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 (LACDMH) proposes to test out the creation and implementation of distinctive place-based Health Neighborhoods as a method to support distinct communities to create the collective will to employ various strategies for people of diverse ages to decrease the risk of or reduce the degree of trauma experienced by community members.

The innovation proposed here is the development of health neighborhoods that center on building the capacity of the community to identify the correlates of trauma in its members and address trauma or trauma risk through building upon the assets of the community.

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. Community clubhouse for 0-5 population
2. TAY Peer Support Networks
3. TAY outreach and engagement
4. Culturally competent non-traditional self-help activities for families with multiple generations experiencing trauma
5. Support Networks Without Walls for Older Adults with a Pre-Existing Mental Illness
6. Community-Based Strategies to Support Caregivers for older adults with a mental illness

Increase access to mental health services:

1. Veterans peer support via a social media application for smartphones

Promoting interagency or community collaboration related to mental health services:

1. Trauma-informed psycho-education and community support for school personnel in health neighborhoods
2. Coordinated employment within a health neighborhood
3. Community integration for individuals with a mental illness with recent incarcerations or who were diverted from the criminal justice system.

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, reduce trauma and increase protective factors.

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 by utilizing the assets of particular 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 drawing upon the assets within specific communities, including mobilizing 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 and it's correlates 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 and early intervention. 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.

The correlates of trauma that will be addressed through the implementation of the strategies listed below are social isolation/disconnectedness, exposure to inter-personal or community violence, repeated victimization as a result of homelessness or living in areas of high poverty and crime, combat-related post traumatic stress, historic/cultural trauma and grief and loss-induced trauma secondary to a mental disorder.

Overarching learning questions

1. What strategies contribute most significantly to increasing a community's ability and willingness to support its members in ways that reduces the likelihood of or the impact of trauma? What is the relative impact of selected asset-based culturally competent community capacity-building strategies on reducing trauma?

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?

3. What is the added value of investing in community capacity building, as opposed to investing solely in mental health service delivery in addressing the correlates of trauma?

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. 29 (twenty-nine) 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

February 2, 2015

February 9, 2015

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

While the SLT approved a proposal on December 17, 2014, subsequent feedback resulted in a re-evaluation of the proposal and a re-tooling of the strategies to better align the strategies with the definition and purpose of MHSA Innovation and an Asset-Based Community Capacity and Development approach.

The final proposal was re-presented to the SLT on February 18, 2015 and again approved by stakeholders.

Timeframe of the Project and Project Milestones

Upon approval of the Mental Health Services Oversight and Accountability Commission (MHSOAC), 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 April or May 2015, the following is an estimated implementation timeline:

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

- May 2015: Innovation 2 Implementation workgroup formed within LACDMH, 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.
- May – December 2015: Development of solicitations, review and approval of solicitations by the Department, County Counsel and Chief Executive Office.
- January – March 2016: Bidders conferences held, proposals received.
- March – April 2016: Solicitations scored and award letters distributed.

May – July 2016: Board letters drafted and adopted.

August 2016 – June 30 2020: Four (4) year implementation plan. The Department will replicate the successful approach of Innovation 1 and develop 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 SLT periodically and will be reported on in MHSA Annual Updates/MHSA Three Year Program and Expenditure Plans.

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
- 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, perhaps through measuring community social capital and conducting a social network analysis prior to implementing specific health neighborhood strategies and at the conclusion of the project.

Health Neighborhood Selection

Each of the five (5) Supervisorial Districts will have at least one, and not to exceed two, distinct health neighborhoods. Lead agencies will be selected through a solicitation process. Qualified organizations that meet certain minimum mandatory requirements, particularly related to their experience in a particular community, to their organizational status within a community, to their ability to leverage resources and to their community's readiness and infrastructure in place to support a health neighborhood, will be eligible to submit proposals. Each proposing organization must be endorsed by any existing neighborhood councils, in order to align this work with the work of existing councils. Each proposing organization will select specific strategies from the menu on the following pages.

Health Neighborhood Strategies

The strategies listed in the following pages are based on the different correlates of trauma for different age groups, including trauma correlates for families where one or more generations reside together. These strategies represent a continuum of community-based approaches to addressing the correlates of trauma across the age spectrum.

LACDMH will set aside an annual training budget to support each health neighborhood, including providing or procuring training on trauma and mental illness for community partners. Such trainings may include Mental Health First Aid, CPR as well as training on specific mental health issues as identified by each health neighborhood.

Health Neighborhood Strategy Menu by Trauma Correlate and Age Group of Focus

Strategy 1: A community clubhouse. To provide activities and developmentally appropriate family play activities in a community location that the health neighborhood chooses. The activities would promote young children's social skills and help parents learn developmentally appropriate play activities and/or socio-emotional literacy. The strategies would be used to reduce (the trauma of) social isolation and disrupted relationships (including loss and attachment issues), enhance parent/caregiver knowledge of child development, and promote positive social skills in children.

Age Group(s) of Focus: 0-5 (including activities involving TAY and Older Adults)

Trauma to be Addressed: Social Isolation and Disrupted Relationships

Key Learning Questions:

1. Would increasing positive social connections decrease the negative impacts of trauma for children and their families?
2. Would increasing positive social connections increase positive coping strategies for children and families to deal with trauma?
3. Would increasing positive social connections by providing non-traditional outreach and engagement practices enhance utilization of mental health services for at risk children and their families who are exposed to trauma?

Intended Outcomes:

1. Children and families will have access to peer and community support to promote use of positive coping strategies to reduce the impact of trauma.
2. Social isolation reported by parents or caregivers will decrease.
3. At-risk children with trauma symptoms who have been underserved will receive referrals to mental health treatment/systems when necessary (improve mental health access for children in underserved at risk communities).

Primary Purpose of this Innovation Strategy:

Increase access to underserved groups

Strategy 2: **Trauma-Informed Psycho-education and Support for School Communities in the Health Neighborhoods** (workforce and community resource development around trauma for existing agencies supporting children). In this model, training/workshops on recognizing behaviors and symptoms of stress and trauma in children will be provided to early care/education (EC/E) and school personnel and community mentors who work with children ages 0-15. The workshops would also teach simple trauma-informed coping techniques (attunement skills, self-regulation, affect management, mindfulness, meditation, breathing, etc.) that can be implemented within EC/E and school settings to reduce stress experienced by children.

Age group(s) of focus: 0-15

Trauma to be addressed: Community Violence & Child Abuse (exposure to domestic violence, physical abuse, emotional abuse, and sexual abuse)

Key Learning Questions:

1. Would increasing training for EC/E and school personnel and community mentors around trauma needs of children decrease the negative impacts of trauma for children and their families.
2. Would EC/E and school personnel and community mentors modeling and promoting simple coping skills in EC/E and school settings improve children's academic performance?
3. Would trauma-informed training and support for EC/E and school personnel and community mentors enable identification of trauma and mental health needs in previously unserved or underserved children who have experienced trauma?

Intended Outcomes:

1. Children's suspension and expulsion rates will decrease.
2. Compassion fatigue reported by teachers will decrease.
3. At-risk children with trauma symptoms who have been underserved will receive referrals to mental health treatment/systems when necessary (improve mental health access for children in underserved at risk communities).

Primary Purpose of this Innovation strategy:

Promotes interagency collaboration related to mental health services and supports

Strategy 3: TAY Peer support networks involving TAY residents who are capable of engaging with those TAY who are isolated or withdrawn in the Health Neighborhood.

Employ or compensate TAY Peers for full-time or part-time work in developing and implementing TAY Peer Support Networks. TAY Peer Support Networks will provide a direct pathway for TAY to provide the Health Neighborhoods with TAY related issues that directly impact the trauma of social isolation.

1. Employ or compensate TAY Peers for full-time or part-time work in developing and implementing TAY Peer Support Networks
    a. The TAY Peers and the TAY Peer Networks should be representative of the various ethnic/cultural considerations of their Health Neighborhood (also including, but not limited to: TAY from different ethnic/cultural groups; LGBTQ TAY; TAY formerly involved with gangs; TAY who were abused; formerly homeless TAY; formerly substance abusing TAY; and TAY who have emancipated form the dependency/justice systems)
    b. The TAY Peers and the TAY Peer Support Networks should be incorporated within the Health Neighborhood to ensure that the needs and issues of TAY are being appropriately recognized and addressed by the community collaboratives and community initiatives
    c. The TAY Peers and the TAY Peer Networks should prioritize engaging TAY in the Health Neighborhoods who are of higher risk of social isolation, especially TAY from different ethnic/cultural groups and LGBTQ TAY
    d. The TAY Peers should utilize engagement approaches that focus on developing positive relationships with TAY within the Health Neighborhood
    e. The TAY Peers should connect socially isolated TAY to other community-based supports and services within their Health Neighborhood

Age Group(s) of Focus: Transition Age Youth (TAY) and Lesbian, Gay, Bisexual, Transgender and Questioning (LBGTQ) TAY.

Trauma to be Addressed: The trauma correlate of social isolation has negative consequences. Disconnection from family, friends, and society increases the risk for developing or worsening a mental illness. It also increases risk of suicide, especially among transition age youth and the elderly. Often, fear and stigma of mental illness precedes social isolation, as those with early onset symptoms of mental illness may begin to withdraw from their support systems or are avoided by those closest to them. Rejection, real or perceived, by family, friends, and community is a serious trauma that can be most effectively countered within a Health Neighborhood, by the residents and stakeholders in proximity to the disengaged.

The Transition Age Youth developmental period is marked by identity and close relationship formation, which provide the foundation for all future adult interactions and behaviors. Social isolation disrupts the natural development of healthy relationships and leads to distorted identity development as a coping mechanism. This is especially critical for TAY at risk of developing a mental illness, TAY with minority ethnic and cultural backgrounds, and LGBTQ TAY. Although social isolation is traumatic for people of all ages, the developmental and mental health consequences for TAY are substantial.

Key Learning Questions:

Can a Health Neighborhood that provides TAY with safe and anonymous pathways to connect with community services and social supports utilizing non-traditional outreach, engagement practices, and peer support increase positive social connections?

1. Would increasing positive social connections decrease the negative impact(s) of trauma for TAY?
2. Would increasing positive social connections increase positive coping strategies for TAY to deal with trauma?

Intended Outcomes:

1. Social isolation/withdrawal and negative social connections will decrease
2. 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.
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.

Primary Purpose of this Innovation Strategy:

Increase access to underserved groups

Strategy 4: Outreach & Engagement to TAY by TAY who are representative of the various ethnic/cultural considerations of their Health Neighborhood (also including, but not limited to: TAY from different ethnic/cultural groups; LGBTQ TAY; TAY formerly involved with gangs; TAY who were abused; formerly homeless TAY; formerly substance abusing TAY; and TAY who have emancipated form the dependency/justice systems) who are involved in the Health Neighborhood TAY Peer Support Networks to develop a variety of approaches to engage their peers.

1. Develop, implement, and utilize social media and other technology methods to connect TAY within the Health Neighborhood to each other and to the TAY Peer Support Network.
2. Outreach and engagement efforts should be based on competent strategies which are sensitive to all ethnic/cultural considerations and to issues specific for LGBTQ TAY.
3. TAY-focused/TAY-Led Health Neighborhood events to provide opportunities for engagement, education, prosocial recreation, and positive relationships.
    a. Host events that are innovative and appeal to TAY; not to be limited to only resource fairs and educational seminars/conferences
    b. Provide incentives for TAY residents to participate in events (e.g. tangibles such as gift cards and fun activities that TAY would enjoy and that would encourage positive connections with other TAY, etc.)
    c. The events should be organized within each Health Neighborhood that focuses on activities appropriate for the community
    d. The Health Neighborhood events should focus on reaching out to all TAY (including, but not limited to: TAY from different ethnic/cultural groups; LGBTQ TAY; TAY formerly involved with gangs; TAY who were abused; formerly homeless TAY; formerly substance abusing TAY; and TAY who have emancipated form the dependency/justice systems)

Age Group(s) of Focus: Transition Age Youth (TAY) and Lesbian, Gay, Bisexual, Transgender and Questioning (LBGTQ) TAY.

Trauma to be Addressed: The trauma correlate of social isolation has negative consequences. Disconnection from family, friends, and society increases the risk for developing or worsening a mental illness. It also increases risk of suicide, especially among transition age youth and the elderly. Often, fear and stigma of mental illness precedes social isolation, as those with early onset symptoms of mental illness may begin to withdraw from their support systems or are avoided by those closest to them. Rejection, real or perceived, by family, friends, and community is a serious trauma that can be most effectively countered within a Health Neighborhood, by the residents and stakeholders in proximity to the disengaged.

The Transition Age Youth developmental period is marked by identity and close relationship formation, which provide the foundation for all future adult interactions and behaviors. Social isolation disrupts the natural development of healthy relationships and leads to distorted identity development as a coping mechanism. This is especially critical for TAY at risk of developing a mental illness, TAY with minority ethnic and cultural backgrounds, and LGBTQ TAY. Although social isolation is traumatic for people of all ages, the developmental and mental health consequences for TAY are substantial.

Key Learning Questions:

Can a Health Neighborhood that provides TAY with safe and anonymous pathways to connect with community services and social supports utilizing non-traditional outreach, engagement practices, and peer support increase positive social connections?

1. Would increasing positive social connections decrease the negative impact(s) of trauma for TAY?
2. Would increasing positive social connections increase positive coping strategies for TAY to deal with trauma?
3. 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. Social isolation/withdrawal and negative social connections will decrease
2. 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.
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.

Primary Purpose of this Innovation Strategy:

Increase access to underserved groups

Strategy 5: Coordinated Employment within a Health Neighborhood

This strategy aims to create a network of businesses within a specific Health Neighborhood that will provide job opportunities to individuals who are mentally ill and homeless/formally homeless. Job opportunities will be sought out in the competitive employment market and through the development of social enterprises within the neighborhood. A standardized employment assessment tool and a coordinated, systematic approach will be used to match the individuals to the jobs opportunities that the network of businesses provides. The current Coordinated Entry System that has been developed across the County to match individuals who are homeless to housing will be leveraged to target those individuals that have obtained permanent housing and to match individuals to jobs. Supportive services to help individuals apply for and obtain and retain employment will be provided to each participant and will include peer service providers and support groups.

Age Group(s) of Focus: TAY, Adults, Older Adults with employment goals.

Trauma to be Addressed: The trauma association with the social isolation and stigma that results from being an individual who is mentally ill and homeless/formally homeless. Common traumatic experiences for this population include: physical violence, stigma of mental illness and homelessness, victimization, poverty, loss of home, safety and sense of security, and being unable to meet basic needs of food and shelter.

Key Learning Questions: Can creating a network of businesses within a specific Health Neighborhood that provide jobs to individuals who are mentally ill and homeless/formally homeless reduce the social isolation and related trauma they experience by providing them with opportunities to develop relationships with those with whom they work and by utilizing natural supports within the Health Neighborhood and community infrastructure to promote health and well-being.

Intended Outcomes:

1. An increased sense of well-being and self-sufficiency
2. An increase in the individual's sense of integration into and connection with the community
3. An increase in the individual's income and a reduction in poverty
4. A reduction in the use of public resources including SSI and Medi-Cal as a result of income and health insurance through employment

Primary Purpose of this Innovation Strategy:

Promotes interagency collaboration

Strategy 6: Community Integration for individuals with a mental illness with recent incarcerations or who were diverted from the criminal justice system

This strategy will capitalize on knowledge and networking of community groups dedicated to community reintegration for incarcerated or diverted individuals. This strategy proposes a consortium be established to focus on several key goals to facilitate reintegration. Elements of this strategy may include the following:

1. Training for Court staff (e.g. Attorneys, Judges), law enforcement, substance use agencies and other related community agencies on working with individuals diagnosed with mental illness, the benefits and scope of treatment, and stigma and community resources.
2. Community development to establish partnerships with landlords and other housing agencies to establish housing opportunities for individuals with forensic and mental health histories.
3. Increase training for Law Enforcement on the Crisis Intervention Team (CIT) model. While this training has been implemented in some neighborhoods, it is not wide spread.
4. Provide training on Evidenced Based Practices (EBP) for mental health providers treating forensic populations. Trainings should ensure understanding of the impact of trauma and criminogenic factors.
5. Identify at least three community social agencies, clubs or groups and work with them to modify their mission to include welcoming individuals with mental illness and a history of incarceration.
6. Engage self-help community support groups to welcome individuals with co-occurring mental health and substance use conditions and incarceration histories. Establish self-help support groups to serve individuals with incarceration history in communities where they are not already present.
7. Develop and implement improved communication protocols and structures for information sharing between jail personal, mental health navigators and providers to support those exiting or being diverted from incarceration who need access to mental health services.
8. Develop and implement a protocol to facilitate scheduled release times for those in booking or being realized from incarceration who have been assessed to need mental health services to allow for proper “warm hand off’ for mental health services.

Age Group(s) of Focus: TAY, Adults, Older Adults

Trauma to be Addressed: Individuals with a mental illness and histories of incarcerations often have extensive histories of trauma that are re-activated after release from jail by lack of pro-social community supports, high risk housing and

substance use. The trauma correlates addressed in this strategy are social isolation and stigma.

Key Learning Questions:

1. Can an established community consortium affect the capacity for a community to welcome individuals with a history of mental illness and incarceration and/or diversion?
2. Will training for judicial team members, mental health providers and law enforcement personnel lead to an improved experience with law enforcement and the court, and improved access to care?
3. Will improved coordination and communication result in increased linkage and improved outcomes for individuals with recent incarceration/diversion and mental illness?
4. Will focused efforts to establish housing for individuals with recent incarceration/diversion and mental illness reduce homelessness?
5. Does targeted self-help support groups reduce re-incarceration?

Intended Outcomes:

This strategy, through smaller focused projects, is designed to:

1. Reduce Stigma in the judicial system, law enforcement, and the community.
2. Increase housing for individuals with a recent history of incarceration and mental illness.
3. Increase successful linkages from incarceration or diversion to mental health services in the community.
4. Reduce re-incarcerations, sampling client incarceration rates prior to implementation of this strategy vs. after implementation.

Primary Purpose of this Innovation Strategy:

Promote interagency collaboration

Strategy 7: Veterans Peer Support via Social Media Application for Smartphones

This strategy provides for a mobile, proximity-based peer support network designed exclusively for military veterans. According to the Department of Veterans Affairs (VA), 22 veterans a day commit suicide. In a recent Iraqi and Afghanistan Veterans of America (IAVA) study, 47% of Iraq and Afghanistan veterans know someone who has attempted suicide. Forty-three percent also report knowing a veteran who has committed suicide. The VA's Veterans Crisis Line is based on 33 year old technology plagued by prolonged hold times and inadequate referral services. This proposed social media platform will address institutional gaps in care delivery by training a cadre of certified veteran peer support specialists, who will provide mental health access with on-demand, peer support. Once a veteran self-identifies as needing assistance on the social medial application, he or she will be linked to the nearest veteran peer support specialist for instant support and assistance navigating local mental health resources.

Age Group(s) of Focus: TAY, Adult, Older Adult

Trauma to be Addressed: Social isolation due to combat-related traumatic experiences and resulting stigma of mental illness.

Key Learning Questions:

1. Does a social media platform for veterans in crisis increase effective linkage to services?
2. Does the use of veteran peers reduce emotional distress in veterans using the application for assistance?
3. Will training military and veteran peers on mental health support interventions increase use of needed services?

Intended Outcomes:

1. Improve access to mental health care and effective linkage to mental health and crisis care for veterans who have experienced trauma.
2. Reduced emotional distress as a result of peer interventions

Primary Purposes of this Innovation Strategy:

Increase access to mental health care

Strategy 8: Support Networks Without Walls for Older Adults with a Pre-Existing Mental Illness

Establish support networks for older adults building upon already existing resources to create opportunities for social support, self-help support for coping with grief and loss, utilizing technology and providing training and support for older adults to use the technology. This strategy would build upon the array of community-based organizations located in the Health Neighborhood, including senior apartment residences, assisted living facilities, faith-based organizations, community centers, senior centers, libraries, food banks and parks are some potential examples of where participants would be recruited. Support networks would be built either by creating face to face groups when possible, providing participants with low cost lap tops and internet access and building Skype support groups, or connecting people over the telephone either with conference calling, or in a chain, where one person calls the next, and so on. Faith based organizations would be included to provide help to older adults with any existential/spiritual components to their grieving process.
The group modality, including building virtual groups by telephone and/or Skype connections, would be employed to reduce isolation, reduce stigma, normalize the experience of grief and loss and foster connectedness among older adults in the HN. Components of the training would include stress and anger management, stages of grief, relaxation techniques, self-care, effective coping strategies exercise and faith/spirituality. The use of peers including older adults would be an important element of the program design.

Trained peers and other paraprofessionals will play a vital role in facilitating and coaching older adults through the grief and loss group process. Coaching shall also serve as a tool to work with individuals to help supplement and support the material learned in the psycho educational groups. Furthermore, group participants will be encouraged to increase their involvement in their community by joining existing neighborhood councils.

Collaboration with key primary healthcare, faith based ministers and peers, mental health and substance use providers in the HN will be essential to accessing this vulnerable population. Clinical consultation will also help to guide the group facilitators in terms of when grief progresses into Major Depression or other mental health conditions that require a mental health referral and intervention.

Age Group of Focus: Older Adults

Trauma to be Addressed: The trauma to be addressed is grief and loss that oftentimes leads to social isolation and despair. Although, loss is part of life, and grief is a natural part of the healing process, older adults oftentimes struggle with multiple layers of grief and loss issues. Grief and loss issues are more pronounced pertaining to

older adults, due to their support system generally declining as they age and longstanding friends and family members die. Due to the aging and disease processes, older adults may experience vision, hearing, energy and mobility changes, which impact their ability to independently engage in meaningful activities in the community and often raise existential/spiritual issues integrally related to their grieving process and mental health. Dealing with a significant loss can be one of the most difficult times in a person's life, and particularly due to cascading losses, older adults grieving may find it difficult to function in everyday situations. Losses associated with strong feelings of grief include death of loved ones, loss of roles such as jobs, physical decline, illness and/or loss of health, loss of support system, and loss of financial security. In geographic areas with a weaker economic base, there are service gaps and fewer social, health, substance use and other resources. This factor underscores the importance of implementing culturally relevant, including religiously relevant, grief and loss support networks, real and virtual, to under and inappropriately served older adults.

Key Learning Questions:

1. Is building community capacity to reduce trauma related to grief and loss an effective model for improving the well-being of older adults in a Health Neighborhood?
2. Will older adults with co-morbid mental illness and grief and loss issues report feeling less socially isolated and experience less depression through the use of social media technology, such as Skype?

Intended Outcomes:

1. Increase access to grief and loss support for older adults within a Health Neighborhood.
2. Decrease social isolation by offering support networks facilitated by community agencies.

Primary Purpose of this Innovation Strategy:

Increase access to underserved groups

Strategy 9: Community-Based Strategies to Support Caregivers for older adults with a mental illness

Build the capacity of the Health Neighborhood to create and facilitate support and assistance for caregivers of older adults with a mental illness, including funding caregiver respite, exercise and wellness programs, motivational interviewing-based interventions and other forms of social support which can reduce the stress associated with providing care. This strategy may include the following components:

- Increase public awareness and knowledge regarding the full spectrum of elder abuse and/or neglect.
- Development and implementation of caregiver support groups to reduce stress, increase caregiver skill-set, thereby reducing the likelihood of elder abuse and/or neglect.
- Provide motivational interviewing approach to direct intervention with elder abuse victims and potential victims.

This strategy would also build upon any existing elder abuse prevention initiatives operating in the Health Neighborhood. Should these initiatives not exist in the neighborhood, training would be provided to community leaders and would highlight awareness and education on what elder abuse is, warning signs, forms of abuse experienced by older adults (i.e. financial, physical, emotional/psychological, and sexual), and which elders are more vulnerable to be mistreated or abused. Overcoming barriers to reducing the harmful impact of elder abuse will also include training community leaders in a motivational interviewing approach to help reluctant victims become willing to accept helpful interventions. The training would offer information about community resources available to caregivers for self-care, caregiver support, and respite care options. Assertive outreach and "warm' referral to community resources would also be included.

Age Group of Focus: Older adults

Trauma to be Addressed: Older adult abuse and neglect as a result of the challenges of caregiving.

Key Learning Question:

Is building community capacity to support caregivers of older adults an effective model in reducing elder abuse and neglect within health neighborhoods?

Intended Outcomes:

1. Increase community awareness regarding abuse and neglect.

2. Improve community ability to recognize, prevent, and report abuse.
3. Improve caregiver coping strategies to prevent abuse and neglect, measured through pre and post surveys.

Choose one Primary Purpose of this Innovation strategy:

- Increases access to underserved groups
- Preventing and treating elder abuse is important to older adults' mental health due in part because the trauma of elder abuse can contribute to mental illnesses such as depression, anxiety, and PTSD; can worsen preexisting mental illnesses, including Schizophrenia and Bipolar disorders; and mental illnesses can place older adults at risk of being abused.

Strategy 10: Culturally Competent Non-Traditional Self-Help Activities for Families with multiple generations experiencing trauma

Families serve as the best translators of their own culture. This is true for broad identifiers of culture such as language, religion, and behavior, but also the micro-culture of each family, which they clearly know and understand better than any outside professional. A centralized family friendly community space will be utilized to provide intergenerational families with an opportunity to engage in culturally relevant self-help activities and groups that focus on the inherent strengths of intergenerational families and emphasize resilience, rather than vulnerability. These self-help activities will be led by community peers, who are well versed in the multi-faceted needs of intergenerational families in each of the targeted health neighborhoods. The self-help activities listed below, will promote healing and reconnection by identifying and accessing inherent strengths within intergenerational families and communities. As a result, there will be a reduction in maladaptive behaviors, emotional and relational disturbances, and severe psychological symptoms related to collective, historical, or cumulative trauma. Key activities would include:

1. Intergenerational Family Storytelling Groups – Trauma impacts members of a family differently and often results in a lack of communication and/or isolation within a family and community. Storytelling can be reassuring and gratifying for family members, in particular for families who have experienced collective, historical, or cumulative trauma. Stories shared by family members can provide an alternative healing experience designed to shift and change the destructive effects of trauma on a family. Storytelling serves as a reminder that it's possible to survive and thrive after experiencing trauma and provides an opportunity to identify successful coping skills. For example, a Native American elder could share stories about tribal traditions and how to overcome adversity with Native youth, who may not be familiar with their cultural history, and are struggling with gang violence.

2. Engagement of Intergenerational Families in Cultural Activities – Cultural activities have shown to improve cultural identity, which is often negatively impacted by trauma. These cultural activities can include, but are not limited to, gardening, mediation, jewelry making, dance, drumming, cooking, music, and spiritual activities. These activities allow families to have a healing experience without the use of traditional mental health services. For example, a Cambodian mother who survived the genocide may share her favorite family recipe with her children and grandchildren as part of the cooking class.

3. Intergenerational Family Mentorship Program – To extend the healing beyond the cultural relevant activities and self-help groups, intergenerational families will be invited to participate in a cross family mentorship program. Families will be paired such that they can provide support and guidance to each other in the community at any time. This connection of families to each other will build resiliency within a community and decrease isolation. For example, a family who is experiencing domestic violence will be paired with a family who has overcome this trauma and can serve as a role model and engage in family activities in the neighborhood.

Age Group(s) of Focus: Intergenerational families

Trauma to Be Addressed: Community or societally-induced trauma experienced by intergenerational families (nuclear, extended, or as defined by a family).
Community or societally-induced trauma can include:

1. Collective trauma (e.g., a school shooting affects everyone in the school community) and/or
2. Historical or cumulative trauma (e.g., refugees escaping genocide from their countries of origin).

Learning Questions:

1. Can culturally relevant non-traditional self-help activities and groups improve the ability of the neighborhood or community to reduce the impact trauma on intergenerational families?
2. Will family focused social connections increase positive coping strategies for intergenerational families with trauma-related mental illness or who are at risk of developing trauma-related mental illness?

Intended Outcomes:

1. The culturally relevant non-traditional self-help activities and groups will result in a decrease in stigma related to accessing mental health services, should they desire to seek services.
2. Increased sense of social connectedness for intergenerational families participating in the culturally relevant non-traditional self-help activities and groups.
3. Increased ability to cope with trauma as reported by intergenerational families.
4. Shame and stigma related to trauma and mental illness will be reduced as reported by intergenerational families.

Primary Purpose of this Innovation Strategy:

Increase access to care for underserved groups

Consistency with the values of the Mental Health Services Act

Community collaboration: This project centers on building the capacity of under-resourced communities across Los Angeles County to address the mental health needs of individuals residing in those communities as it relates to the reduction of trauma and its correlates.

Cultural competence: Among the requirements of health neighborhood lead agency will be to utilize community or neighborhood councils to inform the work associated with this Innovation project. In doing so, the work should address the distinct ethnic and cultural makeup of each neighborhood, including those related to the age groups targeted. Strategy 10, Culturally Competent Non-Traditional Self-Help Activities for Families with multiple generations experiencing trauma, is particular focused on addressing trauma often suffered by specific ethnic populations.

Client and family-driven approach to planning and service delivery: Peer and self-help services and the recognition of families as supports are woven throughout the 10 strategies. Clients and family members will play an integral role in shaping each health neighborhood.

Wellness, recovery and resiliency focused: The key outcome in this project to be achieved is a reduction in the impact of trauma, reduced symptoms of trauma and reduced risk for experiencing trauma. Reducing the incidence and impact of trauma and increasing protective factors have significant implications for increased wellness and resiliency.

Integrated service experience: While the Department's first Innovation project focused specifically on strategies to integrate health, mental health and substance use services, this project builds on that work and focuses on the community's ability to utilize it's assets and support community members in the reduction of trauma and its correlates.

Ensuring Each Health Neighborhood is Trained on Trauma

As part of the LACDMH's annual Innovation training budget, training needs for each neighborhood will be identified and training will be procured. This will include training for lead agencies and their community partners on the LACDMH services, including Service Area Navigation as well as mental health services and supports available within each community. LACDMH will also fund training on different aspects of trauma across the age spectrum.

Creating a Culture of Learning

At its heart, MHSA Innovation is focused on learning and the application of learning to improve services. Consequently, each selected lead agency and their community partners will participate in learning sessions that will inform ongoing training and

support. Outcome data will be reviewed regularly, in order to determine the status of learning goals and to make mid-course corrections should they need to be made. This approach was used in Innovation 1 and facilitated trust, shared learning and adoption of best practices and data-informed decision-making at the program and Department levels.

Sustaining Successful Learning

Each health neighborhood lead agency will be expected to develop the collective will and the leadership in each community to sustain successful practices at the conclusion of this project. Successful practices will be documented and spread to other communities who did not have an opportunity to participate in this Innovation project.

Estimated Annual Innovation Budget:

Annual DMH Costs:

DMH Strategy Leads and administration (14 staff)	$1,958,720
Training:	$50,000
Evaluation:	$1,000,000
Total Annual Cost:	**$3,008,720**

Estimated Annual Budget Per Supervisorial District:

$4.0 million for each of 5 Districts:	$20,000,000
Total MHSA Innovation 2 Annual Budget:	**$23,008,720**

Fiscal Years 2016-17 through 2019-20

Total Innovation 2 Project Projected Budget: **$92,034,880**

Fiscal Years 2016-17 through 2019-20

Note: There will be no Medi-Cal funding associated with this project.

Budget Narrative:

14 staff are funded through MHSA Innovation to develop solicitations, develop policies, procedures and guidelines for services, develop and negotiate contracts, monitor contracts, develop a training and technical assistance plan and procure training.

An annual training budget of $50,000 year has been established that will cover learning sessions (likely quarterly) as well as other training and technical assistance to enhance the success and learning associated with this Innovation project.

The evaluation of this Innovation project will be contracted out at $1,000,000 per year for 4 Fiscal Years. The evaluation will involve 5-10 geographic health neighborhoods across the county.

Health neighborhood budget- Through a solicitation process, lead agencies, based on their neighborhood priorities, will select any number of the 10 strategies and develop a budget for implementation of those proposed strategies. Each qualifying proposal will be scored and 1-2 lead agencies will be awarded contracts per Supervisorial District with those contracts collectively not to exceed $4 million annually.

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.

Rev. 2/16/15