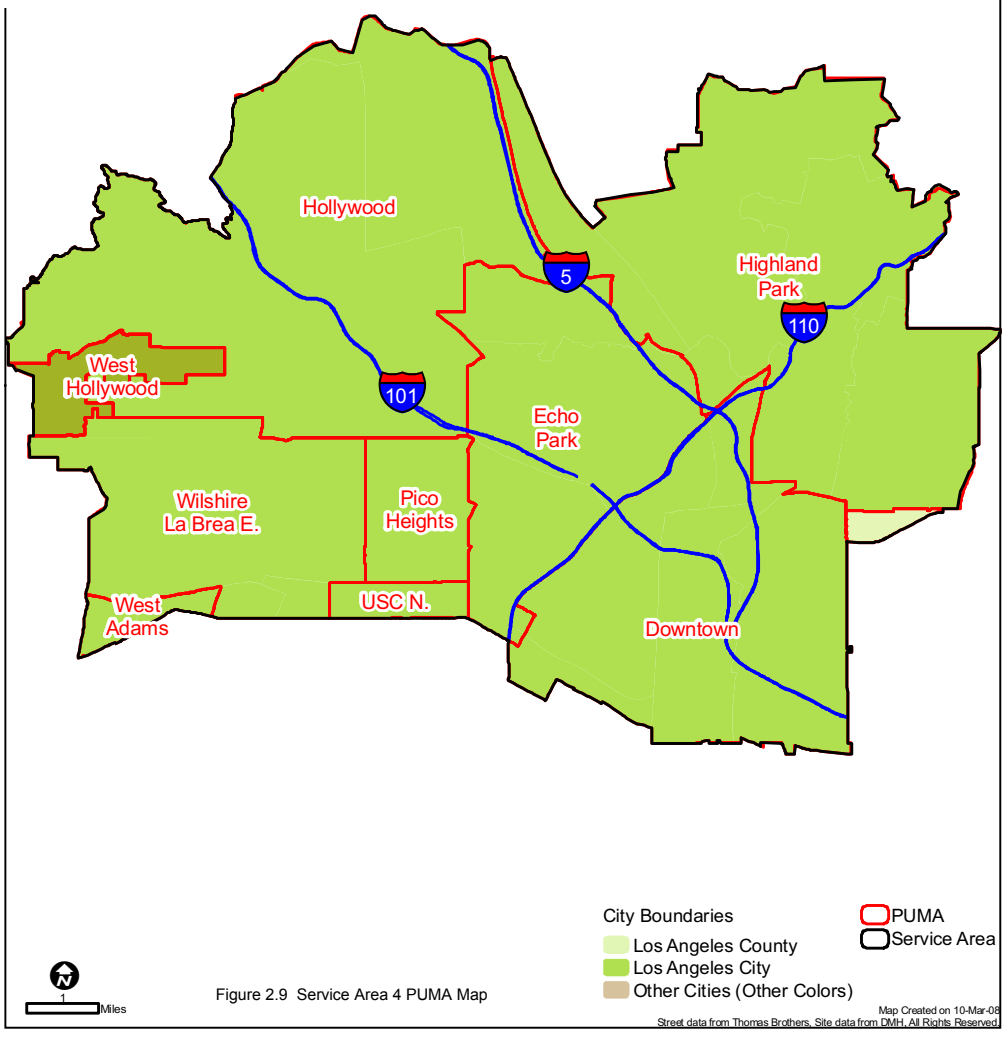


Figure 2.9 Service Area 4 PUMA Map

Demographic Profile

Ethnic Diversity: Latino Majority

Service Area 4 (SA4) is comprised primarily of the cities of Los Angeles and Hollywood, and the Pico Heights, Echo Park, Highland Park, Boyle Heights, and Wilshire La Brea E. communities. The majority of the population in SA4 is Latino (54.1%), followed by Western European Whites (17.3%), Asians (16.8%), and African-Americans (5.1%). Russian, Iranian, Armenian, Other Middle Eastern, South Asian, American Indian, Pacific Islander, and Multi-ethnic Individuals are other ancestry groups numbering over 1,000. Latinos are a majority in the Pico Heights (60.1%), Echo Park (58.3%), Highland Park (66.6%), and Downtown (82.9%) communities.

Service Area 4 residents reported that Spanish was the most common language they spoke at home (46.1%). This was followed by English (26.0%), Korean (5%), and Tagalog (4.7%) speakers. The Downtown area has the highest Spanish-speaking rate in the service area (68.7%). English speakers are primarily located in the West Hollywood area (68.9%), Korean speakers in the Pico Heights area (17.8%) and Wilshire La Brea E. (12.0%), and Tagalog speakers in smaller numbers in the Echo Park (11.2%) and Highland Park (6.1%) areas.

Age Distribution:
Uneven Distribution of Children

The percentage of children ages 0-15 in SA4 (23%) is slightly lower than the county average (25%). The percentage of persons aged 60 and older in SA4 (12%) is also slightly lower than the county average (14%). SA4 communities vary with regard to the numbers of children who reside there. The Downtown community, for example, has a child population that is 28.7% of their total numbers. In contrast, children in the Wilshire La Brea area account for 18% of the area's respective total. Overall, the service area's older adult population is 12.2%. In the West Hollywood area, older adults account for 21% of the community's population.

Economic Diversity: Low Incomes and Low Homeownership for Most

The average median household income in the service area was $34,652, substantially lower than the county median of $48,282. Similarly, mean incomes were also lower than the county mean. It is important to consider both median and mean statistics when examining incomes. The median or midpoint gives a better indication of the typical level of income reported by individuals within the service area. The mean or arithmetic average, however, is a better statistic to compare different geographical areas such as between and across service areas. Mean household incomes ranged from the low of $25,658 in the USC N. area to $80,019 in the West Hollywood area. Home ownership of 24.3% was well below the county average of 48.9% and was the lowest home ownership rate in the county. Fewer than 5% of the Pico Heights population own a home.

In terms of household size, the West Hollywood area had households that tended to be the smallest within the county (1.6 individuals/household).

Memory and Educational Attainment: Education Gaps

In terms of memory problems as measured by the ACS, 4.9% of individuals in Service Area 4 reported memory problems, a bit more than the countywide average of 4.6%. The USC N. area had the lowest rates of memory problems reported at 2.9% while the West Adams area reported the highest levels of memory problems in the service area and across the county (7.6%). Educationally, Service Area 4 had a college graduation rate of 29.4% (in adults 25+), slightly higher than the countywide average of 27.8%. The community of West Hollywood had the highest number of college graduates in the service area (55.1%) while the Downtown area had the fewest college graduates (10.1%).

Key Indicators: Summary and Excerpts

Underserved Cultural Populations

Ethnicity

In Service Area 4, over half of the population is Hispanic and four of the largest Hispanic communities in the county are contained within the service area boundaries. Western European Whites are the next most numerous group with a large community in the Hollywood area. Nearly equal to Western European Whites, Asians have three of their largest communities within the service area. African-Americans account for about 5% of the service area population. Looking within the service area reveals communities which are ethnically diverse and relatively large. The Hollywood area, for instance, is home to seven ethnic groups with respectively large populations. In these terms, across the entire county, no other community is as diversely populated as the Hollywood area. Similar but to a lesser degree, the Echo Park and Highland Park areas are also quite ethnically diverse.

Primary Language

Overall, the Metro area has no clear majority of speakers for any language group, although like the other service areas, most of the population have listed English (26%) or Spanish (46.1%) as their Primary Language. This is followed by Korean (5%), Tagalog (4.7%), Armenian (1.2%), and Chinese (1.2%). This particular service area demonstrates why it is important to drill down to the community level data. Examining the service area composite communities reveals that, in fact, five communities do have a majority of Spanish speakers contained within their boundaries (the Pico Heights, Echo Park, Highland Park, Downtown, and USC N. areas); two communities have a majority of English speakers (the West Adams and West Hollywood areas); and two other communities have no majority (the Wilshire La Brea E. and Hollywood areas). Clearly the service area level data, in this instance, does not tell the whole story. Two language groups, Korean and Tagalog, have their largest proportions of speakers in the county contained within the service area. Korean speakers are located in the Wilshire La Brea E. and Pico Heights areas. And Tagalog speakers are found in most numbers in the Pico Heights (Koreatown), Echo Park, and Highland Park areas.

Linguistic Isolation

In the Metro area, 14% of households reported that they were Linguistically Isolated, almost twice the county percentage and the highest percentage in the county. Six communities reported over 10% of their households were isolated and two of these were over 20%: the Echo Park area (21%) and the Pico Heights area (25.5%). Examining the Echo Park area indicates that the majority of the population regard Spanish as their primary language. There is also a sizeable Tagalog-speaking population there. This is similar to the Pico Heights area where, in addition to Spanish and Tagalog, there is a large Korean-speaking population (17.8% of the community). Moreover, the Pico Heights area has the highest level of Linguistic Isolation found within all county communities, (i.e., PUMAs), with one out of four people in the area unable to converse in English. With the relatively large and varied ethnic population in the service area, it is not surprising to see a language barrier this high. One would also expect to see a large and recent immigrant population (within two generations) in the various communities who were unfamiliar with English.

Individuals Experiencing Onset of Serious Psychiatric Illness

Serious Mental Illness Penetration Rate

The overall Penetration Rate for Service Area 4 was 0.31, slightly below the countywide rate of 0.34. Across ethnicities, Asians (0.16) were the least-served by county mental health services, though for the Asian population this was the highest Penetration Rate obtained across all service areas. Following this, in order of Penetration Rates, were the Latino population (0.23), the White population (0.26), the Native American population (0.67) and the African-American population (1.28). This was the highest Penetration Rate seen for the African-American population across all service areas.

Depressive Disorders

Age Groups

Service Area 4 accounted for 21.6% of depressed clients served in the county. The majority of depressed clients in the service area were from the Adult age (26-59) group (50.2%). In all but two communities, the adult population was the most commonly treated depressed client. The exceptions were the Wilshire-La Brea E. area where 52.0% of depressed clients came from the TAY (16-25) group and the Pico Heights area where 37.9% of depressed clients were from the Child (0-15) group. Across the service area, 41.6% of all depressed clients were treated in the Downtown area.

Ethnicity

No one ethnic group constituted a majority of depressed clients served in Service Area 4. Across all ethnicities, Latinos made up the largest proportion of clients, 44.0%, followed by African-Americans clients, 22.3%; White clients, 16.7%; and Asian clients, 5.7%. Native American and Pacific Islander clients accounted for less than 1% of all depressed clients served in the service area. Drilling down into the composite communities indicated that that two areas treated a majority of African-American clients: the USC N. and West Adams areas. Two other areas treated a majority of Latino clients: the Echo Park and Highland Park areas. No other ethnicity constituted a majority of depressed clients served in any other community in the service area.

Co-occurring Disorders (COD)

Age Groups

Service Area 4 clients accounted for 28.3% of individuals with COD treated in the county's mental health system. The majority of clients with COD in the service area were adults (26-59). Examining the composite communities revealed that in all but two areas, adults were the majority of COD clients treated. In two communities, this percentage was above 80%: the Hollywood area, 80.5%, and the West Adams area, 82.2%. In the two communities which did not have an adult majority, TAY (16-25) and children (0-15) accounted for a majority of clients diagnosed with a COD. The Pico Heights area and the Highland Park area saw 62.0% and 60.6%, respectively, of its COD population under the age of 26. The majority of COD clients were treated in the Downtown area (65.1%) followed by the Hollywood area (13.7%) and the Echo Park area (9.5%).

Ethnicity

In Service Area 4, no ethnic group constituted a majority of COD clients. Latino clients accounted for 33.6% of the COD population treated in the area. This was followed by African-American clients (31.0%), White clients (18.4%), and Asian clients (2.0%). Native American and Pacific Islander groups each accounted for less than 1% of the COD population in the Service area. When compared with population estimates, it is clear that African-American (5.1%) were overrepresented in the COD client counts, whereas, Latino (54.1%) and Asian (17.9%) clients were underrepresented. Examining the composite communities revealed that two areas, USC N. and West Adams, treated a majority of African-Americans within the COD population. Latinos were a majority of COD cases within the Highland Park area. No other ethnic group constituted a majority in any other area.

Children/Youth in Stressed Families

Poverty

The Metro area had the second-highest poverty rate in the county with a majority (51.3%) of its residents living beneath the 200% FPL. This figure is considerably higher than the county–wide rate of 38.7%. Across the service area, the USC N. community experienced the highest levels of poverty with 72.3% of its residents living below the 200% FPL. Additionally, four other communities had overall poverty rates in excess of 50%: the Pico Heights area (64.2%), the Echo Park area (62.8%), the Downtown area (68.7%), and the West Adams area (54.0%). Examining poverty across ethnicities revealed that all groups were affected to varying degrees. 65.1% of the Hispanic population within the service area were living beneath the 200% FPL; seven communities had a poverty rate over 50%: the Wilshire La Brea E. area (54.7%), the Hollywood area (66.3%), the Pico Heights area (76.6%), the Echo Park area (73.4%), the Downtown area (68.7%), the USC N. area (72.3%), and the West Adams area (54.0%). 40.6% of African-Americans living within the service area were beneath the 200% FPL with three communities seeing rates in excess of 50%: the Pico Heights area (54.8%), the Downtown area (70.4%), and the USC N. area (59.4%). Three communities saw over 50% of their respective Asian populations living below the 200% FPL: the Echo Park area (63.2%), the Downtown area (62.9%), and the USC N. area (76.8%). Three communities saw over 50% of its American Indian population living below the 200% FPL: the Pico Heights area (100%), the Highland Park area (78.1%), and the USC N. area (51.5%). A majority of Whites were living below the 200% FPL in one community, the USC N. area (71.4%).

Unemployment Rate

Service Area 4 had a self-reported unemployment rate of 9.1% which was above the countywide rate of 7.4%. Four communities reported unemployment rates over 10%: the Hollywood area (10.3%), the Pico Heights area (13.6%), the USC N. area (11.7%), and the West Adams area (11.7%). The Pico Heights area had the second highest unemployment rate reported in the county across all communities. The Echo Park area (5.7%) had the lowest self-reported unemployment rate in the service area.

Disrupted Families

Service Area 4 had an overall DF ratio of 1.6, which was below the countywide average of 2.2. This figure indicated that Service Area 4, along with Service Area 5, had the highest rate of disrupted families in the county. Looking within the service area indicated that six communities had a DF less than 2.0; the West Adams and Pico Heights areas both had a DF ratio of 1.0 meaning that there were equal numbers of intact families and single parent families in those areas. The other four communities included the Echo Park area (1.6), the Highland Park area (1.7), the Downtown area (1.9), and the USC N. area (1.2). Only the West Hollywood area (4.3) had a DF ratio that exceeded the county average; there, intact families were four times as numerous as single parent families.

Safe Place to Play (Countywide Summary Only)

Age Groups

Across the three age groups reported, there appeared to be a trend in parent-report. Parents were more likely to report that a safe place to play was less available for older children than for younger ones.

Ethnicity

There did not appear to be any significant difference between parent reports across ethnicities.

Trauma-exposed Individuals

Child Abuse

Child Abuse and Neglect Base Rates

Service Area 4 had an overall CAN Rate of 1.20, which was greater than the county Rate of 0.96. Two communities, the Downtown area (1.92) and the USC N. area (1.61), had CAN Rates greater than 84% or more of the county's communities, (i.e., greater than 1 standard deviation from the mean). 25.2% of SCAN reports were substantiated in the Downtown area and 22.8% were substantiated for the USC N. area.

Triage Response Acuity

Service Area 4 had an overall Acuity score of 0.18, which was above the county score of 0.15. Many communities within the service area had scores above this figure and two had very high scores (greater than 84% of all other county communities): the Echo Park area (0.25) and the Downtown area (0.23).

Ethnicity

Across Service Area 4, 86.1% of SCAN Reports involved three ethnic groups: African-American, White, and Hispanic. Overall, African-American children accounted for 10.6% of SCAN Reports, White children, 4.7%, and Hispanic children, 71.1%. Only two other ethnic groups accounted for more than 1% of victimized children: Central American, 1.5%, and Mexican, 3.6%. Within the service area, Hispanic children were involved in a majority of SCAN Reports in six areas: the Hollywood area, the Pico Heights area, the Echo Park area, the Highland Park area, the Downtown area, and the USC N. area. African-American children were a majority of victims within the West Adams area. White children were nearly a majority of victims (49%) in the West Hollywood area.

Elder and Dependent Adult Abuse

Service Area 4 had an APS Rate[1] of 3.1, which was above the countywide rate. Within the service area, the Downtown area had the highest APS Rate[1] score (4.6).

Posttraumatic Stress Disorder (PTSD)

Age Groups

Service Area 4 accounted for 18.5% of the county's PTSD cases, the largest proportion between service areas. Children (0-15) accounted for a majority of PTSD cases treated in Service Area 4 (59.2%). Examining the service area composite communities revealed that children were a majority in six areas: the Wilshire La Brea E., Hollywood, Pico Heights, Downtown, USC N., and West Hollywood areas. One community, the West Adams area, saw a majority of adult (25-59) clients with PTSD. In two other communities, the Child group accounted for the largest proportion of cases but did not constitute a majority (the Echo Park and Highland Park areas). Across the service area, the Down-

town area accounted for 41.0% of the total PTSD cases seen. This was followed by the Pico Heights area, 21.6%, the Echo Park area, 12.7%, and the Hollywood area, 10.9%.

Ethnicity

In Service Area 4, Latino clients (59.1%) accounted for a majority of the PTSD population treated in the area. This was followed by African-American clients (18.9%), White clients (6.1%), Asian clients (7.9%), and Native American clients (1.2%). The Pacific Islander group accounted for less than 1% of the PTSD population in the Service area. When compared with population estimates, the African-American (5.1% of population) , Latino (54.1% of population), and Native American (0.3% of population) clients were overrepresented in the PTSD client counts, while Asian (17.9%) clients were underrepresented. Examining the composite communities revealed that one area, West Adams, treated a majority of African-Americans. All other communities, with the exception of the USC N. area, treated a majority of Latino clients.

Homelessness

Age Groups

In Service Area 4, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (64.8%) of the homeless population. This was followed by the Under 18 Age Group at 13.8%, the 56+ Age Group at 12.7%, and the 18-24 Age Group at 8.7%.

Ethnicity

Within Service Area 4, Black/African-Americans accounted for the majority of the homeless population (56.8%). Hispanics or Latinos accounted for 17.3%, Whites, 16.3%, and Multi-Racial or Others, 9.6% of the homeless population.

Sub-populations

In Service Area 4, 45.1% of the homeless population reported that they had a mental illness; 38.1% of homeless individuals reported they were substance abusers; and 10.5% reported they were victims of domestic violence.

Children/Youth at Risk for School Failure

4-year Dropout Rate
(Countywide Summary Only)

State figures indicated that over a quarter of all students in Los Angeles County drop out from high school over a four-year period. Examining ethnic categories indicated that African-American students were most at risk for not finishing high school, followed by Pacific Islander, American Indian/Alaska Native, and Hispanic or Latino Students. 15.5% of White students drop out of high school. Two ethnic groups had dropout rates below this: Asian, 7.4%, and Filipino, 12.8%.

High School Graduation Rates

Service Area 4 had the lowest graduation rates across all ethnic groups within the county without exception. Overall, 59.4% of students graduated with communities ranging from a low of 42.5% in the Downtown area to a high of 95.4% in the Pico Heights area. Ethnic groups within the Downtown area were particularly at risk. African-American students, for example, graduated at a rate of 20.7%, or about one out of every five students. For American Indian or Alas-

kan Native and Pacific Islander students, this rate was about one out of four. Similarly, Hispanic and White students in the Downtown area were more likely to drop out than graduate.

English Fluency

Service Area 4 had a fluency rate of 54.3% in its student population, which was the second lowest figure in the county. As mentioned above, Service Area 4 also had the second lowest graduation rate among the county service areas. Examining the composite communities does not always yield a simple one-to-one correspondence between English Fluency and graduation rate. Consider the Pico Heights area, for example, which held the *lowest* fluency rate in the service area at 36.8% but also held one of the *highest* graduation rates in service area. In a similar vein, the West Adams area, which held one of the *highest* fluency rates in the Service at 74.5%, also held one of the *lowest* graduation rates in the service area. These figures suggested that variables other than fluency, such as Ethnicity, Poverty, School Quality, etc., are associated with graduation rates in complex ways.

3rd Grade Reading Level

Overall, 23.3% of third graders in Service Area 4 scored at or above the 50th percentile in reading. Only one community, the West Hollywood area (50.6%), had over 50% of its third graders scoring above the 50th percentile. This community also held the highest English Fluency rate and the highest high school graduation rate. All other communities had less that 40% of its third graders performing at or above the 50th percentile. The lowest performing community, the Downtown area (16.4%), also had the lowest high school graduation rate in the service area.

Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

School Discipline

Service Area 4 had an overall suspension rate of 2.5%, which was below the countywide rate of 3.7%. The West Adams area (5.6%) had the highest suspension rate in the service area. Very few students are expelled in the service area; the West Hollywood area (0.1%) had the highest rate for this.

Juvenile Felony Arrests (Countywide Summary Only)

Of the 23,787 youths arrested on felony charges during the reporting period, 84.2% were males, 15.8%, females. Ethnically, Hispanic youths were involved in the majority of felony arrests (57.2%), followed by Black/African-American youths (30.3%) and Whites (9.1%). All other ethnicities combined accounted for less than 4% of the juvenile felony arrests.

Youths on Probation

Camp Population

Service Area 4 had a total of 222 youths consigned to camp, with the greatest numbers coming from the Echo Park, Highland Park and Downtown areas. The overwhelming majority of these youths were Hispanic (85.7%), followed by African-Americans (12.3%).

Supervised Youths

Over 1,000 youths in Service Area 4 were under supervision and a large majority of these individuals were Hispanic (82.7%).

This was followed by African-American youths (11.2%) and White youth (2.6%). The Highland Park area had the largest number of youths under supervision, followed by the Downtown and Echo Park areas.

Key Indicators of Stigma and Discrimination

Language Capacity of Mental Health Providers

Across the service area, staffing ratios for English speakers were six times greater than ratios for Spanish speakers; seven times greater than ratios for Armenian speakers; two times greater than ratios for Farsi speakers; two times greater than ratios for Arabic and Cambodian speakers; four times greater than ratios for Russian speakers; five times greater than ratios for Korean speakers; eight times greater than ratios for Chinese speakers; and twelve times greater than ratios for Tagalog speakers. Of the thirteen threshold languages, Tagalog speakers had the fewest resources allocated to them (8). About a quarter of all Tagalog speakers reside within Service Area 4, the largest Tagalog community in the county. Only Vietnamese speakers had resources allocated to them at a level similar to English speakers.

Key Indicators of Suicide Risk

Deaths by Suicide

Service Area 4 had an overall suicide rate of 8.4, which was above the countywide rate of 7.0. Males, Whites, and Older Adults had the highest suicide rates within their respective categories. The West Hollywood area (39.9) had the highest rate within the gender category. Six areas saw White rates exceeding 25.0 and two areas saw African-American rates exceeding 25.0. Whites in the Pico Heights (92.7) area had the highest suicide rate in any category across the county. Four communities within the service area had overall suicide rates in excess of 50.0. Two of these areas, Pico Heights (77.0) and Hollywood (72.8), had exceptionally high rates (above 70).

Mental Health Emergency Statistics

Service Area 4 had an overall MHE-Rate of 6.6, which was above the countywide rate of 5.9. Four communities generated more than 1,000 psychiatric emergency calls each: the Hollywood area (1,382), the Echo Park area (1,250), the Highland Park area (1,199), and the Downtown area (1,774). The Downtown area had the highest MHE-Rate recorded in the County, 13.2.

PUMA REFERENCE MAP
DEMOGRAPHIC PROFILE
KEY INDICATORS SUMMARY

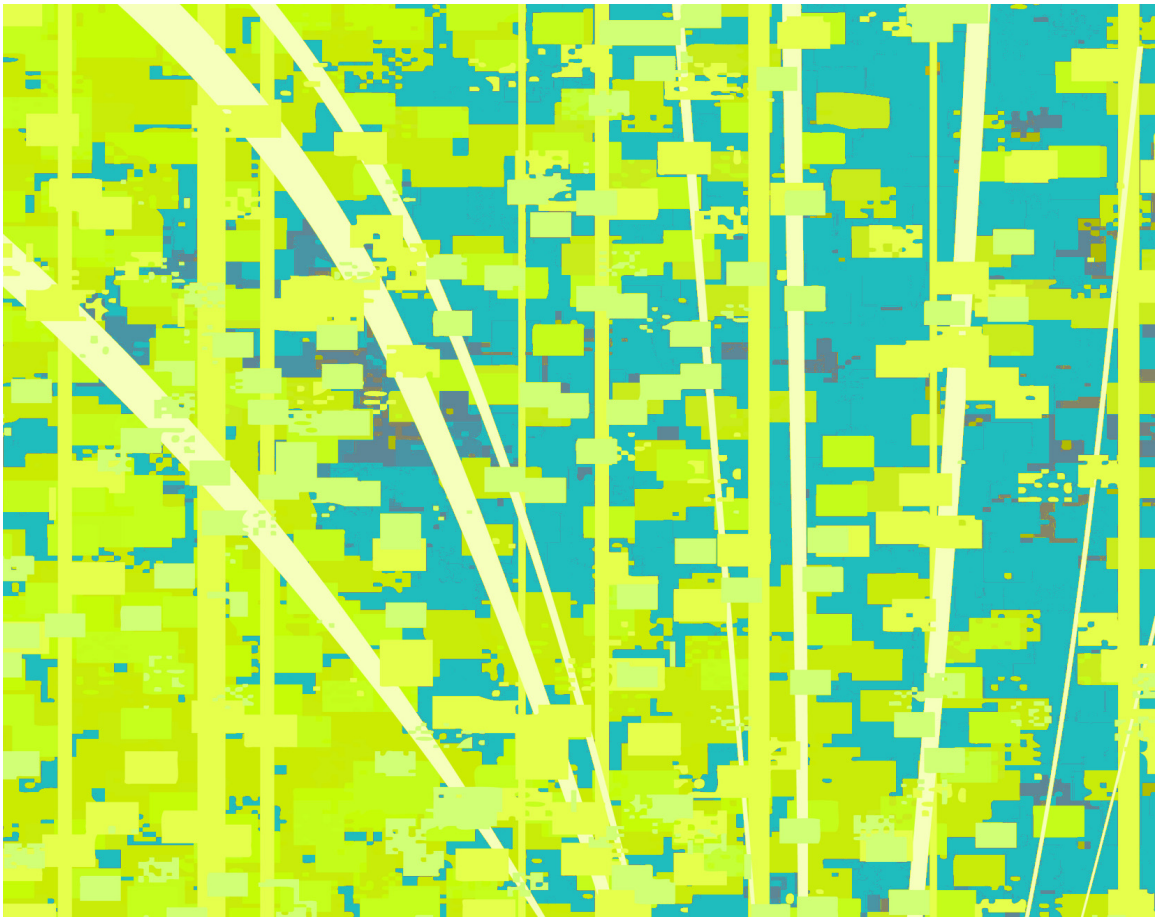
5

SERVICE AREA

VULNERABLE COMMUNITIES IN LOS ANGELES COUNTY
PREVENTION AND EARLY INTERVENTION

SERVICE AREA EXECUTIVE SUMMARY

West



Service Area 5: West

Communities

Brentwood S.
West LA
Wilshire La Brea W.
Baldwin Hills W.
Playa Vista
Santa Monica-Culver City-Beverly Hills
Malibu

ZIP Codes

90009	90049	90077	90209	90231	90272	90311	90405
90024	90056	90080	90210	90232	90291	90312	90406
90025	90064	90083	90211	90233	90292	90397	90407
90034	90066	90094	90212	90263	90293	90401	90408
90035	90067	90095	90213	90264	90294	90402	90409
90045	90073	90099	90230	90265	90295	90403	90410
					90296	90404	90411

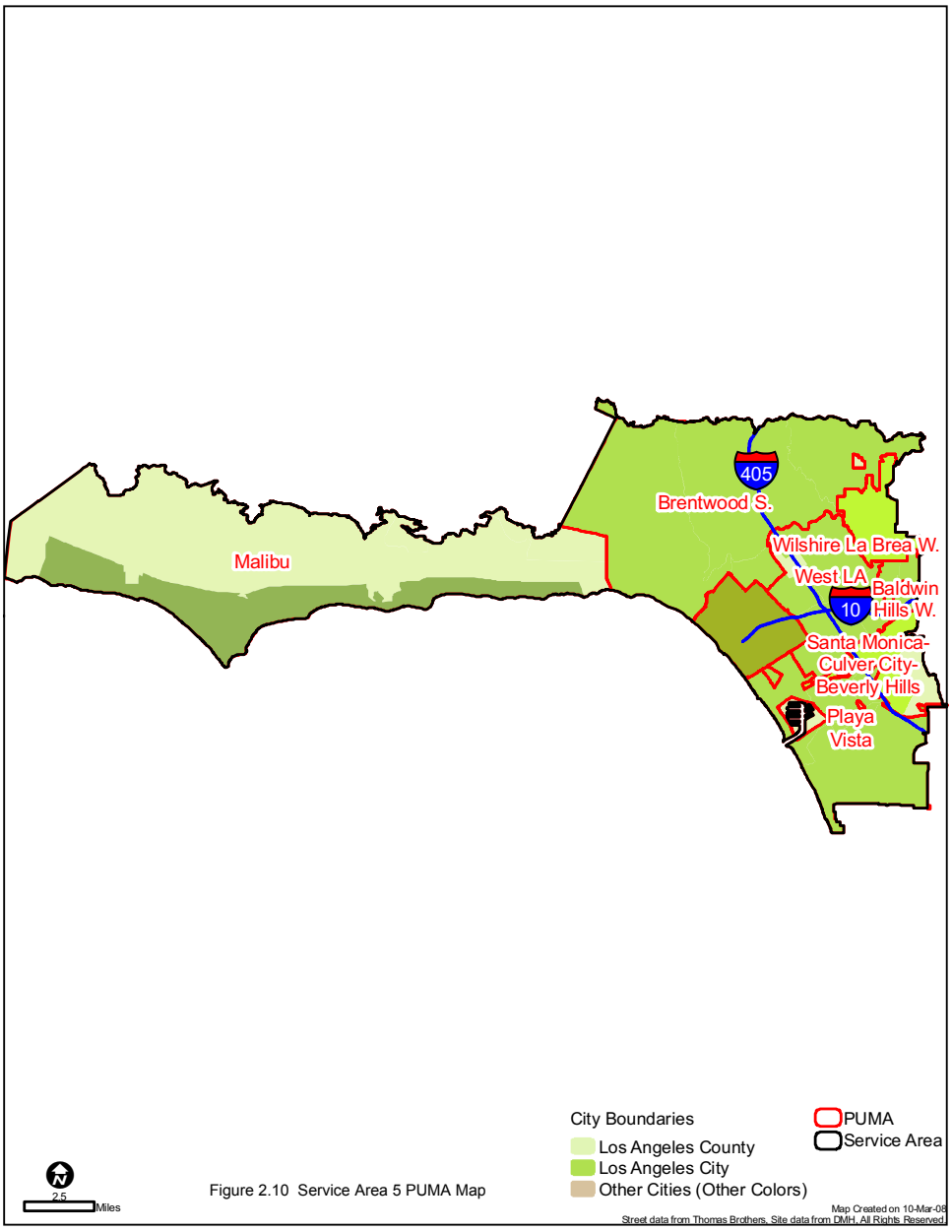


Figure 2.10 Service Area 5 PUMA Map

Demographic Profile

Ethnic Diversity:
Western European White Majority
Service Area 5 (SA5) is comprised primarily of West Los Angeles, Brentwood, Playa Vista, and the cities of Santa Monica, Culver City, and Beverly Hills. A majority of the population are Western European Whites (55%), followed in size by Latinos (12%), Asians (10%), and African-Americans (7%). Russian, Armenian, Iranian, Other Middle Eastern, South Asian, and Multi-ethnic Individuals are other ancestry groups and number over 1,000 individuals. Among the SA5 communities, West Los Angeles has a sizeable Asian population (20%).

In terms of primary language, SA5 has the highest proportion of individuals across the county who report English as the language they speak at home (64.6%). This is also true for Farsi speakers (3.0%) and Russian speakers (1.4%). Service Area 5 has the lowest proportion of individuals across the county whose primary language is Spanish (11.4%).

Age Distribution:
Largest Numbers of Older Adults
The age distribution in the service area is very different from the county. The proportion of children though young adulthood, (i.e., ages 0-25 years) at 27.6% is substantially lower in number than the countywide proportion of (39.8%). This trend is seen on the other end of the lifespan with older adults accounting for 18% of the service area population while, countywide, this age group accounts for 13.5% of the population.

Economic Diversity:
High Incomes, Small Households
The median household income in the service area of $61,151 was much higher than the county median of $48,282. Service area community mean incomes were similarly elevated over the county mean. It is important to consider both median and mean statistics when examining incomes. The median or mid-point gives a better indication of the typical level of income reported by individuals within the service area. The mean or

arithmetic average, however, is a better statistic to compare different geographical areas, such as between and across service areas. Mean household incomes ranged from the low of $39,101 in the Baldwin Hills W. area to $120,118 in the Malibu area. Overall in the service area, home ownership of 40.1% was below the county average of 48.9%. The Wilshire La Brea W. area had the lowest home ownership rates at 24.3%, while the Malibu area had the highest rate at 77%.

Memory and Educational Attainment: Memory Problems Inversely Related to Education

In terms of mental disability as measured by the ACS, 4.2% of individuals in Service Area 5 reported memory problems, slightly lower than the countywide average of 4.6%. The Malibu area had the lowest rates of memory problems reported at 2.5%, while the Baldwin Hills W. community reported the highest levels of memory problems (7.6%) in the service area and the entire county. Educationally, Service Area 5 had a college graduation rate of 53.9% (in adults 25+), well above the countywide average of 27.8%. The community of Brentwood S. had the highest number of college graduates in the service area (59.5%) and county. The Baldwin Hills W. area had the fewest college graduates (17.7%).

Key Indicators: Summary and Excerpts

Underserved Cultural Populations

Ethnicity

In Service Area 5, Western European Whites are the majority population and three of the largest Western European White communities are found there. The service area has fewest numbers of Hispanics, American Indians/Alaskan Natives, and Other Races across the county. Even so, two communities, West LA and the aggregate of Santa Monica-Culver City-Beverly Hills, are fairly diverse with relatively large populations of six ethnic groups (Western European White, Asian, Russian, South Asian, Iranian, Other Middle Eastern). Both Russians and Iranians have three of their largest communities in the West area.

Primary Language

English speakers (64.6%) are the majority Primary Language in Service Area 5, followed by Spanish (11.4%), Farsi (3%), Korean (1.7%), Russian (1.4%) and Chinese (1.1%) speakers. Service Area 5 has the smallest proportion of primary Spanish speakers (1.9%) in the county. All identified composite communities in the service area have a majority of primary English speakers and each community has Spanish as its next most frequently designated Primary Language. Relatively large clusters of primary Farsi speakers are located in three communities: Brentwood S., Wilshire-La Brea W., Santa Monica-Culver City-Beverly Hills, and Malibu. Primary Russian speakers have relatively large groups located in the Brentwood S., West

LA, and Santa Monica-Culver City-Beverly Hills areas. Primary Korean speakers are found in the West LA, Wilshire-La Brea W., and Playa Vista areas. A couple of communities appear to have a fair amount of language diversity: Brentwood S., for example, has five language groups with more than 1% of its relative population; the West LA area has eight.

Linguistic Isolation

Service Area 5 had a Linguistic Isolation score of 2.8%. This was the lowest rate of isolation found across the eight service areas. Two communities with the highest rates within the service area were still below the county average. For example, the Wilshire-La Brea W. area (7.2%) had a portion of the Korean-speaking population within its boundary and this likely contributed to this figure. The Baldwin Hills W. area (7.3%) had a majority of primary Spanish speakers within its boundaries and no other language group, aside from English, in significant numbers. Here, it was clear that isolated households were likely to be monolingual Spanish-speaking.

Individuals Experiencing Onset of Serious Psychiatric Illness

Serious Mental Illness Penetration Rate

The overall Penetration Rate for Service Area 5 was 0.24., which was lower than the countywide rate of 0.34. Across ethnicities, Asians (0.04) were the least-served by county mental health services. Following this, in order of Penetration Rates, were the White population (0.16), the Latino population (0.28), the Native American population (0.61), and the African-American population (0.84).

Depressive Disorders

Age Groups

Service Area 5 accounted for 5.8% of depressed clients served in the county. The majority of depressed clients in the service area were adults, 26-59, (54.0%). However, a couple of communities had other age groups that were predominantly served in the service area. The Malibu area, for instance, overwhelmingly served the Child (0-15) group (73.9%). The majority of depressed clients served in the Wilshire-La Brea W. area were from the TAY (16-25) group. Across the service area, the majority of depressed clients of all age groups were served in the West LA area.

Ethnicity

No one ethnic group constituted a majority of depressed clients served in Service Area 5. Across all ethnicities, White clients were the largest proportion of clients served, 39.9%. This was followed by African-American clients, 21.6%; Latino clients, 22.3%; and Asian clients, 2.2%. Native American and Pacific Islander ethnic groups accounted for less than 1% of all depressed clients in the service area. Examining the composite communities revealed two communities where there was a clear ethnic majority of depressed clients: the Baldwin Hills W. area ,where 65.8% of depressed clients were African-American, and the Malibu area where 67.4% of depressed clients were Latino.

Co-occurring Disorders (COD)

Age Groups

Service Area 5 clients accounted for 6.6% of individuals with COD treated in the county's

mental health system. Within the service area, the COD population was largely adult (26-59) and accounted for 78.7% of all COD cases. This was the highest proportion of adult COD cases seen in the county. All communities with the exception of the Malibu area (with small numbers), saw an overwhelmingly adult population. In two communities, adults accounted for over 80% of the COD population: the West LA area (81.6%) and the Baldwin Hills W. area (82.2%). Across the service area, the majority of COD cases were treated in the West LA area (69.0%), followed by the Santa Monica-Culver City-Beverly Hills area (15.0%) and the Playa Vista area (11.4%).

Ethnicity

White clients accounted for 52.6% of the COD population treated in Service Area 5 and this was the only area in the county where Whites were a majority of COD clients. This was followed by African-American clients (22.3%), Latino clients (13.0%), Native American clients (1.0%), and Asian clients (1.8%). When compared with population estimates for these groups, Whites and Latinos had COD rates consistent with their population shares. African-American (8.1%) and Native American (0.1%) clients were overrepresented in the COD client counts and Asian (12.9%) clients were underrepresented. Examining the service area composite communities revealed that Whites were a majority of clients treated for COD in the West LA area; African-American clients were a majority in the Baldwin Hills W. area; and Latino clients were a majority in the Malibu area.

Children/Youth in Stressed Families

Poverty

Service Area 5 had the lowest poverty rate in the county with 23.4% of its population living beneath the 200% FPL. Close to one-half of all individuals living in poverty in the West were Whites (48%). Across the service area, the Baldwin Hills W. community had the highest poverty rate with 54%, or a majority of its residents living below the 200% FPL. Two communities had Hispanic populations in which over 50% were living below the 200% FPL: the Wilshire La Brea W. area (54.7%) and the Baldwin Hills W. area (67.4%). One community, the Playa Vista area (82.2%), had an American Indian population with 82% of its population living below the 200% FPL (keep in mind that the American Indian population within the service area is less than 1%).

Unemployment Rate

Service Area 5 had an overall self-reported unemployment rate of 6.1%, the lowest rate in the county. Two exceptions were the Baldwin Hills W. area, with an unemployment rate of 11.7%, and the Wilshire La Brea W. area with rate of 9.5%. All other named areas held unemployment rates that were under the countywide rate of 7.4%. The Playa Vista area had the lowest unemployment rate in the service area (4.4%).

Disrupted Families

Like Service Area 4, Service Area 5 had an overall DF ratio of 1.6. These were the two lowest overall service area ratios seen across the county. However, within the service area, there was great variation in the relative num-

bers of intact versus single-parent families in neighboring communities. The West LA area, for example, had a DF score of 0.9; only the community of West Covina in Service Area 3 had a DF score as low. A DF score of less than 1 indicated that there were more single-parent households than two-parent households for a given area. The West LA area and the West Covina area were the only two parts of the county where this phenomenon occurred. There were three other communities with a DF ratio less than 2.0: the Baldwin Hills W. area (1.0), the Playa Vista area (1.5), and the Malibu area (1.7). At the other end of the spectrum, the Brentwood S. area had a DF ratio of 5.6 and the Santa Monica-Culver City-Beverly Hills area had a DF ratio of 4.3.

Safe Place to Play (Countywide Summary Only)

Age Groups

Across the three age groups reported, there appeared to be a trend in parent-report. Parents were more likely to report that a safe place to play was less available for older children than for younger ones

Ethnicity

There did not appear to be any significant difference between parent reports across ethnicities.

Trauma-exposed Individuals

Child Abuse

Child Abuse and Neglect Base Rates

Service Area 5 had an overall CAN Rate of 0.45, which was the lowest in the county and below the countywide rate of 0.96. In fact, all communities within the service area were below the countywide Rate. The Baldwin Hills W. area (0.86) had the highest CAN Rate within the service area and the Malibu area (0.04) had the lowest rate.

Triage Response Acuity

Service Area 5 had the lowest Acuity score (0.08) seen within the county (a full standard deviation below the mean) and most communities had very low Acuity scores. The Brentwood S. area (0.03) and Malibu area (0.04), for example, had two of the lowest Acuity scores in the county. The Baldwin Hills W. area (0.15) had the highest Acuity score in the service area.

Ethnicity

Across Service Area 5, 87% of SCAN Reports involved four ethnic groups: African-American, White, Hispanic, and White Middle Eastern. Overall, African-American children accounted for 17.5% of SCAN Reports, White children, 32.9%, Hispanic children, 31.5%, and White Middle Eastern children, 5.1%. Only two other ethnic groups accounted for more than 1% of the victimized children in the area: Mexican, 1.3%, and Filipino, 1.0%. White children were a majority of SCAN Reports in two communities: the Brentwood S. area and the Malibu area. No other ethnic group constituted a majority of victims in any other area.

Elder and Dependent Adult Abuse

Service Area 5 had an APS Rate[1] of 2.4, which was below the countywide rate. Only one community within the service area saw an APS Rate[1] score above 3: Wilshire La Brea W. (3.6).

Posttraumatic Stress Disorder (PTSD)

Age Groups

Service Area 5 accounted for 4.4% of the

county's PTSD cases. Close to half of these came from the Child age (0-15) group (48.4%), though in four of the composite communities, children with PTSD did constitute a majority of cases (the Wilshire La Brea W., Playa Vista, Santa Monica-Culver City-Beverly Hills, and Malibu areas). One community, the Baldwin Hills W. area, saw a majority of Adult (26-59) cases. About half of the service area cases were seen in the West LA area (49.3%), followed by the Santa Monica-Culver City-Beverly Hills area (22.0%), the Playa Vista area (15.8%), and the Baldwin Hills W. area (10.1%).

Ethnicity

In Service Area 5, no ethnic group constituted a majority of PTSD clients. Latino clients accounted for the largest proportion of PTSD cases (38.7%), followed by African-American clients (28.1%), White clients (18.3%), and Asian clients (3.0%). Native American and Pacific Islander clients each accounted for less than 1% of the PTSD population in the service area. When compared with population estimates for these groups, Latino clients (14.4% of population) and African-American clients (8.1% of population) appeared to be overrepresented, while Whites (58%) and Asians (12.9%) appeared to be underrepresented. Examining the service area composite communities revealed that African-Americans were a majority of clients treated for PTSD in the Baldwin Hills W. area; Latino clients were a majority in the Santa Monica-Culver City-Beverly Hills area.

Homelessness

Age Groups

In Service Area 5, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (64.0%) of the homeless population. This was followed by the Under 18 Age Group at 14.5%, the 56+ Age Group at 14.0%, and the 18-24 Age Group at 7.5%.

Ethnicity

Within Service Area 5, Black/African-Americans accounted for 35.2% of the homeless population. Hispanic or Latinos accounted for 17.0%; Whites, 35.8%; and Multi-Racial or Others accounted for 12.0% of the homeless population. This was the largest proportion of Multi-Racial or Other homeless individuals across the county.

Sub-populations

In Service Area 5, 32.3% of the homeless population reported that they had a mental illness; 42.9% of homeless individuals reported they were substance abusers; and 8.4% reported they were victims of domestic violence.

Children/Youth at Risk for School Failure

4-year Dropout Rate
(Countywide Summary Only)

State figures indicated that over a quarter of all students in Los Angeles County drop out of high school over a four-year period. Examining ethnic categories indicated that African-American students were most at risk for not finishing high school, followed by Pacific Islander, American Indian/Alaska Native, and Hispanic or Latino Students. 15.5% of White students drop out from high school.

Two ethnic groups had dropout rates below this: Asian, 7.4%, and Filipino, 12.8%.

High School Graduation Rates

Service Area 5 had an overall high school graduation rate of 75.7%, which indicated that about one out of four students fails to graduate. Within the service area only one ethnic group had a graduation rate lower than 50%: American Indians or Alaskan Natives (48.1%). Half of the service area communities had fairly high graduation rates (Brentwood S., Santa Monica-Culver City-Beverly Hills, and Malibu), while the other half had fairly low rates (West LA, Wilshire La Brea W., and Baldwin Hills W.) Almost all students graduate from the Malibu area, while about half of all students graduate from the higher-risk areas.

English Fluency

Next to Service Area 1, Service Area 5 had the highest fluency rate in the county, 80.2%. Only one area, Wilshire La Brea W. (61.4%), saw its fluency rate dip below 70%. This area also had the lowest high school graduation rate in the service area. In fact, the areas with the three lowest fluency rates, West LA, Wilshire La Brea W., and Baldwin Hills W., also had the three lowest graduation rates in the service area.

3rd Grade Reading Level

Overall, 45.6% of third graders in Service Area 5 scored at or above the 50th percentile in reading, the highest percentage across service areas. The three lowest performing communities, the West LA area, Wilshire La Brea W. area, and the Baldwin Hills W. area, were areas with the lowest high school graduation rates in the service area. 67% of the White third graders in the service area scored at or above the 50th percentile, the highest score for this ethnic group across the other service areas.

Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

School Discipline

Overall, Service Area 5 had a suspension rate of 3.0%, which was below the countywide rate of 3.7%. The Baldwin Hills W. area (5.6%) had the highest suspension rate across the service area. Very few students got expelled in the service area and the Santa Monica-Culver City-Beverly Hills area (0.1%) had the highest rate of school exclusion.

Juvenile Felony Arrests (Countywide Summary Only)

Of the 23,787 youths arrested on felony charges during the reporting period, 84.2% were males, 15.8%, females. Ethnically, Hispanic youths were involved in the majority of felony arrests (57.2%), followed by Black/African-American youths (30.3%) and Whites (9.1%). All other ethnicities combined accounted for less than 4% of the juvenile felony arrests.

Youths on Probation

Camp Population

Across the county, Service Area 5 had the fewest youths consigned to camp: 51.

Supervised Youths

In terms of supervision, Service Area 5 also had, by far, the lowest numbers of youth on probation: 349. Ethnically, Hispanic youths accounted for 42.1% of the population, Afri-

can-Americans, 27.8%, and Whites, 21.5%.

Key Indicators of Stigma and Discrimination

Language Capacity of Mental Health Providers

Service Area 5 was the only service area where Spanish and English speakers had equal staffing ratios (29). Within the service area, Chinese speakers (2) had the fewest staff resource allocated to them (for populations > 1,000) followed by Farsi speakers (6), Russian speakers (7), and Arabic speakers (8).

Key Indicators of Suicide Risk

Deaths by Suicide

Overall Service Area 5 had the highest suicide rate across the County, 10.2. Again, Males, Whites and Older Adults had the highest rates within their respective categories. Within the Service Area, the highest rates were seen for the older adult population. The Playa Vista area (12.6) had the highest suicide rate within the Service Area followed by the West LA area (11.5) and the Malibu area (10.4).

Mental Health Emergency Statistics

Service Area 5 had the fewest emergency calls placed in the county and it also had the lowest MHE-Rate of 4.5. The bulk of the calls came from two areas: West LA (898) and Santa Monica-Culver City-Beverly Hills (868). The Baldwin Hills W. area had the highest MHE-Rate (8.7) in the service area.

PUMA REFERENCE MAP
DEMOGRAPHIC PROFILE
KEY INDICATORS SUMMARY

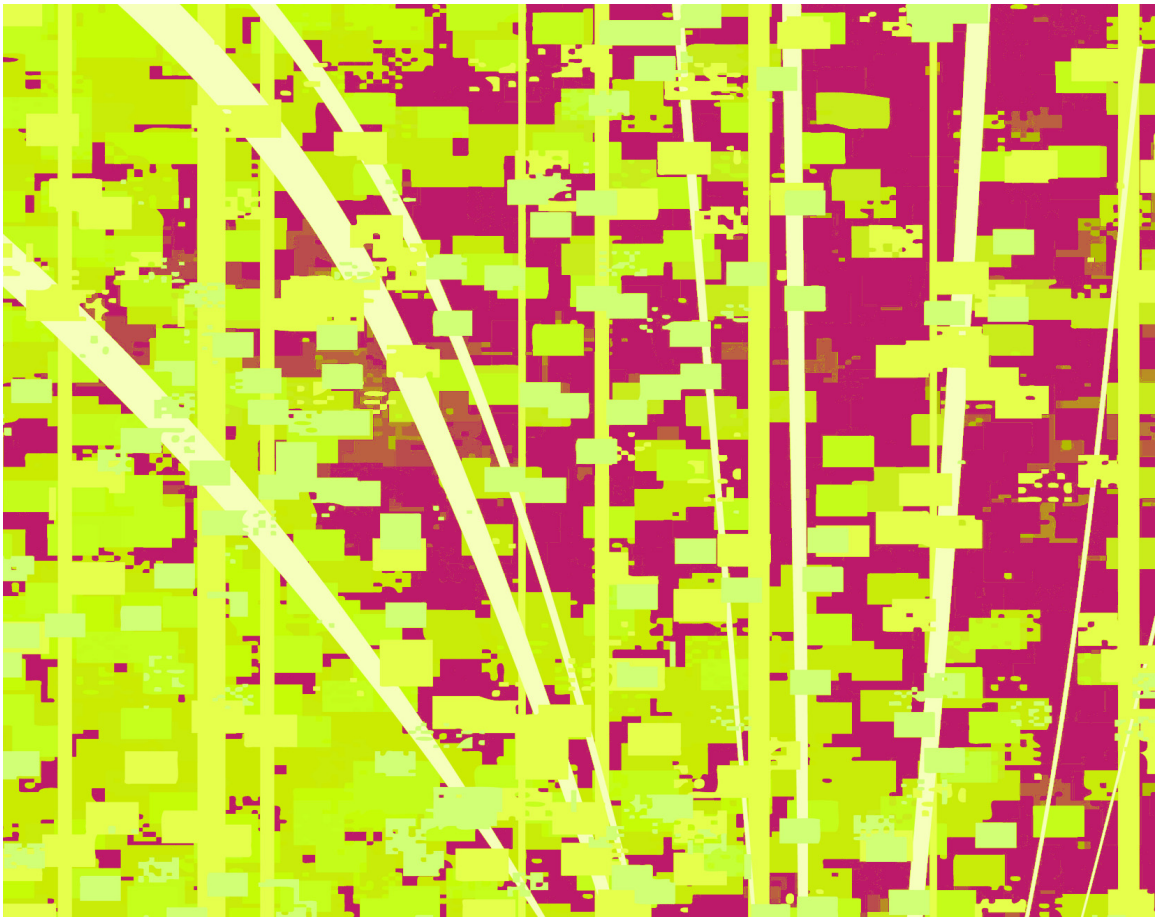
6

SERVICE AREA

VULNERABLE COMMUNITIES IN LOS ANGELES COUNTY
PREVENTION AND EARLY INTERVENTION

SERVICE AREA EXECUTIVE SUMMARY

South



Service Area 6: South

Communities

USC S.
Baldwin Hills S.
Hancock N.
USC E.
Watts
Florence-Firestone
Lynwood
Paramount
Compton

ZIP Codes

90001	90007	90016	90043	90052	90062	90174	90221	90224
90002	90008	90018	90044	90059	90082	90185	90222	90262
90003	90011	90037	90047	90061	90089	90220	90223	90723

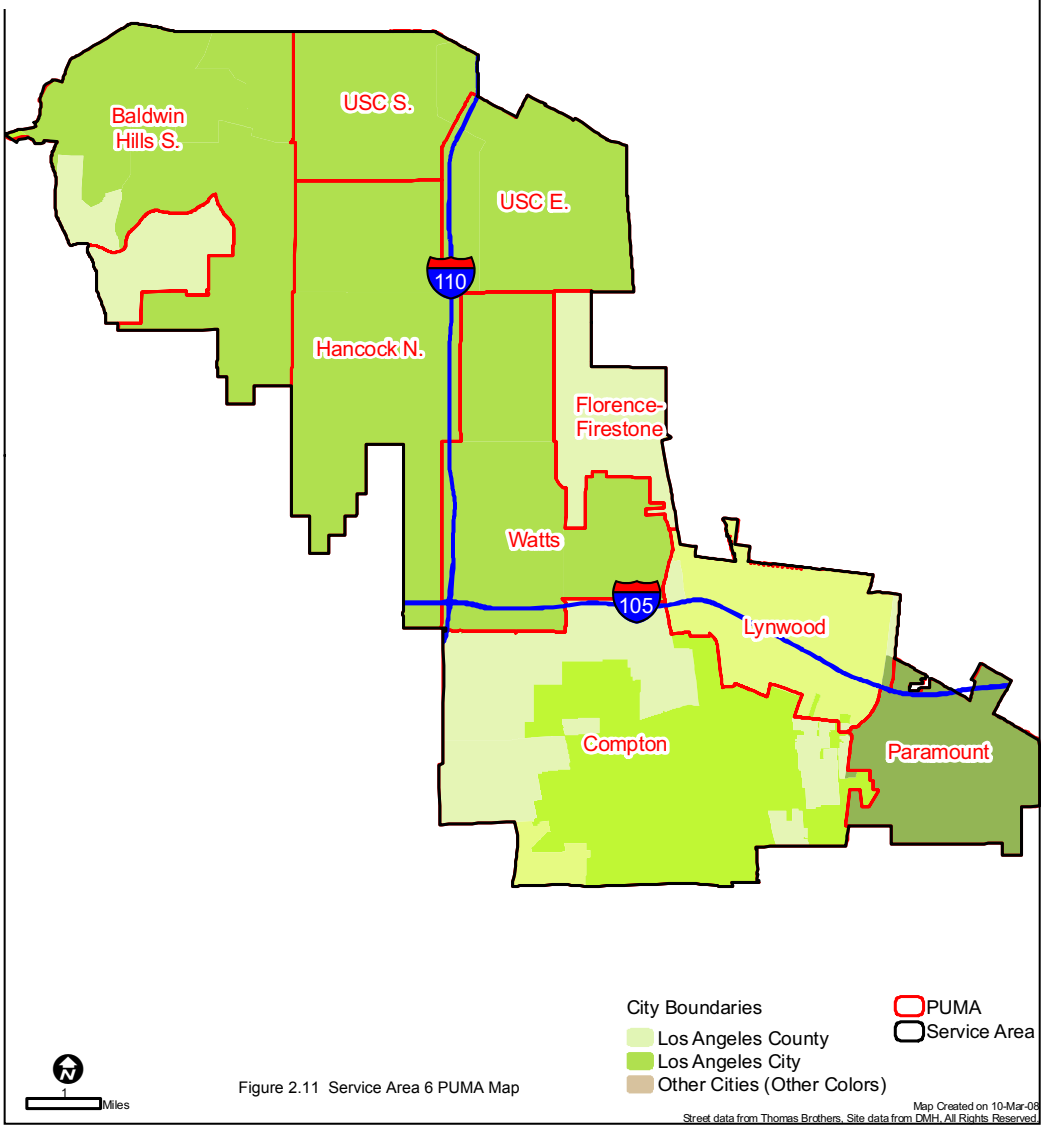


Figure 2.11 Service Area 6 PUMA Map

Demographic Profile

Ethnic Diversity: Latino Majority

The majority group in SA6 is Latino (65.9%), followed by African-American (28.2%), Western European White (2.8%), and Asian (1.6%). Russian, Iranian, Other Middle Eastern, South Asian, American Indian, Pacific Islander, and Multi-ethnic Individuals are other ancestry groups and number over 1,000 individuals. Latinos are the majority group in all the SA6 communities except Baldwin Hills S., where African-American's are the majority. Western European Whites and Asians are less than 5% of the population in all of the communities. Spanish is the primary language spoken in most homes throughout the service area. This is most evident in the communities of Florence-Firestone (81.9%), Lynwood (76.6%), and USC E. (73.5%).

Age Distribution:
Youngest Population in the County

A greater percentage of Service Area 6's population is 25 years of age or less (47.9) than any other service area in the county. With 30% of its population 0-15 years of age, it is second only to Service Area 1 in the relative numbers of young children in the area. On the other end of the lifespan, there are correspondingly fewer older adults in the service area communities (10.0%). The USC E. community, for example, has an older adult population (60+ years) of 5.4%, which is quite a bit below the countywide proportion of 13.5%.

Economic Diversity:
Widespread Poverty and Lack of Assets

The median household income in the service area of $30,576 was the lowest figure across the county and substantially below the county median of $48,282. It is important to consider both median and mean statistics when examining incomes. The median or mid-point gives a better indication of the typical level of income reported by individuals within the service area. The mean or arithmetic average, however, is a better statistic to compare different geographical areas, such as between and across service areas. Mean incomes across communities were similarly depressed and well below the

county average of $63,244. Mean household incomes ranged from the low of $25,417 in the USC E. area to $47,686 in the Paramount area. Home ownership of 39.6% was well below the county average of 48.9%. Only the communities of Lynwood and Compton had home ownership rates above 50%.

In terms of household size, the Watts (3.7 persons/household) and Lynwood (3.8 persons/household) areas had households that tended to be larger than other parts of the service area.

Memory and Educational Attainment: High Memory Problems, Low Educational Attainment

In terms of mental disability as measured by the ACS, 5.2% of individuals in Service Area 6 reported memory problems, above the countywide average of 4.6%. The Florence-Firestone area had the lowest rates of memory problems reported at 2.3%, while the Baldwin Hills S. community (7.6%) reported the highest levels of memory problems in the service area and the county. Educationally, Service Area 6 had a college graduation rate of 9.4% (in adults 25+), well below the countywide average of 27.8%. The community of Watts had the fewest college graduates (2.6%) throughout the entire county. In other communities such as USC E., Florence-Firestone, and Lynwood, fewer than 4% of their respective populations were college graduates.

Key Indicators: Summary and Excerpts

Underserved Cultural Populations

Ethnicity

Service Area 6 is populated by a majority of Hispanics (65.9%), followed by African-Americans (28.2%); together, these two groups account for 94.1% of the entire population of the service area. Four of the largest African-American communities are found within this service area (the Baldwin Hills S., Hancock N., Watts, and Compton areas). Two of the largest Hispanic communities are found here, as well (the USC E. and Watts areas).

Primary Language

Primary Spanish speakers are the majority in Service Area 6 (56.7), followed by primary English speakers (30.9%). No other identified primary language group accounts for more than 1% of the service area population. Six of the composite communities have a majority of primary Spanish speakers (the USC S., Hancock N., USC E., Watts, Florence-Firestone, and Lynwood areas); one has a majority of primary English speakers (Baldwin Hills S.); and two have no clear majority. Only one community, Paramount, has primary language speakers accounting for more than 1% of its population: Cambodian speakers (1.0%) and Tagalog speakers (3.6%).

Linguistic Isolation

Service Area 6 had a Linguistic Isolation score of 10.3%, which was above the countywide score, 7.8%, and second only to Service Area 4. Four of its composite communities had isolation scores above 10%, and the four were quite similar in their demographic make up: USC S. (15.1%), USC E. (16.2%), Florence-Firestone (14.8), and Lynwood (11.9%) All four areas are characterized by a majority of primary Spanish speakers and all have very few numbers of language groups other than English. There is little question that isolated households in the service area are primarily monolingual Spanish-speaking.

Individuals Experiencing Onset of Serious Psychiatric Illness

Serious Mental Illness Penetration Rate

The overall Penetration Rate for Service Area 6 was 0.32, very close to the countywide rate of 0.34. Along with Service Area 1, this was the highest rate seen in the county. Across service area ethnicities, Latinos (0.17) were the least-served by county mental health services. Following this, in order of Penetration Rates, were the Asian population (0.24), the Native American population (0.40), the African-American population (0.56), and the White population (0.83). Service Area 6 differed considerably from the other service areas in the relative rates across ethnicities. It is the only service area where the Asian population did not have the lowest Penetration Rate, and the only service area where the White population had the highest Penetration Rate.

Depressive Disorders

Age Groups

Service Area 6 accounted for 11.6% of depressed clients served in the county. Overall, a majority of depressed clients were adults, 26-59 (60.4%). This was the largest proportion seen for the adult population across all service areas. Examining the service area communities revealed that four areas treated a majority of adults: the Baldwin Hills S., Hancock N., USC E., and Compton areas. Three communities treated a majority of child (0-15) clients: the Florence-Firestone, Lynwood, and Watts areas. And one community treated a majority of TAY (16-25) clients: the Paramount area. Across the service area, 41.9% of all depressed clients were treated in the Compton area.

Ethnicity

African-Americans were a majority of depressed clients served in Service Area 6 (52.4%). This was followed by Latino clients, 34.3%, and White clients; 3.4%. Asian, Native American, and Pacific Islander clients each accounted for less than 1% of the population served in the service area. Examining the composite communities revealed that in five communities, African-Americans were a majority of depressed clients: the USC S., Baldwin Hills S., Hancock N., USC E., and Florence-Firestone areas. In two communities, Latinos were a majority of depressed clients receiving treatment: the Watts and Lynwood areas. No other community saw an ethnic majority receiving treatment for depressive disorders.

Co-occurring Disorders (COD)

Age Groups

Service Area 6 clients accounted for 8.4% of individuals with COD treated in the county's mental health system. Like other parts of the county, adults (26-59) accounted for a majority of COD cases in the service area (73.6%). This large proportion of adult clients was second only to Service Area 5. Differing from this, three communities appeared to have children (0-15) and TAY (16-25) groups as a majority of clients with COD (the Watts, Florence-Firestone, and Paramount areas), but the relative numbers of cases in these areas was relatively small (in sum accounting for only 2.8% of all COD cases in the service area). All other composite communities saw an large percentages of COD cases from the adult group. Three communities saw these figures greater than 80%: the Baldwin Hills S. area (82.2%), the Hancock N. area (81.8%), and the Lynwood area (82.6%). Across the service area, treatment for 49.2% of clients with a COD occurred in the Compton area.

Ethnicity

African-American clients accounted for a majority (63.0%) of the COD population treated in Service Area 6, the only service area where this occurred. Following this, Latino clients (21.9%) and White clients (5.8%) were the next most numerous ethnic groups represented. Native American, Asian, and Pacific Islander clients each accounted for less than 1% of the COD population. When compared with population estimates, African-Americans (28.2%) appeared to be overrepresented in the COD client counts; Latinos (65.9%) were underrepresented.

Children/Youth in Stressed Families

Poverty

Service Area 6 had the highest poverty rate within the county with 60.6% of its residents living beneath the 200% FPL. This is substantially above the countywide percentage of 38.7%. The USC E. community had the highest poverty rate in the county with 80.4% of its residents living beneath the 200% FPL. The USC S. area had the second highest rate in the county with 72.3% of its residents below the 200% FPL. The Watts area (65.3%) had the fourth-highest rate in the county. Poverty was widespread across all ethnic groups. The Hispanic population saw 67.6% of its population living below the 200% FPL; African-Americans, 48.3%; Asians, 48.8%; American Indians 48.3%; and Whites, 33.8%. The Hispanic population saw a majority of its population living below the 200% FPL in every service area community, a finding unique to Service Area 6. Over 50% of the African-American population in four communities were below the 200% FPL: the USC S. area (59.4%), the USC E. area (62.1%), the Watts area (66.2%), and the Florence-Firestone area (60.2%). For the White population, there were four areas, as well: the USC S. area (71.4%), the USC E. area (63.1%), the Watts area (100%), and the Florence-Firestone area (60.2%). For the Asian population there were also four areas: the USC S. area (76.8%), the Hancock N. area (53.3%), the Watts area (100%), and the Compton area (53.9%).

Unemployment Rate

Service Area 6 had a self-reported unemploy-

ment rate of 11.4%, the highest in the county and substantially above the countywide rate of 7.4%. Seven communities in the service area were characterized by unemployment rates well above 10%: the USC S. area (11.7%), the Baldwin Hills S. area (11.7%), the Hancock N. area (10.3%), the USC E. area (15.8% -- highest in the county), the Watts area (12.2%), the Paramount area (11.1%), and the Compton area (12.1%). Only the Florence-Firestone area (5.1%) had a self-reported unemployment rate below the county average.

Disrupted Families

Service Area 6 had a DF ratio of 2.0, which was slightly lower than the countywide average of 2.2. Of the named communities within the service area, four had DF ratios below 2.0 indicating greater levels of single parents for a given area: USC S. (1.2), Baldwin Hills S. (1.0), USC E. (1.8), and the Lynwood area (1.8). The Watts area (3.1) had the highest DF ratio in the service area; there, intact families outnumbered single-parent families about 3 to 1.

Safe Place to Play (Countywide Summary Only)

Age Groups

Across the three age groups reported, there appeared to be a trend in parent-report. Parents were more likely to report that a safe place to play was less available for older children than for younger ones

Ethnicity

There did not appear to be any significant difference between parent reports across ethnicities.

Trauma-exposed Individuals

Child Abuse

Child Abuse and Neglect Base Rates

Service Area 6 had the second-highest CAN Rate seen across service areas and several communities had very high rates. The Watts area (2.15) had the highest CAN Rate (along with Palmdale) in the county. Additionally, three other communities had CAN Rates that were greater than 84% or more of the county's communities: the Hancock N. area (1.66), the Florence-Firestone area (1.51), and the Compton area (1.67).

Triage Response Acuity

Service Area 6 had the second-highest Acuity score (0.23) within the county (whose overall score was 0.15). All Communities within the service area, save the Lynwood area, had Acuity scores above the county score. The Watts area (.32) had the highest Acuity score in the county. Other communities with very high Acuity scores included the Baldwin Hills S. area (0.22), the Hancock N. area (0.26), the Florence-Firestone area (0.22), and the Compton area (0.21).

Ethnicity

Across Service Area 6, 92.1% of SCAN Reports involved two ethnic groups: African-Americans and Hispanics. Overall, African-American children accounted for 42.1% of SCAN Reports and Hispanic children, 50%. Only two other ethnic groups accounted for more than 1% of the victimized children in the area: Mexican, 2.1%, and White, 1.4%. African-American children were a majority of victims in two communities: the Baldwin Hills S. area and the Hancock N. area. Hispanic children were a majority of victims in

five communities: the USC S. area, the USC E. area, the Florence-Firestone area, the Lynwood area, and the Paramount area.

Elder and Dependent Adult Abuse

Service Area 6 (3.9) had the highest APS Rate[1] among all county service areas. Three of the six most at-risk communities across the county were contained within the service area in terms of their respective APS Rate[1] scores. The Baldwin Hills S. area (5.8) had the highest rate found within the county, followed by the Hancock N. area (4.7) and the Watts area (4.4).

Posttraumatic Stress Disorder (PTSD)

Age Groups

Service Area 6 accounted for 13% of the county's PTSD cases. It was the only service area where adults (26-59) accounted for a greater proportion of cases than children (0-15). 46.2% of cases treated in the service area came from the Adult group while 38.0% came from the Child group. Examining the composite communities revealed that several did treat a majority of child cases, though their relative proportions may have been small (the USC S., Hancock N., USC E., Watts, Florence-Firestone, Lynwood, and Paramount areas). The Baldwin Hills S. area, which saw the greatest proportion of cases in the service area (32.9%), also saw mostly adult PTSD cases. The Compton area saw about a quarter of the PTSD cases in the service area and a large proportion of these clients were from the Adult group.

Ethnicity

African-American clients accounted for a majority (58.0%) of the PTSD population treated in Service Area 6, the only service area where this occurred. Following this, Latino clients (33.0%) and White clients (2.5%) were the next most numerous ethnic groups represented. Native American, Asian, and Pacific Islander clients each accounted for less than 1% of the PTSD population. When compared with population estimates, African-Americans (28.2%) appeared to be overrepresented in the PTSD client counts, whereas, Latinos (65.9%) were underrepresented. Examining the composite communities revealed that African-American clients formed a majority of PTSD clients in four areas (the Baldwin Hills S., Hancock N., Florence-Firestone, and Compton areas). Latino clients constituted a majority of PTSD cases in the Watts area. The Paramount area was equally split between Latinos and African-American clients.

Homelessness

Age Groups

In Service Area 6, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (64.0%) of the homeless population. This was followed by the Under 18 Age Group at 15.3%, the 56+ Age Group at 14.2%, and the 18-24 Age Group at 6.5%.

Ethnicity

Within Service Area 6, Black/African-Americans accounted for a majority of the homeless population (81.7%). Hispanic or Latinos accounted for 12.3%, Whites, 3.5%, and Multi-Racial or Others accounted for 2.5% of the homeless population.

Sub-populations

In Service Area 6, 32.1% of the homeless population reported that they had a mental

illness; 37.1% of homeless individuals reported they were substance abusers; and 12.5% reported they were victims of domestic violence.

Children/Youth at Risk for School Failure

4-year Dropout Rate
(Countywide Summary Only)
State figures indicated that over a quarter of all students in Los Angeles County drop out of high school over a four-year period. Examining ethnic categories indicated that African-American students were most at risk for not finishing high school, followed by Pacific Islander, American Indian/Alaska Native, and Hispanic or Latino Students. 15.5% of White students drop out of high school. Two ethnic groups had dropout rates below this: Asian, 7.4%, and Filipino, 12.8%.

High School Graduation Rates
Across the county, Service Area 6 had the lowest graduation rate, 55.7%, or slightly more than half of all students. Four communities within the service area had overall graduation rates below 50%, indicating that less than half of all students in the area graduate. The most at-risk community, Watts, had a 35.8% graduation rate, the lowest in the county. Hispanic and African-American students were particularly at risk for not graduating. In the Watts area, for example, the graduation rate for Hispanic students was 37.6%; in the Florence-Firestone area, the graduation rate for African-Americans was 15.4%, or fewer than two students out of ten.

English Fluency
Across the county, Service Area 6 had the lowest English Fluency (52.7%) rate in its student population across the service areas. It was also the service area with the lowest high school graduation rate, as identified above. English Fluency in the USC E., Florence-Firestone, and Compton areas was below 50%. These areas had correspondingly low high school graduation rates (this was especially true in the USC E. and Florence-Firestone areas ,and to a lesser degree in the Compton area.)

3rd Grade Reading Level
Overall, 15.9% of third graders in Service Area 6 scored at or above the 50th percentile in standardized reading tests. This was the lowest proportion of students failing to reach the 50th percentile across all service areas. Within the service area, the lowest reading scores were found in the USC E. area (10.4%), where about one in ten third graders were at or above the 50th percentile. Together, with the indicators listed above (e.g. service area 6 had the lowest high school graduation rate and the lowest English Fluency rate among the other service areas), Service Area 6 is clearly the most at-risk service area for school failure.

Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

School Discipline
Service Area 6 had an overall suspension rate of 4.8%, which was above the countywide rate of 3.7%. The Compton (8.2%), Paramount (7.7%), and Baldwin Hills S. (5.6%)

areas had the highest suspension rates in the service area. Few students were expelled in the service area. The Paramount (0.4%) and the Compton (0.1%) areas had the highest expulsion rates in the service area.

Juvenile Felony Arrests (Countywide Summary Only)

Of the 23,787 youths arrested on felony charges during the reporting period, 84.2% were males, 15.8%, females. Ethnically, Hispanic youths were involved in the majority of felony arrests (57.2%) followed by Black/African-American youths (30.3%) and Whites (9.1%). All other ethnicities combined accounted for less than 4% of the juvenile felony arrests.

Youths on Probation

Camp Population

Across the county, Service Area 6 had the largest numbers of youth sent to camp: 567; the majority of these were African-Americans (55.4%), followed by Hispanic youth (44.2%). The Hancock N. area had the largest population of youth in camp (108) across the county. This was followed closely by the Watts area (98), the Compton area (94), and the USC E. area (87). Combined, these four communities had more youths in camp than any single service area.

Supervised Youths

Service Area 6 had the highest numbers of supervised youth across the county: 3,322. Of these, a majority were African-American (51.4%), followed by Hispanic youth at 47%. No other ethnicity exceeded 1% of the population. Three communities had over 500 youths under supervision: the Watts area (714), the Compton area (651), and the Hancock N. area (584).

Key Indicators of Stigma and Discrimination

Language Capacity of Mental Health Providers

Across the service area, Chinese speakers (52), Korean speakers (170), and Tagalog speakers (60) had about the same or more staffing resources allocated to them compared to English speakers (57). Of the language groups with over 1,000 residents, Spanish speakers (8) had the fewest staff resources allocated to them, even though Spanish speakers were a majority of the population in the service area. In five communities, there were fewer than five Spanish-speaking therapists/10,000 Spanish speakers.

Key Indicators of Suicide Risk

Deaths by Suicide

Service Area 6 had an overall suicide rate of 3.8, which was the lowest seen in the county. Even so, the countywide trends were still evidenced here: the highest suicide rates were found in Males, Whites, Adults, and Older Adults. Whites were most at risk in the USC S. (40.8) and Baldwin Hills S. (49.2) areas, African-Americans were most at risk in the Lynwood area (33.6), and Asians (38.2) in the USC S. area. The USC S. area (8.6) had the highest suicide rate within the service area followed by the Compton area (6.0).

Mental Health Emergency Statistics

Service Area 6 had the second-highest MHE-Rate (8.2) across the county. Two communities, the Baldwin Hills S. area (1,574) and the Hancock N. area (1,624), had more than 1,500 calls; two other areas had over 1,000 calls: the

Watts area (1,290) and the Compton area (1,176). Three of the five highest MHE-Rates across the county were found in Service Area 6: the USC S. area (10.7), the Baldwin Hills S. area (11.9), and the Hancock N. area (10.9).

PUMA REFERENCE MAP
DEMOGRAPHIC PROFILE
KEY INDICATORS SUMMARY

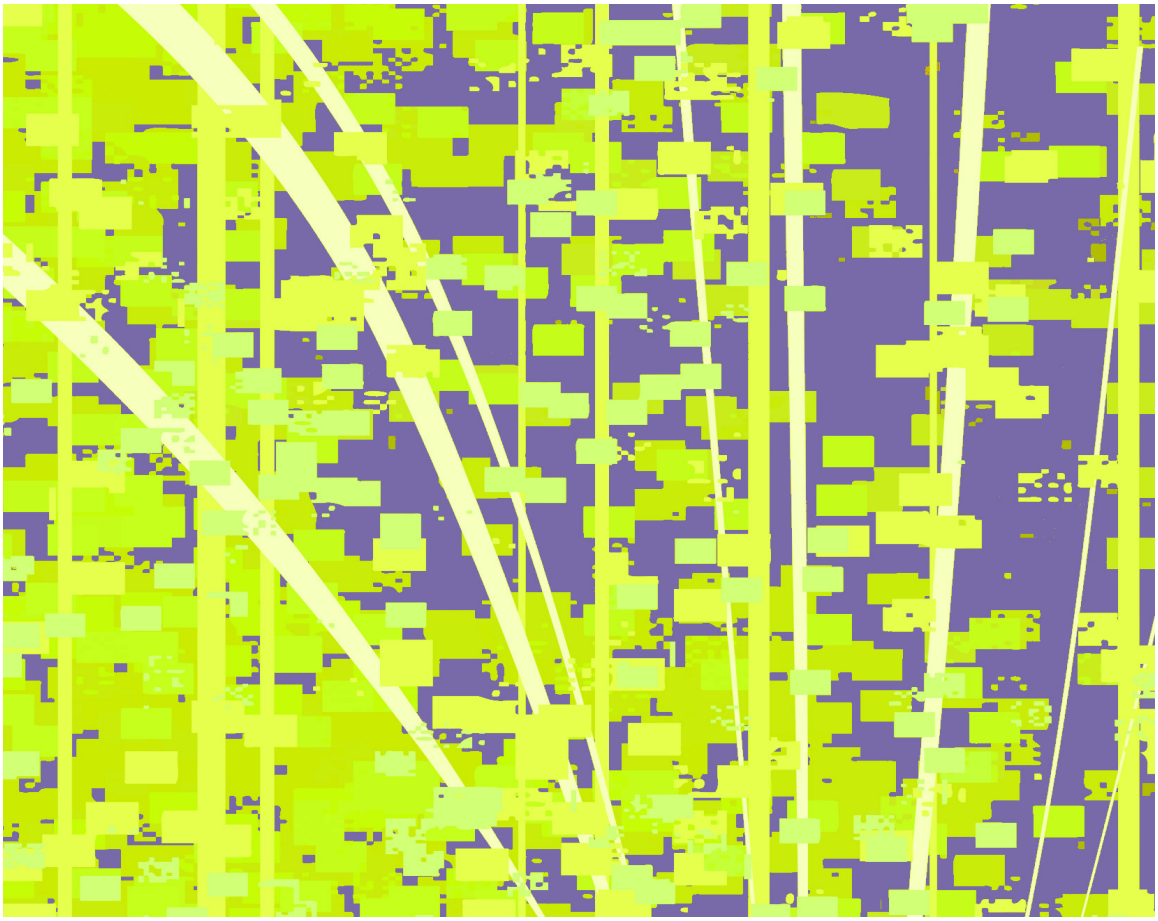
7

SERVICE AREA

VULNERABLE COMMUNITIES IN LOS ANGELES COUNTY
PREVENTION AND EARLY INTERVENTION

SERVICE AREA EXECUTIVE SUMMARY

East



Service Area 7: East

Communities

East LA
Downey
Norwalk
Whittier
Montebello
Bell Gardens-Bell-Maywood-Cudahy-Commerce
Huntington Park
South Gate
Bellflower
La Mirada-Santa Fe Springs
Lakewood-Cerritos-Artesia-Hawaiian Gardens
Signal Hill

ZIP Codes

90255	90603	90608	90637	90651	90662	90703	90713
90270	90604	90609	90638	90652	90665	90706	90714
90280	90605	90610	90639	90659	90670	90707	90715
90601	90606	90631	90640	90660	90701	90711	90716
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							90888

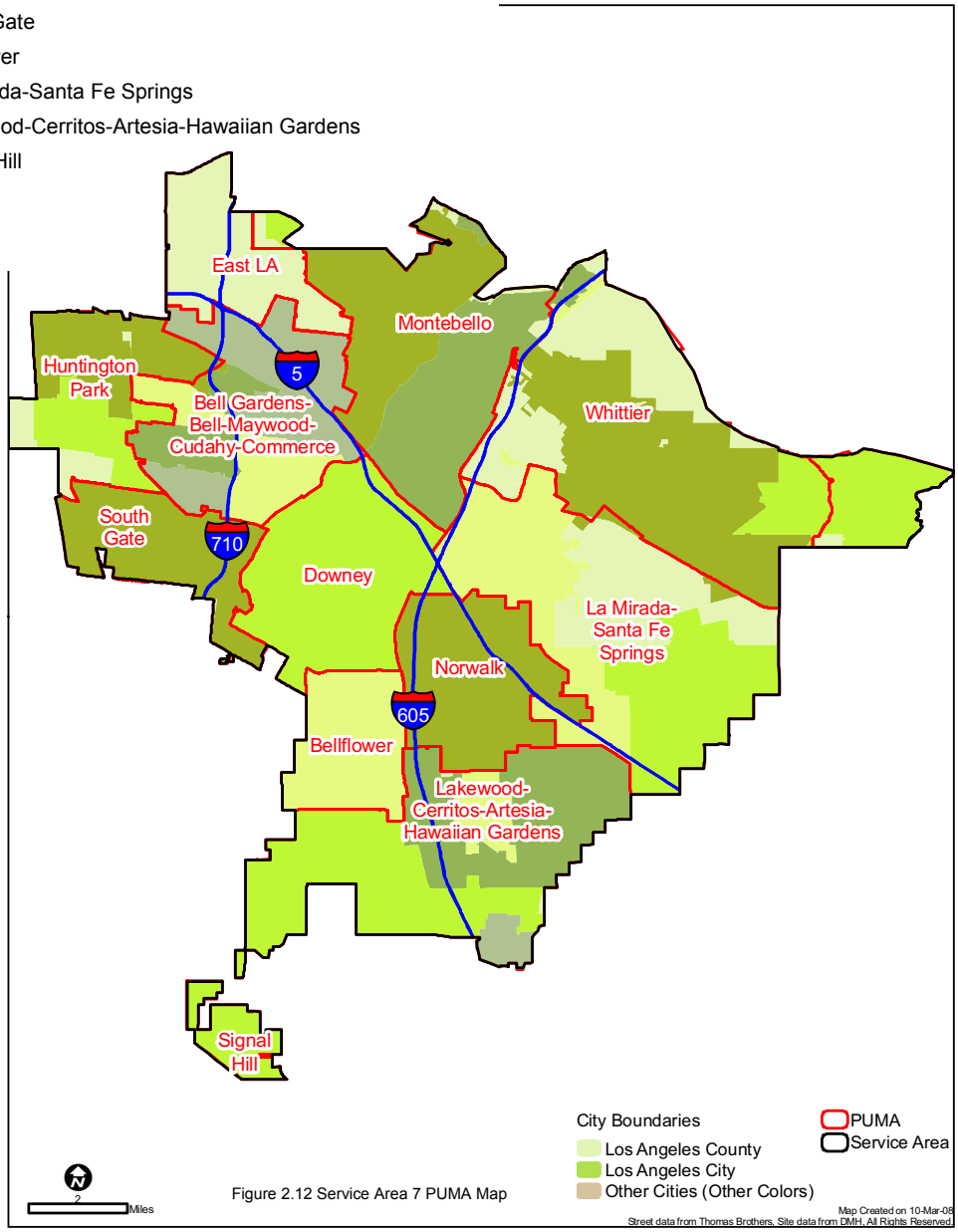


Figure 2.12 Service Area 7 PUMA Map

Demographic Profile

Ethnic Diversity: Latino Majority

Service Area 7 (SA7) is comprised primarily of eleven communities in the east central portion of the county. The majority of the population in SA7 is Latino (70.9%), followed by Western European Whites (14.8%), Asians (9.1%), and African-Americans (2.9%). Russian, Iranian, Armenian, Other Middle Eastern, South Asian, American Indian, Pacific Islander, and Multi-ethnic individuals are other ancestry groups that number over 1,000 individuals. Latinos are a majority in all the communities except the Lakewood-Cerritos-Artesia-Hawaiian Gardens community, which has no majority group. Latinos account for over 90% of the population in the East Los Angeles, Bell Gardens-Bell-Maywood-Cudahy-Commerce, Huntington Park, and South Gate communities.

Across the service area, Spanish is the primary language in 54% of households. Two communities, East Los Angeles (84.4%) and Huntington Park (81.9%), have the highest Spanish-speaking rates in the county. English is spoken in 28.9% of the households in the service area and a handful of Asian languages account for a few percentage points (Chinese, 1.1%; Korean, 1.4%; and Tagalog, 2.0%).

Age Distribution: Youthful Population

Service Area 7 had a young population with 43.1% under the age of 26. Across the county, this age group accounts for 38.9% of the population. Within the service area, older adults accounted for 12.2% of the population.

Economic Diversity: About Average

The median household income in the service area of $48,717 was equal to the county median of $48,282, though the mean income was a bit lower than the county mean. It is important to consider both median and mean statistics when examining incomes. The median or mid-point gives a better indication of the typical level of income reported by individuals within the service area. The mean or arithmetic average, however, is a better statistic to compare different geographical areas, such as between and across service areas. Across the service area, mean household

incomes ranged from the low of $40,475 in the East Los Angeles area to $119,174 in the Signal Hill area (containing portions of Rancho Palos Verdes). Overall, home ownership in the service area of 55.6% was above the county average of 48.9% The La Mirada-Santa Fe Springs and Lakewood-Cerritos-Artesia-Hawaiian Gardens areas had home ownership rates of 72.5% and 74.6%, respectively. The community with the lowest rate of home ownership was the Bell Gardens-Bell-Maywood-Cudahy-Commerce area (27.4%).

Looking within the service area indicated that the South Gate and Huntington Park area had households that were the largest in the county (median = 4.1).

Memory and Educational Attainment: Low Memory Problems, Low Educational Attainment

In terms of memory problems as measured by the ACS, 4.1% of individuals in Service Area 7 reported memory problems, lower than the countywide average of 4.6%. The Huntington Park area had the lowest rates of memory problems reported at 2.3%, while the Norwalk and Whittier communities reported the highest levels of memory problems. Educationally, Service Area 7 had a college graduation rate of 15.9% (in adults 25+), much lower than the countywide average of 27.8%. The community of Signal Hill had the highest number of college graduates in the service area (53.1%), while the East Los Angeles, Bell Gardens-Bell-Maywood-Cudahy-Commerce, Huntington Park, and South Gate communities had less than 4% of their respective populations with a college degree.

Key Indicators: Summary and Excerpts

Underserved Cultural Populations

Ethnicity

In Service Area 7, Hispanics are the most populous group, where they account for 70.9% of the area's population. The over 900,000 Hispanics in the area represent over 20% of all Hispanics in the county. Three of the ten largest Hispanic communities are found within this service area (the East LA, Montebello, and Bell Gardens-Bell-Maywood-Cudahy-Commerce areas). Western European Whites, scattered throughout the service area, account for 14% of the service area population. Three Asian and South Asian communities are represented in relatively large numbers for their population; however, the two South Asian communities in the Downey area and the aggregate area of Lakewood-Cerritos-Artesia-Hawaiian Gardens represent less than 10% of the service area's total population.

Primary Language

Primary Spanish speakers are the majority in Service Area 7 (54%), followed by primary English speakers (28.9%) Tagalog speakers (2.0%), Korean speakers (1.4%), and Chinese speakers (1.1%). The East area is home to the largest proportion of primary Spanish speakers and smallest proportion of primary Farsi speakers in the county. Examining the composite communities revealed that five have large majorities of primary Spanish speakers: the Montebello, Bell Gardens-Bell-Maywood-Cudahy-Commerce, Bellflower, East LA, and Huntington Park areas. The East LA and the Huntington Park areas have over 80% of their respective populations reporting Spanish as their primary language. Three communities (the La Mirada-Santa Fe Springs, Lakewood-Cerritos-Artesia-Hawaiian Gardens, and Signal Hill areas) have a majority of primary English speakers, and four others have no clear majority, though primary English or Spanish speakers are the most numerous in all communities. Relatively large numbers of primary Tagalog speakers are found in the Norwalk and Lakewood-Cerritos-Artesia-Hawaiian Gardens areas. Primary Korean speakers are found in significant numbers in at least five communities. Primary Chinese speakers may be found in significant numbers in the Montebello and Lakewood-Cerritos-Artesia-Hawaiian Gardens areas. Two communities, Signal Hill and the Lakewood-Cerritos-Artesia-Hawaiian Gardens area, have six primary language groups in excess of 1% of their respective populations.

Linguistic Isolation

Service Area 7 had a Linguistic Isolation score of 8.8%, which was above the county figure of 7.8%. Four named communities within the service area had isolation levels in excess of 10%: South Gate (11.9%), Huntington Park (14.8%), Bell Gardens-Bell-Maywood-Cudahy-Commerce (14.8), and East LA (22.7%). Like Service Area 6, these four communities are demographically similar in terms of primary language composition: a large majority of residents in each of these communities are primary Spanish speakers, (e.g., in the East LA area, 84.4% of the population; in Huntington Park, 81.9%). Each community has very few speakers of other languages besides English. As in Service Area 6, there is little question that isolated households in these communities are likely to be monolingual Spanish-speaking.

Individuals Experiencing Onset of Serious Psychiatric Illness

Serious Mental Illness Penetration Rate

The overall Penetration Rate for Service Area 7 was 0.16; this was the lowest rate seen in the county (whose overall rate was 0.34). This suggests that county mental health services may have the least reach into the SMI population here than elsewhere in the county. Across ethnicities, Asians (0.06) were the least-served by county mental health services. Following this, in order of Penetration Rates, were the Latino population (0.14), the White population (0.17), the African-American population (0.57), and the Native American population (1.33). This was the highest Penetration Rate obtained for the Native American population in the county.

Depressive Disorders

Age Groups

Service Area 7 accounted for 11.1% of depressed clients served in the county. No age group had a majority of depressed clients treated in the service area. 43.6% of depressed clients came from the Adult group and this was below the countywide figure of 49.2%. Children (0-15) were a majority of depressed clients served in four communities (the Whittier, Huntington Park, South Gate, and Signal Hill areas). Two communities saw a majority of depressed clients coming from the TAY (16-25) group: the Downey and Bellflower areas. Two communities treated a majority of depressed Adults (26-59): the La Mirada-Santa Fe Springs and the Lakewood-Cerritos-Artesia-Hawaiian Gardens areas. Across the service area, the large proportion of depressed clients, 32.9%, were treated in the Lakewood-Cerritos-Artesia-Hawaiian Gardens area.

Ethnicity

Latinos were a majority of depressed clients served in Service Area 7 (62.0%). No other service area saw as large a proportion of clients representing a single ethnic group. This was followed by White clients, 12.6%; African-American clients, 10.7%; Native American clients, 2.6%; and Asian clients, 2.8%. Pacific Islander clients accounted for less than 1% of the population served in the service area. Examining the composite communities in further detail showed eight communities where Latinos were the majority of depressed clients served: the East LA, Whittier, Montebello, Bell Gardens-Bell-Maywood-Cudahy-Commerce, South Gate, La Mirada-Santa Fe Springs, Lakewood-Cerritos-Artesia-Hawaiian Gardens, and Signal Hill areas. African-Americans were a majority of depressed clients in the Huntington Park area.

Co-occurring Disorders (COD)

Age Groups

Service Area 7 clients accounted for 11.5% of individuals with COD treated in the county's mental health system. Unlike other areas of the county, no age group accounted for a majority of clients with a COD. This meant that other age groups, particularly children (0-15) and TAY (16-25), accounted for relatively larger proportions of the COD population. Children accounted for 20.3% of the service area's COD cases, the largest proportion in the county for this age group. The TAY group accounted for 36.5% of the COD population and this was also the largest proportion in the county for this age group. Across the service area, the Lakewood-Cerritos-Hawaiian Gardens community treated the largest proportion of clients with COD (29.9%). This was followed by the Downey area (25.9%), the La Mirada-Santa Fe Springs area (13.6%), the Bell Gardens-Bell-Cudahy-Commerce area (13.3%), and the Norwalk area (10.4%).

Ethnicity

Latino clients accounted for a majority (52.1%) of the COD population treated in Service Area 7, the only service area where this occurred. Following this, White clients (19.7%), African-American clients (14.6%), Native American clients (3.3%), and Asian clients (1.3%), were, in order, the next most numerous ethnic groups represented. Pacific Islanders accounted for less than 1% of the COD population. When compared with

population estimates, African-Americans (2.9%) and Native Americans (0.2%) appeared to be overrepresented in the COD client counts; Latinos (70.9%) and Asians (10.0%) were underrepresented.

Children/Youth in Stressed Families

Poverty

Service Area 7 had an overall poverty rate of 39.5%, which is close to the county rate of 38.7%. Overall, four communities, East LA, the aggregate of Bell Gardens-Bell-Maywood-Cudahy-Commerce, Huntington Park, and South Gate, had a majority of its residents living beneath the 200% FPL. Because of the very large Hispanic population in the service area, Hispanic groups accounted for 83% of the total poverty population within the service area. Five communities saw over 50% of the Hispanic population living below the 200% FPL: the East LA area (57.7%), the Bell Gardens-Bell-Maywood-Cudahy-Commerce area (58.4%), the Huntington Park area (59.2%), the South Gate area (60.8%), and the Bellflower area (55.0%). Two communities had White populations with over 50% of its numbers living in poverty: the East LA area (51.5%) and the Huntington Park area (60.2%). Also above the 50% level were two African-American communities, the East LA area (55.5%) and the Huntington Park area (53.6%); three American Indian communities, the Montebello area (89.2%), the Huntington Park area (100%), and the South Gate area (100%); and one Asian community, the Downey area (52.3%).

Unemployment Rate

Service Area 7 had an unemployment rate of 7%, which was very close to the countywide average of 7.4%. Two communities had reported unemployment rates of at least 10%: the Norwalk area (10%) and the Bellflower area (11.1%). The Signal Hill area (2.1%) yielded the lowest unemployment rate in the service area and the county (the Palos Verdes-Lomita area in Service Area 8 also had an unemployment rate of 2.1%).

Disrupted Families

Service Area 7 had a DF ratio of 2.3, similar to the countywide ratio of 2.2. As in other parts of the county, Service Area 7 had areas with relatively high DF scores, (e.g., Lakewood-Cerritos-Artesia-Hawaiian Gardens, 5.0, and Signal Hill, 5.1), and relatively low DF scores, (e.g., East LA, 1.5, La Mirada-Santa Fe Springs, 1.8, and South Gate, 1.8). In both the Lakewood-Cerritos-Artesia-Hawaiian Gardens area and the Signal Hill area, intact families outnumbered single-parent families 5 to 1.

Safe Place to Play (Countywide Summary Only)

Age Groups

Across the three age groups reported, there appeared to be a trend in parent-report. Parents were more likely to report that a safe place to play was less available for older children than for younger ones

Ethnicity

There did not appear to be any significant difference between parent reports across ethnicities.

Trauma-exposed Individuals

Child Abuse

Child Abuse and Neglect Base Rates

Service Area 7 had an overall CAN Rate of 0.94, which was very close to the countywide Rate of 0.96. Within the service area, 20.5% of all SCAN reports were substantiated by DCFS staff. Examining the composite communities revealed that the East LA area (1.76) had the highest CAN Rate; moreover, this was greater than 84% the county's communities, (i.e., PUMAs). This was followed by the Montebello area (1.38). Both of these areas had high percentages of their SCAN reports substantiated.

Triage Response Acuity

Service Area 7 had an Acuity score of 0.12, which was below the countywide score of 0.15. Three communities had scores which equaled or exceed the countywide figure: the East LA area (0.18), the Norwalk area (0.15), and the Signal Hill area (0.16).

Ethnicity

Across Service Area 7, 92% of SCAN Reports involved three ethnic groups: African-American, White, and Hispanic. Overall, African-American children accounted for 4.4% of SCAN Reports, White children, 10.5%, and Hispanic children, 77.1%. Only one other ethnic group accounted for more than 1% of the victimized children in the area: Mexican at 3.2%. Hispanic children were involved in a majority of SCAN Reports in ten communities: the East LA area, the Downey area, the Norwalk area, the Whittier area, the Montebello area, the Bell Gardens-Bell-Maywood-Cudahy-Commerce area, the Huntington Park area, the South Gate area, the Bellflower area, and the La Mirada-Santa Fe Springs area.

Elder and Dependent Adult Abuse

Service Area 7 had an overall APS Rate[1] of 2.2, which was a bit below the countywide rate of 2.6. Within the service area, the East LA area (3.1) had the highest APS Rate[1] score.

Posttraumatic Stress Disorder (PTSD)

Age Groups

Service Area 7 accounted for 9.9% of the county's PTSD cases. A majority of these cases came from the Child (0-15) group (54.3%). Examining the composite communities revealed that seven areas saw a majority of child PTSD cases: the East LA, Norwalk, Whittier, Huntington Park, South Gate, Bellflower, and Signal Hill areas. One community, the Downey area, saw a majority of TAY (16-25) PTSD cases. In the county, this occurred only in one other community, the Granada Hills area in Service Area 2. Adults (26-59) were seen in a majority of PTSD cases in one community: the La Mirada-Santa Fe Springs area. The communities with the four largest proportions of PTSD cases were, in order: the Lakewood-Cerritos-Hawaiian Gardens area (18.1%), the Bell Gardens-Bell-Maywood-Cudahy-Commerce area (16.3%), the Whittier area (12.2%), and the East LA area (11.5%).

Ethnicity

Latino clients accounted for a majority (62.7%) of the PTSD population treated in Service Area 7. Following this, African-American clients (16.5%), White clients (7.2), Asian clients (6.1), and Native American clients (1.3%) were, in order, the next most nu-

merous ethnic groups represented. Pacific Islanders accounted for less than 1% of the PTSD population. When compared with population estimates, African-Americans (2.9%) and Native Americans (0.2%) appeared to be overrepresented in the COD client counts, whereas, Latinos (70.9%), Whites (15%), and Asians (10.0%) appeared to be underrepresented. African-American clients were a majority in three communities (the Norwalk, Huntington Park, and Bellflower areas); Latino clients were a majority of PTSD cases in six communities (the East LA, Whittier, Bell Gardens-Bell-Maywood-Cudahy-Commerce areas); and White and Latino clients were equally represented in the Signal Hill area.

Homelessness

Age Groups

In Service Area 7, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (63.4%) of the homeless population. This was followed by the Under 18 Age Group at 15.5%, the 56+ Age Group at 13.1%, and the 18-24 Age Group at 7.9%.

Ethnicity

Within Service Area 7, Black/African-Americans accounted for 24.7% of the homeless population. Hispanic or Latinos accounted for 43.4%; Whites, 24.7%; and Multi-Racial or Others accounted for 7.2% of the homeless population.

Sub-populations

In Service Area 7, 34.5% of the homeless population reported that they had a mental illness; 40.6% of homeless individuals reported they were substance abusers; and 14.8% reported they were victims of domestic violence.

Children/Youth at Risk for School Failure

4-year Dropout Rate (Countywide Summary Only)

State figures indicated that over a quarter of all students in Los Angeles County drop out of high school over a four-year period. Examining ethnic categories indicated that African-American students were most at risk for not finishing high school, followed by Pacific Islander, American Indian/Alaska Native, and Hispanic or Latino Students. 15.5% of White students drop out of high school. Two ethnic groups had dropout rates below this: Asian, 7.4%, and Filipino, 12.8%.

High School Graduation Rates

Service Area 7 had an overall high school graduation rate of 84.8% and saw no one ethnic group below the 80th percentile. However, one community within the service area had a graduation rate lower than 50%: the Huntington Park area (49.6%). Looking within this area revealed that students of all ethnicities found it difficult to succeed in graduating. Hispanic students, for example, graduated there at a rate of 50%, meaning that one out two students did not graduate. African-American students graduated there at a rate of 15.4%, and Whites at 16.7%.

English Fluency

Service Area 7 had an English Fluency rate of 68% in its student population, which was nearly identical to the countywide rate of 68.3% The Huntington Park area (45.9%) and the South Gate area (55.6%) had low English

Fluency rates and, as mentioned above, the two lowest high school graduation rates in the service area. The aggregate community of Bell Gardens-Bell-Maywood-Cudahy-Commerce also had a low English Fluency rate, but a moderate high school graduation rate. All three of these communities have very large numbers of individuals whose primary language is Spanish, (i.e., greater than 75% of the population).

3rd Grade Reading Level

Overall, 27.7% of third graders in Service Area 7 scored at or above the 50th percentile in standardized reading tests. In four communities, less than 20% (or less than one in five third graders) scored at or above the 50th percentile: the East LA area (17.2%), the aggregate of Bell Gardens-Bell-Maywood-Cudahy-Commerce (19.6%), the Huntington Park area (15.3%), and the South Gate area (19%). All four of these communities had the lowest English Fluency rates in the service area. The Huntington Park area, which had the lowest 3rd grade reading scores in the service area, also had the lowest high school graduation rate.

Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

School Discipline

Service Area 7 had an overall suspension rate of 3.5%, which was similar to the countywide rate of 3.7%. The Bellflower (7.7%) and Norwalk (5.4%) areas had the highest suspension rates for the service area. Overall, the service area had an expulsion rate of 0.2%, with the Montebello area (0.7%) having the highest rate, followed by the Downey area (0.6%).

Juvenile Felony Arrests (Countywide Summary Only)

Of the 23,787 youths arrested on felony charges during the reporting period, 84.2% were males, 15.8%, females. Ethnically, Hispanic youths were involved in the majority of felony arrests (57.2%), followed by Black/African-American youths (30.3%) and Whites (9.1%). All other ethnicities combined accounted for less than 4% of the juvenile felony arrests.

Youths on Probation

Camp Population

Service Area 7 had 244 youths who were sent to camp; of these, 86.8% were Hispanic, followed by Whites (6.4%) and African-Americans (5.9%). The Bell Gardens-Bell-Maywood-Cudahy-Commerce area had the greatest number of youths sent to camp (35), followed closely by the East LA area (33) and the Montebello area (33).

Supervised Youths

Service Area 7 had 2,726 youths under supervision. Hispanic youths were a large majority of these individuals (84.1%), followed distantly by Whites (7.0%) and African-Americans (6.8%). Although the aggregate community of Bell Gardens-Bell-Maywood-Cudahy-Commerce had the largest number of probationers, virtually all of the service area communities, save the Signal Hill area, had at least two hundred youths under supervision.

Key Indicators of Stigma and Discrimination

Language Capacity of Mental Health Providers

In Service Area 7, where Spanish speakers were a majority of the population, all language groups with the exception of Chinese speakers (2) had higher staffing ratios than those found for Spanish speakers (7). Four communities with sizeable Spanish-speaking populations had fewer than five Spanish-speaking therapists/10,000: the Montebello area (0), the Bell Gardens-Bell-Maywood-Cudahy-Commerce area (2), the Huntington Park area (4), and the South Gate area (1).

Key Indicators of Suicide Risk

Deaths by Suicide

Service Area 7 had an overall suicide rate of 6.5, which was a bit below the countywide rate of 7.0. countywide trends seen in other service areas were also in evidence here. Individuals most at risk for suicide were Males, Whites, and Older Adults across their respective demographic categories. (though the rates for TAY and Adults were fairly close to the Older Adult rate.) The suicide rate was particularly high for Whites in the Montebello area (56.3), followed by the La Mirada-Santa Fe Springs area (33.7), the Downey area (27.3), and the Whittier area (26.9).

Mental Health Emergency Statistics

Service Area 7 had a MHE-Rate that reached 6.9 and was above the countywide rate of 5.9 by a full call. No one community reached the 1,000 call mark, but there were many communities that had several hundred calls placed. The Norwalk area (7.9), Bellflower area (6.7), and the Whittier area (6.7) had the highest MHE-Rates in the service area.

PUMA REFERENCE MAP
DEMOGRAPHIC PROFILE
KEY INDICATORS SUMMARY

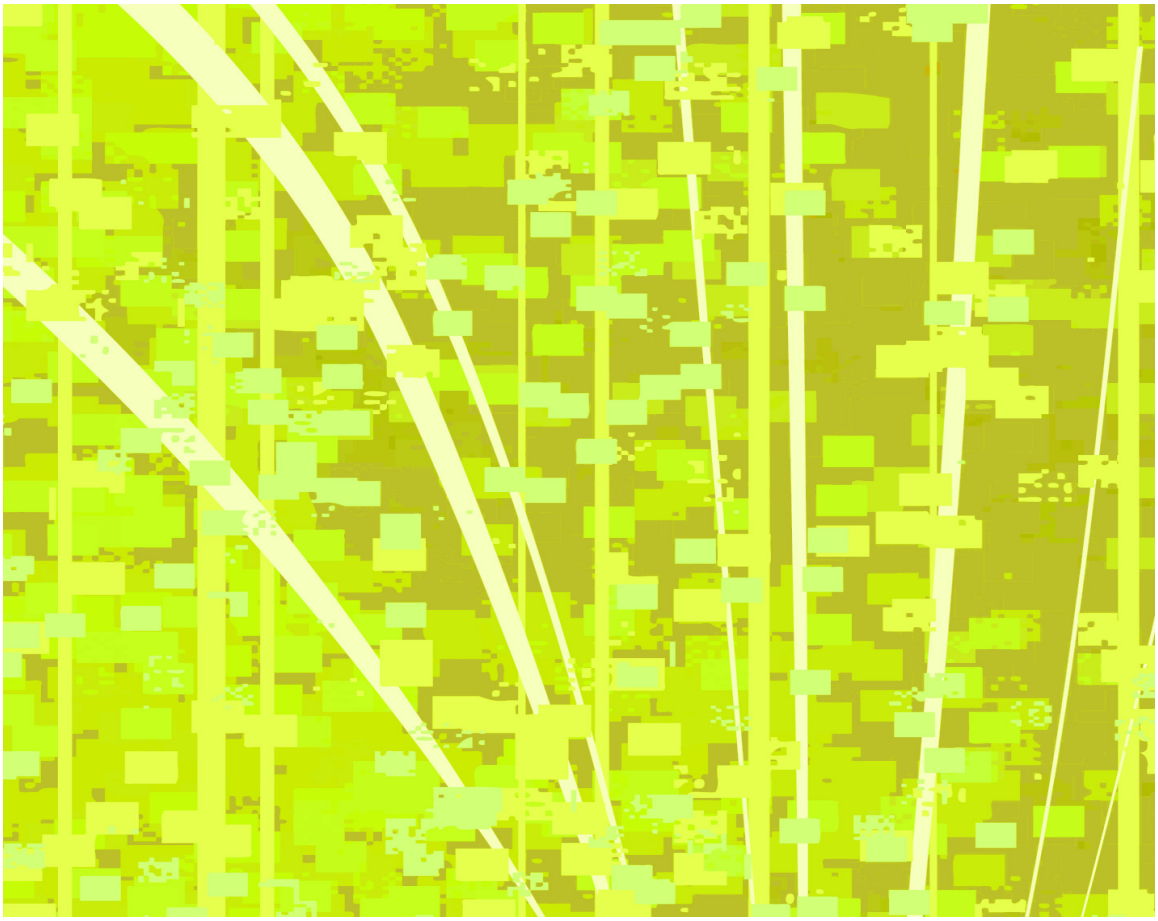
8

SERVICE AREA

VULNERABLE COMMUNITIES IN LOS ANGELES COUNTY
PREVENTION AND EARLY INTERVENTION

SERVICE AREA EXECUTIVE SUMMARY

South Bay



Service Area 8: South Bay

Communities

Hancock S.
Wilmington
Inglewood
Torrance
Long Beach N.
Long Beach S.
Long Beach E.
Carson
Palos Verdes-Lomita
Redondo-Manhattan-Hermosa-El Segundo
Gardena-Lawndale
Hawthorne

ZIP Codes

90310	90504	90510	90733	90748	90806	90822	90842
90313	90505	90704	90734	90749	90807	90831	90844
90398	90506	90710	90744	90801	90808	90832	90845
90501	90507	90717	90745	90802	90810	90833	90846
90502	90508	90731	90746	90803	90813	90834	90847
90503	90509	90732	90747	90804	90814	90835	90848
				90805	90815	90840	90853

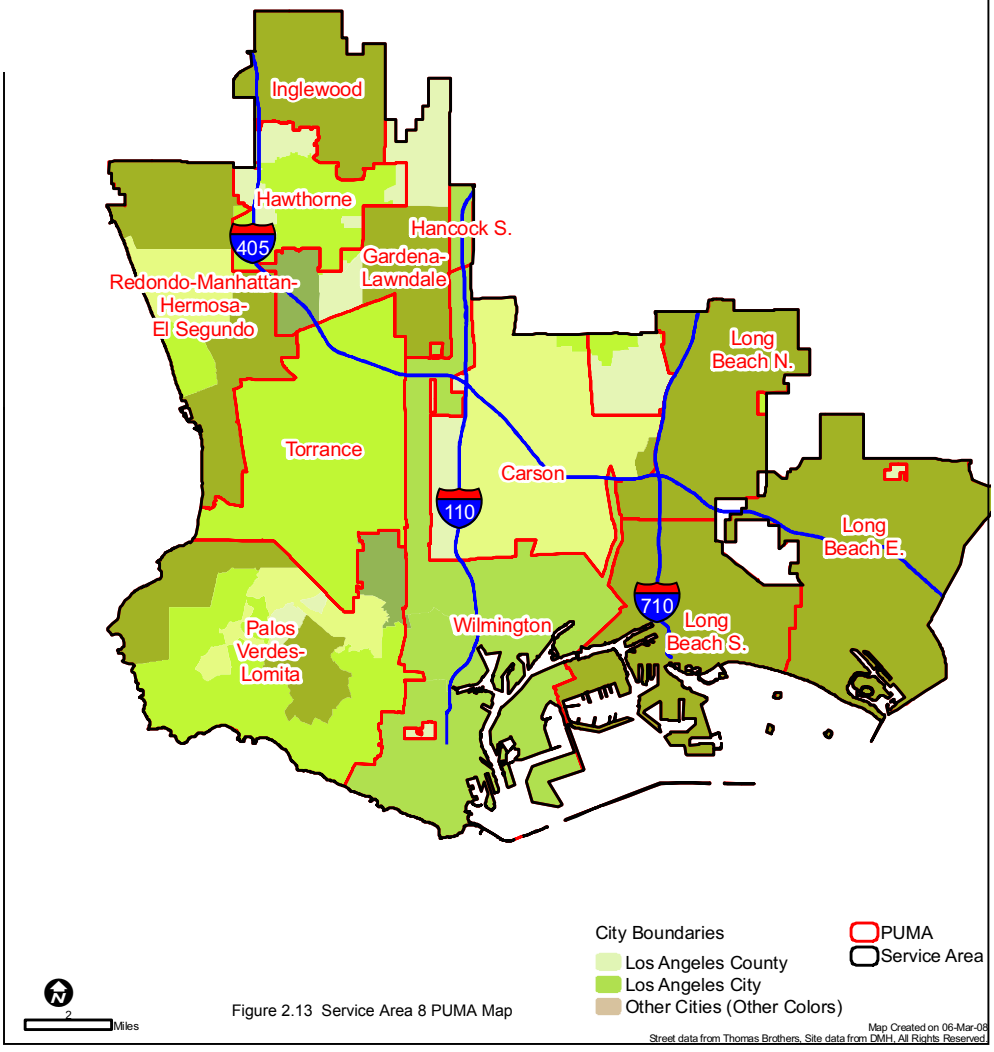


Figure 2.13 Service Area 8 PUMA Map

Demographic Profile

Ethnic Diversity: Distinct Ethnic Neighborhoods

Service Area 8 (SA8) is comprised of 11 communities in and around the South Bay area of the county. There is no overall ethnic majority group in SA8. The largest group is Latino (36%), followed by Western European White (29%), African-American (15%), and Asian (14%). Russian, Armenian, Iranian, Other Middle Eastern, South Asian, American Indian, Pacific Islander, and Multi-ethnic individuals are other ancestry groups in the service area and number over 1,000 individuals. Examining the communities comprising the service area reveals that Latinos are the majority group in Wilmington, Inglewood, and Hawthorne. Western European Whites are the majority group in Long Beach E. and the beach community composite of Redondo-Manhattan-Hermosa-El Segundo.

English and Spanish are the two main languages spoken at home throughout the service area. The communities of Long Beach E. (76.2%), Redondo-Manhattan-Hermosa-El Segundo (74.0%), and Palos Verdes-Lomita (62.7%) have the highest rates of English speakers. The communities of Hawthorne (46.8%), Inglewood (45.6%), and Long Beach S. (41.2%) have the highest rates of Spanish speakers. Other language groups are in evidence throughout the service area in small numbers. The most prominent of these are Cambodian speakers, who comprise 7.1% of the Long Beach S. population; Korean speakers, who comprise 7.0% of the population in Torrance; and Tagalog speakers, who comprise 14.2% of the Carson population.

Age Distribution: Similar to County Averages

Age groupings across the service area are similar to the countywide average statistics. Children 0-15 years accounted for 25.3% of the population, which is equal to the county average of 25.1%. Transition-age Youths (16-25 years) accounted for 12.7%; countywide, this number was 13.8%. The adult population (48.3%) was slightly higher than the overall

county proportion of 47.6%. The proportion of older adults (13.7%) was very close to the county figure of 13.5%. The communities of Hancock S., Inglewood, Long Beach S., and Hawthorne contained more individuals under the age of 26 than other parts of the service area. Two communities, Long Beach E. (18.8%) and Torrance (20.1%) ,were home to the largest proportion of older adults in the service area.

Economic Diversity:

Average Incomes, Low Home Ownership

The median household income for the service area, $50,960, was a bit higher than the county median of $48,282. Similarly, the service area communities' mean incomes were also elevated over the county mean. It is important to consider both median and mean statistics when examining incomes. The median or mid-point gives a better indication of the typical level of income reported by individuals within the service area. The mean or arithmetic average, however, is a better statistic to compare different geographical areas, such as between and across service areas. Mean household incomes in the service area ranged from $37,900 in the Hancock S. area to $119,174 in the Redondo-Manhattan-Hermosa-El Segundo area. As in other parts of the county, there are marked disparities in wealth throughout the service area. Home ownership of 30.0% was below the county average of 48.9%. The Redondo-Manhattan-Hermosa-El Segundo area had the highest home ownership rate in the service area (57.5%), while the Hancock S. (13.0%) and Hawthorne (13.7%) areas had the lowest rates.

In terms of household size, the Inglewood (median = 3.7) and Torrance (median = 3.7) areas had households that tended to be larger than other parts of the service area.

Memory and Educational Attainment

In terms of memory problems as measured by the ACS, 4.6% of individuals in Service Area 8 reported memory problems, identical to the countywide average. The Redondo-Manhattan-Hermosa-El Segundo area had the lowest rates of memory problems reported at 2.6%, while the Carson (6.5%) and Long Beach N. (5.6%) communities reported the highest levels of memory problems. Educationally, Service Area 8 had a college graduation rate of 30% (in adults 25+), exceeding the countywide average of 27.8%. The community of Redondo-Manhattan-Hermosa-El Segundo had the highest number of college graduates in the service area (57.5%), while the Hancock S. (13.0%) and Hawthorne (13.7%) communities had the fewest college graduates.

Key Indicators: Summary and Excerpts

Underserved Cultural Populations

Ethnicity

No one ethnic group has a majority in the South Bay area. Hispanics are the most numerous, but no Hispanic community is relatively densely-clustered. Five of the largest African-American communities in the county are found within the service area (the Inglewood, Long Beach N., Long Beach S., Carson, Gardena-Lawndale, and Hawthorne areas); four of the largest communities with multi-ethnic individuals are there (the Wilmington, Long Beach N., Long Beach S., and Redondo-Manhattan-Hermosa-El Segundo areas); and three of the largest Western European White (the Torrance, Long Beach E., and Redondo-Manhattan-Hermosa-El Segundo areas) and Pacific Islander (the Wilmington, Long Beach N., and Carson areas) communities are there. Asians are most numerous in the Torrance and Long Beach N. communities.

Primary Language

No Primary Language constituted a majority in the South Bay, though primary English speakers account for close to 50% of the population. Primary Spanish speakers are the next most numerous, followed by primary Tagalog speakers (2.7%), Korean speakers (1.5%), and Cambodian speakers (1.2%). By far, though, primary English or Spanish speakers account for the bulk of the population throughout the service area. Drilling down tells us more about the Asian language-speaking populations in the South Bay. Examining the composite communities indicates that primary Cambodian speakers reside in the Long Beach N. and Long Beach S. areas. 62.3% of all Cambodian speakers in the county reside in the South Bay area. Two other Asian language groups have relatively large heritage language speakers: Korean (7%) in the Torrance area and Tagalog (14.2%) in the Carson area. Additionally, the Korean and Tagalog-speaking populations have scattered clusters of individuals in significant numbers in about 8-9 composite communities.

Linguistic Isolation

The South Bay area had a Linguistic Isolation score of 5.7%, which was below the county figure of 7.8%. Two of the county's least-isolated communities were found here: Long Beach E. (0.4%) and the beach aggregate of Redondo-Manhattan-Hermosa-El Segundo (0.5%). Both of these communities were among the largest primary English-speaking communities in the county. Two communities within the service area did have Linguistic Isolation levels around 10%: the Gardena-Lawndale area (9.5%) and the Long Beach S. area (10.9%). It was not clear whether one or more language groups contribute to these figures, as both areas are ethnically diverse. The Gardena-Lawndale area, for instance, has a large primary Spanish-speaking population, but also sizeable numbers of Korean and Vietnamese-speaking individuals. The

Long Beach S. area also has a large primary Spanish-speaking population and the largest primary Cambodian-speaking population in the county. A more in-depth analysis would need to be conducted in order to determine the exact languages that are being spoken within these isolated households.

Individuals Experiencing Onset of Serious Psychiatric Illness

Serious Mental Illness Penetration Rate

The overall Penetration Rate for Service Area 8 was 0.24, lower than the county rate of 0.34. This suggested that county mental health services may have less of a reach into the SMI population in this area than elsewhere in the county. Across ethnicities, Asians (0.10) were the least served by county mental health services. Following this, in order of Penetration Rates, were the Latino population and the White population, both 0.18, the Native American population (0.31), and the African-American population (0.47).

Depressive Disorders

Age Groups

Service Area 8 accounted for 15.2% of depressed clients served in the county. A majority of the depressed clients in the service area were from the adult (26-59) group (53.1%). Seven communities treated a majority of adults clients for depressive disorders: the Hancock S., Wilmington, Long Beach S., Carson, Redondo-Manhattan-Hermosa-El Segundo, Gardena-Lawndale, and Hawthorne areas. Four communities treated a majority of child (0-15) clients: the Torrance, Long Beach N., Long Beach E., and Palos Verdes-Lomita areas. Across the service area, the Carson area treated the largest proportion of depressed clients in the service area (30.9%). The Long Beach S. area treated 25.6%.

Ethnicity

No one ethnic group constituted a majority of depressed clients served in Service Area 8. Across all ethnicities, Latinos made up the largest proportion of clients, 33.4%, followed by African-Americans clients, 23.9%, White clients, 20.9%, and Asian clients, 9.3%. Native American and Pacific Islander clients each accounted for less than 1% of all depressed clients served in the service area. Drilling down into the composite communities indicated that that four areas treated a majority of Latino clients: the Torrance, Long Beach N., Long Beach E., and Palos Verdes-Lomita areas. One community, the Redondo-Manhattan-Hermosa-El Segundo area, treated a majority of White clients. Another community, the Hancock S. area, treated a majority of African-American clients. And finally, another community, the Gardena-Lawndale area, treated a majority of Asian clients.

Co-occurring Disorders (COD)

Age Groups

Service Area 8 clients accounted for 14.8% of individuals with COD treated in the county's mental health system. As in other parts of the county, adults (26-59) were a large majority of clients with COD (67.9%) treated in the service area. Eight communities saw an adult majority of its clients with CODs: the Hancock S., Wilmington, Inglewood, Long Beach S., Carson, Redondo-Manhattan-Hermosa-El Segundo, Gardena-Lawndale, and Hawthorne areas. In one community, the Long

Beach N. area, children (0-15) were a majority of COD cases treated there (55.8%). It should be noted, though, that this particular area accounted for only 3.4% of the total COD population in the service area. Similarly, the Long Beach E. and Palos Verdes-Lomita areas saw a majority of COD cases from the TAY (16-25) population, but, again, the total COD population figures for these to communities accounted for a combined total of 2.0% of the service area cases. Most COD cases were seen in the Carson area (34.2%), followed by the Long Beach S. area (26.4%), the Hawthorne area (13.1%), and the Wilmington area (11.3%).

Ethnicity

White clients accounted for 33.2% of the COD population treated in Service Area 8. This was followed by African-American clients (29.2%), Latino clients (26.5%), and Asian clients (3.6%). Native Americans and Pacific Islanders each accounted for less than 1% of the COD population in the service area. When compared with population estimates for these groups, African-Americans (15.6%) were overrepresented in the COD client counts; Latinos (37.3%) and Asians (15.3%) appeared to be underrepresented.

Children/Youth in Stressed Families

Poverty

Service Area 8 had an overall poverty rate of 35.5%, which was slightly below the countywide rate of 38.7%. Two communities, the Hancock S. area (57.6%) and Long Beach S. area (57.2%), had a majority of its population living beneath the 200% FPL. Across ethnic groups, 54.3% of the Hispanic population were below the 200% FPL, as were 36.2% of the African-American population, 13.5% of the White population, 28.0% of the Asian population, and 18.8% of the American Indian population. Seven communities saw over 50% of its Hispanic population below the 200% FPL: the Hancock S. area (70.1%), the Wilmington area (53.6%), the Inglewood area (58.8%), the Torrance area (56.5%), the Long Beach N. area (56.5%), the Long Beach S. area (66.8%), the Gardena-Lawndale area (60.5%), and the Hawthorne area (62.9%). 52.4% of African-Americans in the Long Beach S. community were below the 200% FPL. Over 50% of Asians in the Hancock S. area (53.3%) and Long Beach S. area (53.9%) were below the 200% FPL. And two Pacific Islander communities had poverty rates exceeding 50%: Hancock S. (91.1%) and Long Beach N. (63.6%). When looking over these figures, please note that the relative numbers of some populations may be quite low, (e.g., American Indians living in poverty account for 0.1% of the population).

Unemployment Rate

Service Area 8 had an overall self-reported unemployment rate of 6.5%, which was below the countywide average of 7.4%. Only one community exceeded a self-reported unemployment rate of 10%: the Hancock S. area (10.3%); however, the Long Beach S. area at 9.6% nearly reached this benchmark, as well. The Palos Verdes-Lomita area (2.1%) had the lowest unemployment rate in the service area and the county (the Signal Hill area in Service Area 7 also had an unemployment rate of 2.1%).

Disrupted Families

Service Area 8 had an overall DF ratio of 2.5, which was slightly higher than the countywide ratio of 2.2. Only one community, the Inglewood area (1.5), had a DF ratio below 2.0. On the other end of the spectrum, there were two communities with DF ratios above 5.0: the Palos Verdes-Lomita area (5.1) and the Torrance area (5.8). The Torrance area had the highest DF ratio in the county with nearly a 6:1 ratio of intact families to single-parent families.

Safe Place to Play (Countywide Summary Only)

Age Groups

Across the three age groups reported, there appeared to be a trend in parent-report. Parents were more likely to report that a safe place to play was less available for older children than for younger ones

Ethnicity

There did not appear to be any significant difference between parent reports across ethnicities.

Trauma-exposed Individuals

Child Abuse

Child Abuse and Neglect Base Rates

Service Area 8 had an overall CAN Rate of 0.98, which was close to the countywide Rate of 0.96. 19.5% of the SCAN reports in the area were substantiated by DCFS. Within the service area, two communities had very high CAN Rates that were greater than 84% of the county communities, (i.e., PUMAs): the Hancock S. area (1.62) and the Long Beach S. area (1.62).

Triage Response Acuity

Service Area 8 had an Acuity score of 0.14, which was close to the countywide score of 0.15. About half of the communities in the service area had Acuity scores above this figure: the Hancock S. area (0.20), the Wilmington area (0.16), the Long Beach N. area (0.19), the Gardena-Lawndale area (0.18), the Hawthorne area (0.16), and the Long Beach S. area (0.22), which had the highest Acuity score in the service area.

Ethnicity

Across Service Area 8, 88.4% of SCAN Reports involved three ethnic groups: African-American, White, and Hispanic. Overall, African-American children accounted for 28.6% of SCAN Reports, White children, 14.7%, and Hispanic children, 45.1%. Only three other ethnic groups accounted for more than 1% of the victimized children in the area: Mexican, 2.1%, Filipino, 1.1%, and Cambodian, 1.2%. White children accounted for a majority of SCAN Reports in two communities: the Long Beach E. area and the Redondo-Manhattan-Hermosa-El Segundo area. Hispanic children were a majority of victims in two communities: the Wilmington and Hawthorne areas. African-American children were nearly a majority of victims in two communities: the Inglewood area (49.7%) and the Gardena-Lawndale area (49.0%).

Elder and Dependent Adult Abuse

Service Area 8 had an overall APS Rate[1] score of 2.7, which was slightly above the countywide rate of 2.6. Within the service area, a few communities had relatively high APS rates. For example, the Long Beach S. area (3.9) had the highest rate seen within the

service area, followed by the Long Beach N. area (3.2) and the Hancock S. area (3.2).

Posttraumatic Stress Disorder (PTSD)

Age Groups

Service Area 8 accounted for 17.7% of the county's PTSD, second only to Service Area 4. Children (0-15) accounted for the largest proportion of PTSD cases in the service area, 46. 3%, followed by Adult (26-59) cases, 36.1%, TAY (16-25), 13.4%, and Older Adults (60+), 4.2%. Nine of the composite communities saw a majority of Child cases (the Hancock S., Wilmington, Inglewood, Torrance, Long Beach N., Long Beach E., Carson, Palos Verdes-Lomita, Redondo-Manhattan-Hermosa-El Segundo, areas). And two communities, the Long Beach S. and Gardena-Lawndale areas, saw a majority of Adult cases. Across the service area, the Long Beach N. area saw the greatest proportion of cases, 26.2% followed by the Long Beach S. area, 21.7% and the Carson area, 19.4%.

Ethnicity

No ethnic group constituted a majority of PTSD cases in Service Area 8., though, Latino clients accounted for the largest proportion of PTSD cases, 36.4%. This was followed by African-American clients (25.7%), Asian clients (15.5%), and White clients (10.8%). Native Americans and Pacific Islanders each accounted for less than 1% of the PTSD population in the service area. When compared with population estimates for these groups, African-Americans (15.6%) were over represented in the PTSD client counts; Latinos (37.3%) and Asians (15.3%) had client counts consistent with their population; White clients were under represented in the PTSD population.

Homelessness

Age Groups

In Service Area 8, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (63.2%) of the homeless population. This was followed by the Under 18 Age Group at 16.0%, the 56+ Age Group at 12.6%, and the 18-24 Age Group at 8.2%.

Ethnicity

Within Service Area 8, Black/African-Americans accounted for a majority of the homeless population (56.2%). Hispanic or Latinos accounted for 16.7%; Whites, 20.5%; and Multi-Racial or Others accounted for 6.6% of the homeless population.

Sub-populations

In Service Area 8, 18.5% of the homeless population reported that they had a mental illness; 34.3% of homeless individuals reported they were substance abusers; and 5.4% reported they were victims of domestic violence.

Children/Youth at Risk for School Failure

4-year Dropout Rate
(Countywide Summary Only)

State figures indicated that over a quarter of all students in Los Angeles County drop out of high school over a four-year period. Examining ethnic categories indicated that African-American students were most at risk for not finishing high school, followed by Pacific Islander, American Indian/Alaska Native, and Hispanic or Latino Students. 15.5% of White students drop out of high school. Two ethnic groups had dropout rates below this: Asian, 7.4%, and Filipino, 12.8%.

High School Graduation Rates

Service Area 8 had an overall graduation rate of 77.9%, which was close to the countywide rate of 77%. Only one ethnic group held a graduation rate that was below 70%: African-American students at 65.4%. Within the service area, the highest risk areas appeared to be the Long Beach N. area (55.3%) and the Gardena-Lawndale area (56.7%). In both of these communities, four of ten students do not graduate. In the Long Beach N. area, White and Hispanic students had graduation rates that were close to 50%, or one out of two students. The American Indian or Alaskan Native graduation rate was very low in the area, but must be interpreted with caution as the numbers of those students was relatively small. In the Gardena-Lawndale area, Hispanic, African-American, and White students all had low graduation rates between 50-60%.

English Fluency

Service Area 8 had an English Fluency rate of 75.8% which was above the countywide rate, 68.3%. The Hancock area (54.8%) and the Hawthorne area (56.1%) had the two lowest English Fluency rates in the service area. The Hawthorne and Hancock S. areas had graduation rates on the lower end in the service area, but were not the most extreme in this regard.

3rd Grade Reading Level

Overall, 35.2% of third graders in Service Area 8 scored at or above the 50th percentile in standardized reading tests, which was above the countywide rate of 22.4%. The Hancock S. area (14.7%) had the lowest reading scores and the lowest English Fluency rates in the service area (but not the lowest high school graduation rate).

Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

School Discipline

Service Area 8 had an overall suspension rate of 3.4%, which was a bit below the countywide rate of 3.7%. The Gardena-Lawndale (8.4%) area had the highest suspension rate, followed by the Hawthorne area (6.6%) and the Carson area (5.7%). The Hawthorne area (0.3%) had the highest expulsion rate in the service area followed by the Gardena-Lawndale area (0.2%) and the Torrance area (0.2%).

Juvenile Felony Arrests (Countywide Summary Only)

Of the 23,787 youths arrested on felony charges during the reporting period, 84.2% were males, 15.8%, females. Ethnically, Hispanic youths were involved in the majority of felony arrests (57.2%) followed by Black/African-American youths (30.3%) and Whites (9.1%). All other ethnicities combined accounted for less than 4% of the juvenile felony arrests.

Youths on Probation

Camp Population

Service Area 8 had the second-highest count of youth consigned to camp: 340. Three communities accounted for 57% of this total: about 21% of these youths came from the Long Beach S. area, 19% from the Hawthorne area, and 17% from the Gardena-Lawndale area. No ethnic group formed a majority of probationers: Hispanic youths (45%), African-American youths (44.2%), and White youths (7%).

Supervised Youths

Service Area 8 had 3,180 youths under supervision, second only to Service Area 6. Within

the service area, the Long Beach S. area had the largest number of youth under supervision: 891 (highest total in the county). Three other communities saw over 300 youths under supervision: the Long Beach N. area (522), the Wilmington area (398), and the Gardena-Lawndale area (347). Ethnically, Hispanic youths accounted for 45.4% of the probationers under supervision, followed by African-Americans, 36.6%, and Whites, 9.5%.

Key Indicators of Stigma and Discrimination

Language Capacity of Mental Health Providers

Across the service area, English speakers had a staffing ratio of 32. Only Russian speakers (41), Mandarin speakers (154), and Cantonese speakers (57) had more language-capable therapist resources available to them than for English speakers; all other language groups had fewer. Of these, Arabic speakers, who numbered over 1,000 individuals, had the lowest staffing ratio (5), followed by Tagalog (6) and Farsi speakers (8).

Key Indicators of Suicide Risk

Deaths by Suicide

Service Area 8 had an overall suicide rate of 7.3, which was about the countywide average. As in the other service areas, the South Bay saw similar trends in high-risk populations: Males, Whites, Adults, and Older Adults. Whites had the highest rates of suicide within the Carson area (63.6), Hawthorne area (37.1), Long Beach S. area (30.9), and the Gardena-Lawndale area (28.2). The Adult and Older Adult population had high suicide rates five service area communities. Of these, the Long Beach E. area (14.3) had the highest community rate followed by the Redondo-Manhattan-Hermosa-El Segundo area (12.1) and the Carson area (11.6). The highest rate seen for Older Adults occurred in the Hawthorne area (45.2). And the highest rate seen for the TAY population occurred in the Redondo-Manhattan-Hermosa-El Segundo area (35.3).

Mental Health Emergency Statistics

Service Area 8 had an overall MHE-Rate of 7.4, above the countywide rate of 5.9. Two communities were notable for their high call volumes and correspondingly high MHE-Rates: the Wilmington area had a call volume of 1,433 and a MHE-Rate of 8.2; the Long Beach S. area had a call volume of 1,787 (the highest count in the county) and a MHE-Rate of 9.2.

Part III

Key Indicators of Mental Health

Underserved Cultural Populations

Individuals Experiencing Onset of Serious Psychiatric Illness

Children/Youth in Stressed Families

Trauma-exposed

Children/Youth at Risk for School Failure

Children/Youth at Risk of or Experiencing Juvenile Justice

Stigma and Discrimination

Suicide Risk

Table 3.0
Ethnicity Across Los Angeles County (Percent of Population)

Service Area	Hispanic	Western European White	Asian	Black/African American	Two or more major races	Armenian	Russian	Other Middle Eastern	South Asian	Iranian	Other Race	American Indian, Alaska Native	Pacific Islander	Total[1]
Within Service Areas														
1	41.1	39.0	4.1	12.8	3.1	0.3	0.4	0.8	0.2	0.2	0.3	0.3	0.5	103.1
2	38.4	35.4	8.6	3.9	2.3	5.6	2.6	1.6	1.4	1.8	0.4	0.3	0.1	102.3
3	45.0	23.3	23.7	4.6	2.3	0.6	0.4	0.8	0.7	0.3	0.4	0.1	0.1	102.3
4	54.1	17.3	16.8	5.1	2.0	1.2	1.6	0.9	1.1	0.7	0.6	0.3	0.2	102.0
5	14.4	53.1	11.4	8.1	2.7	0.3	5.3	2.3	1.5	3.1	0.4	0.1	0.1	102.7
6	65.9	2.8	1.6	28.2	0.8	0.0	0.2	0.1	0.2	0.1	0.6	0.1	0.1	100.8
7	70.9	14.8	9.1	2.9	1.8	0.2	0.2	0.5	0.9	0.0	0.1	0.1	0.1	101.8
8	37.3	29.3	14.4	15.6	3.5	0.2	0.6	0.4	0.9	0.2	0.3	0.2	0.6	103.5
Total	47.0	25.2	12.5	8.9	2.3	1.7	1.3	0.9	0.9	0.8	0.4	0.2	0.2	102.3
Between Service Areas[2]														
1	3.2	5.7	1.2	5.3	4.9	0.7	1.3	3.2	0.6	0.8	2.5	5.3	8.6	3.7
2	17.2	29.6	14.5	9.2	21.7	77.9	42.9	37.9	31.7	50.0	20.9	29.4	8.9	21.1
3	17.0	16.4	33.6	9.2	17.9	6.6	5.3	15.7	14.0	6.2	18.4	12.9	8.9	17.7
4	13.4	8.0	15.7	6.7	10.0	9.4	14.3	11.8	13.2	11.3	18.3	17.9	12.7	11.6
5	1.9	12.9	5.6	5.6	7.1	1.2	25.5	15.6	9.4	25.2	5.8	3.2	3.5	6.1
6	14.3	1.1	1.3	32.2	3.6	0.0	1.3	1.6	2.5	1.7	16.2	5.7	6.6	10.2
7	20.5	8.0	9.9	4.4	10.7	2.0	2.5	7.2	13.5	0.4	4.5	8.3	8.5	13.6
8	12.5	18.3	18.2	27.5	24.2	2.1	7.0	7.1	15.2	4.4	13.4	17.3	42.2	15.8
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100

1.Totals may exceed 100% due to the multi-ethnic category being counted twice.
2.Cells are color coded to identify the smallest and largest ethnic populations in the County

Low
High

Figure 3.1 (opposing page)

The series of population maps depict the ethnic composition and transformation of Los Angeles County during a 60-year period. Data tracking for Asian and American Indian populations has been available since the 1980 Census. Over time, the county has become more densely populated in all areas and more ethnically diverse. Most change appears to have occurred in the South and Southeast parts of the county where Whites have left and other ethnicities have settled in great numbers.

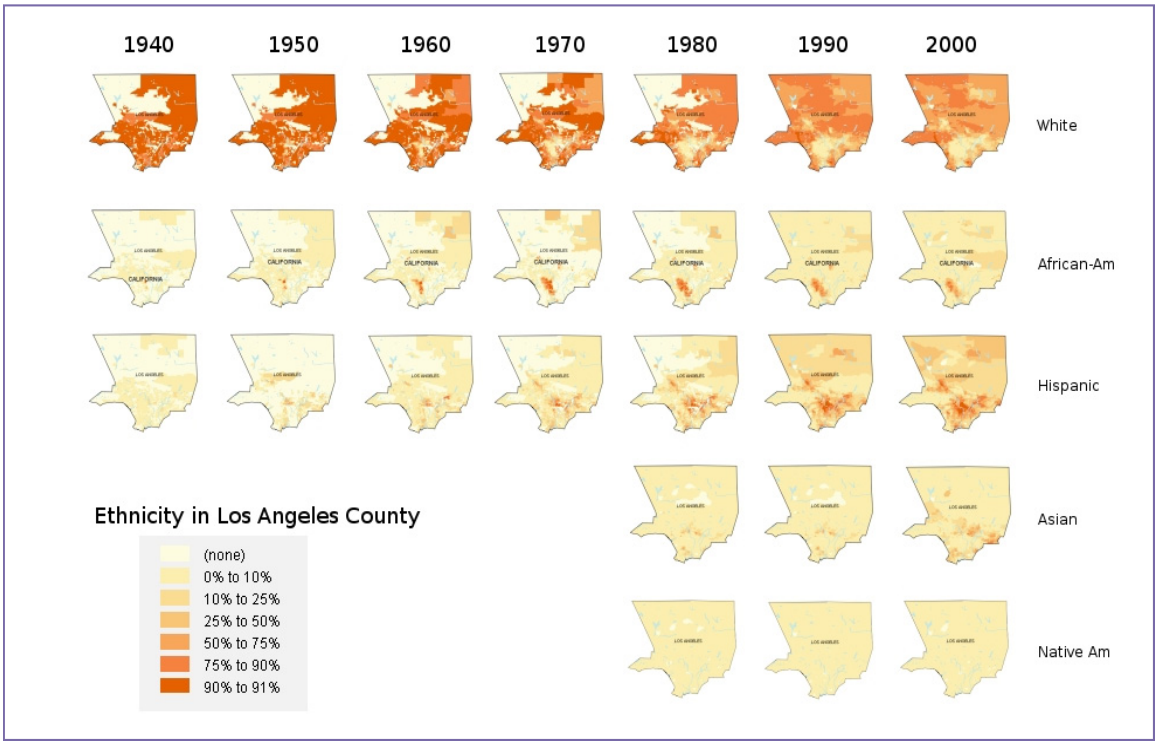


Figure 3.1 Ethnicity in Los Angeles County over Time

INDICATORS FOR UNDERSERVED CULTURAL POPULATIONS

Ethnicity

Description of Indicator

The Ethnicity indicator counts the number of individuals residing within a given area who have identified themselves as belonging to a particular ethnic group. Ethnic groups were defined by the ACS 2005 and include a breakdown of Eastern European, Middle Eastern, and Asian/Pacific Islander groups.

Research Base and Relevance to PEI

Ethnicity is the single most important indicator in terms of mental health disparities in the research literature. Numerous studies have shown that ethnic minorities and, in particular, African-Americans, Latinos, Asian/Pacific Islanders, and American Indians, encounter more barriers in accessing mental health services than Whites. The Surgeon General's 2001 Mental Health: Culture, Race, and Ethnicity (supplement) reported the following:

- Minorities have less access to, and availability of, mental health services.
- Minorities are less likely to receive needed mental health services.
- Minorities in treatment often receive poorer quality of mental health care.
- Minorities are underrepresented in mental health research.

Since then, research has supported these findings fairly consistently. Other research

using the Institute of Medicine's definition of disparities indicated that between 2001 and 2004, racial disparities in mental health care actually increased (Cook, McGuire, & Miranda, 2007).

What the Numbers Show

Los Angeles County has a diverse ethnic population representing nationalities and ethnic groups from all over the world. With space and reporting constraints in place, only 13 ethnic categories are reported above. The Hispanic population is the largest ethnic group residing in the county and makes up 47.0% of residents, or almost one-half of the population. Following this, Western European Whites are the second most populous ethnic group and account for 25.2 percent of the population. Asians are the third most populous group at 12.5%, and African-Americans make up 8.9% of the county population. No other ethnic group accounts for more than 3% of the population. Even so, there are sizeable numbers of Armenians, Russians, South Asians, Iranians, multi-ethnic individuals, and other Middle Easterners throughout the county.

From the countywide summary Table 3.0 above, it is possible to see where the composite ethnic groups are dispersed across service areas. Low and high numbers of individuals are denoted by light green and blue highlighting for each ethnic group. Hispanics, for example, are most populous within Service Area 7 and most sparsely located in Service Area 5. Western European Whites are most populous within the San Fernando Valley and least populous within Service Area 6. Additionally, the countywide summary table tells us that the San Gabriel Valley has the largest percentage of Asians across the County at 33.6%; whereas, Asians are relatively few in number in the Antelope Valley, 1.2%. African-Americans are most populous in the South and South Bay areas with the remaining individuals somewhat evenly dispersed across the county. 32.2% of all African-Americans in the county live within Service Area 6. Individuals with multi-ethnic backgrounds and Pacific Islanders have their largest numbers living within the South Bay area.

Since the US Census 2000, when individuals gained the opportunity to be counted as having "Two or more major races," the nation has seen a rising trend in the numbers of individuals within this category. Multi-ethnic individuals now are more numerous in the county than Armenians, Russians, South Asians, Iranians, and American Indians/ Alaskan Natives. Research on the mental health problems of multi-ethnic individuals within clinic populations indicates that the severity of their behavior problems may exceed those with a mono-ethnic identity (Choi, Harachi, Gillmore, Catalano, 2006; Shih & Sanchez, 2005).

In order to see where ethnic groups have settled within a given service area, the service area communities tables highlight the ten or eleven largest communities where you may find sizeable numbers of a particular group. The figure next to the population count is the relative percentage of the particular ethnic group across a given community. The American Indian/Alaskan Native community, for example, have two of their most populous communities in the Metro area – yet, collectively, they account for less than 10% of the

service area population. If you consider that social services, including mental health treatment services, have traditionally been developed for majority populations, it is important to look at areas where sizeable numbers of a particular ethnic group reside who may be isolated within the larger community. Such isolation functions as barrier toward accessing mental health services and undoubtedly fuels the disparities in care that are of most concern for the PEI planner.

Service Area Communities (Tables 3.1, 3.2)

Service Area 1: Antelope Valley

Within Service Area 1, Hispanics (41.1%) and Western European Whites (38.0%) account for nearly 80% of the total population. Hispanics are a majority in the Palmdale area while Western European Whites are more numerous in the Lancaster area and surrounding North County E. area. Additionally, the Lancaster area is home to relatively large communities of African-Americans, Multi-racial individuals, American Indians/ Alaskan Natives, and Pacific Islanders. However, in terms of actual numbers, Multi-racial individuals, Pacific Islanders and American Indians/Alaska Natives, together account for less than 5% of the service area's population. African-Americans comprise 12.5% of the population in the service area and in terms of actual numbers, the Lancaster area has one of the largest African-American populations in the county.

Service Area 2: San Fernando

As the largest service area, it is not surprising to see that several ethnic groups have large populations throughout the San Fernando Valley area. Western European Whites have the highest proportion of its population in the San Fernando Valley as do Armenians, Russians, South Asians, and American Indians/Alaskan Natives. The San Fernando Valley is home for the majority of Armenians residing in the county with 69.7% of its overall population contained within its boundaries. Nine of the ten largest Armenian communities are located within the San Fernando Valley; together they account for 5.6% of the service area's population. Similar to this, Russians, Iranians and South Asians have 42.9%, 50%, and 31.7% of their respective populations living in the San Fernando Valley area. American Indians/Alaskan Natives have close to 30% of their population living within the San Fernando Valley. It should be noted that although non-White/non-Hispanic groups are *relatively* numerous, they make up a fraction of the total population in the service area. Within the service area, a handful of communities are noteworthy in their ethnic diversity. The Glendale and Encino areas, for instance, have six different ethnic groups with relatively large numbers residing within its boundaries; the communities of Northridge, Sherman Oaks, and Woodland Hills have five.

Service Area 3: San Gabriel

Within Service Area 3, Hispanics are the most populous ethnic group and comprise 45.0% of the area's population; Asians and Western European Whites each account for 23% of the overall population. No other group has over 5% of the total service area population. Within the service area communities, Pomona and the aggregate of Baldwin Park-Azusa-Duarte, are among the largest

Table 3.1
Ethnicity Within Service Area Communities (Percent of Population)

	Hispanic	Western European White	Asian	Black/African American	Two or more major races	Armenian	Russian	Other Middle Eastern	South Asian	Iranian	Other Race	American Indian, Alaska Native	Pacific Islander	Total *
Within Service Area 1 Communities														
Lancaster	33.3	40.3	3.2	20.4	5.5	0.4	0.3	0.6	0.1	0.1	0.5	0.1	0.7	105.5
Palmdale	56.3	27.0	3.7	11.1	2.6	0.3	0.5	0.6	0.3	0.0	0.0	0.1	0.1	102.6
North County E.	27.3	57.4	6.2	4.3	0.0	0.1	0.7	1.3	0.0	0.6	0.3	0.8	1.1	100.0
Total	41.1	39.0	4.1	12.8	3.1	0.3	0.4	0.8	0.2	0.2	0.3	0.3	0.5	103.1
Within Service Area 2 Communities														
Santa Clarita	27.5	59.2	5.7	2.3	4.2	0.1	2.0	1.0	1.2	0.5	0.0	0.4	0.0	104.2
Burbank	22.2	46.2	9.2	3.0	3.9	7.9	6.1	2.3	0.4	1.6	0.3	0.7	0.2	103.9
Glendale	19.4	26.8	13.4	1.8	1.6	29.2	0.9	2.8	1.8	2.6	0.6	0.6	0.1	101.6
Northridge	24.5	41.8	17.7	2.4	2.4	2.4	2.5	1.2	5.2	1.6	0.3	0.4	0.0	102.4
Granada Hills	38.5	32.2	7.6	12.6	3.2	2.7	1.6	2.1	1.4	0.4	0.4	0.2	0.2	103.2
Pacoima-Arleta	86.8	7.2	1.8	3.4	1.4	0.0	0.2	0.0	0.0	0.0	0.6	0.1	0.0	101.4
La Tuna Cyn.	53.6	24.1	8.4	1.6	2.7	10.1	0.6	0.1	0.6	0.5	0.2	0.2	0.1	102.7
Panorama City	70.0	7.9	14.4	3.9	1.3	2.7	0.1	0.0	0.5	0.0	0.3	0.1	0.0	101.3
North Hollywood	48.1	28.6	5.6	3.0	1.1	6.5	2.4	4.8	0.3	0.1	0.3	0.3	0.0	101.1
Sherman Oaks	54.7	23.1	4.0	6.1	3.4	4.9	3.0	1.5	1.4	0.3	0.8	0.3	0.0	103.4
Encino	31.4	38.1	9.1	3.7	1.6	2.6	4.5	1.5	2.0	6.4	0.7	0.0	0.0	101.6
Woodland Hills	34.1	39.0	9.1	3.4	4.0	1.1	3.4	1.8	2.1	5.8	0.0	0.2	0.0	104.0
Brentwood N.	6.9	66.3	6.3	2.9	0.0	1.0	9.2	2.0	1.0	3.7	0.2	0.3	0.3	100.0
North County W.	27.3	57.4	6.2	4.3	5.0	0.1	0.7	1.3	0.0	0.6	0.3	0.8	1.1	105.0
La Canada-Flintridge	23.0	47.0	9.1	13.6	0.0	3.0	0.3	2.1	0.4	0.0	0.9	0.3	0.4	100.0
San Fernando-Calabasas-Agoura	28.4	58.6	2.1	1.0	0.0	0.3	5.3	1.6	0.7	1.6	0.4	0.0	0.1	100.0
Total	38.4	35.4	8.6	3.9	2.3	5.6	2.6	1.6	1.4	1.8	0.4	0.3	0.1	102.3
Within Service Area 3 Communities														
Pasadena	29.5	37.9	12.1	14.4	3.7	2.1	1.3	0.1	1.5	0.7	0.2	0.1	0.0	103.7
El Monte	64.9	7.1	26.1	1.7	1.2	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0	101.2
Pomona	70.4	10.4	10.5	7.0	3.0	0.1	0.0	0.0	1.3	0.0	0.3	0.0	0.0	103.0
West Covina	52.5	16.1	21.0	7.8	4.9	0.0	0.2	1.4	0.1	0.0	0.8	0.0	0.0	104.9
Altadena-Monrovia-Sierra Madre	23.0	47.0	9.1	13.6	2.1	3.0	0.3	2.1	0.4	0.0	0.9	0.3	0.4	102.1
Alhambra-S. Pasadena	24.9	21.5	47.5	2.4	2.8	0.2	0.3	1.3	0.2	0.3	1.2	0.1	0.0	102.8
Arcadia-San Gabriel-Temple City-San Marino	17.0	31.1	47.5	0.9	2.7	0.5	0.5	0.9	0.5	0.5	0.1	0.1	0.5	102.7
Baldwin Park-Azusa-Duarte	73.3	12.3	9.2	3.5	2.5	0.2	0.1	0.1	0.6	0.1	0.6	0.1	0.1	102.5
Glendora-Claremont-San Dimas-La Verne	26.4	57.7	6.3	2.5	2.7	0.7	0.9	3.1	1.2	0.3	0.5	0.4	0.1	102.7
Covina-Walnut	47.9	26.3	17.5	4.9	1.8	0.2	0.5	0.6	1.2	0.4	0.3	0.0	0.2	101.8
Diamond Bar	24.2	19.0	50.2	2.4	0.0	0.4	0.4	1.0	1.3	0.6	0.4	0.3	0.0	100.0
La Puente-S. El Monte	83.9	7.2	6.4	1.2	2.6	0.2	0.0	0.2	0.0	0.0	0.2	0.5	0.1	102.6
Hacienda Heights	59.2	23.0	14.9	1.1	0.0	0.2	0.6	0.0	0.2	0.0	0.2	0.4	0.1	100.0
Monterey Park-Rosemead	33.2	5.5	58.4	0.6	0.0	0.1	0.4	0.1	1.0	0.7	0.1	0.0	0.0	100.0
Other	27.3	57.4	6.2	4.3	5.0	0.1	0.7	1.3	0.0	0.6	0.3	0.8	1.1	105.0
Total	45.0	23.3	23.7	4.6	2.3	0.6	0.4	0.8	0.7	0.3	0.4	0.1	0.1	102.3

Table 3.2
Ethnicity Between Service Area Communities (Percent of Population)

	Hispanic	Western European White	Asian	Black/African American	Two or more major races	Armenian	Russian	Other Middle Eastern	South Asian	Iranian	Other Race	American Indian, Alaska Native	Pacific Islander	Total *
Between Service Area 1 Communities														
Lancaster	29.5	37.5	28.5	57.6	65.5	47.0	23.7	28.1	13.5	16.5	73.9	16.7	45.6	36
Palmdale	54.7	27.6	35.6	34.6	34.5	45.6	41.8	32.7	86.5	0.0	0.0	15.8	5.7	40
North County E.	15.8	34.9	36.0	7.9	0.0	7.4	34.5	39.2	0.0	83.5	26.1	67.5	48.7	24
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Between Service Area 2 Communities														
Santa Clarita	5.7	13.3	5.3	4.8	14.4	0.2	6.1	5.0	6.8	2.1	0.9	11.8	0.0	8
Burbank	2.7	6.2	5.1	3.7	7.9	6.7	11.3	6.8	1.2	4.4	4.0	10.9	7.9	5
Glendale	4.7	7.1	14.6	4.3	6.3	49.0	3.2	16.2	11.9	13.8	13.8	19.4	12.8	9
Northridge	5.2	9.6	16.8	5.0	8.4	3.6	7.9	5.9	30.1	7.4	6.2	11.0	0.0	8
Granada Hills	6.6	6.0	5.8	21.3	8.9	3.2	4.0	8.4	6.7	1.6	7.5	5.2	14.6	7
Pacoima-Arleta	12.9	1.2	1.2	4.9	3.5	0.0	0.4	0.0	0.0	0.0	9.2	1.6	0.0	6
La Tuna Cyn.	8.9	4.4	6.3	2.6	7.3	11.6	1.4	0.4	2.9	1.7	2.8	3.6	4.5	6
Panorama City	12.9	1.6	11.9	7.1	3.8	3.4	0.3	0.2	2.7	0.0	5.3	2.7	0.0	7
North Hollywood	8.2	5.3	4.3	5.1	3.1	7.6	6.3	19.4	1.4	0.4	4.6	7.3	0.0	7
Sherman Oaks	11.3	5.2	3.7	12.3	11.5	7.0	9.4	7.2	7.8	1.3	15.7	7.1	0.0	8
Encino	6.6	8.7	8.5	7.6	5.5	3.8	14.2	7.4	11.6	28.8	15.0	0.0	0.0	8
Woodland Hills	6.8	8.4	8.1	6.6	12.9	1.6	10.2	8.5	11.2	24.8	0.9	4.8	0.0	8
Brentwood N.	0.8	7.9	3.1	3.1	0.0	0.8	15.1	5.3	3.0	8.7	2.2	3.7	12.6	4
North County W.	2.2	4.9	2.2	3.3	6.4	0.1	0.8	2.4	0.0	1.0	2.3	8.9	34.5	3
La Canada-Flintridge	1.2	2.6	2.1	6.9	0.0	1.1	0.2	2.5	0.5	0.0	4.6	2.0	8.4	2
San Fernando-Calabasas-Agoura	3.4	7.6	1.1	1.2	0.0	0.3	9.4	4.4	2.1	4.1	5.0	0.0	4.7	5
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Between Service Area 3 Communities														
Pasadena	4.9	12.1	3.8	23.2	12.1	28.4	25.2	1.1	15.3	19.9	3.8	3.5	0.0	7.5
El Monte	9.3	2.0	7.1	2.4	3.5	0.0	0.0	0.0	0.9	0.0	1.0	0.0	0.0	6.4
Pomona	14.4	4.1	4.1	13.8	11.8	1.3	1.0	0.0	16.8	0.0	6.2	0.0	4.0	9.2
West Covina	7.8	4.6	5.9	11.2	14.3	0.0	3.6	11.6	1.2	0.0	13.6	0.0	0.0	6.7
Altadena-Monrovia-Sierra Madre	3.2	12.6	2.4	18.4	5.8	33.7	4.8	16.3	3.1	0.0	14.1	12.1	22.2	6.3
Alhambra-S. Pasadena	3.2	5.4	11.7	3.1	7.2	2.5	5.3	9.1	1.8	6.3	17.9	3.5	0.0	5.8
Arcadia-San Gabriel-Temple City-San Marino	3.6	12.7	19.1	1.9	11.2	7.8	11.8	11.1	6.8	17.2	1.3	9.3	40.7	9.5
Baldwin Park-Azusa-Duarte	17.0	5.5	4.0	7.8	11.4	3.6	2.0	1.5	8.1	3.0	15.4	4.1	7.9	10.4
Glendora-Claremont-San Dimas-La Verne	5.2	22.0	2.4	4.8	10.5	11.9	20.1	34.1	14.3	9.7	10.5	23.9	5.4	8.9
Covina-Walnut	6.9	7.2	4.8	6.8	4.9	2.3	7.9	4.5	10.6	10.8	4.6	0.0	10.2	6.4
Diamond Bar	3.3	5.0	13.2	3.2	0.0	4.0	5.7	7.7	11.0	14.4	6.2	11.2	0.0	6.2
La Puente-S. El Monte	11.7	1.9	1.7	1.7	7.1	2.4	0.0	1.7	0.0	0.0	3.0	22.9	5.1	6.3
Hacienda Heights	4.1	3.1	2.0	0.8	0.0	1.3	5.0	0.1	0.7	0.0	1.5	9.2	4.0	3.1
Monterey Park-Rosemead	5.3	1.7	17.8	0.9	0.0	0.8	7.6	1.1	9.4	18.6	1.0	0.0	0.0	7.2
Other	0.0	0.1	0.0	0.0	0.1	0.0	0.1	0.1	0.0	0.1	0.0	0.3	0.5	0.1
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Ten Largest Communities

* Totals may exceed 100% due to the multi-ethnic category being counted twice.

Table 3.1 continued
Ethnicity Within Service Area Communities (Percent of Population)

	Hispanic	Western European White	Asian	Black/African American	Two or more major races	Armenian	Russian	Other Middle Eastern	South Asian	Iranian	Other Race	American Indian, Alaska Native	Pacific Islander	Total *
Within Service Area 4 Communities														
Wilshire La Brea E.	23.2	32.2	18.9	12.8	0.0	0.1	3.2	3.0	1.3	3.2	1.7	0.3	0.1	100.0
Hollywood	44.3	28.5	10.7	3.0	2.1	4.7	3.9	1.5	2.2	0.7	0.3	0.2	0.0	102.1
Pico Heights	60.1	3.6	29.3	3.9	1.6	0.2	0.0	0.4	1.6	0.2	0.2	0.0	0.6	101.6
Echo Park	58.3	13.0	23.5	2.6	3.2	0.2	0.4	0.4	0.0	0.0	1.0	0.5	0.2	103.2
Highland Park	66.6	10.5	17.1	2.1	3.6	0.7	0.2	0.2	0.9	0.0	0.6	0.6	0.6	103.6
Downtown	82.9	3.6	9.9	2.8	0.6	0.1	0.1	0.0	0.1	0.0	0.1	0.3	0.0	100.6
USC N.	66.6	3.6	3.9	24.1	0.0	0.0	0.0	0.2	1.1	0.0	0.5	0.1	0.0	100.0
West Adams	36.8	3.1	3.3	53.8	0.0	0.0	0.5	0.2	0.5	0.5	1.0	0.2	0.0	100.0
West Hollywood	10.7	56.9	6.6	11.7	0.0	0.1	5.7	2.0	1.4	4.5	0.1	0.1	0.1	100.0
Other	97.9	0.8	0.8	0.0	0.0	0.0	0.1	0.2	0.0	0.0	0.2	0.0	0.0	100.0
Total	54.1	17.3	16.8	5.1	2.0	1.2	1.6	0.9	1.1	0.7	0.6	0.3	0.2	102.0
Within Service Area 5 Communties														
Brentwood S.	6.9	66.3	6.3	2.9	2.4	1.0	9.2	2.0	1.0	3.7	0.2	0.3	0.3	102.4
West LA	12.6	48.2	20.2	3.9	2.6	0.2	5.1	3.2	2.4	3.6	0.4	0.1	0.0	102.6
Wilshire La Brea W.	23.2	32.2	18.9	12.8	1.6	0.1	3.2	3.0	1.3	3.2	1.7	0.3	0.1	101.6
Baldwin Hills W.	36.8	3.1	3.3	53.8	2.1	0.0	0.5	0.2	0.5	0.5	1.0	0.2	0.0	102.1
Playa Vista	20.5	55.8	9.4	7.2	2.6	0.2	3.3	1.8	0.7	0.3	0.3	0.0	0.4	102.6
Santa Monica-Culver City-Beverly Hills	10.7	56.9	6.6	11.7	3.2	0.1	5.7	2.0	1.4	4.5	0.1	0.1	0.1	103.2
Malibu	28.4	58.6	2.1	1.0	1.6	0.3	5.3	1.6	0.7	1.6	0.4	0.0	0.1	101.6
Other	58.1	2.8	0.3	38.0	0.0	0.1	0.0	0.1	0.1	0.0	0.6	0.0	0.0	100.0
Total	14.4	53.1	11.4	8.1	2.7	0.3	5.3	2.3	1.5	3.1	0.4	0.1	0.1	102.7
Within Service Area 6 Communities														
USC S.	66.6	3.6	3.9	24.1	2.6	0.0	0.0	0.2	1.1	0.0	0.5	0.1	0.0	102.6
Baldwin Hills S.	36.8	3.1	3.3	53.8	2.1	0.0	0.5	0.2	0.5	0.5	1.0	0.2	0.0	102.1
Hancock N.	56.6	0.5	0.2	41.9	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.2	100.0
USC E.	87.3	0.3	0.1	10.5	0.5	0.0	0.0	0.1	0.1	0.0	1.6	0.0	0.0	100.5
Watts	73.4	0.0	0.1	26.1	1.4	0.0	0.0	0.0	0.0	0.0	0.1	0.3	0.0	101.4
Florence-Firestone	95.3	1.0	0.3	3.0	0.0	0.1	0.0	0.0	0.0	0.0	0.1	0.2	0.0	100.0
Lynwood	92.4	2.6	0.2	3.9	0.0	0.0	0.1	0.0	0.5	0.0	0.0	0.3	0.1	100.0
Paramount	62.9	16.2	9.9	8.3	0.0	0.0	0.2	1.0	0.5	0.1	0.1	0.1	0.7	100.0
Compton	55.5	1.3	0.8	40.9	0.0	0.0	0.1	0.0	0.0	0.0	0.9	0.0	0.5	100.0
Other	10.7	56.9	6.6	11.7	3.2	0.1	5.7	2.0	1.4	4.5	0.1	0.1	0.1	103.2
Total	65.9	2.8	1.6	28.2	0.8	0.0	0.2	0.1	0.2	0.1	0.6	0.1	0.1	100.8
Within Service Area 7 Communities														
East LA	97.9	0.8	0.8	0.0	0.8	0.0	0.1	0.2	0.0	0.0	0.2	0.0	0.0	100.8
Downey	66.7	20.2	7.7	2.1	2.7	0.0	0.2	0.9	2.1	0.1	0.2	0.0	0.0	102.7
Norwalk	60.4	14.3	15.8	6.1	4.5	0.0	0.1	0.8	2.0	0.0	0.5	0.0	0.2	104.5
Whittier	59.2	23.0	14.9	1.1	2.9	0.2	0.6	0.0	0.2	0.0	0.2	0.4	0.1	102.9
Montebello	85.4	5.4	6.1	0.4	1.4	1.8	0.2	0.3	0.3	0.0	0.1	0.2	0.0	101.4
Bell Gardens-Bell-Maywood-Cudahy-Commerce	93.7	3.1	0.5	1.1	0.8	0.0	0.0	1.4	0.0	0.0	0.0	0.1	0.0	100.8
Huntington Park	95.3	1.0	0.3	3.0	0.9	0.1	0.0	0.0	0.0	0.0	0.1	0.2	0.0	100.9
South Gate	92.4	2.6	0.2	3.9	0.4	0.0	0.1	0.0	0.5	0.0	0.0	0.3	0.1	100.4
Bellflower	62.9	16.2	9.9	8.3	3.2	0.0	0.2	1.0	0.5	0.1	0.1	0.1	0.7	103.2
La Mirada-Santa Fe Springs	61.5	28.7	5.9	2.0	3.8	0.0	0.4	0.5	0.7	0.0	0.1	0.0	0.1	103.8
Lakewood-Cerritos-Artesia-Hawaiian Gardens	25.9	35.8	27.7	6.1	0.0	0.0	0.5	0.2	3.3	0.0	0.0	0.0	0.5	100.0
Signal Hill	13.6	48.9	26.8	4.8	0.0	0.1	1.6	0.4	1.7	0.6	0.6	0.5	0.4	100.0
Other	29.1	11.6	54.7	1.4	1.9	0.2	0.4	0.5	1.1	0.6	0.2	0.1	0.0	101.9
Total	70.9	14.8	9.1	2.9	1.8	0.2	0.2	0.5	0.9	0.0	0.1	0.1	0.1	101.8

Table 3.2 continued
Ethnicity Between Service Area Communities (Percent of Population)

	Hispanic	Western European White	Asian	Black/African American	Two or more major races	Armenian	Russian	Other Middle Eastern	South Asian	Iranian	Other Race	American Indian, Alaska Native	Pacific Islander	Total *
Between Service Area 4 Communities														
Wilshire La Brea E.	5.4	23.7	14.2	31.7	0.0	0.6	26.2	41.9	15.4	55.9	34.8	12.9	3.3	12.7
Hollywood	17.6	35.6	13.7	12.7	23.1	83.2	54.3	34.8	43.7	21.9	10.6	11.3	0.0	21.5
Pico Heights	12.1	2.3	19.0	8.3	8.8	1.7	0.0	4.4	16.7	2.3	2.8	0.0	28.6	10.9
Echo Park	19.4	13.6	25.1	9.1	29.9	2.9	4.5	7.0	0.5	0.0	28.2	26.1	17.2	18.0
Highland Park	23.2	11.5	19.1	7.6	34.6	10.2	2.6	4.6	15.7	0.0	17.3	35.4	50.1	18.9
Downtown	18.5	2.5	7.1	6.7	3.6	1.0	0.5	0.0	1.5	0.0	2.6	12.7	0.0	12.1
USC N.	2.2	0.4	0.4	8.5	0.0	0.0	0.0	0.4	1.8	0.0	1.4	0.6	0.0	1.8
West Adams	0.5	0.1	0.2	8.3	0.0	0.0	0.2	0.2	0.3	0.6	1.4	0.4	0.0	0.8
West Hollywood	0.6	10.4	1.2	7.2	0.0	0.3	11.6	6.8	4.3	19.3	0.8	0.6	0.8	3.2
Other	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.2
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Between Service Area 5 Communities														
Brentwood S.	6.3	16.5	7.2	4.7	11.7	45.8	22.9	11.7	9.0	15.6	7.2	30.9	28.5	13.2
West LA	25.8	26.6	52.0	14.0	28.2	22.9	28.2	40.7	47.7	34.4	34.1	37.5	0.0	29.3
Wilshire La Brea W.	7.1	2.7	7.3	7.0	2.7	0.9	2.7	5.8	3.9	4.6	20.1	13.1	2.2	4.4
Baldwin Hills W.	6.0	0.1	0.7	15.4	1.9	0.0	0.2	0.2	0.7	0.4	6.6	3.6	0.0	2.3
Playa Vista	26.6	19.6	15.4	16.6	18.4	14.6	11.6	14.8	8.5	1.9	16.7	0.0	52.6	18.6
Santa Monica-Culver City-Beverly Hills	21.6	30.9	16.8	41.7	35.0	12.4	31.1	24.7	28.6	41.5	11.6	14.9	14.3	28.8
Malibu	6.4	3.6	0.6	0.4	2.0	3.5	3.2	2.2	1.5	1.7	3.7	0.0	2.4	3.3
Other	0.3	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Between Service Area 6 Communities														
USC S.	7.0	9.0	17.2	6.0	22.5	0.0	0.0	9.1	32.4	0.0	5.4	6.1	0.0	7.0
Baldwin Hills S.	7.5	14.9	28.3	25.5	36.0	0.0	39.9	22.5	27.4	56.1	22.5	19.5	0.0	13.3
Hancock N.	13.0	2.9	2.2	22.6	0.0	0.0	0.0	0.0	0.0	0.0	11.7	0.0	20.4	15.1
USC E.	16.7	1.3	0.9	4.7	8.0	0.0	0.0	7.4	5.9	0.0	33.1	0.0	0.0	12.6
Watts	18.3	0.3	0.8	15.2	29.0	0.0	0.0	0.0	0.0	0.0	2.9	37.0	0.0	16.4
Florence-Firestone	8.0	2.0	1.1	0.6	0.0	76.3	0.0	0.0	0.0	0.0	0.7	10.1	0.0	5.5
Lynwood	11.0	7.3	0.9	1.1	0.0	0.0	3.6	0.0	15.6	0.0	0.4	19.6	2.8	7.8
Paramount	5.5	33.0	36.4	1.7	0.0	0.0	8.1	41.4	11.7	5.6	0.5	7.1	25.9	5.7
Compton	12.9	7.1	7.5	22.2	0.0	0.0	8.3	4.6	0.0	0.0	22.6	0.0	50.4	15.3
Other	0.2	22.2	4.7	0.5	4.4	23.7	40.1	15.0	7.0	38.2	0.3	0.5	0.5	1.1
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Between Service Area 7 Communities														
East LA	13.6	0.6	0.8	0.0	4.5	0.0	2.2	3.9	0.0	0.0	18.5	3.7	0.0	9.9
Downey	7.9	11.5	7.1	6.1	12.8	0.0	6.4	15.7	18.7	24.9	10.9	0.0	0.0	8.4
Norwalk	6.5	7.4	13.3	16.0	19.3	0.0	2.2	12.4	16.3	0.0	29.4	0.0	8.4	7.7
Whittier	7.3	13.6	14.3	3.4	14.3	9.2	22.9	0.7	1.5	0.0	12.8	30.7	9.1	8.7
Montebello	12.1	3.7	6.7	1.2	7.6	82.7	6.7	5.6	3.0	0.0	7.4	13.3	0.0	10.1
Bell Gardens-Bell-Maywood-Cudahy-Commerce	14.2	2.3	0.6	3.9	4.5	0.0	0.0	31.9	0.5	0.0	0.0	12.6	0.0	10.7
Huntington Park	9.7	0.5	0.2	7.4	3.6	2.7	0.0	0.0	0.0	0.0	4.2	12.0	0.0	7.2
South Gate	10.2	1.4	0.1	10.5	1.9	0.0	2.4	0.0	3.7	0.0	1.8	17.7	2.9	7.8
Bellflower	5.0	6.2	6.2	16.3	10.2	0.0	5.4	12.4	2.8	33.8	2.4	6.4	26.6	5.7
La Mirada-Santa Fe Springs	8.4	18.9	6.3	6.8	20.8	2.0	17.5	10.2	7.0	0.0	8.1	0.0	5.9	9.7
Lakewood-Cerritos-Artesia-Hawaiian Gardens	4.6	30.8	38.6	26.7	0.0	2.4	27.8	5.9	44.3	0.0	0.0	0.0	44.7	12.7
Signal Hill	0.2	2.7	2.4	1.4	0.0	0.5	5.6	0.8	1.5	24.5	3.6	3.2	2.4	0.8
Other	0.2	0.4	3.3	0.3	0.6	0.5	0.9	0.6	0.7	16.8	0.9	0.5	0.0	0.6
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Table 3.1 continued
Ethnicity Within Service Area Communities (Percent of Population)

	Hispanic	Western European White	Asian	Black/African American	Two or more major races	Armenian	Russian	Other Middle Eastern	South Asian	Iranian	Other Race	American Indian, Alaska Native	Pacific Islander	Total *
Within Service Area 8 Communities														
Hancock S.	56.6	0.5	0.2	41.9	1.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.2	101.0
Wilmington	55.1	24.6	10.2	7.3	5.2	0.0	0.3	0.4	0.8	0.3	0.3	0.3	0.5	105.2
Inglewood	58.1	2.8	0.3	38.0	1.4	0.1	0.0	0.1	0.1	0.0	0.6	0.0	0.0	101.4
Torrance	13.0	45.4	30.6	1.4	3.7	1.1	1.4	1.9	3.4	0.4	0.3	0.8	0.2	103.7
Long Beach N.	46.2	18.3	12.9	18.4	4.5	0.0	0.1	0.0	1.2	0.4	0.3	0.2	2.1	104.5
Long Beach S.	48.5	15.5	19.4	15.4	3.5	0.1	0.2	0.1	0.6	0.1	0.1	0.0	0.0	103.5
Long Beach E.	16.2	70.9	6.0	4.0	4.4	0.1	1.4	0.7	0.5	0.1	0.0	0.0	0.1	104.4
Carson	37.4	13.0	23.6	22.1	2.8	0.0	0.1	0.0	0.1	0.0	0.2	0.2	3.2	102.8
Palos Verdes-Lomita	13.6	48.9	26.8	4.8	5.0	0.1	1.6	0.4	1.7	0.6	0.6	0.5	0.4	105.0
Redondo-Manhattan-Hermosa-El Segundo	10.4	74.7	8.8	1.2	5.8	0.8	1.6	0.6	0.6	0.5	0.4	0.0	0.4	105.8
Gardena-Lawndale	38.2	9.9	16.2	33.5	1.6	0.0	0.1	0.0	0.7	0.0	0.7	0.4	0.3	101.6
Hawthorne	55.3	15.3	6.0	22.2	1.0	0.0	0.0	0.4	0.3	0.0	0.2	0.2	0.0	101.0
Other	41.0	18.3	14.0	23.8	2.5	0.0	0.3	0.1	1.6	0.0	0.5	0.0	0.5	102.5
Total	37.3	29.3	14.4	15.6	3.5	0.2	0.6	0.4	0.9	0.2	0.3	0.2	0.6	103.5

Hispanic communities in the county. The San Gabriel Valley is home to the largest proportion of Asians within the county with 33.6% of their entire population residing within its boundaries. Looking closer reveals four of the largest Asian communities are found within Service Area 3. The largest community of Western European Whites may be found in the aggregate of Glendora-Claremont-San Dimas-La Verne. Three other communities are home to relatively large groups of American Indians/Alaskan Natives and Pacific Islanders though these individuals make up less than 10% of their respective community populations (Glendora-Claremont-San Dimas-La Verne, Arcadia-San Gabriel-Temple City-San Marino, and La Puente-S. El Monte areas).

Service Area 4: Metro

In Service Area 4, over half of the population is Hispanic and four of the largest Hispanic communities in the county are contained within the service area boundaries. Western European Whites are the next most numerous group with a large community in the Hollywood area. Nearly equal to Western European Whites, Asians have three of their largest communities within the service area. African-Americans account for about 5% of the service area population. Looking within the service area reveals communities which are ethnically

Table 3.2 continued
Ethnicity Between Service Area Communities (Percent of Population)

	Hispanic	Western European White	Asian	Black/African American	Two or more major races	Armenian	Russian	Other Middle Eastern	South Asian	Iranian	Other Race	American Indian, Alaska Native	Pacific Islander	Total *
Between Service Area 8 Communities														
Hancock S.	0.9	0.0	0.0	1.5	0.2	0.0	0.0	0.0	0.0	0.0	0.8	0.0	0.2	0.6
Wilmington	16.3	9.3	7.8	5.1	16.3	0.0	5.9	9.7	10.3	16.5	8.9	14.5	8.6	11.0
Inglewood	12.7	0.8	0.1	19.9	3.2	2.8	0.0	2.8	0.8	0.0	14.7	0.0	0.0	8.1
Torrance	3.1	13.7	18.8	0.8	9.2	48.2	22.3	42.2	33.6	17.0	8.7	30.9	2.5	8.8
Long Beach N.	11.4	5.7	8.2	10.8	11.8	0.0	1.6	0.0	12.0	17.0	9.5	6.5	32.3	9.2
Long Beach S.	16.3	6.6	16.9	12.4	12.5	4.8	4.3	2.3	8.8	3.2	5.2	1.3	0.0	12.5
Long Beach E.	3.5	19.4	3.3	2.1	10.2	2.2	20.2	13.9	4.5	4.3	0.0	0.0	1.1	8.0
Carson	7.3	3.2	11.9	10.3	5.8	0.0	1.6	0.0	0.7	0.0	5.4	7.7	39.2	7.2
Palos Verdes-Lomita	2.5	11.7	13.0	2.2	10.0	4.6	19.4	7.5	13.0	20.6	11.8	14.8	4.7	7.0
Redondo-Manhattan-Hermosa-El Segundo	2.3	21.3	5.1	0.7	13.8	33.3	23.2	11.3	5.1	21.5	9.2	0.0	5.9	8.3
Gardena-Lawndale	9.7	3.2	10.6	20.4	4.3	2.0	1.4	0.0	7.2	0.0	20.5	15.3	5.2	9.5
Hawthorne	13.9	4.9	3.9	13.4	2.6	2.0	0.0	10.1	3.5	0.0	4.9	9.0	0.0	9.4
Other	0.3	0.2	0.3	0.5	0.2	0.0	0.2	0.1	0.6	0.0	0.4	0.0	0.3	0.3
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Ten Largest Communities

* Totals may exceed 100% due to the multi-ethnic category being counted twice.

diverse and relatively large. The Hollywood area, for instance, is home to seven ethnic groups with respectively large populations. In these terms, across the entire county, no other community is as diversely populated as the Hollywood area. Similar but to a lesser degree, the Echo Park and Highland Park areas are also quite ethnically diverse.

Service Area 5: West

In Service Area 5, Western European Whites are the majority population and three of the largest Western European White communities are found there. The service area has fewest numbers of Hispanics, American Indians/ Alaskan Natives, and Other Races across the county. Even so, two communities, West LA and the aggregate of Santa Monica-Culver City-Beverly Hills, are fairly diverse with relatively large populations of six ethnic groups (Western European White, Asian, Russian, South Asian, Iranian, Other Middle Eastern). Both Russians and Iranians have three of their largest communities in the West area.

Service Area 6: South

Service Area 6 is populated by a majority of Hispanics (65.9%), followed by African-Americans (28.2%); together, these two groups account for 94.1% of the entire population of the service area. Four of the largest

African-American communities are found within this service area (the Baldwin Hills S., Hancock N., Watts, and Compton areas). Two of the largest Hispanic communities are found here, as well (the USC E. and Watts areas).

Service Area 7: East

In Service Area 7, Hispanics are the most populous group, where they account for 70.9% of the area's population. The over 900,000 Hispanics in the area represent over 20% of all Hispanics in the county. Three of the ten largest Hispanic communities are found within this service area (the East LA, Montebello, and Bell Gardens-Bell-Maywood-Cudahy-Commerce areas). Western European Whites, scattered throughout the service area, account for 14% of the service area population. Three Asian and South Asian communities are represented in relatively large numbers for their population; however, the two South Asian communities in the Downey area and the aggregate area of Lakewood-Cerritos-Artesia-Hawaiian Gardens represent less than 10% of the service area's total population.

Service Area 8: South Bay

No one ethnic group has a majority in the South Bay area. Hispanics are the most numerous, but no Hispanic community is relatively densely-clustered. Five of the largest African-American communities in the county are found within the service area (the Inglewood, Long Beach N., Long Beach S., Carson, Gardena-Lawndale, and Hawthorne areas); four of the largest communities with multi-ethnic individuals are there (the Wilmington, Long Beach N., Long Beach S., and Redondo-Manhattan-Hermosa-El Segundo areas); and three of the largest Western European White (the Torrance, Long Beach E., and Redondo-Manhattan-Hermosa-El Segundo areas) and Pacific Islander (the Wilmington, Long Beach N., and Carson areas) communities are there. Asians are most numerous in the Torrance and Long Beach N. communities.

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Primary Language

Description of Indicator

The Primary Language indicator is a count of the number of individuals residing within a given area who have identified their primary language spoken at home. The numbers do not reflect the number of individuals who are able to speak English as a second language. In Los Angeles County, thirteen threshold languages have been identified pursuant to Title 9 CCR 1810.410 (a) (3) and are reported here (viz. Threshold language means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.). Out of 58 California counties, only 6 have five or more identified threshold languages; Los Angeles County has 13.

Research Base and Relevance to PEI

An individual's Primary Language, if something other than English, can function as a barrier to accessing mental health services. Results from the ACS 2003-2006 consistently

rank California as the state with the highest numbers of individuals (about 20%) reporting limited English proficiency, (i.e., they report speaking English "less than very well", ACS American Factfinder, 2008). Studies conducted with Spanish-speaking and Asian language-speaking populations have reported large disparities in accessing mental health services; individuals proficient in English have a clear advantage in getting mental health help over those who are not proficient (Snowden, Masland, & Guerrero, 2007). In addition to examining this indicator, planners may want to compare these numbers with the language capacity of county mental health rendering providers, (i.e., the county's therapist staff), as well as the next indicator in this report, Linguistic Isolation.

What the Numbers Show

With over 200 languages spoken in Los Angeles County, space allows for the reporting of thirteen threshold languages determined by the CCR mentioned above. Across the county, in Table 3.3, the most common Primary Language, English, was only identified by 40.0% of the population and this was only a few percentage points higher than Spanish (37.1%). This also indicates that 60% of the county's population identifies a language other than English as the language they speak at home. Following English and Spanish, and at far fewer numbers, the most frequently spoken languages across the county were Tagalog (2.2%), Korean (1.9%), Chinese (1.7%), and Armenian (1.4%).

In order to answer questions regarding the Primary Language of individuals throughout the county, two color-coded tables have been prepared: a countywide summary above and a more detailed service area breakdown of communities below. The countywide summary allows one to make comparisons both across and within service areas. The more detailed service area communities tables allows for similar lightweight analyses at the community level. It may help to run through an example of how to find information of interest to the PEI planner as the tables are quite dense. Suppose, for example, that a planner wanted to know where Armenian speakers reside in the county; how would one find that information? It is suggested that the countywide summary Table 3.3 be consulted first to determine the service area that is home to the largest proportion of Armenian speakers. Finding the Armenian column, one can see that the dark blue percentage indicates that over 80% of all Armenian speakers in the county live in Service Area 2, the San Fernando Valley area; the fewest percentage of Armenian speakers reside in Service Area 6, denoted by the light blue percentage.

Following this, it is suggested that one consult the service area communities tables. Drilling down into the table indicates more precisely where Armenian speakers are located. By inspecting the Armenian column for Service Area 2, it is apparent that the largest community of Armenian speakers is located in the Glendale, La Tuna Canyon, North Hollywood, and Burbank areas. If the planner were interested the relative percentage of Armenian speakers in a particular area, they could examine the percentages to the right of each language column. In Glendale, for example, 28.9% of all residents have

listed Armenian as their primary language. These percentages are color coded to assist you in quickly identifying varying levels of primary language density. Red highlighting, for instance, indicates that over 50% of a community have identified a language as the one they speak at home.

Service Area Communities (Tables 3.4, 3.5)

Service Area 1: Antelope Valley

The majority of the population in Service Area 1 lists English as their Primary Language (57.7%)followed by Spanish, 28.0%. Only one other language, Tagalog (1.1%), is spoken by more than 1% of the population in the service area. Although English is the majority Primary Language, in actual numbers (and due to the relatively small population in Service Area 1), it has the smallest proportion of English speakers across the entire county (5.4%). Several Asian languages and Russian are similarly represented in low relative proportions. Drilling down and examining the composite service area communities indicates that English speakers are the majority in the Lancaster and North County E. areas but not in the Palmdale area. Small numbers of Korean speakers and Tagalog speakers (over 1%) are found in the surrounding North County E area.

Service Area 2: San Fernando

Five language groups (English, Armenian, Farsi, Arabic, and Russian) have their largest proportion of speakers residing in the San Fernando Valley. Across the service area, English is the most common Primary Language (42.8%), followed by Spanish (31.4%), Armenian (5.5%), Tagalog (2.2%), Farsi (1.8%), Korean (1.7%), and Russian (1.1%). Drilling down into the service areas composite communities indicates that seven communities are predominately English-speaking; two are Spanish-speaking, and seven others have no clear majority of speakers. Large communities of Armenian speakers are found in the Burbank, Glendale, La Tuna Cyn., and North Hollywood areas. In the Encino area, 6.1% of the residents report Farsi as their Primary Language and in Panorama City, 6.5% of the population are Tagalog speakers.

Service Area 3: San Gabriel

English (38.6%) is the most commonly listed Primary Language for the San Gabriel Valley followed by Spanish (31.7%) and Chinese (6.3%). The Service area has four language groups whose largest proportion of speakers throughout the county resides there: Cantonese, Chinese, Mandarin, and Vietnamese. This is most evident when examining the service area composite communities of Alhambra-S. Pasadena, Arcadia-San Gabriel-Temple City-San Marino, Covina-Walnut, Diamond Bar, and Monterey Park-Rosemead. English speakers are the majority in two communities, Altadena-Monrovia-Sierra Madre and Glendora-Claremont-San Dimas-La Verne, while Spanish speakers are the majority in three: Pomona, Baldwin Park-Azusa-Duarte, and La Puente-S. El Monte. Other Asian language groups have relatively large communities, such as Korean speakers in the Diamond Bar area, Vietnamese speakers in Monterey Park-Rosemead area, and Tagalog speakers in the West Covina area.

Service Area 4: Metro

Overall, the Metro area has no clear majority of speakers for any language group, al-

Table 3.3
Primary Language Across Los Angeles County (Percent of Population)

Within Service Areas[1]

Service Area	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese	Mandarin	Cambodian	Korean	Vietnamese	Tagalog	NA or Blank	All Others	Total
1	57.7	28.0	0.1	0.2	0.5	0.1	0.0	0.1	0.0	0.0	0.5	0.4	1.1	9.7	1.6	100
2	42.8	31.4	5.5	1.8	0.7	1.1	0.1	0.3	0.1	0.1	1.7	0.7	2.2	6.7	4.9	100
3	38.6	31.7	0.5	0.2	0.6	0.1	2.0	6.3	1.6	0.2	1.9	2.6	2.2	7.5	3.4	100
4	26.0	46.1	1.2	0.7	0.2	0.7	0.7	1.2	0.1	0.2	5.0	0.3	4.7	7.8	5.0	100
5	64.6	11.4	0.2	3.0	0.6	1.4	0.2	1.1	0.3	0.0	1.7	0.6	0.8	5.1	8.7	100
6	30.9	56.7	0.0	0.2	0.1	0.0	0.0	0.2	0.0	0.1	0.2	0.1	0.3	9.8	1.3	100
7	28.9	54.0	0.1	0.0	0.3	0.0	0.2	1.1	0.3	0.2	1.4	0.4	2.0	8.1	2.7	100
8	49.4	28.7	0.1	0.2	0.4	0.2	0.1	0.8	0.1	1.2	1.5	0.8	2.7	8.4	5.3	100
Total	40.0	37.1	1.4	0.7	0.4	0.5	0.5	1.7	0.4	0.3	1.9	0.9	2.2	7.8	4.2	100

Between Service Areas[2]

1	5.4	2.8	0.4	0.9	4.6	0.5	0.0	0.3	0.1	0.1	1.0	1.6	1.8	4.7	1.4	3.7
2	22.7	18.0	80.8	52.2	34.0	49.9	2.5	3.9	3.3	5.5	19.7	17.6	21.0	18.4	24.9	21.3
3	17.1	15.2	5.9	3.9	22.1	4.1	70.6	65.6	72.9	11.1	18.1	51.2	17.7	17.1	14.7	17.7
4	7.6	14.5	10.1	10.9	4.3	18.8	16.1	8.4	2.5	7.4	31.0	4.5	24.5	11.7	14.1	11.7
5	9.9	1.9	0.7	25.9	8.3	18.8	2.7	3.8	5.3	0.6	5.7	3.9	2.2	4.0	12.7	6.1
6	7.8	15.4	0.1	2.2	1.8	1.0	0.4	1.4	0.8	3.0	1.1	0.6	1.5	12.8	3.2	10.1
7	9.8	19.8	0.9	0.5	10.7	1.4	4.0	8.7	9.5	10.0	10.5	6.4	11.9	14.2	8.8	13.6
8	19.7	12.3	1.2	3.4	14.3	5.5	3.6	7.9	5.5	62.3	13.0	14.3	19.4	17.2	20.2	15.9
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

1. Within Service Area Comparisons

1-5%
5-50%
> 50%

Denotes percentages within service areas. For example, in Service Area 7, highlighted in orange, 28.7% of the population indicated that English was their primary language. 54.0%, highlighted in red, indicated that Spanish was their primary language. And 1.1% of the Service Area, highlighted in yellow, indicated that they were primary Chinese speakers.

2. Between Service Area Comparisons

Low
High

Denotes Low and High percentages across service areas. For example, 22.7% of individuals who reported that English was their primary language reside in Service Area 2. The dark blue highlighting indicates that this is where the largest proportion of English speakers reside. The smallest proportion of English speakers are found in Service Area 1, 5.4% and is indicated by the light blue highlighting.

though like the other service areas, most of the population have listed English (26%) or Spanish (46.1%) as their Primary Language. This is followed by Korean (5%), Tagalog (4.7%), Armenian (1.2%), and Chinese (1.2%). This particular service area demonstrates why it is important to drill down to the community level data. Examining the service area composite communities reveals that, in fact, five communities do have a majority of Spanish speakers contained within their boundaries (the Pico Heights, Echo Park, Highland Park, Downtown, and USC N. areas); two communities have a majority of English speakers (the West Adams and West Hollywood areas); and two other communities have no majority (the Wilshire La Brea E. and Hollywood areas). Clearly the service area level data, in this instance, does not tell the whole story. Two language groups, Korean and Tagalog, have their largest proportions of speakers in the county contained

within the service area. Korean speakers are located in the Wilshire La Brea E. and Pico Heights areas. And Tagalog speakers are found in most numbers in the Pico Heights (Koreatown), Echo Park, and Highland Park areas.

Service Area 5: West

English speakers (64.6%) are the majority Primary Language in Service Area 5, followed by Spanish (11.4%), Farsi (3%), Korean (1.7%), Russian (1.4%) and Chinese (1.1%) speakers. Service Area 5 has the smallest proportion of primary Spanish speakers (1.9%) in the county. All identified composite communities in the service area have a majority of primary English speakers and each community has Spanish as its next most frequently designated Primary Language. Relatively large clusters of primary Farsi speakers are located in three communities: Brentwood S., Wilshire-La Brea W., Santa Monica-Culver City-Beverly Hills, and Malibu. Primary Russian speakers have relatively large groups located in the Brentwood S., West LA, and Santa Monica-Culver City-Beverly Hills areas. Primary Korean speakers are found in the West LA, Wilshire-La Brea W., and Playa Vista areas. A couple of communities appear to have a fair amount of language diversity: Brentwood S., for example, has five language groups with more than 1% of its relative population; the West LA area has eight.

Service Area 6: South

Primary Spanish speakers are the majority in Service Area 6 (56.7), followed by primary English speakers (30.9%). No other identified primary language group accounts for more than 1% of the service area population. Six of the composite communities have a majority of primary Spanish speakers (the USC S., Hancock N., USC E., Watts, Florence-Firestone, and Lynwood areas); one has a majority of primary English speakers (Baldwin Hills S.); and two have no clear majority. Only one community, Paramount, has primary language speakers accounting for more than 1% of its population: Cambodian speakers (1.0%) and Tagalog speakers (3.6%).

Service Area 7: East

Primary Spanish speakers are the majority in Service Area 7 (54%), followed by primary English speakers (28.9%) Tagalog speakers (2.0%), Korean speakers (1.4%), and Chinese speakers (1.1%). The East area is home to the largest proportion of primary Spanish speakers and smallest proportion of primary Farsi speakers in the county. Examining the composite communities revealed that five have large majorities of primary Spanish speakers: the Montebello, Bell Gardens-Bell-Maywood-Cudahy-Commerce, Bellflower, East LA, and Huntington Park areas. The East LA and the Huntington Park areas have over 80% of their respective populations reporting Spanish as their primary language. Three communities (the La Mirada-Santa Fe Springs, Lakewood-Cerritos-Artesia-Hawaiian Gardens, and Signal Hill areas) have a majority of primary English speakers, and four others have no clear majority, though primary English or Spanish speakers are the most numerous in all communities. Relatively large numbers of primary Tagalog speakers are found in the Norwalk and Lakewood-Cerritos-Artesia-Hawaiian Gardens areas. Primary Korean speakers are found in significant numbers in

at least five communities. Primary Chinese speakers may be found in significant numbers in the Montebello and Lakewood-Cerritos-Artesia-Hawaiian Gardens areas. Two communities, Signal Hill and the Lakewood-Cerritos-Artesia-Hawaiian Gardens area, have six primary language groups in excess of 1% of their respective populations.

Service Area 8: South Bay

No Primary Language constituted a majority in the South Bay, though primary English speakers account for close to 50% of the population. Primary Spanish speakers are the next most numerous, followed by primary Tagalog speakers (2.7%), Korean speakers (1.5%), and Cambodian speakers (1.2%). By far, though, primary English or Spanish speakers account for the bulk of the population throughout the service area. Drilling down tells us more about the Asian language-speaking populations in the South Bay. Examining the composite communities indicates that primary Cambodian speakers reside in the Long Beach N. and Long Beach S. areas. 62.3% of all Cambodian speakers in the county reside in the South Bay area. Two other Asian language groups have relatively large heritage language speakers: Korean (7%) in the Torrance area and Tagalog (14.2%) in the Carson area. Additionally, the Korean and Tagalog-speaking populations have scattered clusters of individuals in significant numbers in about 8-9 composite communities.

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Table 3.4
Primary Language Within Service Area Communities (Percent of Population)

Community	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese	Mandarin	Cambodian	Korean	Vietnamese	Tagalog	NA or Blank	All Others	Total
Within Service Area 1 Communities																
Lancaster	67.6	20.1	0.1	0.1	0.6	0.0	0.0	0.0	0.0	0.0	0.2	0.7	0.9	8.8	1.0	100
Palmdale	45.5	38.9	0.3	0.0	0.4	0.1	0.0	0.1	0.0	0.0	0.1	0.3	1.2	11.5	1.6	100
North County E.	62.6	22.2	0.0	0.6	0.7	0.0	0.0	0.3	0.0	0.0	1.6	0.0	1.2	8.2	2.6	100
Total	57.7	28.0	0.1	0.2	0.5	0.1	0.0	0.1	0.0	0.0	0.5	0.4	1.1	9.7	1.6	100
Within Service Area 2 Communities																
Santa Clarita	64.7	20.6	0.1	0.2	0.3	0.0	0.1	0.4	0.0	0.0	1.3	0.1	0.9	7.5	3.7	100
Burbank	52.0	18.2	6.5	2.0	1.3	3.7	0.1	0.2	0.0	0.0	3.4	0.1	2.3	6.2	3.9	100
Glendale	31.6	15.6	28.9	2.5	1.8	1.2	0.0	0.3	0.0	0.0	4.7	0.0	3.4	5.0	4.9	100
Northridge	48.7	20.3	2.9	2.5	0.4	0.3	0.2	0.8	0.3	0.0	3.5	4.7	2.2	5.0	8.3	100
Granada Hills	50.1	30.3	2.7	0.1	0.9	1.1	0.0	0.3	0.0	0.2	2.0	0.0	2.6	5.9	3.8	100
Pacoima-Arleta	15.0	72.9	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.5	0.0	0.9	9.7	0.6	100
La Tuna Cyn.	27.6	47.5	9.4	1.0	0.0	0.3	0.0	0.0	0.0	0.0	3.2	0.0	2.1	6.5	2.4	100
Panorama City	16.9	60.2	2.9	0.0	0.1	0.1	0.0	0.1	0.0	0.2	1.4	0.5	6.5	7.5	3.6	100
North Hollywood	32.8	40.7	6.9	0.1	2.7	1.9	0.0	0.1	0.0	0.1	0.0	1.4	1.8	6.7	4.8	100
Sherman Oaks	35.2	42.2	4.1	0.3	0.2	2.2	0.0	0.1	0.0	0.3	0.3	0.0	0.9	8.7	5.4	100
Encino	46.8	24.9	2.7	6.1	0.7	2.1	0.2	0.7	0.1	0.2	0.7	0.6	3.0	6.2	5.1	100
Woodland Hills	44.8	27.6	1.1	4.8	0.4	1.2	0.1	0.1	0.0	0.0	0.5	2.2	2.3	7.5	7.3	100
Brentwood N.	70.9	6.2	1.1	3.7	0.1	1.6	0.2	1.0	0.3	0.0	0.2	0.1	0.7	6.5	7.5	100
North County W.	62.6	22.2	0.0	0.6	0.7	0.0	0.0	0.3	0.0	0.0	1.6	0.0	1.2	8.2	2.6	100
La Canada-Flintridge	63.3	17.1	2.9	0.0	1.7	0.2	0.2	0.8	0.1	0.0	3.3	0.1	1.0	6.2	3.2	100
San Fernando-Calabasas-Agoura	61.3	21.8	0.0	1.3	0.2	0.3	0.0	0.2	0.1	0.0	0.9	0.0	0.1	5.1	8.7	100
Total	42.8	31.4	5.5	1.8	0.7	1.1	0.1	0.3	0.1	0.1	1.7	0.7	2.2	6.7	4.9	100
Within Service Area 3 Communities																
Pasadena	53.1	23.7	2.0	0.7	0.1	0.5	0.4	2.0	0.4	0.0	1.1	0.3	2.7	7.9	5.0	100
El Monte	15.1	52.5	0.0	0.0	0.0	0.1	3.2	6.3	1.3	0.3	0.2	11.3	0.4	8.4	0.8	100
Pomona	27.6	52.4	0.2	0.0	0.0	0.0	0.3	1.0	0.0	0.4	2.1	2.3	1.6	9.8	2.2	100
West Covina	41.0	33.7	0.1	0.0	1.0	0.0	1.1	3.0	0.7	0.0	0.6	2.1	5.8	8.4	2.4	100
Altadena-Monrovia-Sierra Madre	63.3	17.1	2.9	0.0	1.7	0.2	0.2	0.8	0.1	0.0	3.3	0.1	1.0	6.2	3.2	100
Alhambra-S. Pasadena	34.6	17.6	0.1	0.3	0.7	0.3	8.0	17.3	3.2	0.3	2.0	2.4	1.8	6.6	4.9	100
Arcadia-San Gabriel-Temple City-San Marino	41.3	11.3	0.1	0.2	0.4	0.0	4.2	16.6	5.9	0.1	2.4	3.1	1.1	6.0	7.3	100
Baldwin Park-Azusa-Duarte	24.1	56.5	0.1	0.1	0.1	0.1	0.4	1.2	0.1	0.0	0.2	0.7	4.1	10.2	2.2	100
Glendora-Claremont-San Dimas-La Verne	70.6	13.8	0.8	0.1	1.9	0.1	0.1	0.7	0.2	0.0	0.5	0.4	1.4	5.5	3.8	100
Covina-Walnut	45.5	34.6	0.1	0.0	0.4	0.2	1.2	3.8	1.6	0.2	2.4	0.6	2.4	4.2	2.8	100
Diamond Bar	35.7	12.9	0.1	0.6	1.1	0.0	2.4	14.3	5.6	0.1	10.7	0.7	3.4	7.1	5.2	100
La Puente-S. El Monte	31.6	55.2	0.2	0.0	0.4	0.0	0.2	0.4	0.0	0.3	0.4	1.0	1.8	7.6	1.0	100
Hacienda Heights	46.9	32.6	0.2	0.0	0.0	0.1	0.3	4.4	1.5	0.0	1.9	0.4	0.8	8.1	2.7	100
Monterey Park-Rosemead	17.8	25.2	0.0	0.2	0.0	0.0	7.4	19.7	2.7	0.9	1.1	11.1	2.0	8.1	3.8	100
Other	62.6	22.2	0.0	0.6	0.7	0.0	0.0	0.3	0.0	0.0	1.6	0.0	1.2	8.2	2.6	100
Total	38.9	31.9	0.5	0.2	0.6	0.1	2.0	6.3	1.6	0.2	1.9	2.6	2.2	7.5	3.5	100

1. Within Community Comparisons

1 - 5%
5 - 50%
> 50%

Table 3.5
Primary Language Between Service Area Communities (Percent of Population)

Community	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese	Mandarin	Cambodian	Korean	Vietnamese	Tagalog	NA or Blank	All Others	Total
Between Service Area 1 Communities																
Lancaster	43.1	26.4	13.7	15.0	38.9	0.0	0.0	0.0	0.0	100.0	14.8	65.3	30.7	33.3	22.8	36.8
Palmdale	31.0	54.6	78.7	0.0	31.8	82.1	0.0	44.0	0.0	0.0	9.6	34.7	43.9	46.5	38.6	39.3
North County E.	25.9	19.0	7.5	85.0	29.3	17.9	100.0	56.0	100.0	0.0	75.5	0.0	25.5	20.2	38.5	23.9
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Between Service Area 2 Communities																
Santa Clarita	12.2	5.3	0.2	1.1	3.9	0.2	11.9	9.2	0.0	1.5	5.9	0.9	3.4	8.9	6.1	8.1
Burbank	5.9	2.8	5.7	5.4	9.1	16.4	6.1	3.0	0.0	1.8	9.5	0.6	5.0	4.4	3.8	4.8
Glendale	7.1	4.8	50.6	13.9	23.9	10.2	3.6	9.6	3.6	5.2	26.1	0.6	15.0	7.1	9.6	9.6
Northridge	9.2	5.2	4.3	11.7	4.6	2.0	22.9	20.0	37.2	0.0	16.2	51.1	8.1	6.1	13.7	8.1
Granada Hills	7.7	6.3	3.2	0.5	8.2	6.9	0.0	6.3	3.3	14.0	7.4	0.0	7.9	5.7	5.2	6.6
Pacoima-Arleta	2.0	13.1	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	1.5	0.0	2.4	8.1	0.7	5.6
La Tuna Cyn.	4.1	9.7	11.0	3.8	0.0	2.1	0.9	0.6	0.6	0.6	11.7	0.0	6.1	6.2	3.2	6.4
Panorama City	2.8	13.4	3.7	0.2	1.2	0.6	0.0	2.3	1.0	15.8	5.7	4.7	20.4	7.7	5.1	7.0
North Hollywood	5.0	8.4	8.1	0.2	24.3	11.3	2.1	2.1	2.2	5.7	0.0	12.2	5.4	6.5	6.4	6.5
Sherman Oaks	6.6	10.8	5.9	1.3	2.7	16.1	3.6	3.5	3.5	30.1	1.2	0.0	3.5	10.4	8.8	8.0
Encino	8.7	6.3	3.9	27.6	8.1	15.5	21.2	17.7	15.7	25.2	3.2	6.1	10.7	7.3	8.3	7.9
Woodland Hills	8.1	6.8	1.6	21.1	4.5	8.7	7.6	1.9	2.3	0.0	2.2	23.2	8.0	8.6	11.6	7.7
Brentwood N.	7.0	0.8	0.8	8.9	0.8	6.1	12.5	13.1	19.0	0.0	0.5	0.4	1.4	4.0	6.4	4.2
North County W.	4.5	2.2	0.0	1.1	2.9	0.1	1.0	2.7	2.0	0.0	2.8	0.0	1.6	3.8	1.6	3.1
La Canada-Flintridge	2.9	1.1	1.0	0.0	4.6	0.3	6.1	5.1	4.4	0.0	3.7	0.2	0.9	1.8	1.3	2.0
San Fernando-Calabasas-Agoura	6.5	3.1	0.0	3.3	1.1	1.4	0.6	2.9	5.2	0.0	2.3	0.0	0.2	3.4	8.1	4.5
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Between Service Area 3 Communities																
Pasadena	10.4	5.6	31.1	32.3	1.6	37.8	1.6	2.5	1.7	0.6	4.5	0.9	9.1	8.0	11.0	7.6
El Monte	2.5	10.5	0.0	0.0	0.0	6.5	10.2	6.4	5.2	11.2	0.7	27.8	1.2	7.2	1.5	6.4
Pomona	6.6	15.3	3.9	0.0	0.0	0.0	1.3	1.5	0.3	20.4	10.3	8.3	6.8	12.1	5.9	9.3
West Covina	7.2	7.2	0.8	0.0	12.8	0.0	3.8	3.3	3.1	0.7	2.2	5.6	17.7	7.7	4.7	6.9
Altadena-Monrovia-Sierra Madre	10.2	3.4	37.4	0.0	19.0	9.1	0.6	0.8	0.5	0.0	10.9	0.2	2.7	5.1	5.8	6.3
Alhambra-S. Pasadena	5.2	3.2	1.8	10.3	7.4	14.0	22.9	15.9	11.7	8.9	6.1	5.5	4.6	5.1	8.3	5.8
Arcadia-San Gabriel-Temple City- San Marino	9.9	3.3	1.4	13.7	6.3	0.0	19.2	24.4	33.9	4.1	11.8	11.2	4.4	7.4	19.7	9.3
Baldwin Park-Azusa-Duarte	6.5	18.5	2.3	4.8	1.3	6.7	2.3	2.0	0.8	0.0	0.8	2.8	19.2	14.1	6.8	10.5
Glendora-Claremont-San Dimas-La Verne	16.3	3.9	14.1	7.6	30.5	10.3	0.5	1.0	0.9	1.7	2.3	1.5	5.7	6.6	9.9	9.0
Covina-Walnut	7.5	6.9	1.8	0.0	4.4	11.2	3.7	3.8	6.1	8.0	7.9	1.5	6.9	3.6	5.1	6.4
Diamond Bar	5.6	2.5	1.4	23.4	12.3	0.0	7.2	13.7	21.2	2.8	33.8	1.5	9.2	5.7	9.1	6.1
La Puente-S. El Monte	5.1	10.9	2.8	0.0	4.2	0.0	0.5	0.4	0.1	9.0	1.2	2.3	5.0	6.4	1.8	6.3
Hacienda Heights	3.8	3.2	1.1	0.0	0.2	4.3	0.5	2.2	2.8	0.0	3.1	0.5	1.1	3.3	2.4	3.1
Monterey Park-Rosemead	3.3	5.6	0.0	7.7	0.0	0.0	25.8	22.1	11.7	32.8	4.2	30.3	6.4	7.6	7.9	7.1
Other	0.1	0.0	0.0	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

[2] Total

Figures in this column reflect relative percentages of individuals reporting a primary language. Percentages correspond closely with population estimates.

Table 3.4 continued
Primary Language Within Service Area Communities (Percent of Population)

Community	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese	Mandarin	Cambodian	Korean	Vietnamese	Tagalog	NA or Blank	All Others	Total
Within Service Area 4 Communities																
Wilshire La Brea E.	45.0	21.0	0.1	3.0	0.2	0.5	0.0	0.2	0.0	0.0	12.0	0.1	1.5	7.0	9.5	100
Hollywood	31.4	39.6	4.8	0.7	0.3	2.7	0.1	0.4	0.1	0.0	2.3	0.3	3.0	6.8	7.5	100
Pico Heights	10.2	51.7	0.1	0.1	0.4	0.0	0.0	0.2	0.0	0.0	17.8	0.0	5.4	9.7	4.4	100
Echo Park	18.5	51.5	0.3	0.0	0.0	0.1	0.7	1.6	0.1	0.6	3.8	0.1	11.2	7.5	4.2	100
Highland Park	24.3	53.1	0.7	0.0	0.1	0.0	1.9	2.7	0.1	0.3	0.9	0.9	6.1	7.4	1.6	100
Downtown	11.4	68.8	0.1	0.0	0.0	0.0	1.5	2.2	0.2	0.2	1.7	0.5	0.4	10.7	2.4	100
USC N.	26.0	59.7	0.0	0.0	0.0	0.2	0.1	1.0	0.4	0.0	0.9	0.2	0.6	8.5	2.5	100
West Adams	52.8	32.4	0.0	0.6	0.0	0.0	0.1	0.3	0.0	0.0	0.5	0.1	0.4	8.6	4.0	100
West Hollywood	69.0	8.3	0.0	3.8	0.4	2.5	0.0	0.4	0.1	0.0	0.4	0.4	0.4	4.7	9.6	100
Other	6.4	84.4	0.0	0.0	0.0	0.1	0.1	0.3	0.1	0.0	0.1	0.0	0.0	8.6	0.1	100
Total	26.0	46.2	1.2	0.7	0.2	0.7	0.7	1.2	0.1	0.2	5.0	0.3	4.7	7.8	5.0	100
Within Service Area 5 Communities																
Brentwood S.	70.9	6.2	1.1	3.7	0.1	1.6	0.2	1.0	0.3	0.0	0.2	0.1	0.7	6.5	7.5	100
West LA	60.6	9.9	0.1	4.1	1.2	1.1	0.6	2.3	0.9	0.0	2.3	1.2	1.1	4.6	10.0	100
Wilshire La Brea W.	45.0	21.0	0.1	3.0	0.2	0.5	0.0	0.2	0.0	0.0	12.0	0.1	1.5	7.0	9.5	100
Baldwin Hills W.	52.8	32.4	0.0	0.6	0.0	0.0	0.1	0.3	0.0	0.0	0.5	0.1	0.4	8.6	4.0	100
Playa Vista	67.1	15.8	0.0	0.2	0.5	0.7	0.1	0.6	0.1	0.1	2.0	0.5	1.0	4.7	6.5	100
Santa Monica-Culver City-Beverly Hills	69.0	8.3	0.0	3.8	0.4	2.5	0.0	0.4	0.1	0.0	0.4	0.4	0.4	4.7	9.6	100
Malibu	61.3	21.8	0.0	1.3	0.2	0.3	0.0	0.2	0.1	0.0	0.9	0.0	0.1	5.1	8.7	100
Other	42.9	45.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.3	1.2	100
Total	64.8	11.5	0.2	3.0	0.6	1.4	0.2	1.1	0.3	0.0	1.7	0.6	0.8	5.1	8.7	100
Within Service Area 6 Communities																
USC S.	26.0	59.7	0.0	0.0	0.0	0.2	0.1	1.0	0.4	0.0	0.9	0.2	0.6	8.5	2.5	100
Baldwin Hills S.	52.8	32.4	0.0	0.6	0.0	0.0	0.1	0.3	0.0	0.0	0.5	0.1	0.4	8.6	4.0	100
Hancock N.	39.5	51.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	8.7	0.7	100
USC E.	13.6	73.5	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	12.7	0.0	100
Watts	24.8	64.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.3	0.4	100
Florence-Firestone	6.5	81.9	0.2	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.0	0.2	10.7	0.4	100
Lynwood	10.2	76.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	12.4	0.6	100
Paramount	29.6	49.9	0.0	0.4	0.9	0.0	0.0	0.4	0.0	1.0	0.7	0.3	3.6	9.9	3.2	100
Compton	43.2	47.0	0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.0	0.0	0.0	0.0	8.5	0.5	100
Other	69.0	8.3	0.0	3.8	0.4	2.5	0.0	0.4	0.1	0.0	0.4	0.4	0.4	4.7	9.6	100
Total	30.9	56.7	0.0	0.2	0.1	0.0	0.0	0.2	0.0	0.1	0.2	0.1	0.3	9.8	1.3	100
Within Service Area 7 Communities																
East LA	6.4	84.4	0.0	0.0	0.0	0.1	0.1	0.3	0.1	0.0	0.1	0.0	0.0	8.6	0.1	100
Downey	35.2	49.8	0.1	0.0	0.9	0.0	0.0	0.0	0.0	0.2	3.0	0.3	0.6	7.0	2.9	100
Norwalk	29.5	47.6	0.0	0.0	0.7	0.1	0.2	0.6	0.2	0.6	3.2	0.4	6.0	6.8	4.0	100
Whittier	46.9	32.6	0.2	0.0	0.0	0.1	0.3	4.4	1.5	0.0	1.9	0.4	0.8	8.1	2.7	100
Montebello	23.3	63.0	0.7	0.0	0.0	0.1	0.2	1.6	0.1	0.0	0.1	0.1	0.8	7.4	2.5	100
Bell Gardens-Bell-Maywood-Cudahy-Commerce	10.3	78.7	0.0	0.0	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	9.7	0.2	100
Huntington Park	6.5	81.9	0.2	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.0	0.2	10.7	0.4	100
South Gate	10.2	76.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	12.4	0.6	100
Bellflower	29.6	49.9	0.0	0.4	0.9	0.0	0.0	0.4	0.0	1.0	0.7	0.3	3.6	9.9	3.2	100
La Mirada-Santa Fe Springs	52.4	35.9	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.1	0.8	0.4	2.0	5.4	2.4	100
Lakewood-Cerritos-Artesia-Hawaiian Gardens	52.1	17.2	0.0	0.0	0.2	0.0	0.4	2.5	0.7	0.5	4.4	1.7	6.4	6.0	7.9	100
Signal Hill	63.4	8.6	0.0	0.3	0.3	0.6	0.2	3.3	0.7	0.6	3.0	0.8	1.1	6.3	10.8	100
Other	26.0	19.6	0.1	0.4	0.5	0.0	5.1	17.3	4.0	0.5	5.5	6.4	2.6	7.7	4.5	100
Total	28.9	54.2	0.1	0.0	0.3	0.0	0.2	1.1	0.3	0.2	1.5	0.4	2.0	8.1	2.7	100

Table 3.5 continued
Primary Language Between Service Area Communities (Percent of Population)

Community	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese	Mandarin	Cambodian	Korean	Vietnamese	Tagalog	NA or Blank	All Others	Total
Between Service Area 4 Communities																
Wilshire La Brea E.	21.8	5.7	0.6	56.0	16.8	9.0	0.2	1.7	1.0	1.7	30.1	3.8	4.0	11.3	23.7	12.6
Hollywood	26.2	18.6	83.3	22.8	39.7	77.4	2.5	6.9	19.8	2.6	9.9	21.2	13.9	18.8	32.4	21.6
Pico Heights	4.2	12.1	1.2	2.4	24.3	0.0	0.0	1.7	4.9	0.0	38.4	0.0	12.5	13.4	9.5	10.8
Echo Park	12.9	20.2	3.7	0.0	3.4	2.4	19.2	23.6	19.2	56.1	13.7	3.2	43.4	17.3	15.0	18.2
Highland Park	17.9	21.9	10.2	0.0	7.0	0.0	52.5	42.1	15.3	26.8	3.4	50.7	24.7	18.0	6.2	19.1
Downtown	5.2	17.6	1.0	0.0	0.0	0.0	25.0	21.3	27.4	12.7	4.0	16.8	0.9	16.2	5.6	11.8
USC N.	1.8	2.3	0.0	0.0	0.0	0.5	0.3	1.4	7.7	0.0	0.3	0.8	0.2	2.0	0.9	1.8
West Adams	1.6	0.6	0.0	0.8	0.0	0.0	0.1	0.2	0.4	0.1	0.1	0.3	0.1	0.9	0.6	0.8
West Hollywood	8.4	0.6	0.0	18.1	8.8	10.7	0.2	1.1	4.2	0.0	0.2	3.3	0.2	1.9	6.0	3.2
Other	0.0	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.2	0.0	0.2
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Between Service Area 5 Communities																
Brentwood S.	14.4	7.1	88.9	16.1	3.0	14.6	10.1	12.0	10.6	0.0	1.7	1.5	12.3	16.7	11.4	13.2
West LA	27.4	25.4	9.5	39.7	57.2	21.8	74.4	63.7	73.8	16.9	37.8	63.5	42.2	26.3	33.7	29.2
Wilshire La Brea W.	3.0	8.0	1.6	4.3	1.6	1.6	0.2	0.7	0.1	4.0	30.1	0.8	8.2	6.0	4.8	4.4
Baldwin Hills W.	1.9	6.5	0.0	0.5	0.0	0.1	0.7	0.7	0.3	1.3	0.7	0.5	1.2	3.9	1.1	2.3
Playa Vista	19.3	25.6	0.0	1.5	15.8	9.7	8.7	11.0	4.9	77.8	21.9	15.9	22.6	17.2	13.9	18.6
Santa Monica-Culver City-Beverly Hills	30.9	21.0	0.0	36.5	21.6	51.4	5.9	11.4	9.7	0.0	6.2	17.8	13.1	26.5	32.0	29.0
Malibu	3.1	6.1	0.0	1.4	0.9	0.8	0.1	0.6	0.7	0.0	1.6	0.0	0.4	3.2	3.2	3.2
Other	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Between Service Area 6 Communities																
USC S.	5.9	7.4	0.0	0.0	0.0	29.2	43.1	28.9	79.7	0.0	33.8	20.4	13.3	6.1	13.0	7.1
Baldwin Hills S.	23.0	7.7	0.0	56.5	0.0	11.6	45.3	17.4	16.3	2.4	34.7	28.7	16.7	11.8	40.9	13.4
Hancock N.	19.3	13.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.9	0.0	0.0	2.0	13.3	7.7	15.1
USC E.	5.5	16.2	0.0	0.0	13.6	0.0	0.0	0.0	0.0	25.3	0.0	0.0	0.0	16.1	-0.1	12.5
Watts	13.2	18.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.4	0.0	0.0	1.7	17.3	5.1	16.4
Florence-Firestone	1.2	7.9	100.0	0.0	0.0	0.0	0.0	1.9	0.0	0.0	3.9	0.0	2.8	6.0	1.7	5.5
Lynwood	2.6	10.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	5.5	0.0	0.7	9.8	3.4	7.8
Paramount	5.6	5.1	0.0	16.0	71.5	0.0	9.0	10.8	0.0	67.0	19.9	31.2	61.7	5.9	14.1	5.8
Compton	21.3	12.6	0.0	0.0	8.4	0.0	0.0	38.9	0.0	0.4	0.0	12.3	0.0	13.2	6.2	15.2
Other	2.5	0.2	0.0	27.5	6.4	59.2	2.6	2.0	4.0	0.0	2.1	7.3	1.2	0.5	8.0	1.1
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Between Service Area 7 Communities																
East LA	2.1	15.2	0.0	0.0	0.0	10.4	3.6	2.4	1.9	0.0	0.7	0.0	0.0	10.3	0.2	9.7
Downey	10.3	7.8	7.7	0.0	21.0	0.0	0.0	0.0	0.0	8.1	17.7	5.6	2.6	7.4	9.0	8.5
Norwalk	8.0	6.9	0.0	0.0	16.7	21.0	7.8	4.1	5.4	23.1	17.1	7.2	24.1	6.6	11.7	7.8
Whittier	14.1	5.3	14.1	0.0	0.9	27.1	19.8	35.4	46.0	0.0	11.6	9.2	3.5	8.7	8.7	8.7
Montebello	8.1	11.7	66.5	0.0	0.0	20.2	13.2	14.6	3.9	0.7	0.8	3.2	4.0	9.2	9.4	10.0
Bell Gardens-Bell-Maywood-Cudahy-Commerce	3.8	15.4	0.0	0.0	24.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	12.6	0.9	10.6
Huntington Park	1.6	10.7	11.4	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.7	0.0	0.6	9.4	1.1	7.1
South Gate	2.7	10.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.7	0.0	0.1	11.7	1.7	7.7
Bellflower	5.9	5.3	0.0	84.7	15.7	0.0	1.2	2.3	0.0	26.9	2.7	3.9	10.4	7.0	6.8	5.7
La Mirada-Santa Fe Springs	17.9	6.5	0.0	0.0	13.4	0.0	0.0	0.0	0.0	5.3	5.5	10.4	10.3	6.5	8.8	9.9
Lakewood-Cerritos-Artesia-Hawaiian Gardens	23.1	4.1	0.0	0.0	6.6	10.6	35.3	29.7	32.8	31.8	38.8	50.8	42.0	9.5	37.4	12.8
Signal Hill	1.8	0.1	0.0	8.4	0.7	10.7	0.8	2.6	2.2	2.5	1.8	1.5	0.5	0.7	3.4	0.8
Other	0.5	0.2	0.3	6.9	0.8	0.0	18.3	8.5	7.9	1.3	2.0	8.1	0.7	0.5	0.9	0.5
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Table 3.4 continued
Primary Language Within Service Area Communities (Percent of Population)

Community	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese	Mandarin	Cambodian	Korean	Vietnamese	Tagalog	NA or Blank	All Others	Total
Within Service Area 8 Communities																
Hancock S.	39.5	51.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	8.7	0.7	100
Wilmington	41.7	39.1	0.0	0.2	0.3	0.1	0.2	0.8	0.1	0.1	1.5	0.0	2.8	8.6	4.6	100
Inglewood	42.9	45.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.3	1.2	100
Torrance	56.6	8.9	1.1	0.4	0.9	0.1	0.5	2.5	0.5	0.0	7.1	0.5	1.0	6.3	13.7	100
Long Beach N.	47.8	30.5	0.0	0.1	0.3	0.1	0.1	0.8	0.0	1.6	0.7	1.3	3.0	9.3	4.4	100
Long Beach S.	34.2	41.2	0.0	0.1	0.0	0.0	0.0	0.2	0.0	7.1	0.5	0.9	4.1	7.5	4.1	100
Long Beach E.	76.3	11.2	0.0	0.1	0.3	0.0	0.0	0.2	0.1	0.6	0.6	0.1	1.3	5.6	3.6	100
Carson	42.0	29.4	0.0	0.0	0.0	0.5	0.0	1.2	0.0	0.1	1.2	0.4	14.2	7.8	3.4	100
Palos Verdes-Lomita	63.4	8.6	0.0	0.3	0.3	0.6	0.2	3.3	0.7	0.6	3.0	0.8	1.1	6.3	10.8	100
Redondo-Manhattan-Hermosa-El Segundo	74.0	6.9	0.2	0.3	0.2	0.3	0.2	0.3	0.2	0.0	0.3	0.5	1.5	9.2	5.9	100
Gardena-Lawndale	46.0	32.8	0.0	0.3	0.0	0.0	0.1	0.4	0.1	0.0	2.5	2.1	1.0	9.9	4.9	100
Hawthorne	32.9	46.8	0.0	0.0	2.1	0.3	0.0	0.3	0.0	0.0	0.1	2.1	1.1	11.4	2.8	100
Other	47.6	32.2	0.0	0.0	0.1	0.0	0.2	1.6	0.3	0.3	2.2	0.9	3.2	7.3	4.2	100
Total	49.4	28.7	0.1	0.2	0.4	0.2	0.1	0.8	0.1	1.2	1.5	0.8	2.7	8.4	5.3	100

[1] Within Community Comparisons

1 - 5%
5 - 50%
> 50%

Table 3.5 continued
Primary Language Between Service Area Communities (Percent of Population)

Community	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese	Mandarin	Cambodian	Korean	Vietnamese	Tagalog	NA or Blank	All Others	Total
Between Service Area 8 Communities																
Hancock S.	0.4	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.1	0.6
Wilmington	9.4	15.3	0.0	15.6	9.6	6.6	18.0	10.1	4.7	1.0	10.9	0.0	11.6	11.4	9.7	11.2
Inglewood	6.9	12.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	9.7	1.8	8.0
Torrance	10.1	2.7	83.3	21.0	20.2	7.4	36.2	26.4	31.9	0.0	40.6	5.0	3.2	6.6	23.0	8.8
Long Beach N.	8.9	9.8	0.0	6.5	7.4	3.6	9.4	8.8	0.0	12.7	4.0	14.5	10.3	10.3	7.8	9.3
Long Beach S.	8.7	18.0	0.0	4.3	0.0	0.0	3.8	2.7	2.2	77.2	4.5	14.4	18.8	11.2	9.8	12.5
Long Beach E.	12.5	3.2	0.0	5.7	6.2	0.0	3.1	2.0	3.6	4.5	3.0	1.1	3.8	5.4	5.6	8.1
Carson	6.1	7.4	0.0	0.0	0.0	22.8	0.0	10.4	1.9	0.3	5.4	3.3	37.5	6.6	4.6	7.2
Palos Verdes-Lomita	9.0	2.1	0.0	13.1	5.2	26.2	9.3	27.7	36.8	3.9	13.8	6.6	2.7	5.3	14.4	7.0
Redondo-Manhattan-Hermosa-El Segundo	12.8	2.1	16.7	14.8	3.9	15.3	12.9	3.2	12.1	0.0	1.7	5.6	4.6	9.4	9.5	8.5
Gardena-Lawndale	8.6	10.6	0.0	18.9	0.0	0.0	6.9	4.3	4.6	0.0	15.0	24.6	3.3	10.9	8.6	9.3
Hawthorne	6.1	14.9	0.0	0.0	47.4	18.1	0.0	3.7	1.4	0.2	0.7	24.5	3.8	12.4	4.8	9.2
Other	0.3	0.3	0.0	0.0	0.1	0.0	0.6	0.6	0.8	0.1	0.4	0.3	0.4	0.3	0.2	0.3
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

[2] Total

Figures in this column reflect relative percentages of individuals reporting a primary language. Percentages correspond closely with population estimates.

Linguistic Isolation

Description of Indicator

This ACS variable is an indication of a severe language barrier affecting families. A household is considered linguistically isolated when all adults and children over the age of 14 residing there do not speak English or have very limited English skills.

Research Base and Relevance to PEI

Limited English proficiency represents a strong barrier to mental health treatment, learning, and school success. Besides ethnicity, limited English contributes to mental health disparities involving access to services (Snowden, Masland, & Guerrero, 2007). Linguistically isolated families represent some of the most disadvantaged individuals in society. In terms of mental health, linguistically isolated families may not be receiving information on where or how to get help when a family member needs it.

What the Numbers Show

Overall, approximately 247,418, or 7.8% percent, of households in Los Angeles County reported that they were linguistically isolated. Across the county, this percentage ranged from the low of 0.4% in the Long Beach E. area and 0.5% in the Redondo-Manhattan-Hermosa-El Segundo Beach areas to 22.7% in the East LA area and 25.5% in the

Pico Heights area. As you inspect the following tables, you may find that it is possible to make some educated guesses on the types of households that are reporting isolation. This requires that you make a cross comparison between the ethnicity and primary language tables above. Sometimes it may be quite obvious that isolated households are likely to be primarily Hispanic or Asian in heritage, but other times, especially when communities are ethnically diverse, it becomes less clear. So we do not know the precise heritage language for those isolated with these data; more data mining with the ACS would be required to completely answer that question.

Service Area Communities

Service Area 1: Antelope Valley

All Service Area 1 communities had Linguistic Isolation scores that were all below the county's average of 7.8%. Of these, the North County E. area, which surrounds the two urban areas of Palmdale and Lancaster, reported the lowest percentage of individuals who were Linguistically Isolated (2.5%). This figure is consistent with finding that the majority of residents within the service area designated English as their primary language.

Service Area 2: San Fernando

Service Area 2 had an overall Linguistic Isolation score of 6.9%, which was lower than the countywide figure of 7.8%. Examining the composite communities with the San Fernando Valley area indicated that there was a great deal of variability in isolated households. The Brentwood N. area, for example, had an isolation score of 1.2%, whereas the Pacoima-Arleta area (11.5%) and the Panorama City area (18.2%) had isolation scores much higher. Because the Pacoima-Arleta area reported a primary language of Spanish in over 72.9% of the population, it seems likely that most isolated households are primarily monolingual Spanish-speaking. This would also seem to hold for the Panorama City area, as well, with 80.2% of its population reporting Spanish as their primary language. Additionally, in the Panorama City area, there were large numbers of Koreans and Filipinos who spoke their heritage language at home and undoubtedly these households also contributed to the high isolation score for the service area. The Glendale area (9.7%) had nearly 10% of its households reporting Linguistic Isolation, as well. One might be tempted to attribute this to the large population of Armenians living in the area who report Armenian as their primary language (28.9%), but a more careful inspection of the primary language table indicates that several other ethnic groups may contribute to this figure, as well, (e.g., Spanish, Arabic, Farsi, Korean, Russian, and Tagalog speakers account for well over 10% of the community's population).

Service Area 3: San Gabriel

In terms of Linguistic Isolation, the San Gabriel Valley had an overall isolation score of 7.0%, which was a slightly below the county score of 7.8%. Drilling down into the composite communities of the service area indicated that three areas had Linguistic Isolation scores in excess of 10%: the Alhambra-S. Pasadena area (10.9%), largely Spanish and Chinese-speaking; the Monterey Park-Rosemead area (15.2%), largely Spanish, Chinese, and Vietnamese-speaking; and the El Monte area (17%), largely Spanish, Chinese, and Vietnamese-speaking. It is especially

Table 3.6
Linguistic Isolation in Los Angeles County[1]

Service Area 1: Antelope Valley	
Lancaster	4.4
Palmdale	4.3
North County E.	2.5
Total	3.9

Service Area 2: San Fernando	
Santa Clarita	3.7
Burbank	2.8
Glendale	9.7
Northridge	5.5
Granada Hills	3.6
Pacoima-Arleta	11.5
La Tuna Cyn.	6.1
Panorama City	18.2
North Hollywood	8.4
Sherman Oaks	8.7
Encino	7.6
Woodland Hills	6.9
Brentwood N.	1.2
North County W.	2.5
La Canada-Flintridge	2.3
San Fernando-Calabasas-Agoura	1.3
Total	6.9

Service Area 3: San Gabriel	
Pasadena	3.6
El Monte	17.0
Pomona	8.9
West Covina	2.6
Altadena-Monrovia-Sierra Madre	2.3
Alhambra-S. Pasadena	10.9
Arcadia-San Gabriel-Temple City-San Marino	6.4
Baldwin Park-Azusa-Duarte	6.8
Glendora-Claremont-San Dimas-La Verne	0.9
Covina-Walnut	3.8
Diamond Bar	8.3
La Puente-S. El Monte	8.7
Hacienda Heights	4.0
Monterey Park-Rosemead	15.2
Other	2.5
Total	7.0

Service Area 4: Metro	
Wilshire La Brea E.	7.2
Hollywood	12.1
Pico Heights	25.5
Echo Park	21.0
Highland Park	7.3
Downtown	17.3
USC N.	15.1
West Adams	7.3
West Hollywood	3.4
Other	22.7
Total	14.0

Service Area 5: West	
Brentwood S.	1.2
West LA	3.2
Wilshire La Brea W.	7.2
Baldwin Hills W.	7.3
Playa Vista	1.3
Santa Monica-Culver City-Beverly Hills	3.4
Malibu	1.3
Other	6.3
Total	2.8

Service Area 6: South	
USC S.	15.1
Baldwin Hills S.	7.3
Hancock N.	8.4
USC E.	16.2
Watts	10.2
Florence-Firestone	14.8
Lynwood	11.9
Paramount	5.6
Compton	7.6
Other	3.4
Total	10.3

5-10%
11-20%
> 20%

1. Percentage of families within a community who have no one over the age of 14 who speaks English well.

Table 3.6 continued
Linguistic Isolation in Los Angeles County[1]

Service Area 7: East	
East LA	22.7
Downey	3.4
Norwalk	5.2
Whittier	4.0
Montebello	6.2
Bell Gardens-Bell-Maywood-Cudahy-Commerce	14.8
Huntington Park	14.8
South Gate	11.9
Bellflower	5.6
La Mirada-Santa Fe Springs	3.7
Lakewood-Cerritos-Artesia-Hawaiian Gardens	4.8
Signal Hill	1.8
Other	12.1
Total	8.8
Service Area 8: South Bay	
Hancock S.	8.4
Wilmington	8.4
Inglewood	6.3
Torrance	3.2
Long Beach N.	5.3
Long Beach S.	10.9
Long Beach E.	0.4
Carson	5.2
Palos Verdes-Lomita	1.8
Redondo-Manhattan-Hermosa-El Segundo	0.5
Gardena-Lawndale	9.5
Hawthorne	7.0
Other	6.2
Total	5.7

5-10%
11-20%
> 20%

1. Percentage of families within a community who have no one over the age of 14 who speaks English well.

important to review the community level data for the San Gabriel Valley because like the San Fernando Valley, the difference in neighborhoods is quite dramatic. One might be tempted to think that because the service area percentage is actually below the county percentage that isolated households are less commonly encountered there. Instead, the numbers clearly indicate that for these three communities, large numbers of Linguistically Isolated households do exist.

Service Area 4: Metro

In the Metro area, 14% of households reported that they were Linguistically Isolated, almost twice the county percentage and the highest percentage in the county. Six communities reported over 10% of their households were isolated and two of these were over 20%: the Echo Park area (21%) and the Pico Heights area (25.5%). Examining the Echo Park area indicates that the majority of the population regard Spanish as their primary language. There is also a sizeable Tagalog-speaking population there. This is similar to the Pico Heights area where, in addition to Spanish and Tagalog, there is a large Korean-speaking population (17.8% of the community). Moreover, the Pico Heights area has the highest level of Linguistic Isolation found within all county communities, (i.e., PUMAs), with one out of four people in the area unable to converse in English. With the relatively large and varied ethnic population in the service area, it is not surprising to see a language barrier this high. One would also expect to see a large and recent immigrant population (within two generations) in the various communities who were unfamiliar with English.

Service Area 5: West

Service Area 5 had a Linguistic Isolation score of 2.8%. This was the lowest rate of isolation found across the eight service areas.

Two communities with the highest rates within the service area were still below the county average. For example, the Wilshire-La Brea W. area (7.2%) had a portion of the Korean-speaking population within its boundary and this likely contributed to this figure. The Baldwin Hills W. area (7.3%) had a majority of primary Spanish speakers within its boundaries and no other language group, aside from English, in significant numbers. Here, it was clear that isolated households were likely to be monolingual Spanish-speaking.

Service Area 6: South

Service Area 6 had a Linguistic Isolation score of 10.3%, which was above the county-wide score, 7.8%, and second only to Service Area 4. Four of its composite communities had isolation scores above 10%, and the four were quite similar in their demographic make up: USC S. (15.1%), USC E. (16.2%), Florence-Firestone (14.8), and Lynwood (11.9%) All four areas are characterized by a majority of primary Spanish speakers and all have very few numbers of language groups other than English. There is little question that isolated households in the service area are primarily monolingual Spanish-speaking.

Service Area 7: East

Service Area 7 had a Linguistic Isolation score of 8.8%, which was above the county figure of 7.8%. Four named communities within the service area had isolation levels in excess of 10%: South Gate (11.9%), Huntington Park (14.8%), Bell Gardens-Bell-Maywood-Cudahy-Commerce (14.8), and East LA (22.7%). Like Service Area 6, these four communities are demographically similar in terms of primary language composition: a large majority of residents in each of these communities are primary Spanish speakers, (e.g., in the East LA area, 84.4% of the population; in Huntington Park, 81.9%). Each community has very few speakers of other languages besides English. As in Service Area 6, there is little question that isolated households in these communities are likely to be monolingual Spanish-speaking.

Service Area 8: South Bay

The South Bay area had a Linguistic Isolation score of 5.7%, which was below the county figure of 7.8%. Two of the county's least-isolated communities were found here: Long Beach E. (0.4%) and the beach aggregate of Redondo-Manhattan-Hermosa-El Segundo (0.5%). Both of these communities were among the largest primary English-speaking communities in the county. Two communities within the service area did have Linguistic Isolation levels around 10%: the Gardena-Lawndale area (9.5%) and the Long Beach S. area (10.9%). It was not clear whether one or more language groups contribute to these figures, as both areas are ethnically diverse. The Gardena-Lawndale area, for instance, has a large primary Spanish-speaking population, but also sizeable numbers of Korean and Vietnamese-speaking individuals. The Long Beach S. area also has a large primary Spanish-speaking population and the largest primary Cambodian-speaking population in the county. A more in-depth analysis would need to be conducted in order to determine the exact languages that are being spoken within these isolated households.

INDICATORS FOR INDIVIDUALS EXPERIENCING ONSET OF SERIOUS PSYCHIATRIC ILLNESS

Mental Health Treatment Penetration Rate (McGee Method, 2002)

Description of Indicator

"Serious mental illness (SMI): is a term defined by Federal regulations that generally applies to mental disorders that interfere with some area of social functioning, approximately 5.4% of US adults." (California State Department of Mental Health, Statistics and Data Analysis, 2008). Obviously, the term may or may not include a variety of clinical diagnoses and there are different methods for assessing the prevalence of SMI in a given community, (e.g., using rating scales and performing statistical analyses). The present report utilizes SMI prevalence data published by the California State Department of Mental Health.

Table 3.7
Countywide Summary: SMI Penetration Rates

Service Area	White	African American	Latino	Native American	Asian	Total
1	0.25	0.82	0.21	0.30	0.08	0.32
2	0.14	0.62	0.18	0.27	0.05	0.18
3	0.12	0.52	0.16	0.38	0.04	0.17
4	0.26	1.28	0.23	0.67	0.16	0.31
5	0.16	0.84	0.28	0.61	0.04	0.24
6	0.83	0.56	0.17	0.40	0.24	0.32
7	0.17	0.57	0.14	1.33	0.06	0.16
8	0.19	0.47	0.20	0.31	0.10	0.24
Total*	0.18	0.69	0.18	0.47	0.07	0.34

* includes Countywide Programs

< 0.1
0.1 – 0.2

Calculating penetration rates involves using prevalence estimates to determine the actual numbers of individuals expected to have SMI in a given area. This figure is then divided into the number of recipients receiving mental health services for the area. The quotient is known as the penetration rate:

Penetration Rate = Individuals Receiving MHS/(total population * SMI prevalence)

Calculating penetration rates in this manner is thought to yield a more precise estimate of individuals with SMI than other population-based estimates.

Research Base and Relevance to PEI

"A penetration rate provides an indicator of whether persons with mental illness are receiving services and whether the system is responsive to various consumer populations." (McGee, 2002). Calculating penetration rates in this manner is thought to yield a more precise estimate of individuals with SMI receiving services than other population based estimates. This figure can give us information on the extent to which mental health treatment could theoretically reach the population most in need of services, (i.e., those with SMI). A relatively low penetration rate indicates that there is likely a need for services in the community, while high penetration rates suggest that a large number of individuals have been identified by the mental health system and are receiving treatment.

What the Numbers Show

Overall, the countywide penetration rate was

0.34. One way to understand this figure is to read it as a measure of how well a mental health system of care can serve the local SMI population. In general, larger numbers reflect greater penetration into the SMI population. But, it is important to understand that even at a penetration rate at or above 100%, one cannot be certain that all individuals with SMI are necessarily being served. To be sure, one would need to analyze individual client records to ascertain diagnoses, assess levels of functional impairment, and levels of treatment. Still the penetration rate figures are important to consider since they can point to disparities across county regions and across ethnic groups.

Countywide, there was wide variation in penetration rates seen across ethnic groups. The Asian population (0.07) had the lowest overall penetration rate, followed by the Latino population (0.18), the White population (0.18), the Native American population (0.47), and the African-American population (0.69). Undoubtedly, there is a complex social process driving these results. Without conducting more involved statistical analyses, we can only speculate about the degree to which factors such as mental health stigma, language barriers, and therapists' language capacities may be responsible for these numbers.

Service Area Communities

Service Area 1: Antelope Valley
The overall Penetration Rate for Service Area 1 was 0.32, and along with Service Area 6, this was the highest rate seen across the county. Relatively speaking, this indicates that treatment services may be reaching the SMI population here to a greater degree than found in other parts of the county. Examining penetration rates across ethnicities indicated that Asians (0.08) were the least served by county mental health services. Penetration rates for the other major ethnic groups were as follows: the Latino population (0.21), the White population (0.25), the Native American population (0.30) and the African-American population (0.82).

Service Area 2: San Fernando
The overall Penetration Rate for Service Area 2 was 0.18 and was well below the countywide rate of 0.34. Such a figure suggested that the local mental health resources may have a smaller reach into the SMI population than other parts of the county. Across ethnicities, Asians (0.05) were the least-served by county mental health services. Following this, in order of Penetration Rates, were the White population (0.14), the Latino population (0.18), the Native American population (0.27) and the African-American population (0.62).

Service Area 3: San Gabriel
The overall Penetration Rate for Service Area 3 was 0.17, below the countywide rate of 0.34. Such a figure suggested that the local mental health resources may have a smaller reach into the SMI population than other parts of the county. Across ethnicities, Asians (0.04) were the least-served by county mental health services. Following this, in order of Penetration Rates, were the White population (0.12), the Latino population (0.16), the Native American population (0.38) and the African-American population (0.52).

Service Area 4: Metro
The overall Penetration Rate for Service Area 4 was 0.31, slightly below the countywide

rate of 0.34. Across ethnicities, Asians (0.16) were the least-served by county mental health services, though for the Asian population this was the highest Penetration Rate obtained across all service areas. Following this, in order of Penetration Rates, were the Latino population (0.23), the White population (0.26), the Native American population (0.67) and the African-American population (1.28). This was the highest Penetration Rate seen for the African-American population across all service areas.

Service Area 5: West

The overall Penetration Rate for Service Area 5 was 0.24., which was lower than the countywide rate of 0.34. Across ethnicities, Asians (0.04) were the least-served by county mental health services. Following this, in order of Penetration Rates, were the White population (0.16), the Latino population (0.28), the Native American population (0.61), and the African-American population (0.84).

Service Area 6: South

The overall Penetration Rate for Service Area 6 was 0.32, very close to the countywide rate of 0.34. Along with Service Area 1, this was the highest rate seen in the county. Across service area ethnicities, Latinos (0.17) were the least-served by county mental health services. Following this, in order of Penetration Rates, were the Asian population (0.24), the Native American population (0.40), the African-American population (0.56), and the White population (0.83). Service Area 6 differed considerably from the other service areas in the relative rates across ethnicities. It is the only service area where the Asian population did not have the lowest Penetration Rate, and the only service area where the White population had the highest Penetration Rate.

Service Area 7: East

The overall Penetration Rate for Service Area 7 was 0.16; this was the lowest rate seen in the county (whose overall rate was 0.34). This suggests that county mental health services may have the least reach into the SMI population here than elsewhere in the county. Across ethnicities, Asians (0.06) were the least-served by county mental health services. Following this, in order of Penetration Rates, were the Latino population (0.14), the White population (0.17), the African-American population (0.57), and the Native American population (1.33). This was the highest Penetration Rate obtained for the Native American population in the county.

Service Area 8: South Bay

The overall Penetration Rate for Service Area 8 was 0.24, lower than the county rate of 0.34. This suggested that county mental health services may have less of a reach into the SMI population in this area than elsewhere in the county. Across ethnicities, Asians (0.10) were the least served by county mental health services. Following this, in order of Penetration Rates, were the Latino population and the White population, both 0.18, the Native American population (0.31), and the African-American population (0.47).

❖ ❖ ❖

SELECTED DIAGNOSES

Depressive Disorders

Description of Indicators

This indicator is a frequency count of individuals in the County of Los Angeles Department of Mental Health's (DMH's) information system with a depressive disorder diagnosis, including Major Depression, Dysthymic Disorder, and Depressive Disorder NOS. Figures are reported for the 2006-07 fiscal year by PEI Age Groups and Ethnicity.

Research Base and Relevance to PEI

Depressive disorders rank as the most debilitating mental health disorders worldwide in terms of disease burden. The World Health Organization reports, "Depression is the leading cause of disability as measured by Years Lived with a Disability (YLD) and the 4th leading contributor to the global burden of disease in 2000. By the year 2020, depression is projected to reach 2nd place of the ranking of Disability Adjusted Life Years (DALYs, the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability) calculated for all ages, both sexes. Today, depression is already the 2nd cause of DALYs in the age category 15-44 years for both sexes combined." Depressive disorders are associated with poorer outcomes in terms of physical health, economic well-being, school achievement, co-occurring disorders, and criminal behavior. All of these outcomes are important for the PEI planner to consider. Additionally, research has indicated that ethnic disparities exist in terms of depression treatment with African-American and Hispanic clients receiving treatment at a lower rate than for Whites (Simpson, S. M., Krishnan, L. L., Kunik, M. E., & Ruiz, P. (2007).

Table 3.8
Depression Disorders by Age Groups
Across Los Angeles County (% of population)

	0-15	16-25	26-59	60+	Total
Within Service Areas[1]					
Service Area 1	25.9	30.9	39.5	3.7	100
Service Area 2	18.5	22.8	50.0	8.8	100
Service Area 3	34.9	22.0	37.0	6.1	100
Service Area 4	19.9	21.0	50.2	8.9	100
Service Area 5	19.9	16.3	54.0	9.8	100
Service Area 6	18.2	15.1	60.4	6.3	100
Service Area 7	24.6	26.4	43.6	5.5	100
Service Area 8	21.2	17.8	53.1	8.0	100
Total	22.2	21.0	49.2	7.5	100
Between Service Areas[2]					
Service Area 1	5.6	7.0	3.8	2.4	4.8
Service Area 2	15.4	20.0	18.8	21.5	18.5
Service Area 3	17.9	11.9	8.6	9.3	11.4
Service Area 4	19.4	21.5	22.0	25.4	21.6
Service Area 5	5.3	4.5	6.4	7.6	5.8
Service Area 6	9.6	8.3	14.3	9.7	11.6
Service Area 7	12.4	13.9	9.8	8.0	11.1
Service Area 8	14.5	12.8	16.3	16.1	15.2
Total	100	100	100	100	100

1. Within Service Areas: 30 - 40%; 40 - 50 %; > 50%

2. Between Service Areas: Low; High

What the Numbers Show

Age Groups

Across the county, 60,203 DMH clients were diagnosed with a Depressive Disorder. In Table 3.8, 49.2% of these clients were adults (26-59 years), 22.2% were children (0-15 years), 21.0% where TAY, and 7.5% were older adults (60+). In five service areas (2, 4,5,6, and 8), adults accounted for 50% or more of the depressed clients treated. The three other service areas saw well over 30 and 40% of the individuals treated for depressive disorders coming from their respective adult populations as well. With respect to the other age groups, Table 3.8 shows that the relative percentages of depressed clients roughly corresponded with the population estimates for each age category (cf. Table

Table 3.9

Depressive Disorders by Ethnicity Across Los Angeles County (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Within Service Areas[1]									
Service Area 1	28.9	32.3	0.7	0.7	29.5	0.1	2.1	5.7	100
Service Area 2	29.2	10.7	0.4	1.8	41.9	0.0	6.7	9.2	100
Service Area 3	16.7	12.0	0.6	7.0	53.3	0.0	2.2	8.1	100
Service Area 4	16.7	22.3	0.4	5.7	44.0	0.1	2.7	8.0	100
Service Area 5	39.9	21.6	0.5	2.2	22.3	0.1	3.7	9.7	100
Service Area 6	3.4	52.4	0.2	0.9	34.3	0.1	0.7	8.0	100
Service Area 7	12.6	10.7	2.6	2.8	62.0	0.1	1.6	7.6	100
Service Area 8	20.9	23.9	0.3	9.3	33.4	0.3	1.7	10.2	100
Total	19.6	21.9	0.6	4.4	42.0	0.1	2.9	8.5	100

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Between Service Areas[2]									
Service Area 1	7.0	7.0	5.1	0.8	3.3	3.0	3.4	3.2	4.8
Service Area 2	27.6	9.0	11.8	7.8	18.5	7.6	42.5	20.0	18.5
Service Area 3	9.7	6.3	10.2	18.3	14.5	1.5	8.7	10.9	11.4
Service Area 4	18.4	22.0	12.3	28.4	22.6	23.4	20.1	20.2	21.6
Service Area 5	11.9	5.8	4.4	2.9	3.1	7.2	7.3	6.6	5.8
Service Area 6	2.0	27.9	3.6	2.4	9.5	10.2	2.7	11.0	11.6
Service Area 7	7.2	5.4	45.8	7.1	16.4	10.5	6.2	9.8	11.1
Service Area 8	16.1	16.6	6.9	32.3	12.0	36.5	9.1	18.2	15.2
Total	100	100	100	100	100	100	100	100	100

1. Within Service Areas: 30 - 40%; 40 - 50 %; > 50%

2. Between Service Areas: Low; High

1.0). Children accounted for 22.2% of the depressed clients in the county while making up 25.1% of the county population. The TAY group accounted for 21.0% of depressed clients while making up 13.8% of the population. The adult group mentioned above closely corresponded to its population proportion of 47.6%. The older adult group accounted for 7.5% of depressed clients while making up 13.5% of the county population.

Comparisons across service areas indicated that Service Area 4 had the largest proportion of depressed clients in county, 21.6%. This is in contrast with its population share of 11.6%.

Ethnicity

Across seven tracked ethnic groups in Table 3.9, Latinos accounted for 42.0% of depressed clients. This was followed by African-Americans (21.9%), Whites (19.6%), Asians (4.4%), and Other Ethnicities (2.9%). Native Americans (0.6%) and Pacific Islanders (0.1%) accounted for less than 1% of the client population. The bottom half of Table 3.9 shows where the largest proportion of depressed individuals of a given ethnicity were treated. For example, 27.9% of depressed African-American clients were served in Service Area 6, 45.8% of depressed Native American clients were served in Service Area 7, 32.3% of depressed Asian clients were served in Service Area 8, and 22.0% of depressed Latino clients were served in Service Area 4, and so forth.

Service Area Communities (Tables 3.10, 3.11)

Service Area 1: Antelope Valley

Age Groups

Service Area 1 clients accounted for 4.8% of depressed clients in the county. Each of the service area's communities had a different age group that accounted for the largest proportion of depressed clients in their respective area. In the North County E. area, for example, the Child group accounted for 45% of the depressed population. In the Lancaster area, 40.4% of the depressed population came from the TAY group. And in the Palmdale area, the Adult group constituted 50.3% of the depressed population for the community. Across the service area, the Lancaster area had the majority of depressed clients (56.6%), including 74.0% of the depressed TAY group.

Ethnicity

No one ethnic group constituted a majority of depressed clients served in Service Area 1. Across all ethnicities, African-Americans made up the largest proportion of clients, 32.3%, followed by Latino clients, 29.5%; and White clients, 28.9%. Asian, Native American, and Pacific Islander groups each accounted for less than 1% of the depressed clients served in the service area.

Service Area 2: San Fernando

Age Groups

Service Area 2 clients accounted for 18.5% of depressed clients in the county. In general, composite communities saw either the majority of depressed clients coming from either the Child (0-15) group, (the Burbank, Northridge, Encino, San Fernando-Calabasas-Agoura areas), or the Adult (26-59) Group, (the Santa Clarita, Granada Hills, North Hollywood, Woodland Hills areas). Similar to the county numbers, 50% of all depressed clients in the service area were in the Adult group. Across the service area, the largest proportion of clients (25.9%) were served in the Granada Hills area.

Ethnicity

No one ethnic group constituted a majority of depressed clients served in Service Area 2. Across all ethnicities, Latinos comprised the largest proportion of depressed clients, 41.9%, followed by White clients, 29.2%, African-American clients, 10.7%, and Asian clients, 1.8%. Native American and Pacific Islander clients each accounted for less than 1% of the depressed clients served in the service area. Examining the composite communities revealed that in six areas, Latinos were the majority of clients served (the Burbank, Northridge, Pacoima-Arleta, Panorama City, Encino, and San Fernando-Calabasas-Agoura areas). Whites were a majority of depressed clients served in the Santa Clarita area.. No other ethnic group constituted a majority of depressed clients in any other Service Area 2 community.

Service Area 3: San Gabriel

Age Groups

Service Area 3 clients accounted for 11.4% of depressed clients in the county. No age group had a majority of depressed clients in the service area. Examining the relative differences within each community indicated that some areas predominantly treated either children (0-15) or adults (26-59). Five areas, for example, had children as the majority of clients (the West Covina, Alhambra-S. Pasa-

Table 3.10

Depressive Disorders by Age Across Service Areas (% of population)

	0-15	16-25	26-59	60+	Total
Within Service Area 1 Communities[1]					
Lancaster	23.4	40.4	32.6	3.5	100
Palmdale	28.1	17.3	50.3	4.2	100
North County E.	45.5	36.5	16.6	1.4	100
Total	25.9	30.9	39.5	3.7	100
Within Service Area 2 Communities					
Santa Clarita	4.8	13.8	74.6	6.9	100
Burbank	81.2	18.8	0.0	0.0	100
Glendale	23.5	13.9	46.2	16.4	100
Northridge	54.4	30.3	15.4	0.0	100
Granada Hills	11.5	25.6	54.2	8.6	100
Pacoima-Arleta	18.1	23.8	48.9	9.3	100
La Tuna Cyn.	0.0	0.0	0.0	0.0	0
Panorama City	31.9	45.7	22.1	0.3	100
North Hollywood	14.9	17.4	54.6	13.1	100
Sherman Oaks	23.0	25.3	42.2	9.5	100
Encino	60.6	36.4	3.0	0.0	100
Woodland Hills	4.0	13.0	72.7	10.3	100
Brentwood N.	0.0	0.0	0.0	0.0	0
North County W.	45.5	36.5	16.6	1.4	100
La Canada-Flintridge	43.8	22.8	30.1	3.4	100
San Fernando-Calabasas-Agoura	73.9	25.4	0.7	0.0	100
Total	18.5	22.8	50.0	8.8	100
					0
Within Service Area 3 Communities					
Pasadena	38.0	25.5	28.2	8.3	100
El Monte	42.7	25.4	29.5	2.4	100
Pomona	23.0	26.9	47.8	2.4	100
West Covina	77.4	19.9	1.9	0.8	100
Altadena-Monrovia-Sierra Madre	43.8	22.8	30.1	3.4	100
Alhambra-S. Pasadena	66.3	33.7	0.0	0.0	100
Arcadia-San Gabriel-Temple City-San Marino	0.0	9.8	79.6	10.6	100
Baldwin Park-Azusa-Duarte	81.3	18.7	0.0	0.0	100
Glendora-Claremont-San Dimas-La Verne	45.5	27.7	26.4	0.4	100
Covina-Walnut	51.6	25.8	22.6	0.0	100
Diamond Bar	0.0	0.0	0.0	0.0	0
La Puente-S. El Monte	3.7	11.3	71.2	13.8	100
Hacienda Heights	57.1	23.2	19.7	0.0	100
Monterey Park-Rosemead	12.6	12.9	55.3	19.2	100
Other	45.5	36.5	16.6	1.4	100
Total	34.9	22.0	37.0	6.1	100
					0
Within Service Area 4 Communities					
Wilshire La Brea E.	18.3	52.0	28.0	1.8	100
Hollywood	14.2	12.9	62.9	10.0	100
Pico Heights	37.9	27.8	19.0	15.3	100
Echo Park	22.2	24.8	42.9	10.1	100
Highland Park	24.2	26.2	39.7	10.0	100
Downtown	14.7	18.9	60.3	6.1	100
USC N.	29.0	21.5	47.4	2.1	100
West Adams	6.2	9.0	74.9	9.8	100
West Hollywood	23.7	16.1	48.9	11.3	100
Other	34.3	25.4	40.2	0.2	100
Total	19.9	21.0	50.2	8.9	100

	0-15	16-25	26-59	60+	Total
Between Service Area 1 Communities[2]					
Lancaster	51.1	74.0	46.8	53.3	56.6
Palmdale	44.4	22.9	52.1	45.8	40.9
North County E.	4.5	3.0	1.1	0.9	2.6
Total	100	100	100	100	100
Between Service Area 2 Communities					
Santa Clarita	1.5	3.5	8.6	4.5	5.8
Burbank	6.7	1.3	0.0	0.0	1.5
Glendale	8.8	4.2	6.4	12.9	6.9
Northridge	5.1	2.3	0.5	0.0	1.7
Granada Hills	16.1	29.1	28.1	25.5	25.9
Pacoima-Arleta	10.5	11.1	10.4	11.2	10.7
La Tuna Cyn.	0.0	0.0	0.0	0.0	0.0
Panorama City	9.0	10.4	2.3	0.2	5.2
North Hollywood	4.1	3.9	5.5	7.6	5.1
Sherman Oaks	23.5	21.0	16.0	20.4	18.9
Encino	3.9	1.9	0.1	0.0	1.2
Woodland Hills	3.2	8.4	21.4	17.3	14.7
Brentwood N.	0.0	0.0	0.0	0.0	0.0
North County W.	1.2	0.8	0.2	0.1	0.5
La Canada-Flintridge	1.9	0.8	0.5	0.3	0.8
San Fernando-Calabasas-Agoura	4.6	1.3	0.0	0.0	1.1
Total	100	100	100	100	100
Between Service Area 3 Communities					
Pasadena	29.2	31.2	20.4	36.3	26.8
El Monte	17.6	16.6	11.5	5.6	14.4
Pomona	3.6	6.7	7.1	2.1	5.5
West Covina	8.1	3.3	0.2	0.5	3.7
Altadena-Monrovia-Sierra Madre	4.3	3.6	2.8	1.9	3.5
Alhambra-S. Pasadena	8.4	6.8	0.0	0.0	4.4
Arcadia-San Gabriel-Temple City-San Marino	0.0	6.0	29.0	23.3	13.5
Baldwin Park-Azusa-Duarte	6.3	2.3	0.0	0.0	2.7
Glendora-Claremont-San Dimas-La Verne	10.7	10.3	5.8	0.5	8.2
Covina-Walnut	6.7	5.3	2.8	0.0	4.5
Diamond Bar	0.0	0.0	0.0	0.0	0.0
La Puente-S. El Monte	0.6	3.2	11.8	13.8	6.1
Hacienda Heights	2.6	1.7	0.8	0.0	1.6
Monterey Park-Rosemead	1.9	3.0	7.7	16.1	5.2
Other	0.0	0.0	0.0	0.0	0.0
Total	100	100	100	100	100
Between Service Area 4 Communities					
Wilshire La Brea E.	1.7	4.5	1.0	0.4	1.8
Hollywood	12.8	11.0	22.5	20.2	17.9
Pico Heights	26.6	18.5	5.3	24.1	14.0
Echo Park	14.7	15.6	11.3	15.1	13.2
Highland Park	10.3	10.6	6.7	9.5	8.5
Downtown	30.6	37.4	50.0	28.4	41.6
USC N.	1.8	1.3	1.2	0.3	1.2
West Adams	0.2	0.3	0.9	0.7	0.6
West Hollywood	1.2	0.8	1.0	1.3	1.1
Other	0.1	0.1	0.0	0.0	0.1
Total	100	100	100	100	100

Within Service Area 5 Communities	0-15	16-25	26-59	60+	Total
Brentwood S.	0.0	0.0	0.0	0.0	0
West LA	18.8	16.5	57.0	7.7	100
Wilshire La Brea W.	18.3	52.0	28.0	1.8	100
Baldwin Hills W.	6.2	9.0	74.9	9.8	100
Playa Vista	20.5	13.7	47.0	18.8	100
Santa Monica-Culver City-Beverly Hills	23.7	16.1	48.9	11.3	100
Malibu	73.9	25.4	0.7	0.0	100
Other	40.8	21.9	35.1	2.2	100
Total	19.9	16.3	54.0	9.8	100

0

Between Service Area 5 Communities	0-15	16-25	26-59	60+	Total
Brentwood S.	0.0	0.0	0.0	0.0	0.0
West LA	59.1	63.4	66.0	49.3	62.6
Wilshire La Brea W.	1.1	3.9	0.6	0.2	1.2
Baldwin Hills W.	1.1	1.9	4.9	3.5	3.5
Playa Vista	13.7	11.2	11.6	25.5	13.3
Santa Monica-Culver City-Beverly Hills	22.2	18.4	16.9	21.4	18.6
Malibu	2.8	1.2	0.0	0.0	0.7
Other	0.1	0.0	0.0	0.0	0.0
Total	100	100	100	100	100

Within Service Area 6 Communities	0-15	16-25	26-59	60+	Total
USC S.	29.0	21.5	47.4	2.1	100
Baldwin Hills S.	6.2	9.0	74.9	9.8	100
Hancock N.	18.7	15.4	62.9	3.0	100
USC E.	22.9	16.0	55.2	5.9	100
Watts	60.5	16.9	22.2	0.4	100
Florence-Firestone	78.1	21.9	0.0	0.0	100
Lynwood	76.5	21.7	1.8	0.0	100
Paramount	41.7	58.3	0.0	0.0	100
Compton	9.5	15.1	67.9	7.5	100
Other	23.7	16.1	48.9	11.3	100
Total	18.2	15.1	60.4	6.3	100

0

Between Service Area 6 Communities	0-15	16-25	26-59	60+	Total
USC S.	12.3	11.0	6.1	2.6	7.7
Baldwin Hills S.	5.8	10.2	21.1	26.3	17.0
Hancock N.	5.5	5.5	5.6	2.6	5.4
USC E.	24.2	20.5	17.7	18.1	19.3
Watts	22.1	7.5	2.5	0.5	6.7
Florence-Firestone	1.6	0.6	0.0	0.0	0.4
Lynwood	5.6	1.9	0.0	0.0	1.3
Paramount	0.3	0.6	0.0	0.0	0.1
Compton	21.6	41.6	46.6	49.0	41.4
Other	0.8	0.6	0.5	1.1	0.6
Total	100	100	100	100	100

Within Service Area 7 Communities	0-15	16-25	26-59	60+	Total
East LA	34.3	25.4	40.2	0.2	100
Downey	33.6	65.0	1.3	0.0	100
Norwalk	44.9	26.6	25.3	3.2	100
Whittier	57.1	23.2	19.7	0.0	100
Montebello	30.0	28.4	41.6	0.0	100
Bell Gardens-Bell-Maywood-Cudahy-Commerce	14.5	25.0	48.3	12.3	100
Huntington Park	78.1	21.9	0.0	0.0	100
South Gate	76.5	21.7	1.8	0.0	100
Bellflower	41.7	58.3	0.0	0.0	100
La Mirada-Santa Fe Springs	24.2	19.7	50.5	5.6	100
Lakewood-Cerritos-Artesia-Hawaiian Gardens	12.4	17.3	63.1	7.2	100
Signal Hill	64.3	35.7	0.0	0.0	100
Other	12.6	12.9	55.3	19.2	100
Total	24.6	26.4	43.6	5.5	100

0

Between Service Area 7 Communities	0-15	16-25	26-59	60+	Total
East LA	9.7	6.7	6.4	0.3	7.0
Downey	15.3	27.7	0.3	0.0	11.2
Norwalk	12.1	6.7	3.8	3.8	6.6
Whittier	8.0	3.1	1.6	0.0	3.5
Montebello	5.5	4.8	4.3	0.0	4.5
Bell Gardens-Bell-Maywood-Cudahy-Commerce	9.5	15.3	17.8	36.2	16.1
Huntington Park	2.2	0.6	0.0	0.0	0.7
South Gate	5.7	1.5	0.1	0.0	1.8
Bellflower	0.3	0.5	0.0	0.0	0.2
La Mirada-Santa Fe Springs	15.0	11.4	17.7	15.6	15.3
Lakewood-Cerritos-Artesia-Hawaiian Gardens	16.5	21.6	47.7	43.5	32.9
Signal Hill	0.1	0.0	0.0	0.0	0.0
Other	0.1	0.1	0.2	0.6	0.2
Total	100	100	100	100	100

Within Service Area 8 Communities	0-15	16-25	26-59	60+	Total
Hancock S.	18.7	15.4	62.9	3.0	100
Wilmington	13.2	22.5	53.7	10.6	100
Inglewood	40.8	21.9	35.1	2.2	100
Torrance	55.6	43.1	1.3	0.0	100
Long Beach N.	67.7	17.5	14.2	0.7	100
Long Beach S.	6.3	10.7	71.6	11.4	100
Long Beach E.	70.5	29.5	0.0	0.0	100
Carson	17.2	20.4	55.2	7.3	100
Palos Verdes-Lomita	64.3	35.7	0.0	0.0	100
Redondo-Manhattan-Hermosa-El Segundo	22.2	11.1	66.7	0.0	100
Gardena-Lawndale	8.6	10.0	56.7	24.7	100
Hawthorne	1.3	10.8	78.4	9.5	100
Other	10.6	16.0	66.0	7.4	100
Total	21.2	17.8	53.1	8.0	100

Between Service Area 8 Communities	0-15	16-25	26-59	60+	Total
Hancock S.	0.2	0.2	0.3	0.1	0.2
Wilmington	5.3	10.7	8.6	11.2	8.5
Inglewood	8.8	5.7	3.0	1.2	4.6
Torrance	11.1	10.2	0.1	0.0	4.2
Long Beach N.	31.8	9.8	2.7	0.8	10.0
Long Beach S.	7.6	15.4	34.5	36.6	25.6
Long Beach E.	7.3	3.6	0.0	0.0	2.2
Carson	25.1	35.6	32.1	28.1	30.9
Palos Verdes-Lomita	0.4	0.3	0.0	0.0	0.1
Redondo-Manhattan-Hermosa-El Segundo	0.1	0.1	0.1	0.0	0.1
Gardena-Lawndale	1.3	1.8	3.4	9.9	3.2
Hawthorne	0.6	5.8	14.1	11.4	9.6
Other	0.4	0.8	1.0	0.8	0.8
Total	100	100	100	100	100

1. Within Service Areas: 30 - 40%; 40 - 50 %; > 50%

2. Between Service Areas: Low; High

Table 3.11

Depressive Disorders by Ethnicity Across Service Areas (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Re-sponse	Total
Within Service Area 1 Communities									
Lancaster	26.6	33.3	0.7	0.8	30.4	0.1	1.9	6.2	100
Palmdale	31.7	31.7	0.6	0.7	27.5	0.1	2.4	5.4	100
North County E.	33.7	21.6	1.1	0.7	39.4	0.0	1.1	2.4	100
Total	28.9	32.3	0.7	0.7	29.5	0.1	2.1	5.7	100
Within Service Area 2 Communities									
Santa Clarita	56.4	4.0	0.4	2.2	22.8	0.0	3.1	10.9	100
Burbank	12.4	15.3	0.0	4.1	64.7	0.0	2.4	1.2	100
Glendale	21.5	3.4	0.5	1.3	33.8	0.0	34.6	4.9	100
Northridge	26.7	9.2	0.5	2.1	53.3	0.0	3.1	5.1	100
Granada Hills	31.1	11.3	0.5	1.6	41.6	0.0	6.9	7.0	100
Pacoima-Arleta	20.1	9.5	0.3	1.3	56.7	0.0	1.3	10.8	100
La Tuna Cyn.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Panorama City	13.3	26.9	0.2	0.9	55.5	0.0	1.4	1.9	100
North Hollywood	31.0	15.4	0.2	0.9	40.8	0.0	1.8	9.9	100
Sherman Oaks	24.5	13.0	0.4	3.4	45.5	0.1	4.1	8.9	100
Encino	11.4	4.5	0.0	2.3	73.5	0.0	5.3	3.0	100
Woodland Hills	40.6	6.2	0.4	1.2	25.9	0.1	7.1	18.5	100
Brentwood N.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
North County W.	33.7	21.6	1.1	0.7	39.4	0.0	1.1	2.4	100
La Canada-Flintridge	23.9	12.7	0.0	2.4	44.3	0.0	4.3	12.3	100
San Fernando-Calabasas-Agoura	21.5	7.2	1.3	0.0	67.4	0.0	0.7	2.0	100
Total	29.2	10.7	0.4	1.8	41.9	0.0	6.7	9.2	100
Within Service Area 3 Communities									
Pasadena	16.8	22.6	0.4	1.4	46.5	0.0	2.2	10.1	100
El Monte	16.8	9.3	0.4	6.6	60.0	0.0	1.5	5.3	100
Pomona	22.4	12.5	0.5	1.8	54.0	0.3	3.3	5.2	100
West Covina	9.8	5.3	0.4	2.4	75.1	0.0	2.3	4.8	100
Altadena-Monrovia-Sierra Madre	23.9	12.7	0.0	2.4	44.3	0.0	4.3	12.3	100
Alhambra-S. Pasadena	5.3	3.3	0.3	8.6	79.2	0.0	2.3	1.0	100
Arcadia-San Gabriel-Temple City-San Marino	26.2	7.3	1.0	7.6	43.6	0.0	2.3	12.1	100
Baldwin Park-Azusa-Duarte	4.8	11.8	0.5	0.0	79.7	0.0	1.6	1.6	100
Glendora-Claremont-San Dimas-La Verne	17.7	13.4	1.3	1.3	59.5	0.0	2.6	4.2	100
Covina-Walnut	17.9	7.0	0.6	0.7	66.6	0.0	3.0	4.2	100
Diamond Bar	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
La Puente-S. El Monte	16.2	5.6	0.9	2.5	65.4	0.0	1.5	7.9	100
Hacienda Heights	9.1	2.4	0.9	0.3	80.3	0.0	4.4	2.6	100
Monterey Park-Rosemead	1.4	0.8	0.0	72.3	5.8	0.0	0.5	19.2	100
Other	33.7	21.6	1.1	0.7	39.4	0.0	1.1	2.4	100
Total	16.7	12.0	0.6	7.0	53.3	0.0	2.2	8.1	100

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Between Service Area 1 Communities									
Lancaster	52.2	58.2	61.4	61.3	58.4	50.0	51.5	60.8	56.6
Palmdale	44.8	40.1	34.6	36.3	38.2	50.0	47.2	38.1	40.9
North County E.	3.0	1.7	4.0	2.4	3.4	0.0	1.3	1.1	2.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Between Service Area 2 Communities									
Santa Clarita	11.1	2.2	6.4	7.1	3.1	0.0	2.7	6.8	5.8
Burbank	0.6	2.2	0.0	3.4	2.4	0.0	0.5	0.2	1.5
Glendale	5.1	2.2	8.9	4.9	5.6	0.0	35.7	3.7	6.9
Northridge	1.6	1.5	2.2	2.0	2.2	0.0	0.8	1.0	1.7
Granada Hills	27.6	27.3	28.8	23.0	25.7	20.0	26.9	19.7	25.9
Pacoima-Arleta	7.3	9.5	8.8	7.3	14.4	0.0	2.0	12.5	10.7
La Tuna Cyn.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Panorama City	2.4	13.1	2.2	2.5	6.9	0.0	1.1	1.1	5.2
North Hollywood	5.4	7.3	2.2	2.5	4.9	0.0	1.3	5.4	5.1
Sherman Oaks	15.9	23.0	20.0	34.8	20.5	60.0	11.7	18.3	18.9
Encino	0.5	0.5	0.0	1.5	2.1	0.0	0.9	0.4	1.2
Woodland Hills	20.5	8.6	15.5	9.8	9.1	20.0	15.6	29.5	14.7
Brentwood N.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
North County W.	0.6	1.0	1.3	0.2	0.5	0.0	0.1	0.1	0.5
La Canada-Flintridge	0.7	1.0	0.0	1.1	0.8	0.0	0.5	1.1	0.8
San Fernando-Calabasas-Agoura	0.8	0.8	3.7	0.0	1.8	0.0	0.1	0.2	1.1
Total	100	100	100	100	100	100	100	100	100
Between Service Area 3 Communities									
Pasadena	27.0	50.5	17.9	5.4	23.4	0.0	27.0	33.5	26.8
El Monte	14.5	11.1	10.0	13.6	16.2	0.0	9.8	9.5	14.4
Pomona	7.3	5.7	5.0	1.4	5.5	94.1	8.2	3.5	5.5
West Covina	2.1	1.6	2.6	1.2	5.1	0.0	3.8	2.1	3.7
Altadena-Monrovia-Sierra Madre	5.0	3.7	0.0	1.2	2.9	0.0	6.7	5.2	3.5
Alhambra-S. Pasadena	1.4	1.2	2.6	5.4	6.6	0.0	4.6	0.5	4.4
Arcadia-San Gabriel-Temple City-San Marino	21.1	8.2	23.3	14.5	11.0	0.0	13.8	20.0	13.5
Baldwin Park-Azusa-Duarte	0.8	2.7	2.6	0.0	4.1	0.0	2.0	0.5	2.7
Glendora-Claremont-San Dimas-La Verne	8.7	9.1	18.1	1.5	9.1	5.9	9.6	4.2	8.2
Covina-Walnut	4.8	2.6	5.1	0.4	5.7	0.0	6.0	2.3	4.5
Diamond Bar	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
La Puente-S. El Monte	6.0	2.9	10.3	2.2	7.5	0.0	4.1	6.0	6.1
Hacienda Heights	0.9	0.3	2.4	0.1	2.4	0.0	3.1	0.5	1.6
Monterey Park-Rosemead	0.4	0.4	0.0	53.1	0.6	0.0	1.3	12.1	5.2
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100	100	100	100	100	100	100	100	100

Table 3.11 Continued

Depressive Disorders by Ethnicity Across Service Areas (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Re-sponse	Total
Within Service Area 4 Communities									
Wilshire La Brea E.	21.1	35.8	1.1	1.8	28.3	0.0	3.6	8.2	100
Hollywood	30.5	20.7	0.4	1.6	30.0	0.2	6.4	10.1	100
Pico Heights	26.0	22.1	0.4	2.6	40.8	0.0	3.5	4.6	100
Echo Park	6.0	12.6	0.4	16.4	59.0	0.1	1.7	3.7	100
Highland Park	9.0	7.7	0.2	1.6	73.8	0.4	0.6	6.7	100
Downtown	12.7	27.0	0.3	6.5	41.8	0.1	1.6	9.9	100
USC N.	1.8	52.2	0.1	0.9	39.7	0.0	0.7	4.6	100
West Adams	2.7	65.8	0.1	0.4	18.7	0.1	1.2	10.8	100
West Hollywood	32.6	26.1	0.1	1.9	26.3	0.2	3.2	9.5	100
Other	3.2	1.1	0.2	0.2	93.1	0.0	0.2	2.1	100
Total	16.7	22.3	0.4	5.7	44.0	0.1	2.7	8.0	100
Within Service Area 5 Communities									
Brentwood S.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
West LA	47.3	17.7	0.7	2.1	18.9	0.1	4.2	9.0	100
Wilshire La Brea W.	21.1	35.8	1.1	1.8	28.3	0.0	3.6	8.2	100
Baldwin Hills W.	2.7	65.8	0.1	0.4	18.7	0.1	1.2	10.8	100
Playa Vista	28.4	21.6	0.0	3.6	30.3	0.0	2.4	13.7	100
Santa Monica-Culver City-Beverly Hills	32.6	26.1	0.1	1.9	26.3	0.2	3.2	9.5	100
Malibu	21.5	7.2	1.3	0.0	67.4	0.0	0.7	2.0	100
Other	9.1	44.5	0.0	0.2	41.8	0.0	1.0	3.4	100
Total	39.9	21.6	0.5	2.2	22.3	0.1	3.7	9.7	100
Within Service Area 6 Communities									
USC S.	1.8	52.2	0.1	0.9	39.7	0.0	0.7	4.6	100
Baldwin Hills S.	2.7	65.8	0.1	0.4	18.7	0.1	1.2	10.8	100
Hancock N.	4.5	72.4	0.2	0.0	14.9	0.0	1.0	7.0	100
USC E.	1.5	50.7	0.1	2.5	36.9	0.0	0.7	7.5	100
Watts	7.1	35.5	0.4	0.6	52.6	0.0	0.6	3.2	100
Florence-Firestone	0.0	65.8	1.4	0.0	28.8	0.0	0.0	4.1	100
Lynwood	2.3	13.8	0.0	0.9	78.8	0.0	0.9	3.2	100
Paramount	29.2	25.0	0.0	0.0	41.7	0.0	4.2	0.0	100
Compton	3.7	49.3	0.2	0.5	36.8	0.2	0.3	8.9	100
Other	32.6	26.1	0.1	1.9	26.3	0.2	3.2	9.5	100
Total	3.4	52.4	0.2	0.9	34.3	0.1	0.7	8.0	100

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Between Service Area 4 Communities									
Wilshire La Brea E.	2.3	2.9	5.4	0.6	1.2	0.0	2.4	1.9	1.8
Hollywood	32.7	16.6	21.2	5.1	12.2	32.4	42.3	22.6	17.9
Pico Heights	21.7	13.9	14.9	6.4	13.0	0.0	17.9	8.0	14.0
Echo Park	4.7	7.5	14.9	37.8	17.7	13.0	8.2	6.2	13.2
Highland Park	4.6	2.9	4.2	2.4	14.3	25.9	2.0	7.1	8.5
Downtown	31.7	50.2	38.2	47.1	39.5	25.9	25.3	51.5	41.6
USC N.	0.1	2.9	0.5	0.2	1.1	0.0	0.3	0.7	1.2
West Adams	0.1	1.8	0.2	0.0	0.3	0.7	0.3	0.8	0.6
West Hollywood	2.0	1.2	0.3	0.4	0.6	2.1	1.3	1.2	1.1
Other	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.1
Total	100	100	100	100	100	100	100	100	100
Between Service Area 5 Communities									
Brentwood S.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
West LA	74.0	51.2	89.5	59.8	53.1	63.2	72.4	58.0	62.6
Wilshire La Brea W.	0.6	2.0	2.8	1.0	1.6	0.0	1.2	1.0	1.2
Baldwin Hills W.	0.2	10.7	1.1	0.7	2.9	3.7	1.2	3.9	3.5
Playa Vista	9.5	13.3	0.0	22.1	18.1	0.0	8.6	18.7	13.3
Santa Monica-Culver City-Beverly Hills	15.2	22.5	4.7	16.4	22.0	33.1	16.5	18.2	18.6
Malibu	0.4	0.2	2.0	0.0	2.2	0.0	0.1	0.1	0.7
Other	0.0	0.1	0.0	0.0	0.1	0.0	0.0	0.0	0.0
Total	100	100	100	100	100	100	100	100	100
Between Service Area 6 Communities									
USC S.	4.2	7.7	5.6	7.3	8.9	0.0	8.1	4.4	7.7
Baldwin Hills S.	13.2	21.3	12.4	8.1	9.3	25.4	30.5	22.9	17.0
Hancock N.	7.1	7.5	6.9	0.0	2.4	0.0	7.9	4.7	5.4
USC E.	8.8	18.7	7.3	53.8	20.8	0.0	21.0	18.1	19.3
Watts	13.8	4.5	14.6	4.7	10.2	0.0	6.3	2.7	6.7
Florence-Firestone	0.0	0.5	2.7	0.0	0.3	0.0	0.0	0.2	0.4
Lynwood	0.9	0.4	0.0	1.4	3.1	0.0	1.8	0.5	1.3
Paramount	1.3	0.1	0.0	0.0	0.2	0.0	0.9	0.0	0.1
Compton	44.9	39.0	50.2	23.4	44.4	73.1	20.7	45.8	41.4
Other	5.7	0.3	0.4	1.3	0.5	1.5	2.8	0.7	0.6
Total	100	100	100	100	100	100	100	100	100

Table 3.11 Continued

Depressive Disorders by Ethnicity Across Service Areas (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Within Service Area 7 Communities									
East LA	3.2	1.1	0.2	0.2	93.1	0.0	0.2	2.1	100
Downey	9.3	35.6	0.3	1.6	42.4	0.4	3.2	7.2	100
Norwalk	29.1	16.0	0.7	4.3	42.7	0.0	2.5	4.7	100
Whittier	9.1	2.4	0.9	0.3	80.3	0.0	4.4	2.6	100
Montebello	5.3	5.3	1.0	0.7	81.7	0.0	1.0	5.0	100
Bell Gardens-Bell-Maywood-Cudahy-Commerce	4.1	7.6	0.3	0.1	78.8	0.0	0.9	8.2	100
Huntington Park	0.0	65.8	1.4	0.0	28.8	0.0	0.0	4.1	100
South Gate	2.3	13.8	0.0	0.9	78.8	0.0	0.9	3.2	100
Bellflower	29.2	25.0	0.0	0.0	41.7	0.0	4.2	0.0	100
La Mirada-Santa Fe Springs	11.4	4.4	0.6	0.8	67.9	0.1	1.2	13.7	100
Lakewood-Cerritos-Artesia-Hawaiian Gardens	19.3	7.8	7.0	6.0	50.6	0.1	1.6	7.4	100
Signal Hill	42.9	0.0	0.0	0.0	57.1	0.0	0.0	0.0	100
Other	1.4	0.8	0.0	72.3	5.8	0.0	0.5	19.2	100
Total	12.6	10.7	2.6	2.8	62.0	0.1	1.6	7.6	100
Within Service Area 8 Communities									
Hancock S.	4.5	72.4	0.2	0.0	14.9	0.0	1.0	7.0	100
Wilmington	27.7	19.8	0.0	0.9	42.3	0.3	1.0	8.0	100
Inglewood	9.1	44.5	0.0	0.2	41.8	0.0	1.0	3.4	100
Torrance	11.2	31.4	0.3	0.8	50.6	0.8	1.8	3.1	100
Long Beach N.	7.8	28.1	0.4	7.0	51.3	0.4	1.2	3.7	100
Long Beach S.	21.8	21.1	0.1	22.0	19.9	0.1	1.2	13.7	100
Long Beach E.	13.5	24.5	0.0	3.0	51.5	3.0	3.5	1.0	100
Carson	28.8	18.4	0.3	2.8	33.8	0.2	2.4	13.2	100
Palos Verdes-Lomita	42.9	0.0	0.0	0.0	57.1	0.0	0.0	0.0	100
Redondo-Manhattan-Hermosa-El Segundo	66.7	11.1	0.0	0.0	11.1	0.0	11.1	0.0	100
Gardena-Lawndale	7.9	8.9	0.7	56.7	12.4	0.3	1.7	11.3	100
Hawthorne	16.9	38.5	0.7	1.0	32.2	0.0	1.9	8.7	100
Other	9.9	32.9	2.9	2.7	42.3	0.2	0.8	8.3	100
Total	20.9	23.9	0.3	9.3	33.4	0.3	1.7	10.2	100

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Between Service Area 7 Communities									
East LA	1.7	0.7	0.6	0.5	10.5	0.0	0.9	1.9	7.0
Downey	8.3	37.4	1.1	6.5	7.7	43.1	22.1	10.7	11.2
Norwalk	15.3	9.9	1.7	10.3	4.6	0.0	10.1	4.2	6.6
Whittier	2.5	0.8	1.2	0.4	4.5	0.0	9.4	1.2	3.5
Montebello	1.9	2.2	1.7	1.1	5.9	0.0	2.8	3.0	4.5
Bell Gardens-Bell-Maywood-Cudahy-Commerce	5.2	11.5	1.7	0.5	20.5	0.0	9.2	17.4	16.1
Huntington Park	0.0	4.3	0.4	0.0	0.3	0.0	0.0	0.4	0.7
South Gate	0.3	2.4	0.0	0.6	2.4	0.0	1.1	0.8	1.8
Bellflower	0.5	0.5	0.0	0.0	0.1	0.0	0.5	0.0	0.2
La Mirada-Santa Fe Springs	13.7	6.3	3.4	4.3	16.7	14.4	11.1	27.7	15.3
Lakewood-Cerritos-Artesia-Hawaiian Gardens	50.5	24.1	88.2	71.3	26.9	42.5	32.7	32.4	32.9
Signal Hill	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	4.5	0.0	0.0	0.1	0.4	0.2
Total	100	100	100	100	100	100	100	100	100
Between Service Area 8 Communities									
Hancock S.	0.1	0.7	0.2	0.0	0.1	0.0	0.1	0.2	0.2
Wilmington	11.2	7.0	0.0	0.8	10.7	8.3	5.0	6.6	8.5
Inglewood	2.0	8.5	0.0	0.1	5.7	0.0	2.5	1.5	4.6
Torrance	2.3	5.5	3.8	0.4	6.4	12.4	4.4	1.3	4.2
Long Beach N.	3.7	11.7	15.2	7.5	15.3	16.6	6.9	3.6	10.0
Long Beach S.	26.7	22.6	11.4	60.3	15.3	8.3	18.3	34.3	25.6
Long Beach E.	1.4	2.2	0.0	0.7	3.4	24.9	4.4	0.2	2.2
Carson	42.7	23.8	30.4	9.4	31.3	24.9	43.4	39.9	30.9
Palos Verdes-Lomita	0.3	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.1
Redondo-Manhattan-Hermosa-El Segundo	0.3	0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.1
Gardena-Lawndale	1.2	1.2	7.6	19.4	1.2	4.1	3.1	3.5	3.2
Hawthorne	7.7	15.4	22.8	1.1	9.2	0.0	10.7	8.1	9.6
Other	0.4	1.2	8.5	0.2	1.1	0.5	0.4	0.7	0.8
Total	100	100	100	100	100	100	100	100	100

1. Within Service Areas

30 - 40%
40 - 50 %
> 50%

dena, Baldwin Park-Azusa-Duarte, Covina-Walnut, and Hacienda Heights areas). Three communities treated a majority of adults (the Arcadia-San Gabriel-Temple City-San Marino, La Puente-S. El Monte, and Monterey Park-Rosemead areas). Across the service area, the largest proportion of clients (26.8%) were served in the Pasadena area.

Ethnicity

Latinos were a majority of depressed clients served in Service Area 3 (53.3%). This was followed by White clients, 16.7%; African-American clients; 12.0%, and Asian clients, 7.0%. Native American and Pacific Islander clients each accounted for less than 1% of the population served in the service area. Examining the composite communities in further detail showed that in nine communities, Latinos were a majority of depressed clients served (the El Monte, Pomona, West Covina, Alhambra-S. Pasadena, Baldwin Park-Azusa-Duarte, Glendora-Claremont-San Dimas-La Verne, La Puente-S. El Monte, and Hacienda Heights areas). Asians were the majority of depressed clients served in one area, Monterey Park-Rosemead. No other ethnic group constituted a majority of depressed clients in the service area.

Service Area 4: Metro
Age Groups

Service Area 4 accounted for 21.6% of depressed clients served in the county. The majority of depressed clients in the service area were from the Adult age (26-59) group (50.2%). In all but two communities, the adult population was the most commonly treated depressed client. The exceptions were the Wilshire-La Brea E. area where 52.0% of depressed clients came from the TAY (16-25) group and the Pico Heights area where 37.9% of depressed clients were from the Child (0-15) group. Across the service area, 41.6% of all depressed clients were treated in the Downtown area.

Ethnicity

No one ethnic group constituted a majority of depressed clients served in Service Area 4. Across all ethnicities, Latinos made up the largest proportion of clients, 44.0%, followed by African-Americans clients, 22.3%; White clients, 16.7%; and Asian clients, 5.7%. Native American and Pacific Islander clients accounted for less than 1% of all depressed clients served in the service area. Drilling down into the composite communities indicated that that two areas treated a majority of African-American clients: the USC N. and West Adams areas. Two other areas treated a majority of Latino clients: the Echo Park and Highland Park areas. No other ethnicity constituted a majority of depressed clients served in any other community in the service area.

Service Area 5: West
Age Groups

Service Area 5 accounted for 5.8% of depressed clients served in the county. The majority of depressed clients in the service area were adults, 26-59, (54.0%). However, a couple of communities had other age groups that were predominantly served in the service area. The Malibu area, for instance, overwhelmingly served the Child (0-15) group (73.9%). The majority of depressed clients served in the Wilshire-La Brea W. area were from the TAY (16-25) group. Across the service area, the majority of depressed clients of all age groups were served in the West LA area.

Ethnicity

No one ethnic group constituted a majority of depressed clients served in Service Area 5. Across all ethnicities, White clients were the largest proportion of clients served, 39.9%. This was followed by African-American clients, 21.6%; Latino clients, 22.3%; and Asian clients, 2.2%. Native American and Pacific Islander ethnic groups accounted for less than 1% of all depressed clients in the service area. Examining the composite communities revealed two communities where there was a clear ethnic majority of depressed clients: the Baldwin Hills W. area ,where 65.8% of depressed clients were African-American, and the Malibu area where 67.4% of depressed clients were Latino.

Service Area 6: South

Age Groups

Service Area 6 accounted for 11.6% of depressed clients served in the county. Overall, a majority of depressed clients were adults, 26-59 (60.4%). This was the largest proportion seen for the adult population across all service areas. Examining the service area communities revealed that four areas treated a majority of adults: the Baldwin Hills S., Hancock N., USC E., and Compton areas. Three communities treated a majority of child (0-15) clients: the Florence-Firestone, Lynwood, and Watts areas. And one community treated a majority of TAY (16-25) clients: the Paramount area. Across the service area, 41.9% of all depressed clients were treated in the Compton area.

Ethnicity

African-Americans were a majority of depressed clients served in Service Area 6 (52.4%). This was followed by Latino clients, 34.3%, and White clients; 3.4%. Asian, Native American, and Pacific Islander clients each accounted for less than 1% of the population served in the service area. Examining the composite communities revealed that in five communities, African-Americans were a majority of depressed clients: the USC S., Baldwin Hills S., Hancock N., USC E., and Florence-Firestone areas. In two communities, Latinos were a majority of depressed clients receiving treatment: the Watts and Lynwood areas. No other community saw an ethnic majority receiving treatment for depressive disorders.

Service Area 7: East

Age Groups

Service Area 7 accounted for 11.1% of depressed clients served in the county. No age group had a majority of depressed clients treated in the service area. 43.6% of depressed clients came from the Adult group and this was below the countywide figure of 49.2%. Children (0-15) were a majority of depressed clients served in four communities (the Whittier, Huntington Park, South Gate, and Signal Hill areas). Two communities saw a majority of depressed clients coming from the TAY (16-25) group: the Downey and Bellflower areas. Two communities treated a majority of depressed Adults (26-59): the La Mirada-Santa Fe Springs and the Lakewood-Cerritos-Artesia-Hawaiian Gardens areas. Across the service area, the large proportion of depressed clients, 32.9%, were treated in the Lakewood-Cerritos-Artesia-Hawaiian Gardens area.

Ethnicity

Latinos were a majority of depressed clients served in Service Area 7 (62.0%). No other

service area saw as large a proportion of clients representing a single ethnic group. This was followed by White clients, 12.6%; African-American clients, 10.7%; Native American clients, 2.6%; and Asian clients, 2.8%. Pacific Islander clients accounted for less than 1% of the population served in the service area. Examining the composite communities in further detail showed eight communities where Latinos were the majority of depressed clients served: the East LA, Whittier, Montebello, Bell Gardens-Bell-Maywood-Cudahy-Commerce, South Gate, La Mirada-Santa Fe Springs, Lakewood-Cerritos-Artesia-Hawaiian Gardens, and Signal Hill areas. African-Americans were a majority of depressed clients in the Huntington Park area.

Service Area 8: South Bay
Age Groups

Service Area 8 accounted for 15.2% of depressed clients served in the county. A majority of the depressed clients in the service area were from the adult (26-59) group (53.1%). Seven communities treated a majority of adults clients for depressive disorders: the Hancock S., Wilmington, Long Beach S., Carson, Redondo-Manhattan-Hermosa-El Segundo, Gardena-Lawndale, and Hawthorne areas. Four communities treated a majority of child (0-15) clients: the Torrance, Long Beach N., Long Beach E., and Palos Verdes-Lomita areas. Across the service area, the Carson area treated the largest proportion of depressed clients in the service area (30.9%). The Long Beach S. area treated 25.6%.

Ethnicity

No one ethnic group constituted a majority of depressed clients served in Service Area 8. Across all ethnicities, Latinos made up the largest proportion of clients, 33.4%, followed by African-Americans clients, 23.9%, White clients, 20.9%, and Asian clients, 9.3%. Native American and Pacific Islander clients each accounted for less than 1% of all depressed clients served in the service area. Drilling down into the composite communities indicated that that four areas treated a majority of Latino clients: the Torrance, Long Beach N., Long Beach E., and Palos Verdes-Lomita areas. One community, the Redondo-Manhattan-Hermosa-El Segundo area, treated a majority of White clients. Another community, the Hancock S. area, treated a majority of African-American clients. And finally, another community, the Gardena-Lawndale area, treated a majority of Asian clients.

❖ ❖ ❖

Co-occurring Disorders (COD)

Description of Indicator

Co-occurring Disorders refer to the simultaneous presence of at least one mental health disorder (DSM-IV-TR Axis I) along with an alcohol or substance abuse disorder. This indicator is a frequency count of individuals in the County of Los Angeles DMH's information system with Co-occurring Disorders for the 2006-07 fiscal year.

Research Base and Relevance to PEI

CODs are difficult to treat and are associated with unfavorable outcomes in economic status, health status, mental health disorders, and family relations. Individuals with COD have a greater likelihood of dropping out of school or becoming involved in criminal be-

havior. Treatment-resistant COD can lead to heavy and repeated service utilization for inpatient and outpatient episodes.

What the Numbers Show

Age Groups

Across the county, 30,439 DMH clients were diagnosed with a co-occurring disorder. A majority of these clients, 59.0%, were adults (26-59 years), 13.0% were children (0-15 years), 25.6% were TAY, and 2.3% were older adults (60+). In all service areas, with the exception of Service Area 7, adults accounted for 50% or more of the individuals with a COD. With respect to the other age groups, Table 3.12 shows that the percent of COD clients under the age of 26 was 38.6%. In general, the TAY population accounted for a quarter of all COD clients but, in some areas, it was higher. In Service Area 7, for example, 36.5% of the COD clients treated were from the TAY group. Children under the age of 16 accounted for a large number of COD cases with clear regional differences. Service Areas 1, 5 and 7 saw percentages in the single digits, but in the other areas of the county, these figures were much higher. In Service Area 7, over 20% of the clients with a COD were children.

Comparisons across service areas indicated that Service Area 4 had the largest proportion of clients treated for COD in the county, 28.3%. This is in contrast to its population share of 11.6% (cf. Table 1.0). With the smallest population in the county, Service Area 1 accounted for the smallest numbers of COD cases in the county.

Ethnicity

Across seven tracked ethnic groups in Table 3.13, Latinos accounted for 33.2.% of clients diagnosed with a co-occurring disorder. This was followed by African-Americans (26.3%), Whites (27.3%), Asians (1.9%), and Other Ethnicities (2.2%). Native Americans (0.9%) and Pacific Islanders (0.1%) each accounted for less than 1% of the COD client population.

The bottom half of Table 3.13 shows where the largest proportion of individuals treated for CODs occurred. For example, 33.3% of African-American clients with a COD were served in Service Area 4; 41.3% of Native

Table 3.12
Co-occurring Disorders by Age Groups
Across Los Angeles County (% of population)

	0-15	16-25	26-59	60+	Total
Within Service Areas[1]					
Service Area 1	7.7	23.6	66.8	1.9	100
Service Area 2	14.5	28.9	54.1	2.4	100
Service Area 3	14.4	25.7	57.5	2.5	100
Service Area 4	15.2	27.4	55.2	2.2	100
Service Area 5	4.4	12.6	78.7	4.2	100
Service Area 6	7.3	16.8	73.6	2.3	100
Service Area 7	20.3	36.5	41.9	1.4	100
Service Area 8	8.9	21.1	67.9	2.1	100
Total	13.0	25.6	59.0	2.3	100

	0-15	16-25	26-59	60+	Total
Between Service Areas[2]					
Service Area 1	2.0	3.2	3.9	2.9	3.4
Service Area 2	21.1	21.3	17.3	20.2	18.9
Service Area 3	8.9	8.1	7.8	8.8	8.1
Service Area 4	33.0	30.2	26.5	26.9	28.3
Service Area 5	2.3	3.3	8.9	12.3	6.6
Service Area 6	4.7	5.5	10.5	8.4	8.4
Service Area 7	17.9	16.4	8.2	6.8	11.5
Service Area 8	10.1	12.1	17.0	13.6	14.8
Total	100	100	100	100	100

1. Within Service Areas: 30 - 40%; 40 - 50 %; > 50%

2. Between Service Areas: Low; High

American clients with a COD were served in Service Area 7; 28.5% of Asian clients with a COD were served in Service Area 4; and 22.0% of Latino clients with a COD were served in Service Area 4.

Service Area Communities (Tables 3.14, 3.15)

Service Area 1: Antelope Valley

Age Groups

Age Groups

Service Area 1 clients accounted for 3.4% of individuals with COD treated in the county's mental health system. Overall, 66.8% of the clients with COD in the service area were adults. In the two urban areas, adults were a majority of COD cases, and in the surrounding North County E. area this figure was 48.0%. Across the service area, the Lancaster area had the majority of clients with CODs (61.5%) even though it had only 36% of the service area population. The Lancaster area also included 74.4% of the TAY COD group, 52.8% of the child group, 57.7% of the adult group, and 69.2% of the older adult group.

Ethnicity

White clients accounted for 42.7% of the COD population treated in Service Area 1. This was followed by African-American clients (27.4%), Latino clients (21.8%), Native American clients (1.3%) and Asian clients (1.0%). When compared with population estimates for these groups, it appeared that African-American (12.8%) and Native American (0.3%) clients were overrepresented in the COD client counts, whereas, Latino (41.1%) and Asian (4.3%) clients were underrepresented.

Service Area 2: San Fernando

Age Groups

Service Area 2 clients accounted for 18.9% of individuals with COD treated in the county's mental health system. Within the service area, and similar to the county as a whole, the majority of clients with a COD were adults (26-59). However, examining the composite communities revealed that certain areas treated a majority of other age groups for CODs. Two communities, the Burbank and San Fernando-Calabasas-Agoura areas, for example, treated a majority of children (0-15) for CODs. Two other areas focused on a majority of TAY (16-25) clients with a COD, the Panorama City and Encino areas. Finally, seven communities provided treatment to a majority of adults with CODs (the Santa Clarita, Glendale, Pacoima-Arleta, North Hollywood, Sherman Oaks, Woodland Hills, and La Canada-Flintridge areas). Across the service area, 39.9% of clients with a COD were treated in the Granada Hills area. This was followed by the Woodland Hills area (14.9%), the Pacoima-Arleta area (11.9%), the Sherman Oaks area (9.6%), and the Santa Clarita area (9.0%).

Ethnicity

White clients accounted for 39.1% of the COD population treated in Service Area 2. This was followed by Latino clients (35.0%), African-American clients (14.1%), and Asian clients (1.4%). Native American and Pacific Islander groups each accounted for less than 1% of the COD population in the county's mental health system. When compared with population estimates for these groups, Latino and White groups appeared to be repre-

Table 3.13

Co-Occurring Disorders by Ethnicity Across Los Angeles County (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Within Service Areas[1]									
Service Area 1	26.9	34.0	0.6	0.2	32.7	0.0	0.9	4.7	100
Service Area 2	18.2	16.7	0.3	4.6	50.7	0.1	5.5	3.9	100
Service Area 3	13.2	15.2	0.6	3.2	60.0	0.0	3.5	4.3	100
Service Area 4	6.1	18.9	1.2	7.9	59.1	0	2.5	4.2	100
Service Area 5	18.3	28.1	0.1	3.0	38.7	0	3.7	8.2	100
Service Area 6	2.5	58.0	0.5	0.5	33.0	0.1	0.8	4.6	100
Service Area 7	7.2	16.5	1.3	6.1	62.7	0	2.5	3.6	100
Service Area 8	10.8	25.7	0.1	15.5	36.4	0.3	1.8	9.4	100
Total	11.6	25.7	0.6	6.2	47.9	0.1	2.7	5.3	100

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Between Service Areas[2]									
Service Area 1	18.3	10.4	8.2	0.3	5.4	0.4	2.5	7.0	7.9
Service Area 2	24.3	10.0	8.0	11.5	16.4	19.6	31.8	11.4	15.5
Service Area 3	15.0	7.7	13.5	6.7	16.4	0.0	17.2	10.7	13.1
Service Area 4	9.8	13.7	36.1	23.8	22.9	0.0	17.4	14.8	18.5
Service Area 5	6.9	4.8	0.5	2.1	3.6	0.0	6.0	6.8	4.4
Service Area 6	2.8	29.3	9.4	1.1	8.9	19.7	3.8	11.3	13.0
Service Area 7	6.2	6.4	21.4	9.9	13.0	0.0	9.2	6.8	9.9
Service Area 8	16.6	17.7	3.0	44.6	13.4	60.3	12.0	31.2	17.7
Total	100	100	100	100	100	100	100	100	100

1. Within Service Areas: 30 - 40%; 40 - 50 %; > 50%

2. Between Service Areas: Low; High

sented close to their population counts. African-American clients appeared to be overrepresented when compared to their population share of 3.9%. Examining the service area composite communities revealed two areas where White clients were a majority of the COD population, the Santa Clarita and Woodland Hills areas. Three areas saw a majority of Latino clients with a COD (the Burbank, Encino, and San Fernando-Calabasas-Agoura areas). No other ethnic group constituted a majority of COD cases in the Service area.

Service Area 3: San Gabriel

Age Groups

Service Area 3 clients accounted for 8.1% of individuals with COD treated in the county's mental health system. The majority of clients with a COD were adults (57.5%), followed by the TAY group (25.7%), children (14.4%), and older adults (2.5%). While most communities followed the countywide trend in treating a majority of adults, there were three exceptions to this. Two communities, the Alhambra-S. Pasadena area and the Hacienda Heights area ,treated a majority of clients with COD who were children. One community, the Baldwin Park-Azusa-Duarte area, saw that a majority of their COD cases were youths from the TAY group. Eight communities saw the majority of their COD cases from the adult group (the El Monte, Pomona, West

Table 3.14

Co-Occurring Disorders by Age Across Service Areas (% of population)

	0-15	16-25	26-59	60+	Total
Within Service Area 1 Communities					
Lancaster	6.6	28.6	62.7	2.2	100
Palmdale	8.8	15.0	74.6	1.6	100
North County E.	20.4	30.4	48.0	1.2	100
Total	7.7	23.6	66.8	1.9	100
Within Service Area 2 Communities					
Santa Clarita	1.7	14.7	81.6	2.0	100
Burbank	71.4	28.6	0.0	0.0	100
Glendale	4.7	13.0	78.0	4.3	100
Northridge	48.4	41.1	10.5	0.0	100
Granada Hills	21.9	37.2	39.3	1.6	100
Pacoima-Arleta	11.3	26.2	59.4	3.2	100
La Tuna Cyn.	0.0	0.0	0.0	0.0	0
Panorama City	30.9	59.6	9.6	0.0	100
North Hollywood	3.8	16.7	74.3	5.2	100
Sherman Oaks	13.8	28.2	54.4	3.6	100
Encino	45.0	50.0	5.0	0.0	100
Woodland Hills	1.4	16.8	78.4	3.4	100
Brentwood N.	0.0	0.0	0.0	0.0	0
North County W.	20.4	30.4	48.0	1.2	100
La Canada-Flintridge	6.4	25.6	66.4	1.6	100
San Fernando-Calabasas-Agoura	64.6	35.4	0.0	0.0	100
Total	14.5	28.9	54.1	2.4	100
Within Service Area 3 Communities					
Pasadena	20.6	33.5	41.8	4.1	100
El Monte	12.5	25.7	58.7	3.0	100
Pomona	11.9	22.9	64.5	0.8	100
West Covina	4.8	22.2	64.4	8.6	100
Altadena-Monrovia-Sierra Madre	6.4	25.6	66.4	1.6	100
Alhambra-S. Pasadena	65.0	35.0	0.0	0.0	100
Arcadia-San Gabriel-Temple City-San Marino	0.0	18.5	79.9	1.5	100
Baldwin Park-Azusa-Duarte	44.1	55.9	0.0	0.0	100
Glendora-Claremont-San Dimas-La Verne	43.9	30.6	25.5	0.0	100
Covina-Walnut	20.8	27.3	51.8	0.1	100
Diamond Bar	0.0	0.0	0.0	0.0	0
La Puente-S. El Monte	0.6	13.5	83.2	2.7	100
Hacienda Heights	66.7	20.0	13.3	0.0	100
Monterey Park-Rosemead	21.9	21.9	53.1	3.1	100
Other	20.4	30.4	48.0	1.2	100
Total	14.4	25.7	57.5	2.5	100

	0-15	16-25	26-59	60+	Total
Between Service Area 1 Communities					
Lancaster	52.8	74.4	57.7	69.2	61.5
Palmdale	42.1	23.1	40.9	29.6	36.6
North County E.	5.1	2.5	1.4	1.2	1.9
Total	100.0	100.0	100.0	100.0	100.0
Between Service Area 2 Communities					
Santa Clarita	1.0	4.6	13.5	7.5	9.0
Burbank	0.6	0.1	0.0	0.0	0.1
Glendale	1.4	2.0	6.4	7.8	4.4
Northridge	5.5	2.3	0.3	0.0	1.7
Granada Hills	60.3	51.4	29.0	25.7	39.9
Pacoima-Arleta	9.2	10.8	13.0	15.7	11.9
La Tuna Cyn.	0.0	0.0	0.0	0.0	0.0
Panorama City	6.6	6.4	0.5	0.0	3.1
North Hollywood	1.0	2.1	5.0	7.8	3.7
Sherman Oaks	9.1	9.3	9.6	14.3	9.6
Encino	2.2	1.2	0.1	0.0	0.7
Woodland Hills	1.4	8.7	21.6	20.7	14.9
Brentwood N.	0.0	0.0	0.0	0.0	0.0
North County W.	0.4	0.3	0.2	0.1	0.3
La Canada-Flintridge	0.3	0.5	0.7	0.4	0.6
San Fernando-Calabasas-Agoura	1.1	0.3	0.0	0.0	0.2
Total	100	100	100	100	100
Between Service Area 3 Communities					
Pasadena	45.0	41.1	22.9	52.1	31.5
El Monte	7.0	8.0	8.2	9.6	8.0
Pomona	4.5	4.8	6.1	1.6	5.4
West Covina	0.6	1.6	2.1	6.3	1.8
Altadena-Monrovia-Sierra Madre	1.7	3.7	4.3	2.4	3.7
Alhambra-S. Pasadena	3.7	1.1	0.0	0.0	0.8
Arcadia-San Gabriel-Temple City-San Marino	0.0	17.3	33.4	14.8	24.0
Baldwin Park-Azusa-Duarte	4.2	3.0	0.0	0.0	1.4
Glendora-Claremont-San Dimas-La Verne	17.3	6.8	2.5	0.0	5.7
Covina-Walnut	6.5	4.8	4.0	0.2	4.5
Diamond Bar	0.0	0.0	0.0	0.0	0.0
La Puente-S. El Monte	0.4	5.5	15.0	11.4	10.4
Hacienda Heights	7.2	1.2	0.4	0.0	1.6
Monterey Park-Rosemead	1.9	1.1	1.2	1.6	1.3
Other	0.0	0.0	0.0	0.0	0.0
Total	100	100	100	100	100

	0-15	16-25	26-59	60+	Total
Within Service Area 4 Communities					
Wilshire La Brea E.	4.7	37.7	54.7	2.8	100
Hollywood	3.0	14.0	80.5	2.5	100
Pico Heights	30.3	31.7	30.5	7.5	100
Echo Park	16.0	30.2	50.9	2.9	100
Highland Park	21.0	39.6	35.5	3.8	100
Downtown	16.5	28.8	53.2	1.5	100
USC N.	15.8	19.2	65.1	0.0	100
West Adams	0.6	14.2	82.2	2.9	100
West Hollywood	5.4	15.0	73.9	5.7	100
Other	22.9	40.1	37.0	0.0	100
Total	15.2	27.4	55.2	2.2	100

	0-15	16-25	26-59	60+	Total
Between Service Area 4 Communities					
Wilshire La Brea E.	0.3	1.4	1.0	1.4	1.0
Hollywood	2.7	7.0	19.9	15.5	13.7
Pico Heights	9.6	5.6	2.7	16.5	4.8
Echo Park	9.9	10.4	8.7	12.8	9.5
Highland Park	5.9	6.1	2.7	7.5	4.2
Downtown	70.8	68.5	62.7	43.7	65.1
USC N.	0.4	0.3	0.5	0.0	0.4
West Adams	0.0	0.3	0.8	0.7	0.5
West Hollywood	0.3	0.4	1.0	1.9	0.7
Other	0.0	0.0	0.0	0.0	0.0
Total	100	100	100	100	100

	0-15	16-25	26-59	60+	Total
Within Service Area 5 Communities					
Brentwood S.	0.0	0.0	0.0	0.0	0
West LA	3.4	11.4	81.6	3.6	100
Wilshire La Brea W.	4.7	37.7	54.7	2.8	100
Baldwin Hills W.	0.6	14.2	82.2	2.9	100
Playa Vista	10.0	14.3	69.1	6.5	100
Santa Monica-Culver City-Beverly Hills	5.4	15.0	73.9	5.7	100
Malibu	64.6	35.4	0.0	0.0	100
Other	11.3	17.1	68.9	2.7	100
Total	4.4	12.6	78.7	4.2	100

	0-15	16-25	26-59	60+	Total
Between Service Area 5 Communities					
Brentwood S.	0.0	0.0	0.0	0.0	0.0
West LA	52.5	62.4	71.7	59.4	69.2
Wilshire La Brea W.	0.9	2.4	0.6	0.5	0.8
Baldwin Hills W.	0.5	3.9	3.6	2.4	3.4
Playa Vista	25.7	13.0	10.0	17.5	11.4
Santa Monica-Culver City-Beverly Hills	18.3	17.9	14.1	20.2	15.0
Malibu	2.1	0.4	0.0	0.0	0.1
Other	0.1	0.0	0.0	0.0	0.0
Total	100	100	100	100	100

	0-15	16-25	26-59	60+	Total
Within Service Area 6 Communities					
USC S.	15.8	19.2	65.1	0.0	100
Baldwin Hills S.	0.6	14.2	82.2	2.9	100
Hancock N.	4.7	10.1	81.8	3.4	100
USC E.	22.8	21.4	54.1	1.8	100
Watts	61.2	34.3	4.5	0.0	100
Florence-Firestone	80.0	20.0	0.0	0.0	100
Lynwood	8.7	4.3	82.6	4.3	100
Paramount	0.0	100.0	0.0	0.0	100
Compton	4.1	16.8	77.0	2.2	100
Other	5.4	15.0	73.9	5.7	100
Total	7.3	16.8	73.6	2.3	100

	0-15	16-25	26-59	60+	Total
Between Service Area 6 Communities					
USC S.	9.4	5.0	3.9	0.0	4.4
Baldwin Hills S.	2.3	22.2	29.2	33.6	26.1
Hancock N.	3.5	3.3	6.1	8.1	5.4
USC E.	34.0	13.9	8.0	8.6	10.9
Watts	21.8	5.3	0.2	0.0	2.6
Florence-Firestone	0.8	0.1	0.0	0.0	0.1
Lynwood	0.5	0.1	0.4	0.7	0.4
Paramount	0.0	0.3	0.0	0.0	0.1
Compton	27.2	49.1	51.5	47.2	49.2
Other	0.6	0.7	0.8	1.9	0.8
Total	100	100	100	100	100

Table 3.14 continued

Co-Occurring Disorders by Age Across Service Areas (% of population)

	0-15	16-25	26-59	60+	Total
Within Service Area 7 Communities					
East LA	22.9	40.1	37.0	0.0	100
Downey	40.9	59.0	0.1	0.0	100
Norwalk	32.1	33.2	32.1	2.5	100
Whittier	66.7	20.0	13.3	0.0	100
Montebello	14.2	37.1	48.6	0.0	100
Bell Gardens-Bell-Maywood-Cudahy-Commerce	19.1	37.4	40.0	3.4	100
Huntington Park	80.0	20.0	0.0	0.0	100
South Gate	8.7	4.3	82.6	4.3	100
Bellflower	0.0	100.0	0.0	0.0	100
La Mirada-Santa Fe Springs	5.5	21.3	71.2	2.1	100
Lakewood-Cerritos-Artesia-Hawaiian Gardens	2.3	26.0	70.6	1.1	100
Signal Hill	25.0	75.0	0.0	0.0	100
Other	22.0	22.0	52.9	3.1	100
Total	20.3	36.5	41.9	1.4	100

	0-15	16-25	26-59	60+	Total
Between Service Area 7 Communities					
East LA	2.1	2.0	1.6	0.0	1.8
Downey	52.2	41.9	0.1	0.0	25.9
Norwalk	16.5	9.5	8.0	19.0	10.4
Whittier	7.7	1.3	0.7	0.0	2.3
Montebello	1.6	2.3	2.6	0.0	2.2
Bell Gardens-Bell-Maywood-Cudahy-Commerce	12.5	13.6	12.7	33.7	13.3
Huntington Park	0.4	0.0	0.0	0.0	0.1
South Gate	0.2	0.0	0.7	1.2	0.4
Bellflower	0.0	0.1	0.0	0.0	0.0
La Mirada-Santa Fe Springs	3.7	7.9	23.1	21.1	13.6
Lakewood-Cerritos-Artesia-Hawaiian Gardens	3.3	21.3	50.5	25.0	29.9
Signal Hill	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.1	0.0
Total	100	100	100	100	100

Within Service Area 8 Communities					
Hancock S.	4.7	10.1	81.8	3.4	100
Wilmington	9.0	25.7	63.0	2.4	100
Inglewood	11.3	17.1	68.9	2.7	100
Torrance	48.8	48.8	2.3	0.0	100
Long Beach N.	55.8	26.6	17.5	0.0	100
Long Beach S.	2.5	15.9	79.3	2.3	100
Long Beach E.	44.2	55.8	0.0	0.0	100
Carson	8.4	21.6	67.8	2.1	100
Palos Verdes-Lomita	25.0	75.0	0.0	0.0	100
Redondo-Manhattan-Hermosa-El Segundo	0.0	0.0	100.0	0.0	100
Gardena-Lawndale	4.3	17.1	74.4	4.3	100
Hawthorne	0.0	17.8	79.8	2.4	100
Other	3.3	20.6	74.3	1.7	100
Total	8.9	21.1	67.9	2.1	100

	0-15	16-25	26-59	60+	Total
Between Service Area 8 Communities					
Hancock S.	0.1	0.1	0.2	0.3	0.2
Wilmington	11.5	13.8	10.5	12.7	11.3
Inglewood	5.3	3.4	4.2	5.3	4.2
Torrance	10.5	4.4	0.1	0.0	1.9
Long Beach N.	21.5	4.3	0.9	0.0	3.4
Long Beach S.	7.5	19.9	30.9	28.5	26.4
Long Beach E.	9.5	5.1	0.0	0.0	1.9
Carson	32.5	35.1	34.2	33.7	34.2
Palos Verdes-Lomita	0.2	0.3	0.0	0.0	0.1
Redondo-Manhattan-Hermosa-El Segundo	0.0	0.0	0.5	0.0	0.4
Gardena-Lawndale	1.0	1.7	2.3	4.2	2.1
Hawthorne	0.0	11.1	15.4	14.8	13.1
Other	0.3	0.8	0.8	0.6	0.8
Total	100	100	100	100	100

1. Within Service Areas: 30 - 40%; 40 - 50 %; > 50%

2. Between Service Areas: Low; High

Covina, Altadena-Monrovia-Sierra Madre, Acadia-San Gabriel-Temple City-San Marino, Covina-Walnut, La Puente-S. El Monte, and Monterey Park-Rosemead areas). Across the service area, 31.5% of clients with a COD were treated in the Pasadena area. This was followed by the Arca-

dia-San Gabriel-Temple City-San Marino area (24.0%) and the La Puente-S. El Monte area (10.4%).

Ethnicity

Latino clients accounted for 45.7% of the COD population treated in Service Area 3. This was followed by White clients (26.7%), African-American clients (14.1%), and Asian clients (2.7%). Native American and Pacific Islander groups each accounted for less than 1% of the COD population in the service area. When compared with population estimates for these groups, COD percentages were similar to population counts for Latinos and Whites. However, it was clear that African-Americans (4.6%) were overrepresented in the COD client counts, while Asians (24.4%) were underrepresented. In six communities, Latinos were a majority of clients with a COD: the Alhambra-S. Pasadena, Baldwin Park-Azusa-Duarte, Glendora-Claremont-San Dimas-La Verne, Covina-Walnut, La Puente-S. El Monte, and Hacienda Heights areas. In one community, the Monterey Park-Rosemead area, Asians were a majority of COD clients, but this particular area only accounted for 1.3% of the total COD population for the service area.

Service Area 4: Metro

Age Groups

Service Area 4 clients accounted for 28.3% of individuals with COD treated in the county's mental health system. The majority of clients with COD in the service area were adults (26-59). Examining the composite communities revealed that in all but two areas, adults were the majority of COD clients treated. In two communities, this percentage was above 80%: the Hollywood area, 80.5%, and the West Adams area, 82.2%. In the two communities which did not have an adult majority, TAY (16-25) and children (0-15) accounted for a majority of clients diagnosed with a COD. The Pico Heights area and the Highland Park area saw 62.0% and 60.6%, respectively, of its COD population under the age of 26. The majority of COD clients were treated in the Downtown area (65.1%) followed by the Hollywood area (13.7%) and the Echo Park area (9.5%).

Ethnicity

In Service Area 4, no ethnic group constituted a majority of COD clients. Latino clients accounted for 33.6% of the COD population treated in the area. This was followed by African-American clients (31.0%), White clients (18.4%), and Asian clients (2.0%). Native American and Pacific Islander groups each accounted for less than 1% of the COD population in the Service area. When compared with population estimates, it is clear that African-American (5.1%) were overrepresented in the COD client counts, whereas, Latino (54.1%) and Asian (17.9%) clients were underrepresented. Examining the composite communities revealed that two areas, USC N. and West Adams, treated a majority of African-Americans within the COD population. Latinos were a majority of COD cases within the Highland Park area. No other ethnic group constituted a majority in any other area.

Service Area 5: West

Age Groups

Service Area 5 clients accounted for 6.6% of individuals with COD treated in the county's mental health system. Within the service area, the COD population was largely adult

(26-59) and accounted for 78.7% of all COD cases. This was the highest proportion of adult COD cases seen in the county. All communities with the exception of the Malibu area (with small numbers), saw an overwhelmingly adult population. In two communities, adults accounted for over 80% of the COD population: the West LA area (81.6%) and the Baldwin Hills W. area (82.2%). Across the service area, the majority of COD cases were treated in the West LA area (69.0%), followed by the Santa Monica-Culver City-Beverly Hills area (15.0%) and the Playa Vista area (11.4%).

Ethnicity

White clients accounted for 52.6% of the COD population treated in Service Area 5 and this was the only area in the county where Whites were a majority of COD clients. This was followed by African-American clients (22.3%), Latino clients (13.0%), Native American clients (1.0%), and Asian clients (1.8%). When compared with population estimates for these groups, Whites and Latinos had COD rates consistent with their population shares. African-American (8.1%) and Native American (0.1%) clients were overrepresented in the COD client counts and Asian (12.9%) clients were underrepresented. Examining the service area composite communities revealed that Whites were a majority of clients treated for COD in the West LA area; African-American clients were a majority in the Baldwin Hills W. area; and Latino clients were a majority in the Malibu area.

Service Area 6: South

Age Groups

Service Area 6 clients accounted for 8.4% of individuals with COD treated in the county's mental health system. Like other parts of the county, adults (26-59) accounted for a majority of COD cases in the service area (73.6%). This large proportion of adult clients was second only to Service Area 5. Differing from this, three communities appeared to have children (0-15) and TAY (16-25) groups as a majority of clients with COD (the Watts, Florence-Firestone, and Paramount areas), but the relative numbers of cases in these areas was relatively small (in sum accounting for only 2.8% of all COD cases in the service area). All other composite communities saw an large percentages of COD cases from the adult group. Three communities saw these figures greater than 80%: the Baldwin Hills S. area (82.2%), the Hancock N. area (81.8%), and the Lynwood area (82.6%). Across the service area, treatment for 49.2% of clients with a COD occurred in the Compton area.

Ethnicity

African-American clients accounted for a majority (63.0%) of the COD population treated in Service Area 6, the only service area where this occurred. Following this, Latino clients (21.9%) and White clients (5.8%) were the next most numerous ethnic groups represented. Native American, Asian, and Pacific Islander clients each accounted for less than 1% of the COD population. When compared with population estimates, African-Americans (28.2%) appeared to be overrepresented in the COD client counts; Latinos (65.9%) were underrepresented.

Service Area 7: East

Age Groups

Service Area 7 clients accounted for 11.5% of individuals with COD treated in the county's

mental health system. Unlike other areas of the county, no age group accounted for a majority of clients with a COD. This meant that other age groups, particularly children (0-15) and TAY (16-25), accounted for relatively larger proportions of the COD population. Children accounted for 20.3% of the service area's COD cases, the largest proportion in the county for this age group. The TAY group accounted for 36.5% of the COD population and this was also the largest proportion in the county for this age group. Across the service area, the Lakewood-Cerritos-Hawaiian Gardens community treated the largest proportion of clients with COD (29.9%). This was followed by the Downey area (25.9%), the La Mirada-Santa Fe Springs area (13.6%), the Bell Gardens-Bell-Cudahy-Commerce area (13.3%), and the Norwalk area (10.4%).

Ethnicity

Latino clients accounted for a majority (52.1%) of the COD population treated in Service Area 7, the only service area where this occurred. Following this, White clients (19.7%), African-American clients (14.6%), Native American clients (3.3%), and Asian clients (1.3%), were, in order, the next most numerous ethnic groups represented. Pacific Islanders accounted for less than 1% of the COD population. When compared with population estimates, African-Americans (2.9%) and Native Americans (0.2%) appeared to be overrepresented in the COD client counts; Latinos (70.9%) and Asians (10.0%) were underrepresented.

Service Area 8: South Bay

Age Groups

Service Area 8 clients accounted for 14.8% of individuals with COD treated in the county's mental health system. As in other parts of the county, adults (26-59) were a large majority of clients with COD (67.9%) treated in the service area. Eight communities saw an adult majority of its clients with CODs: the Hancock S., Wilmington, Inglewood, Long Beach S., Carson, Redondo-Manhattan-Hermosa-El Segundo, Gardena-Lawndale, and Hawthorne areas. In one community, the Long Beach N. area, children (0-15) were a majority of COD cases treated there (55.8%). It should be noted, though, that this particular area accounted for only 3.4% of the total COD population in the service area. Similarly, the Long Beach E. and Palos Verdes-Lomita areas saw a majority of COD cases from the TAY (16-25) population, but, again, the total COD population figures for these to communities accounted for a combined total of 2.0% of the service area cases. Most COD cases were seen in the Carson area (34.2%), followed by the Long Beach S. area (26.4%), the Hawthorne area (13.1%), and the Wilmington area (11.3%).

Ethnicity

White clients accounted for 33.2% of the COD population treated in Service Area 8. This was followed by African-American clients (29.2%), Latino clients (26.5%), and Asian clients (3.6%). Native Americans and Pacific Islanders each accounted for less than 1% of the COD population in the service area. When compared with population estimates for these groups, African-Americans (15.6%) were overrepresented in the COD client counts; Latinos (37.3%) and Asians (15.3%) appeared to be underrepresented.

Table 3.15

Co-Occurring Disorders by Ethnicity Across Service Areas (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Within Service Area 1 Communities									
Lancaster	42.2	28.1	1.6	1.3	21.1	0.0	2.0	3.8	100
Palmdale	43.3	27.0	0.8	0.5	22.3	0.0	2.4	3.6	100
North County E.	48.2	9.4	0.4	1.0	34.7	0.0	2.4	3.9	100
Total	42.7	27.4	1.3	1.0	21.8	0.0	2.2	3.7	100
Within Service Area 2 Communities									
Santa Clarita	65.9	5.2	0.6	1.7	16.8	0.0	4.1	5.8	100
Burbank	14.3	0.0	0.0	14.3	71.4	0.0	0.0	0.0	100
Glendale	42.5	5.1	1.6	2.0	29.1	0.0	19.3	0.4	100
Northridge	38.9	5.3	0.0	0.0	49.5	0.0	4.2	2.1	100
Granada Hills	29.2	16.7	0.8	1.4	43.1	0.1	2.5	6.2	100
Pacoima-Arleta	29.9	15.2	1.0	1.2	46.2	0.0	1.2	5.3	100
La Tuna Cyn.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Panorama City	14.0	39.9	0.6	0.6	42.1	0.0	1.7	1.1	100
North Hollywood	49.0	17.1	0.5	2.4	23.8	0.0	2.9	4.3	100
Sherman Oaks	41.5	17.6	1.1	2.0	29.6	0.2	3.1	4.9	100
Encino	15.0	0.0	2.5	0.0	80.0	0.0	2.5	0.0	100
Woodland Hills	58.6	8.2	1.3	0.8	17.6	0.1	3.3	10.2	100
Brentwood N.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
North County W.	48.2	9.4	0.4	1.0	34.7	0.0	2.4	3.9	100
La Canada-Flintridge	38.3	7.4	0.0	2.4	27.9	0.0	1.6	22.3	100
San Fernando-Calabasas-Agoura	23.6	11.8	0.0	0.0	64.6	0.0	0.0	0.0	100
Total	39.1	14.1	0.9	1.4	35.0	0.1	3.4	6.0	100
Within Service Area 3 Communities									
Pasadena	21.3	22.7	0.1	0.8	41.0	0.0	1.4	12.6	100
El Monte	25.5	10.5	0.1	3.7	46.0	0.0	5.2	8.9	100
Pomona	33.3	11.8	1.5	0.0	46.7	0.7	1.5	4.4	100
West Covina	41.2	10.9	0.0	0.0	34.9	0.0	0.0	13.1	100
Altadena-Monrovia-Sierra Madre	38.3	7.4	0.0	2.4	27.9	0.0	1.6	22.3	100
Alhambra-S. Pasadena	5.0	0.0	0.0	0.0	85.0	0.0	10.0	0.0	100
Arcadia-San Gabriel-Temple City-San Marino	36.4	11.7	0.5	4.2	40.3	0.0	2.8	4.2	100
Baldwin Park-Azusa-Duarte	2.9	20.6	0.0	0.0	64.7	0.0	2.9	8.8	100
Glendora-Claremont-San Dimas-La Verne	20.0	11.7	1.4	0.0	59.6	0.0	1.4	5.9	100
Covina-Walnut	35.0	8.3	0.0	0.0	52.1	0.0	1.8	2.8	100
Diamond Bar	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
La Puente-S. El Monte	21.7	7.2	1.6	1.6	64.5	0.0	2.1	1.2	100
Hacienda Heights	7.5	5.0	0.8	0.0	80.0	0.0	5.0	1.7	100
Monterey Park-Rosemead	3.1	3.1	0.0	75.0	0.0	0.0	0.0	18.8	100
Other	48.2	9.4	0.4	1.0	34.7	0.0	2.4	3.9	100
Total	26.7	14.1	0.5	2.7	45.7	0.0	2.3	7.9	100

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Re-sponse	Total
Between Service Area 1 Communities									
Lancaster	60.7	63.2	76.5	78.4	59.5	0.0	57.8	62.2	61.5
Palmdale	37.1	36.1	22.9	19.6	37.4	0.0	40.0	35.9	36.6
North County E.	2.2	0.7	0.6	2.0	3.0	0.0	2.2	2.0	1.9
Total	100.0	100.0	100.0	100.0	100.0	0.0	100.0	100.0	100.0
Between Service Area 2 Communities									
Santa Clarita	15.1	3.3	5.6	11.0	4.3	0.0	10.8	8.6	9.0
Burbank	0.0	0.0	0.0	1.3	0.2	0.0	0.0	0.0	0.1
Glendale	4.8	1.6	7.7	6.4	3.7	0.0	25.0	0.3	4.4
Northridge	1.6	0.6	0.0	0.0	2.3	0.0	2.0	0.6	1.7
Granada Hills	29.8	47.2	34.7	39.4	49.1	50.0	29.6	41.4	39.9
Pacoima-Arleta	9.1	12.8	13.4	10.2	15.7	0.0	4.1	10.4	11.9
La Tuna Cyn.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Panorama City	1.1	8.7	1.9	1.3	3.7	0.0	1.5	0.6	3.1
North Hollywood	4.6	4.4	1.9	6.4	2.5	0.0	3.1	2.6	3.7
Sherman Oaks	10.1	12.0	11.6	14.0	8.1	25.0	8.7	7.8	9.6
Encino	0.3	0.0	1.9	0.0	1.6	0.0	0.5	0.0	0.7
Woodland Hills	22.3	8.6	21.2	8.9	7.5	25.0	14.3	25.2	14.9
Brentwood N.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
North County W.	0.3	0.2	0.1	0.2	0.3	0.0	0.2	0.2	0.3
La Canada-Flintridge	0.6	0.3	0.0	1.0	0.5	0.0	0.3	2.2	0.6
San Fernando-Calabasas-Agoura	0.1	0.2	0.0	0.0	0.5	0.0	0.0	0.0	0.2
Total	100	100	100	100	100	100	100	100	100
Between Service Area 3 Communities									
Pasadena	25.2	50.7	8.0	8.9	28.2	0.0	19.8	49.8	31.5
El Monte	7.7	5.9	2.2	10.8	8.0	0.0	18.6	8.9	8.0
Pomona	6.7	4.5	16.2	0.0	5.5	94.1	3.6	3.0	5.4
West Covina	2.8	1.4	0.0	0.0	1.4	0.0	0.0	3.0	1.8
Altadena-Monrovia-Sierra Madre	5.3	2.0	0.1	3.2	2.3	0.0	2.7	10.5	3.7
Alhambra-S. Pasadena	0.2	0.0	0.0	0.0	1.5	0.0	3.6	0.0	0.8
Arcadia-San Gabriel-Temple City-San Marino	32.8	19.9	22.1	36.4	21.1	0.0	29.6	12.6	24.0
Baldwin Park-Azusa-Duarte	0.2	2.0	0.0	0.0	2.0	0.0	1.8	1.5	1.4
Glendora-Claremont-San Dimas-La Verne	4.3	4.7	16.2	0.0	7.4	5.9	3.6	4.2	5.7
Covina-Walnut	5.9	2.6	0.0	0.0	5.1	0.0	3.6	1.6	4.5
Diamond Bar	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
La Puente-S. El Monte	8.5	5.3	32.5	6.2	14.7	0.0	9.7	1.6	10.4
Hacienda Heights	0.4	0.6	2.6	0.0	2.7	0.0	3.4	0.3	1.6
Monterey Park-Rosemead	0.1	0.3	0.0	34.5	0.0	0.0	0.0	3.0	1.3
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100	100	100	100	100	100	100	100	100

Table 3.15 continued

Co-Occurring Disorders by Ethnicity Across Service Areas (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Re-sponse	Total
Within Service Area 4 Communities									
Wilshire La Brea E.	31.1	29.2	1.9	2.8	23.6	0.0	6.6	4.7	100
Hollywood	42.0	27.1	0.5	1.8	20.5	0.0	3.2	4.9	100
Pico Heights	30.8	28.1	0.7	1.2	30.3	0.0	3.8	5.0	100
Echo Park	16.8	25.6	0.2	7.6	44.4	0.0	3.8	1.5	100
Highland Park	13.9	9.6	0.5	3.8	66.4	0.0	0.5	5.2	100
Downtown	12.6	33.6	0.2	1.1	33.5	0.2	1.3	17.3	100
USC N.	1.4	71.9	0.0	1.4	20.5	0.0	0.7	4.1	100
West Adams	6.9	74.2	0.8	0.8	14.2	0.0	0.6	2.5	100
West Hollywood	48.3	25.8	0.3	1.0	15.0	0.0	2.1	7.5	100
Other	6.2	0.0	0.0	0.0	92.3	0.0	0.0	1.5	100
Total	18.4	31.0	0.3	2.0	33.6	0.1	1.9	12.7	100
Within Service Area 5 Communities									
Brentwood S.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
West LA	57.3	18.0	1.3	2.0	11.4	0.2	3.5	6.3	100
Wilshire La Brea W.	31.1	29.2	1.9	2.8	23.6	0.0	6.6	4.7	100
Baldwin Hills W.	6.9	74.2	0.8	0.8	14.2	0.0	0.6	2.5	100
Playa Vista	45.2	27.8	0.0	2.2	17.8	0.0	1.7	5.2	100
Santa Monica-Culver City-Beverly Hills	48.3	25.8	0.3	1.0	15.0	0.0	2.1	7.5	100
Malibu	23.6	11.8	0.0	0.0	64.6	0.0	0.0	0.0	100
Other	24.0	44.4	0.5	0.5	23.0	0.5	0.5	6.4	100
Total	52.6	22.3	1.0	1.8	13.0	0.1	3.0	6.2	100
Within Service Area 6 Communities									
USC S.	1.4	71.9	0.0	1.4	20.5	0.0	0.7	4.1	100
Baldwin Hills S.	6.9	74.2	0.8	0.8	14.2	0.0	0.6	2.5	100
Hancock N.	4.7	77.0	0.7	0.0	12.2	0.0	0.0	5.4	100
USC E.	9.6	52.3	0.7	2.1	30.2	0.0	1.1	3.9	100
Watts	3.0	46.3	0.0	0.0	46.3	0.0	0.0	4.5	100
Florence-Firestone	0.0	40.0	0.0	0.0	60.0	0.0	0.0	0.0	100
Lynwood	21.7	65.2	0.0	0.0	13.0	0.0	0.0	0.0	100
Paramount	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	100
Compton	4.3	58.6	0.5	0.5	24.0	0.0	0.3	11.8	100
Other	48.3	25.8	0.3	1.0	15.0	0.0	2.1	7.5	100
Total	5.8	63.0	0.5	0.8	21.9	0.0	0.5	7.5	100

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Re-sponse	Total
Between Service Area 4 Communities									
Wilshire La Brea E.	1.8	1.0	5.8	1.5	0.7	0.0	3.6	0.4	1.0
Hollywood	31.2	12.0	20.5	12.5	8.3	0.0	22.8	5.3	13.7
Pico Heights	8.1	4.4	10.3	3.0	4.3	0.0	9.6	1.9	4.8
Echo Park	8.7	7.8	6.8	36.9	12.5	0.0	18.6	1.1	9.5
Highland Park	3.2	1.3	6.8	8.3	8.4	0.0	1.2	1.7	4.2
Downtown	44.8	70.7	47.9	36.9	64.9	100.0	43.2	88.9	65.1
USC N.	0.0	0.9	0.0	0.3	0.2	0.0	0.1	0.1	0.4
West Adams	0.2	1.3	1.2	0.2	0.2	0.0	0.2	0.1	0.5
West Hollywood	1.9	0.6	0.6	0.4	0.3	0.0	0.8	0.4	0.7
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100	100	100	100	100	100	100	100	100
Between Service Area 5 Communities									
Brentwood S.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
West LA	75.4	55.7	91.7	75.4	61.0	99.9	80.6	70.2	69.2
Wilshire La Brea W.	0.5	1.1	1.6	1.2	1.5	0.0	1.8	0.6	0.8
Baldwin Hills W.	0.5	11.5	2.7	1.4	3.8	0.0	0.7	1.4	3.4
Playa Vista	9.8	14.2	0.0	13.5	15.6	0.0	6.6	9.6	11.4
Santa Monica-Culver City-Beverly Hills	13.8	17.4	4.0	8.5	17.4	0.0	10.3	18.2	15.0
Malibu	0.1	0.1	0.0	0.0	0.7	0.0	0.0	0.0	0.1
Other	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0
Total	100	100	100	100	100	100	100	100	100
Between Service Area 6 Communities									
USC S.	1.0	5.0	0.0	7.8	4.1	0.0	6.2	2.4	4.4
Baldwin Hills S.	31.0	30.8	36.5	25.9	17.0	0.0	34.5	8.8	26.1
Hancock N.	4.4	6.7	6.7	0.0	3.0	0.0	0.0	3.9	5.4
USC E.	18.1	9.1	14.3	30.4	15.1	0.0	24.2	5.7	10.9
Watts	1.3	1.9	0.0	0.0	5.5	0.0	0.0	1.6	2.6
Florence-Firestone	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.1
Lynwood	1.4	0.4	0.0	0.0	0.2	0.0	0.0	0.0	0.4
Paramount	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.1
Compton	36.4	45.8	42.1	34.9	54.0	0.0	31.8	76.9	49.2
Other	6.3	0.3	0.4	1.0	0.5	0.0	3.2	0.8	0.8
Total	100	100	100	100	100	0	100	100	100

Table 3.15 continued

Co-Occurring Disorders by Ethnicity Across Service Areas (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Re-sponse	Total
Within Service Area 7 Communities									
East LA	6.2	0.0	0.0	0.0	92.3	0.0	0.0	1.5	100
Downey	8.6	24.1	0.2	0.7	53.6	0.6	4.3	7.9	100
Norwalk	26.1	26.4	0.3	2.2	36.0	0.0	1.6	7.4	100
Whittier	7.5	5.0	0.8	0.0	80.0	0.0	5.0	1.7	100
Montebello	5.1	9.0	0.0	0.0	84.6	0.0	0.0	1.3	100
Bell Gardens-Bell-Maywood-Cudahy-Commerce	11.6	16.6	0.6	0.2	66.0	0.0	0.9	4.1	100
Huntington Park	0.0	40.0	0.0	0.0	60.0	0.0	0.0	0.0	100
South Gate	21.7	65.2	0.0	0.0	13.0	0.0	0.0	0.0	100
Bellflower	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	100
La Mirada-Santa Fe Springs	28.2	4.0	1.5	0.8	49.9	0.0	1.1	14.5	100
Lakewood-Cerritos-Artesia-Hawaiian Gardens	29.8	7.4	9.6	2.5	44.5	0.2	1.7	4.2	100
Signal Hill	75.0	0.0	0.0	0.0	25.0	0.0	0.0	0.0	100
Other	3.2	3.2	0.0	74.8	0.2	0.0	0.0	18.7	100
Total	19.7	14.6	3.3	1.3	52.1	0.2	2.2	6.7	100
Within Service Area 8 Communities									
Hancock S.	4.7	77.0	0.7	0.0	12.2	0.0	0.0	5.4	100
Wilmington	41.6	20.4	0.2	0.8	34.3	0.0	0.8	2.0	100
Inglewood	24.0	44.4	0.5	0.5	23.0	0.5	0.5	6.4	100
Torrance	12.8	26.7	0.0	1.2	53.5	0.0	2.3	3.5	100
Long Beach N.	13.0	27.9	0.0	5.2	49.4	1.3	0.6	2.6	100
Long Beach S.	35.7	28.8	0.4	5.0	19.7	0.3	1.9	8.1	100
Long Beach E.	14.0	24.4	0.0	1.2	54.7	0.0	4.7	1.2	100
Carson	38.6	26.0	0.6	3.4	25.1	0.3	1.4	4.5	100
Palos Verdes-Lomita	75.0	0.0	0.0	0.0	25.0	0.0	0.0	0.0	100
Redondo-Manhattan-Hermosa-El Segundo	25.0	50.0	0.0	12.5	12.5	0.0	0.0	0.0	100
Gardena-Lawndale	27.6	18.1	0.0	28.7	17.1	0.0	3.2	5.3	100
Hawthorne	22.8	43.1	0.7	1.0	25.6	0.0	2.4	4.4	100
Other	14.9	37.3	4.3	1.4	32.6	0.1	0.9	8.6	100
Total	33.2	29.2	0.5	3.6	26.5	0.3	1.6	5.1	100

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Re-sponse	Total
Between Service Area 7 Communities									
East LA	0.6	0.0	0.0	0.0	3.2	0.0	0.0	0.4	1.8
Downey	11.3	43.0	1.7	12.9	26.7	71.7	51.4	30.6	25.9
Norwalk	13.8	18.8	0.9	17.2	7.2	0.0	7.9	11.5	10.4
Whittier	0.9	0.8	0.6	0.0	3.6	0.0	5.4	0.6	2.3
Montebello	0.6	1.4	0.0	0.0	3.6	0.0	0.0	0.4	2.2
Bell Gardens-Bell-Maywood-Cudahy-Commerce	7.8	15.1	2.6	2.2	16.8	0.0	5.3	8.1	13.3
Huntington Park	0.0	0.2	0.0	0.0	0.1	0.0	0.0	0.0	0.1
South Gate	0.4	1.7	0.0	0.0	0.1	0.0	0.0	0.0	0.4
Bellflower	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
La Mirada-Santa Fe Springs	19.4	3.7	6.1	8.6	13.0	0.0	6.6	29.4	13.6
Lakewood-Cerritos-Artesia-Hawaiian Gardens	45.2	15.3	88.0	57.4	25.6	28.3	23.4	18.9	29.9
Signal Hill	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	1.6	0.0	0.0	0.0	0.1	0.0
Total	100	100	100	100	100	100	100	100	100
Between Service Area 8 Communities									
Hancock S.	0.0	0.5	0.2	0.0	0.1	0.0	0.0	0.2	0.2
Wilmington	14.2	7.9	4.4	2.5	14.7	0.0	5.5	4.3	11.3
Inglewood	3.0	6.3	4.4	0.6	3.6	8.3	1.4	5.2	4.2
Torrance	0.7	1.7	0.0	0.6	3.9	0.0	2.7	1.3	1.9
Long Beach N.	1.3	3.3	0.0	5.0	6.4	16.6	1.4	1.7	3.4
Long Beach S.	28.5	26.1	22.2	36.5	19.7	33.3	31.4	41.7	26.4
Long Beach E.	0.8	1.6	0.0	0.6	3.9	0.0	5.5	0.4	1.9
Carson	39.8	30.4	44.4	32.2	32.5	41.6	28.6	30.4	34.2
Palos Verdes-Lomita	0.2	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.1
Redondo-Manhattan-Hermosa-El Segundo	0.3	0.6	0.0	1.2	0.2	0.0	0.0	0.0	0.4
Gardena-Lawndale	1.7	1.3	0.0	16.7	1.3	0.0	4.1	2.2	2.1
Hawthorne	9.0	19.3	17.7	3.7	12.7	0.0	19.1	11.3	13.1
Other	0.3	1.0	6.6	0.3	0.9	0.2	0.4	1.3	0.8
Total	100	100	100	100	100	100	100	100	100

1. Within Service Areas

30 - 40%
40 - 50 %
> 50%

INDICATORS FOR CHILDREN/YOUTH IN STRESSED FAMILIES

Poverty

Description of Indicator

The percent of people living at or below the 200% Federal Poverty Level (FPL) is a common measure of socioeconomic status (SES). Poverty levels published by the US Department of Health and Human Services (DHHS) are determined by the number of family members in a household and the total income a family has in a given year. In 2005, for example, the FPL for a family of four in California was $19,350, a level found by many to be exceedingly low. Even at 200%, or two times this amount ($38,700), the numbers of individuals below this level are substantial (DHHS, 2008). Any family of four in California with a household income of less than this amount is considered to be living below the 200% FPL. Using 200% FPL captures more families that are experiencing economic stress and provides a better mapping of where poverty exists in the county.

Research Base and Relevance to PEI

Research on neighborhood effects demonstrates that SES is an important predictor of behavioral, mental health and academic outcomes for children (Leventhal & Brooks-Gunn, 2000; Wadsworth & Achenbach, 2005). Children and adolescents residing in impoverished areas are more likely to develop mental disorders, commit crimes, and have problems in school. Adults in disadvantaged neighborhoods have been found to be more likely to develop major depression and substance abuse disorders (Silver, Mulvey, Swanson, 2002).

What the Numbers Show

County summary figures indicated that poverty is widespread and disproportionately affects ethnic minority populations. In Table 3.16, three percentages are reported for each ethnic group. The first of these figures indicates the percent of individuals within an ethnic group who fall under 200% FPL. Table 3.16 shows that 40.2% of African-Americans in Los Angeles County are living below the 200% FPL, 30.3% of Asians, 53.5% of Hispanics and 18.5% of Whites. The second of these figures is the percentage of individuals living under 200% FPL by ethnicity. Here, Whites make up 14.1% of the poverty population, African-Americans, 9.3%, and Hispanics 65.2%. These figures also tell us that Hispanics are overrepresented within the poverty population, as they make up 47% of the county's total population. The final figure in each row depicts the ethnic group's population living in poverty as a percentage of the total population. So, one can see that 5.5% of the entire population in Los Angeles County are Whites living in poverty or 3.6% of the county's population are African-Americans living in poverty. The most striking figure in this set shows that 25.2%, or one in four individuals in the county, are Hispanic and living in poverty. As you turn to the service area level data and drill down into the community data, please review this last set of figures when looking at the preceding two percentages as this will tell you how numer-

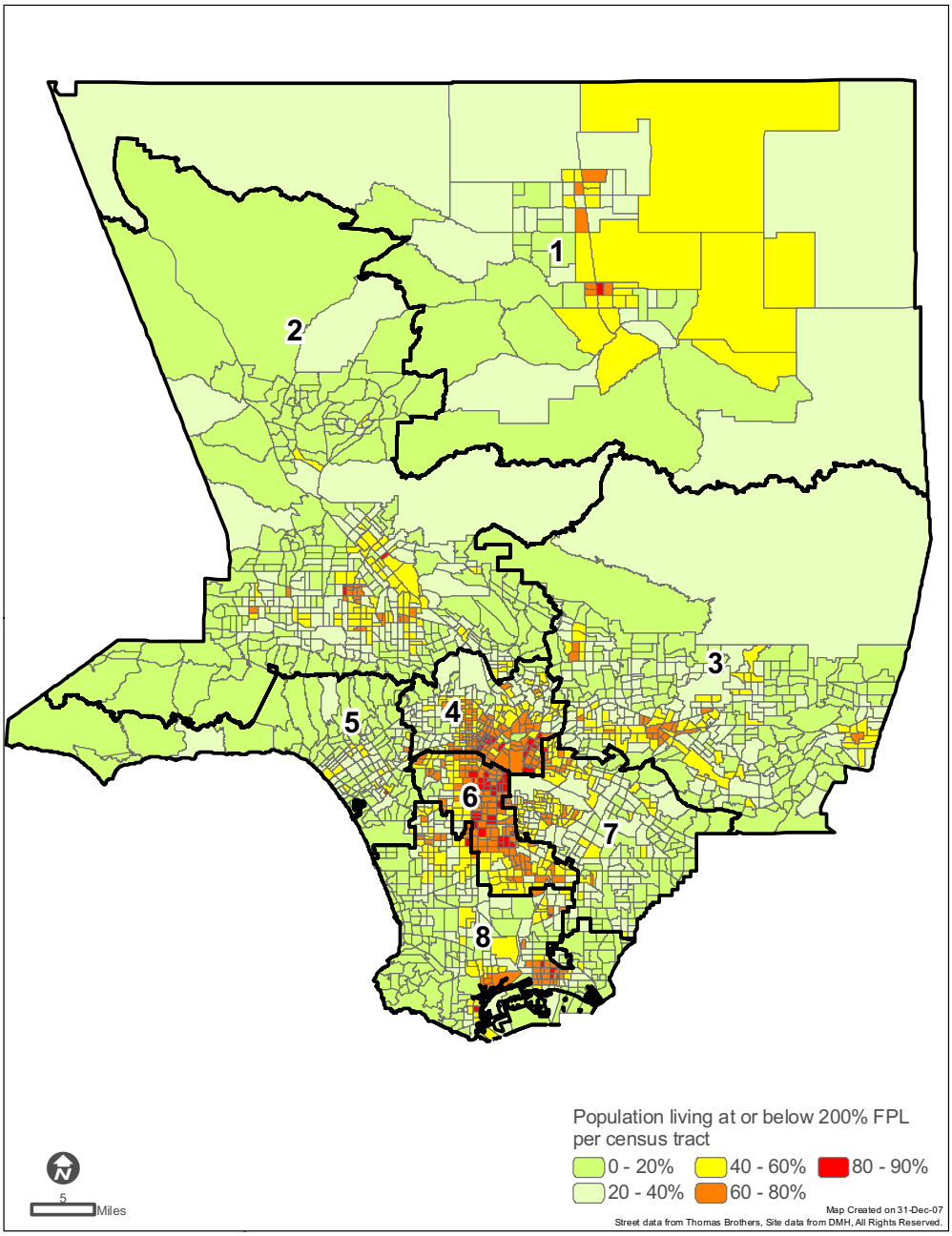
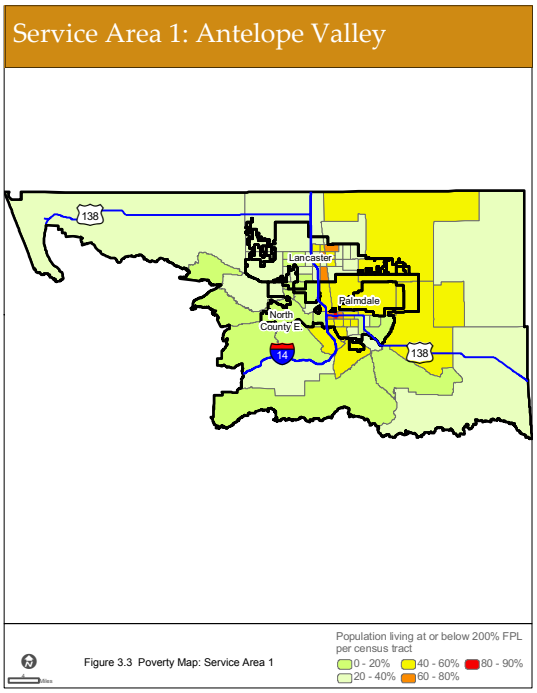
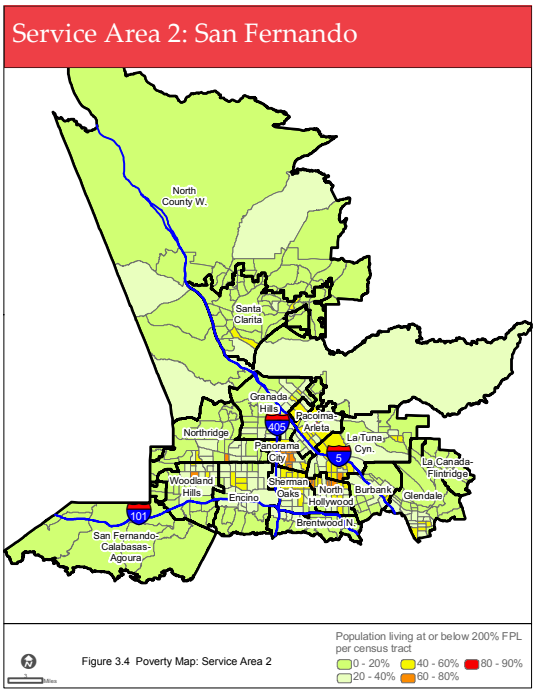


Figure 3.2 Poverty Map of Los Angeles County

ous a particular group is within a geographic area. Without doing so, one can be misled into thinking that high percentages translate into large groups of people. This is not necessarily true, especially for ethnic groups such as American Indians and Pacific Islanders who are relatively few in numbers.





Service Area 1: Antelope Valley

The overall poverty rate in Service Area 1 of 41.2% was higher than the county average of 38.7%. Examining ethnic groups indicated that in all communities, over 50% of African-Americans were living beneath the 200% FPL. This was more pronounced in the two urban areas of Lancaster and Palmdale where over 60% of African-Americans were below this level. Similarly, the Hispanic population had over 50% of its population in the urban areas living beneath the 200% FPL. The only other group who had a majority of its members living beneath the 200% FPL were American Indians living in the Palmdale area.. Overall, Hispanics account for 56% of the entire poverty population in the service area.

Service Area 2: San Fernando

The overall poverty rate in Service Area 2, 30.8%, was below the county average of 38.7%. Overall, the Panorama City area had the highest rate of individuals living beneath the 200% FPL, 52.9%. Examining the ethnic groups within the service area indicated that the Hispanic population were a majority of the poverty population (60.6%). Over 50% of the Hispanic population in six communities in the San Fernando Valley were living below the 200% FPL: the Pacoima-Arleta area (52.2%), the La Tuna Cyn. area (50.0%), the Panorama City area (63.1%), the North Hollywood area (54.4%), the Encino area (51.3%), and the Woodland Hills area (54.4%). In two communities, over 50% of African-Americans were living under 200% FPL, the North Hollywood area (66.9%) and the North County W. area (51.6%). In one community, the Panorama City area, 55.8% of the Ameri-

Service Area 3: San Gabriel

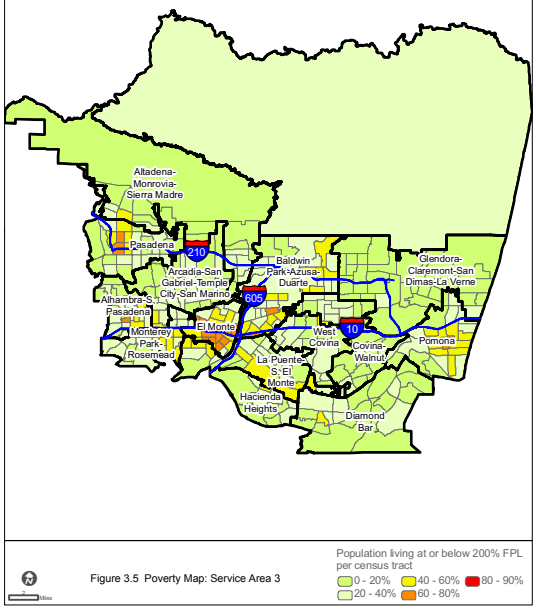


Figure 3.5 Poverty Map: Service Area 3

Service Area 4: Metro

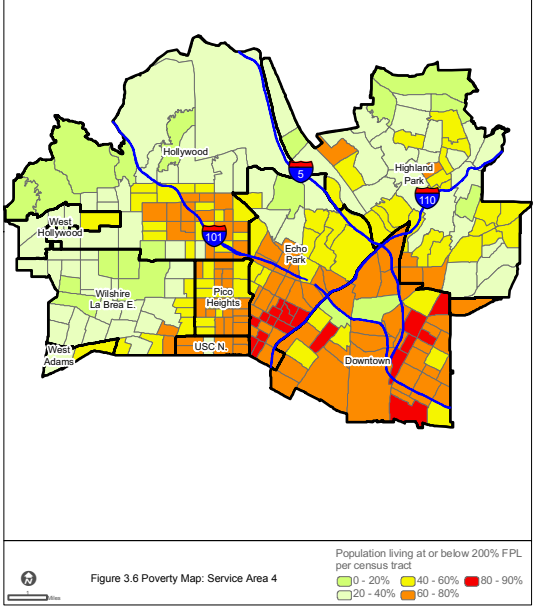


Figure 3.6 Poverty Map: Service Area 4

Service Area 3: San Gabriel

The overall poverty rate in Service Area 3, 34.4%, was below the county figure of 38.7%. Across the service area, the El Monte (56.3%) and La Puente-S. El Monte areas (50.4%) had the highest rates of individuals living beneath the 200% FPL. Examining the ethnic groups within the service area indicated that the Hispanic population were a majority of the poverty population (61.6%). Over 50% of the Hispanic population in four communities in the San Gabriel Valley were living below the 200% FPL: the El Monte area (58.0%), the Pomona area (56.2%), the Baldwin Park-Azusa-Duarte area (57.1%), and the La Puente-S. El Monte area (56.3%). In the El Monte community, 53.5% of the Asian population were living below the 200% FPL. In four communities, over 50% of African-Americans were living under this level, the Pasadena area (55.3%), the El Monte area (53.1%), the La Puente-S. El Monte area

Service Area 4: Metro

The Metro area had the second-highest poverty rate in the county with a majority (51.3%) of its residents living beneath the 200% FPL. This figure is considerably higher than the county–wide rate of 38.7%. Across the service area, the USC N. community experienced the highest levels of poverty with 72.3% of its residents living below the 200% FPL. Additionally, four other communities had overall poverty rates in excess of 50%: the Pico Heights area (64.2%), the Echo Park area (62.8%), the Downtown area (68.7%), and the West Adams area (54.0%). Examining poverty across ethnicities revealed that all groups were affected to varying degrees. 65.1% of the Hispanic population within the service area were living beneath the 200% FPL; seven communities had a poverty rate over 50%: the Wilshire La Brea E. area (54.7%), the Hollywood area (66.3%), the Pico Heights area (76.6%), the Echo Park area

Service Area 2 continued.

can Indian population was living below this level. It should be noted that, in actual numbers, the African-American and American Indians living in poverty accounted for only 1.2% of the service area's total population.

Service Area 3 continued.

(75.8%), and the Monterey Park-Rosemead area (89.9%); in three communities, over 50% of the American Indian population were living below this level, the El Monte area (100%), the Baldwin Park-Azusa-Duarte area (51.5%), and the La Puente-S. El Monte area (100%). It should be noted that, in actual numbers, African-Americans and American Indians living in poverty accounted for only 1.9% of the service area's total population.

Service Area 4 continued.

(73.4%), the Downtown area (68.7%), the USC N. area (72.3%), and the West Adams area (54.0%). 40.6% of African-Americans living within the service area were beneath the 200% FPL with three communities seeing rates in excess of 50%: the Pico Heights area (54.8%), the Downtown area (70.4%), and the USC N. area (59.4%). Three communities saw over 50% of their respective Asian populations living below the 200% FPL: the Echo Park area (63.2%), the Downtown area (62.9%), and the USC N. area (76.8%). Three communities saw over 50% of its American Indian population living below the 200% FPL: the Pico Heights area (100%), the Highland Park area (78.1%), and the USC N. area (51.5%). A majority of Whites were living below the 200% FPL in one community, the USC N. area (71.4%).

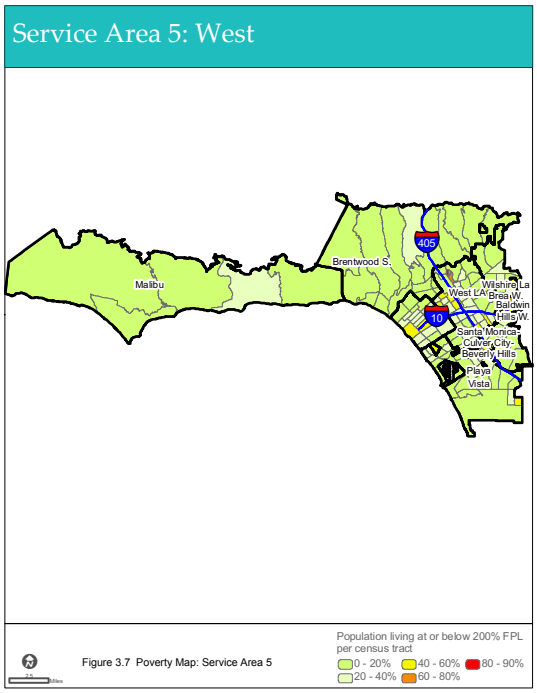


Figure 3.7 Poverty Map: Service Area 5

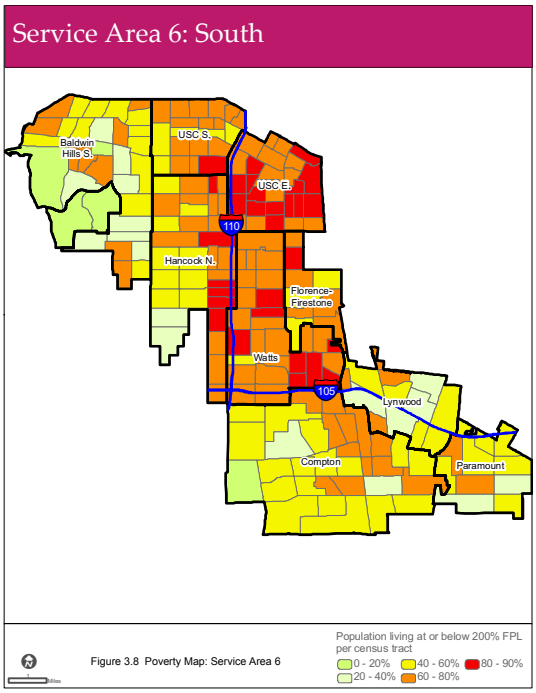


Figure 3.8 Poverty Map: Service Area 6

Service Area 5: West

Service Area 5 had the lowest poverty rate in the county with 23.4% of its population living beneath the 200% FPL. Close to one-half of all individuals living in poverty in the West were Whites (48%). Across the service area, the Baldwin Hills W. community had the highest poverty rate with 54%, or a majority of its residents living below the 200% FPL. Two communities had Hispanic populations in which over 50% were living below the 200% FPL: the Wilshire La Brea W. area (54.7%) and the Baldwin Hills W. area (67.4%). One community, the Playa Vista area (82.2%), had an American Indian population with 82% of its population living below the 200% FPL (keep in mind that the American Indian population within the service area is less than 1%).

Service Area 6: South

Service Area 6 had the highest poverty rate within the county with 60.6% of its residents living beneath the 200% FPL. This is substantially above the countywide percentage of 38.7%. The USC E. community had the highest poverty rate in the county with 80.4% of its residents living beneath the 200% FPL. The USC S. area had the second highest rate in the county with 72.3% of its residents below the 200% FPL. The Watts area (65.3%) had the fourth-highest rate in the county. Poverty was widespread across all ethnic groups. The Hispanic population saw 67.6% of its population living below the 200% FPL; African-Americans, 48.3%; Asians, 48.8%; American Indians 48.3%; and Whites, 33.8%. The Hispanic population saw a majority of its population living below the 200% FPL in every service area community, a finding unique to Service Area 6. Over 50% of the African-American population in four com-

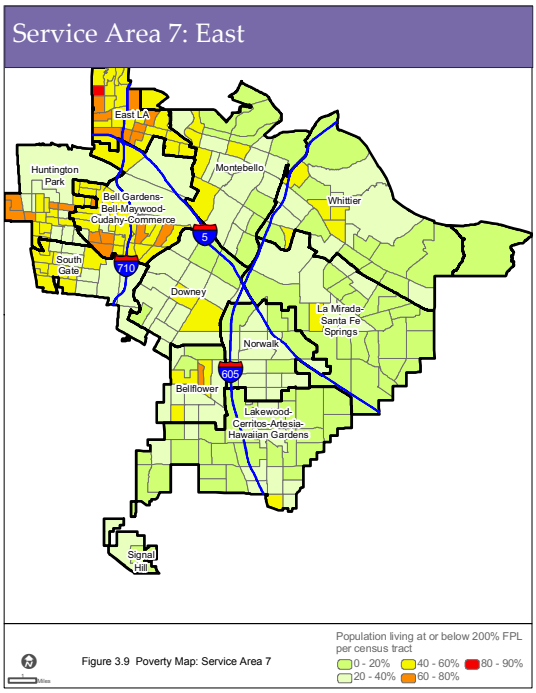


Figure 3.9 Poverty Map: Service Area 7

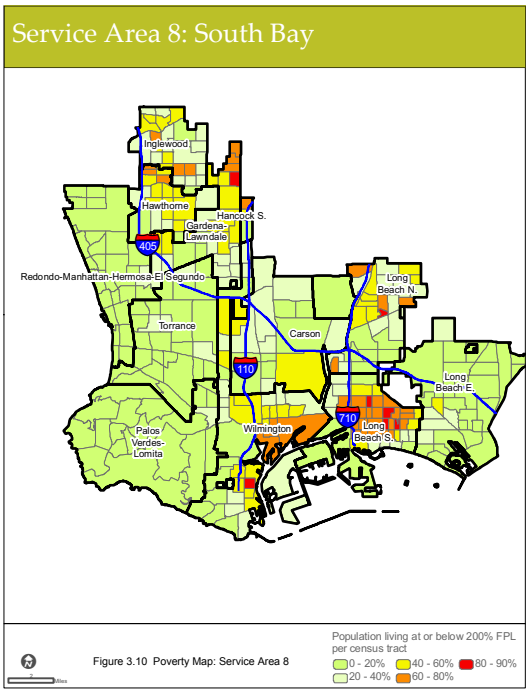


Figure 3.10 Poverty Map: Service Area 8

Service Area 7: East

Service Area 7 had an overall poverty rate of 39.5%, which is close to the county rate of 38.7%. Overall, four communities, East LA, the aggregate of Bell Gardens-Bell-Maywood-Cudahy-Commerce, Huntington Park, and South Gate, had a majority of its residents living beneath the 200% FPL. Because of the very large Hispanic population in the service area, Hispanic groups accounted for 83% of the total poverty population within the service area. Five communities saw over 50% of the Hispanic population living below the 200% FPL: the East LA area (57.7%), the Bell Gardens-Bell-Maywood-Cudahy-Commerce area (58.4%), the Huntington Park area (59.2%), the South Gate area (60.8%), and the Bellflower area (55.0%). Two communities had White populations with over 50% of its numbers living in poverty: the East LA area (51.5%) and the Huntington Park area (60.2%). Also above the 50% level

Service Area 8: South Bay

Service Area 8 had an overall poverty rate of 35.5%, which was slightly below the county-wide rate of 38.7%. Two communities, the Hancock S. area (57.6%) and Long Beach S. area (57.2%), had a majority of its population living beneath the 200% FPL. Across ethnic groups, 54.3% of the Hispanic population were below the 200% FPL, as were 36.2% of the African-American population, 13.5% of the White population, 28.0% of the Asian population, and 18.8% of the American Indian population. Seven communities saw over 50% of its Hispanic population below the 200% FPL: the Hancock S. area (70.1%), the Wilmington area (53.6%), the Inglewood area (58.8%), the Torrance area (56.5%), the Long Beach N. area (56.5%), the Long Beach S. area (66.8%), the Gardena-Lawndale area (60.5%), and the Hawthorne area (62.9%). 52.4% of African-Americans in the Long Beach S. community were below the 200%

Service Area 6 continued.

munities were below the 200% FPL: the USC S. area (59.4%), the USC E. area (62.1%), the Watts area (66.2%), and the Florence-Firestone area (60.2%). For the White population, there were four areas, as well: the USC S. area (71.4%), the USC E. area (63.1%), the Watts area (100%), and the Florence-Firestone area (60.2%). For the Asian population there were also four areas: the USC S. area (76.8%), the Hancock N. area (53.3%), the Watts area (100%), and the Compton area (53.9%).

Service Area 7 continued.

were two African-American communities, the East LA area (55.5%) and the Huntington Park area (53.6%); three American Indian communities, the Montebello area (89.2%), the Huntington Park area (100%), and the South Gate area (100%); and one Asian community, the Downey area (52.3%).

Service Area 8 continued.

FPL. Over 50% of Asians in the Hancock S. area (53.3%) and Long Beach S. area (53.9%) were below the 200% FPL. And two Pacific Islander communities had poverty rates exceeding 50%: Hancock S. (91.1%) and Long Beach N. (63.6%). When looking over these figures, please note that the relative numbers of some populations may be quite low, (e.g., American Indians living in poverty account for 0.1% of the population).

Table 3.16

Population at or below 200% FPL in Los Angeles County

	White			Black			American Indian		
	White[1]	Poverty Pop[2]	Com Pop[3]	Black[1]	Poverty Pop[2]	Com Pop[3]	Am Ind[1]	Poverty Pop[2]	Com Pop[3]
Service Area 1									
Lancaster	24.0	22.6	9.7	64.3	29.4	12.7	22.9	0.5	0.2
Palmdale	25.7	14.9	7.2	60.5	14.0	6.8	50.9	0.3	0.2
North County E.	19.1	42.4	11.1	51.6	9.3	2.4	21.3	0.9	0.2
Total	22.8	22.0	9.1	61.9	19.2	7.9	26.9	0.5	0.2
Service Area 2									
Santa Clarita	8.2	26.8	5.0	19.8	2.6	0.5			
Burbank	17.6	52.1	11.1	23.5	3.6	0.8	35.2	1.4	0.3
Glendale	29.0	62.2	18.3				29.9	0.8	0.2
Northridge	16.5	35.2	8.3	16.6	1.7	0.4			
Granada Hills	10.6	15.9	4.0	33.3	16.5	4.2			
Pacoima-Arleta	17.3	2.6	1.3	13.9	1.0	0.5			
La Tuna Cyn.	23.6	22.0	8.3	41.8	2.0	0.8			
Panorama City	30.7	6.4	3.4	21.0	1.6	0.8	55.8	0.3	0.1
North Hollywood	35.7	33.5	15.2	66.9	4.5	2.0	37.4	0.5	0.2
Sherman Oaks	26.6	23.5	8.7	35.5	5.9	2.2	35.9	0.4	0.1
Encino	15.9	30.5	8.4	16.8	2.3	0.6			
Woodland Hills	12.6	22.5	6.4	12.9	1.8	0.5			
Brentwood N.	14.8	69.4	12.1	19.0	3.4	0.6	33.4	0.9	0.2
North County W.	19.1	42.4	11.1	51.6	9.3	2.4	21.3	0.9	0.2
La Canada-Flintridge	11.8	26.5	6.1	48.1	29.0	6.6	15.3	0.3	0.1
San Fernando-Calabasas-Agoura	9.3	32.5	6.2						
Total	18.3	27.7	8.6	28.5	3.7	1.1	18.3	0.3	0.1
Service Area 3									
Pasadena	13.7	17.0	5.7	55.3	23.4	7.8	20.8	0.1	
El Monte	50.5	6.4	3.6	53.1	1.7	1.0	100.0	0.2	0.1
Pomona	25.2	5.6	2.7	33.3	5.1	2.4	17.1	0.1	0.1
West Covina	19.8	9.7	3.4	33.7	7.7	2.7			
Altadena-Monrovia-Sierra Madre	11.8	26.5	6.1	48.1	29.0	6.6	15.3	0.3	0.1
Alhambra-S. Pasadena	19.8	14.7	4.6						
Arcadia-San Gabriel-Temple City-San Marino	11.3	18.5	3.7	4.6	0.2		42.5	0.3	0.1
Baldwin Park-Azusa-Duarte	20.6	5.4	2.6	14.3	1.1	0.5	51.5	0.1	0.1
Glendora-Claremont-San Dimas-La Verne	8.4	40.5	5.1	4.5	1.0	0.1			
Covina-Walnut	14.0	15.2	3.9	32.1	6.1	1.6			
Diamond Bar	9.0	8.3	1.9	31.8	3.5	0.8	26.1	0.5	0.1
La Puente-S. El Monte	22.5	3.4	1.7	75.8	1.9	1.0	100.0	1.2	0.6
Hacienda Heights	18.2	15.4	4.2	18.8	0.7	0.2	35.4	0.6	0.2
Monterey Park-Rosemead	34.4	5.2	2.3	89.9	1.1	0.5			
Other	19.1	42.4	11.1	51.6	9.3	2.4	21.3	0.9	0.2
Total	14.5	10.6	3.6	37.7	5.2	1.8	31.1	0.2	0.1

Asian[1]	Asian Poverty Pop[2]	Com Pop[3]	Pac Is[1]	Pacific Islander Poverty Pop[2]	Com Pop[3]	Hispanic[1]	Hispanic Poverty Pop[2]	Com Pop[3]	Other[1]	Other Poverty Pop*[2]	Com Pop[3]	Totalpov[4]	Totalpop[5]	Total
23.6	2.0	0.9	16.1	0.3	0.1	57.1	44.4	19.2	58.9	0.7	0.3	57819	133996	43.1
24.4	2.0	1.0				59.4	68.8	33.3				69465	143307	48.5
2.0	0.5	0.1	11.8	0.5	0.1	42.8	46.2	12.1	30.0	0.3	0.1	22913	87213	26.3
16.6	1.8	0.7	13.1	0.2	0.1	56.0	56.0	23.1	42.8	0.3	0.1	150197	364516	41.2
24.2	9.4	1.7				39.2	61.2	11.4				30967	166873	18.6
17.9	8.1	1.7				31.2	33.7	7.2	79.0	1.2	0.2	21206	99781	21.3
21.7	10.7	3.1	84.6	0.8	0.2	39.4	25.5	7.5				58491	199170	29.4
15.8	14.3	3.4				46.3	48.9	11.6				39726	167964	23.7
23.1	8.1	2.0				38.6	59.5	15.1				34462	135999	25.3
33.4	1.3	0.6				52.2	94.2	45.3	70.4	0.9	0.4	56038	116628	48.0
20.6	4.9	1.8	41.4	0.1		50.0	70.5	26.6	52.1	0.4	0.2	50232	133280	37.7
28.9	8.0	4.3				63.1	83.2	44.0	100.0	0.5	0.3	76444	144398	52.9
34.3	4.5	2.0	100.0	0.1		54.4	56.9	25.8	4.9			61003	134361	45.4
29.7	4.4	1.6				44.2	64.8	24.0	38.5	1.0	0.4	61310	165768	37.0
17.1	6.4	1.8				51.3	59.0	16.3	42.5	1.9	0.5	45360	164602	27.6
27.1	10.3	2.9				54.4	65.4	18.5				45275	159861	28.3
28.2	12.1	2.1	90.3	1.6	0.3	28.2	11.5	2.0	74.5	1.1	0.2	15135	87031	17.4
2.0	0.5	0.1	11.8	0.5	0.1	42.8	46.2	12.1	30.0	0.3	0.1	16766	63814	26.3
11.3	4.7	1.1	16.3	0.4	0.1	38.5	39.1	9.0				9308	40579	22.9
17.0	2.8	0.5				42.5	63.0	12.0	74.5	1.8	0.3	17893	93680	19.1
22.0	7.0	2.1	30.1	0.1		48.7	60.6	18.7	32.8	0.5	0.2	639616	2073789	30.8
36.2	14.6	4.9				48.4	44.5	14.8	60.1	0.4	0.1	43618	131032	33.3
53.5	24.7	13.9				58.0	66.9	37.7				62034	110266	56.3
29.9	7.2	3.5	31.1	0.1		56.2	81.4	39.2	90.4	0.5	0.3	77139	160331	48.1
19.3	11.6	4.0	48.0	0.1		45.1	69.6	24.1	54.8	1.4	0.5	40916	118157	34.6
11.3	4.7	1.1	16.3	0.4	0.1	38.5	39.1	9.0				24788	108061	22.9
43.0	63.7	20.0				25.5	20.7	6.5	22.7	0.9	0.3	31868	101317	31.5
23.7	56.0	11.3	10.1	0.3	0.1	28.1	24.4	4.9	40.5	0.4	0.1	33357	165408	20.2
25.5	5.2	2.5				57.1	88.2	42.0	6.0	0.1		85816	180138	47.6
25.3	13.3	1.7	12.4	0.1		18.9	41.1	5.2	38.6	3.9	0.5	19469	154287	12.6
13.1	9.7	2.5				37.3	69.0	17.7				28440	110759	25.7
22.5	48.9	11.4				36.9	38.6	9.0	11.1	0.2	0.1	25152	108005	23.3
22.8	2.9	1.4				54.4	90.3	45.6	55.2	0.3	0.2	54648	108363	50.4
17.7	9.5	2.6				33.7	73.6	20.2	18.6	0.2		14933	54331	27.5
45.3	61.1	26.7				41.5	31.9	13.9	100.0	0.7	0.3	53855	123141	43.7
2.0	0.5	0.1	11.8	0.5	0.1	42.8	46.2	12.1	30.0	0.3	0.1	240	912	26.3
31.2	21.8	7.5	11.9	0.1		46.8	61.6	21.2	33.0	0.5	0.2	596273	1734507	34.4

Table 3.16 continued

Population at or below 200% FPL in Los Angeles County

	White			Black			American Indian		
	White[1]	Poverty Pop[2]	Com Pop[3]	Black[1]	Poverty Pop[2]	Com Pop[3]	Am Ind[1]	Poverty Pop[2]	Com Pop[3]
Service Area 4									
Wilshire La Brea E.	20.7	27.2	8.6	33.8	13.6	4.3	32.6	0.5	0.1
Hollywood	29.1	25.0	11.5	33.8	2.4	1.1	20.8	0.1	0.1
Pico Heights	41.1	2.7	1.7	54.8	3.3	2.1	100.0	0.1	
Echo Park	25.9	5.8	3.6	31.8	1.3	0.8	12.3	0.1	0.1
Highland Park	34.4	9.2	4.0	47.2	2.2	0.9	44.8	0.7	0.3
Downtown	43.0	2.4	1.7	70.4	2.9	2.0	78.1	0.4	0.3
USC N.	71.4	4.0	2.9	59.4	19.5	14.1	51.5	0.2	0.2
West Adams	27.2	2.3	1.2	48.0	47.1	25.5	31.8	0.2	0.1
West Hollywood	21.0	67.8	14.3	13.8	7.7	1.6	18.3	0.4	0.1
Other	51.5	0.8	0.5						
Total	27.2	11.5	5.9	40.6	4.1	2.1	35.2	0.3	0.1
Service Area 5									
Brentwood S.	14.8	69.4	12.1	19.0	3.4	0.6	33.4	0.9	0.2
West LA	21.5	46.7	12.8	44.6	6.8	1.9	17.3	0.1	
Wilshire La Brea W.	20.7	27.2	8.6	33.8	13.6	4.3	32.6	0.5	0.1
Baldwin Hills W.	27.2	2.3	1.2	48.0	47.1	25.5	31.8	0.2	0.1
Playa Vista	10.6	31.6	6.4	27.4	10.0	2.0	82.2	0.7	0.1
Santa Monica-Culver City-Beverly Hills	21.0	67.8	14.3	13.8	7.7	1.6	18.3	0.4	0.1
Malibu	9.3	32.5	6.2						
Other	29.6	1.9	1.0	36.9	28.4	14.0	100.0	0.2	0.1
Total	17.9	48.0	11.3	27.3	9.6	2.3	28.7	0.4	0.1
Service Area 6									
USC S.	71.4	4.0	2.9	59.4	19.5	14.1	51.5	0.2	0.2
Baldwin Hills S.	27.2	2.3	1.2	48.0	47.1	25.5	31.8	0.2	0.1
Hancock N.	20.0	0.2	0.1	41.5	30.0	17.3	100.0	0.1	0.1
USC E.	63.1	0.3	0.2	62.1	8.1	6.5	100.0		
Watts	100.0	0.1	0.1	66.2	26.4	17.2	90.7	0.6	0.4
Florence-Firestone	60.2	1.1	0.7	53.6	2.7	1.6	100.0	0.3	0.2
Lynwood	25.7	1.2	0.7	35.3	2.3	1.4	100.0	0.5	0.3
Paramount	33.0	12.3	5.9	36.4	6.3	3.0	38.6	0.4	0.2
Compton	45.4	1.4	0.7	39.4	30.8	16.0			
Other	21.0	67.8	14.3	13.8	7.7	1.6	18.3	0.4	0.1
Total	33.8	1.9	1.1	48.3	22.3	13.5	66.8	0.3	0.2

Asian[1]	Asian Poverty Pop[2]	Asian Com Pop[3]	Pacific Islander Pac Is[1]	Pacific Islander Poverty Pop[2]	Pacific Islander Com Pop[3]	Hispanic[1]	Hispanic Poverty Pop[2]	Hispanic Com Pop[3]	Other[1]	Other Poverty Pop[2]	Other Com Pop[3]	Totalpov[4]	Totalpop[5]	Total
22.8	14.5	4.6	79.1	0.2	0.1	54.7	40.9	12.9	58.4	3.0	1.0	45033	142790	31.5
33.5	9.3	4.3	100.0			66.3	62.6	28.9	51.9	0.5	0.2	113341	245911	46.1
44.9	21.3	13.7	14.7	0.2	0.1	76.6	72.2	46.3	87.4	0.3	0.2	78720	122706	64.2
63.2	23.2	14.6				73.4	68.1	42.8	100.0	1.5	0.9	129574	206234	62.8
28.0	11.2	4.9	100.0	1.5	0.6	49.7	75.2	33.1	5.6	0.1		95388	216758	44.0
62.9	9.2	6.3				70.5	84.9	58.3	64.0	0.1	0.1	92367	134506	68.7
76.8	5.2	3.8				76.9	70.5	51.0	55.4	0.4	0.3	14817	20498	72.3
43.3	3.1	1.7	100.0			67.4	46.0	24.8	51.7	1.2	0.7	4853	8987	54.0
21.8	8.2	1.7				27.1	15.0	3.2	67.9	0.9	0.2	7591	36085	21.0
10.9	0.2	0.1				57.7	98.6	56.5	100.0	0.5	0.3	1275	2225	57.3
42.1	14.5	7.4	47.3	0.3	0.1	65.1	68.6	35.2	59.0	0.8	0.4	582959	1136700	51.3
28.2	12.1	2.1	90.3	1.6	0.3	28.2	11.5	2.0	74.5	1.1	0.2	13639	78427	17.4
31.9	26.0	7.1				39.7	19.1	5.2	49.1	1.2	0.3	47777	174593	27.4
22.8	14.5	4.6	79.1	0.2	0.1	54.7	40.9	12.9	58.4	3.0	1.0	8197	25992	31.5
43.3	3.1	1.7	100.0			67.4	46.0	24.8	51.7	1.2	0.7	7447	13790	54.0
32.1	15.9	3.2				39.4	41.4	8.4	15.5	0.3	0.1	22522	111122	20.3
21.8	8.2	1.7				27.1	15.0	3.2	67.9	0.9	0.2	36381	172942	21.0
17.0	2.8	0.5				42.5	63.0	12.0	74.5	1.8	0.3	3665	19188	19.1
						58.8	68.9	33.9	39.4	0.5	0.2	183	373	49.2
29.2	15.9	3.7	26.4	0.2		38.9	24.8	5.8	51.2	1.1	0.3	139812	596427	23.4
76.8	5.2	3.8				76.9	70.5	51.0	55.4	0.4	0.3	50169	69407	72.3
43.3	3.1	1.7	100.0			67.4	46.0	24.8	51.7	1.2	0.7	71462	132324	54.0
53.3	0.2	0.1	91.1	0.4	0.2	70.1	68.7	39.6	31.9	0.3	0.2	85616	148523	57.6
47.8	0.1	0.1				82.4	89.5	72.0	100.0	2.0	1.6	98996	123105	80.4
100.0	0.1	0.1	100.0	0.1	0.1	64.7	72.4	47.3	100.0	0.2	0.1	105581	161632	65.3
44.6	0.3	0.2				59.2	95.5	56.4	51.8	0.1	0.0	31923	54039	59.1
						60.8	95.9	56.3	0.0	0.0	0.0	44862	76427	58.7
41.3	8.7	4.1				55.0	72.2	34.5	100.0	0.2	0.1	27451	57485	47.8
53.9	0.8	0.4				62.2	66.6	34.6	24.6	0.4	0.2	77869	149837	52.0
21.8	8.2	1.7				27.1	15.0	3.2	67.9	0.9	0.2	2314	11001	21.0
48.8	1.4	0.9	30.1	0.1	0.1	67.6	73.4	44.5	60.1	0.7	0.4	596243	983780	60.6

Table 3.16 continued

Population at or below 200% FPL in Los Angeles County

	White			Black			American Indian		
	White[1]	Poverty Pop[2]	Com Pop[3]	Black[1]	Poverty Pop[2]	Com Pop[3]	Am Ind[1]	Poverty Pop[2]	Com Pop[3]
Service Area 7									
East LA	51.5	0.8	0.5						
Downey	15.6	9.1	3.3	55.5	3.1	1.1			
Norwalk	24.3	10.5	3.6	24.4	4.2	1.5			
Whittier	18.2	15.4	4.2	18.8	0.7	0.2	35.4	0.6	0.2
Montebello	34.0	8.0	2.5				89.2	0.5	0.2
Bell Gardens-Bell-Maywood-Cudahy-Commerce	69.3	5.4	3.1	19.6	0.4	0.2			
Huntington Park	60.2	1.1	0.7	53.6	2.7	1.6	100.0	0.3	0.2
South Gate	25.7	1.2	0.7	35.3	2.3	1.4	100.0	0.5	0.3
Bellflower	33.0	12.3	5.9	36.4	6.3	3.0	38.6	0.4	0.2
La Mirada-Santa Fe Springs	11.3	17.2	3.3	11.1	1.2	0.2			
Lakewood-Cerritos-Artesia-Hawaiian Gardens	13.6	22.3	4.9	16.8	4.8	1.1	28.9	0.5	0.1
Signal Hill	5.4	20.0	2.7	27.1	9.8	1.3			
Other	15.8	6.2	2.1	43.7	1.9	0.6	26.1	0.2	0.1
Total	19.1	7.6	3.0	27.8	2.1	0.8	39.9	0.2	0.1
Service Area 8									
Hancock S.	20.0	0.2	0.1	41.5	30.0	17.3	100.0	0.1	0.1
Wilmington	14.1	8.5	3.6	48.7	8.2	3.4	28.9	0.4	0.2
Inglewood	29.6	1.9	1.0	36.9	28.4	14.0	100.0	0.2	0.1
Torrance	12.3	38.2	6.1	7.5	0.7	0.1	5.4	0.3	
Long Beach N.	28.3	12.2	5.5	35.4	14.1	6.4	39.0	0.6	0.3
Long Beach S.	37.2	10.3	5.9	52.4	13.9	7.9	9.1		
Long Beach E.	14.8	54.8	10.6	16.2	3.5	0.7	25.7	0.5	0.1
Carson	18.7	9.9	2.5	25.7	22.5	5.6			
Palos Verdes-Lomita	5.4	20.0	2.7	27.1	9.8	1.3			
Redondo-Manhattan-Hermosa-El Segundo	9.7	73.8	7.4	18.2	2.3	0.2			
Gardena-Lawndale	21.1	5.0	2.2	35.7	27.0	11.9	5.6	0.1	
Hawthorne	32.4	10.4	5.1	31.7	14.1	7.0	58.7	0.3	0.1
Other	14.9	7.6	2.8	36.4	23.1	8.6	27.3	0.2	0.1
Total	15.8	13.5	4.8	36.2	15.6	5.5	18.8	0.2	0.1
County Total	18.5	14.1	5.5	40.2	9.3	3.6	28.4	0.3	0.1

	Asian			Pacific Islander			Hispanic				Other				
Asian[1]	Poverty Pop[2]	Com Pop[3]	Pac Is[1]	Poverty Pop[2]	Com Pop[3]	Hispanic[1]	Poverty Pop[2]	Com Pop[3]	Other[1]	Poverty Pop[2]	Com Pop[3]	Totalpov[4]	Totalpop[5]	Total
10.9	0.2	0.1				57.7	98.6	56.5	100.0	0.5	0.3	73753	128674	57.3
52.3	13.8	5.0				39.7	74.0	26.7				40465	112100	36.1
36.0	17.7	6.1				38.1	67.4	23.3	9.8	0.2	0.1	35897	103792	34.6
17.7	9.5	2.6				33.7	73.6	20.2	18.6	0.2		32027	116520	27.5
28.5	5.9	1.9				31.4	85.5	26.8	18.2	0.1		41654	132755	31.4
21.3	0.2	0.1				58.4	94.1	54.8				81671	140203	58.3
44.6	0.3	0.2				59.2	95.5	56.4	51.8	0.1		55537	94013	59.1
						60.8	95.9	56.3				59468	101311	58.7
41.3	8.7	4.1				55.0	72.2	34.5	100.0	0.2	0.1	36241	75891	47.8
14.0	5.0	1.0				24.2	76.7	14.8		0.0		25270	130538	19.4
20.5	28.0	6.2	30.1	0.9	0.2	36.9	42.7	9.5	75.6	0.8	0.2	37929	171176	22.2
14.4	29.9	4.0	22.0	0.7	0.1	33.5	39.6	5.3				1514	11291	13.4
35.7	57.3	19.7				39.7	34.0	11.7	48.3	0.5	0.2	2501	7280	34.4
26.6	6.9	2.7	14.9	0.1		46.5	83.0	32.8	37.0	0.2	0.1	526428	1332823	39.5
53.3	0.2	0.1	91.1	0.4	0.2	70.1	68.7	39.6	31.9	0.3	0.2	4983	8644	57.6
39.0	10.1	4.2	41.3	0.5	0.2	53.6	71.9	29.9	52.6	0.3	0.1	72324	173969	41.6
						58.8	68.9	33.9	39.4	0.5	0.2	60979	123868	49.2
22.1	45.8	7.3	20.2	0.5	0.1	15.8	14.0	2.2	23.1	0.6	0.1	22070	137823	16.0
37.0	11.3	5.1	83.6	4.0	1.8	56.5	57.1	25.7	57.4	0.7	0.3	64809	143934	45.0
53.9	18.3	10.5				66.8	57.3	32.8	24.0	0.1		111280	194578	57.2
18.0	6.2	1.2				39.8	34.6	6.7	40.9	0.5	0.1	24386	125932	19.4
9.5	8.9	2.2	12.1	1.6	0.4	37.5	57.2	14.2				27808	111913	24.8
14.4	29.9	4.0	22.0	0.7	0.1	33.5	39.6	5.3				14768	110115	13.4
8.1	8.6	0.9				13.3	13.8	1.4	31.4	1.5	0.2	13341	132514	10.1
35.2	13.3	5.8	16.4	0.1	0.1	60.5	52.9	23.2	100.0	1.6	0.7	63359	144372	43.9
30.8	3.8	1.9				62.9	70.6	34.9	87.2	0.8	0.4	70223	142151	49.4
21.3	8.9	3.3	17.6	0.3	0.1	54.2	59.5	22.0	34.7	0.5	0.2	1805	4867	37.1
28.0	11.9	4.2	35.8	0.7	0.2	54.3	57.5	20.4	47.8	0.6	0.2	553939	1559547	35.5
30.3	10.4	4.0	29.7	0.2	0.1	53.5	65.2	25.2	44.6	0.5	0.2	3781161	9769942	38.7

Key

30-50%
50-70%
> 70%

1. Relative percent within ethnic group
2. Relative percent of poverty population for a given community
3. Relative percent of total community population
4. Totalpov = total number of individuals living under 200% FPL within a given geography
5. Totalpop = total number of individual living within a given geography

Unemployment Rate

Description of Indicators

This indicator represents the number of unemployed people as a percentage of the civilian labor force. For example, if the civilian labor force equals 100 people and five people are unemployed, then the unemployment rate would be 5%. Overall figures for the nation, state, and county are reported by various government agencies, while detailed data come from the ACS.

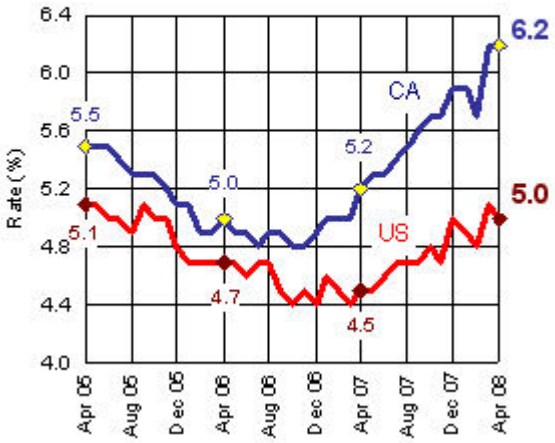
Research Base and Relevance to PEI

Though correlated with the poverty indicator, unemployment rate is another way that one can understand the economic stress that families face across the county. Additionally, unemployment itself contributes to mental illness, especially when it occurs at critical points in a family's life cycle (McKee-Ryan, Song, Wanberg, & Kinicki, 2005). Specifically, unemployment has been linked with increased rates of somatic complaints, anxiety, depression, marital problems, suicide, and child abuse in families (Dew, M. A., Penkower, L., & Bromet, E. J., 1991).

What the Numbers Show

The two graphs above provide different perspectives on the unemployment rate in Los Angeles County. The top two tables generated from Californian Labor Market Information (State of California, Employment Development Division) indicates that unemployment rates over the last two years have risen in Los Angeles County, the State of California, and the United States. Notice that these data indicate that Los Angeles County has a higher unemployment rate than the nation as a whole and somewhat of a lower rate compared to the state's figures. Table 3.17 represents unemployment estimates from the ACS 2005. These different sources do produce different numbers as a result of their collection methodology. The EDD data is generated based upon unemployment claims that have been filed, while the ACS data reflects self-reported unemployment at a given point in time. The self-reported data reflects a noticeably higher rate than the government supplied labor market statistics.

Figure 3.11
Three-Year Trend in California and United States Unemployment



Countywide, the EDD data suggested that the annual unemployment rate in Los Angeles County was 5.3%, while the ACS data indicated the rate was much higher at 7.4%. The difference in these two estimates, both of which may be correct, is explained by the way they are calculated. The EDD data, among other things, does not take into consideration those individuals who may have given up searching for a job and have exhausted their unemployment benefits; thus, one can think of it as a conservative estimate of the real unemployment rate. On the other

Figure 3.12
Government Calculated Unemployment Rates in Los Angeles County

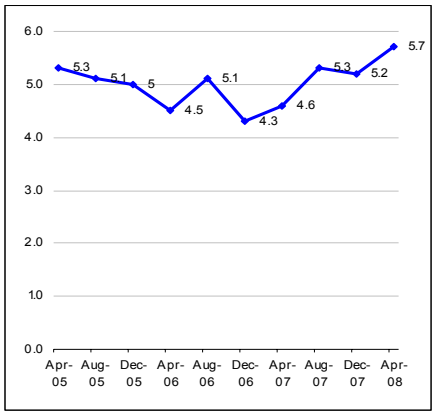


Table 3.17
Countywide Self-Reported Unemployment Rates

Service Area	Unemployment Rate
1	9.2%
2	6.9%
3	6.2%
4	9.1%
5	6.1%
6	11.4%
7	7.0%
8	6.5%
Total	7.4%

5-7%
8-10%
> 10%

hand, because the ACS relies upon self-reported information, one cannot rule out inherent self-reported inaccuracies (which may occur for a variety of reasons) in the data. So, the real number, if one must have one, *probably* lies somewhere between the two estimates (and may *possibly*, though unlikely, lie outside of them). Of most importance, though, and in spite of the different methodologies, one can see there is a clear rising trend in the unemployment across the county, state, and nation.

For more information regarding the differences in unemployment statistics, please see the US Census Bureau's Labor Force Statistics webpage: http://www.census.gov/hhes/www/laborfor/laborguidance082504.html.

The countywide summary table indicates that Service Area 6 has the highest self-reported unemployment rates in the county, followed by Service Areas 1 and 4. Service Area 5 had the lowest unemployment rate in the county.

Service Area Communities: Self-Reported Unemployment Rates

Service Area 1: Antelope Valley

Service Area 1 had a self-reported unemployment rate of 9.2%, which was higher than the countywide average of 7.4%. Of the three communities in the service area, the Palmdale area had the highest unemployment rate reported, 11%. The Lancaster area reported an unemployment rate of 9.9%, also high by county standards. The area surrounding the two urban areas, North County E., had a much lower unemployment rate (5.5%) than either city area.

Service Area 2: San Fernando

Service Area 2 had a self-reported unemployment rate of 6.9%, which was below the countywide average of 7.4%. Two communities, the Pacoima-Arleta (10.2%) and the North Hollywood (11.1%) areas, had rates in excess of 10%. Two other communities, the La Tuna Cyn. (9.8%) and the Panorama City (9.6%) areas were close to the 10% mark, as well. The Granada Hills area saw the lowest

unemployment rate in the service area (5.1%).

Service Area 3: San Gabriel
Service Area 3 had an overall self-reported unemployment rate of 6.2, which was below the countywide average of 7.4%. Only one community had an unemployment rate above 10%, the El Monte area (12.1%). Three communities had relatively low unemployment rates, the West Covina area (3.3%), the Alhambra-S. Pasadena area (4.8%), and the aggregate Arcadia-San Gabriel-Temple City-San Marino area (3.8%).

Service Area 4: Metro
Service Area 4 had a self-reported unemployment rate of 9.1% which was above the countywide rate of 7.4%. Four communities reported unemployment rates over 10%: the Hollywood area (10.3%), the Pico Heights area (13.6%), the USC N. area (11.7%), and the West Adams area (11.7%). The Pico Heights area had the second highest unemployment rate reported in the county across all communities. The Echo Park area (5.7%) had the lowest self-reported unemployment rate in the service area.

Service Area 5: West
Service Area 5 had an overall self-reported unemployment rate of 6.1%, the lowest rate in the county. Two exceptions were the Baldwin Hills W. area, with an unemployment rate of 11.7%, and the Wilshire La Brea W. area with rate of 9.5%. All other named areas held unemployment rates that were under the countywide rate of 7.4%. The Playa Vista area had the lowest unemployment rate in the service area (4.4%).

Service Area 6: South
Service Area 6 had a self-reported unemployment rate of 11.4%, the highest in the county and substantially above the countywide rate of 7.4%. Seven communities in the service area were characterized by unemployment rates well above 10%: the USC S. area (11.7%), the Baldwin Hills S. area (11.7%), the Hancock N. area (10.3%), the USC E. area (15.8% -- highest in the county), the Watts area (12.2%), the Paramount area (11.1%), and the Compton area (12.1%). Only the Florence-Firestone area (5.1%) had a self-reported unemployment rate below the county average.

Service Area 7: East
Service Area 7 had an unemployment rate of 7%, which was very close to the countywide average of 7.4%. Two communities had reported unemployment rates of at least 10%: the Norwalk area (10%) and the Bellflower area (11.1%). The Signal Hill area (2.1%) yielded the lowest unemployment rate in the service area and the county (the Palos Verdes-Lomita area in Service Area 8 also had an unemployment rate of 2.1%).

Service Area 8: South Bay
Service Area 8 had an overall self-reported unemployment rate of 6.5%, which was below the countywide average of 7.4%. Only one community exceeded a self-reported unemployment rate of 10%: the Hancock S. area (10.3%); however, the Long Beach S. area at 9.6% nearly reached this benchmark, as well. The Palos Verdes-Lomita area (2.1%) had the lowest unemployment rate in the service area and the county (the Signal Hill area in Service Area 7 also had an unemployment rate of 2.1%).

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Table 3.18
Service Area Communities: Unemployment Rates

Service Area 1

Lancaster	9.9
Palmdale	11.0
North County E.	5.5
Total	9.2

Service Area 2

Santa Clarita	5.3
Burbank	5.3
Glendale	6.0
Northridge	5.4
Granada Hills	5.1
Pacoima-Arleta	10.2
La Tuna Cyn.	9.8
Panorama City	9.6
North Hollywood	11.1
Sherman Oaks	8.2
Encino	5.5
Woodland Hills	6.1
Brentwood N.	5.3
North County W.	5.5
La Canada-Flintridge	6.8
San Fernando-Calabasas-Agoura	6.6
Total	6.9

Service Area 3

Pasadena	5.3
El Monte	12.1
Pomona	7.3
West Covina	3.3
Altadena-Monrovia-Sierra Madre	6.8
Alhambra-S. Pasadena	4.8
Arcadia-San Gabriel-Temple City-San Marino	3.8
Baldwin Park-Azusa-Duarte	7.2
Glendora-Claremont-San Dimas-La Verne	5.9
Covina-Walnut	7.3
Diamond Bar	6.7
La Puente-S. El Monte	5.7
Hacienda Heights	5.0
Monterey Park-Rosemead	7.0
Other	5.5
Total	6.2
	0.0

Service Area 4

Wilshire La Brea E.	9.5
Hollywood	10.3
Pico Heights	13.6
Echo Park	5.7
Highland Park	8.9
Downtown	8.5
USC N.	11.7
West Adams	11.7
West Hollywood	6.8
Other	8.4
Total	9.1

Service Area 5

Brentwood S.	5.3
West LA	6.1
Wilshire La Brea W.	9.5
Baldwin Hills W.	11.7
Playa Vista	4.4
Santa Monica-Culver City-Beverly Hills	6.8
Malibu	6.6
Other	7.8
Total	6.1

Service Area 6

USC S.	11.7
Baldwin Hills S.	11.7
Hancock N.	10.3
USC E.	15.8
Watts	12.2
Florence-Firestone	5.1
Lynwood	8.4
Paramount	11.1
Compton	12.1
Other	6.8
Total	11.4

Service Area 7

East LA	8.4
Downey	6.5
Norwalk	10.0
Whittier	5.0
Montebello	8.5
Bell Gardens-Bell-Maywood-Cudahy-Commerce	5.3
Huntington Park	5.1
South Gate	8.4
Bellflower	11.1
La Mirada-Santa Fe Springs	5.2
Lakewood-Cerritos-Artesia-Hawaiian Gardens	5.5
Signal Hill	2.1
Other	6.1
Total	7.0

Service Area 8

Hancock S.	10.3
Wilmington	6.3
Inglewood	7.8
Torrance	4.2
Long Beach N.	7.7
Long Beach S.	9.8
Long Beach E.	4.6
Carson	8.3
Palos Verdes-Lomita	2.1
Redondo-Manhattan-Hermosa-El Segundo	3.6
Gardena-Lawndale	8.8
Hawthorne	6.9
Other	9.6
Total	6.5

5-7%
8-10%
> 10%

Disrupted Families

Description of Indicator

Disrupted Families is a derived measure drawn from ACS data designed to indicate social disorganization at the family level. Disrupted Families is defined as a ratio of families with married couples to families with single parents for a given geographical location.

Disrupted Families = number of intact families/number of single-parent families

For example, a Disrupted Families ratio of 3.0 means that in a given community, there are three intact families for every single-parent family. A Disrupted Families ratio of 1.0 indicates there are equal numbers of intact versus single parent families for a given area. A Disrupted Families ratio less than 1.0 indicates there are more single-parent families than intact families in a given area.

Research Base and Relevance to PEI

Research indicates that, in general, single-parent families encounter more stress and have more difficulty coping with stressful life events than families headed by a married couple. This measure can show areas where high concentrations of disrupted families reside. Lower ratios indicate more social disruption (Goodman & Haugland, 1994).

What the Numbers Show

Countywide, the Disrupted Families (DF) ratio was 2.2, which means that there were over twice as many intact families, (i.e., families with two parents), as single-parent families across the county. Across service areas, the DF ratio ranged from 2.7 in Service Area 3 to 1.6 in Service Areas 4 and 5. The smaller ratio in the West and Metro areas may indicate more widespread family stress typically associated with single parenting.

Service Area Communities

Service Area 1: Antelope Valley

Service Area 1 had an overall DF ratio of 2.0, indicating that there were two intact families for every single-parent family in the service area. This figure was slightly lower than the countywide figure of 2.2. The Palmdale area had the lowest DF ratio (1.6) in the service area while the surrounding North County E. area had the greatest DF ratio of 3.0, or three intact families for each single-parent family.

Service Area 2: San Fernando

Service Area 2 had an overall DF ratio of 2.3 similar to the countywide average of 2.2. Across the service area, there was a broad range of scores with some areas, such as Panorama City (1.3) having close to a 1:1 ratio of two-parent to single-parents households. Four other communities saw DF ratios below 2.0: the Granada Hills area (1.6), the Sherman Oaks area (1.6), the La Canada-Flintridge area (1.8), and the San Fernando-Calabasas-Agoura area (1.7). On the other end of scale, the Brentwood N. area had a DF ratio of 5.6, indicating over a 5:1 ratio of two-parent to single-parents households.

Service Area 3: San Gabriel

Service Area 3 had an overall DF ratio of 2.7, which was higher than the countywide average of 2.7. Communities across the service area ranged widely in their DF scores. The West Covina area yielded the lowest DF ratio in the county (0.9) along with the West LA area in Service Area 5. A DF ratio less than 1 indicated that there were more single parent families in a given area than two parent families. Two other communities saw DF

Table 3.19
Disrupted Families in Los Angeles County

Service Area 1

Lancaster	2.1
Palmdale	1.6
North County E.	3.0
Total	2.0

Service Area 2

Santa Clarita	3.1
Burbank	2.4
Glendale	3.4
Northridge	2.6
Granada Hills	1.6
Pacoima-Arleta	2.5
La Tuna Cyn.	3.0
Panorama City	1.3
North Hollywood	2.4
Sherman Oaks	1.6
Encino	2.9
Woodland Hills	3.7
Brentwood N.	5.6
North County W.	3.0
La Canada-Flintridge	1.8
San Fernando-Calabasas-Agoura	1.7
Total	2.3

Service Area 3

Pasadena	1.3
El Monte	4.0
Pomona	2.2
West Covina	0.9
Altadena-Monrovia-Sierra Madre	1.8
Alhambra-S. Pasadena	2.2
Arcadia-San Gabriel-Temple City-San Marino	2.9
Baldwin Park-Azusa-Duarte	2.8
Glendora-Claremont-San Dimas-La Verne	5.0
Covina-Walnut	3.3
Diamond Bar	2.4
La Puente-S. El Monte	2.8
Hacienda Heights	4.0
Monterey Park-Rosemead	5.0
Other	3.0
Total	2.7

Service Area 4

Wilshire La Brea E.	2.2
Hollywood	2.0
Pico Heights	1.0
Echo Park	1.6
Highland Park	1.7
Downtown	1.9
USC N.	1.2
West Adams	1.0
West Hollywood	4.3
Other	1.5
Total	1.6

Service Area 5

Brentwood S.	5.6
West LA	0.9
Wilshire La Brea W.	2.2
Baldwin Hills W.	1.0
Playa Vista	1.5
Santa Monica-Culver City-Beverly Hills	4.3
Malibu	1.7
Other	1.5
Total	1.6

Service Area 6

USC S.	1.2
Baldwin Hills S.	1.0
Hancock N.	2.1
USC E.	1.8
Watts	3.1
Florence-Firestone	2.1
Lynwood	1.8
Paramount	2.3
Compton	2.6
Other	4.3
Total	2.0

Service Area 7

East LA	1.5
Downey	4.5
Norwalk	3.1
Whittier	4.0
Montebello	2.9
Bell Gardens-Bell-Maywood-Cudahy-Commerce	2.6
Huntington Park	2.1
South Gate	1.8
Bellflower	2.3
La Mirada-Santa Fe Springs	1.8
Lakewood-Cerritos-Artesia-Hawaiian Gardens	5.0
Signal Hill	5.1
Other	3.7
Total	2.3

Service Area 8

Hancock S.	2.1
Wilmington	2.0
Inglewood	1.5
Torrance	5.8
Long Beach N.	3.9
Long Beach S.	2.6
Long Beach E.	3.8
Carson	2.5
Palos Verdes-Lomita	5.1
Redondo-Manhattan-Hermosa-El Segundo	3.7
Gardena-Lawndale	2.9
Hawthorne	2.0
Other	3.2
Total	2.5

County Total	2.2

1.0-2%
< 1.0%

ratios below 2.0: the Pasadena area (1.3) and the Altadena-Monrovia-Sierra Madre area (1.8). On the other end of the spectrum, two communities, the Glendora-Claremont-San Dimas-La Verne area and the Monterey Park-Rosemead area, had a DF ratio equal to 5.0, or a 5:1 ratio of intact families to single-parent families.

Service Area 4: Metro

Service Area 4 had an overall DF ratio of 1.6, which was below the countywide average of 2.2. This figure indicated that Service Area 4, along with Service Area 5, had the highest rate of disrupted families in the county. Looking within the service area indicated that six communities had a DF less than 2.0; the West Adams and Pico Heights areas both had a DF ratio of 1.0 meaning that there were equal numbers of intact families and single parent families in those areas. The other four communities included the Echo Park area (1.6), the Highland Park area (1.7), the Downtown area (1.9), and the USC N. area (1.2). Only the West Hollywood area (4.3) had a DF ratio that exceeded the county average; there, intact families were four times as numerous as single parent families.

Service Area 5: West

Like Service Area 4, Service Area 5 had an overall DF ratio of 1.6. These were the two lowest overall service area ratios seen across the county. However, within the service area, there was great variation in the relative numbers of intact versus single-parent families in neighboring communities. The West LA area, for example, had a DF score of 0.9; only the community of West Covina in Service Area 3 had a DF score as low. A DF score of less than 1 indicated that there were more single-parent households than two-parent households for a given area. The West LA area and the West Covina area were the only two parts of the county where this phenomenon occurred. There were three other communities with a DF ratio less than 2.0: the Baldwin Hills W. area (1.0), the Playa Vista area (1.5), and the Malibu area (1.7). At the other end of the spectrum, the Brentwood S. area had a DF ratio of 5.6 and the Santa Monica-Culver City-Beverly Hills area had a DF ratio of 4.3.

Service Area 6: South

Service Area 6 had a DF ratio of 2.0, which was slightly lower than the countywide average of 2.2. Of the named communities within the service area, four had DF ratios below 2.0 indicating greater levels of single parents for a given area: USC S. (1.2), Baldwin Hills S. (1.0), USC E. (1.8), and the Lynwood area (1.8). The Watts area (3.1) had the highest DF ratio in the service area; there, intact families outnumbered single-parent families about 3 to 1.

Service Area 7: East

Service Area 7 had a DF ratio of 2.3, similar to the countywide ratio of 2.2. As in other parts of the county, Service Area 7 had areas with relatively high DF scores, (e.g., Lakewood-Cerritos-Artesia-Hawaiian Gardens, 5.0, and Signal Hill, 5.1), and relatively low DF scores, (e.g., East LA, 1.5, La Mirada-Santa Fe Springs, 1.8, and South Gate, 1.8). In both the Lakewood-Cerritos-Artesia-Hawaiian Gardens area and the Signal Hill area, intact families outnumbered single-parent families 5 to 1.

Service Area 8: South Bay

Service Area 8 had an overall DF ratio of 2.5, which was slightly higher than the countywide ratio of 2.2. Only one community, the Inglewood area (1.5), had a DF ratio below

Table 3.20
Countywide Summary: A Safe Place to Play*

Service Area	% of Children w/Safe Place to Play (by parent report)
1	82.5
2	83.9
3	87.4
4	73.1
5	85.1
6	72.1
7	86.1
8	90.0
Total	83.1

Table 3.21
Age Groups: A Safe Place to Play*

Age Group	
18-24	83.2%
25-29	86.2%
30-39	84.0%
40-49	83.1%
50-59	76.4%
60-64	66.3%
65 or over	85.7%

* Los Angeles County Health Survey 2005

2.0. On the other end of the spectrum, there were two communities with DF ratios above 5.0: the Palos Verdes-Lomita area (5.1) and the Torrance area (5.8). The Torrance area had the highest DF ratio in the county with nearly a 6:1 ratio of intact families to single-parent families.

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A Safe Place to Play

Description of Indicator

A Safe Place to Play is an Los Angeles Health Survey 2005 variable. Survey respondents were asked if there was a safe place for their children to play nearby. Figures reflect the percentage of individuals residing within a given geographic location who answered, "Yes".

Research Base and Relevance to PEI

Research on neighborhood effects indicates that impoverished neighborhoods are characterized by high crime, crowded living conditions, lack of park spaces, and limited opportunities to engage in organized extracurricular activities. Not having a safe place to play is one indication of the chronic urban stress that a family may have to endure. Families with a safe place to play are thought to be living in a less stressful and harmful environment than those families who do not have a safe place to play.

What the Numbers Show

The data from the above table indicated that 83.1% of parents across the county believed that their children could easily get to a park, playground, or some other safe place to play. Two service areas were below 75% on this indicator: Service Area 4 (73.1%) and Service Area 6 (72.1%). Put another way, 1 of 4 parents in Service Areas 4 and 6 did not believe their children had a safe place play nearby. On the other end of spectrum, Service Area 8 had the highest percent of parents reporting a safe place to play was close by (90%), though the five other service areas had percentages in the 80's.

Age Groups

Across the three age groups reported, there appeared to be a trend in parent-report. Parents were more likely to report that a safe place to play was less available for older children than for younger ones.

Ethnicity

There did not appear to be any significant difference between parent reports across ethnicities

INDICATORS FOR TRAUMA-EXPOSED INDIVIDUALS

California State defines trauma-exposed individuals as "those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health services." (California Department of Mental Health, 2007)

Child Abuse

Description of Indicators

Four indicators are reported here detailing child abuse and neglect cases throughout the county. One indicator, substantiated child abuse and neglect cases, made it possible to report on the child abuse/neglect base rates for a given community. A second indicator, the Department of Children and Family Services (DCFS) triage response following a suspected child abuse/ neglect report, led to the creation of a triage response acuity score.

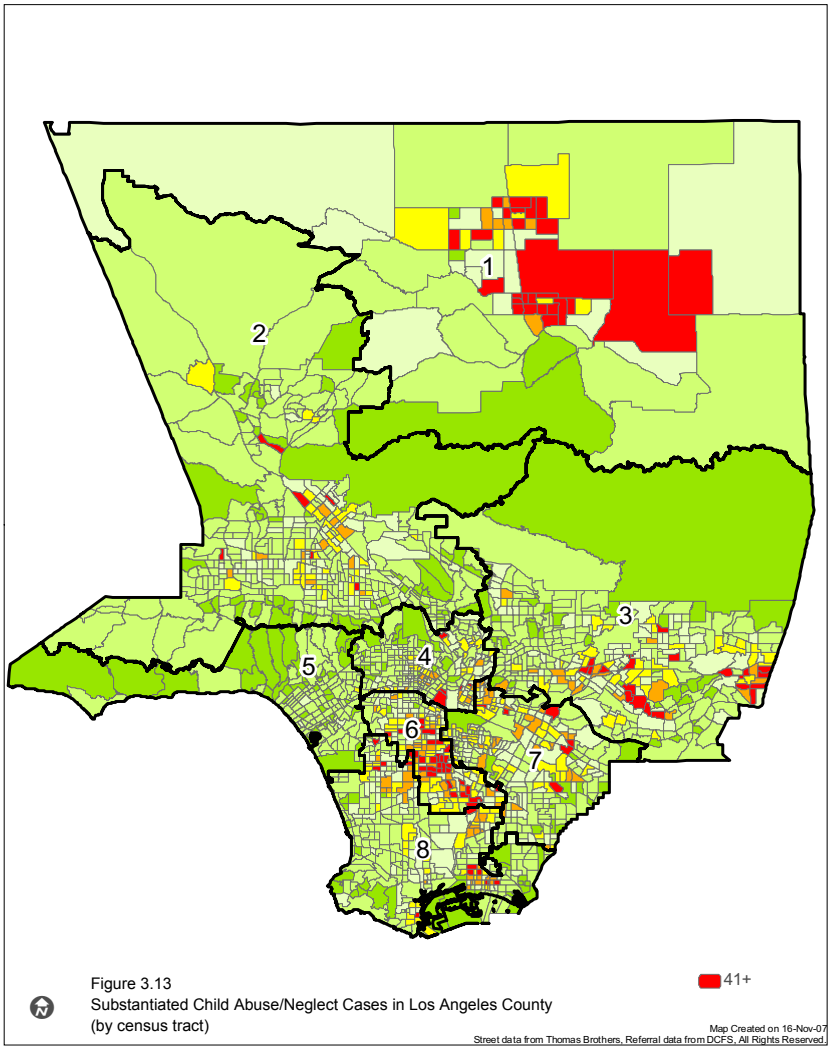


Figure 3.13
Substantiated Child Abuse/Neglect Cases in Los Angeles County
(by census tract)

Child Abuse and Neglect Rate (CAN Rate) was defined as follows:

CAN Rate = (Number of substantiated case * 100)/child population

A Triage Response Acuity score was defined as follows:

Acuity = ((number of immediate responses * 5) + (number of 3-day responses * 2) + (number of 5-day responses * 1) + (number of 10-day responses * 1))/child population

This acuity score is a weighted sum adjusted to child populations within a given community that indicates the severity of victimization for a given area. The third and fourth indicators, ethnicity and age, indicate the scope of victimization across the county. All raw data come from the DCFS for the 2006 calendar year.

Research Base and Relevance to PEI

All forms of abuse and neglect have been linked to increased risk of developing a mental health disorder (Cohen, Brown, & Smailes, 2001). Recent research continues to support this finding. Physical abuse of children predicts later depression, anxiety, anger problems, and an array of medical diagnoses and physical symptoms (Springer, Sheridan, Kuo, & Carnes, 2007). Younger children experiencing abuse are at higher risk for developing a long-term mental health problem than older children (Kaplow & Widom, 2007). And child abuse, combined with impoverished neighborhoods, have placed child victims at increased risk for developing criminal behavior themselves (Schuck & Spatz, 2007).

Each statistic reported should be interpreted carefully. Case disposition indicates how many Suspected Child Abuse and Neglect (SCAN) reports were taken by DCFS in a given geographic area; Percent Substantiated is the percentage of SCAN reports verified by DCFS staff. It is an indicator of where child abuse occurred most frequently.

Response statistics indicate the risk assessment that was performed at the time the SCAN report was taken. A derived measure of acuity is a weighted sum across response categories. Since an immediate response indicates an emergency situation, it was assigned an a priori weight of 5; three-day responses were given a weight of 2; and five- and ten-day responses were given a weight of 1. Scores were then weighted by the child population for a given geographic area, resulting in an population-adjusted acuity score (range = 0.1 – 2.2; SD = 0.07).

What the Numbers Show

Data indicated that across the county, 148,343 suspected child abuse reports were filed, with 20.6% of these, or 30,533 allegations, substantiated. On the average , a child is abused every 17 minutes in the county. There was wide variation in whether abuse was substantiated by DCFS across service areas. Service Area 5, for instance, had the lowest rate of substantiated abuse reports at 14.3%, while Service Area 1 had the highest rate of confirmed child abuse, 23.9%.

Child Abuse/Neglect Base Rates

In order to make comparisons across areas, a child abuse base rate was calculated for each area. The CAN Rate is standardized to 100 children/geographic area. Table 3.22 shows that countywide, the CAN Rate was 0.97, or about 1 in 100 children. Service Area 1 had the highest overall CAN Rate of 1.98 (> 2 standard deviations from the mean). This was followed by Service Area 6 (1.51) and Service Area 4 (1.20). Service Area 5 had the lowest CAN Rate at 0.45.

Triage Response Acuity

Overall, the Triage Response Acuity score for the county was 0.15. Service Area 1 had the highest Acuity score (0.25), followed closely by Service Area 6 (0.23) and Service Area 4 (0.18). Service Area 5 had the lowest Acuity score (0.08). While these data indicate that Service Area 1 has the most emergent child abuse and neglect problems across the county, it should be noted that the data are subject to reporting and triage bias. That is, these data do not tell us whether there is consistency across service areas in terms of triag-

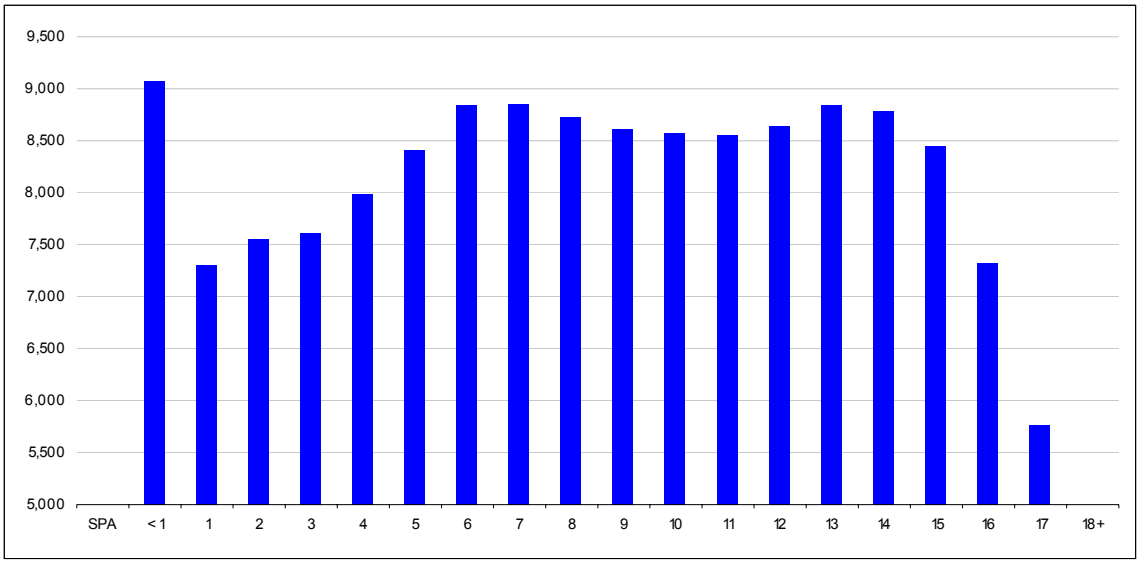


Figure 3.14 Age Distribution of Child Abuse/Neglect in Los Angeles County

VICTIM AGE DISTRIBUTION PATTERNS

Service Area 1: Antelope Valley

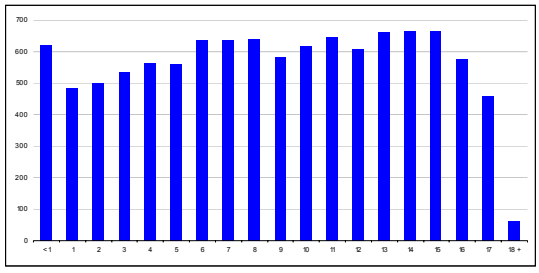


Figure 3.15 Age Distribution of Child Abuse/Neglect in Service Area 1

Service Area 2: San Fernando

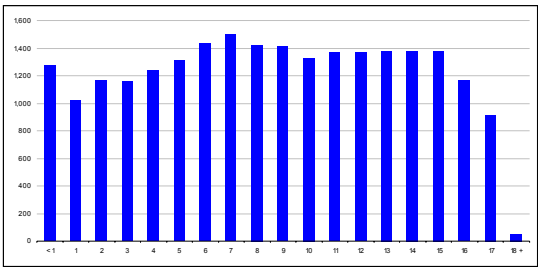


Figure 3.16 Age Distribution of Child Abuse/Neglect in Service Area 2

Service Area 3: San Gabriel

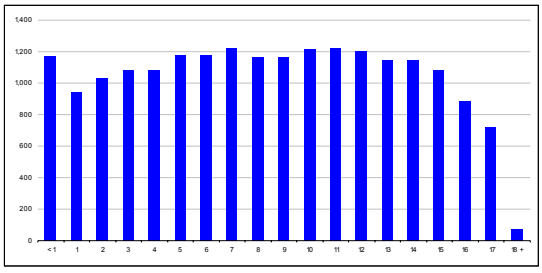


Figure 3.15 Age Distribution of Child Abuse/Neglect in Service Area 1

Service Area 4: Metro

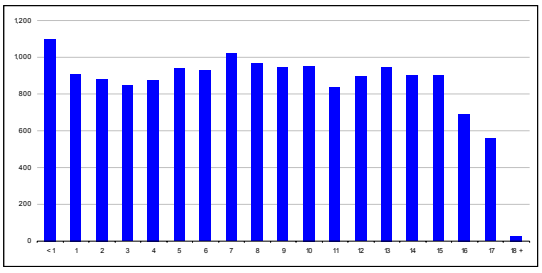


Figure 3.18 Age Distribution of Child Abuse/Neglect in Service Area 4

ing calls, classifying risk, and substantiating abuse and neglect.

Ethnicity of Victims

In Table 3.24, 21 ethnic groups or county/area of origin categories for child abuse/neglect victims are reported. Highlighted in red are groups within geographic locations that exceed a count of 2000. Countywide, four groups exceed 2000 reports: African-Americans, Whites, Mexican nationals, and Hispanics. As a group, Hispanics are the majority of SCAN Report victims, followed by African-Americans, Whites, and Mexican nationals. Examining communities across Los Angeles County indicated that over 2000 SCAN reports involving African-American children occurred in the Lancaster area in Service Area 1 and in the Hancock S. and Watts areas in Service Area 6. Hispanic children were involved in over 2000 SCAN reports in the Pomona area in Service Area 3, the Echo Park, Highland Park, and Downtown areas in Service Area 4, the USC E. and Watts areas in Service Area 6, the East LA and Bell Gardens-Bell-Maywood-Cudahy-Commerce areas in Service Area 7, and the Wilmington and Long Beach S. areas in Service Area 8. Although across service areas,

ACROSS LOS ANGELES COUNTY

Service Area 5: West

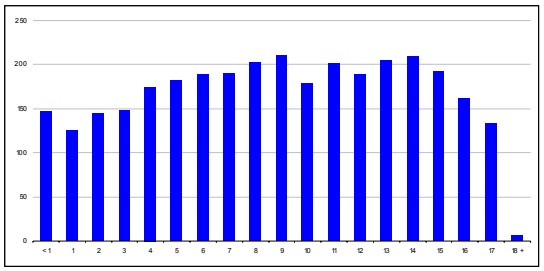


Figure 3.19 Age Distribution of Child Abuse/Neglect in Service Area 5

Service Area 6: South

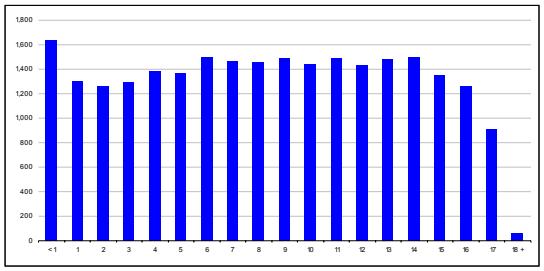


Figure 3.20 Age Distribution of Child Abuse/Neglect in Service Area 6

Service Area 7: East

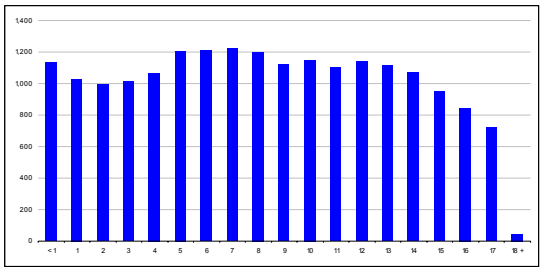


Figure 3.21 Age Distribution of Child Abuse/Neglect in Service Area 7

Service Area 8: South Bay

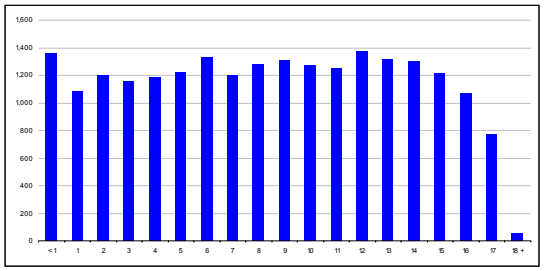


Figure 3.22 Age Distribution of Child Abuse/Neglect in Service Area 8

Table 3.22

Child Abuse and Neglect Rates

Service Area 1	Inconclusive	Not Disposed	Unfounded	Substantiated[1]	Percent Substantiated[2]	Total	CAN Rate[3]
Lancaster	1,202	6	2,621	930	19.5	4,758	1.98
Palmdale	744		2,112	1146	28.6	4,002	2.15
North County E.	406		1,054	486	25.0	1,946	1.66
Total	2,352	6	5,787	2562	23.9	10,707	1.98
Service Area 2							
Santa Clarita	180		1,282	292	16.6	1,754	0.60
Burbank	82		443	110	17.3	635	0.49
Glendale	83		576	141	17.6	799	0.36
Northridge	189	1	1,148	277	17.1	1,615	0.68
Granada Hills	203		1,327	361	19.1	1,891	0.81
Pacoima-Arleta	244		1,788	453	18.2	2,486	1.22
La Tuna Cyn.	214	4	1,343	339	17.8	1,900	0.98
Panorama City	278		1,960	416	15.7	2,654	0.94
North Hollywood	190		1,284	358	19.5	1,832	1.26
Sherman Oaks	322	1	1,716	460	18.4	2,499	1.01
Encino	201	1	1,148	270	16.7	1,620	0.66
Woodland Hills	218		1,037	256	16.9	1,511	0.69
Brentwood N.	41		244	44	13.4	329	0.27
North County W.	84		488	98	14.7	670	0.46
La Canada-Flintridge	15		104	22	15.8	142	0.23
San Fernando-Calabasas-Agoura	80		709	121	13.3	910	0.49
Total	2,625	7	16,596	4018	17.3	23,246	0.75
Service Area 3							
Pasadena	237		896	206	15.4	1,339	0.71
El Monte	440	4	1,007	518	26.3	1,968	1.57
Pomona	595		1,661	799	26.2	3,056	1.60
West Covina	283		710	347	25.9	1,339	1.10
Altadena-Monrovia-Sierra Madre	237		735	186	16.0	1,158	0.71
Alhambra-S. Pasadena	179		489	121	15.3	789	0.61
Arcadia-San Gabriel-Temple City-San Marino	163		576	188	20.3	927	0.46
Baldwin Park-Azusa-Duarte	572		1,357	588	23.4	2,517	1.33
Glendora-Claremont-San Dimas-La Verne	321		868	339	22.2	1,528	0.85
Covina-Walnut	318	2	733	312	22.8	1,365	0.94
Diamond Bar	138		332	133	22.0	603	0.51
La Puente-S. El Monte	402	0	1,098	485	24.4	1,986	1.23
Hacienda Heights	106		228	108	24.4	442	0.66
Monterey Park-Rosemead	127		518	267	29.3	911	1.10
Other			3		0.0	3	0.00
Total	4,118	6	11,207	4596	23.1	19,928	1.01
Service Area 4							
Wilshire La Brea E.	209		788	222	18.2	1,219	0.73
Hollywood	371		1,332	361	17.5	2,064	0.96
Pico Heights	213		974	335	22.0	1,522	1.29
Echo Park	558		2,456	577	16.1	3,591	1.40
Highland Park	671		2,517	678	17.5	3,866	1.02
Downtown	508		1,805	779	25.2	3,092	1.92
USC N.	77		272	103	22.8	452	1.61
West Adams	37		85	26	17.6	148	1.01
West Hollywood	15		60	23	23.5	98	0.39
Other	17		43	15	20.0	75	2.22
Total	2,659	0	10,289	3104	19.3	16,052	1.20

there were thousands of SCAN reports involving White children, no one community across the county exceeded 2000.

Age of Victims

This collection of figures is presented to give you an sense for which PEI Age Groups are

Service Area 5	Inconclusive	Not Disposed	Unfounded	Substantiated[1]	Percent Substantiated[2]	Total	CAN Rate[3]
Brentwood S.	23		142	16	8.8	181	0.11
West LA	110		538	115	15.1	763	0.48
Wilshire La Brea W.	17		88	13	11.0	118	0.23
Baldwin Hills W.	31	1	124	34	17.9	190	0.86
Playa Vista	93		592	135	16.4	819	0.71
Santa Monica-Culver City-Beverly Hills	153		742	141	13.6	1,036	0.50
Malibu	6		67	2	2.7	75	0.04
Other	0		2	0	10.9	3	0.23
Total	433	1	2,293	456	14.3	3,182	0.45
Service Area 6							
USC S.	177		902	207	16.1	1,286	0.95
Baldwin Hills S.	386	3	1,947	503	17.7	2,839	1.32
Hancock N.	703		2,869	844	19.1	4,416	1.66
USC E.	517		2,101	630	19.4	3,248	1.27
Watts	887		3,392	1162	21.4	5,441	2.15
Florence-Firestone	207		857	266	20.0	1,330	1.51
Lynwood	149	1	734	285	24.4	1,169	0.99
Paramount	133		849	257	20.7	1,239	1.23
Compton	641		2,355	987	24.8	3,983	1.67
Other	11		99	19	14.7	129	1.05
Total	3,811	4	16,105	5160	20.6	25,080	1.51
Service Area 7							
East LA	382	1	1,304	687	28.9	2,374	1.76
Downey	268		903	179	13.3	1,350	0.50
Norwalk	310		1,098	253	15.2	1,661	0.90
Whittier	305		1,119	392	21.6	1,816	1.11
Montebello	365		914	532	29.4	1,812	1.38
Bell Gardens-Bell-Maywood-Cudahy-Commerce	405		1,513	593	23.6	2,512	1.03
Huntington Park	233		945	320	21.4	1,498	1.04
South Gate	258		1,016	207	14.0	1,481	0.54
Bellflower	272		805	201	15.7	1,278	0.73
La Mirada-Santa Fe Springs	264		1,201	303	17.1	1,768	0.75
Lakewood-Cerritos-Artesia-Hawaiian Gardens	280	1	1,008	253	16.4	1,541	0.55
Signal Hill	32		100	28	17.5	160	0.99
Other	6	0	49	14	20.3	69	0.89
Total	3,380	2	11,976	3961	20.5	19,319	0.94
Service Area 8							
Hancock S.	30		108	48	25.8	186	1.62
Wilmington	629		2,248	623	17.8	3,501	1.05
Inglewood	486		942	369	20.5	1,797	0.90
Torrance	232		485	159	18.2	876	0.48
Long Beach N.	453		1,797	538	19.3	2,788	1.22
Long Beach S.	673	1	3,146	1024	21.1	4,844	1.62
Long Beach E.	129		452	130	18.3	711	0.56
Carson	218	1	877	266	19.5	1,363	0.99
Palos Verdes-Lomita	159		333	111	18.4	603	0.40
Redondo-Manhattan-Hermosa-El Segundo	146		385	118	18.2	649	0.40
Gardena-Lawndale	531		1,592	492	18.8	2,615	1.06
Hawthorne	471		1,121	396	19.9	1,988	1.04
Other	10	0	21	14	32.1	45	0.90
Total	4,166	2	13,507	4290	19.5	21,965	0.98
County Total				28147	20.2	139480	0.97

1. Number of Cases

100 - 500
500 - 1000
> 1000

2. Red highlighting: Greater than 25%

> 25%

3. CAN Rate color-coding

> 84% or 1 σ
> 95% or 1.96 σ

Table 3.23
Triage Response Acuity

Service Area 1	Immediate	3 Day	5 Day	10 Day	NR	Total	Acuity
Lancaster	2464	3	2288	3		4758	0.31
Palmdale	2135	0	1867			4002	0.24
North County E.	960	2	984	1		1946	0.20
Total	5559	5	5139	4	0	10707	0.25
Service Area 2							
Santa Clarita	725	4	1025			1754	0.10
Burbank	257		378			635	0.07
Glendale	335		464			799	0.05
Northridge	682		933			1615	0.11
Granada Hills	863	3	1025			1891	0.12
Pacoima-Arleta	1066		1420			2486	0.18
La Tuna Cyn.	814		1086			1900	0.15
Panorama City	1171		1483			2654	0.17
North Hollywood	843		989			1832	0.18
Sherman Oaks	1095	2	1402			2499	0.15
Encino	734	3	883			1620	0.11
Woodland Hills	604	2	905			1511	0.11
Brentwood N.	129		200			329	0.05
North County W.	273		397			670	0.08
La Canada-Flintridge	40		102			142	0.03
San Fernando-Calabasas-Agoura	330		580			910	0.09
Total	9961	14	13271	0	0	23246	0.12
Service Area 3							
Pasadena	580		758			1339	0.13
El Monte	1055		914			1968	0.19
Pomona	1548		1508			3056	0.19
West Covina	618	2	720			1339	0.12
Altadena-Monrovia-Sierra Madre	545	4	609			1158	0.13
Alhambra-S. Pasadena	336	1	452			789	0.11
Arcadia-San Gabriel-Temple City-San Marino	401		526			927	0.06
Baldwin Park-Azusa-Duarte	1241		1276			2517	0.17
Glendora-Claremont-San Dimas-La Verne	648		880			1528	0.10
Covina-Walnut	634	1	730			1365	0.12
Diamond Bar	249		354			603	0.06
La Puente-S. El Monte	994	0	991			1986	0.15
Hacienda Heights	223		219			442	0.08
Monterey Park-Rosemead	425		487			911	0.11
Other	1		2			3	0.02
Total	9498	8	10425	0	0	19931	0.13
Service Area 4							
Wilshire La Brea E.	561	6	652			1219	0.11
Hollywood	923		1141			2064	0.15
Pico Heights	732		790			1522	0.17
Echo Park	1685	9	1897			3591	0.25
Highland Park	1833	3	2030			3866	0.17
Downtown	1523	1	1568			3092	0.23
USC N.	205		247			452	0.20
West Adams	61		87			148	0.15
West Hollywood	54		44			98	0.05
Other	39		36			75	0.34
Total	7616	19	8492	0	0	16127	0.18

most at risk for suffering abuse in Los Angeles County. The pattern you see in the countywide graph indicated that abuse occurs trimodally, with the high numbers of abuse seen under the age of 1, around 6-7 years, and around 13 years. These ages correspond

Service Area 5	Immediate	3 Day	5 Day	10 Day	NR	Total	Acuity
Brentwood S.	51		130			181	0.03
West LA	298		465			763	0.08
Wilshire La Brea W.	36		82			118	0.05
Baldwin Hills W.	104		86			190	0.15
Playa Vista	339		480			819	0.11
Santa Monica-Culver City-Beverly Hills	423	4	609			1036	0.10
Malibu	31		44			75	0.04
Other	1		1			3	0.06
Total	1283	4	1898	0	0	3185	0.08
Service Area 6							
USC S.	641		645			1286	0.18
Baldwin Hills S.	1377	3	1459			2839	0.22
Hancock N.	2250	5	2161			4416	0.26
USC E.	1721	4	1523			3248	0.20
Watts	2928	1	2512			5441	0.32
Florence-Firestone	658		672			1330	0.22
Lynwood	623	1	545			1169	0.13
Paramount	660	1	578			1239	0.19
Compton	2149	7	1827			3983	0.21
Other	69		60			129	0.22
Total	13076	22	11982	0	0	25080	0.23
Service Area 7							
East LA	1169	1	1203			2374	0.18
Downey	548		802			1350	0.10
Norwalk	644	1	1016			1661	0.15
Whittier	662	1	1153			1816	0.13
Montebello	817	1	993			1812	0.13
Bell Gardens-Bell-Maywood-Cudahy-Commerce	1161	10	1340			2512	0.12
Huntington Park	686		812			1498	0.14
South Gate	555		926			1481	0.10
Bellflower	527		751			1278	0.12
La Mirada-Santa Fe Springs	619	10	1139			1768	0.11
Lakewood-Cerritos-Artesia-Hawaiian Gardens	539	0	1002			1541	0.08
Signal Hill	76		84			160	0.16
Other	36	0	33	0	0	69	0.13
Total	8040	24	11255	0	0	19319	0.12
Service Area 8							
Hancock S.	101		85			186	0.20
Wilmington	1524	1	1976			3501	0.16
Inglewood	928		869			1797	0.13
Torrance	324		552			876	0.07
Long Beach N.	1367		1421			2788	0.19
Long Beach S.	2310	4	2530			4844	0.22
Long Beach E.	317	2	390		1	711	0.09
Carson	547		815			1363	0.13
Palos Verdes-Lomita	210		393			603	0.05
Redondo-Manhattan-Hermosa-El Segundo	264		385			649	0.06
Gardena-Lawndale	1381	2	1231			2615	0.18
Hawthorne	982	1	1005			1988	0.16
Other	16	0	30	0	0	45	0.07
Total	10272	10	11682	0	1	21965	0.14
Countywide Total	65305	106	74144	4	1	139560	0.15

Mean – 1 σ

1 σ - 1.96 σ

> 1.96 σ

to difficult times in the life cycle of a family: caring for an infant, having your children attend primary grades, and raising early to mid-adolescents. This pattern is essentially replicated in all of the service areas.

Table 3.24
SCAN Reports by Ethnicity in Los Angeles County (percent of population)

Community	Black	Hmong	White	Korean	Samoan	Chinese	Laotian	Mexican	Filipino	Hawaiian	Hispanic	Japanese	Cambodian	Caribbean	Ethiopian
1	35.7	0.0	27.8	0.0	0.1	0.0	0.0	1.3	0.4	0.0	29.5	0.0	0.1	0.0	0.0
2	8.3	0.0	21.7	0.4	0.0	0.2	0.0	5.6	1.0	0.1	55.2	0.1	0.0	0.0	0.1
3	8.4	0.0	14.0	0.2	0.1	2.3	0.0	2.3	0.8	0.1	63.2	0.2	0.3	0.0	0.0
4	10.6	0.0	4.7	0.8	0.0	0.4	0.0	3.6	1.0	0.0	71.1	0.0	0.2	0.0	0.0
5	17.5	0.0	32.9	0.2	0.0	0.8	0.0	1.3	1.0	0.1	31.5	0.7	0.2	0.2	0.0
6	42.1	0.0	1.4	0.0	0.1	0.0	0.0	2.1	0.1	0.1	50.0	0.0	0.0	0.0	0.0
7	4.4	0.0	10.5	0.1	0.1	0.1	0.1	3.2	0.5	0.1	77.1	0.1	0.1	0.0	0.0
8	28.6	0.1	14.7	0.3	0.8	0.2	0.1	2.0	1.1	0.0	45.1	0.4	1.2	0.1	0.0
Invalid SA	34.6	0.0	14.8	0.1	0.2	0.2	0.0	1.7	0.4	0.1	43.1	0.1	0.2	0.1	0.0
Total	20.5	0.0	13.2	0.3	0.2	0.5	0.0	2.9	0.7	0.1	55.4	0.1	0.3	0.0	0.0

Table 3.25
SCAN Reports by Ethnicity in Service Area Communities (percent of population)

Community	Black	Hmong	White	Korean	Samoan	Chinese	Laotian	Mexican	Filipino	Hawaiian	Hispanic	Japanese	Cambodian	Caribbean	Ethiopian
Service Area 1															
Lancaster	43.4	0.0	27.2	0.0	0.0	0.0	0.0	1.0	0.2	0.0	24.5	0.0	0.0	0.0	0.0
Palmdale	33.9	0.1	21.8	0.0	0.1	0.0	0.0	1.8	0.5	0.1	36.0	0.1	0.0	0.1	0.0
North County E.	20.6	0.0	41.9	0.0	0.2	0.0	0.0	1.2	0.6	0.0	28.2	0.0	0.5	0.0	0.0
Total	35.7	0.0	27.8	0.0	0.1	0.0	0.0	1.3	0.4	0.0	29.5	0.0	0.1	0.0	0.0
Service Area 2															
Santa Clarita	6.7	0.0	47.6	0.4	0.0	0.0	0.2	1.0	0.4	0.1	37.0	0.2	0.0	0.0	0.1
Burbank	4.1	0.0	41.3	0.9	0.0	3.1	0.0	3.3	0.9	0.6	37.8	0.0	0.0	0.0	0.0
Glendale	4.5	0.0	23.0	2.9	0.0	0.4	0.0	4.4	3.5	0.0	43.1	0.4	0.0	0.1	0.1
Northridge	11.2	0.0	28.9	0.4	0.0	0.1	0.0	0.9	1.7	0.1	46.7	0.2	0.1	0.0	0.1
Granada Hills	6.9	0.0	16.9	0.1	0.0	0.4	0.0	1.2	1.4	0.1	65.9	0.0	0.2	0.0	0.3
Pacoima-Arleta	6.7	0.0	4.5	0.0	0.0	0.1	0.0	11.8	0.8	0.0	72.9	0.0	0.0	0.0	0.0
La Tuna Cyn.	5.9	0.0	18.8	0.3	0.0	0.0	0.0	8.0	0.5	0.1	62.1	0.3	0.0	0.0	0.0
Panorama City	8.2	0.0	5.8	0.0	0.0	0.0	0.0	10.3	1.5	0.2	69.5	0.0	0.2	0.0	0.0
North Hollywood	12.4	0.0	13.6	0.0	0.0	0.0	0.0	10.5	1.4	0.0	54.5	0.1	0.0	0.0	0.0
Sherman Oaks	13.0	0.0	11.9	0.4	0.0	0.1	0.0	7.4	0.4	0.0	60.3	0.0	0.0	0.0	0.0
Encino	10.6	0.0	24.8	0.0	0.0	0.0	0.0	1.8	1.0	0.2	50.0	0.1	0.0	0.1	0.0
Woodland Hills	9.4	0.0	28.1	0.5	0.0	0.3	0.0	1.9	0.5	0.3	49.0	0.2	0.0	0.0	0.1
Brentwood N.	9.7	0.0	53.5	0.6	1.5	0.0	0.0	0.3	0.6	0.0	17.6	0.0	0.0	0.3	0.0
North County W.	5.4	0.1	55.3	2.5	0.0	0.0	0.0	0.5	1.7	0.1	27.4	0.2	0.0	0.0	0.0
La Canada-Flintridge	0.0	0.0	75.0	4.9	0.0	1.4	0.0	0.0	0.7	0.0	7.4	0.0	0.0	0.0	0.0
San Fernando-Calabasas-Agoura	1.5	0.1	36.5	0.1	0.0	0.2	0.0	4.1	0.7	0.0	50.6	0.2	0.0	0.0	0.0
Total	8.3	0.0	21.7	0.4	0.0	0.2	0.0	5.6	1.1	0.1	55.2	0.1	0.0	0.0	0.1

Guamanian	Polynesian	Vietnamese	Other_Asian	Asian_Ind	Alaskan_Native	South_Am	American_Ind	Central_Am	White_Am	White_Eur	White_Romanian	Oth_Pac_Isl	White_Mid_Eastern	White_Central_Am	Oth_Asn_Pac	Total[1]
0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.3	0.2	0.1	0.1	0.0	0.0	0.2	0.0	0.0	10707
0.0	0.0	0.3	0.2	0.3	0.0	0.1	0.2	0.8	0.9	0.3	0.1	0.0	1.2	0.0	0.0	23278
0.0	0.0	0.8	0.4	0.1	0.0	0.0	0.2	0.3	0.1	0.1	0.0	0.1	0.4	0.0	0.0	19931
0.0	0.0	0.2	0.2	0.1	0.0	0.1	0.2	1.5	0.3	0.2	0.0	0.1	0.3	0.0	0.0	16127
0.0	0.0	0.1	0.1	0.5	0.0	0.1	0.2	0.2	0.2	0.8	0.0	0.0	5.1	0.0	0.0	3185
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	25080
0.0	0.0	0.1	0.1	0.1	0.0	0.0	0.3	0.3	0.1	0.0	0.0	0.1	0.3	0.0	0.0	19319
0.0	0.1	0.2	0.2	0.1	0.0	0.0	0.1	0.3	0.1	0.1	0.0	0.2	0.3	0.0	0.1	21965
0.0	0.0	0.2	0.2	0.1	0.0	0.0	0.8	0.3	0.1	0.1	0.1	0.1	0.2	0.0	0.0	8751
0.0	0.0	0.2	0.2	0.1	0.0	0.1	0.2	0.5	0.2	0.1	0.0	0.1	0.5	0.0	0.0	148343

Guamanian	Polynesian	Vietnamese	Other_Asian	Asian_Ind	Alaskan_Native	South_Am	American_Ind	Central_Am	White_Am	White_Eur	White_Romanian	Oth_Pac_Isl	White_Mid_Eastern	White_Central_Am	Oth_Asn_Pac	Total[1]
0.0	0.0	0.0	0.2	0.1	0.0	0.0	0.2	0.2	0.1	0.1	0.0	0.0	0.1	0.0	0.0	4758
0.0	0.0	0.0	0.0	0.2	0.0	0.1	0.1	0.3	0.1	0.1	0.0	0.1	0.2	0.0	0.0	4002
0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.9	0.1	0.1	0.1	0.0	0.0	0.2	0.0	0.0	1946
0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.3	0.2	0.1	0.1	0.0	0.0	0.2	0.0	0.0	10707
0.0	0.0	1.0	0.2	0.2	0.1	0.0	0.3	0.3	0.3	0.1	0.0	0.0	1.0	0.0	0.0	1754
0.0	0.0	0.3	0.3	0.2	0.0	0.0	0.3	0.6	0.9	1.3	0.0	0.0	1.9	0.0	0.2	635
0.0	0.0	0.1	0.3	0.3	0.0	0.1	0.4	0.0	10.9	0.8	0.0	0.1	2.9	0.0	0.0	799
0.0	0.0	0.7	0.5	1.1	0.0	0.2	0.1	0.2	0.5	0.8	0.0	0.0	1.5	0.0	0.1	1615
0.0	0.0	0.1	0.1	0.4	0.0	0.3	0.1	0.2	0.6	0.3	0.0	0.0	1.4	0.0	0.0	1891
0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.6	0.6	0.1	0.0	0.0	0.0	0.2	0.0	0.0	2486
0.0	0.0	0.0	0.0	0.1	0.0	0.2	0.4	0.4	0.6	0.1	0.0	0.0	0.4	0.0	0.0	1900
0.0	0.0	0.0	0.2	0.2	0.0	0.1	0.2	0.8	0.2	0.1	0.0	0.0	0.3	0.0	0.0	2654
0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	2.3	1.1	0.5	0.2	0.0	0.7	0.1	0.1	1832
0.0	0.0	0.3	0.1	0.3	0.0	0.2	0.1	1.8	0.6	0.0	0.4	0.0	0.6	0.0	0.0	2499
0.0	0.0	0.4	1.2	0.5	0.0	0.6	0.2	0.6	0.3	0.1	0.0	0.1	3.3	0.0	0.0	1620
0.0	0.0	0.7	0.0	0.8	0.0	0.1	0.3	1.5	0.3	0.3	0.0	0.2	2.4	0.0	0.0	1511
0.0	0.0	0.0	0.6	0.6	0.0	0.0	0.3	0.0	1.8	0.9	0.0	0.0	6.7	0.0	0.0	329
0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.1	0.7	0.5	0.0	0.0	1.8	0.0	0.0	670
0.0	0.0	1.4	0.0	0.7	0.0	0.0	0.0	0.0	2.8	0.7	0.0	0.0	3.2	0.0	0.0	142
0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.2	0.2	0.9	0.0	0.0	1.1	0.0	0.0	910
0.0	0.0	0.3	0.2	0.3	0.0	0.1	0.2	0.8	0.9	0.3	0.1	0.0	1.2	0.0	0.0	23246

Table 3.25 continued

SCAN Reports by Ethnicity in Service Area Communities (percent of population)

Community	Black	Hmong	White	Korean	Samoan	Chinese	Laotian	Mexican	Filipino	Hawaiian	Hispanic	Japanese	Cambodian	Caribbean	Ethiopian
Service Area 3															
Pasadena	23.5	0.0	14.1	0.0	0.0	0.1	0.0	2.2	1.1	0.1	51.8	0.1	0.0	0.0	0.0
El Monte	0.8	0.0	4.6	0.0	0.0	1.8	0.0	3.6	0.0	0.2	82.3	0.0	0.4	0.0	0.0
Pomona	11.5	0.1	9.0	0.3	0.1	0.2	0.1	2.2	0.4	0.1	68.7	0.0	0.1	0.0	0.0
West Covina	9.3	0.0	15.6	0.2	0.0	1.3	0.0	1.5	2.4	0.0	60.4	0.0	0.0	0.1	0.0
Altadena-Monrovia-Sierra Madre	29.5	0.0	19.6	0.1	0.4	0.0	0.1	2.5	1.6	0.1	39.6	0.0	0.0	0.0	0.0
Alhambra-S. Pasadena	4.4	0.0	10.1	0.1	0.0	8.7	0.0	1.5	1.1	0.0	60.3	0.8	0.1	0.0	0.0
Arcadia-San Gabriel-Temple City-San Marino	5.9	0.1	23.6	0.8	0.0	15.0	0.0	1.0	0.3	0.3	41.0	0.6	0.8	0.0	0.0
Baldwin Park-Azusa-Duarte	4.4	0.1	9.3	0.0	0.0	0.2	0.0	2.9	1.0	0.1	75.8	0.2	0.0	0.0	0.0
Glendora-Claremont-San Dimas-La Verne	7.5	0.0	44.1	0.2	0.1	0.2	0.0	1.3	0.4	0.0	36.7	0.1	0.0	0.0	0.0
Covina-Walnut	5.4	0.0	16.2	0.0	0.0	1.2	0.0	2.1	0.6	0.1	65.8	0.0	0.0	0.0	0.0
Diamond Bar	8.3	0.0	18.1	1.8	0.5	6.9	0.0	0.3	3.0	0.0	50.8	0.0	0.0	0.0	0.0
La Puente-S. El Monte	2.9	0.0	5.5	0.0	0.0	0.0	0.0	2.3	0.2	0.6	79.5	0.1	0.1	0.0	0.0
Hacienda Heights	2.3	0.0	19.5	0.9	0.0	4.5	0.0	2.9	0.5	0.0	61.1	0.0	0.0	0.0	0.0
Monterey Park-Rosemead	3.1	0.0	6.8	0.5	0.0	10.6	0.0	3.1	0.5	0.1	58.2	1.8	3.9	0.0	0.0
Other	0.0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	8.4	0.0	14.0	0.2	0.1	2.3	0.0	2.3	0.8	0.1	63.2	0.2	0.3	0.0	0.0
Service Area 4															
Wilshire La Brea E.	32.1	0.0	10.5	3.8	0.0	0.4	0.0	1.1	0.6	0.1	40.0	0.0	0.0	0.0	0.0
Hollywood	7.7	0.0	8.1	0.1	0.0	0.0	0.0	2.1	1.5	0.0	68.5	0.0	0.0	0.0	0.0
Pico Heights	10.0	0.1	1.9	4.0	0.0	0.1	0.0	2.6	1.1	0.0	71.6	0.0	0.0	0.3	0.2
Echo Park	13.1	0.0	2.6	0.3	0.1	0.1	0.1	3.4	1.3	0.0	72.3	0.0	0.4	0.0	0.0
Highland Park	3.8	0.0	5.3	0.1	0.0	1.0	0.0	4.6	1.3	0.1	77.7	0.0	0.2	0.1	0.0
Downtown	7.5	0.0	2.6	0.1	0.0	0.5	0.0	5.7	0.1	0.0	78.4	0.1	0.1	0.0	0.0
USC N.	15.3	0.2	1.3	1.8	0.0	0.0	0.0	3.3	0.4	0.0	68.4	0.0	0.0	0.0	0.0
West Adams	58.1	0.0	6.1	0.0	0.0	0.0	0.0	3.4	0.0	0.0	31.1	0.0	0.0	0.0	0.0
West Hollywood	10.2	0.0	49.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	20.4	0.0	0.0	1.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.3	0.0	0.0	93.3	0.0	0.0	0.0	0.0
Total	10.6	0.0	4.7	0.8	0.0	0.4	0.0	3.6	1.0	0.0	71.1	0.0	0.2	0.0	0.0
Service Area 5															
Brentwood S.	3.3	0.0	74.6	0.0	0.0	1.1	0.0	0.0	0.6	0.0	3.9	0.0	0.0	0.0	0.0
West LA	9.8	0.0	31.6	0.5	0.0	0.9	0.0	1.0	1.4	0.1	36.7	1.6	0.0	0.5	0.0
Wilshire La Brea W.	8.5	0.0	45.8	0.0	0.0	0.0	0.0	0.0	2.5	0.0	10.2	0.0	0.0	0.0	0.0
Baldwin Hills W.	36.8	0.0	5.3	0.0	0.0	2.1	0.0	0.0	0.5	0.5	44.2	0.5	0.0	0.0	0.0
Playa Vista	19.8	0.0	23.8	0.0	0.0	0.1	0.0	3.7	1.4	0.1	42.7	0.1	0.2	0.0	0.0
Santa Monica-Culver City-Beverly Hills	22.0	0.0	34.6	0.3	0.0	0.8	0.0	0.3	0.4	0.0	25.5	0.8	0.4	0.1	0.0
Malibu	6.7	0.0	72.0	0.0	0.0	2.7	0.0	0.0	0.0	0.0	8.0	0.0	0.0	0.0	0.0
Other	74.5	0.0	1.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	9.1	0.0	0.0	0.0	0.0
Total	17.5	0.0	32.9	0.2	0.0	0.8	0.0	1.3	1.0	0.1	31.5	0.7	0.2	0.2	0.0
Service Area 6															
USC S.	41.2	0.0	1.6	0.0	0.0	0.1	0.0	1.2	0.2	0.0	50.6	0.0	0.0	0.1	0.2
Baldwin Hills S.	62.8	0.0	1.6	0.2	0.0	0.0	0.0	0.7	0.0	0.0	29.6	0.1	0.0	0.2	0.2
Hancock N.	51.2	0.0	1.2	0.0	0.0	0.0	0.0	1.4	0.0	0.0	41.8	0.0	0.0	0.0	0.0
USC E.	25.0	0.1	0.6	0.0	0.0	0.0	0.0	3.5	0.2	0.0	66.9	0.0	0.1	0.0	0.0
Watts	47.7	0.0	0.4	0.0	0.0	0.0	0.0	1.8	0.0	0.2	45.5	0.0	0.0	0.0	0.0
Florence-Firestone	21.0	0.1	0.8	0.0	0.0	0.0	0.0	2.9	0.2	0.1	68.7	0.0	0.0	0.0	0.0
Lynwood	22.7	0.0	2.3	0.0	0.5	0.0	0.0	5.5	0.0	0.2	66.8	0.0	0.0	0.0	0.1
Paramount	14.0	0.0	6.5	0.0	0.0	0.0	0.0	1.7	0.0	0.0	74.3	0.0	0.2	0.0	0.0
Compton	43.8	0.0	1.7	0.0	0.6	0.0	0.0	2.3	0.1	0.0	48.3	0.0	0.1	0.0	0.0
Other	85.3	0.0	1.6	0.0	0.0	0.0	0.0	1.6	0.0	0.0	7.8	0.0	0.0	0.0	0.0
Total	42.1	0.0	1.4	0.0	0.1	0.0	0.0	2.1	0.1	0.1	50.0	0.0	0.0	0.0	0.0

Guamanian	Polynesian	Vietnamese	Other_Asian	Asian_Ind	Alaskan_Native	South_Am	American_Ind	Central_Am	White_Am	White_Eur	White_Romanian	Oth_Pac_Isl	White_Mid_Eastern	White_Central_Am	Oth_Asn_Pac	Total[1]
0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.4	0.8	0.7	0.0	0.0	0.0	0.4	0.0	0.0	1339
0.0	0.1	1.5	0.3	0.0	0.0	0.0	0.0	0.3	0.0	0.4	0.0	0.0	0.0	0.0	0.0	1968
0.0	0.0	0.4	0.2	0.0	0.0	0.0	0.6	0.0	0.0	0.2	0.0	0.0	0.1	0.0	0.0	3056
0.0	0.0	0.8	0.6	0.0	0.0	0.0	0.3	0.2	0.0	0.0	0.0	0.0	0.6	0.1	0.0	1339
0.0	0.0	0.1	0.1	0.3	0.0	0.1	0.2	0.4	0.1	0.0	0.0	0.0	0.2	0.0	0.0	1158
0.0	0.0	2.7	2.2	0.8	0.0	0.3	0.1	0.3	0.0	0.3	0.0	0.1	1.0	0.0	0.1	789
0.0	0.0	2.3	1.0	0.5	0.0	0.0	0.0	0.0	0.4	0.2	0.1	0.1	0.6	0.0	0.0	927
0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.2	0.2	0.0	0.0	0.0	0.1	0.2	0.0	0.0	2517
0.0	0.0	0.5	0.4	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.3	2.2	0.0	0.0	1528
0.0	0.0	0.0	0.4	0.1	0.0	0.1	0.3	0.0	0.1	0.0	0.0	0.8	0.3	0.0	0.1	1365
0.0	0.0	0.3	2.5	0.5	0.0	0.2	0.3	0.3	0.0	0.2	0.0	0.2	0.8	0.0	0.0	603
0.0	0.0	1.2	0.1	0.0	0.0	0.0	0.0	0.3	0.1	0.0	0.0	0.0	0.1	0.0	0.0	1986
0.2	0.0	0.0	0.2	0.2	0.0	0.0	0.2	1.8	0.2	0.0	0.0	0.0	0.0	0.0	0.5	442
0.0	0.0	4.0	1.0	0.1	0.0	0.0	0.0	0.9	0.0	0.1	0.0	0.1	0.4	0.0	0.0	911
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3
0.0	0.0	0.8	0.4	0.1	0.0	0.0	0.2	0.3	0.1	0.1	0.0	0.1	0.4	0.0	0.0	19931
0.2	0.0	0.1	0.3	0.4	0.0	0.2	0.5	1.6	0.2	0.3	0.0	0.7	1.6	0.0	0.1	1219
0.0	0.0	0.1	0.6	0.7	0.0	0.0	0.0	3.0	1.7	0.6	0.0	0.0	0.7	0.0	0.0	2064
0.0	0.1	0.1	0.3	0.3	0.0	0.0	0.0	3.2	0.2	0.1	0.0	0.3	0.2	0.0	0.1	1522
0.0	0.0	0.1	0.2	0.0	0.0	0.2	0.2	1.5	0.1	0.0	0.0	0.0	0.0	0.1	0.0	3591
0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.3	0.5	0.2	0.2	0.0	0.1	0.2	0.0	0.0	3866
0.0	0.0	0.5	0.2	0.0	0.0	0.1	0.0	0.6	0.0	0.1	0.0	0.0	0.0	0.0	0.1	3092
0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.3	2.4	0.0	0.0	0.0	0.0	0.2	0.0	0.0	452
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	148
0.0	0.0	0.0	3.1	0.0	0.0	0.0	0.0	0.0	0.0	3.1	0.0	0.0	12.2	0.0	0.0	98
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	75
0.0	0.0	0.2	0.2	0.1	0.0	0.1	0.2	1.5	0.3	0.2	0.0	0.1	0.3	0.0	0.0	16127
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.0	2.2	0.0	0.0	8.8	0.0	0.0	181
0.0	0.0	0.1	0.1	0.9	0.0	0.3	0.0	0.1	0.1	1.0	0.0	0.0	6.3	0.0	0.0	763
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	24.6	0.0	0.0	118
0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	190
0.0	0.0	0.2	0.4	0.4	0.0	0.0	0.5	0.4	0.4	0.0	0.0	0.0	0.9	0.0	0.1	819
0.0	0.0	0.1	0.0	0.5	0.0	0.1	0.1	0.2	0.1	1.2	0.1	0.0	6.0	0.0	0.0	1036
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.7	0.0	0.0	0.0	0.0	0.0	75
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.6	0.0	0.0	3
0.0	0.0	0.1	0.1	0.5	0.0	0.1	0.2	0.2	0.2	0.8	0.0	0.0	5.1	0.0	0.0	3185
0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	1.9	0.0	0.2	0.0	0.0	0.2	0.0	0.0	1286
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	1.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2839
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4416
0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.4	0.2	0.0	0.1	0.0	0.0	0.0	0.0	0.0	3248
0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.4	0.0	0.0	0.0	0.0	0.1	0.0	0.0	5441
0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1330
0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.2	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	1169
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1239
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.1	0.0	0.0	0.0	3983
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	129
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	25080

Table 3.25 continued

SCAN Reports by Ethnicity in Service Area Communities (percent of population)

Community	Black	Hmong	White	Korean	Samoan	Chinese	Laotian	Mexican	Filipino	Hawaiian	Hispanic	Japanese	Cambodian	Caribbean	Ethiopian
Service Area 7															
East LA	1.3	0.0	1.3	0.0	0.0	0.0	0.0	5.6	0.0	0.0	89.3	0.0	0.0	0.0	0.0
Downey	6.6	0.0	13.3	0.0	0.1	0.0	0.1	2.8	0.3	0.2	71.6	0.1	0.0	0.1	0.0
Norwalk	6.6	0.0	16.2	0.1	0.2	0.1	0.0	1.9	0.7	0.0	71.1	0.0	0.1	0.0	0.0
Whittier	1.4	0.1	15.5	0.0	0.0	0.2	0.0	1.1	0.2	0.2	78.3	0.1	0.0	0.0	0.0
Montebello	0.9	0.0	4.3	0.0	0.1	0.3	0.0	3.6	0.3	0.2	87.2	0.0	0.0	0.0	0.0
Bell Gardens-Bell-Maywood-Cudahy-Commerce	0.6	0.0	3.3	0.0	0.0	0.0	0.0	3.9	0.2	0.1	88.1	0.0	0.0	0.2	0.0
Huntington Park	2.1	0.0	1.3	0.0	0.0	0.0	0.0	5.1	0.6	0.1	87.0	0.0	0.0	0.0	0.0
South Gate	0.9	0.1	3.2	0.0	0.0	0.1	0.0	3.6	0.0	0.0	89.7	0.1	0.0	0.0	0.0
Bellflower	17.8	0.0	19.2	0.0	0.8	0.0	0.0	2.0	1.3	0.1	54.4	0.1	0.2	0.0	0.0
La Mirada-Santa Fe Springs	3.7	0.0	16.5	0.1	0.2	0.0	0.2	2.8	0.8	0.0	71.9	0.0	0.2	0.0	0.0
Lakewood-Cerritos-Artesia-Hawaiian Gardens	12.1	0.0	28.0	1.2	0.5	1.0	0.0	2.1	1.6	0.3	48.3	0.3	0.6	0.0	0.0
Signal Hill	18.7	0.0	41.3	0.0	0.0	0.0	5.6	0.6	2.5	0.0	22.5	0.0	1.3	0.0	0.0
Other	18.9	0.0	11.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	68.1	0.0	0.0	0.0	0.0
Total	4.4	0.0	10.5	0.1	0.1	0.1	0.1	3.2	0.5	0.1	77.1	0.1	0.1	0.0	0.0
Service Area 8															
Hancock S.	42.5	0.0	1.6	0.0	0.0	0.0	0.0	3.2	0.0	0.0	48.9	0.0	0.0	0.0	0.0
Wilmington	10.5	0.0	13.5	0.2	0.3	0.0	0.0	2.1	0.7	0.1	67.3	0.1	0.0	0.0	0.0
Inglewood	49.7	0.0	3.0	0.0	0.3	0.0	0.0	1.9	0.0	0.0	39.6	0.0	0.1	0.1	0.0
Torrance	6.1	0.0	46.8	2.5	0.1	1.6	0.0	0.0	3.8	0.0	25.7	3.3	0.0	0.0	0.0
Long Beach N.	37.1	0.0	10.4	0.0	2.4	0.1	0.6	2.3	1.0	0.0	40.4	0.1	0.9	0.1	0.0
Long Beach S.	29.4	0.1	8.2	0.0	0.6	0.1	0.1	3.3	0.7	0.1	48.6	0.0	4.8	0.0	0.0
Long Beach E.	14.9	0.0	60.2	0.0	0.4	0.1	0.0	0.1	0.4	0.0	19.3	0.1	0.4	0.0	0.0
Carson	28.7	0.0	14.0	0.1	3.2	0.3	0.0	1.6	6.2	0.0	42.0	0.1	0.0	0.0	0.0
Palos Verdes-Lomita	8.3	0.0	42.1	1.5	0.7	2.2	0.0	0.2	1.0	0.0	29.4	4.6	0.0	0.0	0.0
Redondo-Manhattan-Hermosa-El Segundo	4.2	0.0	64.3	0.5	0.0	0.8	0.0	0.8	1.5	0.0	16.6	1.4	0.0	0.0	0.0
Gardena-Lawndale	49.0	0.1	6.3	0.4	0.5	0.1	0.0	1.1	0.8	0.0	36.1	0.2	0.0	0.0	0.0
Hawthorne	28.5	0.0	6.9	0.1	0.2	0.0	0.0	1.5	0.4	0.0	54.5	0.1	0.0	0.3	0.1
Other	23.7	0.0	24.2	0.0	0.7	0.0	0.0	8.9	0.0	0.0	34.5	0.0	0.2	0.0	0.0
Total	28.6	0.1	14.7	0.3	0.8	0.2	0.1	2.0	1.1	0.0	45.1	0.4	1.2	0.1	0.0

1. Total reflects actual count

30 – 40 %
40 - 50%
> 50%

Guamanian	Polynesian	Vietnamese	Other_Asian	Asian_Ind	Alaskan_Native	South_Am	American_Ind	Central_Am	White_Am	White_Eur	White_Romanian	Oth_Pac_Isl	White_Mid_Eastern	White_Central_Am	Oth_Asn_Pac	Total[1]
0.0	0.0	0.1	0.2	0.1	0.0	0.1	0.3	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2374
0.0	0.0	0.2	0.0	0.3	0.0	0.1	0.1	0.3	0.1	0.3	0.0	0.0	1.8	0.0	0.0	1350
0.0	0.1	0.0	0.3	0.1	0.0	0.0	0.4	0.1	0.3	0.1	0.0	0.2	0.0	0.0	0.0	1661
0.0	0.3	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1816
0.0	0.0	0.0	0.2	0.1	0.0	0.0	0.1	0.3	0.5	0.0	0.0	0.0	0.1	0.0	0.0	1812
0.0	0.0	0.0	0.0	0.2	0.0	0.1	0.8	0.4	0.0	0.0	0.0	0.0	0.1	0.0	0.0	2512
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.8	0.0	0.0	0.0	0.0	0.0	0.1	0.0	1498
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3	0.0	0.0	0.0	0.0	0.4	0.0	0.0	1481
0.0	0.0	0.6	0.0	0.0	0.0	0.0	0.3	0.2	0.0	0.1	0.0	0.5	0.8	0.0	0.0	1278
0.0	0.0	0.1	0.2	0.1	0.0	0.0	0.6	0.0	0.1	0.0	0.0	0.0	0.2	0.0	0.0	1768
0.0	0.1	0.1	0.5	0.5	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.1	0.8	0.0	0.5	1541
0.0	0.6	0.0	0.0	0.0	0.0	0.0	0.0	5.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	160
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	69
0.0	0.0	0.1	0.1	0.1	0.0	0.0	0.3	0.3	0.1	0.0	0.0	0.1	0.3	0.0	0.0	19319
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	186
0.0	0.1	0.1	0.3	0.1	0.0	0.0	0.1	0.3	0.1	0.3	0.0	0.1	0.1	0.1	0.1	3501
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.7	0.1	0.1	0.0	0.2	0.0	0.0	0.0	1797
0.0	0.0	0.3	0.7	0.7	0.0	0.0	0.0	0.0	0.5	0.3	0.0	0.1	2.6	0.0	0.1	876
0.0	0.0	0.2	0.1	0.1	0.0	0.0	0.2	0.6	0.0	0.0	0.0	0.3	0.0	0.0	0.4	2788
0.0	0.0	0.1	0.2	0.0	0.0	0.1	0.2	0.3	0.0	0.0	0.0	0.2	0.1	0.0	0.2	4844
0.0	0.0	0.1	0.7	0.0	0.0	0.0	0.4	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	711
0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.1	1363
0.0	0.0	0.3	0.2	1.2	0.0	0.0	0.0	0.0	0.3	0.3	0.0	0.3	0.5	0.0	0.0	603
0.0	0.0	0.2	0.2	0.8	0.0	0.0	0.3	0.3	0.6	1.1	0.0	0.0	1.8	0.0	0.0	649
0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.1	0.4	0.0	0.0	0.2	0.0	0.5	0.0	0.0	2615
0.0	0.9	0.4	0.0	0.2	0.0	0.1	0.3	0.3	0.1	0.0	0.0	0.1	0.0	0.0	0.0	1988
0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.2	45
0.0	0.1	0.2	0.2	0.1	0.0	0.0	0.1	0.3	0.1	0.1	0.0	0.2	0.3	0.0	0.1	21965

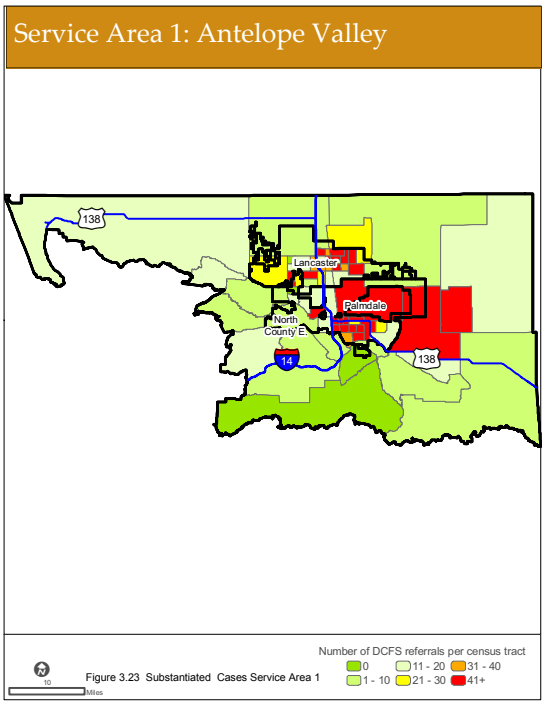


Figure 3.23 Substantiated Cases Service Area 1

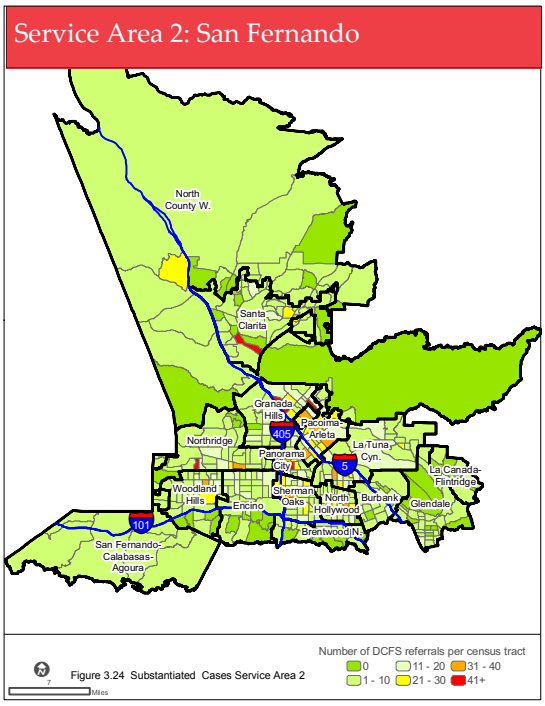


Figure 3.24 Substantiated Cases Service Area 2

Service Area 1: Antelope Valley
Child Abuse and Neglect Base Rates

Service Area 1 had the highest CAN Rate (1.98) found across the county. This indicated that approximately 2 out of 100 children in the service area suffered from some form of abuse or neglect during the 2006 calendar year. Within the service area, both urban centers had relatively high CAN rates with the Palmdale area having some of the highest numbers of substantiated abuse cases seen in the county (28.6%).

Triage Response Acuity

Service Area 1 had the highest Acuity score (0.25) in the county and all of its communities had Acuity scores above the countywide score of 0.15. The Lancaster area (0.31) had the second highest Acuity score seen across the county signifying an area with particularly high needs for immediate response by DCFS staff. The Palmdale area also had a

Service Area 2: San Fernando
Child Abuse and Neglect Base Rates

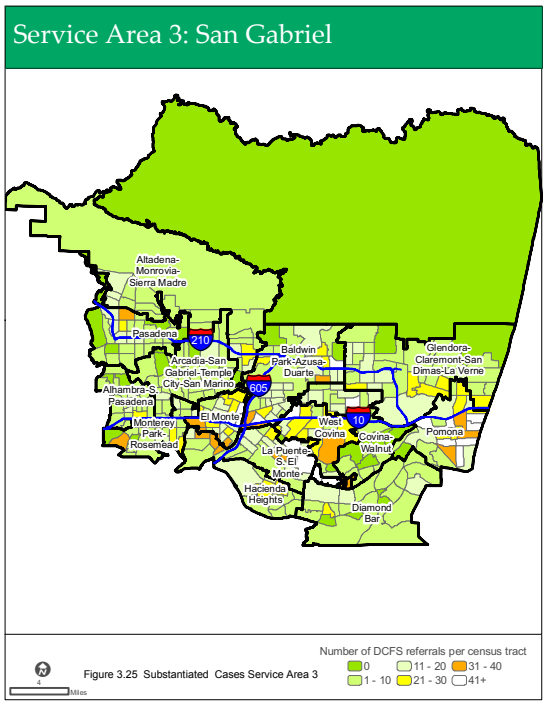
Service Area 2 had an overall CAN Rate of 0.75, which was below the county rate of 0.96. Within the service area, the North Hollywood area (1.26) and the Pacoima-Arleta area (1.22) had the highest CAN Rates. Overall, 17.3% of all SCAN reports were eventually substantiated.

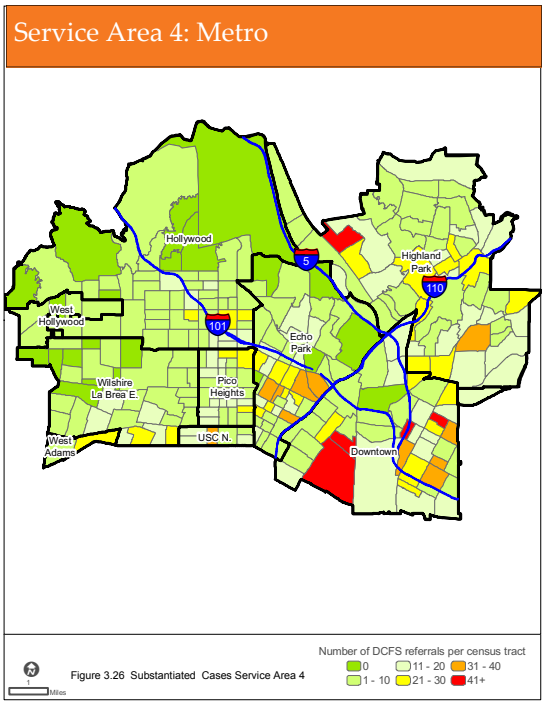
Triage Response Acuity

Service Area 2 had an overall Acuity score of 0.12, which was below the countywide score of 0.15. Five communities had Acuity scores which were at or above this figure: the Pacoima-Arleta area (0.18), the La Tuna Cyn area (0.15), the Panorama City area (0.17), the North Hollywood area (0.18), and the Sherman Oaks area (0.15).

Ethnicity

Across Service Area 2, 90.8% of SCAN Reports involved four ethnic groups: African-





Service Area 3: San Gabriel
Child Abuse and Neglect Base Rates

Service Area 3 had an overall CAN Rate of 1.01, which was slightly above the county rate. Across the service area, 23.1% of all SCAN reports were eventually substantiated. Two areas, Pomona (1.60) and El Monte (1.57), had CAN Rates greater than 84% or more of the county's communities, (i.e., rates were in excess of one standard deviation from the mean).

Triage Response Acuity

Service Area 3 had an overall Acuity score of 0.13, which was below the countywide score of 0.15. Four communities had Acuity scores that were at or above this figure: the El Monte area (0.19), the Pomona area (0.19), the Baldwin Park-Azusa-Duarte area (0.17), and the La Puente- S. El Monte area (0.15).

Ethnicity

Across Service Area 3, 85.6% of SCAN Re-

Service Area 4: Metro
Child Abuse and Neglect Base Rates

Service Area 4 had an overall CAN Rate of 1.20, which was greater than the county Rate of 0.96. Two communities, the Downtown area (1.92) and the USC N. area (1.61), had CAN Rates greater than 84% or more of the county's communities, (i.e., greater than 1 standard deviation from the mean). 25.2% of SCAN reports were substantiated in the Downtown area and 22.8% were substantiated for the USC N. area.

Triage Response Acuity

Service Area 4 had an overall Acuity score of 0.18, which was above the county score of 0.15. Many communities within the service area had scores above this figure and two had very high scores (greater than 84% of all other county communities): the Echo Park area (0.25) and the Downtown area (0.23).

Service Area 1 continued.

relatively high Acuity scores (0.24) which was greater than 84% of the county's communities, (i.e., PUMAs).

Ethnicity

Across Service Area 1, 93% of SCAN Reports involved three ethnic groups: African-American, White, and Hispanic. This pattern was essentially the same in all of the service area communities. Overall, African-American children accounted for 35.7% of SCAN Reports, White children, 27.8% and Hispanic children, 29.5%. Within the Lancaster area, African-American children (43.4%) were more frequently victimized than other ethnicities. In the Palmdale area, Hispanic children (36.0%) were more frequently victimized than other ethnicities. And in the surrounding North County E. area, White children (41.9%) were more frequently victimized than other ethnicities.

Service Area 2 continued.

American, White, Hispanic, and Mexican. Overall, African-American children accounted for 8.3% of SCAN Reports, White children, 21.7%, Hispanic children, 55.2%, and Mexican children, 5.6%. Hispanic children were a majority of victims in eight communities: the Granada Hills area, the Pacoima-Arleta area, the La Tuna Cyn area, the Panorama City area, the North Hollywood area, the Sherman Oaks area, the Encino area, and the San Fernando-Calabasas-Agoura area. White children were the majority of victims in three communities: the Brentwood N. area, the North County W. area, and the La Canada-Flintridge area.

Service Area 3 continued.

ports involved three ethnic groups: African-American, White, and Hispanic. Overall, African-American children accounted for 8.4% of SCAN Reports, White children, 14.0%, and Hispanic children, 63.2%. Only two other ethnic groups accounted for more than 1% of victimized children: Chinese, 2.3%, and Mexican, 2.3%. Hispanic children accounted for a majority of abuse reports in eleven communities: the Pasadena area, the El Monte area, the Pomona area, the West Covina area, the Alhambra-S. Pasadena area, the Baldwin Park-Azusa-Duarte area, the Covina-Walnut area, the Diamond Bar area, the La Puente-S. El Monte area, the Hacienda Heights area, and the Monterey Park-Rosemead area.

Service Area 4 continued.

Ethnicity

Across Service Area 4, 86.1% of SCAN Reports involved three ethnic groups: African-American, White, and Hispanic. Overall, African-American children accounted for 10.6% of SCAN Reports, White children, 4.7%, and Hispanic children, 71.1%. Only two other ethnic groups accounted for more than 1% of victimized children: Central American, 1.5%, and Mexican, 3.6%. Within the service area, Hispanic children were involved in a majority of SCAN Reports in six areas: the Hollywood area, the Pico Heights area, the Echo Park area, the Highland Park area, the Downtown area, and the USC N. area. African-American children were a majority of victims within the West Adams area. White children were nearly a majority of victims (49%) in the West Hollywood area.

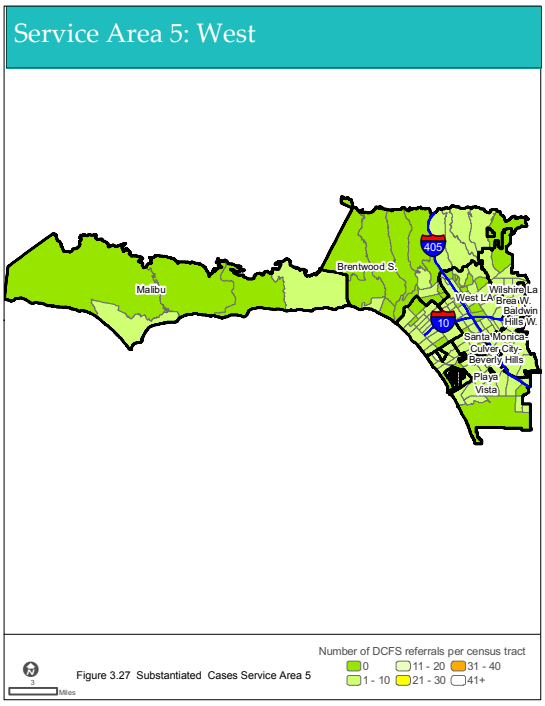


Figure 3.27 Substantiated Cases Service Area 5

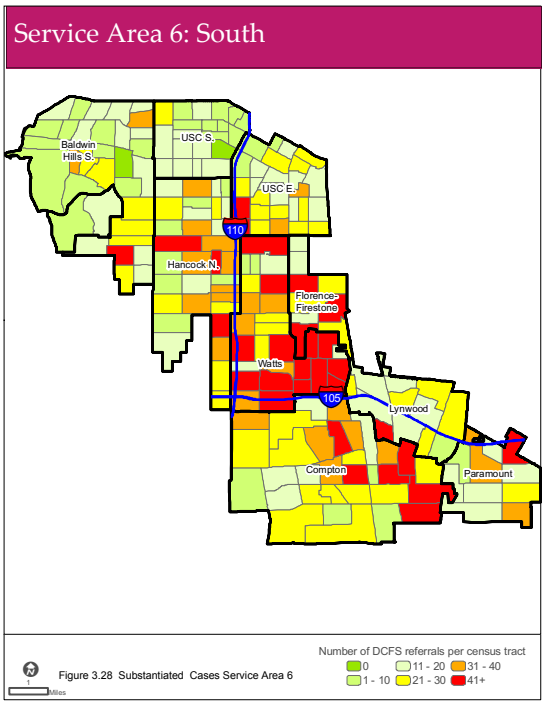


Figure 3.28 Substantiated Cases Service Area 6

Service Area 5: West
Child Abuse and Neglect Base Rates

Service Area 5 had an overall CAN Rate of 0.45, which was the lowest in the county and below the countywide rate of 0.96. In fact, all communities within the service area were below the countywide Rate. The Baldwin Hills W. area (0.86) had the highest CAN Rate within the service area and the Malibu area (0.04) had the lowest rate.

Triage Response Acuity

Service Area 5 had the lowest Acuity score (0.08) seen within the county (a full standard deviation below the mean) and most communities had very low Acuity scores. The Brentwood S. area (0.03) and Malibu area (0.04), for example, had two of the lowest Acuity scores in the county. The Baldwin Hills W. area (0.15) had the highest Acuity score in the service area.

Ethnicity

Service Area 6: South
Child Abuse and Neglect Base Rates

Service Area 6 had the second-highest CAN Rate seen across service areas and several communities had very high rates. The Watts area (2.15) had the highest CAN Rate (along with Palmdale) in the county. Additionally, three other communities had CAN Rates that were greater than 84% or more of the county's communities: the Hancock N. area (1.66), the Florence-Firestone area (1.51), and the Compton area (1.67).

Triage Response Acuity

Service Area 6 had the second-highest Acuity score (0.23) within the county (whose overall score was 0.15). All Communities within the service area, save the Lynwood area, had Acuity scores above the county score. The Watts area (.32) had the highest Acuity score in the county. Other communities with very high Acuity scores included the Baldwin

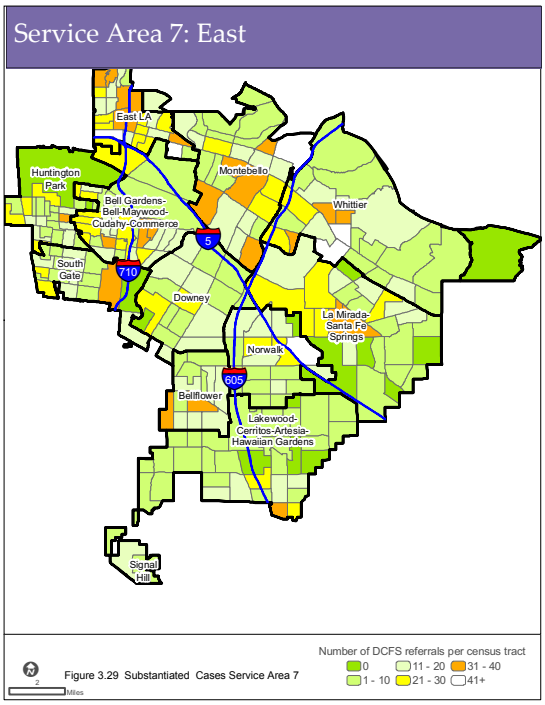


Figure 3.29 Substantiated Cases Service Area 7

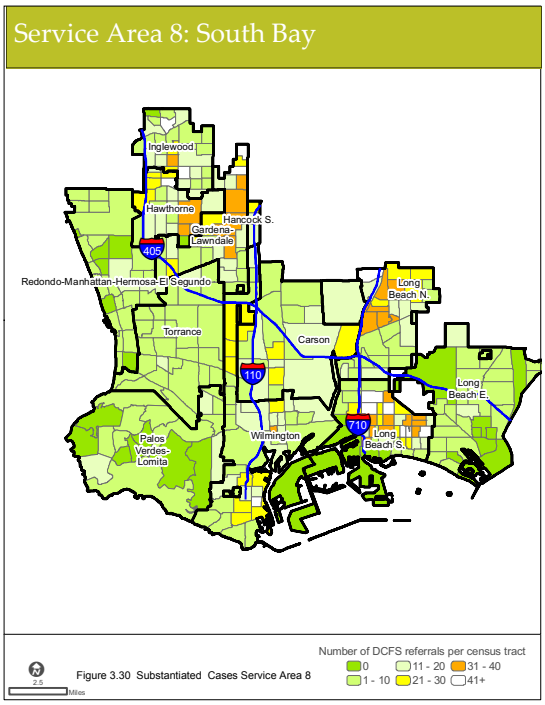


Figure 3.30 Substantiated Cases Service Area 8

Service Area 7: East
Child Abuse and Neglect Base Rates

Service Area 7 had an overall CAN Rate of 0.94, which was very close to the countywide Rate of 0.96. Within the service area, 20.5% of all SCAN reports were substantiated by DCFS staff. Examining the composite communities revealed that the East LA area (1.76) had the highest CAN Rate; moreover, this was greater than 84% the county's communities, (i.e., PUMAs). This was followed by the Montebello area (1.38). Both of these areas had high percentages of their SCAN reports substantiated.

Triage Response Acuity

Service Area 7 had an Acuity score of 0.12, which was below the countywide score of 0.15. Three communities had scores which equaled or exceed the countywide figure: the East LA area (0.18), the Norwalk area (0.15), and the Signal Hill area (0.16).

Service Area 8: South Bay
Child Abuse and Neglect Base Rates

Service Area 8 had an overall CAN Rate of 0.98, which was close to the countywide Rate of 0.96. 19.5% of the SCAN reports in the area were substantiated by DCFS. Within the service area, two communities had very high CAN Rates that were greater than 84% of the county communities, (i.e., PUMAs): the Hancock S. area (1.62) and the Long Beach S. area (1.62).

Triage Response Acuity

Service Area 8 had an Acuity score of 0.14, which was close to the countywide score of 0.15. About half of the communities in the service area had Acuity scores above this figure: the Hancock S. area (0.20), the Wilmington area (0.16), the Long Beach N. area (0.19), the Gardena-Lawndale area (0.18), the Hawthorne area (0.16), and the Long Beach S. area (0.22), which had the highest Acuity

Service Area 5 continued.

Across Service Area 5, 87% of SCAN Reports involved four ethnic groups: African-American, White, Hispanic, and White Middle Eastern. Overall, African-American children accounted for 17.5% of SCAN Reports, White children, 32.9%, Hispanic children, 31.5%, and White Middle Eastern children, 5.1%. Only two other ethnic groups accounted for more than 1% of the victimized children in the area: Mexican, 1.3%, and Filipino, 1.0%. White children were a majority of SCAN Reports in two communities: the Brentwood S. area and the Malibu area. No other ethnic group constituted a majority of victims in any other area.

Service Area 6 continued.

Hills S. area (0.22), the Hancock N. area (0.26), the Florence-Firestone area (0.22), and the Compton area (0.21).

Ethnicity

Across Service Area 6, 92.1% of SCAN Reports involved two ethnic groups: African-Americans and Hispanics. Overall, African-American children accounted for 42.1% of SCAN Reports and Hispanic children, 50%. Only two other ethnic groups accounted for more than 1% of the victimized children in the area: Mexican, 2.1%, and White, 1.4%. African-American children were a majority of victims in two communities: the Baldwin Hills S. area and the Hancock N. area. Hispanic children were a majority of victims in five communities: the USC S. area, the USC E. area, the Florence-Firestone area, the Lynwood area, and the Paramount area.

Service Area 7 continued.

Ethnicity

Across Service Area 7, 92% of SCAN Reports involved three ethnic groups: African-American, White, and Hispanic. Overall, African-American children accounted for 4.4% of SCAN Reports, White children, 10.5%, and Hispanic children, 77.1%. Only one other ethnic group accounted for more than 1% of the victimized children in the area: Mexican at 3.2%. Hispanic children were involved in a majority of SCAN Reports in ten communities: the East LA area, the Downey area, the Norwalk area, the Whittier area, the Montebello area, the Bell Gardens-Bell-Maywood-Cudahy-Commerce area, the Huntington Park area, the South Gate area, the Bellflower area, and the La Mirada-Santa Fe Springs area.

Service Area 8 continued.

score in the service area.

Ethnicity

Across Service Area 8, 88.4% of SCAN Reports involved three ethnic groups: African-American, White, and Hispanic. Overall, African-American children accounted for 28.6% of SCAN Reports, White children, 14.7%, and Hispanic children, 45.1%. Only three other ethnic groups accounted for more than 1% of the victimized children in the area: Mexican, 2.1%, Filipino, 1.1%, and Cambodian, 1.2%. White children accounted for a majority of SCAN Reports in two communities: the Long Beach E. area and the Redondo-Manhattan-Hermosa-El Segundo area. Hispanic children were a majority of victims in two communities: the Wilmington and Hawthorne areas. African-American children were nearly a majority of victims in two communities: the Inglewood area (49.7%) and the Gardena-Lawndale area (49.0%).

Elder and Dependent Adult Abuse

Description of Indicator

This indicator is a count of open Adult Protective Services (APS) (Los Angeles County Department of Community and Senior Services) cases for the calendar years 2006-07. In order to provide a context to evaluating relative levels of risk, two APS rates are reported. Each rate is calculated using the average number of open cases over the two-year reporting period and two population estimates for each community, (i.e., PUMA), which are then standardized to APS cases/1000 residents. APS Rate1 uses the community population 18 years and older and APS Rate2 uses the community population of older adults (65+). Because APS cases involve 66% Elder Abuse, 29% Dependent Adult Abuse, and 5% Other non-APS issues, it was not possible with the current data set to calculate precise base rates for each respective population. So, APS Rate1 underestimates the base rate of APS Elder Abuse cases while APS Rate2 overestimates it. The true APS Elder Abuse base rate falls somewhere between these two scores. Another evaluation issue involves possible differences in the reporting elder or dependent adult abuse across various regions in the county. Determining whether any such differences did occur was not discernable from the present data.

Research Base and Relevance to PEI

Elder abuse is related to mental health issues in two ways: 1. Older adults who have a mental disorder, cognitive impairment, or alcohol problem are at increased risk for being abused, and 2. once experiencing abuse, the elderly are at increased risk for a variety of mental health, (e.g., Posttraumatic Stress Disorder; Depression) disorders, physical disorders and injury, and death (including suicide) (Baker, 2007). In other words, traumatized older adults may be more vulnerable to developing mental disorders than those who are un-traumatized, and older adults with some form of mental illness or cognitive disability are more likely to be abused than mentally healthier older adults.

APS Rate[1]

(Number of open APS cases * 1000) / 18+ community population

APS Rate[2]

((Number of open APS cases * 1000) / 65+ community population) * ((65+ community population / 18+ community population) / (65+ County population / 18+ County population))

What the Numbers Show
Service Area Communities

Service Area 1: Antelope Valley

Service Area 1 had an APS Rate1 of 3.2, which was the second highest rate seen in the county across all service areas. Within the service area, the Lancaster community had the highest rate of APS cases using two different base rates calculations. This would suggest that the Lancaster area was particu-

larly at risk for Elder and Dependent Adult abuse.

Service Area 2: San Fernando
Service Area 2 had an APS Rate[1] of 2.3, which was below the countywide rate. Within the service area, the Sherman Oaks area (3.0), the Panorama City area (2.7), and the North Hollywood area (3.0) had the highest APS Rate[1] scores.

Service Area 3: San Gabriel
Service Area 3 had an APS Rate1 of 2.0, which was below the countywide rate. Within the service area, the Altadena-Monrovia-Sierra Madre aggregate (2.9) had the highest APS Rate1 followed by the Pomona Area (2.7).

Service Area 4: Metro
Service Area 4 had an APS Rate1 of 3.1, which was above the countywide rate. Within the service area, the Downtown area had the highest APS Rate1 score (4.6).

Service Area 5: West
Service Area 5 had an APS Rate1 of 2.4, which was below the countywide rate. Only one community within the service area saw an APS Rate1 score above 3: Wilshire La Brea W. (3.6).

Service Area 6: South
Service Area 6 (3.9) had the highest APS Rate1 among all county service areas. Three of the six most at-risk communities across the county were contained within the service area in terms of their respective APS Rate1 scores. The Baldwin Hills S. area (5.8) had the highest rate found within the county, followed by the Hancock N. area (4.7) and the Watts area (4.4).

Service Area 7: East
Service Area 7 had an overall APS Rate1 of 2.2, which was a bit below the countywide rate of 2.6. Within the service area, the East LA area (3.1) had the highest APS Rate[1] score.

Service Area 8: South Bay
Service Area 8 had an overall APS Rate1 score of 2.7, which was slightly above the countywide rate of 2.6. Within the service area, a few communities had relatively high APS rates. For example, the Long Beach S. area (3.9) had the highest rate seen within the service area, followed by the Long Beach N. area (3.2) and the Hancock S. area (3.2).

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Table 3.26

APS Open Cases Calendar Years: 2006-2007

Service Area 1	2006	2007	APS Rate[1]	APS Rate[2]
Lancaster	476	449	5.0	36.2
Palmdale	197	192	2.2	15.6
North County E.	144	160	2.2	16.0
Total	817	802	3.2	23.3
Service Area 2				
Santa Clarita	166	188	1.6	11.6
Burbank	187	215	2.4	17.1
Glendale	260	282	1.8	12.8
Northridge	262	306	2.1	15.4
Granada Hills	195	218	2.1	15.0
Pacoima-Arleta	160	194	2.1	15.2
La Tuna Cyn.	243	240	2.6	18.8
Panorama City	231	248	2.7	19.4
North Hollywood	261	284	3.0	21.7
Sherman Oaks	374	356	3.0	21.6
Encino	344	368	2.6	19.0
Woodland Hills	273	347	2.7	19.7
Brentwood N.	157	199	2.5	17.9
North County W.	53	47	1.0	7.1
La Canada-Flintridge	40	42	1.4	9.8
San Fernando-Calabasas-Agoura	83	105	1.5	10.7
Total	3287	3639	2.3	16.4
Service Area 3				
Pasadena	318	314	2.7	19.8
El Monte	177	160	2.1	15.0
Pomona	261	298	2.7	19.6
West Covina	184	192	2.3	16.7
Altadena-Monrovia-Sierra Madre	243	223	2.9	20.8
Alhambra-S. Pasadena	163	153	1.8	13.3
Arcadia-San Gabriel-Temple City-San Marino	276	242	1.8	13.1
Baldwin Park-Azusa-Duarte	218	246	1.9	14.0
Glendora-Claremont-San Dimas-La Verne	263	257	2.1	15.5
Covina-Walnut	159	160	1.8	13.0
Diamond Bar	76	83	1.0	7.0
La Puente-S. El Monte	184	177	2.0	14.1
Hacienda Heights	82	54	1.7	11.9
Monterey Park-Rosemead	138	168	1.5	11.2
Other	1	1	1.6	11.4
Total	2741	2727	2.0	14.8
Service Area 4				
Wilshire La Brea E.	388	364	3.4	24.5
Hollywood	549	592	3.0	21.7
Pico Heights	202	204	2.2	16.2
Echo Park	427	422	2.9	21.2
Highland Park	430	496	2.8	19.9
Downtown	513	540	4.6	33.3
USC N.	45	46	2.3	16.9
West Adams	25	24	3.7	26.6
West Hollywood	109	122	3.7	27.0
Other	5	5	3.3	23.8
Total	2694	2816	3.1	22.7

Service Area 5	2006	2007	APS Rate[1]	APS Rate[2]
Brentwood S.	111	111	1.7	12.4
West LA	357	369	2.2	16.2
Wilshire La Brea W.	67	80	3.6	26.3
Baldwin Hills W.	26	26	2.5	17.9
Playa Vista	221	188	2.2	16.0
Santa Monica-Culver City-Beverly Hills	413	444	2.9	21.0
Malibu	23	23	1.7	12.6
Other	1	1	2.3	16.7
Total	1219	1240	2.4	17.4
Service Area 6				
USC S.	232	224	3.5	25.2
Baldwin Hills S.	587	569	5.8	41.8
Hancock N.	512	555	4.7	33.9
USC E.	235	249	3.0	21.6
Watts	397	372	4.4	32.1
Florence-Firestone	120	118	3.4	24.8
Lynwood	85	98	1.8	12.7
Paramount	64	72	1.7	12.2
Compton	396	383	3.7	26.8
Other	46	50	5.1	37.0
Total	2675	2691	3.9	28.2
Service Area 7				
East LA	270	273	3.1	22.7
Downey	139	159	1.9	13.6
Norwalk	141	187	2.1	15.0
Whittier	220	236	2.6	18.7
Montebello	271	276	2.7	19.7
Bell Gardens-Bell-Maywood-Cudahy-Commerce	148	148	1.5	11.0
Huntington Park	125	129	2.1	15.2
South Gate	81	106	1.4	9.8
Bellflower	110	133	2.3	16.6
La Mirada-Santa Fe Springs	227	262	2.4	17.4
Lakewood-Cerritos-Artesia-Hawaiian Gardens	229	253	1.9	13.7
Signal Hill	6	15	1.4	9.8
Other	14	17	2.7	19.3
Total	1981	2194	2.2	15.8
Service Area 8				
Hancock S.	21	21	3.2	22.7
Wilmington	351	370	2.7	19.7
Inglewood	287	253	3.1	22.0
Torrance	227	245	2.2	15.6
Long Beach N.	277	355	3.2	22.9
Long Beach S.	520	525	3.9	27.9
Long Beach E.	223	246	2.3	16.7
Carson	250	243	3.0	21.3
Palos Verdes-Lomita	136	138	1.8	12.8
Redondo-Manhattan-Hermosa-El Segundo	158	145	1.4	10.2
Gardena-Lawndale	315	327	3.2	22.8
Hawthorne	202	187	2.2	16.1
Other	12	12	3.4	24.4
Total	2979	3068	2.7	19.3
Countywide Total	18392	19177	2.6	

1. APS Rate[1]
> 4

1. APS Rate[2]
20 - 30
> 30

Posttraumatic Stress Disorder (PTSD) Rates

Description of Indicator

This indicator reports the number of individuals diagnosed with PTSD by the Los Angeles County Department of Mental Health for the fiscal year 2006-07. The DSM-IV-TR (APA, 2000) defines PTSD as exposure to a traumatic event resulting in intense fear, helplessness, or horror that is persistently re-experienced and results in avoidant behaviors, heightened levels of arousal, and psychological numbing.

Research Base and Relevance to PEI

The diagnosis of PTSD encompasses a more narrow focus than the state's definition of Trauma-exposed individuals. Moreover, the figures reported are for individuals within the county's information system, so it likely underestimates the numbers of individuals with PTSD in the county to some extent. PTSD is more frequent in women (Nemeroff, Bremner, Foa, Mayberg, North, & Stein, 2006), increases an individual's risk for exhibiting suicidal behaviors (Oquendo, Brent, Birmaher, Greenhill, Kolko, Stanley, Burke, Firinciogullari, Ellis, & Mann, 2005), and for developing co-morbid mental disorders (Brady, Killen, Brewerton, & Lucerini, 2000).

What the Numbers Show

Age Groups

5,912 individuals were seen within the county mental health system during the 2006-07 reporting period. As shown in Table 3.27, children under the age of 16 accounted for a majority of PTSD cases, 51.8% or 3,062 individuals. In all service areas, child cases outnumbered adult cases with the exception of Service Area 6, where adult PTSD cases were more numerous. Across the county adults accounted for 28.2% of PTSD cases, TAY, 17.7%, and older adults, 2.3%. Shown in the bottom half of Table 3.27, across service areas the largest proportion of total PTSD cases were found in Service Area 4. Service Area 4 also had the largest proportion of child cases, 21.2%. Service Area 2 had the largest proportion of TAY cases (21.1%), though Service Area 4 (20.6%) was very close to this figure. Service Area 8 had the largest proportion of PTSD in the adult and older adult populations, 22.6% and 32.9%, respec-

Table 3.27
PTSD by Age Groups
Across Los Angeles County (% of population)

Within Service Areas1	0-15	16-25	26-59	60+	Total
Service Area 1	51.5	18.9	28.1	1.5	100
Service Area 2	45.9	24.1	27.5	2.5	100
Service Area 3	68.7	13.8	15.8	1.6	100
Service Area 4	59.2	19.6	19.2	2.0	100
Service Area 5	48.4	13.2	35.8	2.6	100
Service Area 6	38.0	14.4	46.2	1.4	100
Service Area 7	54.9	22.1	21.7	1.4	100
Service Area 8	46.3	13.4	36.1	4.2	100
Total	51.8	17.7	28.2	2.3	100

Between Service Areas2	0-15	16-25	26-59	60+	Total
Service Area 1	7.8	8.4	7.8	5.2	7.9
Service Area 2	13.7	21.1	15.1	17.2	15.5
Service Area 3	17.4	10.3	7.4	9.5	13.1
Service Area 4	21.2	20.6	12.6	16.0	18.5
Service Area 5	4.1	3.3	5.6	5.0	4.4
Service Area 6	9.5	10.6	21.2	8.0	13.0
Service Area 7	10.5	12.4	7.6	6.1	9.9
Service Area 8	15.8	13.4	22.6	32.9	17.7
Total	100	100	100	100	100

1. Within Service Areas: 30 - 40%; 40 - 50 %; > 50%

2. Between Service Areas: Low; High

Table 3.28

PTSD by Ethnicity Across Los Angeles County (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Within Service Areas1									
Service Area 1	26.9	34.0	0.6	0.2	32.7	0.0	0.9	4.7	100
Service Area 2	18.2	16.7	0.3	4.6	50.7	0.1	5.5	3.9	100
Service Area 3	13.2	15.2	0.6	3.2	60.0	0.0	3.5	4.3	100
Service Area 4	6.1	18.9	1.2	7.9	59.1	0.0	2.5	4.2	100
Service Area 5	18.3	28.1	0.1	3.0	38.7	0.0	3.7	8.2	100
Service Area 6	2.5	58.0	0.5	0.5	33.0	0.1	0.8	4.6	100
Service Area 7	7.2	16.5	1.3	6.1	62.7	0.0	2.5	3.6	100
Service Area 8	10.8	25.7	0.1	15.5	36.4	0.3	1.8	9.4	100
Total	11.6	25.7	0.6	6.2	47.9	0.1	2.7	5.3	100

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Between Service Areas2									
Service Area 1	18.3	10.4	8.2	0.3	5.4	0.4	2.5	7.0	7.9
Service Area 2	24.3	10.0	8.0	11.5	16.4	19.6	31.8	11.4	15.5
Service Area 3	15.0	7.7	13.5	6.7	16.4	0.0	17.2	10.7	13.1
Service Area 4	9.8	13.7	36.1	23.8	22.9	0.0	17.4	14.8	18.5
Service Area 5	6.9	4.8	0.5	2.1	3.6	0.0	6.0	6.8	4.4
Service Area 6	2.8	29.3	9.4	1.1	8.9	19.7	3.8	11.3	13.0
Service Area 7	6.2	6.4	21.4	9.9	13.0	0.0	9.2	6.8	9.9
Service Area 8	16.6	17.7	3.0	44.6	13.4	60.3	12.0	31.2	17.7
Total	100	100	100	100	100	100	100	100	100

1. Within Service Areas: 30 - 40%; 40 - 50 %; > 50%

2. Between Service Areas: Low; High

tively. Service Area 6 had nearly the same proportion of Adult cases, 21.2%. Across the county, Service Area 5 had the smallest proportion of PTSD cases.

Ethnicity

Across seven tracked ethnic groups in Table 3.28, Latinos accounted for 47.9.% of clients diagnosed with PTSD. This was followed by African-Americans (25.9%), Whites (11.6%), Asians (6.2%), and Other Ethnicities (2.7%). Native Americans (0.6%) and Pacific Islanders (0.1%) each accounted for less than 1% of the PTSD client population. Examining the service areas in greater detail revealed that Latino clients were a majority of PTSD in Service Areas 2, 3, 4 and 7. African-American clients were a majority of cases in Service Area 6.

The bottom half of Table 3.28 shows where the largest proportion of individuals treated for PTSD occurred. For example, 44.6% of Asian and 60.3% of Pacific Islander clients with PTSD were served in Service Area 8; 24.3% of White clients in Service Area 2; 29.3% of African-American clients in Service Area 6; and 36.1% of Native American clients and 22.9% of Latino clients in Service Area 4.

Service Area Communities (Tables 3.29, 3.30)

Service Area 1: Antelope Valley

Age Groups

Service Area 1 clients accounted for 7.9% of individuals with PTSD treated in the county's mental health system. The majority of clients with PTSD in the service area were children (51.5%). Examining the composite communities revealed that about half of all cases fell within the Child age group. The TAY group accounted for about a quarter of all cases in the Lancaster area and more than a third of all cases in the surrounding North County E. area. In the Palmdale area, Adults accounted for more than a third of PTSD cases. Across the service area, the Palmdale area accounted for a majority of all PTSD cases.

Ethnicity

African-American clients accounted for 34.0% of the PTSD population treated in Service Area 1. This was followed by Latino clients (32.7%) and White clients (26.9%). Native American, Asian, and Pacific Islander clients each accounted for less than 1% of the PTSD cases in the area. When compared with population estimates for these groups, it appeared that African-American (12.8%) and Native American (0.3%) clients were overrepresented in the PTSD client counts, while Latino (41.1%), White (≈ 39%), and Asian (4.3%) clients were underrepresented.

Service Area 2: San Fernando

Age Groups

15.5% of the county's PTSD cases came from Service Area 2. Though no age group constituted an overall majority of PTSD cases in the Service Area 2, the Child group (0-15) accounted for the largest proportion of cases (45. 9%). However, drilling down into the composite communities did show that the Child group were a majority in seven areas (the Burbank, Northridge, Pacoima-Arleta, Encino, North County W., La Canada-Flintridge, and San Fernando-Calabasas-Agoura areas). Only one community, the Granada Hills area, saw a majority of TAY clients (16-25) with PTSD and only one community, the Santa Clarita area, saw a majority of Adult clients (26-59). Across the service area, about half of all PTSD cases were treated in the Glendale, Granada Hills, and Sherman Oaks areas. The Sherman Oaks area saw about a quarter of all PTSD cases in the San Fernando Valley.

Ethnicity

Latino clients (50.7%) accounted for a majority of the PTSD population treated in Service Area 2. This was followed by White clients (18.2%), African-American clients (16.7%), and Asian clients (4.6%). Native American and Pacific Islander groups each accounted for less than 1% of the PTSD population in the county's mental health system. When compared with population estimates for these groups, Latino, Asian, and White groups appeared to be underrepresented relative to their population counts. African-American clients appeared to be overrepresented when compared to their population share of 3.9%. Examining the service area composite communities revealed seven communities where Latino clients were a majority of PTSD cases (the Burbank, Northridge, Pacoima-Arleta, Panorama City, North Hollywood, Encino, and La Canada-Flintridge areas). In one community, the Santa Clarita

area, White clients constituted a majority of the PTSD population. No other ethnic group constituted a majority of PTSD cases in the Service area.

Service Area 3: San Gabriel
Age Groups

Service Area 3 accounted for 13.1% of the county's PTSD cases. In terms of age groups, children (0-15) accounted for a majority of PTSD cases treated in the service area (68.7%). This strong majority was seen in all but a few composite communities. Only the Arcadia-San Gabriel-Temple City-San Marino area and the La Puente-S. El Monte areas, which had majorities of Adult (26-59) cases, were exceptions to this trend. Across the service area, the Pasadena area accounted for 29.1% of the total PTSD cases seen in the San Gabriel Valley. This was followed by the Glendora-Claremont-San Dimas area, 14.1%; the remainder of cases was distributed fairly evenly across the remaining communities.

Ethnicity

Latino clients accounted for 60.0% of the PTSD population treated in Service Area 3. This was followed by African-American clients (15.2%), White clients (13.2%), and Asian clients (3.2%). Native American and Pacific Islander groups each accounted for less than 1% of the PTSD population in the service area. When compared with population estimates for these groups, African-Americans (4.6%) were over represented in the PTSD client counts, while Asians (24.4%), Latinos (45.0%), and Whites (24%) were underrepresented. In ten communities, Latinos were a majority of clients diagnosed with PTSD: the El Monte, Pomona, West Covina, Alhambra-S. Pasadena, Altadena-Monvovia-Sierra Madre, Baldwin Park-Azusa-Duarte, Glendora-Claremont-San Dimas-La Verne, Covina-Walnut, La Puente-S. El Monte, and Hacienda Heights areas. No other ethnic group accounted for a majority of PTSD cases within the composite communities besides Latinos.

Service Area 4: Metro
Age Groups

Service Area 4 accounted for 18.5% of the county's PTSD cases, the largest proportion between service areas. Children (0-15) accounted for a majority of PTSD cases treated in Service Area 4 (59.2%). Examining the service area composite communities revealed that children were a majority in six areas: the Wilshire La Brea E., Hollywood, Pico Heights, Downtown, USC N., and West Hollywood areas. One community, the West Adams area, saw a majority of adult (25-59) clients with PTSD. In two other communities, the Child group accounted for the largest proportion of cases but did not constitute a majority (the Echo Park and Highland Park areas). Across the service area, the Downtown area accounted for 41.0% of the total PTSD cases seen. This was followed by the Pico Heights area, 21.6%, the Echo Park area, 12.7%, and the Hollywood area, 10.9%.

Ethnicity

In Service Area 4, Latino clients (59.1%) accounted for a majority of the PTSD population treated in the area. This was followed by African-American clients (18.9%), White clients (6.1%), Asian clients (7.9%), and Native American clients (1.2%). The Pacific Islander group accounted for less than 1% of the PTSD population in the Service area. When compared with population estimates, the

Table 3.29

PTSD Disorders by Age Across Service Areas (% of population) [1]

	0-15	16-25	26-59	60+	Total
Within Service Area 1 Communities					
Lancaster	53.7	26.2	19.6	0.5	100
Palmdale	49.6	11.6	36.3	2.5	100
North County E.	50.3	36.0	13.7	0.0	100
Total	51.5	18.9	28.1	1.5	100
Within Service Area 2 Communities					
Santa Clarita	19.4	16.1	64.5	0.0	100
Burbank	87.1	12.9	0.0	0.0	100
Glendale	43.6	10.6	37.2	8.5	100
Northridge	76.7	18.6	4.7	0.0	100
Granada Hills	26.9	53.8	17.9	1.4	100
Pacoima-Arleta	69.8	18.6	11.6	0.0	100
La Tuna Cyn.	0.0	0.0	0.0	0.0	0
Panorama City	37.8	29.7	32.4	0.0	100
North Hollywood	32.8	20.9	46.3	0.0	100
Sherman Oaks	40.4	17.5	36.8	5.4	100
Encino	62.5	37.5	0.0	0.0	100
Woodland Hills	18.4	30.6	49.0	2.0	100
Brentwood N.	0.0	0.0	0.0	0.0	0
North County W.	50.3	36.0	13.7	0.0	100
La Canada-Flintridge	78.3	11.6	10.1	0.0	100
San Fernando-Calabasas-Agoura	100.0	0.0	0.0	0.0	100
Total	45.9	24.1	27.5	2.5	100
Within Service Area 3 Communities					
Pasadena	70.3	15.9	12.0	1.8	100
El Monte	81.3	15.4	3.1	0.2	100
Pomona	59.4	13.1	27.6	0.0	100
West Covina	81.9	18.1	0.0	0.0	100
Altadena-Monrovia-Sierra Madre	78.3	11.6	10.1	0.0	100
Alhambra-S. Pasadena	90.9	9.1	0.0	0.0	100
Arcadia-San Gabriel-Temple City-San Marino	0.0	8.7	87.0	4.3	100
Baldwin Park-Azusa-Duarte	97.9	2.1	0.0	0.0	100
Glendora-Claremont-San Dimas-La Verne	58.3	15.7	26.1	0.0	100
Covina-Walnut	71.2	20.9	7.9	0.0	100
Diamond Bar	0.0	0.0	0.0	0.0	0
La Puente-S. El Monte	14.7	22.5	62.8	0.0	100
Hacienda Heights	85.7	7.6	6.7	0.0	100
Monterey Park-Rosemead	36.2	10.6	36.2	17.0	100
Other	50.3	36.0	13.7	0.0	100
Total	68.7	13.8	15.8	1.6	100

	0-15	16-25	26-59	60+	Total
Between Service Area 1 Communities					
Lancaster	48.0	63.6	32.2	14.3	46.0
Palmdale	49.5	31.4	66.6	85.7	51.4
North County E.	2.5	4.9	1.3	0.0	2.6
Total	100.0	100.0	100.0	100.0	100.0
Between Service Area 2 Communities					
Santa Clarita	1.4	2.2	7.7	0.0	3.3
Burbank	21.0	5.9	0.0	0.0	11.1
Glendale	9.8	4.5	13.9	34.8	10.3
Northridge	7.9	3.6	0.8	0.0	4.7
Granada Hills	9.3	35.4	10.3	8.7	15.9
Pacoima-Arleta	7.2	3.6	2.0	0.0	4.7
La Tuna Cyn.	0.0	0.0	0.0	0.0	0.0
Panorama City	6.7	10.0	9.5	0.0	8.1
North Hollywood	5.2	6.4	12.3	0.0	7.3
Sherman Oaks	21.5	17.7	32.6	52.2	24.4
Encino	1.2	1.4	0.0	0.0	0.9
Woodland Hills	2.1	6.8	9.5	4.3	5.4
Brentwood N.	0.0	0.0	0.0	0.0	0.0
North County W.	1.1	1.4	0.5	0.0	1.0
La Canada-Flintridge	3.5	1.0	0.8	0.0	2.1
San Fernando-Calabasas-Agoura	2.2	0.0	0.0	0.0	1.0
Total	100	100	100	100	100
Between Service Area 3 Communities					
Pasadena	29.8	33.5	22.0	31.4	29.1
El Monte	8.9	8.4	1.5	0.7	7.6
Pomona	5.9	6.4	11.8	0.0	6.8
West Covina	7.7	8.4	0.0	0.0	6.4
Altadena-Monrovia-Sierra Madre	7.4	5.5	4.2	0.0	6.5
Alhambra-S. Pasadena	5.6	2.8	0.0	0.0	4.3
Arcadia-San Gabriel-Temple City-San	0.0	1.7	14.8	7.1	2.7
Baldwin Park-Azusa-Duarte	8.8	0.9	0.0	0.0	6.2
Glendora-Claremont-San Dimas-La Verne	12.0	16.0	23.2	0.0	14.1
Covina-Walnut	5.1	7.5	2.4	0.0	4.9
Diamond Bar	0.0	0.0	0.0	0.0	0.0
La Puente-S. El Monte	0.3	2.0	4.9	0.0	1.2
Hacienda Heights	5.4	2.4	1.8	0.0	4.3
Monterey Park-Rosemead	3.1	4.5	13.4	60.8	5.9
Other	0.0	0.0	0.0	0.0	0.0
Total	100	100	100	100	100

	0-15	16-25	26-59	60+	Total		0-15	16-25	26-59	60+	Total
Within Service Area 4 Communities						Between Service Area 4 Communities					
Wilshire La Brea E.	58.8	35.3	5.9	0.0	100	Wilshire La Brea E.	2.6	4.7	0.8	0.0	2.6
Hollywood	58.8	22.7	18.5	0.0	100	Hollywood	10.8	12.6	10.4	0.0	10.9
Pico Heights	75.9	17.3	5.9	0.8	100	Pico Heights	27.7	19.1	6.6	9.3	21.6
Echo Park	42.4	20.9	28.1	8.6	100	Echo Park	9.1	13.5	18.5	55.9	12.7
Highland Park	44.3	31.4	24.3	0.0	100	Highland Park	4.8	10.2	8.1	0.0	6.4
Downtown	59.9	17.4	21.2	1.6	100	Downtown	41.4	36.3	45.0	32.6	41.0
USC N.	59.2	13.6	27.2	0.0	100	USC N.	2.1	1.5	3.0	0.0	2.1
West Adams	8.4	14.9	74.0	2.7	100	West Adams	0.2	1.2	6.0	2.2	1.6
West Hollywood	60.2	15.0	24.8	0.0	100	West Hollywood	1.1	0.8	1.4	0.0	1.1
Other	56.3	20.4	23.3	0.0	100	Other	0.1	0.1	0.1	0.0	0.1
Total	59.2	19.6	19.2	2.0	100	Total	100	100	100	100	100
Within Service Area 5 Communities						Between Service Area 5 Communities					
Brentwood S.	0.0	0.0	0.0	0.0	0	Brentwood S.	0.0	0.0	0.0	0.0	0.0
West LA	49.2	14.8	34.4	1.6	100	West LA	50.2	55.4	47.4	29.8	49.3
Wilshire La Brea W.	58.8	35.3	5.9	0.0	100	Wilshire La Brea W.	2.5	5.4	0.3	0.0	2.0
Baldwin Hills W.	8.4	14.9	74.0	2.7	100	Baldwin Hills W.	1.8	11.4	20.9	10.6	10.1
Playa Vista	51.2	2.4	36.6	9.8	100	Playa Vista	16.7	2.9	16.1	59.6	15.8
Santa Monica-Culver City-Beverly Hills	60.2	15.0	24.8	0.0	100	Santa Monica-Culver City-Beverly Hills	27.3	24.9	15.2	0.0	22.0
Malibu	100.0	0.0	0.0	0.0	100	Malibu	1.5	0.0	0.0	0.0	0.7
Other	67.2	11.6	21.2	0.0	100	Other	0.1	0.1	0.0	0.0	0.1
Total	48.4	13.2	35.8	2.6	100	Total	100	100	100	100	100
Within Service Area 6 Communities						Between Service Area 6 Communities					
USC S.	59.2	13.6	27.2	0.0	100	USC S.	16.2	9.8	6.1	0.0	10.4
Baldwin Hills S.	8.4	14.9	74.0	2.7	100	Baldwin Hills S.	7.3	34.0	52.8	63.3	32.9
Hancock N.	52.2	15.2	32.6	0.0	100	Hancock N.	7.8	6.0	4.0	0.0	5.7
USC E.	50.5	11.9	36.6	1.0	100	USC E.	17.5	10.9	10.4	9.3	13.2
Watts	56.9	21.6	21.6	0.0	100	Watts	10.0	9.9	3.1	0.0	6.6
Florence-Firestone	75.0	25.0	0.0	0.0	100	Florence-Firestone	0.8	0.7	0.0	0.0	0.4
Lynwood	89.6	10.4	0.0	0.0	100	Lynwood	12.7	3.9	0.0	0.0	5.4
Paramount	83.3	16.7	0.0	0.0	100	Paramount	0.7	0.4	0.0	0.0	0.3
Compton	40.6	14.1	43.8	1.6	100	Compton	26.4	24.0	23.3	27.4	24.6
Other	60.2	15.0	24.8	0.0	100	Other	0.8	0.5	0.3	0.0	0.5
Total	38.0	14.4	46.2	1.4	100	Total	100	100	100	100	100

Table 3.29 continued

PTSD Disorders by Age Across Service Areas (% of population)

Within Service Area 7 Communities					
East LA	56.3	20.4	23.3	0.0	100
Downey	45.1	52.9	2.0	0.0	100
Norwalk	76.2	19.0	4.8	0.0	100
Whittier	85.7	7.6	6.7	0.0	100
Montebello	37.9	24.9	37.2	0.0	100
Bell Gardens-Bell-Maywood-Cudahy-Commerce	49.0	42.7	7.3	1.0	100
Huntington Park	75.0	25.0	0.0	0.0	100
South Gate	89.6	10.4	0.0	0.0	100
Bellflower	83.3	16.7	0.0	0.0	100
La Mirada-Santa Fe Springs	39.6	7.5	52.8	0.0	100
Lakewood-Cerritos-Artesia-Hawaiian Gardens	36.1	12.0	45.4	6.5	100
Signal Hill	75.0	25.0	0.0	0.0	100
Other	36.2	10.6	36.1	17.0	100
Total	54.9	22.1	21.7	1.4	100

Between Service Area 7 Communities					
East LA	11.8	10.6	12.3	0.0	11.5
Downey	7.1	20.8	0.8	0.0	8.7
Norwalk	5.0	3.1	0.8	0.0	3.6
Whittier	19.0	4.2	3.7	0.0	12.2
Montebello	6.6	10.8	16.5	0.0	9.6
Bell Gardens-Bell-Maywood-Cudahy-	14.6	31.6	5.5	12.3	16.3
Huntington Park	1.2	1.0	0.0	0.0	0.9
South Gate	15.2	4.4	0.0	0.0	9.3
Bellflower	0.9	0.4	0.0	0.0	0.6
La Mirada-Santa Fe Springs	6.5	3.1	22.0	0.0	9.0
Lakewood-Cerritos-Artesia-Hawaiian Gardens	11.9	9.9	37.9	84.7	18.1
Signal Hill	0.1	0.1	0.0	0.0	0.1
Other	0.2	0.1	0.4	3.1	0.3
Total	100	100	100	100	100

Within Service Area 8 Communities					
Hancock S.	52.2	15.2	32.6	0.0	100
Wilmington	54.9	29.6	15.5	0.0	100
Inglewood	67.2	11.6	21.2	0.0	100
Torrance	66.7	28.0	5.3	0.0	100
Long Beach N.	68.6	7.7	21.9	1.8	100
Long Beach S.	5.7	8.4	72.7	13.2	100
Long Beach E.	92.6	7.4	0.0	0.0	100
Carson	53.7	18.2	27.6	0.5	100
Palos Verdes-Lomita	75.0	25.0	0.0	0.0	100
Redondo-Manhattan-Hermosa-El Segundo	100.0	0.0	0.0	0.0	100
Gardena-Lawndale	3.9	3.9	61.5	30.8	100
Hawthorne	16.9	12.7	70.4	0.0	100
Other	39.2	13.4	44.3	3.2	100
Total	46.3	13.4	36.1	4.2	100

Between Service Area 8 Communities					
Hancock S.	0.3	0.3	0.2	0.0	0.2
Wilmington	8.0	15.0	2.9	0.0	6.8
Inglewood	8.5	5.1	3.4	0.0	5.9
Torrance	10.3	15.0	1.1	0.0	7.2
Long Beach N.	38.8	15.0	15.9	11.3	26.2
Long Beach S.	2.7	13.6	43.7	68.0	21.7
Long Beach E.	5.2	1.4	0.0	0.0	2.6
Carson	22.5	26.4	14.8	2.3	19.4
Palos Verdes-Lomita	0.6	0.6	0.0	0.0	0.3
Redondo-Manhattan-Hermosa-El Segundo	0.2	0.0	0.0	0.0	0.1
Gardena-Lawndale	0.2	0.7	4.2	18.1	2.5
Hawthorne	2.5	6.4	13.2	0.0	6.8
Other	0.4	0.4	0.5	0.3	0.4
Total	100	100	100	100	100

1. Within Service Areas

30 - 40%
40 - 50 %
> 50%

African-American (5.1% of population) , Latino (54.1% of population), and Native American (0.3% of population) clients were overrepresented in the PTSD client counts, while Asian (17.9%) clients were underrepresented. Examining the composite communi-

ties revealed that one area, West Adams, treated a majority of African-Americans. All other communities, with the exception of the USC N. area, treated a majority of Latino clients.

Ethnicity

In Service Area 4, Latino clients (59.1%) accounted for a majority of the PTSD population treated in the area. This was followed by African American clients (18.9%), White clients (6.1%), and Asian clients (7.9%). And Native American clients (1.2%). The Pacific Islander group accounted for less than 1% of the PTSD population in the Service area. When compared with population estimates (cf. Table 2.2), African Americans (5.1% of population) , Latino (54.1% of population), and Native American (0.3% of population) clients were over represented in the PTSD client counts; Asian (17.9%), clients were underrepresented. Examining the composite communities revealed that one area, West Adams, treated a majority of African Americans. All other communities with the exception of the USC N. area, treated a majority of Latino clients.

Service Area 5: West

Age Groups

Service Area 5 accounted for 4.4% of the county's PTSD cases. Close to half of these came from the Child age (0-15) group (48.4%), though in four of the composite communities, children with PTSD did constitute a majority of cases (the Wilshire La Brea W., Playa Vista, Santa Monica-Culver City-Beverly Hills, and Malibu areas). One community, the Baldwin Hills W. area, saw a majority of Adult (26-59) cases. About half of the service area cases were seen in the West LA area (49.3%), followed by the Santa Monica-Culver City-Beverly Hills area (22.0%), the Playa Vista area (15.8%), and the Baldwin Hills W. area (10.1%).

Ethnicity

In Service Area 5, no ethnic group constituted a majority of PTSD clients. Latino clients accounted for the largest proportion of PTSD cases (38.7%), followed by African-American clients (28.1%), White clients (18.3%), and Asian clients (3.0%). Native American and Pacific Islander clients each accounted for less than 1% of the PTSD population in the service area. When compared with population estimates for these groups, Latino clients (14.4% of population) and African-American clients (8.1% of population) appeared to be overrepresented, while Whites (58%) and Asians (12.9%) appeared to be underrepresented. Examining the service area composite communities revealed that African-Americans were a majority of clients treated for PTSD in the Baldwin Hills W. area; Latino clients were a majority in the Santa Monica-Culver City-Beverly Hills area.

Service Area 6: South

Age Groups

Service Area 6 accounted for 13% of the county's PTSD cases. It was the only service area where adults (26-59) accounted for a greater proportion of cases than children (0-15). 46.2% of cases treated in the service area came from the Adult group while 38.0% came from the Child group. Examining the composite communities revealed that several did treat a majority of child cases, though their relative proportions may have been small (the USC S., Hancock N., USC E.,

Watts, Florence-Firestone, Lynwood, and Paramount areas). The Baldwin Hills S. area, which saw the greatest proportion of cases in the service area (32.9%), also saw mostly adult PTSD cases. The Compton area saw about a quarter of the PTSD cases in the service area and a large proportion of these clients were from the Adult group.

Ethnicity

African-American clients accounted for a majority (58.0%) of the PTSD population treated in Service Area 6, the only service area where this occurred. Following this, Latino clients (33.0%) and White clients (2.5%) were the next most numerous ethnic groups represented. Native American, Asian, and Pacific Islander clients each accounted for less than 1% of the PTSD population. When compared with population estimates, African-Americans (28.2%) appeared to be overrepresented in the PTSD client counts, whereas, Latinos (65.9%) were underrepresented. Examining the composite communities revealed that African-American clients formed a majority of PTSD clients in four areas (the Baldwin Hills S., Hancock N., Florence-Firestone, and Compton areas). Latino clients constituted a majority of PTSD cases in the Watts area. The Paramount area was equally split between Latinos and African-American clients.

Table 3.30

PTSD by Ethnicity Across Service Areas (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Within Service Area 1 Communities									
Lancaster	23.4	33.2	0.9	0.5	34.1	0.0	1.4	6.5	100
Palmdale	29.3	35.2	0.4	0.0	31.5	0.0	0.4	3.2	100
North County E.	40.7	23.3	0.2	0.0	33.7	0.2	0.4	1.5	100
Total	26.9	34.0	0.6	0.2	32.7	0.0	0.9	4.7	100
Within Service Area 2 Communities									
Santa Clarita	58.1	3.2	3.2	0.0	25.8	3.2	0.0	6.5	100
Burbank	14.9	20.8	0.0	1.0	57.4	0.0	3.0	3.0	100
Glendale	21.3	7.4	0.0	2.1	30.9	0.0	29.8	8.5	100
Northridge	23.3	7.0	0.0	2.3	62.8	0.0	2.3	2.3	100
Granada Hills	13.1	33.8	0.0	0.0	47.6	0.0	3.4	2.1	100
Pacoima-Arleta	16.3	13.9	0.0	0.0	62.8	0.0	2.3	4.6	100
La Tuna Cyn.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Panorama City	8.1	18.9	1.4	1.4	70.3	0.0	0.0	0.0	100
North Hollywood	20.9	17.9	0.0	1.5	53.7	0.0	3.0	3.0	100
Sherman Oaks	16.1	11.2	0.4	15.7	49.8	0.0	2.7	4.0	100
Encino	25.0	12.5	0.0	0.0	62.5	0.0	0.0	0.0	100
Woodland Hills	24.5	12.2	0.0	0.0	49.0	0.0	4.1	10.2	100
Brentwood N.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
North County W.	40.7	23.3	0.2	0.0	33.7	0.2	0.4	1.5	100
La Canada-Flintridge	4.4	29.0	0.0	0.0	55.1	0.0	7.2	4.3	100
San Fernando-Calabasas-Agoura	36.5	0.0	0.0	9.1	45.3	0.0	9.1	0.0	100
Total	18.2	16.7	0.3	4.6	50.7	0.1	5.5	3.9	100

Service Area 7: East

Age Groups

Service Area 7 accounted for 9.9% of the county's PTSD cases. A majority of these cases came from the Child (0-15) group (54.3%). Examining the composite communities revealed that seven areas saw a majority of child PTSD cases: the East LA, Norwalk, Whittier, Huntington Park, South Gate, Bellflower, and Signal Hill areas. One community, the Downey area, saw a majority of TAY (16-25) PTSD cases. In the county, this occurred only in one other community, the Granada Hills area in Service Area 2. Adults (26-59) were seen in a majority of PTSD cases in one community: the La Mirada-Santa Fe Springs area. The communities with the four largest proportions of PTSD cases were, in order: the Lakewood-Cerritos-Hawaiian Gardens area (18.1%), the Bell Gardens-Bell-Maywood-Cudahy-Commerce area (16.3%), the Whittier area (12.2%), and the East LA area (11.5%).

Ethnicity

Latino clients accounted for a majority (62.7%) of the PTSD population treated in Service Area 7. Following this, African-American clients (16.5%), White clients (7.2), Asian clients (6.1), and Native American clients (1.3%) were, in order, the next most numerous ethnic groups represented. Pacific Islanders accounted for less than 1% of the PTSD population. When compared with population estimates, African-Americans (2.9%) and Native Americans (0.2%) appeared to be overrepresented in the COD client counts, whereas, Latinos (70.9%),

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Between Service Area 1 Communities									
Lancaster	40.0	44.9	66.2	100.0	47.9	0.0	75.6	63.8	46.0
Palmdale	56.1	53.3	33.1	0.0	49.4	0.0	23.2	35.3	51.4
North County E.	3.9	1.8	0.7	0.0	2.7	100.0	1.1	0.8	2.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Between Service Area 2 Communities									
Santa Clarita	10.4	0.6	32.3	0.0	1.7	98.4	0.0	5.4	3.3
Burbank	9.0	13.8	0.0	2.4	12.5	0.0	6.0	8.4	11.1
Glendale	12.0	4.6	0.0	4.8	6.3	0.0	55.7	22.3	10.3
Northridge	6.0	2.0	0.0	2.4	5.8	0.0	2.0	2.8	4.7
Granada Hills	11.4	32.1	0.0	0.0	14.9	0.0	10.0	8.4	15.9
Pacoima-Arleta	4.2	3.9	0.0	0.0	5.8	0.0	2.0	5.6	4.7
La Tuna Cyn.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Panorama City	3.6	9.2	33.6	2.4	11.2	0.0	0.0	0.0	8.1
North Hollywood	8.4	7.9	0.0	2.4	7.8	0.0	4.0	5.6	7.3
Sherman Oaks	21.7	16.4	33.6	83.7	24.0	0.0	11.9	25.1	24.4
Encino	1.2	0.7	0.0	0.0	1.1	0.0	0.0	0.0	0.9
Woodland Hills	7.2	3.9	0.0	0.0	5.2	0.0	4.0	13.9	5.4
Brentwood N.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
North County W.	2.2	1.3	0.5	0.0	0.6	1.6	0.1	0.4	1.0
La Canada-Flintridge	0.5	3.6	0.0	0.0	2.3	0.0	2.7	2.3	2.1
San Fernando-Calabasas-Agoura	2.0	0.0	0.0	2.0	0.9	0.0	1.7	0.0	1.0
Total	100	100	100	100	100	100	100	100	100

Table 3.30

PTSD by Ethnicity Across Service Areas (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Re-sponse	Total
Within Service Area 3 Communities									
Pasadena	15.5	25.7	1.8	1.3	49.5	0.0	4.0	2.2	100
El Monte	3.8	10.6	1.7	0.3	72.9	0.0	8.4	2.3	100
Pomona	16.9	16.9	0.0	0.0	58.9	0.0	1.9	5.5	100
West Covina	2.3	6.3	0.0	0.0	81.3	0.0	0.0	10.0	100
Altadena-Monrovia-Sierra Madre	4.4	29.0	0.0	0.0	55.1	0.0	7.2	4.3	100
Alhambra-S. Pasadena	6.1	6.1	0.0	3.0	84.8	0.0	0.0	0.0	100
Arcadia-San Gabriel-Temple City-San Marino	13.0	8.7	0.0	8.7	47.8	0.0	4.3	17.4	100
Baldwin Park-Azusa-Duarte	6.3	2.1	0.0	0.0	85.4	0.0	0.0	6.3	100
Glendora-Claremont-San Dimas-La Verne	25.7	10.2	0.0	0.9	57.6	0.0	3.7	1.9	100
Covina-Walnut	17.9	15.3	0.0	0.0	64.2	0.0	2.6	0.0	100
Diamond Bar	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
La Puente-S. El Monte	0.8	0.0	0.0	0.0	97.7	0.0	1.5	0.0	100
Hacienda Heights	4.8	3.8	0.0	0.0	81.9	0.0	7.6	1.9	100
Monterey Park-Rosemead	19.1	8.5	0.0	38.3	17.0	0.0	0.0	17.0	100
Other	40.7	23.3	0.2	0.0	33.7	0.2	0.4	1.5	100
Total	13.2	15.2	0.6	3.2	60.0	0.0	3.5	4.3	100
Within Service Area 4 Communities									
Wilshire La Brea E.	14.7	26.5	0.0	8.8	29.4	0.0	0.0	20.6	100
Hollywood	5.9	29.4	0.0	1.7	54.6	0.0	6.7	1.7	100
Pico Heights	9.7	19.4	2.1	1.7	60.3	0.0	3.0	3.8	100
Echo Park	4.3	10.8	3.6	24.5	54.0	0.0	1.4	1.4	100
Highland Park	1.4	7.1	0.0	0.0	87.1	0.0	1.4	2.9	100
Downtown	5.3	16.0	0.7	9.8	61.0	0.0	2.0	5.1	100
USC N.	1.0	49.5	1.0	0.0	44.7	0.0	1.0	2.9	100
West Adams	2.4	73.3	0.7	0.3	12.8	0.0	1.4	9.1	100
West Hollywood	11.0	23.3	0.0	0.0	64.3	0.0	0.0	1.4	100
Other	4.3	0.0	0.0	0.0	92.8	0.0	1.4	1.4	100
Total	6.1	18.9	1.2	7.9	59.1	0.0	2.5	4.2	100
Within Service Area 5 Communities									
Brentwood S.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
West LA	29.7	22.7	0.0	2.3	32.8	0.0	4.7	7.8	100
Wilshire La Brea W.	14.7	26.5	0.0	8.8	29.4	0.0	0.0	20.6	100
Baldwin Hills W.	2.4	73.3	0.7	0.3	12.8	0.0	1.4	9.1	100
Playa Vista	2.4	24.4	0.0	9.8	39.0	0.0	7.3	17.1	100
Santa Monica-Culver City-Beverly Hills	11.0	23.3	0.0	0.0	64.3	0.0	0.0	1.4	100
Malibu	36.5	0.0	0.0	9.1	45.3	0.0	9.1	0.0	100
Other	4.9	23.0	0.0	4.9	55.9	0.0	4.9	6.5	100
Total	18.3	28.1	0.1	3.0	38.7	0.0	3.7	8.2	100
Within Service Area 6 Communities									
USC S.	1.0	49.5	1.0	0.0	44.7	0.0	1.0	2.9	100
Baldwin Hills S.	2.4	73.3	0.7	0.3	12.8	0.0	1.4	9.1	100
Hancock N.	4.3	56.5	0.0	0.0	37.0	0.0	0.0	2.2	100
USC E.	3.0	47.5	0.0	3.0	43.6	0.0	0.0	3.0	100
Watts	3.9	41.2	0.0	0.0	51.0	0.0	2.0	2.0	100
Florence-Firestone	0.0	87.5	0.0	0.0	12.5	0.0	0.0	0.0	100
Lynwood	5.2	45.8	0.0	0.0	41.7	0.0	2.1	5.2	100
Paramount	0.0	50.0	0.0	0.0	50.0	0.0	0.0	0.0	100
Compton	1.6	54.7	0.5	0.0	41.1	0.5	0.0	1.6	100
Other	11.0	23.3	0.0	0.0	64.3	0.0	0.0	1.4	100
Total	2.5	58.0	0.5	0.5	33.0	0.1	0.8	4.6	100

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Re-sponse	Total
Between Service Area 3 Communities									
Pasadena	34.1	49.2	80.0	12.3	24.0	0.0	33.0	14.9	29.1
El Monte	2.1	5.3	20.0	0.7	9.2	0.0	18.2	4.1	7.6
Pomona	8.7	7.5	0.0	0.0	6.7	0.0	3.7	8.6	6.8
West Covina	1.1	2.7	0.0	0.0	8.7	0.0	0.0	14.9	6.4
Altadena-Monrovia-Sierra Madre	2.2	12.4	0.0	0.0	6.0	0.0	13.4	6.5	6.5
Alhambra-S. Pasadena	2.0	1.7	0.0	4.1	6.0	0.0	0.0	0.0	4.3
Arcadia-San Gabriel-Temple City-San Marino	2.7	1.5	0.0	7.4	2.2	0.0	3.3	10.8	2.7
Baldwin Park-Azusa-Duarte	2.9	0.8	0.0	0.0	8.8	0.0	0.0	8.9	6.2
Glendora-Claremont-San Dimas-La Verne	27.4	9.4	0.0	4.1	13.5	0.0	14.7	6.3	14.1
Covina-Walnut	6.7	5.0	0.0	0.0	5.3	0.0	3.7	0.0	4.9
Diamond Bar	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
La Puente-S. El Monte	0.1	0.0	0.0	0.0	2.0	0.0	0.5	0.0	1.2
Hacienda Heights	1.6	1.1	0.0	0.0	5.9	0.0	9.4	1.9	4.3
Monterey Park-Rosemead	8.5	3.3	0.0	71.4	1.7	0.0	0.0	23.1	5.9
Other	0.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0
Total	100	100	100	100	100	100	100	100	100
Between Service Area 4 Communities									
Wilshire La Brea E.	6.3	3.7	0.0	2.9	1.3	0.0	0.0	12.8	2.6
Hollywood	10.4	16.9	0.0	2.3	10.0	0.0	29.1	4.3	10.9
Pico Heights	34.2	22.2	37.5	4.6	22.1	0.0	25.5	19.4	21.6
Echo Park	8.9	7.2	37.5	39.3	11.6	0.0	7.3	4.3	12.7
Highland Park	1.5	2.4	0.0	0.0	9.4	0.0	3.6	4.3	6.4
Downtown	35.7	34.7	22.5	50.8	42.3	0.0	32.8	49.6	41.0
USC N.	0.3	5.6	1.7	0.0	1.6	0.0	0.8	1.5	2.1
West Adams	0.6	6.0	0.9	0.1	0.3	0.0	0.8	3.4	1.6
West Hollywood	1.9	1.3	0.0	0.0	1.2	0.0	0.0	0.4	1.1
Other	0.1	0.0	0.0	0.0	0.2	0.0	0.1	0.0	0.1
Total	100	100	100	100	100	0	100	100	100
Between Service Area 5 Communities									
Brentwood S.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
West LA	80.2	39.8	0.0	38.8	41.8	0.0	62.9	47.0	49.3
Wilshire La Brea W.	1.6	1.9	0.0	6.0	1.5	0.0	0.0	5.1	2.0
Baldwin Hills W.	1.3	26.4	100.0	1.1	3.4	0.0	3.7	11.2	10.1
Playa Vista	2.1	13.7	0.0	51.7	15.9	0.0	31.5	32.9	15.8
Santa Monica-Culver City-Beverly Hills	13.3	18.2	0.0	0.0	36.5	0.0	0.0	3.7	22.0
Malibu	1.4	0.0	0.0	2.2	0.8	0.0	1.8	0.0	0.7
Other	0.0	0.1	0.0	0.1	0.1	0.0	0.1	0.1	0.1
Total	100	100	100	100	100	0	100	100	100
Between Service Area 6 Communities									
USC S.	4.0	8.8	22.3	0.0	14.0	0.0	12.8	6.5	10.4
Baldwin Hills S.	31.2	41.6	49.3	22.2	12.8	0.0	56.5	65.0	32.9
Hancock N.	9.9	5.5	0.0	0.0	6.3	0.0	0.0	2.7	5.7
USC E.	15.7	10.8	0.0	77.8	17.4	0.0	0.0	8.5	13.2
Watts	10.4	4.7	0.0	0.0	10.3	0.0	16.5	2.8	6.6
Florence-Firestone	0.0	0.6	0.0	0.0	0.1	0.0	0.0	0.0	0.4
Lynwood	11.2	4.2	0.0	0.0	6.8	0.0	14.2	6.1	5.4
Paramount	0.0	0.3	0.0	0.0	0.5	0.0	0.0	0.0	0.3
Compton	15.4	23.2	28.4	0.0	30.7	100.0	0.0	8.3	24.6
Other	2.1	0.2	0.0	0.0	0.9	0.0	0.0	0.1	0.5
Total	100	100	100	100	100	100	100	100	100

Table 3.30

PTSD by Ethnicity Across Service Areas (% of population)

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Re-sponse	Total
Within Service Area 7 Communities									
East LA	4.3	0.0	0.0	0.0	92.8	0.0	1.4	1.4	100
Downey	3.9	43.1	0.0	0.0	35.3	0.0	3.9	13.7	100
Norwalk	14.3	52.4	0.0	0.0	33.3	0.0	0.0	0.0	100
Whittier	4.8	3.8	0.0	0.0	81.9	0.0	7.6	1.9	100
Montebello	1.8	7.1	1.8	0.0	82.2	0.0	1.8	5.3	100
Bell Gardens-Bell-Maywood-Cudahy-Commerce	8.3	9.4	1.0	0.0	78.1	0.0	2.1	1.0	100
Huntington Park	0.0	87.5	0.0	0.0	12.5	0.0	0.0	0.0	100
South Gate	5.2	45.8	0.0	0.0	41.7	0.0	2.1	5.2	100
Bellflower	0.0	50.0	0.0	0.0	50.0	0.0	0.0	0.0	100
La Mirada-Santa Fe Springs	13.2	3.8	0.0	0.0	77.4	0.0	0.0	5.7	100
Lakewood-Cerritos-Artesia-Hawaiian Gardens	11.1	13.9	5.6	33.3	32.4	0.0	1.9	1.9	100
Signal Hill	50.0	0.0	0.0	0.0	50.0	0.0	0.0	0.0	100
Other	19.1	8.5	0.0	38.3	17.0	0.0	0.0	17.0	100
Total	7.2	16.5	1.3	6.1	62.7	0.0	2.5	3.6	100
Within Service Area 8 Communities									
Hancock S.	4.3	56.5	0.0	0.0	37.0	0.0	0.0	2.2	100
Wilmington	15.5	39.4	0.0	0.0	36.6	1.4	1.4	5.6	100
Inglewood	4.9	23.0	0.0	4.9	55.9	0.0	4.9	6.5	100
Torrance	10.7	32.0	0.0	0.0	50.7	0.0	4.0	2.7	100
Long Beach N.	8.4	21.9	0.4	15.7	48.5	0.7	1.8	2.6	100
Long Beach S.	6.2	11.9	0.0	40.1	11.5	0.0	0.4	30.0	100
Long Beach E.	11.1	29.6	0.0	7.4	51.9	0.0	0.0	0.0	100
Carson	19.2	31.0	0.0	1.5	41.4	0.0	2.0	4.9	100
Palos Verdes-Lomita	50.0	0.0	0.0	0.0	50.0	0.0	0.0	0.0	100
Redondo-Manhattan-Hermosa-El Segundo	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Gardena-Lawndale	7.7	7.7	0.0	76.9	3.9	0.0	0.0	3.8	100
Hawthorne	9.9	56.3	0.0	0.0	28.2	0.0	2.8	2.8	100
Other	4.7	41.3	2.2	10.9	38.3	0.4	0.6	1.7	100
Total	10.8	25.7	0.1	15.5	36.4	0.3	1.8	9.4	100

Whites (15%), and Asians (10.0%) appeared to be underrepresented. African-American clients were a majority in three communities (the Norwalk, Huntington Park, and Bell-flower areas); Latino clients were a majority of PTSD cases in six communities (the East LA, Whittier, Bell Gardens-Bell-Maywood-Cudahy-Commerce areas); and White and Latino clients were equally represented in the Signal Hill area.

Service Area 8: South Bay
Age Groups

Service Area 8 accounted for 17.7% of the county's PTSD, second only to Service Area 4. Children (0-15) accounted for the largest proportion of PTSD cases in the service area, 46. 3%, followed by Adult (26-59) cases, 36.1%, TAY (16-25), 13.4%, and Older Adults (60+), 4.2%. Nine of the composite communities saw a majority of Child cases (the Hancock S., Wilmington, Inglewood, Torrance, Long Beach N., Long Beach E., Carson, Palos

	White	African American	Native American	Asian	Latino	Pacific Islander	Other Ethnicity	Non Response	Total
Between Service Area 7 Communities									
East LA	6.9	0.0	0.0	0.0	17.0	0.0	6.6	4.5	11.5
Downey	4.7	22.7	0.0	0.0	4.9	0.0	13.7	32.7	8.7
Norwalk	7.1	11.4	0.0	0.0	1.9	0.0	0.0	0.0	3.6
Whittier	8.0	2.8	0.0	0.0	15.9	0.0	37.5	6.4	12.2
Montebello	2.4	4.1	12.6	0.0	12.6	0.0	7.0	14.1	9.6
Bell Gardens-Bell-Maywood-Cudahy-Commerce	18.8	9.3	12.6	0.0	20.3	0.0	13.7	4.7	16.3
Huntington Park	0.0	4.6	0.0	0.0	0.2	0.0	0.0	0.0	0.9
South Gate	6.7	25.9	0.0	0.0	6.2	0.0	7.8	13.3	9.3
Bellflower	0.0	1.8	0.0	0.0	0.5	0.0	0.0	0.0	0.6
La Mirada-Santa Fe Springs	16.5	2.1	0.0	0.0	11.1	0.0	0.0	14.0	9.0
Lakewood-Cerritos-Artesia-Hawaiian Gardens	27.8	15.3	74.7	98.4	9.4	0.0	13.6	9.2	18.1
Signal Hill	0.4	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.1
Other	0.7	0.1	0.0	1.6	0.1	0.0	0.0	1.2	0.3
Total	100	100	100	100	100	0	100	100	100
Between Service Area 8 Communities									
Hancock S.	0.1	0.5	0.0	0.0	0.2	0.0	0.0	0.1	0.2
Wilmington	9.7	10.4	0.0	0.0	6.8	33.2	5.3	4.1	6.8
Inglewood	2.6	5.2	0.0	1.8	9.0	0.0	15.7	4.1	5.9
Torrance	7.1	8.9	0.0	0.0	10.0	0.0	15.8	2.0	7.2
Long Beach N.	20.3	22.3	91.2	26.5	34.9	66.3	26.3	7.1	26.2
Long Beach S.	12.4	10.0	0.0	56.0	6.8	0.0	5.3	69.3	21.7
Long Beach E.	2.7	3.0	0.0	1.2	3.7	0.0	0.0	0.0	2.6
Carson	34.5	23.4	0.0	1.8	22.1	0.0	21.0	10.2	19.4
Palos Verdes-Lomita	1.6	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.3
Redondo-Manhattan-Hermosa-El Segundo	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Gardena-Lawndale	1.8	0.7	0.0	12.3	0.3	0.0	0.0	1.0	2.5
Hawthorne	6.2	14.8	0.0	0.0	5.3	0.0	10.5	2.0	6.8
Other	0.2	0.7	8.8	0.3	0.5	0.5	0.1	0.1	0.4
Total	100	100	100	100	100	100	100	100	100

1. Within Service Areas

30 - 40%
40 - 50 %
> 50%

Verdes-Lomita, Redondo-Manhattan-Hermosa-El Segundo, areas). And two communities, the Long Beach S. and Gardena-Lawndale areas, saw a majority of Adult cases. Across the service area, the Long Beach N. area saw the greatest proportion of cases, 26.2% followed by the Long Beach S. area, 21.7% and the Carson area, 19.4%.

Ethnicity

No ethnic group constituted a majority of PTSD cases in Service Area 8., though, Latino clients accounted for the largest proportion of PTSD cases, 36.4%. This was followed by African-American clients (25.7%), Asian clients (15.5%), and White clients (10.8%). Native Americans and Pacific Islanders each accounted for less than 1% of the PTSD population in the service area. When com-

pared with population estimates for these groups, African-Americans (15.6%) were over represented in the PTSD client counts; Latinos (37.3%) and Asians (15.3%) had client counts consistent with their population; White clients were under represented in the PTSD population.

❖ ❖ ❖

Homelessness

Description of Indicator

This indicator is a cross-sectional count of homeless individuals in the county conducted in 2007 by the Los Angeles Homeless Services Authority. Data for this indicator was excerpted from the Los Angeles Homeless Services Authority's 2007 Greater Los Angeles Homeless Count. Complete tables of their study may be obtained from the Los Angeles Homeless Services Authority (www.lahsa.org).

Research Base and Relevance to PEI

Homeless individuals, especially homeless youth, represent one of the most vulnerable populations in the county. Research indicates that nearly most homeless youth have experienced a trauma in their lives and most have endured multiple traumas (Gwadz, Nish, Leonard & Strauss, 2007; Stewart, Steiman, Cauce, Cochran, Whitbeck, & Hoyt, 2004). A great many of these children suffer from Posttraumatic Stress Disorder.

What the Numbers Show

The Greater Los Angeles Homeless Count estimated 156,380 individuals were homeless in Los Angeles County in 2007. Homelessness occurs in virtually all geographic locations and ethnic groups across the county. In four service areas, 2, 3, 4 and 6, estimates were well over 20,000 individuals in each area; the majority of these individuals were unsheltered. In terms of age groupings, the most populous category was individuals between the ages of 25-55 years, who accounted for 65.5% of the entire estimated homeless population. Children under the age of 18 accounted for 14.9% of the estimated homeless population. With respect to gender, adult males accounted for 69% of the estimated homeless population, adult females, 28.5%, and adult transgender individuals, 2.5%. In terms of ethnicity, Black/African-Americans accounted for 43.9% of the estimated homeless population, Hispanic or Latino, 27.2%, White, 22.4%, and Multi-racial and Other individuals, 6.5%. Homeless Black/African-Americans were estimated in large numbers, (i.e., greater than 20,000 individuals), in Service Areas 4 and 6. The largest group of homeless Hispanic or Latinos was estimated at 15,942 in Service Area 3 and the largest group of Whites was estimated at 11,064 in Service Area 2.

There are thousands of estimated homeless individuals from high-risk groups across the county. Estimates indicated, for example, that 20,454 children were homeless across the county -- and of these, 8,853 children were under the age of 5. 57,473 individuals with mental illness were homeless across the county; 18,075 of the homeless were veterans and 16,540 individuals were victims of domestic violence.

Service Area 1: Antelope Valley

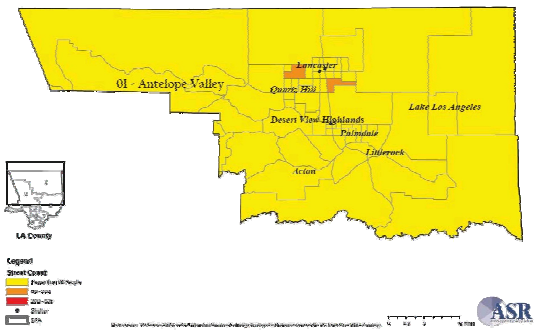

Figure 3.31 Homeless in Service Area 1

Service Area 1: Antelope Valley

Age Groups

In Service Area 1, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (68.5%) of the homeless population. This was followed by the Under 18 Age Group at 13.6%, the 18-24 Age Group at 10.1%, and the 56+ Age Group at 7.8%.

Ethnicity

Within Service Area 1, Black/African-Americans accounted for 40.8% of the homeless population. Hispanic or Latinos accounted for 14.3%, Whites, 40.1%, and Multi-Racial and Others accounted for 4.8% of the homeless population.

Sub-populations

In Service Area 1, 50.4% of the homeless population reported that they had a mental illness. This was the highest proportion of mentally ill homeless individuals seen within the county. 26.7% of homeless individuals reported they were substance abusers; and, 7.7% reported they were victims of domestic violence.

Service Area 2: San Fernando

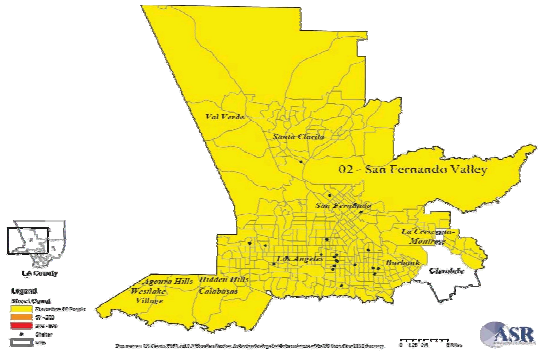

Figure 3.32 Homeless in Service Area 2

Service Area 2: San Fernando

Age Groups

In Service Area 2, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (69.9%) of the homeless population. This was followed by the Under 18 Age Group at 15.7%, the 56+ Age Group at 9.9%, and the 18-24 Age Group at 4.6%.

Ethnicity

Within Service Area 2, Black/African-Americans accounted for 26.2% of the homeless population. Hispanic or Latinos accounted for 25.0%, Whites, 42.7%, and Multi-Racial or Others accounted for 6.1% of the homeless population.

Sub-populations

In Service Area 2, 38.6% of the homeless population reported that they had a mental illness; 33.3% of homeless individuals reported they were substance abusers; and 10.4% reported they were victims of domestic violence.

Service Area 3: San Gabriel

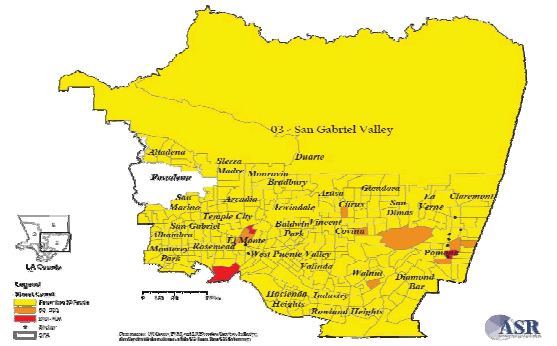

Figure 3.33 Homeless in Service Area 3

Service Area 4: Metro

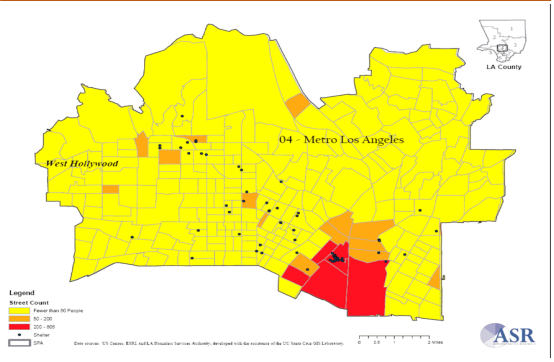

Figure 3.34 Homeless in Service Area 4

Service Area 3: San Gabriel

Age Groups

In Service Area 3, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (65.2%) of the homeless population. This was followed by the Under 18 Age Group at 15.1%, the 56+ Age Group at 11.1%, and the 18-24 Age Group at 8.7%.

Ethnicity

Within Service Area 3, Hispanic or Latinos accounted for a majority of the homeless population (58.9%). Black/African-Americans accounted for 20.5% of the homeless population; Whites, 16.6%, and Multi-Racial or Others accounted for 4.0% of the homeless population.

Sub-populations

In Service Area 3, 31.1% of the homeless population reported that they had a mental illness; 31.3% of homeless individuals reported they were substance abusers; and 9.6% reported they were victims of domestic violence.

Service Area 4: Metro

Age Groups

In Service Area 4, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (64.8%) of the homeless population. This was followed by the Under 18 Age Group at 13.8%, the 56+ Age Group at 12.7%, and the 18-24 Age Group at 8.7%.

Ethnicity

Within Service Area 4, Black/African-Americans accounted for the majority of the homeless population (56.8%). Hispanics or Latinos accounted for 17.3%, Whites, 16.3%, and Multi-Racial or Others, 9.6% of the homeless population.

Sub-populations

In Service Area 4, 45.1% of the homeless population reported that they had a mental illness; 38.1% of homeless individuals reported they were substance abusers; and 10.5% reported they were victims of domestic violence.

Service Area 5: West

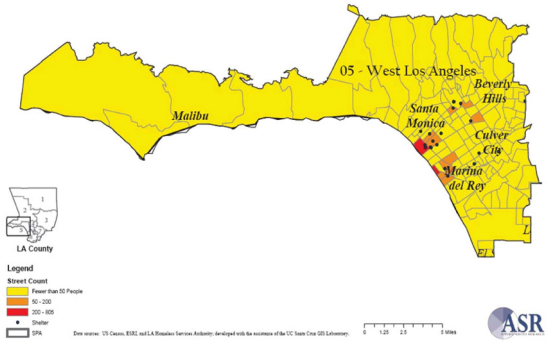

Figure 3.35 Homeless in Service Area 5

Service Area 6: South

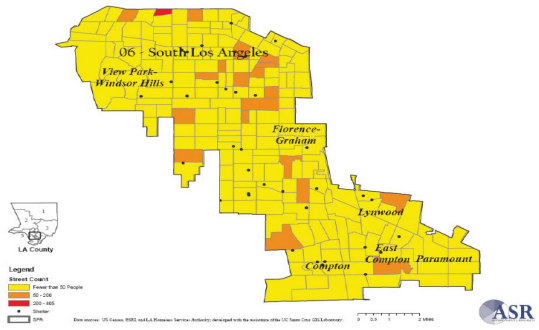

Figure 3.36 Homeless in Service Area 6

Service Area 5: West

Age Groups

In Service Area 5, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (64.0%) of the homeless population. This was followed by the Under 18 Age Group at 14.5%, the 56+ Age Group at 14.0%, and the 18-24 Age Group at 7.5%.

Ethnicity

Within Service Area 5, Black/African-Americans accounted for 35.2% of the homeless population. Hispanic or Latinos accounted for 17.0%; Whites, 35.8%; and Multi-Racial or Others accounted for 12.0% of the homeless population. This was the largest proportion of Multi-Racial or Other homeless individuals across the county.

Sub-populations

In Service Area 5, 32.3% of the homeless population reported that they had a mental illness; 42.9% of homeless individuals reported they were substance abusers; and 8.4% reported they were victims of domestic violence.

Service Area 6: South

Age Groups

In Service Area 6, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (64.0%) of the homeless population. This was followed by the Under 18 Age Group at 15.3%, the 56+ Age Group at 14.2%, and the 18-24 Age Group at 6.5%.

Ethnicity

Within Service Area 6, Black/African-Americans accounted for a majority of the homeless population (81.7%). Hispanic or Latinos accounted for 12.3%, Whites, 3.5%, and Multi-Racial or Others accounted for 2.5% of the homeless population.

Sub-populations

In Service Area 6, 32.1% of the homeless population reported that they had a mental illness; 37.1% of homeless individuals reported they were substance abusers; and 12.5% reported they were victims of domestic violence.

Service Area 7: East

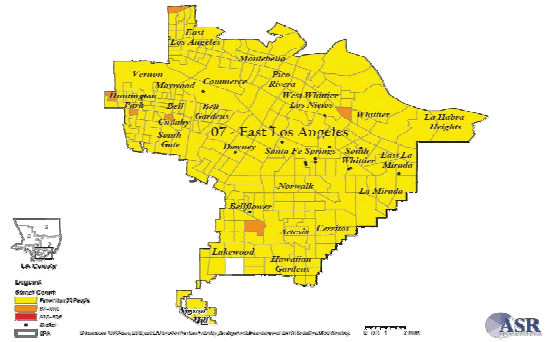

Figure 3.37 Homeless in Service Area 7

Service Area 8: South Bay

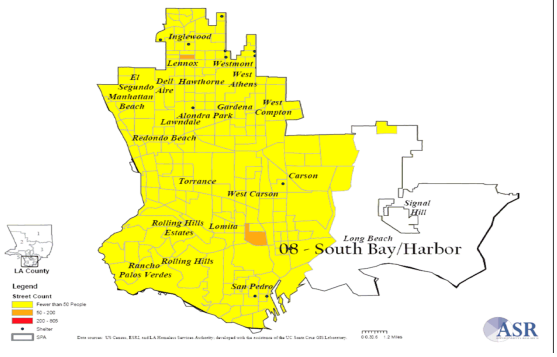

Figure 3.38 Homeless in Service Area 8

Service Area 7: East

Age Groups

In Service Area 7, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (63.4%) of the homeless population. This was followed by the Under 18 Age Group at 15.5%, the 56+ Age Group at 13.1%, and the 18-24 Age Group at 7.9%.

Ethnicity

Within Service Area 7, Black/African-Americans accounted for 24.7% of the homeless population. Hispanic or Latinos accounted for 43.4%; Whites, 24.7%; and Multi-Racial or Others accounted for 7.2% of the homeless population.

Sub-populations

In Service Area 7, 34.5% of the homeless population reported that they had a mental illness; 40.6% of homeless individuals reported they were substance abusers; and 14.8% reported they were victims of domestic violence.

Service Area 8: South Bay

Age Groups

In Service Area 8, annual homeless estimates for 2007 indicated that the 25-55 Age Group constituted a majority (63.2%) of the homeless population. This was followed by the Under 18 Age Group at 16.0%, the 56+ Age Group at 12.6%, and the 18-24 Age Group at 8.2%.

Ethnicity

Within Service Area 8, Black/African-Americans accounted for a majority of the homeless population (56.2%). Hispanic or Latinos accounted for 16.7%; Whites, 20.5%; and Multi-Racial or Others accounted for 6.6% of the homeless population.

Sub-populations

In Service Area 8, 18.5% of the homeless population reported that they had a mental illness; 34.3% of homeless individuals reported they were substance abusers; and 5.4% reported they were victims of domestic violence.

INDICATORS FOR CHILDREN/YOUTH AT RISK FOR SCHOOL FAILURE

4-year Dropout Rate

Description of Indicator

California Department of Education High School Dropout Rates as reported by Los Angeles County educational agencies for the 2006-07 academic year by ethnicity.

The 4-year derived dropout rate is an estimate of the percent of students who would drop out in a four-year period based on data collected for a single year.

"What criteria is used to define a dropout? In October, 2003, the California Department of Education (CDE) adopted the National Center for Educational Statistics (NCES) Dropout definition. Following the new guidelines, the CDE now defines a dropout as a person who: 1. Was enrolled in grades 7, 8, 9, 10, 11 or 12 at some time during the previous

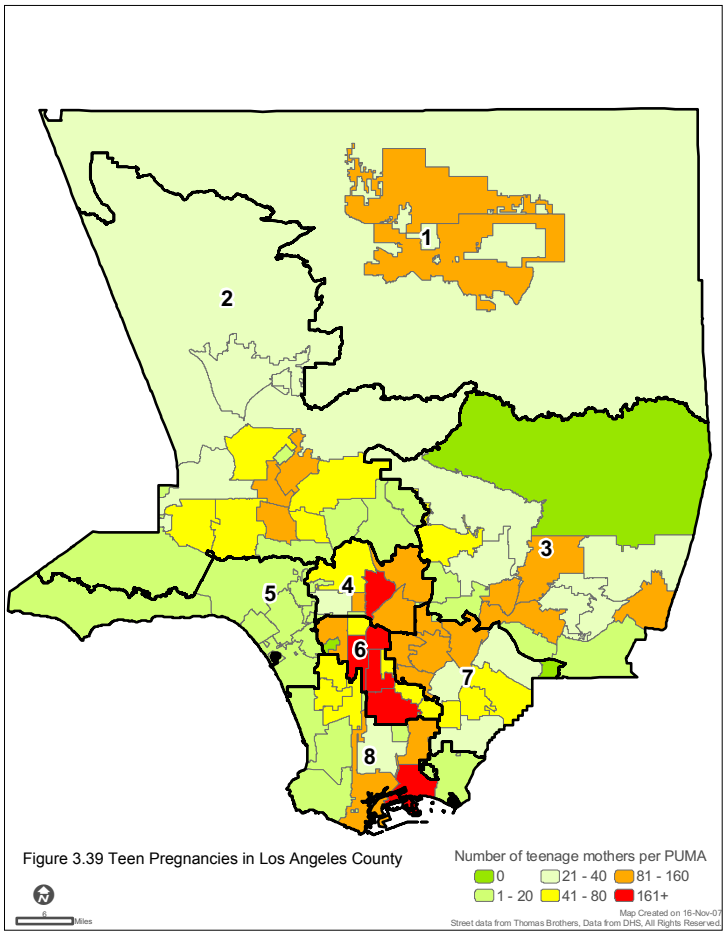

Figure 3.39 Teen Pregnancies in Los Angeles County

As shown in the Figure 3.39, teen pregnancy is most prevalent in parts of Service Area 4, throughout Service Area 6, and in the Southeastern part of Service Area 8 (i.e. Long Beach S.). The lowest rates were found in Service Area 5.

Teen mothers are less likely to complete the education necessary to qualify for a well-paying job —only 40 percent of mothers who have children before age 18 ever graduate from high school compared with about three-quarters of similarly situated young women who delay childbearing until age 20 or 21.5 Furthermore, less than two percent of mothers who have children before age 18 complete college by the age of 30 compared to nine percent of young women who wait until age 20 or 21 to have children. This disparity in education, not surprisingly, tends to affect income level. In fact, over the past 20 years the median income for college graduates has increased 19 percent while the median income for high school dropouts has decreased 28 percent.

Why it Matters, National Campaign to Prevent Teenage Pregnancy
www.teenpregnancy.org

school year AND left school prior to completing the school year AND has not returned to school as of Information Day OR 2. Did not begin attending the next grade (7, 8, 9, 10, 11 or 12) in the school to which they were assigned or in which they had preregistered or were expected to attend by Information Day." (CDE, 2008)

What the Numbers Show

State figures indicated that over a quarter of all students in Los Angeles County drop out of high school over a four-year period. Examining ethnic categories indicated that African-American students were most at risk for not finishing high school, followed by Pacific Islander, American Indian/Alaska Native, and Hispanic or Latino Students. 15.5% of White students drop out of high school. Two ethnic groups had dropout rates below this: Asian, 7.4% and Filipino, 12.8%.

Table 3.31
Four-year Dropout Rates for 2006-07

Ethnicities	Rate[1]
American Indian/Alaska Native	36.1
Asian	7.4
Pacific Islander	37.6
Filipino	12.8
Hispanic or Latino	32.1
African American (not Hispanic)	42.3
White	15.5
Multiple/No Response	37.7

1. Adjusted Grade 9-12 Four-year Derived Dropout Rate %

High School Graduation Rates

Description of Indicator

High School Graduation Rates are calculated for each neighborhood by the following formula: Graduation Rate = Number of high school seniors who graduated/number of students enrolled in their senior year of high school. Numbers are reported for the 2004-05 academic year.

The 4-year Derived Rate Formula:

(1-((1-(Reported or Adjusted Gr. 9 Dropouts/Gr. 9 Enrollment))*(1-(Reported or Adjusted Gr. 10 Dropouts/Gr. 10 Enrollment))*(1-(Reported or Adjusted Gr. 11 Dropouts/Gr. 11 Enrollment))*(1-(Reported or Adjusted Gr. 12 Dropouts/Gr. 12 Enrollment))))*100

Overall, these figures indicated that over a quarter of all students drop out from high school over a four-year period. Examining ethnic categories indicated that African-American students were most at risk for not finishing high school, followed by Pacific Islander, American Indian/Alaska Native, and Hispanic or Latino Students. 15.5% of White students drop out of high school. Two ethnic groups had dropout rates below this: Asian, 7.4% and Filipino, 12.8%.

Research Base and Relevance to PEI

This measure is an indication of the numbers of adolescents who succeed in graduating and, conversely, the numbers of those who did not. The indicator only reports on the senior year and does not take into consideration those children who dropped out of school at some earlier year. An absolute measure of total dropouts is difficult to ob-

Table 3.32
Countywide Summary: High School Graduation Rates

Service Area	Am Ind or Alaska	Asian	Pac Isl	Filip	Hisp	Afr Am	White	Mult/ No Resp	Total
1	89.4	98.2	93.8	96.4	86.3	80.6	93.9	100.0	89.1
2	77.6	93.5	78.3	90.6	69.1	68.7	87.6	75.5	77.9
3	66.1	97.0	76.0	96.0	81.0	75.3	91.2	88.9	86.8
4	39.1	75.5	56.0	79.3	56.7	50.7	72.9	93.8	59.4
5	48.1	89.2	75.9	89.8	64.7	69.8	90.6	88.2	75.7
6	66.7	79.7	62.4	84.6	56.1	51.8	80.0	95.4	55.7
7	85.6	97.4	91.5	96.2	81.7	83.5	93.9	82.4	84.8
8	84.3	92.3	71.8	88.1	70.3	67.9	92.4	79.8	77.9
Total	70.8	93.9	75.9	90.3	70.9	65.4	89.6	84.0	77.0

61-70
50-60
< 50

tain since it requires at least a cross-district analysis on all children who may leave a school, move out of district, re-emerge, and so forth. In spite of its imperfections, graduation rates are a good indicator of where school failures are occurring within the county.

What the Numbers Show

Across the county, African-Americans had the lowest high school graduation rates reported: 65.4%. This was followed by American Indians or Alaskan Natives at 70.8%; Hispanics, 70.9%; Pacific Islanders, 75.9%; Whites, 89.6%; Filipinos, 70.9%; and Asians, 93.9%. When comparing service areas, one can see that Service Areas 4 and 6 had graduation rates below 60% -- about 4 out of every 10 children in those areas do not graduate. Looking within the services areas yielded two American Indian or Alaskan Native populations in Service Areas 4 and 5 whose high school graduation rates were below 50% -- less than one out of every two children. The following service area tables provide more detailed information on where education problems are occurring at very high rates.

Service Area Communities

Service Area 1: Antelope Valley

Across the county, the Antelope Valley had the highest graduation rate of all service areas, 89.1%. No population saw graduation rates below 50%. The American Indian/Alaskan Native population in the Palmdale area had the lowest graduation rate in the area, 66.7%.

Service Area 2: San Fernando

Across the service area, two ethnic groups, African-Americans and Hispanic students, had the lowest graduation rates seen with both under 70%. Examining the service

Table 3.33
Service Area Communities: High School Graduation Rates

Service Area 1	American Indian or Alaska Native	Asian	Pacific Islander	Filipino	Hispanic	African-American	White	Multiple or No Response	Total
Lancaster	88.9	97.9	100.0	94.6	81.3	74.9	92.2		86.0
Palmdale	66.7	96.6	87.5	97.5	89.2	86.8	92.9	100.0	90.0
North County E.	100.0	100.0	100.0	97.4	88.4	84.7	98.6	100.0	94.0
Service Area 2									
Santa Clarita	86.4	97.2	91.7	94.0	71.1	65.1	89.5	44.4	83.2
Burbank	42.9	86.0	100.0	88.1	42.2	53.7	73.4	53.9	57.7
Glendale		94.3	100.0	97.2	84.6	90.5	91.1	100.0	90.5
Northridge	83.3	92.0	75.0	100.0	71.2	77.0	87.3		80.0
Granada Hills	77.8	98.6	60.0	92.2	78.1	72.5	89.7	100.0	83.2
Pacoima-Arleta	66.7	100.0		75.0	77.3	64.3	71.4		77.1
La Tuna Cyn.	33.3	88.0	100.0	95.1	71.9	61.0	77.7		73.8
Panorama City	100.0	84.0	100.0	80.0	59.9	52.5	73.5		62.9
North Hollywood		85.3	60.0	92.3	64.3	44.8	70.9		66.0
Sherman Oaks		90.8	71.4	88.9	56.3	66.2	77.9		66.4
Encino	100.0	95.6	71.4	87.6	78.2	84.8	87.4		82.7
Woodland Hills	66.7	93.6	80.0	84.9	70.3	69.2	87.5		79.5
Brentwood N.	100.0	90.4		81.8	78.7	74.4	83.9		81.3
North County W.	100.0	100.0	100.0	97.4	88.4	84.7	98.6	100.0	93.8
La Canada-Flintridge	50.0	87.6	7.7	82.8	42.5	33.8	89.6	54.5	66.3
San Fernando-Calabasas-Agoura	100.0	100.0	100.0	100.0	84.7	85.7	98.4	80.0	97.4
Service Area 3									
Pasadena	42.9	99.3	100.0	93.8	72.6	69.0	94.0	100.0	79.8
El Monte	66.7	93.4	100.0	100.0	86.4	80.0	64.2		86.7
Pomona	80.0	96.2	81.8	100.0	77.5	84.4	88.4	96.2	81.1
West Covina		100.0	100.0	100.0	98.5	100.0	99.0	100.0	99.0
Altadena-Monrovia-Sierra Madre	50.0	87.6	7.7	82.8	42.5	33.8	89.6	54.5	66.3
Alhambra-S. Pasadena	66.7	95.7	77.8	92.3	76.2	71.0	66.5	58.5	84.4
Arcadia-San Gabriel-Temple City-San Marino	100.0	98.0	50.0	100.0	88.9	96.6	96.0	100.0	96.0
Baldwin Park-Azusa-Duarte	42.9	79.3	100.0	87.2	67.7	72.4	76.0	72.5	70.2
Glendora-Claremont-San Dimas-La Verne	66.7	97.9	88.9	97.0	90.6	88.7	95.7	97.1	94.2
Covina-Walnut	66.7	99.3	80.0	98.2	93.8	78.3	93.4	84.6	94.1
Diamond Bar	100.0	99.6	100.0	100.0	94.7	96.9	99.6	100.0	98.5
La Puente-S. El Monte	100.0	86.5	75.0	86.4	79.6	79.3	73.3	100.0	79.8
Hacienda Heights	87.5	98.8	81.8	100.0	96.0	90.0	98.5	80.0	96.7
Monterey Park-Rosemead	100.0	98.1	100.0	100.0	80.2	82.5	100.0	100.0	88.6

Service Area 4	American Indian or Alaska Native	Asian	Pacific Islander	Filipino	Hispanic	African-American	White	Multiple or No Response	Total
Wilshire La Brea E.		58.2	50.0	92.6	50.5	58.9	84.5		55.4
Hollywood	50.0	72.1		89.3	71.5	71.8	80.6		73.4
Pico Heights			100.0		95.5	94.1	100.0	100.0	95.4
Echo Park	57.1	74.1	85.7	72.3	54.7	57.2	79.6		59.1
Highland Park	66.7	91.7	66.7	88.7	69.5	74.0	80.6		73.0
Downtown	25.0	63.7	27.3	70.0	44.1	20.7	45.4		42.5
USC N.		75.0			73.4	55.6	0.0		68.8
West Adams		75.8		66.7	51.9	55.7	77.8		56.6
West Hollywood		98.3	87.5	95.5	84.2	82.4	97.6	90.0	92.3
Service Area 5									
Brentwood S.	100.0	90.4		81.8	78.7	74.4	83.9		81.3
West LA		76.1	100.0	66.7	52.3	57.5	67.0		58.6
Wilshire La Brea W.		58.2		92.6	50.5	58.9	84.5		55.4
Baldwin Hills W.	100.0	75.8	66.7	66.7	51.9	55.7	77.8		56.6
Playa Vista	41.7	88.9	50.0	90.9	62.6	71.5	75.2		68.3
Santa Monica-Culver City-Beverly Hills		98.3	87.5	95.5	84.2	82.4	97.6	90.0	92.3
Malibu		100.0	100.0	100.0	84.7	85.7	98.4	80.0	97.4
Service Area 6									
USC S.	100.0	75.0			73.4	55.6	20.0		68.8
Baldwin Hills S.	62.5	75.8	66.7	66.7	51.9	55.7	77.8		56.6
Hancock N.	25.0	100.0		100.0	71.5	44.8			63.5
USC E.	100.0	25.0			52.9	20.4			48.8
Watts		100.0			37.6	30.9	33.3		35.8
Florence-Firestone		62.5			50.0	15.4	16.7		49.6
Lynwood			22.2		67.7	73.0	66.7		67.8
Paramount	100.0	86.2	83.3	93.8	82.4	75.6	81.7	95.7	81.9
Compton	100.0	100.0	64.3	100.0	65.7	66.1	100.0		66.1

area's composite communities indicated that the Burbank area had the lowest overall graduation rate in the service area, 57.7%. Additionally, several ethnic groups had especially low rates in particular communities. For example, Hispanic students in the Burbank and La Canada-Flintridge areas were more likely to drop out than graduate. African-American students in the North Hollywood area and La Canada-Flintridge areas were similarly at risk for not graduating. American Indians/Alaskan Natives in the Burbank and La Tuna Cyn. areas were also more likely to not graduate than graduate from high school.

Table 3.33 continued
Service Area Communities: High School Graduation Rates

Service Area 7	American Indian or Alaska Native	Asian	Pacific Islander	Filipino	Hispanic	African-American	White	Multiple or No Response	Total
East LA	100.0	50.0		50.0	79.8	50.0	66.7		79.5
Downey	85.7	97.2	100.0	80.8	76.7	72.3	89.4	44.4	79.1
Norwalk	66.7	96.8	100.0	100.0	89.8	93.3	91.7	100.0	91.0
Whittier	87.5	98.8	81.8	100.0	96.0	90.0	98.5	80.0	96.7
Montebello	100.0	98.8	100.0	94.4	97.3	100.0	96.8	100.0	97.4
Bell Gardens-Bell-Maywood-Cudahy-Commerce	100.0	100.0			75.9	100.0	69.2		76.1
Huntington Park		62.5			50.0	15.4	16.7		49.6
South Gate			22.2		67.7	73.0	66.7		67.8
Bellflower	100.0	86.2	83.3	93.8	82.4	75.6	81.7	95.7	81.9
La Mirada-Santa Fe Springs	66.7	94.6	100.0	100.0	87.5	80.0	94.5	50.0	89.4
Lakewood-Cerritos-Artesia-Hawaiian Gardens	100.0	97.6	93.5	97.2	91.7	93.3	96.0	97.1	94.7
Signal Hill		100.0		93.3	89.3	100.0	99.3		98.6
Service Area 8									
Hancock S.									0.0
Wilmington	87.5	83.1	56.8	79.3	65.4	56.1	76.8		66.3
Inglewood		100.0	100.0	100.0	97.7	95.1	75.0		96.6
Torrance	100.0	99.7	100.0	100.0	99.4	98.8	99.1	100.0	99.4
Long Beach N.	25.0	64.9	60.3	61.8	51.9	60.2	50.3	50.0	55.3
Long Beach S.	100.0	83.4	76.8	94.8	73.4	81.6	91.1		80.4
Long Beach E.	75.0	93.3	88.9	88.3	80.9	82.3	95.1		87.3
Carson	100.0	96.6	75.8	87.7	71.4	71.6	71.9		77.2
Palos Verdes-Lomita		100.0	50.0	93.3	89.3	100.0	99.3	100.0	98.6
Redondo-Manhattan-Hermosa-El Segundo	100.0	97.9	90.0	100.0	95.7	91.5	97.1	93.9	98.5
Gardena-Lawndale	85.7	79.8	79.3	73.3	57.2	53.0	56.4	58.8	56.7
Hawthorne		70.0	55.6	80.0	67.6	62.2	62.5	16.7	66.0

61-70
50-60
< 50

Service Area 3: San Gabriel

The San Gabriel Valley had the second highest graduation rate in the county, 86.8%. Across the service area, the Altadena-Monrovia-Sierra Madre aggregate had the lowest overall graduation rate of all communities, 66.3%. Three ethnic groups had very low graduation rates within this community: Pacific Islanders, Hispanics, and African-Americans. Overall, across service area ethnic groups, American Indian or Alaskan Natives had the lowest graduation rate (66.1%). In two communities, the Pasadena and Baldwin Park-Azusa-Duarte areas, this figure was less than 50%, or less than one out of every two students.

Service Area 4: Metro

Service Area 4 had the lowest graduation rates across all ethnic groups within the county without exception. Overall, 59.4% of students graduated with communities ranging from a low of 42.5% in the Downtown area to a high of 95.4% in the Pico Heights area. Ethnic groups within the Downtown area were particularly at risk. African-American students, for example, graduated at a rate of 20.7%, or about one out of every five students. For American Indian or Alaskan Native and Pacific Islander students, this rate was about one out of four. Similarly, Hispanic and White students in the Downtown area were more likely to drop out than graduate.

Service Area 5: West

Service Area 5 had an overall high school graduation rate of 75.7%, which indicated that about one out of four students fails to graduate. Within the service area only one ethnic group had a graduation rate lower than 50%: American Indians or Alaskan Natives (48.1%). Half of the service area communities had fairly high graduation rates (Brentwood S., Santa Monica-Culver City-Beverly Hills, and Malibu), while the other half had fairly low rates (West LA, Wilshire La Brea W., and Baldwin Hills W.) Almost all students graduate from the Malibu area, while about half of all students graduate from the higher-risk areas.

Service Area 6: South

Across the county, Service Area 6 had the lowest graduation rate, 55.7%, or slightly more than half of all students. Four communities within the service area had overall graduation rates below 50%, indicating that less than half of all students in the area graduate. The most at-risk community, Watts, had a 35.8% graduation rate, the lowest in the county. Hispanic and African-American students were particularly at risk for not graduating. In the Watts area, for example, the graduation rate for Hispanic students was 37.6%; in the Florence-Firestone area, the graduation rate for African-Americans was 15.4%, or fewer than two students out of ten.

Service Area 7: East

Service Area 7 had an overall high school graduation rate of 84.8% and saw no one ethnic group below the 80th percentile. However, one community within the service area had a graduation rate lower than 50%: the Huntington Park area (49.6%). Looking within this area revealed that students of all ethnicities found it difficult to succeed in graduating. Hispanic students, for example, graduated there at a rate of 50%, meaning that one out two students did not graduate. African-American students graduated there at a rate of 15.4%, and Whites at 16.7%.

Service Area 8: South Bay

Service Area 8 had an overall graduation rate of 77.9%, which was close to the countywide rate of 77%. Only one ethnic group held a graduation rate that was below 70%: African-American students at 65.4%. Within the service area, the highest risk areas appeared to be the Long Beach N. area (55.3%) and the Gardena-Lawndale area (56.7%). In both of these communities, four of ten students do not graduate. In the Long Beach N. area, White and Hispanic students had graduation rates that were

close to 50%, or one out of two students. The American Indian or Alaskan Native graduation rate was very low in the area, but must be interpreted with caution as the numbers of those students was relatively small. In the Gardena-Lawndale area, Hispanic, African-American, and White students all had low graduation rates between 50-60%.

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English Fluency

Description of Indicator

This indicator is a measure of an individual's self-reported difficulty in speaking English on the ACS. Fluency problems were counted when an individual claimed they spoke English "Not well" or "Not at all." Numbers are reported as percentages of the population within a neighborhood.

Research Base and Relevance to PEI

English fluency is a predictor of school failure. Children who are from non-English-language backgrounds may be more than 1.5 times likely to leave school than those with an English language background. It should be noted that when considering an individual's risk in dropping out of school, multiple risk factors have a better predictive ability than just one indicator. (Purcell, 2003).

What the Numbers Show

Across the county, the overall fluency rate for all students was 68.3% and suggested that a large number of children are at risk for school failure as a result of a language barrier. Service Area 6 had the lowest fluency rate in the county at 52.7% and Service Area 4 was close to this figure at 54.3%. In fact, these two service areas held the lowest high school graduation rates in the county as mentioned above.

Table 3.34

Countywide Summary: Fluency Rate

Service Area	Fluency Rate
1	81.3
2	70.2
3	74.2
4	54.3
5	80.2
6	52.7
7	68.0
8	75.8
Countywide	68.3

61-70
50-60
< 50

Service Area Communities

Service Area 1: Antelope Valley

Across the county, Service Area 1 had the highest fluency rate, 81.3%, within its school population. Examining the composite communities indicated that all communities had a fluency rate that exceeded the county average of 68.7%. Only the Palmdale area (76.5) had a fluency rate below 80%.

Service Area 2: San Fernando

Service Area 2 had an overall fluency rate of 70.2% within its student population, slightly above the county average of 68.3%. Two communities, the Pacoima-Arleta area (49.6%) and the Panorama City area (42.5%) dipped below 50% indicating that one of two students had difficulty with speaking English. Spanish was the most common primary

language spoken at home in both of these communities.

Service Area 3: San Gabriel

Service Area 3 had an overall fluency rate of 74.2% in its student population, which was above the countywide figure of 68.3%. Although two communities, the El Monte area (57.6%) and the Pomona area (53.3%), had relatively low fluency rates, this did not appear to impact the high school graduation rates noted above, which were relatively high. A majority of residents in the these two areas spoke Spanish as their primary language.

Service Area 4: Metro

Service Area 4 had a fluency rate of 54.3% in its student population, which was the second lowest figure in the county. As mentioned above, Service Area 4 also had the second lowest graduation rate among the county service areas. Examining the composite communities does not always yield a simple one-to-one correspondence between English Fluency and graduation rate. Consider the Pico Heights area, for example, which held the *lowest* fluency rate in the service area at 36.8% but also held one of the *highest* graduation rates in service area. In a similar vein, the West Adams area, which held one of the *highest* fluency rates in the Service at 74.5%, also held one of the *lowest* graduation rates in the service area. These figures suggested that variables other than fluency, such as Ethnicity, Poverty, School Quality, etc., are associated with graduation rates in complex ways.

Service Area 5: West

Next to Service Area 1, Service Area 5 had the highest fluency rate in the county, 80.2%. Only one area, Wilshire La Brea W. (61.4%), saw its fluency rate dip below 70%. This area also had the lowest high school graduation rate in the service area. In fact, the areas with the three lowest fluency rates, West LA, Wilshire La Brea W., and Baldwin Hills W., also had the three lowest graduation rates in the service area.

Service Area 6: South

Across the county, Service Area 6 had the lowest English Fluency (52.7%) rate in its student population across the service areas. It was also the service area with the lowest high school graduation rate, as identified above. English Fluency in the USC E., Florence-Firestone, and Compton areas was below 50%. These areas had correspondingly low high school graduation rates. This was especially true in the USC E. and Florence-Firestone areas , and to a lesser degree in the Compton area.

Service Area 7: East

Service Area 7 had an English Fluency rate of 68% in its student population, which was nearly identical to the countywide rate of 68.3% The Huntington Park area (45.9%) and the South Gate area (55.6%) had low English Fluency rates and, as mentioned above, the two lowest high school graduation rates in the service area. The aggregate community of Bell Gardens-Bell-Maywood-Cudahy-Commerce also had a low English Fluency rate, but a moderate high school graduation rate. All three of these communities have very large numbers of individuals whose primary language is Spanish, (i.e., greater than 75% of the population).

Table 3.35
Service Area Communities: Fluency Rate

	Enrollment	English Learners	English Speakers	Fluency Rate
Service Area 1				
Lancaster	31039	4529	26510	85.4
Palmdale	35431	8326	27105	76.5
North County E.	17977	2906	15071	83.8
Total	84447	15761	68686	81.3
Service Area 2				
Santa Clarita	36064	4190	31874	88.4
Burbank	16648	2459	14189	85.2
Glendale	21918	6573	15345	70.0
Northridge	24252	5267	18985	78.3
Granada Hills	27865	7132	20733	74.4
Pacoima-Arleta	21963	11078	10885	49.6
La Tuna Cyn.	24022	10017	14005	58.3
Panorama City	19976	11486	8490	42.5
North Hollywood	15143	6785	8358	55.2
Sherman Oaks	23764	10632	13132	55.3
Encino	30357	8928	21429	70.6
Woodland Hills	23202	6302	16900	72.8
Brentwood N.	7493	1003	6489	86.6
North County W.	13152	2126	11026	83.8
La Canada-Flintridge	5357	855	4502	84.0
San Fernando-Calabasas-Agoura	17115	3051	14064	82.2
Total	328291	97884	230407	70.2
Service Area 3				
Pasadena	19104	3738	15366	80.4
El Monte	24722	10479	14243	57.6
Pomona	31462	14696	16766	53.3
West Covina	15573	2020	13553	87.0
Altadena-Monrovia-Sierra Madre	14249	2273	11976	84.0
Alhambra-S. Pasadena	18150	5282	12868	70.9
Arcadia-San Gabriel-Temple City-San Marino	29596	6179	23417	79.1
Baldwin Park-Azusa-Duarte	33602	11107	22495	66.9
Glendora-Claremont-San Dimas-La Verne	29331	1385	27946	95.3
Covina-Walnut	29667	5090	24577	82.8
Diamond Bar	18801	2789	16012	85.2
La Puente-S. El Monte	24066	8559	15507	64.4
Hacienda Heights	9291	1769	7522	81.0
Monterey Park-Rosemead	17576	5870	11706	66.6
Other	176	28	147	83.8
Total	315191	81237	233954	74.2

	Enrollment	English Learners	English Speakers	Fluency Rate
Service Area 4				
Wilshire La Brea E.	15473	5966	9506	61.4
Hollywood	21898	10673	11225	51.3
Pico Heights	16793	10605	6188	36.8
Echo Park	31202	14806	16396	52.5
Highland Park	39552	15020	24532	62.0
Downtown	34919	17434	17485	50.1
USC N.	3765	1833	1932	51.3
West Adams	1300	332	968	74.5
West Hollywood	3953	503	3450	87.3
Other	400	214	186	46.4
Total	168855	77172	91682	54.3
Service Area 5				
Brentwood S.	6754	905	5850	86.6
West LA	17292	4596	12696	73.4
Wilshire La Brea W.	2818	1087	1732	61.4
Baldwin Hills W.	1997	510	1488	74.5
Playa Vista	14683	2952	11731	79.9
Santa Monica-Culver City-Beverly Hills	19006	2420	16586	87.3
Malibu	3513	626	2887	82.2
Other	53	15	39	72.5
Total	66064	13095	52968	80.2
Service Area 6				
USC S.	12722	6193	6529	51.3
Baldwin Hills S.	19243	4911	14331	74.5
Hancock N.	23732	10722	13011	54.8
USC E.	26590	16960	9630	36.2
Watts	34802	16705	18097	52.0
Florence-Firestone	12082	6540	5541	45.9
Lynwood	17487	7761	9726	55.6
Paramount	9671	3667	6004	62.1
Compton	33790	16916	16874	49.9
Other	1213	154	1058	87.3
Total	191332	90530	100801	52.7

Table 3.35 continued

Service Area Communities: Fluency Rate

	Enrollment	English Learners	English Speakers	Fluency Rate
Service Area 7				
East LA	23188	12425	10763	46.4
Downey	29297	7043	22254	76.0
Norwalk	18826	4450	14376	76.4
Whittier	19921	3792	16129	81.0
Montebello	29653	9025	20628	69.6
Bell Gardens-Bell-Maywood-Cudahy-Commerce	32504	16427	16077	49.5
Huntington Park	21043	11392	9652	45.9
South Gate	23217	10304	12913	55.6
Bellflower	12761	4839	7922	62.1
La Mirada-Santa Fe Springs	28429	4150	24279	85.4
Lakewood-Cerritos-Artesia-Hawaiian Gardens	38884	5624	33260	85.5
Signal Hill	1905	234	1671	87.7
Other	1156	277	879	76.0
Total	280784	89982	190802	68.0
Service Area 8				
Hancock S.	1389	627	761	54.8
Wilmington	31664	9177	22487	71.0
Inglewood	18838	5185	13652	72.5
Torrance	25428	3304	22124	87.0
Long Beach N.	23599	6500	17099	72.5
Long Beach S.	29093	10472	18621	64.0
Long Beach E.	28881	3755	25126	87.0
Carson	19110	3462	15648	81.9
Palos Verdes-Lomita	18674	2297	16377	87.7
Redondo-Manhattan-Hermosa-El Segundo	18665	993	17672	94.7
Gardena-Lawndale	30449	9308	21141	69.4
Hawthorne	22000	9667	12333	56.1
Other	1079	349	730	67.6
Total	268868	65097	203772	75.8
County Total	3140052	996935	2143116	68.3

61-70
50-60
< 50

Service Area 8: South Bay

Service Area 8 had an English Fluency rate of 75.8% which was above the countywide rate, 68.3%. The Hancock area (54.8%) and the Hawthorne area (56.1%) had the two lowest English Fluency rates in the service area. The Hawthorne and Hancock S. areas had graduation rates on the lower end in the service area, but were not the most extreme in this regard.

3rd Grade Reading Level

Description of Indicator

This indicator reports the percent of public school students reading at or above the 50th percentile in the 3rd grade.

Research Base and Relevance to PEI

Research shows that early abilities and academic skills can be used to predict school failure in later years (Lloyd, 1978; Alexander,

Entwisle, Horsey, 1997). 3rd grade reading level routinely assessed by standardized tests can be used with other risk factors to identify children at risk for dropping out of school. Early identification is a key component in any prevention program. Neighborhoods with a majority of children failing to read at the 50% percentile are at risk for school problems in the future.

What the Numbers Show

Overall, 22.4% of third graders tested in Los Angeles County scored at or above the 50th percentile in standardized reading tests. All ethnic minority groups (with the exception of Other Asians and Chinese students) were well below 50%. Filipino (13.4%) and Vietnamese (15.6%) students had the most difficulty with reading tests, followed by African-American (23.5%) and Latino (21.7%) students. Only White students and other Asians had the majority of their population scoring at or above the 50th percentile.

Service Area Communities

Service Area 1: Antelope Valley

Overall, Service Area 1 saw 32.7% of its third graders score at or above the 50th percentile in a standardized reading test. This figure was above the countywide figure of 22.4%. For the three ethnic groups for whom we do have data in this area (we do not have complete data for this indicator for Asian populations), African-American students had the lowest reading scores (17.9%), followed by Latino students (25.9%) and White students (53.5%). The overall high school graduation rates in the Antelope Valley mirror these reading scores with African-Americans having the lowest rate, followed by Hispanic students, and then White students.

Service Area 2: San Fernando

Overall, 35.9% of Service Area 2 third graders were reading at or above the 50th percentile. This mark was still higher than the countywide figure of 22.4%. The Panorama City area (18.4%), followed closely by the Pacoima-Arleta area (18.9%), had the lowest reading rates in the service area. This appeared to be associated with the language barrier identified above. Both areas had the lowest English Fluency rates in the service area, as well. Although third grade is a long way from high school graduation, these data indicated that the Panorama City area, with the lowest reading scores in third grade, also had the lowest high school graduation rate in the service area.

Service Area 3: San Gabriel

Overall, 36.5% of Service Area 3 third graders scored at or above the 50th percentile in standardized reading tests. The two lowest scores were found in the El Monte area (23.9%) and the Pomona area (20.8%) where English Fluency was low. Across ethnic groups, 13.9% of African-American students scored at or above the 50th percentile (and this was the lowest score for African-American students across all service areas). Filipino (9.0%), Korean (9.6%), and Vietnamese (16.4%) student reading scores were very low in the third grade. Over 50% of White and Chinese third graders scored above the 50th percentile in reading. Examining high school graduation rates for Asian groups (though aggregated differently from the third grade data) appeared to be quite high. (This may either be due to these groups over-

Table 3.36

3rd Grade Reading Level

Service Area 1	African-Am	Filipino	Latino	White	Chinese	Japanese	Korean	Vietnamese	Other Asian	Total
Lancaster	16.7		25.3	46.0						29.2
Palmdale	22.5		23.9	43.6						29.4
North County E.	13.8	8.9	28.4	58.8			8.8			45.5
Total	17.9	8.9	25.9	53.5			8.8			32.7
Service Area 2										
Santa Clarita	10.7		33.4	63.6			17.7			52.1
Burbank		11.7	24.9	50.5			17.1			41.3
Glendale		27.3	32.3	42.1			45.3			41.8
Northridge	9.3		25.4	58.4	35.5		51.9			44.2
Granada Hills	12.9		28.0	41.5			23.0			34.6
Pacoima-Arleta	10.3	27.9	17.1	41.3						18.9
La Tuna Cyn.	3.8		19.1	34.5						23.4
Panorama City		12.8	15.9	30.8						18.4
North Hollywood	7.4		19.0	37.5						23.1
Sherman Oaks	16.9		19.1	40.7						23.7
Encino		11.1	31.1	53.3						40.6
Woodland Hills	7.2		19.2	57.2						38.7
Brentwood N.	28.9		31.9	65.4			40.0			54.8
North County W.	13.8	8.9	28.4	58.8			8.8			45.5
La Canada-Flintridge	21.5		25.7	66.0	31.6		45.7			47.5
San Fernando-Calabasas-Agoura			16.3	69.7						51.0
Total	17.4	15.0	23.4	58.4	32.3		36.8			35.9
Service Area 3										
Pasadena	20.9		23.6	51.2						31.4
El Monte			20.3		15.3			13.4		23.9
Pomona	16.0		19.2	17.9					14.1	20.8
West Covina		19.8	34.5	42.6	16.1					38.3
Altadena-Monrovia-Sierra Madre	21.5		25.7	66.0	31.6		45.7			47.5
Alhambra-S. Pasadena			29.5	56.3	43.1		36.0	29.4	9.4	44.5
Arcadia-San Gabriel-Temple City-San Marino			33.2	65.4	63.8			12.9	16.7	58.8
Baldwin Park-Azusa-Duarte	22.6		22.9	5.7						24.4
Glendora-Claremont-San Dimas-La Verne	4.2		40.5	63.0						54.9
Covina-Walnut		13.2	24.6	37.9	62.6					36.9
Diamond Bar	13.8		32.0	45.9	58.7		30.1		58.2	52.5
La Puente-S. El Monte			23.6							24.3
Hacienda Heights			28.9	37.5	59.6					37.4
Monterey Park-Rosemead			26.2		39.5			15.6	39.8	33.8
Other	13.8	8.9	28.4	58.8			8.8			45.5
Total	13.9	9.0	28.1	58.6	52.4		9.6	16.4	38.7	36.5

Service Area 4	African-Am	Filipino	Latino	White	Chinese	Japanese	Korean	Vietnamese	Other Asian	Total
Wilshire La Brea E.	21.7		21.4	58.6			47.7			32.2
Hollywood	3.2	8.7	19.7	49.1			24.9			26.6
Pico Heights		35.8	18.1				48.9			23.1
Echo Park		20.7	14.3	25.4	44.4					17.5
Highland Park		23.6	23.0	41.7	8.9					25.7
Downtown			15.0		30.0					16.4
USC N.	19.0		17.8							18.5
West Adams	19.2		19.7							20.1
West Hollywood	28.3		29.8	64.1		38.8				50.6
Other			17.2							17.2
Total	20.4	19.9	17.7	62.0	22.7	38.8	45.4			23.3

Service Area 5	African-Am	Filipino	Latino	White	Chinese	Japanese	Korean	Vietnamese	Other Asian	Total
Brentwood S.	28.9		31.9	65.4			40.0			54.8
West LA	5.8		23.7	63.1	37.1	45.8				44.4
Wilshire La Brea W.	21.7		21.4	58.6			47.7			32.2
Baldwin Hills W.	19.2		19.7							20.1
Playa Vista	32.3		24.0	64.5						40.0
Santa Monica-Culver City-Beverly Hills	28.3		29.8	64.1		38.8				50.6
Malibu			16.3	69.7						51.0
Other	27.8		20.3							24.5
Total	27.5		20.3	67.0	37.1	40.7	47.2			45.6

Service Area 6	African-Am	Filipino	Latino	White	Chinese	Japanese	Korean	Vietnamese	Other Asian	Total
USC S.	19.0		17.8							18.5
Baldwin Hills S.	19.2		19.7							20.1
Hancock N.	14.7		14.6							14.7
USC E.	5.3		10.7							10.4
Watts	12.3		15.0							14.2
Florence-Firestone	6.1		15.4							15.3
Lynwood	9.8		18.6							19.0
Paramount	13.1		24.6	17.0						25.3
Compton	14.5		16.0							15.5
Other	28.3		29.8	64.1		38.8				50.6
Total	23.2		20.5	63.4		38.8				15.9

Table 3.36 continued

3rd Grade Reading Level

Service Area 7	African-Am	Filipino	Latino	White	Chinese	Japanese	Korean	Vietnamese	Other Asian	Total
East LA			17.2							17.2
Downey	3.2		33.0	35.4						34.1
Norwalk			22.2	10.8						24.4
Whittier			28.9	37.5	59.6					37.4
Montebello			26.8	9.9						27.3
Bell Gardens-Bell-Maywood-Cudahy-Commerce			19.4							19.6
Huntington Park	6.1		15.4							15.3
South Gate	9.8		18.6							19.0
Bellflower	13.1		24.6	17.0						25.3
La Mirada-Santa Fe Springs			29.9	50.1			20.9		42.6	34.9
Lakewood-Cerritos-Artesia-Hawaiian Gardens	23.4	15.8	28.9	44.9	45.7		43.2			42.8
Signal Hill	29.1	36.8	27.9	72.0	43.6	15.5	33.0			58.1
Other	13.8		28.3	45.9	47.0		30.1	15.6	53.0	42.3
Total	18.2	32.1	26.1	57.1	47.0	15.5	31.2	15.6	53.0	27.7
Service Area 8										
Hancock S.	14.7		14.6							14.7
Wilmington	15.5		24.6	47.2						29.4
Inglewood	27.8		20.3							24.5
Torrance		13.4	36.1	59.9		24.3	19.6		58.9	53.7
Long Beach N.	24.9	39.4	23.2	45.0						28.3
Long Beach S.	22.7	37.5	19.9						15.3	22.4
Long Beach E.	25.5		36.1	67.8						52.7
Carson	27.4	29.0	25.1							28.5
Palos Verdes-Lomita	29.1	36.8	27.9	72.0	43.6	15.5	33.0			58.1
Redondo-Manhattan-Hermosa-El Segundo	9.4		33.9	75.5						69.0
Gardena-Lawndale	15.2		21.4	13.9			50.4			22.5
Hawthorne	16.1		21.6	39.8						22.7
Other	18.2	15.8	21.2	44.9	45.7		43.2			28.5
Total	17.8	16.4	20.5	46.9	45.7	19.1	43.1		55.7	35.2
County Total	23.5	13.4	21.7	57.5	46.9	30.3	29.9	15.6	52.5	22.4

40-50
20-39
< 20

coming their language barrier or the impact of aggregating the lower performing Asian groups with the more populous and higher performing Chinese group.)

Service Area 4: Metro

Overall, 23.3% of third graders in Service Area 4 scored at or above the 50th percentile in reading. Only one community, the West Hollywood area (50.6%), had over 50% of its third graders scoring above the 50th percentile. This community also held the highest English Fluency rate and the highest high school graduation rate. All other communities had less that 40% of its third graders performing at or above the 50th percentile. The lowest performing community, the Downtown area (16.4%), also had the lowest high school graduation rate in the service area.

Service Area 5: West

Overall, 45.6% of third graders in Service Area 5 scored at or above the 50th percentile in reading, the highest percentage across service areas. The three lowest performing communities, the West LA area, Wilshire La Brea W. area, and the Baldwin Hills W. area, were areas with the lowest high school graduation rates in the service area. 67% of the White third graders in the service area scored at or above the 50th percentile, the highest score for this ethnic group across the other service areas.

Service Area 6: South

Overall, 15.9% of third graders in Service Area 6 scored at or above the 50th percentile in standardized reading tests. This was the lowest proportion of students failing to reach the 50th percentile across all service areas. Within the service area, the lowest reading scores were found in the USC E. area (10.4%), where about one in ten third graders were at or above the 50th percentile. Together, with the indicators listed above (e.g. service area 6 had the lowest high school graduation rate and the lowest English Fluency rate among the other service areas), Service Area 6 is clearly the most at-risk service area for school failure.

Service Area 7: East

Overall, 27.7% of third graders in Service Area 7 scored at or above the 50th percentile in standardized reading tests. In four communities, less than 20% (or less than one in five third graders) scored at or above the 50th percentile: the East LA area (17.2%), the aggregate of Bell Gardens-Bell-Maywood-Cudahy-Commerce (19.6%), the Huntington Park area (15.3%), and the South Gate area (19%). All four of these communities had the lowest English Fluency rates in the service area. The Huntington Park area, which had the lowest 3rd grade reading scores in the service area, also had the lowest high school graduation rate.

Service Area 8: South Bay

Overall, 35.2% of third graders in Service Area 8 scored at or above the 50th percentile in standardized reading tests, which was above the countywide rate of 22.4%. The Hancock S. area (14.7%) had the lowest reading scores and the lowest English Fluency rates in the service area (but not the lowest high school graduation rate).

INDICATORS FOR CHILDREN/YOUTH AT RISK OF OR EXPERIENCING JUVENILE JUSTICE INVOLVEMENT

School Discipline

Description of Indicator

School Discipline is measured by the numbers of youths suspended or expelled from school as a result of violent behavior or drug-related activities.

Research Base and Relevance to PEI

There is a strong link between disruptive classroom behaviors, school suspensions and expulsions with later criminal behaviors (Skiba & Peterson, 2000). And researchers suggest that early intervention of low-level disruptive behavior may prevent later delinquency. The social burden of crime committed by youth can be quantified in dollar amounts. For instance, in Pittsburg (with a population one-quarter of Los Angeles County's) it has been estimated to be between $89-100 million/year (Welsh, Loeber, Stevens, Stouthamer-Loeber, Cohen, & Farrington, 2008). Identifying where disciplinary actions occur may shed light on the neighborhood effect contributing to criminal behavior, though bear in mind that other factors likely influence these figures. Local educational practices and philosophies, for example, undoubtedly shape disciplinary standards.

Minorities and, in particular, African-Americans, are overrepresented in these disciplinary actions when other factors have been controlled. Youths entering the juvenile justice system are more likely to have mental health and behavior problems than youths who have never been arrested (Hirschfield,

Table 3.37

Countywide Summary: School Discipline

	Enroll	Susp	%[1]	Expul	%[2]
Service Area 1	82260	7326	8.9	518	0.6
Service Area 2	313430	8589	2.7	154	0.0
Service Area 3	293409	11130	3.8	640	0.2
Service Area 4	175741	4330	2.5	23	0.0
Service Area 5	67747	2027	3.0	18	0.0
Service Area 6	193463	9300	4.8	82	0.0
Service Area 7	272881	9575	3.5	532	0.2
Service Area 8	270382	9325	3.4	219	0.1
Total	1669313	61602	3.7	2185	0.1

1. Suspensions: 3-5%; 5-7%; > 7%

2. Expulsions: > 0.5

Table 3.38

Service Area Communities: School Discipline

Service Area 1	Enroll	Susp	%[1]	Expul	%[2]
Lancaster	31039	3456	11.1	265	0.9
Palmdale	35431	2523	7.1	174	0.5
North County E.	15790	1347	8.5	79	0.5
Total	82260	7326	8.9	518	0.6
Service Area 2					
Santa Clarita	17673	272	1.5	0	0.0
Burbank	15328	680	4.4	25	0.2
Glendale	21918	1003	4.6	15	0.1
Northridge	24398	511	2.1	2	0.0
Granada Hills	32056	747	2.3	10	0.0
Pacoima-Arleta	28064	615	2.2	8	0.0
La Tuna Cyn.	24776	441	1.8	0	0.0
Panorama City	20108	436	2.2	4	0.0
North Hollywood	15725	279	1.8	1	0.0
Sherman Oaks	24553	662	2.7	2	0.0
Encino	31129	686	2.2	6	0.0
Woodland Hills	24622	664	2.7	8	0.0
Brentwood N.	8935	134	1.5	1	0.0
North County W.	11554	985	8.5	58	0.5
La Canada-Flintridge	4123	159	3.8	11	0.3
San Fernando-Calabasas-Agoura	8468	315	3.7	4	0.0
Total	313430	8589	2.7	154	0.0

Maschi, White, Traub, & Loeber, 2006).

What the Numbers Show

Overall, 3.7% of students were suspended throughout the county and 0.1% were expelled from their school. Tables 3.37 and 3.38 highlight communities where suspensions and expulsions have occurred at a high rate. Across the county, Service Area 1 had the highest suspension and expulsion rate.

Service Area Communities

Service Area 1: Antelope Valley

Service Area 1 had the highest suspension rate seen across the county with 8.9% of its students excluded from school at some point in time during the year. The Lancaster area had the highest suspension rate in the county at 11.1%, or one out of ten students. Service Area 1 also had the highest expulsion rate throughout the county with 0.6% of its students permanently denied access to their school. In particular, the Lancaster area had the highest expulsion rate in the county with 0.9%, or about one out of one hundred students receiving this action.

Service Area 2: San Fernando

Service Area 2 had an overall suspension rate of 2.7, which was below the countywide rate of 3.7%. Only one community, the North County W. (8.5%), area saw a suspension rate above 5% -- this particular area was also marked by the highest expulsion rate for the service area, (0.5%, or one out of every two hundred students).

Service Area 3: San Gabriel

Service Area 3 had an overall suspension rate of 3.8%, which was close to the countywide

Table 3.38 continued

Service Area Communities: School Discipline

Service Area 3	Enroll	Susp	%[1]	Expul	%[2]
Pasadena	3556	130	3.7	6	0.2
El Monte	24722	799	3.2	15	0.1
Pomona	31372	1855	5.9	18	0.1
West Covina	15573	625	4.0	39	0.3
Altadena-Monrovia-Sierra Madre	10978	422	3.8	29	0.3
Alhambra-S. Pasadena	17617	630	3.6	90	0.5
Arcadia-San Gabriel-Temple City-San Marino	29596	761	2.6	62	0.2
Baldwin Park-Azusa-Duarte	31060	1201	3.9	67	0.2
Glendora-Claremont-San Dimas-La Verne	29331	1166	4.0	148	0.5
Covina-Walnut	29667	803	2.7	69	0.2
Diamond Bar	18803	433	2.3	12	0.1
La Puente-S. El Monte	24066	1182	4.9	31	0.1
Hacienda Heights	9289	359	3.9	13	0.1
Monterey Park-Rosemead	17613	750	4.3	41	0.2
Other	165	14	8.5	1	0.5
Total	293409	11130	3.8	640	0.2
Service Area 4					
Wilshire La Brea E.	16209	536	3.3	2	0.0
Hollywood	23914	724	3.0	2	0.0
Pico Heights	17790	697	3.9	0	0.0
Echo Park	32832	586	1.8	4	0.0
Highland Park	41840	978	2.3	9	0.0
Downtown	33334	563	1.7	4	0.0
USC N.	3961	64	1.6	0	0.0
West Adams	1446	81	5.6	0	0.0
West Hollywood	3991	91	2.3	2	0.1
Other	424	11	2.5	0	0.0
Total	175741	4330	2.5	23	0.0
Service Area 5					
Brentwood S.	8052	121	1.5	0	0.0
West LA	17986	461	2.6	3	0.0
Wilshire La Brea W.	2951	97	3.3	0	0.0
Baldwin Hills W.	2219	124	5.6	0	0.0
Playa Vista	15621	719	4.6	1	0.0
Santa Monica-Culver City-Beverly Hills	19127	438	2.3	12	0.1
Malibu	1735	65	3.7	1	0.0
Other	57	2	4.1	0	0.0
Total	67747	2027	3.0	18	0.0
Service Area 6					
USC S.	13412	216	1.6	0	0.0
Baldwin Hills S.	21290	1191	5.6	1	0.0
Hancock N.	24707	1114	4.5	3	0.0
USC E.	29193	850	2.9	5	0.0
Watts	36781	1748	4.8	3	0.0
Florence-Firestone	12446	503	4.0	2	0.0
Lynwood	16651	561	3.4	9	0.1
Paramount	3871	300	7.7	17	0.4
Compton	33894	2788	8.2	41	0.1
Other	1217	28	2.3	1	0.1
Total	193463	9300	4.8	82	0.0

rate of 3.7%. The Pomona area (5.9%) had the highest suspension rate throughout the service area., though this did not translate into the highest expulsion rates. That distinction was held jointly by the Alhambra-Monrovia-Sierra Madre and Glendora-Claremont-San Dimas-La Verne areas at 0.5%, or one out of every two hundred students.

Service Area 4: Metro

Service Area 4 had an overall suspension rate of 2.5%, which was below the countywide rate of 3.7%. The West Adams area (5.6%) had the highest suspension rate in the service area. Very few students are expelled in the service area; the West Hollywood area (0.1%) had the highest rate for this.

Service Area 5: West

Overall, Service Area 5 had a suspension rate of 3.0%, which was below the countywide rate of 3.7%. The Baldwin Hills W. area (5.6%) had the highest suspension rate across the service area. Very few students got expelled in the service area and the Santa Monica-Culver City-Beverly Hills area (0.1%) had the highest rate of school exclusion.

Service Area 6: South

Service Area 6 had an overall suspension rate of 4.8%, which was above the countywide rate of 3.7%. The Compton (8.2%), Paramount (7.7%), and Baldwin Hills S. (5.6%) areas had the highest suspension rates in the service area. Few students were expelled in the service area. The Paramount (0.4%) and the Compton (0.1%) areas had the highest expulsion rates in the service area.

Service Area 7: East

Service Area 7 had an overall suspension rate of 3.5%, which was similar to the countywide rate of 3.7%. The Bellflower (7.7%) and Norwalk (5.4%) areas had the highest suspension rates for the service area. Overall, the service area had an expulsion rate of 0.2%, with the Montebello area (0.7%) having the highest rate, followed by the Downey area (0.6%).

Table 3.38 continued

Service Area Communities: School Discipline

Service Area 7	Enrollment	Suspensions	%	Expulsions	%
East LA	24523	625	2.5	2	0.0
Downey	29297	1193	4.1	177	0.6
Norwalk	18590	1012	5.4	16	0.1
Whittier	19923	770	3.9	27	0.1
Montebello	29653	1048	3.5	207	0.7
Bell Gardens-Bell-Maywood-Cudahy-Commerce	32543	657	2.0	17	0.1
Huntington Park	21653	876	4.0	4	0.0
South Gate	22073	744	3.4	11	0.1
Bellflower	5111	396	7.7	23	0.4
La Mirada-Santa Fe Springs	28429	1184	4.2	29	0.1
Lakewood-Cerritos-Artesia-Hawaiian Gardens	38030	1010	2.7	17	0.0
Signal Hill	1912	23	1.2	0	0.0
Other	1145	37	3.3	2	0.1
Total	272881	9575	3.5	532	0.2
Service Area 8					
Hancock S.	1438	65	4.5	0	0.0
Wilmington	32420	941	2.9	8	0.0
Inglewood	19071	785	4.1	5	0.0
Torrance	25428	707	2.8	39	0.2
Long Beach N.	22897	278	1.2	5	0.0
Long Beach S.	29093	393	1.4	14	0.0
Long Beach E.	28882	253	0.9	4	0.0
Carson	19630	1113	5.7	2	0.0
Palos Verdes-Lomita	18647	226	1.2	5	0.0
Redondo-Manhattan-Hermosa-El Segundo	18665	439	2.4	10	0.1
Gardena-Lawndale	31057	2613	8.4	66	0.2
Hawthorne	22063	1453	6.6	60	0.3
Other	1091	60	5.5	1	0.1
Total	270382	9325	3.4	219	0.1

1. Suspensions: 3-5%, 5-7%, > 7%

2. Expulsions: > 0.5

Service Area 8: South Bay

Service Area 8 had an overall suspension rate of 3.4%, which was a bit below the countywide rate of 3.7%. The Gardena-Lawndale (8.4%) area had the highest suspension rate, followed by the Hawthorne area (6.6%) and the Carson area (5.7%). The Hawthorne area (0.3%) had the highest expulsion rate in the service area followed by the Gardena-Lawndale area (0.2%) and the Torrance area (0.2%).

Juvenile Felony Arrests

Description of Indicator

This indicator reports the number of juvenile felony arrests by ethnicity. Because of the differences in geographies of the law enforcement agencies reporting these data, it was not possible to map or summarize across service areas or communities.

Research Base and Relevance to PEI

This indicator shows in actual numbers the population of youth that have been arrested under the suspicion of committing a serious crime. This number does not capture the entire population who may enter the justice system for lesser offenses.

What the Numbers Show

Of the 23,787 youths arrested on felony charges during the reporting period, 84.2% were males, 15.8%, females. Ethnically, Hispanic youths were involved in the majority of felony arrests (57.2%), followed by Black/ African-American youths (30.3%) and Whites (9.1%). All other ethnicities combined accounted for less than 4% of the juvenile felony arrests.

Table 3.39a

Juvenile Felony Arrests by Ethnicity

Ethnicity	M	%	F	%	Total	%
Asian	23	62.2	14	37.8	37	100.0
Black	5931	82.4	1269	17.6	7200	100.0
Chinese	53	82.8	11	17.2	64	100.0
Cambodian	1	50.0	1	50.0	2	100.0
Filipino	32	72.7	12	27.3	44	100.0
Gaumanian	0	0.0	0	0.0	0	0.0
Hispanic	11775	86.5	1835	13.5	13610	100.0
American Indian	5	83.3	1	16.7	6	100.0
Japanese	3	100.0	0	0.0	3	100.0
Korean	4	80.0	1	20.0	5	100.0
Laotian	0	0.0	0	0.0	0	0.0
Other	511	82.4	109	17.6	620	100.0
Pacific Islander	21	72.4	8	27.6	29	100.0
Samoan	2	100.0	0	0.0	2	100.0
Hawaiian	0	0.0	0	0.0	0	0.0
Vietnamese	9	75.0	3	25.0	12	100.0
White	1669	77.5	484	22.5	2153	100.0
Total	20039	84.2	3748	15.8	23787	100.0

Figure 3.40 Juvenile Felony Arrests by Ethnicity

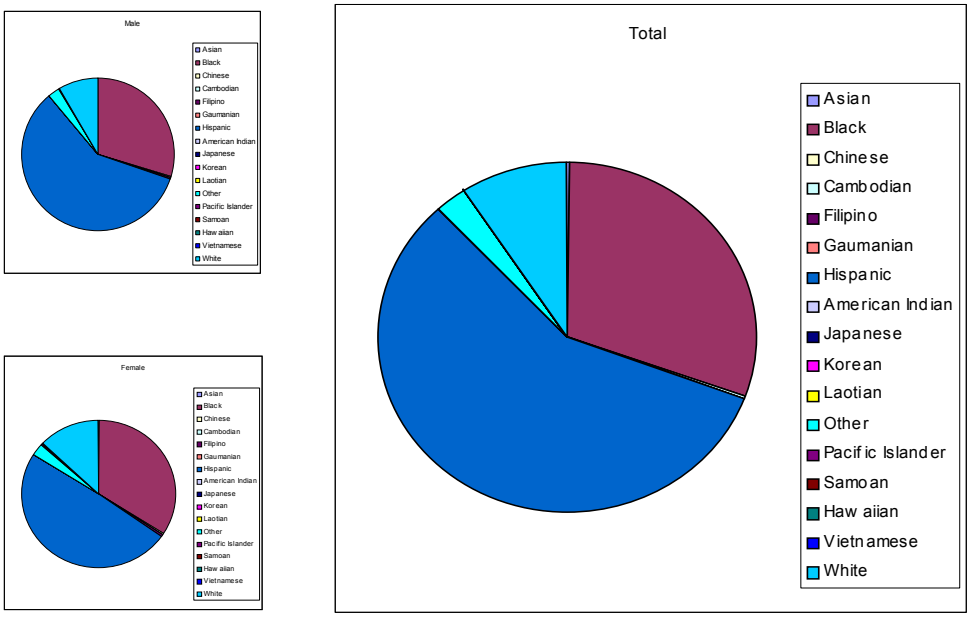


Table 3.39b

Juvenile Felony Arrests by Jurisdiction[1]

Jurisdiction	Asian	African American	Chinese	Cambodian	Filipino	Guamanian	Hispanic
Los Angeles Sheriff's Dept Unincorporated	0	476	0	0	2	0	972
Alhambra	0	2	10	0	0	0	63
Arcadia	10	6	18	0	0	0	28
Artesia	0	0	0	0	0	0	17
Avalon	0	1	0	0	0	0	3
Azusa	0	5	0	0	0	0	26
Baldwin Park	0	6	2	0	3	0	93
Bell	0	1	0	0	0	0	70
Bellflower	0	39	1	0	0	0	59
Bell Gardens	0	0	0	0	0	0	100
El Camino Community College	0	0	0	0	0	0	2
La Habra Heights	0	0	0	0	0	0	1
Los Angeles Union Pacific RR	0	0	0	0	0	0	4
Metropolitan Trans. Authority (MTA)	0	93	0	0	1	0	38
Pasadena Comm. College	0	0	0	0	0	0	0
Westlake Village	0	0	0	0	0	0	0
Beverly Hills	0	7	0	0	0	0	3
Bradbury	0	1	0	0	0	0	0
Burbank	6	11	0	0	2	0	94
Claremont	1	5	0	0	0	0	11
Commerce	0	0	0	0	0	0	30
Compton	0	221	0	0	0	0	147
Covina	0	13	0	0	0	0	99
Cudahy	0	0	0	0	0	0	45
Culver City	0	69	0	0	1	0	58
Cerritos	0	25	1	0	3	0	37
Agoura Hills	0	3	0	0	0	0	1
West Hollywood	0	6	0	0	0	0	4
Santa Clarita	0	12	0	0	0	0	71
Diamond Bar	0	8	3	0	0	0	16
Downey	0	31	0	0	0	0	142
Duarte	0	5	0	0	0	0	12
El Monte	0	8	3	1	0	0	240
El Segundo	0	11	0	0	0	0	12
Gardena	0	65	0	0	0	0	67
Glendale	5	13	1	0	10	0	188
Glendora	0	1	0	0	0	0	33
Hawaiian Gardens	0	2	0	0	0	0	39
Hawthorne	1	126	0	0	0	0	124
Hermosa Beach	0	2	0	0	3	0	2
Calabasas	0	0	0	0	0	0	1
Malibu	0	0	0	0	0	0	3
Los Angeles Transit Serv. Bureau	0	2	0	0	0	0	0
Huntington Park	0	6	0	0	0	0	157
Industry	0	3	4	0	1	0	57
Inglewood	0	122	0	0	0	0	61
Irwindale	0	0	0	0	0	0	5
Lakewood	0	41	0	0	1	0	76
La Mirada	0	0	0	0	0	0	18
La Puente	0	3	0	0	0	0	33
La Verne	0	2	0	0	0	0	13
Lawndale	0	29	0	0	0	0	38
Los Angeles City San Fernando Valley	0	179	0	0	2	0	1279

American Indian	Japanese	Korean	Laotion	Other	Pacific Islander	Samoan	Hawaiian	Vietnamese	White	Total
1	0	0	0	27	2	0	0	0	162	3284
0	0	0	0	10	0	0	0	0	3	176
0	0	0	0	1	0	0	0	3	25	182
0	0	0	0	0	0	0	0	0	2	38
0	0	0	0	1	0	0	0	0	0	10
0	0	0	0	0	0	0	0	0	7	76
0	0	0	0	1	0	0	0	0	14	238
0	0	0	0	0	0	0	0	0	1	144
0	0	0	0	1	0	0	0	0	10	220
0	0	0	0	0	0	0	0	0	3	206
0	0	0	0	0	0	0	0	0	1	6
0	0	0	0	0	0	0	0	0	0	2
0	0	0	0	0	0	0	0	0	1	10
0	0	0	0	0	0	0	0	0	0	264
0	0	0	0	0	0	0	0	0	1	2
0	0	0	0	0	0	0	0	0	3	6
0	0	1	0	1	0	0	0	0	23	70
0	0	0	0	0	0	0	0	0	1	4
0	0	0	0	1	0	0	0	0	62	352
0	0	0	0	0	0	0	0	0	12	58
0	0	0	0	0	0	0	0	0	0	60
0	0	0	0	0	0	0	0	0	2	740
0	0	0	0	2	0	0	0	1	23	276
0	0	0	0	0	0	0	0	0	0	90
0	0	1	0	4	0	0	0	0	13	292
2	0	0	0	13	0	0	0	0	4	170
0	0	0	0	0	0	0	0	0	13	34
0	0	0	0	0	0	0	0	0	4	28
0	0	0	0	3	0	0	0	0	111	394
0	0	0	0	8	0	0	0	0	9	88
0	0	0	0	0	0	0	0	0	13	372
0	0	0	0	4	0	0	0	0	1	44
0	0	0	0	4	0	0	0	2	9	534
0	0	1	0	2	0	0	0	0	16	84
0	0	0	0	9	0	0	0	0	7	296
0	1	2	0	14	1	0	0	0	111	692
0	0	0	0	3	0	0	0	0	32	138
0	0	0	0	0	1	0	0	0	0	84
0	0	0	0	6	4	0	0	0	15	552
0	0	0	0	0	0	0	0	0	5	24
0	0	0	0	1	0	0	0	0	15	34
0	0	0	0	0	0	0	0	0	4	14
0	0	0	0	0	0	0	0	0	1	6
0	0	0	0	0	0	0	0	0	1	328
0	0	0	0	12	0	0	0	0	4	162
0	0	0	0	0	0	0	0	0	2	370
0	0	0	0	0	0	0	0	0	8	26
0	0	0	0	7	4	0	0	0	28	314
0	0	0	0	3	0	0	0	0	16	74
0	0	0	0	0	1	0	0	0	1	76
0	0	0	0	0	0	0	0	0	13	56
0	0	0	0	2	0	0	0	0	8	154
0	0	0	0	59	1	0	0	0	233	3506

Table 3.39b continued

Juvenile Felony Arrests by Jurisdiction[1]

Jurisdiction	Asian	African American	Chinese	Cambodian	Filipino	Guamanian	Hispanic
Los Angeles City Non San Fernando Valley	0	1792	0	0	4	0	2417
Lomita	0	4	0	0	1	0	12
Long Beach	2	576	5	1	0	0	442
Los Angeles	0	1971	0	0	6	0	3696
Lynwood	0	48	0	0	0	0	135
Manhattan Beach	0	14	0	0	0	0	8
Maywood	0	0	0	0	0	0	34
Monrovia	0	6	0	0	0	0	24
Montebello	2	1	1	0	0	0	99
Monterey Park	0	0	2	0	0	0	51
Norwalk	0	27	0	0	0	0	150
Palmdale	0	266	0	0	0	0	201
Palos Verdes Estates	0	1	0	0	0	0	4
Paramount	0	32	0	0	1	0	93
Pasadena	3	135	0	0	0	0	163
Pico Rivera	0	2	0	0	0	0	109
Pomona	2	58	0	0	0	0	244
Redondo Beach	0	34	0	0	0	0	38
Rolling Hills	0	1	0	0	0	0	0
Rolling Hills Estates	0	0	0	0	0	0	0
Rosemead	0	0	1	0	0	0	31
San Dimas	0	8	0	0	0	0	13
San Fernando	0	1	0	0	0	0	37
San Gabriel	0	0	8	0	0	0	33
San Marino	0	0	1	0	0	0	0
Santa Fe Springs	0	1	0	0	0	0	44
Santa Monica	1	32	0	0	0	0	45
Signal Hill	0	12	0	0	0	0	15
South El Monte	0	0	0	0	0	0	18
South Gate	0	6	0	0	0	0	192
South Pasadena	1	7	0	0	0	0	9
Temple City	0	0	0	0	0	0	13
Torrance	0	48	0	0	0	0	79
Vernon	0	0	0	0	0	0	25
Walnut	0	0	0	0	0	0	9
West Covina	0	22	3	0	1	0	114
Whittier	2	3	0	0	0	0	92
Carson	0	83	0	0	2	0	63
Cal Poly - Pomona	0	0	0	0	0	0	2
Rancho Palos Verdes	0	2	0	0	0	0	9
CSU Dominguez Hills	0	0	0	0	0	0	2
CSU Northridge	0	0	0	0	0	0	1
La Canada-Flintridge	0	1	0	0	0	0	4
Lancaster	0	341	0	0	0	0	114
UC Los Angeles	0	1	0	0	0	0	0
Los Angeles CHP	1	3	0	0	0	0	34
Total	37	7200	64	2	44	0	13610

American Indian	Japanese	Korean	Laotion	Other	Pacific Islander	Samoan	Hawaiian	Vietnamese	White	Total
0	0	0	0	69	0	0	0	0	104	8772
0	0	0	0	1	0	0	0	0	11	58
2	0	0	0	101	1	2	0	0	114	2492
0	0	0	0	128	1	0	0	0	337	12278
0	0	0	0	1	0	0	0	0	2	372
0	0	0	0	5	0	0	0	0	30	114
0	0	0	0	0	0	0	0	0	0	68
0	0	0	0	1	0	0	0	0	9	80
0	0	0	0	2	0	0	0	0	5	220
0	1	0	0	2	0	0	0	0	0	112
0	0	0	0	5	0	0	0	0	7	378
0	0	0	0	0	0	0	0	0	97	1128
1	0	0	0	1	0	0	0	0	12	38
0	0	0	0	1	0	0	0	0	3	260
0	0	0	0	3	0	0	0	0	16	640
0	0	0	0	0	0	0	0	0	3	228
0	0	0	0	2	1	0	0	1	18	652
0	0	0	0	2	0	0	0	0	36	220
0	0	0	0	0	0	0	0	0	0	2
0	0	0	0	1	0	0	0	0	3	8
0	0	0	0	19	0	0	0	0	3	108
0	0	0	0	0	0	0	0	0	13	68
0	0	0	0	0	0	0	0	0	2	80
0	1	0	0	2	0	0	0	1	3	96
0	0	0	0	1	0	0	0	0	0	4
0	0	0	0	0	0	0	0	0	2	94
0	0	0	0	4	0	0	0	0	12	188
0	0	0	0	11	0	0	0	0	5	86
0	0	0	0	0	0	0	0	0	1	38
0	0	0	0	0	0	0	0	0	0	396
0	0	0	0	0	0	0	0	0	8	50
0	0	0	0	4	0	0	0	0	7	48
0	0	0	0	27	0	0	0	0	53	414
0	0	0	0	0	0	0	0	0	0	50
0	0	0	0	2	0	0	0	0	3	28
0	0	0	0	1	0	0	0	4	14	318
0	0	0	0	0	1	0	0	0	16	228
0	0	0	0	4	11	0	0	0	11	348
0	0	0	0	0	0	0	0	0	0	4
0	0	0	0	3	0	0	0	0	12	52
0	0	0	0	0	0	0	0	0	0	4
0	0	0	0	0	0	0	0	0	3	8
0	0	0	0	6	0	0	0	0	6	34
0	0	0	0	3	0	0	0	0	112	1140
0	0	0	0	2	0	0	0	0	1	8
0	0	0	0	7	0	0	0	0	6	102
6	3	5	0	620	29	2	0	12	2153	47574

1. Actual Arrests > 500

Youths on Probation

Description of Indicator

This indicator is a count of youth on probation in Los Angeles County as of January 2008. Figures are reported for the youth detained in probation camps and others at home or in placement, (e.g., residential treatment) under probation supervision.

Research Base and Relevance to PEI

It is important to track the number of youth currently on various forms of probation because they reflect roughly two-thirds of all youth initially referred to the Probation Department for disposition (McCrosky, 2006). The overwhelming majority of youths arrested in Los Angeles County are referred to the Probation Department (99.2% in 2003; McCrosky, 2006), so the probation numbers are good indicators of juvenile justice involvement.

What the Numbers Show

Table 3.40 indicated that the countywide camp population was similar in composition to the Juvenile Felony Arrest data. Hispanic youths were a majority of the camp population (58.6%), followed by Black/African-American youths (33.7%) and Whites (5.8%). All other ethnicities accounted for less than 2% of the entire camp population of 2,082 youths. Service Areas 6 (27.2% or about one in four) and 8 (16.3%) had the most youths consigned to camps.

The relative percentages of youths under supervision by the Probation Department again revealed a similar pattern: Hispanic youths were a majority under supervision (55.2%), followed by African-American (23.2%) and Whites (8.4%). Ethnicity was unknown for 9.5% of the population and the remaining ethnicities accounted for less than 4% of the population. Service Areas 6 and 8 had the highest numbers of youths under supervision.

Table 3.41

Countywide Summary: Supervised Youths[1]

Service Area	Am Ind	Asian Ind	Afr Am	Cambod	Chinese	Filipino	Hawaiian	Hispanic	Japanese	Korean	Laotian
1	1		618					469	1		
2			200		4	7		1388	2	5	
3			370	2	31	8	1	2184	5	0	
4		1	146		1	6	0	1078		2	
5	1		97					147			
6			1707		0	5		1562			1
7	2		186	0	3	4		2293	0		
8			1164	4	4	17	1	1444	1		1
Invalid SPA	1		58			1		254			
Total	5	1	4545	6	43	48	2	10819	9	7	2

Table 3.40

Countywide Summary: Camp Population

Service Area	Black	Hispanic	White	Camb	Filipino	Japanese	Viet	Pacific Is	Oth Asian	Other	Unknown	Total
1	106	53	22							1		182
2	20	144	29		1				1	2		197
3	49	193	23		1	1			1	9	1	278
4	27	191	2		0				1	1		222
5	20	25	4							2		51
6	314	251	0		1			0	0	1		567
7	15	212	16					1	0	1		244
8	151	153	24	1			1	4	1	5	1	340
Total	702	1221	120	1	3	1	1	5	4	22	2	2082

1. Actual counts

197
278
567

Service Area Communities (Tables 3.40, 3.41, 3.42, 3.43)

Service Area 1: Antelope Valley

Camp Population

Both the Lancaster and Palmdale areas have relatively large numbers of youths sent to camp. Service Area 1 had twice as many African-American youth in camp as Hispanic youth. African-American youths accounted for 58.2% of the camp population, Hispanics (29.1%), and Whites (12.1%).

Supervised Youths

Similar to the Camp census, African-American youths under supervision (618) were greater in number than Hispanic youths (469) in the service area. Both of the urban areas within the service area had over

Oth Asian	Other	Pacific Is	Samoan	Unknown	Viet	White	Total
1	10			1		208	1309
2	71			5	1	510	2194
20	109	2		6	1	303	3042
2	32	2		1		34	1304
2	22			5		75	349
2	19	2	1	4		20	3322
8	33	2	0	4		192	2726
13	206	13	4	7		301	3180
	47		1	1822		5	2189
50	548	21	6	1855	2	1647	19616

1. Actual counts

500-1000
1001-1500
> 1500

Table 3.42

Service Area Communities: Camp Population (percent of population)[1]

Within Service Area 1	Afr Am	Hispanic	White	Camb	Filipino	Japanese	Pac Is	Viet	Oth Asian	Other	Unknown	Total
Lancaster	65.4	25.6	7.8	0.0	0.0	0.0	0.0	0.0	0.0	1.2	0.0	100
Palmdale	53.2	32.9	13.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
North County E.	47.8	30.2	22.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Total	58.2	29.1	12.1	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	100
Within Service Area 2												
Santa Clarita	5.8	51.4	42.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Burbank	10.8	33.3	44.6	0.0	0.0	0.0	0.0	0.0	0.0	11.3	0.0	100
Glendale	0.0	58.3	25.0	0.0	8.3	0.0	0.0	0.0	8.4	0.0	0.0	100
Northridge	24.4	64.1	11.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Granada Hills	12.4	74.5	13.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Pacoima-Arleta	13.3	86.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
La Tuna Cyn.	0.2	81.1	18.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Panorama City	8.3	87.4	4.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
North Hollywood	28.0	58.2	13.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Sherman Oaks	5.5	89.3	5.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Encino	6.8	79.7	13.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Woodland Hills	11.2	66.3	11.6	0.0	0.0	0.0	0.0	0.0	0.0	10.9	0.0	100
Brentwood N.	6.5	93.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
North County W.	44.1	20.5	35.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
La Canada-Flintridge	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
San Fernando-Calabasas-Agoura	12.5	87.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Total	10.2	73.0	14.8	0.0	0.5	0.0	0.0	0.0	0.5	1.0	0.0	

500 youths under supervision.

Service Area 2: San Fernando
Camp Population

Service Area 2 had 196 youths in camp. A large majority of these were Hispanic youth, who accounted for 73% of the population, followed by Whites (14.8%), and African-Americans (10.2%).

Supervised Youths

Across the service area, the Santa Clarita and Panorama City areas had the largest numbers of youths under supervision. Within the service area, 63.3% of youths under supervision were Hispanic, 23.2% were White, and 9.1% were African-American. The San Fernando Valley had the largest group of White youths under supervision across the county.

Service Area 3: San Gabriel
Camp Population

Service Area 3 had a total of 278 youths sent to camp with the Pomona and Baldwin Park-Azusa-Duarte areas consigning the most numbers. Of these, 69.3% were Hispanic, 17.6% were African-American, and 8.4% were White.

Supervised Youths

Service Area 3 had over 3,000 youths under supervision and a majority of these were Hispanic (71.7%). This was followed by African-American youth (12.2%) and White youth (9.9%). The largest Asian group, Chinese youth, accounted for 1% of the youths under supervision. Within the service area, the Baldwin Park-Azusa-Duarte area had the most numbers of youth under supervision,

Between Service Area 1	Afr Am	Hispanic	White	Camb	Filipino	Japanese	Pac Is	Viet	Oth Asian	Other	Unknown	Total
Lancaster	52.5	41.1	30.3							99.3		46.8
Palmdale	37.1	45.9	46.7							0.0		40.6
North County E.	10.3	13.1	23.0							0.7		12.6
Total	100	100	100							100		100
Between Service Area 2												
Santa Clarita	4.8	6.0	24.7		0.0				0.0	0.0		8.5
Burbank	4.8	2.1	13.7		0.0				0.0	50.0		4.5
Glendale	0.0	4.9	10.3		100.0				100.0	0.0		6.1
Northridge	10.6	3.9	3.5		0.0				0.0	0.0		4.4
Granada Hills	4.7	3.9	3.4		0.0				0.0	0.0		3.8
Pacoima-Arleta	16.4	14.8	0.0		0.0				0.0	0.0		12.5
La Tuna Cyn.	0.2	14.0	15.9		0.0				0.0	0.0		12.6
Panorama City	9.8	14.3	3.4		0.0				0.0	0.0		11.9
North Hollywood	24.1	7.0	8.2		0.0				0.0	0.0		8.8
Sherman Oaks	5.5	12.4	3.6		0.0				0.0	0.0		10.1
Encino	4.9	8.0	6.7		0.0				0.0	0.0		7.3
Woodland Hills	5.1	4.2	3.6		0.0				0.0	50.0		4.7
Brentwood N.	0.5	1.0	0.0		0.0				0.0	0.0		0.8
North County W.	5.2	0.3	2.9		0.0				0.0	0.0		1.2
La Canada-Flintridge	0.0	0.0	0.0		0.0				0.0	0.0		0.0
San Fernando-Calabasas-Agoura	3.3	3.2	0.0		0.0				0.0	0.0		2.7
Total	100	100	100		100				100	100		100

followed by the Pomona and El Monte areas.

Service Area 4: Metro
Camp Population

Service Area 4 had a total of 222 youths consigned to camp, with the greatest numbers coming from the Echo Park, Highland Park and Downtown areas. The overwhelming majority of these youths were Hispanic (85.7%), followed by African-Americans (12.3%).

Supervised Youths

Over 1,000 youths in Service Area 4 were under supervision and a large majority of these individuals were Hispanic (82.7%). This was followed by African-American youths (11.2%) and White youth (2.6%). The Highland Park area had the largest number of youths under supervision, followed by the Downtown and Echo Park areas.

Service Area 5: West
Camp Population

Across the county, Service Area 5 had the fewest youths consigned to camp: 51.

Supervised Youths

In terms of supervision, Service Area 5 also had, by far, the lowest numbers of youth on probation: 349. Ethnically, Hispanic youths accounted for 42.1% of the population, African-Americans, 27.8%, and Whites, 21.5%.

Service Area 6: South
Camp Population

Across the county, Service Area 6 had the largest numbers of youth sent to camp: 567; the majority of these were African-Americans (55.4%), followed by Hispanic

Table 3.42 continued

Service Area Communities: Camp Population

Within Service Area 3	Afr Am	Hispanic	White	Camb	Fili-pino	Japanese	Pac Is	Viet	Oth Asian	Other	Unknown	Total
Pasadena	52.5	44.1	3.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
El Monte	3.6	96.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Pomona	18.9	71.7	5.7	0.0	0.0	0.0	0.0	0.0	0.0	3.8	0.0	100
West Covina	30.1	57.4	12.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Altadena-Monrovia-Sierra Madre	41.5	36.0	21.9	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.0	100
Alhambra-S. Pasadena	0.0	58.7	13.8	0.0	0.0	0.0	0.0	0.0	0.0	27.5	0.0	100
Arcadia-San Gabriel-Temple City-San Marino	0.0	52.9	23.6	0.0	0.0	0.0	0.0	0.0	0.0	23.6	0.0	100
Baldwin Park-Azusa-Duarte	4.4	83.7	6.8	0.0	0.2	0.2	0.0	0.0	0.0	4.7	0.0	100
Glendora-Claremont-San Dimas-La Verne	25.8	46.1	27.8	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	100
Covina-Walnut	21.0	64.7	1.3	0.0	6.5	6.5	0.0	0.0	0.0	0.0	0.0	100
Diamond Bar	16.5	66.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	16.5	100
La Puente-S. El Monte	0.0	98.6	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	100
Hacienda Heights	0.0	66.7	33.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Monterey Park-Rosemead	0.0	74.7	0.0	0.0	0.0	0.0	0.0	0.0	8.4	16.9	0.0	100
Other	26.0	54.8	19.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Total	17.6	69.3	8.4	0.0	0.4	0.4	0.0	0.0	0.4	3.2	0.4	100
Within Service Area 4												
Wilshire La Brea E.	46.1	51.3	2.2	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.0	100
Hollywood	5.8	92.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.9	0.0	100
Pico Heights	15.4	79.8	3.1	0.0	0.0	0.0	0.0	0.0	0.0	1.7	0.0	100
Echo Park	7.2	92.5	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	100
Highland Park	3.6	92.8	2.1	0.0	0.0	0.0	0.0	0.0	1.5	0.0	0.0	100
Downtown	7.2	92.3	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	100
USC N.	23.9	76.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
West Adams	58.3	39.3	1.4	0.0	0.0	0.0	0.0	0.0	0.0	1.1	0.0	100
West Hollywood	22.8	77.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Other	9.7	90.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Total	12.3	85.7	1.0	0.0	0.0	0.0	0.0	0.0	0.4	0.5	0.0	100
Within Service Area 5												
Brentwood S.	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
West LA	47.1	37.0	12.2	0.0	0.0	0.0	0.0	0.0	0.0	3.8	0.0	100
Wilshire La Brea W.	46.0	29.7	21.5	0.0	0.0	0.0	0.0	0.0	0.0	2.7	0.0	100
Baldwin Hills W.	62.2	25.1	6.5	0.0	0.0	0.0	0.0	0.0	0.0	6.2	0.0	100
Playa Vista	30.9	66.1	2.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Santa Monica-Culver City-Beverly Hills	29.3	64.1	0.6	0.0	0.0	0.0	0.0	0.0	0.0	5.9	0.0	100
Malibu	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Other	87.5	12.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Total	40.0	48.7	7.4	0.0	0.0	0.0	0.0	0.0	0.0	3.9		100

youth (44.2%). The Hancock N. area had the largest population of youth in camp (108) across the county. This was followed closely by the Watts area (98), the Compton area (94), and the USC E. area (87). Combined, these four communities had more youths in camp than any single service area.

Supervised Youths

Service Area 6 had the highest numbers of supervised youth across the county: 3,322. Of these, a majority were African-American (51.4%), followed by Hispanic youth at 47%. No other ethnicity exceeded 1% of the population. Three communities had over 500 youths under supervision: the Watts area (714), the Compton area (651), and the Hancock N. area (584).

Between Service Area 3	Afr Am	Hispanic	White	Camb	Filipino	Japanese	Pac Is	Viet	Oth Asian	Other	Unknown	Total
Pasadena	25.9	5.5	3.6		0.0	0.0			0.0	0.0	0.0	8.7
El Monte	2.0	14.0	0.0		0.0	0.0			0.0	0.0	0.0	10.1
Pomona	20.3	19.6	12.9		0.0	0.0			0.0	22.3	0.0	19.0
West Covina	9.8	4.7	8.5		0.0	0.0			0.0	0.0	0.0	5.7
Altadena-Monrovia-Sierra Madre	17.3	3.8	19.1		0.0	0.0			0.0	1.3	0.0	7.3
Alhambra-S. Pasadena	0.0	2.2	4.3		0.0	0.0			0.0	22.3	0.0	2.6
Arcadia-San Gabriel-Temple City-San Marino	0.0	1.0	3.8		0.0	0.0			0.0	9.8	0.0	1.3
Baldwin Park-Azusa-Duarte	3.7	18.0	12.1		6.9	6.9			0.0	22.0	0.0	14.9
Glendora-Claremont-San Dimas-La Verne	12.9	5.9	29.2		3.6	3.6			0.0	0.1	0.0	8.8
Covina-Walnut	5.9	4.6	0.8		89.5	89.5			0.0	0.0	0.0	5.0
Diamond Bar	2.0	2.1	0.0		0.0	0.0			0.0	0.0	100.0	2.2
La Puente-S. El Monte	0.0	12.9	1.4		0.0	0.0			0.0	0.3	0.0	9.1
Hacienda Heights	0.0	1.0	4.2		0.0	0.0			0.0	0.0	0.0	1.1
Monterey Park-Rosemead	0.0	4.5	0.0		0.0	0.0			100.0	21.8	0.0	4.2
Other	0.1	0.0	0.1		0.0	0.0			0.0	0.0	0.0	0.1
Total	100	100	100		100	100			100	100	100	100
Between Service Area 4												
Wilshire La Brea E.	38.2	6.1	21.5		0.0				0.0	9.9		10.2
Hollywood	5.3	12.2	0.0		0.0				0.0	47.5		11.3
Pico Heights	13.3	9.9	32.4		0.0				0.0	39.3		10.7
Echo Park	12.7	23.4	0.0		0.0				10.2	0.3		21.7
Highland Park	6.1	22.6	43.2		100.0				68.3	0.0		20.9
Downtown	12.1	22.3	1.0		0.0				21.5	0.0		20.7
USC N.	5.2	2.4	0.0		0.0				0.0	0.0		2.7
West Adams	6.4	0.6	1.9		0.0				0.0	3.1		1.3
West Hollywood	0.5	0.3	0.0		0.0				0.0	0.0		0.3
Other	0.1	0.2	0.0		0.0				0.0	0.0		0.2
Total	100	100	100		100				100	100		100
Between Service Area 5												
Brentwood S.	0.0	0.1	0.0							0.0		0.1
West LA	44.6	28.9	62.7							36.9		38.0
Wilshire La Brea W.	8.4	4.5	21.4							5.1		7.3
Baldwin Hills W.	11.5	3.8	6.5							11.8		7.4
Playa Vista	13.0	22.9	6.7							0.0		16.9
Santa Monica-Culver City-Beverly Hills	22.1	39.8	2.6							46.2		30.2
Malibu	0.0	0.0	0.0							0.0		0.0
Other	0.4	0.0	0.0							0.0		0.2
Total	100	100	100							100		100

Service Area 7: East

Camp Population

Service Area 7 had 244 youths who were sent to camp; of these, 86.8% were Hispanic, followed by Whites (6.4%) and African-Americans (5.9%). The Bell Gardens-Bell-Maywood-Cudahy-Commerce area had the greatest number of youths sent to camp (35), followed closely by the East LA area (33) and the Montebello area (33).

Supervised Youths

Service Area 7 had 2,726 youths under supervision. Hispanic youths were a large majority of these individuals (84.1%), followed distantly by Whites (7.0%) and African-Americans (6.8%). Although the aggregate community of Bell Gardens-Bell-Maywood-Cudahy-Commerce had the largest number

Table 3.42 continued

Service Area Communities: Camp Population

Within Service Area 6	Afr Am	Hispanic	White	Camb	Filipino	Japanese	Pac Is	Viet	Oth Asian	Other	Unknown	Total
USC S.	49.2	49.8	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Baldwin Hills S.	74.9	24.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	100
Hancock N.	70.4	28.9	0.0	0.0	0.7	0.0	0.0	0.0	0.0	0.0	0.0	100
USC E.	34.8	65.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Watts	52.4	47.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Florence-Firestone	42.0	58.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Lynwood	33.5	66.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Paramount	38.5	61.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Compton	56.6	43.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Other	83.6	13.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.9	0.0	100
Total	55.4	44.2	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.2	0.0	
Within Service Area 7												
East LA	5.0	94.8	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Downey	12.5	87.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Norwalk	4.3	91.3	4.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Whittier	0.0	85.4	14.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Montebello	0.0	99.5	0.2	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	100
Bell Gardens-Bell-Maywood-Cudahy-Commerce	0.2	91.5	5.5	0.0	0.0	0.0	0.0	0.0	0.0	2.8	0.0	100
Huntington Park	17.8	82.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
South Gate	0.1	95.6	4.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Bellflower	21.1	63.2	10.5	0.0	0.0	0.0	5.3	0.0	0.0	0.0	0.0	100
La Mirada-Santa Fe Springs	6.5	67.7	25.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Lakewood-Cerritos-Artesia-Hawaiian Gardens	16.6	58.1	25.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Signal Hill	55.6	33.3	11.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Other	3.3	96.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Total	5.9	86.8	6.4	0.0	0.0	0.0	0.4	0.0	0.0	0.4	0.0	100
Within Service Area 8												
Hancock S.	54.7	40.8	4.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Wilmington	7.2	85.0	7.8	0.0	0.0	0.0			0.0	0.0	0.0	100
Inglewood	60.2	36.7	3.1	0.0	0.0	0.0			0.0	0.0	0.0	100
Torrance	0.5	98.8	0.7	0.0	0.0	0.0			0.0	0.0	0.0	100
Long Beach N.	53.1	33.6	3.4	0.0	0.0	0.0	2.7	0.0	2.7	3.6	0.9	100
Long Beach S.	47.1	38.7	8.1	1.0	0.0	0.0	0.0	1.0	0.0	3.5	0.6	100
Long Beach E.	25.5	35.5	34.5	2.2	0.0	0.0	0.0	2.2	0.0	0.0	0.0	100
Carson	42.5	38.2	0.6	0.0	0.0	0.0	10.9	0.0	0.0	6.6	1.2	100
Palos Verdes-Lomita	42.4	56.6	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Redondo-Manhattan-Hermosa-El Segundo	0.0	21.0	79.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Gardena-Lawndale	60.3	32.7	5.3	0.0	0.0	0.0	1.7	0.0	0.0	0.0	0.0	100
Hawthorne	41.8	55.1	3.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Other	51.7	45.4	2.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Total	44.2	45.0	7.0	0.3	0.0	0.0	1.2	0.3	0.3	1.5	0.3	100
County Total	33.7	58.6	5.8	0.0	0.1	0.0	0.2	0.0	0.2	1.1	0.1	100

of probationers, virtually all of the service area communities, save the Signal Hill area, had at least two hundred youths under supervision.

Service Area 8: South Bay
Camp Population

Service Area 8 had the second-highest count of youth consigned to camp: 340. Three communities accounted for 57% of this total: about 21% of these youths came from the

Between Service Area 6	Afr Am	Hispanic	White	Camb	Filipino	Japanese	Pac Is	Viet	Oth Asian	Other	Unknown	Total
USC S.	4.4	5.6	0.0		27.3					0.0		4.9
Baldwin Hills S.	18.7	7.5	0.0		0.3					80.8		13.8
Hancock N.	24.1	12.4	0.0		72.4					0.0		19.0
USC E.	9.7	22.7	0.0		0.0					0.0		15.4
Watts	16.3	18.6	0.0		0.0					0.0		17.3
Florence-Firestone	3.6	6.3	0.0		0.0					0.0		4.8
Lynwood	2.9	7.1	0.0		0.0					0.0		4.7
Paramount	1.6	3.2	0.0		0.0					0.0		2.3
Compton	16.9	16.2	100.0		0.0					0.0		16.6
Other	1.8	0.4	0.0		0.0					19.2		1.2
Total	100	100	100		100					100		100
Between Service Area 7												
East LA	11.4	14.7	0.3				0.0		0.0	0.0		13.4
Downey	13.8	6.6	0.0				0.0		0.0	0.0		6.5
Norwalk		0	0									0
Whittier	0.0	7.2	16.6				0.0		0.0	0.0		7.3
Montebello	0	1										1
Bell Gardens-Bell-Maywood-Cudahy-Commerce	0.4	15.2	12.4				0.0		0.0	95.6		14.4
Huntington Park	18.9	6.0	0.0				0.0		0.0	0.0		6.3
South Gate	0.2	10.4	6.4				0.0		0.0	0.0		9.5
Bellflower	27.6	5.7	12.7				99.9		0.0	0.0		7.8
La Mirada-Santa Fe Springs	6.9	5.0	25.5				0.0		0.0	0.0		6.3
Lakewood-Cerritos-Artesia-Hawaiian Gardens	13.7	3.3	19.2				0.1		3.9	0.1		4.9
Signal Hill	0.1	0.0	0.0				0.0		0.0	0.0		0.0
Other	0.2	0.4	0.0				0.0		0.0	0.0		0.4
Total	100	100	100				100		100	100		100
Between Service Area 8												
Hancock S.	1.4	1.0	0.7	0.0			0.0	0.0	0.0	0.0	0.0	1.1
Wilmington	1.6	18.7	10.9	0.0			0.0	0.0	0.0	0.0	0.0	9.9
Inglewood	12.8	7.7	4.2	0.0			0.0	0.0	0.0	0.0	0.0	9.4
Torrance	0.0	2.2	0.1	0.0			0.0	0.0	0.0	0.0	0.0	1.0
Long Beach N.	13.0	8.1	5.2	0.0			25.0	0.0	100.0	26.7	33.4	10.8
Long Beach S.	21.8	17.6	23.7	67.8			0.0	67.8	0.0	49.0	44.9	20.4
Long Beach E.	2.4	3.4	20.9	32.2			0.0	32.2	0.0	0.0	0.0	4.2
Carson	5.2	4.6	0.4	0.0			50.0	0.0	0.0	24.4	21.7	5.4
Palos Verdes-Lomita	0.6	0.8	0.1	0.0			0.0	0.0	0.0	0.0	0.0	0.7
Redondo-Manhattan-Hermosa-El Segundo	0.0	0.5	12.5	0.0			0.0	0.0	0.0	0.0	0.0	1.1
Gardena-Lawndale	22.9	12.2	12.7	0.0			24.9	0.0	0.0	0.0	0.0	16.8
Hawthorne	17.4	22.6	8.1	0.0			0.1	0.0	0.0	0.0	0.0	18.4
Other	0.8	0.7	0.3	0.0			0.0	0.0	0.0	0.0	0.0	0.7
Total	100	100	100	100			100	100	100	100	100	100

1. > 50%

Long Beach S. area, 19% from the Hawthorne area, and 17% from the Gardena-Lawndale area. No ethnic group formed a majority of probationers: Hispanic youths (45%), African-American youths (44.2%), and White youths (7%).

Supervised Youths

Service Area 8 had 3,180 youths under supervision, second only to Service Area 6. Within the service area, the Long Beach S. area had the largest number of youth under supervision: 891 (highest total in the county). Three

Table 3.43
Service Area Communities: Supervised Youths (actual population counts)[1]

Service Area 1 Communities	Am Ind	Asian Ind	Afri Am	Cambod	Chinese	Filipino	Hawaiian
Lancaster			298				
Palmdale	1		253				
North County E.	0		67				
Total	1	0	618	0	0	0	0
Service Area 2 Communities							
Santa Clarita			30				
Burbank			10		1	2	
Glendale			5		3	4	
Northridge			12				
Granada Hills			11				
Pacoima-Arleta			16				
La Tuna Cyn.			12		0	1	
Panorama City			16				
North Hollywood			16			0	
Sherman Oaks			21				
Encino			16				
Woodland Hills			17				
Brentwood N.			5				
North County W.			10				
La Canada-Flintridge			0		0		
San Fernando-Calabasas-Agoura			3				
Total	0	0	200	0	4	7	0
Service Area 3 Communities							
Pasadena			123			0	0
El Monte			2		4		
Pomona			53	1			
West Covina			20		0	4	
Altadena-Monrovia-Sierra Madre			74		0		
Alhambra-S. Pasadena			6	1	6	1	1
Arcadia-San Gabriel-Temple City-San Marino			10	0	13		0
Baldwin Park-Azusa-Duarte			20		0	1	
Glendora-Claremont-San Dimas-La Verne			31			0	
Covina-Walnut			14		0	1	
Diamond Bar			3	0	1	1	
La Puente-S. El Monte			6		1	0	
Hacienda Heights			1				
Monterey Park-Rosemead			7		6	0	
Other			0			0	
Total	0	0	370	2	31	8	1

Hispanic	Japanese	Korean	Laotian	Oth Asian	Other	Pacific Is	Samoan	Unknown	Vietnam	White	Total
128					4					94	524
275	1			1	5			1		72	609
65	0			0	1			0		42	176
469	1	0	0	1	10	0	0	1	0	208	1309
146	1				7				1	122	308
66					8			0		69	156
80	1	3		0	11			1		58	166
50					3					26	91
90					4				0	22	127
164					2					5	188
130	0	0			6			1		26	175
181					0					6	202
117					5					14	152
122					5					23	170
83					6					23	128
78					7			1		29	132
13					3					7	28
33	0				3			2	0	36	84
7	0	2		2	2					13	26
28				0	1					29	61
1388	2	5	0	2	71	0	0	5	1	509	2193
140				0	3				0	11	278
280	1			0	9					6	302
295				2	5			1		21	378
137				1	8	0		1		18	188
95	2	0		0	4					29	204
67				4	8			2	0	11	107
65	0			4	15			0	1	29	136
380	1			1	4	1		0		22	430
106				0	11			0		104	252
143				0	5	0		2		24	189
49				4	6					6	69
266				0	3	1		0		10	288
51					6	0		0		5	63
111	1			4	22					5	155
1	0			0	0			0		0	2
2183	5	0	0	20	109	2	0	6	1	302	3041

Table 3.43 continued
Service Area Communities: Supervised Youths (actual population counts)[1]

Service Area 4 Communities	Am Ind	Asian Ind	Afri Am	Cambod	Chinese	Filipino	Hawaiian
Wilshire La Brea E.		0	39				
Hollywood		0	22			0	
Pico Heights		0	10				
Echo Park		0	27		0	1	
Highland Park			28		1	5	0
Downtown			7		0	0	
USC N.			5				
West Adams			6				
West Hollywood			1				
Other			0				
Total	0	1	146	0	1	6	0
Service Area 5 Communities							
Brentwood S.			2				
West LA	1		23				
Wilshire La Brea W.			7				
Baldwin Hills W.			6				
Playa Vista			26				
Santa Monica-Culver City-Beverly Hills			32				
Malibu			0				
Other			1				
Total	1	0	97	0	0	0	0
Service Area 6 Communities							
USC S.			70			1	
Baldwin Hills S.			225			0	
Hancock N.			383			0	
USC E.			94			0	
Watts			395			1	
Florence-Firestone			71			1	
Lynwood			57			0	
Paramount			49			0	
Compton			337		0	2	
Other			25				
Total	0	0	1707	0	0	5	0

other communities saw over 300 youths under supervision: the Long Beach N. area (522), the Wilmington area (398), and the Gardena-Lawndale area (347). Ethnically, Hispanic youths accounted for 45.4% of the probationers under supervision, followed by African-Americans, 36.6%, and Whites, 9.5%.

Hispanic	Japanese	Korean	Laotian	Oth Asian	Other	Pacific Is	Samoan	Unknown	Vietnam	White	Total
50				0	2	1		1		7	100
136		1			5	0		0		9	173
99		0		1	8					2	119
205		1		0	5					3	242
308				0	5					11	357
244				1	5	1		0		0	259
25					1			0		0	32
5					0			0		0	12
1		0			1	0				3	6
4					0	0				0	4
1078	0	2	0	2	32	2	0	1	0	34	1304
0				0	2			0		6	10
54					3			1		12	95
5					1			0		2	14
8					0			0		1	15
33					2			2		11	74
47				1	14			2		43	138
				1						1	2
0					0						1
147	0	0	0	2	22	0	0	5	0	75	349
73					1					1	145
100					5			0		3	333
198					1			1		1	584
209				1	0			1		0	305
307				0	4			1		6	714
126				0	1	0		0		1	200
145			0		2			0		0	204
94				1	0	1		0		5	150
300			1	0	4	1	1	1		3	651
9					0					0	35
1562	0	0	1	2	19	2	1	4	0	20	3322

Table 3.43 continued
Service Area Communities: Supervised Youths (actual population counts)[1]

Service Area 7 Communities	Am Ind	Asian Ind	Afri Am	Cambod	Chinese	Filipino	Hawaiian
East LA			8			0	
Downey			19			1	
Norwalk	0		19			0	
Whittier			3				
Montebello			4			1	
Bell Gardens-Bell-Maywood-Cudahy-Commerce			3			0	0
Huntington Park			15			1	
South Gate			4			0	
Bellflower	1		56			1	1
La Mirada-Santa Fe Springs			10				
Lakewood-Cerritos-Artesia-Hawaiian Gardens	1		37			1	1
Signal Hill			7	0		0	0
Other	0	0	0	0		0	0
Total	2	0	186	0		3	4
							0
Service Area 8 Communities							
Hancock S.			15				
Wilmington			66			3	1
Inglewood			135				
Torrance			12			1	2
Long Beach N.			220	2		2	3
Long Beach S.			335	2		1	4
Long Beach E.			28	0		0	1
Carson			61				3
Palos Verdes-Lomita			8				0
Redondo-Manhattan-Hermosa-El Segundo			4				1
Gardena-Lawndale			194				
Hawthorne			79				
Other	0	0	8	0		0	0
Total	0	0	1164	4		4	17
							1
Total	5	1	4545	6		43	48
							2

Hispanic	Japanese	Korean	Laotian	Oth Asian	Other	Pacific Is	Samoan	Unknown	Vietnam	White	Total
265					2					1	276
181				1	4	0		0		23	229
191				0	3					15	228
213				0	0			1		29	248
285				0	1			0		7	298
310					1					5	319
185				0	1			0		2	204
213				0	1	1		1		2	222
109				2	3					18	191
199				1	2			2		47	260
123				3	11	1	0			38	216
8				0	3	0		0		3	21
11	0	0	0	1	0	0	0	0	0	2	14
2293	0	0	0	8	33	2	0	4	0	192	2726
10					0					1	26
282	1			1	11	1	0	1		31	398
89			1		3	0		0		1	230
34					8	1				33	91
203				1	53	4	1	1		31	522
399				9	91		0	4		47	891
36				0	12	0		0		58	135
91	0			1	8	4	2			9	178
24	0			0	3	2		0		14	51
19					3	0		0		53	80
137				1	6	0		0		9	347
114					8	2		1		13	216
7	0	0	0	0	0	0	0	0	0	1	15
1444	1	0	1	13	206	13	4	7	0	301	3180
10819	9	7	2	50	548	21	6	1855	2	1646	19615

1.

100 – 200
200—300
> 300

INDICATORS FOR STIGMA AND DISCRIMINATION

Language Capacity of Mental Health Providers

Description of Indicator

This indicator reports on the language capabilities of therapists working in Department of Mental Health directly-operated and contracted clinics during fiscal year 2006-07.

Research Base and Relevance to PEI

It is difficult to find a single measure of mental health stigma or discrimination for Los Angeles County. Like other forms of discrimination, it is difficult to identify, quantify, and track. Only recently have hate crimes committed against individuals with mental disorders been tallied. The FBI reported 74 "anti-mental disability" crimes were logged by local law enforcement across the county in 2006; Los Angeles County only had one official "anti-disability"-related hate crime investigated (FBI, 2006).

Mental health stigma (including self-stigma) has been found to be a barrier to mental health treatment. We do not have any firm numbers detailing how much stigma prevents individuals in Los Angeles County from accessing treatment, though we do know it contributes, in part, to this problem. One way that we can look at this is to examine the language capacity of clinics to treat individuals most vulnerable to mental health stigma and discrimination: ethnic minorities. Because the burden of mental health stigma is the most extreme for populations already experiencing discrimination, it is important to have in place clinicians who can communicate with clients in their primary language and who are versed in their client's cultural milieu. Doing so may attenuate the numbers of individuals experiencing a double stigma by providing them with someone who can address the issues within an appropriate cultural context (Gary, 2005).

Table 3.44

Countywide Summary:
DMH Providers and Clients

	Rendering Providers[1]	DMH Clients[2]
Countywide Programs	12,719	190,058
Service Area 1	629	7,555
Service Area 2	2,657	24,885
Service Area 3	2,982	18,738
Service Area 4	2,356	42,250
Service Area 5	1,172	8,764
Service Area 6	2,099	20,559
Service Area 7	1,343	17,861
Service Area 8	2,441	25,412
Total	28,398	356,082

1. Providers that served DMH clients during calendar year 2007.
2. Clients served by LA County DMH providers during fiscal year 2006-07.

What the Numbers Show

In order to get a sense for the population numbers involved, Table 3.44 shows that 28,398 rendering providers saw a total of 356,082 clients over the course of the reporting period. Dividing the number of providers into the number of clients yields a benchmark case load of 12.5 clients/provider. Across the county, there are large variations in this figure due to regional and program differences.

Client-based Staffing Ratios

Table 3.45 depicts county mental health therapist language abilities across identified primary languages. Calculating a Client/Provider ratio tells us that on average, for

each English-speaking rendering provider, (i.e., a mental health therapist), there are 7.7 clients who have identified them as English-speaking. If one uses this figure as a benchmark of service, then one would be interested to determine which ethnic groups were above and below this number. Ethnicities with higher ratios indicated that there were fewer therapists with a particular language capability. Among the highest of these appeared to be the Cambodian population (23.4), the Armenian population (13.2), and the Vietnamese population (9.5). One should also make note of the "Other" category, which is so often ignored. These data indicate that 26,581 clients reported a language other than the identified threshold languages. It is impossible to tell from these data whether the rendering providers were able to meet the needs of the "Others" as their language capabilities were not specified with this data set. Future data gathering should attempt to rectify this by becoming more specific. In a county as large as Los Angeles, there will be a multitude of language needs that are unmet that fall below the language thresholds. Documenting these unmet needs is a first step in providing services to this large and linguistically diverse group of clients.

Table 3.45

Countywide Summary: Mental Health Providers' Language Capacity - Client-based

Threshold Languages	Rendering Providers[1]	DMH Clients Self Reported Primary Language	Client/ Provider
Arabic	55	117	2.1
Armenian	121	1599	13.2
Cambodian	57	1332	23.4
Cantonese	157	575	3.7
English	16127	124981	7.7
Farsi	153	408	2.7
Korean	269	1220	4.5
Mandarin	265	571	2.2
Other Chinese	59	214	3.6
Russian	126	393	3.1
Spanish	4056	30467	7.5
Tagalog	192	392	2.0
Vietnamese	119	1132	9.5
Other	1163	26581	22.9
Total	22919	189982	8.3

1: Rendering Providers that rendered a service to a client in calendar year 2007. The total count for providers exceeds the unique count because a provider may report more than one language. Includes directly operated clinic staff, contacted providers, and fee for service providers.

Population-based Staffing Ratios

Table 3.46, drawn from different sources than Table 3.45 depicts ethnic population/ rendering provider ratios. This differs from the data in the Table 3.45 which was limited to mental health clients. Table 3.46, calculates its ratios using general population data (instead of the mental health client population) and adds an additional calculation to standardize the number of rendering providers/10,000 individuals. Calculating staffing ratios in this manner resulted in a somewhat different picture. In Table 3.46, cells are highlighted in red to show areas where the numbers of therapists/10,000 is less than five. Additionally, an asterisk appears next to figures where the population numbers were less than 1,000 individuals. It is important to look at both the rate and whether there were sizeable numbers of individuals living in a given area. In Service Area 6, for example, the summary table indicated that there were 265 therapists who could speak Vietnamese/10,000 Vietnamese-speaking individuals. The asterisk next to this figure indicates that fewer than 1,000 Vietnamese speakers were

actually living in Service Area 6; so we know that the high rate is due to the small numbers of individuals involved.

Countywide, these data indicated that there were 41 English-speaking therapists/10,000 English speakers across the county. If we use this as a benchmark then we see that only Mandarin speakers (67) have a higher therapist rate. The lowest rates were found for Chinese (3), Armenian (8), Tagalog (8), and Arabic (10) speakers, who had 10 or fewer therapists/10,000. Spanish speakers had 11 therapists/10,000, or less than a third of what was available to English speakers.

It is unclear how much of the discrepancy between the two tables (3.45, 3.46) is accounted for by mental health stigma, but it is likely that some stigma works as a barrier to accessing services. Individuals are more apt to contact mental health therapists when they know they speak a common language. The gap between what is currently offered, what is currently being utilized, next to the population numbers may be a fuzzy indication of where a stigma-busting intervention may be of use. Consider Armenian speakers, for instance, who in Table 3.45 were shown to have one of the highest client/therapist ratios across the county, an indication of need. Next, examine the low therapist ratio in Table 3.46, which indicates that there are only 7 therapists/10,000 Armenian speakers across the county, another broader indication of need. And, finally, consult the population tables (cf. Table 3.0) to verify that there are over 140,000 Armenian speakers in the county, a sizeable population. However, not every population is as clear.

It is arguable that failure to provide adequate staffing to meet the language needs of the county's population is institutional discrimination. These data indicated that virtually all threshold language groups had staffing ratios that were disproportionately smaller than for English speakers. The discrepancy is likely to be even larger when one considers the relative prevalence of mental illness across language groups compared to English speakers. Using estimates of individuals with mental illness across ethnicities as the denominator for the calculated staffing ratios instead of actual population estimates would yield even more divergent results.

Service Area Communities

Service Area 1: Antelope Valley
Across the service area, staffing ratios for English speakers (29) was over three times the ratio for Spanish speakers (8) and over four times that for Vietnamese speakers (7). For populations numbering over 1000 individuals, only Korean speakers (38) saw a staffing ratio that exceeded that for English speakers.

Service Area 2: San Fernando
Data for the La Tuna Cyn. and Brentwood N. areas were not available for analysis.

Across the service area, overall staffing ratios indicated that Armenian (4), Arabic (4), and Chinese speakers had the least resources available to them. Staffing ratios for Spanish speakers were low in the Panorama City area (3), Encino area (3) and North County W. area (0). Staffing ratios for Armenian speakers were low in virtually all communities where sizeable numbers of Armenian speakers resided with the exception of the Gra-

Table 3.46
Countywide Summary: Mental Health Providers' Language Capacity
- Population-based Staffing Ratios[1]

Service Area	English	Spanish	Armen	Farsi	Arabic	Russian	Canton	Chinese	Mandarin	Cambod	Korean	Vietnam	Tagalog	All Other
1	29	8	59*	65*	0	346*	1818*	23*	582*	0*	38	7	18	97
2	30	9	4	12	4	16	49	3	151	38	8	7	6	18
3	42	14	21	22	8	82	11	1	28	9	8	5	6	24
4	94	15	13	43	44	24	64	11	682*	52	17	95	8	43
5	29	29	11*	6	8	7	29	2	64	181*	13	15	17	21
6	57	8	809*	20	39*	170*	926*	52	665*	0*	170	265*	60	49
7	41	8	30	211*	20	32*	75	1	55	14	14	13	8	19
8	33	13	52	85	10	48	73	8	172	15	13	14	6	21
Total	41	11	8	18	10	24	30	3	67	19	14	13	8	26

1. Rendering Providers / 10,000 individuals

< 5

* < 1000 individuals

nada Hills and Woodland Hills areas. Staffing ratios for Farsi speakers were 0 in the Burbank, La Tuna Cyn., Brentwood N., and San Fernando-Calabasas-Agoura areas where there were over 1000 Farsi speakers in each of these areas. Staffing ratios for Arabic speakers was 0 in the Burbank and Granada Hills areas. Staffing ratios for Russian speakers were lowest in the Burbank area (3), North Hollywood area (4), and the Encino area (3). Chinese speakers in the Northridge and Encino communities had a staffing ratio of 0. Staffing ratios for Korean speakers was 0 in the Santa Clarita, Burbank, Panorama City, Encino, and North County W. areas. Staffing ratios for Vietnamese speakers was 0 in the North Hollywood and Woodland Hills areas. Staffing ratios for Tagalog speakers were 0 in the Panorama City, North Hollywood, Encino, and Woodland Hills areas.

Service Area 3: San Gabriel

Data for the Diamond Bar area were not available for analysis

Across the service area, Chinese (1), Tagalog (6), and Vietnamese (5) speakers had the fewest staffing resources available to them. Staffing ratios for English speakers (42) was exceeded only by the staffing ratio for Russian speakers (82) in populations over 1,000 individuals. Within the service area communities, Spanish speakers saw low staffing ratios in the Pomona area (4), the Baldwin Park-Azusa-Duarte area (2), the Diamond Bar area (0), and the Hacienda Heights area (0). Cantonese speakers saw low staffing ratios in the communities of Covina-Walnut (0) and Diamond Bar (0). Chinese speakers saw low staffing ratios (below 5) in all communities with the exception of the Pasadena area. Mandarin speakers saw similarly low staffing ratios in the Alhambra-S. Pasadena area (3) and the Diamond Bar area (0). Korean speakers saw staffing ratios below 5 in the Pomona area (0), the Arcadia-San Gabriel-Temple City-San Marino area (2), the Covina-Walnut area (4), the Diamond Bar area (0), and the Hacienda Heights area (0). Vietnamese speakers saw staffing ratios below 5 in all large communities, (i.e., over 1,000 indi-

Table 3.47

Service Area Communities: Mental Health Providers' Language Capacity - Population-based Staffing Ratios[1]

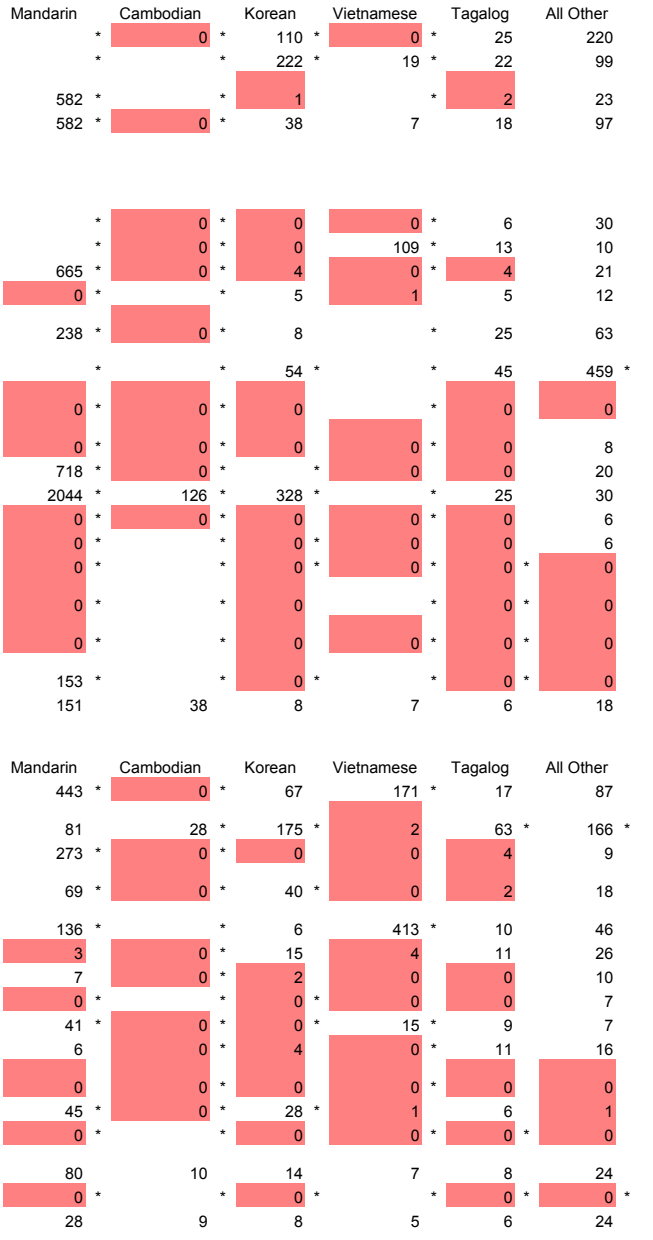
Service Area 1 Communities	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese
Lancaster	34	16	139 *	316 *	0 *	*	*	*
Palmdale	35	6	48 *	*	0 *	179 *	*	53 *
North County E.	12	3	29 *	1 *	0 *	21 *	0 *	0 *
Total	29	8	59 *	65 *	0	346 *	1818 *	23 *
Service Area 2 Communities								
Santa Clarita	27	7	204 *	128 *	0 *	701 *	0 *	0 *
Burbank	14	12	0	0	0	3	0 *	0 *
Glendale	31	10	4	16	6	30	230 *	0 *
Northridge	32	31	4	9	0 *	44 *	0 *	0
Granada Hills	36	11	17	284 *	0	58	*	0 *
Pacoima-Arleta	199	12	*	*	*	109 *	*	*
La Tuna Cyn.		0	0	0	*	0 *	0 *	0 *
Panorama City		3	2	308 *	0 *	81 *	*	0 *
North Hollywood	33	7	1	519 *	3	4	0 *	0 *
Sherman Oaks	132	18	3	154 *	0 *	6	681 *	88 *
Encino	7	3	0	2	8	3	0 *	0
Woodland Hills	14	8	17	5	0 *	20	0 *	0 *
Brentwood N.	0	0	0 *	0	0 *	0	0 *	0 *
North County W.	0	0	0 *	0 *	0 *	0 *	0 *	0 *
La Canada-Flintridge	0	0	0	*	0 *	0 *	0 *	0 *
San Fernando-Calabasas-Agoura	6	8	*	0	0 *	0 *	0 *	0 *
Total	30	9	4	12	4	16	49	3

Service Area 3 Communities	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese
Pasadena	160	99	51	0 *	135 *	144 *	35 *	7
El Monte	174	17	*	*	*	168 *	29	3
Pomona	29	4	0 *	*	*	*	0 *	0
West Covina	21	10	147 *	*	8	*	15	0
Altadena-Monrovia-Sierra Madre	35	28	3	*	0	1 *	50 *	0 *
Alhambra-S. Pasadena	45	41	67 *	0 *	42 *	0 *	3	1
Arcadia-San Gabriel-Temple City-San Marino	10	11	0 *	49 *	0 *	*	5	0
Baldwin Park-Azusa-Duarte	8	2	0 *	0 *	0 *	0 *	0 *	0 *
Glendora-Claremont-San Dimas-La Verne	23	15	0	49 *	3	0 *	0 *	0
Covina-Walnut	38	11	0 *	*	0 *	2 *	0	0
Diamond Bar	0	0	0 *	0 *	0	*	0	0
La Puente-S. El Monte	20	5	0 *	*	0 *	*	8 *	23 *
Hacienda Heights	0	0	0 *	*	0 *	0 *	0 *	0
Monterey Park-Rosemead	71	9	*	48 *	*	*	21	2
Other	0 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *
Total	42	14	21	22	8	82	11	1

viduals), with the exception of the Monterey Park-Rosemead area (7). Tagalog speakers saw low staffing ratios in the Pomona area (4), the West Covina area (2), the Arcadia-San Gabriel-Temple City-San Marino area (0), the Baldwin Park-Azusa-Duarte area (0), the Diamond Bar area (0), and the Hacienda Heights area (0).

Service Area 4: Metro

Across the service area, staffing ratios for



English speakers were six times greater than ratios for Spanish speakers; seven times greater than ratios for Armenian speakers; two times greater than ratios for Farsi speakers; two times greater than ratios for Arabic and Cambodian speakers; four times greater than ratios for Russian speakers; five times greater than ratios for Korean speakers; eight times greater than ratios for Chinese speakers; and twelve times greater than ratios for Tagalog speakers. Of the thirteen threshold languages, Tagalog speakers had the fewest resources allocated to them (8). About a quarter of all Tagalog speakers reside within Service Area 4, the largest Tagalog community in the county. Only Vietnamese speakers had resources allocated to them at a level similar to English speakers.

Service Area 5: West

Service Area 5 was the only service area where Spanish and English speakers had equal staffing ratios (29). Within the service area, Chinese speakers (2) had the fewest staff resource allocated to them (for populations > 1,000) followed by Farsi speakers (6), Russian speakers (7), and Arabic speakers (8).

Service Area 6: South

Across the service area, Chinese speakers (52), Korean speakers (170), and Tagalog speakers (60) had about the same or more staffing resources allocated to them compared to English speakers (57). Of the language groups with over 1,000 residents, Spanish speakers (8) had the fewest staff resources allocated to them, even though Spanish speakers were a majority of the population in the service area. In five communities, there were fewer than five Spanish-speaking therapists/10,000 Spanish speakers.

Table 3.47 continued

Service Area Communities: Mental Health Providers' Language Capacity - Population-based Staffing Ratios[1]

Service Area 4 Communities	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese
Wilshire La Brea E.	17	6	0 *	9	0 *	0 *	765 *	0 *
Hollywood	54	11	2	23	27 *	6	0 *	21 *
Pico Heights	418	28	405 *	380 *	22 *	*	*	0 *
Echo Park	173	18	38 *	*	159 *	248 *	105	12
Highland Park	89	14	21	*	78 *	*	2	3
Downtown	403	13	360 *	*	*	*	162	24
USC N.	0	0	*	*	*	0 *	0 *	0 *
West Adams	0	0	*	0 *	*	0 *	0 *	0 *
West Hollywood	0	0	*	0	0 *	0 *	0 *	0 *
Other	0 *	0	*	*	*	0 *	0 *	0 *
Total	94	15	13	43	44	24	64	11

Service Area 5 Communities	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese
Brentwood S.	0	0	0 *	0	0 *	0	0 *	0 *
West LA	42	40	0 *	7	5	16	20	2
Wilshire La Brea W.	0	0	0 *	0 *	0 *	0 *	0 *	0 *
Baldwin Hills W.	0	0	*	0 *	*	0 *	0 *	0 *
Playa Vista	8	6	*	38 *	0 *	0 *	0 *	0 *
Santa Monica-Culver City-Beverly Hills	52	81	*	6	26 *	7	251 *	0 *
Malibu	0	0	*	0 *	0 *	0 *	0 *	0 *
Other	0 *	0 *	*	*	*	*	*	*
Total	29	29	11 *	6	8	7	29	2

Service Area 6 Communities	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese
USC S.	223	32	*	*	*	0 *	836 *	45 *
Baldwin Hills S.	18	11	*	0 *	*	0 *	0 *	25 *
Hancock N.	22	3	*	*	*	*	*	*
USC E.	117	4	*	*	0 *	*	*	*
Watts	66	6	*	*	*	*	*	*
Florence-Firestone	0	0	0 *	*	*	*	*	0 *
Lynwood	0	0	*	*	*	*	*	*
Paramount	0	0	*	0 *	0 *	*	0 *	0 *
Compton	93	20	*	*	313 *	*	*	34 *
Other	0	0 *	*	0 *	0 *	0 *	0 *	0 *
Total	57	8	809 *	20	39 *	170 *	926 *	52

Service Area 7: East

In Service Area 7, where Spanish speakers were a majority of the population, all language groups with the exception of Chinese speakers (2) had higher staffing ratios than those found for Spanish speakers (7). Four communities with sizeable Spanish-speaking populations had fewer than five Spanish-speaking therapists/10,000: the Montebello area (0), the Bell Gardens-Bell-Maywood-



Cudahy-Commerce area (2), the Huntington Park area (4), and the South Gate area (1).

Service Area 8: South Bay

Across the service area, English speakers had a staffing ratio of 32. Only Russian speakers (41), Mandarin speakers (154), and Cantonese speakers (57) had more language-capable therapist resources available to them than for English speakers; all other language groups had fewer. Of these, Arabic speakers, who numbered over 1,000 individuals, had the lowest staffing ratio (5), followed by Tagalog (6) and Farsi speakers (8).

Table 3.47 continued

Service Area Communities: Mental Health Providers' Language Capacity - Population-based Staffing Ratios[1]

Service Area 7 Communities	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese
East LA	199	8	*	*	*	0 *	0 *	0 *
Downey	8	1	0 *	*	10 *	*	*	*
Norwalk	46	6	*	*	0 *	0 *	255 *	0 *
Whittier	12	7	54 *	*	0 *	0 *	25 *	0
Montebello	33	9	0 *	*	*	0 *	0 *	0
Bell Gardens-Bell-Maywood-Cudahy-Commerce	215	10	*	*	36	*	*	*
Huntington Park	146	4	0 *	*	*	*	*	0 *
South Gate	117	6	*	*	*	*	*	*
Bellflower	25	4	*	0 *	0 *	*	0 *	0 *
La Mirada-Santa Fe Springs	28	16	*	*	0 *	*	*	*
Lakewood-Cerritos-Artesia-Hawaiian Gardens	34	35	*	*	0 *	151 *	85 *	0
Signal Hill	0	0 *	*	0 *	0 *	0 *	0 *	0 *
Other	0	0	0 *	0 *	0 *	*	0 *	0
Total	41	8	30	211 *	20	32 *	75	1

Service Area 8 Communities	English	Spanish	Armenian	Farsi	Arabic	Russian	Cantonese	Chinese
Hancock S.	0	0	*	*	*	*	*	*
Wilmington	21	6	*	0 *	0 *	0 *	0 *	7
Inglewood	29	5	*	*	*	*	*	*
Torrance	33	33	0	61 *	0	55 *	16 *	0
Long Beach N.	81	32	*	325 *	0 *	114 *	239 *	17
Long Beach S.	51	7	*	198 *	*	*	0 *	56 *
Long Beach E.	11	9	*	74 *	0 *	*	0 *	0 *
Carson	177	64	*	*	*	88 *	*	29
Palos Verdes-Lomita	2	2	*	0 *	0 *	0 *	0 *	0
Redondo-Manhattan-Hermosa-El Segundo	4	7	0 *	0 *	0 *	0 *	0 *	0 *
Gardena-Lawndale	9	2	*	0 *	*	*	164 *	0 *
Hawthorne	10	1	*	*	0	22 *	*	0 *
Other	0	0	*	*	0 *	0 *	0 *	0 *
Total	33	13	52	85	10	48	73	8

Mandarin	Cambodian	Korean	Vietnamese	Tagalog	All Other
296	*	154	*	*	748
*	0	3	32	0	3
101	0	0	74	2	12
6	*	0	0	11	6
70	0	124	56	10	12
*	*	*	*	32	208
*	*	151	*	125	50
*	0	71	*	319	84
*	0	0	0	0	8
*	0	19	0	26	41
67	44	23	7	6	17
0	0	0	0	0	0
0	0	0	0	0	0
55	14	14	13	8	19

Mandarin	Cambodian	Korean	Vietnamese	Tagalog	All Other
*	0	*	*	0	0
205	58	4	*	4	13
*	*	*	*	176	46
30	*	0	0	15	5
*	35	106	6	11	57
661	11	37	17	6	30
131	0	0	0	6	20
3013	0	69	192	4	183
0	0	0	0	0	1
0	*	0	0	0	1
419	*	11	13	7	7
0	0	0	0	6	3
0	0	0	0	0	0
172	15	13	14	6	21

1. Rendering Providers / 10,000 individuals

≤ 5

* < 1000 individuals

INDICATORS FOR SUICIDE RISK

Deaths by Suicide

Description of Indicator

Numbers of suicides are reported by community for the year 2003.

Research Base and Relevance to PEI

Reducing suicide risk is a key PEI mental health initiative. The number of completed suicides is important to consider since it may reveal neighborhood effects contributing to an individual's environmental stress. Completed suicides represent failures in the mental health system to identify and adequately treat individuals at risk.

What the Numbers Show

Suicide rates were calculated and standardized to the number of suicides/100,000 residents. Across the county, the suicide rate was 7.0. Data indicated that Service Area 5 had the highest suicide rate (10.6), followed by Service Area 1 (9.9) and Service Area 4 (8.4). By inspection, a few trends were apparent: males were at higher risk than females, Whites and Native Americans were at higher risk than other ethnicities, and older adults were at higher risk than other age groups.

Service Area Communities (Tables 3.48, 3.49)

Service Area 1: Antelope Valley

Service Area 1 data indicated that males had higher suicide rates than females in all communities. Across ethnicities, Whites had the highest suicide rates in all communities. In the Lancaster area, for example, the suicide rate for Whites was five times that for Latinos. Across age groups, Older Adults were at higher risk than all other groups. The Lancaster area (40.2) had one of the highest suicide rates in the county for Older Adults. Additionally, there was a relatively high rate seen for the TAY population (29.4) in the surrounding North County E. area.

Table 3.48

Countywide Summary: Suicide Rate

Service Area	Suicides/100k
1	9.9
2	7.7
3	5.4
4	8.4
5	10.2
6	3.8
7	6.5
8	7.3
Total	7.0

Service Area 2: San Fernando

Service Area 2 had an overall suicide rate of 7.7, which was above the countywide rate of 7.0. Summary tables indicate that Whites, Males, Adults, and Older Adults are at most risk for committing suicide. The suicide rates were particularly high for Whites residing in the Panorama City. Other ethnic groups with elevated suicide rates include African-Americans residing within the Brentwood N. area and Asians residing within the La Canada-Flintridge area.

Service Area 3: San Gabriel

Overall, Service Area 3 had a suicide rate of 5.4, which was below the countywide rate of 7.0. Mirroring countywide trends, summary statistics indicated that Whites, Males, and Older Adults were at most risk for committing suicide. Whites (52.6) residing in the La

Puente-S. El Monte area had the highest rates in the service area. Whites also had a relatively high rate in the Monterey Park-Rosemead area (29.8). African-Americans (26.7) were at risk in the Glendora-Claremont-San Dimas-La Verne area. Adults and Older adults were at risk throughout the service area; seven areas had rates above 10/100,000 for either or both of these groups: the Alhambra-S. Pasadena, Arcadia-San Gabriel-Temple City-San Marino, Baldwin Park-Azusa-Duarte, Glendora-Claremont-San Dimas-La Verne, Covina-Walnut, and La Puente-S. El Monte areas.

Service Area 4: Metro
Service Area 4 had an overall suicide rate of 8.4, which was above the countywide rate of 7.0. Males, Whites, and Older Adults had the highest suicide rates within their respective categories. The West Hollywood area (39.9) had the highest rate within the gender category. Six areas saw White rates exceeding 25.0 and two areas saw African-American rates exceeding 25.0. Whites in the Pico Heights (92.7) area had the highest suicide rate in any category across the county. Four communities within the service area had overall suicide rates in excess of 50.0. Two of these areas, Pico Heights (77.0) and Hollywood (72.8), had exceptionally high rates (above 70).

Service Area 5: West
Overall Service Area 5 had the highest suicide rate across the County, 10.2. Again, Males, Whites and Older Adults had the highest rates within their respective categories. Within the Service Area, the highest rates were seen for the older adult population. The Playa Vista area (12.6) had the highest suicide rate within the Service Area followed by the West LA area (11.5) and the Malibu area (10.4).

Service Area 6: South
Service Area 6 had an overall suicide rate of 3.8, which was the lowest seen in the county. Even so, the countywide trends were still evidenced here: the highest suicide rates were found in Males, Whites, Adults, and Older Adults. Whites were most at risk in the USC S. (40.8) and Baldwin Hills S. (49.2) areas, African-Americans were most at risk in the Lynwood area (33.6), and Asians (38.2) in the USC S. area. The USC S. area (8.6) had the highest suicide rate within the service area followed by the Compton area (6.0).

Service Area 7: East
Service Area 7 had an overall suicide rate of 6.5, which was a bit below the countywide rate of 7.0. countywide trends seen in other service areas were also in evidence here. Individuals most at risk for suicide were Males, Whites, and Older Adults across their respective demographic categories. (though the rates for TAY and Adults were fairly close to the Older Adult rate.) The suicide rate was particularly high for Whites in the Montebello area (56.3), followed by the La Mirada-Santa Fe Springs area (33.7), the Downey area (27.3), and the Whittier area (26.9).

Service Area 8: South Bay
Service Area 8 had an overall suicide rate of 7.3, which was about the countywide aver-

Table 3.49

Service Area Communities Summary: Suicide Rate[1,2]

	Gender		Ethnicity						Age Groups				
Service Area 1	Male	Female	White	Latino	Afr-Am	Asian	Am Ind	Other	0-15	16-25	26-59	60+	Total
Lancaster	19.0	7.1	25.5	5.0	1	0.0	0.0	0.0	0.0	4.6	16.7	40.2	12.8
Palmdale	12.8	2.8	21.3	1.3	1	19.5	0.0	0.0	0.0	9.5	15.0	0.4	7.7
North County E.	16.4	2.2	10.3	8.3	1	0.0	0.0	0.0	0.0	29.4	6.3	23.9	8.9
Total	15.9	4.2	19.0	3.5	1	6.9	0.0	0.0	0.0	11.2	13.3	23.7	9.9

Service Area 2	Male	Female	White	Latino	Afr-Am	Asian	Am Ind	Other	0-15	16-25	26-59	60+	Total
Santa Clarita	10.2	4.8	11.2	4.5	0	0.0	0.0	0.0	0.0	15.9	10.6	4.7	7.6
Burbank	18.6	1.9	13.7	14.2	0	0.0	160.0	0.0	0.0	0.0	17.6	5.9	10.0
Glendale	16.8	1.0	27.7	11.0	0	0.0	0.0	0.0	0.0	8.0	12.0	11.0	9.0
Northridge	12.2	4.6	15.9	2.5	1	3.4	0.0	0.0	0.0	5.0	10.8	13.6	8.3
Granada Hills	8.6	6.0	11.8	3.9	2	0.0	0.0	0.0	0.0	9.9	12.2	0.0	7.4
Pacoima-Arleta	10.6	1.7	36.3	4.0	0	0.0	0.0	0.0	0.0	4.7	10.1	7.8	6.0
La Tuna Cyn.	10.8	2.9	19.4	4.3	0	0.0	0.0	0.0	0.0	5.9	9.4	11.7	6.8
Panorama City	8.0	2.9	53.6	2.0	0	0.0	0.0	0.0	0.0	9.5	3.0	31.3	5.5
North Hollywood	9.4	1.4	15.9	0.0	0.0	13.6	0.0	0.0	0.0	5.5	2.8	26.0	5.2
Sherman Oaks	15.4	3.7	24.5	4.6	20.7	15.7	0.0	0.0	0.0	18.2	12.7	5.2	9.7
Encino	20.4	7.4	32.5	0.0	0.0	20.5	0.0	0.0	0.0	16.1	18.2	17.5	14.0
Woodland Hills	11.3	1.3	13.4	3.8	0.0	0.0	0.0	0.0	0.0	13.3	8.0	4.5	6.3
Brentwood N.	16.6	4.5	12.4	17.1	40.7	0.0	0.0	0.0	0.0	12.7	10.6	17.5	10.3
North County W.	1.0	3.3	1.1	6.0	0.0	0.0	0.0	0.0	0.0	0.7	4.0	1.5	2.2
La Canada-Flintridge	10.5	0.0	5.4	0.0	0.0	27.6	0.0	0.0	0.0	0.0	5.0	15.4	4.9
San Fernando-Calabasas-Agoura	7.0	0.0	2.1	7.6	0.0	0.0	0.0	0.0	4.2	0.0	4.4	0.9	3.3
Total	12.3	3.2	16.0	4.0	9.0	4.1	0.0	0.0	0.2	9.2	10.1	10.9	7.7

Service Area 3	Male	Female	White	Latino	Afr-Am	Asian	Am Ind	Other	0-15	16-25	26-59	60+	Total
Pasadena	1.4	0.0	0.1	0.0	0.0	5.7	0.0	0.0	0.0	5.8	0.0	0.1	0.7
El Monte	6.5	0.0	12.8	4.2	0.0	0.0	0.0	0.0	0.0	0.0	5.7	7.4	3.6
Pomona	4.0	1.3	18.6	1.2	0.0	0.0	0.0	0.0	0.0	0.0	6.0	0.0	2.7
West Covina	7.0	0.0	11.0	2.8	0.7	0.0	0.0	0.0	0.0	6.7	5.1	0.0	3.1
Altadena-Monrovia-Sierra Madre	14.0	1.7	14.0	4.1	0.0	1.3	0.0	0.0	0.0	1.0	9.4	17.3	7.5
Alhambra-S. Pasadena	10.6	1.9	4.7	8.1	0.0	6.4	0.0	0.0	0.0	0.0	11.5	0.0	5.9
Arcadia-San Gabriel-Temple City-San Marino	16.6	0.0	18.0	3.7	0.0	3.9	0.0	0.0	0.0	0.0	11.3	11.4	7.9
Baldwin Park-Azusa-Duarte	10.3	1.1	13.9	4.7	0.0	6.2	0.0	0.0	0.0	3.3	7.9	14.5	5.6
Glendora-Claremont-San Dimas-La Verne	18.3	7.6	18.5	6.8	26.7	0.0	0.0	0.0	3.2	0.0	18.0	17.8	12.8
Covina-Walnut	5.3	1.8	3.5	2.0	17.6	5.2	0.0	0.0	0.0	11.9	1.8	6.1	3.6
Diamond Bar	7.5	1.8	5.0	0.0	0.0	7.6	0.0	0.0	0.0	0.0	1.9	23.9	4.6
La Puente-S. El Monte	11.3	5.7	52.6	4.9	0.0	14.9	0.0	0.0	0.0	18.8	13.9	0.0	8.6
Hacienda Heights	3.8	0.0	0.0	0.0	0.0	12.7	0.0	0.0	0.0	0.0	4.3	0.0	1.8
Monterey Park-Rosemead	8.1	0.0	29.8	2.5	0.0	2.8	0.0	0.0	0.0	0.0	5.1	8.6	4.1
Total	9.3	1.7	12.7	3.3	2.6	4.3	0.0	0.0	0.2	3.5	7.6	8.6	5.4

Service Area 4	Male	Female	White	Latino	Afr-Am	Asian	Am Ind	Other	0-15	16-25	26-59	60+	Total
Wilshire La Brea E.	14.1	7.0	19.9	0.0	11.1	15.1	0.0	0.0	0.0	5.1	12.4	23.2	10.5
Hollywood	16.8	5.8	30.8	1.9	41.5	7.8	0.0	0.0	0.0	0.0	15.5	24.3	11.4
Pico Heights	14.2	3.4	92.7	2.8	42.6	8.5	0.0	0.0	0.0	6.1	14.2	8.6	9.0
Echo Park	7.1	4.3	27.0	2.6	0.0	4.3	0.0	0.0	0.0	5.6	6.8	15.2	5.8
Highland Park	10.2	1.8	31.9	3.6	0.0	2.8	0.0	0.0	0.0	3.0	8.8	9.8	6.0
Downtown	8.5	1.6	20.9	3.6	0.0	15.1	0.0	0.0	0.0	4.9	7.1	10.5	5.2
USC N.	10.2	0.0	0.0	7.5	0.0	0.0	0.0	0.0	0.0	0.0	10.5	0.0	4.9
West Adams	24.4	0.0	0.0	0.0	21.2	0.0	0.0	0.0	0.0	72.8	0.0	0.0	11.2
West Hollywood	39.9	0.0	35.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	20.0	39.7	19.5
Total	12.7	3.8	29.3	2.8	14.1	7.5	0.0	0.0	0.0	4.3	11.3	16.6	8.4

Service Area 5	Male	Female	White	Latino	Afr-Am	Asian	Am Ind	Other	0-15	16-25	26-59	60+	Total
Brentwood S.	13.2	7.4	13.8	19.0	0.0	0.0	0.0	0.0	0.0	28.1	4.7	25.9	10.2
West LA	17.8	5.5	18.3	9.3	15.2	5.8	0.0	0.0	0.0	3.2	15.5	17.2	11.5
Wilshire La Brea W.	7.7	0.0	12.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.8	0.0	3.8
Baldwin Hills W.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Playa Vista	24.1	1.7	18.2	9.0	12.8	0.0	0.0	0.0	0.0	10.0	13.7	21.9	12.6
Santa Monica-Culver City-Beverly Hills	16.6	2.3	16.8	0.0	0.0	0.0	0.0	0.0	0.0	7.1	8.3	19.3	9.2
Malibu	11.0	9.9	18.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	21.6	0.0	10.4
Total	16.9	3.9	16.9	6.0	4.3	3.0	0.0	0.0	0.0	7.1	11.1	18.7	10.2

Service Area 6	Male	Female	White	Latino	Afr-Am	Asian	Am Ind	Other	0-15	16-25	26-59	60+	Total
USC S.	18.0	0.0	40.8	4.4	12.3	38.2	0.0	0.0	0.0	16.2	12.5	0.0	8.6
Baldwin Hills S.	8.2	1.4	49.2	0.0	5.7	0.0	0.0	0.0	0.0	0.0	6.7	9.5	4.5
Hancock N.	4.2	0.0	0.0	1.2	3.2	0.0	0.0	0.0	0.0	0.0	3.1	5.7	2.0
USC E.	1.6	1.7	0.0	0.0	15.5	0.0	0.0	0.0	0.0	0.0	4.1	0.0	1.6
Watts	4.5	0.0	0.0	3.4	0.0	0.0	0.0	0.0	0.0	3.2	1.6	15.8	2.5
Florence-Firestone	4.1	0.0	0.0	2.3	0.0	0.0	0.0	0.0	0.0	6.1	2.5	0.0	2.1
Lynwood	5.6	0.0	0.0	1.4	33.6	0.0	0.0	0.0	0.0	0.0	6.3	0.0	2.6
Paramount	14.4	0.0	22.2	2.9	21.6	0.0	0.0	0.0	0.0	0.0	11.6	16.8	7.0
Compton	10.9	1.3	0.0	4.9	8.2	0.0	0.0	0.0	2.2	7.9	9.6	0.0	6.0
Total	6.9	0.6	23.1	2.2	6.2	6.9	0.0	0.0	0.3	3.5	5.9	6.0	3.8

age. As in the other service areas, the South Bay saw similar trends in high-risk populations: Males, Whites, Adults, and Older Adults. Whites had the highest rates of suicide within the Carson area (63.6), Hawthorne area (37.1), Long Beach S. area (30.9), and the Gardena-Lawndale area (28.2). The Adult and Older Adult population had high suicide rates five service area communities. Of these, the Long Beach E. area (14.3) had the highest community rate followed by the Redondo-Manhattan-Hermosa-El Segundo area (12.1) and the Carson area (11.6). The highest rate seen for Older Adults occurred

Table 3.49 continued

Service Area Communities Summary: Suicide Rate

Service Area 7	Male	Female	White	Latino	Afr-Am	Asian	Am Ind	Other	0-15	16-25	26-59	60+	Total
East LA	9.6	1.5	0.0	5.6	0.0	0.0	0.0	0.0	2.6	12.7	5.6	0.0	5.4
Downey	12.2	3.7	27.3	4.1	0.0	0.0	0.0	0.0	0.0	6.2	12.2	13.8	8.0
Norwalk	9.6	3.8	0.0	6.7	0.0	12.2	0.0	0.0	0.0	12.5	7.8	9.6	6.7
Whittier	15.9	5.0	26.9	6.0	0.0	5.9	0.0	0.0	0.0	0.0	16.0	20.5	10.3
Montebello	9.0	3.1	56.3	3.6	0.0	0.0	0.0	0.0	3.1	21.0	4.9	0.0	6.1
Bell Gardens-Bell-Maywood-Cudahy-Commerce	8.8	0.0	23.0	3.8	0.0	0.0	0.0	0.0	0.0	9.2	4.8	10.2	4.3
Huntington Park	17.7	0.0	182.3	7.8	0.0	0.0	0.0	0.0	5.8	21.2	8.6	0.0	9.3
South Gate	12.7	1.8	0.0	7.5	0.0	0.0	0.0	0.0	0.0	5.9	14.2	0.0	6.9
Bellflower	5.5	5.1	33.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.8	25.4	5.3
La Mirada-Santa Fe Springs	2.9	3.2	5.5	1.3	0.0	13.4	0.0	0.0	3.2	5.6	3.2	0.0	3.1
Lakewood-Cerritos-Artesia-Hawaiian Gardens	12.1	3.4	17.0	4.7	0.0	2.4	0.0	0.0	0.0	4.8	9.0	16.9	7.6
Signal Hill	8.4	1.6	7.1	6.3	0.0	3.2	0.0	0.0	0.0	8.8	6.8	4.8	5.0
Total	10.2	2.8	18.6	4.7	0.0	4.5	65.3	0.0	1.1	9.0	8.1	9.6	6.5

Service Area 8	Male	Female	White	Latino	Afr-Am	Asian	Am Ind	Other	0-15	16-25	26-59	60+	Total
Hancock S.	3.9	0.0	0.0	1.1	3.0	0.0	0.0	0.0	0.0	0.0	2.9	5.4	1.9
Wilmington	9.2	2.3	9.8	5.5	0.0	6.0	0.0	0.0	0.0	5.6	8.1	8.7	5.7
Inglewood	1.7	0.0	0.0	0.0	2.2	0.0	0.0	0.0	0.0	0.0	1.9	0.0	0.8
Torrance	10.4	5.7	13.3	0.0	0.0	7.4	0.0	0.0	0.0	0.0	11.6	11.0	8.0
Long Beach N.	2.7	1.3	11.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.2	0.0	2.0
Long Beach S.	11.0	5.3	30.9	3.3	6.9	5.5	0.0	0.0	0.0	5.9	10.8	24.0	8.2
Long Beach E.	25.0	4.6	19.9	5.1	0.0	0.0	0.0	0.0	0.0	5.7	20.4	16.9	14.3
Carson	21.2	3.3	63.6	2.5	4.1	7.8	0.0	0.0	0.0	7.1	15.9	21.4	11.6
Palos Verdes-Lomita	9.2	1.8	7.8	7.0	0.0	3.6	0.0	0.0	0.0	9.7	7.5	5.3	5.4
Redondo-Manhattan-Hermosa-El Segundo	17.1	7.3	12.8	15.4	64.9	9.0	0.0	0.0	0.0	35.3	13.4	11.6	12.1
Gardena-Lawndale	15.3	1.3	28.2	5.5	2.1	13.0	0.0	0.0	0.0	14.7	7.6	13.1	7.6
Hawthorne	5.5	5.8	37.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.5	45.2	5.6
Total	11.3	3.5	17.7	2.9	2.6	6.0	0.0	0.0	0.0	6.6	9.6	13.2	7.3
County Total	11.2	2.8	17.4	3.5	5.4	5.1	10.2	0.0	0.3	6.5	9.3	11.9	7.0

1.Suicides/100,000 for each population

2.Rates exceeding 100 are considered to be statistical anomalies.

3. 10-25
25-50
50-100

in the Hawthorne area (45.2). And the highest rate seen for the TAY population occurred in the Redondo-Manhattan-Hermosa-El Segundo area (35.3).

Mental Health Emergency Statistics

Description of Indicator
These indicators report on the numbers of phone calls made to the Department of Mental Health's emergency call center, ACCESS, for the 2005-06 fiscal year. Additionally, a Mental Health Emergency Rate (MHE-rate) was calculated and standardized to the number of calls/1000 residents in a given geographic location.

Research Base and Relevance to PEI
While an analysis of call content is not available, suicidal ideology, behaviors, or other self-injurious behaviors are often at the heart of a mental health emergencies. The ACCESS Center identifies risk and dispatches emergency response teams to further evaluate crisis situations. Thus, this indicator provides a measure of individuals in distress in the community, many of whom may be at risk for suicidal behaviors.

What the Numbers Show
Across the county for the reporting period, there were 57,541 calls made to the ACCESS Center requiring consultation and/or action by the county's Psychiatric Mobile Response Team (PMRT). An overall MHE-Rate of 5.9 meant that for every 1000 residents, about six emergency calls were placed to the Department of Mental Health. Table 3.50 shows in actual numbers that Service Area 2 was responsible for over 10,000 calls and this is consistent with its place as the largest service area in population across the county.

Service Area Communities: (Tables 3.50, 3.51)

Service Area 1: Antelope Valley
Overall, Service Area 1 had the highest MHE-Rate (9.4) for all service areas. The Lancaster area not only had one of the highest call counts in the county, but also the second-highest MHE-Rate, 12.4.

Service Area 2: San Fernando
Service Area 2 had the largest number of psychiatric emergency calls placed throughout the county (consistent with its largest population size). However, its MHE-Rate was 5.4, which was below the countywide figure of 5.9. Within the service area, the North Hollywood (1,008) and Sherman Oaks (1,279) areas had the most calls placed and also had the highest MHE-Rates, 7.5 and 7.7, respectively.

Service Area 3: San Gabriel
Overall, Service Area 3 had a MHE-Rate of 5.0, which was below the countywide rate of 5.9. Only one community, the aggregate of Glendora-Claremont-San Dimas-La Verne, saw the number of psychiatric emergency calls placed exceed 1,000. Otherwise, based upon population, the highest MHE-Rates were found in the El Monte area (7.2), the Altadena-Monrovia-Sierra Madre area (7.0), and the Glendora-Claremont-San Dimas-La Verne (6.6) area.

Service Area 4: Metro
Service Area 4 had an overall MHE-Rate of 6.6, which was above the countywide rate of 5.9. Four communities generated more than 1,000 psychiatric emergency calls each: the Hollywood area (1,382), the Echo Park area (1,250), the Highland Park area (1,199), and the Downtown area (1,774). The Downtown area had the highest MHE-Rate recorded in the County, 13.2.

Service Area 5: West
Service Area 5 had the fewest emergency

Table 3.50

Countywide Summary:
Mental Health Emergencies

Service Area	Total	MH E-rate
1	3425	9.4
2	10527	5.1
3	8723	5.0
4	7435	6.6
5	2697	4.5
6	8335	8.2
7	7200	6.9
8	9199	7.4
Total	57541	5.9

Table 3.51

Service Area Communities::
Mental Health Emergencies

Service Area 1 Communities	Total	MH E-rate
Lancaster	1663	12.4
Palmdale	1023	7.1
North County E.	739	8.5
Total	3425	9.4
Service Area 2 Communities		
Santa Clarita	433	2.6
Burbank	404	4.0
Glendale	769	3.9
Northridge	771	4.6
Granada Hills	973	7.2
Pacoima-Arleta	862	7.4
La Tuna Cyn.	864	6.5
Panorama City	795	5.5
North Hollywood	1008	7.5
Sherman Oaks	1279	7.7
Encino	898	5.5
Woodland Hills	692	4.3
Brentwood N.	310	3.6
North County W.	123	1.9
La Canada-Flintridge	80	2.0
San Fernando-Calabasas-Agoura	267	2.8
Total	10527	5.1
Service Area 3 Communities		
Pasadena	818	6.2
El Monte	790	7.2
Pomona	864	5.4
West Covina	468	4.0
Altadena-Monrovia-Sierra Madre	759	7.0
Alhambra-S. Pasadena	501	4.9
Arcadia-San Gabriel-Temple City-San Marino	536	3.2
Baldwin Park-Azusa-Duarte	772	4.3
Glendora-Claremont-San Dimas-La Verne	1013	6.6
Covina-Walnut	548	4.9
Diamond Bar	253	2.3
La Puente-S. El Monte	553	5.1
Hacienda Heights	181	3.3
Monterey Park-Rosemead	664	5.4
Other	4	
Total	8723	5.0

calls placed in the county and it also had the lowest MHE-Rate of 4.5. The bulk of the calls came from two areas: West LA (898) and Santa Monica-Culver City-Beverly Hills (868). The Baldwin Hills W. area had the highest MHE-Rate (8.7) in the service area.

Service Area 6: South

Service Area 6 had the second-highest MHE-Rate (8.2) across the county. Two communities, the Baldwin Hills S. area (1,574) and the Hancock N. area (1,624), had more than 1,500 calls; two other areas had over 1,000 calls: the Watts area (1,290) and the Compton area (1,176). Three of the five highest MHE-Rates across the county were found in Service Area 6: the USC S. area (10.7), the Baldwin Hills S. area (11.9), and the Hancock N. area (10.9).

Service Area 7: East

Service Area 7 had a MHE-Rate that reached 6.9 and was above the countywide rate of 5.9 by a full call. No one community reached the 1,000 call mark, but there were many communities that had several hundred calls placed. The Norwalk area (7.9), Bellflower area (6.7), and the Whittier area (6.7) had the

Service Area 4 Communities	Total	MH E-rate
Wilshire La Brea E.	730	5.1
Hollywood	1382	5.6
Pico Heights	727	5.9
Echo Park	1250	6.1
Highland Park	1199	5.5
Downtown	1774	13.2
USC N.	136	6.6
West Adams	73	8.1
West Hollywood	156	4.3
Other	10	
Total	7435	6.6
Service Area 5 Communities		
Brentwood S.	146	1.9
West LA	898	5.1
Wilshire La Brea W.	192	7.4
Baldwin Hills W.	120	8.7
Playa Vista	432	3.9
Santa Monica-Culver City-Beverly Hills	868	5.0
Malibu	40	2.1
Other	3	
Total	2697	4.5
Service Area 6 Communities		
USC S.	744	10.7
Baldwin Hills S.	1574	11.9
Hancock N.	1624	10.9
USC E.	828	6.7
Watts	1290	8.0
Florence-Firestone	299	3.2
Lynwood	383	5.0
Paramount	296	5.1
Compton	1176	7.8
Other	122	
Total	8335	8.2

Service Area 7 Communities	Total	MH E-rate
East LA	680	5.3
Downey	723	6.4
Norwalk	820	7.9
Whittier	777	6.7
Montebello	731	5.5
Bell Gardens-Bell-Maywood-Cudahy-Commerce	857	6.1
Huntington Park	314	5.8
South Gate	363	3.6
Bellflower	505	6.7
La Mirada-Santa Fe Springs	660	5.1
Lakewood-Cerritos-Artesia-Hawaiian Gardens	675	3.9
Signal Hill	27	2.4
Other	68	
Total	7200	6.9
Service Area 8 Communities		
Hancock S.	65	7.5
Wilmington	1433	8.2
Inglewood	833	6.7
Torrance	671	4.9
Long Beach N.	992	6.9
Long Beach S.	1787	9.2
Long Beach E.	483	3.8
Carson	768	6.9
Palos Verdes-Lomita	249	2.3
Redondo-Manhattan-Hermosa-El Segundo	352	2.7
Gardena-Lawndale	939	6.5
Hawthorne	600	4.2
Other	25	
Total	9199	7.4
County Total	57541	5.9

1, 500 -999
1000 -1500
> 1500

2, > 10/1000

highest MHE-Rates in the service area.

Service Area 8: South Bay

Service Area 8 had an overall MHE-Rate of 7.4, above the countywide rate of 5.9. Two communities were notable for their high call volumes and correspondingly high MHE-Rates: the Wilmington area had a call volume of 1,433 and a MHE-Rate of 8.2; the Long Beach S. area had a call volume of 1,787 (the highest count in the county) and a MHE-Rate of 9.2.

Data Sources

Abuse and Neglect Statistics. Child abuse and neglect statistics were obtained via special tabulation by the County of Los Angeles, Department of Children and Family Services, 2006. Elder and dependent adult abuse statistics were obtained via special tabulation by the County of Los Angeles, Adult Protective Services, Department of Community and Senior Services, 2008.

Crime Statistics. State of California, Office of the Attorney General, Department of Justice, Criminal Justice Statistics Center. http://stats.doj.ca.gov/cjsc_stats/prof05/19/11.pdf. More detailed geographic data for the Los Angeles Police Department (LAPD) is available in their Statistical Digest 2005. Data are published for the Central, South, West and Valley Bureaus; there are 19 stations within these bureaus. For more information, please see the Los Angeles Police Department Statistical Digest 2005, Information Technology Division Management Report Unit, http://www.lapdonline.org/crime_maps_and_compstat/content_basic_view/9098. The County of Los Angeles Sheriff's Department, 2005 Crime and Arrest Statistics, breaks the unincorporated data in to smaller geographic units. For more information, please see County of Los Angeles Sheriff's Department 2005 Crime and Arrest Statistics, Management Information Services, http://www.lasd.org/sites/YIR/index.htm. Probation data was obtained via special tabulation by the County of Los Angeles, Department of Probation, 2008.

Demographic Estimates. The demographic estimates incorporated data from the American Community Survey, 2005, 2006, 2007 (ACS). The ACS, designed by the US Census Bureau to eventually replace the Decennial Census, collects data on a rolling basis, surveying approximately 3 million households each year. This continuous sampling method provides more current and accurate data than the Decennial Census. Additionally the ACS allows for the analysis of small geographic areas such as those found in the present report. Public Use Microdata Areas or PUMAs have made it possible to examine communities within the County's service areas. For more information on the ACS, see http://www.census2010.gov/acs/www/.

Economic Data. Poverty estimates (e.g. the number of Individuals living at or below 200% of Federal Poverty Level in Los Angeles County) and self reported unemployment rates such were obtained from the U.S., Bureau of the Census, 2005 American Community Survey. Other employment data was obtained from the State of California Employment Development Department. Medi-Cal eligibility data was obtained from the California State-Issued Monthly Medi-Cal Eligibility Data Systems (MEDS) Extracted File, May, 2007.

Education Data. High school and college graduation rates were provided by the US Census Bureau's ACS 2005. 3rd grade reading rates, English literacy rates, and drop out data was provided by the State of California, Department of Education.

Homeless Statistics. Homeless statistics were

obtained from the Los Angeles Homeless Services Authority's Greater Los Angeles Homeless Count. For more information, please see http://www.lahsa.org/homelesscount.asp.

Mental Health Statistics. Mental health diagnoses, mental health emergency data, and mental health therapist language data were provided by the County of Los Angeles Department of Mental Health, 2008. SMI estimates were provided by the California State Department of Mental Health, Statistics and Data Analysis, 2008.

Vital and Health Statistics. Vital and Health statistics were provided by the County of Los Angeles, Department of Health Services and the Department of Public Health. Teen Pregnancy Statistics were obtained via special tabulation by the County of Los Angeles, Department of Health Services, 2005.

Data Definitions and Formulae

APS Rate1

(Number of open APS cases * 1000) / 18+ community population

APS Rate2

((Number of open APS cases * 1000) / 65+ community population) * ((65+ community population / 18+ community population) / (65+ County population / 18+ County population))

Child Abuse and Neglect Rate (CAN Rate):

(Number of substantiated case * 100)/child community population

Client/Provider Ratio:

Number of DMH clients / number of DMH rendering providers

Population/Provider Ratio:

(Community ethnic population * 10,000) / number of DMH rendering providers

Disrupted Families:

Number of intact families / number of single parent families

Infant Death Rate:

(Number of Infant Deaths under 1 year of age * 1000)/number of live births

High School Graduation Rate:

(Number of high school seniors who graduated / number students enrolled in senior year of high school) * 100

Mental Health Emergency Rate (MHE-Rate):

(Number of mental health emergency calls * 1000) / community population

Penetration Rate:

Individuals Receiving MHS/(total community population * SMI prevalence)

Suicide Rate:

(Number of suicides * 100,000) / community population

Triage Response Acuity:

((Number of immediate responses * 5) + (number of 3-day responses * 2) + (number of 5-day responses * 1) + (number of 10-day responses * 1))/child community population

Unemployment Rate

(Number of unemployed people/total civilian workforce) * 100

Violent Crime Rate:

(Number of crimes per Sheriff reporting district* 100,000)/total population in the reporting district

4 Year Dropout Rate:

(1-((1-(Reported or Adjusted Gr. 9 Dropouts/Gr. 9 Enrollment))*(1-(Reported or Adjusted Gr. 10 Dropouts/Gr. 10 Enrollment))*(1-(Reported or Adjusted Gr. 11 Dropouts/Gr. 11 Enrollment))*(1-(Reported or Adjusted Gr. 12 Dropouts/Gr. 12 Enrollment))))*100

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APPENDIX 10

Findings from the Key Individual Interviews

WRMA
Walter R. McDonald & Associates, Inc.

FINDINGS FROM THE

KEY INDIVIDUAL INTERVIEWS

CONDUCTED FOR THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN
IN LOS ANGELES COUNTY

November 2008

Prepared for:
The Los Angeles County Department of Mental Health

Prepared by:
Walter R. McDonald and Associates, Inc.
EVALCORP Research & Consulting, Inc.

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I. Introduction

The Los Angeles County Department of Mental Health (LACDMH) is engaged in an intensive, inclusive, multi-faceted and community-based approach to developing the County's Prevention and Early Intervention (PEI) Plan to be funded through the Mental Health Services Act (MHSA) enacted by California voters in 2004.

The focus for developing the PEI Plan is at the Service Area level, utilizing informational meetings, key individual interviews, focus groups, and community forums in each of eight geographic areas of Los Angeles County. Because each Service Area has distinct and varying populations, geography, and resources, PEI services must be specific and responsive to regional and community-based needs.

The California Department of Mental Health (CDMH) has defined *mental health prevention* as reducing risk factors or stressors, building protective factors and skills, and increasing support to allow individuals to function well in challenging circumstances. Whereas, *mental health early intervention* involves a short duration (usually less than one year) and relatively low-intensity intervention to measurably improve a mental health problem or concern early in its manifestation, and avoid the need for more extensive mental health treatment or services.

In addition, CDMH has targeted five community mental health needs, six priority populations, and six statewide efforts for the PEI Program, and has identified seven sectors that counties must partner with to develop their PEI Plan.

This report presents findings from the Key Individual Interviews that were conducted across Los Angeles County for the purpose of collecting data on mental health issues and needs to help inform the PEI planning process.

II. Methodology

Participants

A "key individual" is someone who is knowledgeable about a specific community, issue, or problem related to prevention and early intervention.

Using recommendations from LACDMH District Chiefs, Service Area Advisory Committee (SAAC) members, and other stakeholders, LACDMH identified interviewees based on Service Area representation and the categories of MHSA age group, sector, priority populations, and key community mental health needs for PEI. Additionally, LACDMH selected key stakeholder interviewees that qualified in at least two PEI categories.

- A total of 54 key individuals participated in the interviews, with at least five participants from each Service Area and 14 participants with countywide representation. Interviews were conducted from February through September 2008.

- Key individual interviewees included community leaders, community members, gatekeepers, service providers, consumers, and other individuals who possessed noteworthy insight and understanding about mental health prevention and early intervention. A list of participating key individual interviewees is located in **Appendix A**.

Procedures

The purpose of the key individual interviews was to conduct in-depth discussions with community leaders, gatekeepers, and other individuals in each Service Area and countywide who are particularly knowledgeable about their constituency and have insight into community mental health needs and strategies for prevention and early intervention.

Facilitators representing LACDMH at the key individual interviews as a neutral third party included staff from Walter R. McDonald & Associates, Inc. (WRMA) and their subcontractor, EvalCorp, Inc. Written interview procedures and protocols were developed by WRMA and EvalCorp staff in collaboration with LACDMH.

Key individual interviewees were identified by LACDMH. WRMA and EvalCorp staff contacted the interviewees, explained the purpose of the interviews, invited them to participate, and worked closely with the interviewees to arrange dates, times, and locations for the interviews. Once the interviews were arranged, interviewees were provided the following documentation: A Letter of Invitation, a PEI Informational Brochure, Key Individual Profile, Key Individual Consent Form, and Key Individual Interview Questions (see **Appendices B, C, and D**).

The key individual interviews were conducted at interviewees' offices or agencies, LACDMH sites, or other community-based locations, as needed. The interviews each took about 1 to 1½ hours to complete and contained 23 questions, some of which contained sub-questions. During the interviews, participants were asked about community and mental health needs, prioritized age groups and priority populations, existing and needed prevention and early intervention services, challenges, and recommendations for providing effective prevention and early intervention services.

The interview questions were designed to produce information needed to inform the PEI planning process, as well as, to inform upcoming focus groups and community forums. The interview questionnaire and protocols were piloted and revisions were made accordingly based upon the results.

Two facilitators were present at each key individual interview. One facilitator conducted the interview and the other facilitator documented the content of the interview by taking notes. Audio recordings were made of each interview, which were then transcribed so that a full transcript was available for each interview conducted. Once the interviews were complete, participants received a thank-you letter acknowledging the interviewee's participation.

Interview documentation and recording included: the Key Individual Profile, a signed Key Individual Consent Form indicating that the interview would be audio recorded, the facilitator's notes, an audio recording of the interview, and a transcript of the interview developed from the audio recording. A report was written for each key individual interview, summarizing the participant's responses to the questions. Information from each interview was coded so that the data could be analyzed in aggregate form and presented in summary format.

III. Demographics of Key Individual Interviewees, Target Groups Served, and Knowledge of the PEI Planning Process

Key individual interviews were conducted with 54 participants, selected for their representation of the eight Los Angeles County Service Areas and countywide, as well as, for their representation across age groups, sectors, priority populations, and key mental health needs. Background information on the interviewees was collected from the Key Individual Profile and as part of the first four questions asked during the key individual interviews.

Demographic Characteristics of Interviewees

Demographic data reported in this section was collected through the Key Individual Profile completed by each interviewee (see **Tables 1 – 3**). Because participants were directed to select all that apply to them, some of the demographic totals are higher than the number of participants. In addition, some counts are lower than the total number of participants because a few participants failed to supply information on some of the demographic indicators.

Key individual interviewees supplied information on the following demographic variables: age, gender, languages spoken, ethnicity, and roles.

- Three-quarters of the participants were Adults (26-59), just under one-quarter were Older Adults (60+), and one participant was a Transition-age Youth (TAY) (16-25).
- Two-thirds of the interviewees were female and one-third was male.
- All of the participants spoke English, one-quarter spoke Spanish, and about one-fourth spoke Tagalog. Additional languages spoken by smaller percentages of participants included Farsi, Armenian, Cambodian, and Chinese.
- Approximately half of the interviewees were Caucasian, 15% were Latino/Hispanic, 10% were Asian/Pacific Islanders, 8% were Eastern European/Middle Eastern, 7% were African-American, 6% were American Indian, and 4% were Other ethnicities.
- Almost half of the interviewees were Mental Health Advocates, 41% were Mental Health Service Providers, 37% were Health/Human Services/Social Services Providers, 28% were Interested Community Members, 22% were Los Angeles County Employees, 20% were Family Members of Consumers of Mental Health Services and/or Other. Additionally, 15% were Other Government Employees and 9% were Consumers of Mental Health Services.

Table 1. Demographic Characteristics of Interviewees

Type of Demographic	Number of Interviewees	Percent of Interviewees
Age (N = 49)		
TAY 16-25	1	2%
Adults 26-59	37	76%
Older Adults 60+	11	22%
Gender (N = 53)		
Female	35	66%
Male	18	34%
Language Spoken (N = 54)		
English	54	100%
Spanish	13	24%
Tagalog	12	22%
Farsi	3	6%
Other	3	6%
Armenian	2	4%
Cambodian	1	2%
Cantonese	1	2%

Table 2. Ethnicity of Interviewees

Ethnicity	Number of Interviewees (N = 54)	Percent of Interviewees
Caucasian	28	52%
Latino/Hispanic	8	15%
African-American	4	7%
American Indian	3	6%
API Filipino	2	4%
EE/ME Armenian	2	4%
EE/ME Persian	2	4%
Other	2	4%
API Cambodian	1	2%
API Chinese	1	2%
API Korean	1	2%

Table 3. Roles of Interviewees

Role	Number of Interviewees (N = 54)	Percent of Interviewees
Mental Health Advocate	24	44%
Mental Health Service Provider	22	41%
Health/Human Services/Social Services Provider	20	37%
Interested Community Member	15	28%
Los Angeles County Employee	12	22%
Family Member of Consumer of Mental Health Services	11	20%
Other	11	20%
Other Government Employee	8	15%
Consumer of Mental Health Services	5	9%
Not Provided	2	4%

Underserved Populations/Communities Represented by the Interviewees

On the Key Individual Profile, interviewees were directed to indicate all of the underserved populations/communities they represent, as shown in **Table 4**; thus, the total number of interviewees across the underserved populations/communities is higher than the total of interviewees overall.

- Over 65% of the participants serve Latino/Hispanic and/or African-American populations, and about 60% serve Co-occurring Disorders, Homeless, and Immigrants. Half of the interviewees serve Lesbian/Gay/Bisexual/Transgender/Questioning Individuals, 43% serve Refugees, 35% serve American Indians, 33% serve Chinese and/or Korean Asian Pacific Islanders, and 30% serve Filipinos.
- Additionally, about one-quarter of the participants serve Vietnamese, Armenian, Persian and Russian populations and between one-eighth and one-fifth serve Cambodian, Samoan, and Lao Asian Pacific Islanders.

Table 4. Underserved Populations Served by Interviewees

Underserved Population	Number of Interviewees (N = 54)	Percent of Interviewees
Latino/Hispanic	38	70%
African-American	37	66%
Co-occurring Disorders	33	61%
Homeless	32	59%
Immigrants	32	59%
Lesbian/Gay/Bisexual/Trans-gender/Questioning Individuals	27	50%
Refugees	23	43%
American Indian	19	35%
API Chinese	18	33%
API Korean	18	33%
API Filipino	16	30%
API Vietnamese	14	26%
EE/ME Armenian	13	24%
EE/ME Persian	13	24%
EE/ME Russian	12	22%
API Cambodian	10	19%
API Samoan	8	15%
API Lao	7	13%

Priority Populations and Age Groups Represented by the Interviewees

Interviewees were also asked to select all of the priority populations and age groups that they serve on the Key Individual Profile. Results are displayed in **Table 5**.

- Over three-quarters of the participants serve Underserved Cultural Populations, 70% serve Children/Youth in Stressed Families, and 67% serve Trauma-exposed Individuals. Just under 60% serve Children/Youth at Risk of or Experiencing Juvenile Justice involvement, Individuals Experiencing Onset of Serious Psychiatric Illness, and/or Children/Youth at Risk for School Failure.
- Three-quarters of the participants serve Children (6-15) and/or Transition-age Youth (TAY) (16-25), and almost two-thirds serve Adults (26-59) and/or Older Adults (60+). Additionally, over half of the interviewees serve Prenatal to Pre-K (0-5).

Table 5. Priority Populations and Age Groups Served by Interviewees

Population/Age Group	Number of Interviewees	Percent of Interviewees
Priority Populations (N = 54)		
Underserved Cultural Populations	41	76%
Children/Youth in Stressed Families	38	70%
Trauma-exposed Individuals	36	67%
Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	32	59%
Individuals Experiencing Onset of Serious Psychiatric Illness	31	57%
Children/Youth at Risk for School Failure	31	57%
Age Groups (N = 54)		
Prenatal to Pre-K (0-5)	30	56%
Children (6-15)	40	74%
Transition-age Youth (TAY) (16-25)	40	74%
Adults (26-59)	34	63%
Older Adults (60+)	32	59%

Service Areas Represented by the Interviewees

On the Key Individual Profile, participants were asked to select all of the service areas that they represent. As displayed in **Table 6**, the key individual interviewees indicated that they represent the following service areas:

- Slightly more than one-third of the participants provide countywide representation, 13% represent Service Areas 3 and/or 4, 11% represent Service Areas 1, 6, 7, and/or 8, and 9% represent Service Areas 2 and/or 5.

Table 6. Service Area Representation of Interviewees

Service Area	Number of Interviewees (N = 54)	Percent of Interviewees
Countywide	19	35%
3	7	13%
4	7	13%
1	6	11%
6	6	11%
7	6	11%
8	6	11%
2	5	9%
5	5	9%

Services Provided by Interviewees

On the Key Individual Profile, interviewees were directed to indicate the primary sector they represented (see **Table 7**). As some participants checked more than one sector, the total number of interviewee's selections is larger than the number of participants.

- The services provided by interviewees represent seven community sectors. Mental Health Services and Social Services were the sectors represented most by participants with 39% and 26% representation, respectively. Health and Education each represented almost one-fifth of the interviewees; and 15% of the interviewees represented Law Enforcement, 11% represented Individuals with Serious Mental Illness, 4% represented Community Family Resource Centers, and 2% represented Employment.

Table 7. Types of Services Represented

Service Type	Number of Interviewees (N = 54)	Percent of Interviewees
Mental Health Services	21	39%
Social Services	14	26%
Health	10	19%
Education	9	19%
Law Enforcement	8	15%
Individuals with Serious Mental Illness and/or their Families	6	11%
Community Family Resource Centers	2	4%
Employment	1	2%

Interviewee Participation in the PEI Planning Process

During the Key Individual Interviews, participants were asked about their level of knowledge in the PEI planning process (Q3) and their level of participation in the PEI planning process (Q4 and Q4a).

When interviewees were asked how knowledgeable they were about the PEI planning process, 60% of participants were "*somewhat knowledgeable"* and just over one-quarter was *"very knowledgeable"* about the PEI planning process. Only 13% were *"not at all knowledgeable*." Data are displayed in **Table 8.**

Over half of the interviewees were personally involved in the PEI planning process, primarily by attending SAAC meetings, informational meetings, and some committee involvement. In addition, 13% were involved passively, learning PEI information from colleagues. In contrast, one-third of the interviewees had no involvement in the process prior to participating in the key individual interviews.

Table 8. Knowledge of and Participation in PEI Planning Process by Interviewees

Knowledge/Participation Type	Number of Interviewees	Percent of Interviewees
Knowledge of PEI Planning Process (N = 54)		
Somewhat Knowledgeable	32	59%
Very Knowledgeable	15	28%
Not at all Knowledgeable	7	13%
Participation in PEI Planning Process (N = 54)		
Yes, Personally	29	54%
No	18	33%
Yes, Through Others	7	13%

IV. Community Issues and Mental Health Needs

When asked about the greatest problem and mental health needs in their community, many interviewees provided multiple responses to each question; therefore, the number of mentions discussed in this section is greater than the total number of interviewees.

Community Issues

The first key question interviewees were asked was "What would you say is the greatest problem in your community?" (Q5). Responses to this question covered a wide range of issues. The three most highly mentioned issues were: (1) Access to mental health services; (2) The social and economic conditions under which community members live; and, (3) The increasing number of mental health issues arising in communities (see **Table 9**).

- Access concerns included the following:
    - Lack of mental health services available to meet community needs;
    - The costs of services including insurance coverage, eligibility criteria, and limitations of Medi-Cal;
    - Lack of culturally and linguistically competent services;
    - Stigma;
    - General overall inability to obtain needed services; and,
    - Inability to physically access services because of geographic, physical, or social isolation.

- The most cited access issue was the lack of available services, with some interviewees pointing out the need for services for children, including those with special needs, as well for young and older adults. In addition, interviewees indicated the need for services within schools and community agencies, and pointed out the lack of available services to address substance abuse issues as well as family issues. One interviewee noted that the lack of capacity to respond to mental health issues extends to health issues, as well.

"People do not get the care they need."

- Some of those who considered the lack of service availability and capacity as important community issues also noted that the stigma surrounding mental health, especially among some cultural groups, prevents individuals and families from getting the services they need. Furthermore, stigma was often associated with the lack of linguistic and culturally competent services.

- With respect to cost issues surrounding mental health, interviewees noted that a substantial proportion of consumers are not insured, including students pursuing higher education, and newly returning war veterans.

- Interviewees also mentioned the limitations that geography, physical frailty, and social isolation can have on community members' ability to access services. Specifically, interviewees pointed out that the lack of transportation to and from services for older adults who no longer drive or are physically frail, for those who are unable to access transportation due to health conditions or inability to pay, and for those who live in geographically remote areas with services few and far between severely limits access to services for many individuals and families.

- The economic and social conditions in communities was the second highest community issue mentioned by interviewees. More specifically, the following economic and social issues were indicated:
    - Lack of affordable housing leading to increased homelessness;
    - High rates of unemployment;
    - Poverty;
    - Crime; and,
    - The social disparities that exist in employment, education, health care, insurance coverage, and socio-economic status.

"There are great pockets of poverty in our area."

- Interviewees also discussed the serious impact the rise in mental health issues is having on the social and emotional well-being of families and community members.
    - Some interviewees have observed an increase in the number of co-occurring disorders, such as substance abuse and bipolar disorder, in addition to an increase in other complex issues, such as post-traumatic stress disorder.
    - Others were concerned about depression among seniors and depression associated with the trauma that comes with exposure to community and/or domestic violence.
    - Stress and the ability to cope were also concerns; specifically, the stress and anxiety that immigrants experience as they assimilate and acculturate to living in the United States.

"Mental illness accounts for a lot of the homelessness in our local community."

"We see a large number of children who have experienced traumatic events – children and their parents or caretakers."

Community and domestic violence were also noted by interviewees as having an increasingly deleterious effect on families and the community as a whole. Some interviewees commented that the violence and abuse to which families and community members are currently exposed is largely the cause of the complex trauma and many mental health problems community members are experiencing and presenting to service providers.

"People do not know where to go for what services."

Another predominant issue in the community is the limited knowledge and awareness among community members about mental health and the social/emotional needs of children and families, including the developmentally disabled. One interviewee pointed out that there is an assumption that families know when mental, developmental, and social/emotional needs arise, know how to address them, and know where to go to treat them.

In addition to the lack of general knowledge about mental health, there is also a lack of awareness of existing services and resources, where those services and resources are located, and how to navigate the system to access them.

Table 9. Community Issues

Community Issues	Number of Mentions (N=171)	Percent of Mentions
Access Issues	**38**	**22%**
• Available Services/Capacity	12	7%
• Cost/Insurance/Medi-Cal/Eligibility Criteria	7	4%
• Service Linguistic/Cultural Competency	6	4%
• Stigma	6	5%
• Service Access (General)	4	2%
• Geographic Location/Social & Physical Conditions	3	2%
Social/Economic Conditions	**26**	**15%**
Mental Health Issues	**19**	**11%**
• Substance Abuse	5	3
• Depression/Suicide Risk	4	2
• Specific	4	2
• General	3	2
• Co-occurring Disorders	2	1
• Trauma/PTSD/Anxiety	1	1
Community/Domestic Violence	**11**	**6%**
Outreach/Education/Awareness	**11**	**6%**
• Available Services	5	3%
• General	5	3%
• Families/Parents	1	1%
Community/Family Breakdown/Hopelessness	**6**	**4%**
Health Care Issues	**6**	**4%**
Funding and Resources	**5**	**3%**
Specific Services (Various)	**5**	**3%**
Service Integration/Continuity of Care	**4**	**2%**
Service Engagement/Benefits (General)	**4**	**2%**
School Issues	**2**	**1%**
Academic Outcomes	**2**	**1%**
Staff/Provider Education/Training/Recruiting	**2**	**1%**
Assessment/Identification/Intervention-Early/Better Outcomes	**2**	**1%**
Accountability	**1**	**1%**
Specific Strategies/Approaches	**1**	**1%**
Service Quality	**1**	**1%**
Service Engagement/Benefits-Families/Parents	**1**	**1%**
Safety/Stability	**1**	**1%**
Generational Cycle	**1**	**1%**
Immigration/Cultural Matters	**1**	**1%**
Case Management	**1**	**1%**
No Comment/No Response	**1**	**1%**
Other	**8**	**5%**

Community Issues by Service Area

The number of mentions by Service Area shows that all areas consider access issues, the social and economic conditions in which people live, and mental health issues, the top three community issues affecting the mental health and well-being of current and community members. Community and domestic violence, outreach/education and awareness, funding and resources, and specific services were also mentioned more often by participants as community issues (see **Table 10**).

Table 10. Community Issues by Service Area

Community Issues	Number of Mentions*	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Access Issues	**66**	**7**	**8**	**6**	**8**	**6**	**5**	**8**	**5**	**13**
• Available Services/Capacity	20	5	2	1	3	3	1		3	2
• Cost/Insurance/Medi-Cal/ Eligibility Criteria	11		2	1	1	2	1	4		
• Service Linguistic/Cultural Competency	10	1	1	1	1		1	2		3
• Stigma	10		1	2	1		1	1		4
• Service Access (General)	8		1		1	1	1		1	3
• Geographic Location/Social & Physical Conditions	7	1	1	1	1			1	1	1
Social/Economic Conditions	**29**		**2**	**2**	**3**	**3**	**5**	**2**	**2**	**10**
Mental Health Issues	**18**		**1**	**1**	**2**		**4**	**3**	**4**	**3**
• Depression/Suicide Risk	5				1		2		2	
• Substance Abuse	4		1				1			2
• Specific	4				1		1	1	1	
• General	3							1	1	1
• Co-occurring Disorders	2			1				1		
• Trauma/PTSD/Anxiety	1								1	
Community/Domestic Violence	**12**				**2**		**3**	**2**	**1**	**4**
Outreach/Education/Awareness	**11**		**1**	**2**	**1**	**1**			**3**	**3**
• Available Services	5				1	1			2	1

Community Issues	Number of Mentions*	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
• General	5		1	2						2
• Families/Parents	1								1	
Funding and Resources	**10**	**1**	**1**	**2**	**2**		**1**	**2**		**1**
Specific Services (Various)	**9**	**2**	**1**	**1**	**1**	**1**			**2**	**1**
Service Integration/Continuity of Care	**8**	**1**	**1**	**2**	**1**				**2**	**1**
Community/Family Breakdown/Hopelessness	**6**		**1**	**1**			**2**			**2**
Health Care Issues	**6**	**1**	**1**			**1**		**2**	**1**	
Service Engagement/Benefits (General)	**3**			**1**					**1**	**2**
School Issues	**2**		**1**							**1**
Academic Outcomes	**2**									**2**
Staff/Provider Education/Training/Recruiting	**2**	**1**		**1**						
Assessment/Identification/Intervention-Early/Better Outcomes	**2**								**1**	**1**
Accountability	**1**			**1**						
Specific Strategies/Approaches	**1**								**1**	
Service Quality	**1**									**1**
Service Engagement/Benefits-Families/Parents	**1**			**1**						
Safety/Stability	**1**									**1**
Generational Cycle	**1**									**1**
Immigration/Cultural Matters	**1**				**1**					
Case Management	**1**									**1**
No Comment/No Response	**1**	**1**								
Other	**12**	**2**	**2**	**1**	**2**				**3**	**2**

*Reflects duplicate counts as a number of interviewees represent more than one Service Area.

Impact of Community Issues on Mental Health

As a follow-up to the question about community issues, interviewees were asked to indicate how these community issues impact the mental health of these same communities (Q5a). Ways in which community issues impact the mental health of the community parallel the top three community issues cited by interviewees. The only difference is the weight given to each. As shown in **Table 11**, concerns about mental health issues were the most highly mentioned impact, followed by access issues, and social and economic conditions.

- Interviewees were concerned about the impact that community issues have on the mental health of community members in general. They noted the prevalence of multiple stressors, such as, low income, lack of affordable housing, inability to access services, and community violence as precursors to a host of mental health issues, such as, depression, suicide attempts, anxiety disorders, substance abuse, as well as, co-occurring disorders.

"We're really a depressed community. We don't feel hopeful. We're fearful. We think we sort of transfer that to our kids. It's hard for me to go to a local park and take my child because I am worried about his safety. That's a real issue here."

- Interviewees also pointed out that stigma, service capacity, and service availability are highly associated with the mental health of the community. The lack of education about mental health and the difficulties community members currently experience accessing services further reinforces existing fears, suspicions, and shame associated with mental health, which, in turn, further solidifies and confirms existing stigmas.

"Understanding where to get help is an extremely difficult problem."

- The communities' lack of available services to support the rising cognitive, social, and emotional needs of community members compounds the impact on mental health, resulting in escalating mental health conditions requiring higher and higher levels of care.
- Interviewees also viewed such economic and social conditions as poverty, lack of employment, and homelessness as part of a vicious cycle preventing community members from engaging in and addressing their social and emotional well-being, and becoming self-sufficient and productive members of society.

"The number one issue to homelessness is really about the mental health services not being met."

"In the words of parents, we would like teachers and others to understand that when our kids come to school and they are acting out and they are misbehaving, it may be because we're very stressed out and they're just experiencing it."

In addition, a number of interviewees emphasized poor academic outcomes as a consequence of the existing social and economic difficulties communities face, as well as, a consequence of community and family violence. Interviewees expressed concern over the high rates of illiteracy and special education needs among young children, the high drop-out rates in area high schools, the number of children who are discouraged and unmotivated to learn, and the high rates of expulsions and suspensions.

Community issues also affect the behavioral, social, and emotional skills and behaviors of children and their families. Due to traumatic experiences, unaddressed mental health needs, and other stressors, individuals lack coping skills, exhibit inappropriate behaviors, engage in poor social interactions, lack the ability to care and love others, and grow up with a sense of distrust of others.

- Community issues result in a general breakdown of the community and family infrastructure, as well as, an increase in community and domestic violence. For example, a couple of interviewees reported an increase in willful homicides and murder-suicides in their communities. Others reported that increased exposure to gang violence and other community violence inures and numbs youth and community members to continued violent behavior and aggression. Likewise, a couple of interviewees talked about the intergenerational cycle of untreated child abuse as a growing concern in communities.

- Less frequently mentioned impacts on the mental health of the community were:
    - The negative and destructive behaviors that community members engage in when anxious, depressed, or in a general malaise about their existing situations, such as sexual promiscuity, crime, and substance abuse;
    - General and specific health concerns;
    - Safety and stability in the community and in service provider environments; and,
    - The lack of service integration and continuity of care among service providers, public agencies, and community sectors.

Table 11. Ways in which Community Issues Impact the Mental Health Needs of the Community

Impacts on Mental Health	Number of Mentions (N=184)	Percent of Mentions
Mental Health Issues	**40**	**22%**
• Depression/Suicide Risk	15	8%
• Trauma/PTSD/Anxiety	11	6%
• Substance Abuse	5	3%
• Specific Issues	4	2%
• General Mental Health Issues	3	2%
• Co-occurring Disorders	2	1%
Access Issues	**22**	**12%**
• Stigma	10	5%
• Available Services/Capacity	9	5%
• Service Linguistic/Cultural Competency	2	1%
• General Service Access	1	1%
Social/Economic Conditions	**20**	**11%**
Academic Outcomes	**14**	**8%**
Unaddressed/Exacerbated Mental Health Conditions/Higher Levels of Care	**14**	**8%**
Behavioral/Social/Emotional Issues/Outcomes	**10**	**5%**
Community/Family Violence/Abuse	**9**	**5%**
Community/Family Breakdown/Hopelessness	**7**	**4%**
Outreach/Education/Awareness	**7**	**4%**
• General	6	3%
• Available Services	1	1%
Negative/Risky Behaviors	**5**	**3%**
Health Care Issues	**4**	**2%**
Safety/Stability	**4**	**2%**
Service Integration/Continuity of Care	**4**	**2%**
Child Welfare/Foster Care	**3**	**2%**
Juvenile Justice Involvement/Incarceration	**3**	**2%**
Medication Issues/Management	**3**	**2%**
Available Services-Other than MH	**2**	**1%**
Service Quality	**2**	**1%**
Collaboration/Partnerships/Teams	**1**	**1%**
Sensitive Staff/Can Relate	**1**	**1%**
Service Engagement/Benefits	**1**	**1%**
Specific Services (Various)	**1**	**1%**
Staff Provider Education/Training/Recruiting	**1**	**1%**
No Comment/No Response/No Knowledge/NA	**1**	**1%**
Other	**5**	**3%**

Service Barriers

Interviewees also were asked, "What barriers do people encounter accessing mental health services?" (Q7). Of all the service barriers discussed by participants, stigma surrounding mental health; lack of outreach, education, and awareness about mental health and available services; and issues surrounding the costs, insurance, and eligibility requirements involved in accessing services were the top three (See **Table 12**).

"Many travel an hour to this clinic [LA Gay and Lesbian Center] because they don't feel safe going to a clinic in their own community."

Interviewees also mentioned the lack of available services, as well as, the lack of capacity of current providers to serve the needs of the community.

"There is no routine access to services, no routine referral source. It's kind of a have and have not, you know about it or you don't."

- Geographic location and the physical and emotional well-being of individuals was mentioned as a barrier, particularly due to the lack of transportation available in geographically isolated areas and for those who lack the ability to travel on their own to get services.

- Some interviewees also cited the lack of service providers offering bilingual and culturally competent services as a barrier, as well as, provider staffs' lack of education and training to identify and diagnose symptoms across age groups.

- Barriers surrounding the competency of the staff were often mentioned in conjunction with the limited operating hours, long wait lists, and the unfriendly, uninviting service environments, which discourage consumers from seeking services.

- Some interviewees considered the inability to engage consumers in assessment and treatment a barrier to access. Interviewees indicated that a number of consumers lack the interest, motivation, or incentive to access services, others wait too long to access services, while others minimize or deny their symptoms. One interviewee noted that resistance is prevalent among the homeless, and often secrecy prevents children and families who have been exposed to trauma from accessing treatment services.

"At the time they sign up, the patient is willing to go [for services]. By the time they get called, it is too late."

Table 12. Service Barriers

Service Barriers	Number of Mentions (N=191)	Percent of Mentions
Stigma	**32**	**17%**
Outreach/Education/Awareness	**26**	**14%**
• General	16	8%
• Available Services	9	5%
• Families/Parents	1	1%
Cost/Insurance/Medi-Cal/Eligibility Criteria	**22**	**12%**
Available Services/Capacity	**17**	**9%**
Geographic Location/Social and Physical Condition	**11**	**6%**
Service Linguistic and Cultural Competence	**10**	**5%**
Service Operations	**10**	**5%**
Staff/Provider Education/Training/Recruiting	**9**	**5%**
• General	6	3%
• Linguistic/Cultural Competency	3	2%
Service Engagement/Benefits	**9**	**5%**
• General	8	4%
• Families/Parents	1	1%
Service Integration/Continuity of Care	**7**	**3%**
School Issues	**6**	**3%**
Service Access (General)	**5**	**3%**
Funding and Resources	**5**	**3%**
Location-Based Services	**2**	**1%**
Referral Network	**2**	**1%**
System/Support/Assistance/Navigators	**2**	**1%**
Traditional/Risk Orientation	**2**	**1%**
Accountability	**1**	**1%**
Need for Flexible/Adaptable Services/Systems	**1**	**1%**
Health Care Issues	**1**	**1%**
Immigration and Cultural Matters	**1**	**1%**
Medication Issues/Management	**1**	**1%**
Mental Health Issues-Trauma/PTSD/Anxiety	**1**	**1%**
Service Quality	**1**	**1%**
No Comments/No Response	**1**	**1%**
Other	**6**	**3%**

<u>Greatest Mental Health Needs to be Addressed</u>

When asked about the greatest mental health needs in the community (Q6), interviewees overwhelmingly mentioned the need to address specific mental health issues, such as, depression and suicide risk, followed by disorders resulting from excess stress, anxiety, and trauma exposure (see **Table 13**).

"We need earlier identification and intervention for trauma, combined with early intervention of attachment disorders."

"It is not uncommon that we would speak to a [Korean] family member for several months before we meet them face-to-face when they come into the door."

Access issues were the second most discussed mental health need. Specifically, the need for more culturally competent providers who not only offer services in different languages, but also whose staff understands and is sensitive to the stigma of mental health among different cultures. Interviewees also cited the need for more low-cost services, services for the uninsured, and available services accepting Medi-Cal. One interviewee advocated for Medi-Cal accepting psychiatrists who can provide medications for the developmentally disabled patients with mental illness.

The third greatest mental health need identified by interviewees was a range of specific services. These services included, but were not limited to, the following:

"When it's not a crisis, it takes forever, and often families don't stick with it that long for the service."

- Services for the homeless;
- Services for the deaf and hard of hearing who are mentally ill;
- Services for the working poor and underserved;
- Ongoing support for children and families;
- Services that address the poverty and crime in communities;
- Providers willing to serve youth on parole;
- Full service prevention and intervention treatment to help children and families cope with domestic and community trauma and abuse;
- Early intervention services and treatment that promote mental health in the workplace, school, and home;
- Prevention services that educate children about mental health;
- Services for caregivers experiencing depression or anxiety;
- A gate-keeper approach to identify those older adults who need services; and,
- The incorporation of mental health into elementary school.

"If we were able to intervene really early on after traumatic events, taking into account not only the needs of the child but of the family -- helping them resolve any ongoing intergenerational aspects of trauma -- I think we would be serving our community well."

"The most powerful investment, in terms of prevention, would be in the curricula in the schools starting with Kindergarten or first grade. Just like you learn about how to eat right and the new pyramid, you could have children learn about mental health as part of the physical health curriculum."

While not discussed to the same extent as the mental health needs stated above, the importance of raising awareness about mental health among parents and families, as well as, educating them in such areas as stress management and coping skills, were among the more frequently cited mental health needs.

Table 13. Mental Health Needs to be Addressed

Mental Health Needs to be Addressed	Number of Mentions (N=162)	Percent of Mentions
Mental Health Issues	**39**	**24%**
• Depression/Suicide Risk	15	9%
• Trauma/PTSD/Anxiety	12	7%
• Substance Abuse	6	4%
• General	4	2%
• Co-occurring Disorders	1	1%
• Specific	1	1%
Access Issues	**28**	**17%**
• General Service Access	7	4%
• Available Services/Capacity	6	4%
• Service Linguistic/Cultural Competency	6	4%
• Cost/Insurance/Medi-Cal/Eligibility Care	5	3%
• Service Operations	2	1%
• Geographic Location/Social & Physical Condition	1	1%
• Stigma	1	1%
Specific Services	**18**	**11%**
Outreach/Education/Awareness	**10**	**6%**
• Families/Parents	4	2%
• General	3	2%
• Specific	1	1%
• Specific Locations	1	1%
• Available Services	1	1%
Service Integration/Continuity of Care	**9**	**6%**
Social/Economic Conditions	**8**	**5%**
Community and Domestic Violence	**7**	**4%**
Assessment/Identification/Intervention-Early/Better Outcomes	**6**	**4%**
System Support/Assistance/Navigators	**3**	**2%**
Staff/Provider Education/Training/Recruiting	**3**	**2%**
Location-Based Services	**2**	**1%**
Safety/Stability	**2**	**1%**
Specific Strategies	**2**	**1%**
Community/Family Breakdown/Hopelessness	**2**	**1%**
Service Quality	**2**	**1%**
Behavioral/Social/Emotional Issues/Outcomes	**2**	**1%**
Collaboration/Partnerships/Teams	**2**	**1%**
Service Engagement Benefits (General)	**2**	**1%**
Case Management	**2**	**1%**
Academic Outcomes	**1**	**1%**
Unaddressed/Exacerbated Mental Health Conditions/Higher Levels of Care	**1**	**1%**
Negative Risky Behaviors	**1**	**1%**
Anger Management/Conflict Resolution	**1**	**1%**
Self-Care/Self-Esteem/Socialization	**1**	**1%**
Available Services-Other than MH	**1**	**1%**
School Issues	**1**	**1%**
Medication Issues/Management	**1**	**1%**
Education/Training-Specific	**1**	**1%**
No Comment/No Response	**2**	**1%**
Other	**2**	**1%**

Mental Health Needs to be Addressed by Service Area

Responses from the Service Areas varied in distribution of mentions among the top three mental health needs: mental health issues; access; specific services; and outreach, education, and awareness. Service Area 4 cited access more often than mental health issues, and Service Areas 5 and 6 predominantly cited specific services; whereas, Service Areas 2 and 3 gave equal weight to mental health issues and access (see **Table 14**).

Table 14. Mental Health Needs to be Addressed by Service Area

Community Mental Health Needs	Number of Mentions*	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Mental Health Issues	**50**	**5**	**3**	**5**	**6**	**0**	**3**	**5**	**4**	**19**
• Depression/Suicide Risk	20	2	1	2	2		2	2	2	7
• Trauma/PTSD/Anxiety	17	2	1	2	3		1	2	2	4
• Substance Abuse	6	1			1					4
• General	4		1							3
• Co-occurring Disorders	2			1				1		
• Specific	1									1
Access Issues	**31**	**3**	**3**	**6**	**8**	**1**	**1**	**3**	**0**	**6**
• Service Linguistic/Cultural Competency	10	1	1	3	3		1	1		
• General Service Access	7	1	1	1	2	1		1		
• Cost/Insurance/Medi-Cal/Eligibility Care	5			2	1					2
• Available Services/Capacity	5		1					1		3
• Service Operations	2				2					
• Geographic Location/Social & Physical Condition	1	1								
• Stigma	1									1
Specific Services	**26**			**2**	**2**	**7**	**5**	**1**	**3**	**6**
Outreach/Education/Awareness	**10**	**1**	**0**	**0**	**0**	**3**	**1**	**1**	**1**	**3**

Community Mental Health Needs	Number of Mentions*	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
• Families/Parents	4	1				1	1			1
• General	3					1			1	1
• Specific	1									1
• Specific Locations	1							1		
• Available Services	1					1				
Specific Strategies	**10**	**1**	**1**	**1**	**2**	**1**	**1**		**2**	**1**
Social/Economic Conditions	**8**		**1**			**1**	**1**			**5**
Community and Domestic Violence	**8**		**1**	**2**				**1**		**4**
Service Integration/Continuity of Care	**9**	**1**	**1**	**2**			**1**		**2**	**2**
Assessment/Identification/Intervention-Early/Better Outcomes	**7**				**1**		**2**	**1**	**1**	**2**
Location-Based Services	**6**	**1**	**1**	**1**	**1**				**1**	**1**
Safety/Stability	**4**				**2**		**2**			
System Support/Assistance/Navigators	**3**									**3**
Staff/Provider Education/Training/Recruiting	**3**		**1**	**2**						
Community/Family Breakdown/Hopelessness	**2**		**1**							**1**
Service Quality	**2**									**2**
Behavioral/Social/Emotional Issues/Outcomes	**2**						**1**			**1**
Collaboration/Partnerships/Teams	**2**									**2**
Service Engagement Benefits (General)	**2**		**1**							**1**
Case Management	**2**					**2**				
Academic Outcomes	**1**									**1**

Community Mental Health Needs	Number of Mentions*	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Unaddressed/Exacerbated Mental Health Conditions/Higher Levels of Care	**1**			**1**						
Negative Risky Behaviors	**1**						**1**			
Anger Management/Conflict Resolution	**1**		**1**							
Self-Care/Self-Esteem/Socialization	**1**									**1**
Available Services-Other than MH	**1**									**1**
School Issues	**1**								**1**	
Medication Issues/Management	**1**									**1**
Education/Training-Specific	**1**									**1**
No Comment/No Response	**2**	**1**								**1**
Other	**2**								**1**	**1**

*Reflects duplicate counts as a number of interviewees represent more than one Service Area.

PEI Mental Health Needs

Interviewees were asked to select the number one mental health need in their community from among the following five CDMH-identified mental health needs: 1) Disparities in access to mental health services; 2) Psycho-social impact of trauma; 3) At-risk children, youth, and young adult populations; 4) Stigma and discrimination; and, 5) Suicide risk (Q8). A significant proportion of the interviewees had difficulty selecting only one need, saying they were all important and interrelated. **Table 15** reflects each interviewee's selection, including multiple selections made by some interviewees.

- Between one-half and two-thirds of the interviewees selected At-risk children, youth, and young adult populations and Disparities in access to mental health services as key mental health needs in the community.
- About one-quarter considered the Psycho-social impact of trauma a key mental health need; and, between 13 and 17 percent identified Stigma and discrimination or Suicide risk key mental health needs.

Table 15. PEI Mental Health Needs

PEI Mental Health Need	Number of Participants (N=54)	Percent of Participants
At-risk children, youth, and young adult populations	32	59%
Disparities in access to mental health services	28	52%
Psycho-social impact of trauma	13	24%
Stigma and discrimination	9	17%
Suicide risk	7	13%

PEI Mental Health Needs by Service Area

With one exception, all Service Areas also considered Disparities in access to mental health services and At-risk children, youth and young adult populations the top two key mental health needs in their communities.

- When counts denote interviewees representing more than one Service Areas, Disparities in access to mental health services received greater weight than At-risk children, youth and young adult populations. Nevertheless, proportionally they both represent the majority of the interviewees.

- Service Area 4 selected Disparities in access to mental health services as a top priority, but also viewed the Psycho-social impact of trauma as an important mental health need.

- Disparities in access to mental health services was the top priority for Service Areas 3, 4, 5, and 8; whereas, At-risk children, youth, and young adult populations was a top priority for Service Areas 1, 6, 7, and countywide. Service Area 2 placed equal emphasis on both mental health needs (see **Table 16**).

Table 16. PEI Mental Health Needs by Service Area

PEI Mental Health Need	TOTAL*	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Disparities in access to mental health services	40	3	3	6	5	4	3	4	4	8
At-risk children, youth, and young adult populations	37	5	3	4	2	2	4	5	3	9
Psycho-social impact of trauma	18	1	1	1	3	0	3	1	2	6
Stigma and discrimination	13	2	1	2	2	0	2	2	0	2
Suicide risk	11	0	1	2	1	0	2	1	2	2

*Reflects duplicate counts as a number of interviewees represent more than one Service Area, and multiple selections.

Reasons for Choosing PEI Mental Health Needs

Interviewees were asked why they considered the mental health need selected to be a top priority for PEI services in their community (Q8a). The results are displayed in **Table 17**.

- Primary reasons why interviewees selected Disparities in access to mental health as a key mental health need to be addressed included the lack of services available to meet the mental health demands of the underserved, homeless, and general public. In addition, financial barriers, such as, lack of insurance coverage, inability to pay for services, and Medi-Cal restrictions have made it very difficult for the underserved to obtain needed services, and the PEI Plan provides an opportunity to address these issues.

"The key is the disparity in access. If they have more access, then we could deal with every single population."

- Interviewees who selected At-risk children, youth, and young adult populations and Psycho-social impact of trauma as a key mental health need did so because they felt that early assessment and intervention with this population would prevent issues from escalating and requiring higher levels of care.

"Investing in [at-risk children and youth] has a really significant impact, not only on their lives but in society, in general."

- Children, youth, and young adults were considered most at risk due to the many issues that arise across this age group, such as, teen pregnancies, drug use, violence, anger, and bullying in schools.

"We have a pretty good idea of the kids who are at risk. If we invested in really good prevention and early intervention, we might be able to break the cycles with some of these families."

It should be noted that nine of the 54 interviewees did not respond to this question and/or did not provide a reason for their selection of key mental health needs.

Table 17. Reasons for Choosing PEI Mental Health Needs

PEI Mental Health Need Selection Reason	TOTAL	Disparities in access to mental health services	At-risk children, youth, and young adult populations	Psycho-social impact of trauma	Stigma and discrimination	Suicide Risk
Access Issues	**29**	**20**	**4**	**1**	**4**	
• Access Issues-Available Services/Capacity	9	8	1			
• Access Issues-Stigma	8	1	2	1	4	
• Access Issues-Cost/ Insurance/Medi-Cal/ Eligibility Criteria	5	5				
• Access Issues-Service Access (General)	3	3				
• Access Issues-Service Linguistic/Cultural Competence	3	1	1		1	
• Access Issues-Geographic Location/Social & Physical Condition	1	1				
• Access Issues-Service Operations	1	1				
Assessment/Identification/ Intervention-Early/Better Outcomes	**14**	**1**	**7**	**3**		**3**
No Comment/No Response/ No Knowledge	**9**	**2**	**1**	**1**	**2**	3
High Need/High Risk	**8**	**2**	**4**	**2**		
Social/Economic Conditions	**7**	**2**	**4**	**1**		
Other	**7**	**2**	**2**	**3**		
Behavioral/Social/Emotional Issues/Outcomes	**6**	**1**	**2**	**2**	**1**	
Community/Family Violence/ Abuse	**6**	**1**	**1**	**2**	**1**	1
Address First/Other Needs/ Ages/Pops Follow	**4**	**3**	**1**			
Service Quality	**3**	**2**	**1**			
Unaddressed/Exacerbated Mental Health Conditions/ Higher Levels of Care	**3**	**2**	**1**			

PEI Mental Health Need Selection Reason	TOTAL	Disparities in access to mental health services	At-risk children, youth, and young adult populations	Psycho-social impact of trauma	Stigma and discrimination	Suicide Risk
Academic Outcomes	**2**		**2**			
Community/Family Breakdown/Hopelessness	**2**		**1**	**1**		
Generational Cycle	**2**		**2**			
Outreach/Education/Awareness -General	**2**	**1**	**1**			
Service Engagement/Benefits-General	**2**	**1**			**1**	
Able to Engage in Identification/Treatment	**1**		**1**			
Collaboration/Partnerships/ Teams	**1**	**1**				
High Impact	**1**		**1**			
Self-care/Self-Esteem/ Socialization/Functioning	**1**			**1**		
Specific Strategies/Approaches	**1**		**1**			

V. Age Group Priorities

The interview included two questions asking interviewees to select from the following five age groups: Prenatal to Pre-K (0-5); Children (6-15); Transition-age youth (TAY; 16-25); Adults (26-59); or Older Adults (60+). One question asked interviewees to select the age group they felt would most benefit from **prevention** mental health services (Q9). Another question made a similar request, asking which age group they felt would most benefit from **early intervention** mental health services (Q11).

As with selecting the most significant mental health need, most of the interviewees also had difficulty selecting only one age group for both questions. Interviewees considered prevention and/or early intervention services important for all of the age groups. **Tables 18** and **19** reflect each interviewee's selection, including multiple selections made by a number of interviewees.

About one-quarter of the interviewees felt that all of the PEI age groups were either important or interrelated. Some of these participants narrowed their selections down; others did not and selected all of the categories. One-fifth of the participants either prioritized their selections, qualified them, or combined categories.

"At every step of the age range, you can intervene."

Priority Age Group for Mental Health Prevention Services

Over half of the interviewees selected Children (6-15), and under half of the interviewees selected both Prenatal to Pre-K (0-5) and Transition-age Youth (TAY) (16-25) as the age groups that could best benefit from prevention services. Just over one-tenth of the interviewees selected Adult and Older Adult age groups.

Table 18. Prevention Services Priority Age Groups

Age Group	Number of Participants (N=54)	Percent of Participants
Prenatal to Pre-K (0-5)	23	43%
Children (6-15)	31	57%
Transition-age Youth (TAY) (16-25)	25	46%
Adults (26-59)	7	13%
Older Adults (60+)	6	11%

Priority Age Groups for Mental Health Prevention Services by Service Area

Table 19 shows that interviewees representing all Service Areas considered Pre-Natal to Pre-K, Children, and Transition-age Youth to be the top three age groups that could benefit from prevention services.

Prenatal to Pre-K was selected as the top priority by participants from Service Areas 1, 2, and 5; whereas, Children was selected as the top priority by participants from Service Areas 6, 7, and countywide. In addition, Transition-age Youth was chosen as the top priority by participants from Service Area 3.

- Participants from Service Area 8 placed equal emphasis on Children and Pre-Natal to Pre-K, and participants from Service Area 4 placed equal emphasis on Children and Transition-Age Youth.

Table 19. Prevention Services Priority Age Groups by Service Area

Priority Age Groups for Prevention Services	TOTAL* (N=111)	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Prenatal to Pre-K (0-5)	28	4	2	1	2	3	4	1	3	8
Children (6-15)	41	2	1	3	4	2	5	6	3	15
Transition-age Youth (16-25)	29	3	1	4	4	2	3	1	2	9
Adults (26-59)	7				1	2	1		2	1
Older Adults (60+)	6	1	1	1					1	2

*Reflects duplicate counts as a number of interviewees represent more than one Service Area.

Reasons for Choosing Priority Age Groups for Mental Health Prevention Services

Following up on their age group selections, interviewees were asked to explain why they considered the age group chosen to be the top priority (Q10). Results are displayed in **Table 20**.

- The top reason given by interviewees for selecting age groups as the priority for prevention services was that assessment, identification, and/or intervention at that age led to better outcomes. This reason was cited most for Children, Pre-Natal to Pre-K, and Transition-age Youth (in descending order). Participants stated that it was most beneficial if problems were addressed before they manifested in adulthood, leading to resiliency and positive long-term outcomes.

"The earlier the services are provided to children, the better the outcomes."

- Participants selecting Children and Prenatal to Pre-K as the priority for prevention services also reasoned that engagement in services at this age benefits families and parents. For Children, interviewees stated that it provides an entrée into providing services to the whole family. Participants selecting Prenatal to Pre-K emphasized that the earlier the services, the better as it allows parents to change patterns and experiences, thereby impacting children's development.

"If those early years are healthy, children have more long-term resiliency."

- Interviewees selecting Children as the priority also stated that there were more opportunities to engage individuals to identify and treat problems during this age period.

- For participants selecting Transition-age Youth, another frequently mentioned reason for prioritizing this age group for prevention services is because it is a critical developmental period where individuals are susceptible to outside influences, make decisions that impact their lives, and may experience the onset of serious mental illness. Interviewees stated that it was a time of high risk and high need.

"[Children] are still susceptible to family and parental influence. They still care what their parents think."

"[Transition-age youth] are the kids most influenced by peer pressure, media, trends, fads, phases, and make decisions that impact their adult lives."

Table 20. Reasons for Choosing Priority Age Group for Mental Health Prevention Services

Prevention Priority Age Group Reason for Selection	TOTAL (N=109)	Prenatal to Pre-K (0-5)	Children (6-15)	Transition-age Youth (16-25)	Adults (26-59)	Older Adults (60+)
Assessment/Identification/ Intervention-Early/Better Outcomes	**41**	**14**	**16**	**8**	**2**	**1**
Services Engagement/Benefits-Families/Parents	**14**	**5**	**6**	**2**	**1**	
Critical Developmental Period	**9**	**1**	**3**	**5**		
Able to Engage in Identification/Treatment	**7**		**5**	**1**	**1**	
Social/Economic Conditions	**5**	**1**	**1**	**1**	**1**	**1**
Don't Know/No Comment/No Response/No Knowledge/NA	**6**	**1**	**1**	**2**	**1**	**1**
Behavioral/Social/Emotional Issues/Outcomes	**4**	**1**	**1**	**1**	**1**	
High Need/High Risk	**4**		**1**	**3**		
Mental Health Issues-Substance Abuse	**2**			**1**		**1**
Symptoms More Evident/Recognizable	**2**		**1**	**1**		
School as Natural Gatekeeper	**2**		**2**			
Other	**2**			**2**		
Last Chance	**2**			**1**	**1**	
Community/Family Breakdown/Hopelessness	**1**	**1**				
High Impact	**1**		**1**			
Mental Health Issues-Depression/Suicide Risk	**1**					**1**
Outreach/Education/Awareness	**2**	**1**		**1**		
• Families/Parents	1	1				
• General	1			1		
Service Effectiveness/ Acceptance/Utilization	**1**	**1**				
Specific Services	**2**			**2**		
• Various Services	1			1		
• Counseling/Therapy/Groups/ Hotlines	1			1		
Unaddressed/Exacerbated Mental Health Conditions/ Higher Levels of Care	**1**			**1**		

Priority Age Group for Mental Health Early Intervention Services

Over half of the interviewees selected Children (6-15) as the age group that could best benefit from mental health early intervention services (see **Table 21**). In addition, over one-third selected Transition-age Youth (16-25) and just under one third selected Prenatal to Pre-K (0-5). Less than one-fifth and one-tenth of the interviewees selected Adults and Older Adults age groups respectively.

Table 21. Early Intervention Services Priority Age Groups

Age Group	Number of Participants (N=54)	Percent of Participants
Prenatal to Pre-K (0-5)	15	28%
Children (6-15)	30	56%
Transition-age Youth (TAY) (16-25)	19	35%
Adults (26-59)	9	17%
Older Adults (60+)	5	9%

Priority Age Groups for Mental Health Early Intervention Services by Service Area

As shown in **Table 22**, interviewees representing Service Areas 2, 6, 7, and countywide prioritized Children as the top age group to benefit from mental health early intervention services. Participants from Service Areas 1 and 3 prioritized both Children and Transition-age Youth (TAY) equally. In comparison, participants from Service Areas 4 and 5 prioritized Adults, and participants from Service Area 8 prioritized Pre-Natal to Pre-K, Children, and Adults equally.

Table 22. Early Intervention Services Priority Age Groups by Service Area

Priority Age Groups for Early Intervention Services	TOTAL* (N=92)	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Prenatal to Pre-K (0-5)	16	2	1	2	1	1	1	1	2	5
Children (6-15)	32	3	2	3	2		4	4	2	12
Transition-age Youth (16-25)	22	3	1	3	2	1	2	2		8
Adults (26-59)	13				3	3	1		2	4
Older Adults (60+)	9	2	1	1	1				1	3

*Reflects duplicate counts as a number of interviewees represent more than one Service Area

Reasons for Choosing Priority Age Groups for Mental Health Early Intervention Services

Participants were asked why they considered the age group selected to be the top priority for early intervention services (Q12). Results are presented in **Table 23**.

- Across all age groups, the top reason given for the selections was that assessment, identification, and/or intervention at that age led to better outcomes earlier on. This reason was cited most by participants prioritizing Children, Transition-age Youth, and Pre-Natal to Pre-K age groups (from highest to lowest frequency of mentions). Participants emphasized that early intervention services would be most beneficial at these ages because if issues could be addressed earlier, problems could be worked through to prevent them from worsening into more serious or long-term mental health problems.

"Early intervention can be quite effective at reducing the onset of serious mental illness among a significant number of mental health needs."

"Intervening early with older adults could maintain that population in a healthier way which could reduce the risk of hospitalization or other more costly interventions down the line."

- In addition to the above-mentioned reason, interviewees selecting Children as the priority age group reasoned that engagement in problem identification and early intervention/treatment could occur with children, particularly in schools as they serve as natural gatekeepers and allow access to reach children and their families.

"[Children] are moldable, still more receptive to following the right track. They are not as influenced by their peers as they are adults."

- Interviewees selecting Transition-age Youth as the top priority for early intervention services also made this choice because it was seen as a critical developmental period for understanding mental health and that symptoms were more recognizable and evident at this age, particularly the symptoms of serious mental illness which manifest during the late teens and early adulthood.

"Early intervention at this age [TAY] facilitates a lifelong process of recovery."

- For those selecting Prenatal to Pre-K as the top priority for early intervention services, other reasons included that the engagement in services benefits families and parenting, thereby preventing issues from worsening and having a positive developmental impact.

"There's research showing that if you address it early, there are a lot of good outcomes for children and their families."

Table 23. Reasons for Choosing Priority Age Group for Early Intervention Services

Early Intervention Priority Age Group Reason for Selection	TOTAL (N=91)	Prenatal to Pre-K (0-5)	Children (6-15)	Transition-age Youth (16-25)	Adults (26-59)	Older Adults (60+)
Assessment/Identification/ Intervention-Early/Better Outcomes	35	8	12	10	3	2
Able to Engage in Identification/Treatment	10	1	7	1	1	
All Benefit/All Important/Address All	7	1	2	1	2	1
Services Engagement/Benefits-Families/Parents	6	3	2		1	
School as Natural Gatekeeper	4		4			
Critical Developmental Period	4		1	3		
High Impact	4	1	2	1		
Last Chance	4	1	2		1	
Symptoms More Evident/Recognizable	5		1	2	2	
Other	2		1	1		
High Need/High Risk	2		1		1	
Behavioral/Social/Emotional Issues/Outcomes	2		2			
Don't Know/No Comment/No Response/No Knowledge/NA	2	1				1
Social/Economic Conditions	1					1
Unaddressed/Exacerbated Mental Health Conditions/ Higher Levels of Care	2		1	1		
Juvenile Justice Involvement/Incarceration	1			1		

VI. Priority Populations

The CDMH has identified the following six priority populations for PEI services: 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children and youth in stressed families; 4) Trauma-exposed individuals; 5) Children at risk for school failure; and, 6) Children and youth at risk of or experiencing juvenile justice involvement.

PEI Priority Populations

Interviewees were asked to select the most important priority population (Q13). Similar to the selection process for PEI mental health needs and age groups, a number of the interviewees had difficulty selecting only one priority population, saying they were all important and interrelated. **Table 24** displays the selections made by each interviewee, including multiple selections made by some of the interviewees.

- The top two priority populations selected by interviewees were Underserved cultural populations and Children and youth in stressed families. The remaining four priority populations were chosen by approximately one-quarter of the interviewees.

Table 24. PEI Priority Populations

PEI Priority Populations	Number of Participants (N=54)	Percent of Participants
Underserved cultural populations	24	44%
Children/youth in stressed families	20	37%
Individuals experiencing the onset of serious psychiatric illness	16	30%
Children/youth at risk of or experiencing juvenile justice involvement	14	26%
Trauma-exposed individuals	13	24%
Children/youth at risk for school failure	12	22%

PEI Priority Populations by Service Area

As **Table 25** demonstrates, the majority of Service Areas considered Underserved cultural populations and Children and youth in stressed families the two key priority populations in their communities. Interviewees in Service Area 5 selected Individuals experiencing the onset of serious psychiatric illness as the top priority population followed by Underserved cultural populations and Children at risk for school failure. Furthermore, interviewees with countywide representation gave Trauma-exposed individuals as much weight as Underserved cultural populations and Children and youth in stressed families.

Table 25. PEI Priority Populations by Service Area

PEI Priority Population	TOTAL*	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Underserved cultural populations	32	2	5	3	4	2	2	5	3	6
Children/youth in stressed families	25	2	3	2	4		2	3	3	6
Individuals experiencing the onset of serious psychiatric illness	19			2	3	3	2	2	2	5
Children/youth at risk of or experiencing juvenile justice involvement	15	1		2	1		2	3	1	5
Trauma-exposed individuals	14	1			2		1	2	2	6
Children/youth at risk for school failure	12	1	1	1	1	2		2	1	3

*Reflects duplicate counts as a number of interviewees represent more than one Service Area, and multiple selections.

Reasons for Choosing PEI Priority Populations

Interviewees were asked to explain why they selected the particular population (Q13). Results are displayed in **Table 26**.

- One of the top reasons for selecting any of the priority populations was to emphasize the importance of addressing all the populations. Interviewees who selected one or more priority populations for this reason were evenly distributed across all six priority populations. Despite the strong emphasis on addressing all the priority populations by interviewees as a whole, access issues were predominant reasons for selecting Underserved cultural populations, and the need to address Children and youth in stressed families before other populations was given more weight than other reasons.

- The need to address the Disparities in access to needed mental health services was the primary reason why interviewees selected Underserved cultural populations. They pointed out that this population is highly at-risk and in great need of services. In particular, interviewees noted the lack of services for the deaf, hard of hearing, and blind; the homeless; the gay and lesbian community; as well as, specific ethnic groups. They also felt that focusing on the underserved provided PEI with an opportunity to address the linguistic and cultural competence of providers.

"The [LGBT community] are at the greatest risk of developing serious mental illness because they have less access to services and ultimately fewer coping abilities as a group because they are more isolated and can't easily access resources that can support them in terms of their mental health."

- Another reason given for interviewees' selection of Individuals with onset of serious psychiatric illness, Children and youth in stressed families, and Children at risk of school failure was that earlier identification and intervention would lead to better outcomes.

> ***"[Children in stressed families] are a precursor to all the other populations listed."***

- Interviewees who selected Children and youth in stressed families as a key priority population felt this population required immediate attention, and would eventually require prevention and early intervention services to address the mental health issues confronting other populations. Interviewees also chose this population due to the long-term benefits of early identification and diagnoses.

> ***"The earlier we can intervene and address these issues and create, not only a safe environment, but if medications are appropriate, we can stop the deterioration and the downslide, and the risk of suicide and the risk of homelessness."***

Table 26. Reasons for Choosing PEI Priority Populations

PEI Priority Population Selection Reason	# of Mentions (N=115)	Under-served cultural populations	Children/ youth in stressed families	Individuals with onset of serious psychiatric illness	Children/youth at risk of or experiencing juvenile justice involvement	Trauma-exposed	Children at risk for school failure
All Benefit/All Important/Address All	**24**	**4**	**4**	**4**	**4**	**4**	**4**
Access Issues	**18**	**12**	**1**	**2**	**1**	**1**	**1**
• Access Issues-Stigma	7	2	1	1	1	1	1
• Access Issues-Available Services/Capacity	4	4					
• Access Issues-Service Linguistic/Cultural Competence	4	3		1			
• Access Issues-Cost/Insurance/Medi-Cal/Eligibility Criteria	1	1					
• Access Issues-Geographic Location/Social & Physical Condition	1	1					
• Access Issues-Service Access (General)	1	1					
Assessment/Identification/ Intervention-Early/Better Outcomes	**11**		**3**	**5**		**1**	**2**
High Need/High Risk	**10**	**3**		**3**	**3**		**1**
Address First/Other Needs/Ages/Pops Follow	**9**	**2**	**5**			**1**	**1**
Service Engagement/Benefits-Families/Parents	**5**	**1**	**3**				**1**
Academic Outcomes	**4**		**1**				**3**
High Impact	**4**	**1**	**1**		**1**		**1**
Negative/Risky Behaviors	**4**		**1**	**1**	**1**	**1**	
Immigration and Cultural Matters	**3**	**3**					
Unaddressed/Exacerbated Mental Health Conditions/Higher Levels of Care	**3**			**1**	**1**	**1**	

PEI Priority Population Selection Reason	# of Mentions (N=115)	Under-served cultural populations	Children/ youth in stressed families	Individuals with onset of serious psychiatric illness	Children/youth at risk of or experiencing juvenile justice involvement	Trauma-exposed	Children at risk for school failure
Mental Health Issues	**2**		**1**			**1**	
• Trauma/PTSD/Anxiety	1		1				
• Depression/Suicide Risk	1					1	
Social/Economic Conditions	**2**	**1**			**1**		
Community and Family Domestic Violence	**1**					**1**	
Research Based Services/Definitions	**1**					**1**	
Juvenile Justice Involvement/Incarceration	**1**				**1**		
Behavior/Social/Emotional Issues/Outcomes	**1**						**1**
Able to Engage in Identification /Treatment	**1**				**1**		
Service/treatment Effectiveness/Acceptance/ Utilization	**1**					**1**	
No Comment/No Response	**3**	**2**			**1**		
Other	**7**	**2**	**3**		**1**	**1**	

Mental Health Service Needs

When interviewees were asked to identify PEI mental health service needs (Q14), three key service areas emerged: 1) Outreach, education, and awareness; 2) Specific mental health services mentioned by interviewees; and, 3) Location-based services (see **Table 27**).

- With respect to outreach, education, and awareness services, interviewees advocated for a comprehensive public education campaign designed to increase the public's understanding of mental health today; a comprehensive definition of mental health; common mental health issues and their accompanying signs and symptoms; when to seek intervention or treatment; and, the needed documentation and requirements to access services.
- In addition, interviewees also mentioned the need to engage parents and families in outreach and education efforts by offering parenting classes, workshops, and services that direct parents' attention to the signs and symptoms of mental health and help them develop preventive coping strategies.

- Among the specific prevention and early intervention service needs mentioned by interviewees, almost one-quarter of them concerned the lack of individual and group counseling or other therapeutic services. Other services interviewees cited were wide-ranging in terms of type, target populations, and mental health needs addressed, as is reflected in the sample below:

"Bombard parents with services to prevent later problems."

    - Treatment and education services;
    - Clinical support for older adults;
    - Strength-based services;
    - Pre-natal to pre-K services;
    - A behavioral screening system for the developmentally disabled;
    - Services that validate and support the gay, lesbian, bi-sexual, and transgender community's sense of self;
    - Mentoring and leadership programs;
    - Services proven effective in clinical settings and among different age groups;
    - Follow-up counseling for trauma-exposed individuals and families;
    - Crisis intervention; and,
    - Services that target children and families with four or more risk factors.

- Interviewees also talked about where services should be located. Location-based services are provided in venues and locations outside of the typical service provider setting, such as, homes, schools, churches and other community organizations. The underlying emphasis among interviewees was to provide services in the community, closer to where community members live and work, as well as, in places they are more likely to frequent for reasons other than mental health. Some interviewees also mentioned the need for one-stop shops and wrap-around services.

"Bring mental health services to where the children are."

Early detection and treatment of developmental delays, as well as, social, emotional, and behavior problems were also among the key services needs cited by interviewees. Among the interviewees who mentioned the need for early detection, one interviewee promoted universal screenings, another suggested targeting at-risk children, and another recommended focusing early identification efforts at schools.

"Mental health can't do it alone, just like each agency can't do it alone."

- Interviewees also mentioned needed services designed to increase access and reduce stigma, developing collaborative networks and using multidisciplinary assessment and intervention teams, and providing education and training about mental health in schools, as well as other sectors, (e.g., law enforcement, social services).

Table 27. Mental Health Service Needs

Mental Health Service Needs	Number of Mentions (N=182)	Percent of Mentions
Outreach/Education/Awareness	**42**	**23%**
• General	16	9%
• Families/Parents	9	5%
• Specific Locations	7	4%
• Specific Mediums	4	2%
• Messaging	4	2%
• Available Services	2	1%
Specific Services	**37**	**20%**
• Various Services	28	15%
• Counseling/Therapy/Groups/Hotlines	9	5%
Location-based Services	**20**	**11%**
Access Issues	**14**	**8%**
• Service Linguistic & Cultural Competency	2	1%
• General Service Access	2	1%
• Cost/Insurance/Medi-Cal/Eligibility Criteria	1	1%
• Stigma	1	1%
Assessment/Identification/Intervention-Early/Better Outcomes	**10**	**5%**
Service Engagement/Benefits-Families/Parents	**8**	**4%**
Specific Strategies/Approaches	**8**	**4%**
Collaboration/Partnerships/Teams	**6**	**3%**
Education/Training-Specific	**6**	**3%**
Staff/Provider Education/Training/Recruiting	**5**	**2%**
Anger Management/Conflict Resolution	**4**	**2%**
Service Integration/Continuity of Care	**3**	**1%**
Mental Health Issues	**2**	**1%**
• Substance Abuse	1	1%
• Depression/Suicide Risk	1	1%
Social/Economic Conditions	**2**	**1%**
Safety/Stability	**1**	**1%**
Community and Domestic Violence	**1**	**1%**
Community/Family Breakdown/Hopelessness	**1**	**1%**
Research Based Services/Definitions	**1**	**1%**
Case Management	**1**	**1%**
Medication Issues/Management	**1**	**1%**
Community/Client Involvement in the Mental Health Process	**1**	**1%**
No Comment/No Response	**4**	**2%**
Other	**4**	**2%**

*Reflects duplicate counts as a number of interviewees represent more than one Service Area.

Mental Health Service Needs by Service Area

When the data and findings are viewed by service area, the top three mental health service needs remain the same, but education and training needs is now the fourth most highly mentioned mental health need, with access issues following closely behind (see **Table 28**).

- The interviewees in Service Areas 2, 5, 8, and countywide cited outreach, education, and awareness most; whereas, Service Areas 3 and 6 identified specific services needed in their communities, and Service Area 4 emphasized the need for early identification and intervention services above the other two mental health service needs.

Table 28. Mental Health Service Needs by Service Area

Mental Health Service Needs	Number of Mentions*	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Outreach/Education/Awareness	**93**		**6**	**7**	**7**	**13**	**9**	**3**	**13**	**35**
• General	32		2	1	2	5	2		3	17
• Families and Parents	24		4	2	2		4	3	1	8
• Specific Locations	13			1	1	5	1		1	4
• Available Services	11				1	1	1		7	1
• Messaging	9			2	1	1	1		1	3
• Specific Mediums	4			1		1				2
Specific Services	**59**	**3**	**2**	**8**	**7**	**5**	**11**	**4**	**3**	**16**
• Various Services	48	3	2	5	5	5	11	3	3	11
• Counseling/Therapy/Groups/Hotlines	11			3	2			1		5
Location-based Services	**43**	**4**	**2**	**5**		**5**	**2**		**7**	**18**
Assessment/Identification/Intervention-Early/Better Outcomes	**30**	**2**	**2**		**19**	**3**	**1**		**1**	**2**
Education/Training-Specific	**17**		**4**	**2**	**2**	**2**	**2**	**4**		**1**
Access Issues	**14**	**1**		**5**		**2**			**6**	
• Cost/Insurance/Medi-Cal/Eligibility Care	6								6	
• Service Linguistic & Cultural Competency	4			4						
• General Service Access	3			1		2				
• Stigma	1	1								

Mental Health Service Needs	Number of Mentions*	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Collaboration/Partnerships/Teams	**9**				**1**					**8**
Staff/Provider Education/Training/Recruiting	**8**			**4**					**2**	**2**
Service Engagement/Benefits-Families/Parents	**8**			**1**	**1**	**1**	**2**	**1**		**2**
Specific Strategies/Approaches	**8**		**2**					**6**		
Safety/Stability	**6**									**6**
Anger Management/Conflict Resolution	**6**				**1**		**4**	**1**		
Community/Client Involvement in the Mental Health Process	**5**				**1**	**1**	**1**		**1**	**1**
Service Integration/Continuity of Care	**4**	**1**							**2**	**1**
Social/Economic Conditions	**4**						**2**			
Mental Health Issues	**3**	**1**					**2**			
• Substance Abuse	2						2			
• Depression/Suicide Risk	1	1								
Community/Family Breakdown/Hopelessness	2						2			
Community and Domestic Violence	2						2			
Research Based Services/Defined	2								2	
Case Management	1								1	
Medication Issues/Management	1									
No Comment/No Response	4	1	2		1					
Other	9	1						6		2

*Reflects duplicate counts as a number of interviewees represent more than one Service Area.

Existing Prevention Services

Interviewees were asked to identify existing prevention services (Q15). When responding to this question, interviewees provided responses in different forms. Some interviewees provided the names of specific services; others mentioned types of services or identified the agencies at which services were provided. All of the services mentioned by interviewees, regardless of type or the form in which they were provided, are listed below in alphabetical order for easier reference:

- ABC in Cerritos
- After-School Programs
- American Indian Counseling Center
- American Society on Aging Outreach
- Armenian Relief Society
- Asian Health Care Venture
- Asian Pacific Mental Health Center
- Baby Steps
- Best Babies (services for teens with babies)
- Bresee Foundation Family Resource Centers
- Care Management Program (case management)
- Child Development Institute
- Child Guidance Programs in schools
- Child Parent Psychotherapy for Domestic Violence (CPP-FV)
- Children's Bureau counseling services in schools
- Children's Bureau Family Resource Centers
- Clinical Partners Offer MH Services to Child 5-15 & TAY
- Community Assessment Service Center (CASC)
- Community Family Preservation Program
- DARE
- Department of Aging Outreach
- DHCMHC-Crisis Response Team
- DHCMHC-Parenting Classes
- DHCMHC-Residential Program for Women
- DHCMHC-Screening Days
- DHCMHC-Site-based Suicide Prevention Services
- DHCMHC-Substance Abuse Programs
- DHCMHC-Suicide Prevention Crisis Line
- Didi Hirsch Community Mental Health Center
- Education and Outreach Program/Trainings
- El Nido School-based Program
- El Nido Early Head Start Home-based Program
- El Nido Parent Education
- Emergency Suicide Response Unit
- ENKI Health and Research Systems
- Family Clinics
- Family Literacy Program
- Family Preservation
- Family Support
- First 5 California/Los Angeles
- First Steps

- Foothill Family Svc MH Consultation Model
- Friends of La Brea
- G & L Center Transgender Employment Program
- G & L Center Support Groups
- Head Start
- Healthy Families
- Healthy Homes
- Healthy Minds Program
- Healthy Start
- HYE WRAP Program
- Jail-based Programs
- KYCC Parent Education Classes
- LA Child Guidance Center
- LA Gender Center
- Latina Adolescence Suicide Prevention Program (LASP)
- Lupin School Student Study Team
- Lupin School Psychologist
- MH America TAY Program
- On-site DMH services in juvenile centers
- On-site DMH services in schools
- Other Partners for Families Coalition Programs
- Pacific Clinics services
- Parent Child Dyadic Treatment-developed by interviewee
- Parent-Child Interaction Therapy (PCIT)
- Parent Groups
- Parenting Class at Community Center in Stanislaus County
- Parks and Recreation Programs
- Partnership for Families
- Partnership for Health (mentoring/tutoring)
- Partners in Care/Prevention Health Care Program
- PC-Asian-American Family Enhancement Network (AAFEN)
- PC-Asian Leaders
- PC-Asian Mastery Mentoring Program
- PC-Familios Unidos
- PC-Family and School Together (FAST)
- PC-Inspire Mobilize People to Achieve Changes Together (IMPACT)
- PC-Latina Suicide Prevention Program (COSMOS)
- PC-Strength Inter-Cult &-Gen Ties in Immigrant Families (SITIF)
- PC-Strength Multi-Ethnic Families & Communities
- Peaceful Playgrounds-Peace Keepers
- Potential Collaborations-Relationships with at-risk populations
- PRIDE Program
- Program Services at National Center for Child Traumatic Stress
- Program Services at CA Clearinghouse for Child Abuse
- Promotoro Model
- Psychological First Aid (PFA)
- Regional Center's Health Provider Panel
- Roybal Health Center's Health Screenings

- Safe and Drug Free Schools
- Safe Schools
- School-based services
- Second Step
- Services by South Bay Mental Health Center
- Services that address drug and alcohol abuse
- Services that address violence
- Services to detect chronic illness
- Services to detect depression in new mothers
- Services to detect dev delays in children
- Shields for Families
- Smoking Cessation Programs
- Social Services & Other Agency that take Family-Centered Approach
- St. Agnes
- Stepping Up to School Readiness/MH Consultation Model
- Targeted Outreach Services for Pregnant Women
- Targeted Outreach Services for Teen Moms
- Teen Mentoring Programs
- Therapists Trained in Early Child Intervention in Pre-Schools
- The VA GET SMART Program
- The Wellness Center
- UAII
- UCLA CAPPS
- Unable to Provide/Did Not Provide
- UPAC Honors Drama Assembly
- VFC Parenting Programs
- VFC Screenings
- VFC Warm Line
- Victim Assistance/Witness Assistance Program
- WIC
- Yellen Learning Center in schools
- Yes to Kids
- YWCA Glendale Program for domestic violence

Existing Early Intervention Services

Interviewees were also asked if they were aware of any existing early intervention services (Q16). Similar to the responses for existing prevention services, some interviewees provided the names of specific services, others mentioned types of services or identified the agencies at which services were provided. All of the services mentioned by interviewees, regardless of type or the form in which they were provided, are listed in alphabetical order for easier reference:

- ALLEGRE (former program)
- Alternative Response Services (ARS, DPSS)
- American Indian Counseling Center
- Asian Pacific Mental Health Center
- Baby Steps
- Best Babies

- CA Division of Juvenile Justice-CA Youth Authority
- Care Management Program (case management)
- Child Development Institute (CDI)
- Child Guidance Programs in schools
- Children's Bureau counseling services in schools
- Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)
- Community Assessment Centers (DPSS)
- Community Assessment Service Center (CASC)
- Community Family Preservation Program
- Community Grass-Roots Organizations
- Counseling
- Daniel's Place
- Department of Aging Outreach Program
- Depression Screenings
- DHCMHC-24-Hour Suicide Prevention Crisis Line
- DHCMHC-Crisis Response Team
- DHCMHC-Residential Program for Women in Recovery
- DHCMHC-School-based Programs
- DHCMHC-Substance Abuse Programs
- DHCMHC-Survivors After Suicide Program
- DHCMHC-Two Buddies
- Didi Hirsch Community Mental Health Center
- Dorothy Kirby Center
- Downtown Women's Center
- Early Head Start Program
- Early Mental Health Initiative Grant
- El Nido Child Abuse Treat & Prevent Program
- El Nido Delinquency Prevent & Partner with LAPD
- El Nido Teen Parent Program
- Eye Movement Desensitization and Reprocessing (EMDR)
- Family Literacy Program
- First Steps
- Foothill Family Service Mental Health Consultation Model
- Gay and Lesbian Center Crisis Intervention Services
- Head Start Strengthening Families Model
- Healthy Families
- Healthy Homes
- Healthy Minds Program
- Heritage Clinic
- Homeless Liaison
- HYE WRAP Program
- JAR (former program)
- KYCC Academic Services & Youth Services
- KYCC Home-based Family Preservation Services
- KYCC School-based Services
- Los Angeles Free Clinic
- My Friend's Place
- Norwegian approach to education of mental health at school level

- Other Partners for Families Coalition Programs
- Para Los Ninos
- Parent-Child Interaction Therapy (PCIT)
- Partners in Care/Prevention Health Care Program
- Part-time Social Workers
- PC-Incredible Years
- PC-Positive Parenting Program
- PC-School Community Law Enforcement (SCALE)
- Peaceful Playgrounds
- Peer Support Groups
- Permanent Housing
- Post-traumatic Play Therapy
- PRIDE Program
- Psychiatric Evaluation Team
- Psycho-educational Process
- Referrals (Black LA County Client Coalition)
- Regional Center's Bio-behavioral Panel
- Roybal Health Center-Physicians assist with Health Screenings
- Safe and Drug Free Schools
- Santa Anita Family Services in Monrovia
- School-based Mental Health Services
- School-based Programs (counseling & education)
- Screenings for Children (Clinica Romero)
- Second Step
- Services by South Bay Mental Health Center
- Shields for Families
- St. John's CFDC Clinic for Learning & Attn Disorders
- St. John's CFDC EC Assessment & Treatment
- St. John's CFDC Families in Schools Together
- St. John's CFDC Partnerships for Families
- St. John's CFDC Therapeutic Preschool
- State CPSP
- Step Up on Second
- Stepping Up to School Readiness/Mental Health Consultation Model
- Student Study Team (SST)
- Substance Abuse Ed & Inter Onsite & at Schools
- T.H.E. Clinic
- Teen Mothers Program (DPSS)
- Therapists Trained in Early Child Intervention in Pre-Schools
- Trauma/Grief-Focused Psychotherapy
- Trauma-Focused Cognitive Behavioral Therapy (FT-CPT)
- UAII
- Unable to Provide/Did Not Provide
- UPAC Honors Assembly
- VFC Group Therapy
- Wise and Healthy Aging in Santa Monica
- Yellen Learning Center in schools
- Yes to Kids

Challenges of Providing Services

Table 29 lists the key challenges to providing PEI services cited by interviewees (Q17). The three most frequently cited challenges concerned: 1) access; 2) outreach, education, and awareness; and, 3) funding and resources.

- One of the greatest access challenges emerging from interviewee responses is reducing and eliminating the stigma associated with mental health to help community members overcome their fears and lack of understanding of mental health. In order to combat stigma, interviewees noted that other access issues need to be addressed as well, including having access to available services, cost and insurance coverage, the linguistic and cultural competency of providers and their staff, getting consumers who are geographically or physically isolated to services, and the environment in which services are conducted.

"If people do not have Medi-Cal or great work benefits, then they are not going to get access [due to] the inflexibility of resources."

- Second, interviewees pointed out the challenges of educating and raising awareness about mental health issues, needs, and services. Specifically, interviewees talked about communities' lack of awareness of the benefits of prevention and early intervention, the lack of user-friendly information available about mental health, and the lack of training among school staff and law enforcement on how to respond to mental health issues in their sectors.
    - In addition, they discussed the challenges of effectively communicating about mental health -- how to communicate the differential needs of different cultures, and how to make the conversation less threatening, particularly when talking to parents about their children; and, how to present mental health in a positive light.
    - Aside from making services more accessible, another challenge is reaching and engaging those individuals and families who need services but do not recognize the need for service, are in denial about their symptoms, are resistant, or simply are unmotivated to pursue treatment. For example, a couple of interviewees noted that the homeless often are resistant to services. Another interviewee pointed out that youth in the juvenile justice system generally refuse services unless court-ordered and even when court-ordered are difficult to engage in treatment. Additionally, a few interviewees conveyed the struggles they have convincing families of the benefits of prevention and early intervention.
- Third, over one-half of the interviewees recognized the current lack of funding and resources, as well as, the competition for funding, as a significant challenge that needs to be addressed in order to serve and meet the communities' mental health needs.

"If we had the funding, we could raise awareness."

While interviewees recognize the challenges discussed above, they also pointed out that a well-trained, culturally appropriate workforce is necessary to address and alleviate these issues. First and foremost interviewees underscored the current lack of a sufficient mental health workforce. Then they emphasized the need for education and training in evidenced-based practices, diagnosis and treatment of older adults, handling complex mental health issues, serving the developmentally disabled, and ongoing training in new treatments and modalities.

Table 29. Challenges of Providing Services

Challenges of Providing Services	Number of Mentions (N=141)	Percent of Mentions
Access Issues	**28**	**20%**
• Stigma	11	8%
• Cost/Insurance/Medi-Cal/Eligibility Criteria	8	6%
• Service Linguistic & Cultural Competency	6	4%
• General Service Access	5	4%
• Available Services/Capacity	5	4%
• Geographic Location/Social & Physical Condition	3	2%
• Service Operations	1	1%
Outreach/Education/Awareness	**24**	**17%**
• General	11	8%
• Available Services	7	5%
• Linguistic/Cultural Appropriate Messaging	2	1%
• Families/Parents	2	1%
• General Messaging	1	1%
• Specific Locations	1	1%
Funding and Resources	**19**	**13%**
Service Engagement/Benefits	**15**	**11%**
• General	8	6%
• Families/Parents	7	5%
Staff/Provider Education/Training/Recruiting	**9**	**6%**
• Staff/Provider Education/Training/Recruiting-General	8	6%
• Staff/Provider Education/Training/Recruiting-Linguistic/Cultural Competency	1	1%
Service Integration/Continuity of Care	**5**	**4%**
Assessment/Identification/Intervention-Early/Better Outcomes	**2**	**1%**
Collaboration/Partnerships/Teams	**2**	**1%**
Referral Network	**2**	**1%**
Community/Client Involvement in the Mental Health Process	**1**	**1%**
System Support/Assistance/Navigators	**1**	**1%**
Mental Health Issues-Substance Abuse	**1**	**1%**
Social/Economic Conditions	**1**	**1%**
Various Specific Services	**1**	**1%**
Need for Flexible/Adaptable Services/Systems	**1**	**1%**
Location-based Services	**1**	**1%**
Sensitive Staff/Can Relate	**1**	**1%**
Service Quality	**1**	**1%**
No Comment/No Response	**3**	**2%**
Other	**23**	**16%**

*Reflects duplicate counts as a number of interviewees represent more than one Service Area.

Challenges of Providing Services by Service Area

Table 30 presents the distribution of interviewee responses across service areas and countywide representation. The order in which the key challenges appear is the same as in **Table 29**, with the exception that the challenge of funding and resources has moved in front of, but is still neck-and-neck with, outreach, education, and awareness.

- With the exception of Service Areas 3, 5 and 8, all the Service Areas considered access and all its accompanying issues as a significant challenge to service provision. Service Area 3 focused its attention on the challenge of engaging individuals and families in assessment and treatment. Service Area 5 regarded outreach, education, and awareness a more significant challenge for its community members than access, funding, and service engagement. And, Service Area 8 gave funding and resources more weight than access.

- Responses from Service Area 2 were equally distributed between the challenges of access and outreach, education, and awareness.

- Service Areas 1, 2, 4, and 8 did not mention service engagement as a challenge in their community, and staff education, training, and recruitment did not arise as a challenge in Service Area 5.

Table 30. Challenges of Providing Services by Service Area

Challenges of Providing Services	Number of Mentions*	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Access Issues	**99**	**8**	**7**	**9**	**16**	**6**	**10**	**18**	**7**	**18**
• Stigma	33	1	2	2	6	1	3	8	2	8
• Available Services/Capacity	17			1	2	3	2	5	2	2
• Cost/Insurance/Medi-Cal/Eligibility Criteria	17	3	3	3	2		2	3	1	
• Service Linguistic & Cultural Competency	16		2	3	4		2	2	1	2
• General Service Access	12	2			1	2	1		1	5
• Geographic Location/Social & Physical Condition	3	2								1
• Service Operations	1				1					
Funding and Resources	**42**	**2**	**3**	**2**	**8**	**2**	**1**	**1**	**12**	**11**
Outreach/Education/Awareness	**42**	**1**	**7**	**4**	**4**	**10**	**4**	**6**	**1**	**5**
• General	21		2	1	2	5	2	6	1	2
• Available Services	9	1	2	2		3				1
• General Messaging	4				2		2			
• Linguistic/Cultural Appropriate Messaging	3		3							

Challenges of Providing Services	Number of Mentions*	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	C W
• Families/Parents	3					2				1
• Specific Locations	1									1
Service Engagement/Benefits	**25**			**10**		**3**	**4**	**1**		**7**
• General	13			4		3	3	1		2
• Families/Parents	12			6			1			5
Staff/Provider Education/Training/Recruiting	**24**	**4**	**3**	**4**	**3**		**2**	**3**	**3**	**2**
• Staff/Provider Education/Training/Recruiting-General	14	4	1	2	1			1	3	2
• Staff/Provider Education/Training/Recruiting-Linguistic/Cultural Competency	10		2	2	2		2	2		
Collaboration/Partnerships/Teams	**9**							**6**		**3**
Service Integration/Continuity of Care	**7**				**4**		**1**		**2**	
Assessment/Identification/Intervention-Early/Better Outcomes	**7**									**7**
System Support/Assistance/Navigators	**4**				**2**		**2**			
Community/Client Involvement in the Mental Health Process	**2**		**2**							
Social/Economic Conditions	**2**					**2**				
Mental Health Issues-Substance Abuse	**2**					**2**				
Referral Network	**2**							**1**		**1**
Need for Flexible/Adaptable Services/Systems	**1**						**1**			
Sensitive Staff/Can Relate	**1**									**1**
Location-based Services	**1**			**1**						
Various Specific Services	**1**									**1**
Service Quality	**1**									**1**
No Comment/No Response	**3**	**1**	**1**					**1**		
Other	**58**	**1**	**3**	**2**	**12**	**4**	**6**	**3**	**11**	**16**

*Reflects duplicate counts as a number of interviewees represent more than one Service Area.

Strategies to Address and/or Minimize Challenges

Interviewees were asked what types of strategies can best address or minimize the challenges mentioned (Q17b). **Table 31** below presents the top three strategies offered by interviewees to address or minimize the top three challenges cited in **Table 30** above. While outreach, education, and awareness was the second most frequently cited challenge, it became the top-cited strategy. Increasing outreach efforts, raising awareness, and educating community members about mental health is clearly a challenge; at the same time outreach, education, and awareness is an appropriate strategy to minimize, if not fully address, the challenges communities face providing mental health services.

- Not only did interviewees advocate conducting community outreach to educate and raise awareness about mental health issues, symptoms, and services, they also suggested different mediums by which outreach and education could be conducted; for instance:
    - Mobile vans;
    - Tip sheets;
    - Schools;
    - Letter writing and online campaigns;
    - General media, (e.g., newspapers, TV, and radio);
    - Community mobilizing model outreach efforts; and,
    - Through organizations such as National Alliance on Mental Illness (NAMI).

- As specific mediums were discussed, interviewees also provided suggestions on how to frame the message and where to disseminate it. With respect to messaging, one interviewee suggested creating messages that moved away from a mental health model and toward a social-emotional model. Similarly, other interviewees were particularly interested in creating a message that tackles and eases the stigma around mental health. Where to disseminate the message centered on non-mental health community locations such as schools, community agencies, community forums, and existing networks and community groups.

"[Provide] a concise presentation of what is available and how to access it."

The second and third most frequently mentioned strategies included specific approaches to minimizing the challenges of service provision, and the implementation of location-based services.

- Specific approaches to addressing the challenges of prevention and early intervention service provision focused on access issues, as well as, early identification, training, and treatment services:
    - Provide accessible community services for older adults;
    - Have a mental health worker or DCFS worker at the police station to identify at-risk children and youth;
    - Consolidate public education and primary prevention to avoid duplication of effort;
    - Engage experts in specific target populations to assist with assessment and diagnosis;
    - Accept waivers to allow non-licensed professionals to provide services incident to a licensed professional; and,

- Implement the five protective factors developed by Strengthening Families to address the needs of children.

Other highly-mentioned strategies included specific approaches to minimizing the challenges, implementing more location-based services, obtaining funding and resources, developing a well-trained work force with culturally and linguistically sensitive and educated staff as part of it.

- Location-based services were recommended by about one-quarter of the interviewees. School-based and community-based programs were often mentioned. Other suggestions included providing mental health services at non-traditional settings, such as faith-based organizations. One interviewee also recommended using community centers to serve as one-stop shops with services ranging from health care, child care, and mental health care.

"There has to be more of a multi-use approach in terms of how services are constructed."

- Targeted and increased funding and resources were mentioned equally as often as developing a workforce of competent mental health staff and service providers. With respect to education and training, interviewees suggested ongoing sensitivity training, as well as, recruiting and training professionals who not only speak the language, but who also understand the culture and can relate to those they serve. One interviewee also emphasized the need to ramp up and improve recruiting by using more intensified and coordinated efforts to hire quality staff.

"If the county or the state can recognize that extra costs go into developing an effective and competent workforce in dealing with immigrant populations, I think that would help."

Table 31. Strategies to Address and/or Minimize the Challenges of Service Provision

Top Three Strategies to Address and/or Minimize Challenges	Number of Mentions	Percent of Mentions
Outreach/Education/Awareness	**40**	**29%**
• General	14	10%
• Specific Mediums	8	6%
• General Messaging	7	5%
• Specific Locations	4	3%
• Available Services	2	1%
• Linguistic/Cultural Appropriate Messaging	2	1%
• Specific	2	1%
• Families/Parents	1	1%
Specific Strategies/Approaches	**13**	**9%**
Staff/Provider Education/Training/Recruiting	**12**	**9%**
• General	5	4%
• Linguistic/Cultural Appropriate	2	1%
Location-based Services	**11**	**8%**
Access Issues	**9**	**7%**
• Available Services/Capacity	2	1%
• Stigma	1	1%
• Service Operations	1	1%
Collaboration/Partnerships/Teams	**8**	**6%**
Various Specific Services	**7**	**5%**
Funding and Resources	**6**	**4%**
Education/Training-Specific	**4**	**3%**
Service Integration/Continuity of Care	**4**	**3%**
System Support/Assistance/Navigators	**3**	**2%**
Community/Client Involvement in the Mental Health Process	**1**	**1%**
Sensitive Staff/Can Relate	**1**	**1%**
Assessment/Identification/Intervention-Early/Better Outcomes	**1**	**1%**
Community/Family Breakdown/Hopelessness	**1**	**1%**
Case Management	**1**	**1%**
Accountability	**1**	**1%**
No Comment/No Response	**1**	**1%**
Other	**13**	**9%**

Evidence-based and Promising Practices

Interviewees were asked to identify any effective programs that they were aware of; more specifically, any Evidenced-based or Promising Practices (Q18). When responding to this question, interviewees provided responses in different forms. Some interviewees provide the names of specific services, others mentioned types of services, and still others identified the agencies at which services were provided.

All the services mentioned by interviewees, regardless of type or the form in which they were provided, are listed in alphabetical order for easier reference:

- AB2034 Model
- ACT Team Approach
- ALLEGRE (former program)
- Arts and Sports Programs
- Boys and Girls Club
- CalWORKs One-stop Service Demonstration Project
- Child Parent Psychotherapy for Domestic Violence (CPP-FV)
- Cognitive Behavior Therapy for Late Life Depression
- Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)
- Cognitive Behavior Therapy
- Collaborative Trial/Prism E (similar to PROSPECT)
- Combined health care-mental health approach
- Co-occurring Disorders Court
- Crisis Response Team
- DDMI Program College Hospital
- Depression Screenings for Home-delivered Meals
- DIR (Developmentally-based; Ind.; Relationship-based)
- DREW for suicide prevention
- Educational Programs
- El Nido & Other Home-based Instructional Programs
- El Nido Family Nurse Partnership Program for 1st Time Moms
- Ethnic/Control Factors in Rates of Depression
- Eye Movement Desensitization and Reprocessing (EMDR)
- Family to Family
- Family-based Programs
- First Steps
- Full-service Partnership
- Hathaway-Sycamores Agency
- Healthy Homes of Antelope Valley Hospital
- Healthy Minds Program
- Heritage Clinic's Mental Health Outreach Protocol
- Housing Programs
- Housing Works, based in NY
- HYE WRAP Program (with cultural related changes)
- Improving Mood-Promote Acc to Collaborative Treatment (IMPACT)
- Improving Health of His Seniors with Depression and Diabetes
- In Our Voice
- Incredible Years
- Individual and Group Counseling
- Intensive Care Management Models
- Intensive Strategies-DCFS/DMH Partnership
- JAR (former program)
- Latina Adolescence Suicide Prevention (LASP) Program
- LAUSD Trauma Services Adaptation Center for Schools and Communities
- Lifespan Therapies

- Live Event Scale/FOA Scale
- Mental Health Programs
- MH America Outreach Programs
- Multi-systemic Therapy (MST)
- Nurse-Family Partnership
- On-site School Counselor
- Outreach Campaign to prevent suicide in seniors
- Parent Child Development Center Programs (PCDP)
- Parent Child Interactive Therapies (PCIT)
- PC-Asian Leaders
- PC-Asian Mastery Mentoring Program
- PC-Asian-American Family Enhancement Network (AAFEN)
- PC-Familios Unidos
- PC-Family and School Together (FAST)
- PC-Incredible Years
- PC-Inspire Mobilize People to Achieve Changes Together (IMPACT)
- PC-Latina Suicide Prevention Program (COSMOS)
- PC-Positive Parenting Program
- PC-School Community Law Enforcement (SCALE)
- PC-Strength Inter-Cultural &-Generational Ties in Immediate Family (SITIF)
- PC-Strengthening Multi-Ethnic Family & Communities
- PC-Student Assistance Program(SAP/Project Success)
- Peace Builders
- Peaceful Playgrounds Program
- Perry Preschool Program
- PHQ-9 to diagnose depression
- Positive Parenting in Adult Ed-South Bay
- Post-traumatic Play Therapy
- Prevention of Suicide in Primary Care Elderly (PROSPECT)
- Prevention from Child Abuse and Neglect (PCAN)
- Program to Encourage Active Rewarding Lives for Seniors (PEARLS)
- Primary Care Screenings for Older Adults
- Programs Integrating Primary Care and Mental Health
- Programs promoting reg. interactions with at-risk
- Project Star (Service Provider is Prototype)
- Promotoras Model
- Psychological First Aid (PFA)
- Safe Schools
- School-based Programs
- Seattle Gate-Keepers Model
- SEEK 1 Screening Tool with children
- SEEK 2 Screening Tool with children
- Senior Mentoring for CalWORKs Families
- Senior Peer Counseling
- Smoking Cessation Programs
- Step Up 2
- Step Up's Daniel's Place Program
- Stepping Up to School Readiness

- Strengthening Families
- Substance Abuse Programs
- Suicide Prevention Crisis Line
- Suicide Training for Physicians & Staff
- Survivors After Suicide Programs
- Teen Screen
- The VA GET SMART Program
- Trauma/Grief-Focused Psychotherapy
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Triple P-Positive Parenting Program
- Unable to Provide/Did Not Provide
- UPAC Honors Assembly-in process
- Women's Re-entry Program
- Wrap-around Programs
- Yellen Program

Effective, Culturally Appropriate Program Components

Interviewees were asked, "What are the necessary components of an effective, culturally appropriate program?" (Q19). In response, the following three components (presented from highest to lowest number of mentions) were cited as essential to providing effective, culturally appropriate prevention and/or early intervention services (see **Table 32**).

- Access is key to culturally appropriate and effective services. Specific components include a linguistically and culturally friendly service environment; inviting service environments that have flexible and adaptable hours; ability to accommodate different income levels, insurance, and public assistance; and, an educational program that engages consumers and reduces the stigma associated with mental health.
- Staff/provider education, training, and recruiting as an effective and culturally appropriate component refers to recruiting and hiring staff who not only speak the language and understand the culture of those they serve, but who also are well qualified, trained, and skilled at service provision.
- In order to be effective and culturally appropriate, outreach, education, and awareness program components should ideally reflect the culture and language of the communities served, use culturally sensitive and appropriate promotional materials, and educate parents and families about mental health.

Other components mentioned by interviewees include location-based services, specific services, specific strategies, and community/client involvement in the mental health process.

- Location-based Services refers to providing services in locations where people can easily access them, such as field- and community-based services, one-stop shops, and services at schools.
- Specific Services include specific ways in which service providers can provide culturally appropriate services, such as the following:
    - Small community-based services/providers;
    - Outcomes and strength-based services; and,

"Small treatment centers integrated and dispersed throughout the local community so they can be culturally-sensitive because they are community-based organizations."

- Support services such as individual and group counseling or therapy and hotlines.

"We should shift from teaching to them, to learning from them."

- Specific Strategies to promote and sustain culturally appropriate programs mentioned by interviewees include recruiting administrators and leaders who support the programs, using community mapping to determine needs and services, and using consultations with research focused experts.

- Community/Client Involvement in the Mental Health Process involves obtaining feedback about services and treatment from consumers; developing community coalitions to address emerging mental health needs; and connecting service providers with community members.

Table 32. Effective and Culturally Appropriate Program Components

Program Components	Number of Mentions (N=159)	Percent of Mentions
Access Issues	**43**	**27%**
• Service Linguistic & Cultural Competency	21	13%
• Service Operations	8	5%
• General Service Access	6	4%
• Geographic Location/Social & Physical Condition	4	3%
• Cost/Insurance/Medi-Cal/Eligibility Criteria	3	2%
• Stigma	1	1%
Staff/Provider Education/Training/Recruiting	**22**	**14%**
• Staff/Provider Education/Training/Recruiting-General	14	9%
• Staff/Provider Education/Training/Recruiting-Linguistic/Cultural Competency	8	5%
Outreach/Education/Awareness	**16**	**10%**
• Linguistic/Culturally Appropriate Messaging	6	4%
• General Messaging	3	2%
• General	2	1%
• Specific Mediums	2	1%
• Families/Parents	2	1%
• Available Services	1	1%
Location-based Services	**13**	**8%**
Specific Services	**12**	**8%**
• Various Services	10	6%
• Counseling/Therapy/Groups/Hotlines	2	1%
Community/Client Involvement in the Mental Health Process	**8**	**5%**
Specific Strategies/Approaches	**6**	**4%**
Collaboration/Partnerships/Teams	**6**	**4%**
Need for Flexible/Adaptable Services/Systems	**5**	**3%**
Sensitive Staff/Can Relate	**4**	**3%**
Education/Training-Specific	**4**	**3%**
Service Integration/Continuity of Care	**3**	**2%**
Funding and Resources	**2**	**1%**
Service Engagement/Benefits-Families/Parents	**2**	**1%**
Health Care Issues	**1**	**1%**
Assessment/Identification/Intervention-Early/Better Outcomes	**1**	**1%**
Case Management	**1**	**1%**
Social/Economic Conditions	**1**	**1%**

No Comment/No Response	**6**	**4%**
Other	**3**	**2%**

VII. Long-range Planning

Long-range planning questions gathered information on three themes: 1) How to improve access to mental health services (Q20); 2) How to provide effective PEI services to communities (Q21); and, 3) How to better educate and inform people about mental health prevention and early intervention (Q22).

Recommendations for Improving Access to Mental Health Services

As shown in **Table 33**, when asked how to improve access to mental health services, interviewees cited outreach, education, and awareness; access; and location-based services as the top three priorities.

- Interviewees suggested that conducting PEI outreach, education, and awareness were necessary to improving access to mental health services. Specific recommendations included the following:
  - Outreach and education about mental health designed to inform the public about mental health illnesses and symptoms, increase awareness of available services, de-stigmatize mental health, and promote good mental health;
  - Outreach and education provided in specific locations, such as, schools, medical facilities, senior centers, homes, and waiting rooms or communal public areas;
  - Positive, culturally appropriate messaging about mental health; and,
  - Increased public awareness through such mediums as the Internet, community boards, brochures, and local and ethnic newspapers, television, and radio programs.

"Break through the resistance, reluctance, and the fear about mental health."

- Interviewees recommended several ways in which to address access. Aside from those access strategies mentioned in response to other questions, (e.g., friendly service operations, transportation, linguistic and culturally competent staff, and greater service availability), interviewees suggested the following specific strategies for improving access: providing hotlines and chat rooms to gain information and support; "Open Days" at health clinics or medical centers; training peer counselors at all age levels; training professionals and natural gatekeepers; and, offering multiple access points and resource persons.

"I didn't know where to find [services], and when I found them I couldn't get to them."

- Another recommendation often given by participants was to provide services in specific locations, such as, schools, community agencies, health clinics, and other non-traditional settings like community organizations, parks, and senior centers.

"Services should be together, at least in our community, because you may not be willing to go to a mental health provider but you may be going to your doctor, so services ought to be easily accessible in that way."

- In addition to the three most cited recommendations, participants suggested networking, multi-disciplinary trainings, and outreach to build collaborative partnerships between mental health, education, law enforcement, medical professionals, and community agencies and organizations. Interviewees also discussed the need for hiring and training mental health personnel to provide high quality, bilingual, and culturally-competent services. This also includes hiring and training of systems navigators and mental health resource persons.

- Other recommendations made to increase access included increased funding and resources, greater service integration to provide more comprehensive continuity of care, increased client involvement in mental health services, and increased accountability.

"Give the community the resources it needs to take care of itself."

Table 33. Access Recommendations

Recommendations for Improving Access to Mental Health Services	Number of Mentions (N = 172)	Percent of Mentions
Outreach/Education/Awareness	**48**	**28%**
• General	15	9%
• Specific Locations	11	6%
• Messaging	9	5%
• Specific Mediums	7	4%
• Available Services	5	3%
• Linguistically/Culturally Appropriate Messages	1	0%
• Families/Parents	1	0%
Access Issues	**32**	**19%**
• Service Operations	8	5%
• Stigma	7	4%
• Cost/Insurance/Medi-Cal/Eligibility Criteria	6	4%
• Service Access (General)	5	3%
• Available Services/Capacity	3	2%
• Geographic Location/Social & Physical Condition	2	1%
• Service Linguistic/Cultural Competence	2	1%
Location-based Services	**18**	**10%**
Specific Strategies	**14**	**8%**
• Specific Strategies/Approaches	9	5%
• Various Strategies	5	3%
Collaboration/Partnerships/Teams	**13**	**8%**
Funding and Resources	**8**	**5%**
Service Integration/Continuity of Care	**7**	**4%**
Staff Provider Education/Training Recruiting	**5**	**3%**
• General	4	2%
• Linguistic/Cultural Competency	1	0%
Systems Support/Assistance/Navigators	**4**	**2%**
Community/Client Involvement in Mental Health Process	**3**	**2%**
Education/Training-Specific	**3**	**2%**
Sensitive Staff/Can Relate	**2**	**1%**
Service Engagement/Benefits-Families/Parents	**2**	**1%**
Accountability	**1**	**0%**
Assessment/Identification/Intervention-Early/Better Outcomes	**1**	**0%**

Service Restrictions-Legal Bureaucratic	**1**	**0%**
Community/Family Breakdown/hopelessness	**1**	**0%**
Social/Economic Conditions	**1**	**0%**
Specific Services	**1**	**0%**
No Comment/No Response/No Knowledge	**3**	**2%**
Other	**4**	**2%**

Recommended Methods for Providing Effective PEI Services

When asked to recommend the best ways to provide effective prevention and early intervention services to their communities, interviewees most often suggested numerous strategies ranging from specific services to general outreach, education, and awareness, and to location-based services (see **Table 34**).

- Specific services recommended by participants included walk-in clinics and services, individual counseling sessions, support groups, 24-hour hotlines, school psychologists on every campus, peer counseling, services for seniors, and services in non-traditional locations.

"To provide effective prevention, it must be done through non-traditional means with non-traditional populations."

The need for outreach, education, and increased awareness was the second most frequently recommended method for providing prevention and early intervention services. Some of the methods mentioned were:

  - Educate the community about services available and how to access them;
  - Aggressive outreach in local communities, schools, and faith-based organizations conducted by linguistically and culturally competent mental health personnel;
  - Communicate effectively to reframe the message in language/terminology that is understood by the community, non-threatening, and non-stigmatizing;
  - Provide ongoing, broad educational efforts such as NAMI's "Friends Helping Friends" campaign; and,
  - Use public service announcements, community workshops and forums, peer-to-peer education, and school Parent Nights in outreach efforts.

- In addition, interviewees emphasized providing services in locations where community members are at, both in centralized locations and in smaller pockets of the community. Specific locations suggested were preschools, schools, community centers, faith-based organizations, community organizations, health clinics, homes, and bringing services to the homeless on the streets.

"Use language that is understandable and relatable instead of terminology."

"The churches in the Korean community play such an important role… they're such a support system for many of the families. I think any prevention or outreach or engagement without involving them is going to be very challenging."

Other recommended methods for providing prevention and early intervention services included addressing access issues, using specific strategies and approaches, integrating services, collaborations and increased funding of existing programs.

- Participants suggested addressing access issues such as transportation, lack of services, and cost by providing services that are available 24/7, bilingual and culturally competent, free or at low cost, have fewer eligibility requirements, and have transportation and bus or taxi vouchers available for those in remote locations.

- Specific approaches to mental health services recommended included using a mental health consultation model to build on universal preschool, looking at the impact of gangs on the community, integrating mental health education into the school curricula at all levels, requiring youth involved in juvenile justice to give back to the community, and providing a mental health liaison to work with developmentally delayed individuals.

- Service integration was also recommended by co-locating and embedding programs in existing sites such as schools, hospitals, health centers, and mental health agencies.

"Embed ourselves in programs that already exist for children that age."

- Collaborations were recommended among service providers in the community to meet mental health needs, with school- and faith-based organizations to promote tutoring and peer support, with businesses to develop opportunities for families and children to lead healthy and active lives, and with families to create healthy spaces that advance the social and emotional well-being of the family.

- Increased funding of existing programs to sustain and expand upon their efforts, allow hiring of qualified and culturally competent staff, and provide outreach into the community.

- Other methods recommended included increased case management, mental health staff training and education, and community and client collaboration in the mental health process to build relationships, engage families, invest in capacity building, identify needs and resources, and raise awareness and reduce stigma associated with mental health services.

Table 34. Methods Recommendations

Methods Recommendations for Providing Prevention and Early Intervention Services	Number of Mentions (N= 142)	Percent of Mentions
Specific Services	**19**	**13%**
• Various Services	13	9%
• Counseling/Therapy/Groups/Hotlines	6	4%
Outreach/Education/Awareness	**18**	**13%**
• General	5	4%
• Available Services	4	3%
• Specific Locations	4	3%
• Messaging	3	2%
• Specific Mediums	3	2%
• Linguistically/Culturally Appropriate Messages	1	1%
Location-based Services	**13**	**9%**
Access Issues	**12**	**8%**
• Service Access (General)	3	2%
• Service Linguistic/Cultural Competence	3	2%
• Available Services/Capacity	2	1%
• Service Operations	2	1%
• Cost/Insurance/Medi-Cal/Eligibility Criteria	1	1%
• Geographic Location/Social & Physical Condition	1	1%
Specific Strategies/Approaches	**12**	**8%**
Collaboration/Partnerships/Teams	**10**	**6%**
Service Integration/Continuity of Care	**10**	**6%**
Assessment/Identification/Intervention-Early/Better Outcomes	**7**	**5%**
Community/Client Involvement in Mental Health Process	**7**	**5%**
Funding and Resources	**7**	**5%**
Staff Provider Education/Training Recruiting	**5**	**4%**
• Staff Provider Education /Training/Recruiting	4	3%
• Staff Provider Education /Training/Recruiting-Linguistic/Cultural Competency	1	1%
Education/Training-Specific	**4**	**3%**
Case Management	**3**	**2%**
Service Engagement/Benefits-Families/Parents	**2**	**1%**
Accountability	**1**	**1%**
School Issues	**1**	**1%**
Sensitive Staff/Can Relate	**1**	**1%**
Service Quality	**1**	**1%**
Social/Economic Conditions	**1**	**1%**
No Comment/No Response/No Knowledge	**3**	**2%**
Other	**3**	**2%**

Recommendations on How to Educate Communities about Mental Health PEI

Although interviewees provided a wide range of recommendations on how to better educate and inform the community about mental health prevention and early intervention, the most frequently mentioned recommendations focused on outreach, education and, awareness (see **Table 35**).

- Launch a mass media public awareness campaign utilizing public service announcements, famous spokespersons, ethnic media, internet, billboards, text messages, health fairs, public education series, guest speakers, mobile outreach vans, community open houses, and school and community agency advertising.

"We have found that you need 12 doors to go through to get the same information. It has to be pretty flexible and it has to be in-depth enough that you do the same information in multiple ways."

- Provide education to the public about mental health issues, signs/symptoms, and services through schools, faith based organizations, medical facilities, and retail and business sites; thereby reaching out to every segment of the community.

- Engender trust with underserved populations by providing culturally sensitive and linguistically appropriate outreach and services, partnering with local ethnic organizations, and targeting messages to specific populations.

- Address stigma and discrimination regarding mental health by using positive approaches, emphasizing social and emotional wellness, and normalizing mental illness and treatment.

"Messaging that is targeted to specific populations in a way that is accessible, entertaining, and understandable."

In addition, interviewees also recommended collaborations between mental health and law enforcement, education, businesses, community members, clients, and the media. Participants suggested having multi-disciplinary teams available to reach and inform community members in sites such as hospitals, schools, community centers, and Department of Children and Family Services sites.

Participants also emphasized the need to train various personnel (school, law enforcement, community agencies and organizations, medical, and even mental health) about mental health in general, how to identify signs and symptoms, and where to refer individuals for services.

- Other recommendations for informing the public included changing the entry system for mental health, providing mental health resource persons and hotlines with updated information, and engaging families and clients in the entire process from planning, information dissemination, outreach and service provision.

"Change the entry system by going into communities – through faith-based organizations, community centers and parks -- to build relationships and educate the population about mental health."

Table 35. Education Recommendations

Recommendations for Educating Communities about Mental Health Prevention and Early Intervention Services	Number of Mentions (N= 146)	Percent of Mentions
Outreach/Education/Awareness	**104**	**71%**
• Specific Mediums	42	29%
• Specific Locations	39	27%
• General	14	10%
• Linguistically/Culturally Appropriate Messages	6	4%
• Families/Parents	3	2%
• Messaging	3	2%
• Available Services	2	1%
Collaboration/Partnerships/Teams	**6**	**4%**
Specific Strategies	**6**	**4%**
Access Issues	**4**	**3%**
• Available Services/Capacity	2	1%
• Service Access (General)	1	1%
• Service Operations	1	1%
Staff Provider Education/Training/Recruiting	**5**	**3%**
Education/Training-Specific	**4**	**3%**
Specific Services (Various)	**3**	**2%**
Assessment/Identification/Intervention-Early/Better Outcomes	**2**	**1%**
Community/Client Involvement in Mental Health Process	**2**	**1%**
Flexible/Adaptable Services/Systems (Need for)	**2**	**1%**
Service Integration/Continuity of Care	**2**	**1%**
Accountability	**1**	**1%**
Location-based Services	**1**	**1%**
Service Engagement/Benefits-Families/Parents	**1**	**1%**
No Comment/No Response/No Knowledge	**1**	**1%**
Other	**2**	**1%**

VIII. Summary

Overall, the interviewees were receptive to the interview process and openly shared their expertise, experience, thoughts, and ideas about the mental health needs in their communities and how prevention and early intervention can address them. Their responses to the 23-plus interview questions provided the valuable information that is contained in this report.

From the interviewees, it was clear that the issues that impact the mental health needs in their communities are complex, and oftentimes, pervasive. Ability to access services and pay for them were a high concern, as were such economic and social issues as homelessness, poverty, and crime. Interviewees noted that these issues result in a host of mental health disorders for which services often are difficult to access or altogether unavailable, further preventing some individuals from becoming self-sufficient productive members of society.

"In our community, the number is so overwhelmingly great regarding how many people cannot access services."

With respect to the CDMH categories, interviewees cited At-risk children, youth, and young adult populations and Disparities in access to mental health services as the two key PEI mental health needs to be addressed. The most highly selected

priority age group for both prevention and early intervention services was Children between the ages of 6 and 15; and the top two priority populations were Underserved cultural populations and Children and youth in stressed families.

When asked to provide their thoughts on the types of PEI mental health services needed in their communities that would address the PEI mental health needs, categories, and priority populations, interviewees indicated services that provide outreach, education, and awareness as a top need. They also cited specific PEI services, among which were counseling and other therapeutic services, and advocated for locating services in venues and locations outside typical service provider settings.

"The earlier you intervene with children, the better your chances of making a real difference."

"[PEI services] need to be familiar to the community, an extension of their way of life."

Accompanying the service needs were three key challenges of providing PEI services and the strategies to minimize them. The three key challenges were: 1) access; 2) outreach, education, and awareness; and, 3) funding and resources. While outreach efforts, raising awareness, and educating community members about mental health presents its challenges, those same efforts are necessary to minimize, if not fully address, the mental health service provision challenges confronting communities. As part of their responses, interviewees offered a number of ideas on different mediums, approaches, and locations by which outreach, education, and awareness efforts could be conducted.

Finally, the focus on outreach, education, and awareness among interviewees arose again when interviewees were asked for recommendations on how to improve access, provide PEI services, and inform communities about PEI. The combined activities of outreach, education, and awareness were among the top three mentioned recommendations in each of these three areas. With respect to improving access to mental health services, it was the top mentioned recommendation, followed closely by access issues. Similarly, it was the top mentioned recommendation for educating communities about mental health prevention and early intervention.

"A lot of people do not know how to access these services, and even if you told them and presented the services to them doesn't mean that they are going to understand it. So you have got to be there and offer it to them constantly until they understand it."

It has to be both -- education and access. If we make them aware, and they have nowhere to go, then that would be a big problem."

In summary, the key findings presented in this report provide a rich array of information that will inform the PEI planning process in terms of the following: existing prevention and early intervention mental health needs in Los Angeles County communities that need to be addressed; the service provision challenges communities face; how to improve access to mental health services; how to educate the community about mental health; and effective ways to provide PEI services.

IX. Appendices

Appendix A: List of Individual Interviewees

Alphabetical Listing of Individual Interviewees and Their Organizational Affiliation

Individual Interviewee	Organizational Affiliation
Victoria Adams	Los Angeles District Attorneys Office – Family Violence Division
Glenda Ahhaitty	LACDMH American Indian Counseling Center
Natalie Ambrose	LACDMH Service Area I Advisory Committee
Lauraine Barber	Los Angeles County Narcotics and Dangerous Drugs Commission & LACDMH Service Area VIII Advisory Committee
Lynn Brandstater	Verdugo Mental Health
Rick Bryant	Los Angeles County Department of Children and Family Services
Cory Campbell	Las Virgenes Unified School District
Don Crane	Los Angeles County Office of Education – Antelope Valley Special Education Local Plan Area
Kita Curry	Didi Hirsch Community Mental Health Center
Deborah Davenport	Los Angeles County Department of Public Health
Carmen Diaz	United Advocates for Children and Families
Pia Escudero	Los Angeles Unified School District
Robert Farran	Los Angeles County Office of Education – Southwest Special Education Local Plan Area
Maryam Fatemi	Los Angeles County Department of Children and Family Services
Grace Floutsis	Clinica Msr Oscar A. Romero
Liz Forer	Venice Family Clinic
Harry Furuya	Roybal Comprehensive Health Center
John Griffith	Kedren Community Health Center
Liz Herrera	El Nido Family Center
Cynthia Jackson	Heritage Clinic
Gregory James	Los Angeles County Probation Department – United Peace Officers Against Crime
Sam Joo	Koreatown Youth and Community Center
Kimthai Kuoch	Cambodian Association of America
Abbe Land	Los Angeles Free Clinic
Tod Lipka	Step Up on Second Street, Inc.
Joan Maltese	Child Development Institute
Susan Mandel	Pacific Clinics
Stella March	National Alliance on Mental Illness
Maria Marquez	National Alliance on Mental Illness – LAPEM (Spanish-speaking)
Robert Martinez	Santa Monica Police Department
Alex Mata	Los Angeles County Sheriff PRIDE Program & Volunteer Clergy Council
Nadia Mirzayans	Los Angeles County Department of Public Social Services – CalWORKs Division
Aurea Montes-Rodriquez	Community Coalition
Nancy Montgomery	Cerritos College – Student Health Services
Stephen Mouton	San Gabriel/Pomona Regional Center
Grace Napolitano	United States Congresswoman
John Denardo	Los Angeles Police Department
Emma Oshagan	Pacific Clinics – HYE WRAP Program
Kelly Perdue	California Department of Corrections and Rehabilitation

Elizabeth Pfromm	Los Angeles Child Guidance Clinic
Jim Preis	Mental Health Advocacy Services
Rebecca Refuerzo	St. Johns Child and Family Development Center
Catherine Royer	Veteran's Administration
Kathy Salazar	MELA Counseling Services Center
Janine Shelby	LACDMH Harbor-UCLA Medical Center
Osbee Sangster	Black Los Angeles County Client Coalition
Grace Sison	T.H.E. Clinic
Stan Sorenson	Tarzana Treatment Center
Ian Stulberg	Los Angeles Gay and Lesbian Center
Laura Trejo	City of Los Angeles Department of Aging
Richard Van Horn	Mental Health America of Los Angeles
Yvonne Washington	Athena Transitional Housing Program
Lisa Watson	Downtown Women's Center
Marleen Wong	Los Angeles Unified School District Crisis Intervention Services & LAUSD/RAND/UCLA Trauma Services Adaptation Center

Appendix B: Key Individual Profile



Key Individual Interview Profile

Please provide the following information regarding the areas of your expertise and representation.

County of Los Angeles
Department of Mental Health
Prevention and Early Intervention
550 S. Vermont Avenue, Suite 605, Los Angeles CA 90020
Phone: (213) 738-2331 Fax: (213) 351-2026
mhsapei@dmh.lacounty.gov

Date:

Last Name: First Name: Initial:

Title:

Agency:

Street:

City: State: Zip:

Phone 1: Phone 2: Fax:

Email 1: Email 2:

Demographic Information

Please check all that apply to you.

Ethnicity

- ☐ African-American
- ☐ American Indian

Asian/Pacific Islander
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Korean
- ☐ Lao
- ☐ Samoan
- ☐ Vietnamese

- ☐ Caucasian

Eastern European/Middle Eastern
- ☐ Armenian
- ☐ Persian
- ☐ Russian

- ☐ Latino/Hispanic

Other

Gender

- ☐ Male
- ☐ Female

Age Group

- ☐ Transition-age Youth (TAY) 16-25
- ☐ Adults 26-59
- ☐ Older Adults 60+

Languages Spoken

- ☐ Armenian
- ☐ Cambodian
- ☐ Cantonese
- ☐ Other Chinese
- ☐ English
- ☐ Farsi
- ☐ Korean
- ☐ Lao
- ☐ Mandarin
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other Language _____



Key Individual Interview Profile (continued)

Please provide the following information regarding the areas of your expertise and representation.

Areas of Expertise and Representation

Populations/Communities that You Serve

Please check all that apply.

Underserved/Unserved

- ☐ African-American
- ☐ American Indian
- Asian/Pacific Islander
  - ☐ Cambodian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Korean
  - ☐ Lao
  - ☐ Samoan
  - ☐ Vietnamese
- ☐ Latino/Hispanic
- Eastern European/Middle Eastern
  - ☐ Armenian
  - ☐ Persian
  - ☐ Russian
- ☐ Lesbian/Gay/Bisexual/Transgender/ Questioning Individuals
- ☐ Co-occurring Disorders
- ☐ Homeless
- ☐ Immigrants
- ☐ Refugees

Priority Populations

- ☐ Individuals Experiencing Onset of Serious Psychiatric Illness
- ☐ Children/Youth in Stressed Families
- ☐ Trauma-Exposed Individuals
- ☐ Children at Risk for School Failure
- ☐ Children/Youth at Risk of or experiencing the Juvenile Justice System
- ☐ Underserved Cultural Populations

Age Groups

- ☐ Prenatal to Pre-K 0-5
- ☐ Children 6-15
- ☐ Transition-age Youth (TAY) 16-25
- ☐ Adults 26-59
- ☐ Older Adults 60+

Other _____

Community Sector Representation

Please indicate primary sector represented.

- ☐ Education
- ☐ Individuals with Serious Mental Illness and/or their Families
- ☐ Mental Health Service Providers
- ☐ Health
- ☐ Social Services
- ☐ Law Enforcement
- ☐ Community Family Resource Centers
- ☐ Employment
- ☐ Media

Geographic Representation

Please check all that apply.

Service Area

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ Countywide

Supervisorial District

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ Countywide

Office Use Only

☐ *entered* _____

Version 0.5

Appendix C: Key Individual Consent Form

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Acting Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

BOARD OF SUPERVISORS
GLORIA MOLINA
YVONNE B. BURKE
ZEV YAROSLAVSKY
DON KNABE
MICHAEL D. ANTONOVICH

DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

KEY INDIVIDUAL INTERVIEW CONSENT FORM

STATEMENT OF PURPOSE

The Department of Mental Health is in the process of developing its countywide Prevention and Early Intervention (PEI) Plan, which will provide services at the local community level. Community input is being sought on multiple levels, including key individual interviews, focus groups, and community forums.

We would like to ask you questions about the mental health needs in your community, what you see as challenges to effective services, and what types of PEI programs are needed. Your input will provide valuable information that will benefit your community. The information you provide will be used to develop the Department's PEI Plan.

CONSENT

- I confirm that I have read and understand the PEI information brochure and letter of invitation to take part in a key individual interview for the MHSA Prevention and Early Intervention Plan.
- I understand that my participation is voluntary. I have the right to not answer any questions that I don't like or to stop the interview and withdraw my answers at any stage of the interview without having to explain why.
- I understand that I am free to withdraw from the interview at any time.
- I understand that the interview will be recorded on audio tape so that none of my important insights and discussions are missed.
- Information obtained in the interviews will not be directly attributed to me or any others. However, a summary of the entire key individual interview process will contain my name listed as a key individual interviewee. The results will focus on the content of the discussion rather than identify who said what. I understand that DMH will provide me a copy of the summary of the key findings from the key individual interviews.

Considering the above information, I agree to take part in the key individual interview.

Name (print)_____

Signed_____

Date_____

"To Enrich Lives Through Effective And Caring Service"

Appendix D: Key Individual Interview Protocol

KEY INDIVIDUAL INTERVIEW QUESTIONS

Issues	Key Individual Questions
Individual's Organizational Affiliation	1. How would you describe your role? *(Select all that apply.)* __ Los Angeles County Employee __ Other Government Employee __ Mental Health Services Provider __ Mental Health Advocate __ Health/Human Services/Social Services Provider (Non-Mental Health) __ Interested Community Member __ Family Member of a Consumer of Mental Health Services __ Consumer of Mental Health Services __ Other *If respondent is not affiliated with a particular organization/agency, skip Question 2.* 2. Briefly describe the types of services your organization/agency provides.
PEI Planning Process	3. How knowledgeable are you about the LA County Department of Mental Health's (DMH) Prevention and Early Intervention (PEI) planning process? __ Very Knowledgeable __ Somewhat Knowledgeable __ Not at all Knowledgeable 4. Have you participated in any part of the PEI planning process so far? __ Yes __ No

Issues	Key Individual Questions
	4a. If yes, please explain how you have participated?
Community Needs and Mental Health Needs	5. Overall in your community, what would you say is the greatest problem?
	5a. How do you see this problem impacting the mental health of your community?
	6. What are the greatest mental health needs in your community or among the people/communities you serve?
	6a. How do these needs present themselves in your community or the communities you serve?
	6b. Of the needs you have mentioned, what do you consider to be the number one mental health need?
	7. What barriers do people encounter accessing mental health services (e.g., what stops people from getting the services they need)?

Issues	Key Individual Questions
	8. The California State Department of Mental Health has identified five key community mental health needs that should be addressed in the PEI plan. Which of the following do you think is the number one community mental health need in your community? __ Disparities in access to mental health services __ Psycho-social impact of trauma __ At-risk children, youth, and young adult populations __ Stigma and discrimination __ Suicide risk 8a. Why do you consider this mental health need to be the top priority for PEI in your community? 8b. Do you know of any existing mental health services that currently address this top mental health need in your community?
Prevention Services	Prevention generally involves services and programs that promote protective factors and reduce risk factors in order to prevent development of signs and symptoms of mental disorders AND strives to create emotional well-being. 9. What do you think is the age group that could best benefit from mental health **prevention** services? __ Prenatal to Pre-K (0-5) __ Children (6-15) __ Transition-age Youth (TAY) (16-25) __ Adults (26-59) __ Older Adults (60+)

Issues	Key Individual Questions
	10. Why do you consider this age group to be the top priority?
Early Intervention Services	Early intervention is defined as services of short duration (less than 1 year) and relatively low intensity, which avoids the need for a more intensive level of services, prevents the mental health condition from worsening, and supports the return to well-being. 11. What do you think is the age group that could best benefit from mental health **early intervention** services? __ Prenatal to Pre-K (0-5) __ Children (6-15) __ Transition-age Youth (TAY) (16-25) __ Adults (26-59) __ Older Adults (60+) 12. Why do you consider this age group to be the top priority?
Priority Population	13. The California State Department of Mental Health has identified the following priority populations for PEI: • Underserved cultural populations • Individuals experiencing the onset of serious psychiatric illness • Children/youth in stressed families • Trauma-exposed individuals • Children at risk for school failure • Children/youth at risk of or experiencing involvement with the Juvenile Justice System Of the list above, what do you consider to be the most important priority population that should receive PEI services in your community? 13a. Please explain why you selected this particular population?

Issues	Key Individual Questions

14. What mental health **prevention** services do you think are important for this priority population?

15. Do you know of any **existing prevention** services that currently address the mental health needs of this priority population?

    15a. What are the strengths of these services?

    15b. What are the weaknesses of these services?

    15c. What recommendations do you have to improve these services?

16. Do you know of any **existing early intervention** services that currently address the mental health needs for this priority population?

    16a. What are the strengths of these services?

    16b. What are the weaknesses of these services?

Issues	Key Individual Questions
	16c. What recommendations do you have to improve these services?
	17. Overall, what are the challenges of providing **prevention** and/or **early intervention** services to this priority population?
	17a. Of these, which is the greatest challenge?
	17b. What types of strategies can best address or minimize these challenges?
	18. Are you aware of any effective programs (Evidence-Based Programs or Promising Practices) that you think would be appropriate for this priority population? *Evidence-Based Programs* include programs that have been evaluated with some quantitative and qualitative data showing positive outcomes AND have been subject to expert/peer review determining that the programs have a significant level of evidence of effectiveness. *Promising Practices* include programs and strategies that have some quantitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes.
	19. What are the necessary components of an effective, culturally appropriate program for this priority population?

Issues	Key Individual Questions
Long Range Planning	20. What specific things do you think would help people better access mental health services?
	21. In your opinion, what are the best ways to provide effective **prevention** and **early intervention** services to your community?
	22. What recommendations do you have to better educate/inform your community about mental health **prevention** and **early intervention**?
Other Comments	23. In closing, is there anything else you would like DMH to know about **prevention** and **early intervention** mental health service needs in your community?

APPENDIX 11

Overall Summary Report of the Focus Groups

WRMA
Walter R. McDonald & Associates, Inc.

OVERALL SUMMARY REPORT OF THE

FOCUS GROUPS

CONDUCTED FOR THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN
IN LOS ANGELES COUNTY

April 2009

Prepared for:
The Los Angeles County Department of Mental Health

Prepared by:
Walter R. McDonald & Associates, Inc.
EVALCORP Research & Consulting, Inc.

ACKNOWLEDGEMENTS

Special thanks and acknowledgement go to the Los Angeles County Department of Mental Health (LACDMH) PEI staff, the Focus Group Coordinators, and to each of those participating in the Focus Groups. We greatly appreciate the assistance we received from the LACDMH PEI staff and the Focus Group Coordinators in coordinating and scheduling the focus groups. We also extend special thanks to all of the focus group participants for taking the time to meet with us and for sharing with us their perspectives. The wealth of information provided during each of the focus group discussions was invaluable to the formation of this report.

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I. Introduction

The Los Angeles County Department of Mental Health (LACDMH) is engaged in an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan to be funded through the Mental Health Services Act (MHSA) enacted by California voters in 2004.

The focus for developing the PEI Plan is at the Service Area level, utilizing informational meetings, key stakeholder interviews, focus groups, and community forums in each of the eight geographic areas of Los Angeles County. Because each Service Area has distinct and varying populations, geography, and resources, it is critical for PEI services to be specific and responsive to regional and community-based needs.

The California Department of Mental Health (CDMH) has defined *mental health prevention* as reducing risk factors or stressors, building protective factors and skills, and increasing support to allow individuals to function well in challenging circumstances. Whereas, *mental health early intervention* involves a short duration (usually less than one year) and relatively low-intensity intervention to measurably improve a mental health problem or concern early in its manifestation and avoid the need for more extensive mental health treatment or services later.

In addition, CDMH has targeted five community mental health needs, six priority populations, and six statewide efforts for the PEI Program, and has identified seven sectors that counties must partner with to develop their PEI Plan.

This report presents a summary of the key findings across 48 Focus Groups with a total of 413 participants conducted across all eight Service Areas, and findings from 17 Focus Groups with a total of 159 participants conducted Countywide. Overall, a total of 65 Focus Groups were conducted across Los Angeles County with a total of 572 participants.

II. Methodology

Participants

Each focus group was comprised of 6 to 10 participants. Participants were drawn from existing groups/agencies for the purpose of participating in a discussion about the mental health service needs, barriers, and strategies in their respective communities.

- As with the Key Individual Interviews, the focus groups were selected based on Service Area representation and the categories of MHSA age group, sector, priority population, and key community mental health needs for PEI. Utilizing recommendations made from LACDMH District Chiefs, Service Area Advisory Committee (SAAC) members, and other stakeholders throughout the county familiar with the categories, LACDMH selected focus groups that qualified in at least two PEI categories.

- LACDMH identified a focus group coordinator from each community group/agency selected. The focus group coordinator sought participation in the focus group from among the agency's membership. Focus group coordinators were asked to identify and invite a diverse group of participants who could speak about service needs, barriers, and recommended strategies for their Service Area.

Procedures

Each focus group coordinator worked closely with a member of the contracted consulting team to arrange focus group dates, times, and locations.

The focus groups were conducted at the organizations or agencies representing the focus group participants or other community-based locations. The focus groups were audio recorded and took about two hours to complete. Nine key questions, some of which contained sub-questions, were posed to focus group participants. The questions were designed to produce information needed to inform the PEI planning process. A copy of the Focus Group Guide can be found in **Appendix A**.

Facilitators representing LACDMH at the focus groups as a neutral third party included a team of three staff members from Walter R. McDonald & Associates, Inc. (WRMA) and their subcontractors, EvalCorp Research & Consulting, Inc. and Laura Valles and Associates, LLC. One team member facilitated the focus group, another observed and documented notes, and a third recorded participants' responses on flip charts, which participants could refer to throughout the focus group.

Focus group documentation included: a Focus Group Profile, a Focus Group Participant Profile, a signed Consent Form indicating that the focus group would be audio recorded, the observer's electronic notes, the paraphrased responses from participants, an audio recording of the focus group, and a transcript of the focus group developed from the audio recording. A report was written by the focus group team observer, summarizing the group's responses to the questions. Information from each focus group was coded so that the data could be analyzed and presented in summary format.

III. Summary of the Findings

This section presents a summary of selected findings across the eight Service Area Focus Groups and the Countywide Focus Groups. The presentation of the summary findings follows a similar format to the individual Service Area and Countywide Focus Group reports, and presents summary data on the following selected topic areas:

- Knowledge of the PEI Planning Process;
- Service Area and Priority Population Representation; and,
- Community Mental Health Needs and Priorities.

Not summarized in tables or in writing in this summary are the following topic areas:

- Impact of the mental health needs on the community;
- Existing and needed prevention and early intervention services;
- Priority prevention and early intervention services and locations;
- Barriers to service access and strategies to increase access; and,
- Recommendations for informing communities about PEI.

The findings in the areas listed above remain an integral part of the individual Service Area and Countywide Focus Group reports and are given full attention therein.

Knowledge of the PEI Planning Process

The first question(s) that focus group participants were asked to answer was "Have you or your group taken part in the Los Angeles County Department of Mental Health's PEI planning process? And, if so, how?" Out of a total of 572 participants, about one-fifth had knowledge of or had participated in the PEI Planning Process. However, this proportion varied considerably by Service Area and Countywide. As shown in **Table 1**, almost half of the focus group participants in Service Area 2 and

Countywide had participated in the Planning Process at some level. In the remaining Service Areas, a considerably smaller proportion of participants had participated in the Planning Process (between 4% and 18%) and in the case of Service Area 7, no one had knowledge of or had been involved in PEI before participation in the focus group.

Table 1. Knowledge of the PEI Planning Process

Knowledge of PEI	Total (N=572)	SA 1 (n=55)	SA 2 (n=44)	SA 3 (n=63)	SA 4 (n=50)	SA 5 (n=45)	SA 6 (n=51)	SA 7 (n=49)	SA 8 (n=56)	CW (n=159)
Yes	22%	13%	45%	5%	18%	4%	4%	--	13%	46%
No	78%	87%	55%	95%	82%	96%	96%	100%	87%	54%

Service Area and Priority Population Representation

Service Area Representation. In each focus group participants were asked to identify the service areas they represented and/or served. **Table 2** provides a sense of the proportion of participants who represent or work with service areas other than the primary one they represented in their respectively assigned focus groups.

As expected, the highest representation in each Service Area directly corresponded to the focus groups conducted in each Service Area (highlighted in bold). Also, Countywide representation was documented in all the Service Area Focus Groups with the exception of Focus Groups in Service Area 7. Interestingly, Service Area 7 received the highest Service Area representation across the board — all participants attending the Service Area 7 Focus Groups represented Service Area 7 only. Overall, **Table 2** shows a considerable amount of cross-representation among Service Areas in the Service Area-based Focus Groups.

Table 2. Service Area Representation

Service Areas	Total	SA 1 (n=55)	SA 2 (n=44)	SA 3 (n=63)	SA 4 (n=50)	SA 5 (n=45)	SA 6 (n=51)	SA 7* (n=49)	SA 8 (n=56)	CW* (n=159)
Service Area 1	66	**83%**	12%	--	3%	--	--	--	--	2%
Service Area 2	62	3%	**58%**	--	8%	19%	--	--	--	13%
Service Area 3	81	--	10%	**70%**	--	14%	--	--	--	7%
Service Area 4	92	--	16%	--	**41%**	18%	--	--	--	24%
Service Area 5	48	--	23%	--	2%	**54%**	2%	--	6%	12%
Service Area 6	109	--	--	--	5%	6%	**36%**	--	29%	25%
Service Area 7	68	--	1%	--	--	--	9%	**72%**	12%	6%
Service Area 8	115	--	7%	13%	2%	4%	7%	--	**42%**	24%
Countywide	104	2%	11%	6%	7%	2%	11%	--	2%	**61%**

*SA 7: Representation in Service Areas other than SA 7 were not documented; CW: Service Area representation was collected from 14 of 17 focus groups only.

Priority Population Representation. The CDMH has identified the following six priority populations for PEI services: 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children and youth in stressed families; 4) Trauma-exposed individuals; 5) Children at risk for school failure; and, 6) Children and youth at risk of or experiencing juvenile justice involvement. Focus group participants were asked to select the priority populations they represent. As shown in **Table 3**, when viewed across the board (Service Areas and Countywide), all six populations were given relatively equal weight, with a five percentage point difference between the priority population most represented – Underserved cultural populations at 19 percent, and the priority population least represented – Suicide risk at 14 percent. The variation occurs among the Service Areas and Countywide.

Underserved cultural populations was the most highly represented priority population among focus group participants in Service Areas 1, 2*, 3, 5*, 6, and 8, as well as Countywide* (an * indicates Underserved cultural populations was tied with at least one other priority population). In Service Area 4 Trauma-exposed and Children at-risk for school failure tied with Underserved cultural populations for the most highly represented population; and, in Service Area 7 Children and youth in stressed families was the most highly represented among participants, instead of Underserved cultural populations. The percentage of participants on behalf of the most highly represented priority population in each Service Area is highlighted in bold.

On the other end of the continuum, Children and youth in stressed families was least represented in Service Areas 3 and 5; Individuals experiencing the onset of serious psychiatric illness was least represented in Service Areas 1, 2, and 7; and, Children and youth at-risk of or experiencing juvenile justice involvement was least represented in Service Areas 1, 6, 8 and Countywide. The percentages corresponding to the priority populations least represented in each Service Area are highlighted in gray.

Table 3. Distribution of PEI Priority Populations Represented

Service Areas	Total	SA 1 (n=55)	SA 2* (n=44)	SA 3 (n=63)	SA 4 (n=50)	SA 5* (n=45)	SA 6 (n=51)	SA 7 (n=49)	SA 8 (n=56)	CW* (n=159)
Underserved cultural populations	19%	**22%**	**19%**	**23%**	15%	**23%**	**20%**	16%	**22%**	**17%**
Trauma-exposed individuals	18%	18%	19%	21%	**19%**	17%	16%	15%	21%	17%
Children/youth in stressed families	17%	19%	16%	11%	18%	14%	17%	**22%**	15%	17%
Individuals experiencing the onset of serious psychiatric illness	16%	12%	13%	19%	15%	23%	17%	14%	18%	17%
Children at- risk of school failure	15%	17%	17%	12%	**19%**	15%	16%	17%	12%	16%
Children/youth at-risk of or experiencing juvenile justice involvement	14%	12%	16%	13%	14%	19%	13%	16%	12%	16%
Total	2,128	172	183	202	166	93	213	172	225	702

Community Mental Health Needs and Priorities

Mental Health Needs in the Community. Each focus group participant identified the most important mental health needs in his or her community based on five MHSA categories: 1) Disparities in access to mental health services; 2) Psycho-social impact of trauma; 3) At-risk children, youth, and young adult populations; 4) Stigma and discrimination; and, 5) Suicide risk.

Overall, Disparities in access to mental health services and At-risk children, youth, and young adult populations arose as two critical mental health needs in the communities served by the Service Area and Countywide Focus Group participants (see **Table 4**). Across the individual Service Areas and Countywide Focus Groups a similar pattern occurred. Disparities in access to mental health services and At-risk children, youth, and young adult populations also arose as the two critical mental health needs among Countywide participants as well as among all Service Areas except three (percentages shaded in gray represent the top two needs). Participants in Service Areas 2 and 5 considered Stigma and discrimination as one of the top mental health needs in their communities in lieu of At-risk children, youth, and young adult populations. Also, Psycho-social impact of trauma was among the top two important mental health needs in Service Areas 6 and 8.

A number of ties with Disparities in access and At-risk populations were revealed and the percentages are underlined in **Table 4** for easy identification. They included Psycho-social impact of trauma in Service Areas 1and 4, and Countywide; Stigma and discrimination in Service Area 6; and, Suicide Risk at the Countywide level. At-risk children, youth, and young adult populations were also tied as a top mental health need in Service Areas 2 and 6.

The least important mental health needs among the Service Areas and Countywide were Suicide Risk (Service Areas 1, 2, 3, 4, and 6); At-risk children, youth, and young adult populations in Service Area 5; Psycho-social impact of trauma in Service Area 7; and Stigma and discrimination in Service Area 8 and Countywide (percentages are bolded).

Table 4. PEI Mental Health Needs

Service Areas	Total	SA 1 (n=55)	SA 2* (n=29)	SA 3 (n=63)	SA 4 (n=50)	SA 5 (n=45)	SA 6 (n=51)	SA 7* (n=41)	SA 8 (n=55)	CW (n=159)
Disparities in access to mental health services	23%	24%	21%	26%	24%	30%	22%	22%	23%	21%
At-risk children, youth, and young adult populations	21%	21%	21%	24%	22%	**15%**	22%	23%	20%	20%
Psycho-social impact of trauma	20%	21%	20%	16%	24%	17%	21%	**15%**	21%	20%
Stigma and discrimination	20%	18%	22%	23%	20%	21%	21%	18%	**17%**	**19%**
Suicide risk	17%	**15%**	**17%**	**10%**	**10%**	17%	**14%**	21%	18%	20%
Total	1,797	175	111	183	124	113	174	112	192	613

*Some participants in these groups did not identify mental health needs resulting in a smaller "n" than in Tables 1, 2, and 3.

Priority Mental Health Needs. When asked to identify the top three mental health needs from among the list of five determined by CDMH, Disparities in access to mental health services arose as the top priority mental health need among six of the eight Service Areas and Countywide (see **Table 5**). Stigma and discrimination was selected as a top priority in Service Area 8, and tied as a top priority in Service Areas 3 and 6. The Psycho-social impact of trauma was the top priority for Service Area 4, and At-risk children, youth, and young adult populations tied as a top priority with Disparities in access to mental health services in Service Area 7.

Interestingly, the Countywide and Service Area 1 and 5 Focus Groups identified Disparities in access to mental health services, Psycho-social impact of trauma, and At-risk children, youth, and young adult populations among their top three priorities. The prioritization process in the other Service Areas resulted in a number of tied priorities, as displayed in **Table 5**.

Table 5. Priority Mental Health Needs

Service Areas	SA 1 (n=55)	SA 2 (n=44)	SA 3 (n=63)	SA 4 (n=50)	SA 5 (n=45)	SA 6 (n=51)	SA 7* (n=49)	SA 8 (n=56)	CW* (n=159)
Priority One	DA	DA	DA, SD	PS	DA	DA, SD	DA, AR	SD	DA
Priority Two	PS	AR, PS	AR, PS	DA, SD	PS	AR, PS	SR	DA, SR	AR
Priority Three	AR	SD	SR	AR	AR	SR	PS	AR, PS	PS

DA=Disparities in access to mental health services; AR=At-risk children, youth, and young adult populations; PS=Psycho-social impact of trauma; SD=Stigma and discrimination; SR=Suicide risk

Additional Findings Presented in the Service Area and Countywide Focus Group Reports

Additional findings specific to the focus groups held in each Service Area and those held Countywide can be found in the individual reports that accompany this overall summary report. Those reports contain complete Service Area and Countywide specific discussions of the information presented in the prior sections. Those reports also present additional findings in the areas described below.

Impact of the Mental Health Needs on the Community. As part of the focus groups, participants reflected upon and relayed the negative impact that the unmet mental health needs discussed in the previous section have had on their communities. Tables identifying those impacts and a discussion surrounding the effects of those impacts on the community are specific to each of the Service Area and Countywide reports.

Existing and Needed Prevention and Early Intervention Services. Each Service Area report and the Countywide report contains separate listings of the existing and needed prevention services identified by focus group participants, as well as separate listings of the existing and needed early intervention services identified by participants.

Priority Prevention and Early Intervention Services and Locations. Focus group participants in each Service Area and Countywide were asked to prioritize the prevention and early intervention needed services they had identified and listed earlier. The individual reports present the top three priorities selected by the focus group participants representing each Service Area and Countywide.

Barriers to Service Access and Strategies to Increase Access. Focus group participants were asked "What keeps people from getting the prevention and/or early intervention services they need?" In response, participants discussed the barriers to service access that exist in their Service Areas and Countywide. As a follow-up to the question about service barriers, focus group participants were asked to discuss the types of strategies that would help people obtain access to the services they needed. Responses regarding strategies to increase access are also discussed in detail in each individual report.

Recommendations for informing communities about PEI. When focus group participants were asked to provide recommendations on how to let people know about prevention and early intervention services, a rich array of ideas, strategies, and approaches emerged. All are presented in tables and described through informative discussion in the individual reports.

IV. APPENDIX A

APPENDIX A: Focus Group Guide

FOCUS GROUP QUESTIONS

Issues	Focus Group Questions
PEI Planning Process	1. Have you or your group taken part in the Los Angeles County Department of Mental Health's (DMH) Prevention and Early Intervention (PEI) planning process? If so, how?
Participants' Organizational Affiliation	These focus groups help us learn more about the types of mental health services and resources that are needed to support the social and emotional well-being in your community and among other groups of people in L.A. County. 2. Which region or area in L.A. County do you represent or will you be talking about in today's discussion? 2a. Of the identified priority populations [*facilitator refers/points to visual aid listing priority populations*], which of these groups of people do you represent?
Community Mental Health Needs	The California State Department of Mental Health said that the Prevention and Early Intervention (PEI) plan should focus on the needs of the following groups: at-risk youth, people who may be at risk of suicide, people who haven't been able to get services, and people who have experienced trauma, stigma and discrimination. 3. What needs are most important to the group of people you represent? *3a. Of the needs that you've listed, which are the top three needs most important to your community?* 4. What do you see happening in your community because of these needs? (what problems are occurring?)
Prevention and Early Intervention Services	As we talked about earlier, there is a difference between prevention and early intervention services [*facilitator refers/points to visual aid defining prevention and early intervention*]. 5. What **prevention** services or resources are currently available in your community or among the group of people you represent? 5a. What **prevention** services or resources are needed? 5b. "O*f the prevention services you've listed, which are the top three needed.* 5c. *Facilitator probes for information on locations for services.* 6. What **early intervention** services or resources are currently available in your

APPENDIX A: Focus Group Guide

Issues	Focus Group Questions
	community or among the group of people you represent? 6a. What **early intervention** services or resources are needed? 6b. *Of the early intervention services you've listed, which are the top three needed in your community?* 6c. F*acilitator probes for information on locations for services.* 7. What keeps people from getting the prevention and/or early intervention services they need? 8. What types of things or strategies would help people get the services they need?
Long Range Planning	9. What recommendations do you have for how to let people know about prevention and early intervention services?

APPENDIX 12

Overall Summary Report of the Community Forums

WRMA
Walter R. McDonald & Associates, Inc.

OVERALL SUMMARY REPORT OF THE

COMMUNITY FORUMS

CONDUCTED FOR THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN
IN LOS ANGELES COUNTY

April 2009

Prepared for:
The Los Angeles County Department of Mental Health

Prepared by:
Walter R. McDonald and Associates, Inc.
EVALCORP Research & Consulting, Inc.

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VI. Appendix 12

I. OVERVIEW

The Los Angeles County Department of Mental Health (LACDMH) is engaged in an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan to be funded through the Mental Health Services Act (MHSA) enacted by California voters in 2004.

The focus for developing the PEI Plan is at the Service Area level, utilizing informational meetings, key individual interviews, focus groups, and community forums in each of the eight geographic areas of Los Angeles County. Because each Service Area has distinct and varying populations, geography, and resources, it is critical for PEI services to be specific and responsive to regional and community-based needs.

In addition, there are populations whose needs are best addressed through a countywide service delivery approach. LACDMH conducted a countywide community forum focused on American Indians; veterans; deaf and hard-of-hearing; lesbian/gay/bisexual/transgender/questioning (LGBTQ) individuals; countywide health plans; and juvenile justice-involved individuals.

PURPOSE. The community forums presented an exciting opportunity for community participants to make recommendations regarding priority populations and strategies for their communities that will help keep community members healthy.

This summary report presents the findings from the Community Forums conducted in Service Areas 1 through 8 and Countywide.

The overall purposes of the Community Forums were:

1. To introduce participants to Los Angeles County Department of Mental Health's Prevention and Early Prevention planning efforts;
2. To summarize what was learned from existing research, community residents and service providers about needs, barriers and strategies for providing quality prevention and early intervention mental health services; and
3. To hear suggestions for where and to whom prevention and early intervention services should be provided.

OUTCOMES. The eight Service Area specific Community Forums and one Countywide Community Forum had two similar outcomes:

Service Area Community Forums	**Countywide Community Forum**
1. To identify the specific priority populations to be served in each service area.	1. To identify the priority populations to be served among specific countywide populations, including American Indians; veterans; deaf and hard-of-hearing; lesbian/gay/bisexual/ transgender/questioning (LGBTQ) individuals; countywide health plans; and juvenile justice-involved individuals.
2. To develop recommendations for strategies to serve these priority populations.	2. To develop recommendations for strategies to serve the priority populations selected for each specific population.

II. COMMUNITY FORUM METHODOLOGY

The community forums were designed to provide community members an additional opportunity to share their input regarding priorities and strategies for addressing the six MHSA priority populations.

With one exception (i.e., Service Area 1), a total of two community forums were held in each service area, for a total of 15 Service Area specific community forums. In addition, one countywide forum was held that focused on specific populations. Each Service Area Community Forum was organized around age- and language-specific breakout sessions/groups for which community members registered in advance. The Service Area and Countywide Community Forums followed the same format and procedures.

PARTICIPANTS. Participants were community members interested in taking part in a discussion about the mental health service strategies that would most effectively address the mental health needs in their communities.

- To inform the public about the community forums, a concerted outreach effort was conducted by LACDMH and the Service Area Advisory Committees regarding the MHSA and the PEI planning process. Outreach efforts also placed a large emphasis on encouraging community members to attend the community forums and provide their ideas and suggestions on effective ways to improve the social and emotional well-being of people in their communities.

- When interested community members registered to attend the community forum in their Service Area, they also elected to participate in one of the following five age-specific breakouts: 1) Children 0 to 5 years; 2) Children 6 to 15 years; 3) Transition-Age Youth, 16 to 25 years; 4) Adults 26 to 59 years; and, 5) Older Adults 60 years or older. Additional language-specific breakout sessions were conducted as needed. Each breakout session was comprised of no more than 35 participants.

- Those attending the countywide community forum elected to participate in one of the following population-specific breakout sessions: American Indians; veterans; deaf and hard-of-hearing; lesbian, gay, bisexual, transgender, and questioning (LGBTQ) individuals; countywide health plans; or juvenile justice-involved individuals.

FORMAT. The Service Area community forums were organized and conducted in the same manner based on a three-hour or three-hour and fifteen minute time period. One of the two community forums in each Service Area was conducted on a weekday and the other on a Saturday, and took place either in the morning or in the late afternoon/early evening. Translators were available for mono-lingual speakers of various languages. The agenda at the forums included: 1) A welcome from the Service Area District Chief; 2) An introduction to the MHSA and Prevention and Early Intervention Plan development process in Los Angeles County; 3) The results of the LACDMH needs assessment conducted in each area in terms of key indicators, key individual interview findings, and focus group findings; 4) Age- and language-specific breakout group discussions; 5) Key findings from breakout sessions/groups to all participants; and, 6) Final thoughts and acknowledgements from the District Chief and LACDMH staff.

The Countywide community forum took place on a weekday over a period of three and one-half hours at the Los Angeles Convention Center. Translators were available for mono-lingual speakers of various languages. The agenda at the forum included: 1) A welcome from the PEI District Chief; 2) An introduction to the MHSA and Prevention and Early Intervention Plan development process; 3) An overview of the LACDMH needs assessment activities; 4) An orientation to population-specific data

handouts; 5) Population-specific breakout groups/discussions; 6) Report-out on key findings from all breakout sessions; and 7) Final thoughts and acknowledgements from the District Chief.

BREAKOUT GROUPS. At each of the forums, the age, language, and population specific breakout sessions/groups were conducted by facilitators representing LACDMH as a neutral third-party. Each breakout session/group was conducted by a team of two staff members from Walter R. McDonald & Associates, Inc. (WRMA) and their subcontractors, EVALCORP Research & Consulting, Inc. and Laura Valles and Associates, LLC. One team member facilitated the breakout session/group, while another served as scribe and recorded participants' responses on flip charts, which participants could refer to throughout the discussion. The emphasis of the Service Area breakout groups was on identifying the top priority populations to be served in the service area and the appropriate strategies for the community. The emphasis of the Countywide population-specific breakout groups was on identifying the top priority populations to be served within the countywide specific population and the appropriate strategies for those populations.

III. SUMMARY OF THE FINDINGS

The following presents a summary of the findings across the eight Service Area Community Forums and the one Countywide Community Forum. This summary follows the same presentation format as the individual reports, and presents summary data on the following:

- Community Sector Representation;
- Breakout Sessions;
- Attendance by Breakout Session; and,
- Priority Populations.

The defined sub-populations, top strategies by priority population, and additional needs and populations are not summarized graphically or in writing in this summary report, but remain an integral part of the individual Service Area and Countywide Community Forum reports.

Community Sector Representation. As shown in **Table 1**, Mental Health Service Providers were the most highly represented community sector and Media represented the least attended sector across Service Areas and Countywide. The sector proportions across Service Areas indicate a range of representation from none to over 40 percent of participants.

Overall, the community representation across Service Areas varies, with representation ranging from a low of 3 percent to a high of 42 percent. Service Areas 6, 7, and 8, and Countywide represent the highest representation across the board in the following sectors (between 20% and 42%): Consumers, Education, Parents and Families of Consumers, Community and Family Resource Centers, Employment, and Media.

The community sector representation for each Service Area also is provided in the individualized Service Area and Countywide Community Forum reports.

Table 1. Community Sector Representation*

Community Sector	Total	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Mental Health Service Providers	568	5%	9%	15%	15%	5%	13%	11%	11%	15%
Underserved Cultural Populations	304	3%	9%	14%	14%	5%	19%	13%	6%	15%
Individuals with Serious Mental Illness (Consumers)	280	5%	5%	16%	10%	5%	22%	19%	4%	13%
Social Services	280	9%	8%	9%	13%	7%	14%	16%	6%	18%
Education	234	7%	14%	14%	8%	6%	9%	21%	10%	12%
Parents/Families of Individuals with Serious Mental Illness (Parents/Families of Consumers)	197	3%	14%	14%	7%	5%	8%	14%	30%	6%
Health	191	9%	8%	7%	14%	7%	11%	8%	18%	18%
Community Family Resource Centers	99	7%	6%	10%	10%	4%	23%	23%	3%	13%
Law Enforcement	53	9%	15%	6%	6%	11%	11%	15%	8%	19%
Employment	19	5%	16%	5%	5%	16%	--	21%	--	32%
Media	12	--	--	--	18%	17%	17%	42%	--	17%
Did Not Indicate	285	4%	7%	5%	13%	3%	13%	12%	32%	12%

*Overall totals are not presented as many participants represented more than one community sector.

Breakout Sessions. A total of 107 breakout sessions were held across eight Service Area Community Forums and one Countywide Forum (see **Table 2**). With the exception of Service Area 1, between 10 and 14 age- and language-specific breakout sessions took place at seven Service Area Community Forums; and, 11 population-specific breakout sessions took place at the one Countywide Forum. Across the five age groups the number of breakout sessions ranged from 12 to 19, with an additional three breakout sessions combining Adults and Older Adults. In addition, a total of 12 Spanish-speaking breakout sessions were conducted, as well two Korean sessions, one Cantonese, one Mandarin, and one Vietnamese session. During the Countywide Forum, a total of 12 breakout sessions were conducted across six populations, ranging from one to four sessions per breakout.

Table 2. Breakout Sessions by Age Group, Language, and Countywide Population

	Total	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Age-specific Groups										
Children, 0 to 5	**15**	1	2	2	2	2	2	2	2	
Children, 6 to 15	**13**	1	2	2	1	2	2	1	2	
Transition-Age Youth, 16 to 25	**19**	1	2	2	3	2	4	2	3	
Adults, 26 to 59	**17**	2	2	2	3	2	2	1	3	
Older Adults, 60+	**12**	1	2	1	2	2	1	1	2	
Adults & Older Adults, 26 to 60+	**3**			1			1	1		
Language-specific Groups										
Cantonese	**1**			1						
Korean	**2**		1		1					
Mandarin	**1**			1						
Spanish	**12**		2		2	2	2	2	2	
Vietnamese	**1**			1						
Population-specific Groups										
American Indians	**1**									1
Countywide Health Plans	**2**									2
Deaf/Hard-of-hearing	**1**									1
Juvenile Justice	**4**									4
LGBTQ	**2**									2
Veterans	**1**									1
TOTAL	**107**	**6**	**13**	**13**	**14**	**12**	**14**	**10**	**14**	**11**

Attendance by Breakout Session. Out of a total of 1,708 Service Area and Countywide Forum participants, each Service Area represents between 6 and 16 total percent of all attendees across age groups, language, and populations (see **Table 3**, bottom row). Attendance by age group ranged between 5 and 24 percent across Service Areas, with the exception of the combined Adult and Older Adult groups. Service Areas 3, 6, and 7 conducted a combined Adults and Older Adults group, represented respectively by 45, 32, and 23 percent of the attendees in that age group. Attendance by breakout session is also presented in the individual community forum reports for each Service Area and Countywide.

Table 3. Attendance by Age Group, Language, and Countywide Population

	Total	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	CW
Age-specific Groups										
Children, 0 to 5	**208**	5%	7%	17%	15%	7%	14%	20%	16%	
Children, 6 to 15	**261**	7%	15%	17%	7%	6%	17%	11%	19%	
Transition-Age Youth, 16 to 25	**410**	8%	12%	10%	12%	6%	24%	12%	16%	
Adults, 26 to 59	**376**	10%	11%	15%	18%	8%	15%	6%	17%	
Older Adults, 60+	**122**	10%	12%	7%	20%	14%	7%	7%	23%	
Adults & Older Adults, 26 to 60+	**62**			45%			32%	23%		
Language-specific Groups										
Cantonese	**16**			100%						
Korean	**18**		67%		33%					
Mandarin	**15**			100%						
Spanish	**205**		6%		13%	3%	12%	51%	15%	
Vietnamese	**15**			100%						
Population-specific Groups										
American Indians	29									100%
Countywide Health Plans	58									100%
Deaf/Hard-of-hearing	23									100%
Juvenile Justice	88									100%
LGBTQ	45									100%
Veterans	29									100%
TOTAL	**1,708**	**7%**	**11%**	**15%**	**13%**	**6%**	**16%**	**16%**	**16%**	**16%**

Priority Populations. Service Area and Countywide Forum participants' selections of the top priority populations by age group are shown in **Table 4**. To show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants representing the respective age groups. Numbers represent participants across the Service Area and Countywide Forums.

Table 4 shows that over half of the participants representing Children, 0 to 5, considered Children and youth in stressed families a priority for prevention and early intervention services (54%), followed by Children at-risk for school failure (37%) and Trauma-exposed individuals (35%). Similarly, almost half of participants speaking on behalf of Children, 6 to 15, selected Children and youth in stressed families (49%) and Trauma-exposed individuals (47%) as populations most in need of services. Among those representing Transition-age youth, 16 to 25, 51 percent prioritized Children and youth at-risk of or experiencing juvenile justice involvement a key priority. In addition, four in ten participants considered Children and youth in stressed families a priority for this age group (42%). Participants representing Adults and Older Adults considered Underserved cultural populations and Individuals experiencing the onset of serious psychiatric illness top priorities in relation to other priority populations. Between 42 and 52 percent of the participants in the Adults and Older Adults breakout groups selected these two priority populations.

Tables 5 through 10 in the Appendix present the top priorities selected by Service Area and Countywide separately for each age group.

The distribution of groups by priority population and the number of participants in the groups who voted for the top priority populations for each age group are also presented in the Service Area and Countywide Community Forum reports.

Table 4. Percentage of Participants Who Selected the Top Priority Populations by Age Groups (Across Service Areas and Countywide)

Priority Populations		Children, 0 to 5	Children, 6 to 15	Transition-age Youth, 16 to 25	Adults, 26 to 59	Older Adults, 60+	Adults & Older Adults 26 to 60+
Underserved Cultural Populations	**# of Votes**	16	36	132	220	44	34
	Total # of Participants	69	128	353	440	85	62
	% Votes Received	**23%**	**28%**	**37%**	**50%**	**52%**	**55%**
Individuals Experiencing the Onset of Serious Psychiatric Illness	**# of Votes**	--	--	23	54	26	9
	Total # of Participants	--	--	71	128	56	34
	% Votes Received	--	--	**32%**	**42%**	**46%**	**26%**
Children and Youth in Stressed Families	**# of Votes**	131	284	140	23	--	--
	Total # of Participants	243	574	332	102	--	--
	% Votes Received	**54%**	**49%**	**42%**	**23%**	--	--
Trauma-exposed	**# of Votes**	17	26	27	117	41	11
	Total # of Participants	49	55	78	318	115	28
	% Votes Received	**35%**	**47%**	**35%**	**37%**	**36%**	**39%**
Children At-Risk for School Failure	**# of Votes**	33	66	73	--	--	--
	Total # of Participants	90	164	197	--	--	--
	% Votes Received	**37%**	**40%**	**37%**	--	--	--
Children and Youth At-Risk of or Experiencing Juvenile Justice Involvement	**# of Votes**	--	18	74	--	--	--
	Total # of Participants	--	44	146	--	--	--
	% Votes Received	--	**41%**	**51%**	--	--	--

Sub-Populations. As part of the Community Forums, participants defined the sub-populations for the top priority populations selected in relation to the five age groups. Those tables are individual to each Service Area and each Countywide population and can be found in the Service Area and Countywide Community Forum reports.

Strategies. The two to three top priority population strategies selected in the age- and language-specific Service Area breakout sessions and in the population-specific Countywide breakout sessions also were documented during the Community Forums. Those strategies are organized and listed in user-friendly tables in the body of the Service Area and Countywide reports.

Additional Needs or Populations. At the end of the Service Area and Countywide breakout sessions, participants were asked to identify any additional needs or populations that were not addressed during the discussion. These needs and or populations are also summarized in tables in the Community Forum reports.

IV. APPENDIX

Table 5. Percentage of Participants Who Selected the Top Priority Populations for Children, 0 to 5

Top Elected Priority Populations	Children, 0 to 5	SA 1 (n=1)	SA 2 (n=4)	SA 3 (n=3)	SA 4 (n=2)	SA 5 (n=4)	SA 6 (n=2)	SA 7 (n=3)	SA 8 (n=2)	CW (n=0)	Total
Children and Youth In Stressed Families	**# of Votes**	6	14	29	14	6	14	33	15	--	**131**
	Total # of Participants	11	27	50	29	14	29	49	34	--	**243**
	% Votes Received	55%	52%	58%	48%	43%	48%	67%	44%	--	**54%**
Children and Youth At-Risk For School Failure	**# of Votes**	--	3		7	3	--	20	--	--	**33**
	Total # of Participants	--	9		29	11	--	41	--	--	**90**
	% Votes Received	--	33%		24%	27%	--	49%	--	--	**37%**
Trauma-exposed	**# of Votes**	3	--	2	--	1	13	--	--	--	**17**
	Total # of Participants	11	--	6	--	3	29	--	--	--	**49**
	% Votes Received	27%	--	33%	--	33%	45%	--	--	--	**35%**
Underserved Cultural Populations	**# of Votes**	--	2	4	--	--	--	--	10	--	**16**
	Total # of Participants	--	6	29	--	--	--	--	34	--	**69**
	% Votes Received	--	33%	14%	--	--	--	--	29%	--	**23%**

Table 6. Percentage of Participants Who Selected the Top Priority Populations for Children, 6 to 15

Top Elected Priority Populations	Children, 6 to 15	SA 1 (n=1)	SA 2 (n=4)	SA 3 (n=3)	SA 4 (n=3)	SA 5 (n=3)	SA 6 (n=4)	SA 7 (n=5)	SA 8 (n=3)	CW (n=8)	Total
Children and Youth In Stressed Families	**# of Votes**	6	34	19	15	9	19	58	26	98	**284**
	Total # of Participants	19	51	45	35	16	44	106	57	201	**574**
	% Votes Received	32%	67%	42%	43%	56%	43%	55%	46%	48%	**49%**
Trauma-exposed	**# of Votes**	--	--	--	4	--	9	13	--	--	**26**
	Total # of Participants	--	--	--	9	--	16	30	--	--	**55**
	% Votes Received	--	--	--	44%	--	56%	43%	--	--	**47%**
Children and Youth At-Risk For School Failure	**# of Votes**	6	34	7	--	4	8	--	7	--	**66**
	Total # of Participants	19	51	25	--	16	21	--	32	--	**164**
	% Votes Received	32%	67%	28%	--	25%	38%	--	22%	--	**40%**
Children At-Risk of or Experiencing Juvenile Justice Involvement	**# of Votes**	--	--	--	--	--	--	6	--	12	**18**
	Total # of Participants	--	--	--	--	--	--	21	--	23	**44**
	% Votes Received	--	--	--	--	--	--	29%	--	52%	**41%**
Underserved Cultural Populations	**# of Votes**	--	3	5	5	2	7	--	14	--	**36**
	Total # of Participants	--	4	20	18	4	32	--	50	--	**128**
	% Votes Received	--	75%	25%	28%	50%	22%	--	28%	--	**28%**

Table 7. Percentage of Participants Who Selected the Top Priority Populations for Transition-age Youth (TAY), 16 to 25

Top Elected Priority Populations	TAY, 16 to 25	SA 1 (n=1)	SA 2 (n=4)	SA 3 (n=2)	SA 4 (n=5)	SA 5 (n=3)	SA 6 (n=5)	SA 7 (n=6)	SA 8 (n=5)	CW (n=8)	Total
Children At-Risk of or Experiencing Juvenile Justice Involvement	**# of Votes**	--	--	--	--	9	--	--	11	54	**74**
	Total # of Participants	--	--	--	--	25	--	--	33	88	**146**
	% Votes Received	--	--	--	--	36%	--	--	33%	61%	**51%**
Children and Youth In Stressed Families	**# of Votes**	14	19	18	17	5	41	6	8	12	**140**
	Total # of Participants	34	42	40	49	10	97	18	19	23	**332**
	% Votes Received	41%	45%	45%	35%	50%	42%	33%	42%	52%	**42%**
Children and Youth At-Risk For School Failure	**# of Votes**	5	13	--	--	--	18	33	4	--	**73**
	Total # of Participants	34	27	--	--	--	45	79	12	--	**197**
	% Votes Received	15%	48%	--	--	--	40%	42%	33%	--	**37%**
Underserved Cultural Populations	**# of Votes**	--	8	12	4	--	12	38	36	22	**132**
	Total # of Participants	--	34	40	14	--	56	81	77	51	**353**
	% Votes Received	--	24%	30%	29%	--	21%	47%	47%	43%	**37%**
Trauma-exposed	**# of Votes**	--	--	--	15	--	--	--	--	12	**27**
	Total # of Participants	--	--	--	49	--	--	--	--	29	**78**
	% Votes Received	--	--	--	31%	--	--	--	--	41%	**35%**
Individuals Experiencing the Onset of Serious Psychiatric Illness	**# of Votes**	--	4	--	9	6	--	--	4	--	**23**
	Total # of Participants	--	15	--	17	18	--	--	21	--	**71**
	% Votes Received	--	27%	--	53%	33%	--	--	19%	--	**32%**

Table 8. Percentage of Participants Who Selected the Top Priority Populations for Adults, 26 to 59

Top Elected Priority Populations	Adults, 26 to 59	SA 1 (n=2)	SA 2 (n=2)	SA 3 (n=4)	SA 4 (n=5)	SA 5 (n=3)	SA 6 (n=3)	SA 7 (n=6)	SA 8 (n=4)	CW (n=4)	Total
Underserved Cultural Populations	**# of Votes**	13	13	29	26	5	30	13	52	39	**220**
	Total # of Participants	23	40	58	68	12	57	21	90	71	**440**
	% Votes Received	57%	33%	50%	38%	42%	53%	62%	58%	55%	**50%**
Individuals Experiencing the Onset of Serious Psychiatric Illness	**# of Votes**	--	6	19	--	14	7	--	8	--	**54**
	Total # of Participants	--	12	45	--	21	31	--	19	--	**128**
	% Votes Received	--	50%	42%	--	67%	23%	--	42%	--	**42%**
Trauma-exposed	**# of Votes**	6	10	25	38	8	5	8	2	16	**117**
	Total # of Participants	14	28	73	83	29	26	21	15	29	**318**
	% Votes Received	43%	36%	34%	46%	28%	19%	38%	48%	55%	**37%**
Children and Youth In Stressed Families	**# of Votes**	10	--	4	--	--	9	--	--	17	**23**
	Total # of Participants	37	--	15	--	--	21	--	--	29	**102**
	% Votes Received	27%	--	27%	--	--	43%	--	--	25%	**23%**

Table 9. Percentage of Participants Who Selected the Top Priority Populations for Older Adults, 60+

Top Elected Priority Populations	Older Adults, 60+	SA 1 (n=1)	SA 2 (n=2)	SA 3 (n=1)	SA 4 (n=2)	SA 5 (n=2)	SA 6 (n=1)	SA 7 (n=1)	SA 8 (n=2)	CW (n=0)	Total
Underserved Cultural Populations	**# of Votes**	--	6	5	17	4	3	6	3	--	**44**
	Total # of Participants	--	15	8	24	13	9	9	7	--	**85**
	% Votes Received	--	40%	63%	71%	31%	33%	67%	42%	--	**52%**
Individuals Experiencing the Onset of Serious Psychiatric Illness	**# of Votes**	3	3	--	--	4	3	--	13	--	**26**
	Total # of Participants	12	7	--	--	7	9	--	21	--	**56**
	% Votes Received	25%	43%	--	--	57%	33%	--	63%	--	**46%**
Trauma-exposed	**# of Votes**	6	3	2	11	10	3	5	7	--	**41**
	Total # of Participants	12	8	8	24	17	9	9	28	--	**115**
	% Votes Received	50%	38%	25%	46%	59%	33%	56%	25%	--	**36%**

Table 10. Percentage of Participants Who Selected the Top Priority Populations for Adults, 26 to 59, and Older Adults, 60+

Top Elected Priority Populations	Adults, 26 to 59 and Older Adults, 60+	SA 1 (n=0)	SA 2 (n=0)	SA 3 (n=1)	SA 4 (n=0)	SA 5 (n=0)	SA 6 (n=1)	SA 7 (n=1)	SA 8 (n=0)	CW (n=0)	Total
Underserved Cultural Populations	**# of Votes**	--	--	15	--	--	13	6	--	--	**34**
	Total # of Participants	--	--	28	--	--	20	14	--	--	**62**
	% Votes Received	--	--	54%	--	--	65%	36%	--	--	**55%**
Individuals Experiencing the Onset of Serious Psychiatric Illness	**# of Votes**	--	--	--	--	--	3	6	--	--	**9**
	Total # of Participants	--	--	--	--	--	20	14	--	--	**34**
	% Votes Received	--	--	--	--	--	15%	43%	--	--	**26%**
Trauma-exposed	**# of Votes**	--	--	11	--	--	--	--	--	--	**11**
	Total # of Participants	--	--	28	--	--	--	--	--	--	**28**
	% Votes Received	--	--	39%	--	--	--	--	--	--	**39%**

APPENDIX 13

PowerPoint: Understanding Evidence-based Practices

Understanding Evidence-Based Practices

Mental Health Services Act
Prevention and Early Intervention Planning
in Los Angeles County

November, 2008

Prepared for:

The Los Angeles County Department of Mental Health

Prepared by:

The California Institute for Mental Health



Topics

- MHSA PEI Planning
- Research informed practice
- Benefits of evidence-based practices (EBPs)
- Understanding levels of effectiveness
- Selecting and implementing interventions
- Examples of prevention and early intervention EBPs



MHSA PEI Planning

- Identify needs, barriers, and strategies
  - Service area profiles, key individual interviews, focus groups, community forums
- Understand EBPs (today's topic)
- Develop a list of program options, organized by levels of evidence, fit to PEI populations and outcomes, appropriateness for diverse consumers/families, and readiness to implement
- Make program recommendations, informed by an understanding of EBPs, specific to priority needs and strategies for each SPA
  - Recommendations advanced by ad hoc Service Area PEI Steering Committees and approved by Service Area Advisory Committees (SAAC)



Research Informed Practice

- Understanding the effectiveness of a service is one important consideration in care planning, *sometimes referred to as evidence-based practice*, which integrates
  - Professional expertise and judgment
  - Consumer and family values and preferences
  - Best research evidence on the effectiveness of services

  - *Informed by the definition used in "Crossing the Quality Chasm: A New Health System for the 21st Century" (2001), by the Institute of Medicine*



Why Prioritize Practices Informed by Effectiveness Research?

- Mental health disorders can be complicated, severe, and difficult to prevent and treat
- The causes of these disorders are not fully understood
- Numerous intervention models are available
- No intervention model is effective for all individuals in all situations
- However, there is a growing body of research showing that some interventions (EBPs) are consistently more successful than others



Why EBPs Now?

- Science base is larger and more specific
- Increased accountability to consumers and families
- Focus on being able to deliver consistent treatment outcomes
- Increase in fiscal accountability
- Increased accountability to the public



Benefits of EBPs

- Achieves outcomes sooner that last longer
- Avoids the adverse consequences of under or over or inappropriately intervening
- Empowers consumers and family members to make informed decisions
- Ethical
- Cost effective use of limited resources



Levels of Effectiveness

- The degree to which research indicates that an intervention is effective, or responsible for achievement of an outcome
- Levels of evidence are on a continuum
- Levels of evidence are related to the quality of the research



Quality of Research

- There is a tendency to assume that if an intervention was provided and there is improvement, then the intervention is responsible for the improvement
- However, positive outcomes may be achieved as a result of a number of factors unrelated to treatment, for example--
  - Self-directed recovery: Individuals naturally strive for health, try strategies and seek social support to reduce distress and achieve their goals; often this is successful!
  - Placebo effect: Improvement associated with non-specific aspects of treatment, for example, the expectation of improvement, that is independent of the unique characteristics of the specific practice; also can be successful!



Quality of Research

- Research is helpful in clarifying the effect of an intervention independent of other factors that promote health, and independent of a proponent's bias in favor of the practice
- Quality of research across studies varies
- The higher the quality of research, the greater the confidence in the conclusions of the study



Quality of Research

- Qualitative studies
  - Anecdotal observations; Case studies
- Quasi- or partially controlled experimental studies
  - Within-subjects (pre and post comparison) studies
  - Between-groups comparisons without random assignment
- Controlled experimental studies
  - Random clinical trials (between groups)
  - Random clinical trial-longitudinal studies
- Studies vary in their ability to answer questions about if (internal validity) and with whom (external validity) an intervention works



Internal Validity

- Level of confidence that the intervention is responsible for the outcome
- Answers the question "Does it work?"
  - Typically involves highly controlled research studies
  - Homogenous populations (for example, to diagnosis, gender, ethnicity)
  - Standard, verified application of the practice (for example, practitioner is highly trained and supervised by the developer)



External Validity

- Level of confidence that the practice will be effective across diverse groups of individuals
- Answers the question "Will it work in my community?"
  - Also, involves highly controlled studies
  - Heterogeneous populations (for example, dual disorders, both genders and diverse ethnicities)
  - Replication in diverse (public mental health) usual care settings with diverse clients and practitioners



Levels of Effectiveness

- Evidence-based practice
  - Clearly articulated model
  - Substantial evidence of positive outcomes based upon experimental or equivalently strong research methods
  - Replication
- Promising practice
  - Clearly articulated model
  - Generally consistent evidence of positive outcomes based upon qualitative or quasi-experimental research methods
  - May have replications



Levels of Effectiveness

- Community-defined evidence practice
  - Identified by local unserved/underserved communities
  - Clearly articulated model (can be replicated)
  - Some level of demonstrated effectiveness in local communities



Confidence in a Practice

- No intervention, including EBPs, work with all individuals
- However, confidence in achieving a positive outcome is increased when controlled research has demonstrated that an intervention is effective, in real world settings and with individuals from diverse backgrounds
- Replicating positive outcomes assumes that the intervention is implemented (and sustained) as intended--with model adherence



Model Adherence or Fidelity

- Degree to which there is adherence to the model (high quality)
- Model adherent programs are most likely to result in achievement of similar outcomes to those reported in the research
- Achieving fidelity or model adherence is critical
- Requires the practice be ready to disseminate
- Requires the community be ready to adopt
  - Consumer and family readiness
  - Staff readiness
  - Agency readiness
  - Service system readiness



Selecting and Implementing

- Fit with target population
- Fit with desired outcome(s)
- Level of demonstrated effectiveness
  - Level of research support
  - Internal and external validity
- Readiness to be implemented and sustained with model adherence
  - Tried and proven training protocols
  - Tools for monitoring model adherence and outcomes



Selecting and Implementing

- Select a practice with a high level of demonstrated evidence
- Select a practice that is valued by consumers, families and community
- Select a practice with a history of successful implementation across diverse communities
  - Relevant MHSA PEI priority populations & outcomes
  - Suitable for use in Los Angeles County
  - Culturally sensitive and responsive to the diverse communities that comprise Los Angeles County



Selecting and Implementing

- Drift from the model (poor fidelity) can jeopardize achievement of outcomes
- Designate an administrator/manager lead to champion learning and using the model
- Develop a concrete intervention-specific implementation plan
- Select providers/staff based on a full understanding of the intervention requirements and commitment to achieving and maintaining fidelity
- Adhere to practice workloads and related intervention characteristics



Selecting and Implementing

- Focus on fidelity from the outset
- Support fidelity through training, coaching, monitoring, and evaluation
- Maintain momentum
- Expect and plan for interrupted progression
- Expect and plan for staff turnover (replacement training)



MHSA PEI Programs

- Prevention and early intervention programs including evidence-based, promising and community defined interventions
- Specific to PEI priority populations and outcomes
- Promoting protective factors and reducing risk factors
- Enhancing emotional well-being and reducing the occurrence and impairment of mental illness



Reviews of Effectiveness

- SAMHSA National Registry of Evidence Based Practices http://www.nrepp.samhsa.gov/index.htm
- SAMHSA A Guide to EBPs on the Web
- http://www.samhsa.gov/ebpWebguide/index.asp



Prevention--Examples

- Children
  - *Triple P Parenting*
- Transition age youth
  - *Nurse-Family Partnership*
- Adults
  - *Early Detection and Intervention for the Prevention of Psychosis (EDIPP)*
- Older adults
  - *The Gate Keeper Case Finding Model*



Triple P Parenting

- Children 0-16 years of age
- Parenting program
- Five levels of intervention
- Universal prevention, early intervention, and treatment
- Individual and group modalities
- Numerous random clinical trials
- Real world (South Carolina) trial
  - Improves parenting skills
  - Decrease in parental stress and depression
  - Decrease in child behavior problems
  - Improves parent anger management skills
  - Decreases social isolation
- www.triplep.net/



Nurse-Family Partnership

- First time, low-income mothers (any age)
- Selective prevention involving home visitation, by public health nurses, intensively supporting maternal-prenatal and early childhood health, and well-being, over a 2 year period
- Focus on parental roles, family and friend support, physical and mental health, home and neighborhood environment, and major life events (e.g. pregnancy planning, education, employment)
- Random clinical trials
- Use with diverse populations and settings
  - Improved prenatal health
  - Increased maternal employment
  - Reduced childhood injuries
- www.nursefamilypartnership.org



EDIPP

- Teenagers to adults
- Universal prevention, early intervention, and treatment
- Educational campaign to reduce stigma and barriers to treatment, and increase identification of individuals showing signs of psychotic disorders by community members (e.g teachers, doctors, nurses, police officers, parents), and use of assertive case management model
- Promising practice
- Several community-based trials in process
  - Delayed onset of psychotic disorders
  - Reduced symptoms
  - Improved functioning
- http://preventmentalillness.org/



Gate Keeper Case Finding Model

- Older community-dwelling adults (60+) at risk of not being able to live independently and safely in the community
- Selective prevention involving non-traditional community referral sources organized/trained to identify high-risk elders
- Link to designated providers for comprehensive assessment and access to needed services (health, mental health, or other social services)
- Recruitment and training of gate keepers
- Emerging research
- Use in public mental health settings
  - Increased enrollment in clinical case management programs
  - Increased engagement in care by under-served elders
- Julie E. Jensen, Ph.D. jjensen@u.washington.edu



Early Intervention--Examples

- Children
  - *Incredible Years*
- Transition age youth
  - *Trauma Focused Cognitive Behavior Therapy (TF-CBT)*
- Adults
  - *Prolonged Exposure Therapy for Post Traumatic Stress*
- Older adults
  - *Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT)*



Incredible Years

- Children ages 0-12 at risk for behavior problems
- Three sets of comprehensive developmentally based curriculums for parents, teachers and children to promote emotional and social competence
- Universal prevention, early intervention, and treatment
- Strengthens parents' and teachers' competence in communication, child directed play, clear limit setting, effective (nonviolent) discipline
- Numerous random clinical trials
- Use with diverse populations and settings
  - Less behavior problems
  - Increases in effective parenting
  - Less parental depression and increase in esteem
- www.incredibleyears.com/



TF-CBT

- Children ages 4-18 years
- Individual sessions (weekly) with the child, parent and joint child-parent (12-16 sessions)
- Therapeutic relationship, psycho-education, emotional regulation, stress management, connecting thoughts-feelings and behaviors, gradual in vivo exposure, cognitive and affective processing of trauma experiences, personal safety and skills training
- Numerous random clinical trials
- Use with diverse populations and settings
  - Decreases PTSD symptoms
  - Decreases negative attributes (self-blame)
  - Decreases externalizing problem behaviors
  - Improves parent-child relationship
- http://tfcbt.musc.edu/



Prolonged Exposure Therapy for Post-Traumatic Stress

- Cognitive behavioral intervention for adults who have PTSD from singe or multiple trauma(s)
- 8-15 session conducted 1-2 times weekly for 90 minutes
- Individual therapy sessions including psycho-education, imaginal exposure and repeated recounting of the traumatic memory, and in vivo exposure
- Random clinical trials
- Use with diverse populations and settings
  - Decrease in PTSD symptoms
  - Reduced depression
  - Improved social adjustment
- www.med.upenn.edu/ctsa/about_therapy.shtml



PROSPECT

- Older primary care patients (55+) with depression at-risk of suicide
- Recognition of depression and suicide ideation by primary care physicians
  - Application of geriatric depression treatment algorithm (medication and/or interpersonal psychotherapy)
  - Treatment management by health specialist
  - Treatment and monitoring over 24 months
- Random clinical trial
- Implemented in numerous primary care centers by developer
  - Reduced depression
  - Decrease in suicide ideation
- Patrick J. Raue, Ph.D. at praue@med.cornell.edu



EBP Common Features

- Clearly articulated models
  - Curriculum or phases or strategies
  - Specific intervention goals
  - Defined start and end
  - Can be replicated
- Emphasis on engagement as an early goal of intervention and responsibility of practitioner
- Specific target populations
- Specific target outcomes
- Grounded in research-based theory



Contact Information

- County of Los Angeles Department of Mental Health Information, planning, and other Resources
  - Web: http://dmh.lacounty.info/mhsa/plans/pei.html
  - email: mhsapei@dmh.lacounty.gov
  - phone: (213) 738-2331

- California Institute for Mental Health
  - web: www.cimh.org
  - Bill Carter, Deputy Director
  - email: bcarter@cimh.org
  - Phone: (916) 556-3480 x 130



APPENDIX 14

Summary of the Service Area PEI
Ad Hoc Steering Committee Recommendations

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT – PREVENTION AND EARLY INTERVENTION (PEI)

Service Area 1 Ad Hoc PEI Steering Committee Recommendations

Young Children (0-5)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Families and children where care is being provided by a grandparent or other relative caregiver; children of parents who have mental health issues and developmental disabilities; or children of adolescent mothers and fathers. 2. Families and children with multiple needs of children and where daily needs are not met, including families with low socioeconomic status and/or support, families with special needs children, and families experiencing food scarcity, children in families without transportation, or children in families on cash aid/family separation due to military service, incarceration or other life trauma. 3. Families and children exposed to substance use and abuse. 4. Families and children linked with the Department of Children and Family Services due to child abuse and neglect/physically/sexually abused and/or neglected children. 5. "High utilizers," meaning that despite services rendered, families continue to have problems and be unstable, including situations where there is homelessness or a mental health need; or families where parents are seriously depressed during their prenatal period, which can contribute to poverty, homelessness, and lower levels of education.	1. Nurse-Family Partnership 2. Triple P 3. Incredible Years Parenting Program 4. Parent-Child Interaction Therapy 5. Healthy Steps for Young Children	There was a heavy emphasis on out of home placements due to abuse/neglect situations (DCFS involvement). Family configurations will often not be with birth families but with foster parents or other out of home arrangements. Poverty, drug abuse and domestic violence are common issues of concern. The geography of Service Area 1 makes is very difficult to serve the population in the same ways that services are provided in other areas. There is a serious lack of qualified staff to serve the residents and it is difficult to recruit for the Region. Services must be provided in settings where the residents go for other reasons in order to be successful. There will be a need to partner with other providers, i.e., schools, churches, DCFS, Probation, etc. Committee did not indicate which sub-populations programs are for.
2. Trauma-exposed	1. Mothers who do not receive prenatal care; children of teen mothers who may be in foster homes or have a long history of being in foster care, who often experience insecure attachment; or, children who did not obtain secure child-parent/caregiver attachment. 2. Families and children whose parents have been sexually or physically abused/domestic violence. 3. Families and children exposed to alcohol, crack and/or other substances (although the effects of the exposure are not technically classified as mental health issues and are often overlooked). 4. Mothers exposed to domestic violence, violent environments (in home and community), and/or drug use during pregnancy, which impedes child brain development. 5. Families and children who are predators because they have been abused.	1. Trauma Focused CBT 2. Celebrating Families 3. Parent-Children Interaction Therapy: GANA Program / Parent Child Interaction Therapy 4. Child-Parent Psychotherapy	

Children (6-15)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children who experience child abuse, domestic violence, divorce or any kind of neglect where the child's needs are not met. 2. Children who have parents with substance abuse addiction issues/gang involvement. 3. Children reunifying with parents, i.e., military families, incarcerations, DCFS, mental illness 4. Lesbian/Gay/Bisexual/Transgender/Questioning (LGBTQ) 5. Foster children and youth or homeless children	1. Homebuilders 2. Strengthening Families 3. Early Risers Skills for Success 4. Functional Family Therapy	Heavy DCFS involvement, many foster children, homeless children and probation kids. School problems such as acting out behavior and low achievement issues. Critical need to identify some of these issues earlier, especially in school settings. LGBTQ issues The geography of Service Area 1 makes is very difficult to serve the population in the same ways that services are provided in other areas. There is a serious lack of qualified staff to serve the residents and it is difficult to recruit for the Region. Services must be provided in settings where the residents go for other reasons in order to be successful. There will be a need to partner with other providers, i.e., schools, churches, DCFS, Probation, etc. Committee did not indicate which sub-populations programs are for.
2. Children and Youth at Risk for School Failure	1. Children who lack parental involvement; or, children lacking role models and positive support systems/gang involvement kids/substance use. 2. Children whose mental health and physical health concerns are not identified or addressed in a timely manner at school; children who have difficulty learning math and are below grade level in math; children who lack academic readiness skills; children reading one to two years below current grade level; children who lack problem solving skills; children whose mental health and physical health concerns are not addressed. 3. Children with disruptive behavior, including truancy, attention deficit disorder, and who are defiant; or, children who have chronic absentee records. 4. Children who have experience with the juvenile justice system; or, foster children and youth who change schools often. 5. Children whose learning style is not addressed and/or learning style and teaching style are not matched or supported by the school; children who do not have behavior support services in class; or, children who need learning disability assessment.	1. Families and Schools Together 2. Olweus Bullying Prevention 3. Across Ages 4. Early Risers Skills for Success 5. Incredible Years Parenting Program	

Transition-age Youth (16-25)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children of substance abusing parents; youth in homes where parents are active drug users; children of incarcerated parents; TAY children of parents who live with chronic disability illness; children living with parents who have mental health issues; youth in homes where parents suffer from mental illness; children living in juvenile justice camps or group homes; or, children being raised by their grandparents. 2. Gang-involved youth, particularly those from families with intergenerational gang patterns; or, youth raised in environments and neighborhoods where gangs and substance abuse are prevalent 3. Foster youth; foster care students who have been expelled from school; emancipating foster youth; or, emancipated foster youth who are at risk for becoming homeless. 4. LGBTQ youth. 5. Youth with mental health issues who may not be appropriately served (e.g., undiagnosed bipolar disorder; youth with learning disabilities whose parents are unable or unwilling to advocate on behalf of their children; or, youth with low self-esteem issues that can lead to suicide).	1. Personal Assessment and Crisis Evaluation (PACE) 2. Adolescent Transitions Program 3. Triple P 4. Homebuilders 5. Functional Family Therapy	Family and community violence; out of home placements (large numbers of foster youth), Undiagnosed mentally ill youth; and no safety net for emancipating youth who fall thru the cracks and become homeless, drug involved, exploited. LGBTQ issues The geography of Service Area 1 makes is very difficult to serve the population in the same ways that services are provided in other areas. There is a serious lack of qualified staff to serve the residents and it is difficult to recruit for the Region. Services must be provided in settings where the residents go for other reasons in order to be successful. There will be a need to partner with other providers, i.e., schools, churches, DCFS, Probation, etc. Committee did not indicate which sub-populations programs are for.
2. Children and Youth at Risk for School Failure	1. Children from homes where parents are unaware of mental health signs, issues, and the affects on kids/youth; children of parents who are absent due to work responsibilities or distance, and as a result may lack parental supervision (parents working “down below” or south of Antelope Valley); youth who have relocated from a large populated city to a small town; or, children from immigrant families with acculturation issues. 2. Children who are engaging in risky behavior (e.g., sexual promiscuity, substance abuse, truancy, and/or street racing); children who have been expelled; or, students with a high truancy record. 3. Substance abusing youth. 4. Children who have a physical or developmental disability but have not been assessed; youth who lack mental health awareness and education. 5. Young adults facing peer pressure to drop out of middle or high school; students who are 18 years old but are behind in school credits; or, children who are advanced to next school grade before they are ready.	1. Prolonged Exposure Therapy (PTSD) 2. EDIPP 3. Strengthening Families 4. Across Ages 5. Boys and Girls Club Project Learn	

Adults (26-59)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. Dually-diagnosed population with developmental disability and/or mental illness and dual-diagnosis/substance abuse population and mental illness. 2. Latino and African-American community; Asian population; African-American single head of household with severe mental health diagnosis; Native American/Alaska Native population; and, multi-cultural families/monolingual (non-English speaking). 3. People who lack financial resources and/or insurance coverage (example: DCFS parents). 4. Veterans, particularly those who are trauma-exposed and experiencing post-traumatic stress disorder; and, families of veteran families, including children. 5. Re-entering families/communities from prisons and jails; and, sex offenders.	1. Group CBT for Major Depression/CBT for Depression with Antidepressant Medication 2. Prolonged Exposure (PTSD) 3. Family Coping Skills Program 4. Mamas y Bebes 5. Coping with Depression	Linguistic and ethnic/cultural issues; co-occurring issues; under and uninsured people; PTSD, persons re-entering from justice system. The geography of Service Area 1 makes is very difficult to serve the population in the same ways that services are provided in other areas. There is a serious lack of qualified staff to serve the residents and it is difficult to recruit for the Region. Services must be provided in settings where the residents go for other reasons in order to be successful. There will be a need to partner with other providers, i.e., schools, churches, DCFS, Probation, etc. Committee did not indicate which sub-populations programs are for.

Older Adults (60+)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Trauma-Exposed	1. Persons on fixed income; or, seniors experiencing financial difficulties, poverty, loss of income, death of spouse, or other types of loss/grief. 2. Grandparents as parents/care-givers. 3. Older adults who are geographically isolated; or, older adults who lack access to services, with barriers such as transportation. 4. Seniors who have been financially abused; or, persons experiencing physical/emotional elder abuse/sexual assault. 5. Seniors dealing with major health issues; or, seniors dealing with a loss of medical services and/or benefits/depression/substance use.	1. IMPACT 2. Live Well, Live Long, Steps to Mental Wellness 3. Prolonged Exposure Therapy for PTSD 4. CBT for Late Life Depression 5. Prevention of Suicide in Primary Care Elderly (PROSPECT)	Loss/grief issues; grandparents as care-givers; geographic isolation/physical/ emotional/financial abuse; medical and mental health issues with loss of benefits or services The geography of Service Area 1 makes is very difficult to serve the population in the same ways that services are provided in other areas. There is a serious lack of qualified staff to serve the residents and it is difficult to recruit for the Region. Services must be provided in settings where the residents go for other reasons in order to be successful. Isolated Older Adults will need to be served with home visits. There will be a need to partner with other providers, i.e., schools, churches, DCFS, Probation, etc. Committee did not indicate which sub-populations programs are for. Concerns: - Semi-rural (urbal) - Transportation - Homebound

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT – PREVENTION AND EARLY INTERVENTION (PEI)

Service Area 2 Ad Hoc PEI Steering Committee Recommendations

Young Children (0-5)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children/Youth in Stressed Families	1. Victims of domestic violence, trauma, abuse, neglect and substance. 2. Children/families impacted by poverty, oppression, racism, linguistic challenges, substance abuse, trauma, and mental/physical challenges. 3. Children whose parents/caregivers lack parenting skills. 4. Parents/caregivers who lack a support system. 5. Children raised by "parents" other than biological parents.	1. Making Parenting a Pleasure 2. Child-Parent Psychotherapy 3. Triple P Positive Parenting Program 4. Incredible Years 5. Parent-Child Interaction Therapy	Committee did not indicate which sub-populations programs are for.
2. Underserved Cultural Populations	1. Trauma exposed children and their families. 2. Children at risk of school failure. 3. Families with insufficient income and resources to meet their children's needs. 4. Children whose parents are in need of a culturally competent parenting class(es). 5. Children at risk of school failure due to parental acculturation.	1. Family Health Promotion 2. Incredible Years Parenting Program 3. Parent-Child Interaction Therapy 4. Trauma Focused Cognitive Behavioral Therapy 5. Nurse-Family Partnership	Committee did not indicate which sub-populations programs are for.

Children (6-15)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children/Youth in Stressed Families	1. Youth exposed to domestic violence, trauma, abuse, neglect and substance abuse. 2. Families experiencing poverty, racism and/or oppression; families with substance abuse and/or domestic violence; or families with individuals experiencing the onset of serious psychiatric illness 3. Underserved cultural population children whose parents are in need of parenting skills 4. Children affected by medical and mental health problems. 5. Children and youth at risk of involvement and/or already involved with the juvenile justice system	1. Brief Strategic Family Therapy 2. Parent-Child Interaction Therapy 3. Abuse Focused Cognitive Behavioral Therapy for Child Physical Abuse 4. Gang Resistance is Paramount 5. Incredible Years	Committee did not indicate which sub-populations programs are for.
2. Children/Youth at risk for school failure	1. Children exposed to Domestic Violence, trauma, abuse, neglect and substance abuse. 2. Children with school phobias, children who are self-injurious, children with anger management and peer pressure issues; or children who lack social skills, and friendship, children who are ineligible to access mental health services due to diagnosis. 3. Children who are fearful of attending school due to the lack of safety in certain schools, children who are victims of bullying or those who bully and mistreat other children, and children targeted by gangs. 4. Families (and children) who lack appropriate parenting skills. 5. Teachers and school staff unable to identify mental health needs in children.	1. Aggression Replacement Therapy 2. Families and Schools Together 3. Trauma Focused Cognitive Behavioral Therapy 4. Incredible Years Parenting Program 5. Incredible Years	Committee did not indicate which sub-populations programs are for.

Transition-age Youth (16-25)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children/Youth in Stressed Families	1. Children who witness/experience domestic violence in the home; c/y living in high crime, gang infested areas; or homeless, runaway, throw-away youth. 2. Undereducated individuals, limited literacy or limited exposure to navigating through systems and resources, including non-English speaking and school drop-outs 3. Depressed youth/children, drug addicted youth, gay and lesbian youth, school drop-out, pregnant teens, and LGBTQ 4. Emancipated and emancipating 5. TAY and families that are trauma exposed	1. Multidimensional Family Therapy 2. Adolescent Transitions Program 3. Aggression Replacement Therapy 4. Brief Strategic Family Therapy 5. Homebuilders	Committee did not indicate which sub-populations programs are for.
2. Individuals Experiencing Onset of Serious Psychiatric Illness	1. People with a combination of Prodromal symptoms such as hallucinations, withdrawal, and decreased self-care. 2. Youth lacking support systems 3. TAY with repeated drug use or exposure to meth use, alcohol, or other substances 4. TAY lacking financial and health care resources 5. Families of TAY who are caregivers of TAY mentally ill or**/***TAY inadequately screened (NEED TO BREAK TIE)	1. Early Detection and Intervention for Prevention of Psychosis (EDIPP) 2. Trauma Focused Cognitive Behavioral Therapy 3. Early Psychosis Prevention and Intervention Center 4. Personal Assessment and Crisis Evaluation 5. Family Coping Skills Program	Committee did not indicate which sub-populations programs are for.

Adults (26-59)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. All ethnic and racial groups experiencing a lack of access due to availability, geography, limited finances, limited transportation, and language issues; and those who are often under-reported due to family stigma about mental health and immigration status; or individuals from a mixed race/culture. 2. Trauma exposed. 3. Homeless, LGBTQ and HIV positive populations, especially those with minority status. 4. Unemployed, impoverished, & uninsured population, especially the undocumented. 5. People with physical and mental disabilities, especially those who lack access due to the lack of insurance or long waiting lists.	1. Group Cognitive Behavioral Therapy for Major Depression 2. Cognitive Behavioral Therapy for Depression with Antidepressant Medication 3. Family Coping Skills Program 4. Coping with Depression 5. Mamas y Bebes	Committee did not indicate which sub-populations programs are for.
Older Adults (60+)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Individuals Experiencing Onset of Serious Psychiatric Illness	1. Individuals experiencing loss of protective factors, social support and independence; or individuals experiencing isolation and frustration due to loss in social support and decreased sense of purpose. 2. Trauma exposed individuals whose trauma leads to serious mental illness 3. Underserved cultural populations. 4. Individuals who are not adequately screened for mental illness, and or minimized, overlooked or misdiagnosed. 5. Individuals whose primary medical providers do not screen for mental illness (depression, psychosis, medication abuse/misuse), or minimized, overlooked or misdiagnosed.	1. Cognitive Behavioral Therapy for Late Life Depression 2. Live Well, Live Long, Steps to Mental Wellness 3. Gatekeeper Case-finding Model 4. Prevention of Suicide in Primary Care Elders 5. Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	Committee did not indicate which sub-populations programs are for.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT – PREVENTION AND EARLY INTERVENTION (PEI)

Service Area 3 Ad Hoc PEI Steering Committee Recommendations

Young Children (0-5)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children who experience a failure to thrive to include physical and/or emotional disabilities, health conditions, attachment and/or regulatory issues. 2. Children whose parents, including teen parents, are experiencing mental and/or physical disability, substance abuse, domestic violence, incarceration, lack of parenting skills and a death or divorce in the family. 3. Families living in poverty, homeless, and/or experiencing economic and social stress, immigrant families, including those separated due to deportation. 4. Physically, sexually, emotionally abused and neglected children. 5. Children in families exposed to violence and abuse, including gang or domestic violence.	1. Incredible Years 2. Triple P Positive Parenting Program 3. Trauma Focused Cognitive Behavioral Therapy	1. Since it is for school implementation, yet serves 0-5, there should be an implementation strategy for community centers/other locations where parents of children not yet in school can and would access. Children's Bureau encounters many "relative" caregivers, including grandparents, aunts, etc. Does this also incorporate the Incredible Years Parenting Program, i.e. the parent training intervention component? It seemed so, but just want to verify. 2. Parents' literacy and reading level, as well as primary language should be kept in mind, especially for "tip sheets" and other written materials. Additionally, for this program, the taboos associated with "PPP" in Chinese should be addressed. (Culturally competent language translation is essential; there should be an accountability team for verification of appropriate translation.) 3. Since there is homework, provisions should be made for those who cannot read and/or read at a lower level. This could include follow-up phone calls during the week, accountability partners, or perhaps photo reminders/task sheets.
2. Underserved Cultural Populations	1. Children of immigrant families and/or undocumented children and families who cannot access mental health services are experiencing stigma, educational, financial and isolation issues. 2. Children in non-traditional or special needs families such as, gay and lesbian families, families with newly adopted children with special needs, deaf children of hearing parents, the religious minorities who shun medical procedures, homeless families and families with disabled children. 3. Populations experiencing stigma, educational, financial, transportation and isolations issues. 4. Populations such as, API, Latinos, Native Americans, African-Americans, Armenian and other underserved populations experiencing stigma, educational, financial, transportation and isolations issues.	1. Incredible Years Parenting Program 2. Trauma Focused Cognitive Behavioral Therapy 3. Family Coping Skills Program	1. Again, parents' literacy/language level should be considered & accommodated. This program may also work well for #1 & #3 subpopulations for C/Y in stressed families. Please see comments under Incredible Years under 1st Priority Population. 2. Again, parents' literacy/language level should be considered & accommodated. Additionally, for these populations, it will be important to incorporate the "Honoring Children, Mending the Circle" model on p. 171 of the Resource Guide. Finally, populations are difficult to choose for TFCBT; disclosure of trauma by anyone in a minority cultural group should be the determining factor for entering the program. Transportation assistance, therefore, may be necessary (save resources by implementing the program in selected locations but when an individual out of the area but within SPA 3 discloses trauma, connect to the service via referral & trans asst.) Expand program to other racial/ethnic groups. 3. Since this is a program developed with and for Latina mothers, there should be due diligence in making necessary changes for mothers from other backgrounds, especially Asian and African American (in said order based on

	5. Historically underserved populations whose representation in mental health service reception is not adequately proportional to population size.		SPA 3 underserved populations). There should be linkages made with organizations serving these communities & with links to those otherwise intimidated by cultural taboo/stigma.

Children (6-15)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children who are abused or exposed to violence, domestic violence and/or trauma within their family or community. 2. Children and families facing multi-generational mental illness, substance-abuse and/or whose parents have poor parenting and coping skills. 3. Children in poverty-stricken families, economically challenged and/or in crisis such as foreclosure, homelessness. 4. Children with developmental disabilities, physical disabilities, learning disabilities and special needs. 5. Children with non-English speaking parents and/or families lacking access to services due to immigrations status.	1. Incredible Years 2. Early Risers Skills for Success 3. Triple P Positive Parenting Program	1. Again, parents' literacy/language level should be considered & accommodated. Six to 15 year olds often have "relative" caregivers. 2. It will be essential to outreach to homeless families and other families in which children do not have regular school attendance. The most fool-proof way we have found to guarantee attendance of parents is to offer a useful free-gift incentive. This will be absolutely necessary to include in budget costs if parents of children who are not receiving adequate care/are exposed to violence & poverty are expected to be affected. The children in these risk categories are more likely to have parents who are unwilling or unable to come to such events and/or trainings. If implemented at a public school, accommodations should be made for children from surrounding schools/communities to attend camp and after-school activities. A student shouldn't have to be fortunate enough to attend the school of implementation in order to benefit from this program. 3. Again, parents' literacy/language level should be considered & accommodated
2. Underserved Cultural Populations	1. Children from immigrant families and from ethnic communities who lack resources, experience social stigma and/or are isolated and may be experiencing social and emotional distress. 2. Children and their families experiencing discrimination and/or have lack of access to services due to stigma or reluctance associated with mental health. 3. Children who are in multi-generational gang affiliated families or who are at risk of gang recruitment. 4. Children and families dealing with gender identity and sexual orientation issues. 5. Single, teenage mothers, fathers and pregnant minors.	1. Incredible Years 2. Trauma Focused Cognitive Behavioral Therapy 3. Multidimensional Family Therapy	1. It is important that on-site translation (since this works with teachers who may not be well-versed in a certain language) be present & available so that children are not placed in the position of being translators. 2. Again, parents' literacy/language level should be considered & accommodated and program modifications should be made (logistically: transportation, referral linkage, etc) to serve those who disclose trauma, since this is an EI model rather than Prevention. 3. Note: this is a program designed for adolescents, so those attending middle & high schools as well as those with delinquency records should be target populations.

Transition-age Youth (16-25)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. Unaccompanied minors (undocumented, homeless and immigrant TAY) who may be experiencing the onset of mental illness, substance-abuse and/or cannot access services. 2. TAY who are uninsured or underinsured. 3. Asian American youth who are at risk but not identified due to, but not limited to, role expectations such as, model minority perception and generational challenges, etc. 4. LGBTQ TAY who come from immigrant families and/or ethnic communities who struggle with social and community stigma, self-esteem or coming out issues. 5. Traditionally underserved TAY individuals such as, LGBTQ, immigrant, undocumented, homeless, and/or uninsured.	1. Placeholder: program for API youth and their families that addresses generational, bicultural competence and life skills similar to the Native American EBPs listed in resource manual. 2. Trauma Focused Cognitive Behavioral Therapy 3. Interpersonal Psychotherapy for Depression	**1. Placeholder Note: Are you looking for a parenting program that includes parents and children, or just parents? Which Native American EBP were you thinking of?** The thinking was a program which includes parents and children or even a program for the youths where they can discuss these issues in a group. Common cultural issues encounter include the "second son syndrome", the daughter who has to leave the family upon marriage and submit to the in-law. Some of these traditions are in conflict with the experience of these young people growing-up in America and with their American peers. When these issues are not addressed early they can fester and contribute to a mental illness and/or break later in life. It would seem that involvement of parents would be most appropriate, but not essential (if the program model does not accommodate parent involvement but is still evidence-based as effective, it probably doesn't need parent involvement). The appropriate EBPs seem to be p. 137: Bicultural Competence Skills & p. 172: Honoring Children, Making Relatives, because they deal with acculturation and multiple-generation conflict/contrast issues. I think that it was discussed that this has to be a two-prong approach. It's not just educating the parents to accept the American way of life, but also the youth needs to understand where their parents are coming from. Perhaps it's about developing mutual understanding and respect. And perhaps, as one matures, the problems may resolve. I don't know. It's sort of like the old saying that when you have children, you understand why your parents did what they did, and you became your parents. Of course, it also varies from person to person. 2. Implementation in nontraditional locations will be advantageous (community center, clinic, rehab center)
2. Trauma-exposed	1. TAY who have experienced severe trauma such as natural disaster, child abuse, sexual abuse, domestic violence, combat in war, victim of violent crime, or have a loved one who died as result of homicide or suicide or was witness to violent crime. 2. TAY who have been incarcerated, have criminal history, substance abuse, and/or at risk of gang association and reside in a high crime area. 3. TAY who are emancipating, in transition, specifically those transitioning in and out of institutions or schools and/or out of home placements and/or at risk of homelessness. 4. Trauma exposed TAY currently engaged in sex crimes or domestic violence or as a perpetrator. 5. TAY who have made suicide attempts or at risk for suicide.	1. Trauma Focused Cognitive Behavioral Therapy 2. Prolonged Exposure Therapy for PTSD 3. Seeking Safety	1. 2 and 3. These will require a homelessness prevention/ recovery component and/or linkage with such an agency. It would be unjust to help TAY recover from trauma and then expose them to it again… 3.

Adults (26-59)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. Immigrants and/or non-English speaking adults and deaf and hard of hearing and their families who are dealing with a family member with psychiatric illness, complex trauma, and cultural barriers regardless of ability to pay. 2. Adults who are homeless, have low income, are uninsured, are experiencing social and economic barriers, or are on the verge of experiencing serious financial difficulties and/or do not qualify for public benefits. 3. Adults, including college students, lacking knowledge/skills and/or awareness of mental health, co-occurring and problem gambling issues, community resources for treatment support to appropriately deal with a child, spouse or family member with a psychiatric illness. 4. Low income uninsured and underinsured adults experiencing socio-economic and cultural barriers such as poverty, language and stigma. 5. Adults experiencing complex trauma including war veterans.	1. Group Cognitive Behavioral Therapy for Major Depression 2. Prolonged Exposure Therapy for PTSD 3. Family Coping Skills Program	1. 2. Perhaps can be implemented in community setting particularly for immigrant population feeling isolated, stigmatized and unwilling to seek treatment in traditional settings. 3. Though this program model is for mothers, adults 26-59 who are not currently caring for young children should not be excluded. Financial, acculturation, and other stressors (see p. 153) are substantial risk factors for depression in and of themselves. Perhaps the parenting components can be replaced with self- or parent-care components for those not caring for children at the time. Some cooperation with those working with older adults or those in health-care should be utilized to develop comparable components focusing on these subjects (self- or older adult-care). Our steering committee frequently mentioned adults caring for parents or other older adults as a significant underserved population. Expand program to other racial/ethnic groups, and to other adults.

Older Adults (60+)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. Immigrants and those with limited English proficiency including deaf and hard of hearing who may lack knowledge about mental illness or who face stigma, linguistic, cultural or other barriers to accessing services. 2. Older Adults residing in nursing facilities, residential placements, homebound or have transportation limitation, co-occurring disorder, suffering from dementia, end of life and/or suicidal issues, loss of loved ones, cultural/linguistic challenges including the deaf. 3. Older Adults reluctant to seek support outside family and lacking knowledge about mental health needs due to cultural norms and/or economic barriers including immigrants, refuges and undocumented who fear seeking services. 4. Older caregivers who are taking care of older parents and raising and supporting adult children and other family members. 5. Homeless and/or impoverished older adults who are uninsured or underinsured.	1. Program to Encourage Active Rewarding Lives for Seniors (PEARLS) 2. Cognitive Behavioral Therapy for Late Life Depression 3. Gatekeeper Case-finding Model	1. PEARLS could be broadly applicable to all of these sub-populations. Accommodations must be implemented for homeless, impoverished older adults. (What kinds of pleasurable activities are appropriate for a person who has no home? Either a focus on positive attitude toward everyday activities or provision for housing assistance should be incorporated so that coordinating of special activities does not end up a temporary solution) 2. I would like to see the CBT model offered in both individual and group formats; and to be offered in a preventative as well as early intervention approach. 3. Gatekeeper model needs to be linked with accessible follow-up services. It was pointed out in our steering committee that this model must be partnered with a model that addresses problems (to avoid finding cases but having nowhere to which they can be referred); perhaps one of the other selected programs here. Additionally, it is important to have an accountability component in place that demonstrates having reached a substantial percentage of those in isolation. How can we be sure that the penetration rate has improved since it is difficult to assess how many individuals are in isolation (since, by virtue of being isolated, they are undetected)? Finally, since this is a preventative model, perhaps a media campaign targeted at recruiting gatekeepers or a hotline that allows the general public to refer the elderly should be established. Is there a possible incentive for gatekeepers to become involved or is the program dependent on the goodwill of individuals and their employers (e.g. utilities companies, banks, etc)? Should an outreach to said employers be engaged? What incentive can be offered to them?

General Comments/Implementation Guidance for DMH

- Incredible Years: A SPA translation accountability team to which each program must submit its literature might be an efficient way to solve the problem of assuring cultural competency
- Incredible Years: No matter where implemented, will need some translation staff, since working with the teacher is part of the model and there is no guarantee of teacher's capacity to communicate with parents. Again, a SPA 3 team of translators may fill this void efficiently & effectively

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT – PREVENTION AND EARLY INTERVENTION (PEI)

Service Area 4 Ad Hoc PEI Steering Committee Recommendations

Young Children (0-5)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children whose parents have mental health issues such as postpartum/maternal depression, etc. 2. Children of uninsured immigrant families. 3. Children in or at risk for involvement in the foster care system or children in the reunification process. 4. Children experiencing domestic violence or living in families with marital problems (i.e. divorce, separation, conflict, etc.) 5. Children at risk for school failure; children who have been suspended or expelled from a preschool program; or children who are exhibiting behavioral/emotional problems but do not qualify for special education.	1. Incredible Years 2. Nurse-Family Partnership 3. Triple P Positive Parenting Program	• Incredible Years would be good for all sub-populations. • NFP would be especially good for sub-populations #1 and #3. • Triple P would be especially good for sub-populations #1, #2 and #3
2. Trauma-exposed	1. Children experiencing, who have been exposed to, or who are at risk for exposure to family or community violence. 2. Children with substance abusing parents, including those prenatally exposed to substances. 3. Children from uninsured families. 4. Children exposed to sexual abuse. 5. Children of immigrant/undocumented families.	1. Child-Parent Psychotherapy 2. Parent-Child Interaction Therapy 3. SafeCare	• Child-Parent Psychotherapy would be especially good for sub-populations #1 and #4. • Parent-Child Interaction Therapy would be especially good for sub-populations #1 and #4. • SafeCare would be especially good for sub-populations #1, #2 and #4

Children (6-15)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children exposed to family trauma (i.e. abuse, domestic violence, incarceration, substance abuse, etc.) 2. Children at risk for school failure. 3. Children who have a parent/sibling absent due to incarceration/deportation. 4. Uninsured. 5. Children exhibiting behavioral/mental health issues due to multiple placements.	1. Multidimensional Family Therapy 2. Triple P Positive Parenting Program 3. CBITS	• Multidimensional Family Therapy would be especially good for sub-population #2. • Triple P would be good for all sub-populations. • CBITS would be especially good for sub-populations #1 and #5.
2. Underserved Cultural Populations	1. Uninsured. 2. Trauma-exposed. 3. Immigrant/undocumented children who have not yet been evaluated for developmental delay, development disabilities, or emotional disturbance due to linguistic or socioeconomic isolation. 4. Children in immigrant families. 5. Children who live in high crime neighborhoods.	1. Incredible Years 2. CBITS 3. Culturally Adapted Parent Management Training for Latinos	• CBITS would be especially good for sub-populations #2 and #5 • Culturally Adapted Parent Management Program for Latinos would be especially good for sub-populations #1, #3, and #4.

Transition-age Youth (16-25)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Trauma-exposed	1. Witnesses/victims of family violence (domestic violence, sexual abuse, etc.) 2. Witnesses/victims of community violence (gangs, sexual assault, bullying, etc.) 3. Foster youth; former foster youth; emancipating/emancipated youth. 4. Homeless or runaway TAY. 5. Youth who have experience with the criminal justice system.	1. Seeking Safety 2. Prolonged Exposure Therapy for PTSD 3. Trauma Focused CBT	• Seeking Safety would be especially good for sub-populations #2 and #5 • TF-CBT and Prolonged Exposure Therapy would be good for all sub-populations.
2. Children and Youth in Stressed Families	1. Families with high risk factors such as domestic violence, substance abuse, or mental illness. 2. Undocumented, immigrant, and/or UREP TAY. 3. TAY at risk of school failure/have truancy issues. 4. Pregnant or parenting youth (including dads). 5. Homeless TAY or TAY at risk of being homeless.	1. EDIPP 2. Triple P Positive Parenting Program 3. Nurse-Family Partnership	• EDIPP would be especially good for sub-populations #1, #2, #3 and #5 • Triple P would be especially good for all TAY 16-18 and sub-population #4 • Nurse-Family Partnership would be especially good for sub-population #4.

Adults (26-59)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. Individuals with exposure to trauma or violence (domestic violence, community violence, etc.) 2. Linguistically isolated families; people experiencing a language barrier due to limited English skills; people who are foreign born/immigrants; or undocumented immigrants. 3. Individuals living in poverty; individuals who are at risk of being homeless; or homeless individuals who do not have access to resources for mental health services. 4. People with physical/mental health symptoms but not seeking services; or individuals who do not identify as having a mental illness. 5. The uninsured or underinsured.	1. Group CBT for Major Depression 2. Seeking Safety 3. Family Coping Skills Program	• Group CBT for Major Depression would be good for all sub-populations • Seeking Safety would be especially good for sub-population #1 • Family Coping Skills Program would be especially good for sub-population #2
Older Adults (60+)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. Home-bound individuals who may or may not have medical or mental health issues; or, socially isolated. 2. Homeless, including those at-risk for homelessness; or, living in residential care; or, multiple families in crowded living conditions; or impoverished persons. 3. Caregivers. 4. Linguistically-isolated; Non-English speaking; Persons who are illiterate. 5. Co-occurring disorders; individuals addicted to prescription medications; individuals with undiagnosed mental illness.	1. Live Well, Live Long, Steps to Mental Wellness 2. Gatekeeper Case-finding Model 3. IMPACT	• Live Well, Live Long, Steps to Mental Wellness would be especially good for sub-populations #1, #2, #3, and #4. • Gatekeeper Case-finding Model would be especially good for sub-populations #1 and #4 • IMPACT would be especially good for sub-populations #1, #3, and #5.

General Comments/Implementation Guidance for DMH

- All programs must serve uninsured/ undocumented populations.
- All programs must be delivered in a culturally competent way and should serve the diverse populations in Service Area 4. This includes the use of culturally diverse trainers. The Service Area 4 Ad Hoc PEI Steering Committee also recognizes that there are some Latino populations who do not speak Spanish (indigenous populations from Mexico and Guatemala), and are therefore are especially isolated. "Promotores de Salud" may be one strategy to outreach to these particularly isolated populations.
- All programs must be implemented in a way that focuses on individuals/families who are homeless or at risk for homelessness. The Service Area 4 Ad Hoc PEI Steering Committee recognizes that homeless and mental health are not separate issues, but that they form a continuum of service need. The Service Area 4 Ad Hoc PEI Steering Committee would like to emphasize that homelessness is countywide issue and that funds should be drawn from multiple sources to address homeless (not only the SA 4 allocation). The Service Area 4 Steering Committee would also like to emphasize the high numbers of former foster youth who experience homelessness and to suggest DCFS as a potential leveraging partner for homeless services.
- The Service Area 4 Ad Hoc PEI Steering Committee would like to see all ages receive services. When programs are selected from the recommendations above, it is important that they are selected in a combination that serves the entire life span.
- When possible, the Service Area 4 Ad Hoc PEI Steering Committee would like the programs selected to serve as many of the sub-populations as possible, even if that means a program needs to be adapted/expanded.
- The Service Area 4 Ad Hoc PEI Steering Committee recognizes that prevention efforts should also have an organizing and advocacy focus to address neighborhood factors (policies, safety, drug availability, community celebrations/alternative activities, etc) affecting the mental wellbeing of a neighborhood. These are community-based environmental prevention strategies that are universal, affecting entire communities (particularly relevant in high risk/high crime neighborhoods) and also addressing early intervention. There is ample data to justify neighborhood specific initiatives when comparing the prevalence of mental health problems as an indicator of vulnerable populations to target for PEI interventions (i.e. skid row and the African American community).
- It is imperative to have a range of prevention and early intervention services that are individually, family, and neighborhood focused.
- Program models should be peer driven, and seeking to address social/neighborhood factors affecting the group. Program models should hire peer advocates and consultants from the community.
- The Service Area 4 Ad Hoc PEI Steering Committee would like DMH to strongly consider adding any Community Defined Evidence Practices that would address the needs of the sub-populations and/or priority populations identified by the committee. The Service Area 4 Ad Hoc PEI Steering Committee would have liked to have had the opportunity to select from the additional array of programs identified by the CDE solicitation.
- The Service Area 4 Ad Hoc PEI Steering Committee would like to point out that the LGBTQ community has a number of unmet needs and few programs to address those needs.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT – PREVENTION AND EARLY INTERVENTION (PEI)

Service Area 5 Ad Hoc PEI Steering Committee Recommendations

Young Children (0-5)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children whose parents need support & guidance to establish healthy and trusting relationships with their children including a need for supports for healthy attachment. 2. Children with caregivers who have a mental illness or substance abuse problem including postpartum depression. 3. Children/families dealing with special needs (i.e. developmental or physical abilities, including siblings affected by special needs.) 4. Children not thriving socially or emotionally, having no sense of security. 5. Children with an absent parent due to incarceration, military service, or multiple jobs.	1. Child-Parent Psychotherapy 2. Incredible Years 3. Family Connections 4. Nurse-Family Partnership	• Child-Parent Psychotherapy should be delivered in a community-based setting. • Incredible Years should be part of a continuum of care. • Family Connections should focus on the birth to 5 age range and should be a part of a continuum of care. • Nurse-Family Partnership should be part of a continuum of care with mental health team members.
2. Trauma-exposed	1. Children experiencing violence, abuse, or neglect in the home or community. 2. Children in families with undiagnosed/unaddressed mental health challenges (i.e. depression) or anger issues. 3. Children with parents with unresolved trauma. 4. Families where children have a newly diagnosed mental health, social, or behavioral problem. 5. Children of immigrants experiencing socioeconomic stressors, discrimination, and a lack of access to resources.	1. Child-Parent Psychotherapy 2. Parent-Child Interaction Therapy 3. Trauma-Focused Cognitive Behavioral Therapy	• Child-Parent Psychotherapy should be delivered in a community-based setting. • The overall lack of relationship-based models in the resource guide was concerning.

Children (6-15)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children in families with substance abuse, untreated mental illness, and/or domestic violence. 2. Children who are homeless or in families that are economically distressed or lack basic resources. 3. Children in non-traditional families such as LGBTQ couples, grandparents in a parenting role, single parent families, foster families, etc. 4. Children exposed to trauma due to neglect, family violence, or community violence. 5. Children in families without support systems and who have not accessed needed services.	1. Incredible Years 2. Functional Family Therapy 3. Strengthening Families	• Incredible Years is applicable to both priority populations. It would be especially good for "Stressed Families" sub-populations #3 and #5 and "School Failure" sub-populations #2, #4, and #5. • Functional Family Therapy would be appropriate for all sub-populations. • Strengthening Families would be especially appropriate for sub-populations #1, #3, and #5. • The committee also liked Parent-Child Psychotherapy, but it was only applicable for 0-7. Consider expanding 0-5 program to include full 0-7 age range.
2. Children and Youth at Risk for School Failure	1. Children with undiagnosed mental health issues, learning disabilities, speech disabilities, and/or inappropriate school placements and without adequate support services from the school system. 2. Children who express or experience emotional distress at school or children who act out at school. 3. Children/families experiencing economic crisis, or experiencing domestic violence and/or exposure to community violence. 4. Children with poor school performance or who have been expelled. 5. Children from underserved cultural populations including English learners.	1. Second Step 2. Families and Schools Together 3. Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	• Second Step would be appropriate for all sub-populations. • Families and Schools Together would be especially appropriate for sub-populations #1, #2, and #4. • CBITS would be especially appropriate for sub-populations #2, #3, and #4.

Transition-age Youth (16-25)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Individuals Experiencing Onset of Serious Psychiatric Illness	1. TAY who would/might reject traditional mental health services. 2. Youth who have experienced trauma. 3. Emancipated youth (DCFS) or youth/young adults who are newly independent. 4. TAY with a family history of mental illness and/or substance abuse. 5. TAY who are struggling academically and/or at work.	1. Early Detection and Intervention for the Prevention of Psychosis (EDIPP). 2. Interpersonal Psychotherapy for Depression (IPT) 3. Trauma Recovery and Empowerment (TREM)	• All TAY programs should support peer development and empowerment. • All TAY programs should serve the entire TAY age range (16-25) which may require that the program models be adapted. • TAY programs should emphasize outreach and collocation at medical clinics and youth centers.
2. Children and Youth in Stressed Families	1. TAY experiencing rejection or lack of support due to sexual orientation, pregnancy, cultural beliefs, etc. 2. Youth who have families with a criminal history and/or are exposed to gangs, community violence, or domestic violence. 3. Youth living "out of home" including TAY who are homeless, runaways, or who are living with friends/relatives. 4. Youth in immigrant families, single parent families, low income communities, and/or families experiencing mental illness. 5. TAY who feel they cannot involve their families when accessing services.	1. Interpersonal Psychotherapy for Depression (IPT) 2. Placeholder: program for TAY who cannot involve their families in their treatment/services. Especially for sub-populations #1, #3, and #5. 3. Seeking Safety	• All TAY programs should serve the entire TAY age range (16-25) especially non-EPSDT populations. This may require that the program models be adapted. • TAY programs should emphasize outreach and collocation.

Adults (26-59)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Individuals Experiencing Onset of Serious Psychiatric Illness	1. Adults experiencing anxiety/depression related to an economic crisis (i.e. homelessness, job loss, change in living situation, etc.) 2. Individuals who do not access services due to limited awareness/understanding of mental illness and/or privacy issues or due to stigma. 3. Adults with a recently diagnosed serious medical condition or a chronic medical condition. 4. Adults caring for children and/or disabled/infirm family members (i.e. spouse, adult children, etc.) 5. Mothers with mental illness raising their children.	1. Group Cognitive Behavioral Therapy for Major Depression 2. Coping with Depression (tie) 2. Family Connections (tie) 3. Clinician-Based Cognitive Psychoeducational Intervention for Families.	• Group CBT for Major Depression would be especially appropriate for sub-population #1. • Coping with Depression would be especially appropriate for sub-populations #1 and #3. • Family Connections would be especially appropriate for sub-population #4. • Clinician-Based Cognitive Psychoeducational Intervention for Families would be especially appropriate for sub-population #5. • All programs should encourage participation in existing self-help groups
Older Adults (60+)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Individuals Experiencing Onset of Serious Psychiatric Illness	1. Older Adults who are isolated or homebound by virtue of living situation, disconnect from family, or neglect. 2. Older Adults lacking access to culturally/linguistically appropriate services. 3. Older Adults caring for children and/or disabled/infirm family members (i.e. spouse, adult children, etc.) 4. Individuals who do not access services due to limited awareness/understanding of mental illness and/or privacy issues or due to stigma. 5. Older Adults with a recently diagnosed serious medical condition or a chronic medical condition.	1. Gatekeeper Case-Finding Model 2. Live Well, Live Long, Steps to Mental Wellness 3. Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	• The Gatekeeper Case-Finding Model would work well for all sub-populations. It should be expanded to include physicians, employers, landlords and older adults service providers as gatekeepers. These individuals can also help with outreach. • Live Well, Live Long, Steps to Mental Wellness would be especially appropriate for sub-populations #1, #2, #3, and #5. • PEARLS would be especially appropriate for sub-populations #1, #2, #4, and #5. It should be adapted so that any licensed mental health professional can provide the supervision, not only a psychiatrist.

General Comments/Implementation Guidance for DMH
• PEI funding should be distributed as follows: o 60% for Children/Youth ages 0-25 o 20% for Adults 26-59 o 20% for Older Adults

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT – PREVENTION AND EARLY INTERVENTION (PEI)

Service Area 6 Ad Hoc PEI Steering Committee Recommendations

Young Children (0-5)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children in families experiencing chronic homelessness. 2. Impoverished children/families. 3. Children in families with substance abuse, domestic violence, and/or gang involvement, or who are living in areas with high rates of substance abuse, crime, and/or poverty. 4. Children/families involved in the child welfare system whose mental health issues have not been diagnosed or addressed, or have not been accurately diagnosed or adequately treated. 5. African American and Hispanic children/families that are disproportionately represented in the Child Welfare system.	1. Nurse Family Partnership 2. Triple P Positive Parenting Program 3. Effective Black Parenting	1. Must address all ethnic groups. Too narrowly focused. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. Given statistics that 65% of SA 6 population is Latino and 56% are primary Spanish speakers, high linguistic isolation. 2. Does not address D.V. Should take into account grandparents parenting and for level 1, who don't have access to view media-based materials. Focus close to neighborhoods with DCFS locations. Excellent, very expensive. Improve parenting skills, decrease negative child behavior. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. Concerned that program chosen for (0-5), 6-15 & TAY) 3. Must address all ethnic groups. Take into account grandparents parenting. Focus zip code 90044. May be useful w/other minority families, unclear. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. Little information on efficacy/adaptability with Latino population considering PEI goals and allocation of funds.
2. Trauma-exposed	1. Children and families exposed to child abuse and neglect, domestic violence, incest and gang violence. 2. Children in families experiencing extreme poverty and/or chronic homelessness due to unemployment, underemployment or incarceration of a family member. 3. Children dealing with grief and loss as result of death or incarceration of family member or loved one. 4. Children in foster care traumatized by multiple placements and/or removal experience.	1. Trauma Focused Cognitive Behavioral Therapy 2. Child-Parent Psychotherapy 3. Celebrating Families	1. Addresses most sub-pop issues. Focus in countywide gang grid areas. Tested w/ positive results. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 2. Must address all ethnic groups. Only one chosen that addresses 0-7 needs. Focus within LAUSD sites or collaborations. Positive; may require more long term. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 3. Must address all ethnic groups. Only one chosen that addresses both P&EI. Limited use by minority families. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population.

Children (6-15)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children in out of home placement or kinship care. 2. Children in homes with economic hardships, lack of access to medical services, limited parental education and/or lack of knowledge of and access to educational resources. 3. Children in homes with alcohol/substance abuse, mental illness, chronic medical illness and/or physical disability. 4. Children at risk of school failure due to suspension, transfers, and/or frequent changes in schools. 5. Children who experience child abuse, domestic violence, gang violence, and/or community violence.	1. Families and Schools Together 2. Triple P Positive Parenting Program 3. Homebuilders	1. Needs to address all ethnic groups and out of home Kinship Care. Meeting times to be conducive to single parents' work schedules. Involve all local school age children. Appears effective. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 2. Should take into account grandparents parenting and for level 1, who don't have access to view media-based materials. Excellent. Expensive, expansive. Decrease parental stress, reinforce positive behavior. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 3. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population.
2. Trauma-exposed	1. Children experiencing behavior and/or academic challenges attending underperforming schools. 2. Homeless, neglected children, and/or children removed from their homes. 3. Children in families and/or communities with domestic violence, child abuse, police brutality and/or gang, racial or community violence. 4. Parents, teachers, and or caregivers of trauma-exposed children. 5. Children dealing with grief and loss as result of death or incarceration of family member or loved one.	1. CBT Intervention for Trauma in School (CBITS) 2. Trauma Focused Cognitive Behavioral Therapy 3. Supporting Adolescents with Guidance and Employment	1. Needs to address all ethnic groups. Should fund intervention workers (community and gangs). Address broad constituency. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 2. Decrease symptoms from trauma, depression and unusual behaviors. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 3. Needs to address all ethnic groups. Primarily prevention. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population.

Transition-age Youth (16-25)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Youth exposed to or at risk of violence, abuse and/or hate crimes including violence/abuse that is the result of racial and/or sexual orientation status. 2. Youth in impoverished families, or independent, who are homeless or with unstable housing and/or lack access/eligibility to health care (primary, mental). 3. Youth emancipating from foster care. 4. Youth lacking parental involvement and/or positive reinforcement due to mental illness, incarceration, and/or substance abuse. 5. Youth coping with grief or loss of family member or loved one due to death or incarceration.	1. Multidimensional Family Therapy 2. Functional Family Therapy 3. Triple P Positive Parenting Program	1. Does not address needs of TAY 18-25, emancipated youth needs, or grief and loss issues. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 2. Does not address needs of TAY 18-25, emancipated youth needs, violence or grief and loss issues. Improve overall family interaction and functioning. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 3. Does not address needs of TAY 18-25, emancipated youth needs, violence or grief and loss issues. Should take into account grandparents parenting and for level 1, who don't have access to view media-based materials. Develop resource, and interventions and solutions, how to cope. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population.
2. Children/Youth at Risk for School Failure	1. Youth who are suspended, truant, or drop-out. 2. High school students funneled into alternative education (i.e. special ed., continuation, probation schools) due to behavioral issues. 3. TAY who did not receive adequate primary education to prepare for high school. 4. TAY in schools with poor conditions or in low socioeconomic areas/inner cities (i.e., overcrowding in classrooms, text books, unqualified teachers, violence, lack of resources). 5. TAY with mental health challenges in secondary/post-secondary schools.	1. Strengthening Families 2. Across Ages 3. Placeholder: program that addresses 18-25 year olds emancipating from child welfare system.	1. Does not address needs of TAY 18-25 or adequate primary education issues. Decrease adverse behaviors, increase child/parent/school communication. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 2. Does not address needs of TAY 18-25, alternative education, TAY with mental health challenges in school issues. Early intervention and prevention. Increase school involvement. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 3. We must find a practice that addresses this population. Meeting times to be conducive to single parents' work schedules. Critical. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population.

Adults (26-59)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. Adults with undiagnosed mental illnesses. 2. Latinos, African-Americans, Asians, and new immigrants not aware of mental illnesses and/or not seeking services due to stigma. 3. Adults returning to the community after incarceration, rehabilitation, and other institutions (i.e. military) who are in need of mental health services. 4. Ineligible, uninsured and underinsured adults. 5. Adults at risk of or exposed to HIV/AIDS and HEP-C.	1. Group Cognitive Behavioral Therapy for Major Depression 2. Family Coping Skills Program 3. Cognitive Behavioral Therapy for Depression with Antidepressant Medication	1. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. Stigma and insurance are major factors affecting provision of mental health services for both Latinos and African Americans. 2. Needs to address all ethnic groups and males. Improve symptoms of depression. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 3. Needs to serve males. Addresses most common mental health diagnosis. Improve functioning, decrease depression. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population.
Older Adults (60+)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. Population in the Lynnwood, Watts, Baldwin Hills, Baldwin Hills South, Crenshaw, and Compton areas. 2. Older adults isolated in their homes without transportation. 3. “Seniors”, including ethnic and immigrant adults, who do not access mental health system due to stigma and/or lack of knowledge. 4. Grandparents who are parenting 5. Adults who are undiagnosed (i.e. cognitive/depressed) yet seek primary health care services.	1. Program to Encourage Active Rewarding Lives for Seniors (PEARLS) 2. Psychogeriatric Assessment and Treatment in City Housing (PATCH) 3. Live Well, Live Long, Steps to Mental Wellness	1. Needs to address all ethnic groups. Involve youth in program to gain wisdom, live to become seniors and to help seniors remember their youth and not give up on them. Broad appeal. Reduce depressive symptoms. Improve quality of health and living. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 2. Decrease mental health symptoms. Support elderly where they live and to maintain housing. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population. 3. Should provide transportation as needed. Reduce depression, improve functioning. Recommend the option to integrate CDE models in correlation with EBP practices in RFP process to give contractors opportunity to innovatively collaborate and serve larger portion of underserved population.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT – PREVENTION AND EARLY INTERVENTION (PEI)

Service Area 7 Ad Hoc PEI Steering Committee Recommendations

Young Children (0-5)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children in families where parents are suffering from mental health issues, suffering from substance abuse, have a family history of domestic violence, child abuse and/or lack parenting skills. 2. Children experiencing emotional and/or behavioral difficulties in school. 3. Children in homes where domestic violence is present; children of abused parents, inter-generational violence; children living with emotional or verbal abuse; or, children who have experienced physical or sexual abuse. 4. Children in isolated families, including immigrant families that are isolated from country of origin and other family members, may not have legal status in this country, and often lack resources, especially financial; children of immigrant parents, where parenting approaches from their country of origin clash with those of the United States. 5. Children in single-parent families; children in families with teen parents; children who are being raised by other children, (e.g., siblings); children of homeless families; children being raised by grandparents; or, children where parents are incarcerated.	1. Child-Parent Psychotherapy 2. Incredible Years 3. Incredible Years Parenting Program	
2. Underserved Cultural Populations	1. Children in isolated families, including immigrant families that are isolated from country of origin and other family members, may not have legal status in this country, and often lack resources, especially financial; children of immigrant parents, where parenting approaches from their country of origin clash with those of the United States. 2. Families living in poverty; homeless families; or, families where there is neglect and abandonment. 3. Children of immigrant or undocumented parents; children of non-English-speaking parents; children may not want to speak native language, which may lead to problems when kids reach kindergarten. 4. Children with prior unsubstantiated child abuse report and the child is still in the home with primary caregiver and was not removed from the home by Department of Children and Family Services; or, children at risk of child abuse. 5. Children who have losses, (e.g., parents, death, migration).	1. Incredible Years 2. Trauma Focused Cognitive Behavioral Therapy 3. Incredible Years Parenting Program	

Children (6-15)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Children and Youth in Stressed Families	1. Children who are physically or sexually abused, and/or experience domestic violence; or, children in families that abuse substances. 2. Children who have experienced trauma, have been abused, or live with other forms of violence. 3. Children of single mothers; or, pregnant teens; or, children with a lack of parental involvement or supervision. 4. Children in newly-immigrated families that are isolated and lack awareness of mental health issues and services; families that lack awareness about risk factors and signs of mental illness. 5. Children using/abusing drugs, either to mask symptoms or who are self-medicating.	1. Nurturing Parenting Program 2. Incredible Years 3. Child-Parent Psychotherapy	
2. Children and Youth at Risk for School Failure	1. Children experiencing prodromal symptoms of psychosis; children experiencing social/emotional maladjustment that results in poor academic achievement. 2. Children at risk of school failure, especially those who do not speak English; children who are truant or absent from school; or, children at risk of delinquency. 3. Children in families who lack knowledge of the educational process/advocacy skills to access school and community resources. 4. Children of single mothers; or, pregnant teens; or, children with lack of parental involvement or supervision; or, children with parents who are separated/divorced. 5. Children who have experienced trauma, have been abused, or live with other forms of violence.	1. Incredible Years 2. Early Risers Skills for Success 3. Olweus Bullying Prevention Program	

Transition-age Youth (16-25)			
Priority Populations	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. Latino immigrants and their families needing mental health services. 2. Youth experiencing physical/sexual abuse or other trauma. 3. Teen parents. 4. Homeless and/or unemployed youth; youth leaving the foster care system; "failure to launch". 5. Youth at risk for depression/suicide.	1. Interpersonal Psychotherapy for Depression 2. Mamas y Bebes 3. Brief Strategic Family Therapy	
2. Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	1. Youth who have dropped out of school, particularly those who are undocumented or lack resources. 2. Youth/families with co-occurring substance abuse and mental health issues. 3. Youth who are failing academically and socially. 4. Youth who have failed in school due to unaddressed mental health needs. 5. Youth surrounded by negative environmental factors, such as, high rates of crime, drugs, graffiti and truancy.	1. Breaking Cycles 2. Functional Family Therapy 3. Adolescent Transitions Programs	
Adults (26-59)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. Individual in crisis due to loss. 2. Latino immigrants and their families needing mental health services. 3. Victims of violence and/or experiencing Post-traumatic Stress Disorder. 4. Caregivers in crisis due to living with a severely mentally ill family member. 5. Monolingual Spanish-speaking males Latinos without insurance.	1. Group Cognitive Behavioral Therapy for Major Depression 2. Family Coping Skills Program 3. Cognitive Behavioral Therapy for Depression with Antidepressant Medication	

Older Adults (60+)			
Priority Population	Sub Populations	Program Models Selected	Comments
1. Underserved Cultural Populations	1. Monolingual Spanish-speaking Latinos who are isolated with physical/mental health issues. 2. Individuals who are at risk for depression/suicide. 3. Homebound individuals who are physically isolated. 4. Individuals with co-occurring substance abuse and mental health disorders. 5. First-generation immigrants.	1. Cognitive Behavioral Therapy for Late Life Depression 2. Prevention of Suicide in Primary Care Elderly (PROSPECT) 3. Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)	

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT – PREVENTION AND EARLY INTERVENTION (PEI)

Service Area 8 Ad Hoc PEI Steering Committee Recommendations

Young Children (0-5)		
Priority Populations	Sub-populations	Interventions Selected
Underserved Cultural Populations	1. Children with physical and developmental disabilities 2. Children in out-of-home care 3. Children not participating in pre-school programs 4. Children who need assistance outside traditional systems, (i.e., homeless, undocumented, uninsured or underinsured) 5. Those for whom cultural/linguistic/social isolation negatively impacts treatment, (i.e., misdiagnosis, etc.)	1. Incredible Years 2. Nurse-Family Partnership 3. Parent-Child Interaction Therapy
Children/Youth in Stressed Families	1. Children in families with mental health/social issues (mental health, drug abuse, poor parenting, teen parents, incarceration, domestic violence, etc.) 2. Children exposed to trauma (child abuse, DV, community violence, etc.) 3. Children involved with DCFS and/or in out-of-home care 4. Children in families with socio-economic issues (poverty, single parents, uninsured) 5. Children with physical and developmental disabilities or health issues	1. Triple P – Positive Parenting Program 2. Parent-Child Interaction Therapy 3. Nurse-Family Partnership
Children (6-15)		
Priority Populations	Sub-populations	Interventions Selected
Underserved Cultural Populations	1. Children in families with mental health/social issues (mental health, drug abuse, poor parenting, teen parents, incarceration, domestic violence, etc.) 2. Groups who are linguistically/culturally/socially isolated and may be inappropriately served (ethnic minorities, deaf & hard-of-hearing, immigrants, affected by stigma) 3. Children who are lesbian/gay/bisexual/transgender/questioning/intersex (LGBTQI) 4. Children involved with DCFS and/or in out-of-home care 5. Children with school issues	1. Trauma-Focused Cognitive Behavioral Therapy 2. Multisystemic Therapy 3. Incredible Years

Children/Youth in Stressed Families	1. Children in families with mental health/social issues (mental health, drug abuse, poor parenting, teen parents, incarceration, domestic violence, etc.) 2. Children exposed to trauma (child abuse, DV, community violence, etc.) 3. Children in families with socio-economic issues (poverty, single parents, immigration status, uninsured) 4. Children involved with DCFS and/or in out-of-home care 5. Children at risk for gang involvement	1. Triple P – Positive Parenting Program 2. Incredible Years 3. Parent-Child Interaction Therapy
Transition-age Youth (16-25)		
Priority Populations	Sub-populations	Interventions Selected
Underserved Cultural Populations	1. Youth in families with mental health/social issues (mental health, drug abuse, poor parenting, teen parents, incarceration, domestic violence, etc.) 2. Groups who are linguistically/culturally/socially isolated and may be inappropriately served (ethnic minorities, deaf & hard of hearing, immigrants, affected by stigma) 3. Youth with socio-economic issues (poverty, single parents, immigration status, uninsured) 4. Youth who are LGBTQI 5. Homeless	1. Group Cognitive Behavioral Therapy for Major Depression 2. Multisystemic Therapy 3. Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)
Individuals Experiencing Onset of Serious Psychiatric Illness	1. Youth with substance abuse problems 2. Youth in juvenile justice system, out-of-home care 3. Youth with physical and/or developmental disabilities and/or behavioral or health issues 4. Youth attending school 5. Veterans	1. Early Detection and Intervention for the Prevention of Psychosis (EDIPP) 2. Trauma-Focused Cognitive Behavioral Therapy 3. Cognitive Behavioral Therapy for Depression with Antidepressant Medication

Adults (26-59)		
Priority Populations	Sub-populations	Interventions Selected
Underserved Cultural Populations	1. Veterans 2. LGBTQI 3. Individuals living in poverty or homeless 4. Ethnic minorities/monolingual (non-English-speaking) 5. Individuals with disabilities, medical/physical issues, and their caregivers	1. Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) 2. Group Cognitive Behavioral Therapy for Major Depression 3. Cognitive Behavioral Therapy for Depression with Antidepressant Medication
Older Adults (60+)		
Priority Populations	Sub-populations	Interventions Selected
Underserved Cultural Populations	1. Frail, chronically ill, and those living with chronic pain; disabled, especially those who have mobility issues and/or are vision-impaired 2. Latino; or non-English-speakers, including elders from the Cambodian community 3. LGBTQI 4. Elderly living alone and isolated; under the care of adult protective services 5. Veterans	1. Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) 2. Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) 3. Gatekeeper Case-Finding Model

Countywide Populations Ad Hoc PEI Steering Committee Recommendations - DRAFT

Juvenile Justice			
Priority Populations	Sub-populations	Interventions Selected	Comments
Children/Youth in Stressed Families	1. Domestic and child abuse/family violence in the home by parent, family, caregiver or youth (victim/witness/participant) involving physical, sexual, emotional, drug or alcohol use or neglect. 2. Substance and alcohol use (including co-occurring disorders), or mental illness of youth or parent that disrupts family or youth functioning.	1. Triple P Positive Parenting (35) 2. Adolescent Transitions Program (32) 3. Multisystemic Therapy (31)	
Children/Youth at Risk for School Failure	1. Children in stressed families – to include parents/caregivers that are struggling to get assistance for their child who may suspect the youth is using drugs, alcohol or may be committing crimes or seeking participation in a gang. Parents/caregivers who are experiencing any of the other items identified herein that is creating stress or dysfunction in the family unit. Parents/caregivers who feel powerless to improve family functioning or to navigate the justice/school/service systems to get help for their children/family and who believe that the youth are at risk drugs/alcohol, school failure, gang involvement, behavioral deterioration. 2. Poverty/deprivation issues – lack of health care or insurance, food, clothing, housing, medication and medical/mental health treatment.	1. Gang Resistance is Paramount (32) 2. Boys & Girls Club Project Learn (31)	
American Indian			
Priority Populations	Sub-populations	Interventions Selected	Comments
Children/Youth in Stressed Families	1. Children/families that lack information and access to resources, including culturally-relevant healthcare. 2. Children suffering from child abuse, families with domestic violence, and families impacted by substance use.	1. Parent-Child Interaction Therapy: Honoring Children, Making Relatives (55) 2. American Indian Life Skills (54) 3. Bicultural Competence Skills Approach (47)	

Trauma-exposed	1. Persons experiencing domestic violence and/or substance use. 2. Acculturating populations and/or populations experiencing a transitory living situation, including the homeless.	1. Trauma Focused Cognitive Behavioral Therapy: Honoring Children, Mending the Circle (46) 2. Parent-Child Interaction Therapy: Honoring Children, Making Relatives (42)	
Veterans			
Priority Populations	Sub-populations	Interventions Selected	Comments
Trauma-exposed	1. Individuals with combat-related post-traumatic stress disorder (PTSD). 2. Survivors of non-combat-related traumatic events (including plane/car/train crashes, physical/mental abuse, gang/community violence, bullying, substance abuse, and domestic violence).	1. Prolonged Exposure Therapy for Post Traumatic Stress Disorder (56)	
Individuals Experiencing Onset of Serious Psychiatric Illness	1. Individuals with a traumatic brain injury (TBI). 2. Survivors of military sexual trauma.	1. Prolonged Exposure Therapy for Post Traumatic Stress Disorder (48)	
Deaf/Hard-of-hearing			
Priority Populations	Sub-populations	Interventions Selected	Comments
Children/Youth in Stressed Families	1. Deaf-blind 2. Hard-of-hearing and/or non-signing	1. Nurse-Family Partnership (26) 2. Nurturing Parenting Program (26) 3. Parent-Child Interaction Therapy (20)	Will need significant adaptation.
Trauma-exposed	1. Deaf-blind 2. Hard-of-hearing and/or non-signing	1. Parent-Child Interaction Therapy (18) 2. Prolonged Exposure Therapy for Post Traumatic Stress Disorder (16) 3. Trauma Recovery and Empowerment (16)	Will need significant adaptation.

LGBTQ			
Priority Populations	Sub-populations	Interventions Selected	Comments
Children/Youth in Stressed Families	1. Trauma-exposed (including bullying; domestic violence; high risk of exposure to violence, such as, dating violence; etc.) 2. Substance use	1. Abuse Focused CBT for Child Physical Abuse (23) 2. Functional Family Therapy (22) 3. Adolescent Transitions Program (21) 4. Brief Strategic Family Therapy (21)	Will need significant adaptation.
Underserved Cultural Populations	1. Transition-age youth 2. Individuals who are 50 years and older.	1. Group Cognitive Behavioral Therapy for Major Depression (23) 2. Trauma Focused Cognitive Behavioral Therapy (21) 3. Cognitive Behavioral Therapy for Depression with Antidepressant Medication (17)	Will need significant adaptation.
Countywide Health Plans			
Priority Populations	Sub-populations	Interventions Selected	Comments
Children/Youth in Stressed Families	1. Trauma-exposed, including gang activity and exposure to domestic and/or community violence, etc. 2. Uninsured	1. Triple P – Positive Parenting Program (40) 2. Abuse Focused CBT for Child Physical Abuse (28)	
Underserved Cultural Populations	1. Uninsured 2. Individuals experiencing language/cultural competence limitations.	1. Cognitive Behavioral Intervention for Trauma in Schools (CBITS) (44) 2. Incredible Years Parenting Program (30) 3. Group Cognitive Behavioral Therapy for Major Depression (29)	

APPENDIX 15

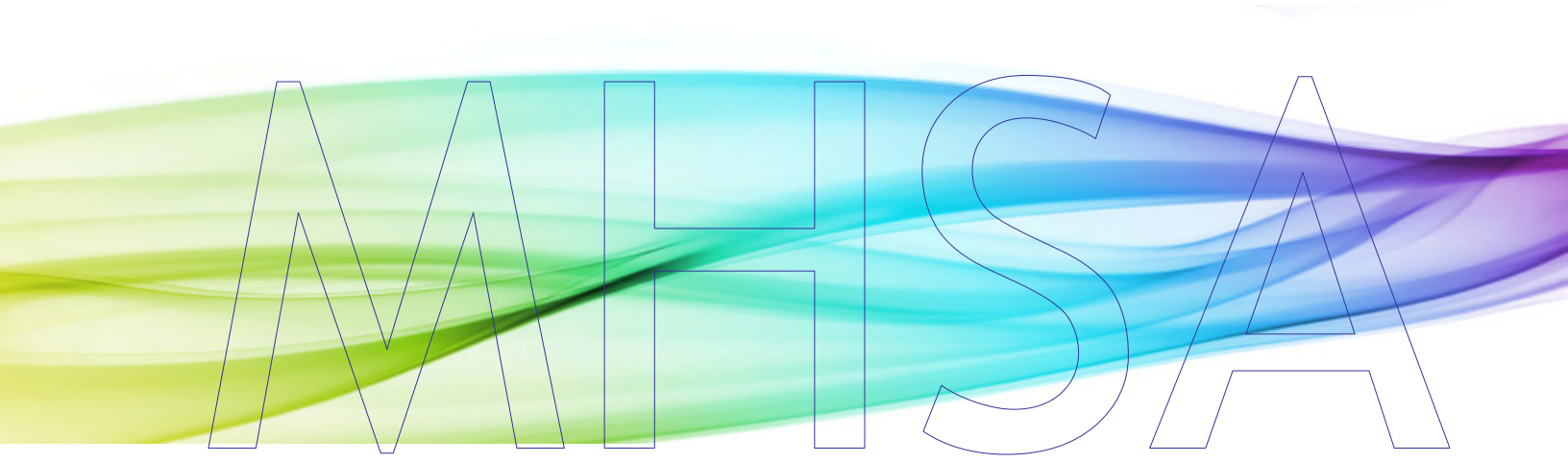
Evidence-based Practices and
Promising Practices
Resource Guide

March 2009
Version 1.0

Evidence-based Practices *and* Promising Practices

Resource Guide

for Los Angeles County



Prepared by
California Institute for Mental Health

Prevention and Early Intervention
County of Los Angeles Department of Mental Health

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Dennis Murata, MSW
Deputy Director
Program Support Bureau

Lisa Wicker, LCSW
District Chief
Program Support Bureau
MHSA PEI Administration Unit

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Bill Carter, LCSW
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County of Los Angeles - Department of Mental Health
Program Support Bureau, Prevention and Early Intervention Administration
Lisa Wicker, LCSW
Lillian Bando, JD, MSW
Mary Silvestrini, LCSW
Randy Ahn PhD, MLIS
Kristen Laws, MSW

Office of the Medical Director
William Arroyo, MD

Consultant
Yvette Townsend, LCSW

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Disclaimer
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Introduction

The County of Los Angeles Department of Mental Health, Prevention and Early Intervention *Evidence-based Practices and Promising Practices Resource Guide*, has been developed by the California Institute for Mental Health (CIMH)* to support Los Angeles County's planning efforts for the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA). This guide is designed to inform the deliberations of the Los Angeles County Service Area PEI Steering Committees, as well as the Los Angeles County Countywide Populations Steering Committee, as they identify priorities to be addressed in the county MHSA PEI Plan. The guide also contains information that will help in the development of the plan once the priorities have been identified.

How to Use the Guide

The guide is a tool crafted to support local stakeholder program recommendations. Many practices and programs listed in the Resource Guide may be used for prevention and/or early intervention purposes as defined in *the Mental Health Services Act: Proposed Guidelines, Prevention and Early Intervention Component of the Three-year Program and Expenditure Plan (California Department of Mental Health, (Sept 2007)*. Prevention practices listed in this guide are consistent with the Institute of Medicine (IOM) definitions of Universal and Selective Prevention and address conditions occurring prior to a diagnosis for a mental illness. Universal prevention practices target the general public or a whole population group that has not been identified on the basis of individual risk. Selective prevention practices target individuals or a subgroup whose risk of developing mental illness is significantly higher than average. Early Intervention practices must be short duration, relatively low intensity, and address a mental health condition early in its manifestation. The short duration and low intensity criteria for early intervention practices and programs do not apply when addressing individuals at first onset of a serious psychiatric illness with psychotic features.

During deliberations, steering committee members should consult this guide as questions arise regarding the suitability of a particular program or practice in relation to the needs of a specific population or geographic area. In this sense, the guide serves as reference material for the PEI Menu of Options (the service area/countywide lists of possible PEI programs that may be included in the PEI Plan). The guide contains a great deal of information and steering committee members are advised to carefully weigh the relative merits of each program or practice along with its relative limitations as they make their recommendations. In some cases, committee members will find the guide information incomplete or entirely lacking. Such omissions usually reflect the paucity of proven programs for a given population. In these cases, planning efforts will be

particularly challenging and steering committees' expertise will be needed to work through these situations as best as possible.

How the Guide was Developed

Information about practices and programs in the present guide was derived from reputable evidence-based practice web sites and each practice or program was rated in terms of its scientific support (see Appendix A for the rating scale). As a starting point, the *Mental Health Services Act Prevention and Early Intervention Resource Materials* developed by the California Department of Mental Health was used to initially screen practices and programs. Practices included in the California Department of Mental Health's *Resource Materials* that did not meet the needs of the Los Angeles County MHSA PEI planning process were excluded from the present guide. Additionally, practices and programs were added where national and Los Angeles County experts identified gaps in programs or practices that could address important Los Angeles County needs. Ultimately, decisions regarding the practices included in this document were guided by parameters and guidelines established by the California Department of Mental Health and the Mental Health Services Act Oversight and Accountability Commission.

What the Guide Contains

The current guide includes information about Evidence-based and Promising Practices designed to support local planning activities. Information regarding Community-defined Evidence practices has been solicited, collected, and is under analysis. This information will be incorporated as soon as it is available.

The *Resource Guide* is organized by the priority populations established by the MHSA PEI guidelines mentioned above. Practices are grouped by the following priority populations:

- Underserved Cultural Populations
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Children/Youth in Stressed Families
- Trauma-exposed
- Children/Youth at Risk for School Failure
- Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

Practice Analysis. Each practice or program reviewed in the Resource Guide includes two tables of information. The first table – Practice Analysis – describes the program and intended outcomes. Each Practice Analysis table includes the following information:

- Population – Identifies key characteristics of individuals for whom the practice/program was developed.
- Cultural Evidence – Specifies where research documents outcomes for diverse and under-represented ethnic populations. In addition, practices developed for specific ethnic populations and practices with ethnic-specific adaptations are identified in the Underserved Cultural Populations section of the Resource Guide.
- Risk and Protective Factors – Consistent with the field of Prevention, lists the risk factors addressed and protective factors supported. Risk factors are any circumstances that may increase the likelihood of an individual developing a mental illness. Conversely, protective factors are any circumstances that promote healthy behaviors and decrease the likelihood that an individual will develop a mental illness.
- Level of Evidence – Describes the strength of empirical evidence (see Appendix A).
- Outcomes – Lists the specific outcomes derived.
- Prevention – Identifies whether the program/practice qualifies as Universal and/or Selective prevention.
- Early Intervention – Describes early intervention function, if any.
- Description – A brief description of the characteristics, strategies, orientations, etc.

Implementation Guide. The second table for each practice/program – Implementation Guide – outlines characteristics associated with implementation that must be taken into consideration prior to selection. Practices and programs vary considerably in the extent to which there is a well-developed process and support for implementation. Given this variability, as well as the complicated nature of system and service planning, implementation information is not always readily available. When CIMH was unable to locate information on websites and in publications, or successfully contact practice/program developers, the guide notes that information was not available at the time of its publication. Each Implementation Guide table includes the following information:

- Staffing Requirements – Outlines qualifications necessary to staff the practice/program.
- Service Delivery Setting – Describes where services can be offered.
- Implementation Costs – Lists costs of training, technical assistance, materials and other associated services needed for start-up.
- Service Delivery Costs – It was beyond the scope of this project to research specific costs. This section describes the manner in which services are delivered to offer context to inform understanding of ongoing service costs.
- Standard Training Protocol – Describes training activities to initiate implementation.
- Proprietary – Indicates if an entity owns the rights to a practice or program, if no entity owns it, or if there is a mix of the two (for example, materials copyrighted but practice can be adopted freely).
- Sustainability – Includes strategies available to agencies to maintain the practice/program over time.
- Contact – Contact information for practice/program implementers.

The fields of prevention and early intervention research are vast and ever-changing. Therefore, the information addressed in this guide is also dynamic and this document must be considered in this context.

*** Conflict of Interest Statement**

Some practices and programs are not proprietary, and multiple trainers are available to support implementation. To provide information regarding implementation processes and costs for some of these practices, this guide utilizes information from CIMH implementation efforts, where CIMH plays an intermediary role. This information is offered to provide data for the decision-making process and is not intended to promote CIMH participation in future Los Angeles County MHSA PEI activities. Wherever CIMH is referenced as a contact for practice/program implementation, there are other agencies and individuals who can support future training and technical assistance. The exception is Functional Family Therapy (FFT), which is proprietary, and for which the FFT national training center works solely with CIMH to support implementation of FFT in California.

Summary Table

Program	Age	Prevention or Early Intervention	Level of Evidence	Cultural Evidence
Abuse Focused Cognitive Behavioral Therapy for Child Physical Abuse	**6-12**	☐ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Strong support for use with African-Americans.**
Across Ages	**6-17**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Strong support for use with African-Americans.**
Adolescent Transitions Program	**11-18**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Aggression Replacement Therapy	**12-17**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
All Stars	**11-14**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Moderate support for use with African-Americans.**
Al's Pals	**3-8**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐**Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Strong support for use with African-Americans.**
American Indian Life Skills	**13-17**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with Native Americans.**
Bicultural Competence Skills Approach	**12-18**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with Native Americans.**
Boys And Girls Club Project Learn	**7-18**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Strong support for use with African-**

Program	Age	Prevention or Early Intervention	Level of Evidence	Cultural Evidence
				Americans and some support for use with Latinos.
Breaking Cycles	**12-17**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Strong support for use with Latinos.**
Brief Strategic Family Therapy	**10-18**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Strong support for use with Latinos.**
Caring School Community	**5-12**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Moderate support for use with Latinos, moderate support for use with African-Americans.**
Celebrating Families	**4-17**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☐ **Promising** ☑ **Emerging**	**Designed for use with all ethnic groups. Moderate support for use with Latinas.**
Child-Parent Psychotherapy	**0-7**	☐ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Strong support for use with Latinos.**
Clinician-Based Cognitive Psychoeducational Intervention for Families	**Parents**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Creating Lasting Family Connections	**9-17**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	**10-14**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with ethnic minorities and immigrants. Support for use with Latinos, African-Americans, and Native Americans.**
Cognitive Behavioral Therapy (CBT) for	**14-17**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☑ **Supported**	**Designed for use with all ethnic groups. Modified**

Program	Age	Prevention or Early Intervention	Level of Evidence	Cultural Evidence
Anxiety			☐ **Promising** ☐ **Emerging**	**for use with African-Americans.**
Cognitive Behavioral Therapy (CBT) for Depression (with antidepressant medication)	**18-55**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Modified for use with Latinas and African-Americans.**
Cognitive Behavioral Therapy for Late Life Depression	**55+**	☐ **Prevention** ☑ **Early Intervention**	☑ **Well-supported** ☐ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Random clinical trials have demonstrated effectiveness among Latinos, Chinese, and African-Americans.**
Coping Power Program	**10-13**	☑ **Prevention** ☑ **Early Intervention**	☑ **Well-supported** ☐ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Strong support for use with African-Americans.**
Coping with Depression	**45+**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Developed for use with Native Americans.**
Culturally Adapted Parent Management Training for Latinos	**11-14**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Adapted for use with Latinos.**
Culturally-Modified Trauma-Focused Treatment (CM-TFT)	**4-18**	☑ **Prevention** ☑ **Early Intervention**	☑ **Well-supported for TFCBT, adaptations being evaluated** ☐ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Adapted for use with Latinos**
Early Detection and Intervention for the Prevention of Psychosis (EDIPP)	**12-25**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Early Psychosis Prevention and Intervention Centre (EPPIC)	**15-25**	☐ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☐ **Promising** ☑ **Emerging**	**Designed for use with all ethnic groups.**

Program	Age	Prevention or Early Intervention	Level of Evidence	Cultural Evidence
Early Risers Skills for Success	**6-12**	☐ Prevention ☑ Early Intervention	☑ Well-supported ☐ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with African-Americans**
Effective Black Parenting	**0-18**	☑ Prevention ☐ Early Intervention	☐ Well-supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with African-Americans.**
Families and Schools Together	**4-12**	☑ Prevention ☐ Early Intervention	☑ Well-supported ☐ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with African-Americans, strong support for use with Native Americans.**
Family Connections	**Families**	☐ Prevention ☑ Early Intervention	☐ Well-supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with African-Americans.**
Family Coping Skills Program (FCSP)	**Adults**	☑ Prevention ☐ Early Intervention	☐ Well-supported ☐ Supported ☐ Promising ☑ Emerging	**Developed for use with Latinas.**
Family Effectiveness Training	**6-12**	☑ Prevention ☑ Early Intervention	☐ Well-supported ☑ Supported ☐ Promising ☐ Emerging	**Developed for use with Latinos.**
Family Health Promotion	**3-8**	☑ Prevention ☐ Early Intervention	☐ Well-supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with Latinos.**
Focus on Families	**3-14**	☐ Prevention ☑ Early Intervention	☐ Well-supported ☑ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Some support for use with African-Americans.**
Functional Family Therapy	**11-18**	☐ Prevention ☑ Early Intervention	☑ Well-supported ☐ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups.**
Gang Resistance is Paramount	**7-16**	☑ Prevention ☐ Early Intervention	☐ Well-supported ☐ Supported	**Designed for use with all ethnic groups. Strong**

Program	Age	Prevention or Early Intervention	Level of Evidence	Cultural Evidence
			☐ Promising ☑ Emerging	support for use with Latinos.
Gatekeeper Case-Finding Model	55+	☑ Prevention ☐ Early Intervention	☐ Well-supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with all ethnic groups.
Group Cognitive Behavioral Therapy (CBT) of Major Depression	Adults	☑ Prevention ☑ Early Intervention	☑ Well-supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Modified for use with Latinos and African-Americans.
Healthy Steps for Young Children	0-3	☑ Prevention ☐ Early Intervention	☐ Well-supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
Homebuilders	0-18	☐ Prevention ☑ Early Intervention	☐ Well-supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)	60+	☐ Prevention ☑ Early Intervention	☑ Well-supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
Incredible Years	3-12	☑ Prevention ☑ Early Intervention	☑ Well-supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Some support for use with African-Americans, Asians, and Latinos.
Incredible Years Parenting Program Used with Korean American Mothers	3-8	☑ Prevention ☑ Early Intervention	☐ Well-supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic populations. Adapted for use with Koreans.
"Integrated Treatment" as Evaluated by the OPUS trial	18-45	☐ Prevention ☑ Early Intervention	☐ Well-supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with all ethnic groups.
Interpersonal Psychotherapy (IPT) for Depression	12-18	☑ Prevention ☑ Early Intervention	☑ Well-supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Modified for use with Latinos.
Live Well, Live Long,	60+	☑ Prevention	☑ Well-supported	Designed for use

Program	Age	Prevention or Early Intervention	Level of Evidence	Cultural Evidence
Steps to Mental Wellness		☑ Early Intervention	☐ Supported ☐ Promising ☐ Emerging	with all ethnic groups.
Making Parenting a Pleasure	**0-8**	☑ Prevention ☐ Early Intervention	☐ Well-supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups.**
Multidimensional Family Therapy	**11-18**	☑ Prevention ☑ Early Intervention	☐ Well-supported ☑ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with African-Americans.**
Multidimensional Treatment Foster Care	**11-18**	☐ Prevention ☑ Early Intervention	☑ Well-supported ☐ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups.**
Multisystemic Therapy	**11-18**	☐ Prevention ☑ Early Intervention	☑ Well-supported ☐ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with African-Americans.**
Nurse Family Partnership	**Pregnancy-2**	☑ Prevention ☑ Early Intervention	☑ Well-supported ☐ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with African-Americans.**
Nurturing Parenting Program	**5-18**	☑ Prevention ☑ Early Intervention	☐ Well-supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with Latinos; some support for use with Native Americans.**
Olweus Bullying Prevention Program	**6-14**	☑ Prevention ☐ Early Intervention	☐ Well-supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups.**
Parent-Child Interaction Therapy (PCIT): "*Guiando a Niños Activos* (GANA) Program"	**3-6**	☑ Prevention ☑ Early Intervention	☐ Well-supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups. Adapted for use with Latinos.**
Parent-Child Interaction Therapy (PCIT): "Honoring	**3-7**	☑ Prevention ☑ Early	☑ Well-supported for PCIT-adaptations not yet	**Designed for use with all ethnic groups. Adapted**

Program	Age	Prevention or Early Intervention	Level of Evidence	Cultural Evidence
Children, Making Relatives"		**Intervention**	**evaluated** **☐ Supported** **☐ Promising** **☐ Emerging**	**for use with Native Americans.**
Parenting Wisely	**3-18**	**☑ Prevention** **☑ Early Intervention**	**☐ Well-supported** **☐ Supported** **☑ Promising** **☐ Emerging**	**Designed for use with all ethnic groups.**
Peacemakers	**10-14**	**☑ Prevention** **☐ Early Intervention**	**☐ Well-supported** **☐ Supported** **☑ Promising** **☐ Emerging**	**Designed for use with all ethnic groups. Strong support for use with African-Americans.**
Personal Assessment and Crisis Evaluation (PACE)	**12-25**	**☑ Prevention** **☑ Early Intervention**	**☐ Well-supported** **☐ Supported** **☑ Promising** **☐ Emerging**	**Designed for use with all ethnic groups.**
Prevention of Suicide in Primary Care Elderly (PROSPECT)	**60+**	**☑ Prevention** **☑ Early Intervention**	**☑ Well-supported** **☐ Supported** **☐ Promising** **☐ Emerging**	**Designed for use with all ethnic groups.**
Program of All-Inclusive Care for the Elderly (PACE)	**60+**	**☑ Prevention** **☐ Early Intervention**	**☐ Well-supported** **☐ Supported** **☑ Promising** **☐ Emerging**	**Designed for use with all ethnic groups.**
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	**60+**	**☑ Prevention** **☑ Early Intervention**	**☐ Well-supported** **☑ Supported** **☐ Promising** **☐ Emerging**	**Designed for use with all ethnic groups. Moderate support for use with African-Americans.**
Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders	**18-65+**	**☐ Prevention** **☑ Early Intervention**	**☑ Well-supported** **☐ Supported** **☐ Promising** **☐ Emerging**	**Designed for use with all ethnic groups. Moderate support for use with African-Americans.**
Promoting Alternative Thinking Strategies	**3-12**	**☑ Prevention** **☐ Early Intervention**	**☑ Well-supported** **☐ Supported** **☐ Promising** **☐ Emerging**	**Designed for use with all ethnic groups. Moderate support for use with African-Americans**
Psychogeriatric Assessment and Treatment in City Housing (PATCH)	**60+**	**☐ Prevention** **☑ Early Intervention**	**☐ Well-supported** **☑ Supported** **☐ Promising** **☐ Emerging**	**Designed for use with all ethnic groups.**

Program	Age	Prevention or Early Intervention	Level of Evidence	Cultural Evidence
SafeCare	**0-5**	☐ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Safe Dates	**13-15**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Second Step	**6-12**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Seeking Safety	**15-55**	☐ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Moderate support for use with African-Americans.**
Social Decision-Making and Problem-Solving	**5-13**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Strengthening Bonds of Chicano Youth and Families	**9-16**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with Latinos.**
Strengthening Families	**3-16**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Moderate support for use with African-Americans; some support for use with Latinos.**
SITCAP-ART **Structured Sensory Intervention for Traumatized Children, Adolescents and Parents**	**12-17**	☐ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Supporting Adolescents with Guidance and Employment	**12-16**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☐ **Promising** ☑ **Emerging**	**Developed for use with African-Americans. Strong support for use with African-Americans.**

Program	Age	Prevention or Early Intervention	Level of Evidence	Cultural Evidence
The Mothers and Babies Course "Mamás y Bebés"	**16-35 – Mothers with babies 0-2**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with Latinas.**
Trauma Focused Cognitive Behavioral Therapy	**3-18**	☐ **Prevention** ☑ **Early Intervention**	☑ **Well-supported** ☐ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Trauma-Focused CBT (TF-CBT): "Honoring Children, Mending the Circle"	**3-18**	☑ **Prevention** ☐ **Early Intervention**	☑ **Well-supported-TFCBT-adaptations not yet evaluated** ☐ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Adapted for use with Native Americans.**
Triple P – Positive Parenting Program	**0-18**	☑ **Prevention** ☑ **Early Intervention**	☑ **Well-supported** ☐ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**

Programs for Children/Youth at Risk for School Failure

Program	Across Ages – NOT a Stand-alone Program	
Population	School age children and youth – ages 6-17 at risk for substance use and school failure	
Cultural Evidence	52% of study participants were African-American	
Risk and Protective Factors	Risk: • Favorable attitudes toward drug use • Poor family bonding • Dropping out • Low academic achievement	Protective: • High expectations • Good relationship with parents • Strong school motivation
Level of Evidence	Supported	
Outcomes	1. Improved school attendance 2. Improved drug refusal skills	
Prevention: Universal/Selective	Selective	
Early Intervention		
Description	Across Ages is a research-based mentoring initiative designed to increase the resiliency and protective factors of at-risk youths through a comprehensive intergenerational approach. The basic concept of the program is to pair older adult volunteers (55 and older) with students (10-13 years old/transitioning to middle school) to create a special bonding relationship. The project also uses community service activities, provides a classroom-based life-skills curriculum, and offers parent-training workshops. Older mentors – by acting as advocates, challengers, nurturers, role models, and friends – help children develop awareness, self-confidence, and skills they need to resist drugs and overcome overwhelming obstacles. The overall goal of the program is to increase protective factors for high-risk students to prevent, reduce, or delay the use of alcohol, tobacco, and other drugs and the problems associated with substance use. Four intervention components: (1) a minimum of 2 hours per week of mentoring by older adults who are recruited from the community, matched with youth, and trained to serve as mentors; (2) 1-2 hours of weekly community service by youth, including regular visits to frail elders in nursing homes; (3) monthly weekend social and recreational activities for youth, their families, and mentors; and (4) 26 45-minute social competence training lessons taught weekly in the classroom using the Social Problem-Solving Module of the Social Competence Promotion Program for Young Adolescents developed by Roger Weissberg and colleagues.	

Program	Across Ages
Staffing Requirements	• Teachers/volunteers (over 55) • 1-full-time project director • 1 half-time project coordinator • 1 outreach coordinator • Support staff (10 hrs per week) • Project director –Masters level • Project coordinator - B.A. or equivalent • Outreach coordinator- community experience
Service Delivery Setting	• Classroom-based • Community-based
Implementation Costs	• Seminar Workshop on-site—basic 2 days; refresher 1-2 days TA cost estimate $1001—$5000 • 2 day package $1,000 per day plus expenses • On-site TA $500 per day plus expenses • Telephone TA $30/hr • Training manual $75.00 • Handbook for parents $25.00 • Mentor handbook $25.00 • Evaluation protocol $25.00 • Video $65.00 • Criminal/background checks
Service Delivery Costs	• 1 staff member for 30-40 mentors/60 youth • 15-20 mentors for 30 youth • 15-20 youth for 10-15 nursing home residents • 12 months in program; minimum 2 hrs per week • Social Competence Training has 26 lessons; 45 minutes each • Monthly family activities
Standard Training Protocol	• Yes
Proprietary	• Yes
Sustainability	• No information available at this time
Contact	Andrea Taylor, Ph.D. Center for Intergenerational Learning 1601 North Broad Street, USB 206 Temple University Philadelphia, PA 19122 215-204-6733 Fax: 215-204-3195 ataylor@temple.edu www.temple.edu/across_ages

Program	All Stars
Population	11-14 year-old youth in middle school and/or junior high
Cultural Evidence	42% of study participants were African-American
Risk and Protective Factors	**Risk:** • Poor refusal skills • Favorable attitudes towards drug use **Protective:** • Social competencies and problem solving skills
Level of Evidence	Promising
Outcomes	1. Positive change in normative beliefs 2. Increase in school commitment 3. Improvement in impulsive decision-making
Prevention: Universal/Selective	Universal/Selective
Early Intervention	
Description	All Stars is a multiyear school-based program for middle school students (11 to 14 years old) designed to prevent and delay the onset of high-risk behaviors such as drug use, violence, and premature sexual activity. The program focuses on five topics important to preventing high-risk behaviors: (1) developing positive ideals that do not fit with high-risk behavior; (2) creating a belief in conventional norms; (3) building strong personal commitments; (4) bonding with school, prosocial institutions, and family; and (5) increasing positive parental attentiveness. The All Stars curriculum includes highly interactive group activities, games and art projects, small group discussions, one-on-one sessions, a parent component, and a celebration ceremony. The All Stars Core program consists of thirteen 45-minute class sessions delivered on a weekly basis by teachers, prevention specialists, or social workers. The All Stars Booster program is designed to be delivered 1 year after the core program and includes nine 45-minute sessions reinforcing lessons learned in the previous year. Multiple program packages are available to support implementation by either regular teachers or prevention specialists.

Program	All Stars
Staffing Requirements	• "Program specialist' or classroom teacher • Training is provided in English or Spanish
Service Delivery Setting	• In classroom • Small group sessions outside classroom • Community-based settings • One on one sessions (not defined where)
Implementation Costs	• A 2-day on-site training for up to 20 participants • Costs $3,000 plus travel expenses • Teacher manuals cost $125 per attendee and must be purchased at least 2 weeks in advance • Off-site trainings are available for $250 per attendee plus their travel expenses • Online training is conducted in four 2-hour modules for $2,400 plus manual costs but is limited to 10 participants.
Service Delivery Costs	• Incorporated into classroom protocol • Ongoing technical assistance provided through email contact
Standard Training Protocol	• Two day training with online follow up TA
Proprietary	• Yes
Sustainability	• Ongoing TA available and manuals are frequently revised.
Contact	Kathleen Nelson-Simley Tanglewood Research 420 Gallimore Dairy Road, Suite A Greensboro, NC 27409 800-822-7148 kathleen@ tanglewood.net

Program	Al's Pals	
Population	3-8 year-olds in preschool and early elementary (K-3)	
Cultural Evidence	Largest study carried out in Head Start – 83% of the children were African-American	
Risk and Protective Factors	Risk: • Early onset of aggression	Protective: • Social competence and problem solving skills • Effective parenting • Presence and involvement of caring and supportive adults
Level of Evidence	Supported	
Outcomes	1. Improved social competence 2. Decreases in aggression and anti-social behaviors	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	Al's Pals: Kids Making Healthy Choices is a school-based prevention program that seeks to develop social-emotional skills such as self-control, problem-solving, and healthy decision making in children ages 3-8 in preschool, kindergarten, and first grade. The program fosters both the personal traits of resilience and the nurturing environments children need to overcome difficulties and fully develop their talents and capabilities. Through fun lessons, engaging puppets, original music and materials, and appropriate teaching approaches, the Al's Pals curriculum helps young children regulate their own feelings and behavior; creates and maintains a classroom environment of caring, cooperation, respect, and responsibility; teaches conflict resolution and peaceful problem-solving; promotes appreciation of differences and positive social relationships; prevents and addresses bullying behavior; conveys clear messages about the harms of alcohol, tobacco, and other drugs; and builds children's abilities to make healthy choices and cope with life's difficulties. The program consists of a year-long, 46-session interactive curriculum delivered by trained classroom teachers who use Al's Pals teaching approaches to infuse the concepts into daily interactions with the children. Ongoing communication with parents is also part of Al's Pals. Teachers regularly send parents letters to update them about the skills the children are learning, suggest home activities to reinforce these concepts, and inform parents about their child's progress.	

Program	Al's Pals
Staffing Requirements	• Classroom teachers • Mental health clinicians (SW, Ph.D)
Service Delivery Setting	• Preschool, early elementary schools • After school programs • Childcare centers • After school programs can be individually tailored to other environments (e.g. residential)
Implementation Costs	• On-site training for 24 staff is $6,500 • For 30 staff is $8,000 (both plus trainer travel costs) presentation "kit." This is a 2-day session • Also newly instituted is an online course comprising of 7 sessions at 2 hours each. Limited to 12-15 attendees costing $325 each • Booster training and TA available • Annual update of materials provided
Service Delivery Costs	• Designed to be integrated into classroom instruction (MH providers encouraged to participate but not required).
Standard Training Protocol	• Training sessions required for teachers of a manualized curriculum.
Proprietary	• Yes
Sustainability	• Fidelity assessment and evaluation available • Annual 3 hour refresher course and a 3 hour advanced training available • Annual follow up calls from a TA staff with a checklist for self measurement and a reminder list sent to prompt necessary tasks • Ongoing relationship with local coordinator sought
Contact	Susan Geller Wingspan, LLC. 4196-A Innslake Dr. Glen AllenM, VA 23060 804-967-9002 contact@wingspanworks.com www.wingspanworks.com

Program	Boys and Girls Club Project Learn
Population	7-18 year-old youth, living in poverty and at risk for school drop out
Cultural Evidence	63% of study participants were African-American and 19% were Latino
Risk and Protective Factors	**Risk:** • Dropping out of school • Low academic achievement • Negative attitude toward school **Protective:** • Social competencies and problem solving • Involvement in organized religious activities • Effective parenting
Level of Evidence	Promising
Outcomes	1. Improved school attendance 2. Improved enjoyment with academic subjects 3. Improved scores in reading, spelling, history and social science
Prevention: Universal/Selective	Selective
Early Intervention	
Description	This program involves enhancing the educational performance of economically disadvantaged adolescents who live in public housing. Program delivery teams consist of local BGCA staff, representatives from the youths' schools, the housing authority, resident councils of the local public housing developments, and parent leaders. Each week the program engages youth in structured activities designed to improve educational enhancement: • 1 to 2 hours of creative writing • 4 to 5 hours of leisure reading • 5 to 6 hours completing school homework • 4 to 5 hours of discussion with knowledgeable adults • 2 to 3 hours helping other youths with school homework, projects, and skill acquisition • 4 to 5 hours of board games and other recreational pursuits that draw on cognitive skills and talents transferable to school lessons. Incentives are given such as school supplies, field trips, additional computer time, and special privileges with their local Boys & Girls Club. Parents are encouraged to become involved in the program by helping their child with homework; reading, discussing current events, and playing board games with their child; and taking part in other educational skill acquisition.

Program	Boys and Girls Club Project Learn
Staffing Requirements	• Local BGCP Staff/Parent Leaders/School Representatives/Housing Authority
Service Delivery Setting	• Boys and girls club site
Implementation Costs	• Information not available at this time
Service Delivery Costs	• 4/5 hours weekly discussions • 4/5 hours weekly leisure reading • One hour weekly writing activities • 5/6 hours per week homework help • 2/3 hours community service • 4/5 hours games using cognitive skills
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Boys/Girls Club of America 404-487-5700 Fax 404-487-5789 1239 Peachtree Street, NW Atlanta, GA 30309 jatkinson@bgca.org info@bcga/org

Program	Caring School Community
Population	Elementary school children 5-12 years old
Cultural Evidence	2 of 4 studies report outcomes by ethnicity. 25% - Latino in one study 37% African-American in a second study
Risk and Protective Factors	Risk: • Mental health problem • Low academic achievement • Negative attitude toward school • Poorly organized and functioning school Protective: • Social competencies and problem-solving skills • Effective parenting • High teacher expectations
Level of Evidence	Supported
Outcomes	1. Decreased alcohol and marijuana use 2. Improved academic achievement 3. Increased concern for others 4. Decreased discipline referrals
Prevention: Universal/Selective	Universal
Early Intervention	
Description	Caring School Community (CSC), formerly called the Child Development Project, is a universal elementary school (K-6) improvement program aimed at promoting positive youth development. The program is designed to create a caring school environment characterized by kind and supportive relationships and collaboration among students, staff, and parents. The CSC model is consistent with research-based practices for increasing student achievement as well as the theoretical and empirical literature supporting the benefits of a caring classroom community in meeting students' needs for emotional and physical safety, supportive relationships, autonomy, and sense of competence. By creating a caring school community, the program seeks to promote prosocial values, increase academic motivation and achievement, and prevent drug use, violence, and delinquency. CSC has four components designed to be implemented over the course of the school year: (1) Class Meeting Lessons, which provide teachers and students with a forum to get to know one another and make decisions that affect classroom climate; (2) Cross-Age Buddies, which help build caring cross-age relationships; (3) Homeside Activities, which foster communication at home and link school learning with home experiences and perspectives; and (4) Schoolwide Community-Building Activities, which link students, parents, teachers, and other adults in the school. School-wide implementation of CSC is recommended because the program builds connections beyond the classroom.

Program	Caring School Community
Staffing Requirements	• Teachers, principals and coaches
Service Delivery Setting	• Schools
Implementation Costs	• Approximately $2000 in curriculum materials. Training costs not available.
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	For more information contact: Ginger Cook, Ph.D. CSC Project Manager Developmental Studies Center 800.666.7270, ext. 263 ginger_cook@devstu.org

Program	Early Risers Skills for Success
Population	6-12 year-old elementary school students who are at high risk for substance abuse and behavior problems leading to early school failure
Cultural Evidence	86% of the research participants were African-American
Risk and Protective Factors	**Risk:** • Early onset of aggression • Life stressors • Poor refusal skills • Presence of a mental health problem • Family management problems • Low academic achievement • Poorly organized and functioning schools • Peer rejection • Association with aggressive peers **Protective:** • Self-efficacy • Involvement in organized religious activities • Effective parenting • Good relationships with parents • High expectations for students • Presence and involvement of caring and supportive adults
Level of Evidence	Well-supported
Outcomes	1. Improved academic achievement 2. Improvements in self-regulation for severely aggressive children 3. Improvement in parental distress for parents of severely aggressive children 4. Improvement in the use of effective parental discipline
Prevention: Universal/Selective	
Early Intervention	Early intervention – elementary school children are referred due to significant behavior problems
Description	Early Risers is based on the premise that early, comprehensive, and sustained intervention is necessary to target multiple risk and protective factors. The program uses integrated child-, school-, and family-focused interventions to move high-risk children onto a more adaptive developmental pathway. A "family advocate" (someone with a bachelor's degree and experience working with children/parents) coordinates the child- and family-focused components. The child-focused component has three parts: (1) Summer Day Camp, offered 4 days per week for 6 weeks and consisting of social-emotional skills education and training, reading enrichment, and creative arts experiences supported by a behavioral management protocol; (2) School Year Friendship Groups, offered during or after school and providing advancement and maintenance of skills learned over the summer; and (3) School Support, which occurs throughout each school year and is intended to assist and modify academic instruction, as well as address children's behavior while in school, through case management, consultation, and mentoring activities performed by the family advocate at school. The family-focused component has two parts: (1) Family Nights with Parent Education, where children and parents come to a center or school 5 times per year during the evening, with children participating in fun activities while their parents meet in small groups for parenting-focused education and skills training; and (2) Family Support, which is the implementation of an individually designed case plan for each family to address their specific needs, strengths, and maladaptive patterns through goal setting, brief interventions, referral, continuous monitoring, and, if indicated, more intensive and tailored parent skills training.

Program	Early Risers Skills for Success
Staffing Requirements	• A "family advocate" (someone with a bachelor's degree and 3-5 years experience working with children/parents) coordinates the child- and family-focused components • One family advocate should be hired for every 25 children/families to be served
Service Delivery Setting	• Center or school • Home • Rural and/or frontier • School • Suburban • Urban
Implementation Costs	• $7,000 training fee includes 2 days of training; travel costs for the trainer; shipping costs for materials; 5 manuals, each with a CD that contains all Early Risers forms (additional manuals may be purchased for $75 each); the rights to use, duplicate, or modify the forms provided in the materials; documentation of training completion (a certificate or letter). • $629 for the PATHS Basic Kit (grades 1-6) or $719 for the PATHS Basic Kit plus the PATHS Turtle Unit (for kindergartners) • $800-$1,200 for school supplies • Staff salaries $25,000-$30,000 per year plus fringe benefits • Total annual cost is approximately $1,500-$2,500 per student
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• On-site 2-day training
Proprietary	• The rights to use, duplicate, or modify the forms provided in the materials are bought
Sustainability	• Ongoing technical assistance after the training, sites are strongly encouraged to purchase the Promoting Alternative Thinking Strategies (PATHS) curriculum, which is used in the program's social skills component and is referenced during the training
Contact	Gerald J. August, Ph.D. Division of Child and Adolescent Psychiatry 2450 Riverside Avenue, F256/2B West Minneapolis, MN 55454–1495 Phone: (612) 273-9711 Fax: (612) 273-9779 E-mail: augus001@tc.umn.edu

Program	Families and Schools Together	
Population	School-aged children 4-12 at risk for academic failure	
Cultural Evidence	Four random assignment studies have been conducted. In one 100% of the participants were African-American and in another 100% of the children were Native American	
Risk and Protective Factors	Risk: • Early onset of aggression • Child maltreatment • Family conflict • Low school achievement • Low community attachment	Protective: • Social competencies and problem solving skills • Effective parenting • Teacher high expectation of students
Level of Evidence	Well-supported	
Outcomes	1. Improved social skills 2. Decreased aggression 3. Improved academic performance 4. Increased parent involvement in school	
Prevention: Universal/Selective	Selective	
Early Intervention		
Description	This is a multi-family group intervention program designed to build protective factors for children (ages 4-12), to empower parents to be the primary prevention agents for their own children, and to build supportive parent-to-parent groups. The overall goal of the FAST program is to intervene early to help at-risk youth succeed in the community, at home, and in school and thus avoid problems such as adolescent delinquency, violence, addiction, and dropping out of school. Another goal of the FAST program is to produce changes at the levels of individual child functioning and the local social network. The program begins when a teacher or other school professional identifies a child with problem behaviors who is at risk for serious future academic and social problems. Trained recruiters then meet with the family at home to discuss the concerns and invite them into the program. The family then gathers with 8-12 other families for eight weekly meetings, usually held at school. The meetings last 2 ½ hours and include: planned opening and closing routines, a family meal, structured family activities and communications, parent mutual-support time, and parent-child play therapy. A trained team consisting of a parent, a school professional, a clinical social worker, and a substance abuse counselor facilitates the meetings. The team is also required to represent the culture of the families participating in the program. After graduation at 8 weeks, the families then continue to participate in monthly follow-up meetings, run by the families, for 2 years.	

Program	Families and Schools Together (FAST)
Staffing Requirements	• Parent • School professional • Clinical social worker • Substance abuse counselor
Service Delivery Setting	• Usually in a school setting
Implementation Costs	• Approximately $21,000 per cycle which includes a 2 day orientation, 3 on-site coaching visits in phase II and a one-day on-site training in phase III after the evaluation has been completed. This is a total cost including manuals and other materials. • Evaluation and monthly TA supports included in cost • Approximate 153 hours of instruction included during each cycle
Service Delivery Costs	• Eight to 12 weekly sessions with families
Standard Training Protocol	• Manualized with fidelity measures
Proprietary	• Yes
Sustainability	• Program evaluation is built into cost of implementation
Contact	Lynn McDonald Wisconsin Center for Education Research 1025 W. Johnson St. University of Wisconsin—Madison Madison, WI 53706 608-253-6338 mrmcdona@facstaff.wisc.edu Technical Assistance Provider Fast National Training and Evaluation Center 2801 International Lane, Suite 105 Madison, WI 53704 888-629-2481

Program	Incredible Years
Population	3-12 year-old children at risk for school failure and juvenile justice involvement
Cultural Evidence	One study comparing outcomes among diverse groups: 22% Asian (Vietnamese and Chinese) 19% Latino 10% African-American 4% Native American
Risk and Protective Factors	**Risk:** • Mental health problems • Early onset of aggression • Maternal depression • Family management problems • Parental conflict • Negative attitude toward school **Protective:** • Effective parenting • Opportunities for prosocial school involvement • Involvement with positive peer group activities
Level of Evidence	Well-supported
Outcomes	1. Increase in positive and nurturing parenting 2. Decrease in harsh discipline 3. Reduction in child behavior problems at home and in school 4. Improvements in children's social competence and school readiness skills 5. Improved parent-child bonding 6. Improved parent-teacher and school involvement
Prevention: Universal/Selective	Selective
Early Intervention	Early intervention for children referred by teachers and pediatricians
Description	Incredible Years is a set of comprehensive, multifaceted, and developmentally based curricula targeting 2-12 year-old children and their parents and teachers. The parent, child, and teacher training interventions that compose Incredible Years are guided by developmental theory on the role of multiple interacting risk and protective factors in the development of conduct problems. The three program components are designed to work jointly to promote emotional and social competence and to prevent, reduce, and treat behavioral and emotional problems in young children. The parent training intervention focuses on strengthening parenting competencies and fostering parents' involvement in children's school experiences to promote children's academic and social skills and reduce delinquent behaviors. The Dinosaur child training curriculum aims to strengthen children's social and emotional competencies, such as understanding and communicating feelings, using effective problem-solving strategies, managing anger, practicing friendship and conventional skills, and behaving appropriately in the classroom. The teacher training intervention focuses on strengthening teachers' classroom management strategies, promoting children's prosocial behavior and school readiness, and reducing children's classroom aggression and noncooperation with peers and teachers. The intervention also helps teachers work with parents to support their school involvement and promote consistency between home and school. In all three training interventions, trained facilitators use videotaped scenes to structure the content and stimulate group discussions and problem solving.

Program	Incredible Years
Staffing Requirements	• Teachers • Parents
Service Delivery Setting	• Home • School • Community
Implementation Costs	• One-time start-up costs include $400-$500 per leader for leader training and $1,500 per series for program materials (the cost for the child program is slightly higher due to the price of puppets) • Ongoing costs include $500 annually for each leader to receive consultation, $476 for each parent in parent groups, $775 for each child in child treatment groups, $15 for each child receiving the Dinosaur curriculum in school, and $30 for each teacher receiving the teacher training.
Service Delivery Costs	• For detailed cost information associated with each program component see the Incredible Year web site
Standard Training Protocol	• Three day on-site training for parenting and 2 day on-site for the child curriculum. Certification takes place after group leaders complete two group cycles and have video tapes reviewed by the developer.
Proprietary	• Mix of public and proprietary
Sustainability	• Mentor who functions as a trainer in the local context.
Contact	Lisa St. George Administrative Director Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: lisastgeorge@comcast.net Carolyn Webster-Stratton, Ph.D. Professor and Director of Parenting Clinic, University of Washington Developer and Director, Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: cwebsterstratton@comcast.net www.incredibleyears.com

Program	Olweus Bullying Prevention Program	
Population	Elementary and junior high school students ages 6-14	
Cultural Evidence	No information available	
Risk and Protective Factors	Risk: • Early onset of aggression • Exposure to violence/victimization • Poorly organized and functioning schools • Negative attitude towards school • Truancy/frequent absences • Negative attitude toward school • Peer rejection • Association with antisocial peers	Protective: • High expectations • Perception of social support from peers and adults • Social competencies and problem solving skills • Good relationships with peers • Involvement with positive peer group activities • High teacher expectations • Rewards for prosocial school involvement
Level of Evidence	Promising	
Outcomes	1. Reduction in reports of bullying and victimization 2. Reduction in student reports of general antisocial behavior – fighting, truancy and vandalism 3. Significant improvement in social climate of the class – less disruption, more order and discipline	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	This is a universal intervention developed to promote the reduction and prevention of bullying behavior and victimization problems for children ages 6-14 years. The program is based on an ecological model, intervening with a child's environment on many levels: the individual children who are bullying and being bullied, the families, the teachers and students with the classroom, the school as a whole, and the community. The main arena for the program is the school, and school staff have the primary responsibility for introducing and implementing the program. Schools are provided ongoing support by project staff.	

Program	Olweus Bullying Prevention Program
Staffing Requirements	• School counselors • Part or full-time coordinator
Service Delivery Setting	• Classroom • School setting
Implementation Costs	• Materials costs - $400 • Training costs - $3000 for a two day on-site training – if two school site are trained together the costs are $4500 (two trainers) • Travel costs for trainer(s) • $1500 for 12 mos. of consultation calls per school site. • Peacemakers - Materials costs - $101.40 for a teacher manual and $7.20 per student workbook
Service Delivery Costs	• 25-52 weeks • Weekly 20-40 minute classroom meetings
Standard Training Protocol	• Yes • $1001 to $5000 • Teachers handbook • Olweus core program against bullying at school • Victim questionnaire • Computer software • Bullying video • Supplemental lesson plans----$300 • Training groups of 12, one certified trainer per school, training materials $1000
Proprietary	• Yes
Sustainability	Information not available at this time
Contact	Marlene Snyder, Ph.D. Institute of Family and Neighborhood Life 158 Poole Agricultural Center Clemson University Clemson, SC 29634 Susan Limber, Ph.D. Institute of Family and Neighborhood Life Clemson University 158 Poole Agricultural Center Clemson, sc 29634 864-656-6320 864-656-6281 fax 864-710-4562

Program	Peacemakers
Population	Students in the 4th through 8th grades
Cultural Evidence	88% of study participants were African-American
Risk and Protective Factors	**Risk:** • Early onset of aggression • Poor refusal skills • Lack of guilt and empathy • School suspensions **Protective:** • High expectations • Self-efficacy • Social competencies and problem solving skills
Level of Evidence	Promising
Outcomes	1. Decreases in aggression for boys and middle school students 2. Reductions in school suspensions for middle school students
Prevention: Universal/Selective	Universal
Early Intervention	
Description	The Peacemakers Program is a school-based violence reduction intervention for grades 4 through 8. The program content is based on studies of psychosocial variables associated with individual differences in aggression and on existing interventions proven to be effective, and is influenced by social and developmental psychology research. Peacemakers consists of a 17-lesson curriculum for teachers and a remediation component for school psychologists and counselors for students referred for aggressive behavior. Each lesson takes 45 minutes to conduct and addresses beliefs supporting the acceptability and utility of violent behavior and deficits in conflict-related psychosocial skills. There are a variety of classroom activities including didactic instruction, discussion, use of the Socratic method, role-plays, and experiential exercises. Emphasis is placed on infusing program content into students' everyday lives by helping them recognize potentially problematic situations and then recall what they have learned in the program. The goal is to have the principles and strategies of the program become a part of the culture at the school.

Program	Peacemakers
Staffing Requirements	• Teachers • School psychologists • Counselors
Service Delivery Setting	• Classroom
Implementation Costs	• $65 for teacher's manual • The Leader's Guide is $169.00. • $50 for counselor's manual. There is no longer a separate manual for counselors • Averages $11 per student, including manuals, workbooks, and training • $150 per hour plus expenses for the 6–8 hours of training • The full-day, 6-hour training is now $1750 + travel expenses if you make arrangements directly with me; it's $2500 if you make arrangements through the publisher.
Service Delivery Costs	• 18 lesson curriculum; 45 minutes per session
Standard Training Protocol	• 6-Hour training with developer
Proprietary	• Proprietary
Sustainability	• New staff trained by experienced staff no certification process
Contact	Solution Tree 304 West Kirkwood Avenue, Suite 2 Bloomington, IN 47404-5132 888-763-9045 812-336-7790—FAX Jeremy Shapiro The Peacemakers Program: Violence Prevention for Students in Grades 4–8 Applewood Centers, Inc. 2525 East 22nd St. 2669 Belvoir Blvd., Shaker Hts., OH 44122 Cleveland, OH 44115 Telephone: 216-696-5800, ext. 1144 216-292-2710 Fax: 216-696-6592 E-mail: jeremyshapiro@yahoo.com Web site: www.applewoodcenters.org/peacemakers.htm

Program	Promoting Alternative Thinking Strategies	
Population	Preschool and elementary school students	
Cultural Evidence	3 studies for elementary school children where at least 30% of participants were African-American and in the Preschool study, 47% of the participants were African-American	
Risk and Protective Factors	Risk: • Early onset of aggression • Poor refusal skills • Mental health problem • Poor family attachment • Sibling antisocial behavior • Poorly organized and functioning schools • Identified as learning disabled	Protective: • Perception of social support from adults and peers • Self-efficacy • Social competencies and problem-solving • Effective parenting • Good relationship with parents • Rewards for prosocial family involvement • Rewards for prosocial school involvement
Level of Evidence	Well-supported	
Outcomes	1. Improved self-control 2. Improved understanding and recognition of emotions 3. Use of more effective conflict resolution strategies 4. Decreased anxiety and depressive symptoms for special needs students 5. Decreased behavior problems for special needs students	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	Promoting Alternative Thinking Strategies (PATHS) and PATHS Preschool are school-based preventive interventions for children in elementary school or preschool. The interventions are designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skill concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations. The elementary school PATHS Curriculum is available in two units: the PATHS Turtle Unit for kindergarten and the PATHS Basic Kit for grades 1-6. The curriculum includes 131 20- to 30-minute lessons designed to be taught by regular classroom teachers approximately 3 times per week over the course of a school year. PATHS Preschool, an adaptation of PATHS for children 3 to 5 years old, is designed to be implemented over a 2-year period. Its lessons and activities highlight writing, reading, storytelling, singing, drawing, science, and math concepts and help students build the critical cognitive skills necessary for school readiness and academic success. The PATHS Preschool program can be integrated into existing learning environments and adapted to suit individual classroom needs.	

Program	Promoting Alternative Thinking Strategies
Staffing Requirements	• Teachers
Service Delivery Setting	• Classroom curriculum
Implementation Costs	• The complete elementary school PATHS Curriculum, including the Turtle Unit for kindergarten and the Basic Kit for grades 1-6, is available for $719. Purchased separately, the Turtle Unit is $189 and the Basic Kit is $629. The PATHS Preschool Kit is $459. Discounts are available for quantities of 10 or more • A 2-day on-site workshop for up to 30 participants is $4,000, plus travel and accommodation expenses for the trainer • Additional costs may include space rental and teacher in-service pay. Developers suggest that all PATHS teachers attend along with assistants, support staff, school principals, and other administrators • Implementers also may choose to attend the PATHS International Learning Community, which is held every 2 years and brings together PATHS practitioners from across the globe for continuing education and peer-to-peer learning opportunities
Service Delivery Costs	• 20-30 minutes teaching time • 130 modules • Estimated costs for implementing PATHS in an elementary school depend on how existing support staff (e.g., counselors, head teachers) will be used • If a school counselor can serve as the curriculum consultant at least half-time, curriculum and training costs approximately $12,000 ($25 per student/year) over the first 3 years, with reduced costs in subsequent years ($10 per student/year) assuming staff turnover is not high • Costs are closer to $80 per student/year if a curriculum consultant must be hired but would continue to decline by half each subsequent year, for an approximate overall cost of $45 per student/year over 3 years
Standard Training Protocol	• Yes
Proprietary	• Yes
Sustainability	• On-site training-of-trainers workshops are also available The developer offers technical assistance by phone and e-mail ($75 per hour) and on-site ($2,000 per day plus travel expenses)
Contact	Mark Greenberg, Ph.D. Prevention Research Center 109 Henderson Building South Pennsylvania State University University Park, PA 16802-6504 814-86-0112 814-865-2530 FAX Carol A. Kusche, Ph.D. Paths Training, LLC 627 10TH Avenue East Seattle, WA 98102 206-323-6688 Mark T. Greenberg, Ph.D. Director, Prevention Research Center Bennett Chair of Prevention Research

	Pennsylvania State University **HDFS, S109 Henderson Building** **University Park, PA 16802** **Phone: (814) 863-0112** **Fax: (814) 865-2530** **E-mail: mxg47@psu.edu** **www.channing-bete.com/paths** **www.channing-bete.com/pathspreschool** **www.prevention.psu.edu/projects/paths.html** **For information about implementation:** **Channing Bete Company, Inc.** **One Community Place** **South Deerfield, MA 01373-0200** **Phone: (877) 896-8532** **Fax: (800) 499-6464** **E-mail: custsvc@channing-bete.com** **Carol A. Kusché, Ph.D.** **Director of Training** **PATHS Training, LLC** **927 10th Avenue East** **Seattle, WA 98102** **Phone: (206) 323-6688** **E-mail: ckusche@comcast.net**

Program	Second Step	
Population	**6-12 year-old elementary school children**	
Cultural Evidence	**Very small percentages of diverse cultural groups have participated in the research**	
Risk and Protective Factors	**Risk:** • **Early onset of aggression** • **Poor refusal skills** • **Mental Health problem** • **Poor family attachment** • **Sibling antisocial behavior** • **Poorly organized and functioning schools** • **Identified as learning disabled**	**Protective:** • **Perception of social support from adults and peers** • **Self-efficacy** • **Social competencies and problem-solving** • **Effective parenting** • **Good relationship with parents** • **Rewards for prosocial family involvement** • **Rewards for prosocial school involvement**
Level of Evidence	**Promising**	
Outcomes	**1. Improvements in social competence and prosocial behavior** **2. Decreases in negative, aggressive and antisocial behavior**	
Prevention: Universal/Selective	**Universal**	
Early Intervention		
Description	**Second Step is a classroom-based social-skills program for children 4 to 14 years of age that teaches socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program builds on cognitive behavioral intervention models integrated with social learning theory, empathy research, and social information-processing theories. The program consists of in-school curricula, parent training, and skill development. Second Step teaches children to identify and understand their own and others' emotions, reduce impulsiveness and choose positive goals, and manage their emotional reactions and decision making process when emotionally aroused. The curriculum is divided into two age groups: preschool through 5th grade (with 20 to 25 lessons per year) and 6th through 9th grade (with 15 lessons in year 1 and 8 lessons in the following 2 years). Each curriculum contains five teaching kits that build sequentially and cover empathy, impulse control, and anger management in developmentally and age-appropriate ways. Group decision making, modeling, coaching, and practice are demonstrated in the Second Step lessons using interpersonal situations presented in photos or video format.**	

Program	Second Step
Staffing Requirements	• Teachers
Service Delivery Setting	• Classroom
Implementation Costs	• Training costs include $499 per participant for preschool through grade 9 (2 1/2-day training) and $169 per participant for preschool through grade 9 (1-day training) • The cost of training includes all training materials but not the Second Step curriculum • Family Guide facilitatory training is $169 per participant for preschool through grade 5; this cost does not include the Family Guide, which is purchased separately • Materials costs include $289 for the Pre-K DVD Kit (ages 4-6), $159 for individual grade-level kits (grades 1-5), $295 each for Level 1 Foundation Lessons (middle school), $149 each for Level 2 Skill Building Lessons (middle school), $149 for Level 3 Skill Building Lessons (middle school), $359 for the Second Step Family Guide, $599 for the Second Step Family Guide and Pre-K DVD kit, $359 for the Spanish-language Family Guide, $39 for the Family Overview Video, $39 for the Spanish-language Family Overview Video, and $59 for the Family Overview DVD (in Spanish and English)
Service Delivery Costs	• The curriculum is divided into 2 age groups: preschool through 5th grade (with 20 to 25 lessons per year) and 6th through 9th grade (with 15 lessons in year 1 and 8 lessons in the following 2 years) • Each curriculum contains 5 teaching kits that build sequentially and cover empathy, impulse control, and anger management in developmentally and age-appropriate ways • Group decision making, modeling, coaching, and practice are demonstrated in the Second Step lessons using interpersonal situations presented in photos or video format
Standard Training Protocol	• Yes
Proprietary	• Mix of public and proprietary
Sustainability	• Train the Trainer Model
Contact	Claudia Glaze Committee for Children 568 First Avenue South, Suite 600 Seattle, WA 98104-2804 Phone: (206) 438-6500

Program	Social Decision-Making and Problem-Solving	
Population	Students in grades K-8	
Cultural Evidence	Not enough information to evaluate	
Risk and Protective Factors	Risk: • Early onset of aggression • Mental health problems • Life stressors • Victimization and exposure to violence • Family management problems • Dropping out of school	Protective: • Social competencies and problem solving skills • Effective parenting • Presence and involvement of caring and supportive adults
Level of Evidence	Promising	
Outcomes	1. Improved social decision making and problem-solving skills 2. Improved prosocial behavior in school 3. Greater ability to cope with stress upon transitioning to middle school	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	The Social Decision Making and Problem Solving Program (SDM) is a social and emotional learning program that assists students in acquiring social and decision-making skills and in developing their ability to effectively use those skills in real-life, with the aim of preventing violence, substance abuse, and related problem behavior. It is a primary prevention program conceptually rooted in research from public health, child development, clinical psychology, cognitive sciences, and organizational and community psychology. The program provides a framework in which students have the ability to learn, reinforce, and practice applying skills necessary to develop social competence. SDM is intended for use with all students (regular and special education) in kindergarten through eighth grade, regardless of ability level, ethnic group, or socioeconomic level. The program has been successfully implemented in urban, suburban, and rural settings nationwide.	

Program	Social Decision-Making and Problem-Solving
Staffing Requirements	• Teachers
Service Delivery Setting	• Classrooms
Implementation Costs	• Training costs are negotiable and include a per diem plus travel expenses for the trainer and approximately $28 per participant (typically limited to 30 people) for workshop materials for a school building-based training. Costs for regional trainings may vary. • Staff provide a two-day curriculum lab training workshop for those teachers and practitioners who will be teaching Social Decision Making directly to the students. Members of the Social Decision Making Committee stay for a third day to prepare them for their role. Information is also available regarding how to bring parents on board with Social Decision Making. • The UMDNJ offers training opportunities to individual schools and/or school districts. At the school district level, training can be tailored to suit each district's local needs. The SDM/PS program staff provides 2-3 day in-service training for a team of up to 30 teachers, administrators, and support personnel. Participants are provided with all of the curriculum materials, classroom posters, and worksheets needed to implement the program immediately following training. • To help ensure that the program becomes an integrated part of the school's curricula, an on-site SDM/PS leadership team is formed to plan and guide the program toward institutionalization. The leadership team consists of a small group of representative teachers, the school principal, and other key resource staff such as a guidance counselor. A half- or full-day of leadership and management training for the leadership team upon the conclusion of the regular training workshop is strongly recommended. • Training for individual teachers or counselors is also available if the number of people to be trained is too small to warrant district-level training. Training sessions cosponsored by the UMDNJ and Rutgers University are held several times per year. • The total cost of the program must include training costs which are estimated to be around $1,600 plus materials and travel. There are also periodic leadership-management trainings that last a half day and cost $400. • The start-up training costs are $800 per day and they typically last for 2 days. The half-day leadership-management trainings are $400 each.
Service Delivery Costs	• In at least one dedicated classroom session per week
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Linda Bruene-Butler University of Medicine and Dentistry of New Jersey University Behavioral Healthcare Behavioral Research and Training Institute 151 Centennial Avenue, Suite 1140 Piscataway, NJ 08854 732-235-9275 732-235-9280 FAX bruene@umdnj.edu www.ubhcisweb.org/sdm

Maurice Elias
Department of Psychology
Rutgers University
53 Avenue E. Livingston Campus
Piscataway, NJ 08854-8046
732-445-2444
MELIAS@RCI-RUTGERS.EDU
732-235-9275
732-235-9280 FAX
Bruene@umdnj.edu
www.ubhcisweb.org/sdm

Program	Strengthening Families	
Population	Children and youth 3-16 years old and their families	
Cultural Evidence	Two studies have been conducted. In one study 30% of the participants were African-American and in the second, 36% of the participants were African-American and 17% were Latino	
Risk and Protective Factors	Risk: • Early onset of aggression • Poor refusal skills • Family history of substance abuse • Family management problems • Pattern of high family conflict	Protective: • Perception of social support from adults and peers • Self-efficacy • Social competencies and problem-solving skills • Effective parenting • Good relationships with parents • Parental high expectations
Level of Evidence	Supported	
Outcomes	1. Decreases in child behavior problems and depressive symptoms 2. Improvement in positive parenting 3. Improvement in family cohesion and communication	
Prevention: Universal/Selective	Universal and selective	
Early Intervention	Early intervention with families where one or both parents has a substance abuse problem	
Description	The Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14) is a family skills training intervention designed to enhance school success and reduce youth substance use and aggression among 10- to 14-year-olds. The program includes seven 2-hour sessions and four optional booster sessions in which parents and youth meet separately for instruction during the first hour and together for family activities the second hour. The sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences to use substances. Sessions, which are typically held once a week, can be taught effectively by a wide variety of staff.	

Program	Strengthening Families
Staffing Requirements	• Low-risk program (SFP10-14) is staffed by school personnel • High-risk program (SFP3-5, 6-11 or 12-16) staffed by community agencies familiar with working with high risk children • Not necessarily mental health workers; can be service agencies • Not necessarily licensed personnel • Level of schooling not an issue • Service delivery staff must have the following: good interpersonal skills; desire to help, knowledge of the program
Service Delivery Setting	• School setting • Community agency
Implementation Costs	• A Master set of materials for SFP3-5, 6-11 or 12-16 is available on CD for $450 and includes the SFP implementation manual; manuals for the parent, child, and family group leaders; handbooks and handouts for parents and children; evaluation instruments; and other implementation materials. Purchase of the CD carries a limited site license for the purchasing agency to make unlimited copies of the materials for its own use • Course materials for SFP10-14 are purchased in hard copy from the extension service of Iowa State University and include master copies for parents' and children's handouts • Costs for a 2-day SFP3-5, 6-11 or 12-16 group leader training for up to 35 trainees is $3,650 (plus travel expenses, lodging, and per diem for 2 trainers). The training fee includes one copy of the SFP master set of course materials on CD, limited site license to reproduce unlimited copies for the agency's own use, and technical assistance in implementation. Reduced fees for smaller groups are available. Training in the United States is available in English and Spanish. Some agencies may find it economical to attend a training hosted by another agency. (LutraGroup SP, the entity that coordinates SFP training and technical assistance, can help in locating other trainings.) Technical assistance and evaluation of SFP implementation are also available. • Implementation of SFP3-5, 6-11 or 12-16 requires a minimum of 5 trained staff: 2 group leaders for the parents, two group leaders for the children, and a site coordinator • SFP10-14 requires only one group leader for the parents, as their curriculum is primarily on video
Service Delivery Costs	• Personnel costs
Standard Training Protocol	• Includes two trainers (usually male/female; diverse ethnicity) • Training 10-35 per group • Two day training - First day didactic. Second day practice.
Proprietary	• Yes
Sustainability	• Availability to train agency personnel to be a certified trainer • Certification process consists of 4 step process. Trained as a group leader • Deliver a training as a group leader • Deliver parts of a training with 2 experienced trainers, deliver roughly half of a training with one experienced trainer
Contact	Karol Kumpfer, Ph.D., Professor Department of Health Promotion and Education 21901 East South Campus Drive, Room 214 University of Utah Salt Lake City, UT 84112

	Tel. 801-582-1562 **Fax: 801-581-5872** **kkumpfer@xmission.com** **www.strengtheningfamilies/program.org** **Henry Whiteside** **Lutra Group SP** **5215 Pioneer Fork Road** **Salt Lake City, UT 84108** **801-583-4601** **801-583-7979 FAX** **Hwhiteside@LUTRAGROUP.com**

Programs for Children/Youth in Stressed Families

Program	Adolescent Transitions Program
Population	11-18 year-old youth at risk for substance abuse or behavior problems
Cultural Evidence	No information available. The developer is currently testing adaptations for Native American, Latino and African-American families.
Risk and Protective Factors	**Risk:** • Family management problems/poor monitoring and supervision • Poor family attachment • Parental use of harsh physical punishment **Protective:** • Effective parenting • Good relationships with parents • Social competencies and problem solving skills
Level of Evidence	Supported
Outcomes	1. Significant improvement in family interactions 2. Improved child behavior 3. Parental positive problem solving with teens
Prevention: Universal/Selective	Universal and selective
Early Intervention	Family check up is used with families referred due to teen behavior problems
Description	The Adolescent Transitions Program (ATP) is a multilevel, family-centered intervention targeting children who are at risk for problem behavior or substance use. Designed to address the family dynamics of adolescent problem behavior, it is delivered in the middle school setting to parents and their children. The parent-focused curriculum concentrates on developing family management skills such as making requests, using rewards, monitoring, making rules, providing reasonable consequences for rule violations, problem-solving, and active listening. Strategies targeting parents are based on evidence about the role of coercive parenting strategies in the development of problem behaviors in youth. The curriculum for teens takes a social learning approach to behavior change and concentrates on setting realistic goals for behavior change, defining reasonable steps toward goal achievement, developing and providing peer support for prosocial and abstinent behavior, setting limits, and learning problem-solving. The long-term goals of the program are to arrest the development of teen antisocial behaviors and drug experimentation. Intermediate goals are to improve parents' family management and communication skills. To accomplish these goals, the intervention uses a "tiered" strategy with each level (universal, selective, and indicated) building on the previous level. The universal level is directed to the parents of all students in a school. Program goals at this level include engaging parents, establishing norms for parenting practices, and disseminating information about risks for problem behavior and substance use. At the selective level of intervention, the Family Check-Up, assessment, and support are provided to identify those families at risk for problem behavior and substance use. At the indicated level, direct professional support is provided to parents based on the results of the Family Check-Up through services including behavioral family therapy, parenting groups, or case management services. Program activities are led by group leaders and include parent group meetings, individual family meetings, and teen group sessions, as well as monthly booster sessions for at least 3 months following completion of the group. Meetings and sessions may include discussion and practice of a targeted skill, group exercises (either oral or written, depending on group needs), role-plays, and setting up home practice activities. Many of the skill-building exercises include activities that parents and children do together. Each curriculum also has six accompanying videotapes that demonstrate the program's targeted skills and behaviors.

Program	Adolescent Transition Program
Staffing Requirements	• Behavioral family therapy, parenting, groups, or case management services • School staff
Service Delivery Setting	• Middle school • Home • The Family Resource Center
Implementation Costs	• Family Management Curriculum 1-2 people, $750 + $75 each/materials (excluding tapes) 3+ people, $1000 + $75 each/materials (excluding tapes) • Family Resource Centers: 1–2 people, $500 + $25 each/materials, 3-5 people, $750 + $25 each/materials • Family Check-Up: 1–2 people, $1350 + $75 each/materials (includes feedback on your implementation), 3+ people, $1850 + $75 each/materials (includes feedback on your implementation • Dishion, T. J., & Kavanagh, K. (2003). Intervening in adolescent problem behavior: A family-centered approach. New York: Guilford paper back: $24.00
Service Delivery Costs	• Information not available at this time
Standard Training Protocol	• Family Management Curriculum*: Length: 1.5 days • Family Resource Centers: Length: 6 hours • Family Check-Up: Length: 2 days
Proprietary	• Yes
Sustainability	• Consultation $75/hour (any format: tape review, video conferencing, phone, review of materials, and so forth)
Contact	kolkodj@upmc.edu Phone: 412-246-5888 Elizabeth 412-246-5886

Program	Celebrating Families!
Population	Parents where one or both are substance-abusing; risk for domestic violence and child abuse
Cultural Evidence	Two studies in which 42% and 45% of the participants were Latinas
Risk and Protective Factors	None noted
Level of Evidence	Emerging
Outcomes	1. Improved positive parenting 2. Decreased parental drug and alcohol use 3. Decreased parental depression 4. Improved family cohesion and communication
Prevention: Universal/Selective	Selective
Early Intervention	Early intervention for parents participating in substance abuse programs
Description	Celebrating Families! (CF!) is a parenting skills training program designed for families in which one or both parents are in early stages of recovery from substance addiction and in which there is a high risk for domestic violence and/or child abuse. The CF! program uses a cognitive behavioral theory (CBT) model to achieve three primary goals: • Break the cycle of substance abuse and dependency within families, • Decrease substance use and reduce substance use relapse, and • Facilitate successful family reunification. The CBT model defines substance use as a learned social behavior that is acquired through modeling or imitation of the observed behavior in others with whom one has some type of social relationship. In this model, addiction is considered a disease. The CF! program provides weekly instruction focusing on a healthy lifestyle free from drugs and alcohol, addressing risk and protective factors as well as developmental assets of family members. Following a family dinner, parents and children participate in separate 90-minute instructional group sessions devoted to a particular theme. Parents then reunite with their children for a 30-minute activity to practice what has been presented and learned and to receive feedback on their performance. Themes include (1) healthy living, (2) nutrition, (3) communication, (4) feelings and defenses, (5) anger management, (6) facts about alcohol, tobacco, and other drugs, (7) chemical dependency as a disease, (8) the effects of chemical dependency on the whole family, (9) goal setting, (10) making healthy choices, (11) healthy boundaries, (12) healthy friendships and relationships, and (13) individual uniqueness. Originally designed for the Family Treatment Drug Court (FTDC) system, CF! is currently used by drug courts, dependency courts, faith-based organizations, residential and outpatient treatment services, and social service agencies serving parents and children ages 4-17. Started in the mid-1990s, the FTDC is the most recent and the fastest growing type of drug court in the United States. It provides a setting for all the participants in the child protection system to come together to determine the individual treatment needs of substance-abusing parents whose children are wards of the court. The goal of the FTDC is to rehabilitate the parents as competent caretakers so that their children can be safely returned to their parents' care.

Program	Celebrating Families!
Staffing Requirements	• Staff in community-based organizations • Women's residential treatment facility • Trained interns • Volunteers
Service Delivery Setting	• Other community settings • Outpatient • Residential • Suburban • Urban
Implementation Costs	• Complete set of program materials: a set of 5 spiral-bound facilitator guides (volumes 1-5) plus appendixes, master handouts and posters, and a program CD and DVD, is $215 plus $9 for shipping and handling • The recommended site implementation package: 10 sets of the facilitator guides, is $1,350 plus $80 for shipping and handling • For those ordering this package, additional facilitator guide sets are available for $135 each plus $8 for shipping and handling. Additional CDs are $8 each plus $3 shipping and handling, and additional DVDs are free other than the $3 shipping and handling charge. Celebrating Families! brochures are free • A 2-day training workshop is $4,000 plus travel expenses, and technical assistance is offered at $100 per hour
Service Delivery Costs	• The projected program operating budget for a 16-session program with 2 weeks allotted for planning and organizing is about $694 per participant, assuming 40 participants per program cycle The cost can be significantly reduced to as little as $360 per participant with the use of staff flex time, trained interns and volunteers to administer the program, and in-kind donations of food, space, and transportation
Standard Training Protocol	• A 2-day training workshop
Proprietary	• Mix of public and proprietary
Sustainability	• Technical assistance is offered at $100 per hour
Contact	www.celebratingfamilies.net Steve Hornberger, M.S.W. Program Director National Association for Children of Alcoholics 11426 Rockville, Suite 301 Rockville, MD 20852 Phone: (301) 468-0985 Fax: (301) 468-0987 E-mail: shornberger@nacoa.org

Program	Clinician-Based Cognitive Psychoeducational Intervention for Families
Population	Families with a parent with a significant mood disorder
Cultural Evidence	There is an adaptation for low-income culturally diverse communities but ethnicity was not reported in the research articles
Risk and Protective Factors	None noted
Level of Evidence	Supported
Outcomes	1. Improvements in child–related behaviors and attitudes towards parent's illness 2. Improvement in children's understanding of parental illness
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	Based on public health models, the intervention is designed to provide information about mood disorders to parents, equip parents with skills they need to communicate this information to their children, and open dialogue in families about the effects of parental depression. The intervention consists of 6-11 sessions that include separate meetings with parents and children, family meetings, and telephone contacts or refresher meetings at 6- to 9-month intervals. Sessions are conducted by trained psychologists, social workers, and nurses. The core elements of the intervention are (1) an assessment of all family members, (2) teaching information about affective disorders and risks and resilience in children, (3) linking information to the family's life experience, (4) decreasing feelings of guilt and blame in children, and (5) helping children to develop relationships within and outside the family to facilitate their independent functioning in school and in activities outside the home. In family meetings, parents talk about their own sessions, their treatment, and how they are working to build resilience and protect their children.

Program	Clinician-Based Cognitive Pyschoeducational Intervention for Families
Staffing Requirements	• Trained psychologists • Social workers • Nurses
Service Delivery Setting	• Office • Phone
Implementation Costs	• Initial training costs in the United States include the Master Trainer fee (at a standard rate of $1,000 per day), the commitment of staff time to learn this intervention (several 1-day or 1/2-day training sessions), and commitment of staff time to use the intervention and receive ongoing peer supervision
Service Delivery Costs	• The cost of delivery is 7-10 hours of clinician time per family (including parent, child, and family sessions)
Standard Training Protocol	• Several 1-day or 1/2-day training sessions
Proprietary	• Public
Sustainability	• Ongoing peer supervision
Contact	William R. Beardslee, M.D. Academic Chair, Department of Psychiatry, Children's Hospital Boston Gardner Monks Professor of Child Psychiatry, Harvard Medical School One Autumn Street, Suite 435 Boston, MA 02215 Phone: (617) 355-6087 Fax: (617) 730-0271 E-mail: william.beardslee@childrens.harvard.edu

Program	Creating Lasting Family Connections
Population	Family-focused program for youth 9-17 at risk for or with substance abuse problems
Cultural Evidence	Data not reported
Risk and Protective Factors	**Risk:** • Early onset of aggression • Favorable attitudes toward drug use • Poor refusal skills • Family management problems • Negative attitude toward school • Community instability • Community crime **Protective:** • Social competencies and problem solving skills • Effective parenting • Good relationships with parents • High expectations • Presence of supportive and caring adults
Level of Evidence	Supported
Outcomes	1. Increased use of community resources when family or personal problems arose 2. Increases in parent knowledge about substance abuse 3. Delayed onset of drug or alcohol use 4. Decreased use of drugs and alcohol
Prevention: Universal/Selective	Universal and Selective
Early Intervention	Indicated for families with an adolescent who is abusing illegal substances
Description	Creating Lasting Family Connections (CLFC), the currently available version of Creating Lasting Connections (CLC), is a family-focused program that aims to build the resiliency of youth aged 9 to 17 years and reduce the frequency of their alcohol and other drug (AOD) use. CLFC is designed to be implemented through a community system, such as churches, schools, recreation centers, and court-referred settings. The six modules of the CLFC curriculum, administered to parents/guardians and youth in 18-20 weekly training sessions, focus on imparting knowledge and understanding about the use of alcohol and other drugs, including tobacco; improving communication and conflict resolution skills; building coping mechanisms to resist negative social influences; encouraging the use of community services when personal or family problems arise; engendering self-knowledge, personal responsibility, and respect for others; and delaying the onset and reducing the frequency of AOD use among participating youth. The program emphasizes early intervention services for parents and youth and follow-up case management services for families. Manuals for trainers, notebooks for participants, and other materials are available, but the program is intended to be modified with each implementation to reflect the needs of the participants and the skill level of the trainers. Creating Lasting Connections was an experimental program implemented and evaluated in church communities with the families of high-risk 11- to 14-year-old youth. CLC served as the basis for CLFC, which is now in use.

Program	Creating Lasting Family Connections
Staffing Requirements	• Information not available at this time
Service Delivery Setting	• Community system, such as churches, schools, recreation centers, and court-referred settings
Implementation Costs	• Materials are $1,425, which includes all curricula, participant notebooks, posters, and a custom evaluation kit • Daily fees for on-site assistance range from $300 to $1,250 • Most organizations should budget at least $750 for 1 week of CLFC implementation training, plus travel costs, for each person needing training • The minimum typical budget is between $15,000 and $25,000 to serve approximately 15 to 25 families
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Implementation training is highly recommended but not required • There are standard 5- and 10-day trainings
Proprietary	• Yes
Sustainability	• On-site training and technical assistance also can be arranged according to the needs and resources of the agency implementing the program
Contact	Ted N. Strader COPES, Inc. 845 Barret Avenue Louisville, KY 40204 Phone: (502) 583-6820 Fax: (502) 583-6832 E-mail: tstrader@sprynet.com Web site: www.copes.org

Program	Family Connections	
Population	Families at risk for child emotional and physical neglect	
Cultural Evidence	88% of the research participants were African-American	
Risk and Protective Factors	Risk: • Caregiver depressive symptoms • Parental stress	Protective: • Parental sense of competence • Family cohesion and communication • Social support
Level of Evidence	Promising	
Outcomes	1. Decreased depressive symptoms 2. Decreased parental stress	
Prevention: Universal/Selective		
Early Intervention	Early Intervention – families are referred by child welfare workers.	
Description	Family Connections (FC) is a multifaceted, community-based service program that works with families in their homes and in the context of their neighborhoods. The goal of FC is to help these families meet the basic needs of their children and reduce the risk of child neglect. Nine practice principles guide FC interventions: community outreach; individualized family assessment; tailored interventions; helping alliance; empowerment approaches; strengths perspective; cultural competence; developmental appropriateness; and outcome-driven service plans. The core components of FC include: (a) emergency assistance/concrete services; (b) home-based family intervention (e.g. family assessment, outcome-driven service plans, individual and family counseling); (c) service coordination with referrals targeted toward risk (e.g. substance abuse treatment) and protective factors (e.g. mentoring program); and (d) multi-family supportive recreational activities (e.g. theme-based gatherings such as Black History month, trips to museums, etc.).	

Program	Family Connections
Staffing Requirements	Social worker Masters level or BA supervised by Masters level
Service Delivery Setting	• Community agency • Family home
Implementation Costs	• Trained social worker • Transportation costs • Emergency needs fund • Weekly supervision
Service Delivery Costs	• One hour face to face with social worker once weekly • 3-9 months
Standard Training Protocol	• Yes/Manualized • On-site, video-conference • Online course/curriculum developed by University of Maryland, School of Social Work • Manual
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	University of Maryland School of Social Work 410-706-3609 www.family.unmaryland.edu

Program	Focus on Families
Population	Families who have children 3 to 14 years of age and where a parent is addicted to drugs
Cultural Evidence	18% of the research participants were African-American
Risk and Protective Factors	**Risk:** • Antisocial behavior and alienation • Poor refusal skills • Family management problems • Parental use of harsh physical punishment • Poor family attachment/bonding • Low academic achievement **Protective:** • Self-efficacy • Social competencies and problem solving skills • Effective parenting • Good relationships with parents • Above average academic achievement • Student bonding
Level of Evidence	Supported
Outcomes	1. Decreased parental drug use 2. Decreased domestic conflict 3. More clearly defined household rules
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	Focus on Families is designed for families with parents who are addicted to drugs. Based on the social development model, the program aims to prevent parents' relapse, help them cope with its occurrence (if it did occur), and reduce the likelihood of substance abuse among their children. It is most appropriate for parents enrolled in methadone treatment who have children ages 3 to 14. Eligible families participate in a 5-hour "family retreat" in which they learn about the curriculum, identify their goals, and participate together in trust-building activities. The first session is followed by 32 curriculum sessions (90 minutes each), conducted twice weekly for 16 weeks. Parent sessions are conducted in the mornings, with practice sessions held in the evenings for parents and children together. Content covered includes family goal setting, relapse prevention, family communications skills, family management skills, creating family expectations about drugs and alcohol, teaching skills to children, and helping children succeed in school. Parent session, follow-up, and home-based care management are provided by masters-level social workers using a structured cognitive-affective-behavioral skills training curriculum.

Program	Focus on Families
Staffing Requirements	• Masters level social workers
Service Delivery Setting	• Home-based and family-based
Implementation Costs	• Manual costs $200.00
Service Delivery Costs	• Five hour family retreat—followed by 32 curriculum sessions, 2x a week 90 five-hour family retreat—followed by 32 curriculum sessions, 2x a week 90 minutes EKS • Follow-up 9 months treatment
Standard Training Protocol	Information not available at this time
Proprietary	• Material can be copied
Sustainability	Information not available at this time
Contact	Kevin Haggerty Social Development Research Group 9725 Third Avenue, NE, Suite 401 Seattle, WA 98115-2024 206-543-3188 Fax 206-543-4507 catalano@u.washington.edu depts.washington.edu/sdrg haggerty@u.washington.edu

Program	Healthy Steps for Young Children	
Population	Pediatric developmental services for young children 0-3 and their parents. Quality of care intervention.	
Cultural Evidence	Data not reported	
Risk and Protective Factors	Risk: • Maternal depression • Harsh discipline	Protective: • Secure attachment • Parental confidence
Level of Evidence	Supported	
Outcomes	1. Decreased use of severe discipline	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	Healthy Steps for Young Children (Healthy Steps) is a national initiative that focuses on the importance of the first three years of life. Healthy Steps emphasizes a close relationship between health care professionals and parents in addressing the physical, emotional, and intellectual growth and development of children from birth to age three. Each Healthy Steps team includes a Healthy Steps Specialist, who enhances the information and services available to parents. The Healthy Steps Specialist can be a new team member or a nurse, child development specialist, or social worker already working in the practice. The Specialists have special training in child development and address major behavioral and developmental issues, focusing on a whole baby, whole family brand of primary care. The Healthy Steps approach is being implemented in pediatric and family practices across the country and is meeting an array of community needs while preserving its unique linkage to a team of health care professionals	

Program	Healthy Steps for Young Children
Staffing Requirements	• Training in social work • Child development • Nursing • Interest in working with young children is prerequisite
Service Delivery Setting	• Pediatric offices • Community • Homes
Implementation Costs	• Training is approximately $600; a DVD is available • Healthy steps multimedia training and resource kit DVD $99 • Original multimedia KD for training is $350
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Yes—there is a standard training given in Chicago • DVD available to purchase
Proprietary	• Yes—however, advocate health care just want to be credited with the materials
Sustainability	• Certification offered through the original training
Contact	Enedina Robles, MSW Health Steps Specialist Childrens Health Center 4460 East Huntington Blvd. Fresno, CA 93702 559-459-4180 559-459-3502--fax

Program	Homebuilders	
Population	Children and families from birth to 18 at risk for placement into foster care, group home or psychiatric hospitals	
Cultural Evidence	Data not reported	
Risk and Protective Factors	Risk: • Family management problems • Child maltreatment • High family conflict • Poor family attachment • Victimization and exposure to violence • Early onset of aggression	Protective: • Effective parenting • Good relationships with parents • Stable family • Perception of social support from adults and peers
Level of Evidence	Supported	
Outcomes	1. Decreased use of placement 2. Increased reunification 3. Improved service provision	
Prevention: Universal/Selective		
Early Intervention	Early Intervention	
Description	HOMEBUILDERS provides intensive, in-home crisis intervention, counseling, and life-skills education for families who have children at imminent risk of placement in state-funded care. The goal is to prevent the unnecessary out-of-home placement of children through intensive, on-site intervention, and to teach families new problem-solving skills to prevent future crises. The program only accepts families referred by the state, in which one or more children are in imminent danger of being placed in foster, group, or institutional care. It is also used for families whose children are being returned from out-of-home care, and for difficult post-adoption situations. Therapists see families when they are in crisis. Client families are seen within 24 hours of referral. Almost all services take place in the client's home or the community where the problems are occurring and ultimately where they need to be resolved. Therapists are on call to their clients 24 hours a day, 7 days a week. Services are time-limited and concentrated in a period targeted at 4 weeks. Each family receives an average of 40-50 hours of direct service. Therapists carry only 2-3 cases at a time. Therapists utilize a range of research-based interventions, including crisis intervention, motivational interviewing, parent education, skill building, and cognitive/behavioral therapy. Services are provided when and where the client wishes. Services include helping clients meet the basic needs of food, clothing, and shelter, to the most sophisticated therapeutic techniques.	

Program	Homebuilders (Intensive Family Preservation and Reunification)
Staffing Requirements	• Professional therapists
Service Delivery Setting	• Home • Community
Implementation Costs	• Program consultation and quality training and assurance skills for Homebuilders supervisors (2-3) days training approx. $11,670 including all expenses • Homebuilders core competency on-site up to 15 service providers approx $13, 912 including all expenses • Other workshops available • Site visit 3x times per year; 2.5 day visit approx $16,512 • Telephone consultations 100 hours per team @ $75/per hour • Written record reviews—4 record reviews per therapist $6,000 • First year cost estimated at $67,864 • Costs depend upon the site
Service Delivery Costs	• Services are time limited and intensive • Four weeks approx. 40-50 hours of direct service • Caseload is 2 families • Supervisors/administrators/therapists available 24 hrs per day • Estimated cost savings for child welfare system, and victim health and mental health costs, per participant: $731 - $7,818. (Lee, et al., 2008)
Standard Training Protocol	• Workshop training • Infrastructure building • Clinical consultation • Technical assistance • Fidelity measures
Proprietary	• (QUEST) Quality enhancement system—focus is on quality assurance • The material is proprietary.
Sustainability	• There is no Train the Trainers Model in place yet but one is under development • No certification process
Contact	Institute for Family Development www.institutefamily.org 253-874-3630 Shelley Leavitt – sleavitt@institutefamily.org

Program	Making Parenting a Pleasure
Population	A parenting program for highly stressed parents of children birth to 8
Cultural Evidence	Data not reported
Risk and Protective Factors	**Risk:** • Social isolation • Parental stress **Protective:** • Self-efficacy • Social support
Level of Evidence	Promising
Outcomes	1. Decrease in inappropriate discipline 2. Increase in parental self-esteem 3. Decrease in parental stress 4. Decrease in child abuse potential
Prevention: Universal/Selective	Universal
Early Intervention	
Description	Make Parenting a Pleasure is a comprehensive group-based positive parenting curriculum for stressed parents of children birth to eight. This curriculum is designed for professional parent educators and does not require additional training, although training is recommended. Parents learn: • The importance of taking care of themselves so they can better care for their children • Practical stress management and communication skills • Effective parenting skills and positive approaches to discipline Parents gain: • Greater understanding of their children • A social support network that can continue after groups end This curriculum is built on the following assumptions: • Parenting is the most important and challenging job there is • Parents are their children's first and most important teachers • There are many right ways to be a parent or a child • Parents are the foundation of the family • Getting and giving support is essential for parents

Program	Making Parenting a Pleasure
Staffing Requirements	• Trained parenting experts
Service Delivery Setting	• Schools • Churches • Community centers • Service clubs
Implementation Costs	• Curriculum costs $899 • Training at program site costs $3800, plus air fare/per diem/hotel/transportation costs for two trainers • At Birth-to-three site; $250 per person/ site/ two 8 hour days • Individualized training can be arranged (25 person limit)
Service Delivery Costs	• Staff • Site costs • TV • DVD • Supplies • Babysitting
Standard Training Protocol	• Yes—curriculum
Proprietary	• Yes
Sustainability	• Curriculum-based • Training not necessary although recommended
Contact	Connie Rose Birth to Three 86 Centennial Loop Eugene, OR 97401 connier@birthto3.org birthtothree@birthto3.org ww.birthto3.org 541-484-5316 Fax 541-484-1449

Program	Nurse-Family Partnership	
Population	Home visiting program for first-time low-income mothers	
Cultural Evidence	92% of research participants from the "Memphis study" were African-American	
Risk and Protective Factors	Risk: • Early sexual involvement • Early onset of aggression • Mental health problem • Teen parenthood • Victimization and exposure to violence • Economic deprivation • Family violence • Maternal depression	Protective: • Self-efficacy • High expectations • Social support • Effective Parenting • Having a stable family • Presence and involvement of caring and supportive adults
Level of Evidence	Well-supported	
Outcomes	1. Improved maternal prenatal health 2. Fewer injuries to children 3. Reduced child abuse and neglect 4. Reduced arrests among mothers 5. Reducing arrests among adolescents of mothers participating in NFP	
Prevention: Universal/Selective	Selective	
Early Intervention	Early intervention	
Description	The Nurse-Family Partnership (NFP) program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. Ideally, nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (about 16 weeks gestation). Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits are weekly for the first 6 weeks after the baby is born, and then every other week through the child's first birthday. Visits continue on an every-other-week basis until the baby is 20 months. The last 4 visits are monthly until the child is 2 years old. Nurses use their professional nursing judgment and increase or decrease the frequency and length of visits based on the client's needs. Clients are able to participate in the program for two-and-a-half years and the program is voluntary.	

Program	Nurse-Family Partnership
Staffing Requirements	• Registered nurses
Service Delivery Setting	• Home • Hospital
Implementation Costs	• Minimum number for implementation of the program is typically 100 families • The application process includes an estimated budget that addresses all the cost categories, including training and materials • 3-year cost to establish a program for 100 families is $780,000, most of which goes for nurse salaries
Service Delivery Costs	• Approximately $4,500 per family per year to fund, and can range from $2,914 to $6,463 per family per year • Estimated cost savings juvenile justice system, crime victim & tax payers: $2,067 to $15,918 (Aos, et al., 2001). • Estimated cost savings for child welfare system, and victim health and mental health costs, per participant: $731 - $7,818. (Lee, et al., 2008)
Standard Training Protocol	• A 4-day intensive training in the model, usually provided by the National Center in Denver • Supervisors receive an additional day of training following completion of the 4 days of intensive training. • A 2-day regional training program is offered 4 months after program implementation begins for training on implementing the infancy guidelines. Supervisors receive an additional day of training • Training following the 2 days of training • A 2-day regional training prepares nurses to conduct intervention during the toddler period
Proprietary	Information not available at this time
Sustainability	• Community education, grants, etc.
Contact	The Nurse–Family Partnership National Office Nurse–Family Partnership National Office 1900 Grant Street, Suite 400 Denver, CO 80203 Phone: (866) 864-5226 Fax: (303) 327-4260 E-mail: info@nursefamilypartnership.org Web site: www.nursefamilypartnership.org

Program	Nurturing Parenting Program
Population	Family-based program for the prevention of child abuse
Cultural Evidence	In one study 60% of the participants were Latino and 10% were Native American
Risk and Protective Factors	**Risk:** • Early onset of aggression • Early sexual involvement • Child maltreatment • Family violence • Poor family attachment **Protective:** • Self-efficacy • Effective parenting • Perception of social support from adults and peers • Having a stable family
Level of Evidence	Promising
Outcomes	1. Positive changes in parenting and childrearing attitudes 2. Clear differentiation of parent-child roles 3. Decrease in the use of corporal punishment
Prevention: Universal/Selective	Selective
Early Intervention	Early intervention for parents with substantiated reports of child maltreatment
Description	The Nurturing Parenting Programs are family-based programs utilized for the treatment and prevention of child abuse and neglect. Program sessions are offered in group-based and home-based formats ranging from 12-48 sessions. Programs are designed for parents with young children birth to 5 years old, school-aged children 5-11 years old, and teens 12-18 years old. In addition, programs for children 5-11 years old and teens 12-18 years old are also offered. Parents and their children meet in separate groups that meet concurrently. Developed from the known behaviors that contribute to the maltreatment of children, the goals of the curriculum are: (1) to teach age-appropriate expectations and neurological development of children, (2) to develop empathy and self worth in parents and children, (3) to utilize nurturing, non-violent strategies and techniques in establishing family discipline, (4) to empower parents and children to utilize their personal power to make healthy choices, and (5) to increase awareness of self and others in developing positive patterns of communication while establishing healthy, caring relationships.

Program	Nurturing Parenting Programs
Staffing Requirements	• B.A. in a related field and experience with groups skills for implementing parent and child sessions.
Service Delivery Setting	• A variety of community settings including home, schools, mental health and social service agencies, prisons or residential care facilities.
Implementation Costs	• $900-1800 in training materials and 1-3 days in training (cost not specified)
Service Delivery Costs	• Weekly group sessions from 2.5 to 3 hours. Home-based sessions run 90 minutes. • 12-48 weeks
Standard Training Protocol	Information not available at this time
Proprietary	• Yes
Sustainability	Information not available at this time
Contact	www.nurturingparenting.com

Program	Parent-Child Interaction Therapy
Population	Families with young children (3-6) experiencing emotional or behavioral problems. There is an adaption for parents who have physically abused their children (4-12).
Cultural Evidence	40% of the research participants in one study were African-American
Risk and Protective Factors	None reported
Level of Evidence	Well-supported
Outcomes	1. Decreased child behavior problems 2. Decreases in re-reports of child abuse 3. Parents report using higher levels of praise and lower levels of criticism
Prevention: Universal/Selective	
Early Intervention	Early intervention
Description	PCIT is an evidence-based treatment model with highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions, and, using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver-child patterns. PCIT was initially targeted for families with children ages 2-7 with oppositional defiant and other externalizing behavior problems. It has been adapted successfully to serve physically abusive parents with children 4-12. PCIT may be conducted with parents, foster parents, or others in a parental/caretaker role. Caregiver and child must have regular, ongoing contact to allow for daily homework assignments to be completed.

Program	Parent-Child Interaction Therapy
Staffing Requirements	• Teachers • Therapists • Researchers • Masters degree or better
Service Delivery Setting	• Twelve to twenty sessions
Implementation Costs	• Forty hours of direct training with ongoing supervision • Consultation for 4 to 6 months via conference calls, videotapes, distance learning • $3,000 per person (5 day workshop)
Service Delivery Costs	• Clinic-based • Community-based • Home-based • Estimated cost savings for child welfare system, and victim health and mental health costs, per participant: $228 - $5,189. (Lee, et al., 2008)
Standard Training Protocol	• Yes • Assessment instruments • Scoring forms • Step by step clinician guide • Manualized training, coding of sessions and handouts.
Proprietary	• Yes
Sustainability	Information not available at this time
Contact	Erical Pearl/Erna Olafson, Ph.D, Psy.D Trauma Treatment Training Center Cincinnati Children's Hospital 3333 Burnett Avenue MLC 3008 Cincinnati, Ohio www.OhioCanDo4kids.org Care Diagnostic and Treatment Center UC Davis Health Systems 3300 Stockton Blvd. Sacramento, CA 95820 800-770-6992 chinh.pham@ucdmc.ucdavis.edu

Program	Parenting Wisely
Population	Parents of children 3-18
Cultural Evidence	Research studies have been carried out with predominately Caucasian participants
Risk and Protective Factors	**Risk:** • Life stressors • Poor refusal skills • Lack of empathy • Family management problems • Poor family attachment • Negative attitude toward school **Protective:** • Self-efficacy • Social competencies and problem solving skills • Effective parenting • Presence and involvement of caring and supportive adults • Good relationships with peers
Level of Evidence	Promising
Outcomes	1. Improvement in child behavior 2. Increased knowledge of adaptive parenting practices 3. Improvements in parental sense of competency
Prevention: Universal/Selective	Universal Selective
Early Intervention	Early Intervention
Description	Parenting Wisely is a set of interactive, computer-based training programs for parents of children ages 3-18 years. Based on social learning, cognitive behavioral, and family systems theories, the programs aim to increase parental communication and disciplinary skills. The original Parenting Wisely program, American Teens, is designed for parents whose preteens and teens are at risk for or are exhibiting behavior problems such as substance abuse, delinquency, and school dropout. Parents use this self-instructional program on an agency's personal computer or laptop, either on-site or at home, using the CD-ROM or online format. During each of nine sessions, users view a video enactment of a typical family struggle and then choose from a list of solutions representing different levels of effectiveness, each of which is portrayed and critiqued through interactive questions and answers. Each session ends with a quiz. All nine sessions can be completed in 2 to 3 hours. Parents also receive workbooks containing program content and exercises to promote skill building and practice. Adaptations of the original Parenting Wisely program have been created for various groups of youth. One of these adaptations, Young Children, targets children ages 3-9 years. Although the studies reviewed in this summary primarily evaluated the original version of Parenting Wisely, the Young Children version was also evaluated, as were adaptations created to be implemented with groups of parents.

Program	Parenting Wisely
Staffing Requirements	• Receptionist or practitioner to introduce family to program • No minimum provider qualifications
Service Delivery Setting	• Adoptive Home • Birth Family Home • Community Agency • Foster Home • Hospital • Outpatient Clinic • Residential Care Facility • School
Implementation Costs	• Parent workbooks (100 pages) are required, one per family cost from $9 to $5.75 depending on the quantity. • The program is delivered on a CD-Rom, which must be purchased for $599. The CD-ROM comes with a kit which includes a manual for community implementation, 5 parent workbooks, program completion certificates, program brochures, referral cards, and a floppy disk containing evaluation forms • Also available in an abbreviated and non-interactive form on a set of three videotapes which can be used as a booster for in-home use after the family has used the CD-ROM. The videotape set is $199 for purchasers of the CD-ROM, and $299 for others • Desktop and laptop computers, small private room • For group administration, LCD projector, screen, and room to hold 10-16 people • No expendable supplies are required, but incentives to get parents to use the program often help
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• 1-2 days, 7-14 hours • No training to implement and one staff member can deliver the program
Proprietary	• Proprietary
Sustainability	• Free telephone consultation is provided if needed
Contact	Donald A. Gordon, Ph.D. Family Works, Inc. 34 West State Street, Room 135B, Unit 8 Athens, OH 45701–3751 Phone: (866) 234-9473 Fax: (541) 482-2829 E-mail: familyworks@familyworksinc.com Web site: www.familyworksinc.com

Program	SafeCare
Population	Parents at risk for child maltreatment. In-home parenting model.
Cultural Evidence	Not reported
Risk and Protective Factors	None noted
Level of Evidence	Promising
Outcomes	1. Lower rates of re-abuse reporting 2. Significant improvements in health, safety and parenting
Prevention: Universal/Selective	
Early Intervention	Early intervention – families are referred by child welfare workers.
Description	SafeCare is an in-home parenting model program that provides direct skill training to parents in child behavior management and planned activities training, home safety training, and child health care skills to prevent child maltreatment. Weekly sessions approximately 1.5 hours each for 18-20 weeks, there is a homework component, and it is typically conducted in an adoptive home, birth family home, and foster home. The parent component addresses difficulty managing behavior and child health and safety concerns. The child component is for children 0-5 and addresses difficult behavior and inability to do developmentally appropriate daily living tasks.

Program	SafeCare
Staffing Requirements	• Home visitor • Coach • BA preferable but not necessary
Service Delivery Setting	• Community-based • In home • Foster homes • Adoptive homes
Implementation Costs	• Small numbers trained at a time • Implementation costs depend on number of staff being trained
Service Delivery Costs	• Weekly session 1. 5 hrs • 18-20 weeks
Standard Training Protocol	• Trained on-site by certified trainers • Five days per week • 8 hours per day
Proprietary	• Yes
Sustainability	• Training provided on-site by certified trainers • Site can have a staff trained as a certified coach who can train new staff
Contact	John Lutzker, Ph.D. SAFE/CARE/UCCED Centers 404-413-1299--fax 404-413-1284 jlutzker@gsu.edu www.safecarecener.org Daniel Whitaker" <dwhitaker@gsu.edu>

Program	Triple P – Positive Parenting Program
Population	Parents and caregivers of children birth through age 18. Multi-level system of parenting and family support.
Cultural Evidence	One study carried out in Hong Kong and a prevention trial underway in South Carolina with a significant percent of African-American participants.
Risk and Protective Factors	None noted
Level of Evidence	Well-supported
Outcomes	1. Decreased child behavior problems 2. Increased parental competence 3. Decreased parental stress 4. Higher levels of parental self-efficacy in handling home and work responsibilities
Prevention: Universal/Selective	Universal and selective prevention
Early Intervention	Early intervention for referred families
Description	The Triple P—Positive Parenting Program is a multilevel system or suite of parenting and family support strategies for families with children from birth to age 12, with extensions to families with teenagers ages 13-16. Developed for use with families from many cultural groups, Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The program, which also can be used for early intervention and treatment, is founded on social learning theory and draws on cognitive, developmental, and public health theories. Triple P has five intervention levels of increasing intensity to meet each family's specific needs. Each level includes and builds upon strategies used at previous levels. • Level 1: Universal Triple P is a media-based information strategy. • Level 2: Selected Triple P provides specific advice on how to solve common child developmental issues and minor child behavior problems includes parent tip sheets and videos delivered in 1-2 brief 20-minute consultations. • Level 3: Primary Care Triple P targets children with mild to moderate behavior difficulties and includes active skills training with rehearsal and self evaluation delivered through brief and flexible consultation, four 20-minute sessions. • Level 4: Standard Triple P and Group Triple P is an intensive strategy for parents of children with more severe behavior difficulties. This level is delivered in 10 individual or 8 group sessions totaling 10 hours. • Level 5: Enhanced Triple P is an enhanced behavioral family strategy for families in which parenting difficulties are complicated by other sources of family distress, includes practice sessions, mood management strategies, stress coping skills, and partner support skills. Enhanced Triple P extends Standard Triple P by adding 3-5 sessions tailored to the needs of the family.

Program	Triple P- Positive Parenting Program
Staffing Requirements	• Professional practitioners • Post-secondary qualifications are required in Health, Education, or Social Services • Practitioners should have knowledge of child/ adolescent development with experience working with families, plus accreditation
Service Delivery Setting	• Adoptive Home • Birth Family Home • Child Care Center • Community Agency • Foster Home • Hospital • Outpatient Clinic • Religious Organization • Residential Care Facility • School
Implementation Costs	• Depends on program level, number of participants, and organizational configuration.
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Attendance at a dedicated training course • Implementation of Triple P in the workplace, including development of peer support networks • Completion of accreditation requirements • Access to Triple P Provider Network • 2-5 day training plus 1 day accreditation depending on level of intervention
Proprietary	• Yes
Sustainability	• Depends on program level, number of participants, and organizational configuration.
Contact	Triple P America 1205 Lincoln Street • Columbia, SC 29201 PO Box 12755 • Columbia, SC 29211 (803) 451.2278 email: contact.us@triplep.net

Programs for Individuals Experiencing Early Onset of Serious Psychiatric Illness

Program	Cognitive Behavioral Therapy for Late Life Depression
Population	Older adults (55+) being treated on an outpatient basis for depression
Cultural Evidence	Random clinical trials have demonstrated effectiveness among Latino, Chinese, and African-American consumers
Risk and Protective Factors	Protective: • Identification of negative thoughts and ability to challenge and develop more adaptive thoughts • Engagement in pleasant activities
Level of Evidence	Well-supported
Outcomes	1. Reduced depressive symptoms 2. Reduced depression and re-occurrence of depression 3. Improved life satisfaction 4. Improved overall adjustment and coping strategies 5. Decreased psychiatric symptoms
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	This program is an active, directive, time-limited, and structured problem-solving approach program that follows the conceptual model and treatment program developed by Aaron Beck and his colleagues. CBT for Late-Life Depression includes specific modifications for elderly depressed individuals who are being treated as outpatients. The intervention includes strategies to facilitate learning with this population, such as repeated presentation of information using different modalities, slower rates of presentation, and greater use of practice along with greater use of structure and modeling behavior. Patients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and develop more adaptive and flexible thoughts. Where appropriate, emphasis is also placed on teaching patients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 50- to 60-minute sessions following a structured manual.

Program	Cognitive Behavioral Therapy for Late Life Depression
Staffing Requirements	• Minimum masters level clinician (ideally trained in CBT)
Service Delivery Setting	• Traditionally delivered in clinic settings, but flexible
Implementation Costs	• Manuals can be downloaded for free from Stanford University's Older Adult and Family Center website (http://oafc.stanford.edu) • Hard copies can be obtained by paying copying and postage to Stanford's clinic
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• None
Proprietary	• No
Sustainability	• No criteria
Contact	Larry W. Thompson, Ph.D. Professor, Emeritus Stanford University School of Medicine P.O. Box 3926 Los Altos, CA 94024-0926 Phone: (650) 400-8171 E-mail: larrywt@stanford.edu Dolores Gallagher-Thompson, Ph.D., ABPP Research Professor Department of Psychiatry and Behavioral Sciences Stanford University School of Medicine P.O. Box 3926 Los Altos, CA 94024-0926 Phone: (650) 400-8172 E-mail: dolorest@stanford.edu

Program	Early Detection and Intervention for the Prevention of Psychosis (EDIPP)
Population	**Young people experiencing ARMS** **Teens and TAY ages 12-25**
Cultural Evidence	**No information available**
Risk and Protective Factors	**None noted**
Level of Evidence	**Promising:** • **Ongoing trials**
Outcomes	**1. Delayed onset of a psychotic disorder** **2. Reduced symptoms** **3. Improved functioning**
Prevention: Universal/Selective	**Universal and selective**
Early Intervention	**Early Intervention for individuals experiencing a first break**
Description	**Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program – currently underway in six sites, funded by the Robert Wood Johnson Foundation and built on the findings of TIP, PACE, EPPIC and PIER programs (PIER serves as program office for funded sites):** • **PIER (Maine Medical Center/Portland, ME)** • **RAP (Zucker Hillside Hospital/Queens, NY)** • **EDAPT (UC Davis/Sacramento, CA)** • **EAST (Mid-Valley Behavioral Health Care Network/Salem, OR)** • **EARLY (Univ. of NM/Albuquerque, NM)** • **M3P (Univ. of Michigan/Ypsilanti, MI)** **a) Targeted and universal community education and outreach aimed at increasing early identification** **b) Universal community education aimed at reducing stigma and removing barriers to treatment** **c) Clinical service activities aimed at engagement and treatment**

Description cont'd	**The focus of these efforts is to interrupt the very early progression of psychotic disorders. The goals are to improve outcomes and prevent the onset of the psychotic phase of illnesses like Bipolar Disorder, Major Depression, and Schizophrenia. The program seeks to:** **1. Educate and train the provider community, the school professional work force, and other key professionals who might encounter young persons in the early stages of deterioration toward psychosis. This extends to the education of the entire area population.** **2. Identify, and help others to identify, young people who are manifesting prodromal (early signs) or active symptoms and signs of schizophrenia and other major psychotic disorders.** **3. Evaluate individuals' risk for actual psychosis.** **4. Treat those who are at substantial risk with an empirically-tested package of psychosocial and psychopharmacological interventions.** **5. Maintain a long-term relationship with individuals and their families to assure the clinical and human support that have been found to be necessary to achieve a full secondary prevention effect.** **The program advocates psychosocial and drug treatments that can be tailored to individual levels.** **The critical feature is the clinical outreach by a team to general practitioners, guidance counselors, and, the population at large to educate and inform them about the early signs of psychosis. This project will use state-of-the-art treatments in a new application: secondary prevention of psychosis in vulnerable individuals.** **This three-phase program initially targets health and educational professionals who work most closely with youth. A team of mental health professionals will reach out to physicians, schools and colleges, social workers, guidance counselors, high school nurses, police and others likely to encounter young persons at risk for psychosis. The second phase is educating the community. Phase three is the establishment of an assessment and treatment service that will identify potential program participants and provide family intervention and education, along with medication therapy, as necessary. The staff will intervene with these at-risk or already ill young persons, with the capacity for longer-term follow-up.** **The program provides comprehensive diagnostic and treatment services for children and young adults who have recently developed a psychotic disorder, or who are at high risk for one of these disorders and are experiencing what might be prodromal symptoms.** **A multi-site study funded by the Robert Wood Johnson Foundation is being implemented to identify and provide mental health services to individuals and their families who are experiencing early signs and symptoms of psychosis.** **The goal of the participating sites is to intervene as early as possible in order to prevent the development of disease-related deficits and treatment-related side effects. In addition, the program attempts to empower individuals to become active participants in their treatment and to help people progress toward their personal, social and occupational goals. The program provides targeted medication and psychosocial interventions, as well as case management services, with the goals of early diagnosis, treatment, and disability prevention.**

Program	**Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program:** • **PIER – program office (Maine Medical Center/Portland, ME)** • **RAP (Zucker Hillside Hospital/ Queens, NY)** • **EDAPT (UC Davis/ Sacramento, CA)** • **EAST (Mid-Valley Behavioral Health Care Network/Salem, OR)** • **EARLY (Univ. of NM/Albuquerque, NM)** • **M3P (Univ. of Michigan/ Ypsilanti, MI)** • **Targeted and universal community education & outreach aimed at increasing early identification** • **Universal community education aimed at reducing stigma & removing barriers to treatment** • **Clinical service activities aimed at engagement and treatment** • **Psychosocial interventions and medication; emphasis on family psycho-education and supported education and employment**
Staffing Requirements	**(This info reflects their current thought process, they are working with RWJF on specifics of dissemination.)** • **.5 FTE Administrative Asst** • **.5 FTE Child Psychiatrist** • **1 FTE Master's level licensed clinician** • **1 FTE RN/Team Leader** • **.2 FTE O/T**
Service Delivery Setting	• **Clinic-based** • **Outreach is largely to middle and high schools with health care providers as secondary audience**
Implementation Costs	• **First year of training, supervision and materials w/b between $95k and $110k** • **Second year w/b additional but significantly less than first**
Service Delivery Costs	**Information not available at this time**
Standard Training Protocol	• **Yes** • **One week initial assessment and clinical training** • **First year would include intensive monitoring - e.g, fidelity assessments (likely multiple modes), monthly supervision of approx. 1 hour in <u>each</u> component (assess, clinical, multi-family groups, outreach). Any additional training needs w/b met within context of supervision.**
Proprietary	• **Yes**
Sustainability	• **Assuming satisfactory performance after first year of fidelity monitoring and supervision, certification is granted** • **Currently no ongoing criteria for maintaining certification**
Contact	**William McFarlane, MD** **PIER Program** **932 Congress St.** **Portland, ME 04102** **1-877-880-3377**

Program	Early Psychosis Prevention and Intervention Centre (EPPIC)
Population	Young people experiencing psychosis • TAY 15-25
Cultural Evidence	No information available
Risk and Protective Factors	None noted
Level of Evidence	Emerging
Outcomes	1. Reduced symptoms 2. Improved functioning
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	Early Psychosis Prevention and Intervention Centre (EPPIC) is a program within the ORYGEN Youth Health Program in Melbourne, Australia: • EPPIC is a comprehensive service addressing the needs of young people with psychotic disorders. EPPIC aims to facilitate early identification and treatment of psychosis and therefore reduce the disruption to the young person's functioning and psychosocial development. There is often an extended period of delay (2-3 years on average) when problems intensify, and there may be a failure to access appropriate help or help may be sought in inappropriate settings. These delays may be damaging to a young person, often in the crucial period of adolescence. Secondary problems such as substance abuse, unemployment and behavioral problems may develop or intensify and the illness itself may become more deeply entrenched. EPPIC aims to change this through: • Early identification and treatment of primary symptoms of psychotic illness • Improved access and reduced delays in initial treatment • Reducing frequency and severity of relapse; and increasing time to first relapse • Reducing secondary morbidity in the post-psychotic phase of illness • Reducing disruption to social and vocational functioning, and psychosocial development in the critical period following onset of illness when most disability tends to accrue • Promote well-being among family members and reduce the burden for caregivers EPPIC takes a 'whole person' approach to mental illness. It aims to: • Explore the possible causes of psychotic symptoms and treat them • Educate the young person and their family about the illness • Reduce disruption in a young person's life caused by the illness • Support the young person through recovery • Reduce the young person's chances of having another psychotic experience in the future • Involvement of youth clients at multiple levels • Case management • Medication management • Group treatment • Inpatient treatment • Family psycho-education

Program	**Early Psychosis Prevention and Intervention Centre (EPPIC) is a program within the ORYGEN Youth Health Program in Melbourne, Australia:** • **Involvement of youth clients at multiple levels** • **Case management** • **Medication management** • **Group treatment** • **Inpatient treatment** • **Family psycho-education**
Staffing Requirements	**Information not available at this time**
Service Delivery Setting	**Information not available at this time**
Implementation Costs	• **All costs below are in AUD and would also include GST (goods & service tax)** • **Package of training manual & video/DVD $55** • **Additional supp videos/DVDs $12-30/each** • **Additional manuals $18-50/each** • **CAARMS training manual & video/DVD $90** • **Community training resources $110** • **Education and training package for MH workers $110 (unclear if avail outside Australia)** • **Distance learning on depression in young people, assessment, treatment and risk $273**
Service Delivery Costs	**Information not available at this time**
Standard Training Protocol	• **Training and Consultation provided w/in Australia** • **Manuals, videos, DVDs, info sheets, and training packages avail from website, and state c/b tailored to meet individual needs**
Proprietary	• **Not specified (except for CAARMS assessment protocol)**
Sustainability	**Information not available at this time**
Contact	

Program	Gatekeeper Case-Finding Model
Population	Older adults (55+) who may be experiencing signs and symptoms of distress
Cultural Evidence	No information available
Risk and Protective Factors	Risk: • Social isolation
Level of Evidence	Emerging
Outcomes	1. Increased identification of older adults in need of mental health, health, and/or social services 2. Increased enrollment and retention in case management services
Prevention: Universal/Selective	Selective
Early Intervention	-
Description	This program is designed to identify at-risk older adults who do not typically come to the attention of the mental health and aging service delivery systems. With this technique, nontraditional community referral sources are organized and trained to identify high-risk elders who may be experiencing problems that threaten their ability to live independently and safely in the community. Once identified, Gatekeepers refer the older person to a designated agency for a comprehensive assessment and evaluation with subsequent linkage to needed mental health, aging, medical, or other social services. Gatekeepers are employees of corporations, businesses, and other community organizations. They include meter readers, utility workers, residential property appraisers from the county assessor's office, bank personnel, apartment and mobile home managers, postal carriers, fuel oil dealers, police, sheriff and fire department personnel, and code enforcement employees. Gatekeepers are trained to become keen observers of an older adult person's personal appearance, mental and emotional states, personality changes, physical changes and losses, social problems, substance abuse, conditions of the home, caregiver stress, abuse or neglect, financial hardship and risk factors of suicide, any of which may indicate that an older person needs assistance.

Program	Gatekeeper Case-Finding Model
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)
Population	Older adults (60+) who have major depression or dysthymic disorder
Cultural Evidence	Evaluation included African-American and Latino consumers
Risk and Protective Factors	Protective: • Behavioral activation (physical activity or engagement in pleasant activities) • Anti-depressant medication when chosen by patient • Problem solving treatment in primary care when chosen by patient
Level of Evidence	Well-supported
Outcomes	1. Reduced severity of depressive symptoms 2. Improved functioning
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	IMPACT is an intervention for patients 60 years or older who have major depression or dysthymic disorder. The intervention is a 1-year, stepped collaborative care approach in which a nurse, social worker, or psychologist works with the patient's regular primary care provider to develop a course of treatment. Intervention participants receive a 20-minute educational videotape and a booklet about late-life depression and are encouraged to have an initial visit with a depression care manager (DCM). During the first visit, the DCM completes an initial assessment, provides education about treatment, and discusses the patient's preference for depression treatment. All patients are encouraged to engage in behavioral activation such as physical activity or pleasant events scheduling. The IMPACT treatment algorithm suggests an initial choice of an antidepressant medication or a course of Problem Solving Treatment in Primary Care, 6-8 sessions of brief structured psychotherapy delivered by a DCM in the primary care setting. The DCM works with the patient and his or her primary care provider to establish a treatment plan according to the recommended treatment algorithm; the patient and provider make the actual treatment choices. The DCM follows up with patients monthly during the continuation phase.

Program	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)
Staffing Requirements	• Depression Case Manager, or DCM (c/b nurse, social worker, or licensed counselor – approx. caseload 100-150 patients) • DCMs work with primary care providers and consulting psychiatrists as an integrated team (not simply co-location)
Service Delivery Setting	• Clinic
Implementation Costs	• The estimated cost per participant is $500 per year. Start-up costs vary depending on how the organization chooses to implement. • All program materials are available free of charge, either via the IMPACT Implementation Center Web site (http://impact-uw.org) or in hard copy from the Center. In-person training is the primary start-up cost; however, free online training is available. If an organization chooses in-person training for DCMs, the average cost is $200 per trainee. • Case-based training in the evidence-based Problem Solving Treatment (PST-PC) technique costs approximately $1,000-$1,500 per trainee (required for certification in PST, whether initial training is in person or online).
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Initial training can be in person or on-line. Case supervision following initial training averages 9 recorded sessions with 2-3 patients to become certified in evidence-based Problem-Solving Treatment (PST) • No booster trainings or ongoing consultation
Proprietary	• No
Sustainability	• No criteria beyond certification in PST
Contact	IMPACT Implementation Center University of Washington Psychiatry & Behavioral Sciences 1959 NE Pacific, Box 356560 Seattle, WA 98195-6560 Diane Powers, Program Manager 206-685-7095 Andrea Panniero, Program Coordinator 206-221-3637

Program	"Integrated Treatment" as evaluated by the OPUS trial
Population	• Young adults and adults experiencing their first episode of psychosis • Adults 18-45
Cultural Evidence	No information available
Risk and Protective Factors	None noted
Level of Evidence	Emerging
Outcomes	1. Reduced symptoms 2. Improved functioning 3. Decreased family burden (outcomes maintained at 1- and 2-yr follow-ups)
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	"Integrated Treatment" as evaluated by the OPUS trial (Norway; Nordentoft et al, 2005) • Max caseload of 10 (standard 25) • Assertive community treatment • Multifamily groups • Psycho-education • Social skills training Integrated treatment consisted of assertive community treatment, psychoeducational multi-family groups and social skills training. Further description unavailable in English.

Program	**"Integrated Treatment" as evaluated by the OPUS trial (Norway; Nordentoft et al, 2005)** • Assertive community treatment • Multifamily groups • Psycho-education • Social skills training
Staffing Requirements	• Case management for min 2 yrs • 1:10 max caseload • Psychiatrist • No clear specs on who runs groups or provides social skills training
Service Delivery Setting	• Community and clinic-based • Multi-disciplinary team provides integrated services (best if co-located)
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	

Program	Live Well, Live Long, Steps to Mental Wellness
Population	Older adults with symptoms of depression and/or anxiety
Cultural Evidence	Intervention guidelines include culturally specific information for addressing depressive symptoms among a variety of diverse racial/ethnic and cultural groups
Risk and Protective Factors	Protective: • Physical activity • Good nutrition • Adequate rest and sleep • Stress reduction activities • Optimistic attitude • Optimal medication management • Emotionally enriched environments
Level of Evidence	Components are Well-supported
Outcomes	Outcomes of specific components include: 1. Reduced depression and/or anxiety symptoms 2. Improved functioning
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	Health promotion strategies and materials developed by the American Society on Aging through a cooperative agreement with the Centers for Disease Control and Prevention. The materials are in the public domain and can be use by staff in senior citizen centers, health education or public health settings or other community-based organizations serving older adults at risk to depression and anxiety.

Program	Live Well, Live Long, Steps to Mental Wellness
Staffing Requirements	• Flexible – need a leader, a speaker for the program, someone who can coordinate efforts
Service Delivery Setting	• Flexible – work with existing community agencies to find venues that are convenient and accessible for older adults
Implementation Costs	• Materials can be downloaded for free from the American Society on Aging program website (http://www.asaging.org/cdc/module5/home.cfm) • Includes handouts, questions to consider in planning, implementation steps, depression screening tools, and steps for evaluation and follow-up
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• None
Proprietary	• No
Sustainability	• No criteria
Contact	

Program	Personal Assessment and Crisis Evaluation (PACE)
Population	Young people experiencing ARMS • TAY 15-25
Cultural Evidence	No information available
Risk and Protective Factors	None noted
Level of Evidence	Promising: • Ongoing trials in Australia • Components evaluated in US and UK
Outcomes	1. Delayed onset of a psychotic disorder 2. Improved functioning (initially and at follow-up, with med adherence)
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	Personal Assessment and Crisis Evaluation (PACE) clinic within the ORYGEN Youth Health program in Melbourne, Australia: • Cognitive-behavioral therapy • Meds (antipsychotics and atypicals) PACE works with young people, aged 15-25 who might be at risk of developing psychosis. By identifying people who are at risk of psychosis and providing them with appropriate treatment, it is hoped that early symptoms will be reduced, while also delaying or perhaps preventing the development of mental health problems. Young people who come to PACE often describe other changes such as: • Having more difficulty than usual coping with work or school • Feeling tired, lacking energy, paranoid or worried about other people and their actions • Noticing a change in the way things look or sound, or seeing things in the environment that other people do not. PACE aims to reduce these issues on the young person, and stop them from getting worse. PACE Clinic offers a free confidential counseling service and can assist in referring to other services if necessary or more appropriate.

Program	**Personal Assessment and Crisis Evaluation (PACE)—clinic within the ORYGEN Youth Health program in Melbourne, Australia:** • **Cognitive-behavioral therapy** • **Meds (antipsychotics and atypicals)**
Staffing Requirements	• **Case management as needed** • **Psychiatry as needed** • **No specs on who provides CBT interventions as needed**
Service Delivery Setting	• **Clinic-based**
Implementation Costs	**Information not available at this time**
Service Delivery Costs	**Information not available at this time**
Standard Training Protocol	**Information not available at this time**
Proprietary	**Information not available at this time**
Sustainability	**Information not available at this time**
Contact	**Information not available at this time**

Program	Prevention of Suicide in Primary Care Elderly (PROSPECT)
Population	Older adults presenting to primary care with signs of depression and/or suicidal ideation
Cultural Evidence	No information available
Risk and Protective Factors	Protective: • Application of treatment algorithm for geriatric depression in primary care • Ongoing treatment management
Level of Evidence	Well-supported
Outcomes	1. Reduced depression 2. Reduced suicidal ideation
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	PROSPECT aims to prevent suicide among older adult primary care patients by reducing suicidal ideation and depression. The intervention components are: (1) recognition of depression and suicide ideation by primary care physicians, (2) application of a treatment algorithm for geriatric depression in the primary care setting, and (3) treatment management by health specialists (e.g., nurses, social workers, and psychologists). The treatment algorithm assists primary care physicians in making appropriate care choices during the acute, continuation, and maintenance phases of treatment. Health specialists collaborate with physicians to monitor patients and encourage patient adherence to recommended treatments. Patients are treated and monitored for 24 months.

Program	Prevention of Suicide in Primary Care Elderly (PROSPECT)
Staffing Requirements	• Health specialists (c/b nurse, social worker or psychologist) who conduct 24-month care management and coordinate with primary care providers • Also a licensed clinician (c/b same as health specialist or c/b different) trained in delivering interpersonal psychotherapy (or the PST intervention trained in IMPACT)
Service Delivery Setting	• Clinic
Implementation Costs	• Funding was only for the effectiveness trial, no formal dissemination materials exist or are planned; • Dr. Paul Raue (praue@med.cornell.edu) is happy to share his hard-copy procedures manual with any site interested in implementing PROSPECT. Per Dr. Raue, intervention is very similar to the IMPACT intervention.
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Patrick J. Raue, Ph.D. Associate Professor of Psychology in Psychiatry Weill Medical College of Cornell University White Plains, NY 10605 Phone: (914) 997-8684 Fax: (914) 682-6979 E-mail: praue@med.cornell.edu

Program	Program of All-Inclusive Care for the Elderly (PACE)
Population	Older adults who meet criteria for admission to a nursing facility but choose to remain in the community (a capitated benefit of integrated Medicare and Medicaid financing)
Cultural Evidence	Evaluated with diverse racial/ethnic groups including African-Americans, Asians, and Latinos
Risk and Protective Factors	None noted
Level of Evidence	Promising
Outcomes	1. Decreased use of high-end medical services and increased use of ambulatory services 2. Increased use of support services 3. Improved health status, quality of life, and 4. Functional status 5. Decreased morbidity 6. Decreased comorbid diagnoses
Prevention: Universal/Selective	Selective
Early Intervention	
Description	The Program of All-Inclusive Care for the Elderly (PACE) features a comprehensive and seamless service delivery system and integrated Medicare and Medicaid financing. Eligible individuals are age 55 years or older and meet the clinical criteria to be admitted to a nursing home but choose to remain in the community. An array of coordinated services is provided to support PACE participants to prevent the need for nursing home admission. An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs; develops care plans; and delivers or arranges for all services (including acute care and, when necessary, nursing facility services), either directly or through contracts. PACE programs provide social and medical services, primarily in an adult day health center setting referred to as the "PACE center," and supplement this care with in-home and referral services in accordance with the participants' needs. Each participant can receive all Medicare- and Medicaid-covered services, as well as other care determined necessary by the interdisciplinary team.

Program	Program of All-Inclusive Care for the Elderly (PACE)
Staffing Requirements	• An interdisciplinary team, consisting of professional and para-professional staff, assesses participants' needs; develops care plans; and delivers or arranges for all services (including acute care and, when necessary, nursing facility services), either directly or through contracts.
Service Delivery Setting	• PACE programs provide social and medical services, primarily in an adult day health center setting referred to as the "PACE center," and supplement this care with in-home and referral services in accordance with the participants' needs.
Implementation Costs	• For a health care organization to be approved as a PACE program, the State must elect PACE as a voluntary State option under its Medicaid plan. In addition, the prospective PACE organization and the State must work together in the development of the PACE provider application. On behalf of the prospective provider, the State submits the application to the Centers for Medicare and Medicaid Services (CMS) with assurance of the State's support of the application and its contents. Each approved PACE program receives a fixed amount of money per PACE participant regardless of the services the participant utilizes. • A membership with the National PACE Association includes access to all the materials needed to implement the program. The fee for the first year of membership, called Exploring PACE, is $3,000, and the fee for subsequent years is $8,500. Other startup costs vary for each facility. PACE programs receive Medicare and Medicaid dollars to support the costs of services; in 2006, the Medicare and Medicaid capitation rate average (per member, per month) was $1,981.16 and $2,968.76, respectively.
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• PACE Technical Assistance Centers (TAC) are comprised of existing PACE programs that provide guidance for prospective PACE providers as well as initial and ongoing consultation for programs. • Not a standard training protocol, per se, but standards must be met and maintained. • (www.npaonline.org)
Proprietary	• Mix of public and proprietary
Sustainability	• Ongoing membership in National PACE Association required, with ongoing state and federal monitoring of regulatory requirements.
Contact	National PACE Association 801 N. Fairfax Street, Suite 309 Alexandria, VA 22314 info@npaonline.org Phone 703/535-1565 Fax 703/535-1566

Program	Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
Population	Older adults (60+) with minor depression or dysthymia receiving home-based social services from community services agencies
Cultural Evidence	Evaluation included African-American consumers (36%)
Risk and Protective Factors	Protective: • Recognizing depressive symptoms • Increasing engagement in social and pleasant activities
Level of Evidence	Supported
Outcomes	1. Reduced symptoms of depression 2. Improved health-related quality of life in functional and emotional well-being
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	PEARLS is an intervention for people 60 years and older who have minor depression or dysthymia and are receiving home-based social services from community services agencies. The program is designed to reduce symptoms of depression and improve health-related quality of life. PEARLS provides eight 50-minute sessions with a trained social service worker in the client's home over 19 weeks. Counselors use three depression management techniques: (1) problem-solving treatment; (2) social and physical activity planning; (3) planning to participate in pleasant events. Counselors encourage participants to use existing community services and attend local events.

Program	Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
Staffing Requirements	• Organizational leader • PEARLS manager • Case Manager (counselors can case manage, but shouldn't serve both roles for any given client) • PEARLS counselor (licensed clinician) • Data coordinator • Clinical supervisor (psychiatrist familiar with Problem Solving Treatment)
Service Delivery Setting	• Home-based
Implementation Costs	• A toolkit can be downloaded free from the PEARLS website (http://depts.washington.edu/pearlspr/) which includes all screening tools, step-by-step instructions for delivering the intervention, a clinician self-assessment for model adherence, and other forms and program materials • A 3-day in-person training is offered intermittently by University of Washington, $500 per trainee (not required to be a PEARLS site, but strongly recommended) • While they have not yet, they are considering traveling to conduct on-site training, particularly in CA b/c w/b convenient (approx 20-25 trainees at a time)
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Strongly recommend participation in 3-day training • Their clinical research psychiatrist provides ongoing consultation & supervision in PST to local WA sites – recommend something similar in other implementation sites
Proprietary	• Mix of public and proprietary
Sustainability	• No criteria
Contact	For general PEARLS questions, please contact Sheryl Schwartz at sheryls@u.washington.edu or 206-685-7258.

Program	Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders
Population	Adults (ages 18-65+) who have experienced single or multiple/continuous traumas and have posttraumatic stress disorder (PTSD)
Cultural Evidence	Evaluations included African-American consumers (25-44%)
Risk and Protective Factors	Protective: • Ability to process traumatic event/s • Symptom management
Level of Evidence	Well-supported
Outcomes	1. Reduced severity of PTSD symptoms 2. Reduced symptoms of depression 3. Improved social adjustment
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	This is a cognitive-behavioral treatment program for adult men and women (ages 18-65+) who have experienced single or multiple/continuous traumas and have post-traumatic stress disorder (PTSD). The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety. PE has three components: (1) post-trauma difficulties, (2) imaginal exposure (also called revisiting the trauma memory in imagination), repeated recounting of the trauma memory, and (3) in vivo exposure, gradually approaching trauma reminders that are feared and avoided despite being safe. Treatment is individualized and is conducted by social workers, psychologists, psychiatrists, and other therapists trained to use the PE manual, which specifies the agenda and treatment procedures for each session. Standard treatment consists of 8-15 sessions conducted once or twice weekly for 90-minutes each. The duration of treatment can be shortened or lengthened depending on the needs of the client and his or her rate of progress.

Program	Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorder
Staffing Requirements	• Masters level and higher clinicians, preferred experience treating trauma victims
Service Delivery Setting	• Clinic-based • Veterans centers • Private practice office • Inpatient units
Implementation Costs	• Four day clinician training $950 (in Philadelphia) • Follow up consultation for a fee • Video or audio recordings for supervision • Reading list • Some materials available for no cost • Train 30 people per training group
Service Delivery Costs	• Individual treatment • Nine to 12 sessions 1-2 times a week; 90 minutes (varies) • Therapist uses the manual
Standard Training Protocol	• Reading lists • Treatment manual • Complete 4-5 day workshop, training varies from ½ day; 2-day; 4-day, requires two clients in treatment for supervision
Proprietary	• Mix of public/proprietary
Sustainability	• Do have a train the trainer model
Contact	Center for the Treatment and Study of Anxiety Department of Psychiatry, University of Pennsylvania 3535 Market Street, 600 N. Philadelphia, pa 19104 ctsa@mail.med.upenn.edu Contact Person: Melissa aworly@mail. med.upenn.edu

Program	Psychogeriatric Assessment and Treatment in City Housing (PATCH)
Population	Older adult (60+) public housing residents identified in need of ongoing mental health services
Cultural Evidence	Evaluation included African-American residents
Risk and Protective Factors	Risk: • Stigma • Decreased mobility • Lack of knowledge about depression and other forms of mental illness
Level of Evidence	Supported
Outcomes	1. Reduced symptoms of depression and other psychiatric symptoms
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	Psychogeriatric Assessment and Treatment in City Housing, also known as PATCH, is a program intended to meet the mental health needs of the elderly who live in public housing. In an effort to maintain the elderly in their existing environment, PATCH attempts to improve and coordinate community services to the elderly and to educate caregivers about their special needs. With two part-time psychiatrists and a nurse, it provides mental health assessments and referrals of the elderly for whom traditional treatment settings have been ineffective.

Program	Psychogeriatric Assessment and Treatment in City Housing (PATCH)
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Programs for Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

Program	Aggression Replacement Therapy
Population	12-17 year-old youth who are aggressive
Cultural Evidence	Data not reported
Risk and Protective Factors	**Risk:** • Pattern of high family conflict • Family violence • Poor parental supervision • Association with delinquent or aggressive peers • Mental health problem • Life stressors • Early onset of aggression **Protective:** • Effective parenting • Good relationships with peers • Social competencies and problem-solving • Self-efficacy
Level of Evidence	Promising
Outcomes	1. Reduced impulsiveness 2. Improved interpersonal skills 3. Decreased recidivism
Prevention: Universal/Selective	Universal for the Skill-streaming component Selective for the complete program
Early Intervention	Youth are referred
Description	Aggression Replacement Training® (ART®) is a multimodal psychoeducational intervention designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART® is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning. *Skill-streaming* uses modeling, role-playing, performance feedback, and transfer training to teach prosocial skills. In *anger-control training,* participating youths must bring to each session one or more descriptions of recent anger-arousing experiences (hassles), and over the duration of the program they are trained in how to respond to their hassles. *Training in moral reasoning* is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others and to train youths to imagine the perspectives of others when they confront various moral problem situations. The program consists of a 10-week, 30-hour intervention administered to groups of 8 to 12 juvenile offenders thrice weekly. The 10-week sequence is the "core" curriculum, though the ART® curriculum has been offered in a variety of lengths. During these 10 weeks, participating youths typically attend three 1-hour sessions per week, one session each of skill-streaming, anger-control training, and training in moral reasoning. The program relies on repetitive learning techniques to teach participants to control impulsiveness and anger and use more appropriate behaviors. In addition, guided group discussion is used to correct antisocial thinking. The ART® training manual presents program procedures and the curriculum in detail and is available in both English and Spanish editions. ART® has been implemented in school, delinquency, and mental health settings.

Program	Aggression Replacement Therapy (Using Teaching Pro-Social Skills)
Staffing Requirements	• Facilitators (minimum of 2 for each group) trained in ART • Clinicians, Bachelor's or paraprofessionals
Service Delivery Setting	• Versatile – outpatient and inpatient settings • Juvenile halls • Camps • Detention centers • School settings, etc.
Implementation Costs	• CIMH Community Development Team Protocol - $8,000 for Team (1 Administrator, 5 Practitioners)
Service Delivery Costs	• Frequency and length of groups vary by implementation. • Some outcome measures must be purchased from publisher – cost determined by order. • Estimated cost savings juvenile justice system, crime victim & tax payers: $8,287 to $33,143 (Aos, et al., 2001).
Standard Training Protocol	CIMH Community Development Team Training Protocol • Pre-implementation Planning calls • Initial Clinical Training 2-3 days • One Booster Training – 1 day (approximately 4 months following initial clinical) • Twenty one–hour, team-based phone consultation calls • Twelve Administrator Calls • Review of 2 video tapes per trained facilitator • All group instructional materials • Outcome evaluation protocols with measures, data base and twice yearly dashboard reports
Proprietary	• All Aggression Replacement Training materials are available through Research Press • Practice is Public
Sustainability	• Regular group supervision • Use of the ART Fidelity Checklist • Agency Trainer Protocol - $2,500 per Agency Trainer. • Replacement Training to address attrition of staff - $950 per Facilitator • Routine collection of evaluation protocol
Contact	Todd Sosna, Ph.D. Senior Associate California Institute for Mental Health 2125 19th St. tmq@verizon.net (916) 549-5506

Program	Breaking Cycles	
Population	Youth 12-17 who are at risk to juvenile justice involvement or who become engaged in delinquent behaviors	
Cultural Evidence	52% of the research participants were Latino	
Risk and Protective Factors	Risk: • School suspensions • Pattern of high family conflict • Association with delinquent peers • Favorable attitudes towards drug use • Early onset of aggression	Protective: • Effective parenting • Involvement with positive peer group activities • Positive expectations
Level of Evidence	Promising	
Outcomes	1. Decreased probation referrals	
Prevention: Universal/Selective	Selective for youth not adjudicated	
Early Intervention	Early intervention for youth on probation	
Description	Breaking Cycles has components of both prevention and graduated sanctions. The prevention component targets youths who are not yet involved in the juvenile justice system but who exhibit problem behavior such as disobeying their parents, violating curfew, repeated truancy, running away from home, or experimenting with drugs or alcohol. Youths can also self-refer if they experience parental neglect or abuse or they have other problems at home. Community Assessment Teams (CATs)—consisting of a coordinator, case managers, probation officers, and other experts—assess the needs of the youth and his or her family and then provide direct services or referrals to resources in the community to reduce the high-risk behaviors. CATs speak many different languages to communicate directly with their clients. Whenever possible, services are brought directly to the client and family. The graduated sanctions component tries to prevent further involvement in delinquency by combining sanctions with treatment. A juvenile who is at risk of an out-of-home placement can be referred to Breaking Cycles through a Juvenile Court Order, then a screening committee determines whether the juvenile will enter the program by examining his or her current offense, prior criminal history, and other personal, social, and family characteristics. A youth is brought to Breaking Cycles, put into Juvenile Hall, and begins a 10- to 14- day evaluation of educational performance, mental health needs, drug/alcohol dependencies, self and family resiliency, institutional adjustment, and strengths and future goals. A case plan is developed for each youth by a multidisciplinary team, with the family's input. A youth can be placed in a community-based institution or a home. Many youths start in a highly structured environment and, through goal attainment, step down to a lower level of commitment. Reassessments are performed weekly on the basis of public safety, the youth's rehabilitation, and subsequent compliance with the program's case plan developed in the assessment plan.	

Program	Breaking Cycles
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	

Program	Brief Strategic Family Therapy	
Population	Families of youth 10-18 with substance use and conduct problems	
Cultural Evidence	Studies have been done primarily with Latino (Cuban) families	
Risk and Protective Factors	Risk: • Family management problems • Pattern of high family conflict • Antisocial behavior and alienation • Favorable attitudes toward drug and alcohol use • Early onset of aggression	Protective: • Effective parenting • Involvement with positive peer group activities • Social competencies and problem-solving
Level of Evidence	Supported	
Outcomes	1. Decrease in drug use 2. Decrease in conduct problems 3. Improvement in family functioning	
Prevention: Universal/Selective	Selective for youth at risk for substance abuse and conduct problems	
Early Intervention	Families with a youth on probation	
Description	Brief Strategic Family Therapy (BSFT) is a family-based intervention designed to prevent and treat child and adolescent behavior problems. BSFT targets children and adolescents who are displaying—or are at risk for developing—behavior problems, including substance abuse. BSFT is based on the assumption that adaptive family interactions can play a pivotal role in protecting children from negative influences and that maladaptive family interactions can contribute to the evolution of behavior problems and consequently are a primary target for intervention. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems. Therapy is tailored to target the particular problem interactions and behaviors in each client family. Therapists seek to change maladaptive family interaction patterns by coaching family interactions as they occur in session to create the opportunity for new, more functional interactions to emerge. Major techniques used are joining (engaging and entering the family system), diagnosing (identifying maladaptive interactions and family strengths), and restructuring (transforming maladaptive interactions). BSFT is a short-term, problem-oriented intervention. A typical session lasts 60 to 90 minutes. The average length of treatment is 12 to 15 sessions over more than 3 months. For more severe cases, such as substance-abusing adolescents, the average number of sessions and length of treatment may be doubled. Treatment can take place in office, home, or community settings.	

Program	Brief Strategic Family Therapy
Staffing Requirements	• Licensed staff preferred • Non-licensed staff (case manager/B.A. Level) possible if a part of a treatment team
Service Delivery Setting	• Office • Home • Community setting
Implementation Costs	• $50,000 - $60,000 Per cohort for first year of implementation • Five therapists per cohort • Total cost of 3 year implementation depends on which out year components are selected and number and length of consultation sessions. • Particular skills area deficiencies can be addressed on an individual basis.
Service Delivery Costs	• Interventions are 12-15 sessions of 60-90 minutes over a period of three months. The entire team is expected to participate.
Standard Training Protocol	• A 2-day on-site consultation with program leadership to determine if BSFT is a good programmatic fit • Training consists of four 3-day sessions with 4 to 6 months of telephone supervisions
Proprietary	• Yes
Sustainability	• In addition to the telephone supervision, best results are achieved if there is an in-house supervisor who has gone through separate supervisor curriculum training • Monthly clinical tapes are submitted for critique and to asses the adherence to the model with up to 40 individually identified skills rated. (Nine to 12 months post training)
Contact	Olva Hervis Family Therapy Training Institute of Miami 1221 Brickell Ave. 9TH Floor Miami, FL 33133 888-527-3828 ohervis@bsft-av.com TA PROVIDER Kathleen Shea 305-668-0850 kshea@bsft-av.com

Program	Coping Power Program
Population	Preadolescent boys who are aggressive and their parents
Cultural Evidence	The majority of the research participants were African-American
Risk and Protective Factors	**Risk:** • Low academic achievement • Family management problems • Association with aggressive peers • Poor refusal skills • Life stressors • Mental health problems **Protective:** • Presence and involvement of caring and supportive adults • Good relationships with parents • High expectations • Good relationships with peers • Social competencies and problem-solving
Level of Evidence	Well-supported
Outcomes	1. Decrease in aggression 2. Decrease in peer rejection 3. Decrease in substance use and in parental substance use 4. Improvement in behavior at school
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	The Coping Power Program is a multicomponent preventive intervention for aggressive children that use the contextual sociocognitive model as its conceptual framework. The sociocognitive model concentrates on the contextual parenting processes and on children's sequential cognitive processing. It posits that aggressive children have cognitive distortions at the appraisal stage of sociocognitive processing because of their difficulties in encoding incoming social information and in accurately interpreting social events and others' intentions. These children also have cognitive deficiencies at the problem solution stage of sociocognitive processing, and tend to generate maladaptive solutions for perceived problems. The model also emphasizes parenting processes in the development and escalation of problem behaviors. Child aggressive behavior arises fundamentally out of early contextual experiences with parents who provide harsh or irritable discipline, poor problem-solving, vague commands, and poor monitoring of their children's behavior. On the basis of this model, Coping Power Program was developed with parent and child components. Intervention covers 15 months (the 2nd half of 1 academic year and all of the next). The child component includes 8 intervention sessions in the 1st intervention year and 25 in the 2nd intervention year. Each group session lasts 40–60 minutes. The sessions include four to six boys and are co-led by a program specialist with a master's or doctoral degree in psychology or social work and by a school guidance counselor. The Coping Power child component was derived from a previously evaluated 18-session Anger Coping Program. The Coping Power child component sessions emphasize the following: behavioral and personal goal-setting, awareness of feelings and associated physiological arousal, use of coping self-statements, distraction techniques and relaxation methods when provoked and made angry, organizational and study skills, perspective taking and attribution retraining, social problem–solving skills, and dealing with peer pressure and neighborhood-based problems by using refusal skills. The parent component consists of 16 group sessions over the same 15-month intervention period. It is delivered in groups of four to six single parents or couples. Groups usually meet at the boys' schools and are led by two staff persons. Assertive attempts are made to promote parent attendance and to include both mothers and fathers in parent groups. The content of the parent

	component was derived from social-learning-theory–based parent training programs. Parents learn skills for identifying prosocial and disruptive behavioral targets in their children, rewarding appropriate child behaviors, giving effective instructions, establishing age-appropriate rules and expectations for children, applying effective consequences to negative child behavior, and establishing ongoing family communication through weekly family meetings. In addition, parents learn to support the sociocognitive skills that children learn in the Coping Power child component and to use stress-management skills to remain calm and in control during stressful or irritating disciplinary interactions with their children.

Program	**Coping Power Program**
Staffing Requirements	• **Masters/Doctorate in psychology or social work** • **School guidance counselor**
Service Delivery Setting	• **Schools in group setting**
Implementation Costs	• **Includes a 2-3 day initial trainings session** • **Two days if only the child component is selected and 3 if the parental component is selected** • **Costs are $1,500 per trainer per day (roughly one trainer per 25 trainees)** • **Trainings occur on-site or there are 2 residential sessions at the university annually**
Service Delivery Costs	• **There are 34 sessions for the child and 16 for the parents**
Standard Training Protocol	• **The curriculum is manualized and there are fidelity measures**
Proprietary	• **Yes**
Sustainability	• **There is group phone supervision (10-12 trainees per call) bi-weekly for 1 year costing $100 per hour** • **Additionally, review of taped sessions is available for evaluation of skill learning and model adherence** • **The cost for the latter is in the range of $4,000-$5,000 annually depending on the number of sessions chosen**
Contact	**John Lochman** **Department of Psychology** **University of Alabama** **383 Gordon Palmer Hall** **P.O. BOX 870348** **Tuscaloosa, AL 35487** **205-348-7678** **jlocjman@gp.as.us.edu**

Program	Functional Family Therapy
Population	Family-based program for youth 11-18 with conduct and substance use/abuse problems
Cultural Evidence	Data not reported
Risk and Protective Factors	**Risk:** • Association with delinquent peers • Family management problems • Pattern of high family conflict **Protective:** • Effective parenting
Level of Evidence	Well-supported
Outcomes	1. Reduced re-arrests 2. Improved family functioning
Prevention: Universal/Selective	
Early Intervention	Early Intervention – families are referred
Description	Functional Family Therapy (FFT) is a family-based prevention and intervention program for dysfunctional youths ages 11 to 18 that has been applied successfully in a variety of multi-ethnic, multicultural contexts to treat a range of high-risk youths and their families. It integrates several elements (established clinical theory, empirically supported principles, and extensive clinical experience) into a clear and comprehensive clinical model. The FFT model allows for successful intervention in complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive. The model includes specific phases: engagement/motivation, behavior change, and generalization. Engagement and motivation are achieved through decreasing the intense negativity often characteristic of high-risk families. The behavior change phase aims to reduce and eliminate the problem behaviors and accompanying family relational patterns through individualized behavior change interventions (skill training in family communication, parenting, problem-solving, and conflict management). The goal of the generalization phase is to increase the family's capacity to adequately use multisystemic community resources and to engage in relapse prevention. FFT ranges from 8 to 12 one-hour sessions for mild cases and incorporates up to 30 sessions of direct service for families in more difficult situations. Sessions are generally spread over a 3-month period and can be conducted in clinical settings as an outpatient therapy and as a home-based model.

Program	Functional Family Therapy
Staffing Requirements	• Bachelor's level practitioners • Masters level clinicians
Service Delivery Setting	• Family Home • Community • Clinic
Implementation Costs	• Phase I Training and Consultation Fee $46,750.00 • Phase II Training and Consultation Fee $23,500.00 • Phase III Training and Consultation Fee $8,000.00
Service Delivery Costs	• Teams comprised of 3-8 FFT Practitioners • Ideally full-time practitioners, but must be at least half-time • Caseload size is 10-15 families per full-time practitioner, 5-6 families per half-time practitioner • 8-20 family sessions over approximately 3-6 months • Estimated cost savings juvenile justice system, crime victim & tax payers: $14,149 -$59,067 (Aos, et al., 2001)
Standard Training Protocol	Phase I • 20-days of training in 1st year • Weekly team consultation conference calls • Monthly administrator conference calls • Bi-Annual Outcome Evaluation Dashboard Reports Phase II • 6-days of training in 2nd year • Bi-monthly team consultation conference calls • Monthly administrator conference calls • Bi-Annual Outcome Evaluation Dashboard Reports Phase III • 1-2 day FFT Symposium • Monthly team consultation conference calls • Monthly administrator conference calls • Bi-Annual Outcome Evaluation Dashboard Reports
Proprietary	• Yes
Sustainability	• Replacement training for new staff $3000 per practitioner – 9 days of training over 1 yr. • Twice per year training offered
Contact	Pam Hawkins, Associate II California Institute for Mental Health 2125 19th Street, Suite 200 Sacramento, CA 95818 (916) 556-3480 ext. 135 phawkins@cimh.org

Program	Gang Resistance Is Paramount
Population	Gang prevention program for youth 7 -16 and their parents
Cultural Evidence	78% of the research participants were Latino
Risk and Protective Factors	**Risk:** • Favorable attitudes toward drug and alcohol abuse • Poor refusal skills • Victimization and exposure to violence • Family management problems • Family transitions • Low parent education level • Low academic achievement • Association with delinquent peers **Protective:** • High expectations • Self-efficacy • Social competencies and problems-solving • Strong school motivation • Involvement in positive peer activities
Level of Evidence	Emerging
Outcomes	1. Decrease in favorable attitudes towards gang activity
Prevention: Universal/Selective	Universal
Early Intervention	
Description	Gang Resistance Is Paramount (GRIP) began as an attempt to curb gang membership and discourage future gang involvement. The program's objectives are to educate students about the dangers of gangs, discourage the city's youth from joining gangs, educate the students' parents about the signs of gang involvement, and provide parents with resources that will help them eliminate gang activities in their homes and neighborhoods. GRIP staff are familiar with gang activity, but have avoided gang involvement. Most of them are community members who live or have lived in Paramount. Their training is updated continually, and the program has had low turnover. GRIP has five elements: 1. A school-based curriculum, consisting of 26 to 29 lessons, for 2nd and 5th graders. The 2nd graders are taught about peer pressure, drugs, alcohol, self-esteem, family, crime, gangs and territory, and gangs and vandalism. They are discouraged from joining a gang through video presentations, coloring exercises, songs, and discussion of alternatives to gangs such as recreational activities. 5th graders review topics such as the danger of many gang activities and alternatives to gang membership. Gang membership is discouraged through the promotion of recreational activities, video presentations, current event discussions, and open dialog between students. An in-school follow-up program in the 9th grade caps the program. Topics such as drugs, alcohol, high school dropout, teen pregnancy, self-esteem, consequences of a criminal lifestyle, higher education, and career opportunities are discussed. 2. Parent education in the form of neighborhood meetings where parents are taught about warning signs of gang involvement and provided with tools to keep their children out of gangs. Handouts are given in both English and Spanish and include everything from information on programs and activities at the city's recreation department to information about tattoo removal programs and graffiti hotline numbers. 3. Counseling of parents and youths regarding the youths' gang activities. Sessions are set up by request or referral and occur in the parents' home, over the phone, or in-office. 4. Recreational activities are offered. Sports, classes, special events, and

	programs specifically for teens are provided, during which gang clothing is not allowed. **5. Neighborhood Watch meetings are combined with the parent meetings, during which information on city services is provided.** **GRIP has undergone six separate studies. The first two tested elementary students before and after participation in the program. Prior to the program, 50 percent of students were undecided about gang involvement, after participation 90 percent responded negatively toward gangs compared to a control group who showed no change over that time period. The third and fourth studies surveyed seventh and ninth graders who had participated in the program, both showed that 90 percent still had negative attitudes toward gangs. The fifth study cross-checked the names of program participants with police records and found that 96 percent were not identified as gang members.**

Program	Gang Resistance is Paramount
Staffing Requirements	• 1 program manager • 4 full-time instructors • 1 part-time intern • College educated staff are familiar with gang activity, but avoided gang involvement. Most of them community members who live or have lived in Paramount
Service Delivery Setting	• School • Home • Phone • Office • Community
Implementation Costs	• All staff members are equipped with a GRIP curriculum manual, • Instructional videos, program instruction slides, student workbooks, program posters, program coloring books, and handouts for parent meetings and recreational activities • $58 per child per year
Service Delivery Costs	• $300,000 annual budget from general fund: salaries, maintenance costs, operational costs, and external conferences costs, etc. • "Internal training" • The staff is provided with and briefed on the curriculum prior to entering the classroom and is then immersed in the program
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	• GRIP staff members continuously attend conferences and seminars in and around Los Angeles County in order to continue to be educated about gangs, gang activity, and the latest educational resources.
Contact	Tony Ostos, Manager Gang Resistance Is Paramount Program 16400 Colorado Avenue Paramount, CA 90723 Phone: (562) 220-2120 Fax: (562) 630-2713 E-mail: tostos@paramountcity.com Web site: www.paramountcity.com

Program	Multidimensional Family Therapy
Population	Family intervention for 11-18 year-olds with conduct and substance abuse problems
Cultural Evidence	72% of the research participants were African-American
Risk and Protective Factors	**Risk:** • Antisocial behavior and delinquent beliefs • Early sexual involvement • Family management problems • Parental use of harsh physical punishment or inconsistent discipline • Association with aggressive or delinquent peers • Peer use of alcohol, drugs and tobacco **Protective:** • Self-efficacy • Social competencies and problem solving • Effective parenting • Involvement with positive peer group activities
Level of Evidence	Supported
Outcomes	1. Decreased drug use 2. Improved family functioning 3. Decreased conduct problems
Prevention: Universal/Selective	Selective for youth at risk to juvenile justice involvement
Early Intervention	Early intervention for families where a youth is on probation
Description	Multidimensional Family Therapy (MDFT) is a family-based treatment and substance-abuse prevention program developed for adolescents with drug and behavior problems. The multidimensional perspective suggests that symptom reduction and enhancement of prosocial and appropriate developmental functions occur by facilitating adaptive developmental events and processes in several domains of functioning. The treatment seeks to significantly reduce or eliminate an adolescent's substance abuse and other problem behavior and to improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. The objectives for the adolescent include transformation of a drug-using lifestyle into a developmentally normative lifestyle and improved functioning in several developmental domains. The objectives for the parent include blocking parental abdication by facilitating parental commitment and investment, improving the overall relationship and day-to-day communication between parent and adolescent, and increasing knowledge about and changes in parenting practices (e.g., limit-setting, monitoring, appropriate autonomy granting). There are two intermediate intervention goals for every family: helping the adolescent achieve an interdependent attachment bond to parents and family, and helping the adolescent forge durable connections with prosocial influences such as schools, peer groups, and recreational and religious institutions.

Program	Multidimensional Family Therapy
Staffing Requirements	• One team consists of: 2 -3 full-time therapists (Masters level) • 1 therapist assistant (high school/Bachelor's level) • On-site clinical supervision
Service Delivery Setting	• Home • Clinic
Implementation Costs	• Training for the 6-month certification is between $25,000-$30,000 per team. This includes all training costs.
Service Delivery Costs	• One MDFT Team (2 therapists, 1 therapist assistant) carry 10-16 families on its caseload. • Each family receives 3-5 visits a week for 3-6 mos.
Standard Training Protocol	• 6-month intensive process leading to certification for 1 year, annual re-certification thereafter
Proprietary	• Yes
Sustainability	• Certified teams need annual re-certification and additional training to address attrition/expansion - $3,000.
Contact	Center for Treatment Research on Adolescent Drug Abuse, University of Miami, Miller School of Medicine www.miami.edu/ctrada Gayle Dakof, Ph.D. (305) 243-3656 gdakof@med.miami.edu

Program	Multidimensional Treatment Foster Care
Population	Alternative to residential and group care for youth 11-18 who are on probation, have emotional and behavioral problems and are placed out of home
Cultural Evidence	Most research participants have been Caucasian
Risk and Protective Factors	**Risk:** • Family management problems • Pattern of high family conflict • Antisocial behavior and alienation • Favorable attitudes toward drug and alcohol use • Early onset of aggression • Mental health problems **Protective:** • Perception of social support from adults and peers • Social competencies and problem solving skills • Effective parenting • Good relationships with parents • Involvement with positive peer group activities
Level of Evidence	Well-supported
Outcomes	1. Decreased hard drug use 2. Decreased recidivism 3. Fewer days in locked settings 4. Significantly fewer psychiatric symptoms 5. Improved school adjustment
Prevention: Universal/Selective	
Early Intervention	Early Intervention – youth and families are referred
Description	Multidimensional Treatment Foster Care (MTFC) is a behavioral treatment alternative to residential placement for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. It is based on the Social Learning Theory model that describes the mechanisms by which individuals learn to behave in social contexts and the daily interactions that influence both prosocial and antisocial patterns of behavior. The intervention is multifaceted and occurs in multiple settings. The intervention activities include behavioral parent training and support for MTFC foster parents, family therapy for biological parents (or other aftercare resources), skills training for youth, supportive therapy for youth, school-based behavioral interventions and academic support, and psychiatric consultation and medication management, when needed. There are three components of the intervention that work in unison to treat the youth: MTFC Parents, the Family, and the Treatment Team. 1. *MTFC Parents:* The program places a youth in a family setting with specially trained foster parents for 6 to 9 months. The foster parents are recruited, trained, and supported to become part of the treatment team. They provide close supervision and implement a structured, individualized program for each child. MTFC parents are supported by a case manager who coordinates all aspects of their youth's treatment program. In addition, MTFC parents are contacted daily (Monday through Friday) by telephone to provide the Parent Daily Report (PDR) information, which is used to relay information about the child's behavior over the last 24 hours to the treatment team and to provide quality assurance on program implementation. MTFC parents are paid a monthly salary and a small stipend to cover extra expenses. 2. *The Family:* The birth family receives family therapy and parent training. Families learn to provide consistent discipline, to supervise and provide encouragement, and to use a modified version of the behavior management system used in the MTFC home. Therapy is provided to prepare parents for their child's return home and to reduce conflict and increase positive relationships in the family. Family sessions and home visits during the child's placement in MTFC provide opportunities for the parents to practice skills and receive feedback. 3. *The Treatment Team:* The MTFC treatment team is led by a program supervisor

	who also provides intensive support and consultation to the foster parents, and also includes a family therapist, an individual therapist, a child skills trainer, and a daily telephone contact person. The team meets weekly to review progress on each case, review the daily behavioral information collected by telephone, and adjust the child's individualized treatment plan. There are three versions of MTFC, each serving specific age groups. Each version has been subjected to rigorous scientific evaluations. The versions are MTFC–P (for preschool children, ages 3 to 5), MFFC–L (for latency-aged children, 6–11), and MTFC–A (for adolescents, 12–17).

Program	Multidimensional Treatment Foster Care (MTFC)
Staffing Requirements	• A team which includes a full-time program supervisor (Master's level); half-time family therapist, ½ time child therapist; foster parent recruiter, trainer, PDR caller (at least B.A. level) and two hourly skills trainers (no degree requirement)
Service Delivery Setting	• Foster Homes
Implementation Costs	• Approximately $40,000 for the first year of implementation and $20,000 in the second with $4000 a year of ongoing costs for WEB Based PDR and certification costs.
Service Delivery Costs	• One team serves 10 youth for 6-9 months. The program is intended for youth who would ordinarily be placed in level 12-14 group homes. • Estimated cost savings juvenile justice system, crime victim & tax payers: $21,836 to $87,622 (Aos, et al., 2001).
Standard Training Protocol	• Program supervisor – 5 day training in Eugene, Oregon • Foster parent recruiter, family and child therapists – 4 day training in Eugene, Oregon • Initial foster parent training in local community • Weekly video tape review and telephone consultation with the program supervisor • Two site visits
Proprietary	• Yes
Sustainability	• Program Certification that typically takes 1 to 2 years to achieve
Contact	Lynne Marsenich, LCSW lmarsenich@cimh.org (909) 816-1284

Program	Multisystemic Therapy
Population	Family based intervention for youth 11-18 at risk for out of home placement and on probation
Cultural Evidence	Five studies report ethnicity data. The range of African-American participants is from 50 to 81%
Risk and Protective Factors	**Risk:** • Low academic achievement • Family management problems • Association with delinquent or aggressive peers • Favorable attitudes towards drugs and alcohol • Early onset of aggression • Mental health problems **Protective:** • Effective parenting • Involvement with positive peer group activities • Perception of social support from adults and peers
Level of Evidence	Well-supported
Outcomes	1. Decreased re-arrest rates 2. Significantly fewer criminal arrests as an adult 3. Decreased alcohol and drug use 4. Decreased peer aggression
Prevention: Universal/Selective	
Early Intervention	Early Intervention – Families are referred
Description	Multisystemic Therapy (MST) typically uses a home-based model of service delivery to reduce barriers that keep families from accessing services. Therapists have small caseloads of four to six families; work as a team; are available 24 hours a day, 7 days a week; and provide services at times convenient to the family. The average treatment involves about 60 hours of contact during a 4-month period. MST therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g., extended family, neighbors, friends, church members) and removing barriers (e.g., parental substance abuse, high stress, poor relationships between partners). Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including behavioral, cognitive-behavioral, and the pragmatic family therapies. This family–therapist collaboration allows the family to take the lead in setting treatment goals as the therapist helps them to accomplish their goals.

Program	Multisystemic Therapy
Staffing Requirements	• Masters level therapists • In some case Bachelor level with supervision
Service Delivery Setting	• Public mental health or private providers • Home-based model
Implementation Costs	• Five days regular training supervisors/staff stakeholders from other agencies • Weekly MST consultation • Regular booster trainings • Track progress/outcomes by completing specific forms • Participate in weekly supervision • Quarterly on-site booster sessions • Master License $4000 • Team License $2500 • Program development and start up fees: $10,000—includes on-site 5 day orientation for up to 4 teams Booster Training • Single Team $26,000 (5,000) GA services • Two teams jointly $20,000 per year • Three or more $17,000 • Replacement staff 5 day on-site $8,000 plus travel costs • If staff goes to Charleston, $750 per day
Service Delivery Costs	• Provide on an as needed basis and regular appointments • Caseload is 4/6 families/ range of treatment is 4-6 months • Estimated cost savings juvenile justice system, crime victim & tax payers: $31,661 – $131,918 (Aos, et al., 2001)
Standard Training Protocol	• Yes—manualized training and program
Proprietary	• Yes •
Sustainability	• New staff must receive the 5-day training either in Charleston or new training on-site
Contact	MST SERVICES 710 J. Dodds Blvd. Suite 200 Mt. Pleasant, SC 29464 Keller.Strother@mstservices.com 843-856-8226 FAX 843-856-8227 CIMH 2125 19TH ST. Sacramento, CA 95818 Bill Carter, LCSW bcarter@cimh.org Tel. 916-556-3480 X 130 Fax 916-446-4519

Programs for Trauma-exposed Individuals

Program	Abuse Focused Cognitive Behavioral Therapy for Child Physical Abuse	
Population	School-aged children who have been physically abused and their parents	
Cultural Evidence	53% of research participants were African-American. In addition the developer has conducted focus groups with African-American parents to explore the relevance and the utility of the intervention.	
Risk and Protective Factors	Risk: • Family violence • Victimization • Family management problems	Protective: • Effective parenting • Social competencies and problem-solving
Level of Evidence	Promising	
Outcomes	1. Improved parental anger 2. Decreases in physical discipline	
Prevention: Universal/Selective		
Early Intervention	Families referred for child physical abuse	
Description	AF-CBT is a treatment based on principles derived from learning and behavioral theory, family systems, cognitive therapy, and developmental victimology. It integrates specific techniques to target school-aged abused children, their offending caregivers, and the larger family system. Through training in specific intrapersonal and interpersonal skills, AF-CBT seeks to promote the expression of appropriate/pro-social behavior and discourage the use of coercive, aggressive, or violent behavior. Essential components include: education about CBT model and physical abuse, establish agreement with family to refrain from using physical force, review child's exposure to emotional abuse, identify and address cognitive contributors to abusive behavior in caregivers, teach affect management skills, teach parents behavioral strategies to reinforce and punish behavior as alternatives to physical discipline, and teach pro-social communication and problem-solving skills to the family and help them to establish them as everyday routines. Recommend 1-2 contacts per week with a minimum one-hour per contact. Typical outpatient course of treatment lasts for 12-18 hours of direct service (or longer), generally spanning 3-6 months. Delivery sites include: adoptive home, birth family home, hospital, outpatient clinic, residential care facility. Parent component addresses: anger management, stress, difficult child behavior, and inadequate parent-child communication and problem-solving skills. Child component addresses: aggression/behavioral dysfunction; poor social skills and limited interpersonal competence; and emotional and cognitive effects of recent abuse for children ages 6-15.	

Program	Abuse Focused Cognitive Behavioral Therapy for Child Physical Abuse
Staffing Requirements	• Masters level clinicians or experienced BA level • Small caseload • Understands the need for carrying enough to meet the needs of the agency
Service Delivery Setting	• Clinic • Home • Private space or office necessary
Implementation Costs	• Individualized costs depending on-site • Bi-weekly/monthly supervision 6-12 months; at least 2 cases for trainee use for training. • Can be a full learning collaborative with workshop training, consultation, tape review, boosters, etc., but can also do separate estimate per service. • Flexible/individualized cost estimates/cost estimates vary depending on the size of the group. • Travel costs reimbursed. • Full training up to 32 hours. Trainings tailored to the agency.
Service Delivery Costs	• Twelve to 18 weeks – one hour per week - of treatment, Individual/Group/ or Family
Standard Training Protocol	• Can be varied • Pre-training assessment • Six hours of didactic • Consultation 6 to 18 hours • Three to 6 months follow-up • Review of tapes of sessions • Phone consultation calls/booster sessions available/advanced case review available
Proprietary	• Yes
Sustainability	• Manual available/Train the Trainers Model being put in place • Developing a certification process
Contact	kolkodj@upmc.edu Phone: 412-246-5888 Elizabeth 412-246-5886

Program	Child-Parent Psychotherapy
Population	Young children , infants to seven years old who have experienced a traumatic event and their care givers
Cultural Evidence	37% Latinas in one study and in another all of the participants (N=93) were immigrants from Mexico and Central America
Risk and Protective Factors	None noted
Level of Evidence	Supported
Outcomes	1. Significant improvement in maternal distress 2. Significant reductions in child behavior problems 3. Reductions in child trauma symptoms
Prevention: Universal/Selective	
Early Intervention	Families referred
Description	CPP-FV is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. Child-parent interactions are the focus of six intervention modalities aimed at restoring a sense of mastery, security, and growth and promoting congruence between bodily sensations, feelings, and thinking on the part of both child and parent and in their relationship with one another.

Program	Child-Parent Psychotherapy
Staffing Requirements	• Requires Master's level clinicians
Service Delivery Setting	• Can be delivered in home or at a clinic
Implementation Costs	Information not available at this time
Service Delivery Costs	• Intervention is delivered one time per week for 1 to 1.5 hours and the sessions occur over a period of 50 weeks.
Standard Training Protocol	Information not available at this time
Proprietary	• Yes
Sustainability	Information not available at this time
Contact	Patricia Van Horn, J.D., Ph.D. UC-San Francisco Patricia.vanhorn@ucsf.edu Phone: 415-205-5323

Program	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	
Population	School-aged children 10-14 who have had substantial exposure to violence	
Cultural Evidence	The studies have involved recent Latino immigrant youth and middle school youth in East Los Angeles	
Risk and Protective Factors	Risk: • Victimization and exposure to violence • Mental health problem • Peer rejection • Family management problems	Protective: • Effective parenting • Good relationships with peers • Social competencies and problem solving • Perception of support from adults and peers
Level of Evidence	Supported	
Outcomes	1. Decreased symptoms of depression 2. Decreased trauma symptoms 3. Improved parental psychosocial functioning	
Prevention: Universal/Selective		
Early Intervention	Early Intervention – youth are referred	
Description	The CBITS program is a cognitive and behavioral therapy group intervention for reducing children's symptoms of posttraumatic stress disorder (PTSD) and depression caused by exposure to violence that has been used successfully in inner city schools with multicultural populations. CBITS has three main goals: to reduce symptoms related to trauma, to build resilience, and to increase peer and parent support. CBITS was designed for use in schools, for children aged 10-14 who have had substantial exposure to violence and who have symptoms of PTSD in the clinical range. The CBITS intervention incorporates Cognitive-Behavioral Therapy skills in a group format (5-8 students per group) to address symptoms of PTSD, anxiety, and depression related to exposure to violence. Treatment includes homework. The program format is 10 child group sessions, 1-3 individual child sessions, two parent education sessions, and a teacher informational meeting. A manual details step-by-step plans and provides scripts for implementing the program.	

Program	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Staffing Requirements	• Clinicians do first round of training; mental health background recommended. • Masters level clinician
Service Delivery Setting	• Schools • Mental Health Clinics
Implementation Costs	• Minimum of two clinicians; two day training costs $3,000 • Follow-up consultation review of sessions • 200 Hours—PRN—Ongoing • Quality Assurance Review is APX $100 per hour • Costs vary depending on CBT experience in clinician being trained. • One trainer for every 15 clinicians per site; two-day training
Service Delivery Costs	• Ten group sessions; approx. 1 hour per week; once a week; 6 to 8 students in group • One to 3 individual sessions, 2 parent education sessions • One teacher education session
Standard Training Protocol	• No standard training protocol • Training depends on the background of the person being trained and the availability of an on-site CBT specialist • Common training approach is for trainees to read background materials, review the manual, watch a training video, attend a two day training, then receive ongoing supervision from a local clinician with CBT experience.
Proprietary	• CBITS Manual available from Sopris Publishers ($35) • Manual alone not sufficient training
Sustainability	• Fidelity assessment measure available; independent rater watch sessions video/audio tape and rate adherence • Regular supervision weekly/biweekly recommended with a CBT expert • Learning collaborative also recommended • Train the Trainer Mode, i.e. work with their trainers in trainings • CBIT works with a local LA community and is “fluid” regarding training
Contact	Sheryl Kataoka, MD/UCLA/NPI 10920 Wilshire Blvd. #300 Los Angeles, CA 90024 310 794-3727 310 794-3724 skataoka@ucla.edu

Program	Prolonged Exposure (PE) Therapy for Post Traumatic Stress Disorder	
Population	Adults 18 to 65+ who have experienced single or multiple traumas	
Cultural Evidence	Three studies reported data: 100% of the participants were female and 36%, 25% and 44% were African-American females	
Risk and Protective Factors	Risk: • Mental health problem	Protective: • Social competencies and problem solving • Self-efficacy
Level of Evidence	Well-supported	
Outcomes	1. Reduced severity of trauma symptoms 2. Significantly reduced symptoms of depression 3. Improved social adjustment 4. Reduced anxiety symptoms	
Prevention: Universal/Selective		
Early Intervention	Early Intervention	
Description	This is a cognitive-behavioral treatment program for adult men and women (ages 18-65+) who have experienced single or multiple/continuous traumas and have post-traumatic stress disorder (PTSD). The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety. PE has three components: (1) post-trauma difficulties, (2) imaginal exposure (also called revisiting the trauma memory in imagination), repeated recounting of the trauma memory, and (3) in vivo exposure, gradually approaching trauma reminders that are feared and avoided despite being safe. Treatment is individualized and is conducted by social workers, psychologists, psychiatrists, and other therapists trained to use the PE manual, which specifies the agenda and treatment procedures for each session. Standard treatment consists of 8-15 sessions conducted once or twice weekly for 90-minutes each. The duration of treatment can be shortened or lengthened depending on the needs of the client and his or her rate of progress.	

Program	Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorder
Staffing Requirements	• Masters level and higher clinicians, preferred experience treating trauma victims
Service Delivery Setting	• Clinic-based • Veterans centers • Private practice office • Inpatient units
Implementation Costs	• Four day clinician training $950 (in Philadelphia) • Follow up consultation for a fee • Video or audio recordings for supervision • Reading list • Some materials available for no cost • Train 30 people per training group
Service Delivery Costs	• Individual treatment • Nine to 12 sessions 1-2 times a week; 90 minutes (varies) • Therapist uses the manual
Standard Training Protocol	• Reading lists • Treatment manual • Complete 4-5 day workshop, training varies from ½ day; 2-day; 4-day, requires two clients in treatment for supervision
Proprietary	• Mix of public/proprietary
Sustainability	• Do have a train the trainer model
Contact	Center for the Treatment and Study of Anxiety Department of Psychiatry, University of Pennsylvania 3535 Market Street, 600 N. Philadelphia, pa 19104 ctsa@mail.med.upenn.edu Contact Person: Melissa aworly@mail. med.upenn.edu

Program	Safe Dates	
Population	8th and 9th grade students	
Cultural Evidence	Data not reported	
Risk and Protective Factors	Risk: • Victimization and exposure to violence	Protective: • Conflict resolution skills
Level of Evidence	Supported	
Outcomes	1. Decrease in psychological abuse against a dating partner 2. Decrease in sexual abuse against a dating partner 3. Decrease in violence against a dating partner	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	Safe Dates is a school-based program designed to stop or prevent the initiation of psychological, physical, and sexual abuse on dates or between individuals involved in a dating relationship. Its goals are to change adolescent dating violence norms, change adolescent gender-role norms, improve conflict resolution skills for dating relationships, promote victims' and perpetrators' beliefs in the need for help and awareness of community resources for dating violence, promote help-seeking by victims and perpetrators, and improve peer help-giving skills. Intended for middle and high school students, the Safe Dates program can stand alone or fit easily within a health education, family, or general life-skills curriculum. Because dating violence is often tied to substance abuse, Safe Dates also may be used with drug and alcohol prevention and general violence prevention programs. The program includes a curriculum with nine 50-minute sessions, a 45-minute play to be performed by students, and a poster contest. Safe Dates involves family members through its parent letter and parent brochure.	

Program	Safe Dates
Staffing Requirements	• Classroom teachers (middle and high school) • Counselors • Prevention specialists
Service Delivery Setting	• Schools
Implementation Costs	• Curriculum materials - $215.00 • $2000-$3500 in training costs as well as reimbursed travel costs for the trainers
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Roxanne Schladweiler Executive Director of Sales Hazelden Publishing and Educational Services 15251 Pleasant Valley Road Center City, MN 55012 Phone: (800) 328-9000 Fax: (651) 213-4577 E-mail: rschladweiler@hazelden.org

Program	Seeking Safety	
Population	Adults and older adolescents with a history of trauma and substance abuse	
Cultural Evidence	Most of the research participants have been female, and the range of African-American participants is from 11 to 42%	
Risk and Protective Factors	Risk: • Mental health problem	Protective: • Self-efficacy
Level of Evidence	Promising	
Outcomes	1. Reductions in substance use 2. Improvement in trauma symptoms 3. Improved psychosocial functioning	
Prevention: Universal/Selective		
Early Intervention	Early intervention – consumers are referred.	
Description	Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psychoeducation and has five key principles: (1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment (working on both posttraumatic stress disorder (PTSD) and substance abuse at the same time); (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) attention to clinician processes (helping clinicians work on counter-transference, self-care, and other issues).	

Program	Seeking Safety
Staffing Requirements	• Clinicians with experience treating trauma and/or substance abuse • Bachelors level • Masters level • Trainees • Case managers
Service Delivery Setting	• Outpatient clinic • Inpatient • Residential • Individual • Group
Implementation Costs	• Depends on the site • Individualized • Supervisions via review of taped sessions • Fidelity scale provided/manual costs $40 • 4.5 hours training video cost $250
Service Delivery Costs	• Clinician costs
Standard Training Protocol	• No specific training required by developers • Formal training is available through the developers • Books, video based training, on-site training/phone consultation is available/intervention adherence part of the consultation
Proprietary	Yes
Sustainability	• Training offered periodically in various sites or can have trainers come to the site • No Train the Trainers Model available • Certification available after sufficient supervision
Contact	Lisa Najavits, Ph.D. 12 Colbourne Crescent Brookline Mass 02445 Phone 617-731-1501 Fax 617 701-1295 e-mail Lnajavits@hms.harvard.edu

Program	SITCAP-ART Structured sensory intervention for traumatized children, adolescents and parents
Population	Youth 12-17 with a history of trauma or loss
Cultural Evidence	85% of the research participants were Caucasian
Risk and Protective Factors	Risk: • Mental health problem Protective: • Problem-solving skills
Level of Evidence	Promising
Outcomes	1. Improvements in some trauma symptoms
Prevention: Universal/Selective	
Early Intervention	Early Intervention – Families are referred
Description	The *SITCAP-ART* program is a comprehensive trauma intervention program, modified from the original *Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP)* program initially researched in 2001. *SITCAP-ART* is designed specifically for at-risk and adjudicated youth. *SITCAP-ART* integrates cognitive strategies with sensory/implicit strategies. When memory cannot be linked linguistically in a contextual framework, it remains at the symbolic level for which there is no words to describe. To retrieve that memory so it can be encoded, given a language, and then integrated into consciousness, it must be retrieved and externalized in its symbolic perceptual (iconic) form (Steele, 2003). *SITCAP-ART*, which is followed by cognitive or explicit strategies, supports moving from victim to survivor thinking, allowing changes in negative behaviors (aggressive and rule-breaking behavior) and making adolescents more resilient to future traumas.

Program	SITCAP-ART Structured sensory intervention for traumatized children, adolescents and parents
Staffing Requirements	• Prefer Master's level clinician with experience working with adjudicated youth.
Service Delivery Setting	• Community agencies; mental health clinics; residential care facilities and schools.
Implementation Costs	• Manual and required 3-5 day training
Service Delivery Costs	• Group treatment • One hour per week for 8-10 weeks
Standard Training Protocol	Information not available at this time
Proprietary	• Yes
Sustainability	Information not available at this time
Contact	Caelean Kuban, LMSW ckuban@tlcinst.org (877) 306-5256 www.tlcinst.org

Program	Trauma Focused Cognitive Behavioral Therapy	
Population	3-18 year-olds who have been trauma exposed and their caregivers	
Cultural Evidence	Data not reported	
Risk and Protective Factors	Risk: • Victimization • Exposure to violence • Mental heath problem • Life stressors • Family violence • Maternal depression • Family transitions	Protective: • Effective parenting • Social competencies and problem solving • Self-efficacy
Level of Evidence	Well-supported	
Outcomes	1. Decreased child behavior problems 2. Decreased trauma symptoms 3. Decreased depression 4. Improved social competence	
Prevention: Universal/Selective		
Early Intervention	Early intervention – families are referred	
Description	TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. Sessions are conducted once a week. Each session is 30-45-minutes for the child (ages 3-18); 30-45 minutes for the parent. The program also includes conjoint child-parent sessions toward the end of treatment that last approximately 30-45 minutes. Treatment lasts 12-18 sessions. Can be provided in groups of 6-10 children and their caregivers. Homework is a component of treatment. Delivery sites include community agency and outpatient clinic.	

Program	Trauma Focused Cognitive Behavioral Therapy
Staffing Requirements	• Clinical staff-Masters degree of higher • Supervisors trained in TF-CBT
Service Delivery Setting	• Outpatient • Foster homes • Residential Treatment Centers • Long term inpatient units • Schools • Community settings
Implementation Costs	• CIMH Community Development Team Training Protocol - $16,000 for Team (1 Administrator, 1 Supervisor, 4 Clinicians)
Service Delivery Costs	• One hour sessions weekly for child and parent • Primary adult • Approximately 12-15 sessions
Standard Training Protocol	CIMH Community Development Team Training Protocol • Pre-implementation Planning Calls • Completion of Web-Based Training Course • Initial Clinical Training 2-3 days • Two Booster Training 1-2 days each • Twenty one hour team based phone consultation calls • Twelve Administrator Calls • One audiotape review per clinician • Outcome evaluation protocols with measures, data base and twice yearly dashboard reports
Proprietary	• Public
Sustainability	• Use of the TF CBT Fidelity Checklist is suggested to sustain fidelity to the model • Trained Site Supervisors • Replacement Training to address attrition of staff • Routine collection of evaluation protocol
Contact	Todd Sosna, Ph.D. Senior Associate California Institute for Mental Health 2125 19th St. tmq@verizon.net (916) 549-5506

Program	Trauma Recovery and Empowerment (TREM)	
Population	Adult women, 18-55 with histories of exposure to physical and sexual abuse	
Cultural Evidence	Three studies have been conducted. The range of African-American participants is from 18 to 82% and for Latinas from 16 to 31%	
Risk and Protective Factors	Risk: • Victimization • Mental heath problem • Life stressors • Family violence • Maternal depression • Family transitions	Protective: • Self-efficacy
Level of Evidence	Promising	
Outcomes	1. Decreases in drug addiction severity 2. Reduction in trauma symptoms 3. Slight improvements in overall health	
Prevention: Universal/Selective		
Early Intervention	Early intervention – consumers are referred	
Description	TREM is a fully manualized group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse. Drawing on cognitive restructuring, psychoeducational, and skills-training techniques, the gender-specific 24-29 session group emphasizes the development of coping skills and social support. It addresses both short and long-term consequences of violent victimization, including mental health symptoms, especially posttraumatic stress disorder (PTSD) and depression, and substance abuse. TREM has been successfully implemented in a wide range of service settings (mental health, substance abuse, criminal justice) and among diverse racial and ethnic populations.	

Program	Trauma Recovery and Empowerment (TREM)
Staffing Requirements	• Master's level clinicians
Service Delivery Setting	• Criminal justice settings, substance abuse settings, residential care facilities and community mental health
Implementation Costs	• On-site training available • Curriculum materials approximately $1500
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Rebecca W. Berley, M.S.W. Director of Trauma Education Community Connections 801 Pennsylvania Avenue, SE, Suite 201 Washington, DC 20003 Phone: (202) 608-4735 Fax: (202) 608-4286 E-mail: rwolfson@ccdc1.org www.ccdc1.org

Programs for Underserved Cultural Populations

Program	American Indian Life Skills	
Population	13-17 year-old Native American Youth at risk for suicide and school failure	
Cultural Evidence	100% of the study participants were Native American Youth	
Risk and Protective Factors	Risk: • Life stressors • Mental health problems • Family history of suicide and/or depression • Peer rejection • Poor school bonding	Protective: • Social competencies and problem-solving skills • Strong school motivation • Good relationships with peers • Presence and involvement of caring, supportive adults
Level of Evidence	Promising	
Outcomes	1. Decrease in hopelessness 2. Improvement in suicide prevention skills	
Prevention: Universal/Selective	Universal for Native American Youth	
Early Intervention		
Description	This program is a curriculum that is school-based, culturally tailored, suicide prevention for American Indian adolescents (11-19 years old). Tailored to American Indian norms, values, beliefs, and attitudes, the curriculum is designed to build self-esteem; identify emotions and stress; increase communication and problem-solving skills; and recognize and eliminate self-destructive behavior, including substance abuse. The curriculum provides American Indian adolescents with information on suicide and suicide-intervention training and helps them set personal and community goals. Each lesson in the curriculum contains standard skills training techniques for providing information about the helpful or harmful effects of certain behaviors, modeling of target skills, experimental activities, behavior rehearsal for skill acquisition, and feedback for skills refinement. The curriculum can be delivered three times a week over 30 weeks, during the school year or as an after-school program.	

Program	American Indian Life Skills
Staffing Requirements	• Team teaching using teachers • Community resource leaders • Local social service agencies
Service Delivery Setting	• School • Community settings rural and/or frontier • Tribal • Urban
Implementation Costs	• Manual costs $30.00 training for school staff costs approx. 3,000 for 3- day training plus travel expenses
Service Delivery Costs	• 3 times a week • 30 weeks
Standard Training Protocol	• Training resources are available • Intervention fidelity tool • Training effectiveness tools
Proprietary	• Mix of public/proprietary
Sustainability	• No information available at this time
Contact	Teresa Lafromboise, Ph.D. Stanford University 485 Lasuen Mall Stanford, CA 94305 650-723-2109 650-725-7412 Lafrom@stanford.edu Griefnet.org/library/review/Americanindian

Program	Bicultural Competence Skills Approach
Population	Native American adolescents
Cultural Evidence	100% of the study participants are Native American adolescents
Risk and Protective Factors	**Risk:** • Negative attitude toward school • Low school bonding • Poorly organized and functioning school **Protective:** • Presence and involvement of caring, supportive adults • Social competencies and problem solving skills
Level of Evidence	Supported
Outcomes	1. Increases in knowledge about substance use 2. Improved problem-solving and refusal skills 3. Decreased substance use
Prevention: Universal/Selective	Universal for Native American youth
Early Intervention	
Description	This approach is an intervention designed to prevent the abuse of tobacco, alcohol, and other drugs by Native American adolescents (ages 12-18) by teaching them social skills in a way that blends the adaptive values and roles of both the Native American and popular American cultures. The intervention groups are led by Native American counselors. Through cognitive and behavioral methods, participants are instructed in and practice communication, coping, and discrimination skills. Communication skills are introduced with biculturally relevant examples of verbal and nonverbal influences on substance use. For instance, leaders model how subjects could turn down offers of tobacco, alcohol, and other drugs from their peers without offending their Native American and non-Native American friends. While the participants practice communication skills, leaders offer coaching, feedback, and praise. Coping skills include self-instruction and relaxation to help subjects deal with pressure and avoid substance use situations. Leaders suggest alternatives to using tobacco, alcohol, and other drugs and teach subjects to reward themselves for positive decisions and actions. Substance abuse awareness is also brought into the community.

Program	Bicultural Competence Skills Approach
Staffing Requirements	• Two Native American counselors
Service Delivery Setting	• Public schools • Tribal schools • Tribal community centers • Student retreats
Implementation Costs	• Program packet for $240, users guide for $18 • Original Instrument: Follow-Instrument (PDF) $2.88 • Original Instrument: Pre/Post Test Instrument (PDF) $3.24
Service Delivery Costs	• Information not available at this time
Standard Training Protocol	• Information not available at this time
Proprietary	• Yes
Sustainability	• Information not available at this time
Contact	Steven P. Schinke Columbia University School of Social Work 622 West 113th Street New York, NY 10025 Phone: (212) 851-2276 Fax: (212) 854-1570 E-mail: schinke@columbia.edu Technical Assistance Provider: Editor Sociometrics 170 State Street, Suite 260 Los Altos, CA 94022 Phone: (415) 949-3282 E-mail: editor@socio.com Web site: www.socio.com/srch/summary/ysappa/ysa01.htm

Program	Brief Strategic Family Therapy
Population	Families with children and adolescents (ages 6-18) with behavioral and substance abuse problems
Cultural Evidence	Studies primarily on Latino youth Developed to enhance bicultural skills and problems associated with minority status and/or migration-related stresses
Risk and Protective Factors	**Risk:** • Anti-social behavior • Early onset of aggression and/or violence • Favorable attitudes toward drug use/early drug or alcohol use • Family management problems/poor parental supervision and/or monitoring • Pattern of high family conflict • Poor family attachment • Sibling antisocial behavior **Protective:** • Perception of social support from adults and peers • Self-efficacy, social competences and problem-solving skills • Effective parenting • Good relationships with parents/bonding • Involvement with positive peer group activities
Level of Evidence	Supported
Outcomes	1. Reductions in conduct and emotional problems 2. Association with antisocial peers 3. Drug use improvements in self-concept 4. Family functioning 5. Engagement into family therapy
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	BSFT is designed to (1) prevent, reduce, and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers; (2) improve prosocial behaviors such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school. BSFT is typically delivered in 12-16 family sessions but may be delivered in as few as 8 or as many as 24 sessions, depending on the severity of the communication and management problems within the family. Sessions are conducted at locations that are convenient to the family, including the family's home in some cases. Hispanic families have been the principal recipients of BSFT, but African-American families have also participated in the intervention.

Program	Brief Strategic Family Therapy
Staffing Requirements	• Licensed staff preferred • Non-licensed staff (case manager/B.A. Level) possible if a part of a treatment team
Service Delivery Setting	• Office • Home • Community setting
Implementation Costs	• $50,000 - $60,000 Per cohort for first year of implementation • Five therapists per cohort • Total cost of 3 year implementation depends on which out year components are selected and number and length of consultation sessions. • Particular skills area deficiencies can be addressed on an individual basis.
Service Delivery Costs	• Interventions are 12-15 sessions of 60-90 minutes over a period of three months. The entire team is expected to participate.
Standard Training Protocol	• A 2-day on-site consultation with program leadership to determine if BSFT is a good programmatic fit • Training consists of four 3-day sessions with 4 to 6 months of telephone supervisions
Proprietary	• Yes
Sustainability	• In addition to the telephone supervision, best results are achieved if there is an in-house supervisor who has gone through separate supervisor curriculum training • Monthly clinical tapes are submitted for critique and to asses the adherence to the model with up to 40 individually identified skills rated. (Nine to 12 months post training)
Contact	Olva Hervis Family Therapy Training Institute of Miami 1221 Brickell Ave. 9TH Floor Miami, FL 33133 888-527-3828 ohervis@bsft-av.com TA PROVIDER Kathleen Shea 305-668-0850 kshea@bsft-av.com

Program	Cognitive Behavioral Therapy (CBT) for Anxiety
Population	African-American adolescents (ages 14-17), low-income, urban school setting
Cultural Evidence	Modified group CBT for African-American adolescents
Risk and Protective Factors	**Risk:** • Neighborhood crime and violence • Issues related to stepparents, siblings, and dating • Drug use • Financial hardship **Protective:** • School-based support
Level of Evidence	Supported
Outcomes	1. Decrease in overall anxiety (both self-report levels and clinician ratings)
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	Cognitive-behavioral therapy is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. (Maladaptive behavior is behavior that is counter-productive or interferes with everyday living.) The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Culturally tailored to fit the needs of African-American youth.

Program	Cognitive Behavioral Therapy (CBT) for Anxiety
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Cognitive Behavioral Therapy (CBT) for Depression (with antidepressant medication)
Population	Low-income women
Cultural Evidence	Evidence for Latina immigrants and African-American women; modified to be sensitive to low-income women and cultural adaptations
Risk and Protective Factors	None reported
Level of Evidence	Supported
Outcomes	1. Decreased depressive symptoms and improved functioning
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	Low-income women (African-American, White and Latina) diagnosed with Major Depressive Disorder. Intervention is antidepressant medication for 6 months; cognitive behavioral therapy (CBT) for 8 weeks (weekly group or individual sessions; followed by 8 further sessions for non-improvers; participant and therapist manuals adapted from a program specifically for low-income English and Spanish speakers), or referral to a community provider.

Program	Cognitive Behavioral Therapy (CBT) for Depression (with antidepressant medication)
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	
Population	Ethnic minority and immigrant youth (ages 10-14) with symptoms of posttraumatic stress disorder and depression (due to exposure to violence). Inner-city schools	
Cultural Evidence	Evidence for Mexican and Central American youth; also for African-American and Native American youth	
Risk and Protective Factors	Risk: • Mental health problem • Victimization and exposure to violence • Child victimization and maltreatment • Family management/poor poor parental supervision and/or monitoring • Poor family attachment • Peer rejection	Protective: • Perception of social support from adults and peers • Resilient temperament • Social competencies and problem-solving skills • Effective parenting • Good relationship with parents/bonding • Good relationship with peers
Level of Evidence	Supported	
Outcomes	1. Decrease in posttraumatic stress and depressive symptoms 2. Parents of children in treatment showed less psychosocial dysfunction	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	The CBITS program is a cognitive and behavioral therapy group intervention for reducing children's symptoms of post-traumatic stress disorder (PTSD) and depression caused by exposure to violence that has been used successfully in inner city schools with multicultural populations. CBITS has three main goals: to reduce symptoms related to trauma, to build resilience, and to increase peer and parent support. CBITS was designed for use in schools, for children aged 10-14 who have had substantial exposure to violence and who have symptoms of PTSD in the clinical range. The CBITS intervention incorporates Cognitive-Behavioral Therapy skills in a group format (5-8 students per group) to address symptoms of PTSD, anxiety, and depression related to exposure to violence. Treatment includes homework. The program format is 10 child group sessions, 1-3 individual child sessions, two parent education sessions, and a teacher informational meeting. A manual details step-by-step plans and provides scripts for implementing the program.	

Program	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Staffing Requirements	• Clinicians do first round of training; mental health background recommended. • Masters level clinician
Service Delivery Setting	• Schools • Mental Health Clinics
Implementation Costs	• Minimum of two clinicians; two day training costs $3,000 • Follow-up consultation review of sessions • 200 Hours—PRN—Ongoing • Quality Assurance Review is APX $100 per hour • Costs vary depending on CBT experience in clinician being trained. • One trainer for every 15 clinicians per site; two-day training
Service Delivery Costs	• Ten group sessions; approx. 1 hour per week; once a week; 6 to 8 students in group • One to 3 individual sessions, 2 parent education sessions • One teacher education session
Standard Training Protocol	• No standard training protocol • Training depends on the background of the person being trained and the availability of an on-site CBT specialist • Common training approach is for trainees to read background materials, review the manual, watch a training video, attend a two day training, then receive ongoing supervision from a local clinician with CBT experience.
Proprietary	• CBITS Manual available from Sopris Publishers ($35) • Manual alone not sufficient training
Sustainability	• Fidelity assessment measure available; independent rater watch sessions video/audio tape and rate adherence • Regular supervision weekly/biweekly recommended with a CBT expert • Learning collaborative also recommended • Train the Trainer Mode, i.e. work with their trainers in trainings • CBIT works with a local LA community and is “fluid” regarding training
Contact	Sheryl Kataoka, MD/UCLA/NPI 10920 Wilshire Blvd. #300 Los Angeles, CA 90024 310 794-3727 310 794-3724 skataoka@ucla.edu

Program	Coping Power Program	
Population	Pre-adolescent children (ages 9-11) with aggression and their parents Low-income, urban communities	
Cultural Evidence	Studies with large percentage of African-American youth	
Risk and Protective Factors	Risk: • Anti-social behavior • Cognitive and neurological deficits/low IQ/hyperactivity • Life stressors • Mental health problem • Poor refusal skills • Family management problems/poor parental supervision and/or monitoring • Poor family bonding • Low academic achievement • Negative attitude toward school • Association with delinquent and/or aggressive peers	Protective: • High and positive expectations • Social competencies and problem-solving skills • Good relationships with parents/bonding • High expectations • High expectations of students • Presence and involvement of caring • Supportive parents • Rewards for pro-social school involvement • Strong school motivation • Student bonding • Good relationships with peers
Level of Evidence	Well-supported	
Outcomes	1. Decrease in aggression 2. Peer rejection 3. Parent-rated substance use 4. Behavioral improvement in school (teacher rated)	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	See Coping Power Program description under Juvenile Justice for program description.	

Program	Coping Power Program
Staffing Requirements	• Masters/Doctorate in psychology or social work • School guidance counselor
Service Delivery Setting	• Schools in group setting
Implementation Costs	• Includes a 2-3 day initial trainings session • Two days if only the child component is selected and 3 if the parental component is selected • Costs are $1,500 per trainer per day (roughly one trainer per 25 trainees) • Trainings occur on-site or there are 2 residential sessions at the university annually
Service Delivery Costs	• There are 34 sessions for the child and 16 for the parents
Standard Training Protocol	• The curriculum is manualized and there are fidelity measures
Proprietary	• Yes
Sustainability	• There is group phone supervision (10-12 trainees per call) bi-weekly for 1 year costing $100 per hour • Additionally, review of taped sessions is available for evaluation of skill learning and model adherence • The cost for the latter is in the range of $4,000-$5,000 annually depending on the number of sessions chosen
Contact	John Lochman Department of Psychology University of Alabama 383 Gordon Palmer Hall P.O. BOX 870348 Tuscaloosa, AL 35487 205-348-7678 jlocjman@gp.as.us.edu

Program	Coping with Depression
Population	Adults (age 45+) at risk for depression due to ailing health
Cultural Evidence	Adapted for Native Americans with chronic health problems Adapted skills-based curriculum for increased cultural relevance
Risk and Protective Factors	Not reported
Level of Evidence	Promising
Outcomes	1. Decreased depressive symptoms 2. Increased involvement in pleasant events
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	Developed for Native American adults at risk for depressive symptomatology as a result of deteriorating health. Comprised of 16 weekly 2-hr sessions, the adapted curriculum emphasizes skills training toward progress in four areas: rehearsed relaxation, increased pleasurable activity, improved patterns of thinking, and cultivated social skills. In order to decrease the potential stigma of an intervention related to "mental health," the program was offered though a local tribal college for adult education credit. Participants received tuition remission in the amount of $10 per each session attended. Curricular resources included lectures, class activities, homework assignments, a textbook, and local community members who were trained as instructors. Curricular materials were modified slightly for increased cultural relevance.

Program	Coping with Depression
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Culturally Adapted Parent Management Training for Latinos	
Population	Latino middle-school-aged youth at risk of problem behaviors	
Cultural Evidence	Adapted for Latino youth (U.S. and foreign born)	
Risk and Protective Factors	Risk: • Acculturation issues for parents, children, and parent-child relations	Protective: • Positive behavioral interactions at home, school and with peers
Level of Evidence	Supported	
Outcomes	1. Improvements in parenting outcomes (overall effective parenting) 2. Parents of U.S.-born youth had better outcomes 3. Decreased child aggression, externalizing behaviors, likelihood of alcohol and drug use	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	Parent management training (PMT) refers to programs that train parents to manage their child's behavioral problems in the home and at school. PMT has emanated from two lines of work. First, maladaptive parent-child interactions, particularly in relation to discipline practices, have been shown to foster and to sustain conduct problems among children. Second, social learning techniques, relying heavily on principles of operant conditioning, have been extremely useful in altering parent and child behavior. In PMT, parent-child interactions are modified in ways that are designed to promote prosocial child behavior and to decrease antisocial or oppositional behavior. Treatment sessions include instruction in social learning principles and techniques. The therapist provides a brief overview of underlying concepts, models the techniques for the parents, and coaches parents in implementing the procedures. Procedures and interaction patterns practiced in the sessions are then used in the home. Parents usually are taught how to define, observe, and record behavior at the beginning of treatment because once behaviors (e.g. fighting, engaging in tantrums) are defined concretely, reinforcement and punishment techniques can be applied. The PMT therapist details the concepts and procedures derived from positive reinforcement (e.g., contingent delivery of attention, praise, points) and punishment (e.g., time out from reinforcement, loss of privileges, and reprimands). Reinforcement for prosocial and non-deviant behavior is central to treatment. Parents are taught how to use reinforcement and punishment techniques contingent on the child's behavior, to provide consequences consistently, to attend to appropriate behaviors and to ignore inappropriate behaviors, to apply skills in prompting, shaping, and fading, and to use these techniques to manage future problems. There is an extensive amount of practice and shaping of parent behavior within the sessions to develop skills in carrying out the procedures.	

Program	Culturally Adapted Parent Management Training for Latinos
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Culturally-Modified Trauma-Focused Treatment (CM-TFT)	
Population	Children and adolescents (ages 4-18) with trauma related to sexual or physical abuse	
Cultural Evidence	Developed for Latino children and adolescents (primarily of Mexican descent); cultural experiences addressed in treatment	
Risk and Protective Factors	Risk: • Barriers (poverty, recent immigrants)	Protective: • Cultural values of *familismo, respeto,* etc.
Level of Evidence	Well-supported for Trauma Focused CBT – Adaptions being evaluated	
Outcomes	(Pilot testing in progress)	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	Based on Cognitive-Behavior Therapy; key components include: psycho-education, emotional regulation skills, coping skills training, distinguishing thoughts, feelings, and behaviors, including trauma-related, gradual exposure (trauma narrative), cognitive and affective processing of trauma experiences, parallel parent treatment, risk reduction skills. Average length of sessions is 12-16. Aspects of culture or group experiences that are addressed: spirituality, gender roles, familismo, personalismo, respeto, sympatia, fatalismo, folk beliefs. Trauma type addressed: sexual abuse and physical abuse. This intervention was developed for use with Latino children and is based on Trauma-Focused Cognitive Behavior Therapy, with the addition of modules integrating cultural concepts throughout treatment.	

Program	Culturally Modified Trauma-Focused Treatment (COPE)
Staffing Requirements	• Case management model • Clinicians must know PCIT or TF-CBT or other CBT treatment • Clinicians do community training • Case managers should have mental health background • Masters level clinicians/ Case managers
Service Delivery Setting	• Home • School • Community-based treatment
Implementation Costs	• Requires weekly review of taped sessions. Need consultation from clinicians trained in CB treatments. • Cost to be determined on individual basis
Service Delivery Costs	• Staff/Travel costs (service delivery in the community) • Program includes child, parent and joint sessions
Standard Training Protocol	• Intensive case management model; weekly supervision of taped sessions • Reading supervision (2-3 hours of group and/or individual)
Proprietary	• Caseload of 6 to 10—intensive CM model/supervision Twelve to 20 sessions, 1-2 sessions per week from 45-90 minutes. (Varies depending on the case)
Sustainability	• Pre-requisites are training in CBT techniques • Certification available • Training is through reading, treatment manuals • Supervision (2-3hours GRP and/or individual supervision for caseload of 6)
Contact	A. deArellano, Ph.D. Medical University of South Carolina, Institute of Psychiatry 165 Cannon street PO box 250852 Charleston SC 29425 843-792-2945 dearelma@musc.edu/Michael

Program	Effective Black Parenting
Population	African-American Families at risk for Child Maltreatment
Cultural Evidence	100% of research participants were African-American
Risk and Protective Factors	Risk: • Parental substance abuse • Parental mental health problems
Level of Evidence	Promising
Outcomes	1. Enhanced family relationships 2. Decreased parental rejection 3. Decreased child behavior problems
Prevention: Universal/Selective	Selective
Early Intervention	
Description	The EBPP was originally developed for parents of African-American children aged 2 to 12. Most of its evaluation studies have been conducted with this population. However, since beginning the national dissemination of the program in 1988, the program has been successfully used with teenage African-American parents and their babies, and with African-American parents of adolescent children. Thus, its widespread usage has been with parents whose children range from 0 to 18. Format: the complete EBPP consists of 14 3-hour training sessions and a graduation ceremony. It has been delivered in a variety of settings: schools, Head Start agencies, churches, mental health clinics, substance abuse agencies, hospitals, counseling centers, etc.. The complete program is usually taught for small groups of parents (8 to 20) and the parents are recruited from the populations that the sponsoring institutions serve. The vast majority of EBPP's are conducted by individuals who completed a CICC-sponsored 5-day instructor training workshop, where, in addition to learning how to deliver the complete program, they learned a variety of recruitment and parent attendance incentive strategies. Recently, a briefer version of the EBPP was created (a one-day seminar version) which is taught with large numbers of parents (50 to 500). Program content is culturally tailored to the African-American community.

Program	Effective Black Parenting
Staffing Requirements	• Doctorate, Master, Bachelor and paraprofessional staff have delivered this practice.
Service Delivery Setting	• Birth Family Home • Community Agency • Foster Home • Outpatient Clinic
Implementation Costs	• Parent Handbook, ($19), an overhead projector and screen, and space for 8-12 parents with enough room to break into dyads for skill practice • The current fee per workshop participant is $975 which covers the cost of the 5 days of professional training and the complete Instructor's Kit of training materials • The price of the Kit is currently $413 • Other program costs vary depending upon which institution sponsors the delivery of the class or seminar, as each institution incurs different costs for marketing and advertising, space, refreshments, transportation, child care, and instructor fees.
Service Delivery Costs	• Recommended intensity: Weekly three-hour sessions or one-day 6.5 hours abbreviated seminar version • Recommended duration: 15 weeks total including a session for graduation and testifying or just one-day for the abbreviated seminar version
Standard Training Protocol	• Five 6.5 hour days • Training is obtained from regularly scheduled workshops in different cities or the workshop can be brought to a specific location on a contractual basis
Proprietary	Information not available at this time
Sustainability	• Booster sessions
Contact	Gary Oltman Center for the Improvement of Child Caring E-mail: gary@ciccparenting.org Phone: 818-980-0903 Website: /www.ciccparenting.org

Program	Family Coping Skills Program (FCSP)
Population	Low-income Latina mothers at risk of depression
Cultural Evidence	Developed for Latina mothers Group-based intervention involving family sessions; culturally relevant content
Risk and Protective Factors	Risk: • Stressors related to child rearing, other stressors • Financial • Acculturation Protective: • Problem-solving/coping skills • Family functioning/competencies
Level of Evidence	Emerging
Outcomes	1. Decreased depressive symptoms
Prevention: Universal/Selective	Selected
Early Intervention	
Description	Developed by E.V. Cardemil, S. Kim, T.M. Pinedo, and I.W. Miller FCSP is a novel depression prevention program developed specifically for low-income Latina mothers. The culturally tailored approach enhances recruitment and retention of participants.

Program	Family Coping Skills Program (FCSP)
Staffing Requirements	• Bilingual clinicians trained in Cognitive Behavioral Therapy
Service Delivery Setting	• A variety of community-based settings including clinics, family resource centers, public health clinics
Implementation Costs	Information not available at this time
Service Delivery Costs	• Intervention consists if 6 group sessions and 2 family sessions. In addition the costs of on-site child care and transportation are included.
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Esteban Cardemil, PhD Associate Professor of Psychology, Clark University ecardemil@clarku.edu (508) 793-7738

Program	Family Effectiveness Training
Population	Children and adolescents (ages 6-12) with behavioral problems and at risk of drug use
Cultural Evidence	Developed for Latino families of preadolescents (primarily males and Cuban)
Risk and Protective Factors	**Risk:** • Anti-social behavior • Early onset of aggression and/or violence • Favorable attitudes toward drugs and alcohol and/or use • Management problems and/or poor parental supervision or monitoring • Harsh punishment • Pattern of high family conflict **Protective:** • Healthy beliefs and clear standards • High expectations • Perception of social support from adults and peers • Social competencies and problem-solving skills • Effective parenting • Good relationships with parents/bonding
Level of Evidence	Supported
Outcomes	1. Improved structural family functioning 2. Decreased problem behaviors reported by parents 3. Increased self-concept of child
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	FET is a family-based program for Hispanics that targets family factors known to place children at risk. FET helps Hispanic immigrant families with children ages 6-12, particularly when the child is exhibiting behavior problems, associating with deviant peers, or experiencing parent-child communication problems. The program consists of three components: Family Development, Bicultural Effectiveness Training, and Brief Strategic Family Therapy. FET uses two primary strategies to initiate change: (1) didactic lessons and participatory activities that help parents master effective family management skills, and (2) organized discussions in which the therapist/facilitator intervenes to correct dysfunctional communications between or among family members. The training sessions last for 13 weeks, are 1 ½ to 2 hours long, and are tailored to each individual family.

Program	Family Effectiveness Training
Staffing Requirements	• Therapist/facilitator • Basic knowledge of how family systems operate • 3 years of clinical experience with children and families. • The ideal candidate has a Master's degree in social work or marriage or family therapy. However, individuals with a Bachelor's degree and experience working with families may qualify
Service Delivery Setting	• Community • Social services agencies • Schools • Mental health clinics • Faith communities • Community youth centers
Implementation Costs	• Videotape equipment, visual teaching aids and handouts for families
Service Delivery Costs	• The program consists of three components: Family Development, Bicultural Effectiveness Training, and Brief Strategic Family Therapy. FET uses two primary strategies to initiate change: 1) didactic lessons and participatory activities that help parents master effective family management skills and 2) organized discussions in which the therapist/facilitator intervenes to correct dysfunctional communications between or among family members. The training sessions last for 13 weeks, are 1½ to 2 hours long, and are tailored to each individual family. • One full-time counselor can provide FET to 15 to 20 families per week, depending on experience and maturity of counselor
Standard Training Protocol	• Agencies should allow 6 months to hire and train counselors, develop referral resources from the community, and recruit and screen participant families.
Proprietary	• Yes
Sustainability	• Video supervision
Contact	Lila Smith, M.D. University of Miami School of Medicine 1425 Northwest 10th Avenue, Third Floor Center for Family Studies Miami, FL 33136 Phone: (305) 243-7585 Fax: (305) 243-2320 E-mail: lsmith@med.miami.edu Web site: www.cfs.med.miami.edu

Program	Family Health Promotion
Population	Latino children 3-8 who live in poverty, have been maltreated and/or who have substance abusing parents
Cultural Evidence	Study participants were drawn from barrio housing projects in Tucson, AZ
Risk and Protective Factors	**Risk:** • Early onset of aggression • Victim of or exposed to violence • Family violence • Parental use of harsh physical punishment • Low academic achievement • Economic deprivation **Protective:** • Effective parenting • Opportunities for prosocial school involvement
Level of Evidence	Promising
Outcomes	1. Increased school readiness for preschoolers 2. Decreased parental stress 3. Decreased parental drug use 4. Increased resource utilization
Prevention: Universal/Selective	Selective
Early Intervention	
Description	The FHP program is a primary prevention program that offers a variety of interventions to children ages 3-8 and to their families. Based on research in risk, resiliency, and protective factors, FHP seeks to reduce risk factors in the child and family domains. The program offers children developmentally appropriate activities in childcare, school, and recreation to help develop resiliency skills. Parents are encouraged to become involved in activities that enable them to increase protective factors. Participants requiring treatment services will receive them on-site. The central feature of the FHP is the family services team that serves as the integrating force of the program. Specific program activities include: • Training in resiliency and protective factors provided to parents through home visitation. The visits occur once a month during year 1, twice a month during year 2, and as needed during year 3. • Parent advisory council meetings • The S.T.E.P. Curriculum workshop series • Support groups • Family weekend activities • Training of school personnel on the Building Me program and cultural competence • Implementation of the Building Me curriculum • Transportation to the program • Art Therapy sessions

Program	Family Health Promotion
Staffing Requirements	Information not available at this time
Service Delivery Setting	• Childcare sites school • Recreation sites
Implementation Costs	• Staff must be trained in step program
Service Delivery Costs	• Visits 1 time per month first year • Visits 2 times a month second year • As needed the third year • 20 hours of intensive In-Home Service • 10 hours of Parent Advisory Council, and Parenting Workshops • 8 hours of Family ATID-Free Weekend activities • 4 hours involving referrals
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Dr. Linda Arzoumanian Codac Behavioral Health Services, Inc. 3100 North First Avenue Tucson, AZ 85719 Amy Graves, M.A. Codac Behavioral Health Services, Inc. 3100 Northfirst Avenue Tucson, AZ 85719 520-327-4505 Fax: 972-401-8801

Program	Group Cognitive Behavioral Therapy (CBT) of Major Depression	
Population	Adults with major depression	
Cultural Evidence	English and Spanish manuals used with diverse populations: various ethnic groups, primarily low-income adults and low-income minority women	
Risk and Protective Factors	Risk: • Stressors (poverty, legal issues, discrimination, etc.)	Protective: • Positive internal and external thought processes
Level of Evidence	Well-supported	
Outcomes	1. Decreased depressive symptoms; increased functioning	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	Cognitive-behavioral therapy is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. (Maladaptive behavior is behavior that is counter-productive or interferes with everyday living.) The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Cultural tailoring and case management show increased effectiveness for low-income Latino and African-American adults.	

Program	Group Cognitive Behavioral Therapy (CBT) of Major Depression
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Incredible Years Parenting Program	
Population	**Families with children (ages 2-10) with conduct problems;** **To promote parenting competencies**	
Cultural Evidence	**Evidence for low-income, ethnically diverse families; insignificant differences in outcomes between ethnic groups.** **Integrates cultural values/practices into parenting program**	
Risk and Protective Factors	**Risk:** • **Cognitive and neurological deficits/ low IQ** • **Hyperactivity** • **Mental health problem** • **Family management problems/poor supervision and/or monitoring** • **Maternal depression** • **Pattern of high family conflict** • **Negative attitude toward school**	**Protective:** • **Effective parenting** • **Good relationships with parents/bonding** • **Opportunities for pro-social school involvement** • **Supportive adults** • **Involvement with positive peer group activities**
Level of Evidence	**Well-supported**	
Outcomes	**1. Improved parenting** **2. Fewer behavioral problems in children**	
Prevention: Universal/Selective	**Selected**	
Early Intervention	**Early Intervention**	
Description	**See previous Incredible Years description in Children/Youth At Risk for School Failure section for details of program. Cultural modifications have been made and implemented with success.**	

Program	Incredible Years Parenting Program
Staffing Requirements	• Teachers • Parents
Service Delivery Setting	• Home • School • Community
Implementation Costs	• One-time start-up costs include $400-$500 per leader for leader training and $1,500 per series for program materials (the cost for the child program is slightly higher due to the price of puppets) • Ongoing costs include $500 annually for each leader to receive consultation, $476 for each parent in parent groups, $775 for each child in child treatment groups, $15 for each child receiving the Dinosaur curriculum in school, and $30 for each teacher receiving the teacher training.
Service Delivery Costs	• For detailed cost information associated with each program component see the Incredible Year web site
Standard Training Protocol	• Three day on-site training for parenting and 2 day on-site for the child curriculum. Certification takes place after group leaders complete two group cycles and have video tapes reviewed by the developer.
Proprietary	• Mix of public and proprietary
Sustainability	• Mentor who functions as a trainer in the local context.
Contact	Lisa St. George Administrative Director Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: lisastgeorge@comcast.net Carolyn Webster-Stratton, Ph.D. Professor and Director of Parenting Clinic, University of Washington Developer and Director, Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: cwebsterstratton@comcast.net www.incredibleyears.com

Program	Incredible Years Parenting Program Used with Korean-American Mothers
Population	Korean-American mothers and their children (ages 3-8) with behavioral problems
Cultural Evidence	Evidence for Korean-American mothers Translation of vignettes into Korean
Risk and Protective Factors	(See above, "Incredible Years Parenting Program")
Level of Evidence	Supported
Outcomes	1. Use of more positive discipline 2. Fewer behavioral problems in children 3. Greater social competency of children as perceived by mothers
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	See Incredible Years for general description. Service delivery carried out by community-based group leaders who spoke Korean and materials are available in Korean.

Program	Incredible Years Parenting Program Used with Korean-American Mothers
Staffing Requirements	• Teachers • Parents
Service Delivery Setting	• Home • School • Community
Implementation Costs	• One-time start-up costs include $400-$500 per leader for leader training and $1,500 per series for program materials (the cost for the child program is slightly higher due to the price of puppets) • Ongoing costs include $500 annually for each leader to receive consultation, $476 for each parent in parent groups, $775 for each child in child treatment groups, $15 for each child receiving the Dinosaur curriculum in school, and $30 for each teacher receiving the teacher training. • For detailed cost information associated with each program component see the Incredible Year web site
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Three day on-site training for parenting and 2 day on-site for the child curriculum. Certification takes place after group leaders complete two group cycles and have video tapes reviewed by the developer.
Proprietary	• Mix of public and proprietary
Sustainability	• Mentor who functions as a trainer in the local context.
Contact	Lisa St. George Administrative Director Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: lisastgeorge@comcast.net Carolyn Webster-Stratton, Ph.D. Professor and Director of Parenting Clinic, University of Washington Developer and Director, Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: cwebsterstratton@comcast.net www.incredibleyears.com

Program	Interpersonal Psychotherapy (IPT) for Depression	
Population	Adolescents (ages 12-18) with depression	
Cultural Evidence	Adapted IPT for Latino adolescents (individual and group); studies on primarily Puerto Rican youth	
Risk and Protective Factors	Risk: • Interpersonal conflict with parents • Acculturation stress • Financial stress	Protective: • Social supports in family, among peers, in school and community
Level of Evidence	Well-supported	
Outcomes	1. Decrease in depressive symptoms 2. Improvements in family outcomes	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	IPT was developed for the treatment of ambulatory depressed, nonpsychotic, nonbipolar patients. It has been demonstrated to successfully treat patients with depression, and has been modified to treat other psychiatric disorders (substance abuse, dysthymia, bulimia) and patient populations (adolescents, late-life, primary medical care). It has primarily been utilized as a short term (approximately 16 week) therapy, but has also been modified for use as a maintenance therapy for patients with recurrent depression. It includes specific strategies such as assessing the symptoms of depression, relating the onset of the depressive inventory and selecting a focus for the treatment for the following problem areas: delayed/incomplete grief, role transitions, role disputes or interpersonal deficit. These tasks are usually accomplished in the first three sessions. The middle phase (sessions 4-13) is devoted to work on the specific problem area with the goal of alleviating the symptoms of depression and improving interpersonal relationships. In the termination phase (sessions 14-16) the course of treatment is reviewed, progress reinforced, feelings about ending the therapy addressed and future problems anticipated.	

Program	Interpersonal Psychotherapy (IPT) for Depression
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Strengthening Bonds of Chicano Youth and Families
Population	9 to 16 year-old Latino youth at risk to substance abuse
Cultural Evidence	80% of the research participants were Latino
Risk and Protective Factors	**Risk:** • Favorable attitudes toward drug use • Family management problems • Family history of substance abuse • Peer alcohol, tobacco or other drug use **Protective:** • Self-efficacy • Effective parenting • Opportunities for prosocial family involvement • Presence and involvement of caring and supportive adults
Level of Evidence	Promising
Outcomes	1. Improved family communication and bonding 2. Increase in awareness of substance abuse issues and decreased substance abuse
Prevention: Universal/Selective	Selective
Early Intervention	
Description	Strengthening the Bonds of Chicano Youth (*El Proyecto de Nuestra Juventud*) is a comprehensive, multilevel, community-based, and culturally appropriate program designed to meet the prevention needs of rural Chicano youth in Central Arizona who demonstrate high-risk characteristics of substance abuse. The program is rooted in a family-oriented approach that is based on Mexican-American culture, values, and principles. The project was conceived and implemented by the Pinal Hispanic Council, a minority nonprofit organization based in Eloy, Ariz. The target population served by the project included 450 high-risk youth (323 female, 127 male) in three age groups (9–11 years old, 12–14 years old, and 15–16 years old), who were residents of low-income housing and students at the elementary, junior, and senior high schools. Availability of alcohol and drugs, attitudes favorable to drug use, negative peer influences, and poor family management were the risk factors used for referral to the project interventions. During the project, 330 families and 60 service providers were reached.

Program	Strengthening Bonds of Chicano Youth and Families
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Ralph Varela, C.M.S.W. Pinal Hispanic Council 712 North Main Street Eloy, AZ 85231–2037 Phone: (520) 466-7765 E-mail: warriors@cgmailbox.com

Program	**The Mothers and Babies Course** **"Mamas Y Bebes"** (Reality Management Approach and Relaxation Methods for Managing Stress)
Population	**Pregnant women, mothers and their babies for prevention of postpartum depression**
Cultural Evidence	**Spanish course available for Relaxation Methods for Managing Stress Course**
Risk and Protective Factors	**Risk:** • **Stressors (financial, work, emotional, physical, etc.)** **Protective:** • **Positive thoughts** • **Coping and problem-solving skills**
Level of Evidence	**Promising**
Outcomes	**1. Fewer major depressive episodes for intervention in pilot trial**
Prevention: Universal/Selective	**Selected**
Early Intervention	**Early Intervention**
Description	**Mamás y Bebés is a prenatal intervention designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The Mamás y Bebés/Mothers and Babies Course is an intervention developed in Spanish and English that uses a cognitive-behavioral mood management framework, and incorporates social learning concepts, attachment theory, and socio-cultural issues. Methods have been adapted from existing psychological treatment approaches, such as interpersonal psychotherapy and cognitive-behavioral therapy. The program consists of a 12-week mood management course and four booster sessions conducted at approximately 1, 2, 6, and 12 months postpartum.** **The explicit goal of the intervention is to help participants create a healthy physical, social, and psychological environment for themselves and their infants. The program is specifically designed to be culturally sensitive and linguistically appropriate for immigrant, low-income Latinas. The program seeks to** **1. Reinforce values such as collectivism** **2. Foster new outlets of support in a foreign context, including using the class as an additional outlet of support** **3. Validate Latinas' values and beliefs regarding pregnancy, childrearing practices, and motherhood** **4. Address Latinas' attitudes toward mental illness and seeking mental health services** **5. Adhere to common cultural verbal and nonverbal communication norms** **6. Validate the role of religion and spirituality in the health and healing of Latinas** **7. Allow them to relate their frustrations and painful experiences of discrimination and racism** **8. Expand Latinas' knowledge without devaluing their cultural beliefs**

Program	The Mothers and Babies Course “Mamas Y Bebes” (Reality Management Approach and Relaxation Methods for Managing Stress)
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	

Program	Multisystemic Therapy (MST)
Population	Youth (ages 12-17) with criminal behavior, substance use and emotional disturbance; youth on juvenile probation
Cultural Evidence	Studies on MST have included African-American
Risk and Protective Factors	**Risk:** • Anti-social behavior and alienation • Early onset of aggression and/or violence • Favorable attitudes toward drug use/early use of drugs or alcohol • Mental health problem • History of problem behavior/parent criminality • Poor family attachment • Low academic achievement • Association with delinquent and/or aggressive peers **Protective:** • Perception of social support from adults and peers • Effective parenting • Good relationships with parents/bonding • School bonding • Good relationships with peers • Involvement with positive peer group activities
Level of Evidence	Well-supported
Outcomes	1. Decrease in delinquency, arrests, and incarceration 2. Decrease in suicide attempts 3. Decrease in alcohol and substance use self-report (decreases not sustained in follow-up studies)
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	See MST description under Juvenile Justice for details of program.

Program	Multisystemic Therapy
Staffing Requirements	• Masters level therapists • In some case Bachelor level with supervision
Service Delivery Setting	• Public mental health or private providers • Home-based model
Implementation Costs	• Five days regular training supervisors/staff stakeholders from other agencies • Weekly MST consultation • Regular booster trainings • Track progress/outcomes by completing specific forms • Participate in weekly supervision • Quarterly on-site booster sessions • Master License $4000 • Team License $2500 • Program development and start up fees: $10,000—includes on-site 5 day orientation for up to 4 teams Booster Training • Single Team $26,000 (5,000) GA services • Two teams jointly $20,000 per year • Three or more $17,000 • Replacement staff 5 day on-site $8,000 plus travel costs • If staff goes to Charleston, $750 per day
Service Delivery Costs	• Provide on an as needed basis and regular appointments • Caseload is 4/6 families/ range of treatment is 4-6 months • Estimated cost savings juvenile justice system, crime victim & tax payers: $31,661 – $131,918 (Aos, et al., 2001)
Standard Training Protocol	• Yes—manualized training and program
Proprietary	• Yes •
Sustainability	• New staff must receive the 5-day training either in Charleston or new training on-site
Contact	MST SERVICES 710 J. Dodds Blvd. Suite 200 Mt. Pleasant, SC 29464 Keller.Strother@mstservices.com 843-856-8226 FAX 843-856-8227 CIMH 2125 19TH ST. Sacramento, CA 95818 Bill Carter, LCSW bcarter@cimh.org Tel. 916-556-3480 X 130 Fax 916-446-4519

Program	Multidimensional Family Therapy (MDFT)	
Population	**Families with adolescents (ages 11-18) with substance abuse and behavioral problems; youth on juvenile probation**	
Cultural Evidence	**Studies on MDFT have included ethnic minority youth (primarily males) and youth in inner cities: African-American, Latino and other ethnicities**	
Risk and Protective Factors	**Risk:** • **Antisocial behavior and alienation/drug dealing** • **Early sexual involvement** • **Favorable attitudes toward drug use/early use of drugs or alcohol** • **Family management problems/poor parental supervision and/or monitoring** • **Parental use of physical punishment/harsh and/or erratic discipline** • **Pattern of high family conflict** • **Negative attitude toward school/low school bonding** • **Association with antisocial peers** • **Gang involvement** • **Peer alcohol, tobacco, and/or other drug use**	**Protective:** • **Healthy/conventional beliefs and clear standards** • **Self-efficacy** • **Social competencies and problem-solving skills** • **Effective parenting** • **Good relationships with parents/bonding** • **Opportunities for pro-social school involvement** • **Involvement with positive peer group activities**
Level of Evidence	**Supported**	
Outcomes	1. **Decrease in cannabis and alcohol use** 2. **Decrease in problem behaviors**	
Prevention: Universal/Selective	**Selected**	
Early Intervention	**Early Intervention**	
Description	**See MDFT description under Juvenile Justice for details of program.**	

Program	Multidimensional Family Therapy (MDFT)
Staffing Requirements	• One team consists of: 2 -3 full-time therapists (Masters level) • 1 therapist assistant (high school/Bachelor's level) • On-site clinical supervision
Service Delivery Setting	• Home • Clinic
Implementation Costs	• Training for the 6-month certification is between $25,000-$30,000 per team. This includes all training costs.
Service Delivery Costs	• One MDFT Team (2 therapists, 1 therapist assistant) carry 10-16 families on its caseload. • Each family receives 3-5 visits a week for 3-6 mos.
Standard Training Protocol	• 6-month intensive process leading to certification for 1 year, annual re-certification thereafter
Proprietary	• Yes
Sustainability	• Certified teams need annual re-certification and additional training to address attrition/expansion - $3,000.
Contact	Center for Treatment Research on Adolescent Drug Abuse, University of Miami, Miller School of Medicine www.miami.edu/ctrada Gayle Dakof, Ph.D. (305) 243-3656 gdakof@med.miami.edu

Program	Parent-Child Interaction Therapy (PCIT): "Honoring Children, Making Relatives"
Population	Native American families with child-parent relational problems
Cultural Evidence	Adapted for Native American children and their parents
Risk and Protective Factors	**Risk:** • De-valuing children and their relationships with adults **Protective:** • Strength of relationships • Embracing Native concepts of parenting • Honoring children
Level of Evidence	Well-supported for PCIT – Adaptations not yet evaluated
Outcomes	1. Treatment goals to enhance relationship between child and parent, enhance parenting skills
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	Honoring Children, Making Relatives incorporates American Indian philosophies into the basic concepts of Parent-Child Interaction Therapy. Included in the curriculum are the issues of implementation and dissemination of evidence-based interventions in rural and/or isolated tribal communities with limited licensed professionals. Procedures are in place for assisting, measuring and monitoring the skills acquisition and treatment fidelity for rural/isolated or reservation based therapist-trainees. Online video consultation is used in the live remote real time coaching sessions to overcome the issue of distance and time constraints. The treatment is appropriate for children between the ages of 3-7.

Program	Parent-Child Interactive Therapy (PCIT) "Honoring Children, Making Relatives"
Staffing Requirements	• Masters level clinicians trained in PCIT
Service Delivery Setting	• Tribal organizations • Tribes
Implementation Costs	• $4000 per person for six months
Service Delivery Costs	• 12-16 sessions
Standard Training Protocol	• Information not available at this time
Proprietary	• Mixed
Sustainability	Information not available at this time
Contact	Dolores Subia BigFoot, Ph.D CHO-38-3406 P.O. Box 26901 OKC, OK 73190 405-271-8858

Program	Parent-Child Interaction Therapy (PCIT): "*Guiando a Niños Activos* (GANA) Program"	
Population	Children (ages 3-6) with behavioral problems and their families	
Cultural Evidence	Mexican-American children, parents and extended family Public health approach to mental health services	
Risk and Protective Factors	Risk: • Financial, cultural, attitudinal barriers to seeking and maintaining services	Protective: • *Familismo* and other Latino cultural values
Level of Evidence	Promising	
Outcomes	1. Decreases in conduct problems for children in GANA Program	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	Culturally modified PCIT for Mexican-American families by including culturally significant practice and understanding into the model's protocol.	

Program	Parent Child Interaction Therapy (PCIT): "*Guiando a Niños Activos* (GANA) Program"
Staffing Requirements	• Teachers • Therapists • Researchers • Masters degree or better
Service Delivery Setting	• Twelve to twenty sessions
Implementation Costs	• Forty hours of direct training with ongoing supervision • Consultation for 4 to 6 months via conference calls, videotapes, distance learning • $3,000 per person (5 day workshop)
Service Delivery Costs	• Clinic-based • Community-based • Home-based
Standard Training Protocol	• Yes • Assessment instruments • Scoring forms • Step by step clinician guide • Manualized training, coding of sessions and handouts.
Proprietary	• Yes
Sustainability	• There is a Train the trainer protocol.
Contact	Erical Pearl/Erna Olafson, Ph.D, Psy.D Trauma Treatment Training Center Cincinnati Children's Hospital 3333 Burnett Avenue MLC 3008 Cincinnati, Ohio www.OhioCanDo4kids.org CAARE Diagnostic and Treatment Center UC Davis Health Systems 3300 Stockton Blvd. Sacramento, CA 95820 800-770-6992 chinh.pham@ucdmc.ucdavis.edu

Program	Supporting Adolescents with Guidance and Employment
Population	Violence prevention program for African-American adolescents
Cultural Evidence	100% of the research participants were African-American males (12-16 year-olds)
Risk and Protective Factors	**Risk:** • Early onset of aggression • Early sexual involvement • Gun possession • Life stressors • Mental health problems • Victimization and exposure to violence • Low academic achievement • Association with delinquent peers **Protective:** • Positive expectations • Self-efficacy • Social competencies and problem-solving skills • Involvement with positive peer group activities
Level of Evidence	Emerging
Outcomes	1. Reduced reports for carrying a gun, selling illegal drugs and injuring others with a weapon
Prevention: Universal/Selective	Selective
Early Intervention	
Description	Supporting Adolescents with Guidance and Employment (SAGE) is a violence-prevention program developed specifically for African-American adolescents. The program consists of three main components, namely a Rites of Passages (ROP) program, a summer Jobs Training and Placement (JTP) program, and an entrepreneurial experience that uses the Junior Achievement (JA) model. The purpose of the first component, ROP, is to develop a strong sense of African-American cultural pride and ethnic identity in the participants and instill a sense of responsibility in their community, their peers, and themselves. In seminars held every other week over 8 months, the program curriculum (developed in 1993 by the Durham, N.C., Business and Professional Chain) also promotes self-esteem, positive attitudes, and the avoidance of a range of risky behaviors. Instructors cover topics such as conflict resolution, African-American history, male sexuality, and manhood training. Mentors from the community provide outreach experiences and tutoring. The second component, the JTP experience, places youths in summer jobs at desirable worksites such as dentist offices, local museums, and recreational centers. Site supervisors are encouraged to provide structure. Youths are trained in appropriate business behavior and dress. Job counselors work with the youths to resolve issues such as transportation. The third component, JA, teaches how to develop and implement a small business. With the guidance of volunteer advisers from the local business community, youths form a legal corporation, develop a business plan, elect officers, and sell stock to family and friends. They also market and sell a product (e.g., T-shirts, caps). The overall approach of SAGE is based on the theory that positive gains in personal and social responsibility, educational aspirations, and academic achievement—in tandem with employment training and opportunities fostered by community mentors—will make a positive impact on reducing violence among the participants.

Program	Supporting Adolescents with Guidance and Employment
Staffing Requirements	• Public health professional • County government officials • Local businessmen—African-American Mentor Program
Service Delivery Setting	• Community-based
Implementation Costs	Information not available at this time
Service Delivery Costs	• Eight month program (adult mentoring/African-American history and culture) • Manhood • Conflict resolution • Six week summer employment • 12 week entrepreneurial component
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Arnold Dennis North Carolina Central University 1801 Fayetteville Street Durham, NC 27707 919-560-7092 Bob Flewelling Pacific Institute for Research and Evaluation 1515 Chapel Hill , NC 27514-3307 919-265-2621 fax 919-265 -2659

Program	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): "Honoring Children, Mending the Circle"	
Population	Native American child trauma victims	
Cultural Evidence	Adapted for Native American children	
Risk and Protective Factors	Risk: • Problems in cognition, relationships and family	Protective: • Embracing Native cultural practices • Strong sense of resiliency through native concepts of well-being and healing • Family strengths
Level of Evidence	Trauma Focused CBT – Well-supported – Adaptations not yet evaluated	
Outcomes	1. Treatment goals to improve spiritual, mental, physical, emotional, and relational well-being	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	Based on TF-CBT (see previous entries for details). Traditional aspects of healing with American Indians and Alaskan Natives from their world view are included.	

Program	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): "Honoring Children, Mending the Circle"
Staffing Requirements	• Need background in CB treatment • Training in Trauma Focused Cognitive Behavioral Therapy • Limited to clinicians working in tribal organizations or with tribes
Service Delivery Setting	• TF-treatment adapted to be culturally appropriate for American Indians/indigenous people
Implementation Costs	• Training is $4,000 per person for 6-month training
Service Delivery Costs	• 12-16 sessions
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Dolores Subia Bigfoot, Ph.D. CHO-38,3406 PO Box 26901 OKC,OK 73190 405-271-8858 dee-bigfoot@ouhsc.edu

APPENDICES

Appendix A: Evidence-based Practices Rating System

Rating	Criteria
Well-supported	**1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.** **2. More than one rigorous randomized controlled trial has been conducted, using valid outcome measures, and has obtained consistent outcomes (positive effects with statistically significant results) in more than one setting and/or with more than one population.** **3. The practice can be replicated.** **4. Fidelity measures exist or can be developed from available information.**
Supported	**1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.** **2. At least one rigorous randomized controlled trial has been conducted, using valid outcome measures, and has identified positive effects with statistically significant results.** **3. The practice can be replicated.** **4. Fidelity measures exist or can be developed from available information.**
Promising	**1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.** **2. A less rigorous research and evaluation design or quasi-experimental design, using valid outcome measures and some form of control, has been conducted with evidence of positive effects.**
Emerging	**1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.** **2. The practice has sound theoretical rationale and has shown to be related to positive change through a minimum of a pre/post evaluation using valid outcome measures.**

Appendix B:
Los Angeles County Department of Mental Health MHSA Prevention and Early Intervention Technical Work Group

Name	Title	Organization
Maria Aranda, Ph.D.	Associate Professor	University of Southern California, School of Social Work
William Beardslee, M.D.	Academic Chair, Department of Psychiatry	Children's Hospital Boston, Department of Psychiatry, Center for Behavioral Science
Michele Berk, Ph.D.	Director, Adolescent CBT and DBT Programs Assistant Professor	UCLA School of Medicine, Harbor—UCLA Medical Center, Psychology Division
John Briere, Ph.D.	Associate Professor of Psychiatry and Psychology Director, Psychological Trauma Program, LAC-USC Medical Center Co-Director, MCAVIC-USC Child and Adolescent Trauma Program, National Child Traumatic Stress Network, SAMHSA	Keck School of Medicine, University of Southern California
Steven Forness, Ed.D.	Retired	Retired- UCLA Neuropsychiatric Institute
Sheryl Kataoka, MPH, M.D.	Assistant Professor, Department of Psychiatry and Biobehavioral Sciences	UCLA NPI, Department of Child Psychiatry, Health Services Research Center
Bob Knight, Ph.D.	Merle H. Bensinger Professor of Gerontology, Professor of Psychology	University of Southern California, Davis School of Gerontology, Ethel Percy Andrus Gerontology Center
John Landsverk, Ph.D.	Director, Child and Adolescent Services Research Center	Rady Children's Hospital San Diego, Child and Adolescent Services Research Center
Kurt Organista, Ph.D.	Associate Professor	University of California, Berkeley, School of Social Welfare
Eric Trupin, Ph.D.	Professor and Vice Chair, Department of Psychiatry and Behavioral Sciences Director, Division of Public Behavioral Health and Justice Policy	University of Washington School of Medicine, Department of Psychiatry & Behavioral Sciences, Division of Public Behavioral Health and Justice Policy
Nolan Zane	Professor of Psychology and Asian American Studies Director, Asian American Studies Program Director, Asian American Center on Disparities Research (AACDR)	University of California, Davis, Department of Psychology

Appendix C:
Los Angeles County Department of Mental Health Ad Hoc Prevention and Early Intervention Advisory Group – Technical Subcommittee

Name	Organization
Michael Alba	DMH/Service Employees International Union
Terri Boykins	DMH/Transition-age Youth Bureau
Bonnie Burstein, Ph.D.	Los Angeles Community College District
Heather Carmichael	My Friend's Place
Sam Chan, Ph.D.	DMH/Child, Youth & Family Program Administration
Rocco Cheng, Ph.D.	Pacific Clinics
James Cunningham, Ph.D.	DMH/Older Adult System of Care
Carmen Diaz	DMH/United Advocates for Children and Families
Cheryl Garcia	L.A. Care Health Plan
Rene Gonzalez	Los Angeles Unified School District
Cynthia Jackson, Ph.D.	Heritage Clinic
Helen Kleinberg	Los Angeles County Commission for Children and Families
Louse McCarthy	Los Angeles County Community Clinic Association
Carl McKnight, Ph.D.	DMH/Adult Systems of Care
Tara Pir, Ph.D.	Institute for Multicultural Counseling & Education Services
Joanne Rotstein	Los Angeles County Public Defenders Office
Wendy Wang	Association of Community Human Service Agencies

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2. **Lee, S., Aos, S., & Miller, M. (2008) *Evidence-based programs to prevent children from entering and remaining in the child welfare system: Interim Report.* Olympia: Washington State Institute for Public Policy, Document No. 08-05-3902**

APPENDIX 16

Community Defined Evidence Models Guide



Prevention and Early Intervention (PEI)

Community-defined Evidence (CDE) Models

Monday, March 30, 2009



Prepared for the
County of Los Angeles Department of Mental Health * MHSA Prevention and Early Intervention

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Programs that Meet All Required CDE Criteria

Program	Asian American Family Enrichment Network (AAFEN) Program
Developer	Terry Gock, PhD, MPA
Submitted by	Pacific Clinics Asian Pacific Family Center-East
Description	• Bicultural 12-week skill-based parenting program for Asian immigrants • Outreach, engagement, and support activities also part of curriculum
Population	• Asian immigrant parents and/or primary caregivers of teenage children
Cultural Evidence	• Curriculum has been evaluated with over 350 immigrant parents of Chinese, Korean, and Vietnamese origin • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Increased bicultural parenting skills • Improved parent/child relationships • Decreased family conflict
Level of Evidence	• Emerging
Outcomes	• Improved family functioning • Improved family relationships and attitudes
Prevention: Universal/Selective	• Selective

Programs that Meet All Required CDE Criteria

Program	Asian Mentoring and Advocacy Support to Enhance Resiliency in Youth (MASTERY): A Mentoring Program
Developer	Terry Gock, PhD, MPA
Submitted by	Pacific Clinics Asian Pacific Family Center-East
Description	• Bicultural, community-based program for middle-school Asian immigrant youth; intensive one-to-one mentoring and 42-week Life Skills curriculum focused on self-awareness & identity, cultural identity, goal setting, communication, anger management, selection of prosocial peer group, and refusal skills for alcohol, tobacco, and other drugs
Population	• Middle-school age Asian immigrant youths at high risk of substance abuse and other delinquent behaviors
Cultural Evidence	• Curriculum has been implemented with Asian immigrant youth • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Enhanced self-awareness and cultural identity • Enhanced relationships with significant adults and prosocial peers • Increased school bonding • Increased knowledge and use of prosocial skills
Level of Evidence	• Promising
Outcomes	• Decreased substance use • Decreased association with substance-using peers • Decreased risk of using alcohol, tobacco, or other drugs
Prevention: Universal/Selective	• Selective

Programs that Meet All Required CDE Criteria

Program	Brand New Day
Developer	Robert Myers, PhD
Submitted by	Universal Care
Description	• Comprehensive program based on model of care that includes active community treatment, individualized case management, motivational interviewing, problem solving therapy and behavior modification
Population	• Transition age youth and adults ages 21-65 years experiencing a first onset • Primary diagnostic categories are schizophrenia, schizoaffective disorder and bipolar disorder
Cultural Evidence	• Serves individuals speaking English, Spanish or Vietnamese
Risk and Protective Factors	• Increased activity level • Improved motivation toward meaningful use of time • Promotes ability to live independently • Improved compliance to treatment • Improved ability to connect in the community • Improved acquisition of part-time or full-time employment or participation in vocational training or a higher education program
Level of Evidence	Emerging
Outcomes	• Reduced psychiatric hospitalization, medical-surgical hospitalization and emergency room visit • Improved psychosocial functioning and physical health
Prevention: Universal/Selective	• Selected

Programs that Meet All Required CDE Criteria

Program	Caring for Our Family (CFOF)
Developer	Special Service for Groups – Asian Pacific Counseling and Treatment Centers
Submitted by	Special Service for Groups – Asian Pacific Counseling and Treatment Centers
Description	• Culturally appropriate adaptation of national "Family Connections" model • Includes community outreach, family assessment, individually tailored program of counseling, referrals and linkages • Direct services provided for minimum of six months, minimum one hour weekly
Population	• Los Angeles County Cambodian and Korean immigrant and refugee families with children between the ages of 5-11
Cultural Evidence	• Monolingual and bilingual services provided • Independent evaluation of adapted model conducted by external third party
Risk and Protective Factors	• Increased social support • Enhanced parenting competence • Decreased parent depression, anxiety, and stress
Level of Evidence	• Promising
Outcomes	• Improved child well-being
Prevention: Universal/Selective	• Selective

Programs that Meet All Required CDE Criteria

Program	Center for the Assessment and Prevention of Prodromal States (CAPPS)
Developer	Tyrone D. Cannon, PhD
Submitted by	University of California, Los Angeles
Description	• Universal prevention through public education and community outreach efforts • Selective prevention of and early intervention for youth at-risk of or experiencing their first episode of psychotic illness through multi-modal, comprehensive psychiatric and psychosocial interventions for one year, with booster sessions as needed for a second year
Population	• Transition age youth experiencing prodromal symptoms of first-break psychosis
Cultural Evidence	• Services provided in English and Spanish
Risk and Protective Factors	• Increased knowledge about and coping skills for identifying and managing psychiatric symptoms • Increased education and support for family members • Reduced stress
Level of Evidence	• Promising
Outcomes	• Increased early identification • Increased knowledge about symptoms • Improved functioning (clinical symptoms, family relationships, social, school/work)
Prevention: Universal/Selective	• Universal • Selective

Program	Circus Arts for Homeless Youth
Developer	Philip Solomon
Submitted by	My Friend's Place
Description	• In partnership with Cirque du Monde (the social outreach arm of Cirque du Soleil), an outreach model to serve as a non-threatening gateway for transition age homeless youth to access more traditional services that may be of benefit
Population	• Homeless transition age youth (15-25) and their children
Cultural Evidence	• This model is being used with a primarily ethnic minority homeless TAY population in Los Angeles County
Risk and Protective Factors	• Homelessness • Histories of trauma • Untreated psychiatric symptoms • Substance use/abuse
Level of Evidence	• Promising
Outcomes	• Increased access to and engagement in traditional case management services, health programs, and employment programs
Prevention: Universal/Selective	• Selective

Programs that Meet All Required CDE Criteria

Program	GLBT CHAMPS: Comprehensive HIV & At-Risk Mental Health Services
Developer	Jack Barbour, MD and William Cunningham, MD, MPH
Submitted by	South Central Health and Rehabilitation Programs, UCLA
Description	• A comprehensive package of interventions that includes: (1) Assertive Community Treatment (ACT) in conjunction with SAMHSA's Treatment Intervention Protocol (TIP); (2) an enhanced case management and outreach intervention (MOHOP); (3) mobile van HIV testing; and, (4) a CDC evidence-based social skills intervention for enhancing risk reduction education and decreasing stigma among HIV+ African American females (SISTA)
Population	• African American GLBT transition age youth (ages 15-25) who are (1) at-risk for or HIV+, and/or (2) at-risk for or experiencing early onset comorbid mental health problems and/or frequent substance abuse [some of whom are probationers or parolees]
Cultural Evidence	• Culturally appropriate for target population • Outcomes achieved with Los Angeles County (SPA 6) target population
Risk and Protective Factors	• Increased education • Decreased stigma • Decreased engagement in risky behaviors • Decreased isolation, depression, anxiety, and other mental health symptoms
Level of Evidence	• Varies by intervention component: Emerging to Promising
Outcomes	• Improved medication management • Improved engagement in medical and mental health care • Improved mental health status • Improved housing and employment stability
Prevention: Universal/Selective	• Selective

Program	IMPACT! (Inspire & Mobilize People to Achieve Change Together): A Youth Development and Leadership Program
Developer	Terry Gock, PhD, MPA
Submitted by	Pacific Clinics Asian Pacific Family Center-East
Description	• Bicultural, school-based, 26-week skill-based curriculum focused on increasing pro-social skills and preventing externalizing behavior problems in Asian immigrant adolescent youth
Population	• High-school age Asian immigrant youths at high risk of behavioral problems
Cultural Evidence	• Curriculum has been implemented with 169 Asian immigrant youth • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Increased self-efficacy • Increased pro-social peer interactions • Increased pro-social connections in school and with family • Decreased substance abuse • Decreased engagement in risky sexual activities • Decreased engagement in delinquent behaviors
Level of Evidence	• Promising
Outcomes	• Increased knowledge of healthy and pro-social behaviors • Increased pro-social attitudes • Increased pro-social behaviors
Prevention: Universal/Selective	• Selective

Programs that Meet All Required CDE Criteria

Program	LIFE (Loving Intervention for Family Enrichment) Program
Developer	Special Service for Groups – Occupational Therapy Training Program
Submitted by	Special Service for Groups – Occupational Therapy Training Program
Description	• Adaptation of Parent Project® national model (22-week skills based curriculum for parents of children at risk of or involved with the juvenile justice system) and multi-family group therapy
Population	• Low income Latino families with monolingual (Spanish) parents of children ages 10-17 at high-risk of delinquency and/or school failure
Cultural Evidence	• Outcomes achieved with Los Angeles County target population
Risk and Protective Factors	• Poor school attendance and performance • Poor relationships with peers, parents, and other authority figures • Antisocial behavior • Substance use/abuse • Parental stress • Inadequate parenting skills
Level of Evidence	• Promising
Outcomes	• Decreases in youth aggressive behaviors and social problems • Improved youth self-efficacy • Improved parenting skills and parenting competence
Prevention: Universal/Selective	• Selective

Programs that Meet All Required CDE Criteria

Program	Maternal Wellness Center
Developer	Emily C. Dossett
Submitted by	LAC+USC Medical Center
Description	• Culturally appropriate, evidence-based prevention and early intervention for perinatal depression through co-location of psychiatric services and perinatal care; includes screening, assessment, individual and/or group therapy, and medication management and support through six months postpartum (employs validated measures and cognitive-behavioral therapy).
Population	• Low income, ethnic minority, high-risk women and infants served in prenatal clinics
Cultural Evidence	• Educational materials for patients and training materials for providers are available in English and Spanish
Risk and Protective Factors	• Untreated depression • Financial stress • Poor social support • Chronic illness or disease (e.g., diabetes, hypertension, HIV) • Increased education regarding perinatal depression • Decreased stigma
Level of Evidence	• Emerging
Outcomes	• Increased identification of perinatal depressive symptoms and disorders • Increased access to care • Increased engagement in care
Prevention: Universal/Selective	• Selective

Programs that Meet All Required CDE Criteria

Program	Positive Directions
Developer	Special Service for Groups – HOPICS Family Center
Submitted by	Special Service for Groups – HOPICS Family Center
Description	• A comprehensive package of three national evidence-based interventions for the prevention and early intervention of substance use/abuse and delinquency including: (1) SAMHSA's Anger Management curriculum; (2) Cannabis Youth Treatment (CYT), based on motivational interviewing and cognitive-behavioral techniques; and, (3) a Life Skills for Teens curriculum. Youth participate for 9-12 months and receive individual case management in addition to the three 12-week, group-based, consecutively delivered interventions.
Population	• Low income, ethnically diverse youth ages 10-17 with substance use/abuse problems at risk of or involved with the juvenile justice system
Cultural Evidence	• Delivered in English and Spanish
Risk and Protective Factors	• Substance abuse • Community violence • Poor school attendance
Level of Evidence	• Promising
Outcomes	• Decreased substance abuse • Increased pro-social behavior • Increased knowledge of and skill use in anger management and conflict resolution • Increased knowledge of and skill use in problem solving, goal setting and communication skills • Increased utilization of community support system, particularly around relapse prevention
Prevention: Universal/Selective	• Selective

Programs that Meet All Required CDE Criteria

Program	Prevention and Early Treatment of Depression in Primary Care
Developer	Isabel T. Lagomasino, MD, MSHS
Submitted by	LAC+USC Medical Center
Description	• Culturally appropriate evidence-based collaborative care model that includes screening, prevention, and early intervention for depressive symptoms and disorders (employs validated measures and cognitive behavioral therapy)
Population	• Low income, ethnic minority, primary care patients (adults and older adults)
Cultural Evidence	• Treatment manuals are available in English and Spanish • Curriculum/intervention does not rely on client/consumer literacy
Risk and Protective Factors	• Increased education regarding symptoms and appropriate care • Decreased stigma • Increased access to evidence-based screening, assessment, and intervention
Level of Evidence	• Promising
Outcomes	• Improved access to care for depressive symptoms and depressive disorders • Improved engagement in care for depressive symptoms and disorders • Decreased depressive symptoms
Prevention: Universal/Selective	• Selective

Programs that Meet All Required CDE Criteria

Program	*Promotores de salud para nuestra tercera edud* (Health Promoters for our Third Age or Community Health Workers for Latino Older Adults)
Developer	Behavioral Health Services, Inc.
Submitted by	Behavioral Health Services, Inc.
Description	• Volunteer community members are trained in outreach and education activities specific to common physical health conditions in older Latino adults and their associated mental health conditions (e.g., diabetes and depression) • Volunteers are trained to conduct basic physical health status assessments and to follow-up with participants who have evidence of chronic health conditions (including knowledge of local referrals)
Population	• Latino older adults (55+) in Los Angeles County
Cultural Evidence	• All older adults served are/have been Latinos in Los Angeles communities • All materials are in English & Spanish
Risk and Protective Factors	• Increased positive health behaviors, presumed to mediate depression and anxiety, which are common to older adults with chronic health conditions • Increased knowledge of and access to appropriate health services
Level of Evidence	• Emerging
Outcomes	• Increased engagement in positive health behaviors, specifically those related to diabetes and hypertension • Improved communication with health providers
Prevention: Universal/Selective	• Selective

Program	Psychological First Aid for Students and Teachers
Developer	Marleen Wong, PhD (Co-Developer)
Submitted by	Los Angeles Unified School District / University of California at Los Angeles / RAND Corp.
Description	• Training and nationally-published educational materials for teachers whose students have experienced a disaster, school crisis, or emergency
Population	• Teachers of pre-school-age children and older who have experienced any disaster, school crisis, or emergency
Cultural Evidence	• This model has been used nationally (endorsed by the US Department of Homeland Security and the US Department of Education) and internationally (i.e., in China after the 2008 Chengdu earthquake)
Risk and Protective Factors	• Increased coping skills for managing the emotional and behavioral sequelae of unanticipated trauma
Level of Evidence	• Emerging
Outcomes	• (anticipated) To stabilize the emotions and behaviors of students • (anticipated) To return students to an improved mental and emotional state after a crisis or disaster, ready to attend school and reengage in classroom learning
Prevention: Universal/Selective	• Selective

Programs that Meet All Required CDE Criteria

Program	Reflective Parenting Program (RPP)
Developer	John Grienenberger, PhD and Paulene Popek, Ph.D.
Submitted by	Vista Del Mar and the Center for Parenting Studies at the New Center for Psychoanalysis
Description	• A 10-week curriculum to help parents build strong, healthy bonds with their children • One and one-half hour workshops actively engage parents in an experiential learning process that includes strategies, techniques, and exercises designed to enhance parental reflective functioning
Population	• Expecting mothers; parents of children age 2-5; parents of children age 6-12 • Families with risk factors: immigration, low socio-economic status, histories of loss or trauma, teen parenthood, single parenthood
Cultural Evidence	• Has curriculum for Spanish speaking parents
Risk and Protective Factors	• Enhanced secure attachment between children and parents • Enhanced caregiver-child relationship and parental reflective functioning
Level of Evidence	• Emerging
Outcomes	• Increases in parent reflective functioning
Prevention: Universal/Selective	• Selective

Programs that Meet All Required CDE Criteria

Program	Resilience and Effectiveness of Asian Adolescents in Countering Hostility (REAACH) Program
Developer	Terry Gock, PhD, MPA
Submitted by	Pacific Clinics Asian Pacific Family Center-East
Description	• Bicultural, school-based, 14-week skill-based curriculum focused on increasing pro-social conflict-management skills in Asian immigrant middle-school youth
Population	• Intermediate-school age Asian immigrant youths at high risk of aggression and behavioral problems
Cultural Evidence	• Curriculum has been implemented with 75 Asian immigrant youth • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Reductions in immigrant-specific stress • Enhanced extended family support • Enhanced connections with school • Increased bicultural competence
Level of Evidence	• Promising
Outcomes	• Decreased engagement in violent and aggressive behaviors when dealing with conflict
Prevention: Universal/Selective	• Selective

Program	UCLA TIES Transition Model (TTM)
Developer	Susan B. Edelstein, LCSW
Submitted by	UCLA TIES for Adoption
Description	• Multi-tiered transitional and supportive intervention • All adoptive parents of high-risk children participate in three 3-hour psycho-educational groups • Additional service and support options available to families, including older children, for up to 1 year (e.g., monthly support sessions, adoption-specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation)
Population	• Children age 0-8 transitioning to or in adoptive placement at high risk for mental health problems and/or placement disruption (including biological vulnerabilities and environmental risk factors)
Cultural Evidence	• Has been delivered to an ethnically and racially diverse population of over 1,000 children in Los Angeles County's foster care system; provided in English & Spanish; and has served diverse adoptive situations, including transracial (56%), single parent (32%), and gay & lesbian individuals and couples (26%)
Risk and Protective Factors	• Decreased parental stress; increased parental satisfaction with adoption
Level of Evidence	• Promising
Outcomes	• Fewer placement disruptions than national average and comparison groups receiving standard community of care • Fewer child mental health problems after 1 year of intervention in comparison to children receiving standard community care
Prevention: Universal/Selective	• Selective

Program	Why Try? Program
Developer	Martha Marquez, LCSW
Submitted by	Los Angeles Unified School District Student Health and Human Services – School Mental Health Services
Description	• National, evidence-based 10-week group curriculum (45 minutes each) designed to prevent delinquency and school failure
Population	• Low income, minority students (2nd thru 12th grade) at risk of school failure, dropping out of school, substance use/abuse, and/or juvenile justice involvement
Cultural Evidence	• This model is being used with low income, minority youth in Los Angeles County
Risk and Protective Factors	• Increased social skills • Increased conflict resolution skills • Increased coping skills
Level of Evidence	• Promising
Outcomes	• Increases in indicators of student resiliency
Prevention: Universal/Selective	• Selective



APPENDICES

Appendix A: Criteria Used in Evaluating CDE Applications

Community-Defined Evidence applications were reviewed for correspondence with the required criteria. Required criteria were specified in the document *Community-Defined Evidence (CDE) Models Guidelines 1.0* (dated Thursday, December 18, 2008; this document was available on the Los Angeles County Department of Mental Health PEI website at http://dmh.lacounty.info/mhsa/peicde/peiCDEguidelines1.0.pdf – prior to the application deadline) and in the blank application form itself. The CDE Guidelines and Application are presented in appendices C and D respectively.

The required criteria were as follows:

1) Conceptual Articulation Sufficient for Replicability: [CDE models] "…must be sufficiently well-articulated to be delivered in a consistent manner and replicated by others….Attach any available manuals, curriculum or other documents".

2) Demonstrated Effectiveness: [CDE models must] "…have some level of demonstrated effectiveness".

3) Targets a Well-Defined Population: "Target population refers to a well-defined group of individuals for which the model is intended".

4) Targets a Priority Population: "All CDE models must have a clearly defined target population that corresponds to PEI priority populations."

5) Specification of Intended Outcomes: "Each CDE model should describe the specific outcomes of the service, answering the question—*What outcomes does this model achieve?* This question may be answered in terms of (1) protective factors that are enhanced, (2) risk factors that are reduced, or (3) improvements in mood or emotional state, thought or cognitive process, and/or behavior."

6) Level of Care: "Specifically, each CDE model should describe the typical level of care, answering the question—*What is the intensity and duration of services provided?*"

7) Clearly Articulated Defining Strategies: "Primary Strategies [are]…clearly articulated strategies that define the practice….Specifically, each CDE model should describe its distinguishing strategies, answering the question—*What is the nature of the services provided?*"

This required criterion is related to criterion 1 above—Conceptual Articulation Sufficient for Replicability.

8) Effectiveness for Intended Outcomes: "Each CDE model should describe evidence that supports its effectiveness, answering the question—*How do we know that the model is working?*"

This required criterion explicates criterion 2 above—Demonstrated Effectiveness.

9) Specified Staffing: "Each CDE model should prescribe service staffing, answering the question—*Who are the core service providers?*"

10) Service Setting: "Each CDE model should prescribe any required service delivery settings, answering the question—*Where is the service provided?*"

Appendix B: Overall Framework for Decisions and Feedback

In order to be accepted for inclusion on Los Angeles County Department of Mental Health's list of PEI interventions, an application must meet all of the required criteria specified above.

If any one of the required criteria 1 through 8 was not met, this was sufficient reason for not accepting the applicant's program. Hence, when a proposal was not accepted, the reviewers did not necessarily give feedback on all of the deficiencies of the application – rather, they focused on specifying the clearest deficiency.

Other programs were excluded in the list of PEI services because they did not fit the MHSA operational definition of a Prevention or Early Intervention program. These definitions are available from the California Department of Mental Health's PEI planning guidelines, and on the Los Angeles County Department of Mental Health PEI website at http://dmh.lacounty.info/mhsa/plans/pei.html.

Finally, other programs were excluded because the submitted application described either a proposal for a program, rather than an existing program, or an evidence-based practice that was already included in the *Evidence-based Practices and Promising Practices Resource Guide for Los Angeles County*.

Whenever any one of the reviewers found that an application involved a difficult judgment, s/he consulted with Lynne Marsenich, LCSW, who directed the review effort and is a nationally recognized authority on prevention and early intervention programs, and on implementation of evidence-based programs in real world settings.

Los Angeles County Department of Mental Health (DMH), as part of its Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) program planning, is identifying a large set of PEI services from which individual practices may be recommended for inclusion in DMH's final PEI plan. The list of identified services will consist of evidence-based (EBP) and promising practices (PP). In addition, community-defined evidence (CDE) practices may be included in the list. All practices on the list will be organized by their appropriateness and effectiveness in serving PEI priority populations and promoting achievement of PEI outcomes across each of the four age groupings (child, transition-age youth, adult, older adult).

CDE has been defined as *"A set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community (CDEP Working Group, 2007)."* CDE models that target PEI priority populations and outcomes may be included in the list of PEI practices.

For inclusion on the list of PEI services, such models must be sufficiently well-articulated to be delivered in a consistent manner and replicated by others, and have some level of demonstrated effectiveness. Specifically, CDE models should have the following characteristics:

Target Population

Target population refers to a well-defined group of individuals for which the model is intended.

The group needs to correspond to a MHSA PEI priority population and may be defined, but not limited to, one or any combination of the following: areas of need, emotional or behavioral problems, diagnostic categories, risk factors, age, gender, ethnicity, nationality, cultural affiliation, primary language, or sexual identity.

In the case of universal prevention programs, the target population may include all individuals in a specific geographical area.

Each CDE model should describe the intended consumers in terms of all relevant criteria for determining when the model is appropriate to use, answering the question—***Who is this model intended to serve?***

This question may be answered in terms of areas of need, risk or protective factors, ethnicity or cultural affiliation, or other key characteristics of the intended target population.

All CDE models must have a clearly defined target population that corresponds to PEI priority populations.

Outcomes
One or more outcomes that can be achieved by the practice.

The outcomes need to correspond to MHSA PEI outcomes, and may include (1) decreasing or preventing an undesirable mood or emotional state, thought or cognitive process, or behavior; (2) increasing or developing desirable mood or emotional state, thought or cognitive process, or behavior; or (3) decreasing risk factors or increasing protective factors that impinge on an individual, family or community.

Each CDE model should describe the specific outcomes of the service, answering the question—
What outcomes does this model achieve?

This question may be answered in terms of (1) protective factors that are enhanced, (2) risk factors that are reduced, or (3) improvements in mood or emotional state, thought or cognitive process, and/or behavior.

Staffing
Staffing necessary and sufficient to deliver the practice.

Staffing requirements may include, but are not limited to (1) staffing levels, (2) credentials, education or experience, (3) primary responsibilities, (4) caseloads, and (5) role as part of a team when delivery of the practice is team-based.

Each CDE model should prescribe service staffing, answering the question—***Who are the core service providers?***

This question may be answered in terms of (1) the level of staffing needed, (2) any required educational attainment, or work or personal experiences, (3) key roles or responsibilities if working as part of a team, and (4) caseload levels if relevant to delivery of the model.

Service Setting
The setting(s) in which the service is delivered.

Settings may include, but are not limited to, homes, schools, community settings, mental health clinics, health care centers, resource centers, and faith-based or civic organizations. Some practices may be appropriate for more than one type of setting.

Each CDE model should prescribe any required service delivery settings, answering the question—***Where is the service provided?***

This question may be answered by describing setting(s) in which practitioners meet with consumers, family members or significant others, for the purposes of delivering the service, or the practice is otherwise provided.

Level of Care
The level of care that will be delivered per individual, family, or group of individuals or families.

Level of care may be described in terms of the frequency of contacts, length of each contact, and/or duration of care. The duration of service delivery and intensity should be less than that which is typical of services provided through MHSA Community Services and Supports (CSS) components.

In the case of universal prevention the level of care may be described in reference to an entire community, as opposed to an individual or family.

Specifically, each CDE model should describe the typical level of care, answering the question—***What is the intensity and duration of services provided?***

This question may be answered by specifying the typical number of contacts, frequency of contacts, and duration of contacts with consumers, family members or significant others.

Primary Strategies
Clearly articulated strategies that define the practice.

Strategies may include, but are not limited to (1) phases or stages of the practice, (2) curriculum, (3) key content that is the focus of one or more contacts, (4) processes, procedures or techniques in communicating with program consumers, family members or significant others.

Specifically, each CDE model should describe its distinguishing strategies, answering the question—***What is the nature of the services provided?***

This question may be answered by describing the model's defining features in terms of (1) therapeutic strategies, (2) curriculum, (3) processes or procedures, or (4) other activities that are critical to the model's success.

Indications of Effectiveness
One or more indications of program effectiveness.

Program effectiveness may be based upon, but not limited to, any or all of the following: (1) experimental evaluation, (2) quasi-experimental evaluation, (3) informal evaluation that includes comparison of pre- and post-measures, (4) case studies, (5) informal evaluation that includes post measures only, (6) anecdotal reports, or (7) testimonials.

Each CDE model should describe evidence that supports its effectiveness, answering the question—***How do we know that the model is working?***

This question may be answered by describing any and all levels of available evidence of effectiveness from testimonials through experimental evaluation.

Appendix D: Los Angeles County Prevention and Early Intervention Community Defined Evidence (CDE) Application

NAME OF INTERVENTION:	
TYPE OF INTERVENTION:	**NAME OF DEVELOPER:** **Phone number:** **Email:**
☐ Universal Prevention	**AFFILIATED AGENCY(IES):** **Address:**
☐ Selective Intervention	
☐ Early Intervention	

TARGET POPULATION—*Who is this practice intended to serve?*
List MHSA PEI priority population(s) targeted by this intervention:
☐ Underserved Cultural/Ethnic Populations
☐ Individuals with Early Signs of Severe Mental Illness
☐ Children/Youth in Stressed Families
☐ Trauma-Exposed
☐ Children/Youth at Risk for School Failure
☐ Children/Youth at Risk of or Experiencing Juvenile Justice Involvement
Describe defining characteristics of the target population for this intervention including the following when relevant: areas of need, risk or protective factors, emotional or behavioral problems, diagnostic categories, age, gender, ethnicity, nationality, cultural affiliation, primary language, or sexual identity.
OUTCOMES-- *What outcomes does this practice achieve?*
Describe the MHSA PEI outcomes achieved by this intervention including, but not limited to, (1) protective factors that are enhanced, (2) risk factors that are reduced, and/or (3) improvements in mood or emotional state, thought or cognitive process, and/or behavior.
STAFFING-- *Who are the core treatment practitioners?*
Describe the full and complete staffing for this intervention including, but not limited to, (1) the level of staffing needed, (2) any required educational attainment, or work or personal experiences, (3) key roles or responsibilities if working as part of a team, and (4) caseload levels if relevant to delivery of the model.
TREATMENT SETTING-- *Where is the practice provided?*
Describe where the practice is delivered including, but not limited to, setting(s) in which practitioners meet with clients, family members or significant others, for the purposes of delivering the intervention, or where the practice is otherwise provided.
LEVEL OF CARE-- *What is the intensity and duration of services provided?*
Describe the typical level of care provided to recipients of this practice including, but not limited to, number of contacts, frequency of contacts, and duration of contacts with consumers, family members and/or significant others.
PRIMARY STRATEGIES-- *What is the nature of the services provided?*
Describe the intervention's defining features including, but not limited to, (1) therapeutic strategies, (2) curriculum, (3) processes or procedures, or (4) other activities that are critical to the model's success. Attach any available manuals, curriculum or other documents describing the intervention.
INDICATIONS OF EFFECTIVENESS -- *How do we know that the model is working?*
Describe evidence of effectiveness by summarizing any and all indications that the practice achieves the intended outcomes. Levels of evidence may be based upon, but not limited to, (1) experimental evaluation, (2) quasi-experimental evaluation, (3) informal evaluation that includes comparison of pre- and post-measures, (4) case studies, (5) informal evaluation that includes post measures only, (6) anecdotal reports, or (7) testimonials. When testimonials are included they must be in writing from a current or past recipient of services.
DEVELOPMENT ACTIVITIES— *What ongoing evaluation activities are occurring?*
Describe evaluation activities that are currently occurring or planned to increase the evidence in support of the intervention's effectiveness. Include information on any study or research methods and data collection and analysis procedures.

Appendix D: Los Angeles County Prevention and Early Intervention Community Defined Evidence (CDE) Application

APPENDIX 17

Summary Of Substantive Recommendations & LACDMH Responses

SUMMARY OF SUBSTANTIVE RECOMMENDATIONS & LACDMH RESPONSES

Public Comment	Department Responses
1. Projects and Programs: Age Groups	
The Plan's piecemeal approach to care emphasizes age-based programs, a differentiation that may hinder the participation of agencies that serve families across the age continuum.	The State guidelines require that services be identified and delivered to specific age groups. Many of the programs require services to and/or interaction with families, and none of these programs would hinder agencies from working with families across the age continuum.
Under the school-based services, increasing mental health services for children under five would reduce the number of school-age children requiring mental health services or serious disorders. There are advantages for extending mental health prevention and early intervention services located on school sites to the preschool programs to help ensure that these cadres of students will success in the K-12 system. We suggest expanding the suggested list of implementation partners to include child care and development programs serving children from birth to five.	There are a number of programs in other projects that address the younger ages, not just the school-based services, e.g., Family Education and Support, which could be based at school sites. Preschool organizations, as well as other organizations, have the opportunity to bid on such services and base these services on school sites. Additionally, many pre-K programs are now being based on school sites. The suggested list of implementation partners, linkages, and collaborative partners was not intended to be exclusive, and child care and development programs have now been added.
There is a need to build core competencies in early educators working in child care and development programs to increase their capacity to work with children in a variety of social/ emotional needs and their family members within the program setting.	Some of the programs include education and interaction with early educators. The Workforce, Education, and Training Plan may be addressing these issues.
Environmentally focused prevention programs are not included.	Some of the programs may address environmental issues at the implementation stage, and future plans for PEI programs may incorporate these approaches.
The PEI Plan should support TAY developers through the selection of TAY targeted practices, providing incentives for more developers to target the 16-25 age spectrum in the future.	The 16-25 age spectrum for Transition Age Youth is pursuant to the State guidelines. While it is true that programs tend to be skewed to the younger TAY (16-17, generally considered children) or the older TAY (18-25, generally considered adults), these two age groups often have significantly divergent issues. As experience with the TAY services expand, the Department anticipates an increase in appropriate services to serve the broad spectrum of TAY.
2. Projects and Programs: Underserved Populations	
We urge you to include the blind and visually impaired among LACDMH's PEI priority populations. The blind and visually impaired are highly susceptible to mental health disorders. Adding this group to the PEI plan will allow L.A. County to be properly prepared to help this at-risk group.	The Department acknowledges the need to serve this high at-risk population, and the blind/visually impaired were added as a countywide population after the MHSA Stakeholder Delegates meeting on May 22nd. At this time the program targeting this group is Group Cognitive Behavioral Therapy. At the implementation stage LACDMH will work with blind/visually impaired experts to ensure that this program and Request for Service (RFS) adequately reflect services appropriate to this target group.

Public Comment	Department Responses
The programs selected for the deaf and hard of hearing are not appropriate for this population. There should be more services and funding available for the deaf/hard of hearing populations..	The Department recognizes that the interventions for the deaf/hard of hearing will need multiple adaptations to fit the needs of signing and non-signing consumers and/or their family members, These interventions will also need adaptations to fit a hearing parent with deaf child or deaf parent with hearing impairment or deaf child. Also, consideration for further communication variables will need to be considered, e.g., monolingual non-English speaking parent and a deaf child learning ASL and written English in school with no knowledge of the parent's language. These issues will need to be addressed at the bidding and implementation stage. Representatives from the deaf/hard of hearing community will be asked to assist the Department in ensuring that proper guidelines are initiated.
It is unclear how the underserved cultural groups will be addressed, with the exception of American Indians. The Improving Access for Underserved Populations Project does not include ethnic minorities.	The programs in the Improving Access for Underserved Populations Project are not the only programs where underserved cultural and minority groups, including African-America, Asian/Pacific Islander, Hispanic/Latino, Middle Eastern/Easter Europeans, will be served. Programs targeting a specific group have been placed in other projects. For example, Promotores de Salud Para Nuestra Tercera Edad (Health Promoters for Our Third Age or Community Health Workers for Latino Older Adults) is listed in the Early Care and Support for Older Adults Project. The Service Area Ad Hoc Steering Committees identified priority populations and subpopulations, including underserved cultural and minority groups, that should be served in specific service areas. Throughout the RFS process the Department will ensure that underrepresented cultural populations will be addressed..
There should be more services for the African-American community. How do we in the African-American community - which is historically adversely impacted and historically underserved – end the "lock-out" and finally get the quality/quantity mental health services we need & deserve?	Several of the Service Area Ad Hoc Steering Committees, particularly those with significant concentrations of African-American populations, were strong advocates for services to the African-American community. These services are listed throughout the different projects and are not limited to the Improving Access for Underserved Populations Project. Again, in the RFS process DMH will address the underrepresented population.
More programs should go to the Asian Americans, especially the youth. Asian Americans are often seen to be "smarter", but that's not always the case. Asians do get involved in gangs, alcohol/drug addiction. The lack of programs for Asian Americans & other youth in the San Gabriel Valley hinders our community.	The Service Area Ad Hoc Steering Committees identified priority populations and subpopulations, including underserved cultural and minority groups, that should be served in specific service areas. The Service Area 3 (San Gabriel Valley) Ad Hoc Steering Committee selected a CDE, the Asian American Family Enrichment Network Program, as a program to serve Asian American TAY.
It appears that the plan has not included the linguistically/culturally marginalized Polish immigrants. Polish born families are not getting their fair share of services.	A stand-alone program for Polish immigrants was not identified by any of the Ad Hoc Steering Committees which had primary responsibility for selecting the priority populations and selecting programs.

Public Comment	Department Responses
The substance abused/co-occurring disorders population was left out of the underserved population category.	Individuals with substance abuse/co-occurring disorders will be served by several programs not listed in the Improving Access for Underserved Populations Project, but in other projects. There are seven programs in the PEI Plan with specific identified outcomes targeted at this population.
Underserved cultural & linguistic groups have been identified as a priority population, but the way the plan and resources area laid out, we are concerned that issues like translation and culturally competent services are not explicitly mentioned. How will that work in terms of engaging those linguistically isolated?	For each project and program, the Department has built in resources for outreach and education in order to ensure that culturally and linguistically appropriate methods are included. At the RFS stage, prospective agencies will be required to demonstrate their experience in outreaching and working with specific cultural and ethnic minorities and to explain their plans for working with the targeted groups.
More CDEs or culturally specific programs need to be included in the PEI Plan. For those programs that did not qualify as a CDE, what plans are there to assist these programs to receive PEI funding?	In early fall 2009 the Department will hold workshops to help agencies with qualifying as CDEs. Technical assistance will be provided for those agencies that submitted CDE applications in January 2009. Agencies that qualify as CDEs will be added to the existing list of CDEs, and as funding becomes available, these new CDEs may be considered. The CDEs would need to meet the priority populations and subpopulation guidelines developed by the Ad Hoc Service Area and Countywide Steering Committees. Most of the EBP's and PP's have been used with multi-cultural populations in other communities in CA and many of these were developed with multi-cultural populations as the study samples.
There were no community/local based interventions selected that were specific to the Los Angeles urban American Indian community. There were programs submitted for PEI CDE consideration, but none qualified. Is there consideration for capacity building (funding, technical assistance) to foster and implement such local interventions?	The initial draft PEI plan had a pilot program to serve urban American Indians, but the Countywide American Indian Steering Committee selected an EBP that was developed for American Indians and was adaptable to American Indians living in urban communities. Programs submitted for American Indians have the opportunity in the fall to qualify as CDE as described above.
There should be outreach and services to the physically disabled populated population groups, whether veteran and not.	As indicated above, the Department has built in resources for outreach and education in order to ensure that culturally and linguistically appropriate methods are included. At the RFS stage, prospective agencies will be required to demonstrate their experience in outreaching and working with underserved populations, including the disabled and Veterans groups, as well as their plans for working with the targeted groups.
TV or radio ads should be funded to inform about the PEI programs. The community needs information from the media about these services.	In addition inclusion in the LACDMH PEI budget for outreach and education, there are the State Administered PEI projects. One of the categories for funding is the reduction of stigma and discrimination, and there is a very preliminary plan to launch a statewide campaign that would use the airways.

Public Comment	Department Responses
3. Projects and Programs: Primary Care and Behavioral Health	
There is little in the Primary Care & Behavioral Health Services Project to actually address with limited duration and intensity any treatment needs that may be identified. Programs are too brief and do not allow the opportunity to build rapport and develop attachment to the therapist facilitating treatment.	Per the State guidelines, all PEI services should be of short duration (one year) and of lower intensity than traditional mental health services.
The plan misses the opportunity to truly transform the service-delivery system by creating person-centered health and mental healthcare homes. In this mode, a spectrum of care, both physical and mental, is offered in a single setting,. A vision and Principles statement for integrated behavioral health services is being developed for California with a myriad of behavioral health and primary care stakeholders.	This model is still in the development stage and has not been finalized. The Department is a participant in determining this model, and once it has been fully developed, it is anticipated that as appropriate the model may be incorporated in the plan. In addition, there are a number of other models that are being considered, and the Department has not selected any particular model at this stage.
Primary care clinics are described as potential settings and partners in the majority of the plans, yet the level to which these relationships are integrated is vague. Clinics providers stressed the need for service integration, but the plan cites the need for service co-location. Co-location is not integration.	The term co-location is used primarily in reference to a strategy to partner with a broad range of other organizations such as education, health, public health, Probation Department, alcohol and drug programs and Sheriffs Department. It is not used in conjunction with health organizations. Integration can be a goal through the actual implementation with some of the partners but not all; integration has a different connotation with each potential partner. The specific providers have not yet been identified, and depending on the outcome of the County's bidding process, the details of service integration or co-location will have to be determined during implementation. During the RFS process DMH will be seeking integrated service based upon the programs and desired strategies.
4. Other Programs	
The Plan is focused too heavily on early intervention and not on true prevention. This is our opportunity to reach out, but instead the Department is working on those with severe mental illness.	The Service Area Steering Committees selected a mix of prevention and early intervention strategies and determined the needs in their communities. There are numerous PEI programs that are universal and selected prevention strategies. State guidelines specifically identify individuals experiencing onset of serious psychiatric illness as a priority populations, and services to address their needs are a necessary part of the PEI Plan.
We have 4 out of the 8 service areas not doing true Early Intervention for Severe Mental Illness. I suspect the funds are used instead for short term programs for less severe mental illness. I think this is wrong. Here we have the opportunity to use money for true Early Intervention for Severe Mental Illness. Instead, we use it for other things.	The Service Area Steering Committees selected a mix of prevention and early intervention strategies and determined the needs in their communities. There are programs that specifically address early detection and treatment of psychotic disorders, but the treatment, in line with the State guidelines regarding the PEI plan, is intended to be short-term. Long-term treatment is addressed in the CSS Plan.

Public Comment	Department Responses
The plan needs to include suicide prevention programs. There was little mention of suicide prevention; only two specific suicide prevention programs were described.	Several of the PEI program identify suicide prevention as one of their objectives and outcomes. Additionally, suicide prevention has been addressed as one of the PEI Early Start Projects and is also a state-wide initiative.
In-Home Support services for families to prevent detentions should be made available.	A number of PEI programs, such as the Nurse-Family Partnership, provide In-Home Support services.
There is a need for voluntary placements to be available for families with children with mental health issues without requiring DCFS intervention.	A number of PEI programs, particularly those in the At-Risk Family Services Project, address services without requiring DCFS intervention.
Respite care for families with children with mental health issues is needed to relieve the stress of caring for special needs children.	Respite Care services are available through the CSS Plan.
Recommend that DMH develop the coordination framework needed to assist both clients and provides with navigation through this labyrinthine systems. A point person – akin to a concierge – whom all providers can call on to help shepherd their clients to needed services would certainly enhance continuity of care and ease of access for the clients.	The Department recognizes that a coordinator for PEI services, similar to the "system navigators" in the CSS Plan, may be needed. The process and point persons will be developed and identified during the implementation process. Moreover, outreach and engagement is a essential element of PEI. Services.
5. Funding Allocations	
The Department should Identify a dollar amount from the various project totals dedicated to serve uninsured clients. The Plan will serve primarily the insured and not the uninsured.	There are no requirements that the programs serve clients who receive Medi-Cal or have other insurance. Unlike the CSS Plan, Medi-Cal leveraging has not been mandated in the PEI Plan, so that it is possible that the predominant majority of recipients could be the uninsured.
Countywide resources target the uninsured, overlook the uninsured.	There are no stated restrictions for the use of these funds with the six countywide groups insofar as coverage is concerned. The one exception is the Advice Line program which will serve Medi-Cal clients. The maximum ceiling for leveraging Medi-Cal will be 15% for the entire PEI plan in large part because of the high need among indigent populations.
Resources should be increased for Service Area 1, which has received the smallest funding.	The MHSA Stakeholder Delegates determined the allocation of funding for the service areas, which was based on the formula of 85% poverty level and 15% population. SA1 is the least populated area in the county.

Public Comment	Department Responses
Skewed Level of Investment: it does not appear that the number of people impacted by each project fits the level of investment. The cost per use across the programs varies greatly. The substantial differences in expenditure are difficult to interpret, leading one to question whether allocations were based on anticipated program expenses, intensity of care of other considerations.	Program costs are based on anticipated program expenses. Staff contacted the program developers directly to ascertain actual program costs (staffing levels, training cost, training materials, etc.) While it is true that some programs cost less dollars per individual while others cost significantly more, the difference is based on the type of service. Education is less costly than short-term intensive treatment, and universal prevention is less costly than early intervention. Moreover, the Plan does not report the actual long-term costs savings and cost avoidance to society and other county/state agencies(such as DCFS, Probation) if these mental health issues are not addressed and prevented at an early stage, and thereby result in severe mental illness, incarceration, foster care, homelessness, etc.
The Department has set aside Inadequate reserves; the 10% operating reserve should be increased. Current budget projections indicate that a reserve of 20% or greater may be needed to sustain programs in this economic downturn.	The 10% operating reserve is the maximum percentage allowable by the State at this time.
DMH should consider giving a higher percentage of funding to providers not currently in their system. The PEI planning required sectors like education, law enforcement, health, social services and the underserved to be encompassed. Allowing such a large proportion go to existing providers does not follow the guidelines.	The percentage of funding to LACDMH, current contractors, and new contractors was determined by the MHSA Stakeholder Delegates. The Stakeholders include not just mental health providers, consumers, and family members, but also law enforcement, health, education, social service, and underserved cultural population representatives, and other organizations not currently funded by LACDMH
Failure to Leverage Resources. While the projects all mention leveraging of resources, DMH has not analyzed how the planned services will link up with our federal and State process, nor with other county departments.	The Department has not pre-identified which programs will be operated by which agencies, whether public or private. This will be determined by the County's MHSA bidding process. The Request for Services will require that prospective providers identify and propose leveraged resources to enhance their services. As indicated by State guidelines, leveraging refers to a broad range of resources that partners can contribute, e.g., office space, training, expertise. During the planning stage, the Department met with several County and City Departments to explore prospective leveraging prospects, but these have not been pre-determined.
6. Implementation Process	
Key to the success of school-based health centers around the country is ensuring student voice in planning and implementing programs. Involving school leaders, parent and students is critical to introducing mental health services on school campuses.	At this time the school sites have not been determined. At the implementation stage, school input, including student, parent, teacher and school administrators, will be required in order to ensure successful planning and implementation.

Public Comment	Department Responses
Other types of providers, not just mental health providers, should be able to provide these services. What qualifies a program to facilitate a PEI program and do they have to be certified? Will they have to already have EBPs in place?	The PEI programs are not restricted to existing mental health providers, and any agency may bid on a program in accordance with the County's MHSA bidding process. These are new services, so that agencies do not have to have an EBP already in place. Furthermore, agencies cannot supplant their existing EBP with a PEI EBP.
We think the plan offers a lot of promise and hope for services that are going to be integrated and improve outcomes for individuals, that are going to leverage resources. What are the assurances that outcomes are met and there is an accountability or the clients that are being seen? This includes the uninsured, that the services are integrated not merely co-located. And that the leveraged service is not only through Med-Cal, but, through state reform and other county processes. There needs to be continuity and efficiencies with the EBPs and CDEs with the populations being addressed.	The Department plans to expand the unit overseeing Prevention and Early Intervention to address the monitoring and evaluation of these issues once the programs have been implemented. At the bidding stage, the RFS will specify the performance requirements to which the agencies must adhere in providing the services.