SEPTEMBER 2019

LA HEALTH

DISABILITY AMONG ADULTS IN LOS ANGELES COUNTY

INTRODUCTION

More than one in five adults living in California has some type of disability.[1] As individuals age, there is a higher likelihood of acquiring a disability. Disability is a complex interaction between a person's functional capacity and their physical and social environments.[2] People with disabilities are a diverse group, some born with a disabling condition and others acquiring a disability later in life due to an injury or illness. Disabilities include a wide range of health and functional impairments that can present significant challenges to activities of daily living, such as impairments in vision, hearing, cognition, or mobility.[1] The impact of the disability on a person's life is determined by multiple factors, such as economic resources and cultural influences. In addition, contextual factors, such as accessibility of the physical environment, transportation options, and housing, as well as societal treatment of those with functional limitations, significantly impact the experience of disability.[2]

Many persons with disability may be at increased risk for other chronic conditions that adversely impact health. For example, more than one in three adults with disabilities in California have high blood pressure, compared with one in four California adults without disabilities.[1] In addition, having a disabling condition from birth or early childhood, without the supportive social and environmental conditions to optimize opportunities, can significantly impact outcomes such as educational attainment, employment, and income.[3] Despite these vulnerabilities, people with disabilities are often overlooked as a priority population for public health intervention, including policy intervention.[1]

Disability can impact not only the individuals with disability, but also their families. People living with disabilities experience significant disparities in health outcomes[1] and inequities in social and economic opportunities that can further impact their health and well-being. Documenting these inequities and the ways in which they intersect is important for developing interventions that create equitable opportunities for persons with disability to achieve optimal health and well-being. In this report we examine the prevalence of disability among Los Angeles County adults, and describe the intersection between disability, social determinants of health, and co-occurring conditions. Finally, we offer some recommendations for intervention to reduce the inequities experienced by those living with disability in LA County.

METHODS

The Los Angeles County Health Survey (LACHS) is a periodic, telephone-based survey of county residents that has been conducted by the Los Angeles County Department of Public Health since 1997. The survey includes a representative sample of approximately 8,000 adults (≥18 years of age) and 6,000 children; interviews are conducted in English, Spanish, Chinese (Mandarin and Cantonese), Korean, and Vietnamese. The survey collects information on topics such as health conditions, health behaviors, and attributes of the physical and social environment. Most of the data in this report come from the 2015 LACHS. Results from earlier cycles of the survey were used to assess trends.

Definition of Disability

For this analysis, a broad, inclusive definition of disability was used. Disability status was assessed by the following three questions:

1. Are you limited in any activities because of a physical, mental, or emotional problem?
2. Do you have any health problem that requires you to use special equipment, such as a cane, wheelchair, a special bed or special telephone?
3. Do you consider yourself a person with a disability?

Respondents answering "yes" to at least one of these three questions were classified as having a disability.

FINDINGS

Prevalence of Disability in LA County

- More than one in five (22.6%) adults in LA County reported having a disability in 2015 (Table 1).
- The prevalence of disability increased with age, from 10.3% among those 18-24 years of age to 41.9% among those 65 and older.
- African Americans had the highest prevalence of disability (33.5%), followed by Whites (29.9%), American Indians/Alaska Natives (27.0%), Latinos (18.1%), and Asians (14.3%).*
- Disability prevalence was inversely related to income; 28.6% of adults living below the federal poverty (FPL) reported disability compared with 18.8% among those with incomes at or above 300% of the FPL.
- Among adults living in poverty, the prevalence of disability was highest among African Americans (53.4%) and Whites (44.0%) (Figure 1).
- Disability prevalence also varied across regions of the county, with the highest prevalence in the Antelope Valley region (30.3%), and the lowest in the East Los Angeles region (18.9%).

Time Trends in Disability Prevalence†

- The prevalence of disability remained steady from 2002-2011 at approximately 20%, before slightly increasing in 2015 (Figure 2).
- Slight increases were observed in all racial/ethnic groups examined (Figure 3).
- The racial/ethnic disparities in disability prevalence were large and remained unchanged from 2002 to 2015.

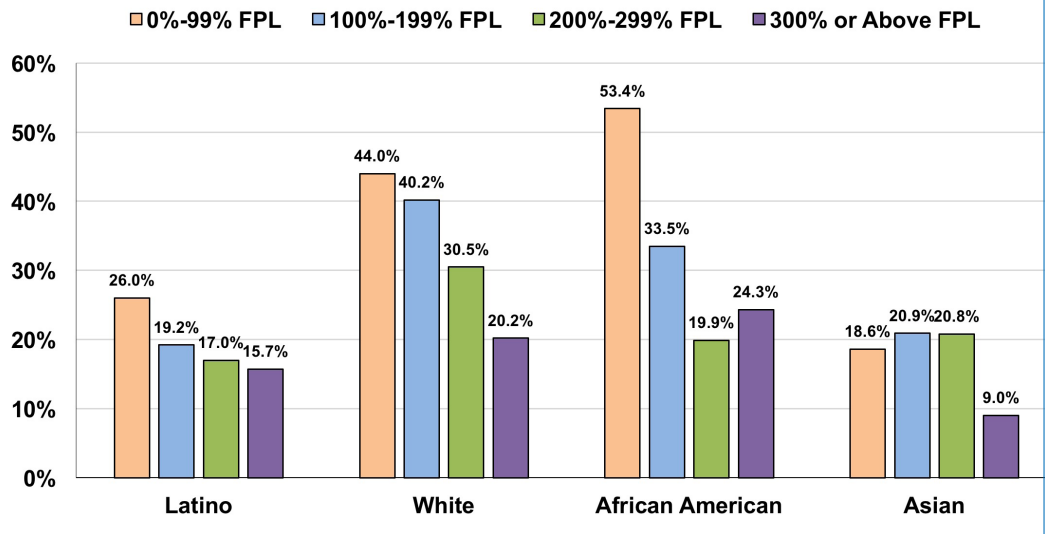
Disability and Health-Related Quality of Life

Those with disability reported their activities were limited due to poor physical or mental health for an average of 7.6 days in the past month, compared with 0.8 days for those without reported disability. This suggests that those who reported disability in LACHS experience substantial limitations, compared with those without disability.

Food Insecurity and Disability

Access to healthy, nutritious food is essential for optimal health. Food insecurity, or the lack of reliable access to enough safe, nutritious foods due to lack of money or resources, affects hundreds of thousands of low-income households in Los Angeles County. Food insecurity is

Figure 1. Prevalence of Adults with Disability by Race/Ethnicity and Poverty



Data Source: Los Angeles County Health Survey, 2015.
Age-adjusted prevalence among adults (18+ years old)
FPL=Federal Poverty Level

* Unadjusted prevalence
† Age adjusted prevalence trends

Table 1. Prevalence of Disability[1] Among Adults (≥ 18 years old) in Los Angeles County, 2015

Demographic Group	Percent of Adults with Disability	95% CI[2]			Estimated #
LA County	22.6%	21.4	-	23.8	1,740,000
Gender					
Male	23.0%	21.1	-	24.8	864,000
Female	22.2%	20.6	-	23.7	876,000
Age Group					
18-24	10.3%	7.4	-	13.1	112,000
25-29	14.4%	10.4	-	18.3	109,000
30-39	14.5%	11.8	-	17.2	209,000
40-49	19.8%	17.0	-	22.6	279,000
50-59	26.9%	24.1	-	29.7	350,000
60-64	35.3%	30.8	-	39.8	180,000
65 or over	41.9%	39.1	-	44.6	502,000
Race/Ethnicity[3]					
Latino	18.1%	16.3	-	20.0	616,000
White	29.9%	27.9	-	31.9	719,000
African American	33.5%	29.6	-	37.4	225,000
Asian	14.3%	11.3	-	17.2	170,000
American Indian/Alaska Native	27.0%	14.6	-	39.4	-
Education					
Less than high school	24.2%	21.2	-	27.3	416,000
High school	20.3%	17.9	-	22.8	335,000
Some college or trade school	25.7%	23.3	-	28.1	568,000
College or post graduate degree	19.8%	18.2	-	21.4	412,000
Federal Poverty Level[4]					
0-99% FPL	28.6%	25.7	-	31.5	493,000
100%-199% FPL	23.1%	20.6	-	25.5	471,000
200%-299% FPL	22.4%	19.0	-	25.8	219,000
300% or above FPL	18.8%	17.2	-	20.4	558,000
Region					
Antelope Valley	30.3%	25.8	-	34.9	86,000
San Fernando	22.0%	19.6	-	24.4	374,000
San Gabriel	21.0%	18.2	-	23.8	291,000
Metro	24.1%	20.1	-	28.0	221,000
West	21.5%	17.3	-	25.6	117,000
South	26.3%	22.4	-	30.3	191,000
East	18.9%	15.6	-	22.2	183,000
South Bay	23.4%	20.3	-	26.4	277,000

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.

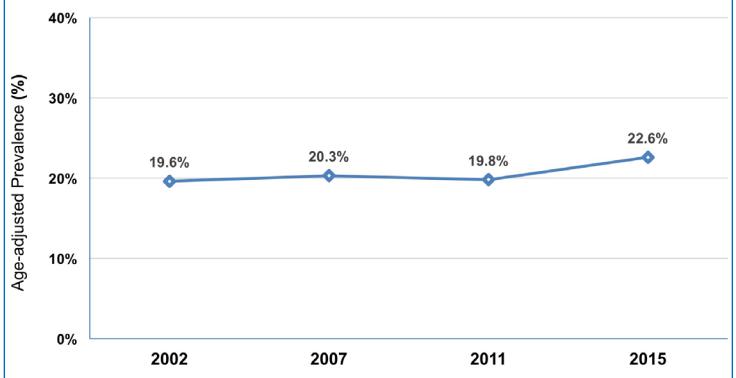
1 Disability is defined as a positive response to any one of the following: 1) Limited activity because of physical, mental, or emotional problem(s), 2) Health problem requiring use of special equipment, 3) Self-perception of being disabled.

2 The information presented is based on self-reported data from a randomly-selected, representative sample of 8,008 Los Angeles County adults. The 95% confidence intervals (CI) represent the margin of error that occurs with statistical sampling, and means that the actual prevalence in the population, 95 out of 100 times sampled, would fall within the range provided.

3 Estimates for Native Hawaiians/Other Pacific Islanders are statistically unstable (relative standard error >30%) and therefore are not presented. Estimated number for American Indians/Alaska Natives has high uncertainty due to small sample size and therefore is not presented.

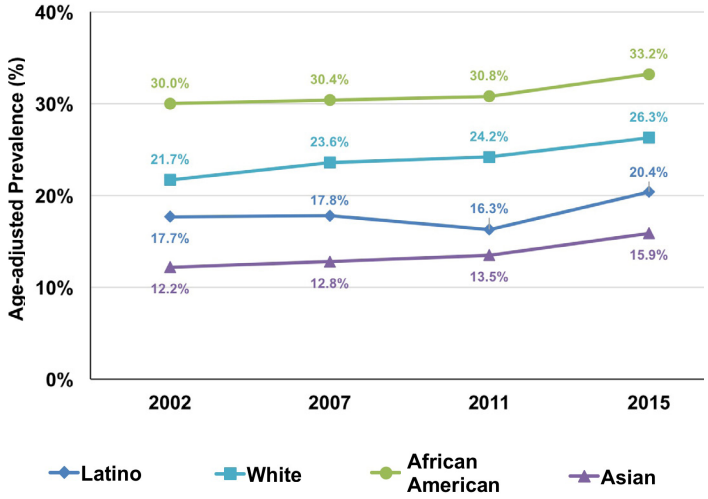
4 Based on U.S. Census 2013 Federal Poverty Level (FPL) thresholds which for a family of four (2 adults, 2 dependents) correspond to annual incomes of $23,624 (100% % FPL), $47,248 (200% FPL), and $70,872 (300% FPL). [These thresholds were the values at the time of survey interviewing.]

Figure 2. Trend in Prevalence of Adults with Disability, 2002-2015



Data Source: Los Angeles County Health Survey, 2002-2015.
Age-adjusted prevalence among adults (18+ years old)

Figure 3. Trends in Prevalence of Disability by Race/Ethnicity



Data Source: Los Angeles County Health Survey, 2002-2015.
Age-adjusted prevalence among adults (18+ years old).
Unable to provide trend for American Indians/Alaska Natives as prior year estimates statistically unstable. Estimates statistically unstable for Native Hawaiians/Other Pacific Islanders.

linked to health problems such as diabetes and high blood pressure. This may be due to eating less healthy food, but also due to stress from worries about not having enough food.[4]

Food insecurity was assessed in the 2015 LACHS among respondents who reported a household income below 300% of the Federal Poverty Level (FPL).[5, 6]

- Among adults who reported disability in 2015, 41.4% lived in food insecure households, compared to 24.2% of adults without disability (Table 2).
- Food insecurity was higher among those with disability compared to those without disability within all racial/ethnic groups examined (Figure 4). More than half of Latino adults with disability and over 40% of African American adults with disability lived in food insecure households.
- 25.4% of adults with disability reported receiving food assistance through the SNAP/CalFresh program (Table 2).

Housing Instability and Disability

Housing instability includes challenges such as having trouble paying rent, overcrowding, moving frequently, needing to stay with friends and relatives, or spending the bulk of household income on housing.[1] Not having stable housing is linked to poor mental health outcomes and higher healthcare costs; poor quality housing can result in negative health outcomes such as lead poisoning and asthma.[7] High housing costs force families to make difficult choices between shelter and other necessities such as food and healthcare. Housing discrimination due to disability may contribute to housing instability among people with disability.[8]

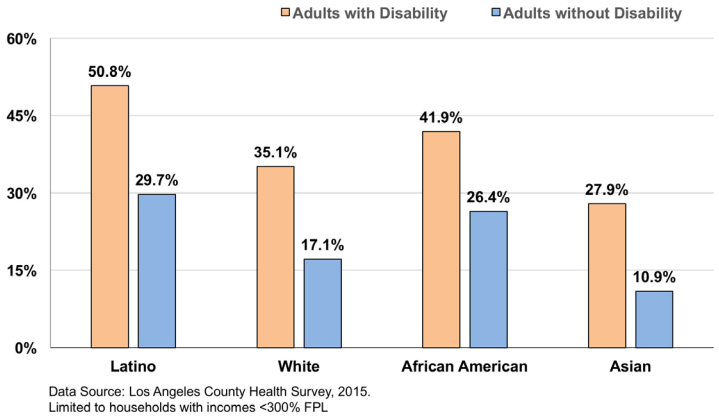
LACHS respondents were identified as having housing instability if they answered "yes" to the following question: "Thinking back over the past five years, was there ever a time when you were homeless or did not have your own place to live or sleep?"

- The percentage of adults with housing instability in 2015 was higher among those with disability (9.3%) compared to those without disability (3.5%) (Table 2).
- Similar patterns were seen for Latinos, Whites, and African Americans*; the prevalence of housing instability was highest among African Americans with disability (23.3%) (Figure 5).

Access to Care and Disability

Access to healthcare includes having health insurance coverage, having a usual healthcare provider, receipt of routine check-ups, and having fewer unmet healthcare needs.[1] Healthcare access is critical for adults living with a disability. If people are unable to access care when they need it, this could lead to delays in diagnosis and treatment of disabilities, and any other health conditions that are related to the disability. Poor access can also worsen any disabilities that result from

Figure 4. Prevalence of Food Insecurity by Race/ Ethnicity and Disability Status



Data Source: Los Angeles County Health Survey, 2015.
Limited to households with incomes <300% FPL

chronic diseases and can lead to the disability lasting longer. This may limit the ability for full employment, thereby limiting income and potentially increasing the risk of food insecurity and housing instability as well. Adequate access to healthcare can help prevent such complications.[1]

- Among adults with disability, 88.4% reported a regular source of care, compared to 77.9% of adults without disability (Table 2).
- Despite the high percentage of adults reporting a regular source of care, 25.6% of adults with disability reported difficulty obtaining needed medical care, similar to the percentage among adults without disability (Table 2).
- The percentage reporting difficulty obtaining medical care was highest among adults with disability who were 18-39 years of age (40.6%) (Figure 6).
- Less than 10% of adults 65 and older reported difficulty obtaining needed medical care, regardless of disability status.

Disability, Depression, and Social Support

Individuals with disabilities may be at higher risk for mental health conditions. The onset of disability in adulthood has been associated with adverse mental health impacts after disability onset in some individuals.[9] Mental health disorders, such as depression, keep people from achieving optimal health and well-being.

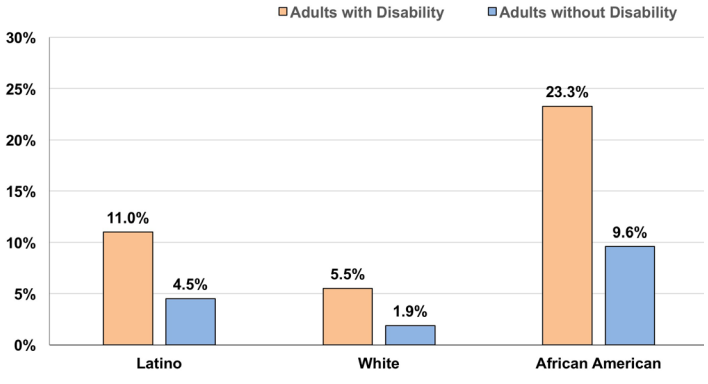
Social support refers to the concrete help, emotional support, or informational resources received from others. High social support is linked to better health and well-being, whereas social isolation is linked to worse physical and mental health outcomes.[10]

In the 2015 LACHS, respondents were identified as having "current depression" if they indicated that they had ever been diagnosed with depression and were currently experiencing symptoms of depression or were receiving treatment for depression. Respondents were identified as being "at risk for major depression" if they answered "several days" or "more than half the days" to the following two questions taken from the Patient Health Questionnaire-2, a validated clinical screening tool for depression[11]: "In the past two weeks, how often have you been bothered by, 1) little interest or pleasure in doing things; 2) feeling down, depressed, or hopeless."

Social or emotional support was assessed with the question, "How often do you receive the social or emotional support you need?" Respondents who indicated "always" or "usually" were identified as having a high level of social or emotional support, whereas respondents who indicated "rarely" or never" were identified as having a low level of social or emotional support.

- Almost one in four adults (23.6%) with disability reported current depression compared to 4.3% of adults without disability (Table 2). A similar pattern was found for those at-risk for depression.
- 59.0% of adults with disability reported a high level of social or emotional support, slightly lower than

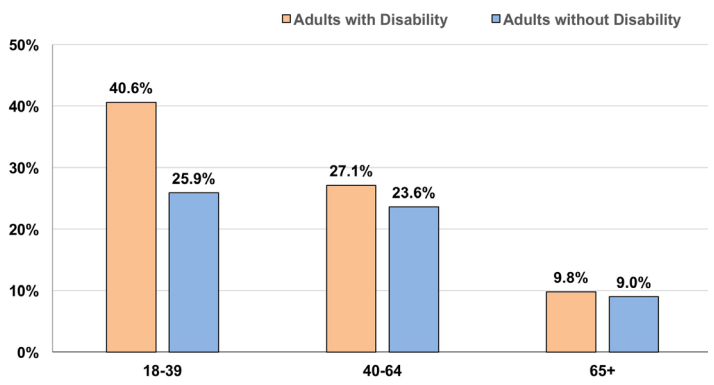
Figure 5. Prevalence of Housing Instability by Race/Ethnicity and Disability Status



Los Angeles County Health Survey, 2015.
Data for all other racial/ethnic groups are suppressed due to unstable estimates.
Percent of adults who reported being homeless or not having their own place to live/sleep in the past 5 years

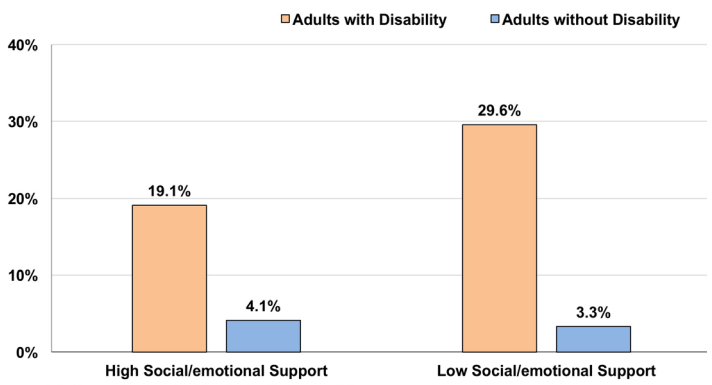
* Sample sizes for all other racial/ethnic groups for this indicator were too small to obtain reliable estimates.

Figure 6. Prevalence of Difficulty Obtaining Care by Age Group and Disability Status



Data Source: Los Angeles County Health Survey, 2015.
Difficulty obtaining needed medical care

Figure 7. Prevalence of Current Depression by Social/ Emotional Support and Disability Status



Data Source: Los Angeles County Health Survey, 2015.
High social/emotional support: Always/usually receiving social/emotional support
Low social/emotional support: Rarely/never receiving social/emotional support

the percent reported by adults without disability (65.5%) (Table 2).

- Conversely, 19.0% of adults with disability reported a low level of social or emotional support, compared to 22.0% among those without disability.
- The prevalence of current depression was lower among adults with disability who reported a high level of social or emotional support (19.1%) compared to those who reported low support (29.6%) (Figure 7).
- This pattern was even more pronounced among adults at-risk for depression; the percentage of adults with disability who were at-risk for depression was almost three times higher among those who reported low support (45.0%) than among those who reported high support (16.4%) (Figure 8).

An important consideration in interpreting these results on disability and depression is that our definition of disability included a "mental or emotional health problem." Therefore, the results do not distinguish between those whose depression constituted the disability versus those who had another type of disability and also had depression.

DISCUSSION

Adults with disability experience cumulative risks that can negatively impact their health. These include higher rates of food insecurity, housing instability, difficulty accessing medical care, and higher rates of depression. High social or emotional support may protect against poor mental health outcomes.

Access to food and to safe housing are basic necessities. A large proportion of people with disabilities, however, do not have adequate access to these necessities. Intersecting vulnerabilities of racial/ethnic minority status and disability place people at even higher risk of food insecurity and housing instability. For people with disabilities who live in low-income neighborhoods, there may be limited access to healthy food purchasing options; lack of accessible transportation makes this worse. The CalFresh Program, known federally as the Supplemental Nutrition Assistance Program (SNAP), is a food assistance program to help low-income families buy food. This can help reduce food insecurity and poverty. Efforts to increase CalFresh access for people with disabilities could lead to reduced food insecurity. The benefits provided by CalFresh may not, however, be enough to bring some households out of food insecurity. Additional efforts to increase access to healthy and affordable food are needed to supplement programs such as CalFresh.

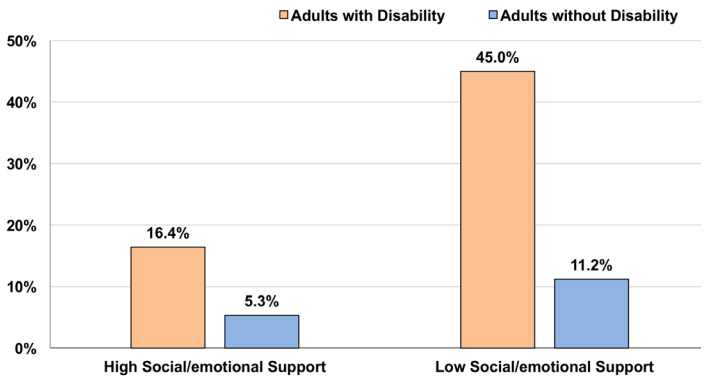
There is a substantial need for accessible, affordable housing for people with disabilities. Accessibility includes physical design elements such as lower kitchen counters, enough space to maneuver with mobility devices, and wheelchair ramps at entrances. Supportive housing provides an opportunity for people with disabilities to live independently, while being connected to community-based support services. The Section 811 rental assistance program focuses on affordable housing for people with disabilities, however, the need for such housing surpasses the available homes. Social

Table 2. Selected Characteristics Among Adults (≥ 18 years old) with Disability[1] and Adults without Disability in Los Angeles County, 2015

	Adults with Disability		Adults without Disability	
Characteristic	**Percent**	**95% CI[2]**	**Percent**	**95% CI**
Food insecurity[3]	41.4%	37.4 - 45.3	24.2%	21.7 - 26.7
Receiving SNAP/Calfresh[4]	25.4%	21.6 - 29.1	20.5%	18.1 - 22.9
Housing instability (past 5 years)	9.3%	7.5 - 11.0	3.5%	2.9 - 4.2
Have a regular source of healthcare	88.4%	86.3 - 90.4	77.9%	76.3 - 79.5
Difficulty obtaining medical care[5]	25.6%	22.9 - 28.3	23.0%	21.3 - 24.7
Current depression	23.6%	21.2 - 26.0	4.3%	3.6 - 4.9
At-risk for major depression[6]	26.9%	24.2 - 29.6	7.5%	6.4 - 8.5
High social/emotional support[7]	59.0%	56.1 - 62.0	65.5%	63.7 - 67.3
Low social/emotional support[8]	19.0%	16.6 - 21.5	22.0%	20.4 - 23.7

Source: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.
1 Disability is defined as a positive response to any one of the following: 1) Limited activity because of physical, mental, or emotional problem(s), 2) Health problem requiring use of special equipment, 3) Self-perception of being disabled.
2 The information presented is based on self-reported data from a randomly-selected, representative sample of 8,008 Los Angeles County adults. The 95% confidence intervals (CI) represent the margin of error that occurs with statistical sampling, and means that the actual prevalence in the population, 95 out of 100 times sampled, would fall within the range provided.
3 Limited to households <300% of the Federal Poverty Level. Food Insecurity is a scaled variable based on a series of five questions. [REFERENCE: SJ Blumberg, K Bialostosky, WL Hamilton, and RR Briefel The effectiveness of a short form of the Household Food Security ScaleAm J Public Health 1999 89: 1231-1234].
4 Limited to households <185% of the federal poverty level.
5Very/somewhat difficult to obtain medical care.
6 The Patient Health Questionnaire-2 (PHQ-2) is used as the initial screening test for major depressive episode. [REFERENCE: Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Med Care 2003; 41:1284-92.].
7 Always/usually receive social/emotional support.
8 Rarely/never receive social/emotional support.

Figure 8. Prevalence of At-risk for Major Depression by Social/Emotional Support and Disability Status



Data Source: Los Angeles County Health Survey, 2015.
High social/emotional support: Always/usually receiving social/emotional support
Low social/emotional support: Rarely/never receiving social/emotional support

Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) are other governmental programs that could provide financial resources for people with disabilities who may have limited employment opportunities and income. Lack of stable housing, however, makes it more difficult to obtain disability-related benefits due to not having a reliable home address.[11] Helping people with disabilities secure stable housing may also help them access needed benefits. This is particularly important in high housing-cost areas such as Los Angeles.

People with disabilities experience inequities in healthcare access and mental health outcomes. Social support may buffer the impact of disability on mental health. It is also possible that those who are depressed are less likely to interact with others and therefore report more social isolation. It is important to address both mental health and social support.

A high proportion of adults with disabilities in LA County have a regular source of care. This may reflect access to benefits such as Medicare, which provides universal health insurance coverage for adults ≥65 years old and for some people with disabilities. Insurance coverage and having an assigned regular healthcare provider, however, does not guarantee adequate access to care. Individuals with disabilities may have difficulty obtaining needed care due to difficulty in getting appointments with their providers, difficulties with transportation, communication barriers, or physical mobility limitations.

Access to digital technology can substantially reduce transportation and mobility burdens for individuals with disabilities, however, lack of home Internet access and skills in using digital technologies can be significant barriers. Individuals with disabilities also may have higher needs for specialty care than those without disabilities and may have more difficulty accessing needed specialists.

This analysis has some important limitations. All data were self-reported and therefore may not be entirely accurate if respondents preferred not to report certain information or were unaware of certain health conditions. The survey only captured information on the non-institutionalized population of Los Angeles County and on residents who have access to a telephone (i.e., landline or cell phone). Because the survey did not offer any accommodations for individuals with disabilities, data are limited to those individuals with disabilities who would be able to participate in a phone survey. The definition of a person with disability used in the analysis was based on a limited number of questions; more specific information about the duration or nature of an individual's disability status was not available. It is possible that among some of the respondents who identified as having a disability, the disability was due to a mental health condition; we were unable to determine whether depression was the mental health condition. Due to this, we could not determine if disability leads to higher risk of depression, as depression may have been the reason for the disability.

Although we were able to assess the intersection between disability, important social determinants of health (e.g., food insecurity and housing instability), and depression, we did not have data to assess other important issues, such as transportation barriers, other mobility challenges, discrimination (e.g., employment discrimination), and stigma. While "having a regular source of care" was used as a measure of access to care, information was not available on the quality of care received.

Finally, since the LACHS was a general survey on the health of the LA County population, it was not focused specifically on the topic of disability; the study design and data analysis did not actively engage the disability community. In the future, it would be preferable to conduct additional, more detailed, studies in collaboration with the disability community.

Despite these limitations, this report provides the first estimates of disability prevalence in the county adult population. The findings highlight some of the important challenges faced by many of the millions of adults in the county living with disability.

RECOMMENDATIONS

The best outcomes to reduce inequities experienced by individuals with disabilities can be achieved when multiple sectors and stakeholders work together. The following recommendations could help people with disabilities achieve health equity. It is important to note that individuals with disabilities are not a homogenous group and therefore policies and practices also need to be culturally and linguistically appropriate to adequately address unique barriers encountered by different racial/ethnic groups.

- **Community advocates and community-based organizations** can provide assistance with navigating the CalFresh enrollment process. Community-based organizations can provide information about food pantries and food distribution programs and advocate for programs that deliver healthy groceries to individuals with disabilities. They can also assist with reducing stigma related to mental health services and encourage community members to seek assistance for mental health needs. It is important for disability advocates to join with housing advocates to champion affordable housing and fair housing policies to ensure equitable

distribution of housing opportunities. Advocates can work together for safe, accessible, and affordable transportation options and improved access to employment-focused resources for individuals with disabilities. Support for families and caregivers of people with disabilities should include support groups, respite care, and information regarding resources.

- **Policymakers** can expand eligibility criteria and increase funding for CalFresh, SSDI, SSI, and health insurance for people with disabilities and simplify the processes to enroll in these programs. Policies can be adopted that increase affordable and accessible housing for people with disabilities, increase funding for supportive housing programs, prohibit housing and employment discrimination, and increase employment opportunities for people with disabilities. The Americans with Disabilities Act must be strongly enforced to provide fair employment, physical accessibility to buildings and other public spaces, accessible transportation, and access to healthcare. Policies are needed that provide fair wages for caregivers of people with disabilities and that allow family members to be paid to be caregivers. Policymakers can increase funding for and access to mental health services and accessible communal spaces. City and county governments can require streets be designed in ways that make it easy for all people, including those with disabilities, to navigate. Policymakers can promote equitable access to digital technology for individuals with disabilities and their caregivers. Finally, given the large and persistent racial disparities in disability and intersecting risks such as food insecurity and housing instability, it is essential to address the root causes of health inequities related to race and discriminatory policies and practices.
- **Public health organizations** can collaborate with individuals, families, communities, advocates, and policymakers by providing data, supporting programs and initiatives that improve the lives of people with disabilities, and advocating for policies and efforts that combat institutional discrimination against those with disabilities. Public health organizations can also work with individuals with disabilities and advocacy organizations to ensure that the lived experiences of people with disabilities are heard by decision-makers. Finally, they can work with communities to reduce the stigma connected to disability and to improve access to benefits such as SSI/SSDI, CalFresh, and housing subsidies.
- **Healthcare providers** and others who provide services for people with disabilities should screen clients with disabilities for food insecurity, housing instability, and depression and provide referrals as needed, through strong linkages with support services. Providers can support families and caregivers by facilitating access to home health and counseling services, as needed. Healthcare facilities should be fully accessible for patients with disabilities and provide interpretation services such as for American Sign Language, and educational materials that are accessible to all patients, including those with visual and cognitive disabilities. Flexible appointment schedules and increased use of digital communication (e.g., online patient portals, telemedicine) may reduce transportation and mobility burdens.
- **Families and caregivers** can help individuals with disabilities by being well-informed about the family member's condition and any medical needs, providing emotional support, advocating for family members with disabilities, and lending their voices to efforts that support inclusion and equity.
- **Community members** can practice disability inclusion by joining with others to advocate for policies and practices that ensure everyone has equitable opportunities to participate in all aspects of life to the best of their abilities.

SELECTED RESOURCES

- **United States Department of Justice Civil Rights Division. Americans with Disabilities Act** (www.ada.gov): Information and advocacy.
- **United States Department of Justice. Disability Rights Section.** (https://www.justice.gov/crt/disability-rights-section): Advocacy.
- **American Association of People with Disabilities** (www.aapd.com): Advocacy.
- **National Disability Rights Network** (https://www.ndrn.org): Advocacy. The local organization is Disability Rights California.
- **Easter Seals** (https://www.easterseals.com): Services for adults and children with disabilities.
- **The Arc** (https://www.thearc.org): Advocacy, information, and referrals for services for people with intellectual and developmental disabilities.
- **National Aging and Disability Transportation Center** (https://www.nadtc.org): Promote availability and accessibility of transportation options for older adults, people with disabilities and caregivers.
- **California Aging and Disability Resource Connection** (https://www.aging.ca.gov/ProgramsProviders/ADRC): Information on long-term support services.
- **California Independent Living Centers** (https://www.calsilc.ca.gov/independent-locator): Listing of Independent Living Centers in California from the California State Independent Living Council.
- **Department of Public Social Services** (https://yourbenefits.laclrs.org/ybn/index.html): Apply for CalFresh, General Relief, and Medi-Cal.
- **211 LA County** (https://www.211la.org): 211 LA County is a phone line that is open 24 hours a day, 7 days a week. Community Resource Advisors provide information and referrals for health and human services in LA County.

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LA HEALTH

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DISABILITY AMONG ADULTS IN LOS ANGELES COUNTY

County of Los Angeles Public Health

Los Angeles County
Department of Public Health
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For additional information about the LA County Health Survey, visit: www.publichealth.lacounty.gov/ha.

The Los Angeles County Health Survey is a periodic, population-based telephone survey that collects information on sociodemographic characteristics, health status, health behaviors, and access to health services among adults and children in the county. The 2015 survey collected information on a random sample of 8,008 adults and 5,982 children. The survey was conducted for the Los Angeles County Department of Public Health by Abt SRBI Inc., and was supported by grants from First 5 LA, the Los Angeles County Department of Mental Health, and Department of Public Health programs including the Division of Chronic Disease and Injury Prevention, Children's Medical Services, the Emergency Preparedness and Response Program, Substance Abuse Prevention and Control, and Environmental Health.