

HEALTH NEIGHBORHOOD INITIATIVE



Preliminary Report to Los Angeles County Department of
Mental Health

Produced by:
UCLA Center for Health Services and Society
California Behavioral Health Center of Excellence

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Health Neighborhood Initiative

PRELIMINARY REPORT TO LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

“MENTAL HEALTH IS NOT JUST THE ABSENCE OF MENTAL DISORDER, BUT A STATE OF WELL-BEING IN WHICH EVERY INDIVIDUAL REALIZES HIS OR HER OWN POTENTIAL, CAN COPE WITH THE NORMAL STRESSES OF LIFE, CAN WORK PRODUCTIVELY AND FRUITFULLY, AND IS ABLE TO MAKE A CONTRIBUTION TO HER OR HIS COMMUNITY.”

- WORLD HEALTH ORGANIZATION

This interim report represents the first phase of an ongoing effort to support the development and document the process of the Health Neighborhood Initiative. The results included in this report summarize information from DMH leadership and community advisors, with a subsequent report forthcoming that will also summarize broader stakeholder leadership. This project has been supported by the UCLA Behavioral Health Center of Excellence, funded by the Mental Health Services Act of California and the National Institute for Minority Health and Health Disparities grant RO1MD007721. This is a preliminary report to stimulate additional feedback for a subsequent final report. The report is for circulation among stakeholders involved with, or giving input, on the Health Neighborhood Initiative (HNI). This HNI Support Initiative is a community-partnered project involving Los Angeles County Departments of Mental Health, Public Health, and Health Services, Healthy African American Families II, the RAND Corporation, the UCLA Center for Health Services and Society, and patient, family, and community partners of the UCLA Behavioral Health Center of Excellence.

The HNI Support Initiative is also a research project with human subjects review by the RAND Corporation. For more information on the HNI Support Initiative, please contact Farbod Kadkhoda at fkadkhoda@mednet.ucla.edu or by phone at (310) 794-1028.

EXECUTIVE SUMMARY

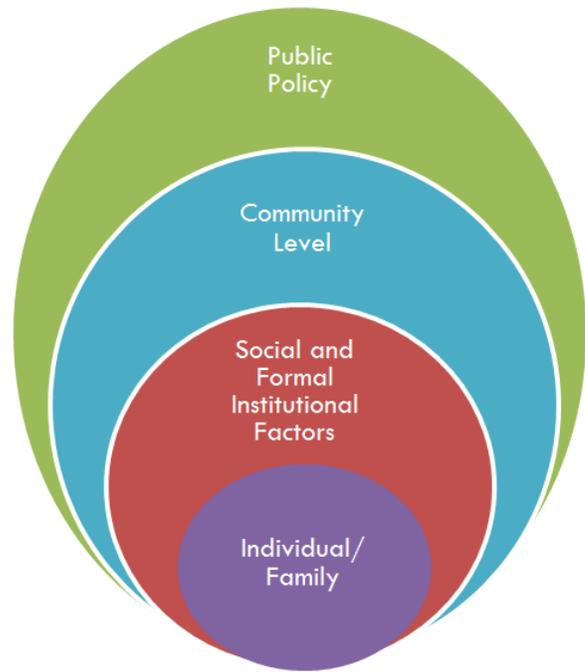
The Health Neighborhood Initiative: An Opportunity for Wellness in LA County

The health of all Americans has been improving over the last 30 years², yet the United States continues to have significant racial/ethnic disparities in mental health care quality and outcomes³⁻⁵. Some of the inequities found in minority communities are due to high rates of unaddressed social risk factors, such as unemployment and homelessness, as well as less access to high quality mental health and health care. The World Health Organization has identified the social determinants of health as “responsible for a major part of the health inequities between and within countries”. They point to inequality in health care, schools, and conditions of work, home, and communities as leading to poor health and mental health.

In the State of California, the Mental Health Services Act (MHSA), funded through a 1% tax on individuals with incomes over \$1 million, has resulted in the dissemination of evidence-based mental health programs in public mental health clinics and has provided some resources to address social risk factors such as homelessness among the mentally ill and mental health stigma. Since 2005, MHSA has provided funding for transforming California’s publicly-funded, mental health system through an innovative continuum of mental health services across the life span from prevention to early intervention and more intensive treatment. In addition to the MHSA, the Los Angeles County Department of Mental Health (LACDMH) partnered with other community agencies and researchers in the recent **Community Partners in Care (CPIC)** study. CPIC examined a community engagement approach for improving depression services that focused on shared planning across networks of health and community-based agencies and community “trusted” places such as churches. This community engagement approach led to improved mental wellness, decreased homelessness, and fewer inpatient hospitalizations for adults with depression, compared to more standard technical assistance for depression treatment.

Building on these system changes, the County of Los Angeles (LAC) Board of Supervisor’s added the *Health Neighborhood Initiative* (HNI) to the LAC Strategic Plan in 2014. Led by the LACDMH, the HNI is an opportunity to radically change how we think about and deliver mental health care. The HNI encourages County staff to partner with neighborhoods and existing place-based initiatives to identify community prioritized social factors (for example, homelessness, unemployment, safety, school dropout, child welfare involvement or incarceration) that lead to adverse mental health outcomes. But instead of county agencies telling communities the solutions, agencies will engage in equal partnerships *with* communities, clients, and families to solve these problems together. Thus far, the HNI has focused on coordination of care between mental health, health, and substance abuse services to improve access to care. In addition to formal healthcare and behavioral health services, HNI will also include supporting clients in such social services as housing, employment coaching, or tutoring to complete a GED, and partnering with non-traditional and trusted members of a community (pastors, park employees, teachers, peers) to support the health and mental health of individuals in their community, provide preventative programs, and facilitate early detection and referral to treatment for behavioral health concerns. It takes a “village”, or in this case a neighborhood, for us to effectively address the major racial/ethnic disparities in behavioral health outcomes in our under-resourced communities.

The Health Neighborhood Initiative offers an important opportunity to implement interventions that focus on the social determinants of mental health and implement these interventions using a community engagement approach such as the one found to be effective in CPIC. In addition, there are a number of other efforts within the LAC Health Agency (DMH, DPH, and DHS) that are aligned with the Health Neighborhood Initiative that address this population health perspective. For example, the Los Angeles County Department of Public Health's *Community Health Improvement Plan for 2015-2020*, cites goals to: Increase Prevention to Improve Health, Create Healthy and Safe Communities, and Achieve Equity and Community Stability. LAC Department of Health has a Housing for Health initiative that supports housing stability to improve health and wellness for clients. There are multiple levels at which to intervene to improve the mental health of a community including:



- 1. Individual / Family levels:** Improving social factors (social support, parenting, resources, employment) and access to evidence-based treatments when needed;
- 2. Services / Institutional level:** Improving mental health supports in schools, public services, and trusted community institutions and integrating health care (DHS, DMH, DPH) for improved access to health services;
- 3. Community level:** Making changes at the neighborhood level to address the social determinants of health (“the conditions in which people are born, grow, live, work, and age”), such as DPH’s emphases on violence prevention and safety and DMH and DHS efforts to improve housing stability.
- 4. Policy level:** Creating local and national policies to support improved public education, employment, housing, access to mental health services. Policy changes such as MHSA at the state level or the creation of a County Health Agency at the county level have significant implications for access and integration of care to address equity.

By integrating interventions across these levels and coordinating services across county agencies and with community-based agencies, initiatives such as the Health Neighborhood Initiative hold promise as a transformational approach to community mental health.. Moving forward, Los Angeles County is now in the planning phase of applying this concept of Health Neighborhoods to address a stakeholder-identified need of communities across the county, that of the major impact that trauma has on the health and mental well-being of those served by our public systems across the lifespan, from infants to the elderly. A sizeable investment by Los Angeles County Department of Mental Health (\$4 million/community/year over 4 years and across 10 communities) will create a unique opportunity to

learn how community coalitions can potentially address health and mental health disparities through engagement of communities. Important next steps to consider include the following:

- What outcomes across these four levels (individual, institutional, community, policy) are possible in addressing trauma through a community engagement approach that focuses on social determinants of health?
- What roles do networks within the Health Neighborhoods play in engagement of community members to improve health and mental wellbeing?
- What social factors improve when Health Neighborhoods address key health and mental health outcomes affected by trauma?
- What cultural factors are essential to consider when addressing trauma and social determinants of health in specific communities?
- What broader policy implications does a Health Neighborhood model offer to other under-resourced communities?

FOREWORD

Health Neighborhoods represent an exciting way of addressing two of the most pressing challenges facing the health care system in the United States. Challenge number one is how to use the opportunities provided under the Affordable Care Act to integrate primary care, mental health care and substance abuse treatment in a fashion that makes all of these treatments more accessible without doing damage to the specific knowledge and wisdom obtained by each of these systems through the years. The second challenge is how to mobilize communities to take on the public health responsibility of making improvements in the social determinants of health outcomes as these factors exist in particular communities. The experience of communities has led us to believe that significant progress in meeting these challenges cannot be done separately, that in fact only by integrating the work of healthcare agencies with that of the individuals and groups in their communities will any aspect of the triple aim be met.

Fortunately, in Los Angeles, New Orleans, New York and other places in the country a body of scientific evidence has demonstrated (for example, Community Partners in Care) that respectful community engagement can have a significant and lasting effect on health outcomes. Program integration efforts between mental health, public health and primary care in Los Angeles and other jurisdictions that have built on the foundation of existing community empowerment efforts have shown similar promise.

Using what we have learned from these foundational efforts that already include governmental, faith-based, academic, and philanthropic partners, as well as health plans, school districts, local businesses and law enforcement agencies, will be an exciting and potentially revolutionary effort. The development of a learning network of similar initiatives across the country will certainly accelerate learning and progress.

In the biggest picture, we believe that this paradigm of joining specific community empowerment efforts meeting locally chosen objectives with larger systems integration plans has the potential to be valuable in criminal justice and child welfare contexts as well. These efforts could well be the seed to significant change across our society.

- *Marvin Southard, DSW, Professor, School of Social Work, University of Southern California former Director of the Los Angeles County Department of Mental Health (1998-2015)*

Introduction of the Health Neighborhood Initiative

The Los Angeles County (LAC) Department of Mental Health's (DMH) **Health Neighborhood Initiative (HNI)** is an important national example of how a large county agency is redesigning its mental health delivery system to include neighborhood-prioritized solutions that address the social risk factors that impact mental health outcomes. Currently, the public mental health system does not have the capacity to meet the tremendous need that exists in this county of over 10 million people. We are only able, with our limited resources, to scratch the tip of the iceberg of mental health need. Below the surface, some people are not being detected until they are severely ill. Those illnesses can lead to job loss or family disruption. Also below the surface are untreated or undertreated comorbid health and substance use problems, and the worsening of symptoms by environmental stresses like crime and violence. Building greater capacity within the health system to provide collaborative care and integrated mental health services is one part of the solution. However, HNI expands this concept of integration to also include integration of mental health services with community social supports within a neighborhood. One opportunity in this natural experiment is to see if these neighborhood solutions integrated with health and mental health services when needed, result in greater wellness within a neighborhood, better quality of life, and improved productivity.

Through the HNI, LACDMH can realize its mission of *"strengthening the community's capacity to support recovery and resiliency"* through:

- 1) Improved individual services coordination and linkages across agencies and
- 2) Partnerships with communities to enhance services access, coordination, and quality while concurrently improving outcomes for community, consumer and family prioritized social risk factors such as support for relative caregivers of children in the child welfare system

The Health Neighborhood Initiative began in fiscal year 2014-2015, with seven LAC pilot Health Neighborhoods identified within the Service Planning Areas (SPA). LACDMH identified two strategies for these neighborhoods:

The Service Delivery Model has focused on improving services coordination across mental health, healthcare, public health, and alcohol / substance abuse. Each neighborhood has identified and developed formal agreements and referral processes established within these pilot neighborhoods.

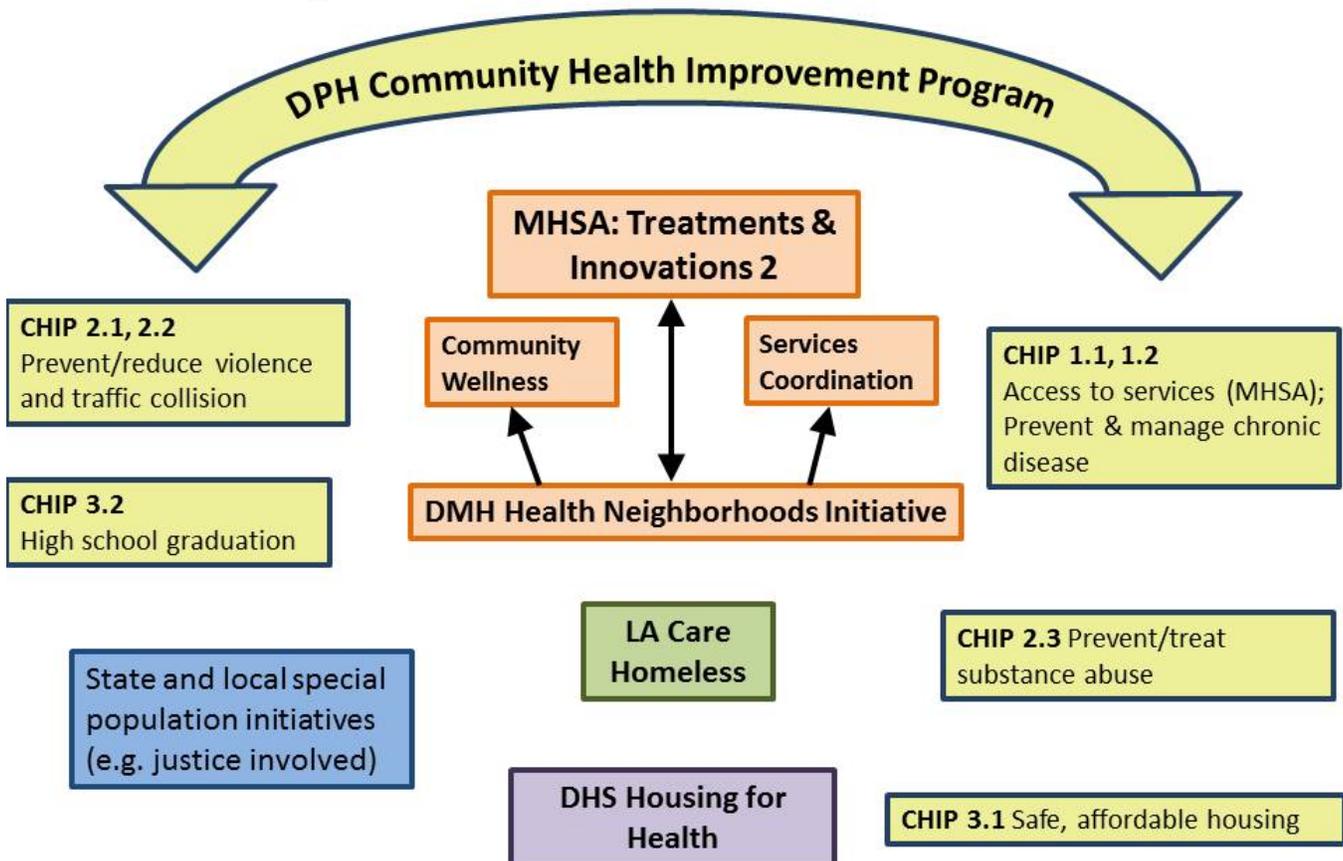
The Community Change Model will focus on improving community health and wellness by building on the service delivery model while concurrently addressing the social risk factors of health. Through a community engagement process in local neighborhoods, Health Neighborhoods will develop innovative solutions to services access, coordination, quality, and outcomes. Broad stakeholder groups from the LACDMH Service Area Advisory Committees (SAAC's) in each SPA and the System Leadership Team (SLT) has included patients, faith-leaders, housing development, probation, schools, health agencies, to name a few, who have contributed to this change model.

Next steps for HNI. Developed by stakeholders and LACDMH, Innovations 2 will be the next phase of the Health Neighborhoods, which will be launched in 2016. This effort will encourage communities to build on their assets and strengths to address the mental health risks due to trauma that affect community members across the lifespan. Each Health Neighborhood will be encouraged to collaborate across

agencies and community organizations and community-trusted institutions to improve health promotion and facilitate mental health service access to underserved populations. Funding from the Mental Health Services Act will total \$92 million over the four-year project timeline, and support 10 Health Neighborhoods throughout LAC. Each Health Neighborhood will be characterized by the following (see the following link for details: http://file.lacounty.gov/dmh/cms1_220189.pdf):

1. Promotes community wellness that results in the improved health of each individual member of that community.
2. Draws on the research supporting the social determinants of health in addressing the needs of communities living in poverty
3. Implements upstream strategies to address social determinants of health, with particular emphasis on trauma experienced in the community
4. Engages community and service systems in partnerships to create an integrated system
5. Builds community capacity to prevent or reduce the incidence of trauma-related mental health problems and promote wellness.

LA County Health Neighborhood Collaborations



Finally, the LAC DMH Health Neighborhoods and Innovations 2 are also part of a larger context in Los Angeles County. Recently the county health agencies in Los Angeles restructured, with the three county health agencies (DMH, DHS, DPH) now each report to the LAC Health Agency. As a more fully integrated set of services, the Health Agency’s strategic priorities include enhancing consumer access and experience

to clinical services, and greater integration of such areas as diversion services for corrections-involved individuals, expanded substance use benefits, and integration of services for chronic disease and prevention. The focus on social determinants of health can also be seen in the other health departments. For example, DHS has a Housing for Health initiative that supports housing stability to improve health and wellness for clients, and DPH’s focus on equity and prevention includes preventing and reducing violence, improving high school graduation, and improving access to services and preventing and managing chronic disease.

Summary of this report. We first provide some background on the significance of implementing a public health approach to mental health care and important policy changes that are pertinent to HNI. We then discuss what is known about the social determinants of health, with illustrations of studies showing the ways in which social determinants affect health and mental health and social outcomes. Next we describe an example of one of the only evidence-based community engagement models shown to improve outcomes for mental health and social risk factors such as homelessness, Community Engagement and Planning, which was used effectively in Los Angeles County in the Community Partners in Care (CPIC) study. From there we provide an example of a Health Neighborhood approach that used Community Engagement and Planning to address mental health and social determinants of health, the CPIC study, which was a partnered study with LACDMH. The final section of the report concludes with our reflections on what can be achieved through this initiative.

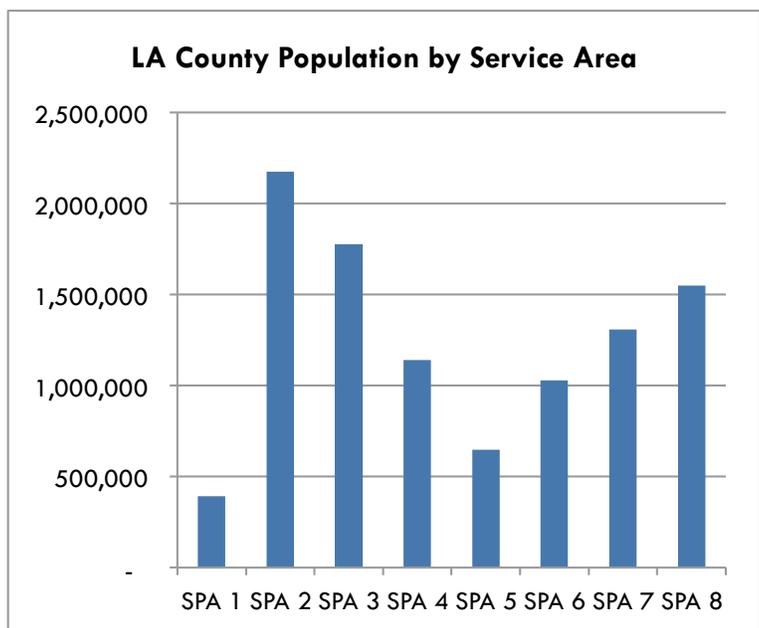
Background

Mental health problems are common and an important priority across the lifespan.

It is estimated that 18.5 % of all U.S. adults experience a mental illness in any given year, representing almost 44 million people. Mental health conditions such as depression are among the most common health conditions across age groups and are leading causes of disability and mortality. Suicide is the leading cause of early mortality in adolescents and young adults, and individuals with severe mental illness are also at increased risk for cardiovascular disease, resulting in premature death. Despite these increased risk factors for those with mental illness, less than 40% with mental illness access health care.⁶

Los Angeles County – Needs and Strengths

Los Angeles County sets itself apart from other counties in the United States through its diverse population and geographic landscape. Resting on 4,000 square miles of urban, suburban, and rural communities, including 88 incorporated and 140 unincorporated cities, Los Angeles County is the home to more than 10 million residents. The diversity in the population and landscape offer unique strengths and challenges to community members and service providers. Each of the eight Service Areas under the purview of the LACDMH has



distinct characteristics and needs that set themselves apart from their neighboring Service Areas. Given these differences, there cannot be a one-size-fits-all approach to addressing the mental health needs of LAC residents.

Mental health problems are associated with higher health care costs.

A recent United States Government Accounting Office (GAO) report to Congress,⁷ noted that the top 5% most expensive Medicaid-only enrollees nationally account for 50% of all costs; in California that number was 63% of all costs. On average, mental health problems account for half of that top 5% of costs, not including alcohol or substance abuse as a primary clinical condition and is the most common co-occurring disorder among the top 5% of Medicaid-only enrollees. In California, Medicaid enrollees with a primary diagnosis of a mental disorder account for about 25% of all Medicaid costs nationally.

Opportunities to improve mental health through policy reform

This is a time of rapid change in the U.S. healthcare system, rich in opportunity for improving the lives of the clients we serve. Around the country, runaway costs and poor health outcomes are fueling reforms to change the status quo of our healthcare system. To improve healthcare, the Center for Medicare and Medicaid Services has incentivized the simultaneous pursuit of three aims (the “Triple Aims”): 1) improving the health of populations, 2) improving the patient experience, and 3) reducing the per capita cost of healthcare. To meet CMS’s Triple Aims, recent healthcare innovations for under-resourced communities are linking traditional healthcare with concurrent investments to address the social determinants of health. The **Affordable Care Act (ACA)**, state policies, and local initiatives converge on three reform themes: 1) coordinated care, 2) community engagement, and 3) social determinants of health. These reforms have the potential to move healthcare toward a team-based endeavor that includes health professionals, local organizations, and the communities and clients that we serve. With its history of successful endeavors in coordinated, community-partnered care, LAC is poised to be a national health reform leader through HNI.

Emerging reforms create coordinated systems that include organizations in sectors outside of healthcare. Examples of this are the ACA’s health home and behavioral health home models.^{8,9} Health homes are coordinated healthcare systems for high-risk Medicaid beneficiaries. In addition to coordinating care, the health home model includes formal linkages to social and other community-based service organizations. Dedicated health home care coordinators refer individuals to partner community organizations and include the outcomes of those referrals in clients’ treatment plans. These models expand coordinated care networks to include partnerships outside of healthcare, including community resources and leadership.

Present-day health reform movements prioritize interventions that address the social determinants of health for under-resourced communities. This is evident in national and state policies and the missions of private funders. At the national level, the ACA raised the profile of prevention through the creation of an evidence-based National Prevention Strategy and the Prevention and Public Health Trust Fund.^{10,11} Influential private-sector funders like the Robert Wood Johnson Foundation and the California Endowment are also investing heavily in interventions that address the social determinants of health.^{12,13}

Innovative community partnerships are occurring across the country in response to policy opportunities and local needs. These policy trends emphasize the importance of community resources and leadership to address clients' holistic needs. Community partnerships in these examples creatively use healthcare dollars to increase access to recovery-oriented social services for behavioral health conditions.

Examples of other HNI-like communities across the country



- New York State's Home and Community-based Services include supportive education, supportive employment, supportive housing, transportation, and peer counseling as part of the Medicaid benefit package for high-risk clients with serious mental illness.¹⁴ Other states have chosen to expand the ACO model to create Medicaid Accountable Communities for Health (ACH) that take on the responsibility for the health of a geographic catchment.¹⁵



- Oregon's ACH models are led by communities themselves via Community Advisory Councils, with regulations that stipulate that the majority of council members be consumers.¹⁵



- A Minnesota ACH model includes a partnership with a county Human Services and Public Health Department. This ACH model uses a portion of Medicaid dollars to contract with community organizations to embed community health workers and vocational specialists in healthcare settings.¹⁶

Robert Wood Johnson Foundation's Culture of Health Initiative

In addition to these recent policy changes, the Robert Wood Johnson Foundation has been leading a national effort to transform health care through their Culture of Health initiative. The **RWJF Culture of Health Action Framework** take a population health perspective that emphasizes the interconnectedness between individuals, communities, and organizations in fostering a culture that promotes health, wellness, and equity. This framework includes four Action Areas:

Making Health a Shared Value: This action area emphasizes improving health through changing a community's expectations and understanding about health and well-being. For mental health, this could be reducing stigma community-wide and expanding the receptivity of mental health programs, accomplished through health promotion campaigns and greater social connectedness, engagement, and support within a community.

Fostering Cross-sector Collaboration: One important way to address disparities in health care is through partnerships between traditional health agencies and community-trusted organizations such as schools, parks, faith-based institutions, and workplaces. These expanded partners could

help in building resilient communities, provide social supports that prevent illness, and detect need for intervention early.

Healthier, More Equitable Communities: Research has demonstrated that the environmental conditions in which people live, work, learn, and play can affect their health and mental health. The social determinants of health and mental health are key areas for intervention, such as available high quality pre-schools, safe schools and parks, and stable housing.

Improve the Integration of the Healthcare System: By having more integrated and coordinated health systems in place, there is a higher likelihood of consumer satisfaction, lower cost, and increased access to mental healthcare.

RWJF will be following 30 Sentinel Communities across the U.S. who will be tracking change over time in these 4 action areas and examining community outcomes such as improved well-being, decreased adverse childhood experiences, and decreased preventable hospitalizations.

Social determinants of health

Marmot defines¹⁷ social determinants of health as community- level contextual factors (e.g. poor housing) and individual-level behavioral factors (e.g. substance abuse) contributing to health and mental health. Markers of low SES associated with health disparities include unemployment, homelessness, violence exposure, school failure, and poor access to health care.¹⁷⁻²⁶ It has been estimated that up to 30% of the variation in health is due to preventable behaviors and exposures (e.g. tobacco use, diet and exercise), and up to 50% is due to individual-level (e.g., poverty) and community-level (e.g., community safety, school quality) social determinants.²⁷ Population-level change in social risk factors and mental health disparities may require policy change, as healthcare and public health programs are often fragmented.^{28,29} *In the box to the right, is an example of the social determinants in cardiac disease.*

To draw attention to social determinants in healthcare delivery, the Institute of Medicine (IOM) identified social and behavioral risk factors as meaningful-use indicators for electronic health records.³⁰ Categories span contextual- and individual-level factors (e.g., education; employment; financial, food, and housing insecurity; stress; physical activity; substance use; neighborhood poverty; exposure to violence; social isolation);³⁰ depression (negative mood and affect); and psychological mediators (assets, patient engagement, self-efficacy).

Mental Health and Social Determinants

Mental health and its social determinants have a two-way relationship. For example, addressing mental health can improve economic outcomes, and reducing poverty may improve depression.^{31,32} Social causation theory suggests that psychological and physical problems result from poverty-related hardship,²³ while mental disorders affect educational attainment³³ and earnings.²⁵

Below are examples of risk factors associated with mental health social determinants within those categories and examples of interventions to address those determinants. This table is adapted from the World Health Organization's report "Closing the Gap in a Generation: Health Equity Through Action on

the Social Determinants of Health”.³⁴ We have included effective interventions for some of these determinants as examples.

There is a growing body of literature demonstrating effectiveness of interventions that improve mental health and social factors simultaneously. For example, Housing First models (modified Assertive Community Treatment teams combined with permanent supported housing without pre-placement sobriety or mandated mental health treatment) have resulted in significantly less homeless days per year, and fewer inpatient and emergency services, and justice involvement³⁵, but mixed results for substance use.³⁶ Supported employment programs have been found to be effective for severe mental illness but have limited evidence in diverse populations, particularly on their ability to improve symptoms of mental illness.^{37,38} From the mental health treatment literature, some mental health interventions have had improved symptoms as well as social risk factors. Depression quality improvement studies have been found to improve depressive symptoms, improve employment status, decrease lost work days, reduce reliance on state disability, increase net worth³⁹, and lessen perceived racial discrimination in care.⁴⁰ For children, a school-based trauma intervention (Cognitive Behavioral Intervention for Trauma in Schools, CBITS) has shown decline in posttraumatic stress and depressive symptoms in youth, along with improvements in grades.⁴¹ Data from an integrated depression QI and microfinance intervention in Vietnam indicate a 50% reduction in depressive symptoms and improved functioning at 3-months.⁴²

Community-wide interventions have also been implemented that address social determinants of mental health. In the *Great Smoky Mountain Study*, a natural experiment that offered cash supplements to Native American families under the federal poverty level resulted in less psychopathology and alcoholism as youth compared to families who did not receive cash assistance, which was maintained into adulthood.⁴³ In the *Moving to Opportunity Demonstration*, families that moved from high to low poverty communities was associated with improved depression and conduct disorder in girls and greater rates of depression, PTSD and conduct disorder in boys.^{44,45}

Similar efforts internationally that combined improvement in healthcare access and quality while concurrently addressing community prioritized social risk factors through a community-engaged participatory services planning and implementation process has been shown to improve birth outcomes such as infant mortality, low-infant birth weight, pre-term delivery, and in one study post-partum maternal depression.^{46,47} As this international study highlights, shared partnership at every step of the intervention planning and delivery is critical if we are to close the gap of disparities in care. The next section describes a community engagement framework that can be used in determining which social determinants are of priority for a neighborhood or community and what strategies should be used to deliver these interventions.

Risk Factors	Mental Health Social Determinants	Possible Intervention
Health-care Access	Lack of available services	Improve availability of mental health services through integration into general health care (e.g. Partners in Care ⁴⁸ ; Collaborative Care for Depression ⁴⁹)
	Unacceptable services (e.g., culturally, linguistically, Etc.)	Ensure mental health staff are culturally and linguistically acceptable (e.g. Women Entering Care ⁵⁰)

	Financial Access	Provide financially accessible services (e.g. ACA, Medicaid)
Consequences of Mental Illness	Productivity	Support to caregivers to protect households from financial consequences of depression; rehabilitation programs
	Social consequences of depression	Anti-stigma campaigns; promotion of supportive family and social networks
	Treatment Costs	Reduce cost, Insurance Coverage
	Lifestyle Impacts	Mental health promotion; including avoidance of substance abuse (e.g. Mental Health First Aid ⁵¹ , SBIRT ⁵²)
Developmental Risk Factors	Early child development	Promote early child development programs (e.g. Triple P Parenting; Parent-Child Interactive Therapy ⁵³)
	Maternal mental illness, poor mother-child bonding	Mother-infant interventions, including breastfeeding (e.g. Nurse Home-Visiting ⁵⁴)
	Adolescent depression risk factors	Depression prevention programs targeting adolescents (e.g. Adolescent Coping with Stress ⁵⁵)
	Older adult social risk factors, isolation, health risks, finances	Education and stress-management programs; peer support mechanisms
	Poverty / Poor family savings	Improve access to credit and savings facilities for poor Cash transfers / income supplements
Community Environment	Trauma/Violence	Violence/crime prevention programs (e.g. Communities that Care; Ending Violence ^{56,57})
	Poor social cohesion	Promote programs building family cohesion and wider social cohesion (e.g. Multidimensional Family Therapy ⁵⁸)
	Disasters	Trauma and stress support programs (e.g. Cognitive Behavioral Intervention for Trauma in Schools, Trauma Focused-Cognitive Behavioral Therapy, Psychological First Aid ⁵⁹⁻⁶¹)
	Injury prevention	Target conditions of multiple deprivation
	Housing improvement	Housing improvement interventions (e.g. Housing First ⁶²)
	Multiple neighborhood risks	Section 8 Housing Vouchers / relocation programs (e.g. Moving to Opportunity ⁶³)
	Unemployment	Employment programs, skills training (e.g. Supported Employment ⁶⁴)
	Policy	Lack of government policy and legislation; human rights framework
	Substance abuse	Alcohol and drug policies
	Stigma	Mental health promotion programs (e.g. Mental Health First Aid ⁵¹)
	Unemployment	Economic policies to promote stability and financial security, and provide adequate funding for a range of public sector services (health, social services, housing) (e.g. Great Smoky Mountain Study ⁴³ ; Supported Employment ⁶⁵)
	Financial insecurity	Welfare policies that provide a financial safety net
	Work stress	Protective labor policies

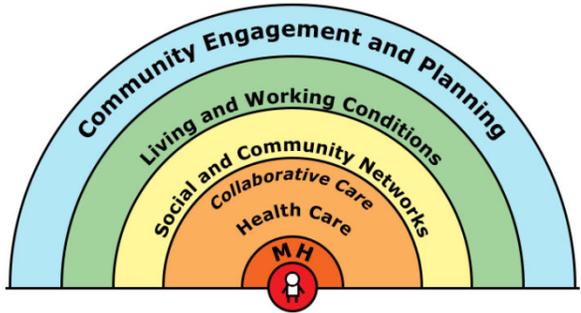
Lack of education	Mandating basic education, incentives, financial support
Discrimination	Anti-discrimination policies, social inclusion in leadership at policy/program levels

COMMUNITY ENGAGEMENT AND PLANNING

An Evidence-Based Engagement Model Tested by LACDMH

“We’re a partnership. There is no us and them like in other projects I’ve been involved with.”
 - Community Partner

Community Engagement and Planning (CEP) emphasizes two-way capacity building, respect, equity, patient-centeredness, and equal authority among partners through inclusion of patients, family members, community leaders, providers, and policymakers in all phases of a project.⁶⁶⁻⁶⁸ The CEP model is an evidence-based community engagement model that was tested in LA County through the CPIC study. This model is recommended for under-resourced communities, given lack of progress in disparities, and discrimination based on mental illness, ethnicity and poverty, requiring a focus on patient and community advocacy. Ultimately, through employing the core values of community engagement, greater equity of care is achieved.



Core Values of Community Engagement, outlined below, provide a framework for the community and partners to review and revise goals of the CEP intervention.⁶⁹

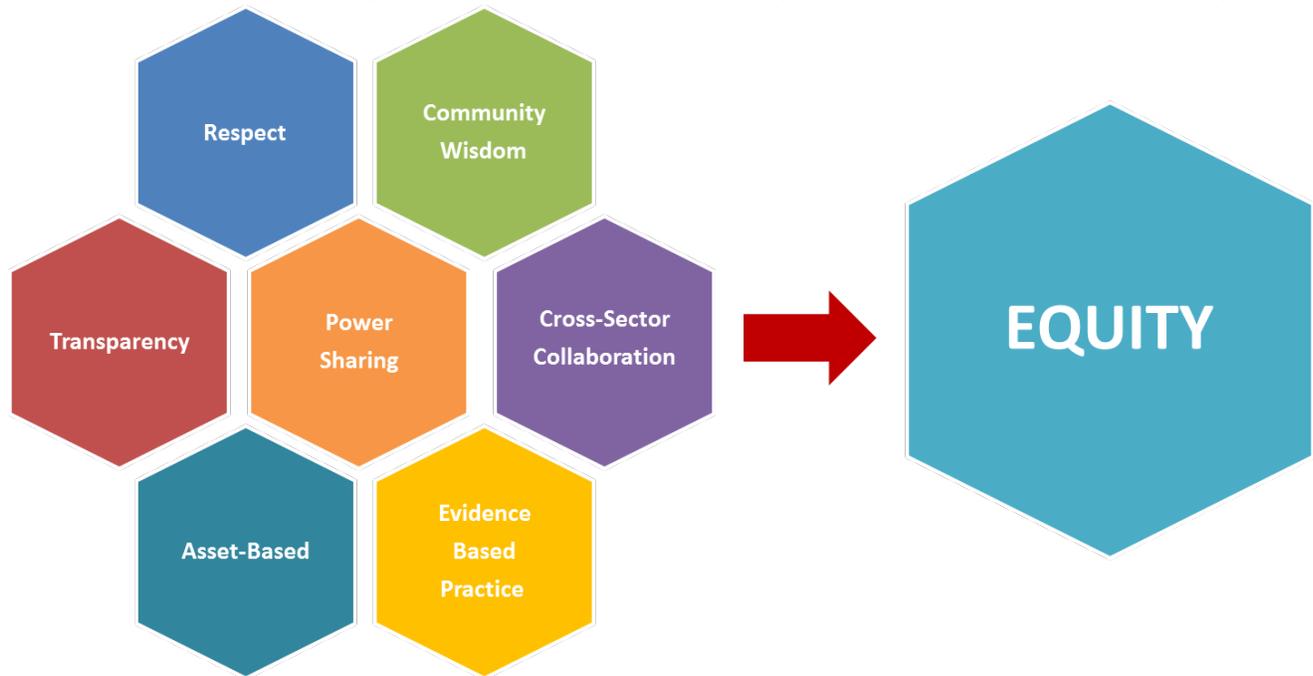
- **Respect for Diversity:** Respecting diversity is essential when working with communities. Through partnership, communities bring diversity in thought and experience. By respecting diversity, trust is gained.
- **Openness:** As goals and objectives may differ among partners, it is important to set clear goals and expectations for a project. Transparency and openness is maintained through communications and inclusion with all stakeholders. Community advocates assure honest dialogue. Community “coaches” support new members. Patients, family, and community members interact with policy and healthcare leaders, e.g., by co-presenting findings to local, state, and national policy makers such as congressional staffers. These approaches have strengthened patient leadership and increased community hope and policymaker commitment to change.
- **Equality:** Equal authority and shared decision-making. Engagement is a two-way knowledge exchange, in

The ABC’s of CEP:

1. Everyone in a community is welcome to the “table”: providers, community leaders, consumers. This is where the focus of a project originates: from community, by community, with community.
2. A partnered leadership structure is created in the form of an oversight council to oversee the project as a whole.
3. Workgroups are formed jointly to address the key areas of the project, as defined by community.
4. Public forums are utilized for broad input on direction of the project and feedback about results.

which patients, family, and community members are invited to share perspectives and educate organizations, agencies, researchers, policymakers, and other organizations. This co-learning is enhanced through community engagement activities that translate concepts into actions or stories (e.g., co-led workgroups, book clubs, storytellers' circles). When understanding is achieved, community members/patients and agency and academics co-lead the presentations to communities.

- **Re-Directed Power:** Re-directed power, or power sharing allows groups to encourage learning from each other and build off existing strengths. Equal leadership and shared authority for patients, community members and other stakeholders and academics are essential to Community Partnered Participatory Research (CPPR). Formal agreements with project partners document sharing of data and resources, strategies to share authority, and rules for raising and resolving disputes.
- **Asset-Based Approach:** Partnerships that build and celebrate capacities take an asset based approach to partnership, as shown below. This recognizes that anyone can add value to the solutions from mental health. For example, when a County Agency leader, a physician, a minister, a therapist, and a homeless patient sit at the same planning table, using an asset-based approach, the most valuable contributed asset may not be an advanced degree or the resources of a large system, but instead the lived experience of the homeless person may be the most important asset to contribute to transforming service delivery. This approach encourages capacity building and future oriented decision-making. Rather than focusing on weaknesses, partnerships focus on strengths to define issues and view problems as opportunities for growth.



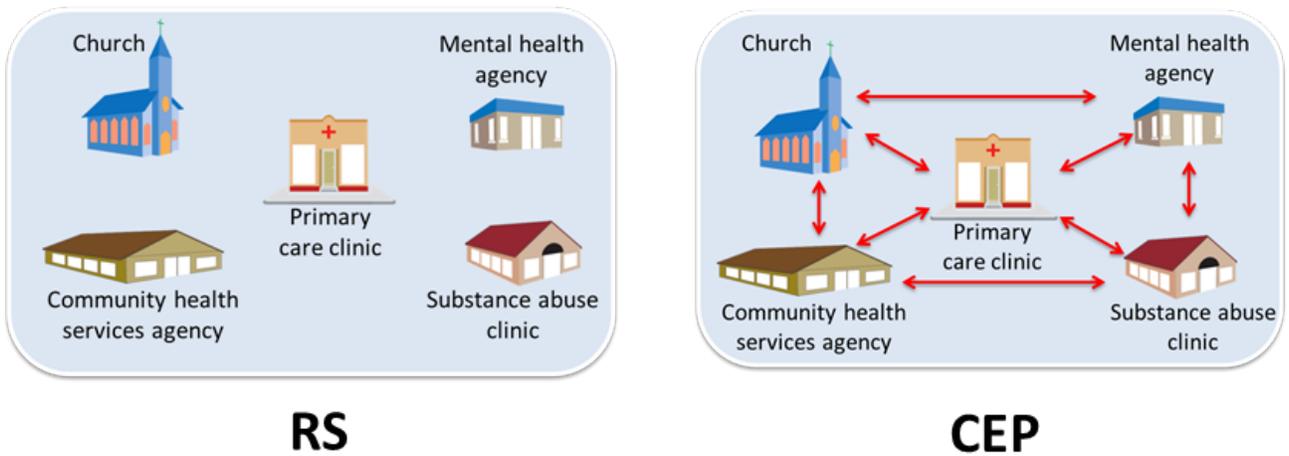
Community Partners in Care: Building blocks for partnership

In this next section, we take a key example from LAC, the *Community Partners in Care* (CPIC) study, to show how a combination of implementing evidence-based treatment for depression and use of Community Engagement and Planning to understand the local needs of each community, resulted in both mental health and social determinant factors improving.

Community Partners in Care – Using CEP to address social determinants of health

Community Partners in Care (CPIC) is a comparative effectiveness trial funded by the National Institute of Mental Health and continuing under a Patient Centered Outcomes Research Institute (PCORI) contract. CPIC and its precursor Witness for Wellness⁷⁰ use a community-partnered approach that promote community co-leadership in research while bringing explicit attention to equity in project leadership.

CPIC compared **Resources for Services (RS)**, a time-limited, technical assistance intervention for individual healthcare and community-based agencies to implement depression quality improvement (QI) programs. RS was compared to **Community Engagement and Planning (CEP)**, a community engagement intervention to support healthcare and community-based agencies as network partners in integrated behavioral health, including cultural adaptation of QI resources to local communities and task-shifting (i.e., transferring tasks where appropriate to non-clinically trained staff within and across different agencies to increase access and efficiency).



For example, in CEP, a minister would be trained provide clients with depression screening, education about depression and care options such as medications or therapy. The minister could refer the client to formal depression care such as medication assessment and management in primary care, depression cognitive behavioral therapy delivered by certified substance abuse counselors, and track the client’s symptoms and coordinate care over time. A minister could also lead a depression cognitive behavioral therapy informed resiliency class to help individuals learn skills to improve their mood as an additional enhancement to formal depression care services from licensed health and mental health professionals.

CPIC was implemented in two Los Angeles communities of color,

CPIC Program Characteristics¹

- 4,440 screened clients
 - 40% African American
 - 45% Latino
 - 50% uninsured
 - 23% employed
 - 65% family income <\$10K
- 93 participating programs
- 50% of depression-related contacts were in social services or other community-based, non-healthcare settings.

Hollywood-Downtown and South Los Angeles, with stakeholder co-leadership using Community-Partnered Participatory Research (CPPR)^{66,71} to build trust and partnerships. Unlike prior studies in primary care, CPIC implemented depression QI in both conditions across primary care, mental health, substance abuse, social services, faith-based, and other agencies to increase depression services access in healthcare shortage areas.¹ Over 50% of depression-related contacts were in social services or other community-based, non-healthcare settings.

Within each community, matched agencies were randomized to RS or CEP. Both RS and CEP interventions used the same evidence-based depression QI toolkits.^{13,72-74} The difference was the use of engagement strategies in CEP across the community. At six-month follow-up, CEP relative to RS significantly improved the primary outcome of mental health-related quality of life, improved physical activity, reduced homelessness risk factors (homelessness, food insecurity, eviction, financial crisis) and behavioral health hospitalizations, and shifted outpatient services from specialty medication visits toward primary care and community trusted institutions such as faith-based settings and senior centers.¹³ There were no intervention effects on formal depression treatments in healthcare settings (e.g., medication, specialty counseling) or on depressive symptoms, suggesting an alternative mechanism for main effects such as social stabilization through shifting tasks to community agencies.

Summary of 6 – 12 month Outcomes continued...

CEP shifted outpatient depression services away from specialty medication visits toward:



BUT: No difference in depressive symptoms, use of antidepressants or healthcare counseling for depression

--So mechanism is not more "formal" treatment

The bottom line is that using a community-engaged approach like CEP across healthcare and community sectors can result in greater mental wellness and outcomes that matter to people, relative to technical assistance to improve services. A Cochrane review identified CPIC as the only study of the added value of community coalitions over a non-coalition alternative to improve health of ethnic minority populations.⁷⁵

I highly recommend this for community. Community Partner In Care is a great vehicle to use to open the doors for communities to identify and initiate policy changes for the social determinants of health. This initiative as a whole will link together a larger group of service provider and individuals and will be able to address the mental health issue.

The partnership will be able to explore vehicles for strengthening existing relationships to better serve our community.

I commend the people who have worked on this project and all of their hard work for the communities. To make changes that we can address this critical need to our communities, in order for us to feel safe and can receive services in a kind and caring environment is welcomed.

Thank you to all.

- Loretta Jones, ThD, Founder and CEO, Healthy African American Families II

Conclusions and next steps

Through the Health Neighborhood Initiative, LACDMH has placed itself at the leading edge of a broad national and international movement to approach mental health and wellness through a focus on integrating and coordinating evidence-based mental health services with attention to **community-prioritized** social determinants of mental health. Not only will LACDMH be improving access to integrated quality mental health services and improving care coordination, the HNI takes one-step further by providing resources and infrastructure for a **community engagement approach** for planning, implementing, and providing oversight for services in equal partnerships with clients, families, grassroots community members, and community agencies to build sustainable community capacity. Aligning the LAC HNI's bold vision with other national efforts and pursuing a rigorous and iterative evaluation of its impact could have major national and international significance.

One example of a national effort to do work in this area is the Robert Wood Johnson Foundation's Culture of Health initiative. The foundation's current focus is aligned with the priorities and activities of the HNI and has as one of its main goals to improve health equity. The **RWJF Culture of Health and Action Framework** emphasizes the interconnectedness between individuals, communities, and organizations in improving population health, and instilling a culture that promotes health. Its framework emphasizes many of the same levers for change that will be strengthened through the HNI:

Value Mental Health and Wellbeing: Innovations 2 will support 10 Health Neighborhoods to address trauma and the social risk factors associated with trauma such as housing instability, adverse childhood events, school discipline, need for peer support and outreach to address social isolation, unemployment, and incarceration. Within these neighborhoods, it is expected that individuals will develop a shared value of mental health and well-being, with reduced stigma around seeking and obtaining mental health services. One tool that Innovations 2 will be offering the health neighborhoods is *Mental Health First Aid*, an evidence-based educational intervention delivered by community members, to inform and empower community members to improve their "mental health literacy" and respond to those with mental illness. Some of the Health Neighborhood strategies for Innovations 2 also focus on improving a "sense of community" by building social support for such populations as the LGBT community and the elderly.

Cross-sector Collaboration: LAC Health Neighborhoods are designed to establish partnerships between traditional health agencies (DMH, DHS, DPH/Substance Abuse Services) with community organizations such as faith-based organizations, schools, vocational/employment services, housing services, domestic violence services, and law enforcement. Innovations 2 supports community organizations to partner around prevention and early intervention services, with cross-sector collaborations with schools, network of businesses to provide employment opportunities within the Health Neighborhood, TAY and LGBTQ serving agencies, community youth mentoring programs, family-serving agencies, law enforcement and community agencies that provide reintegration services, senior centers and service agencies, and senior assisted living facilities, and cultural-specific community agencies. One evidence-based model for cross-sector collaboration tested in LAC and found to be effective is Community Engagement and Planning.

Creating Healthier, More Equitable Communities: Through the cross-sector collaborations above, the Health Neighborhoods and other county agency initiatives will support more equitable communities in the places that they work, learn, play, and live. There are several housing initiatives including Housing for Health (DHS), which increases access to supportive housing and the LA Care homeless initiative. Innovations 2 has priority areas to improve: access to housing for TAY; community locations to support child development and reduce domestic and community violence; schools to support staff in being trauma-informed in the classrooms and on campuses; job opportunities within neighborhoods especially for those with mental illness or who have been homeless or formally homeless; and jails, courts, and reintegration programs to support corrections-involved individuals thrive in neighborhoods.

Strengthening Integration of Health Services & Systems: The County Health Agency has been created to which DHS, DMH, and DPH report, with the goal to improve integration of services. The strategic priorities include enhancing consumer access and experience to clinical services, diversion services for corrections-involved individuals, expanded substance use benefits, and integration of services for chronic disease and prevention. As part of the Health Neighborhood Initiative, there has been an effort to coordinate and integrate health, mental health, and substance use services within each neighborhood.

Tracking & Maximizing Impact

It will be critical moving forward, to document the impact of HNI and assure that communities collect key metrics about the level of engagement of partnerships, care coordination, and the outcomes of implementation and dissemination of evidence-based interventions that address social determinants of mental health. Documenting impact is important to: 1) know what the most effective HNI strategies are, to inform communities and county agencies and to improve HNI implementation and wellness outcomes; 2) to share effective programs with others in the state and nationally and internationally, including through research articles but also broader communication to systems and communities; 3) to inform policymakers, who are in a position to help sustain effective programs and to better address key public mental health issues. The following are a few strategies for documenting the impact of HNI:

- Implementation evaluation that assesses quality of interventions (evidence-based strategies, interventions)
- Data collection that includes key health and social determinant factors in HNI communities as well as in similar comparison communities across all County Services and community services
- Outcome data from multiple levels (e.g., consumer, family, agency, community)
- Process evaluation data that identify changes in the quality and quantity of partnerships (i.e., social network data)
- Learning collaborative activities across HNI communities that can build capacity and create opportunities for documenting change and promote shared learning
- Process evaluation data that uses standard scenario exercises to illustrate how partners work together to address common challenges
- Using research collaborations to link findings with other national efforts in order to facilitate dissemination of findings to national and international audiences
- Adherence to evidence-based, community-engaged, partnership principles (e.g. power-sharing, transparency, co-ownership, strength-based, respect) with client, family, community and community

agency partners in services planning, implementation, oversight, and evaluation to enhance trust in and the relevance of evaluation and its results

- Coupling data with quality improvement processes and groups

Partnership strategies in evaluation with communities and patient and family partners, together with external evaluators, internal quality improvement programs, and diverse county and system/provider partners.

By documenting the process and outcomes of this unique “social experiment”, HNI will be able to inform LA County and the nation about how to support all communities in living healthier and happier lives.

Afterword

The learnings from the pilot HNI’s are the natural outcome of a generation of experimentation with various levels of integration of services and communities. In the mid-eighties, family members in California (parents of young adults with severe mental illness) wanted more than they were finding available for their loved ones. A small task force of family members and professionals scoured the country for model programs and found several that amalgamated provided what they thought would be ideal. That led to legislation for urban and rural pilots to test out a model that would include the best of treatment models, social support programs, financing models and employment programs. This led to the MHA Village in Long Beach in 1990. Over the next dozen years the model was refined, improved and expanded to include housing options, an employment agency, comprehensive social supports and wrap-around treatment. It also included an informal partnership with a community health center so that physical issues would also be covered since by the late 90’s we all knew that life expectancy for people with major mental illness was 15 to 25 years less than the norm.

This all led to the Mental Health Services Act (MHSA) and transformation from a “fail first” system to a help first approach that starts with prevention and early intervention and continues through a whole spectrum of care and involvement in the community.

Now, using the innovation funds in the MHSA, Los Angeles and other counties are developing versions of HNI’s. But, importantly, it is not just health and mental health systems that are involved, but entire community systems. With my own background as pastor and advocate I truly celebrate the building of healthy neighborhoods. We still have much to learn, but we are surely on the right track.

Congratulations to UCLA, CPIC and all the community partners.

-Richard Van Horn, Episcopal Priest, Mental Health America, National Board Chair, President Emeritus, Mental Health America of Los Angeles, Commissioner and Chair of Evaluation, Mental Health Services Oversight and Accountability Commission

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