MONO COUNTY: DATA NOTEBOOK 2021

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Behavioral Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally, and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

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California Behavioral Health Planning Council

Advocacy • Evaluation • Inclusion

NOTICE:

This document contains a textual **preview** of the California Behavioral Health Planning Council 2021 Data Notebook survey, as well as **supplemental data** for your county. It is meant as a **reference document only**.

Some of the survey items appear differently on the live survey due to the difference in formatting. For a more accurate preview of the online survey, please reference the **Data Notebook 2021 SurveyMonkey Preview PDF**, which you received along with this document. We recommend reviewing both documents while preparing your survey responses.

DO NOT RETURN THIS DOCUMENT.

Please use it for preparation purposes only.

To complete your 2021 Data Notebook, please use the following link and fill out the survey online:
https://www.surveymonkey.com/r/DPQT8F8

Table of Contents

Introduction: Purpose and Goals

The Data Notebook is a structured format to review information and report on each county's behavioral health services. A different part of the public behavioral health system is focused on each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the Planning Council. The discussion questions seek input from the local boards and their departments. These responses are analyzed by Planning Council staff to create an annual report to inform policy makers, stakeholders, and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates[1] to review and comment on their county's performance outcome data, and communicate its findings to the CA Behavioral Health Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

The 2021 Data Notebook is focusing on racial/ethnic inequities in behavioral health. This topic comprises only part of the Data Notebook. We also have developed a section (Part I) with questions that are addressed each year to help us detect any trends. Monitoring these trends will assist in identification of unmet needs or gaps in services which may occur due to changes in population, resources available, or public policy.

The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing responses for the Data Notebook. This is an opportunity for the local boards and their county behavioral health departments to work together to identify important issues in their community. This work informs county and state leadership about local behavioral health programs, needs, and services. This

[1] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

Information is used in the Planning Council's advocacy to the legislature and for input to the state mental health block grant application to SAMHSA[2].

CBHPC 2021 Data Notebook – Part I:

Standard Yearly Data and Questions for Counties and Local Boards

In recent years, major improvements in data availability now permit local boards and other stakeholders to consult extensive Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services (SMHS) and Substance Use Disorder Treatment. Similar data are analyzed each year to evaluate county programs and those reports can be found at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data can be found in the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.

In addition, members of the Planning Council would like to examine some county-level data that are not readily available online and for which there is no other publicly-accessible source. The items of interest include data that are collected by the counties because they need to know how much they are spending in these service categories and for how many clients. Collecting these data will help us analyze aspects of the behavioral health system that are not currently tracked.

Please answer these questions using information for fiscal year (FY) 2020-2021 or the most recent fiscal year for which you have data. Not all counties will have readily available data for some of the questions asked below. In that case, please enter N/A for 'data not available.'

Adult Residential Care

There is little public data available about who is residing in licensed facilities on the website of the Community Care Licensing Division at the CA Department of Social Services. This makes it difficult to determine how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires the collection of data from licensed operators about how many residents have SMI and whether these

[2] SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For more information and reports, see www.SAMHSA.gov.

facilities have services these clients need to support their recovery or transition to other housing.

The Planning Council would like to understand what type of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)[3] available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs. 'Bed day' is defined as a treatment slot (or bed) occupied by one person for one day.

The following is a text summary of the survey questions for Part I of the 2021 Data Notebook. Please note that the questions are presented here in a different format than the finalized SurveyMonkey online survey. Refer to the PDF preview of the SurveyMonkey survey to see a more accurate presentation of the items.

1) Please identify your County / Local Board or Commission.

2) For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last fiscal year? (Text response)

3) What is the total number of ARF bed-days paid for these individuals, during the last fiscal year? (Text response)

4) Unmet needs: how many individuals served by your county behavioral health department need this type of housing but currently are <u>not</u> living in an ARF? (Text response)

5) Does your county have any 'Institutions for Mental Disease' (IMD)?
    a. No
    b. Yes (If Yes, how many IMDs?)

6) For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?
    In-county: (Text response) Out-of-county: (Text response)

7) What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period? (Text response)

[3] Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx.

Homelessness: Programs and Services in California Counties

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and homelessness. Federal funding was provided to states that could be used for temporary housing for individuals living on the streets as a method to stop the spread of the COVID-19 virus. Additional policy changes were made to mitigate the rate of evictions for persons who became unemployed as a result of the public health crisis.

Studies indicate that approximately only 1 in 3 individuals who are homeless also have serious mental illness and/or a substance use disorder. While the Planning Council does not endorse the idea that homelessness is caused by mental illness nor that the public BH system is responsible to fix homelessness, financially or otherwise, we know that recovery happens when an individual has a safe, stable place to live. Because this issue is so complex and will not be resolved in the near future, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD.

8) During the most recent fiscal year (2020-2021), what new programs were implemented, or existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness? (Mark all that apply.)
    a. Emergency Shelter
    b. Temporary Housing
    c. Transitional Housing
    d. Housing/Motel Vouchers
    e. Supportive Housing
    f. Safe Parking Lots
    g. Rapid Re-Housing
    h. Adult Residential Care Patch/Subsidy
    i. Other (Please specify)

Child Welfare Services: Foster Children in Certain Types of Congregate Care

About 60,000 children, under the age of 18, in California are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely

with their caregiver(s). Most children are placed with a family who receive foster children, but a small number of the children need a higher level of care and are placed in a 'Group Home'. California is striving to move away from the use of long-term group homes, and prefers to place all youth in family settings, if possible. California has revised the treatment facilities for children whose needs cannot be safely met initially in a family setting. Group homes are to be transitioned into a new facility type called Short-Term Residential Treatment Program (STRTP). STRTPs provide short-term, specialized, and intensive treatment individualized to the needs of each child in placement.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for children in foster care who are not yet able to be placed in a family setting or who are in a family setting and experience a crisis which requires short-term intensive treatment.

9) Do you think your county is doing enough to serve the children/youth in group care?
    a. Yes
    b. No (If No, what is your recommendation? Please list or describe briefly) (Text response)

Many counties do not yet have STRTPs and may place children/youth in another county. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

10) Has your county received any children needing "group home" level of care from another county?
    a. No
    b. Yes (If Yes, how many?)

11) Has your county placed any children needing "group home" level of care into another county?
    a. No
    b. Yes (If Yes, how many?)

CBHPC 2021 Data Notebook – Part II:

Racial/Ethnic Inequities in Behavioral Health

Background

California is one of the most culturally diverse states in the nation regarding race, ethnicity, and language. This diversity is one of the state's greatest assets, but it also comes with a need to provide services in ways that are culturally relevant and respectful of these diverse communities. Health disparities by race and ethnicity are well documented, and there are prominent inequities in behavioral health outcomes and access to services. The state has a responsibility to address these disparities and work towards a mental health system that serves California's cultural and linguistic diversity.

The 2014 Data Notebook touched on some of these issues in a section titled "Access by Unserved and Under-Served Communities." Using data from the External Quality Review Organization (EQRO), the number of individuals eligible for Medi-Cal in the county was compared to the number who were served in county Specialty Mental Health programs in two charts, broken down by race/ethnicity. The counties were then asked 3 questions.

1. Is there a big difference between the race/ethnicity breakdowns on the two charts? Do you feel that the cultural group(s) that needs services in your county is receiving services?
2. What outreach efforts are being made to reach underserved groups in your community?
3. Do you have suggestions for improving outreach to and/or programs for underserved groups?

Since 2014, awareness of inequities in behavioral health has continued to increase. In 2017, Governor Jerry Brown signed AB 470 (Arambula) into law, which requires the tracking and evaluation of Medi-Cal specialty mental health services with the goal of reducing mental health disparities. The California Pan Ethnic Health Network (CPHEN) developed an Advisory Workgroup in 2018 to provide recommendations for the implementation of AB 470. The Department of Health Care Services published the first report of the data in 2019, with an update in 2020. The California Health Care Foundation (CHCF) and CPHEN released a report in November 2020 with analysis of that data, highlighting some of the findings that the data provides while also providing recommendations for additional measures focused on quality of care and outcomes. It also called for continued stakeholder engagement to ensure that "performance and disparity reduction measures reflect consumer needs."

This is just one example of the efforts being made to address behavioral health inequities; there is much more work to be done. The CBHPC Equity Statement

acknowledges the impact of social injustice on the behavioral health system that leads to health inequities, and "supports California in achieving the goals to reduce disparities, rebuild the trust lost from communities that have been historically under/inappropriately served and eliminate social injustice and racial inequities." As part of the effort to put this into action, the 2021 Data Notebook is returning to this timely topic.

County Data: <u>Mono County</u>

The following data has been personalized for your county. Please review it and reflect on the potential trends regarding race and ethnicity. Refer to it as you answer Part II of the 2021 Data Notebook Survey. See Appendix I for statewide California data.

Figure 1 is from the Highlighting Differences to Understand Disparities dashboard of the MHSOAC transparency suite. It compares the percentage of total persons by race/ethnicity in your county from three sources for fiscal year (FY) 18-19:

1. FSP: Persons in Full-Service Partnerships.
2. CSI: Persons receiving publicly funded mental health services as reported in the Clients Services Information system.
3. Total Pop: Department of Finance population estimates based on US Census data.

The data is also presented in table format below the chart. Some values may be unavailable or suppressed due to the low count to protect patient privacy. Comparing these percentages may show some insight into potential disparities in access based on race/ethnicity.

Figure 1. Mental Health Access by Race/Ethnicity in Mono County, FY 18-19, Total

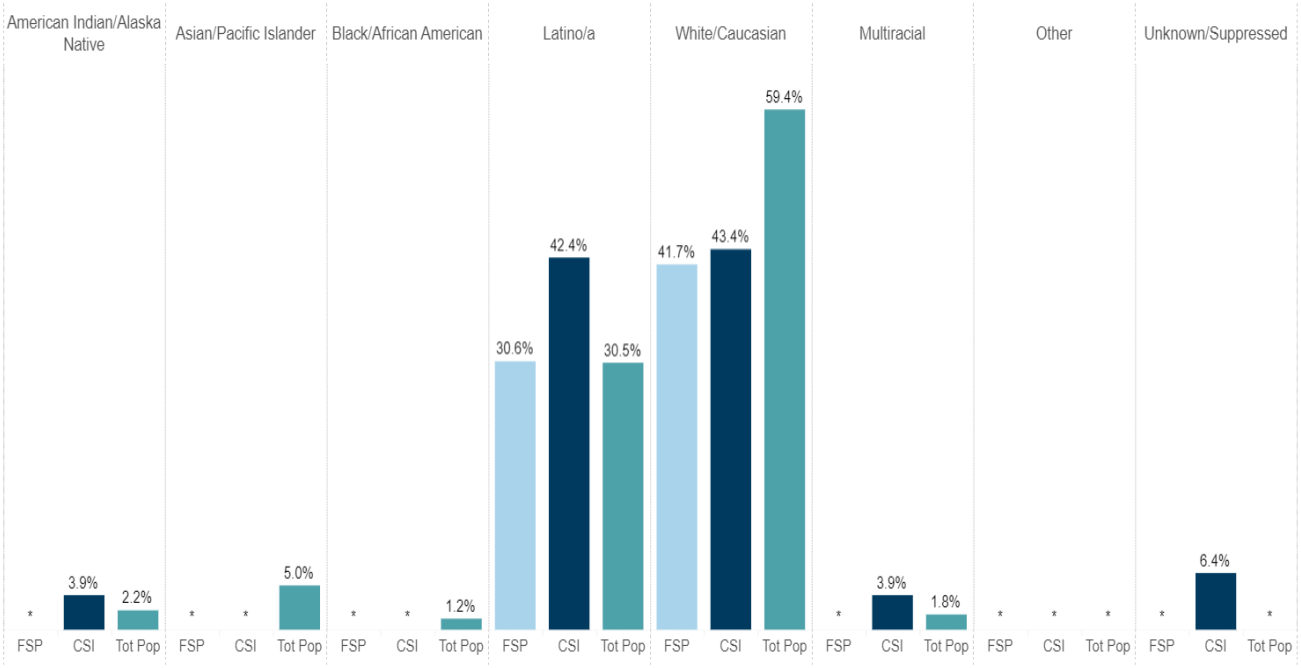


Table 1. Mental Health Access by Race/Ethnicity in Mono County, FY 18 - 19, Total

	American Indian/ Alaska Native	Asian/ Pacific Islander	Black/ African American	Latino/a	White/ Caucasian	Multiracial	Other	Unknown/ suppressed
FSP	*	*	*	30.6%	41.7%	*	*	*
CSI	3.9%	*	*	42.4%	43.4%	3.9%	*	6.4%
Total Pop	2.2%	5.0%	1.2%	30.5%	59.4%	1.8%	*	*

**Data not available or suppressed (any count <11)*

Further data are provided below from the [Performance Dashboard AB 470 Report Application], published by DHCS. The first two charts (Figures 2 & 3) show the percentages of adult beneficiaries in your county receiving **Specialty Mental Health Services** or **Mental Health Services** compared to the overall Medi-Cal eligible count, by race/ethnicity. **Mental Health Services** refers to non-specialty mental health services; mostly mild-moderate mental health services found in fee-for-service claims and managed care encounters. The **access** rate includes beneficiaries receiving **at least one** mental health services visit in a single fiscal year while the **engagement** rate includes beneficiaries with **five or more** visits in a fiscal year.

Differences in the percentages by race/ethnicity may show potential disparities. For example, some groups may have lower penetration and engagement rates than others. There may also be discrepancies between the penetration and engagement rates for the same group, or between the rates for Specialty Mental Health Services compared to Mental Health Services. What does the data for your county say about access and engagement for different racial/ethnic groups?

Figure 2. Medi-Cal Mental Health Access Rates, Mono County Adults, by Race/Ethnicity, FY 19-20

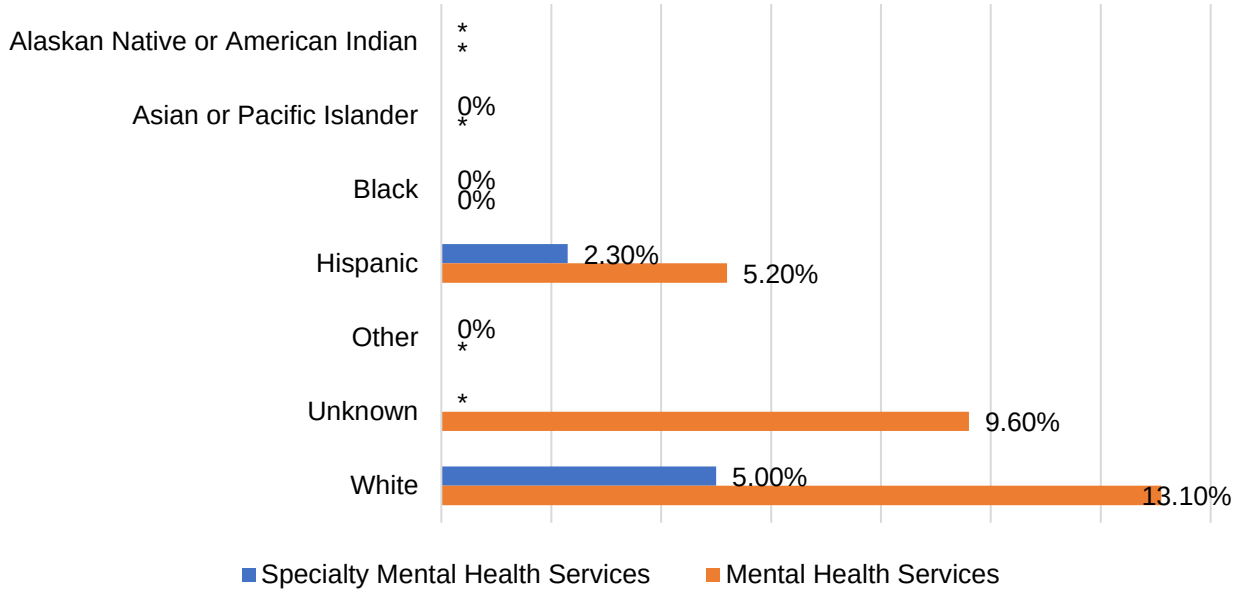
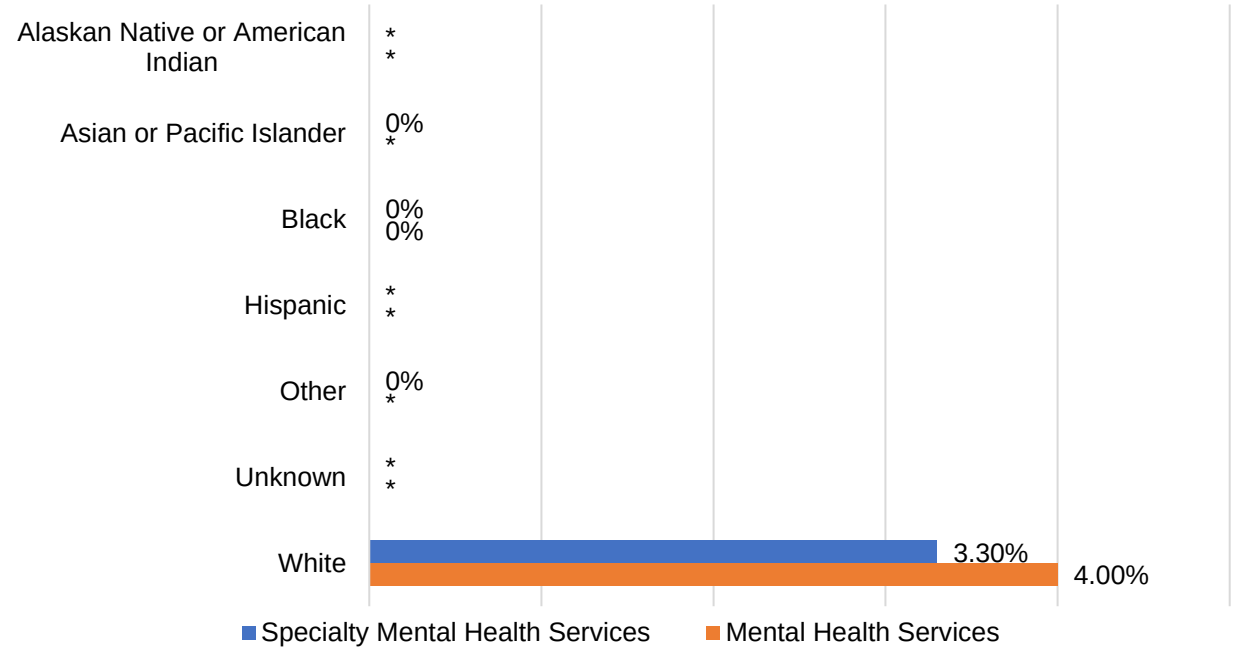


Figure 3. Medi-Cal Mental Health Engagement Rates, Mono County Adults, by Race/Ethnicity, FY 19-20



The next two charts (Figures 4 & 5) show the same measures for children and youth in your county. Once again, differences in rates between groups may indicate inequities in access to care, and trends may be different from the data for adults in your county.

Figure 4. Medi-Cal Mental Health Access Rates, Mono County Children & Youth, by Race/Ethnicity, FY 19-20

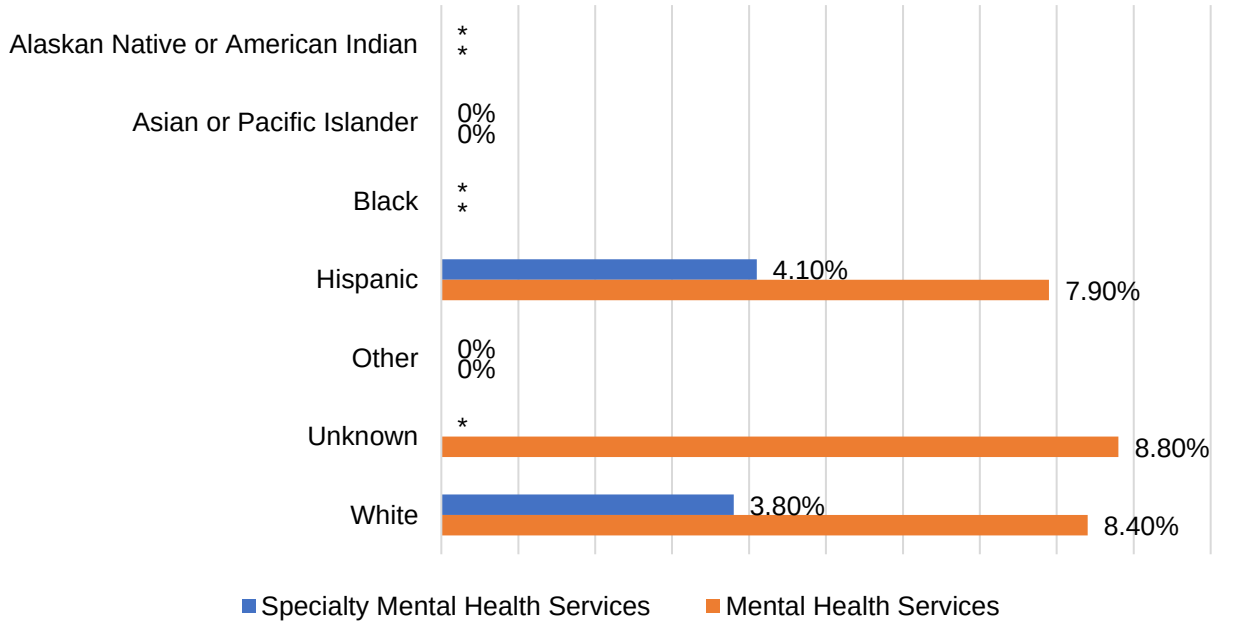
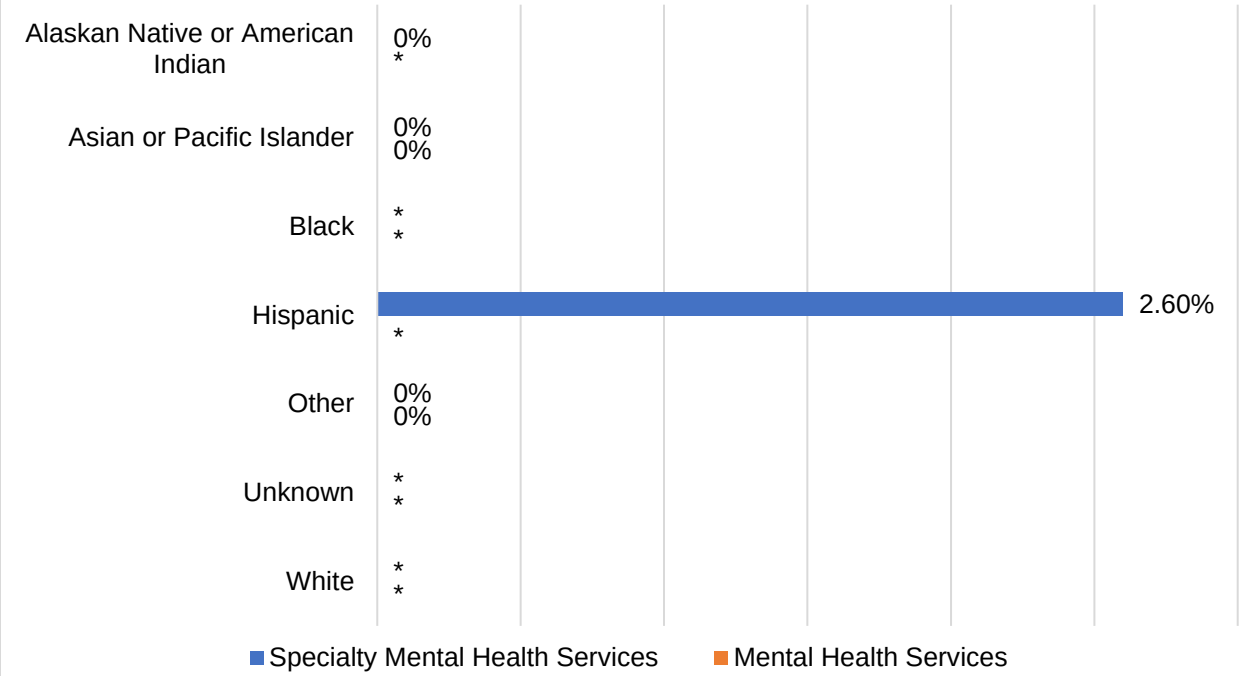


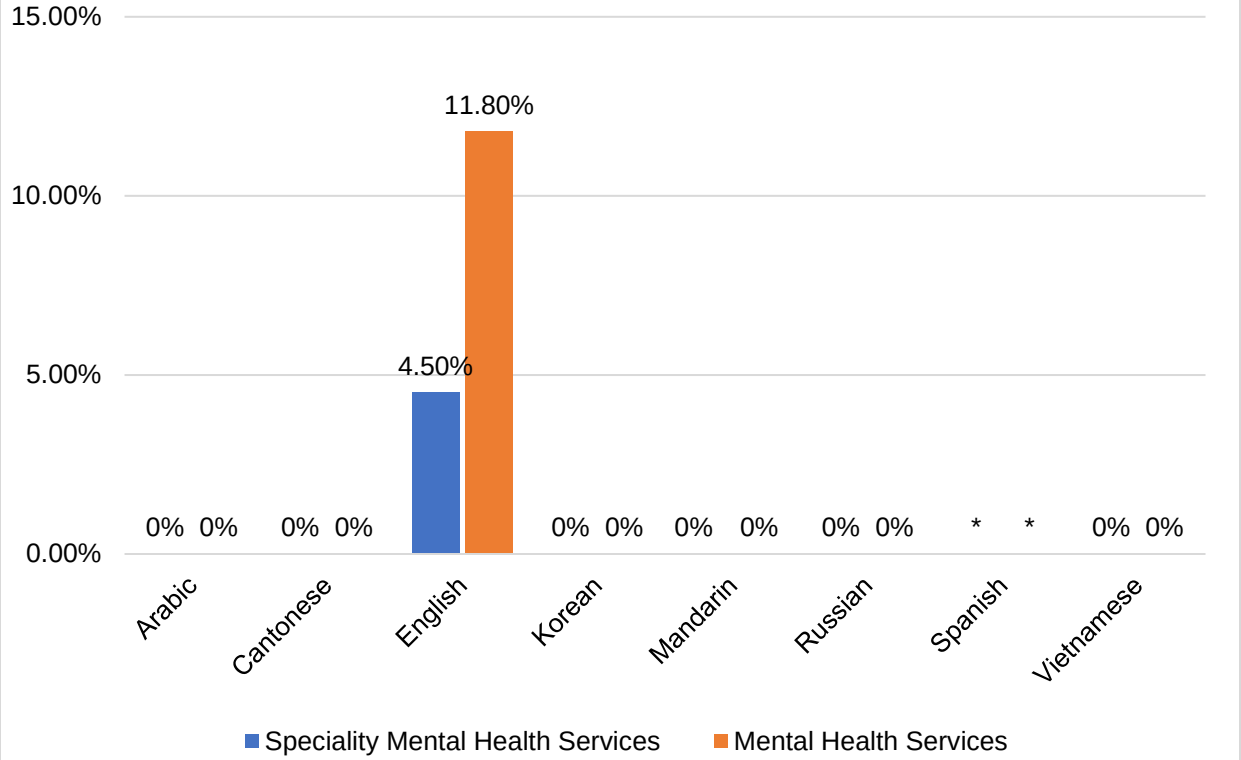
Figure 5. Medi-Cal Mental Health Engagement Rates, Mono County Children & Youth, by Race/Ethnicity, FY 19-20



The next two charts (Figures 6 & 7) show the percentage of beneficiaries receiving Specialty Mental Health Services and Mental Health Services (at least one mental health service visit per FY) compared to the overall Med-Cal eligible count for the 8 most common preferred written languages for Medi-Cal enrollees overall (listed in alphabetical order): Arabic, Cantonese, English, Korean, Mandarin, Russian, Spanish, and Vietnamese. This data does not indicate what language services were delivered in, just the written language preference of the individuals receiving services.

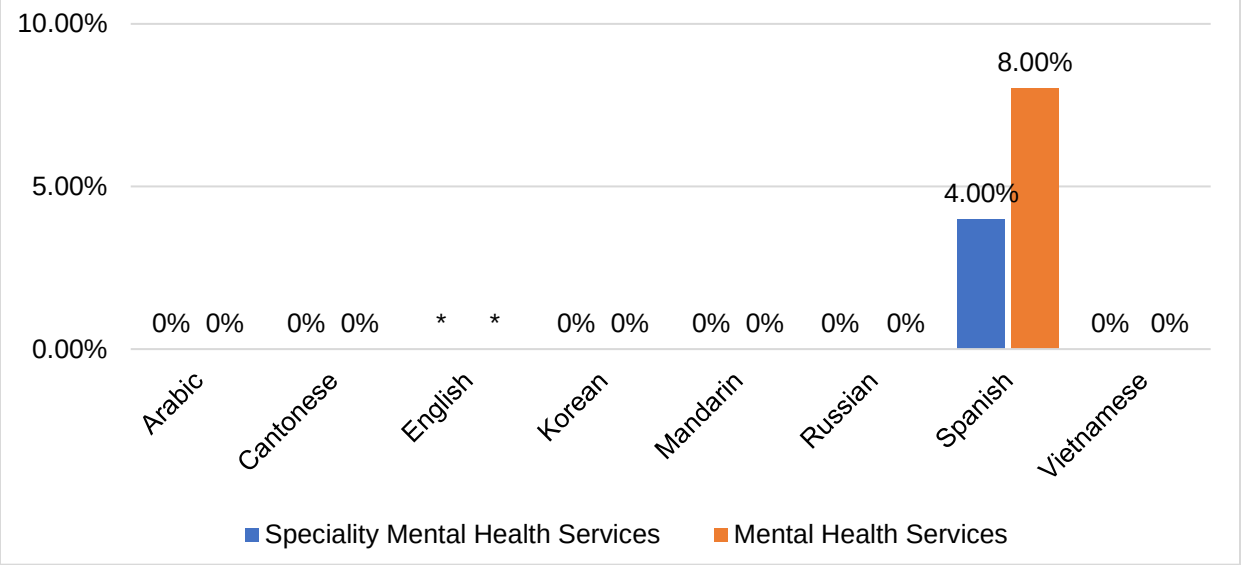
Observe which enrollees in your county were less likely to receive mental health services through either Specialty Mental Health Services or Mental Health Services based on their preferred language. Again, if the data show significant differences, you may want to explore possible reasons and whether there is something that can be done to reduce the differences in your county.

Figure 6. Medi-Cal Mental Health Access Rates by Language, Mono County Adults, FY 19-20



**Data has been suppressed to protect patient privacy.*

Figure 7. Mental Health Access Rates by Language, Mono County Children & Youth, FY 19-20



**Data has been suppressed to protect patient privacy.*

Part II Survey Questions

The following is a text summary of the survey questions for Part II of the 2021 Data Notebook. Please note that the questions are presented here in a different format than the finalized SurveyMonkey online survey. Refer to the PDF preview of the SurveyMonkey survey to see a more accurate presentation of the items.

Please answer the following questions:

12. Based on the data provided for your county, please rate the **access** and **engagement** to stepdown services for each of the following racial/ethnic groups. (Dropdown menus for access rate and engagement rate with the ratings of "Excellent", "Very Good", "Good", "Fair", and "Poor" for each group.)
    a. Alaskan Native / American Indian:
    b. Asian or Pacific Islander:
    c. Black:
    d. Hispanic:
    e. Other:
    f. White:

13. What outreach, community engagement, and/or education methods are being used to reach and serve the following racial/ethnic groups in your community? (Please select all that apply.)

    (Matrix of checkboxes for each item and racial/ethnic group.)
    a. Outreach at local community venues and events
    b. House visits to underserved individuals/communities
    c. Telehealth services to increase access and engagement
    d. Community stakeholder meetings/events
    e. Written materials translated into multiple languages
    f. Live/virtual interpretation services
    g. Educational classes, workshops, or videos
    h. Providing food/drink at meetings and events
    i. Providing reimbursement or stipends for involvement
    j. Providing transportation to and from services
    k. Other (please describe):

14. Which of the following groups are represented on your mental health board/commission or related work groups/task forces? (Please select all that apply.)
    a. Alaskan Native / American Indian
    b. Asian or Pacific Islander
    c. Black
    d. Hispanic

e. White
f. Other race/ethnicity
g. Older adults (65+ years)
h. Transition-age youth (16-24 years)

15. Which of the following steps have been taken to develop a culturally diverse behavioral health work force in your county? (Please check all that apply.)
    a. Tailoring recruitment efforts (re: professional outreach and job ads) to applicants who are representative of the racial/ethnic populations in your county
    b. Utilizing behavioral health workforce pipeline programs that value cultural/linguistic diversity among applicants
    c. Actively cultivating a culturally inclusive workplace environment in which racial/ethnic minority staff are engaged
    d. Conducting listening sessions or other methods for staff to provide feedback on workplace environment and hiring/promoting practices
    e. Providing professional development opportunities such as mentorship or continued education and training for behavioral health staff and providers
    f. Other (please describe):
    g. None of the above.

16. Does your county provide cultural proficiency training for behavioral health staff and providers?
    a. Yes (please describe):
    b. No

17. Which of the following does your county have difficulty with in regard to providing culturally responsive and accessible mental health services? (Please select all that apply.)
    a. Employing culturally diverse staff and providers
    b. Retaining culturally diverse staff and providers
    c. Translating written materials
    d. Providing live/virtual interpretation services
    e. Providing cultural proficiency training for staff and providers
    f. Outreach to racial/ethnic minority communities
    g. Other (please specify):

18. What barriers to accessing mental health services do individuals from underserved communities face in your county? (Please select all that apply.)
    a. Language barriers
    b. Lack of culturally diverse/representative staff providers
    c. Distrust of mental health services

d. Community stigma
e. Lack of information or awareness of services
f. Difficulty securing transportation to or from services
g. Difficulty accessing telehealth services
h. Other (please specify):

19. Do you feel that the COVID-19 pandemic has increased behavioral health disparities for any of the following groups? (Please select all that apply.)
    a. Alaskan Native / American Indian
    b. Asian or Pacific Islander
    c. Black
    d. Hispanic
    e. White
    f. Other race/ethnicity
    g. Older adults (65+ years)
    h. Transition-age youth (16-24 years)
    i. Children (Under 16)

20. Please rate the impact of the use of telehealth services during Covid-19 for the following groups regarding access and utilization of behavioral health services.

    (Rating options for each group are “very positive”, “somewhat positive”, “neutral”, “somewhat negative”, and “very negative”.
    a. Alaskan Native / American Indian:
    b. Asian or Pacific Islander:
    c. Black:
    d. Hispanic:
    e. Other:
    f. White:

21. Which providers or services have been employed, utilized, or collaborated with to serve the following racial/ethnic populations in your county? (Please select all that apply.)

    (Matrix of checkboxes for each item and racial/ethnic group.)

    a. Community Health Workers / *promotoras*
    b. Community-accepted first responders
    c. Peer Support Specialists
    d. SUD providers
    e. Community-based organizations
    f. Faith-based leaders/organizations
    g. Local tribal nations / native communities
    h. Homeless services

i. Local K-12 schools
j. Higher education
k. Domestic violence programs
l. Immigration services
m. Sport/athletic teams or organizations
n. Grocery stores or food pantries
o. Other (Please specify):

22. Do you have suggestions for improving outreach to and/or programs for underserved groups? (Text Response)

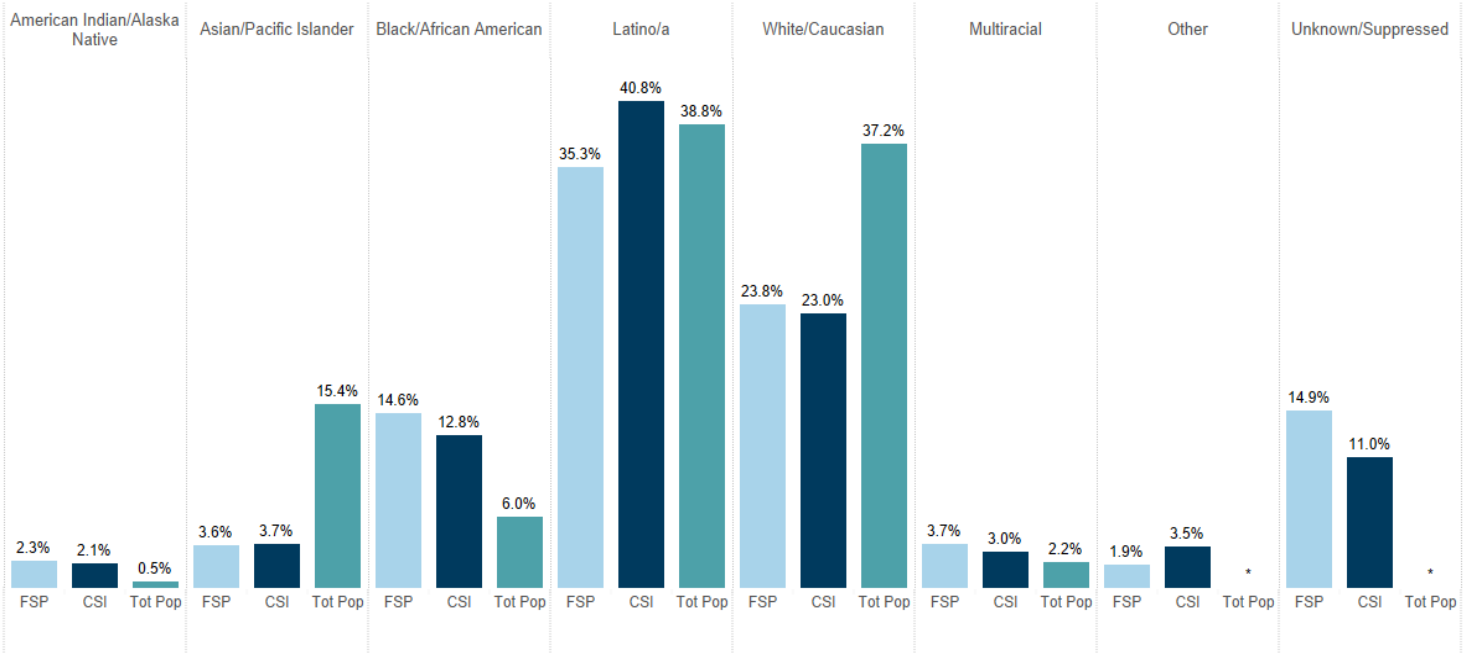
Appendix A: Statewide Data for California

The following data is for the state of California. Figure A1 is from the Highlighting Differences to Understand Disparities dashboard of the MHSOAC transparency suite. It compares the percentage of total persons by race/ethnicity in California from three sources for fiscal year (FY) 18-19:

1. FSP: Persons in Full-Service Partnerships.
2. CSI: Persons receiving publicly funded mental health services as reported in the Clients Services Information system.
3. Total Pop: Department of Finance population estimates based on US Census data.

The data is also presented in table format below the chart. Some values may be unavailable or suppressed due to the low count to protect patient privacy. Comparing these percentages may show some insight into potential disparities in access based on race/ethnicity.

Figure A1. Mental Health Access by Race/Ethnicity in California, FY 18-19, Total



**Data not available or suppressed (any count <11)*

Table A1. Mental Health Access by Race/Ethnicity in California, FY 18-19, Total

	American Indian/ Alaska Native	Asian/ Pacific Islander	Black/ African American	Latino/a	White/ Caucasian	Multiracial	Other	Unknown/ suppressed
FSP	2.3%	3.5%	14.6%	35.3%	23.8%	3.7%	1.9%	14.9%
CSI	2.1%	3.7%	12.8%	40.8%	23.0%	3.0%	3.5%	11.0%
Total Pop.	0.5%	15.4%	6.0%	38.8%	37.2%	2.2%	*	*

**Data not available or suppressed (any count <11)*

Further data is provided below from the Performance Dashboard AB 470 Report Application, published by DHCS. The first two charts (Figures A1 & A2) show the percentages of adult beneficiaries in California receiving **Specialty Mental Health Services** or **Mental Health Services** compared to the overall Medi-Cal eligible count, by race/ethnicity. **Mental Health Services** refers to non-specialty mental health services; mostly mild-moderate mental health services found in fee-for-service claims and managed care encounters. The **access** rate includes beneficiaries receiving **at least one** mental health services visit in a single fiscal year while the **engagement** rate includes beneficiaries with **five or more** visits in a fiscal year.

Differences in the percentages by race/ethnicity may show potential disparities. For example, Asian or Pacific Islander and Hispanic beneficiaries have notably lower access and engagement rates than other racial/ethnic groups.

Figure A2. Medi-Cal Mental Health Access Rates, California Adults, by Race/Ethnicity, FY 19-20

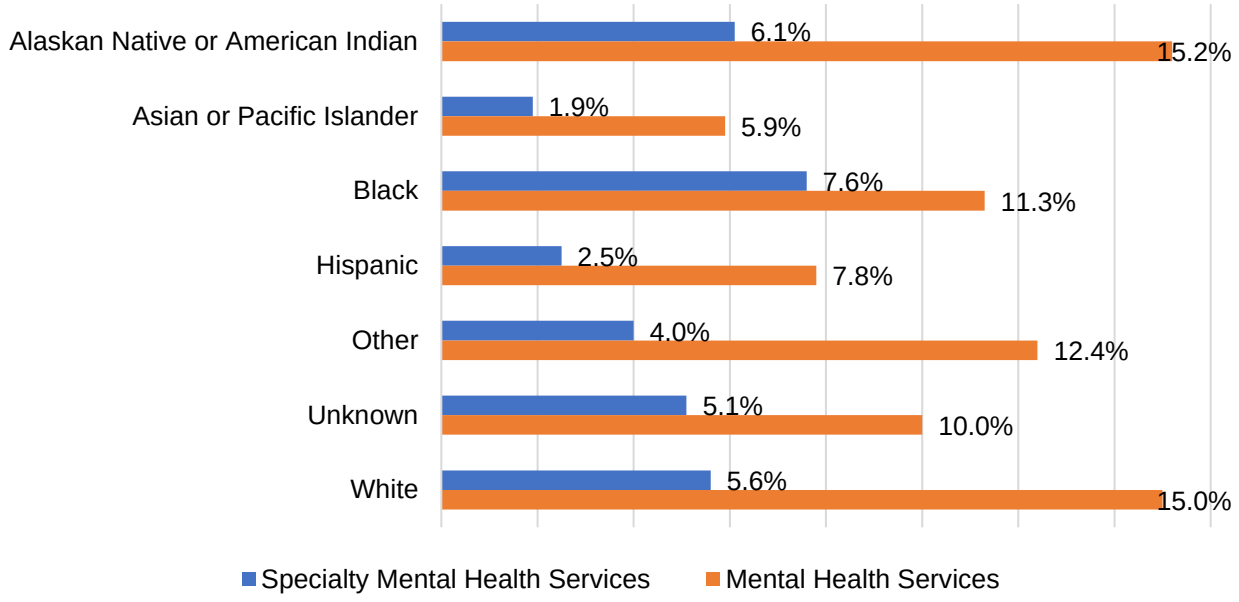
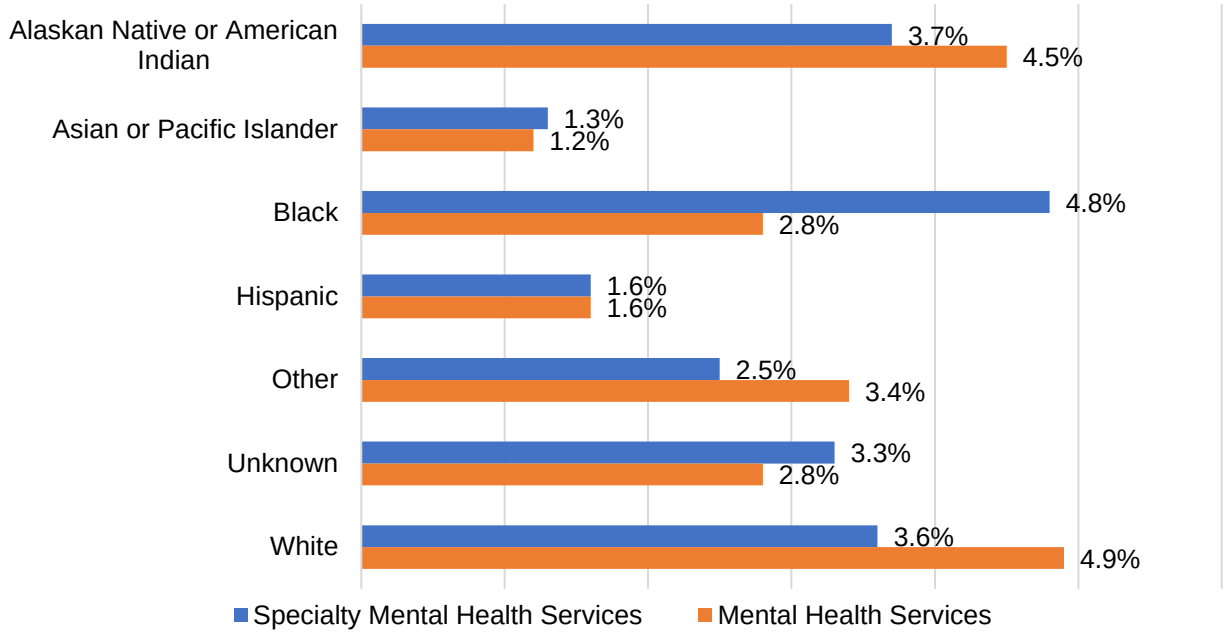


Figure A3. Medi-Cal Mental Health Engagement Rates, California Adults, by Race/Ethnicity, FY 19-20



The next two charts (Figures A4 & A5) show the same measures for children and youth in California. Once again, rates for Asian or Pacific Islander and Hispanic children/youth are lower than for other groups.

Figure A4. Medi-Cal Mental Health Access Rates, California Children & Youth, by Race/Ethnicity, FY 19-20

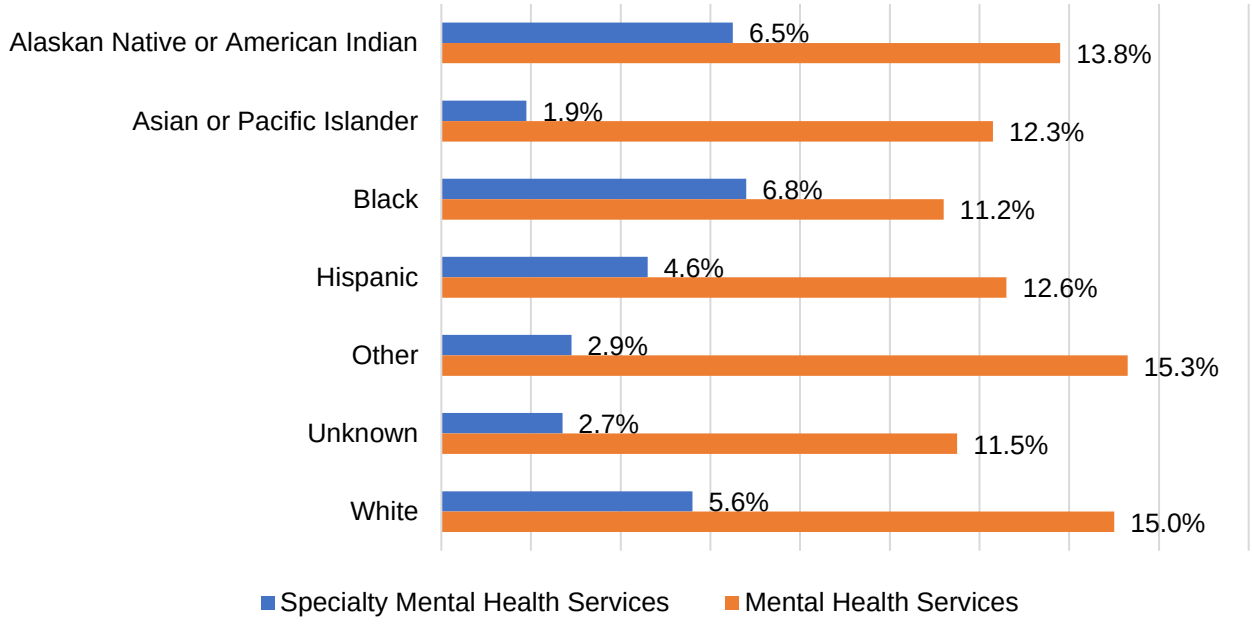


Figure A5. Medi-Cal Mental Health Engagement Rates, California Children & Youth, by Race/Ethnicity, FY 19-20

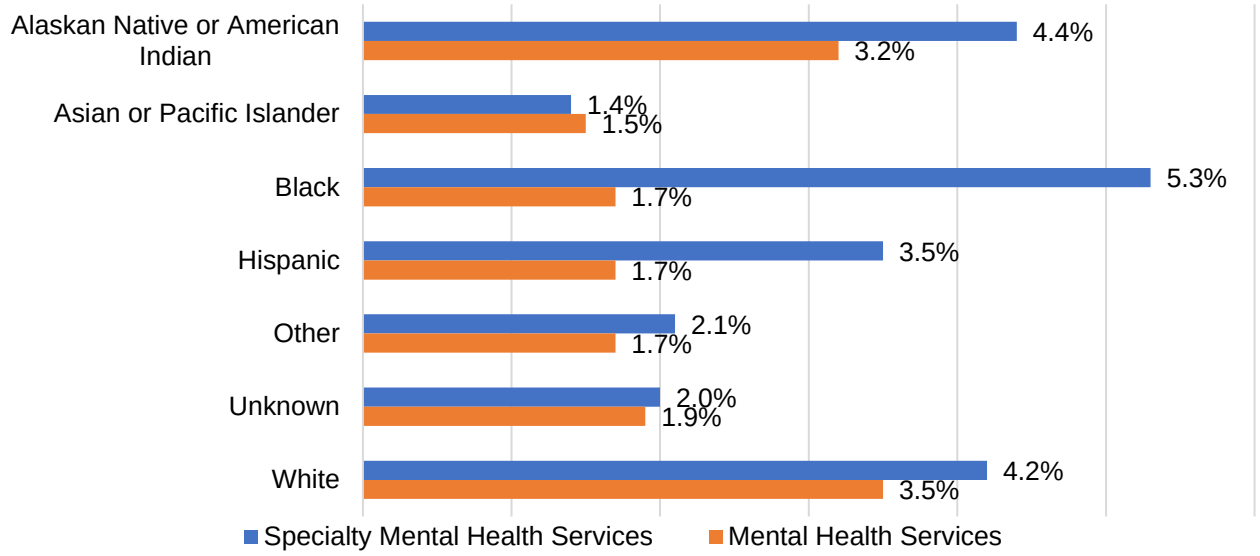


Figure A6 shows the percentage of adult beneficiaries receiving Specialty Mental Health Services and Mental Health Services (at least one mental health service visit per FY) compared to the overall Med-Cal eligible count for each of the 8 most common preferred written languages for Medi-Cal enrollees overall (listed in alphabetical order): Arabic, Cantonese, English, Korean, Mandarin, Russian, Spanish, and Vietnamese. This data does not indicate what language services were delivered in, just the written language preference of the individuals. Based on this data, access rates for Specialty Mental health Services among non-English speaking groups are lower than for English speaking beneficiaries, with Mandarin and Korean having the lowest rates. However, English beneficiaries do not have the highest access rates for Mental Health Services.

Figure A6. Medi-Cal Mental Health Access Rates by Language, California Adults, FY 19-20

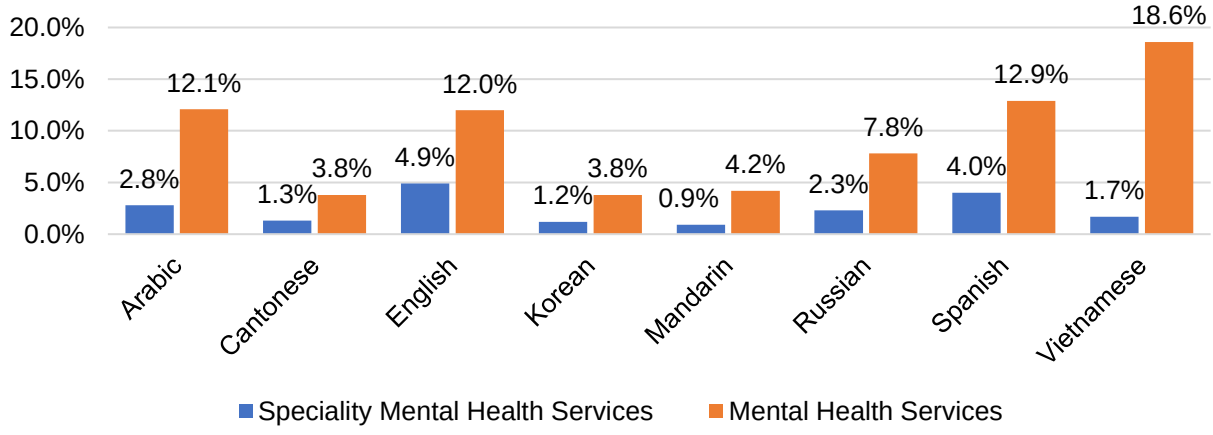


Figure A7 shows the same measures for Children and Youth. Once again, access rates for Specialty Mental health Services among non-English speaking groups are lower than for English speaking children and youth. Among this age group, the lowest rates for Specialty Mental Health Services are among Arabic and Russian speaking beneficiaries.