California Reducing Disparities Project

a culturally responsive mental health initiative

4.4 CRDP Phase 3 Recommendations Report

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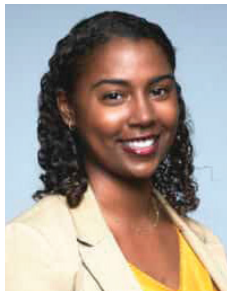
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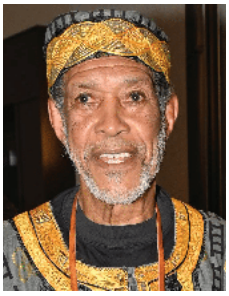
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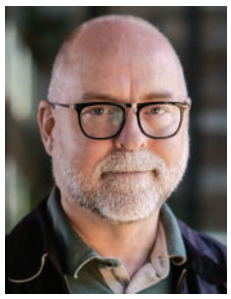
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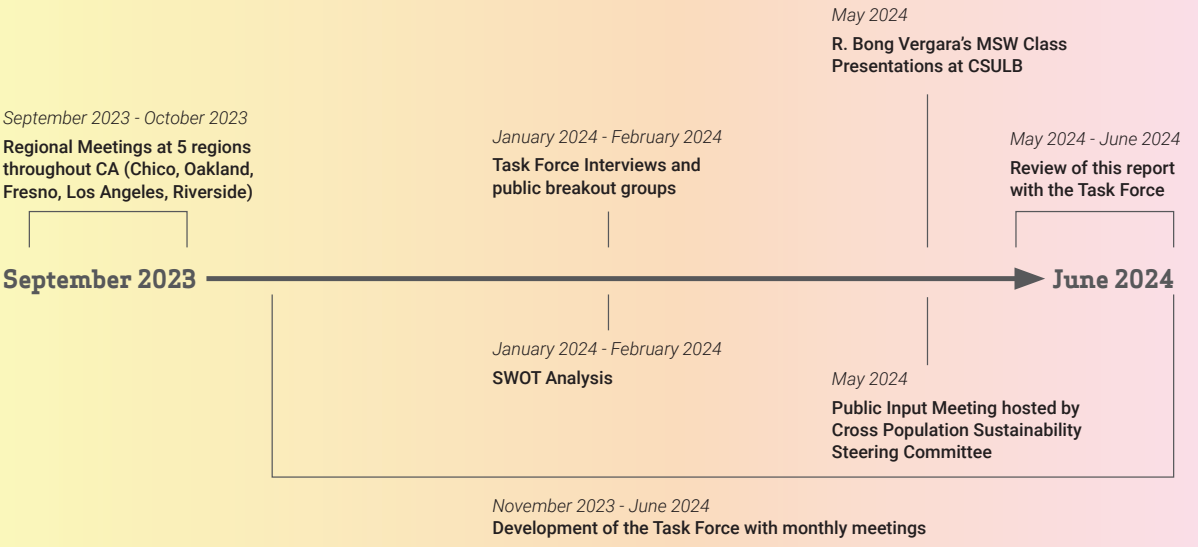


LIST OF ACRONYMS

CRDP	California Reducing Disparities Project
CBOs	Community-Based Organizations
CDEPs	Community Defined Evidence Practices
CDPH	California Department of Public Health
CPSSC	Cross Population Sustainability Steering Committee
DHH	Deaf and Hard of Hearing
IPPs	Implementation Pilot Projects
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer, +
MENA	Middle Eastern and North African
MHSA	Mental Health Services Act
OHE-CDES	Office of Health Equity - Community Development and Engagement Section
PEI	Prevention and Early Intervention
REMHDCO	Racial and Ethnic Mental Health Disparities Coalition
RFPs	Request for Proposals
SUD	Substance Use Disorders
SWE	Statewide Evaluation
SWOT	Strengths, Weaknesses, Opportunities, Threats
TA	Technical Assistance

EXECUTIVE SUMMARY

The California Reducing Disparities Project (CRDP) is a solution-based longitudinal project that seeks to support and grow Community Defined Evidence Practices (CDEPs). Over the past decade, the following principles have guided the planning, implementation, and growth of the CRDP and must continue to guide all future efforts:

- Community Driven
- Equity and Fairness
- Culture is Healing
- Data Sovereignty/Governance
- Solutions Based
- Recognize the Value of Our Own Expertise
- Own Our Influence
- Collective Approach
- Leverage Our Voice on Behalf of Others

CRDP's rich history has thus far culminated in:

1) An increase in access to mental health services
2) Improved mental health among participants in unserved, underserved, and inappropriately served communities,and
3) Strengthened capacity of communities to respond to their own mental health needs.

These accomplishments would not be possible without California's investment in CRDP. No other state has invested the level of funding California has contributed for developing, implementing, evaluating, and disseminating such a project. Building upon this success will require a continued collective commitment to funding, service, and innovation. Many task force members and members of the public have proposed a permanent funding source be secured from **Population-Based Prevention funding**, with these funds from Proposition 1 explicitly set aside by the California Department of Public Health (CDPH) to support CRDP. CDPH must determine if this is a viable option or if other funding mechanisms are more appropriate as CRDP moves from project status to the **California Reducing Disparities Program**, signifying its status within California's mental health services landscape.

The programmatic **vision for the future of CRDP** is that it will be the premier vehicle to train and provide technical assistance for all organizations that are developing and implementing CDEPs in California and throughout the nation. Building from the experience over the course of a decade of nurturing, networking, evaluating and strengthening 35 organizations with CDEPs, known in CRDP as Implementation Pilot Projects (IPPs), there is a strong belief that these IPPs are now positioned to graduate and claim their status as teachers and coaches to the next generation of IPPs. Who better to mentor new IPPs than those who have already experienced similar challenges themselves?

Yet knowing that these graduated IPPs have their expertise in direct service, structure will be put in place to effectively transition **those that desire** to become trainers and technical assistance providers. The TAPs, which have vast experience working with community based organizations and their CDEPs, will partner with those graduated IPPs to teach them how to move from service provision into a training role.

This is how the organizations will move their CDEPs from incubator status to graduation status, with the option to continue with direct service and/or to broaden their offerings and join an expert pool to train up the next cohort of organizations with CDEPs. They will be able to bring with them their lessons learned, their wisdom, and their guidance so that each generation of IPPs has a smoother journey towards implementation and sustainability.

This is the **innovation** that CRDP has been seeking, to maintain the **strong framework** – of robust community participation; data-driven assessment of needs; CDEP service development and delivery; culturally aligned technical assistance; and evaluation that adds utility to the field – that has been built through Phases 1 and 2, while creating a mechanism to only grow stronger over time. This is a vision that moves the CRDP into business development, providing an opportunity for robust workforce development, compensation for the provision of TA and training services through an independent clearinghouse, and national leadership.

Additionally, the future of CRDP will reflect the **expanded needs** of California's diverse communities. The task force recommends that CRDP Phase 3 will require that its next IPPs are able to provide services that are trauma-informed, accessible, and intersectional[1] (which many from the previous phases already are), and will advocate to add a cohort of IPPs dedicated to serving California's Middle Eastern and North African (MENA) communities and potentially Russian/Slavic and other immigrant/refugee communities such as Sub-Saharan African. While maintaining core CRDP values and expertise on the prevention/early intervention end of the spectrum, CRDP recognizes the need to explore serving the full behavioral health spectrum, from mental health to substance use disorders. Given the tremendous need for CDEPs to proliferate throughout California, there is also a need to seek support for a greater number of community-based organizations to be funded in the next round of IPPs.

As with previous phases, evaluation will continue to be highly valued and required in Phase 3. This evaluation emphasis means that CRDP has already established itself as a well-evaluated project with ample research evidence demonstrating that the prior phase CDEPs are effective. The statewide evaluators will be asked to build on their work of determining the main identifying aspects of a successful CDEP and using that as the framework for developing effective CDEPs. Other areas of evaluation where continued attention is still warranted to establish evidence of effectiveness include:

1) the interest in identifying factors that contribute to success in CDEPs that can lead to a CDEP framework,
2) he addition of new population(s) in Phase 3, and
3) maintaining a focus on effectiveness that aligns with the federal Substance Abuse and Mental Health Services Administration's intention to include CDEPs alongside Evidence Based Practices.

This is a bold vision to match the bold State of California.

1 According to K. Crenshaw, the theoretical framework of intersectionality acknowledges how multiple marginalized or disadvantaged social statuses interact at the micro level of individuals' lived experience to reflect interlocking systems of privilege and oppression at the macro social structural level (e.g., racism, classism, colonialism, sexism, heterosexism, ableism). For the purposes of CRDP, intersectional services work effectively with individuals who experience the systemic impact of multiple, interlocking identities and seek to change systems to alleviate that impact.

BACKGROUND AND METHODOLOGY

This report drafted by the Equity and Wellness Institute (EqWI) evolved from review and compilation of a summary document of overarching themes and potential strategic directions derived from the California Reducing Disparities Project (CRDP) Task Force. The CRDP is a first of its kind initiative intended to demonstrate the effectiveness of Community-Defined Evidence Practices (CDEPs) in reducing mental health disparities for diverse, multicultural communities, and reinforce the infrastructure to deliver these services. The CRDP is nearing the end of Phase 2 and planning and designing has begun for Phase 3. Through a meticulous process of review and synthesis, EqWI identified the challenges, aspirations, and priorities for advancing mental health equity through the future of CRDP.

The Equity and Wellness Institute collected data from members of the public during the five regional meetings held throughout the state during the Fall of 2023. The five regions that were visited were Northern (Chico), Bay Area (Oakland), Central Valley (Fresno), Inland Empire (Riverside), and Southern (Los Angeles). EqWI collected public input on seven overarching questions which were posed by the California Health and Human Services Agency ("Agency"). Breakout activities were held with the attendees during the regional meetings, where everyone was given the opportunity to provide written comments on each question, along with an online survey to capture the input from those who were unable to attend. The data collected during the five regional meetings was analyzed to find patterns, themes, and then formulate recommendations. The graphs throughout the report reflect the responses from members of the public during the five regional meetings. The findings and recommendations are reflected in the Themes and Recommendations Report which was shared with the public in January 2024.

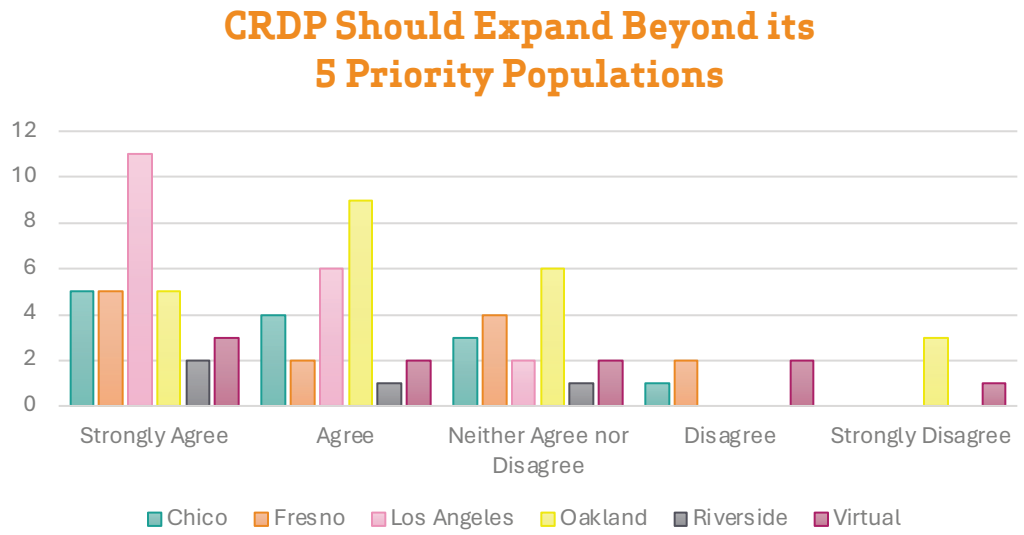
The Equity and Wellness Institute and the Office of Health Equity-Community Development and Engagement Section (OHE-CDES) convened a 13-member task force which met on a monthly basis from November 2023 through June 2024. The purpose of the task force was to review the findings from the Themes and Recommendations report and envision what Phase 3 of the CRDP should look like. The task force meetings were open to the public and the meeting materials were shared online 10 days prior to the meetings, with meeting summaries and recordings available to the public within a week after the meeting.

The Equity and Wellness Institute utilized feedback and suggestions from the task force and public to develop interview questions for the task force members and surveys to receive input from the public and other partners on recommendations for this report. All information learned during the task force meetings, task force interviews, survey responses from the task force and public like the SWOT analysis, California State University Long Beach Masters of Social Work presentations, the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), the Cross Population Sustainability Steering Committee (CPSSC), the CPSSC-hosted public input meeting, letters and emails responding to draft versions of the report, and the Regional Meeting Themes and Recommendations Report were utilized to inform this report. The quotes shared throughout this report were obtained via the regional meetings, task force meetings, task force interviews, surveys, and input shared by the public. The members of the task force reviewed and provided feedback and suggestions on the draft report between April and June 2024 before the final report was presented to OHE-CDES.

Below are the recommendations from the task force and public based on the seven questions posed by Agency for the plan and design of Phase 3.

PRIORITY POPULATIONS

Data collected throughout this whole process has reflected support that the CRDP should expand beyond its five current priority populations, which are: African Americans, Latinos, Native Americans, Asian and Pacific Islanders, and LBGTQ+. The populations identified most often were Middle Eastern and North African (MENA), and Russian/Slavic. There was also support for the sub-Saharan African population to be considered as an additional priority population.



There was overwhelming support, however, for increasing representation and intersectionality within CRDP, and it was affirmed that funds should not be reallocated from the current priority populations to fund new ones. Additionally, there was major support to include intersectional identities such as persons with disabilities, the Deaf and Hard of Hearing (DHH) community, refugees/immigrants, justice-involved, youth, persons contemplating suicide[2], spiritual & faith based communities, and rural communities. Inclusion of these intersectional identities will ensure inclusivity and a deeper understanding of the current priority populations.

"The CRDP partners should be consulting, and check California data for the rise in suicide in BIPOC, the needs for immigrant populations coming over with the border crisis- if expansions happen make it match the data to ensure new populations are also going to be underserved communities."

As additional priority populations are being considered, there was overwhelming support by both task force and community members that any addition of new priority populations be data driven, and a decision-making process be identified prior to those additions taking place. The Phase 1 assessment and reporting process was suggested for the vetting of new priority populations.

Whether it is the Phase 1 process or another one to support the decision-making for the inclusion of new priority populations, it is recommended that considerations be made for the quality and quantity of data that is available for smaller and emerging populations. It is possible that a clear need exists (at least for

2 https://watsoncoleman.house.gov/imo/media/doc/full_taskforce_report.pdf

further exploration), but data may not be readily available due to current policies or conditions that are out of the community's hands.

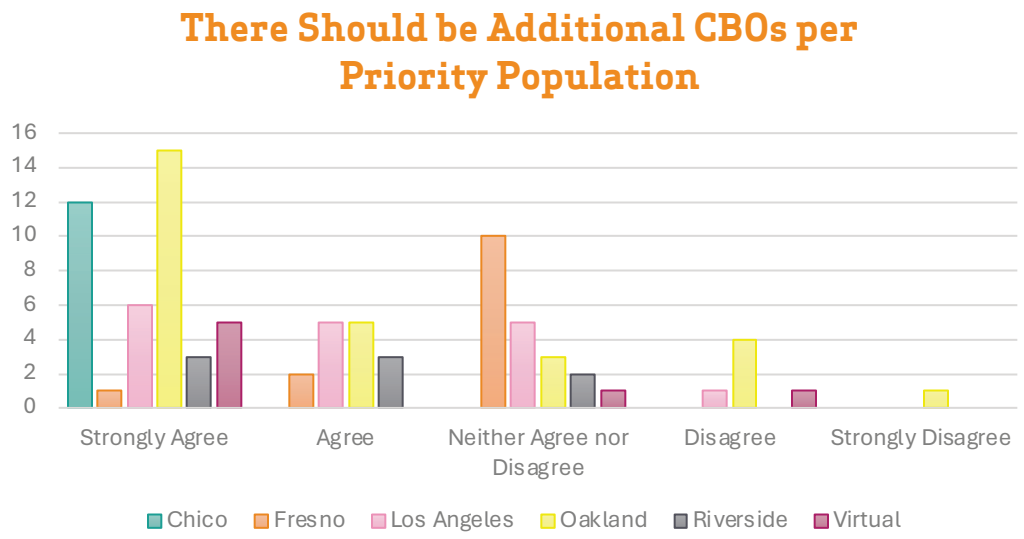
In summary, the task force and the public recommend the addition of MENA, and the Russian/Slavic communities as added priority populations. They are also recommending intersectional identities as an area of focus for greater inclusivity and deeper understanding within priority populations, especially people with disabilities and refugees/immigrants. Finally, it is their recommendation that a clear process be identified to vet the addition of new priority populations prior to adding them. It is important to note that the addition of priority populations and intersectional identities will not result in a reduction of the amount of funding received by the existing priority populations.

Action Items for OHE-CDES

- Add MENA, and the Russian/ Slavic communities as priority populations.
- Emphasize intersectional identities as a focus for each priority population. Request additional funding to accommodate added priority populations. Specifically for people with disabilities and refugees/immigrants.
- Identify a clear process or criteria for new priority populations to be added (Phase I process suggested as a possibility).

COMMUNITY-BASED ORGANIZATIONS

Support of additional Community Based Organizations (CBO) per priority population was an ongoing theme throughout the data retrieved virtually and from the five regions. The data shows that there was consensus in support of the existence of differences around the geographical distribution and the needs throughout California, so it would be optimal to have equitable representation across the state. Additionally, there was support for adding more CBOs that would allow CRDP to tap into intersectional identities and who are trauma-informed. For example, an Implementation Pilot Project (IPP) that serves people who are Latino and who are also a person with a disability.



"CDEPs can provide care that is not restricted. I believe that people deserve to receive care from people that look like them and speak the same language as them."

"More CBOs would allow CRDP to tap into intersectionality - for example an IPP that serves Natives who are Veterans or queer. More CBOs would allow for expansion without adding new priority populations."

Action Items for OHE-CDES

- Determine if funds are available to increase the number of CBOs per priority population and accommodate the inclusion of MENA and Russian/Slavic as priority populations.
- Increase opportunities for capacity building within the IPPs, specifically around fundraising, grant writing and resource development, including diversification of funding portfolios.

The data also suggests that increasing funding to maintain the current support level for the five priority populations, while also incorporating additional CBOs for the new priority populations, is warranted. Since most CBOs are run by community members who find it difficult to navigate various systems, it was also identified that the structural ability of CBOs to survive needs to be addressed. One sustainability suggestion included training of existing IPPs who would then reciprocate by training newer IPPs. Additional suggestions to ensure sustainability include offering fundraising and grant writing workshops to be held in the community and providing support at the legislative level.

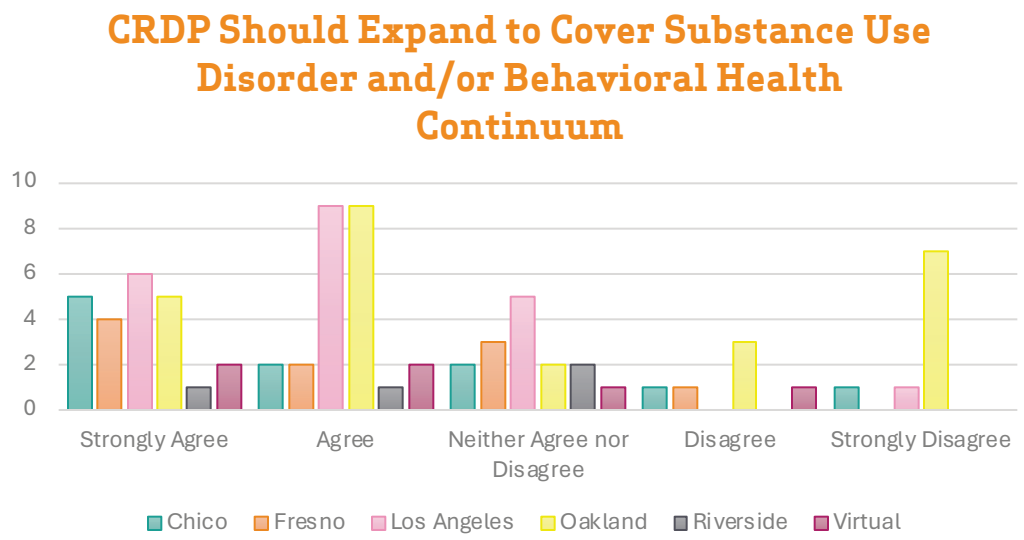
In summary, the task force and members of the public endorse the inclusion of CBOs to accommodate the MENA, Russian/Slavic, and intersectional priority populations, along with an increase in funding and collaboration to be included in Phase 3. The addition of CBOs will provide the community-specific support required to uplift the priority populations.

SUBSTANCE USE DISORDERS AND SPECIALTY MENTAL HEALTH SERVICES

As identified from the data, there is a definite need for Substance Use Disorder (SUD) services within the community to bring an opportunity for new funding avenues. However, there are concerns about the Behavioral Health Continuum and the capacity of current community-based organizations to expand to cover these services.

Two recommendations were identified with regards to whether or not CRDP should expand to cover the SUD and/or Behavioral Health Continuum. The first recommendation looks to continue conversations with key partners to weigh the benefits of expanding to cover substance use disorders as the community is in need of these services. The second recommendation is focused on promotion of culturally appropriate care within SUD services and does not adopt the forced treatment portion

"The drawback is that CDEPs work because the culture and traditional values aren't a westernized colonized model of health, so if CDEPs expand to cover SUD, they cannot be 'watered down'. It has to be culture first with a critical eye on why some of these interventions/treatments don't work for BIPOC, it can't be co-option and culture. That will hurt consumers."



of the Behavioral Health Continuum. It is important to note that the majority of the task force and members of the public specified that if the CRDP expands to cover SUD, that it only focuses on prevention and not treatment.

In summary, it is the overall recommendation of the task force and public members that Phase 3 of the CRDP will include funding for CBOs that provide CDEPs centered around mental health prevention and early intervention that reduce SUD disparities by incorporating prevention services that are trauma-informed. As the data reflects, results varied based upon the region, with some regions in greater support than others. The variations of data can be attributed to the demographics served in each region.

Action Items for OHE-CDES

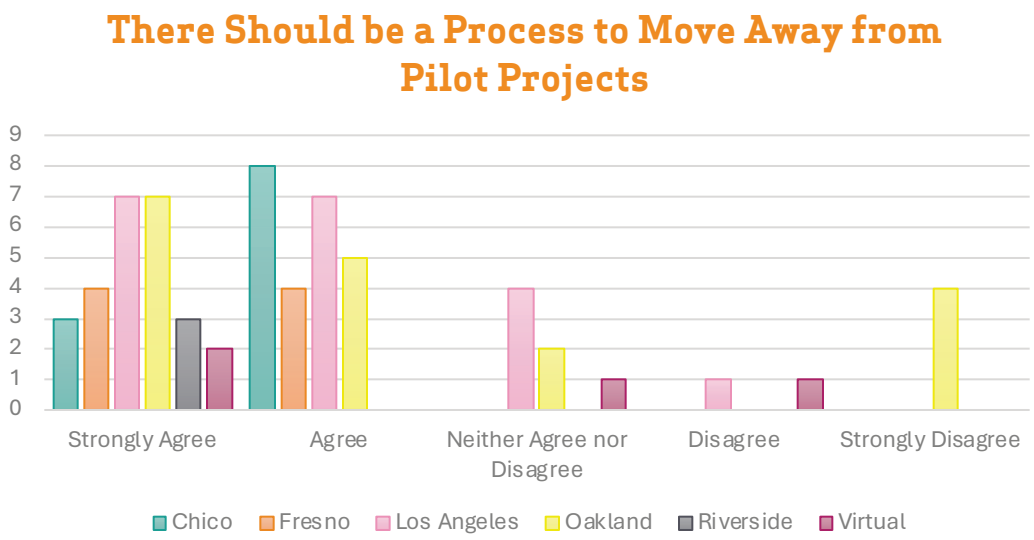
- Expand the CRDP to cover SUD prevention services while maintaining a commitment to Population Prevention and Early Intervention (PEI) with a focus on trauma-informed approaches.

LONG-TERM STABILITY OF IPPS

A major theme across all data collection was the importance of long-term and stable funds for current and future Implementation Pilot Projects (IPPs). It was recommended that this be achieved through a "graduation" process where current IPPs can continue to provide technical assistance to new IPPs in Phase 3. This could be accomplished by having graduated IPPs that are interested in doing so, apply to partner with TAPs in delivering technical assistance (TA). The TAPs would train the graduates as trainers and TA providers themselves, and would support them in their expanded role. This would provide the infrastructure for their success.

The idea of both a CRDP incubator and a CDEP clearinghouse has surfaced. While related, the purposes, design, and autonomy of these structures need to be distinguished.

An incubator would provide seed funding, evaluation, TA, and guidance to prospective entities looking to become new CRDP IPPs.



As originally envisioned by the Cross-Population Sustainability Steering Committee (CPSSC), a CDEP clearinghouse would be an autonomous entity – independent and community-driven – designed to uplift various components of demonstrably effective CDEPs. A key aspect of sustaining and scaling the CRDP, a CDEP clearinghouse would support the systems transformation required to scale investment in CDEPs to increase behavioral health equity. A CDEP clearinghouse may well inform incubator services and provide a structure to leverage TA from experienced CDEP implementers, but its primary role would be to serve as a resource for other CBO's seeking to replicate the approaches and outcomes of the CDEPs represented there.

"Yes, we should charge for access to the clearinghouse. We need to find what equity looks like for charging for scalability and sustainability. And we should spell out that long-term sustainability means inclusion of disability, race, ethnicity, culture, and re-indigenizing the process. We need to embed more of our culture. We need to set the standard and tone so that there is intention in moving away from bureaucracy."

Community-based organizations representing graduated IPPs that want to apply for additional incubator support through future rounds of funding would not be restricted from doing so. They could both apply to provide TA and mentorship in collaboration with the TAPs and apply to have programming that is receiving support to further develop as a CDEP.

The TA for new IPPs would need to include comprehensive financial strategic planning (e.g., navigating software, hardware, data entry, etc.) and working closely with them to achieve their goals so that the IPPs are not just dependent on grants. According to the task force, this deeper level of TA will give the IPPs more flexibility to do what their communities want, and not just what their funder wants. OHE-CDES can aid this process by issuing RFPs that allow the IPPs to build a mix of funding so that they can not just fund direct service, but also fund developers and others to increase the likelihood of their long-term survival.[3]

3 Comprehensive Financial Strategic Planning Framework and Resources

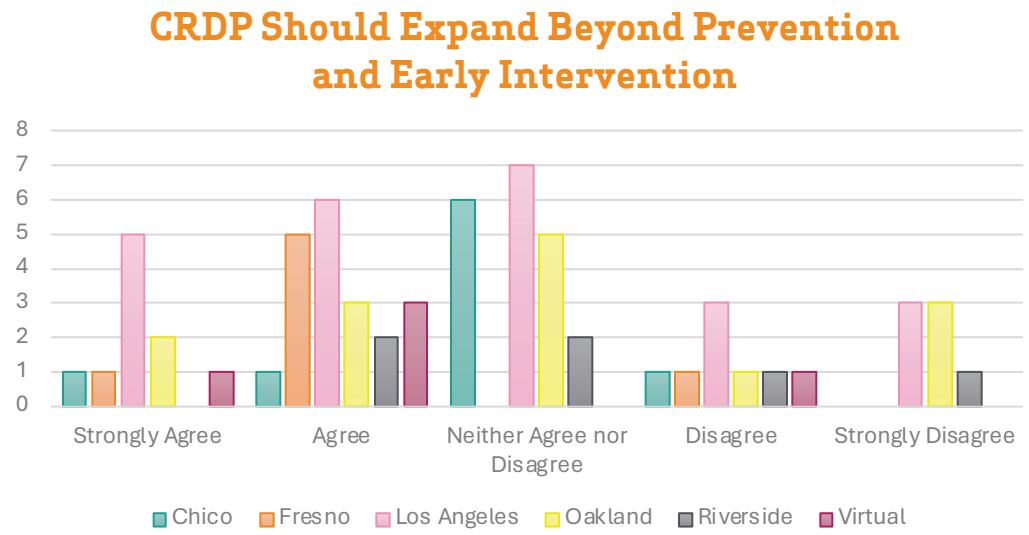
This commitment to long-term stability of the new IPPs will require organizational assessments and TA planning, and the utilization of the Statewide Evaluation (SWE) Organizational Capacity Assessment Tool. Additional TA areas of need include human resource management, codification of policies and procedures, and community support among the 15 areas described in the SWE Tool.

The clearinghouse will also need CDEP implementation procedures codified in writing in order to support replication/scaling up and out (including necessary adaptation to new community environments) to be done with fidelity to the model proven effective through CRDP.

"Scalability and replicability also require written codification of program procedures so that when staff transition out, the 'secret sauce' isn't lost and staff functions don't constantly need to be reinvented. It often takes many months to replace lost staff, so there is no opportunity for job protocols and procedures to be handed down orally."

The graph shows major support for the "graduation" process with others recommending that members of the community help determine the scoring metrics for the release of future request for proposals (RFPs) during Phase 3. Additionally, it was suggested that OHE-CDES increase capacity on knowledge and learning resources within the IPPs to provide technical assistance to new pilot projects and other organizations and efforts outside of the state.

Lastly, the CRDP should look into aligning efforts with opportunities such as the Governor's Social Innovation Impact to open the opportunity for funding via philanthropic organizations. Pursuing long-term sustainability acknowledges that the public sector cannot do it alone. CRDP Phase 1 recognized this early on amid competing pressures on how MHSA funds were to be spent; as such, Phase 1 dialogue called for broad collaboration between the public and philanthropic sectors. This cross-sectoral collaboration is an unfinished business. CRDP Phase 3 should formally enable cross-sectoral collaboration to align and optimize philanthropic sector spending toward CRDP Phase 3 objectives.



"For organizations, if there is an expectation that organizational foundational support will be an outcome of the pilot program, then there should be a process to move away from the pilot program. We must provide responsible structural support and exercise responsible stewardship."

Action Items for OHE-CDES

- Develop an RFP for community-based organizations to apply to receive incubator services such as seed funding, evaluation, TA, and guidance; a phased approach may be necessary as new services are getting established.
- Develop an RFP to create a clearinghouse in which TAPs and IPPs that have graduated would work in partnership to provide technical assistance to the new cohort of IPPs during Phase 3.
- Collaborate with members of the public to determine the scoring metrics for the RFPs for the technical assistance and new set of IPPs. It has been requested that initial RFP drafts should be shared with the public to ensure there are no significant errors or additional suggestions for improvement.
- Explore aligning CRDP with efforts such as the Governor's Social Innovation Impact to seek funding from philanthropic organizations.

While there was support for "graduating" IPPs and increasing their capacity to provide technical assistance to help with long-term funding, the main theme was that prevention and early intervention should continue to be the main focus of the CRDP. The data has shown that while there is support and interest to expand into other aspects during Phase 3, it should be done without sacrificing the identity of the CRDP, which has been in prevention. The results of the March Primary on Prop 1 may impact funding availability for prevention efforts within the mental health field and there have been major concerns regarding the results. This was apparent during the five regional meetings throughout the state where the rapport revolved around how to adjust to the political climate in the state while not losing the identity and purpose of the CRDP during Phase 3.

In summary, the task force and public are recommending that OHE-CDES develop an RFP opportunity for current IPPs to provide technical assistance to new IPPs during Phase 3, in partnership with the TAPs, through an incubator model and independent clearinghouse. The expectation is that the process would incorporate the community's feedback on scoring metrics for the RFP and there is a desire to have people with lived experience included as RFP reviewers. The grant review process should be modeled after other jurisdictions that have protocols for uplifting small, emerging businesses. Lastly, continue to prioritize prevention and align with efforts such as the Governor's Social Innovation Impact.

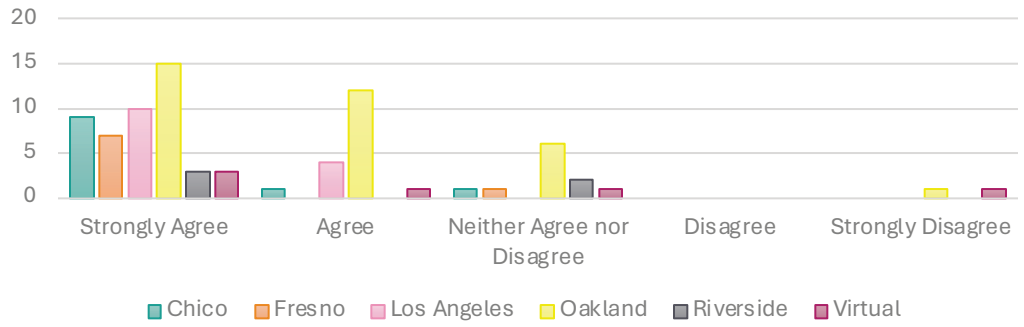
CDEP SCALABILITY AND SYSTEMS CHANGE

There has been major support for scaling CDEPs on a statewide level, with some suggesting they expand nationally. A concern has been the risk of losing the integrity and uniqueness of a CDEP, which is one of the major aspects that has made them successful. Specifically,

CDEPs are incredibly catered and targeted to their priority population and the environmental factors within their community. What may work in one community may not work in another, even within the same

geographical vicinity. It has been recommended that the statewide evaluators build on their work of determining what are the main identifying aspects of a successful CDEP and using that as the framework for future CDEP development. For example, sharing that in order to be considered a CDEP they must be community-driven in terms of the development/implementation/evaluation, consider environmental (built, natural, social, physical) factors within their community, and address issues that the community has shared as a priority. Identifying these core components can assist with scaling the CDEP framework and formula for success instead of an actual CDEP program. The task force noted that CDEPs themselves need to be involved in this process by contributing methodology for what constitutes a CDEP with non-intrusive measures.

Integration of Community-Defined Evidence Based Practices Into Mainstream Public Mental Health Programming Should be a Part of CRDP Phase 3



It was suggested that this framework can be included in a clearinghouse or data sharing system where the CRDP and/or partners can share with other efforts throughout the country and possibly create a revenue stream by charging for access. If charging for the information, there will need to be a process where either a non-profit or nongovernmental organization can manage the clearinghouse via an RFP in order to charge fees since the state does not have the ability to do so.

Other areas of evaluation where continued attention is still warranted to establish evidence of effectiveness include:

1) the interest in identifying factors that contribute to success in CDEPs that can lead to a CDEP framework,
2) the addition of new population(s) in Phase 3, and

"I don't want statewide evaluators to do the same things... I want to know what was the role of the community and have them determine what worked and what did not. CDEPs cannot be duplicated. Let's run with the community driven, so we can notify other CDEPs of what is needed to be successful."

"Systems have harmed BIPOC folks, and integration means losing something very special. It would have to be clearly defined, the scope of work, the boundaries, etc. Counties have different restrictions and regulations so you have to be cautious. Also this is community defined, so it needs to be led by and created by them."

Action Items for OHE-CDES

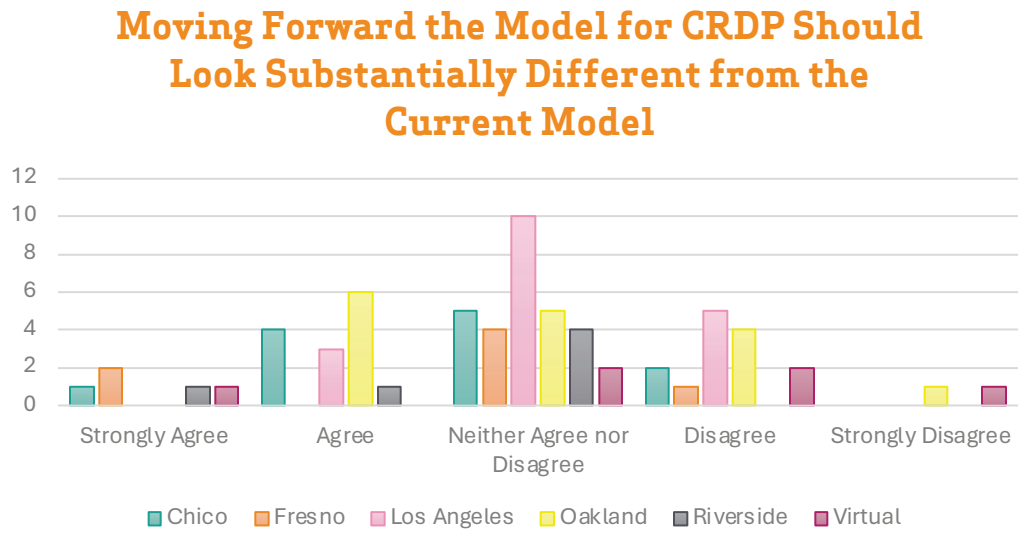
- Have the statewide evaluators deepen their focus on measuring community engagement, codesign, and other factors that can be developed into a framework for best practices in developing a CDEP.
- Develop a RFP for the creation and maintenance of a clearinghouse where the CDEP framework and other information can be shared.

3) maintaining a focus on effectiveness that aligns with the federal Substance Abuse and Mental Health Services Administration's intention to include CDEPs alongside Evidence Based Practices.

In summary, the task force is recommending that the statewide evaluators deepen their focus on the defining factors of a CDEP, specifically measuring the involvement and engagement of the community throughout the development, implementation, and evaluation of a CDEP. Additionally, OHE-CDES and the statewide evaluators should further develop a framework or "instruction manual" based on the findings on what makes a CDEP successful and valuable in their respective communities. Lastly, develop a clearinghouse where such information can be shared with others.

STRUCTURE

The data has shown that there is no major support for drastically changing the CRDP for Phase 3. Instead, there are improvements that task force members and the public would like to see. Specifically, there is agreement that there should be more collaboration between IPPs in the hopes of increasing support, sharing of knowledge on fiscal and capacity development, and increasing efforts to address intersectionality among the priority populations that are being served. Additionally, include community input into the scoring and evaluative metrics for the RFPs for Phase 3 to ensure that all new efforts are truly community-driven.



To increase collaboration, it was recommended that the CRDP continue to fund collaboratives like the task force, annual meeting, Cross Population Sustainability Steering Committee (CPSSC), and other convenings during Phase 3 in addition to continuing the technical assistance support that IPPs receive. The idea behind the collaboratives is that it can serve as an additional space for technical assistance as IPPs can share what has been working for them, what has not, and a general space for knowledge sharing. The biggest takeaway is that IPPs need to continue to be supported through Phase 3 via technical assistance and statewide evaluation. It was suggested that the TAPs facilitate a cross-population community of practice that focuses on fiscal and capacity development with the new IPP cohort and will be a required deliverable for all TAPs that receive contracts during Phase 3.

Lastly, the public shared the need for a CRDP Advisory Committee for Phase 3 that would be composed of representatives from Phases 1 & 2, members of communities who have not had contracts with the CRDP, and other community and county/government representatives. This advisory committee will ensure that various voices are heard while planning and implementing Phase 3 of the CRDP.

In summary, the task force is recommending that there be more opportunities for collaboration during Phase 3, with a focus on intersectionality and incorporating community input into the RFP process and decision making, and create a community of practice for the new IPPs to have additional opportunities for capacity building

"The foundation is extremely strong. However, understanding the intersectionality of priority populations needs to be better considered."

"Less siloes of identities, increase attention to intersectionality, expand to more organizations and programs, expand to more designated sub-cultures within priority populations."

Action Items for OHE-CDES

- Continue to support existing collaborative efforts among all CRDP partners to increase knowledge sharing.
- Increase frequency of meeting opportunities, especially in person, with a focus on intersectionality and community input on RFP decision making processes.
- Add a cross-population community of practice collaborative as a deliverable in the new TAP contracts.
- Convene a CRDP Advisory Committee to ensure various voices are heard, including groups who have not received funding from the CRDP.

CONCLUSION AND NEXT STEPS

In conclusion, the task force is recommending:

1) The addition of the MENA and Russian/Slavic communities as a priority population while increasing the representation of intersectional identities with the priority populations.
2) The addition of more CBOs to help with geographical representation and culturally competent services throughout the state.
3) The expansion of SUD prevention services through CRDP.

4) "Graduating" IPPs and having them provide technical assistance to the new cohort of IPPs.
5) Honing the evaluation focus to build upon what the core components of the CDEP framework are and how to measure community input and engagement while continuing to establish evidence of effectiveness.
6) Increasing opportunities for collaboration between the partners within the CRDP, including the IPPs, statewide evaluators, technical assistance providers, and OHE-CDES.

It is suggested that OHE-CDES review the recommendations report and determine which ones are feasible so that preparations can be put in place prior to the start of Phase 3 in July 2026.

ACKNOWLEDGEMENTS

EqWI would like to extend a special thank you to the members of the CRDP Phase 3 Planning and Design Task Force, members of the public who provided input during this process, the Office of Health Equity Community Development and Engagement Section, Psychology Applied Research Center at LMU, Safe Passages, and the Racial Ethnic Mental Health Disparities Coalition (REMHDCO).

APPENDICES

Regional Meeting Public Input Questions and Survey

Regional Meeting Survey and Feedback Form

Please take a moment to share your thoughts with us on the questions below. We also invite you to consider the State Wide Evaluators report as part of your observations, linked here.

Name: _____

Email:_____

Organization/Affiliation: _____

Why are you interested in providing input into the planning and designing of Phase 3?:

_____

_____

_____

- CRDP should expand beyond its five priority populations (African American, Latino, Asian & Pacific Islander, LGBTQ+, Native American).
  - » Strongly agree
  - » Agree
  - » Neither agree nor disagree
  - » Disagree
  - » Strongly disagree
    - ◊ If so, which priority populations should be added and why?
    - ◊ What would be the best way to decide which populations to include?
    - ◊ What might be the benefits to expanding the five priority populations (African American, Latino, Asian & Pacific Islander, LGBTQ+, Native American)?
    - ◊ What might be the drawbacks to expanding the five priority populations (African American, Latino, Asian & Pacific Islander, LGBTQ+, Native American)?
    - ◊ What could expansion of the five priority populations mean for the CRDP model?
    - ◊ Who should consult and partner on such an expansion, should it occur?
- There should be additional community-based organizations (CBO's) for each priority population (currently there are 7 per population).
  - » Strongly agree
  - » Agree
  - » Neither agree nor disagree
  - » Disagree
  - » Strongly disagree
  - » What kind of CBO's should be added and why?

  - What would be the best way to decide which CBO's to include?
  - What might be the benefits to including additional CBO's?
  - What might be the drawbacks to including additional CBO's?
  - What would expanding CBO's mean for the CRDP model?
  - Who should consult and partner on such an expansion, should it occur?

- CRDP should expand beyond prevention and early intervention (PEI).
  - Strongly agree
  - Agree
  - Neither agree nor disagree
  - Disagree
  - Strongly disagree
    - What might be the benefits of expanding beyond PEI?
    - What other sources of funding should CRDP explore?
    - What might be the drawbacks of expanding beyond PEI?
    - What would expanding beyond PEI mean for the CRDP model?
    - Who should consult and partner on such an expansion, should it occur?

- CRDP should expand to cover Substance Use Disorders (SUD's) and/or the behavioral health continuum.
  - Strongly agree
  - Agree
  - Neither agree nor disagree
  - Disagree
  - Strongly disagree
    - What might be the benefits of expanding to cover SUD's and/or the behavioral health continuum?
    - What might be the drawbacks of expanding to cover SUD's and/or the behavioral health continuum?
    - What would this expansion mean for the CRDP model?
    - Who should consult and partner on such an expansion, should it occur?

- There should be a process to move away from pilot programs.
  - Strongly agree
  - Agree
  - Neither agree nor disagree
  - Disagree
  - Strongly disagree
    - What other funding examples should we be replicating or learning from as this project moves from project stage?
    - In what ways can this project operate differently than it does now?

- ◊ How will we know when it's been achieved?
- ◊ How will we know if the process to move away from pilot programs is successful? (or achieved?)
- ◊ Are there other funding streams that might aid the process?
- ◊ What are other windows of opportunity?

- Integration of community-defined evidence practice (CDEP) into mainstream public mental health programming should be part of CRDP Phase 3.
  - » Strongly agree
  - » Agree
  - » Neither agree nor disagree
  - » Disagree
  - » Strongly disagree
    - ◊ How can we work with the County Behavioral Health Departments, California Department of Health Care Services, and the Mental Health Services Oversight and Accountability Commission to integrate community-defined and -led practices into mainstream public mental health programming?
    - ◊ What other entities need to be involved to integrate community-defined and-led practices into mainstream public mental health programming?
    - ◊ Where is this kind of systems integration already happening?
    - ◊ What are the lessons we can learn for expansion and replication?

- Moving forward, the model for CRDP should look substantially different from the current model.
  - » Strongly agree
  - » Agree
  - » Neither agree nor disagree
  - » Disagree
  - » Strongly disagree
    - ◊ What is your vision for a future version of the CRDP model?
    - ◊ How does this vision capitalize on the lessons and successes of CRDP Phases 1 and 2?
    - ◊ What might be hurdles for this vision, and how would you suggest overcoming them?
    - ◊ How would communities that are underrepresented, under-served, and inappropriately served benefit the most from this vision?

Are you ok if we follow up with you or invite you to participate in our advisory committee or to further engage in the planning process?_____

Is there anything else you wanted to tell us that was not captured in the survey?_____
_____
_____

Please feel free to share this survey with your network, or let us know who we should share or invite into this process?

Task Force Interview Questions

OHE TASK FORCE INTERVIEW

Thank you so much for taking the time to meet with us. We would like to learn more about your vision for the Phase 3 of the CRDP and what should be included in the recommendations report that is due June 2024.

Questions	Answers
Agency:	
Name:	
1. What do you believe to be the unfinished business of CRDP Phases 1 and 2?	
2. How do you think Phase 3 can move closer to the scalability, sustainability, and systems change that is needed?	
3. One of the task force members, Bong Vergara, has noted that there may be system transformation opportunities to make institutional, legal, policy, financing, and social inclusion reforms. What would you like to see CRDP Phase 3 address in these or other areas?	
4. There are so many different opinions around CRDP, how do you think we can come to consensus on what needs to be done in Phase 3?	
5. How would you specifically like to participate in this work? Is there a particular area that you are most passionate about?	
6. Do you have any other ideas or thoughts that you would like to see in Phase 3 that we have not discussed today or during task force meetings?	
7. Do you have all the information you need to meaningfully contribute to this process? If not, what else do you need or other questions do you have?	
8. We are 5 years into the future, what change are you most proud of in the behavioral health system that came about through Phase 3 of CRDP?	

SWOT Analysis Questions

CRDP MODEL - SWOT ANALYSIS

We are interested in understanding your perception of the strengths, weaknesses, opportunities,

and threats that pertain to the current CRDP model so that we can build on the best possible foundation when envisioning Phase 3. Your responses will not be shared in any reporting in conjunction with your name unless your permission is given. This form will close on February 29, 2024.

Strengths

What areas does the CRDP model really excel or shine? What makes the CRDP model special or unique?

_____

_____

What does the CRDP model do better than anyone else?_____

_____

What are we able to accomplish together that we would not be able to accomplish alone in the area of community defined evidence practice?_____

_____

What should always be a part of who we are, and what we do as CRDP?_____

_____

Weaknesses

Where do we have room for growth or improvement? _____

_____

Where do we struggle to do What's in the best interest of all parties involved? _____

_____

What may be holding us back from the kind of systems change we think is needed? Where does it feel like we may not be living up to our full potential? _____

_____

Opportunities

Where do windows of opportunity currently exist? _____

_____

What are the trends in our environment that we should be capitalizing on? How are things changing around us that we should pay attention to?_____

_____

Where could we receive the most support for forging systems change? _____

_____

Threats

What are the negative forces in the environment that have the potential to derail or slow our efforts if not properly navigated? _____

_____

What are the other issues in our state that may be seen as more critical? What would prevent our work from being valued or sustained? _____

_____

What might undercut our efforts through no-fault of our own?_____

_____

California Reducing Disparities Project Strategic Plan to Reduce Mental Health Disparities

California Reducing Disparities Project Phase 2 Statewide Evaluation Report

Final Task Force Meeting Task Force Recording and Notes