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 method to provide comprehensive, community-based care and prevention-oriented services designed to decrease the incidence of or reduce the degree of trauma experienced by clients either experiencing or at risk of experiencing trauma in distinct Los Angeles County communities. Collectively, the strategies associated with this Health Neighborhood project will seek to increase access to underserved groups, increase the quality of mental health services, including better outcomes and promote interagency or community collaboration related to mental health services and supports.

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

1. 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.
2. 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.
3. 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.
4. It actively develops partnerships to engage communities and service systems, building upon the learning of Innovation 1 Integrated Care model outcomes.
5. 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.

The Health Neighborhood framework will be used to test out strategies associated with three (3) distinct Innovation primary purposes, organized by age of intended service recipient, as well as intergenerational strategies.

Increasing access to underserved groups:
1. Transition Age Youth (TAY)
   a. TAY focused and led neighborhood events.
   b. Specialized and targeted outreach.

2. Older Adult
    a. Community-based warm-line.
    b. Older adult neighborhood council.
3. Intergenerational
    a. Trauma-Informed Community Building for intergenerational families.
    b. Community empowerment, mobilization and community building to improve mental health literacy about the short and long range effects of trauma.

Increase quality of mental health services, including better outcomes:
1. Adult
    a. Pre-booking jail diversion into mental health treatment.
    b. Coordinated Entry System for employment of formally homeless individuals living in permanent supported housing.

Promoting interagency or community collaboration related to mental health services:
1. Child
    a. Asset-based community capacity building through strategies aimed at strengthening families, communities and care pathways.

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	X

While Los Angeles County's initial Innovation projects centered around four (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

The challenge to be addressed by this Innovation Project

This project seeks to introduce a new application to the Los Angeles County public mental health system of an approach that has been successful in a non-mental health context by testing out strategies to involve communities in engaging in approaches that will reduce the risk or the harmful effects of trauma within those communities. 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.

By including community resources, cultural and community brokers and community-based organizations 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, thereby, improve the overall community in the process.

Addressing trauma is critical to reducing the risk factors associated with adverse childhood experiences that result in poor health, mental health and increase death rates[1]. Individuals experiencing untreated trauma often do poorly in school and become involved in the juvenile and adult justice systems or the child welfare system. Thus trauma has a significant impact on and cost to communities.

SAMHSA, as part of a review of existing definitions and discussions with an expert panel, 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" (SAMHSA, Trauma and Justice Strategic Initiative, 2014). The National Center for PTSD in 2007 defines trauma as a set of normal human responses to stressful and threatening experiences.[2]

Addressing trauma requires a multi-agency approach within communities that includes education, awareness, prevention and early intervention strategies (SAMHSA, Trauma and Justice Strategic Initiative, 2014).

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. In essence, this proposal seeks to test out strategies to empower local communities to work together in ways that will ultimately lead to better mental health and reductions in trauma for those experiencing or at risk of trauma, through the building of shared community values, leadership development and community member empowerment.

Themes that cut across the proposed Health Neighborhood approaches are age and culturally appropriate strategies to reduce the incidence or impact of trauma and increase protective factors such as increasing social connectedness and decreasing social isolation within a community, utilizing proactive housing and employment first approaches to reducing homelessness and diverting individuals prior to booking from jail into community treatment using the community as support as well as active consumer involvement in outreach, engagement and services. The development of community advisory committees is also a common theme to maximally engage communities in the reduction of trauma and increasing whole health and specifically mental health.

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 four (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

In addition, the September and October SLT meetings were devoted to strategy development and vetting of key strategies with all members of the SLT.

<mark>This proposal was approved by the SLT on _____ and publically posted on the Department's website for 30 (thirty) days (pending).</mark>

Timeframe of the Project and Project Milestones

Upon approval of the Mental Health Services Oversight and Accountability Commission, the Department will initiate an Innovation-2 Implementation workgroup that will meet weekly to outline implementation actions with the Department's Contracts Development and Administrative Division. Strategy leads will begin identifying the type of solicitations that will be drafted and begin immediate work on the solicitations. If the Department receives MHSOAC approval in January or February of 2015, the following is an estimated implementation timeline:

February 2015 – February 2016: Solicitations developed, approved, issued, scored and awarded.

- February – March 2015: Innovation 2 Implementation workgroup formed within the Department, comprised of strategy leads, Innovation administrative staff, Contracts Development and Administration Division staff and lead by the District Chief overseeing Innovation implementation. Workgroup meets weekly to operationalize strategies.
- March – September 2015: Development of solicitations, review and approval of solicitations by Department, County Counsel and Chief Executive Office.
- October – December 2015: Bidders conferences held, proposals received.
- January – February 2016: Solicitations scored and award letters distributed.

March – June 2016: Board letters drafted and adopted

July 2016 – June 30, 2020: Four (4) year implementation plan. The Department will replicate the successful approach of Innovation 1 and developed quarterly learning sessions throughout the life of the project, focused on learning, including addressing barriers to implementation, identifying and promoting successful strategies, using

outcome data to guide learning and implementation and developing opportunities for shared learning and shared decision-making throughout the project.

Summaries of learning sessions will be developed and disseminated after each learning session, with emphasis on how the learning not only informs the current Innovation project but also informs the Department's service delivery system.

As with all components of the MHSA, program implementation and preliminary outcomes will be reviewed with the Department's System Leadership Team periodically and will be reported on in MHSA Annual Updates/MHSA Three Year Program and Expenditure Plans.

Overarching learning questions

1. What is the relative impact of selected asset-based culturally competent 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?

2. Does the development of Health Neighborhoods through an asset-based, culturally competent and 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?

Overall Approach to Evaluation

This project and accompanying strategies will be evaluated through a set of common measures as well as those specific to the particular strategy, primary Innovation purpose, focal population and goals. Each geographic Health Neighborhood will be evaluated according to the degree to which the lead agency facilitated or developed community-based networks and leveraged the resources of the community. Thus, an analysis will be conducted on the strength of the partnerships and the ability of the partnership to impact the mental health of the target population.

Each strategy will be evaluated according to its intended outcomes and primary Innovation purpose. Strategies with the same primary Innovation purpose will be evaluated in relation to each other.

A solicitation will be developed for the parameters of this evaluation and the successful bidder would conduct focus groups to review and obtain feedback on the qualitative and quantitative approach to the evaluation. Specific measures and sampling methodologies would then be determined. The following metrics will be included in the evaluation:

- 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
- Access to care, from the formal mental health system as well as through more informal community supports
- 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

Populations to be Served and Strategies to be Tested Out By Primary Innovation Purpose

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

Children

Multiple strategies will support a continuum of comprehensive community-based care and asset-based capacity-building. These strategies will be guided by a "strengthening families" framework and trauma-informed approaches to care and community engagement. They will align with national, statewide, county, and local community prevention initiatives. The continuum of care will include health, mental health, early care and education, developmental, and other social services for children (prenatal to school age) and their families. Community capacity-building will focus on promoting child/family safety, healthy development, and well-being.

Strategies

1. **Strengthening Families**
   Implement programs and best practices that work directly with **parents/caregivers** to increase family protective factors: parent/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. These specific strengthening families practices may include models that have been identified by the Center for the Study of Social Policy Strengthening Families Initiative. Such models address multiple protective factors and can be implemented within various settings (e.g., home visitation programs, early care and education, schools, health-related programs, parent and community cafes, etc.).

2. **Strengthening Communities**
   Implement programs/practices to **increase community capacity** to support and promote child/family safety, healthy development, and well-being. Such programs/practices include "collective impact" strategies and asset-based approaches to resident-led community service and public education projects that, in turn, contribute to family stability and economic self-sufficiency, community health and nutrition, and community safety. These programs further incorporate psychosocial education and mental health literacy strategies and facilitate access to needed supports and services. Existing strengthening communities strategies have been implemented through countywide resident associations such as Neighborhood Action Councils (NACs). This strategy would focus on reducing social isolation and promoting opportunities for psychosocial education among

families and community residents in order to strengthen the capacity of local residents to reduce social isolation and establish natural communities of support. Staffing would include community organizers and outreach coordinators for selected NAC clusters and defined communities. Provision of psychosocial education would require additional staff such as Mental Health First Aid trainers and parent/family peer educators.

3. **Strengthening Care Pathways**
   Augment **care pathways** and bridges/linkages to needed services **for children/families identified in the Strengthening Families and Communities programs**, with a particular focus on early childhood systems of care. Key elements of this process include screening and early identification resources/models and a network of cross-sector, interdisciplinary Health Neighborhood providers (IT) who can respond to the needs of young children who have experienced trauma and/or are at risk for psychosocial, emotional, and behavioral problems related to abuse, neglect, and developmental delays. The Care Pathway infrastructure for each designated Health Neighborhood would include dedicated resources for screening and assessment, navigation, and referral and linkage (including a web-based linkage system). Corresponding staff would include: interdisciplinary professional screening consultants, interagency liaisons ("organization facilitators"), service navigators (cross-sector care pathway specialists) and community health workers. Resources would also need to be allocated for network development and ongoing support for planning, facilitation, implementation, and evaluation. While DMH has in place teams that are similar in function, this strategy proposes to go beyond services such as MAT, DMH Children's System Navigators, DMH-DCFS initiatives in the following ways:

   - Existing teams include primarily mental health and child welfare representatives, while the ITs would include health professionals, developmental specialists, OTs, etc.
   - The ITs would operate within the context of a "maternal and child health" focus and include perinatal mental health, home visitation (e.g., Nurse Family Partnership, Welcome Baby) specialists, etc. with an emphasis on at-risk infants, young children and families.
   - The ITs would include community health workers (e.g., promotores/as, doulas) and parent/family partners and advocates as core team members.
   - SAMHSA "blessed" early childhood systems of care principles/guidelines as well as Standards of Quality for Family Strengthening and Support would be incorporated to guide best practices.

- The ITs would implement state-of-the-art trauma-informed developmental screening and assessment strategies in early childhood settings (e.g., Adverse Childhood Experiences Study [ACES] screening, Individuals with Disabilities Education Act [IDEA] Part B & C for infants, toddlers and preschool children with disabilities, Early Developmental Screening Intervention Initiative [EDSI] models, 211 screening protocols, and American Academy Pediatrics [AAP] guidelines for Autism Spectrum Disorder [ASD] screening). Many of these practices are already being implemented in programs such the Bright Beginnings Initiative administered by the Children's Clinic in Long Beach (funded by the Everychild Foundation) and the SAMHSA-funded Project ABC.
- The ITs would proactively incorporate cross-sector workforce development/training opportunities (both pre-service and professional development) for clinicians/providers as well as community health workers and partners.
- The ITs would be systematically linked to Health Neighborhood care networks and infrastructures in order to integrate care more effectively as well as augment existing care pathways for children with developmental disabilities and special health care needs as well as mental health issues.

Key Learning Questions

1. Does the strengthening families and protective factors framework serve to align participating programs and establish stronger connections among them as well as the families whom they serve?

2. What is the relative impact of selected asset-based community capacity-building strategies on reducing trauma and promoting child/family safety, stability, health and well-being?

3. What are the necessary elements of a Health Neighborhood community network to ensure access to a continuum of comprehensive services and supports for at-risk, underserved young children and their families? What types of community partners and/or network members are essential in addressing these children's and families' needs and linking them to both formal resources and natural communities of support?

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 may include selected Health Neighborhood communities, 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 at-risk populations by contributing to increased knowledge of:

1. The relative impact of selected strengthening families programs/practices on reducing child abuse/neglect and family mental health crises.

2. The relative impact of selected asset-based community capacity-building strategies on reducing trauma and promoting child/family safety, stability, health and well-being.

3. The relative impact of Health Neighborhood community networks in promoting access to a continuum of comprehensive services and supports for children at risk for psychosocial, emotional, and behavioral problems related to abuse, neglect, developmental delays, and/or special health care needs.

Increase Access to Underserved Groups

Transition Age Youth

Strategies

There is a need to provide Transition Age Youth (TAY) who are at risk of Serious Emotional Disturbance (SED)/Severe and Persistent Mental Illness (SPMI), or who have early-onset symptoms, with safe and anonymous pathways to connect with community services and social supports. Often times SED/SPMI TAY are isolated from their peers and disconnected from major social systems, they often underutilize mental health services. This is especially of concern to TAY who are 18-22 years old who are at high risk for first-break psychosis and other major mental health disorders. This proposal addresses an innovative outreach strategy to increase access to mental health services and create a TAY community within the Health Neighborhood.

Increase mental health service utilization for SED/SPMI TAY by:

1. **Incorporating TAY into outreach efforts with a focus on specific groups known to be at risk for trauma**
   a. Involve TAY residents throughout the planning process of Health Neighborhoods to strengthen connections to other TAY and community services and supports
   b. 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)
      i. 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
      ii. Utilize TAY with similar/shared lived experiences of groups known to be at risk for trauma (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, TAY who have emancipated from the dependency/justice systems, etc.) to develop connections with TAY in the Health Neighborhood

2. **Performing outreach through innovative and nontraditional methods that is relationally focused, not service-focused**
   a. TAY peer leaders will:
      i. Use natural and existing peer networks to make connections and foster relationships within the Health Neighborhood to increase

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utilization of mental health and other community services and supports

 ii. Utilize technology and social media to provide information, education, and outreach

  a. Social media can be a venue for TAY to connect with each other and the neighborhood resources

 iii. Coordinate and host TAY-focused/TAY-led neighborhood events (not focusing on mental health) to connect and develop positive relationships within the Health Neighborhood

 iv. TAY peer leaders will engage with TAY in the community

 v. Perform physical outreach in areas where TAY are (for example: at parks, schools, shopping malls, etc.) to develop positive connections and relationships and to provide information and resources to community supports

  a. 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)

Key Learning Questions

1. 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?

 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?

 c. 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?

Reducing Ethnic and Cultural Disparities

These strategies will engage TAY through culturally relevant and age appropriate approaches and will involve the communities where TAY are living. Disparities will be reduced in the service delivery system by providing TAY with opportunities to provide input and influence on how community services and supports are designed and implemented with specific considerations to the culture of TAY. Specifically, the LBGTQ TAY community will be a cultural focus of this strategy.

Intended Outcomes

1. TAY will have greater access to mental health education and peer support that will promote use of positive coping strategies to reduce the impacts of trauma.

2. Social isolation or withdrawal and negative social connections will decrease.

3. Decreased trauma symptoms.

4. On average, TAY served will have a reduced duration of untreated mental illness, compared to a sample of TAY with a mental health encounter prior to implementation of this strategy.

Older Adults

Strategies
The proposed strategies, embedded within an Older Adult Health Neighborhood, have been designed to reduce and/or prevent the full spectrum of abuse (e.g., physical, sexual, emotional, and fiduciary) and/or neglect, empower older adults impacted by trauma and/or abuse/neglect, provide meaningful roles, and to promote safety, support and well-being for this target population. The following strategies are focused upon improving awareness, knowledge, community capacity and access to mental health and other services for older adults impacted by trauma.

These strategies would be employed in several diverse at-risk communities throughout Los Angeles County. The target communities include communities with a significant percentage of older adults living below the poverty level, under represented ethnic populations, significant crime rate and decreased access to social, economic and health resources. These social determinants are correlated with a higher rate or incidents of mental illness and this project seeks to improve access to mental health services through the HN. Although the basic strategies can be applied to several communities, the implementation, language capacity and cultural framework, will vary depending upon the diverse community served.

1. **Establish a Community-Based Warm-Line** (Senior Safe Talk) to target an identified diverse community and provide a safe and confidential mechanism for older adults impacted by the trauma or at risk of experiencing trauma to receive culturally and linguistically appropriate support by staff that has training or expertise in working with older adults and trauma. Staffing of this warm-line should be inclusive of older adults with lived experience. This would also serve as a linkage for the target population as a vehicle to a broad array of services as part of the HN (i.e., use a survey after phone contact to collect impact).

2. **Develop an Older Adult Neighborhood Council** in specific communities to engage and empower older adults who are at risk of or experiencing mental illness and trauma. Each neighborhood council would develop activities appropriate to

the Health Neighborhood. Examples of types of activities that the council would undertake include the following:

- Bring together community organizations to participate in a mental health/health fair with an emphasis on trauma identification.
- Psychoeducation on mental illness and trauma awareness and how to obtain services.
- Facilitate Wellness activities on site by older adult interest groups and/or Community-Based Organizations (CBOs).
- Forum to discuss community wellness, safety and support (elder abuse).
- Engage with Faith Based Organizations to facilitate activities of interest within the community with a focus on abuse prevention.
- Partnering 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 mental illness and trauma.
- Identify community organizations that would provide "friendly visits" with staff throughout the community to access older adults that seldom leave their homes; distribute information regarding the full range of trauma (abuse, neglect, fiduciary, sexual, physical and etc.).

Key Learning Questions

1. How will these strategies impact social determinants associated with elder abuse and neglect such as isolation and economic vulnerability in this population?

2. Has there been an increase in awareness about factors related to elder abuse among members of the target population as a result of the warm-line and council?

3. Will the heightened awareness around the needs of Older Adults in a community due to the increased involvement of community seniors and local businesses in Older Adult specific projects increase the physical safety and mental well-being of seniors in a community, as evidenced by increased referrals to mental health clinics as well as to Adult Protective Services?

Reducing Ethnic and Cultural Disparities

The Warm-line would be offered in the languages of the relevant target populations of the communities served with specific cultural adaptations that reflect their preferences.

Intended outcomes

The above two strategies were selected based the following information:

1. Under-reporting of elder abuse and neglect.

2. Fear and apprehension around reporting elder abuse and neglect.

3. Limited awareness around what constitutes the full spectrum of elder abuse and neglect.

4. Limited community involvement and advocacy around elder abuse and neglect issues.

5. Stigma around discussing and disclosing elder abuse and neglect.

6. Trauma experienced by victims of elder abuse and neglect.

7. Limited knowledge and skill-set among clinicians regarding effective assessment of trauma, and elder abuse and neglect among members of the target population.

8. Lack of support of the victims and families impacted by abuse and neglect.

The above strategies aim to enhance and increase awareness of what constitutes elder abuse and neglect, while also provide opportunities for members of the target population(s) to access resources and support within their community. As a result of these strategies, we anticipate the following:

- Increase referrals of those impacted by elder abuse and neglect to health/mental health and substance use services.

- Enhance clinicians' self-perceived interviewing and assessment skills related to elder abuse and neglect among members of the target population.

- Improved autonomy and self-determination among members of the target population.

- Improved community capacity, safety and support related to the report of and understanding of trauma/elder abuse and neglect in the target population.

- Better access to the right care at the right time.

- Decrease Economic Vulnerability (social determinant) of older adults at risk of or experiencing a mental illness within the health neighborhood.

- *Economic Vulnerability: a person with limited financial resources may have far fewer choices. Economic Vulnerability impacts* people, property, resources, systems, culture, environmental, and social activity and leaves them susceptible to harm, degradation, or destruction.

- Decrease Isolation (social determinant).

Intergenerational Age Group

Mental health services are primarily geared toward an identified client of a particular age, with family generally being served as "collaterals" within the context of treatment. This approach to care is often contraindicated in cultures where the family is central to well-being and individuality is not valued, relatively.

Hypothesis

Treating the family unit as a whole and across generations by using the strengths and natural supports in a community will reduce stigma, increase protective factors and reduce the negative impact of trauma associated with immigration/refugee status, sexual abuse/sex trafficking, war/genocide, hate crimes, and interpersonal violence (i.e. domestic violence, gang violence, child neglect or abuse, etc.). The composition of a family unit may vary and go beyond the nuclear family model. Empowering the community to build capacity to support intergenerational families will improve the mental health of individuals in the community either suffering from a mental illness associated with trauma or reduce the risk of developing a trauma-related mental illness.

Strategies

1. **Apply the Trauma Informed Community Building (TICB) model to improve the mental health of and reduce risk factors for mental illness in intergenerational families within specific underserved communities.**

   A community-based organization would build on the existing successfully developed networks of care for under-represented ethnic and cultural populations, including the LBGTQ and Deaf and Hard of Hearing populations.

   TICB works to address and reduce the impact and risk of trauma, particularly historic or cumulative trauma, through individual, interpersonal, community and systems work that seek to increase interconnectedness of individuals within a community.   This strategy proposes to apply the TICB model to improve the mental health of individuals who are part of intergenerational families, as well as the family as a whole, in the community either suffering from a mental illness associated with trauma or reduce the risk of developing a trauma-related mental illness. By connecting and strengthening the natural support systems (e.g. faith-based agencies, community organizations, resident associations, etc.) of intergenerational families within a targeted UREP Health Neighborhood, families can be served and supported as a whole.

   This work would involve conducting an assessment within an identified neighborhood to identify a baseline of what intergenerational natural supports are in place and the development of priorities to improve the behavioral health

outcomes of the intergenerational families within a targeted UREP Health Neighborhood using, among others, trauma indicators. This process would apply the concept of "getting beyond collision toward coalition" model.

2. **Community empowerment, mobilization and capacity building to improve behavioral health literacy for intergenerational families.**

Behavioral health literacy is the degree to which individuals in a community have the capacity to obtain, process, and understand basic behavioral health information and services. Further, behavioral health literacy is needed to make appropriate health decisions as well as develop confidence to guide one's own health services.   A "Community Up" approach is being proposed that will promote behavioral health literacy and community-supported wellness by developing culturally relevant Behavioral Health Literacy Hubs. These hubs would serve as educational centers, self-help and community support centers for intergenerational families within specific communities.

Each Hub would be operated by a community-based organization whose role would be to identify influential members and organizations within specific cultural communities who, through their involvement in the community and the trust they have established in the community, would refer intergenerational families that would otherwise be reluctant to seek out mental health services on their own to the Hub.

Each Hub would organize formal and informal community supports as well as provide Mental Health First Aid classes and other effective mental health education information to members of intergenerational families. A particular focus of the engagement to the hubs and the services provided in the hubs will be on the signs and symptoms of intergenerational and historic trauma

Learning Questions

1. The TICB model has developed strategies to address trauma at the individual, interpersonal, community and system levels, but not at the intergenerational family level, where trauma, both historical and immediate, continues to be passed on. Can the TICB model be adapted to increase a community's capacity?

2. What culturally specific strategies, that are focused on behavioral health literacy, can be implemented to empower and mobilize intergenerational families within a targeted UREP Health Neighborhood exposed to intergenerational trauma (e.g. immigration/refugee status, sexual abuse/sex trafficking, war/genocide, hate crimes, and interpersonal violence (i.e. domestic violence, gang violence, child neglect or abuse, etc.) to improve social connectedness with a community,

increase behavioral health literacy, increase access to health and wellness services, and reduce the negative impact of trauma?

Intended Outcomes

1. Intergenerational families will be better educated about trauma associated with, but not limited to immigration/refugee status, sexual abuse/sex trafficking, war/genocide, hate crimes, and interpersonal violence (i.e. domestic violence, gang violence, child neglect or abuse, etc.), and its effects on an individual, the immediate family and the generation before and after, as measured by surveys.

2. Shame and stigma related to mental health seeking will be reduced.

3. Improved mental health outcomes for Hub service recipients

4. There will be less disparity for underserved/unserved/inappropriately served populations to access behavioral health services, which will result in a healthier population with less chronic behavioral illnesses.

5. There will be an increase in the use of preventative services, which will result in a decrease in the utilization rates of higher levels of care (e.g. emergency room visits, psychiatric holds, inpatient substance abuse, etc.).

6. There will be an increase of behavioral health literacy of individuals and families enrolled in the program from the initial point of contact to the completion of the program (pre/post-test).

7. Increased sense of social connectedness for individuals accessing Hub services

Reducing Ethnic and Cultural Disparities

The intergenerational family focus is a culturally relevant approach that aligns the values of UREP groups across Los Angeles County. UREP groups have consistently advocated for strategies that include recognition of the importance of extended families as part of the outreach, education and engagement services and in behavioral health treatment.

These strategies target the following seven (7) UREP groups: African/African American; American Indian/Alaska Native; Asian/Pacific Islander; Eastern European/Middle Eastern; Latino; Lesbian, Bisexual, Gay, Transgender and Queer; and the Deaf and Hard of Hearing.

Increase Quality of Mental Health Services, including Better Outcomes

Adults

Strategies

1. **Pre-booking Jail Diversion into Mental Health Treatment**

   The target population for these projects is individuals with mental illness who have been arrested but not charged with a low-level crime while in acute crisis, who may have experienced trauma related to homelessness and isolation, and whose diagnoses and potential criminal charges fall within the included categories developed for the program by the participating partners.

   Background

   Is an arrest and booking the beginning of "punishment," or the start of "recovery?"

   The reality: The arrest process is not a benign experience for anyone, particularly for those who may have suffered through years of untreated mental illness, compounded by substance abuse and poor physical health. A good day for a member of this target population might be determined by the charity of a stranger or by their own wits and will to survive. For many of these people, people without the means or ability to exercise good judgment, traditional recovery service opportunities offered in clinics and offices seem unreachable.

   This strategy seeks to initiate recovery at the first possible opportunity for a unique target population of those who are mentally ill, often homeless, and who come into contact with law enforcement agencies secondary to committing a low level offense. No matter how compassionately it is described, any description cannot capture the experiences of these people, who often suffering in silence and have also no value among any group or community. In a world where science has theoretically connected us all, in this situation, if you are homeless and mentally ill and come into contact with law enforcement, you are on your own. The myth: Jail, many may believe, is at least a safe place, offering a chance to regain your health, reestablish connections with social service and housing agencies. Too often, it is a place to be feared. Without early intervention in the accepted arrest-judicial process, these clients remain personally vulnerable in a "secured" place, when they need mental health recovery supports and assistance.

A Need for Change

Any effort to help a mentally ill person, arrested on minor or misdemeanor charges, demands both the decision impacting their future well-being, as well as the context where that decision is made--be changed. If punishment begins at the point of arrest, then the concept of "an arrest" must change for these people. Where "processing" occurs, there must be an effort to more humanely intervene in a way that improves the outcome for the mentally ill person, law enforcement officers, and reduces jail overcrowding. A culture change must be initiated at the point where the law enforcement and mental health system initially come into contact.

A new, more flexible relationship between law enforcement and mental health can affirm the early intervention, treatment, and safe housing of mentally ill offenders. Mental health workers, in concert with local communities, need to share the burden without abdicating their responsibility to the general safety of the public, as they attempt to break the cycle of arrest.

Target Population

The target population for this pilot project consists of individuals with mental illness who have been arrested, but not charged with a low-level crime, who may have experienced trauma related to homelessness and isolation, and whose diagnoses and potential criminal charges fall within the included categories developed for the program by the participating partners.

Strategy

The Department of Mental Health (DMH) proposes to build upon a solid history of collaborative community partnerships by introducing an innovative program proposal through the implementation of two pre-booking jail diversion programs, initially as pilot projects serving the Long Beach (LB) and Antelope Valley (AV) areas. If successful, this strategy will be extended to other communities throughout Los Angeles County, utilizing the experience gained through these pilots. While DMH has an array of collaborative criminal justice projects, including law enforcement/mental health crisis intervention teams such as Mental Evaluation Teams (MET) and the System wide Mental Assessment Response Team (SMART), the Mental Health Court Linkage Program, the Assembly Bill (AB) 109 Realignment Program, and post-booking jail diversion projects, none of these programs divert a mentally ill individual into mental health services prior to arrest. Although pre-booking diversion programs have been implemented in a number of jurisdictions throughout the country, this will be the first in Los Angeles County and the first direct link between an arresting officer and a community-based comprehensive mental health service program in the County. The principal goal: intervene with a strong array of dedicated, integrated recovery services for 50 individuals per year over the period of the project, stopping the cycle of repetitive incarcerations and missed or incomplete mental health treatment.

The need for a pre-booking diversion program is statistically significant. Law enforcement responses to calls involving individuals with mental illness take more time to complete than calls involving individuals who are not mentally ill. In the Los Angeles County jails, the cost to provide mental health treatment and custodial care, to a daily census of over 3,500 inmates with mental illness, is substantial. Experience indicates defendants who are mentally ill and unable to afford bail spend longer periods of time in custody than those who are not suffering from mental illness. Their cases often require multiple court appearances to adjudicate, adding costs to the system. A creative pre-booking interagency, community-based diversion program, in which law enforcement, mental health and the community collaborate, will provide a means of reducing the number of individuals entering the criminal justice system and provide a safety measure for individuals experiencing crisis and trauma frequently associated with homelessness, substance abuse, and isolation.

Men and women who come to the attention of law enforcement and the criminal justice system experience exceptionally high rates of physical and sexual abuse in childhood. This abuse results in psychological shock or trauma also known as Post-Traumatic Stress Disorder (PTSD). PTSD manifests itself in a variety of emotional and behavioral symptoms, it is critical mental health treatment professionals be responsive to the impact of traumas.

The proposed INN LB and AV pre-booking diversion strategy will be housed in Urgent Care Centers (UCC) located in these geographic areas. UCCs typically provide up to 24-hours of intensive crisis services and immediate care, including referrals to community-based solutions, to individuals who otherwise would be brought to emergency rooms or jails. As participants in the INN pilot project, the LB and AV UCCs would be expanded to serve as the entry point for specially trained law enforcement/mental health teams linking individuals who voluntarily agree to treatment to dedicated Integrated Care Services (ICS), in lieu of their being charged with low level offenses. The INN diversion programs would provide dedicated ICS capacity to provide recovery-based services directly for this population, including all levels of mental health care, health services, substance abuse treatment, housing, benefits (re)establishment, education and employment, and social services, specifically focused on individuals who have come to the attention of mental health law enforcement teams within the context of their Health Neighborhoods.

This innovative project offers reliance on developing 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. Officers involved in this process must receive consistent, periodic contact from mental health staff as to the progress of those adults placed in the recovery setting. No officer should be surprised to find the same client on the street who they just arrested. And, no mental health

worker should find satisfaction in simply "processing" these program participants. This direct link between officers, mental health workers, and the client must remain active. This collaborative teamwork isn't just a "hand off" by law enforcement. A mental health evaluation is necessary to ensure protection of the rights of the consumer and ascertain the viability of placement in the urgent care center, while reassuring law enforcement the client has a genuine opportunity to begin recovery.

Mental health staff will work with clients to design a package of services and community supports, including housing, in order to interrupt the cycle of arrest. Staff will utilize appropriate and proven treatment regimen matched to the needs of the consumer. In addition, workers with lived experience may be utilized as recovery "guides," supporting the efforts of the consumer to regain an appropriate level of community functioning. These guides will also serve as the feedback point to the original arresting officers. Guides can, without violation of client confidentiality, provide general weekly or monthly summary of recovery information which can reassure law enforcement officers involved know what's going on and values their participation in the client's future recovery success. If this communication link works successfully, it can serve as a model for future jail diversion efforts and begin to engage law enforcement personnel as recovery allies, participating in meaningful work to end a challenging community problem.

Elements of this strategy:

- The development of a "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, will be diverted to appropriate mental health treatment

- Training for police dispatchers and specialized law enforcement mental health team members in the identification of individuals appropriate for transport to the UCCs for evaluation for inclusion in the program

- ICS treatment teams will be specifically trained in evidenced-based practices including: Seeking Safety, Moral Recognition Therapy, and Cognitive Behavioral Therapy

- ICS as an integral partner in a identified Health Neighborhood through community partnerships

- Incorporate a high level of peer/workers with lived experience as part of the ICS team

- The ICS teams will be modeled after existing Full Service Partnership teams with greater resources and clear expectations for housing, employment, and recidivism reduction outcomes. The ICS teams will partner with local community agencies to ensure access to healthcare, financial and transportation services as well as employment services. In addition, the ICS team will be responsible for local community development and partnerships to facilitate client access to local faith based organizations, self-help, and community recreation;

- Coordination/collaboration with specified UCCs to arrange for space where individuals will be evaluated for appropriateness for this collaborative program.

Key Learning Questions

1. Will a pre-booking diversion program for individuals identified by specially trained law enforcement/mental health teams reduce recidivism and begin to restore individuals to higher level of functioning?

2. Will pre-booking diversion, combined with intensive Integrated Care Services (ICS) result in a reduction of trauma among participants?

3. Can pre-booking diversion, combined with intensive Integrated Care Services, utilize focused employment services and directly improve community integration/connectedness?

Reducing Ethnic and Cultural Disparities

Individuals who become involved with the criminal justice system tend to be disproportionately from under-represented ethnic groups. This strategy would seek to address that by diverting individuals into recovery-oriented, culturally relevant outpatient community-based services.

Intended Outcomes

1. Reduction in arrests, comparing incarcerations prior to and after enrollment into ICS services

2. Increased access to mental health services for individuals who come into contact with law enforcement

3. Increased satisfaction of persons with mental illness with ICS services

4. Reduction of trauma symptoms endorsed after enrollment into ICS services

5. Increase in level of recovery after enrollment into ICS services, as measured by a general mental health instrument and the Milestones of Recovery Scale.

2. **Coordinated Entry System for Employment of Formally Homeless Individuals Living In Permanent Supportive Housing**

The Department proposes to use Innovation funding to test the hypothesis that a "housing first and employment second along with community integration" approach will 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. Job supports that are necessary for the participants to be successful in obtaining and retaining their jobs include: networking opportunities, peer support, self-help support groups, community clubs and faith-based community supports. These same supports are also needed to reduce social isolation. Since the participants will be working, supports will be provided during afterhours and weekends.

This project is 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. 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 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. This level of community support is unique, and we hypothesize necessary, to create a more successful employment approach that support clients in their recovery.

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 with this Innovative proposal. This grant proposes to target three populations with multiple barriers: homeless, disconnected youth and incarcerated populations. It will use 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, Los Angeles Trade Technical College, Homeboy, Conservation Corp, Goodwill, Downtown Women's Center, Skid Row Housing Trust and plans to leverage Workforce Investment Act resources such as on the job training funding. Los Angeles was notified about the grant in September 2014 and the first year of the grant will be focused on planning for implementation and will conveniently align with the planning process for Innovation.

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.

Reducing Ethnic and Cultural Disparities

This model will contribute to reducing 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 and a reduction in poverty

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, as measured by service utilization categorized by level of care and transitions from 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

Spreading Successful Results

Outcomes will be collected at regular intervals, based on the metrics used. Consequently, outcome data will inform the ongoing implementation of this Innovation project throughout the course of the project as well as informing various aspects of LA County's public mental health system.

At the conclusion of this Innovation project, all evaluation results will be reviewed and analyzed. Those strategies deemed successful will be considered for infusion within the Department's system of care. Depending upon the nature of the strategy, successful strategies may be infused into existing practice or services. This may involve spread of learning in the form of provider adoption of best practices or through the addition of non-Innovation funding to continue a strategy. Successful strategies may also result in changes to the Department's CSS or, more likely, the Prevention portion of the Department's PEI plan. These changes would be based on stakeholder recommendations after reviewing the outcomes of the Innovation Health Neighborhood project.

Given the Department's interest in moving toward community-based forms of care and support that improve whole health outcomes, this Innovation project has the potential to significantly inform the future mental health system of care and its community partnerships.

Estimated Annual Budget

Detailed budget, including Medi-Cal match, to be developed prior to 30 Day Public Posting.

Child Strategies:
Strategy Lead (1) Salary and Employee Benefits: $129,000
Strategies 1, 2 and 3 (per neighborhood): $1,135,773

TAY Strategies:
Strategy Lead (1) Salary and Employee Benefits: $129,000
Strategies 1 and 2 (per neighborhood): $738,748

Adult Strategies:
Strategy Lead (2) Salary and Employee Benefits: $258,000
Coordinated Entry System for Employment (per neighborhood): $886,505
Jail Diversion – SA 1: $2,190,485
Jail Diversion – SA 8: $2,190,485

Older Adult Strategies:
Strategy Lead (1) Salary and Employee Benefits: $129,000
Strategies 1 and 2 (per neighborhood): $568,198

Intergenerational Strategies:
Strategy Lead (1) Salary and Employee Benefits: $129,000
Strategy 1 and 2 (per neighborhood): $700,000

Annual Total Per Neighborhood: **$9,184,194**

Additional Annual Costs:

Evaluation: $1,000,000

Training: $40,000

References

1."The Relationship of Adult Health Status to Childhood Abuse and Household Dysfunction", published in the *American Journal of Preventive Medicine* in 1998, Volume 14, pages 245–258.

2.''Trauma Informed Community Building: A Model for Strengthening Community in Trauma Affected Neighborhoods", Health Equity Institute, Weinstein, Wolin, Rose, May, 2014.