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 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 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. Older Adult Neighborhood Council
    b. Health Neighborhood Older Adult Specialized Team (HOST)

3. Intergenerational
    a. Culturally Competent Referral and Support Network

Increase quality of mental health services, including better outcomes:

1. Adult
    a. Pre-Booking Jail Diversion Pathway 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. Strengthening Communities
    b. Strengthening Care Pathways for Families

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 clients at risk of or experiencing trauma within specific communities through approaches to community capacity building. 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 and reduce trauma.

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.

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

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 (see Intended Outcomes section of each strategy). 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
- 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
- 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

A qualitative analysis will be conducted on each Health Neighborhood to determine the degree to which each neighborhood's capacity to identify, serve and support individuals at risk of or experiencing trauma was increased. An analysis will also be conducted on the impact of this project on each neighborhood.

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

These two Innovation strategies will align with the Health Neighborhoods and First 5 LA's Best Start communities to create an integrated care model that targets the five protective factors (Parental Resilience, Social Connections, Concrete Support in Times of Need, Knowledge of Parenting and Child Development, Social and Emotional Competence of Children). These five protective factors build on a family's strengths to promote optimal child development.

The strategies will align with each Best Start community's identified protective factor to address trauma-related issues and support the community in improving conditions that mitigate high-risk factors. The collaboration will include a reciprocal process where Innovations would provide trauma informed training and the Best Start community would assist with identifying the early childhood community agencies where early developmental screenings are needed.

Hypothesis: A prevention model that identifies the underlying needs of the child and family system and provides linkage to an array of services will reduce the risk of children developing trauma-related mental illnesses.

The Focal Population includes children ages Birth-5 with the following risk factors for child maltreatment:

1. Maternal depression
2. Alcohol and substance abuse
3. Intimate partner (or domestic) violence
4. Parental stress and difficulty coping

Overall Proposal: An integrated care model of strengthening communities and care pathways for families will utilize advocacy, education, and linkage to an array of services to address the underlying needs of children and families for the purpose of reducing the vulnerability of trauma. This integrated care team will consist of Care Coordinators and Parent Partner/Community Health Workers to arrange a spectrum of services which may include occupational, physical, and speech therapy, perinatal to five mental health services, substance abuse services, medical care, and concrete supports.

Strategies:

1. **Strengthening Communities**
    a. Develop collaborative relationships among partners in the Health Neighborhood and Best Start community. Add trauma as an issue to be addressed within the context of the protective factor identified by the Best Start Partnership. Conduct trauma informed trainings in collaboration with community agencies that are participating in the Best Starts Partnership.

    - Strategy: Employ staff (Community Organizer/Activist) that are an active community member with a good understanding of the needs of the Health Neighborhood and Best Start community to do the following:
        1) Attend a variety of community and leadership meetings (total of 68 meetings per year), which include the Health Neighborhood and Best Start community meetings that focus on the Birth-5 population.
        2) Provide psychosocial education and training on trauma and the impact on Birth to 5 and their families
        3) Develop a one page, culturally appropriate brochure that addresses the impact of trauma on the Birth to 5 population and available resources in the community.

2. **Strengthening Care Pathways for Families**
    a. Conduct developmental screenings for children that meet the focal population criteria.
    b. The screening will be conducted at early childhood systems of care locations (pediatrician offices, daycare centers, family-run/clergy-run preschools, WIC centers, DPSS, and Regional Centers).
    c. Provide linkage to community resources.
    d. The program will utilize a “whatever it takes” approach to deliver an array of services that will prevent future entry into the child welfare or mental health system.

    - Strategy: Employ a team (Care Coordinators, Parent Partner/Community Health Worker) to do the following:
        1) Outreach at early childhood systems of care locations (pediatrician offices, daycare centers, family-run/clergy-run preschools, WIC centers, DPSS, and Regional Centers).
        2) Administer Trauma-informed developmental screening and assessment strategies to identify the underlying needs of the

child/family system (possible screening tools: Ages and Stages, PEDS).

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3) Link to the resources in the community, using strengths-based approach
4) Utilize flex funding for non-traditional interventions (will incorporate stakeholder feedback and include interventions proposed: i.e. DIR floor time, Perinatal Mental Health, Building Essential Skills Together-BEST)
5) Reflective supervision for the staff to address vicarious trauma

Key Learning Questions

1. Does the use of a Community Health Worker contribute to a family establishing stronger connections with the community?

2. 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?

Intended Outcomes

1. Improving the community's capacity to identify un-served/under-served birth to five children and their families and linking them to both formal and informal resources to address their unmet underlying needs.

2. A reduction in DCFS substantiated cases of abuse or neglect.

3. A reduction in the community's high-risk indicators, such as low birth weight, teen pregnancies, and childhood obesity.

4. A parent's knowledge of trauma-related risk factors and improved coping skills to life stressors will be enhanced after attending trainings conducted at the Best Start community meetings.

5. The relative impact of an integrated care team would result in (1) Increased access to mental health services if identified as needed through the screening (2) Increased access to concrete supports (WIC, child care/day care, medical, DPSS benefits) and (3) Increased referrals to the home visitation programs (Welcome Baby, Nurse Family Partnership, Partnerships for Families).

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 will include selected Health Neighborhood and Best Start Communities.

Increase Access to Underserved Groups

Transition Age Youth (TAY)

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 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?

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.

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.

Older Adults

The proposed project combines a Health Neighborhood (HN) strategy that actively promotes well-being for older adults in a high-risk neighborhood and access to mental health early intervention services that reduce trauma-related mental illness for older adults.

The project will be implemented in a geographic area with a significant percentage of older adults living at or below the poverty level, an elevated crime rate, and an absence of social, economic and health resources, including a lack of access to these resources. Within this geographic area, the project will target older adults exposed and/or experiencing conditions associated with high levels of trauma, such as social isolation, abuse and/or neglect (e.g., physical, sexual, emotional, and fiduciary) or other conditions that generate trauma-related mental illness for older adults.

Of particular interest are older adults that belong to communities that are very socially isolated, stigmatized and/or discriminated, such as under-represented ethnic and cultural groups including Lesbian, Gay, Bisexual, Transgender (LGBT) seniors with very limited access to social, economic and health resources. The project will be implemented using a culturally and linguistically competent approach, which may vary depending upon the community (or communities) served.

The following describes the project's two key strategies. Each strategy is itself innovative, but the principal innovation lies in how both strategies are implement simultaneously and in an integrated fashion to reduce the incidence of trauma for older

adults in a neighborhood, while at the same time providing greater access to an array of formal and informal services for older adults with trauma-informed mental illness.

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Strategies

1. **Health Neighborhood Strategy: Older Adult Neighborhood Council**

   Older adults with or at-risk of developing mental illness oftentimes feel isolated, powerless and unable to impact change within their communities. Older AduIts from marginalized and stigmatized communities often experience additional barriers to accessing mental health services and supports, such as the lack of proximity of services, lack of cultural competency of service staff and limited linguistic resources.

   Neighborhood Councils are entities with a long and successful history of engaging in efforts to improve the overall well-being for populations residing in specific places, including in neighborhoods with high concentrations of poverty and other adverse social and economic conditions. They typically mobilize leaders from key stakeholder groups (i.e., residents, community-based agencies, faith-based organizations, public institutions, businesses, among other sectors).

Participants identify key issues (i.e., social determinants of health) affecting the well-being of a neighborhood, such as violence, drug sales, lack of jobs, to name a few.
Neighborhood Councils also actively identify and implement solutions to address the priority issue(s). Examples of solutions include, but are not limited to: (a) direct services or more improved services; (b) events, such as community resource fairs, that bring resources to the community or foster greater connections among residents; (c) leadership development to help the community better advocate for improvements in systems and policy changes; and (d) additional community investments, such as parks, libraries, or other kinds of resources.

Neighborhood Councils, however, have not historically tackled the issue of trauma-related mental illness. Indeed, their actions to address an issue pertaining to mental health may (intentionally or unintentionally) further stigmatize people with mental health problems. For instance, efforts to bring mental health clinics to neighborhoods often confront Not-In-My-Back-Yard (NIMBY) opposition.

Moreover, Neighborhood Councils have not typically prioritized the needs of older adults, particularly those experiencing trauma-related mental illness. On the one hand, elders tend to under-report abuse and neglect largely due to social isolation, fear and apprehension. Victims of elder abuse and neglect face a stigma related to self-reporting and disclosing of their trauma. On the other hand, communities have a very limited awareness around what constitutes the full spectrum of elder abuse and neglect and its relationship to social isolation. There is sparse community information, training, involvement and advocacy related to social isolation and elder abuse and neglect issues. The knowledge and skill set among clinicians regarding effective, screening, assessment, and treatment of trauma for older adults is also very limited. Consequently, there is lack of support of older adults experiencing trauma due to abuse and neglect.

This project seeks to know if an Older Adult Neighborhood Council can indeed provide opportunities for older adults:

- To become a unified group and advocate for community change around an issue that improves the well-being of older adults in the neighborhood.
- To address an issue that produces trauma related to mental illness (albeit the issue does not have to be explicitly mental illness).
- To increase social connections (i.e., reduce social isolation) of older adults at risk for trauma-related mental illness.

The Older Adult Neighborhood Council would be comprised of older adults impacted by trauma (and therefore with or at risk of mental illness), Adult Protective Services, faith-based organizations, family members/concerned community members and community-specific legal and/or advocacy groups,

among others. The Older Adult Neighborhood Council will undertake the following key activities:

- Lead a process that identifies a key issue (or social determinant of health, such as elder abuse) in the neighborhood that generates trauma for older adults. This process can include resident leadership trainings and forums to discuss community wellness, safety and support for older adults.

- 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 (abuse, neglect, fiduciary, sexual, physical and etc.).
  - 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.
  - 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.

2. **Health Neighborhood Older Adult Specialized Team (HOST)**

Because elder abuse and neglect, social isolation, and other issues impacting older adults are under-reported or poorly understood, it is expected that as the Neighborhood Council implements its solutions there will be an increase in the amount of traumatic experiences reported by older adults or others. It is well-documented that individuals exposed to trauma may be at risk for Post-Traumatic Stress Disorder (PTSD) and/or major depression. This raises the issue of access to formal (i.e., professional service providers) and informal supports to address the mental health needs based upon the anticipated spike in the reporting of trauma.

The Health Neighborhood Older Adult Specialized Team (HOST) is 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.

The peer advocate, in particular, will serve as a bridge between the HOST team and the Older Adult Neighborhood Council to promote the flow of information, resources, and coordination. The peer advocate also function as a type of community health worker fostering networks and connections in the neighborhood.

This treatment team will play a vital role in helping older adults access services and supports. Many clinicians are not equipped or trained to work with older adults impacted by trauma, especially those from underserved cultural and ethnic communities. The mobile team will receive referrals and partner with the Health Neighborhoods' provider network that includes health and substance use disorder providers, SB 82 Triage Teams, the Older Adult Neighborhood Council, Older Adult Field Capable Clinical Services (FCCS) programs, community and faith-based organizations, senior and community centers, Adult Protective Services (APS) and domestic/intimate violence programs that are central to the Health Neighborhood community.

The HOST will provide specialized training, information and consultation to the Health Neighborhood network, as well as to community based agencies regarding best practices for working with older adults with trauma and/or trauma related mental illness. HOST will also provide clinical training to clinicians to improve their screening, assessment and treatment skill-set. Another aspect of HOST involves the effective training of community members to enhance their knowledge and awareness of abuse and available community resources.

Key Learning Questions

1. Can an Older Adult Neighborhood Council identify, prioritize and address the key social determinants of trauma impacting older adults in the target neighborhood?

2. 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?

3. 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?

Intended outcomes

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 outcomes:

- Neighborhood-Level Outcomes
    - Decreased number and rate of issue producing trauma (e.g., elder abuse and neglect, domestic violence, economic vulnerability, isolation, etc.)
    - Increased number and percent of informal groups with capacity to provide resources and support to older adults impacted by trauma.

- Access Outcomes
    - Increased number of older adults linked to appropriate formal services.
    - Increased number of older adults linked to appropriate informal supports.
    - Increased number of older adults linked to formal services in a timely manner.
    - Increased number of older adults linked to appropriate informal supports in a timely manner.
    - Improved skills of clinicians (screening and linkage).
    - Improved well-being (i.e., autonomy and self-determination) among older adults accessing services.

Reducing Ethnic and Cultural Disparities

The focus for this Innovations project will be on under-represented ethnic populations and cultural groups. Each strategy will be adapted and implemented in a culturally and linguistically competent manner, which respects, honors and incorporates diversity into all program elements. Collaborating and consulting with key trusted stakeholders from each community served, will help to ensure inclusiveness, as well as effective program design and implementation.

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. Consequently, an intergenerational age group was identified that focuses not just on the immediate nuclear family but on multiple generations of a family.

<u>Nature of Trauma</u>
Trauma tests the resilience of individuals and families who experience it. However, communities also experience collective trauma (e.g., a school shooting affects everyone in the school community) and/or historic or cumulative trauma (e.g., refugees escaping

a genocide and repression from their countries of origin, or cultural groups subjected to continuous violence, exploitation and/or discrimination for multiple generations).

This community-level trauma is experienced simultaneously across age categories. For instance, collective trauma stemming from a street shooting or from domestic violence is experienced by all community or family members at the same time, regardless of their ages (i.e. child, youth, adult or older adult). Community-level trauma, left unaddressed, can in turn be transmitted from one generation to the next (e.g., drug use, incarceration, domestic violence, etc.). For these reasons, community-level trauma cannot be addressed by focusing exclusively or primarily on one age category; addressing community-level trauma necessitates an intergenerational age group approach.

A number of evidence-based programs have been developed to help individuals and families respond to trauma, including Seeking Safety, Trauma-Focused Cognitive Behavioral Therapy (TFCBT) and Crisis-Oriented Resolution Services (CORS). However, little is known about how to address trauma beyond the individual and family levels, particularly at the community level. Few 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.

The Trauma Informed Community Building (TICB) Model addresses the impact and risk of trauma, particularly historic or cumulative trauma (Weinstein et al. 2014). 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. Four principles anchor the TICB Model: do no harm; acceptance; reflective process; and community empowerment.

The community empowerment principle, in particular, stresses community investment and community inclusiveness. Inclusiveness is core to community development in trauma-affected neighborhoods and communities, where generations have been marginalized from development processes and excluded from reaping the benefits. This principle underscores the importance of equitable participation and accountability among stakeholders to build community perception and ownership over change. Peer-based support, moreover, is a key aspect of community empowerment in providing a sense of hope and control. Peer-based support validates the individuals' actions as having meaning and value, and this meaning and values functions as a resource for visioning for the future and actualization of plans.

Although the TICB Model includes strategies and principles that seek to address community-level and individual-level trauma, it lacks a focus on families experiencing intergenerational trauma, or what we call 'intergenerational families.' Intergenerational families, such as those who have lost loved ones to violence, are the ones that perhaps more than any others are most impacted by community-level trauma. Intergenerational

families are arguably the hardest to engage in a process of inclusion because many distrust formal and government agencies, many are dealing with multiple stressors (i.e., lack of income, unstable housing, to name a few), many are socially isolated and stigmatized (e.g., gang or former gang members), often viewed as the source and perpetrators of trauma rather than also victims of trauma.

The proposed project seeks to test the TICB model with families experiencing intergenerational trauma in the context of the neighborhoods or cultural groups with collective and/or historic or cumulative trauma. More specifically, this project seeks to determine the extent to which a 'culturally competent referral and support network' can be developed in a neighborhood (or with a cultural group) and the extent to which this network can provide intergenerational families with support and opportunities that build their resilience to trauma.

Strategy

The primary strategy is the '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:

1. Form a referral and support network for intergenerational families.
2. Engagement of intergenerational families where they are and support their involvement within a broader referral and support network.
3. Opportunities for community members to have multiple interactions with community peers, providers, as well as access to resources. 'culturally competent referral and support network'
4. Community leadership through support and skill building in order to address system changes.

A Community Based Organization (CBO) will build on existing and successfully developed networks of care for underserved ethnic and cultural populations, including the Lesbian Gay Bisexual Transgender and Questioning (LGBTQ) and Deaf and Hard of Hearing populations.

Develop Culturally Competent Referral Networks:

1. Form a Referral and Support Network: Identify key traditional and non-traditional providers who provide wellness services and intergenerational families exposed to trauma in a community who could serve as community peers. Providers may 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. They will serve as referral agents for community members who routinely seek services from them and have been exposed to community

trauma. These providers will refer them to the CBO to avail an array of services to address the trauma related issues.

This includes developing partnerships with these key traditional and non-traditional providers. The CBO will also develop partnerships with community peers including intergenerational families to build a CBO Provider Network.

2. Engage Intergenerational Families: Utilize community peers to connect community members to the CBO Provider Network by using a personalized one-on-one approach in a culturally appropriate manner.

3. Opportunities for Interaction: Coordinate quarterly community forums to facilitate a dialogue between community members, community providers, CBO and governmental entities. The forums will be structured to provide additional outreach and engagement of community; gather community feedback on the implementation and impact of the program; gather community input on topics for trainings/workshops offered by the CBO provider network; facilitate additional linkage of community members with appropriate services.

4. Community Leadership: Review existing resources from their provider network and identify gaps to address the need for additional resources related to wellness of the underserved communities. In order to address these gaps for additional services, the CBO will implement and fund the needed services. The services will include, but are not limited to the following:

    a. 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.

    b. 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.

    c. Skill Building classes related to addressing mental health needs such as early childhood disorders support groups and trainings for families, English as a Second Language (ESL) classes for mono-lingual adults to increase access and communication on their mental health related

needs; effective communication techniques for TAY to address their mental health needs; stress management skills for TAY using non-traditional approaches; parenting classes for adults; basic computer/cell phone skills for older adults to increase access and communication on their mental health related needs; classes on understanding and effectively accessing mental health services and public benefits for adults and older adults.

Learning Questions

1. Can the Culturally Competent Referral and Support Network improve the ability of the neighborhood or community to reduce the impact trauma on intergenerational families?

2. 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?

Intended Outcomes

Community-Level Outcomes

1. Shame and stigma related to mental health seeking will be reduced as measured by Internalized Stigma of Mental Health Scale score pre and post enrollment in CBO provider network services and participation in the community investment and inclusion efforts.

2. Increased sense of social connectedness for individuals accessing CBO provider network services and participating in the “Community Empowerment” process.

Family-Level Outcomes

3. Intergenerational families will be better educated about trauma and its effects on an individual, the immediate family and the generation before and after, as measured by surveys.

4. Intergenerational families will share their experiences and knowledge from their exposure to trauma to serve as community peers and connect other families exposed to trauma to CBO provider network services. This will result in an increase in access to these services.

5. There will be an increase of mental health literacy of individuals and families enrolled in the program from the initial point of contact to the completion of the mental health related services at the CBO provider network services as measure by a pre/post survey.

6. Increased sense of social connectedness for individuals accessing CBO provider network services and participating in the “Community Empowerment” process.

7. Increased ability to cope with community trauma as measured by a pre-post survey at entry into the “community empowerment” process and post participation and receipt of services through the CBO provider network services.

Reducing Ethnic and Cultural Disparities

The strategies specific to the TICB model will be applied to the underserved populations in a culturally appropriate manner to address ethnic and cultural disparities in addressing community trauma and related factors unique to each of the underserved communities including but not limited to the 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 (ages 18 to 59)

Strategies

1. **Pre-Booking Pathway to Mental Health Treatment**

   The purpose of this project is to reduce the number of individuals with a mental illness, often homeless and socially isolated, from entering the criminal justice system in the first place by creating a pathway to mental health treatment instead of jail at the first possible opportunity to initiate the recovery process by providing an array of formal and informal services and supports through a specialized Forensic Full Service Partnership and a Health Neighborhood Network.

   Target Population's Need

   The target population for this project are individuals with an identified mental illness who are experiencing an acute crisis (i.e., psychosis/delusions that do not meet criteria for a 72-hour hold), who could be charged with a low-level crime (e.g., trespassing due to homelessness, disturbance of peace in public), who have been arrested but not yet been booked, and who agree to enter a pathway into appropriate mental health treatment.

   The need to focus on this target population is significant. There are approximately 3,500 inmates with a mental illness in the Los Angeles County jails every day. The acute crisis experienced by these individuals is usually a function of trauma frequently associated with homelessness, substance abuse, and social isolation. Many also have experienced exceptionally high rates of physical and sexual abuse during their childhood, resulting in psychological shock or trauma also known as Post-Traumatic Stress Disorder (PTSD) which manifests itself in a variety of emotional and behavioral symptoms.

   Law enforcement's response to calls involving individuals with a mental illness experiencing an acute crisis takes more time to complete than calls involving individuals who are not mentally ill. Moreover, defendants who are mentally ill are usually unable to afford bail and therefore spend longer periods of time in custody than those who are not suffering from mental illness. Their cases also often require multiple court appearances to adjudicate. Without social support and mental health treatment, many suffer in silence for an unnecessarily long time and without a sense of value among any group or community.

   Simply put, no matter how compassionately it is portrayed, no description can truly capture their harsh experiences when they enter the jail system. It is crucial to find a pathway to mental health treatment at the earliest point possible.

Current System and Community Gaps

DMH does have 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.

However, none of these programs divert a mentally ill individual into mental health services prior to arrest or directly involve law enforcement officers in understanding and participating in the client's recovery process. Moreover, although pre-booking diversion programs have been implemented in a number of jurisdictions throughout the country, none currently exist in Los Angeles County. From this angle, the proposed project meets the MHSA Innovations criteria.

There are three prominent gaps with current way that the law enforcement, mental health systems, and communities address the needs of the target population. The first gap is 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. There is also lack of training to develop skills but perhaps more importantly a recovery-oriented culture to utilize this protocol. This includes law enforcement understanding the clients' recovery process.

The second gap is the absence of a team approach between the mental health and law enforcement systems. Currently, when individuals are diverted to mental health treatment, the police officers or deputies "drop off" the mentally ill person at a mental health facility. But very little coordination happens between law enforcement and mental health staff, with little contact, communication, feedback and ultimately shared responsibility for the client's recovery.

The third gap is related to the communities where Individuals with an identified mental illness experiencing an acute crisis reside. They are oftentimes social isolated. Family members are often unable by themselves to provide the level of support needed. Similarly, community-based organizations, faith-based organizations and other natural support systems in neighborhoods often lack the knowledge, skills and resources to support these individuals. The networks of natural supports and professional services need to work better together to function as a 'health neighborhood' for this target population.

Project Design

The project involves law enforcement officers, mental health staff and community organizations collaborating qualitatively differently to create a shared responsibility with law enforcement personnel without abdicating responsibility to the general safety of the public, as they attempt to break the cycle of arrest for mental health clients who can be diverted prior to the booking process.

Target Group, Scale and Geographic Areas

Candidates for this project are individuals with an identified mental illness who are experiencing an acute crisis (i.e., psychosis/delusions that do not meet criteria for a 72-hour hold), who could be charged with a low-level crime (e.g., trespassing due to homelessness, disturbance of peace in public), and who have been arrested but not yet been booked. Candidates need to agree to be diverted to appropriate mental health treatment.

The specific project will be implemented with the participating partners identified in health neighborhoods in Service Areas I and VIII (Antelope Valley and the Long Beach/Harbor areas). The principal goal is to intervene with a strong array of dedicated, integrated recovery services for 50 individuals, per service area, per year for the length of the project, stopping the cycle of repetitive incarcerations and missed or incomplete mental health treatment.

Mental Health-Law Enforcement-Community Collaboration

Developing a unique collaboration between mental health, law enforcement, and community organizations with regards to the target population requires the establishment of clear protocols, combined team to provide initial intervention and treatment coupled with community follow-up and support, and strong networks of support in the identified neighborhoods. The protocol, team, and networks together hold the potential for changing the dynamic which directly impacts mental health clients who have been arrested, but not charged, with a low-level crime, and for fostering a culture change in the field of local law enforcement towards recovery.

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. Officers involved in this process must receive consistent, periodic contact from mental health staff as to the progress of the 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 on this team should find satisfaction in simply "processing" these program participants.

This direct link between officers and mental health workers must remain active. This collaborative teamwork is not 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 into these specialized teams, while reassuring law enforcement the client has a genuine opportunity to begin recovery.

Officers would work side-by-side with mental health staff as a way of encouraging development of a broadened element of their culture to include the

value of “helping” the positive aspects of client recovery. 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 support of mentally ill individuals, in addition to real community support in the areas of housing and employment.

The initiation of a subtle, but important “helping” cultural change is further enhanced by engaging health neighborhood participants in the development of the valuable contribution law enforcement agencies too long have eschewed in favor of short-term solutions with marginal impact. Crucially, this team—described below in more detail—also actively fosters a set of networks in the neighborhood that can provide greater social connections and support to targeted individuals and their families.

The following describes the four key elements of this project.

- Pre-Booking Diversion Protocol to Guide Mental Health-Law Enforcement Coordination: 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, who agree, will be diverted to appropriate mental health treatment.

    - This protocol will also include instructions 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. The Crisis Intervention Team Training model (CIT) advanced by California Institute for Mental Health (CiMH) and operational in Los Angeles County currently as well as further training in Mental Health First Aid (MHFA) will be incorporated into the pilot program.

- Forensic Full Service Partnership Team: These new mental health/law enforcement teams will have the opportunity to provide an intensive Forensic Full Service Partnership (FFSP) services for diverted clients needing this level of care. The FFSP teams will be modeled after existing Full Service Partnership teams with greater resources and clear expectations for housing, employment, and recidivism reduction outcomes. FFSP teams will partner with local community agencies to ensure access to healthcare, financial and transportation services as well as employment services.

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

- Recovery Guides: In addition, workers with lived experience may be a core aspect of the team as recovery "guides," supporting the efforts of the consumer to regain an appropriate level of community functioning. These recovery 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 assigned team law enforcement officers involved are up to date on program matters and client's recovery and value 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.

- Health Neighborhood Network: This project recognizes the relationship between a community and the residents who reside in it. As the residents receive the service needed the entire community benefits and becomes healthier overall. The FFSP team will be responsible for local community development and partnerships to facilitate client access to local faith based organizations, self-help, and community recreation. A Health Neighborhood Network will be operationalized through the collaborative community-based services and supports provided by:

- Neighborhood organizations such as neighborhood councils, Kiwanis clubs, faith-based organizations, along with NAMI.

- Employment services -two employment providers to engage, train, and assist participants with establishing long term, sustainable employment so necessary to Department recovery goals.

- The Urgent Care Center- 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

- Forensic Full Service Partnership Team- provide dedicated 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.

Key Learning Questions

1. 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?

2. 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?

3. 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?

Intended Outcomes

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

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

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

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 issue by diverting individuals into recovery-oriented, culturally relevant outpatient community-based services.

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.

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 participant 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

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.

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. As with all MHSA-funded programs, the Department's System Leadership Team will receive updates on the status of implementation and outcomes.

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 Per Health Neighborhood

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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**
Training:	
<u>One-Time</u>:	
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, salary and employee benefits)	$780,306
Evaluation:	$1,000,000

Annual Cost:

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**

References

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