Health Care for Communities (HCC)

Partnership Initiative

CHARTBOOK

of Preliminary Study Findings

July 7, 2006

A joint research project of the UCLA-Semel Institute Health Services Research Center and RAND Health, in partnership with BHS, Inc., Healthy African American Families, Los Angeles County Department of Mental Health, and QueensCare Health and Faith Partnership.

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Study Background

The Health Care for Communities (HCC) Partnership Initiative is a pilot project funded by the Robert Wood Johnson Foundation with supplemental support through NIMH and other NIH grants aimed at understanding how local organizations can effectively partner to improve mental health and substance abuse services and reduce disparities related to these needs in Los Angeles communities.

The study is conducted jointly by the UCLA-Semel Institute Health Services Research Center and RAND Health in partnership with Behavioral Health Services, Inc., Healthy African American Families, the Los Angeles County Department of Mental Health, and QueensCare Health and Faith Partnership.

Purpose

As a pilot project, the study has focused on developing a community-partnered, strength-based approach and methodology to distinguish successful strategies and conditions for organizations to partner around mental health and substance abuse issues. The specific goals of the study are to:

1) Identify the capacities and strengths that local organizations bring to addressing mental health and substance abuse issues in a community
2) Map out current inter-agency partnerships and collaborative experiences around these issues, and
3) Explore how organizations can better work together to achieve community health goals

The ultimate objective of the project is to feed back information to study participants and other interested stakeholders in Los Angeles communities in order to help:

1) Identify opportunities for partnering among local organizations
2) Inform the design and implementation of community-based partnerships and health interventions, and
3) Track changes in the capacity of communities and local health partnerships over time to address mental health and substance abuse needs and disparities

A major vehicle for feeding back information from the study and engaging in a community dialogue about implications is a Community Feedback Conference to be held at the USC Davidson Conference Center on July 7th, 2006 to which study participants and other interested stakeholders in Los Angeles communities have been invited. Results from the study will also be disseminated through other community forums, as well as through research and other publications.

Methods

The main method for collecting data for this study consisted of an in-person, semi-structured interview of about an hour in length with administrative staff from a variety of service agencies and community-based organizations serving people with mental health and/or substance abuse needs in two Los Angeles County Service Provision Areas (SPAs): Hollywood Metro/Downtown (***SPA 4***) and South LA (***SPA 6***). These two SPA's each include large and diverse communities of color representing high need for public health and mental health services, but also exhibiting unique sets of community stakeholders, services providers, and different histories of community collaborations.

As described below, this sample included a number of social services, medical care, and other types of agencies in addition to those in the mental health and substance abuse treatment sectors, and also included several agencies based in other SPAs that serve people in the two primary geographic areas of the study.

The interviews covered the following general topics:

- The main mission, target clients or constituents, staff, funding, and other characteristics of the organization
- The health, mental health, and substance abuse priorities of the organization
- Partnership and collaborative experiences with other organizations in serving the needs of people with mental health and substance abuse needs
- Other organizations in the community considered important to serving the needs of people with mental health and substance abuse needs
- Desired partnership or collaborative relationships with other agencies around these needs

The information from these interviews was supplemented with web-based and other secondary sources on agency characteristics.

Community-Partnered Research

The Partnership Initiative study has been conducted according to the spirit and principles of a community-partnered approach in which academic and community partners jointly develop and take ownership of research projects in order to ensure both scientific rigor and community relevance. While the roles and level of participation vary on different projects, the community partners for this study have been integral in determining research goals, study design, data collection instruments, and continue to take active involvement in interpreting and disseminating results, including co-authored, peer-reviewed papers. See the back of the chartbook for a listing of individuals involved from the academic (UCLA, RAND) and community partners (BHS, HAAF, L.A. County DMH, and QueensCare).

The Community Feedback Conference similarly reflects this community-partnered approach to engage a wider community audience in the research and issues it attempts to address.

Sample of Community Agencies

Working with a panel of community experts familiar with services and needs in Los Angeles County, and SPA's 4 and 6 in particular, we identified a sample of 97 agency "sites" rated as important resources for people with mental health and/or substance abuse needs in each area, either because they serve large numbers of people or provide a uniquely important service. A "site", as defined in this study, may represent a central office or a specific department, program, or facility location of a larger agency in order to capture various levels of organizations at which inter-agency partnerships and collaborative relations can form. Seven sites were dropped from the sample due to ineligibility or having ceased operation. Four new "sites" were added as part of a "snowball" sample design that identified agencies mentioned by at least 4 separate respondents from the initial sample. This yielded a final sample of 94 sites—45 in SPA 4, 35 in SPA 6, and 14 sites based in other SPAs that also serve people in the two main study areas.

As Table 1 indicates, respondents were interviewed at a total of 66 sites for a final response rate of **71%** (71% in SPA 4, 74% in SPA 6, and 57% in other sectors). As Table 2 indicates, although the highest representation is from agencies in the mental health and substance abuse sectors (based on the primary mission of the agency as a whole), the sample also includes a substantial number of organizations from the social services, homeless services, and medical care sectors, among others.

Table 1. Completed interview sample by Service Provision Area (SPA)

	Total	*SPA 4*	*SPA 6*	*Other*
Completed interview sties	**66**	32	26	8
Response rate	**71%**	71%	74%	57%

Table 2. Completed interview sites by Main Service Sector*

Main Service Sector	*Total completed*	*% of completed*
Mental health	20	**27%**
Substance abuse	20	**32%**
Social services	10	17%
Homeless services	7	10%
Medical care	8	12%
Other sectors	1	3%

* Based on primary mission of agency.

This chartbook reports preliminary results from 61 of the 66 interviewed sites, since 5 sites were not data-entered in time for the analyses prepared for the project's Community Feedback Conference. Tables 3 and 4 report the response rates and sector composition for the preliminary analyses, which are largely the same as the distributions shown in Tables 1 and 2 above for the full sample. A final report for the study, expected to be issued in the Fall of 2006, will include final results from all completed interview sites as well as information and implications generated from the Community Feedback Conference.

Table 3. Interviewed sites included in Chartbook analyses, by SPA

	*Total**	*SPA 4*	*SPA 6*	*Other*
Number of sites	**61**	30	26	5

Table 4. Interviewed sites included in Chartbook analyses, by Main Service Sector*

Main Service Sector	*# of sites*	*% of sites*
Mental health	19	**31%**
Substance abuse	20	**33%**
Social services	9	15%
Homeless services	6	10%
Medical care	7	11%

* Based on primary mission of agency.

General Site Characteristics

Table 5 reports information on the staff and client composition for the current sample of 61 sites. While the range for these characteristics is wide (e.g., paid staff of sites ranging from 0 to 5,750 employees, and volunteer staff from 0 to 704 individuals), there are relatively few sites on the high end, as reflected in generally higher mean compared to median averages (the latter reflecting the value for the site at the midpoint, or 50th percentile on a measure).

On average, 17% of paid staff at the sites included in this sample had professional mental health training (at a minimum an MSW or equivalent masters degree), and 7% had professional substance abuse training (that is, certified or licensed substance abuse counselors). Substantial portions of the clients or constituents of these organizations have mental health, substance abuse, or a co-occurring combination of these disorders.

Table 6 gives the size distribution of sites based on numbers of paid staff. Nearly half of sites are categorized as small agencies (0-25 paid staff), and approximately a quarter each are categorized as medium (26-80 paid staff) and large (81+ paid staff). Mental

health, homeless services, and medical care sites in this sample tend to be larger, and substance abuse and social services sites tend be smaller (not shown in table).

Table 5. Staff and client composition

	Median	*Range*	*Mean*
Staff			
Paid	30	0 – 5750	166
Volunteer	5	0 – 704	30
With MH training	5	0 – 4313	87
With SA training	2	0 – 50	7
Clients			
Unduplicated clients in past month	260	6 – 4500	667
% with MH disorder	75%	0 – 100	61%
% with SA disorder	60%	0 – 100	57%
% with COD disorder (including above)	30%	0 – 100	40%

Table 6. Size of sites based on numbers of paid staff

Size category	*# of sites*	*% of sites*
Small (0-25 paid staff)	29	48%
Medium (26-80 paid staff)	17	28%
Large (81+ paid staff)	15	25%

Study Findings

The following sections report preliminary findings from the study on the following topics:

1) **Health priorities** of agency sites – including orderings of specific physical health, mental health, and substance abuse needs, and mappings of common health priorities
2) **Inter-agency partnerships** reported by sites -- including statistical breakdowns of reasons/impetus for partnerships, target services/needs, target clients/constituents, and joint activities, as well as mappings of connections among sites around different types of services/needs, and
3) **Partnering issues** – including summary of themes from open-ended questions and other discussions from interview transcripts on motivations for partnering, desired areas for partnering, and partnering obstacles and facilitating conditions

Health Priorities

During the interviews, respondents were asked to prioritize a range of health needs to address in their communities by allocating a fictional $1000 budget across 4 specific mental health, 4 specific substance abuse, and 12 specific physical health needs, as well as a category for co-occurring mental health & substance abuse (COD) disorders. Respondents also had the opportunity to write in other health priorities not included in the list provided, and did not have to allocate any of the budget to health conditions that would not be a priority for their organizations.

Table 7 displays the average emphasis across general categories of health priorities (mental health, substance abuse, COD, and physical health) by SPA area:

- Sites in SPAs 4 & 6 similarly rated mental health as the top health priority according allocations of the fictional budget
- Substance abuse is also rated as a relatively high priority in both SPAs (second in SPA 4, third in SPA 6)
- Sites in SPA 6 placed a stronger emphasis on physical health needs (rated second) compared to sites in SPA 4

Table 8 provides the average ordering of specific health priorities by SPA area:

- Sites in SPAs 4 & 6 similarly rated SMI and Depression as the top mental health priorities
- Sites in SPA 4 rated Meth as the top substance abuse priority, while sites in SPA 6 emphasized Crack/Cocaine and Alcohol

- Co-occurring disorders (COD) have the highest priority compared to any other specific health priority (as opposed to the general categories of need in Table 7)
- HIV/AIDS is the top-rated physical health priority in both SPAs, while sites in SPA 4 tended to emphasize Primary Medical Care, and sites in SPA 6 tended to emphasize Hypertension and Obesity.

Table 7. General health priorities

	Average number of $ points out of $1000*			
	Overall (n=61)	*SPA 4 (n=30)*	*SPA 6 (n=26)*	*Other (n=5)*
Mental health	**$389**	**$395**	**$367**	**$458**
Substance abuse	**$229**	**$220**	**$234**	**$254**
COD	$150	$188	$113	$106
Physical health	**$233**	$197	**$286**	$182
	$1000	$1000	$1000	$1000

* Priorities bolded if average $ points were greater than or equal to $200.

Common Health Priorities

In addition to calculating average orderings of health priorities, we also used network analysis techniques and visualization software[1] to map sites in relation to the main health needs they reported in order to identify natural clusters of sites with common health priorities.

Figure 1 displays the mapping of all interviewed sites and their main health priorities.

[1] UCINet v.6.0 and NetDraw V.1.0

Table 8. Ordering of specific health priorities

	Average number of $ points out of $1000			
	Overall *(n=61)*	*SPA 4* *(n=30)*	*SPA 6* *(n=26)*	*Other* *(n=5)*
Mental health*	**SMI ($118)** **Depression ($106)** Anxiety ($38) Personality ($28) Suicidality ($19)	**SMI ($141)** **Depression ($115)** Anxiety ($47) Personality ($25) Suicidality ($8)	**SMI ($113)** **Depression ($109)** Personality ($36) Anxiety ($33) Suicidality ($29)	Depression ($38) Suicidality ($32) Anxiety ($10) SMI ($2) Personality ($7)
Substance abuse*	**Meth ($57)** **Cocaine/Crack ($57)** **Alcohol ($53)** IDU ($16) Marijuana ($9)	**Meth ($101)** Alcohol ($38) Cocaine/Crack ($33) IDU ($17) Marijuana ($7)	**Cocaine/Crack ($91)** **Alcohol ($75)** Meth ($12) Marijuana ($12) IDU ($6)	**IDU ($57)** Alcohol ($37) Cocaine/Crack ($32) Meth ($20) Marijuana ($9)
COD	**COD ($150)**	**COD ($188)**	**COD ($113)**	**COD ($106)**
Physical health**	**HIV/AIDS ($55)** **Primary Med ($32)** Hep C ($24) Oral Health ($21) Obesity ($17) Hypertension ($17) Diabetes ($14) Tuberculosis ($11) Hep A/B ($8)	**HIV/AIDS ($70)** **Primary Med ($42)** Hep C ($26) Oral Health ($20) Tuberculosis ($9) Hep A/B ($8) Diabetes ($6) Obesity ($5)	**HIV/AIDS ($46)** **Hypertension ($36)** **Obesity ($32)** Diabetes ($24) Primary Med ($22) Oral Health ($22) Hep C ($21) Tuberculosis ($16) Hep A/B ($8) Cancer ($6) CHF ($6)	Primary Med ($27) Hep C ($25) Oral Health ($22) Obesity ($12) Hep A/B ($11) HIV/AIDS ($10) Hypertension ($9) Cancer ($5) CHF ($5) Lung Disease ($5)

* Priorities bolded if average $ points were greater than or equal to $50.

** Priorities bolded if average $ points were greater than or equal to $30. Physical health priorities not listed if average $ points were less than $5.

Notes on reading the graph in Figure 1:

- Circles represent each site, which are colored by main service sector. The first digit of the site id number represents the primary SPA in which the site operates (e.g., site 61761 operates primarily in SPA 6; county-wide organizations have a six digit id number beginning with "10"). Diamonds represent "group partnerships", which include community coalitions, task forces, and joint projects comprised of several organizations (rather than an individual organization per se).
- Health priorities are represented by grey boxes ("n.s." stands for "not specified").
- For this mapping, lines are drawn only between sites and the main health priorities they identified (not between sites)
- The mapping only includes the main health priorities reported by sites (priorities rated at least $100 out of the $1000 fictional budget).

The graphing program places health priorities near each other that tend to be emphasized in similar combinations by sites. Likewise, sites with similar combinations of health priorities will be located near each other and near the clusters of health priorities they emphasize. Sites located in between two clusters tend to emphasize both sets of priorities.

Although this particular type of mapping looks very busy, there are some interesting patterns that emerge:

- 3 clusters of health priorities appear to cohere: (1) a set of mental health disorders (Depression, SMI, Personality, and Anxiety disorders), (2) a group of substance abuse related needs (including Crack/Cocaine, Alcohol, Injection Drug Use (IDU), Methamphetamine addictions, as well as HIV/AIDS and Hepatitis C), and (3) a cluster of physical health needs (Primary Medical Care, Diabetes, and Tuberculosis).
- As might be expected, mental health sites tend to cluster around the set of mental health disorders, and substance abuse sites around the cluster of substance abuse related needs
- COD disorders are located between these two clusters, but appear to fall closer to the cluster of sites and needs associated with substance abuse.
- A few mental health and substance abuse sites tend to straddle the area between substance abuse and mental health needs
- Homeless services sites tend to either fall in between the space between substance abuse and mental health needs, or be more strongly associated with combinations of substance abuse and medical care needs.
- Social services sites appear to be dispersed across a range of separate health priorities throughout the graph.

Figure 1. Common health priorities among interviewed sites (all SPAs)

Note: only includes health priorities for each agency assigned at least $100 out of $1000

Inter-Agency Partnerships

A key section of the interview reviewed all partnerships known by the respondent between their agency and other organizations during the previous year that address the needs of people with mental health and/or substance abuse problems.

The respondents were presented with a relatively conservative definition of partnership as “a collaboration between two or more agencies based on mutual cooperation and responsibility to achieve a specific goal or service” that specifically excluded client referrals or vendor/contractor relations (unless in the context of a wider collaboration).

Numbers and Composition of Partnerships

The total number of reported partnerships for the 61 sites in this analysis was **314**, or an average of **5.2** per site. The average number of reported partnerships was slightly higher for sites in SPA 6 (6.3), compared to sites in SPA 4 (4.3) or other SPAs (4.6).

Table 9 provides a breakdown of partnerships by the services or needs targeted.

Table 9. Target services of partnerships

Target Service Categories*	# of partnerships	% of partnerships	Specific Target Services of partnerships**
Mental health	123	41%	General MH (15%), MH individual counseling (12%), MH assessment (8%), Other MH (6%)
Substance abuse	62	20%	Other SA (11%), General SA (7%)
COD	7	2%	
Mental health & Substance abuse (but not COD)	16	5%	
Medical care	86	28%	HIV tx (7%), Med outreach/prevention (7%), Other Med (6%)
Social services	140	46%	Education/vocational services (18%), Housing assistance (12%), Other Soc Services (9%), Case management (7%), General Soc Services (7%)

* Categories are not mutually exclusive.
** Specific target services listed only if mentioned in at least 5% of partnerships.

- The most common set of services or needs addressed by the reported partnerships was social services, followed closely by mental health services.
- Medical care and substance abuse services were also common (addressed by a fifth and a quarter of partnerships, respectively).
- Partnerships involving both mental health and substance abuse services, or specifically COD, comprised only a small fraction of total partnerships.

Table 10 provides a breakdown of partnerships that reported targeting a specific client or constituent group:

- The most commonly targeted groups were defined by age strata—Children & Families, and Adults; these were followed by women and homeless individuals.
- Partnerships specifically targeting a particular ethnic or racial group (e.g., African-American, Latino, or Asian) represented only a small fraction of partnerships.[2]

Table 11 reports different reasons that the reported partnerships were initiated, as best recalled by the interview respondents:

- By far the most common reason given was to fill a pending need of an agency or its clients.
- Other common reasons included an opportunity that was created when funding became available, and individuals with a vision or passion to establish the collaborative relationship.

Table 12 reports types of joint activities that the partnerships entailed:

- The three most prevalent joint activities included joint/case/care management, joint community planning/coordination, and joint education/outreach initiatives.
- Also common (19-22% of partnerships) were joint administration/management of services, joint policy/advocacy efforts, and joint funding arrangements.

Table 13 provides information on other partnership characteristics, including the number currently ongoing (82%; the remaining had ceased in the past year), whether any formal agreement existed between the agencies, and whether any dedicated funding (internal to the organization or from external sources) supported the partnership.

[2] Almost all of which were reported by sites in SPA 6 (not shown in table).

Table 10. Target clients/constituents of partnerships

Target Clients/ Constituents*	# of partnerships	% of partnerships	Specific Target Clients/Constituents of partnerships
Children & families	102	**32%**	Children (26%), Families (16%)
Adolescents	48	**15%**	
Adults	115	**37%**	
Elderly	6	2%	
Women	43	**14%**	
Gay, Lesbian, Bi-Sexual, or Transgender	9	3%	Gay/Lesbian (3%), Bi-Sexual/Transgender (1%)
African-American	13	4%	
Latino	9	3%	
Asian	5	2%	
Immigrant/Undocumented	7	2%	
Low income	16	5%	
Homeless	38	**12%**	
SMI	29	9%	
COD	13	4%	
Geographic area	18	6%	

* Categories are not mutually exclusive.

Table 11. Impetus for partnerships

Reasons initiated	% of partnerships	More prevalent in partnerships reported by:
To fill client/agency need	61%	
Funding became available	19%	Social Services sites (32%) Homeless Services sites (27%)
Individuals with vision/passion	19%	Social Services sites (36%) Homeless Services sites (45%)
Existing or long-standing relationships between agencies	12%	
Personal connections	9%	By sites in SPA 6 (14%) compared to SPA 4 (4%)
Other reasons	5%	
Don't know	4%	

Table 12. Joint activities of partnerships

Joint activities	% of partnerships	More prevalent in partnerships reported by:
Joint case/care management of clients	46%	Mental Health sites (69%) Substance Abuse sites (44%) By *Large* (55%) and *Medium* (51%) sized sites
Joint community planning/ coordination of services	44%	Social Services agencies (64%)
Joint education/outreach initiatives	40%	Substance Abuse sites (54%) Social Services sites (72%) By *Small* (50%) sized sites
Joint administration/management of services	22%	Social Services sites (44%) Homeless Services sites (50%) Prevalence also increases by size of site
Joint policy/advocacy efforts	19%	Homeless Services sites (44%) Medical Care sites (32%)
Joint funding arrangements (grants, proposals, etc)	19%	Social Services sites (44%)
Joint other activities	10%	
Reciprocal use of services	9%	

Table 13. Other partnership characteristics

Other Characteristics	% of partnerships
Partnership is currently ongoing*	82%
Formal agreement exists between agencies**	46%
Dedicated external funding exists for partnership activities	21%
Dedicated internal funding exists for partnership activities	20%
Partnership supported through in-kind support (time & effort of staff)	54%

Lastly, Table 14 analyzes the degree to which sites partnered with other sites within their same service sector, and Table 15 with other sites within their same SPA area.

Notable findings from Table 14 (within same service sector) include:

- Mental Health, Social Services, and Medical Services sites had the highest proportion of reported partnerships within their own sector (33%, 32%, and 46%, respectively).
- Substance Abuse sector sites had the highest proportion of reported partnerships with agencies in the Medical Services (23%) and Mental Health (17%) sectors.
- Homeless Service sector sites had the highest proportion of reported partnerships with agencies in the Medical Services (36%) sector.

Results from Table 15 (within same SPA) include:

- 51% of reported partnerships are between agencies in the same SPA (20% within SPA 4 and 26% within SPA 6).
- 8% of reported partnerships are between SPA’s 4 and 6, and 39% are from either SPA 4 or 6 to other SPA areas.

Table 14. Partnerships between sectors

			Main service sector of reported partner						Total
			Mental Health	Substance Abuse	Social Services	Homeless Services	Medical Services	Other	
Main service sector of intvwd site	Mental Health	Count	41	11	23	3	22	26	126
		% within sector	32.5%	8.7%	18.3%	2.4%	17.5%	20.6%	100.0%
	Substance Abuse	Count	16	14	14	8	22	20	94
		% within sector	17.0%	14.9%	14.9%	8.5%	23.4%	21.3%	100.0%
	Social Services	Count	3	6	16	1	6	18	50
		% within sector	6.0%	12.0%	32.0%	2.0%	12.0%	36.0%	100.0%
	Homeless Services	Count	1	2	3	1	8	7	22
		% within sector	4.5%	9.1%	13.6%	4.5%	36.4%	31.8%	100.0%
	Medical Services	Count	2	1		1	10	8	22
		% within sector	9.1%	4.5%		4.5%	45.5%	36.4%	100.0%
	Total	Count	63	34	56	14	68	79	314
		% within sector	20.1%	10.8%	17.8%	4.5%	21.7%	25.2%	100.0%

Table 15. Partnerships between Service Provision Areas (SPAs)

			SPA of reported partner			Total
			SPA 4	SPA 6	Other SPA	
SPA of intvwd site	SPA 4	Count	53	7	54	114
		% of Total	19.8%	2.6%	20.1%	42.5%
	SPA 6	Count	14	69	51	134
		% of Total	5.2%	25.7%	19.0%	50.0%
	Other SPA	Count	5	1	14	20
		% of Total	1.9%	.4%	5.2%	7.5%
	Total	Count	72	77	119	268
		% of Total	26.9%	28.7%	44.4%	100.0%

Mappings of inter-agency partnerships

As with health priorities, we also used network analysis techniques and visualization software to map the partnership connections among sites around different types of services and needs to identify the composition and pattern of current inter-agency collaborations.

The mappings of inter-agency partnerships are similar to the graph for common health priorities (see notes on reading mappings on p.9), except that:

- In the inter-agency partnership maps, lines are drawn between sites, each representing a separate partner relationship between site organizations
- In Figures 5 & 7 only, circles (representing each site) are sized according to numbers of paid staff (three sizes: Small 0-25 employees, Medium 26-80 employees, and Large 81+ employees).

Figure 2 displays the mapping of all partnerships (regardless of target services/needs, or other partnership characteristics) that were reported by sites in SPA 4. Figure 3 displays the same mapping for sites in SPA 6.

- First, it is clear that there are many partnerships currently ongoing in both SPA areas, connecting a wide variety of service providers with each other (if indirectly, and perhaps not known to individuals in all sites).
- It is also interesting to note the substantial number of partnerships with sites in other SPA areas, also fairly dispersed throughout the partnership graph.
- The SPA 4 graph contains one large, inter-connected component of partnerships, and four smaller disconnected clusters of partnerships in the upper right corner.
- The SPA 6 graph also contains one large, inter-connected component, but only two smaller disconnected clusters (on right-hand side).
- In addition, the large component in SPA 6 appears much more densely connected than the one in SPA 4 (also reflected in the higher average number of partnerships per site for SPA 6 reported above). Although the density of collaborative connections may not affect the performance of individual partnerships, it is associated with greater information flow and the likelihood that agencies in a community will be aware of what others are doing. This may result in less “reinventing the wheel” and greater ability to form additional collaborations as needed.

Figure 2. Partnerships reported by sites in SPA 4

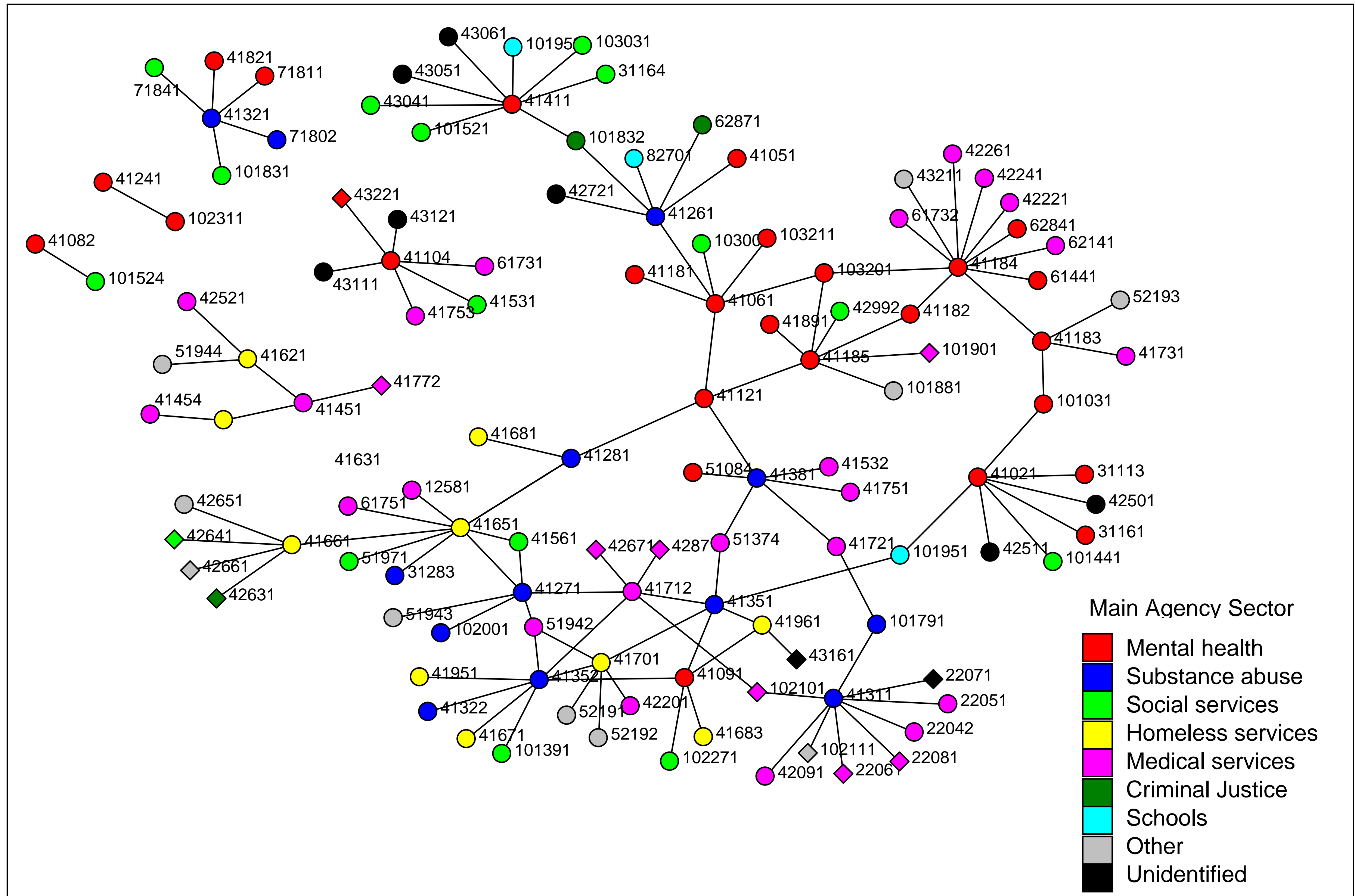

Figure 3. Partnerships reported by sites in SPA 6

Main Agency Sector

- Mental health
- Substance abuse
- Social services
- Homeless services
- Medical services
- Criminal Justice
- Schools
- Other
- Unidentified

In Figure 4, we drill down to partnerships that involve any type of mental health service (from treatment for specific conditions, to assessment and outreach). Figure 5 compares the mappings of mental health partnerships for sites in SPA 4 and 6.

- Although the mappings of all mental health partnerships in Figure 4 contains also contains a large, inter-connected component, it is relatively sparse with no obvious sites or group of sites at its core. Such unrealized connections may represent opportunities for better collaboration and partnering.
- In Figure 5, the mental health partnerships reported by sites in SPA 6 appear generally more inter-connected and dense. The size of sites (indicated by the size of circles), shows these networks to be dominated by larger mental health sites (reflecting the generally larger size, based on paid staff, of mental health agencies in our sample).

The mapping of substance abuse partnerships in Figure 6 indicates an even sparser set of connections among agencies partnering around this need in particular.

The comparison of substance abuse partnerships in SPA 4 and 6 in Figure 7 indicate again somewhat greater numbers and density of connections in SPA 6. Also of note are several smaller substance abuse clusters in each SPA that do not include a substance abuse site as a partner.

The mapping of partnerships focusing on services for co-occurring disorders (COD) in Figure 8 shows that not only are there few such partnerships within our sample as a whole, but that they are for the most part disconnected from each other.

Figure 9 maps partnerships that involve **both** mental health and substance abuse services, and/or COD services.

- Here there are a number of partnerships that include both mental health and substance abuse services, but which were not described specifically as efforts based on a COD approach. These may reflect partnerships in which one agency provides mental health services to a partner agency's clients, and the partner site provides substance abuse services in return.
- Again, even with the additional number of partnerships included in this graph compared to Figure 8, partnerships involving a combination of mental health and substance abuse services appear generally disconnected from one another. The open spaces in this mapping may represent additional opportunities for partnering.

Although we do not analyze the visual graphs of partnerships focusing on social services and medical services, the mappings for these partnerships (all SPAs) are shown in Figures 11 and 12.

Figure 4. Mental health partnerships (all SPAs)

Main Agency Sector

- Mental health
- Substance abuse
- Social services
- Homeless services
- Medical services
- Criminal Justice
- Schools
- Other
- Unidentified

Figure 5. Mental health partnerships (SPAs 4 & 6)

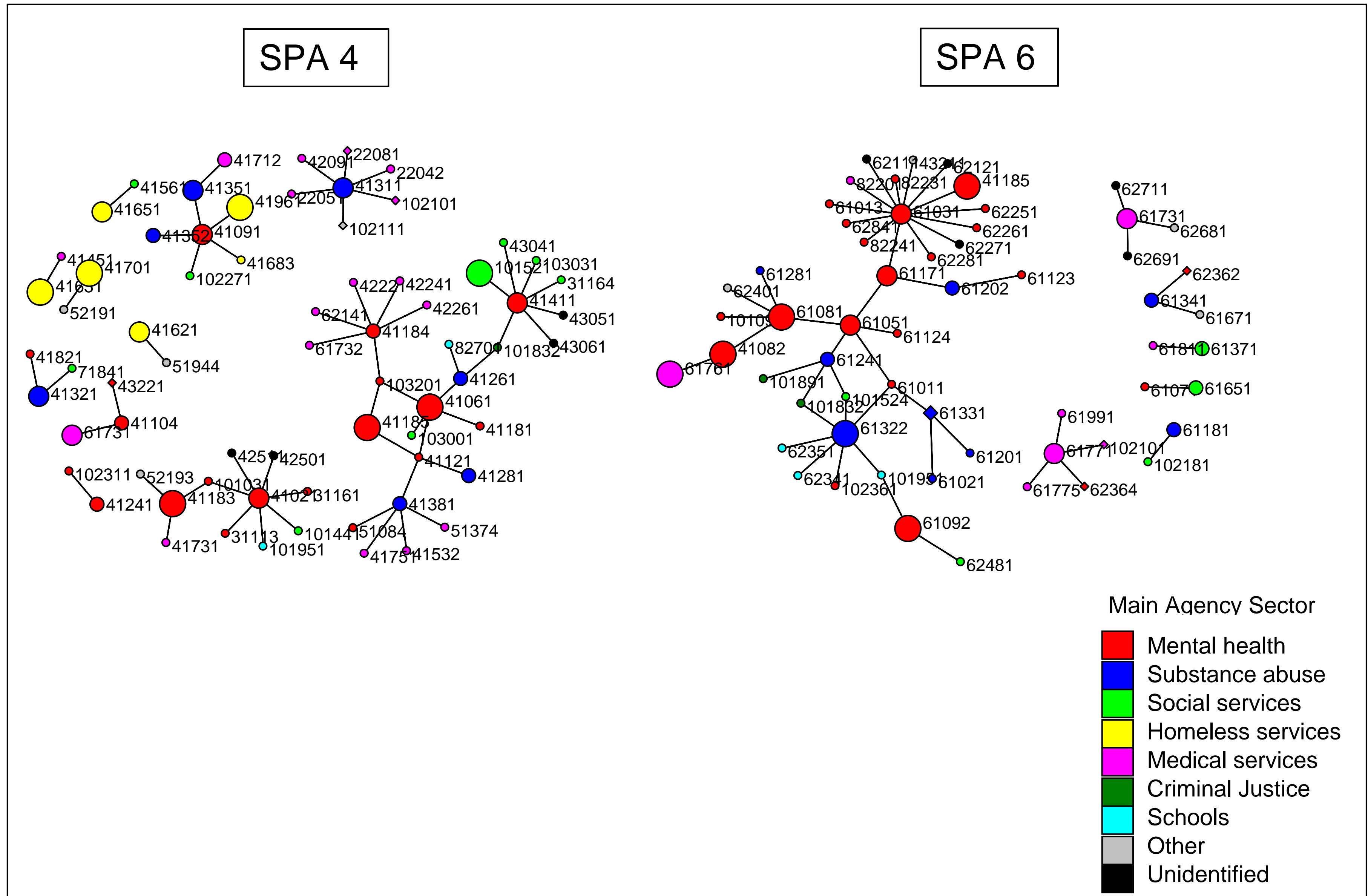

Figure 6. Substance abuse partnerships (all SPAs)

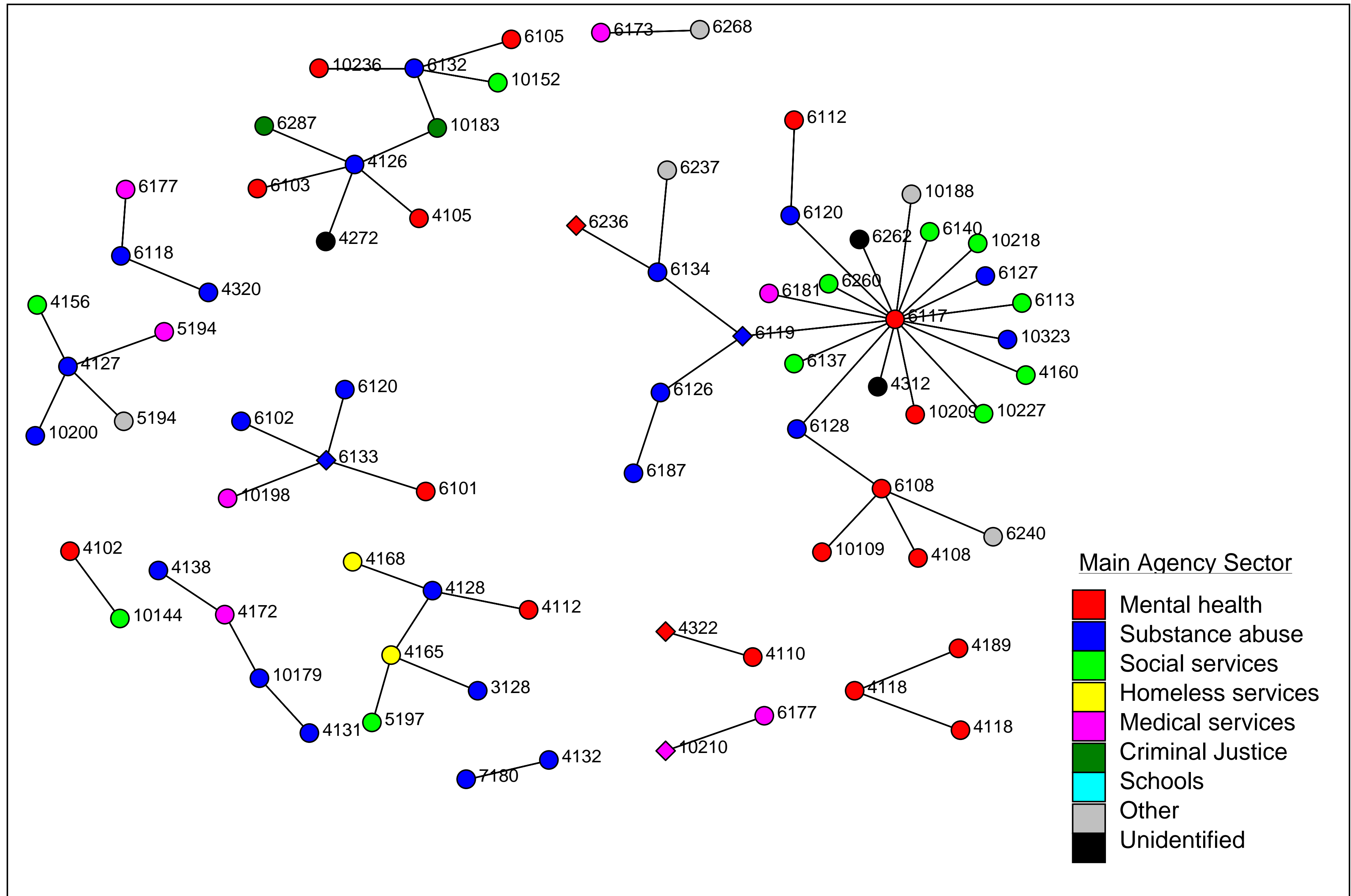

Figure 7. Substance abuse partnerships (SPAs 4 & 6)

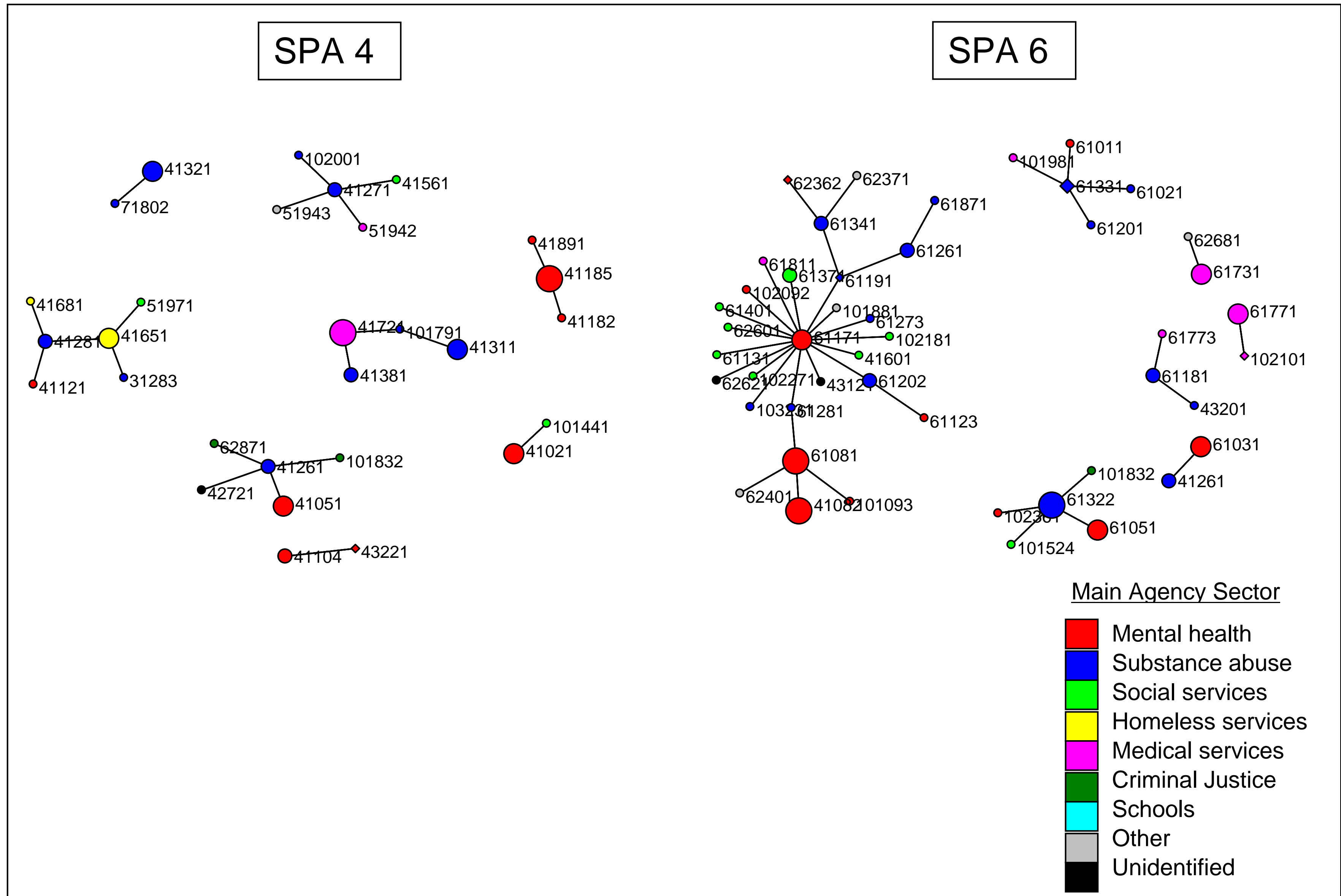

Figure 8. Co-occurring disorder (COD) partnerships (all SPAs)

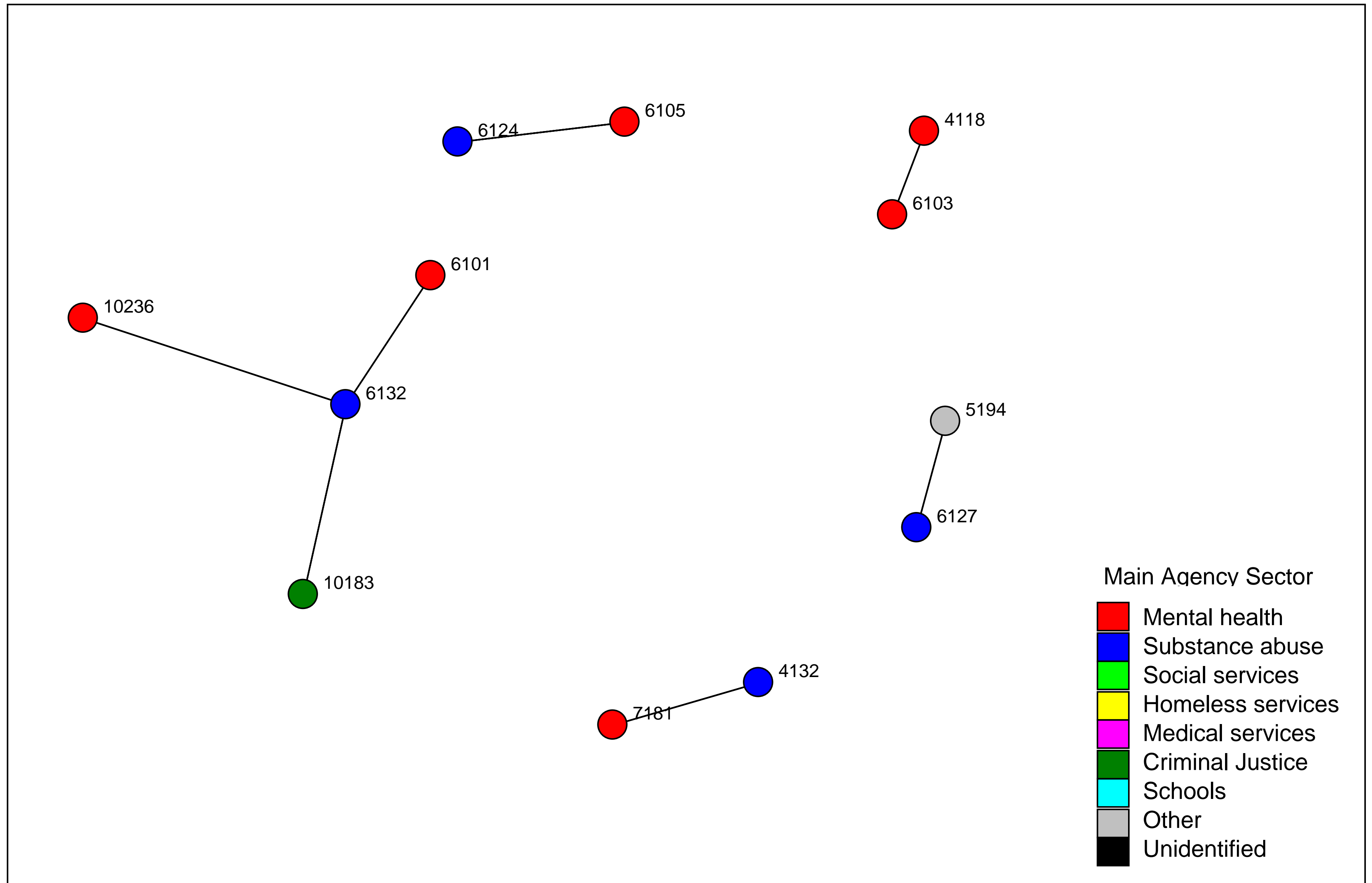

Figure 9. Mental health & substance abuse partnerships (all SPAs)

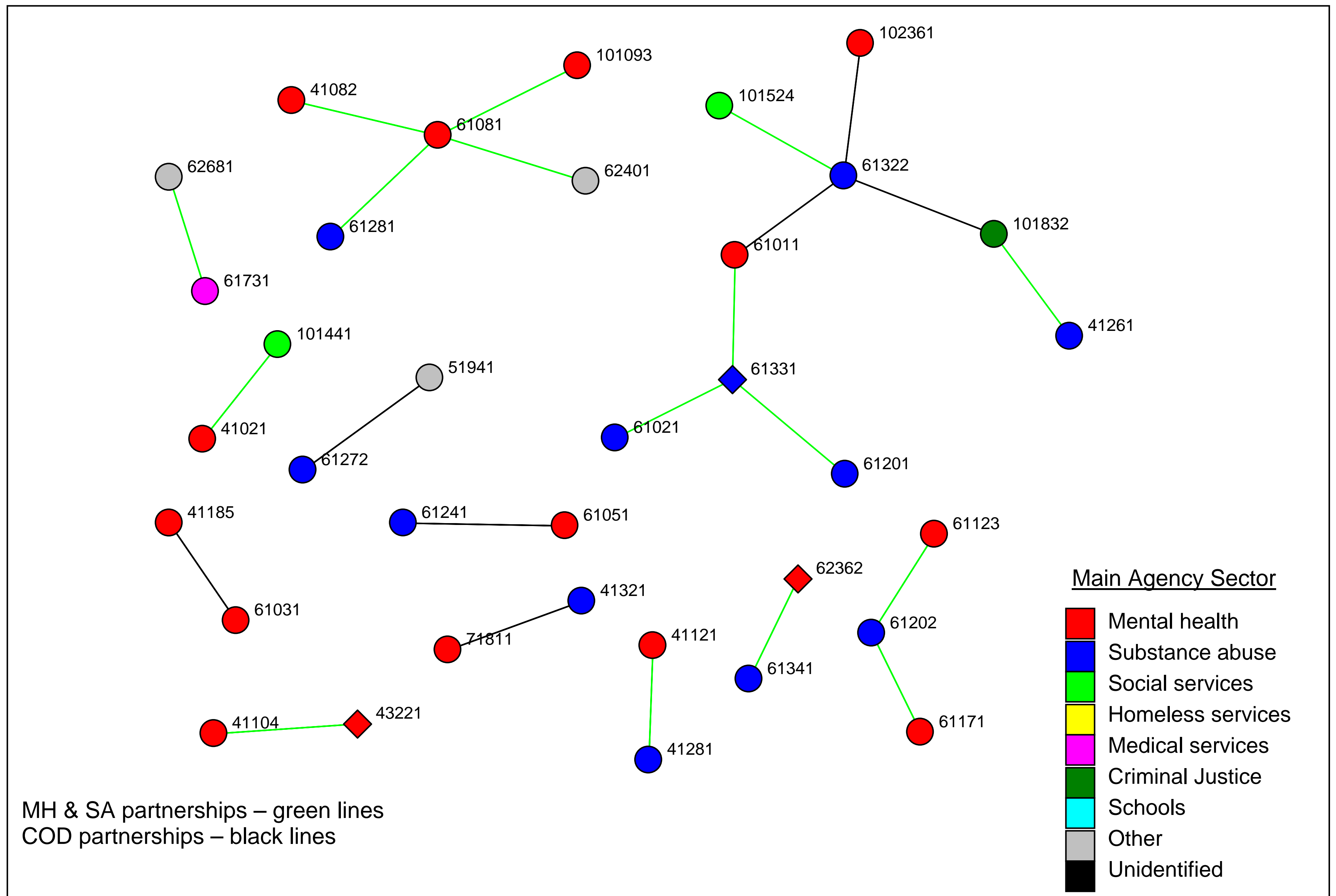

Figure 10. Social services partnerships (all SPAs)

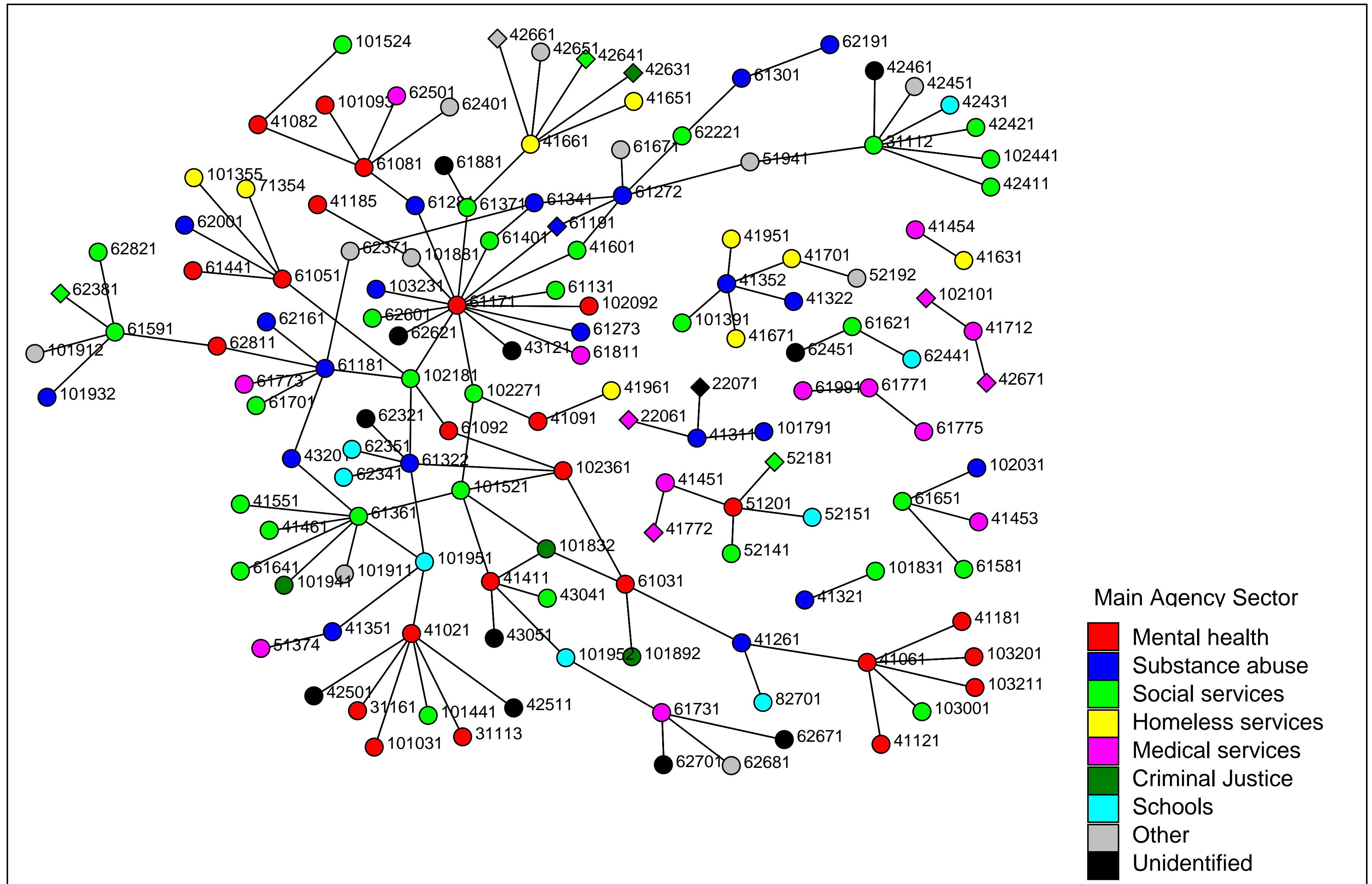

Figure 11. Medical care partnerships (all SPAs)

Main Agency Sector

- Mental health
- Substance abuse
- Social services
- Homeless services
- Medical services
- Criminal Justice
- Schools
- Other
- Unidentified

Partnering Issues

Interview transcripts of the open-ended questions and other discussion in the interviews were analyzed to identify themes related to:

1) Why the respondents' agencies look to partner with other organizations
2) Types of partnerships the respondents' agencies would like to initiate, and
3) Perceived obstacles to partnering

The following analyses are based on interviews from 34 sites. Interview transcripts for remaining sites are currently being coded and will be included in the final report. Although it is difficult to assess exact emphasis of themes based on the limited sample for these analyses, we provide the frequencies of sites that mentioned each theme in parentheses below.

Why agencies look to partner

Two main reasons emerged from the 34 sites analyzed so far on the reasons for agencies to pursue partnerships:

- **Expand Service Offerings** (20) – in a variety of areas, including mental health, substance abuse, COD, children services, medical care, education, shelter, domestic violence, and in general.

- **Expand Client Base** (3) – mentioned several times, although much less frequently than expanding service offerings.

- Other motivations for partnering (1 mention each) included:
    - increasing funding
    - policy advocacy for homeless individuals,
    - educating police and other providers on mental health and substance abuse issues, and
    - conducting research

Types of partnerships desired

Respondents were explicitly asked if there were any types of partnerships or collaborations with other agencies that they would wish their organization had, but didn't have, and why.

Respondents reported a variety of areas, as well as a number of specific agencies, for desired partnerships. Medical care was by far the most common area for desired partnerships, followed by mental health and substance abuse services—at least in the 34 sites analyzed so far in our sample:

- **Medical care** (22)– AHF, community health clinics, Watts Health Foundation, OAPP, LA Public Health, UCLA Medical School, USC Norris Cancer Center, American Cancer Association, American Heart Association.

- **Mental health** (12) – any children's mental health agency, as well as Child Guidance Clinic and Children's Institute International; Did Hirsch, DMH, Kedren, Edelman, Pacific Clinics, and Pepperdine Clinics.

- **Substance abuse** (10) – CSAT, Phoenix House, Tarzana, Walden House, youth drug treatment, sober living centers, churches.

- **None-No desire** (8) – "we're fine", (very) self-sufficient, none desired, unsure.

- **Social services** (5) – mostly youth services, such as Challenger's Club, Children's Bureau, Para Los Ninos; also Catholic Charities.

- Other areas for desired partnerships (1 or 2 mentions each) included:
    - COD (residential center able to provide both mental health and substance abuse treatment, professionalism of mental health combined with zeal of 12-step programs)
    - Shelter and domestic violence services (local 'safe shelter', Jenesse Center)
    - Police (local police, Hollywood Police), and
    - Schools (local high schools, LAUSD)

<u>Perceived obstacles to partnering</u>

Interestingly, the two most commonly mentioned obstacles to partnering—at least in these first 34 sites in our sample—were pessimism and lack of interest in partnering on part of the respondent's agency (similar to the 'No desire' responses above) or other organizations with which they would like to partner. Professional "culture clashes" between mental health, substance abuse, and other providers was next, followed by several system-level obstacles as well as a lack of suitable partners. Below is the full list with specific comments:

- **Pessimism** (5) – collaborations exist in name only, collaborations are poor return on investment, agency prefers not to collaborate in general, agency is cautious to develop collaborations.

- **Lack of interest** (4) – lack of effort, lack of perceived internal need, others not interested, never interested in pursuing partnerships.

- **Professional "culture clashes"** (3) – between mental health and substance abuse providers, as well as with HIV providers.

- Other perceived obstacles to partnering (1 or 2 mentions each) included:
  - "The system" (general complexity, overwhelming numbers of agencies)
  - Funding (structure of funding discourages collaboration, lack of funding)
  - Regulation (paper work and bureaucracy of various agencies prevent collaboration)
  - Lack of suitable partners (lack of partners with professionalism or programs with similar priorities, no suitable partners)
  - Overwhelming need
  - Competition among agencies
  - Lack of organizational capacity (time, resources, size)
  - Poor cultural awareness (in general), and
  - Geographic location/distance

Facilitating factors/conditions

While less commonly mentioned than obstacles or barriers, there was some discussion of factors or conditions that facilitate partnering, as illustrated in the following quotes:

Trust, clarity, and creativity

"We know each other. We tried to go for a grant together. We didn't get it, but we got to know each other's programs, and gain respect for each other, and I think are in that process of making a true partnership. Once again, we have to be very, very clear of what this partnership is going to look like. It's not just referrals. We're talking about doing a mutual project where families can benefit on both ends. And, that means becoming creative." (Child and family service agency)

Receptiveness of other agencies improving (while others not)

"I have a sort of general feeling that substance abuse services may have improved a bit over the time I've been at [this agency]. We certainly found more people to liaise with, and a number of them successfully. Whereas, for mental health, really, we seem to be pretty much on our own. There's not too much we can get from anyone else." (HIV services)

Location, location, location

"…it's really local, like a few blocks away from the center. So in terms of the services, a lot of the families, they look for places in the area. So obviously, that's why we…work with them." (Family services agency)

Follow the money, let's share nice

"It's really difficult…from what I always hear, it's because there's no funds. But now, I hear there's a huge amount of mental health funds, and I'd like to know what they're doing with it, and why we're not able to access some of it for these kids...I don't care whether a kid's documented or undocumented…" (Homeless youth agency)

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