COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – MHSA IMPLEMENTATION AND OUTCOMES DIVISION

MHSA Innovation 2 Project – Health Neighborhoods

Los Angeles County Department of Mental Health proposes to test out the creation and implementation of distinctive place-based Health Neighborhoods as a way to provide comprehensive, community-based care and prevention-oriented services designed to increase the overall health of the population and both decrease the incidence and reduce the degree of trauma experienced within distinct Los Angeles County communities.

A Health Neighborhood, as defined for this proposed project, has 5 key components:

1. Builds the capacity of the community to prevent or reduce the incidence of mental illness by involving communities in promoting the health and well-being of their members.
2. Partnership development and community engagement.
3. An upstream approach addressing the root causes of trauma, embedded within the social determinants of health.
4. Data-informed
5. Population level results, including long term and intermediate outcomes.

The Health Neighborhood framework will have strategies organized by age, as well as inter-generational strategies.

Qualifications for Innovation Project- Health Neighborhoods

"Innovative Project": This is a project that the county designs and implements for a defined time period, and evaluates to develop new best practices in mental health. An Innovative Project meets one of the following criteria:	**Select One**
1. Introduces a new approach or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.	☒
2. Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population	☐
3. Introduces a new application to the mental health system of a promising practice or approach that has been successful in a non-mental health context	☐

While Los Angeles County's initial Innovation projects centered around 4 models to provide integrated health, mental health and substance use services, Health Neighborhoods build upon the learning of Innovation 1 projects but focus on specific age group and geographic strategies to reduce the impact of trauma, reduce the

likelihood of trauma and improve the overall health and well-being of communities. The proposed Health Neighborhoods will incorporate, but not rely upon, the traditional mental and physical health service sector. Instead, Health Neighborhoods will utilize natural supports within specific communities and community infrastructure to promote health and well-being.

Learning from this Health Neighborhood project will inform the future of community-based mental health service delivery in the following ways:

- Prevention services, delivered through the Prevention and Early Intervention component of MHSA will be greatly informed.
- Community outreach and engagement strategies
- Stigma and discrimination reduction activities within specific communities
- Reduction of disparities

Primary Purpose of the Innovation Project

Primary Purpose: The county shall select one of the following purposes for developing and evaluating a new or changed mental health practice**:**	**Select One**
1. Increases access to underserved groups	☐
2. Increases quality of mental health services, including better outcomes	☐
3. Promote interagency collaboration related to Mental Health Services or supports,	☐
4. Increase access to mental health services	☐
❖ **Focus on Mental Health:** An Innovative Project may affect virtually any aspect of mental health practice or assess a new or changed application of a promising approach to solve persistent, seemingly intractable mental health challenge.	

The challenge to be addressed by this Innovation Project:

This project seeks to test out strategies to involve key community [entities] in improving the overall health of members of the community. Through initiatives such as Comprehensive Community Care (CCC) in 2000 and MHSA Innovation 1 projects involving evaluating different integrated care models, the Department has sought to create and sustain a more community-focused mental health service delivery system. Both projects relied heavily on the mental health system and focused much less on the role of the community in improving services, care and outcomes. Those efforts also focused on individuals who already had a diagnosed mental illness. The larger communities involved in CCC and Innovation 1 did not take responsibility for the well-being of community members.

By including community resources and entities, such as local faith organizations, clubs and organizations trusted by the community, members of communities at risk of developing a mental illness or those early in the course of an illness will receive the

care, support and services needed to live more productive lives and improve the overall community.

In order to impact trauma and the rates of mental illness, a distinctly different approach must be taken that involves key community stakeholders that have influence in the community and with whom the community places their trust. The Department has never embarked on comprehensive community capacity building strategies targeted at prevention, early intervention and treatment. MHSA Innovation provides the opportunity to engage in that work through the development of Health Neighborhoods that address the root causes of trauma within specific populations in specific communities across Los Angeles County.

Stakeholder involvement in proposed Innovation project:

Planning for Innovation 2 projects began at the June 18, 2014 System Leadership Team (SLT), the Department's stakeholder group, meeting. The criteria for Innovation, from the draft Innovation regulations, was reviewed. Initial discussion was focused on the question of "what do we want to learn?" Members of the community, as well as DMH staff, were encouraged to submit proposals for Innovation projects. Twenty nine (29) proposals, across all age groups, were reviewed at the July 16, 2014 SLT meeting, with a recommendation made to consider Health Neighborhoods as an organizing framework. An SLT Standing Committee was formed to develop the framework for Health Neighborhoods. The committee consisted of DMH staff representing each of the 4 age groups, including an inter-generational group, providers, family members, consumers, DMH Service Area administrative staff, representatives from under-represented ethnic populations and any other interested individuals.

The standing committee met on the following dates to develop the focus on Innovation 2 projects and the parameters for a Health Neighborhood:

July 14, 2014

July 21, 2014

August 11, 2014

August 14, 2014

September 2, 2014

Timeframe of the Project [to be completed]

Project Milestones [to be completed]

Populations to be Served by Project and Strategies to be Tested Out

Children

Strategies
Multiple strategies will support a continuum of comprehensive community-based care and asset-based capacity-building. They will align with national, statewide, county, and local community prevention initiatives. The primary focus areas will include:

1. **Strengthening Families**

   Increase family protective factors: Caregiver Resilience, Social Connections, Knowledge of Parenting and Child Development, Concrete Support in Times of Need, and Children's Social and Emotional Development and Competency. Examples of programs, resources, and strategies that have incorporated a Strengthening Families framework or similar models include: selected home visitation programs, Partnerships for Families, strength-based and trauma-informed parent education programs, parent and community cafes, 40 Developmental Assets for Children.

2. **Strengthening Communities**

   Increase community capacity to support and promote child/family safety, health, development, and well-being through increased social connectedness, community mobilization and action, mental health literacy and psycho-education, and access to needed supports and services. Examples of related models and strategies include Asset-Based Community Development (ABCD), It Takes a Community (ITC), Seven Generations, disseminating community narratives (digital storytelling, Telling Your Story Training), relationship-based resident organizing and civic engagement, Transforming Early Childhood Community Systems (TECCS).

3. **Strengthening Care Pathways**

   Augment care pathways and bridges/linkages to needed services available through a network of Health Neighborhood providers (including trauma-informed care), in addition to strengthening the capacity of local residents to establish ties to natural communities of support, independent of services. Examples of such strategies include building family-driven early childhood systems of care and communities of care.

Key Learning Questions

1. How does community education regarding trauma (causes, impact, prevention, the protective factors, etc.) impact a selected community's well-being in general and the young children residing in the community in particular?
2. How does screening and early identification of risk factors in young children (developmental delays, ACES and other trauma-related experiences) contribute to

reduction of psychosocial, emotional, and behavioral problems and access to care pathways for needed resources, services, and supports?

3. Can a specific community setting (e.g., WIC centers, Early Head Start programs, Schools and Wellness Centers) serve as a base for Health Neighborhoods and better respond to trauma and the mental health needs of children and families? What structural barriers need to be addressed in these environments? Which community partners need to be engaged? How will the primary goals of such centers/programs be impacted and advanced?

Proposed Approach to Spreading Successful Outcomes

1. Prioritize investments in workforce, program, and policy development to support the scaling of successful "innovation zone" strategies/models in multiple communities and at the countywide level.

2. Support Health Neighborhood networks in establishing or strengthening existing local community councils or partnerships whose residents are placed in control of identifying priority needs and resource allocations.

Reducing Ethnic and Cultural Disparities

Priority target communities for innovation projects will include those with significantly large or predominant populations of at-risk/high-risk children and families and underserved ethnic/cultural groups. Specific geographic areas have already been identified among the initial Health Neighborhood communities (Lancaster, Pacoima, Boyle Heights, MLK/Watts/Willowbrook, Long Beach), First 5 LA's Best Start Communities, and California Endowment's Building Healthy Communities.

Intended Outcomes

In addition to informing previously identified system change priorities, Innovation Projects will improve the mental health system's capacity to address trauma and promote positive mental health for the general population by contributing to increased knowledge of:

1. The relative effectiveness of specific community stakeholder groups and strategic partners in promoting mental health education.
2. The most appropriate community engagement roles for mental health agencies/programs to play in preventing, reducing, and responding early to trauma.
3. The required resources and most conducive settings to effectively implement corresponding community engagement, education, and capacity-building strategies and models.

Transition Age Youth

Strategies
Strategies to provide TAY safe and anonymous pathways (which decreases stigmatization) to connect with community services and social supports include:

1. TAY-focused/TAY-led neighborhood events (not focusing on mental health) to connect and develop positive relationships within the neighborhood
2. Incorporating TAY residents throughout the planning process of Health Neighborhoods
3. Provide opportunities for TAY to contribute to the Health Neighborhood (not limiting TAY only as beneficiaries or recipients of services/resources/support from the Health Neighborhood)
4. Outreach specifically targeting TAY through different means:
   a. Utilizing TAY with similar/shared lived experiences (diverse array: for example, TAY from different ethnic/cultural groups, LGBT TAY, TAY formerly involved in gangs, TAY who were abused, formerly homeless TAY, formerly substance abusing TAY, etc.)
   b. Utilizing technology and social media to provide information, education and outreach as well as providing a means for TAY to connect with each other and the neighborhood resources
   c. Outreach that is relationship focused, rather than service focused (for example: utilizing the 'FORM' method – Family, Occupation, Recreation, and Motivation or Determination)
   d. Outreaching where TAY are (for example: at parks, schools, shopping malls, etc.)

Key Learning Questions

1. Can a Healthy Neighborhood that provides Transition Age Youth (TAY) safe and anonymous pathways to connect with community services and social supports utilizing non-traditional outreach and engagement practices and peer support increase positive social connections?
   a. Would increasing positive social connections decrease the negative impact(s) of trauma for TAY?
   b. Would increasing positive social connections increase positive coping strategies for TAY to deal with trauma

Proposed Approach to Spreading Successful Outcomes

1. Through this Innovation program, DMH (and the service community) will learn effective ways of outreaching, and more importantly effectively engaging TAY.
2. DMH will incorporate these non-traditional (but successful) strategies for outreaching to TAY into the overall service delivery system.

Reducing Ethnic and Cultural Disparities

Intended Outcomes

Adults

Strategies
1. **A Community-Oriented Approach to Pre-Booking Jail Diversion**
   This place based initiative will look at the impact of strategies intended to decrease the trauma of social isolation. Strategies include: (1) working systemically with local Law Enforcement and Criminal Justice Agencies within a specific area to identify a "Pre-booking Diversion Protocol" in which individuals with an identified mental illness who have committed a low-level crime while in acute crisis, i.e. trespassing due to homelessness, disturbance of peace in public secondary to psychosis/ delusions that does not meet criteria for WIC 5150 involuntary detention, and who have been arrested but have not yet been booked for a crime will be diverted to appropriate Mental Health Treatment. (2) Coordination/Collaboration with local Urgent Care Center to arrange for space where individual can be evaluated for appropriate community treatment and "warm hand" of to Community treatment team can be made (3) Community treatment team who can respond to the arrested and participate in a "warm hand-off" approach from law enforcement into treatment. This team can provide emergency supportive housing, benefits establishment, medication management and linkage to ongoing treatment. This team will be comprised of individuals who will have a low identified caseload and will consist of a high level of peer involvement. This treatment team will differ from FSP in that they will be the bridge between law enforcement/ Urgent Care treatment and ongoing mental health support like FSP, Field Capable Clinical Services or Wellness Center services.

   Learning Question

   Can a pre-booking jail diversion program that provides crisis intervention through a warm-handoff approach for low-level offense due to mental health symptoms reduce trauma associated with social isolation and improve the individual's connection to their community?

   Proposed Approach to Spreading Successful Outcomes
   If successful, the learning from this project would inform a larger effort to divert similar individuals from the criminal justice system into community-based services and supports.

Reducing Ethnic and Cultural Disparities

Intended Outcomes

1. Reduction of mentally ill individuals in jail
2. Increased support to local law enforcement by participating in a warm hand-off to the pre-booking jail diversion team
3. A decrease in social isolation as identified by the Determinants of health, or other tool to be identified.

2. **Community Education and Mobilization For Underrepresented Cultural Communities**

The Department will use Innovations funding to test the hypothesis that a "housing first and employment second" approach will reduce the trauma associated with social isolation for adults who have a SMI and have transitioned from homelessness to permanent supportive housing by increasing their opportunities for employment. Having a job will provide increased opportunities for individuals to develop relationships with their co-workers thereby improving their integration into and connection with the community.

This project is Innovative because it will leverage Los Angeles County's regional Coordinated Entry System (CES), a systematic approach to match individuals to appropriate housing based on a standardized assessment, to also systematically match individuals to a menu of volunteer and employment opportunities based on a standardized employment assessment tool. CES is regionally based and this proposed Innovation project will align with the CES within the health neighborhoods that will be targeted through this project. An extremely important component of the proposed model is job development which will include outreaching to and providing incentives to employers and business leaders within the health neighborhood to gain a commitment to partner to provide employment opportunities. Another important component is providing the job supports that are necessary for the participants to be successful in obtaining and retaining their jobs including: networking opportunities, peer support, community clubs, faith-based community supports. Since the participants will be working supports will be provided afterhours and weekends.

There is unique opportunity to leverage a new Workforce Innovation Fund grant from the Department of Labor recently received by the City of Los Angeles. This grant targets three populations with multiple barriers: homeless, disconnected youth and incarcerated populations. It uses an innovative social enterprise model to create jobs for those with multiple barriers to help them gain work

experience and increase their work skills through transitional and bridge employers with the goal of transitioning to competitive employment opportunities. The grant includes multiple partners, including the workforce investment agencies, RedF, trade tech, Homeboy, Conservation Corp, Goodwill, Downtown Women's Center, Skid Row Housing Trust and plans to leverage workforce center resources such as on the job training funding.

Learning Question

Individuals who are homeless and mentally ill have typically experienced multiple traumas prior to becoming homeless and during the time they are homeless. Moving into permanent housing brings a multitude of benefits to these individuals. However, for many of them, the social isolation they experience when they move from a culture of homelessness into permanent supportive housing is traumatic and may be exacerbated by their prior traumas. This project aims to learn if assisting these individuals to obtain employment will decrease their social isolation and reduce the trauma associated with it by providing them with opportunities to develop relationships with those with whom they work.

What you would propose to change if learning was successful?

If successful, this model will become the gold standard approach to "housing first and employment second" and the DMH will incorporate this model into its other programs as appropriate.

Reducing Ethnic and Cultural Disparities

This model will address a reduction in ethnic and cultural disparities because it targets a uniquely marginalized culture - individuals who are homeless and have a mental illness. In Los Angeles County, the highest percentages of adults with SMI who are homeless are African Americans. This model will also reduce poverty amongst those who are homeless thereby reducing the cultural divide and will increase inclusiveness of this marginalized group.

Intended Outcomes

1. An increase in the individual's income
2. An increased sense of well-being and self-sufficiency
3. An increase in the individual's sense of integration into and connection with the community
4. A reduction in the use of public resources including SSI, Federal Housing Subsidies and DMH services as a result of the increase in income through employment

5. Increase in flow through the mental health system
6. Increased housing retention
7. A reduction in the number of times a job position held by these individuals turns over
8. Improved health and mental health for the individual and the community
9. An overall economic benefit to the community when more if its members work

Older Adults

Strategies
1. **Provide education and training to the community regarding how to recognize and report elder abuse, neglect and/or fiduciary abuse (trauma). Learning Question:**

   The learning for this strategy involves whether providing psychosocial education and training to an identified at risk community, will result in increased safety and support for older adults.

   Proposed Approach to Spreading Successful Outcomes
    If the learning in this regard is successful, it would speak to the benefit and need of large-scale community-based educational campaigns to prevent and/or decrease elder abuse, neglect and/or fiduciary abuse.

   Reducing Ethnic and Cultural Disparities:

   This strategy would address reducing ethic and cultural disparities by targeting older adults and communities below the poverty level, with multiple linguistic and cultural needs and an above average crime rate.

   Intended Outcomes

   The intended outcome of this strategy is to educate the community at-large, older adults and their support networks to increase the awareness of what elder abuse, neglect and fiduciary abuse are and how to recognize and prevent these incidents. Increased awareness of these types of abuse, would enlist the community as gate keepers and promote enhanced safety and support for vulnerable and diverse older adults.

2. **Provide a menu of psychosocial educational opportunities to prevent trauma among older adults and the community in general. The menu would include the following:**
   - Stress Management
   - Anger Management
   - Suicide Prevention (Question Persuade and Refer)

- Health and Wellness
- Managing Chronic Conditions
- Fall Prevention
- Grief and Loss

Learning Question

The learning for this strategy is multi-layered. For instance, if an older adult or a community member receives psycho-social education around anger and stress management, will this in turn result in less domestic and/or community violence? Further, would this training lead to better interpersonal relationships, decreased isolation and less depression? In addition, if older adults and the community are effectively trained in suicide prevention, will this lead to a safer and more supportive community environment with less stigma around accessing mental health care?

If the myriad of grief and loss issues that older adults encounter were identified and addressed, would this lead to reduced isolation, improved social engagement and reduced trauma? In many impoverished communities, trauma is commonplace and grief and loss issues are seldom acknowledged and processed. Providing a structured mechanism for older adults and community members to process their grief and loss in a safe and supportive environment, would enhance safety, well-being and build community capacity.

Proposed Approach to Spreading Successful Outcomes

Should the learning prove successful in these areas, it would highlight the importance of interventions and strategies that both improve individual, as well as community safety and well-being.   In addition, this would confirm the need and efficacy of both prevention and early intervention psychosocial education in promoting, both individual and community safety, well-being and collaboration.

Reducing Ethnic and Cultural Disparities

Ethnic and cultural disparities would be reduced by the empowering impact of this psychosocial educational menu. The information would be offered in the relevant languages of the communities served with specific cultural adaptations that reflect the communities' preferences.

Intended outcomes

1. Improved safety
2. Enhance awareness of each aspect of the menu of psychosocial education opportunities.
3. Improved community capacity, safety and support.
4. Better access to the right care at the right time.

Intergenerational

Strategies
Community interventions at 3 different levels:
1. <u>Community Intervention</u>: Foster deeper connections and communication among the natural support systems (e.g., faith-based agencies, community organizations, resident associations, etc.) to offer greater support for families as a whole.
    1. <u>Rationale</u>: Currently, community organizations, resident associations, and service providers are not connecting and communicating well to ensure that services and supports are available and accessible to families as a whole.
    2. <u>How</u>: A community partnership with neighborhood leaders that champions strong families? Trainings for residents and organizations that constitute the natural support system?

2. <u>Systems Intervention</u>: Create a comprehensive continuum of formal services and supports that is welcoming, integrated, and operates as a team to strengthen the whole family.
    1. <u>Rationale</u>: The current system focuses on the individual 'identified patient,' is unidirectional, and rigid in how it identifies and works with families.
    2. <u>How</u>? Establish a service collaborative that is able to work with families as a whole, that is bi-directional, flexible, integrated and operates as a team?

3. <u>Family Intervention</u>: Strengthen the family as a whole by fostering the whole range of protective factors (i.e., parental resilience; social connections; concrete supports in times of need; knowledge of parenting and child development; and safe and nurturing relations).
    1. <u>Rationale</u>: Families are often approached after a trauma has occurred; families are often seen as having deficits;
    2. <u>How</u>? Community health workers that? A social marketing campaign?

Learning Questions

Process Questions—Health Neighborhood Initiative:
1. How do participants engaged in a Health Neighborhood initiative understand and define intergenerational trauma?
    a. Do they see the positive and negative effects of intergenerational trauma?
    b. Do they have a set of shared indicators by which they identify early onset of intergenerational trauma?

    c. How do participants engaged in a Health Neighborhood initiative develop strategies aimed at strengthening families as a whole to reduce intergenerational trauma?

d. What are the successes and obstacles that service providers face in supporting the family as a whole in order to reduce intergenerational trauma?

e. In what ways does treating the "family" as a whole help strengthen the individual and the neighborhood?

Intervention Strategy Question: [These questions need to be refined based on final agreements, but these questions are offered as illustrations]

1. Community Intervention:
   a. Does fostering deeper connections and communication among the natural support systems lead to greater support for families?
   b. If so, in what ways? If not, why not?

2. Systems Intervention:
   a. Does a comprehensive continuum of formal services and supports that is welcoming, integrated and operates as a team strengthens the family as a whole?
   b. Were service providers able to cross the organizational boundaries in order to provide supports that strengthen families as a whole? If so, how? If not, why not?

3. Family Intervention:
   a. Did the community-level intervention and systems-level intervention strengthen families? If so, in which of the following areas?
      i. Parental resilience?
      ii. Social connections?
      iii. Concrete supports in times of need?
      iv. Knowledge of parenting and child development?
      v. Safe and nurturing relations)?
   b. If not, why not?
   c. Does strengthening families have equal or different effects on age groups? Are some age groups more impacted by a family-centered approach?

Pending Work

Define Key Concepts

1. What is <u>intergenerational</u> trauma?
   a. Trauma that occurs to someone during childhood and is being transmitted to a younger generation.
      i. Example: A person who was jumped into a gang as a child and is now reproducing those traumas with a younger generation, or within his/her family.

b. Trauma that is experienced simultaneously by persons of different age groups (or generations) that are part of a group, such as a family.
   i. Example: A family crossing the border is assaulted by drug dealers. This is affects several generations at the same time, and then becomes part of a family history.

c. Trauma that occurred during an earlier generation or generations (e.g., with grandparents) and this trauma is being transmitted.
   i. Example: A generation or two ago, people experienced genocide. The historical memory is still being carried forth. Current war in Syria where they are fighting the same "tribal war" they have been fighting since the 7th century.)

d. Indicators of intergenerational trauma
   i. What are these?
   ii. How are these indicators different or same from trauma?

2. What is a 'strong family'? Indicators of strong families?
   a. Family is made up of individuals.
   b. Family includes people beyond the nuclear family, caregivers, friends, role models, etc.
   c. Family is a natural support unit to individuals that are members of the family.
   d. Family is a system.
   e. Families tend to have several generations within the unit.

3. Proposed approach to spreading successful outcomes

4. How this project will reduce ethnic and cultural disparities

5. Intended outcomes