

October 1, 2014 (11:30pm-1:30pm)
Peter Paul Development Center
1708 North 22nd Street
Richmond, VA – 23223

Executive Summary

The host of the meeting, Richmond Promise Neighborhood, offered updates on their upcoming efforts to engage families and promote mental health and wellbeing. Over the course of the meeting, the group looked at a variety of data sources to get a full demographic picture of Creighton Court and the surrounding area. In discussions of the data, it seemed that mental health was a growing priority in the community as well as an interest in the group. In addition, the group emphasized the importance of wrap-around services, and focused on other issues, such as substance use, intimate partner violence, child and adult obesity, diabetes, asthma, and heart disease. The purpose for convening service providers in the redevelopment process is multifaceted in nature: the group will share recommendations with local and national funders, policymakers, and RRHA and TCB. Suggestions for evidence-based practices were reviewed, and the group offered insight into their perceptions of prioritized wrap around service models and adult mental health and substance abuse as priorities for the next meeting.

Welcome – Please enjoy your lunch

Updates

- **Mental Health First Aid Training Update**
 - Through the partnership of Richmond Promise Neighborhood (RPN) and Richmond Behavioral Health Authority (RBHA), Chimere Miles and one other person were able to complete a training to become a trainer of Mental Health First Aid for those that work with youth. RPN has a formal Memorandum of Understanding with RBHA to track data of, and provide materials for, these trainings. This seems to be an ongoing commitment. To date, Chimere has trained over 100 staff in the City of Richmond, including Peter Paul Development Center staff, Richmond Public Schools staff.
 - Mental Health First Aid training helps reduce the stigma surrounding mental health, and it promotes mental wellbeing. The training yields insight into symptoms, as well as tools for intervening or recommending appropriate services. This training will be a regular offering under the Promise Academy – for service providers and folks who live in the community. The age target is for service providers that work with children ages 8 and older.
- **Powerful Parents Info Feast**



- This RPN event is scheduled for Thursday, October 30th. It will have a focus on Powerful Parents and the ages and stages of growth. The Office of Community Wealth Building Early Childhood Task Force is going to invite parents to participate in focus groups regarding early childcare. The Gents will perform and healthy dinner will be provided. If your organization is interested in having a table at this event, then Michael Parsons is the person to contact.
- **Launch of the Promise Families Network**
 - Peter Paul Development Center (PPDC) has articulated their purpose of educating children, engaging parents, and empowering the community. In 2012, a community needs assessment demonstrated that the community would like to prioritize parental engagement, workforce development, and mental health services. Richmond Promise Neighborhood (RPN) is going to focus on family engagement, as it is defined by Health and Human Services.
 - RPN is making changes and the changes are summarized in handouts. RPN is aligning themselves with the outcomes that PPDC has identified with the educational program for 8th grade to high school. Since RPN's vision offers children and their families a cradle to career pipeline, they have added developmental delays as a focus. RPN has done a slight revision of the action teams. They are launching what they are calling a Promise Families Community – it's about supporting healthy family environments where there are stronger relationships between parents and children that facilitate life-long learning. They are looking at a peer-to-peer coaching model (a strengthening families model). RPN has already launched a Circle of Parents support group. The actual curriculum of the Strengthening Families Model will take place January-February. RPN is targeting about 30 families, and aiming for a cohort of 15-20 families. If there are families from the community that would like to participate, there is an open door for that.

Review of existing data

- **Background maps**
 - Poverty in Richmond, VA: We are working in a high poverty neighborhood, which has some of the lowest life expectancy rates.
- **RRHA descriptive data for Creighton**
 - There are about 1,300 individuals, 504 units, and the average household consists of 2.6 people.
 - It is surprising to see that there are so many houses of single individuals. However, family sizes could be larger than what people report.
 - Age distribution: about 55% of the population is under 18.



- Duration of stay: there are a huge percentage of people that have not been living in Creighton for very long. Then again, this data may only capture the duration of the lease agreement.
- Vulnerable populations: 23% disabled, 63% households with children and a vast majority of children are living with single, female head of households.
- Household income distribution: 43% are living off of \$5,000 or less annual income, and this includes all sources of income.
- Health Systems data
 - This is a peek at data from the Office of Health Innovation. This is data for the VCU Health Systems, only. Creighton Court stands out as a high-cost region.
 - Top 10 diagnoses for the Creighton area: keep in mind that this data records the primary diagnosis – the reason for the visit:
 - Mental health
 - Substance abuse, and mental health and substance abuse comorbidity
 - COPD and Asthma
 - Hypertension
- Community Needs Assessment
 - This was a door-to-door assessment, one facet of which explored health conditions and self-report diagnoses. About 150 surveys were collected.
 - How were the questions framed? For example, how did they arrive at 34 adults diagnosed with depression? “How many of the health conditions are you currently managing?” “Have you been diagnosed with this by a physician?”
 - As TCB and the City interpret this data, they will work with residents to determine what the social cues are. In this way, they will be able to use accurate information when they go to make implications for the community. Some attending service providers were curious about teasing out stress, anxiety, and depression. Were the surveyors able to tease out postpartum depression for the depression question? No.
 - This information will help TCB write grant applications, as well as explain why they will change the look of the community and incorporate mixed income housing. At the Charrette, TCB addressed a plan to bring in businesses and healthy foods to the community. In work with other communities, TCB has engaged city councils to address what businesses are allowed in and what they are allowed to sell. TCB has performed a Market Study – what food sources exist in the community, what is available, etc.
 - Resident Feelings of Safety at Night: Survey coordinator, Ty, spoke about safety. Many residents responded that they do not feel safe because of shootings, fear



of being robbed, and fights. When asked, residents did not feel that police presence is an issue. Many residents live by the philosophy that if they don't bother anyone, they won't be bothered. People also spoke about symptoms of secondary trauma exposure, so there seems to be a bit of a discord in what we hear. Often, parents say that they don't let their children out to play for fear of what may happen.

- TCB is working with the City to identify cohort groups of the disabled at Creighton Court – who is disabled and cannot work, and who is disabled and has the ability to work. For those who cannot work, there will be alternative goal setting.
- Over the course of our work in this convened group, we hope to look at a variety of data sources to get a fuller picture.
 - It seems that mental health is a growing priority in the community as well as an interest in this group. We can see from some of the data, that mental health is also a need. In fact, Allergies, Depression, Asthma, and ADHD jump out.
- Community Health Needs Assessment, Bon Secours, Richmond Community Hospital 2010
 - Health Concerns: adult obesity, diabetes, mental illness, heart disease & stroke, and childhood obesity
 - Looked at existing data
 - Two priorities were identified: adult and childhood obesity, and mental health
 - Obviously, there is a theme. These themes are crucial for us to pay attention to, while we are thinking about bringing best practices to the community.
 - Physicians often report that they cannot even address medical issues because they must first deal with behavioral health issues. The numbers may not tell us the entire story.
- Concerns from the Informed Neighbors Corps:
 - Concerns: substance abuse, crime and public safety, trauma informed mental health care, asthma, services and resources inside the community
 - We heard from the Informed Neighbors that people are concerned about confidential services and prevention education for youth. They stated that attention should be give to reaching youth before they start substance use as well as providing intervention programs for youth and adults. They were also interested in peer counseling.
 - We frequently hear that there is an imaginary boundary and that if services do not exist within that, then people will not access them.



Review evidence-based practices

- Group insight:
 - Anything regarding intimate partner violence (we will be looking at a program out of Chicago on healthy relationships). Amy Strite of Family Lifeline reported that upon intake, they are doing a healthy relationship assessment. This is one of those things where, the dialogue begins at intake, but continues throughout subsequent sessions.
 - In public health research, we are seeing that genetics and the environment should be treated together.
 - Motivational interviewing, assessing where someone is in the change process, is a great tool.
 - In the redevelopment process, programs for teens will be important. Asking adolescents how they would like to see the community in 10 years will buy them in to the community changes and the process of the redevelopment.
- Amber showed a list of examples of Evidence-Based Practices that Urban Institute has begun to compile.
 - Wraparound Models:
 - The Chicago Family Case Management Demonstration
 - Housing Opportunity and Services Together (HOST)
 - Bridges – Trauma Informed Community Building
 - Mercy Housing
 - Question: Where are these models housed?
 - Relocation:
 - Chicago Family Case Management Demonstration, “Hard to House”
 - Enhanced mobility counseling
 - Relocation rights contract: this would raise awareness of residents’ rights during the process.
 - How might we ensure that there will be a social network in which residents will become a part? There have been mentor families models.
 - How will families qualify as compliant? There are barriers to qualification. Who will walk residents through the paperwork? As part of their “Smooth Moves” process, TCB has a property management staff to assist people with their paperwork, and a



relocation company to do moving and packing. Residents will not be moving far. This is a one-for-one replacement and build first model. Families will be able to tour different areas prior to their move.

- Nevertheless, it is important that families have time to prepare. We have to understand that there will be families that will not meet the compliance criteria. These families will go to other public housing units. TCB is not going to build a Creighton Court, Part II. They will construct a mixed income community – a home-ownership component, market rate units, working units, and public housing units. Public housing is federal Housing and Urban Development (HUD); Low-Income Housing Tax Credit (LIHTC) is state supported; and for these, no one in the household can have a felony. People will be speckled throughout the East End in an effort to decentralize poverty. This is why social connections will be of utmost importance. Remember, this is a 10-year process.
 - Service engagement
- Physical and Mental Health
 - Clinical mental health counseling (on-site psychiatrist)
 - Virginia Health Center (VHC) serves adolescents ages 10-19, who face co-occurring, substance abuse and emotional health issues.
 - There is a concern for adults and the lack of support services, especially the availability of psychiatrists.
 - Substance abuse treatment
 - Is there a dearth of services?
 - Sometimes yes, and sometimes no. If a young person needs quick care and has no insurance, it is about impossible to acquire services.
 - Hot spotters
- Socio-economic health
- Youth
 - Early Childhood home visitation model (Family Lifeline)
 - In many areas, Richmond has lots of programs that receive a grant, or schools that get interested in a particular topic area. However, when we try to leverage for impact, could we really dig into a thing (such as school nutrition)? We could leverage what is going on with policy issues.



- At Woodville Elementary, the principal has suspended extracurricular activities until behavioral issues are addressed.
- What needs to be added?
 - ***If you see something that is already here and that is working well, please let us know.***
 - Virginia Supportive Housing – “A Place to Start,” a model based on the Pathways to Housing Program in New York City. A Place to Start (APTS) is a regional program that serves individuals experiencing chronic homelessness and serious mental illness. APTS immediately houses these individuals, providing initial stability, which then allows the individuals to engage in services. The Intensive Community Treatment (ICT) team is comprised of an administrative assistant, a licensed clinician(s), case manager(s), a nurse, a peer counselor, and a part-time psychiatrist. They have partnered with the Daily Planet. They have provided long-term housing for about 100 people.
 - There is interest in wrap-around service models.
 - We are looking at a 2-year timeline for residents, who are not meeting compliance, to get to a point where they can meet the compliance criteria. Wraparound services might provide this sort of assistance.
 - There should be increased cohesion of services. The HOST model, in particular, has a separate system, or additional wraparound services, for youth. HOST is doing a tandem model to coordinate services for each of the family members.
 - *It depends upon what we ultimately want to do.*
 - How long are we looking for these models to assist families? What is the timeline? There is the pre-redevelopment time period, wherein we inventory services in the community and identify gaps. During the revitalization period, transition and relocation will begin. In post-revitalization, folks will be settling. Sometimes, there is a drop-off. TCB attempts to maintain services long-term and integrate them with their property management staff. Their resident services are different from traditional property management services. TCB offers ongoing community-life services at their sites. Thus, TCB offers pre-, during-, and post-services.
 - The first point of consideration is what to do to prepare families. We will also explore what families will continue to need in a sustained way. This service will be provided two years prior to transition and then as an ongoing service. How will people be made aware of these services? Residents will undergo an assessment at lease renewal.
 - We have an opportunity to do better with regard to making residents aware of services that are available to them. At some point, we could



have a conversation about what process exists for outreach? If it were not for Community Health Resource Centers, many service providers might not know that there were people with needs. Service providers would like to know how to coordinate services.

- Sometimes, there are genuine gaps, but often there are knowledge gaps.
- Housing advocate: an additional point of information and resources. One of the outgrowths of the Anti-Poverty effort is someone to live in each of the 6 large public housing developments. This person would help residents understand the intricacies of the lease. These navigators will understand the referral networks available. This year, the housing advocate staff person will begin working in a parallel track with the community health workers.
 - We also have the group, the Informed Neighbors Corps, who are engaged, and could be hubs of contact. We know that there will be common barriers that families will face. And, we want to provide hubs of information that every family at Creighton Court can access.
- Is there a way to use home visiting support? Yes.
- What would those hubs of information and resources be?
 - Resource Centers
 - What services do residents need to know about?
 - Workforce Development plans
 - So often, word of mouth is the best means for telling people about services.
 - Is it a lack of information or is the issue the willingness or trust to access the service?
- What are the top priorities?
 - **Contact Jill Hellman about programs that exist and that potentially the group and residents should know about.**
 - Vulnerable populations: especially those people that have a criminal history. Are there places that help expunge records? If you can demonstrate that in the last 14 years you have not engaged in criminal activity, you can request a waiver, and then a panel interview. Having no criminal history has always been a part of residing in public housing; however, some housing authorities enforce it and some do not.
 - In the build process, are the units going to address the prevalence of asthma? TCB is committed to using green building materials. HUD is moving to smoke-free units, and the new units will be smoke-free. How do we come alongside our residents for tobacco cessation services? This ties right into substance abuse



issues. Challenge Discovery Projects is exploring smoking cessation programming for the community.

- HWI Weekend East End: this is an NIH evidence-based program for nutrition and physical activities at the Fairfield Boys and Girls Club. This is the 3rd cycle this year. They do this 3 times a week.
- We need to think about the points of connectivity for residents and how to get word out to residents.
- We also need to think about how to prioritize future meetings:
 - Wrap around services
 - Mental health
 - The tangible outcome for this group will be multifaceted in nature. We will be tied to local and large-scale funders. For example, tomorrow, VCU is meeting with Kresge, which could present an opportunity to continue this work. Policy change or policy connectivity will be of importance too. Finally, recommendations back to RRHA and TCB will surface through this process.

