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Stakeholder Perspectives on the Social Determinants of Mental Health in Community Coalitions

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Objective: Although evidence supports the potential for community coalitions to positively address social determinants of mental health, little is known about the views of stakeholders involved in such efforts. This study sought to understand county leaders' perspectives about social determinants related to the Health Neighborhood Initiative (HNI), a new county effort to support community coalitions.

Design: Descriptive, qualitative study, 2014.

Setting: Community coalitions, located in a large urban city, across eight service planning areas, that serve under-resourced, ethnic minority populations.

Procedures: We conducted key informant interviews with 49 health care and community leaders to understand their perspectives about the HNI. As part of a larger project, this study focused on leaders' views about social determinants of health related to the HNI. All interviews were audio-recorded and transcribed. An inductive approach to coding was used, with text segments grouped by social determinant categories.

Results: County leaders described multiple social determinants of mental health that were relevant to the HNI community coalitions: housing and safety, community violence, and employment and education. Leaders discussed how social determinants were interconnected with each other and the need for efforts to address multiple social determinants simultaneously to effectively improve mental health.

Conclusions: Community coalitions have an opportunity to address multiple social determinants of health to meet social and mental health needs of low-resourced communities. Future research should examine how community coalitions, like those in the HNI, can actively engage with community members to identify needs and then deliver evidence-based care. *Ethn Dis*. 2018;28(Suppl 2):389-396; doi:10.18865/ed.28.S2.389.

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Introduction

Few public health systems in the United States are designed to simultaneously improve mental health and address social determinants of health. Social risk factors such as poverty, violence exposure, job instability, and discrimination[1] can lead to significant mental health problems, while untreated mental health issues can affect employment, incarceration, and school completion.[2-5] Low-resourced communities are at particularly high risk given high unmet mental health needs as well as greater social determinants of poor health.[1] Further, the public service sectors that serve them are usually engaged around distinct needs, each with its own eligibility criteria and limitations in data sharing, coordination, and communication, and not accustomed to addressing the "whole person."

In conceptualizing health in the context of the "whole person," Marmot and colleagues define social determinants as "conditions in which people are born, grow, live, work and age,"[6] conceptualized as community (eg, poor housing) and individual-level factors (eg, substance abuse). It has been estimated that up to 30% of the variation in health is due to preventable behaviors and exposures (eg, tobacco use, diet and exercise), and up to 50% is due to individual-level (eg, poverty) and community-level (eg, community safety, school quality) social determinants.[7] Population-level change in

social risk factors and mental health disparities may require policy change, as health care and public health programs are often fragmented.[7,8] One advance in addressing social determinants in health care delivery has been the Institute of Medicine's (IOM) identification of social and behavioral risk factors as meaningful use indicators for electronic health records.[7] Categories span contextual- and individual-level factors (ie, employment, food insecurity, social isolation)[7]; depression (ie, negative mood and affect); and psychological mediators (ie, patient engagement, self-efficacy).

This article describes the early phase of a system-led effort to address health, mental health, and substance use care coordination through community coalitions created within neighborhoods, with geographical "neighborhood" defined by each coalition.

A number of initiatives and demonstrations across the United States have begun to apply the concepts of service coordination to address the social determinants of health in under-resourced communities. One example is the Accountable Health Communities, an emerging model designed to intervene with community-level social determinants of health, resulting in decreased emergency room use and improved outpatient service quality and use.[9,10] This model achieves health care savings through universal screening for social determinants of health and coordination of care across sectors, with community service navigators and dissemination of community resource information. Further evaluations of such programs that address mental health care coordination and social determinants are needed.[11]

To begin to explore this knowledge gap, this article describes the early phase of a system-led effort to address health, mental health, and substance use care coordination through community coalitions created within neighborhoods, with geographical "neighborhood" defined by each coalition. To draw on the perspectives of county leaders engaged in early implementation of these coalitions, we used a two-stage approach. First, we used data from key stakeholder interviews to describe leaders' perspectives on social determinants of health, including views of the types of contextual factors most relevant to health and mental health and the role for county-led strategies to address them in the context of health, mental health, and public health services. Second, we conducted targeted literature reviews to highlight evidence-based approaches to social determinants of mental health that align with leaders' priorities or address factors leaders identified as relevant. By using key stakeholder interviews to guide focused literature reviews, we demonstrate a strategy by which policymakers and researchers can link evidence to practice; and we identify gaps in the literature with highest salience to health leaders engaged in innovative initiatives to improve community health.

Methods

Partnership Context

This study was partnered with the Los Angeles County Department of Mental Health (LAC DMH), in collaboration with the Departments of Health Services and Public Health, who together initiated the *Health Neighborhood Initiative* (HNI) in 2014. HNI aims to strengthen the community's capacity to support recovery and resilience through two concepts: 1) a Service Delivery Model that improves access to care and service coordination through integration of care across agencies; and 2) a Community Change Model that "achieve[s] community health and wellness" and "address[es] social determinants of health and community-driven… system change".[12] We developed the aims, interview guide, as well as the list of key informants for this study in partnership. Following main themes identified from these interviews, a rapid review of the literature was conducted to provide information about evidence-based interventions for community partners to consider.

Qualitative Key Informant Interviews

Participants

Forty-nine health care leaders representing all eight service planning areas in LAC participated in key infor-

mant interviews. Leaders came from the LAC departments of public health, mental health, and health services (n=42), and community-based organizations (CBOs; n=7) that work closely with the county agencies serving such populations as children, individuals with mental illness, and individuals who are homeless, and a non-profit Medicaid managed care organization.

Procedures

Trained researchers co-led interviews, with one primary interviewer and one to two other interviewers. Interviews took place about one year following the initiation of the HNI. There were 11 semi-structured interviews with individual leaders either in-person or by telephone, and 14 group discussions with leaders from the same agency (N=25 leaders). Each interview lasted approximately an hour to an hour and a half. Participants were asked about HNI key priorities, activities, and coalition successes and barriers, including ways that they have been addressing social determinants of mental health. All interviews were audio-recorded and transcribed verbatim. The study protocol was approved by the RAND Human Subjects Protection Committee.

Data Analysis

We used an inductive approach to interview coding. One coder (CF) read all interviews marking text segments that described interpersonal, environmental, behavioral, and other contextual factors important to mental health or mental distress. To refine coding categories, the coder compared coded text with well-established conceptual models and classifications of social determinants of health and mental health, such as the World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) conceptual framework.[13] Text segments corresponding to common categories of social determinants (eg, education, violence, housing, employment) were grouped. Remaining text segments were discussed with a second coder (EB) to identify patterns and possibilities for categorization. Coding for all text data segments was then reviewed by the second coder and all discrepancies discussed. Both coders then reviewed text segments that reflected interconnectedness among categories of social determinants.

Rapid Literature Reviews

Based on the interviews, we conducted targeted literature reviews on the four main areas of social determinants of mental health identified as salient to the HNI: housing, community violence, employment, and education. A review of English language studies conducted in the United States related to these social determinant domains, were examined for the time period of February 1997 to February 2017. We conducted searches in PubMed, PsychINFO, and Cochrane Database of Systematic Reviews (Cochrane). Only experimental studies addressing a social determinant either at the individual or community level and which described mental health and social outcomes, were included.

Results

Leaders described the following social determinants as the most prominent: 1) housing and safety; 2) community violence and trauma; and (3) employment and education. The following sections illustrate how leaders envision these main social determinants in the context of Health Neighborhoods grappling with multiple determinants together. Following each of these discussions from leaders, we present examples of evidence-based interventions that target these areas of social determinants of mental health.

Housing and Safety

Interview Themes

Of the discussions on social determinants of mental health, housing was a dominant theme across interviews. Leaders describe different aspects of housing needs, with public health leaders identifying needs across general populations, mental health leaders focusing on the needs of high-risk populations, and CBO leaders emphasizing housing as the primary social determinant and needing to address it within each community through engagement.

One theme that public health leaders outlined is the issue of safety and quality of housing as key components to needed change:

> *"Everyone has the right to safe housing, but not just anything. You're not going to live in something that is unsafe and falling apart. …Safe and stable housing and food. I would say, those are, in addition to violence, [are] really critical social determinants that we need to address if we want to improve outcomes … because people can't really hear or engage in other ways when those two basic things are not there... whether it's child abuse or domestic violence … it's not really a safe environment."*

In discussing issues of housing quality, another public health leader stated:

> *"I really wanted to focus on health equity. I wanted to focus in on initially housing and violence… In [one area it] is mostly an issue of affordable housing and homelessness. [In another neighborhood, it] is also homelessness, but also quality. There are a lot of slum properties …One is more quality and the other is more affordability.*

A mental health agency leader highlighted the housing needs of individuals with severe mental illness and substance use and challenges in finding housing in their neighborhood:

> *"They get a voucher and have to find a landlord who is willing to rent to them. You [have to] leave [this neighborhood to use the voucher]. Some people say that they won't do it... [and stay] homeless… than to go into an area that they don't know. "*

Finally CBO leaders identified housing as a social determinant of mental health that fundamentally needs to be addressed at the community level.

> *"…if we really want to end homelessness … we have to do it in a way that engages and empowers the people … at the community level, because we're going to need their investment into it. … They're the ones that can really impact local resources … And then how we integrate with the mental health system, the criminal justice system…that's one thing about homelessness, we touch every issue, land use, everything."*

Another CBO leader described their approach in taking steps toward addressing housing as a social determinant in spite of larger county issues:

> *"We're not going to address…the supply of affordable housing … or the minimum wage or opportunities for low income people or low skill workers. Those are some very large social determinants … but the fact that not being housed or being very poorly, very unstably [housed] greatly decreases the whole health outcome for an individual, that's something we could address by connecting them to housing navigation and services."*

Key Literature

From the literature on housing as a social determinant of mental health, studies have documented individual- and community-level interventions. There is growing evidence for individual-level interventions for improving housing stability and mental health outcomes among individuals who have severe mental illness and are homeless. For example, Housing First models (modified Assertive Community Treatment teams combined with permanent supported housing without mandated mental health or substance use treatment) result in fewer days homeless per year and lower inpatient and emergency service use and justice involvement,[14] but have mixed results for substance use.[15]

Further, the Housing First model can address the multiple social determinants of mental health in addition to housing. For example, research shows improved overall perceived quality of life, feeling of neighborhood safety, and comfort with one's living situation[16] among individuals receiving the Housing First model. Housing First can also address employment; individuals receiving the Housing First model combined with individual placement and support (IPS) were more than two times as likely to find competitive employment compared to individuals receiving usual vocational sevices.[17]

As another example, the US Department of Housing and Urban Development's Moving to Opportunity (MTO) demonstration randomized families to higher income and safer neighborhoods with housing vouchers.[18] Long-term findings showed improvement in adult health and in subjective well-being.[19] Findings were mixed for adolescents by sex, with improved depression and conduct disorder in girls, but greater rates of depression, posttraumatic stress disorder, and conduct disorder in boys.[20]

Violence and Trauma

Interview Themes

Participants across sectors highlighted the interrelated and complex nature of violence as a social determinant of mental health. Some interviewees saw poverty and lack of employment as the most important precursors to crime and gang-related violence, highlighting a focus on job security as a more effective way to reduce violence.

> "*We have decided to focus on jobs as well as safe passages [safe routes to school]… talking to gang interventionists, the Sheriff's department, probation, multiple other CBOs on the ground. We kind of want to target youth, and the lack of employment."*

For others, violence as a social determinant of mental health meant decreasing homicide rates, because violent neighborhoods hinder healthy behav-

ior and repel access to health resources.

> *"We know from our work from talking to other programs that violence is a huge barrier to physical activity, to health seeking behavior, leading to risk taking behaviors. … Doing this kind of cross sector work is always very difficult to get people out of silos".*

And similarly, those populations at highest risk require creative solutions for resources.

> "*I've had conversations with law enforcement about trauma [and] violence associated with trauma that's related to sex trafficking, gangs, and a lot of our young people who have experienced trauma on the streets. And how do we get resources to those populations, because they remain relatively hidden, right?"*

Key Literature

One example from the literature of an effective intervention using a broad-scale community system-level change is Communities That Care (CTC), a community-wide prevention program where communities identify strengths and risk factors of youth in their community.[21] CTC incorporates community coalitions that implement evidence-based interventions for youth violence, delinquency, and substance abuse. CTC resulted in decreased initiation of delinquent behavior, alcohol and tobacco use, and engagement in violent behavior.[21]

Employment and Education

Interview Themes

In addition to concerns about housing and neighborhood safety, leaders described that employment opportunities and better education were frequently voiced by their community members as urgent and linked needs.

> *"Since the 1990s [my Health Neighborhood] has not had enough employment. They've been complaining since the 90s about not having enough jobs… So that is part of the reason why the kids are not doing very well in school, because, what's the point. There are no jobs in this community."*

These leaders emphasized that education was a primary need, related to the wellbeing of young people and predictive of their future.

> *"We see that the high school there has an 82% truancy rate, which is crazy… The data show that if you don't have a good education, you're more likely to have a host of bad health outcomes... Not getting a good education is tied to so many other things."*

Leaders also discussed that focusing on only job creation was ineffective, when other social determinants such as access to transportation, education, and safe environments were closely associated with successful employment.

> *"Just giving them jobs isn't the answer. You've got to give them some of the skills and make sure they have everything from bus passes, etc. Because there are so many gangs in that area, they can't safely get to school or to work. So, again, it's just not giving them a job."*

Key Literature

Interventions targeting employment at a structural level have yielded results that have had some benefits beyond immediate salary security. Many target welfare in their studies. For example, New Hope, a three-year randomized anti-poverty program was the result of a community-initiated policy effort in Wisconsin, aiming to increase employment of parents via earnings supplements to lift families above poverty, and provide child-care assistance and health care subsidies. Their children were evaluated in a five-year follow-up, and boys benefited from New Hope with greater school achievement and more optimistic views about future employment; however these effects were not found in girls.[22,23] The Great Smoky Mountain Study, a natural experiment that offered cash supplements to Native American families living under the federal poverty level, demonstrated that youth whose families received cash supplements had less psychopathology and alcoholism compared with families who did not receive cash assistance, which sustained into adulthood.[24] Similarly, school Social Emotional Learning programs show improved academic performance, classroom behavior, and emotional distress[25] and school wide approaches such as Positive Behaviors and Intervention Supports (PBIS) have promising effects on attendance, disciplinary actions, and student behavior.[26]

Interconnectedness of Social Determinants

Interview Themes

As seen above, throughout these interviews, leaders from different sectors described social determinants of mental health as interconnected and indicated that it would

be difficult for Health Neighborhoods to address any one social determinant without addressing others:

> *"But not getting good education is tied to so many other things - the community being violent. There's a whole segment of [the neighborhood] that doesn't go to high school because they can't cross the street because of the gangs there. It's safety, it's not having food and stable housing. It's kids that have to care for younger siblings because their parents work 3 - 4 jobs. Or have substance abuse issues or are incarcerated… It's like this huge compounding effect of all of these needs.'*

However leaders also pointed out the challenge in changing how agencies have historically interacted with each other.

> *"Our department is having increased focus on housing … jobs and also education …and violence as a determinant of health… [in] doing this kind of cross-sector work, [it] is always very difficult to get people out of silos."*

Leaders advocated for HNI agencies to address social determinants of mental health in a partnered approach to empower the communities they served. One leader provided an example of a strategy pursued by one neighborhood:

> *"They have a 'narrator.' She is called a 'Rock'. The 'Rock' meets once a week in different places to have coffee with women. And that is how the women are starting to connect. They are also organizing all kinds of activities on the weekends. They don't want to be told – they want to have a voice."*

Key Literature

One comparative effectiveness study that encouraged community "voice" in delivering depression care found that community engaged coalitions can be more effective in promoting wellness and addressing social risk factors, such as improvements in employment status[27,28] and reduction in homelessness risk factors,[29] than enhanced usual care. In the Community Partners in Care (CPIC) study, Los Angeles County (LAC) agencies participated with community and academic partners in a randomized clinical trial of the added value of multi-sector coalitions over individual agency technical assistance to address depression, with positive findings including greater mental health quality of life and mental wellness, and reduced risk for homelessness.[29] County leaders noted this effort as, in part, inspiring HNI. A Cochrane review noted CPIC to be the only high-quality study internationally to compare the effects of community coalitions to an alternative intervention for improving health of minority communities.[30] In CPIC, the coalition approach supported collaboration in planning, implementing and monitoring collaborative care for depression across networks of health and community-based agencies, and community "trusted" places such as churches.

These leaders recognized the importance of coalitions engaging with community members to build community capacity, social cohesion, and collective efficacy.

Discussion

Interviews with key community leaders revealed multiple social determinants of mental health—housing, employment, education, and various forms of violence and safety issues—that affect clients' mental health. Leaders emphasized the importance of simultaneously addressing these multiple social determinants of mental health and viewed this as a role of HNI. Additionally, these leaders recognized the importance of coalitions engaging with community members to build community capacity, social cohesion, and collective efficacy. They described the importance of first addressing basic needs (ie, education, housing and safety), engaging communities around economic factors to boost employment and strengthen local business, and building community collective efficacy.

Findings from our rapid review of evidence-based interventions suggest potential next steps for the Health Neighborhood Initiative to consider in addressing mental health needs and social determinants of mental health. For example, implementing interventions such as PBIS—that improve childhood educational and behavioral outcomes—could address concerns about high truancy rates in some health neighborhoods.[26] Similarly, implementing Housing First

models combined with individual placement and supports within neighborhoods could provide local housing needs and simultaneously improve employment and mental health and lower justice involvement.[17]

Our interviews revealed that leaders valued community-level approaches that could intersect across sectors of care. These coalitions brought together service providers to strengthen care coordination and provide a platform for broader agenda-setting according to coalition-defined goals. By October 2016, 11 HNI coalitions had been established in all eight service areas of LAC and many coalitions were working to make improvements in care coordination, access to care, and social determinants of health—the intended joint goal of this initiative.[12]

However, a recent Cochrane systematic review describes the limited research available on the use of community coalitions to reduce ethnic minority health disparities.[30] It outlines four types of strategies employed by community coalitions: broad-scale community system-level change, broad-scale health or social care system-level change, lay community health outreach workers, and group-based health education and support for targeted groups led by trained peers or by health professionals.[30] Such strategies may serve as a guide for achieving improved health, while addressing interrelated social determinants and building community capacities.

Study Limitations

This study should be viewed in light of several limitations. These interviews reflect the views of leaders from one large, urban county and may not reflect other regions or systems. Leaders were interviewed in the early stage of HNI and thus data do not explore later implementation of HNI efforts. Future publications will describe community-coalition efforts and their impacts, as well as leaders' perceptions of priorities for health services coordination and access to care, other goals of HNI. In addition, leaders may also not share the same perspectives of HNI as those receiving services. Future research would benefit from a broader stakeholder view of these coalitions in addressing social determinants and mental health conditions, particularly from patient and family stakeholder perspectives.

Conclusions

This study highlights how leaders, early in the implementation of a policy initiative in the public-sector, under-resourced, largely ethnic minority communities, first viewed social determinants in the context of these coalitions. Community coalitions, like HNI, provide an opportunity to prioritize the structural and intermediary determinants in a neighborhood, while addressing prevention and treatment of mental health problems and coordination of services across health and community-based service sectors.

Under the health care reform goals of improving population health, reducing costs, and increasing quality of care, increased research efforts are needed to evaluate innovative approaches such as the HNI. Future research on community coalitions should focus on the activities that coalitions deliver and their relationship to stakeholders' perceived priorities, implementation of evidence-based programs for mental health that also address social determinants, and the effects of interventions on community-centered outcomes. This may provide new evidence for integration of services to affect mental health and social determinants through community coalitions and the feasibility and impact of delivering evidence-based programs at this interface.

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Conflict of Interest

No conflicts of interest to report.

Author Contributions

Research concept and design: Kataoka, Wells; Acquisition of data: Figueroa; Data analysis and interpretation: Kataoka, Ijadi-Maghsoodi, Figueroa, Castillo, Bromley, Patel, Wells; Manuscript draft: Kataoka, Ijadi-Maghsoodi, Figueroa, Castillo, Bromley, Patel, Wells; Administrative: Kataoka, Ijadi-Maghsoodi, Figueroa, Castillo, Bromley, Patel, Wells; Supervision: Kataoka, Figueroa, Bromley, Wells

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