COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH

MHSA INNOVATION 2 HEALTH NEIGHBORHOODS

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Key Components of a Health Neighborhood

- It assumes there is a reciprocal inter-connectedness between the community's health and wellbeing and that of individual community members, so **it promotes the community's wellness as a way to improve the health and well-being of individual members**.
- **It draws upon research on the social determinants of health, which finds that health status is heavily mediated by socioeconomic status** so that communities with greater levels of poverty tend to have members who are more disconnected from community supports and services, with fewer health resources and poorer health.
- **It deploys a set of upstream strategies to address the social determinants**—or root causes--of mental illness, namely the trauma experienced by different age groups within a specific community.
- It actively **develops partnerships to engage communities and service systems**, building upon the learning of Innovation 1 Integrated Care model outcomes.
- **It builds the community's capacity to take collective ownership and coordinated action to prevent or reduce the incidence of trauma-related mental illness** by involving communities in promoting the health and well-being of their members.

Defining Trauma

- SAMHSA conceptualizes trauma as "resulting from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being".
- The National Center for Post-Traumatic Stress Disorder (PTSD) in 2007 defines trauma as a set of normal human responses to stressful and threatening experiences.
- Addressing trauma requires a multi-agency approach within communities that includes education, awareness, prevention and early intervention strategies.

Primary Purposes of Innovation 2

Increasing access to underserved groups:

- Transition Age Youth (TAY)
  - TAY community outreach to those at risk of trauma
  - Specialized and targeted outreach through non-traditional, relationally focused approaches
- Older Adult
  - Older adult neighborhood council
  - Health Neighborhood Older Adult Specialized Team (HOST)
- Intergenerational
  - Culturally competent referral and support network for families experiencing intergenerational trauma

Primary Purposes of Innovation 2

Increase quality of mental health services, including better outcomes:

- Adult
  - Pre-booking jail diversion pathway into mental health treatment
  - Coordinated Entry System for employment of formally homeless individuals living in permanent supported housing

Promoting interagency or community collaboration related to mental health services:

- Child
  - Strengthening communities
  - Strengthening care pathways for families

Overarching Learning Questions

- What is the relative impact of selected asset-based community capacity-building strategies on reducing trauma and promoting safety, stability, health and well-being across diverse communities and different age groups in Los Angeles County?
- Does the development of Health Neighborhoods through an asset-based community capacity-building framework result in an increased ability to seek care and support when it is needed (increased access through formal and informal pathways) and does that approach result in decreased trauma and mental health symptoms for those experiencing symptoms or at risk of experiencing symptoms?

Promote Interagency or Community Collaboration Related to Mental Health Services or Supports

Child-Strengthening Communities

- Targeting children ages Birth-5 with the following risk factors for child maltreatment:
  - Maternal depression
  - Alcohol and substance use
  - Intimate partner/domestic violence
  - Parental stress and difficulty coping
- Builds on Best Start community partnerships by:
  - Attend a variety of community and leadership meetings
  - Provide psychosocial education and training on trauma and the impact on Birth to 5 and their families.
  - Develop a culturally appropriate brochure educating on the impact of trauma on the Birth to 5 population and available resources in the community.

Promote Interagency or Community Collaboration Related to Mental Health Services or Supports

Child-Strengthening Care Pathways for Families

- Employ a team (Care Coordinators, Parent Partner/Community Health Worker) to do the following:
  - Outreach at early childhood systems of care (pediatrician offices, daycare centers, family-run/clergy-run preschools, WIC centers, DPSS, and Regional Centers).
  - Administer Trauma-informed developmental screening and assessment strategies to identify the underlying needs of the child/family system.
  - Link to the resources in the community, using strengths-based approach.
  - Utilize flex funding for non-traditional interventions.
  - Reflective supervision for the staff to address vicarious trauma.

Child Strategies – Key Learning Questions

- Does the use of a Community Health Worker contribute to a family establishing stronger connections with the community?
- Will a prevention model that incorporates a "whatever it takes" philosophy reduce children and families developing a trauma-related illness that leads to accessing the mental health system?

Increase Access to Underserved Groups

Increase Mental Health Service Utilization for SED/SPMI TAY by:

- **Incorporating TAY into outreach efforts with a focus on specific groups known to be at risk for trauma**
  - Involve TAY residents throughout the planning process of Health Neighborhoods to strengthen connections to other TAY and community services and supports
  - Provide opportunities for TAY to contribute to the Health Neighborhood
  - Create paid positions for TAY to serve as peer leaders to coordinate
  - Outreach and engagement, and activities/events to connect TAY to each other and to community supports in the Health Neighborhood
  - Utilize TAY with similar/shared lived experiences of groups known to be at risk for trauma to develop connections with TAY in the Health Neighborhood

Increase Access to Underserved Groups

TAY- Performing outreach through innovative and nontraditional methods that is relationally focused, not service-focused

- TAY peer leaders will:
  - Use natural and existing peer networks to make connections and foster relationships within the Health Neighborhood to increase utilization of mental health and other community services and supports
  - Utilize technology and social media to provide information, education, and outreach
  - Coordinate and host TAY-focused/TAY-led neighborhood events to connect and develop positive relationships within the Health Neighborhood
  - TAY peer leaders will engage with TAY in the community
  - Perform physical outreach in areas where TAY are to develop positive connections and relationships and to provide information and resources to community supports
  - Use rapport building techniques to facilitate conversation and begin developing relationships (for example, the 'FORM' method: talking with TAY about their Family, Occupation, Recreation, and Motivation or Determination)

Transition Age Youth Strategies

Key Learning Questions

- Can a Health Neighborhood that provides TAY with safe and anonymous pathways to connect with community services and social supports utilizing non-traditional outreach, engagement practices, and peer support increase positive social connections?
- Would increasing positive social connections decrease the negative impact(s) of trauma for TAY?
- Would increasing positive social connections increase positive coping strategies for TAY to deal with trauma?
- Would increasing positive social connections by providing non-traditional outreach, engagement practices, and peer support increase utilization of mental health services for SED/SPMI TAY and those TAY who are at high risk of first-break psychosis and developing major mental health issues?

Increase Access to Underserved Groups

- **Older Adult** – Two strategies geared to reduce trauma and increasing access to formal and informal supports
- **Older Adult Neighborhood Council:** Will mobilize leaders from key stakeholder groups (i.e., residents, community-based agencies, faith-based organizations, public institutions, businesses, among other sectors) to Identify and implement solutions that can address the key issue(s) generating trauma for older adults. Solutions can include, but are not limited to the following:
  - Distribute information regarding the full range of trauma
  - Facilitate wellness activities on site by older adult interest groups and/or community-based organizations
  - Partner with local businesses and agencies to develop public service announcements related to prevention and awareness of elder abuse by posting them in multiple languages on local billboards and at libraries
  - Build capacity within communities to support health and wellness of older adults at-risk of or experiencing trauma-related mental illness and trauma

Increase Access to Underserved Groups

Older Adult Neighborhood Council:

- Bring together community organizations to participate in a mental health/health fair with an emphasis on trauma identification.
- Psycho-education on trauma awareness, mental health and how to obtain services.
- Engage with faith-based organizations to facilitate activities of interest within the community with a focus on abuse prevention.
- Identify community organizations that would provide “friendly visits” with staff throughout the community to access older adults who seldom leave their homes.

Increase Access to Underserved Groups

Older Adult- Health Neighborhood Older Adult Specialized Team (HOST):

- A field-based service that will offer screening, assessment, treatment and case management services to older adults with or at risk of mental illness who have been impacted by traumatic event(s) and have had very limited or no clinical intervention.
- The members of this mobile team will include a peer advocate that will provide peer support and mentoring.
- The team will be trained in best practices for working effectively with older adults impacted by the full spectrum of trauma.

Increase Access to Underserved Groups

Older Adult Key Learning Questions:

- Can an Older Adult Neighborhood Council identify, prioritize and address the key social determinants of trauma impacting older adults in the target neighborhood?
- Can a Health Neighborhood Older Adult Team increase access to formal and informal support services for older adults at high risk for and/or with trauma-related mental health problems?
- Can an Older Adult Council and Health Neighborhood Older Adult Team, working together, improve the overall well-being of older adults in a high-risk neighborhood and reduce trauma-related mental illness for older adults?

Increase Access to Underserved Groups

Intergenerational Strategy:

- Few trauma treatment models exist that provide guidance on how formal and informal groups to foster resilience and self-sustenance at a community level, and how this community-level resilience in turn can improve how individuals and families respond to trauma.
- Even less is known about how to do this work with underserved communities in ways that incorporate culturally appropriate and sensitive approaches to address trauma-related factors unique to these communities.

Increase Access to Underserved Groups

- Test the Trauma Informed Community Building (TICB) model with families experiencing intergenerational trauma in the context of the neighborhoods or cultural groups with collective and/or historic or cumulative trauma.
- The strategies of the TICB Model are guided by the social-ecological theory that underscores the interconnectedness of individuals with the social and environmental dynamics that influence them, including interpersonal, community, and system factors.

Increase Access to Underserved Groups

- **Intergenerational Families strategy:** Culturally Competent Referral and Support Network- that promotes community investment, inclusiveness, and health literacy for families experiencing intergenerational trauma. It consists of the following four elements:
  - Form a referral and support network for intergenerational families to include doctors, nurses, nutritionists, health educators, mental health professionals, peers, as well as non-traditional healers (mind/wellness/health literacy experts, spiritual healers, holistic healers, etc.). These providers are highly connected, and respected individuals in the community.
  - Engagement of intergenerational families where they are and support their involvement within a broader referral and support network.
  - Opportunities for community members to have multiple interactions with community peers, providers, as well as access to resources. 'culturally competent referral and support network' .
  - Community leadership through support and skill building in order to address system changes.

Increase Access to Underserved Groups

Intergenerational Families:

- Community Leadership: Review service and supports gap and implement and fund the needed services. The services will include, but are not limited to the following:
  - Intergenerational mentorship programs that will match up community members in order to improve health related knowledge and skills. Individuals would be matched up based on age group, skill level and health needs. This will lead to an increase in social connectedness among community members and intergenerational families.
  - Mental health-related Knowledge classes that can include Mental Health First Aid trainings, basic signs and symptoms related to various health issues such as suicide, domestic violence, substance use and addiction.

Intergenerational Strategies

Learning Questions:

- Can the Culturally Competent Referral and Support Network improve the ability of the neighborhood or community to reduce the impact trauma on intergenerational families?
- Can the Culturally Competent Referral and Support Network improve the knowledge and skills of intergenerational families with trauma-related mental illness or who are at risk of developing trauma-related mental illness?

Increase Quality of Mental Health Services, including Better Outcomes

Adult - Pre-booking Jail Diversion into Mental Health Treatment:

- This project envisions a new "team" of mental health and law enforcement personnel working together to establish a delicate mechanism based on strong feedback and shared responsibility for recovery.
  - Not a "hand off" by law enforcement
  - A new, more flexible relationship between law enforcement and mental health can affirm the early intervention, treatment, and support of mentally ill individuals, in addition to real community support in the areas of housing and employment.

Increase Quality of Mental Health Services, including Better Outcomes-Pre-Booking Jail Diversion

Making the case:

Three prominent gaps with the current way that the law enforcement, mental health systems, and communities address the needs of the target population:

- The absence of a pre-booking protocol that articulates recovery-oriented principles and corresponding functions, roles, responsibilities and tasks for law enforcement agents and mental health staff
- The absence of a team approach between the mental health and law enforcement systems
- The networks of natural supports and professional services need to work better together to function as a 'health neighborhood' for this target population

Increase Quality of Mental Health Services, including Better Outcomes- Pre-Booking Jail Diversion

Key Elements:

- Pre-booking Diversion Protocol in which individuals with an identified mental illness (who could be charged with a low-level crime while in acute crisis, i.e. trespassing due to homelessness, disturbance of peace in public, secondary to psychosis/delusions that do not meet criteria for a 72-hour hold) who have been arrested but not yet been booked, who agree, will be diverted to appropriate mental health treatment.
- Forensic Full Service Partnership Team- Building on the FSP model of service, will be specifically trained in evidenced-based practices including: Seeking Safety, Moral Recognition Therapy, and Cognitive Behavioral Therapy.

Increase Quality of Mental Health Services, including Better Outcomes- Pre-Booking Jail Diversion

Key Elements:

- Use of Recovery Guides
- Urgent Care Centers- the hub site for law enforcement officers to take consumers for initial crisis support.
- Coordination/collaboration with specified UCCs to arrange for space where individuals will be evaluated for appropriateness for this collaborative program.
- Law Enforcement – Mental Health Team

Adult – Pre-Booking Diversion

Key Learning Questions:

- Will individuals who are identified by a specially trained law enforcement-mental health teams prior to booking be more likely to be diverted away from jail and placed into mental health treatment?
- Will individuals supported by a Forensic Full Service Partnership team and a Health Neighborhood Network experience reductions in trauma and improvements in their level of functioning?
- Will individuals supported a Forensic Full Service Partnership team and a Health Neighborhood Network experience an increase in positive social connections in their communities (i.e., less social isolation and greater community integration) and a decrease in recidivism?

Increase Quality of Mental Health Services, including Better Outcomes

Adult - Coordinated Entry System for Employment of Formally Homeless Individuals Living In Permanent Supportive Housing:

- A "housing first and employment second along with community integration" approach to reduce the trauma associated with social isolation for adults who have a SMI and have transitioned from homelessness to permanent supportive housing.
- 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.
- Innovative because it will use Los Angeles County's newly developed regional Coordinated Entry System (CES), a systematic approach to match individuals who are homeless 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.

Increase Quality of Mental Health Services, including Better Outcomes

- CES is regionally based and will align with the health neighborhoods that will be targeted through this project.
- An extremely important component of the proposed model and one that is new to Los Angeles County 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 innovation is to use peer service providers to find jobs and support people in their jobs.

Adult – Coordinated Entry System Housing and Employment 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 and by utilizing natural supports within specific Health Neighborhoods and community infrastructure to promote health and well-being.

Overall Intended Outcomes

- Reductions in trauma using age-specific trauma measures administered to individuals and/or via the reduction of events associated with increased trauma (incarcerations and homelessness, for example).
- Increased protective factors such as changes in social connectedness, parental or caregiver resilience, concrete supports in times of need, and social-emotional competency.
- For Transition Age Youth (TAY), the duration of untreated mental illness will be measured, comparing that to a sample of TAY not engaged through a Health Neighborhood.
- Access to care, from the formal mental health system as well as through more informal community supports.

Overall Intended Outcomes

- For education or training-oriented strategies, changes in knowledge of mental illness or well-being.
- Decreases in stigma associated with mental illness and help seeking behavior.
- For specific child and older adult strategies, abuse and neglect reporting will be tracked.
- Culturally and age appropriate recovery and resiliency measures as well as a general mental health measure.
- Substance use
- Consumer perception of connection to one's community, measured at the beginning of contact and/or service and periodically.

Estimated Budget By Strategy for 1 Health Neighborhood

Child Strategies:	**$1,903,770**
TAY Strategies:	**$675,408**
Adult Strategies:	
Pre-Booking Jail Diversion (service areas 1&8):	
MHSA INN:	**$1,707,550**
FFP:	$900,000
MCE:	$300,000
Total Pre-Booking:	$2,907,550
Coordinated Entry System	**$814,910**
Older Adult Strategies:	
MHSA INN:	**$803,345**
FFP:	$278,304
Total Older Adult:	$1,081,649
Intergenerational Strategy:	**$559,724**
Total Cost For All Age Group Strategies Per Health Neighborhood (MHSA INN only, no Medi-Cal):	**$6,464,707**

Estimated Budget By Strategy for 1 Health Neighborhood

Training:	
One-Time:	
Adult – CES	$60,000
Adult – Pre-Booking Jail Diversion	$100,000
Total One-time training:	**$160,000**
Annual Training Cost:	$50,000
DMH Strategy leads (6 FTEs, S & EB)	$780,306
Evaluation:	$1,000,000

Total Cost Summary

Age group strategies Per 1 Health Neighborhood:	$6,464,707
DMH Strategy Leads:	$780,306
Space and other costs for DMH staff:	$54,000
Training:	$50,000
Evaluation:	$1,000,000
Total Annual Cost:	**$8,349,013**