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California Reducing Disparities Project (CRDP)

Phase 2
Statewide Evaluation Guidelines 1.0
2017

Psychology Applied Research Center @ Loyola Marymount University

1 LMU Drive
University Hall 4725
Los Angeles, CA 90045
http://bellarmine.lmu.edu/psychology/parc/

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Acronyms

AAPA	Asian American Psychological Association
ABPsi	The Association of Black Psychologists
Alliance	3 national ethnic psychology associations (ABPsi, AAPA, NLPA), Division 44 members of the APA and the Indigenous Wellness Research Institute
APA	American Psychological Association
API	Asian and Pacific Islander
CBPP	Capacity Building Pilot Project
CBPR	Community-Based Participatory Research
CDC	Centers for Disease Control and Prevention
CDEP	Community-Defined Evidence Based Programs and/or Practices
CDPH	California Department of Public Health
CRDP	California Reducing Disparities Project
CRDP Phase 1	Strategic Planning Workgroups tasked with identifying mental health service delivery approaches that use community-defined evidence to improve outcomes and reduce disparities
CRDP Phase 2	Demonstration and evaluation of community-defined evidence based practices across 5 priority communities
DMH	Department of Mental Health
EBP	Evidence Based Practice
EOA	Education, Outreach, & Awareness
IPP	Implementation Pilot Project
IRB	Institutional Review Board
IWRI	Indigenous Wellness Research Institute
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
NLPA	National Latina/o Psychological Association
NREPP	National Registry of Evidence-based Programs and Practices
OHE	Office of Health Equity
PAR	Participatory Action Research
PARC@LMU	Psychology Applied Research Center at Loyola Marymount University
PEI	Prevention & Early Intervention
RCT	Randomized Control Trial
SAMHSA	Substance Abuse & Mental Health Services Administration
SMS	Subject Matter Specialists
SPW	Strategic Planning Workgroup
SWE	Statewide Evaluator
TA	Technical Assistance
TAP	Technical Assistance Provider
WHO	World Health Organization

"The world changes according to the way people see it, and if you can alter, even by a millimeter, the way people look at reality, then you can change the world."

—James Baldwin

About the Statewide Evaluation Guidelines

Now more than ever, a window of opportunity is before us to expand the inclusion of culturally, linguistically and contextually grounded approaches in mental health prevention and early intervention (PEI) practice. California Reducing Disparities Project (CRDP) Phase 2 does more than just involve partners; it has created a process of shared decision making. In partnership with local community based organizations, Phase 2 launched community grounded Implementation Pilot Projects (IPPs) known as Community Defined Evidence Projects (CDEPs) supported by 1) Technical Assistance Providers (TAPs), 2) Education, Outreach, and Awareness (EOA), and 3) a Statewide Evaluator (SWE).

This innovative effort is akin to designing a car of the future in real time, which in a sense means we are continuing to build the car as it is being driven uphill. In other words,

- The community is driving the car. They know the terrain, where they need to go, and who should be in the car.
- The CDEPs are the car's engine. This is where the magic happens and contains high quality products designed by the community.
- The TAPs are the mechanics ready to ensure the IPP car engine is well tuned and operating at peak efficiency.
- The EOAs keep the public updated on this new innovation—advertising, marketing, alerts, and possible directions for mass production.
- The SWE is the car warranty, protecting the innovation bumper to bumper with regular guaranteed benefits and periodic checkups to keep the vehicle at peak performance.
- The CDPH is the car manufacturer providing an innovative design and cutting edge technology, informing government regulations, and maintaining a space to house the car as it moves from concept to mass production.

The IPPs are in an unprecedented position to represent the unique features of their CDEPs—that is, community-defined, culturally-situated practices that offer the field community-based views that have never been documented in this way or on this scale, ever before. Their success will be established through the SWE and CDEP local evaluations. They are ***the*** mechanism through which we can ensure that IPPs inform and change the field, but also contribute in significant ways to reducing mental health disparities for the five priority populations. The CDEP evaluations are oriented towards capturing the cultural nuances as well as the outcomes of their approaches and this ***requires*** a participatory approach (since community members are the only ones who have the subject-matter expertise or information needed to make the case).

But as we can see from the car metaphor above, it's a partnership. Each of us has a vital and essential role to play. The SWE Guidelines serve as a resource for IPPs, their community members, local evaluators, the TAPs, CDPH, and other key stakeholders to establish culturally and linguistically credible evidence for CRDP Phase 2 and the CDEPs. The Guidelines also serve to establish a shared understanding of our respective roles in this initiative.

The CRDP Phase 2 SWE Evaluation Guidelines provide an overview of:

1. CRDP Phase 2 and CDPH expectations,
2. Phase 2 partners,
3. The public health approach to mental health disparities,
4. The Statewide Evaluation,
5. Evaluation and research strategies,
6. Re-defining credible evidence and
7. The CDEP Evaluation Plan and Final Report requirements.

While the Guidelines offer ideas about how to develop a rigorous CDEP evaluation plan, they are not intended to serve as an exhaustive resource on program evaluation. Additional information, tools, and resources can be found in the links below and through technical assistance from the TAPs and PARC@LMU.

The following hyperlinks as follows:

- Centers for Disease Control and Prevention (CDC) Framework for Program Evaluation in Public Health (https://www.cdc.gov/eval/)
- A Framework for Program Evaluation: A Gateway to Tools (http://ctb.ku.edu/en/table-of-contents/evaluate/evaluation/framework-for-evaluation/main)
- American Evaluation Association (http://www.eval.org/)
- RAND Corp: Program Evaluation (http://www.rand.org/topics/program-evaluation.html)
- Penn State Extension Program Evaluation Resources (http://extension.psu.edu/evaluation)

“Individually, we are one drop.
Together, we are an ocean.”

— Ryunosuke Satoro

Introduction

Overview

CDPH launched the CRDP in 2009 in response to a call for national action to reduce mental health disparities. Phase 1 identified issues and recommendations for five historically underserved populations—African Americans; Asian and Pacific Islanders; Latinos; Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ); and American Indian/Alaska Native.
A Strategic Planning Workgroup (SPW) was established for each priority population. These planning groups identified promising CDEP elements and strategies along with recommendations for reducing mental health disparities in their respective constituencies. These were summarized in five population reports and compiled into a single, comprehensive CRDP strategic plan that informed the basis of Phase 2.

Interrelated Elements

Phase 2 launched in 2016 and will run through 2022. It is focused on the implementation of the strategic plan and consists of four interrelated elements:

1. Implementation Pilot Projects (IPPs): 35 organizations will receive grants to provide culturally competent prevention and early intervention services to specific priority populations.
2. Technical Assistance Providers (TAPs): Five population specific organizations will focus on supporting the IPPs by working to improve administration and operations, identifying and securing additional resources, and building strategic partnerships to better serve communities.
3. Education, Outreach, and Awareness (EOA): (to be determined by CDPH), and
4. Statewide Evaluation (SWE): The Psychology Applied Research Center at Loyola Marymount University (PARC@LMU) will design and implement an overall evaluation of CRDP Phase 2, develop the SWE Evaluation Guidelines, provide evaluation training and technical support to TAPs and IPPs as needed, assess the 35 IPP local evaluations (plans and reports), and make recommendations to CDPH.

Each IPP will be expected to execute a community-based participatory evaluation plan for its CDEP to determine program effectiveness. IPPs will receive support in the development and implementation of their evaluation plans via: a) SWE guidelines, b) TAP population guidelines, c) IPP local evaluators, and d) tailored individual or group subject-matter assistance from the TAPs and PARC@LMU.

CDPH Defined Contractor Responsibilities

The CDPH Call for Applications lists a set of responsibilities for all Phase 2 contractors and grantees.

PARC@LMU will provide feedback on each IPP's CDEP Evaluation Plan within 60 days of the grant's initiation. Each IPP will work with their TAP to discuss evaluation strategies, identify opportunities for refinement, ensure alignment of the CDEP evaluation plan with both the TAP and SWE Evaluation Guidelines, and make certain IPPs fulfill all data collection needs. The IPPs will revise their proposed CDEP Evaluation Plan, as appropriate, and resubmit it for review and acceptance by CDPH within 90 days of the start of the grant period. CDPH has the sole discretion to accept or reject the CDEP Evaluation Plan.

IPPs will submit a draft version of their CDEP Evaluation Plan to PARC@LMU on May 26th, 2017. PARC@LMU will provide feedback and recommendations. IPPs will revise the CDEP evaluation as appropriate. Implementing feedback and recommendations will occur at the sole discretion of the IPP. PARC@LMU will also provide subject-matter support to CDPH during their review of the IPP Final Evaluation Report. At the end of the data collection period, IPPs will provide a Final Evaluation Report that details the results/outcomes of their CDEP, including the development of a business case that documents return on investment. The Final Evaluation Report should be based on the CDEP Evaluation Plan, which should be aligned with the TAP and SWE Evaluation Guidelines. CDPH has the sole discretion to accept or reject the Final CDEP Evaluation Plan and Report.

IPPs are also required to submit an Annual Update to CDPH within 60 days after the end of each grant year. This report must include an overview of yearly data, provide a recap of activities during the year, and an overview of the activities planned for the upcoming year. The Annual Update must also include a narrative description of evaluation successes and challenges to the extent available. After the first grant year, IPPs are expected to submit an updated CDEP evaluation plan by the end of each following grant year to account for program insights obtained during the previous year, additional guidelines issued by CDPH, PARC@LMU, and/or TAPs, and new circumstances. In addition, the Updated Evaluation Plan should address any challenges collecting or providing SWE data required by PARC@LMU. CDPH has the sole discretion to accept or reject the Updated Evaluation Plan.

The TAPs will provide IPPs with ongoing technical assistance. Technical assistance will include, at a minimum: evaluation planning, design and implementation, baseline measurement, data collection, engaging community members in the evaluation process, pursuit of evidence-based practice status, hiring an evaluator, and obtaining Institutional Review Board approval of research protocols (if necessary). The TAP will also provide ongoing support throughout the implementation stage to help refine and troubleshoot issues that may arise regarding evaluation. This may include, but is not limited to, assistance regarding data collection, interpretation, and validation.

CDPH
Defined Contractor Checklist:

- [ ] IPPs will work with their TAP to finalize their local evaluation plan and submit to CDPH by May 26th, 2017.
- [ ] IPPs are responsible for collecting the SWE core measures as part of their local CDEP evaluation.
- [ ] PARC@LMU will review all CDEP Evaluation Plans and provide recommendations to CDPH and the IPPs on how to improve them, if warranted.
- [ ] IPPs will revise the CDEP evaluations as appropriate. TAPs and PARC@LMU will support IPPs in these revisions.
- [ ] IPPs will submit Annual Updates to CDPH within 60 days after the end of each grant year; IPPs, TAPs, and EOA will complete and submit a SWE semi-annual report until the end of the data collection period.
- [ ] PARC@LMU will provide ongoing technical assistance and support to TAPs, IPPs, and the local evaluators and throughout the implementation stage related to the CDEP evaluation or SWE core measures.
- [ ] TAPs and PARC@LMU will provide ongoing support throughout the implementation stage of their CDEP evaluation to help refine and troubleshoot issues that may arise.
- [ ] IPPs will consult with TAPs regarding any TA needs.
- [ ] IPPs will provide a CDEP Final Evaluation Report that details the results/outcomes of their CDEP at the end of the data collection period.
- [ ] PARC@LMU will review the CDEP evaluation reports and provide recommendations and solutions to CDPH on how to improve them, if warranted.

"When you have people together
who believe in something very strongly —
whether it's religion or politics or unions —
things happen."

— Cesar Chavez

1. The CRDP Phase 2 Partners

The purpose of the following section is to introduce you to four partners central to CRDP Phase 2: the 35 Implementation Pilot Projects (IPPs); the 5 Technical Assistance Providers (TAPs); the Education, Outreach and Awareness Specialist (EOA); the State-wide Evaluation team (SWE) (PARC@LMU); and the California Department of Public Health (CDPH).

AFRICAN AMERICAN

California Black Women's Health Project
(Los Angeles, Alameda, Sacramento and San Bernadino County)
CDEP: *Sister Circle*

Catholic Charities of the East Bay
(Richmond and Oakland)
CDEP: *Restorative Trauma-Informed Practices for Teens*

Healthy Heritage Movement
(Riverside and San Bernadino County)
CDEP: *Broken Crayons…Still Color*

Safe Passages
(Oakland)
CDEP: *Law and Social Justice Pipeline*

The Village Project
(Monterey County)
CDEP: *Emanyatta ("Warrior's Camp")*

West Fresno Health Care Coalition
(Fresno County)
CDEP: *The Sweet Potato Project*

Whole Systems Learning
(Los Angeles and Riverside County)
CDEP: *Turning Resilience Into Brilliance For Eternity*

ASIAN AND PACIFIC ISLANDER

Hmong Cultural Center of Butte County
(Butte County)
CDEP: *Zoosiab Program*

Muslim American Society: Social Services Foundation
(Sacramento County)
CDEP: *Shifa*

Cambodian Association of America
(Long Beach and Santa Ana)
CDEP: *API Strength-Based Community Wellness Program*

East Bay Asian Youth Center
(Oakland and Sacramento)
CDEP: *GroundWork Program*

Fresno Center for New Americans
(Fresno, Merced and San Joaquin Counties)
CDEP: *Southeast Asian Cross Cultural Counseling Model*

HealthRIGHT 360
(North San Mateo County)
CDEP: *Asian American Recovery Services*

Korean Community Services
(Orange County)
CDEP: *Promotora ("Community Health Workers")*

LATINO

Humanidad Therapy and Education Services
(Sanoma County)
CDEP: *Humanidad Therapy and Education Services*

Integral Community Solutions Institute
(Fresno County)
CDEP: *Platicas and el Circulo*

Latino Service Providers
(Sanoma County)
CDEP: *TESTIMONIOS*

Health Education Council
(24 Counties)
CDEP: *Ventanilla de Salud*

La Clinica de La Raza
(Alameda County)
CDEP: *Cultura y Bienestar*

La Familia Community Counseling
(Sacramento County)
CDEP: *Cultura de Salud*

Mixteco-Indigena Community Organizing Project
(Ventura County); CDEP: *Living with Love*

LGBTQ

Gay & Lesbian Center of Bakersfield
(Kern County)
CDEP: *Reducing Isolation through Support and Empowerment*

Gender Health Center
(Sacramento County)
CDEP: *Mental Health, Health Advocacy, Community-Building Social and Recreational Programming*

San Joaquin County Pride Center, Inc.
(San Joaquin County)
CDEP: *Mental Health Access and Youth Empowerment Program*

Asian & Pacific Islander Wellness Center
(San Francisco Bay Area)
CDEP: *Touchpoints*

Gender Spectrum
(San Francisco Bay Area)
CDEP: *Gender Spectrum*

On The Move
(Napa, Sonoma, and Solano County)
CDEP: *OASIS Model*

Openhouse
(San Francisco Bay Area)
CDEP: *Community Engagement Program*

AMERICAN INDIAN/ALASKA NATIVE

Friendship House Association of America
(San Francisco and Alameda County)
CDEP: *Friendship House Youth Program*

Indian Health Center of Santa Clara Valley
(Santa Clara County)
CDEP: *Classes and the Gathering*

Indian Health Council, Inc.
(San Diego County)
CDEP: *REZolution*

Native American Health Center
(Alameda, Contra Costa and San Francisco County)
CDEP: *Gathering of Native Americans*

United American Indian Involvement, Inc.
(Los Angeles County)
CDEP: *The Native Drum, Dance and Regalia ProgramTo Be Announced*

Sonoma County Indian health Project and Two Feathers Native American Family Services

TAPs-At-A-Glance

African American TAP: ONTRACK Program Resources
Lilyane Glamben (lglamben@ontrackconsulting.org)
Website: https://ontrackconsulting.org/

Asian and Pacific Islander TAP: Special Services for Groups
Erica Shehane (eshehane@ssg.org)
Website: http://www.ssg.org/

Latino TAP: UC Davis Center for Reducing Health Disparities
Kaytie Speziale (kspeziale@ucdavis.edu)
Website: http://www.ucdmc.ucdavis.edu/crhd/

LGBTQ TAP: Center for Applied Research Solutions
Daniel Toleran (dtoleran@cars-rp.org)
Website: http://www.cars-rp.org/

Native American TAP: Pacific Institute for Research and Evaluation
Roland Moore (roland@PREV.org)
Website: http://www.pire.org/index.aspx

AFRICAN AMERICAN TAP

ONTRACK Program Resources
Email: mcrucker@ontrackconsulting.org

ONTRACK Program Resources, a Sacramento-based non-profit consulting agency, has worked to bridge the gap between health and human services systems and resources to reach communities most impacted by social, economic and political disparities. ONTRACK has provided culturally sensitive technical assistance to community based organizations that serve the African American community since 1998. The team will be led by Madalynn Rucker who brings 24 years of experience providing behavioral health technical assistance. She is a member of the Substance Abuse and Mental Health Services Administration (SAMHSA) Addiction Technology Transfer Center Network National Advisory Board and the SAMHSA Women's Addiction Services Leadership Institute. Lilyane Glamben will serve as Project Manager. She brings over 25 years of nonprofit management experience to the team.

API TAP

Special Services for Groups
Email: eshehane@ssg.org

Special Services for Groups (SSG) is a Los Angeles community based organization that has been supporting grassroots communities to develop social, health, educational and economic solutions for over 60 years. The project will be led by SSG's Research and Evaluation Team whose approach includes cultural sensitivity and deep community roots to help non-profit organizations, philanthropy and public agencies make greater impact. Erica Shehane, Director of Research and Evaluation at SSG will act as Project Manager. Ms. Shehane has recently led projects for the Orange County Health Care Agency, The California Endowment and the National Institute of Mental Health. Loraine Park, Director at Harder+Company Community Research, will be part of the management team and support Ms. Shehane on this project. Ms. Park has advised on projects for the MHS OAC (as a subcontractor to UCSD), Los Angeles Department of Public Health, and Tulare County Health and Human Services Agency. SSG and Harder+Company have assembled a team of technical assistance providers that will provide individualized support to the API pilot projects. Collectively, this team has extensive expertise in social work, mental health, public health, Asian American studies, and public policy.

LGBTQ TAP

Center for Applied Research Solutions
Email: knakai@cars-rp.org

Center for Applied Research Solutions (CARS) is a California-based nonprofit focused on supporting the prevention field with high-quality technical assistance. The project is co-directed by Ken Einhaus and Daniel Toleran. Mr. Einhaus has over 18 years of experience providing technical assistance and similar services in support of LGBTQ communities and other marginalized populations. His experience includes supporting the Veterans Administration's treatment facility for homeless veterans in accepting and supporting its first transgender client. Mr. Toleran has over 15 years of experience directing programs that provide integrated mental and behavioral health, HIV/AIDS services, comprehensive social supports, and community advocacy to historically underserved LGBTQ communities. Focus populations have included transgender persons, homeless adults, urban immigrants, and transition age youth living with HIV. The team is supported by several subcontractors and two dozen subject matter experts that can be called upon to support with specific technical assistance needs.

LATINO TAP

University of California, Davis
Email: aguilargaxiola@ucdavis.edu

UC Davis is a member of the University of California system. The team primarily operates out of Sacramento. The project will be led by Dr. Sergio Aguilar-Gaxiola of the Center for Reducing Health Disparities. Dr. Aguilar-Gaxiola is the Founding Director of theCenter for Reducing Health Disparities, a World Health Organization scientist and was the Latino population lead for CRDP, Phase I. He has over 25 years of experience directing federal, state and foundation funded research programs that focused on community engaged approaches to reducing health disparities.

The team will include Dr. Linda Ziegahn, Dr. Heather Diaz and Dr. Gustavo Loera, who will each be responsible for working closely with two to three pilot projects. In addition, Rachel Guerrero will advise on cultural and linguistic competence and support the development of materials and curricula.

NATIVE AMERICAN TAP

Pacific Institute for Research and Evaluation
Email: vanesscia.cresci@crihb.org

Pacific Institute for Research and Evaluation (PIRE) is a California-chartered non-profit organization founded in the Bay Area in 1974. Since that time, they have worked with federal government, states, and communities to better understand behavioral health issues, to provide training and technical assistance and to evaluate interventions to prevent or reduce health disparities among vulnerable populations. This project will be led by Dr. Roland Moore, an anthropologist who has engaged in community-based participatory research, mentoring, and technical support with Native American populations in California and other western states. Dr. Moore will lead a team of seasoned experts with extensive experience collaborating with, serving and providing technical assistance to Native Americans in California. Attuned to cultural and linguistic nuances, the PIRE team will work effectively with the seven Native American Implementation Projects.

Education, Outreach, and Awareness (EOA) Placeholder

[Coming Soon]

The Psychology Applied Research Center @Loyola Marymount University (PARC@LMU)

PARC At-A-Glance

PARC@LMU

General Information:
http://bellarmine.lmu.edu/psychology/parc/

My SWE Contact
General information and requests for evaluation technical assistance & support:
Diane Terry
diane.terry@lmu.edu
310 338.7095

PARC Priority Population SWE Team Assignments

African American
Deanna Cooke

Asian American and Pacific Islander
Jennifer Abe

Latino
Sandra Villanueva

LGBTQ
Negin Ghavani

American Indian/Alaskan Native
The Alliance
Cheryl Grills

Business Case
Sean D'Evelyn

Data Analysis
Ben Fitzpatrick

PARC@LMU, located in Los Angeles, California is housed in the Psychology Department of LMU's Bellarmine College of Liberal Arts. PARC is a grant-funded center that collaborates with a variety of community-based organizations and groups to inform social change and community empowerment through applied, action-oriented research. Established in 2009 under the leadership of Center Director Cheryl Grills, Ph.D., PARC has conducted evaluation and technical assistance on dozens of local and national projects. Its community-based participatory research is primarily focused on direct service and the social justice priority issues of underserved communities of color addressing inequity, disproportionality, and disparity.

The Core Values of PARC@LMU

Strong collaboration with our partners (IPPs, local evaluators, TAPs, EOA, CDPH), and a shared understanding of the unique strengths and characteristics brought by each is key to an effective statewide evaluation of this multi-site, multifaceted initiative.

The core values guiding the PARC SWE are:

Shared Vision— creating a common identity, purpose, and commitment with IPPs, local evaluators, TAPs, EOA, and CDPH about the CRDP Phase 1 and Phase 2 goals and objectives;

Inclusiveness— engaging diverse stakeholders and those most affected by mental health disparities to create intended change at the local and state levels;

Collaboration— working cooperatively to get the SWE and CDEP evaluations successfully implemented;

Flexibility— adapting and making changes to the SWE and CDEP evaluations to meet local circumstances;

Empowerment— helping IPPs to develop lasting skills in evaluation that strengthen organizational capacity; and

Cultural Responsiveness— viewing the strengths and needs of the specific populations served by the IPPs within the context of their cultural, linguistic, organizational, community, historical, and intersectional perspectives.

For an example of PARC's CBPR approach, refer to Appendix 1 ("Improving school conditions by changing public policy in South Los Angeles: The Community Coalition partnership" found in Minkler et al., 2008).

PARC@LMU will be working collaboratively with a team of experts, known as The Alliance, on cultural issues connected to the priority populations. Experts in matters of culture and identity, they will provide TA and support to PARC to inform specific SWE deliverables. They are members and representatives of three ethnic psychology organizations—The Association of Black Psychologists (ABPsi), The Asian American Psychological Association (AAPA), The National Latina/o Psychological Association (NLPA); one research center, and members of Division 44 of the American Psychological Association; and The Indigenous Wellness Research Institute; and The American Psychological Association.

The Asian American Psychological Association
Since its inception, the Association has advocated on behalf of Asian Americans and worked to advance the mental health and well-being of Asian American communities through research, professional practice, education, and policy.

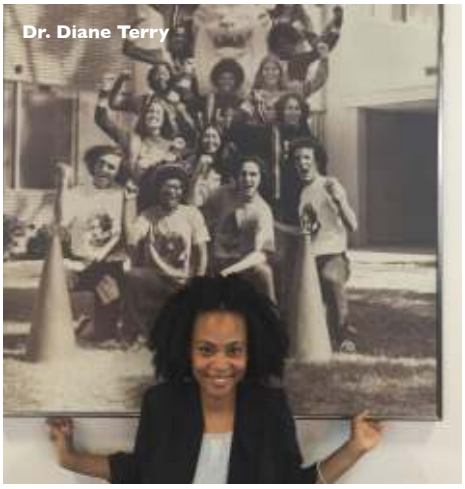
The Association of Black Psychologists
The Association of Black Psychologists sees its mission and destiny as the liberation of the African Mind, empowerment of the African Character, and enlivenment and illumination of the African Spirit. The Association is organized to operate exclusively for charitable and educational purposes through promoting and advancing the profession of African Psychology, and influencing social change.

The National Latino Psychological Association
The NLPA aims to create a supportive professional community that advances psychological education and training, science, practice, and organizational change to enhance health and mental health, and promote culturally competent delivery of services towards Latino populations.

The Indigenous Wellness Research Institute
IWRI is located at University of Washington and aims to support the inherent rights of Indigenous peoples to achieve full and complete health and wellness by collaborating on decolonization research, knowledge building, and sharing.

The American Psychological Association
Members of APA's Division 44—The Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues—will bring their expertise that reflects this division's aim to use psychological knowledge to advocate for the advancement of the public interest and the welfare of lesbian, gay, bisexual and transgender people. They inform the general public about research, education and training, practice, and advocacy on LGBT issues.


Dr. Cheryl Grills


Dr. Diane Terry


Aisha Walker


Brian Clark

Say Hey to SWE!

Dr. Cheryl Grills is a Clinical Psychologist with an emphasis in Community & African Psychology and community-based, participatory research and program evaluation. For over 25 years, she has worked on social justice action projects and community change/prevention efforts in partnership with communities of color in California, the nation, and internationally.
Cheryl.Grills@lmu.edu

Dr. Sandra Villanueva is a Community-Clinical Psychologist with over 20 years experience in program evaluation & community-based participatory action research on systems/policy change efforts with communities of color focused on a host of social
justice issues in LA, CA, and across the nation.
Sandra.Villanueva@lmu.edu

Dr. Diane Terry is a Social Welfare Researcher focused on youth and families involved in the juvenile justice or foster care system. As a program evaluator, her work has focused on individual and systems level change for kinship families and youth in communities of color in LA County.
Diane.Terry@lmu.edu

Dr. Chris Hill is a Developmental Psychologist with a research focus on the academic achievement gap, performance, and motivation for students of color in K-20.
chrisopher.hill@lmu.edu

Dr. Jennifer Garcia is a Public Health Researcher whose research focuses on the social determinants of health inequity, residential segregation, and access to resources in communities of color.
jennifer.garcia@lmu.edu

Aisha Walker is a Research/Administrative Coordinator who has examined racial microagressions and discrimination for African American women in the workforce.
aisha.walker@lmu.edu

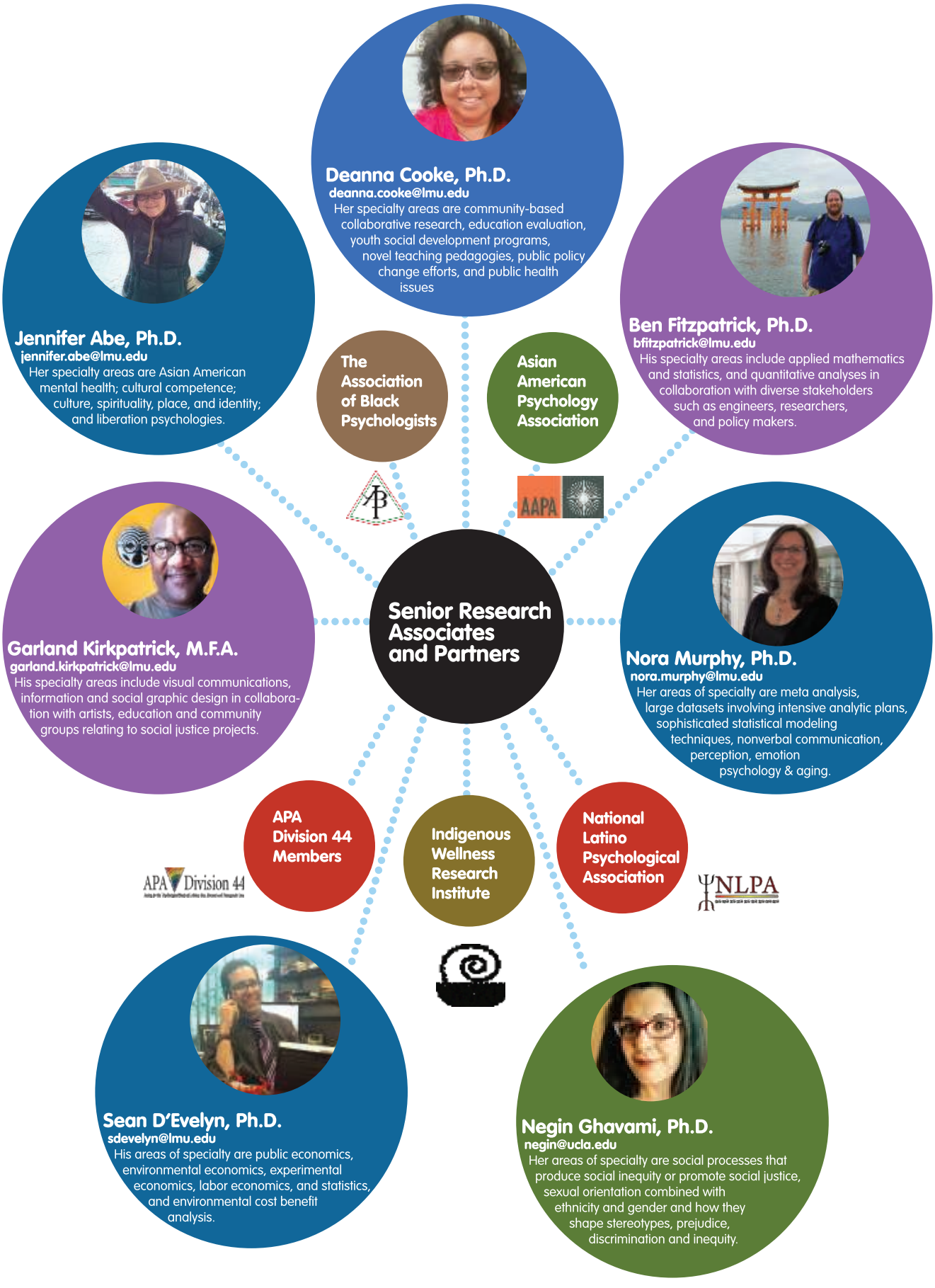
Brian Clark is a Research Assistant whose work has centered on cultural competence, health disparities, human trafficking, and crisis services to victims of sexually based violence.
brian.clark@lmu.edu

Justin Ludwig
(not pictured) is a research assistant who specializes in psychological research and has conducted studies in areas related to moral psychology, gender, empathy, and autism spectrum disorder.
justin.ludwig@lmu.edu


Dr. Sandra Villanueva


Dr. Jennifer Garcia

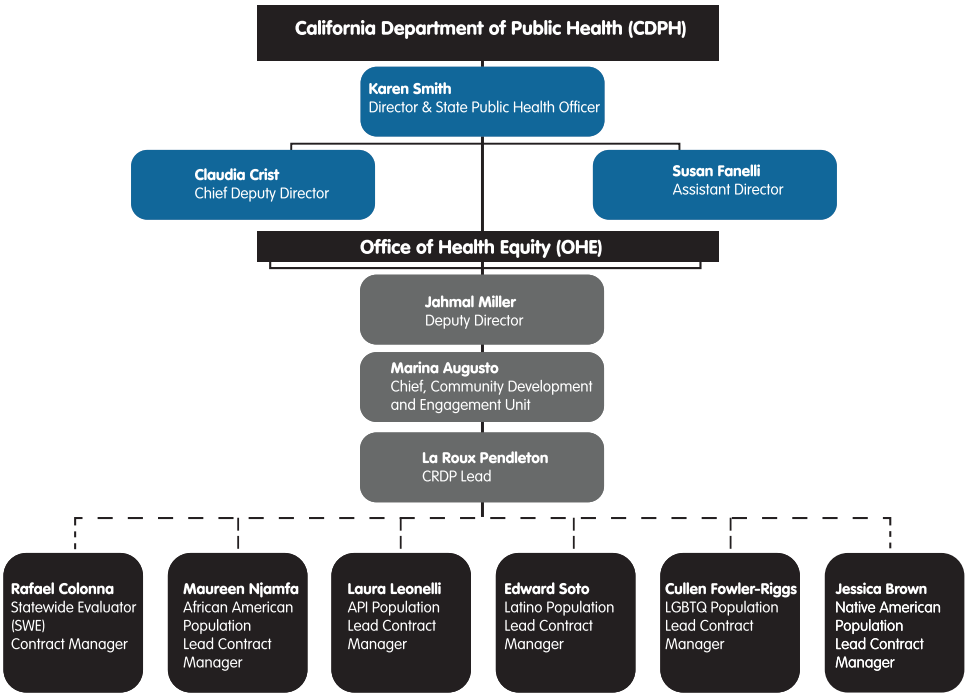
Dr. Chris Hill


Deanna Cooke, Ph.D.
deanna.cooke@lmu.edu
Her specialty areas are community-based collaborative research, education evaluation, youth social development programs, novel teaching pedagogies, public policy change efforts, and public health issues
Jennifer Abe, Ph.D.
jennifer.abe@lmu.edu
Her specialty areas are Asian American mental health; cultural competence; culture, spirituality, place, and identity; and liberation psychologies.
Ben Fitzpatrick, Ph.D.
bfitzpatrick@lmu.edu
His specialty areas include applied mathematics and statistics, and quantitative analyses in collaboration with diverse stakeholders such as engineers, researchers, and policy makers.
The Association of Black Psychologists
Asian American Psychology Association
AAPA
Senior Research Associates and Partners
Garland Kirkpatrick, M.F.A.
garland.kirkpatrick@lmu.edu
His specialty areas include visual communications, information and social graphic design in collaboration with artists, education and community groups relating to social justice projects.
Nora Murphy, Ph.D.
nora.murphy@lmu.edu
Her areas of specialty are meta analysis, large datasets involving intensive analytic plans, sophisticated statistical modeling techniques, nonverbal communication, perception, emotion psychology & aging.
APA Division 44 Members
APA Division 44
Indigenous Wellness Research Institute
National Latino Psychological Association
NLPA
Sean D'Evelyn, Ph.D.
sdevelyn@lmu.edu
His areas of specialty are public economics, environmental economics, experimental economics, labor economics, and statistics, and environmental cost benefit analysis.
Negin Ghavami, Ph.D.
negin@ucla.edu
Her areas of specialty are social processes that produce social inequity or promote social justice, sexual orientation combined with ethnicity and gender and how they shape stereotypes, prejudice, discrimination and inequity.

CRDP At-A-Glance

The California Reducing Disparities Project (CRDP) is a project of the California Department of Public Health's Office of Health Equity (OHE). CRDP is funded by the Mental Health Services Act (MHSA) of 2004 to support and strengthen mental health programs in California.

CRDP within the context of CDPH



"Behavioral health is essential..., prevention works, treatment is effective, and people recover from mental and/or substance use disorders."

— Substance Abuse and Mental Health Services Administration

2. The Public Health Approach to Mental Health

CRDP Phase 2 is imbued with the perspective of public health. IPPs should be able to describe their CDEPs in terms of three basic components found in public health.

- Level of prevention: Primary or Secondary
- Type of program: Prevention and/or Early Intervention
- Prevention strategy (to reach people): Selected or Indicated

Public health is concerned with preventing illness and promoting health across entire populations. Three core components of public health are highlighted in this section to demonstrate how it is well-suited for the prevention of mental illness and the promotion of mental health at the population level. Please consider how 1) Level of Prevention, 2) Type of Prevention, and 3) Prevention Strategy relate to your CDEP and priority population.

Level of Prevention

Within public health, prevention occurs at three levels:

- *Primary:* prevent disease or injury before it occurs
- *Secondary:* reduce the impact of disease or injury after it has occurred
- *Tertiary:* manage the disease or injury to maximize function and quality of life

Considering these LEVELS of prevention, where do your CDEP strategies best fit?

Levels of Prevention: A Public Health Example

Let's look at how the three levels of prevention can apply to cancer—one of the top causes of disability and death among communities of color.

- **Health education campaigns that encourage healthy lifestyles demonstrate a primary prevention strategy. These messages (such as promoting high fiber diets and regular physical activity) are intended to reduce cancer risk and can prevent individuals from getting cancer in the first place.**

- **Cancer screening (such as mammograms or hemoccult stool testing) is an important secondary prevention tool, because early diagnosis is a key to improving cancer survival odds.**

- **For those individuals who do have cancer, tertiary prevention includes follow-up exams (to check if the cancer has spread) and access to quality care. The goal is to effectively treat the cancer (treatments are most effective in earlier stages) or to soften the impact of the illness, and improve functioning and quality of life.**

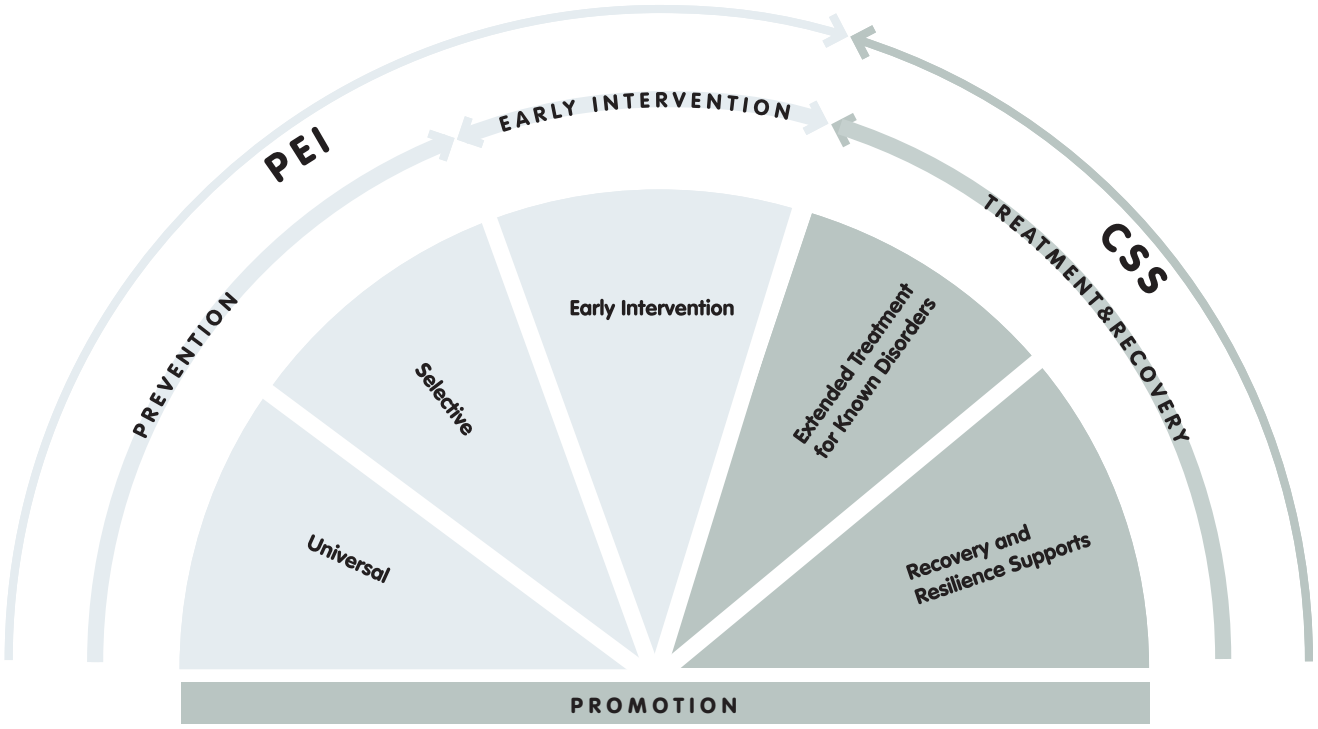
Source: AFMC Primer on Population Health

Type of Program

Public health tends to focus on primary prevention since it aims to prevent people from getting "sick" in the first place. However, if people do become ill, public health is concerned with minimizing the impact of the illness, and reducing pain and suffering. Consistent with this thinking are Prevention and Early Intervention (PEI) programs (note: more detail on PEI can be found in Section 3 of this document).

- Prevention: avoid the initial onset of a mental illness
- Early Intervention: identify warning signs for individuals at risk for mental health problems and intervene early to prevent/mitigate/delay the development of mental illness.

Prevention and Early Intervention are only one part of a continuum of care that also includes health promotion, treatment, and recovery. Use the diagram below to identify where your CDEP fits in the public health continuum of care.



ADAPTED MHSA
SPECTRUM OF SERVICES

Prevention Strategy

Public health draws upon three prevention strategies to reach individuals and/or communities.

- *Universal* prevention strategies are designed to reach the entire population
- *Selective* prevention strategies address "at-risk" subgroups within the general population. Individuals who are part of an at-risk group, may or may not exhibit problem behavior themselves (e.g., youth in the foster care system)
- *Indicated* prevention strategies focus on individuals who exhibit high-risk behaviors. This type of prevention strategy includes tailored interventions for individuals who may not have a clinical diagnosis, but are exhibiting serious problematic behavior.

Considering these three prevention STRATEGIES, where does your CDEP approach best fit?

Prevention Strategies: A Substance Abuse Prevention Example

- A school-based substance abuse curriculum designed for all children within a school district is a universal prevention strategy. It reaches a very large and general audience.

- One school in this same district designed a mentoring program for a select number of children who have substance abusing parents. This selective prevention strategy focuses on an at-risk subgroup.

- Within this same school, a group of children are experiencing serious behavioral problems such as truancy, suicidal ideation, and early signs of substance abuse. A substance abuse program tailored to these students is an indicated prevention strategy.

Source: Texas DSHS

Health Promotion

A public health approach is holistic, attends to the root causes, is strengths-based, engages community, and is multidisciplinary. This approach is aligned with CRDP and the CDEPs in several ways. Both CRDP and CDEPs:

1. Recognize the "whole person." The World Health Organization (WHO) defines health as: a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. This understanding of health emphasizes the whole person and the mind-body connection. Mental health is explicitly included as part of the definition of health.

2. Look for and prioritize the "root causes" of disease and health inequality. Examining root causes (i.e., the social and economic determinants that shape health status) helps to identify the places for intervention that will have the greatest impact on improving health. For example, one root cause connected to health and mental health disparities includes lack of access to affordable services. Providing universal healthcare will benefit more people than opening a new clinic in one neighborhood. Focusing on root causes also supports systems change (e.g., increasing access to care) rather than blaming the victim.

3. Use an asset-model rather than deficit-model to identify and build upon pre-existing strengths and resources in communities. Deficit-model thinking tends to focus on the "problems that need fixing" within a community, which often obscures or ignores different forms of cultural wealth, experience and wisdom of community members, and non-Western healing practices (e.g., talking circles and drumming led by traditional Indian healers) (Native American Population Report, 2012).

4. Engage community members and partners using a collaborative process to address issues that affect the health and well-being of people facing similar challenges. Community engagement can build trust, identify allies, and improve communication among those working toward shared health goals. "Community engagement is grounded in the principles of community organization: fairness, justice, empowerment, participation, and self-determination" (CTSA, 2011).

5. Draw on the subject-matter experience from multiple disciplines and recognize the linkages across various sectors that can help support mental health and well-being. For example, allied health professionals, such as nurses, social workers, and physicians, are key members of a public health team. In addition, they also work with urban planners, public policymakers (housing, economic, etc.), and educators to design institutions, policies, and community resources that best support mental health.

Mental health is essential to overall health and well-being. Oftentimes mental and physical illness can occur at the same time—when both mental and physical problems are present, people experience more suffering and worse quality of life, not to mention higher utilization of health care services (Dohery & Gaughran, 2014).

"Heal the soul and the body will follow."
—Stevenson Kuartei, Minister of Health, Republic of Palau

"'Health equity' means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives."

— California Health and Safety Code Section 131019.5

3. The Mental Health Services Act & Prevention and Early Intervention

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provided the first opportunity for the then California Department of Mental Health (DMH) to provide increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families. Implemented in 2005, the MHSA is designed to improve coordinated care and comprehensive mental health services for those with serious mental illness and for underserved populations in five funding streams:

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET)
- Capital Facilities and Technology (CFT) and
- Innovative Programs (INN)

About PEI

Prevention and Early Intervention (PEI) strategies represent a "help-first" system for mental health services that allow individuals "at risk of serious mental illness to get treatment before the mental illness becomes severe and disabling" (MHSOAC, 2016).

- *Prevention* includes building protective factors and skills, increasing support, and reducing risk factors or stressors prior to a diagnosis of mental illness.

- *Early Intervention* is directed toward individuals and families for whom a short (usually less than one year), relatively low-intensity intervention is appropriate to improve mental health problems and avoid the need for more extensive mental health treatment.

Counties are required to use PEI Statewide Funds to address three program areas: 1) Suicide Prevention, 2) Stigma and Discrimination Reduction, and 3) Student Mental Health. All counties engage in a community planning process to obtain local stakeholder (e.g., clients, family members, etc.) input on how to use their PEI funds. PEI strategies are designed with health equity in mind—for example, addressing disparities in access to services for underserved ethnic communities and across geographic regions within a county, or ensuring that children and youth programs receive adequate funds. Additionally, because one goal of MHSA is to reach underserved groups, PEI programs are provided in "non-traditional" health services locations such as schools, community centers, and faith-based organizations. These various strategies are helping to build a more comprehensive and equitable mental health system.

PEI and CRDP

CRDP is funded through MHSA state administrative funding. The CRDP is a statewide PEI effort to improve mental health access and outcomes among five historically underserved communities:

- African American
- Asian and Pacific Islander
- Latino
- Lesbian, Gay, Bisexual Transgender, Queer and Questioning (LGBTQ)
- American Indian/Alaska Native.

The PEI impact of CRDP Phase 2 will be assessed through two types of programs:

1) *Direct Programs* intend to reduce MHSA-specified "negative outcomes" that "may result from untreated mental illness" for individuals with risk (Prevention) or early onset (Early Intervention) of a mental illness.

2) *Indirect Programs* goals include timely access to treatment and other mental health services and supports, and/or changes in someone's attitude, knowledge, and/or behavior that are likely to facilitate access to mental health services. Indirect programs include: timely access to services for underserved populations, access and linkage to treatment for people with serious mental illness, outreach for increasing recognition of early signs of mental illness, stigma and discrimination reduction, non-stigmatizing and non-discriminatory service delivery implementation strategy, suicide prevention, and systems level changes.

Refer to the following table for more details on the types of indicators and outcomes typically measured in county PEI programs.

MHSA Prevention & Early Intervention: Program Evaluation Standards and Regulations

Name	Definition	Types of Indicators	Levels of Outcomes	Short-Term and Intermediate Outcomes	Long Term Outcomes (Public Health)
Direct Programs: intend to reduce MHSA-specified "negative outcomes" that "may result from untreated mental illness" for individuals with risk (Prevention) or early onset (Early Intervention) of a mental illness.					
Early Intervention Program	Directed toward individuals and families for whom a short (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve mental health problems or concerns very early on in its manifestation, and avoid the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse	Unduplicated number of individuals served annually	Individual and Family	-Mental health recovery (e.g., healthy relationships, physical health, stable living situation) -Reduction of symptoms/ negative outcomes (anxiety, trauma, crisis, first break/TAY; depression, emotional dysregulation difficulties, disruptive behavior disorders, severe behaviors/conduct disorder, parenting and family difficulties)	Reduced Suicide Mental Health Related: prolonged suffering, incarceration, homelessness, school drop-out, out of home removal, unemployment, differences across groups
Prevention Program	Reducing individual/family or community risk factors or stressors, building protective factors and skills, and increasing support; promotes positive cognitive, social and emotional development and encourages a state of well-being	Unduplicated number of individuals served annually Community activities	Individual and Family Community	-Reduced risk or sub clinical manifestation of mental illness & other indicators related to negative outcomes -Increased protective factors (risks/protective factors: social, environmental, economic determinants, individual, family)	
Indirect Programs: goals include early and prompt access to treatment and other mental health services and supports, and/or changes in someone's attitude, knowledge, and/or behavior that are likely to facilitate access to mental health services					
Timely Access to Services for Underserved Populations	To increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services	Unduplicated number of individuals referred	Individual and Family Program and Service	-Number of individuals referred who followed through with referral (participated at least once) -Average interval between referral and participation in service -Duration of onset of risks for referred individuals (interval between onset and entry into treatment) -Dosage of Treatment	
Access and Linkage to Treatment for People with Serious Mental Illness	Connecting children, adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs	Unduplicated number of individuals referred Kinds of treatment referred	Individual and Family	-Number of individuals referred who followed through with referral (participated at least once) -Duration of untreated mental illness for referred individuals (interval between onset and entry into treatment) -Dosage of treatment	

MHSA Prevention & Early Intervention: Program Evaluation Standards and Regulations					
Name	**Definition**	**Types of Indicators**	**Levels of Outcomes**	**Short-Term and Intermediate Outcomes**	**Long Term Outcomes (Public Health)**
Indirect Programs: goals include early and prompt access to treatment and other mental health services and supports, and/or changes in someone's attitude, knowledge, and/or behavior that are likely to facilitate access to mental health services					
Non-Stigmatizing and Non-Discriminatory Service Delivery Implementation Strategy	Promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and make services accessible, welcoming, and positive	Types of strategies used,	Program and Service	**Changes in attitudes** towards mental illness and increased accessibility of services	Reduced Suicide Mental Health Related: prolonged suffering, incarceration, homelessness, school drop-out, out of home removal, unemployment, differences across groups
Suicide Prevention	Organized activities to prevent suicide as a consequence of mental illness; does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness		Community	**Changes in knowledge, and/or behaviors** related to preventing suicide associated with risk or presence of mental illness	

Simple Rule #1: "Evaluations of complex, major initiatives are not experiments, but part of the community change process."

—Thomas Kelly, Jr., The Annie E. Casey Foundation

4. The Statewide Evaluation Plan At-A-Glance

The SWE is charged with measuring the overall effectiveness of CRDP Phase 2 and the CDEPs. It must demonstrate the extent to which this $60 million investment by OHE/CDPH contributed to:

- reductions in the severity of mental illness for the five priority populations
- systems changes in county PEI level operations
- the return on investment (business case), and
- changes in state/county mental health policies and practices.

The final SWE Plan was developed using a Community-Based Participatory Research (CBPR) process with direct and substantive feedback from CRDP partners. It was finalized in December 2016. Maintaining its CBPR approach, the SWE plan will be updated annually to incorporate necessary refinements. An important role for the SWE is to balance a) the cultural, linguistic, and contextual realities and needs of the priority populations with b) the standards and expectations of current evaluation and research practice.

The Statewide Evaluation Plan At-A-Glance:

- The SWE is a cross-site evaluation with data collected about the IPP, TAP, SWE, EOA, and CDPH contributions and efforts to promote change.
- Comparison data for the SWE will be obtained from county PEI data and other state and federal data.
- IPPs design and implement individual CDEP evaluations plus collect SWE core measures data.
- For a summary reference guide of SWE core outcome measures— see Appendix 2.
- For a summary table of SWE core process measures— see Appendix 3.

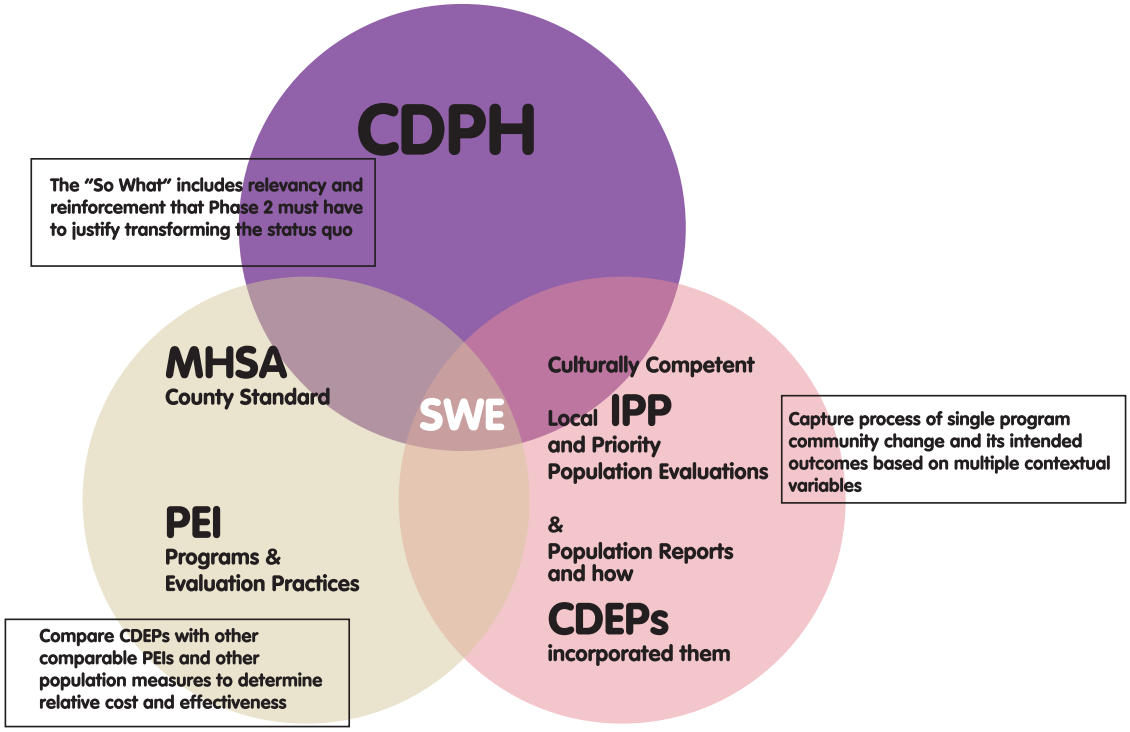
Simple Rule #2: "Evaluations of Complex Community Initiatives need a strong focus on the processes of community change."

—Thomas Kelly, Jr., The Annie E. Casey Foundation

Doing Business Differently

Holistic and culturally responsive local evaluation approaches are the heart and soul of demonstrating CDEP effectiveness in Phase 2. Each CDEP evaluation will capture change related to specific CDEP strategies with special consideration paid to the priority population culture and context within which it was developed and implemented.

CDPH is committed to "doing business differently" as evidenced by CRDP Phase 1 and 2. As a result, they must also be focused on the big picture—"the so what". In other words, they must obtain credible evidence about CRDP to justify transforming the status quo in the California mental health delivery system. This is particularly the case since the CDEPs and CRDP as a whole will undoubtedly be viewed in relationship to standard PEI county programs and evaluations. The SWE is situated in the middle and must attend to these comparisons, expectations, and complex relationships. In real time, the SWE must therefore clearly document and examine implementation strategies and processes, convergence and divergence with business as usual, and intended and unintended effects for CRDP as a whole and each of its parts (IPPs, TAPs, EOA, SWE, and even CDPH).



Simple Rule #3: "Evaluations of CCIs need to measure ongoing progress towards achieving outcomes and results in order to help a community guide its change process and hold itself accountable."

—Thomas Kelly, Jr., The Annie E. Casey Foundation

SWE Objectives and Questions

The SWE is addressing 2 Objectives with 7 Statewide Evaluation Questions. They provide an opportunity to track process and change as it occurs for the benefit of CDPH, the TAPs, and the IPPs. Objective 1 contains four evaluation questions and objective 2 contains three evaluation questions developed in response to the interests articulated by CDPH. It is worth noting here that CDPH is interested in knowing about outcomes "and" strategies to validate outcomes.

Objective 1—Evaluate Overall CRDP 2 Effectiveness in Identifying and Implementing Strategies to Reduce Mental Health Disparities

1. How effective are CRDP strategies and operations at preventing and/or reducing the severity of mental illness in California's historically unserved, underserved and/or inappropriately served communities?
2. How can CRDP strategies and operations be strengthened?
3. What are vulnerabilities or weaknesses in CRDP's overarching strategies and operations?
4. To what extent do CRDP strategies show an effective Return on Investment, including developing a business case and evaluating the potential to reduce mental health disparities by expanding effective strategies to a statewide scale?

Objective 2—Determine Effectiveness of Community-Defined Evidence Programs

1. To what extent were IPPs effective in preventing and/or reducing severity of targeted mental health conditions in their participants and within specific or sub-populations?
2. To what extent did CRDP Phase 2 Implementation Pilot Projects effectively validate Community-Defined Evidence Practices?
3. What evaluation frameworks were developed and used by the Pilot Projects?

Simple Rule #4: "Evaluations of CCIs need to understand, document, and explain the multiple theories of change at work over time."

—Thomas Kelly, Jr., The Annie E. Casey Foundation

SWE Data Sources

Multiple data sources will be used to determine both overall effectiveness and the business case component (return on investment) of CRDP Phase 2. This "triangulation" of data using methodologically diverse data sources can collectively explain the mechanisms and outcomes of CRDP 2 and begin to validate different culturally tailored methods of evaluation. This will strengthen the internal and external validity of the findings, potentially increase the generalizability of the findings to similar populations within the state and throughout the nation, and expand the range of evaluation research strategies that can be employed with our priority populations. These diverse data sources include:

SWE Data Sources

- IPP CDEP participant (adult, youth, child) questionnaire items including demographic information
- IPP assessment tools administered by the TAPs
- A web-based data system (Qualtrics), in which Phase 2 grantees/contractors report process and outcome related data about their respective grants/contracts on a semi-annual basis
- Phase 2 grantees/contractors and key stakeholders interviews and/or brief surveys (e.g., with community/tribal leaders; county decision makers; state level policy makers, etc.)
- Local CDEP evaluation findings and the collective findings within priority populations (including data gathered using population-specific research and evaluation methods)
- County PEI programs and other state and federal comparison data (e.g., from the California Health Interview Survey)
- Review of archival documents, records, and the extant literature (e.g., Population Reports from Phase 1, grant/contractor applications and reports to CDPH, etc.)

Simple Rule #5: "Evaluations of Complex Community Initiatives need to prioritize real time learning and the community's capacity to understand and use data from evaluations."

—Thomas Kelly, Jr., The Annie E. Casey Foundation

SWE Core Measures

In order to determine effectiveness of Phase 2 as a whole, a common set of agreed upon SWE Core Process and Outcome Measures were identified using a CBPR process. The goal was to develop meaningful measures of progress that were capable of informing, providing critical feedback, and reinforcing positive change on an ongoing basis over several years. Even though each IPP will approach their local evaluation quite differently (because of the unique cultural, linguistic, historical, and contextual factors of each community), the SWE will allow multiple stakeholders and community constituencies to share in the successes and accomplishments of both Phase 1 and 2.

Core Outcome Measures. The core outcome measures reflect immediate, intermediate, and long-term outcomes associated with each of the CRDP partners (IPPs, TAPs, EOA, SWE, and CDPH).

- IPPs are required to collect specific data from their CDEP participants and submit them to PARC@LMU. They are the most meaningful measures of progress that could work simultaneously across 5 priority populations, their respective subpopulations and unique contextual realities
- TAPs are required to collect data related to the technical assistance and support provided to their respective priority population IPPs
- Data will also be collected periodically from the EOA and CDPH related to their contributions to community change
- PARC@LMU will systematically track and document their contributions to Phase 2 (e.g., requests for and impact of TA/subject matter specialists; SWE implementation approaches and strategies, challenges, successes and opportunities, etc.)

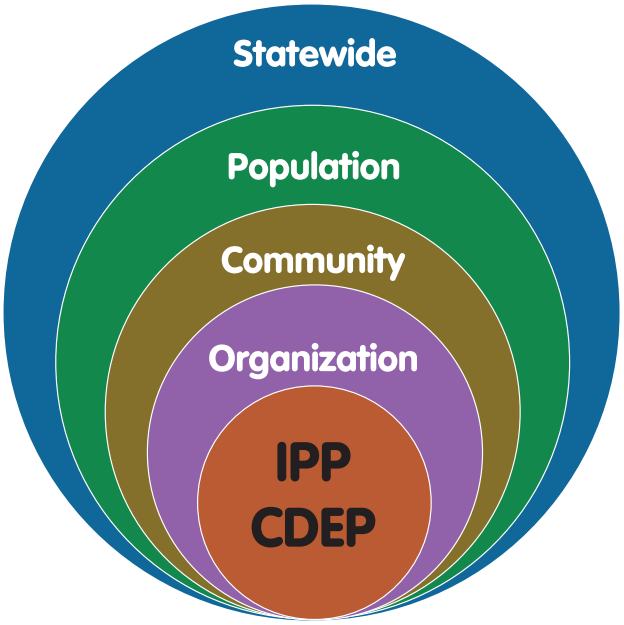
Core Demographic Information. While each of the CDEPs is designed to serve a particular priority population, it is understood that many CDEP participants are members of multiple priority population and subpopulation groups. For example, while a CDEP may serve the Latino community, it is critical to acknowledge that the population is not homogenous. Rather, there is great diversity within this population on the basis of gender identity, sexual orientation, immigration/refugee status, and so on which would contribute to variation in outcomes. To ensure that the experience and needs of all segments of each population are adequately addressed in the SWE and local evaluations, IPPs are being asked to collect demographic data to address issues of intersectionality (i.e., overlapping populations). We recognize that some individuals may feel stressed, uncomfortable, or fearful about disclosing sensitive information, especially given the current political and social climate. Participants have the option to not respond to these or any given item in the SWE Core Measures. TAPs and IPPs can work together to determine which set of SWE demographic questions are best suited for their community.

Core Process Measures. The core process measures track the delivery of Phase 2 strategies and each partner's implementation of their strategies and approaches. This includes the collection of basic information about:

- Implementation approaches and strategies
- Implementation fidelity and flexibility
- Implementation barriers and successes
- Technical assistance requests/provision and
- Satisfaction with CRDP Phase 2 and lessons learned

The SWE Core Outcome Measures provide information at several levels: CDEP, IPP, Community (priority population), Population, and State.

SWE Core Measures



How They Work

Shifts in policy and awareness of MH disparities

Shifts in negative outcomes from untreated mental illness (e.g., substance abuse) & changes in county mental health delivery

Differences for CDEP individuals served to those served by comparable County PEI programs; Business Case

Changes in organizational capacity & cultural/linguistic competency

1) Before CDEP:
Level of unmet need, stigma/discrimination with services, level of Psychological distress & functioning (CHIS, NUSDH)
2) Current: Quality of CDEP services (MHSIP, CPCI)
3) After: Demographics of those served by CDEP
4) Protective Factors

The following table provides a detailed overview the SWE Core

Core Outcome Measure Levels and Information Yielded	
CDEP	• Number People Served (by key demographics) • Access/Utilization (e.g., number served who had prior unmet needs; number served who had experienced stigma/barriers to help-seeking prior to CDEP; number served who were psychologically distressed at program entry) • Help-Seeking Behavior (changes over time) • Psychological Distress (e.g., general improvement) • Social Isolation/Marginalization (changes over time) • Functioning (e.g., changes in impairment in performance at work, personal relationships, etc.) • Protective Factors (e.g., changes in spirituality/religiosity, wellness, social/community connectedness, cultural connectedness, etc.) • Quality (e.g., general satisfaction, accessibility, quality & cultural appropriateness, perceived outcomes, cultural competence, etc.)
Organization (IPP)	• Changes in organizational capacity and cultural/linguistic competency
Community	• Differences between CDEP individuals served and those served by comparable County PEI programs; business cases.
Population	• Shifts in negative outcomes from untreated mental illness (e.g., substance abuse) and changes in county mental health delivery systems.
Statewide	• Shifts in policy and awareness regarding mental health disparities.

"When I dare to be powerful, to use my strength in the service of my vision, then it becomes less and less important whether I am afraid."

—Audre Lorde

5. Collecting and Reporting SWE Core Measures

This section is a must-read for IPPs, local evaluators, and TAPs.

All IPPs are required to design and conduct a local evaluation that incorporates the SWE core measures, but is tailored to the specific cultural and linguistic needs of their CDEP. While the local evaluation provides an opportunity to produce holistic and culturally responsive local CDEP evaluation findings, the SWE core measures will be used to make the case for the overall effectiveness of CRDP Phase 2 across priority populations.

This section will assist you with understanding the different required core measures, data collection and submission processes, and helpful hints and tips related to collection and/or submission of the core measures to PARC@LMU.

PARC Support

An effective cross-site evaluation depends on collecting and reporting data to PARC that is accurate, reliable, and timely. However, we recognize that data collection is not always a smooth process. Your CDEP is situated in a particular context that undoubtedly influences implementation of your evaluation and data reporting. If you have any questions about collecting and/or submitting SWE core measures for any reason, the PARC team is here to help!

Please contact: Diane Terry
Email: diane.terry@lmu.edu
Phone: 310.338.7095

Part I: Understanding the SWE Core Measures

Most of the SWE Core Measures will be built into an online survey tool called Qualtrics. This tool is easy-to-use and allows IPPs to easily collect and submit data electronically. Some IPPs may require alternate methods to submit data. PARC@LMU will provide consultation with the respective IPP and their TAP should this arise. To learn more about the SWE Core Outcome Measures, a Reference Guide is available in Appendix 2.

The SWE Core Measures include the following

1. Core Outcome Questionnaire Items (including demographics)
2. Organization/Program Core Data
3. Organizational and Cultural Competency Core Data
4. Phase 2 Surveys and/or Interview Core Data

1. Core Outcome Question Items (including demographics)
A set of core outcome questionnaire items are to be administered to CDEP participants at the beginning and/or end of the natural project cycles that occur for your program. PARC@LMU has developed youth-friendly versions of the core questionnaire items for CDEPs serving children (11 and under) and adolescents (12-17).

Data Sources
Data will come from either all of your CDEP participants or from a sub-sample of participants. Section 6 provides an overview of basic sampling strategies. IPPs and their local evaluators can use this as a starting point for determining which type of evaluation sampling strategy will best meet their CDEP capacity and needs.

Timing of Data Collection
Each participant receives, at most, a pre and post assessment. CDEPs may have different program start times and activity dosage/lengths, and therefore, we recognize your data may need to be submitted on a continual/revolving basis. Your sampling strategy, method of administration, and data collection time points should be discussed with your local evaluator. As needed, feel free to consult with your TAP and PARC@LMU about these issues, including any organizational, cultural, linguistic, and community considerations.

For CDEPs who have program cycles these items will be administered using data collection time points that make the most sense for your program. For example, depending on how you have structured your CDEP, cycles may vary from weekly, to monthly, to every 6 months, to seasonally, etc. Refer to the helpful hints later on in this section for assistance with thinking through data collection time points for your CDEP.

It is important to note that some core items are administered only at the "pre" (baseline or before CDEP), some at the "post" (after CDEP), and some at both "pre *and* post" (before and after). Participant level pre- and post-items should be *matched* (i.e., the same participant responds to pre- and post-items) in a way that can be linked.

The following table provides definitions, time frames, and points to consider for each type of item.

Questionnaire Items: When, Why, What If?

Time Point	When is it collected?	Why at this time?	What happens if the time points are missed?
Pre- and/or Post- Items	Pre-items (baseline) should be collected just prior to the start of your CDEP program cycle, but no later than 1-week of the CDEP cycle start date.	Baseline data describes participants' mental health needs and experiences before exposure to your CDEP intervention. In other words, they answer the question: "How were participants doing/feeling before they participated in our CDEP?"	Participants' responses to questions about their mental health functioning, well-being, and service access will ideally change after exposure to your CDEP. Pre-items given after the program has started give you a less accurate depiction of participants' true status prior to program involvement. This means you may have weakened the effect of your CDEP.
Demographic Items	Post-items (i.e., outcome or program quality) should be collected within the last 2 weeks of the end of your CDEP program cycle.	Matched post-items capture the effect of your program by comparing participant status at the start and the end of their CDEP experience. In other words, "What changed for participants as a result of their CDEP involvement?" Post-only items measure the quality of the CDEP experience and overall satisfaction for the participants.	Giving the post-items as close to program completion as possible allows participants to have the maximum amount of CDEP exposure to determine its effect (i.e., outcomes) on them. If post-items occur too long after program completion, the opportunity to assess outcomes and program quality for your CDEP may be lost.
	Demographic items should be collected one time only, at the pre (baseline or intake) along with the pre core questionnaire items above.	Demographic information is collected at one time point only, typically at the pre.	One solution is to attempt to collect the information at the pre, and again a month or so later (depending on the frequency and quality of program involvement) once trust in confidentiality has been established (CARS, 2016). This may be especially important for sensitive demographic information such as refugee status, gender identity, sexual orientation, etc.

Demographic Items

The SWE Core Demographic Items, were created after consulting with multiple specialists (including The Williams Institute and Center for Applied Research Solutions), Based on their feedback, IPP recommendations for collecting data on gender, gender identity, sexual orientation, race/ethnicity, preferred language, and immigration and refugee status have been developed.

The SWE created a minimum and maximum number of items IPPs would ask participants related to sexual orientation and gender identity. The minimum number can be utilized by IPPs who serve communities with high LGBTQ stigma, while the maximum number can be asked by IPPs with a larger LGBTQ community or where stigma would not be as much of an issue. TAPs and IPPs can work together to determine which set of questions are best suited for their community. SWE also included a response option of "not comfortable answering this question."

Paper-Pencil vs. Web Administration

You have the option to use paper-pencil versions or web-based version of the core items. Paper-pencil versions of the adult, child, and adolescent items are provided in Appendix 4. The demographic information items are embedded in the paper-pencil (PRE) versions. You may also access them through these Qualtrics links. To comply with CDPH data protection policies, IPPs are required to submit paper-pencil items to PARC via Qualtrics. In the purple box, the following hyperlinks are as follows:

- **SWE Core Measures Adult Version (PRE)** (https://mylmu.co1.qualtrics.com/jfe/form/SV_0JR2aun9bg5cQap)
- **SWE Core Measure Child Version (PRE)** (https://mylmu.co1.qualtrics.com/jfe/form/SV_e4YNozKjoa5SFsV)
- **SWE Core Measures Adolescent Version (PRE)** (https://mylmu.co1.qualtrics.com/jfe/form/SV_eEyF8JgnFxKW3bv)
- **SWE Core Measures Adult Version (POST)** (https://mylmu.co1.qualtrics.com/jfe/form/SV_6gPVDq2swdAo3vn)
- **SWE Core Measure Child Version (POST)** (https://mylmu.co1.qualtrics.com/jfe/form/SV_6PxmsT8J8dcPwNv)
- **SWE Core Measures Adolescent Version (POST)** (https://mylmu.co1.qualtrics.com/jfe/form/SV_8p1IXElmt0UQNDL)

Protecting Participant Confidentiality and Anonymity

To protect the identity of CDEP evaluation participants, IPPs will limit access to identifiable information by assigning a unique code to each participant. In order for an IPP and the SWE to link individual participants with their responses/data, each participant will be assigned an evaluation ID prior to collecting data. On a separate master code document/file, the IPP will maintain a file consisting of each participant's name along with their unique evaluation ID that will contain their Population Code (e.g., 1=African American), IPP Code (e.g., CBWHP=1.1) and Participant Code (e.g., 001). Codes for all population groups and IPPs are provided in the table below. Each participant within a given IPP will receive their own 3 digit code. The example below shows how the codes would be assigned for 21 participants in IPP 1.1 (CBWHP).

Participant Codes Example (Pre/Post)	
1.1_001_PRE	1.1_001_POST
1.1_002_PRE	1.1_002_POST
...	...
1.1_021_PRE	1.1_021_POST

IPPs will store the master code file separately from actual participant data and they must have a clearly detailed plan for how this master list will be destroyed as soon as reasonably possible at the conclusion of the project. Evaluation data will be stored securely in locked cabinets or rooms at the IPP's location. The IPPs will insert the de-identified participant code into a specified field on the SWE pre-assessment and post-assessment measure. Each ID will be used only for that participant for the duration of the project. It is imperative that each grantee follow this protocol to protect participant confidentiality and ensure consistency across all projects. The final ID method will be developed in consultation with CDPH and a review of existing state/county agreements for ID protocols. Please work with your local evaluator to ensure that this matching and coding of participants is clearly developed.

IPP Priority Population Evaluation Codes		
Population Group	**IPP Name**	**IPP Code**
1= AFRICAN AMERICAN	California Black Women's Health Project	1.1
	Healthy Heritage Movement	1.2
	Whole Systems Learning	1.3
	The Village Project	1.4
	Catholic Charities	1.5
	West Fresno Health Care Coalition	1.6
	Safe Passages	1.7
2= ASIAN PACIFIC ISLANDER	MAS SSF	2.1
	Hmong Cultural Center of Butte County	2.2
	East Bay Asian Youth Center	2.3
	Korean Community Services	2.4
	Cambodian Association of America	2.5
	HealthRight 360	2.6
	Fresno Center for New Americans	2.7
3= LATINO	Humanidad Therapy & Education Services	3.1
	Integral Community Solutions Institute	3.2
	Latino Service Providers	3.3
	Health Education Council	3.4
	La Familia Counseling Center Inc.	3.5
	La Clinica de la Raza	3.6
	Mixteco/Indigena Community Organizing Project	3.7
4= LGBTQ	Gay & Lesbian Center Bakersfield	4.1
	San Joaquin Pride Center	4.2
	Gender Health Center	4.3
	Open House	4.4
	Gender Spectrum	4.5
	API Wellness Center	4.6
	On the Move	4.7
5= NATIVE AMERICAN	United American Indian Involvement	5.1
	Friendship House	5.2
	Indian Health Council	5.3
	Indian Health Center of Santa Clara	5.4
	Native American Health Center	5.5
	Sonoma County Indian Health Center Inc.	5.6
	Two Feathers Native American Family Services	

2. Organization/Program Level Core Data. Organization/Program level data will be reported to PARC@LMU via the SWE Semi-Annual Evaluation Report, and will primarily consist of process data. However, some outcome data will be collected through this report as well. These data will help capture CDEP implementation, which is critical to improving and validating your CDEP. *"You can't take credit for positive results if you can't show what caused them"* (SAMHSA, 2016). It will also assist the SWE with not only demonstrating the effectiveness of Phase 2 overall, but giving CDPH and the partners an opportunity to make adjustments to Phase 2 as needed.

Click on the following link for more information on the importance of process evaluation to an outcome evaluation. ***(Using Process Evaluation to Monitor Program Implementation (https://www.samhsa.gov/capt/tools-learning-resources/process-evaluation-monitor-implementation)***

Type of Organizational/Program Data

With assistance from their local evaluators, IPPs will report the following:

- Process Data: CDEP approaches/strategies, outreach/recruitment, fidelity to and/or flexibility in the implementation of your CDEP and local evaluation, challenges and successes encountered in the course of implementation, technical assistance and support, etc.
- Outcome Data: successes/victories connected to organizational capacity/cultural competency, community engagement, partnerships/collaborations, systems changes, access-service referrals (if applicable), and workforce development (if applicable).

The following table provides definitions, time frames, and points to consider for each type of item.

Process and Outcome Data: When, Why, What If?			
Data	**When is it collected?**	**Why is this important?**	**What happens if these data are not systematically collected?**
Process and Outcome Data	Process and outcome data should be systematically collected from the time your CDEP begins to the end of CDEP data collection.	Process and outcome data should be tracked on a consistent basis to paint a clear and compelling picture of the inner workings of your CDEP. It helps diverse stakeholders see how your program outcomes were achieved. Although some data will be reported numerically in this report, there are other data that cannot easily be measured by numbers. It requires more descriptive or qualitative data. These data capture the real-life impact of your work.	If IPPs don't keep up with process and outcome data collection, they run the risk of not being able to accurately remember what they did, how they did it, and what impact it had on participants, the organization, or community. Imagine having to recall from memory the number of individuals you outreached to for your CDEP over the last 6 months, or the important lessons learned during the first quarter of your evaluation. Not consistently tracking this information would result in inaccurate reporting for your local evaluation and the SWE. You would miss a valuable opportunity to tell your CDEP's story including the type of outcomes achieved and the specific steps taken to achieve success.

The SWE Semi-Annual Evaluation Report

The SWE Semi-Annual Evaluation Report will be tailored specifically to your IPP and CDEP. These data are part of a larger reporting process that collectively provides critical cross-site evaluation data related to the effectiveness of CRDP Phase 2. Data will be submitted via Qualtrics. A generic paper-pencil version of the semi-annual evaluation report is provided in Appendix 5. You may also access it through this Qualtrics link **(You may also access it through this Qualtrics link (Qualtrics SWE Semi-Annual Evaluation Report). (http://mylmu.co1.qualtrics.com/jfe/form/SV_eEyF8JgnFxKW3bv).**

- Written instructions will be provided separately 3 months before the first submission date on 11/01/2017.
- Upon successful submission of your report, you will receive an email receipt of its submission from PARC@LMU. You will have the option to print or save it as a PDF.

The following table provides an overview of IPP, TAP, and EOA semi-annual reporting periods, dates when semi-annual reports will be submitted to PARC@LMU, and the timeline for the SWE to analyze and provide summaries of these data to CDPH.

SWE Semi-Annual Reporting Schedule

Semi-Annual Reporting Periods	TAPs, EOAs, & IPPs have 1 month to prepare their reports & submit to SWE	Semi-Annual Submission to the SWE	SWE has 2 months to analyze data	SWE Summary Reporting of Semi-Annual Data to CDPH
#1: 4/1/2017 – 9/30/2017		#1: 11/1/2017		#1: 1/1/2017
#2: 10/1/2017 - 3/31/2018		#2: 5/1/2018		#2: 7/1/2018
#3: 4/1/2018 – 9/30/2018		#3: 11/1/2018		#3: 1/1/2018
#4: 10/1/2018 - 3/31/2019		#4: 5/1/2019		#4: 7/1/2019
#5: 4/1/2019 – 9/30/2019		#5: 11/1/2019		#5: 11/1/2019
#6: 10/1/2019 - 3/31/2020		#6: 5/1/2020		#6: 7/1/2020
#7: 4/1/2020 – 9/30/2020* tentative		#7: 11/1/2020		#7: Data to be included in SWE Final Evaluation Report

3. Organizational and Cultural Competency Core Data will be gathered at the launch and conclusion of IPP data collection. For more information on this assessment tool (purpose, use of the data, items, etc.) refer to the paper-pencil version provided in Appendix 6.

4. Phase 2 Surveys and/or Interview Core Data, gathered towards the middle and end of CRDP Phase 2, are related to satisfaction with the initiative and lessons learned. These tools will be developed using a CBPR process as we get closer to the data collection time period.

Part 2. Helpful Hints for Collecting and Submitting CDEP Participant SWE Core Outcome Items

1) Should I collect core outcome questionnaire items electronically or paper-pencil? Select the most feasible process to administer these items to your participants. PARC will have two options: electronically via Qualtrics or paper-pencil. There are pros and cons to both methods.

- Computerized electronic assessments can be easily and more accurately completed online, but require consistent internet access and a comfort level with technology.
- Paper-pencil surveys can be given anywhere at any time, but add another layer of labor because at some point the information will have to be entered into an electronic database for analysis and reporting. This introduces a higher likelihood of errors related to data entry.

The following questions can help you determine which administration method works best for your organization and the communities you serve.

- **Do you have reliable and consistent internet access?**
- **Does your CDEP program staff have access to computers or tablet devices?**
- **How comfortable are your CDEP participants with technology?**

2) What method of administration should I use for the core questionnaire items? Select the most appropriate method for your CDEP. There are three options.

- Self-administered (i.e., participants complete it by themselves)
- One-on-one (i.e., administered to participant by IPP trained staff)
- Group administration (i.e., facilitated by IPP trained staff to a group)

The following questions can help you determine which administration method works best for your IPP and the communities you serve.

- **What is the literacy level of your CDEP participants?**
- **What age considerations do you need to attend to?**
- **Given staffing and time constraints or amount of access to CDEP participants, how feasible is one-on-one versus group administration?**
- **If group administration is ideal, do you have the physical space to ensure confidentiality?**
- **Do you need opportunities to build rapport or reflect on the participant's experience of the CDEP, making one-on-one administration preferable?**

3) Where should I administer the core questionnaire items? Select the most appropriate location to administer the pre-and post-assessment. Data collection should take place in a quiet location where CDEP participants can feel safe to provide honest answers without feeling rushed, or fearful of being overheard and/or judged by others.

The following questions can help you determine which physical space works best for your IPP and the communities you serve.

- **What type of space does your IPP have to facilitate data collection?**
- **Is the space you designated for data collection comfortable for participants?**
- **Do you have staffing for childcare and space to accommodate participants accompanied by small children?**

4) Do we need to train staff to administer the core questionnaire items? Yes, training staff on how to administer or supervise the collection of the items will ensure that responses are reliable and valid. Staff responsible for administering or overseeing the administration of the questionnaire should have time to practice (i.e., giving instructions, monitoring collection, etc.). Training allows staff to:

- Become familiar with the language of the items including prompts (i.e., instructions) used to introduce the different sets of items
- Know how long it will take to complete from start to finish
- Anticipate questions participants may have and develop consistent, helpful answers
- Understand basic principles for effective collection of data (e.g., watching for response sets, adhering to the actual verbiage in the assessment tool, attending to possible social desirability bias—i.e., saying what one thinks is politically or socially correct rather than what one really thinks or feels—communication techniques when asking sensitive questions etc.). If you have questions about data collection strategies, including how to avoid social desirability bias, make sure to contact your TAP and/or PARC@LMU to troubleshoot the situation.

5) Do we need informal or formal consent procedures for the core items? Yes, it very is important to develop procedures for handling either formal or informal participant consent. For CDEPs whose evaluations require IRB approval, written consent and/or assent forms will have to be obtained from program participants prior to survey administration. Section 9 includes a set of guidelines to help you and your local evaluator decide if IRB approval is necessary for your project.

If your project requires the use of consent and assent forms, consider the following to help you prepare.

- **Have your consent and assent forms been translated into each of the languages your IPP serves?**
- **Have you built in time to review the consent form with participants prior to the start of data collection?**
- **Have staff members been trained on how to answer questions participants may have about the consent form or the evaluation?**

6) How do I introduce the core items to our CDEP participants? Develop talking points for how they will be introduced to participants. Your IPP should have a standardized way of introducing the items so that regardless of who is conducting administration, each participant walks away with a clear understanding of the evaluation purpose, goals, content, and requirements. In collaboration with your TAP, your IPP should determine the best way to convey this information, especially if you are working with participants who may be skeptical about participating in data collection based on historical and current trauma, and sociopolitical conditions. Incorporating some of the following points may help to address concerns and gain community buy-in to the importance of the evaluation.

- The evaluation represents an opportunity for the organization and community to use their own strategies to achieve and maintain well-being and mental health.
- The data will help the IPP learn more about the community's strengths, needs and experiences.
- The data will help the IPP determine the extent to which the program is a useful resource for the community.
- The data will help the IPP understand how they can do a better job serving the community.
- Evaluation of this program will inform the state and local county how to better serve your community.

7) How can we make participants more comfortable with answering the core items? Warm up activities such as icebreaker questions can increase participants' comfort with evaluation items. These types of activities can be useful for building rapport, and can be modified to fit a variety of age groups.

8) What if my participants don't want to respond to sensitive core items? IPPs are encouraged to collect data on sexual orientation, gender identity, preferred language, immigration and refugee status, and ethnic/racial background. Because certain social group memberships are stigmatized in the current U.S. social, political, and cultural climate broadly, and more specifically within an individual's community, explicitly identifying with such groups may place the respondents at risk for a wide range of negative consequences with respect to workplace, family, and social outcomes. As such, respondents might be reluctant or fearful of reporting sensitive information, including disclosing their undocumented status, transgender status, and/or sexual minority status for fear that this information could be accessible to third parties. Here are some general strategies for collecting sensitive information.

- It is always good to reassure participants that their responses are confidential and their participation will help with the ongoing development of programs like your CDEP.
- Collect data once at intake, and again a month or so later (depending on the frequency and quality of program involvement) once trust in confidentiality has been established.
- Refer to Appendix 2 which recommends a minimum and maximum number of items IPPs may ask participants related to sexual orientation and gender identity.
- Work with your TAP and local evaluator to determine which questions are best suited for your community.

Not all group memberships are equally stigmatized across individuals and populations, or experience the same set of issues. Awareness of the unique challenges associated with each group will help better serve individuals from diverse communities. Consult with your TAP for guidance on the collection of sensitive data from your priority population.

Part 3: Data Collection and Reporting FAQs

Your IPP is taking place in real-time, and must be responsive to participant, organizational, and community needs and concerns. These factors can cause data collection and reporting to feel unpredictable and overwhelming at times, and sometimes even a burden or distraction from other critical aspects of your work. Below is a list of commonly encountered evaluation scenarios and sample solutions to help navigate these challenges should they arise for your IPP.

1. What if I am unable to collect statewide or IPP evaluation data due to specific population needs and cultural considerations?

Scenario: Outreach and attendance for your CDEP events have been low (for any of a variety of reasons—e.g., weather, community crises, holidays, transitory patterns in your community, community distrust, etc.). You have not been able to meet your program enrollment or evaluation sample goals this quarter.

Solution/Opportunity: You can call your TAP and/or PARC@LMU for subject matter consultation and technical assistance. Troubleshooting with input from members of the Alliance could lead to creative ways to address the unique circumstances faced by your IPP. This is also an excellent opportunity to use CBPR and engage stakeholders in your community to better understand the issues at play and to identify solutions.

2. What if I need to make modifications to core measures/indicators for cultural or linguistic reasons?

Scenario: Participants are having trouble understanding some of the terms used in the assessment and staff report difficulty helping them understand the meaning or intent of certain items.

Solution/Opportunity: Each IPP can work with their TAP and with PARC@LMU to modify or adapt survey language to better fit their particular CDEP intervention and attend to potential cross-site and comparison group consequences associated with these modifications.

3. What if I am having difficulty with matching SWE core measures pre-and-post items?

Scenario: You did a great job collecting your pre-assessment surveys, but now that your CDEP program cycle has ended, participants aren't completing the post-assessment for any of a number of reasons. You're worried that your number of matched pre- and post- assessments will be too low.

Solution/Opportunity: IPPs could: 1) offer incentives to participants to complete the post assessment, 2) offer creative data collection events, 3) engage your stakeholders to generate ideas for how to best frame, locate, and time completion of post-assessments, and 4) ensure post-assessments are clearly marked on the IPP's calendar of tasks to ensure proper planning and implementation.

4. What if I have missing process data?

Scenario: Your SWE semi-annual evaluation report to PARC@LMU is due and you are missing a large chunk of process data (e.g., number and type of referrals your CDEP provided to clients, the number of participants that attended your CDEP events, etc.).

Solution/Opportunity: In advance, work with your TAP to develop a data tracking system that allows you to build in mini-deadlines with your staff for data tracking. Additionally, you should contact your CDPH contract manager, and PARC@LMU to discuss options and resolution.

5. What if I am having difficulty with my local evaluation plan?

Scenario: Your evaluation plan sounds good on paper but there are problems with the research design, procedures, or assessment tools.

Solution/Opportunity: IPPs that are encountering challenges related to their evaluation plans should first troubleshoot strategies and solutions with their local evaluator and TAP. Any lingering concerns can then be shared with the PARC@LMU team and the Alliance members, who can provide additional evaluation consultation.

6. What if I am having internet issues and it's affecting SWE data collection or reporting?

Scenario: Your internet is down and you can't open Qualtrics to collect data or submit your SWE evaluation semi-annual report.

Solution/Opportunity: Back-up paper versions of the pre- and post-assessment should be kept on hand in the event the assessments are unable to be administered electronically. Contact PARC@LMU to discuss how to submit the hard copy assessments. If you are having problems while trying to submit your semi-annual report, simply contact us and we can discuss alternate ways to submit your report.

7. What if I made a mistake on the SWE Semi-annual Evaluation Report?

Scenario: You submitted your SWE Semi-annual Evaluation Report through Qualtrics, but realized that some of the information was incorrect.

Solution/Opportunity: IPPs should follow these steps to submit addendums to previously submitted report.

Step 1: Email PARC@LMU to inform them that an error was made and an addendum will need to be submitted. Emails can be sent directly to Diane Terry (diane.terry@lmu.edu). Your TAP representative should also be included on this email.
Step 2: Within 48 hours you will receive a Qualtrics survey link. Use this link to submit a "SWE Semi-annual Evaluation Report Addendum," where you can make the necessary edits, including a description of the reasons for any changes.

8. What If I am using the paper-pencil administration option? How should I submit the data from these surveys to PARC@LMU?

Scenario: You have several completed hard copy surveys and are unsure how to transfer these data safely to PARC@LMU.

Solution/Opportunity: In accordance with CDPH data security protocols, all data must be submitted via Qualtrics, and NOT through email or snail mail. But fear not! In Qualtrics you can upload scanned versions (e.g., PDF, JPG) of your paper-pencil surveys. This option allows for CDEPs to administer the survey in a way that works best for their organization and community, while maintaining the safe transfer of data.

9. How do I know if the data I submitted was received by PARC@LMU?

Scenario: You submitted participant-level data and/or your SWE Semi-annual Evaluation Report, but you don't know if it was received.

Solution/Opportunity: Qualtrics will send you a message indicating that the data was received. PARC@LMU will regularly review data submitted by your IPP and contact you should there be any data errors. Upon successful submission of your SWE Semi-Annual Evaluation Report, you will receive an email receipt from PARC@LMU of its submission and you will have the option to save the report as a PDF or to print it. We highly recommend printing or saving an electronic version of your receipt for your records.

"From the vantage point of the colonized…. the word 'research'…is probably one of the dirtiest words in the indigenous world's vocabulary."

— Smith, 1999

6. Program Evaluation and Research 101

The SWE + IPP Partnership = Synergy

The purpose and methods of the SWE evaluation were described in Section 4. Section 6 provides guidelines to assist you in the design and implementation of a CDEP evaluation. Both the SWE and the IPP evaluations are essential to establishing 1) evidence for the contribution and effectiveness of CDEPs to prevention and early intervention efforts in the state; 2) the value of community-defined, culturally, and linguistically grounded mental health strategies generally and specific to your priority populations; and 3) the case for state and county systems to provide policies and practices that support CDEPs.

The SWE IPP Synergy

Together the IPP and SWE evaluations can have a synergistic effect by demonstrating the effectiveness of CRDP Phase 2 and CDEPs grounded in credible evidence to inform a cross section of decision makers (e.g., grant makers, foundations, policy makers, agency directors, and intermediary organizations). The IPPs will design and complete evaluations of their CDEPs that, in conjunction with the SWE evaluation, can lead to more than an additive effect. In other words, the sum is greater than its parts. If both the SWE and the local evaluations do their parts very well, we collectively create that credible evidence. *The SWE cannot do a "business as usual" evaluation—and in some instances neither will the IPPs.* Therefore in the methods we apply, we must be even more diligent to cross our t's and dot our i's. By doing so we can open people's eyes not only about the effectiveness of CDEPs but also reveal the value of doing business differently using innovative, rigorous mixed-methods that capture the lived experience of our communities.

Overview

Section 6 in conjunction with Section 7 is designed to inform your thinking about "how" to approach your local evaluation with an emphasis on using strategies that can maximize your ability to state conclusions grounded in rigorous and credible evidence. Latter sections will provide you with details for writing your local evaluation plan and your final evaluation report. Helpful hints are offered for the following:

- Grounding Your Evaluation in Theory, Logic, and Cultural Principles
- Evaluation Questions and Indicators
- Evaluation Designs
- Sampling Procedures
- Data Collection Strategies
- Data Analysis Strategies
- Fidelity, Quality Assurance and Improvement

The guidelines for completing your CDEP local Evaluation Plan are detailed in Section 11.

Grounding Your Evaluation in Theory, Logic, and Cultural Principles

Your evaluation should evolve from a well thought out theory or rationale associated with your CDEP. It should provide the logic of why the evaluation is examining the relationship, for example, between increased social ties and decreased youth school absences. It also helps people understand why your CDEP is focused on strengthening particular things, for example, family and friendship relationships as part of a school-based truancy prevention strategy. A theory typically articulates formal statements about specific relationships among variables and how and why those variables are related (Passer, 2014). Generally, a theory describes a larger pattern of events or relationships and provides a unifying framework that explains a particular issue. A cultural principle or value represents the worldview or belief system of a group. These may not necessarily be supported by empirical studies but may be supported by community practice and culture.

A typical theory in psychology is **cognitive dissonance theory** which argues that individuals prefer that their inner attitudes and thoughts are consistent with their external behavior (Festinger, 1957); when attitudes are not in line with behavior, individuals are motivated to change either an attitude or behavior to be consistent. A CDEP interested in increasing helping behavior might use the cognitive dissonance theory as a framework. The CDEP's rationale is based on cognitive dissonance theory—individuals who see themselves as helpful and caring will be more likely to help a stranger in order to maintain consistency between their beliefs ("I am a caring person") and behavior (helping a stranger).

Alternatively, a CDEP may rely on a culturally grounded rationale using values and principles from the priority population. For example, a CDEP's theory might be that African-American culture is communal in nature and that people of African ancestry are oriented to the well-being of others as a natural inclination and cultural value. In this instance then, the CDEP is grounded in African centered theory—individuals see themselves as connected to others ("I am because we are") and their well-being is enhanced when they engage in helpful and caring behavior toward others (helping others is good and necessary) (Neville, Tynes, & Utsey, 2009).

A theory, cultural principle/belief, and corresponding framework make clear the relationships between the variables articulated in your evaluation question. Choosing a theoretical framework requires spending time examining the community's views and cultural principles, the existing literature, and what other studies (if available) have found on the topic. Thoughtful consideration to these issues establishes the legitimacy of a project and helps others understand why the outcomes associated with your CDEP represent credible evidence of its effectiveness.

CDPH is providing an unprecedented opportunity to develop evidence for culturally and contextually grounded intervention strategies. If there is no available theory that fits your CDEP, **don't force it**. Instead, offer a clearly articulated rationale of the cultural principles, beliefs, and practices that undergird the intervention strategy and selected outcomes. Following the steps in the cube (See Section 7) can be useful as is consultation with the TAPs and PARC.

Evaluation Questions and Indicators

This section will provide tips and rules of thumb when developing *evaluation questions* and *indicators* (i.e., what kind of evidence might you look for to answer your specific evaluation questions).

1. Be clear about what you want the evaluation to answer.

Knowing what you want answered will help you select an appropriate evaluation design and methods. Your CDEP evaluation questions should be developed and prioritized with CDEP staff, evaluator, other stakeholders (e.g., youth and adult community members), and your TAP.

2. Different stakeholders are likely to be interested in different evaluation questions related to your CDEP.

For example, county-level decision makers and future funders may be most concerned about your CDEP's impact on the community. Program staff may be more interested in improving their CDEP's delivery or performance. No evaluation will succeed in being "all things to all people."

3. Prioritize and narrow your list of evaluation questions by considering the resources (e.g., time, funding, personnel etc.) your IPP has available.

It is often the case in evaluations that too many evaluation questions are posed than is feasible. The following questions can assist you with prioritizing and narrowing your list of questions:

- Which questions will yield the most practical information related to cost?
- Which questions will yield the most practical information related to important outcomes for your priority population?
- What are the most important questions that will require all of your current

4. Develop your outcome questions—the extent to which your CDEP accomplished its intended results—at one or more levels based on your goals and purpose:

- Individual Level (CDEP participants): changes in knowledge, attitudes, beliefs, practices, resilience indicators, and behaviors
- Community Level (population): changes in norms, attitudes, awareness, practices, and behaviors
- Systems/Policy Level: changes in organizations, policies, laws, and power structures with a focus on the systems that impact mental health
- Three other interrelated issues that can be the focus of evaluation questions include: merit (i.e., quality of CDEP), worth (i.e., cost-effectiveness of CDEP), and significance (i.e., importance of CDEP).

5. Make sure to include process evaluation questions; namely address the WHO, WHAT, WHEN, WHERE, and HOW MANY of your CDEP activities and outputs.

For example, process evaluation questions yield the following types of information:

- Extent of CDEP implementation with the priority population
- Differential priority population constituents' engagement with the CDEP
- Satisfaction with CDEP program
- Fidelity to CDEP
- External barriers/challenges impacting your CDEP implementation

6. Avoid framing your questions using yes or no answers.

- Weak Question: Was the CDEP implemented as planned in the priority population?
- Strong Question: To what extent was your CDEP implemented in the priority population?

Sample Process Evaluation Questions:

1) Who are the participants involved in the program? How consistently did they participate?
2) What types of CDEP activities took place? How often did they occur? Were participants reached as expected?
3) To what extent has the partnership between [IPP and x] been collaborative and successful?
4) How satisfied are CDEP participants?
5) What aspect(s) of the CDEP particularly addressed the unique cultural, linguistic, and contextual needs of the priority population?

Sample Outcome Evaluation Questions:

1) To what extent did CDEP participants show reductions in [mental health issue a, b, and c]?
2) To what extent did CDEP participants strengthen [protective factor x, y, and z)?
3) To what extent did the CDEP reduce stigma and barriers to improve priority population to access mental health support?
4) To what extent did the CDEP increase the priority population's ability to navigate the mental health system?

7. Connect each of your evaluation questions to indicators that are specific, observable, and measurable.

Indicator(s) should be a good reflection of the outcomes you are evaluating. Having more than one indicator for each evaluation question will help you determine: a) whether or not your CDEP is making progress, and b) what it has accomplished by the end of the grant.

- Process indicators are often described in evaluation reports in numerical terms, such as counts, percentages, and proportions.
- While some outcome indicators can be described in numerical terms, more often, they illustrate the change related directly to the activities undertaken by an intervention. It is not required that outcome indicators be described with the type of change expected (e.g., decrease/increase in x, higher/lower x) as your evaluation questions will indicate the direction of change.

Sample Indicators:

- # of CDEP activities held (process)
- # of people reached for key demographics (process)
- # and type of changes obtained in local mental health delivery systems (outcome)
- Rates of violence against women (outcome)
- Changes in mental health awareness (outcome)
- Changes in feelings of isolation (outcome)

8. Developing research questions is not a linear process!

For example, identifying indicators may lead you back to refining your evaluation questions and vice versa.

Evaluation Designs

It is important to select an evaluation design that is capable of appropriately and feasibly testing your evaluation questions. Below we provide a decision tree based on some of the most common designs used in evidence-based practices and/or program evaluations. It can help you determine the type of experimental or quasi-experimental design most appropriate for your CDEP. If you do not see an evaluation design in the decision tree that fits your CDEP, we recommend that you seek TA from your TAP to discuss evaluation designs that will best contribute to your evidence base.

1. Can you RANDOMLY ASSIGN participants to either participate in the CDEP or not? For example, do you have a waiting list that you can pull names from randomly? Can you ethically not serve some people based ONLY on RANDOM ASSIGNMENT? Can you ethically delay service to some RANDOMLY ASSIGNED participants until post-service data can be collected from other participants?

Yes → You may be able to use randomized controlled trial (RCT). Go to Question #2

No → You may be able to use a quasi-experimental design. Go to Question #2

2. Which design best describes what your evaluation will use? Select from A, B, or C

A. You will use a pre- and post-test with two groups: one group gets randomly assigned to the CDEP intervention (treatment) and the other gets none or a variation of "business as usual" services (control)

Yes → This is a randomized controlled trial (RCT).

B. You will use a pre- and post-test with CDEP participants.

Yes → You may be able to use a quasi-experimental design. Go to Question #3

C. You have a community or population level intervention and will be examining at minimum 3 to 6 data points before and after the introduction of the CDEP intervention (see example below)

Yes → You may be able to use a quasi-experimental design such as Interrupted Time Series Design.

(See the example below.) Go to Question #3

Interrupted Time Series Design

T-2	T-1	T-3	X	T+1	T+2	T-3
Graduation Rate (3 yrs before)	Graduation Rate (2 Years before)	Graduation Rate Year before)	CDEP Intervention	Graduation Rate (Year after)	Graduation Rate (2 yrs after)	Graduation Rate (3 years after)

D. None of the above fits or I am unsure if the above will work in my context. Consult with your TAP.

3. Are you able to have a COMPARISON GROUP or COMPARISON COMMUNITY— a group of people similar to your participants (or community) who may receive other types of services or no services at all but for whom you can get or collect evaluation assessment data (or archival data)?

For example, can you get data for students at a similar school, parents who are too far away from your location to participate in your CDEP, foster youth in group homes located in a nearby section of your county, or people on a waiting list who signed up too late to participate in your intervention?

Yes → You will use a quasi-experimental design with comparison data.

No → You will use an observational (non-experimental) design with no comparison data.

TIP:

A comparison group should be similar to the treatment group on key factors that can affect your outcomes. If you are using a comparison group, don't assume that they are completely similar. You will have to control for potential differences as part of your statistical analyses.

For more information on Experimental and Quasi-experimental Designs:

- Types of Evaluation Designs (https://www.urbanreproductivehealth.org/toolkits/measuring-success/types-evaluation-designs)
- Focus the Evaluation Design (https://www.cdc.gov/eval/guide/step3/)
- Quasi-Experimental Evaluations (https://www.childtrends.org/wp-content/uploads/2008/01/Child_Trends-2008_01_16_Evaluation6.pdf)
- Quasi-Experimental Design and Methods (https://www.unicef-irc.org/publications/753/)

Remember, program evaluations use basic research designs to investigate a social intervention and its effectiveness with data and research methods. Taking the time to carefully think through the design of your study is critical to its success for the following reasons:

- Your evaluation will be reliable and credible.
- You can pinpoint areas you need to work on, as well as those that are successful.
- You can identify factors unrelated to what you're doing that have an effect — positive or negative — on your results and on the lives of participants.
- You can identify unintended consequences (both positive and negative) and correct them
- You will have a coherent plan and organizing structure for your evaluation.

Your evaluation questions and aims will help determine which type of design is best suited for your CDEP. The type of design you choose should be based upon your CDEP theory of change, proposed evaluation questions, monetary and organizational resources, and CDPH requirements. Below we provide an example of a CDEP to illustrate different types of evaluation designs, their accompanying methods, and the types of information to be learned from each approach.

Example: The Building Homes Project provides case management services for homeless LGBTQ youth. They recently launched a CDEP called "Pathways" which provides specialized, intensive case management model for youth. How might different types of evaluation design benefit this CDEP?

Interrupted Time Series Design		
Type of Design	**Key Features**	**Example**
EXPERIMENTAL		
Experimental	Participants randomly assigned to intervention and control groups	All Building Homes clients have an equal chance of being assigned to traditional program services or to the CDEP. Random assignment strengthens Pathways' findings because it minimizes the possibility that positive client outcomes happened by chance.
QUASI-EXPERIMENTAL		
Post-Test only w/comparison group (USE NOT RECOMMENDED)	No randomization of participants with a comparison; positive client outcomes collected only after program has ended.	After the CDEP program ends, staff surveys all youth participants and a comparison group of youth who received traditional Building Homes services
Pre- and post w/comparison group	No randomization of youth with comparison; positive client outcomes collected before the program begins and after the program has ended.	Pathways clients and clients who received traditional program services take pre-and post-tests to measure changes in civic engagement before and after their program participation. Scores between the 2 groups will be compared.
Interrupted time series with a single group	Randomization of participants; multiple observations before (baseline measurement) and after the program has ended; participants will serve as their own control group.	Civic engagement is examined multiple times prior to and multiple times after youth's participation in the Pathways CDEP. Youth serve as their own control.
Interrupted time series with multiple groups	Randomization of participants; multiple observations before (baseline measurement) and after the program has ended; control group.	Civic engagement is measured among Pathways and Building Homes clients 3 times before the program begins and 3 times after the program ends. Scores between the 2 groups will be compared.
NON-EXPERIMENTAL/NON QUASI-EXPERIMENTAL		
Post-Test only no comparison group (USE NOT RECOMMENDED)	No comparison group; positive client outcomes collected only after program has ended.	Program staff survey all youth participants at the end of the CDEP
Pre- and post with no comparison group	No randomization of participants with no comparison; positive client outcomes collected before the program begins and after the program has ended.	Civic engagement will be measured among CDEP participants at the start and end of the program period

Community ToolBox "Selecting an Appropriate Design for the Evaluation" http://ctb.ku.edu/en/table-of-

Sampling Procedures

Sampling procedures should specify how participants included in the evaluation are identified and recruited. Sampling is commonly discussed in research and program evaluation in terms of probability and non-probability sampling. Probability sampling means that every individual in your population has an equal chance of being selected. Randomization is a key technique of this selection process. Obtaining a random sample is considered ideal, but in community-based projects it is often unrealistic. Non-probability sampling can be useful for more complex evaluation designs and are a good fit in applied settings such as the IPPs. In non-probability sampling the equal chance of a participant being selected is not present. Non-probability sampling allows you to select participants on bases of availability and IPP/evaluator judgment. In other words, strengths of non-probability sampling include: 1) convenience and feasibility, and 2) the ability to collect rich data about the members of your participants in your CDEP. While generalizability is limited, valuable information can be obtained from sampling among those the program is most engaged with. Within the context of using non-probability techniques, IPPs and their evaluators should pay careful attention to ensure that bias is minimized and generalizability is increased. The most common non-probability sampling methods include: 1) convenience sampling, 2) quota control sampling; and 3) judgment sampling. See the following table to help you determine which approach works best for your CDEP evaluation.

Sampling

Sampling Procedure	What is it?	Best when	Pro's & Con's	What does it look like?
PROBABILITY SAMPLING				
Random selection (also random sampling)	Everyone in the entire priority population has an equal chance of being selected.	Whole population is available	Pro: 1) generally representative of the population being studied; 2) high external validity Con: 1) requires a list of the total population being studied in order to sample	A researcher wants to measure cultural competency of school personnel around LGBTQ issues. Each personnel's name is put into a randomizer, and the first 10 chosen are given a survey to measure levels of cultural competency
Stratified sampling	The population is divided into characteristics of importance for the project.	There are specific sub-groups to investigate (e.g., demographic groupings)	Pro: 1) can capture key populations characteristics; 2) generally representative of the population being studied Con: 1) can only be carried out if a complete list of the population is available; 2) each participant can only belong to one stratum group	A researcher wants to measure the number of uninsured clients at an ER by race. The racial breakdown of clients at the ER is: White (28%), API (12%), African American (24%), Latino (24%), and American Indian (15%). A probability sample is drawn from each group
Systematic random sampling	Divide the population into separate groups called strata. A probability sample (a random sample) is drawn from each group.	When a stream of representative people are available	Pro: 1) usually quicker and more efficient; 2) generally representative of the population being studied Con: 1) sample may not be generalizable	An API legal organization wants to measure client satisfaction of the organization's legal staff. A survey is given to every 4th client that comes into the organization for an appointment.

NON-PROBABILITY SAMPLING				
Sampling Procedure	**What is it?**	**Best when**	**Pro's & Con's**	**What does it look like?**
Purposive sampling	The sample is purposely selected to include people of interest to the study/evaluation	You are studying particular groups	Pro: 1) Generally useful when needing to reach a priority sample quickly; 2) useful when there is a limited number of desired potential participants in the population; 3) cost- and time-effective Con: 1) potential for researcher bias; 2) difficult to generalize results to greater populations.	A researcher wants to measure levels of discrimination among LGBTQ youth of color. During events hosted by the local LGBTQ center, the researcher only surveys participants of color.
Convenience sampling	Uses people from priority population available at the time and willing to take part. It is literally based on convenience.	You cannot proactively seek out subjects	Pro: 1) generally requires less cost and time in comparison to other sampling strategies; 2) generally easier to implement with few rules governing how the sample needs to be collected; 3) best when you cannot proactively seek out participants Con: 1) Findings may not apply to other samples or individuals in that population	A mental health organization wants to measure counseling center use by African American college students during finals week. They use a Facebook Poll to assess these levels.
Snowball sampling	A researcher may ask participants to refer other people who fit the study requirements, then follow up with these new people. Repeat this method of requesting referrals until you have gotten enough people.	You seek similar subjects (e.g., young alcohol consumers)	Pro: 1) It allows for studies to take place where otherwise it might be impossible to conduct because of a lack of participants; 2) may help you discover characteristics about a population that you weren't aware existed Con: 1) impossible to determine the sampling error or make inferences about populations based on the obtained sample.	A researcher giving a survey to a Vietnamese homeless youth may ask that youth to refer other Vietnamese homeless youth to the study
Quota Sampling	The proportions of particular sub-groups within a population and you want to ensure each group is proportionately represented.	You have access to a wide population, including sub-groups.	Pro: 1) Insures some degree of representativeness of all the strata in the population Con: 1) Degree of generalizability is questionable	The student council at Cedar Valley Public School wants to gauge student satisfaction on a new pilot wellness program. They decide to survey 100 of 1,000 students using the grade levels (7 to 12) as the sub-population.
Multistage Random Sampling	Constructed by taking a series of simple random samples. Larger clusters are further subdivided into smaller, more specific groupings for the purposes of surveying.	When sample is geographically dispersed and face-to-face is required and there's a high level of flexibility.	Pro:1) can help reduce time and cost of large-scale survey research Con: 1) can be arbitrary. Researcher may employ whichever method they see fit at each level risking potential bias. 2) not highly representative	In Iyoke et al. (2006) researchers used a multi-stage sampling design to survey teachers in Nigeria to examine if socio-demographic characteristics determine teachers' attitudes towards adolescent sexuality education. First-stage sampling included a simple random sample to select 20 schools in the region. In the second stage of sampling 13 teachers from each were administered questionnaires.

Data Collection Strategies

The evaluation plan should include descriptions of the measures and procedures about how data will be collected from participants and other data sources. These include any instruments, surveys, questionnaires, direct observation protocols, administrative data, or any other method from which data will be collected. For many constructs, pre-existing standardized measures may already exist. For example, there are many reliable and valid self-report measures of depression (e.g., Centre for Epidemiological Studies Depression Scale, Radloff, 1977; Beck Depression Inventory, Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). This does not mean it is valid and/or reliable for your priority population. Thus, a CDEP interested in measuring depression may need to modify or create an entirely new measure. There are multiple strategies that can be considered (e.g., use a qualitative measure along with the standardized measure, modify or develop a new measure, or compare findings from both the standardized and newly developed measures). This is an opportunity to consult with the TAPs, PARC@LMU, and the Alliance.

Direct observations (i.e., behavioral measures) are also frequently used as part of data collection. For example, the evaluator may count how many times community members walk past or walk into the IPP's CDEP location. Behavioral measures could also include teacher or parental reports of a child's behavior.

Data Analysis Strategies

The evaluation plan should provide a description of your anticipated data analysis strategy. Basic analytic strategies fall into two broad categories: 1) descriptive statistics (a description of your sample) and 2) inferential statistics (to test whether the data supported your original CDEP hypotheses).

Common Statistics Symbols Used When Reporting Data

Symbol	Meaning
N	Population size
n	Sample size
$\bar{x}$	Sample mean
μ	Population Mean
s	Standard deviation of the sample
σ	Standard deviation of the population
$\sigma\,\bar{x}$	Standard error of mean
p	p-value (attained level of significance)
r	Correlation coefficient

Descriptive statistics describe the basic features of your evaluation data. They provide simple summaries about your sample and the measures you used. You are simply describing what's going on in your data.
It typically includes the following information.

- Sample size (i.e. # of participants) (N)
- Demographic variables such as:
  - Language
  - Age (please describe)
  - Racial/Ethnic Group (please describe)
  - Education
  - Gender Identity (please describe)
  - Sexual Orientation (please describe)
  - Geography (urban, rural or frontier)
  - Homeless/transient
  - Immigrants/Refugees
  - Religion (please describe)
  - Tribal Groups (please describe)
  - Non-native English speakers (please describe)
  - SES/income
  - Disabilities (cognitive or physical) (please describe)
  - Uninsured/underinsured
  - Length of residence in the community

Please note that this is not an exhaustive list of demographic variables. You are free to include other demographic markers that are relevant for your CDEP evaluation, activities, and population group as needed (e.g. % mothers and fathers, arrests and incarceration rates, school absenteeism etc.).

When reporting an average or mean you should also report the standard deviation (or another measure of variance, such as standard error). The standard deviation shows the relationship of the scores in each measure to the mean of each measure. In other words, the standard deviation helps you to know whether your data are close to the average (almost all the youth in the program have a score of 100) or whether the data are spread out over a wide range (the youth scores vary widely from scores of 30 to 100). Without your standard deviation, you could overlook the most interesting part of the story you are trying to tell.

For example:

If you find that the mean score for spirituality is 100 you may think, "Wow! That's great. Our participants are really spiritually grounded."

But if the standard deviation shows high variation in spirituality scores, that's a lot of different responses, so the assumption that everyone is spiritually grounded is not quite accurate. On the other hand, if the standard deviation is really small, you would have a much better idea that most of your sample really does have high levels of spirituality.

Inferential statistics describe summary findings related to your CDEP evaluation questions. They allow you to make judgments about the probability that an observed difference (e.g., between groups) is a dependable one or one that might have happened by chance. Inferential statistics should always be reported with an observed probability value (p-value). The specific inferential statistic you select is dependent on both the evaluation design and evaluation questions posed.

Inferential statistics that are useful for making group comparisons include:

- A t-test could be used to compare the means of two groups and whether the difference between means is significant (i.e., unlikely due to chance). For example, a CDEP may want to know whether boys have higher resilience scores than girls. A t-test would determine whether boys' mean resilience score was significantly different than the girls' mean resilience scores; again, a corresponding p-value would indicate the probability of obtaining those results by chance alone.
- Analysis of variance (ANOVA) is another statistical technique CDEPs might use to compare the means of more than two groups. The ANOVA inferential statistic is the F-test and it shows whether the means of two or more groups are statistically significant. Follow-up tests (post-hoc tests) would show which specific groups are different from one another at a statistically significant level.
- Chi-square (X^2) is an inferential statistic used with data based on categories. For instance, perhaps a researcher is interested in whether gender is related to political affiliation. Because gender (male or female) and political affiliation (Republican, Democrat, etc.) are both categorical data, X^2 would be used to indicate whether and how gender and political affiliation are associated (e.g., more men are Republican); a corresponding p-value would indicate whether the results were unlikely due to chance.

Other Inferential Statistic Examples:

- A correlation (correlation coefficient r) measures the strength and direction of an association between variables. For example, a CDEP that predicts that stronger social ties are related to lower drug use would run a correlational analysis to examine whether the variables were related, the strength of the relationship, and if the hypothesis was supported. The observed p-value with the correlation would indicate whether the results were unlikely due to chance. Ideally, your p-value would fall around .05, indicating a 95% likelihood that the lower drug usage found did not happen by chance,
- A CDEP might use more advanced correlational statistics such as multiple regression where multiple variables are used to predict an outcome variable. For instance, the CDEP may be interested in predicting stress scores based on participant's SES-levels, number of friends, and years of education. Multiple Regression would use SES, number of friends, and education as predictor variables to predict the outcome variable of stress in one statistical test.
- Resources such as the following can be useful to make decisions about what statistical analyses to use.

The Decision Tree for Statistics
(https://www.microsiris.com/Statistical%20Decision%20Tree/)

Case Example:

Experimental Design—Gold Standard Typical of an EBP

Zeedyk-Ryan and Smith (1983) studied the effects of crowding on hostility and anxiety. The researchers hypothesized that individuals in crowded conditions would display more hostility and anxiety than individuals in less-crowded conditions. The researchers made this prediction based on the psychological theory of crowding which postulates that being crowded leads to excessive social stimulation and in turn results in stress and pathology. Recruited participants were part of a college course. The sample consisted of 15 men and 7 women; no other demographic information was reported. In an experimental design, participants were randomly assigned to one of two conditions: a crowded room, where they shared a 12 x 18 foot room with 15 other participants; or less-crowded room, where they shared a 12 x 18 foot room with 5 other participants. After approximately 2 hours, all participants completed the Affect Adjective Checklist, which measured hostility and anxiety. Participants (N = 16) in the crowded room reported statistically significantly higher levels of hostility than participants (N = 6) in the less crowded room, F = 7.54, p < .05. The researchers concluded that they had evidence to support their hypothesis and that confinement plus high density contributed to higher hostility rates.

Qualitative Data Analysis. If you will be using qualitative methods and analysis in your local evaluation, your strategy should be clearly described in both your evaluation plan and final evaluation report. Qualitative methods yield data that consists of words and observations, not numbers. Analysis and interpretation of this data require systematic procedures. Often referred to as content analysis, it requires that you have clear procedures to review, organize, code, and interpret your data. Presented another way by Miles and Huberman (1994), the essential steps are data reduction, data display, and conclusion drawing and verification. These steps can be done via manual analysis which involves organizing and labeling your data by hand or by using computer software programs such as Dedoose or ATLAS.ti.

- Dedoose is a web-based application for qualitative and mixed-methods research data in the form of text, photos, audio, video, spreadsheet data and more. Dedoose projects can be analyzed by an entire team of researchers. You may access more information about Dedoose through this link: http://www.dedoose.com/
- ATLAS.ti is a statistical package for the qualitative analysis of large bodies of textual, graphical, audio and video data. This program provides tools that will allow the user to locate, code, and annotate findings in primary data material, to weigh and evaluate their importance with visuals to highlight the complexities of those relationships. You may access more information about ATLAS.ti through this link: http://atlasti.com/

The goals of qualitative research are to uncover and describe patterns, use the patterns to compare differences between individuals or groups, and then test assumptions about the patterns (Bernard, Wutich, and Ryan, 2016). Analysis of qualitative data requires coding of the information collected and the use of a systematic strategy to extract qualitative themes (e.g., ranging from searching for repetitions within the text, to identifying linguistic connectors, to considering missing text).

- For information and examples about eight coding strategies, click on the following link: Analyzing qualitative data: systematic approaches (https://www.chapters.indigo.ca/en-ca/books/analyzing-qualitative-data-systematic-approaches/9781483347103-item.html) (Bernard, Wutich, and Ryan, 2016).

  A typical sequence of content analysis includes defining the texts you will use, creating the codes, checking the text, creating a matrix for the codes, and determining inter-coder reliability. When coding you must select your approach, for example:

- Codes might be selected from the literature or some theory—a priori codes.
- Codes could be developed from the data based on what participants say—in vivo codes, also known as inductive or grounded coding.

It is also important to determine what type of validity checks will be used as part of your data analysis process (for example, among others are profile matrices and proximity matrices—two types of matrices that can be used to display data). Here validity is particularly concerned with whether the conclusions being drawn from the data are credible, defensible, warranted, and able to withstand alternative explanations. The most common types of qualitative data analysis are:

- Domain/content
- Thematic
- Grounded theory/constant comparative
- Ethnographic/cultural
- Metaphorical/hermeneutical
- Phenomenological
- Biographical/narrative analysis
- Case study
- Mixed methods
- Focus groups

For more information on qualitative data analysis refer to the following two resources:

O'Connor and Gibson provide an easy to use reference. Click here: Step-by-step Guide to Qualitative Data Analysis (http://www.pimatisiwin.com/uploads/1289566991.pdf)

Miles, M. B., & Huberman, A. M. (2013). Qualitative data analysis: An expanded sourcebook. (3rd ed.). Los Angeles, CA: Sage.

So, it is important to describe your data analytic strategy...

Data Analytic Strategy Checklist
In your evaluation plan, did you:

- [ ] Describe participant characteristics with descriptive statistics, including number of participants (N), means (M) and standard deviations (SDs)?
- [ ] Use percentages to describe the percentage of participants in categorical data (e.g., percent of participants who were African-American, Korean)?
- [ ] Use inferential statistics to test hypotheses and whether a hypothesis was supported at a statistically significant level ($p < .05$)?
- [ ] Select from common inferential statistics to examine whether variables are associated such as correlation coefficient (r) and multiple regression?
- [ ] Use ANOVA and/or t-tests for inferential statistics that test the difference between group means?
- [ ] Describe qualitative data analysis procedures to review, organize, code, and interpret your data, including how you handled interrater reliability and validity?

Quality Assurance, Improvement, and Fidelity

Conducting program evaluations are a complicated affair. Behavior is difficult to measure and participants are not always easy to recruit. **The reality is that evaluations, often, never run perfectly**. Nonetheless, CDEPs and the SWE can still employ methods and strategies to ensure that their project is carried out in a credible and valid fashion.

The quality of an evaluation is typically judged against the extent to which there is adherence to general scientific principles. Adhering to such principles increases the legitimacy and potential implications of your findings. Some general scientific principles that strengthen any evaluation or research project are as follows.

- Transparency: Openly report evaluation results with the appropriate amount of detail, even if mistakes were made or findings were not significant. Provide clarity in defining variables and constructs.
- Precision: Be accurate and precise through each step of the evaluation process, from developing clear evaluation questions, administering measures and instructions in a consistent fashion, to entering and analyzing data in a careful fashion.
- Consistency: Maintain consistency throughout the data collection process. All participants should receive the same instructions and measurement protocols. Keep an ongoing log and record details during all phases of the project. Just as the evaluation plan helps structure the project timeline, keeping detailed notes throughout the process will assist in recalling and reporting evaluation results. For example, if two participants were dropped because they failed to complete all the questionnaires, the dropped participants would be recorded in the research log (or whatever record-keeping mechanism is being used). The CDEP could consult the evaluation log when writing up results and would be transparent about dropping those participants in the final evaluation report.
- Quality: Maintain quality assurance through periodic data checks and reliability procedures. If a project entails multiple evaluators or staff collecting data from participants, periodic checks of each person's protocols and procedures would ensure that all members of the team are collecting data consistently. Quality assurance can also occur during data entry and data analysis. If one person entered the data into a computer database, another evaluation team member could recheck the data entry (or a subset of data) for possible data entry errors.

These procedures are not about performance reviews of team members but rather an acknowledgement that human error may occur and good evaluations ensure that data are as accurate and precise as possible.

Quality Assurance and Improvement

- **Evaluation findings are compelling and legitimate when sound research principles are applied. Did you use the principles of transparency, accuracy, precision, consistency, and good record-keeping?**
- **Quality assurance of data and evaluation findings includes confirming that all evaluation and program personnel are adhering to the same procedures and protocol. Did you maintain quality assurance through data entry checks and double-checking data analysis findings by re-running analyses and confirming results?**

Implementation Fidelity

In addition to understanding the effectiveness of your CDEP, evaluation is also frequently concerned with program fidelity, or, the extent to which services were delivered in a manner that matches the true intent of your CDEP. Why is this important to know?

Imagine a CDEP that facilitated support groups for individuals who had experienced domestic violence. A recent evaluation found that participants had decreased mental health symptoms after program participation. However, the evaluation also revealed that 1) there were no standard protocols for how the support groups were facilitated; 2) staff also used different strategies for engaging participants during the groups; and 3) participation in the groups varied, with some individuals attending only a few sessions and others attending for months. As a result, although the CDEP showed signs of effectiveness, it was difficult to pinpoint exactly how this effectiveness was achieved.
Fidelity studies usually encompass the following 5 components:

- Adherence—the extent to which program components are delivered as prescribed by the model
- Dosage—amount of services received by participant
- Quality of delivery—manner in which services were provided
- Participant responsiveness—client engagement and involvement
- Program differentiation—analysis of program components to ascertain their unique contributions to the outcomes, and the ways they differ from other programs

Here are two useful links for more discussion and examples of how to evaluate fidelity at Measuring Implementation Fidelity
(http://www.jbassoc.com/ReportsPublications/Evaluation%20Brief%20-%20Measuring%20Implementation%20Fidelity_Octob%E2%80%A6.pdf)
and Assessing Program Fidelity and Adaptations
(http://www.promoteprevent.org/sites/www.promoteprevent.org/files/resources/FidelityAdaptationToolkit.pdf).

"Indigenous communities and researchers have voiced a variety of concerns with 'research as usual' and emphasized the value of true partnerships, including decolonizing research to instill a balance between Indigenous and Western frameworks and methods."

— Simonds and Christopher, 2013

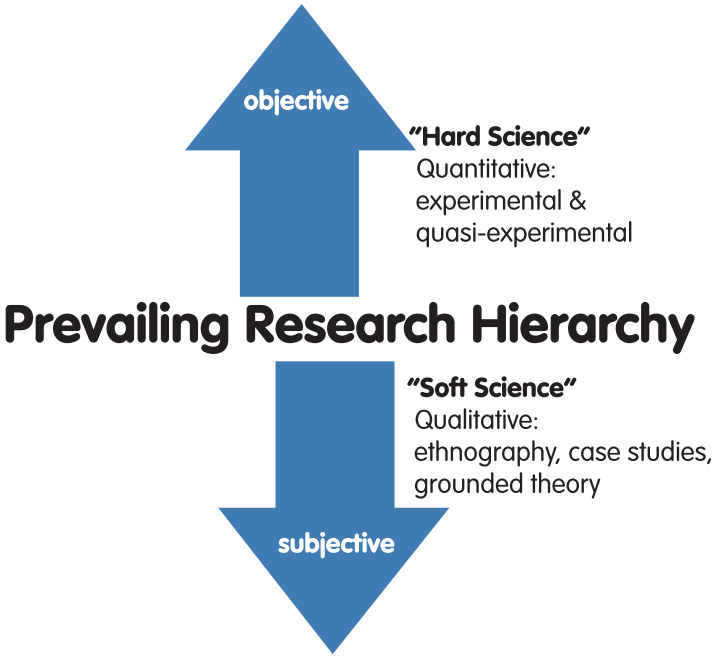
7. Re-defining "Credible" Evidence

A prevailing research hierarchy exists within the behavioral and social sciences, which dictates the strength of designs, methods, and techniques. This black and white thinking of "right" (gold standard) and "wrong" methodological approaches often ignores the:

- appropriateness of the method to the problem being evaluated,
- centrality of local, culturally specific knowledge unique to certain populations,
- resources available (e.g., financial, people power) to an organization,
- socio-cultural context, and
- level of analysis (individual vs. community or population wide).

The Challenge

IPPs are being asked to validate their CDEPs via their local evaluations using credible evidence. This is both a challenge and an opportunity. It is a challenge because a very narrow research framework has encumbered what is conventionally considered credible evidence (Schorr & Farrow, 2011).



Some may ask, "What is the danger or problem with only using the "hard" methodological approaches in the Phase 2 CDEP evaluation?" Quantitative methodologies do not necessarily reflect or align with the worldviews of our priority populations informed by the CRDP Phase 1 Priority Population Reports. These narrow research frameworks do not capture the collectivistic/holistic perspectives on health articulated by the 5 priority communities as exemplified below.

"Too often, quantitative approaches focus on change scores or other indices of improvement, stagnation, or loss…The real changes that transpire in whole communities occur, qualitatively, in more complex ways than can be placed on a measurement scale or averaged in a statistic."
— Olson, Cooper, Viola, and Clark (2016)

Priority Population Worldviews on Health

Priority Population	Collectivistic/Holistic Emphasis on Health
AFRICAN AMERICAN	**Cited from the CRDP Phase I African American Population Report:** • "Black family kinship (Stack, 1974), healthy psychological functioning (Martin and Martin, 1978), and collective personhood (Penningroth, 2009; Rowe & Webb- Msemaji, 2004). The intricate relationship between culture and mental health remains an important topic of discussion. There cannot be mental health without culture and, therefore it has been argued for the need to see culture and mental health as mutually embedded." (p.73) • "In focus groups, when asked: 'What practices do Blacks say help them to have "good" mental health?' Some themes included: Natural support system (God, Family, Friends); positive role models; Family Settings; Prevention; Freedom from Micro-Aggressions; Positive Systems Interaction for Participation; Cultural Compassion." (p.163) • "Leveraging the positive traditions of strong faith based values and community participation may help to lead us to clues about how to design and implement successful programs and interventions for African Americans throughout Los Angeles County." (p. 51) • "Our belief in the collective, group resiliency of the African people group should also be carefully considered when applied to young Black children." (p. 62) • "Outcomes from this tradition shed no light on mental health disparities and subsequent treatment needs of people of African ancestry because they are not informed by indigenous frameworks that are congruent with African-centered world views about health, mental health and successful functioning when one cultural group is surrounded by a majority culture group with a different world view. Specifically, they are based on a model of disease/ cure, rather than one of wound/heal." (p. 65) • "The lack of understanding Blacks in America has created a deficit of unmet needs, especially in mental health. Ignoring African American culture is relative to how individuals are socialized and the exchange of knowledge about the population." (p. 73)
ASIAN AND PACIFIC ISLANDER	**Cited from the CRDP Phase I Asian & Pacific Islander Population Report:** • "…given the cultural preference for a holistic view of 'health', the API-SPW deliberately chose the term 'wellness' for the focus group discussions." (p.43) • "Wellness is physical, mental, and spiritual. Physical means having good food and living well with basic needs met. Emotional means having self-control and not getting angry easily. For example, if something is bothering us, we have to deal with it and find ways to solve problems. Spiritually means we are Buddhist, we have to be good." (p.43) • "We consult with our spiritual healer. We talk among our family to try to release our tension by sharing our problems with our spiritual counselor or try to go to community service." (p. 57)
LATINO	**Cited from the CRDP Phase I Latino Population Report:** • "Familismo (family) is the cultural value that focuses on the contribution of the extended family. Improvements in individuals' outlook on life and health have resulted from intervention models that account for familismo by focusing on family cohesion." (p. 8) • "In this instance, simply feeling a sense of connectedness and tapping into the strengths of his community resulted in the increase of protective factors and persistence in the face of challenges." (p.31) • "[Being connected to one's spirituality] helps an LGBTQ person accept himself and in defining how do they deal with shortcomings, how do they deal with mental health issues, how do they deal with substance abuse, and all things that put them at higher risk." (p. 32)
LGBTQ	**Cited from the CRDP Phase I LGBTQ Population Report:** • "Having community spaces for LGBTQ folks of color helps queer folks of color create a better sense of identity." (p. 84) • "LGBTQ of color folks have support groups within the larger organizations. There are several different events for African American women that branch up and down the state. These allow me choices and it makes me feel good." (p. 88) • "Sometimes people don't need an actual service, they need to feel welcome. We want to feel comfortable in our own communities, in our own skins, and not have to feel judged all the time." (p.107) • "Being apart of it [GSA- gay straight alliance clubs] helped me maintain my sanity and kept me away from drugs." (p. 117)
NATIVE AMERICAN	**Cited from the CRDP Phase I Native American Population Report** • "The role of culture is central to healing and is of great significance as a protective factor for many indigenous people. Ceremonies and cultural activities often have the ability to connect to a native person and help them on their wellness journey in a way that cannot be described in terms of evidence based practice or even by words." (p. 14) • "Knowledge of the use of traditional foods, traditional medicines and traditional ceremonial healers is the process through which tribal communities reclaim the rights to their knowledge and empower their communities to believe in their own teachings." (p. 24) • "Traditional healing is holistic wellness; it is a way of life that does not separate the importance of the land, environment, prayer, community, language and all things that are a part of life." (p. 24) • "The healing power of weaving baskets comes from connecting with something in the past, recognizing and honoring the beauty of the skill, and feelings of pride and a sense of mastery." (p. 27)

In this emerging process of research and evaluation decolonization, there is no shortage of criticism of the dominance of Western research frameworks and methods as they relate to our priority populations. We can and must learn from these critiques while establishing credible evidence for the CDEPs.

"Past researchers have disempowered communities, imposed stereotypes that reinforced internalized racism, and conducted research that benefited the careers of individual researchers, or even science at large, but brought no tangible benefit to the communities struggling with significant health disparities. Many tribal nations have provided accounts of researchers who have exploited tribes by coming in, taking information from tribal members, and providing nothing in return. This is not distant history; rather it characterizes much of present behavior."
— Simonds and Christopher, 2013

Culturally defined and indigenous knowledge systems have typically been reduced to pseudoscience while the Western empirical research tradition is held high as the gold standard. Within this context, we can expect close scrutiny and comparisons of CDEP evaluations against this narrowly defined framework of what constitutes evidence. Furthermore, IPPs who want to establish their CDEP as an evidence-based practice (EBP) will require an even more advanced level of program evaluation research, resulting in pressure to adhere to the Western gold standard. This is problematic culturally and methodologically.

"Thinking of some methods as intrinsically better than others, despite the nature of the research task is absurd. It's akin to asking: "what's better, a banana or a wristwatch?" One obviously cannot tell time with a banana, nor are wristwatches edible."
— McKinlay, Behavioral & Social Science Research

"When conducting studies with Latino immigrants in a culturally competent manner, researchers must not only be well versed in qualitative research methods but also know how to work with communities that have been historically exploited by mainstream society. Some of the skills involved in working with vulnerable communities, such as Latino immigrants, involve relying on gatekeepers, having knowledge of the Spanish language, and understanding cultural nuances."
— Ojeda, Flores, Meza, & Morales, 2011

The Opportunity

CRDP Phase 2 presents an opportunity to expand notions of "appropriateness" in social and behavioral research methods by joining the growing movement advocating for alternative criteria for what may be deemed "credible" (reliable and trustworthy) evidence. For example, the state of California may have a different set of guidelines for what may be considered credible evidence of effectiveness than other states. These guidelines may vary based on how information is collected, the reliability of measures, how research questions are posed, and so on. Keep in mind; many of these guidelines may not be a good fit for all situations, problems, or populations you serve.

CDEPs represent one of the most diverse, multi-faceted projects ever implemented to address mental health disparities using a bottom-up (community-defined) approach.

CDEP evaluations have a chance to both contribute to and challenge what constitutes credible, traditional, and often culturally inappropriate views of mental health promotion. **But how do we do this? We do this in partnership as we together balance business as usual with innovation and culturally anchored evaluation methods.**

- While the SWE must stay focused on the cross-site evaluation (and in part yield to more traditional Western research and evaluation methods), the local evaluations can consider and use evaluation methods that more fully capture the shared perspective and experiences of their specific priority population (i.e., values; worldviews; language patterns; cultural, historical, and political experiences; behavioral tendencies and belief systems that undergird their cultural distinctiveness; etc.).
- PARC@LMU will expand on the findings from the cross-site evaluation with findings from the local evaluations. The goal is to collectively (SWE + CDEP evaluation) generate evidence through triangulation for systems and policy making in mental health service delivery that is not only methodologically, but also culturally and contextually defensible.
- As each of the IPP's priority populations have their own unique history, social capital, and social identities, the CDEP evaluations should focus on issues of intersectionality (i.e., each person belongs to multiple social groups). For example, a person's understanding of their ethnic group membership is filtered through their gender identity and class, and their understanding of their gender identity is filtered through their ethnicity and class. **Addressing issues of intersectionality in the CDEP evaluation will help us to nuance this within-group diversity, and ensure groups are not stereotyped or essentialized in order to preserve an overly simple understanding of culture.**
- Through the use of more flexible, collaborative, innovative, and alternative methods or approaches, IPPs will be contribute to the expansion of not only CDEP practice but also what constitutes appropriate methodologies that reflect culturally responsive and indigenous research and evaluation approaches.

"The notion of "appropriate methodology" emphasizes the match between the level of intervention and the most suitable evaluation approach, with the choice of approach contingent on the problem, state of knowledge, availability of resources, audience, and so forth. There is no right or wrong methodological approach: appropriateness to the level and purpose must be our central concern."
— McKinlay, Behavioral & Social Science Research

A brief overview of tools, resources, approaches, and methods are provided below to aid your thinking about how your CDEP evaluation can reflect and align with the worldviews of your priority populations. These include:

- The Cube (PARC, 2017)
- Flexible and Collaborative Investigative Methods/Approaches
- Alternative and Innovative Methods
- Examples of Culturally Based Quantitative Measures.

"When research about African Americans is approached from a culturally sensitive perspective, the varied aspects of their culture and their varied historical and contemporary experiences are acknowledged."
— Tillman, 2002

"Understanding Indigenous culture and contexts is critically important in developing an effective Indigenous evaluation or research design."
— Hood, Hopson, & Frierson, 2015

The Cube — A Conceptual Tool

All research is culturally-based, and therefore the "hard" approaches are biased towards the Western- dominant culture. For example, the prevailing view within the "hard" sciences is that health is *individualistic* (emphasis on individual well-being) and *mechanistic* (disease leads to imbalance, dysfunction and more disease). It is also focused on risk factors. In contrast, the cultural perspectives and worldviews of many of our priority populations view health as *collectivistic* (emphasis on the well-being of the group over, or at least as much, as individual well-being) and *holistic* (integration of mind, body and for many *spirit*). As a result, there is greater focus on protective factors. Consequently, these worldview differences often lead researchers/evaluators/decision-makers/stakeholders to draw conclusions about findings that may not be valid or justified. Improving measurement techniques and statistical manipulation, increasing sample sizes, including more measurement of risk factors, etc., will not solve the problem and we risk continuing to blame the victim. It will require the use of different, innovative, and culturally responsive research methods that are appropriate to task, evaluation question, community context, culture, and language.

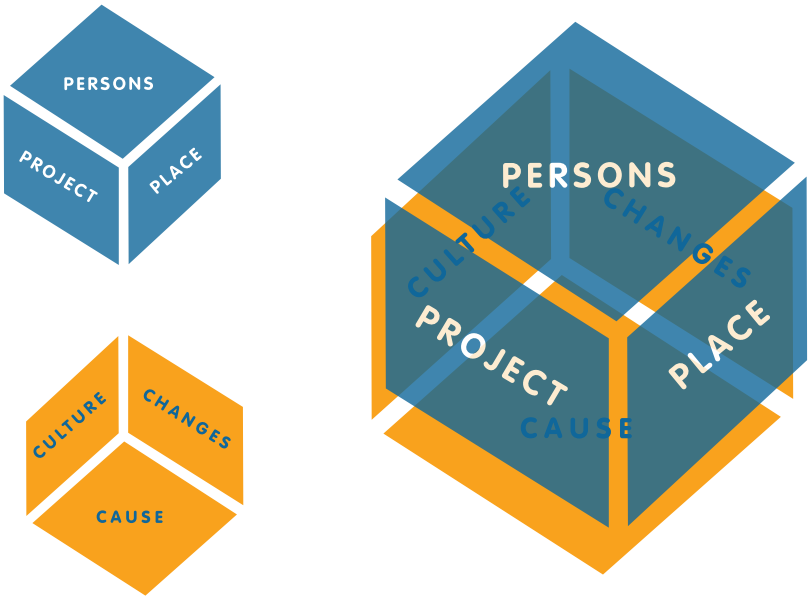
PARC@LMU encourages IPPs to employ **The Cube**, a conceptual tool developed for the IPPs, to help you reflect, deliberate, and ultimately "unpack" your CDEP and inform your approach to the local evaluation. This tool will assist with articulating both the visible and invisible dimensions of your CDEP **and it encourages IPPs to go beyond business as usual in the evaluation of their pilot projects**.

The Cube is a two dimensional conceptualization that:

- guides descriptions of culture, as manifested and expressed in the CDEP,
- accounts for historical factors that influence organizational, community, and systems contexts of the CDEP, and
- encourages "thick" (ethnographic) description (Nastasi & Hitchcock, 2016) of an IPP's worldview, cultural values and beliefs, practices, and cultural/community indices of health and wellness.

The CDEP's unique values are captured through an understanding of the dynamic interaction of both visible and invisible aspects of the cube. This is important because, communities have at least two levels of "culture," one they share with outsiders (visible) and one that they live with (invisible).

- The culture they share with outsiders, are the "visible" sides of the Cube, or the Projects—Persons—and Place (which are bold and prominent in the illustration of the model). These are generally the more commonly referred to elements of culture.
- The culture they live with—with insiders are the "invisible" parts of the Cube, or the Culture—Causes—and Changes. These are less evident and are less commonly articulated for those outside of the culture. They represent the culturally-based "explanatory models" that underlie the strategy[2].



The following are five recommended steps for how to use the Cube by IPPs.

Step 1:

Each IPP will revisit the evaluation plan in their grant proposal to begin the process of refining and elaborating of what was proposed. Sometimes what is written in a grant proposal does not fully capture the heart and soul or reasoning behind what a group actually plans to do. Living one's culture is one thing, trying to explain it to someone else is another. This is an opportunity to further define the visible cultural elements in your CDEP. Shared meaning through collaborative dialogue can be particularly useful at this juncture. Therefore, we recommend that IPPs in a participatory session with key community stakeholders collectively answer the following questions:

The Visible

Projects: What is the activity or the community defined practice(s)/intervention(s)? See Section 11 for guidance on how to describe your CDEP.

Persons: Who will be involved in delivering and participating in your CDEP and what will be their roles?

Place: Where does your CDEP take place in terms of space and place—i.e., the physical space, organizational and/or community setting, and geographic location and why are they important?

2. Kleinman and his colleagues (1978) first developed this approach to uncover differences between patients' culturally-based understandings of their illnesses compared with their physicians' medical culture-based views of their conditions, in order to facilitate the development of shared understandings in managing and negotiating health treatments.

Step 2:
Identify the invisible cultural worldviews surrounding the mental health issue(s) being prioritized by each CDEP. IPPs can use the following adapted questions to elicit the underlying cultural worldviews to provide an "explanatory model" for the design and development of their CDEPs. These include:

The Invisible
Culture: How does your CDEP project reflect the cultural values, practices, and beliefs of our community?

Causes: What are the problems the project is trying to address? How did they start and why? How are causes understood in a) a historical context, b) through the lens of the community's values, c) through a community's practice, and d) things that concern or bother the community.

Changes: What are the desired outcomes of the CDEP for your community from a cultural perspective? What does the community want to see more of? What does the community want to see less of?

Step 3:
Summarize your CDEP's explanatory framework that includes the cultural assumptions that usually remain implicit and unstated. This can assist with clearly identifying the ways in which cultural influences and values, including spirituality, contribute to your CDEP. Assessing these issues will enable a holistic understanding of the CDEP, both in its visible aspects (project, persons, and place), as well as its underlying, hidden explanatory model or rationale (culture, causes, and changes).

Step 4:
IPPs are encouraged to include the Cube explanatory framework narrative in their local evaluation plan. The identification of critical elements of the CDEPs within an adapted activity setting framework can be used to:

- identify relevant process and outcome measures and methods that flow out of your Cube,
- problem solve ways to capture relevant cultural variables in the evaluation,
- examine assumptions about the change process required to achieve CDEP goals,
- develop a clear description of your CDEP that can be included in your final evaluation report, and
- in collaboration with your assigned TAP, discern cultural variables, outcomes, and measures that might be used across IPPs within a priority population.

Step 5:
Use the Cube over the grant period to 1) understand the CDEPs; 2) validate assumptions in the CDEPs in a CBPR fashion with community stakeholders and key informants; and 3) make necessary course corrections in the SWE and local evaluations. See Table 7.2 for sample applications of the Cube with two Phase 2 CDEPs.

Cube Elements	*Sweet Potato West Fresno Family Center*
THE OBSERVABLE	
Project What is the activity or the community defined practice(s)/ intervention(s)?	**Direct prevention program for youth that includes 4 primary components:** 1) Small business training (harvesting and selling sweet potatoes) 2) Motivational counseling 3) Life and coping skills development 4) Systems level change (economic development throughout the county) (More detail would be provided here)
Project What is the activity or the community defined practice(s)/ intervention(s)?	Program delivery by 5 program staff with strong trusted relationships with West Fresno families. Small business training and professional development led by various professionals from Cal State University, Fresno, Fresno State, and Fresno Unified School District. Project participants include African American middle school youth ages 12–15 residing in Fresno.
Place Where does our CDEP take place in terms of the organizational and/or community setting and geographic location and why is this important?	The CDEP takes place in Southwest Fresno. This area has historically been a low-income community with high levels of unemployment and poverty, with more than 40% of the households reliant on Cal-Fresh food subsidies. Improving economic development, job opportunities, and educational outcomes is therefore critical. (More detail would be provided here, e.g., an abandoned community lot, community center and its importance)
THE INVISIBLE	
Culture How does our CDEP project reflect the cultural values, practices, and beliefs of our community?	**Cultural values are present in the following areas:** 1) Selection of the sweet potato as the crop, as it is traditionally an African American "soul food," which is associated with social interaction, African American history, and African cultural retentions. 2) Use of the African centered perspective to recreate traditional supportive relationships around productive activities with competent adult community members; reinforcing youth and adult relationships as the village raises the child. 3) Emphasis on strengthening the sense of spiritual connection between the land and the people and the spiritual connection of people with each other—all within the context of the village. These ties promote resilience and well-being: "I am because we are."
Causes What are the problems the project is trying to address? How did it start and why? How are causes understood in a) a historical context, b) through the lens of the community's values and c) things that concern or bother the community.	• 54% of children in Southwest Fresno live in poverty, compared to the California rate of 20.9%. • African American youth 12-15 in the low-income community of Southwest Fresno experience disproportionately higher rates of poor health and mental health, poverty, violent crimes, and lower rates of high school graduation. • Youth need job training through dignified work and stipends. • Southwest Fresno neighborhood needs to become safer and more economically self-reliant and self-sustainable. • On a yet deeper level, the tattered community safety net compromised for African Americans from 400 years of oppression and ongoing racial stress has weakened sense of connection and self-sustaining, vibrant communities. (Additionally, information to further enrich and nuance this description of causes might include: Why is connection to the land important (culturally, historically, spiritually to people of African ancestry and how do the elders relative to the youth understand this? What values are important in the community and if one looked at this intervention in that context how/why is the strategy relevant to get at a deeper understanding of causes from a community perspective? What are peoples' concerns about the community that are connected to this strategy that again, further reveal the community's perspective on the causes of the focal problems of this project?)
Changes From our cultural perspective, what are the desired outcomes of the CDEP for our community? We will see more of …. and less of …..	**Expected outcomes for the community include:** 1) Increased opportunities for youth ages 12-15 to develop skills related to job responsibility and follow-through, effective communication and business planning, 2) Strengthened community ties through resilience from increased cultural programs and practices for African Americans, 3) Increased outreach opportunities and locations available for residents to receive support and education about mental health issues, 4) Decreased stigmatization surrounding mental health issues, 5) Reduced residential segregation challenges including neighborhood violence and lack of resources (These outcomes could be strengthened by linking them more directly to the cultural values and the perceived causes of problems identified. For example, articulating the relationship between connection to the land, connection to each other, community building, and resilience for youth and adults). Further, how are these all related to reducing stigma and increase spaces for mental health support. There are proximal and distal outcomes that are discernable in the project that could be clearly articulated and measured.)

Cube Elements **THE OBSERVABLE**	*Native American Drum Dance and Regalia (UAIM)*
Project Project What is the activity or the community defined practice(s)/ intervention(s)?	**Direct prevention program that promotes health and wellness through the following culturally-based workshops:** 1) Drumming (historical customs) 2) Dancing (instructional classes on how various dance styles are performed) 3) Arena tradition (pow wow arena etiquette) 4) Regalia design (design and creation of regalia worn at events) (More detail would be provided here)
Project **Persons** Who will be involved in delivering and participating in our CDEP and what are they doing?	Project staff includes 2 executive staff members who are experienced in culturally based mental health and substance abuse research and treatment; a Culture Coordinator responsible for program planning; and community subcontractors including 5 dance instructors, 4 drum/song instructors, and regalia making instructors. All instructors are recognized and respected within the community. Program participants include children ages 3-17 and adults ages 18-59 in Los Angeles County.
Place Where does our CDEP take place in terms of the organizational and/or community setting and geographic location and why is this important?	The program is located in Los Angeles County, one of the largest urban AI/AN populations in the country. Despite these high numbers, AI/AN community members only make up .6% of the population, which makes it difficult for the AIAN population to find one another to create bonds and be involved in a community. (More detail would be provided here regarding exact location and setting, e.g., x neighborhood in highly recognized AI/AN community center and its importance)
THE INVISIBLE	
Culture Conceptualization How does our CDEP project reflect the cultural values, practices, and beliefs of our community?	**Cultural traditions and values are reflected in the following areas:** 1) Drumming, dancing, and regalia making provide opportunities to learn cultural traditions and engage in healing activities that have been utilized for centuries among indigenous communities. 2) Use of the Medicine Wheel highlights the four dimensions of wellness recognized historically by AI/ANs (How is the Medicine Wheel central to healing? How does it inform the culture's understanding of the essential elements of human beings – for example, the spiritual element) 3) Program staff represent several different tribes which helps maintain cultural relevance and legitimacy. 4) Workshops teach musical techniques, and traditional values, protocols, and expectations. (What are the traditional values, protocols and expectations; how are these related to mental health and wellness?)
Causes What are the problems the project is trying to address? How did it start and why? How are causes understood in a) a historical context, b) through the lens of the community's values and c) things that concern or bother the community.	Social isolation among AI/AN communities and shortage of treatments and supports that can address the unique needs of the AI/AN population, including historical trauma, oppression, and racial and cultural identity. This leads to needs not being met and the perpetuation of mental health issues, such as loneliness and a disconnect with native identity. (What others needs aren't being met?) AI/AN community members are likely to experience increased rates of depression and addiction, including exposure to trauma such as child abuse, domestic violence, and crime victimization further contributes to mental health disorders among this population.
Changes From our cultural perspective, what are the desired outcomes of the CDEP for our community? We will see more of …. and less of …..	**Cultural activities promote mental health PEI and will result in the following outcomes:** 1) Strengthened connection to AI/AN traditions 2) Increased connection to cultural identity 3) Increased spirituality 4) Reduced rates of mental disorders 5) Reduced substance abuse rates 6) Improved coping skills 7) Improved health and wellness (How can this be further nuanced or explained from AI/AN cultural lens?)

"Research should be grounded in the expertise and knowledge of community-based organizations, whose experience and work often defy popular misconceptions that stem from traditional research that lumps Asian Americans (AA) & Native Hawaiians and Pacific Islanders (NHPI) into one monolithic community and/or neglects to collect enough data to produce reliable findings on many smaller or medium-sized ethnic populations. This grounding should come at a minimum from a literature review of some community-based research and the active participation of appropriate AA & NHPI advisory committee members, and at a maximum, from a Community-Based Participatory Research Model."
— Applied Research Center & The National Council of Asian Pacific Americans

Flexible and Collaborative Investigative Methods/Approaches

In evaluations that involve groups of vulnerable people who are marginalized (e.g., refugees, LGBTQ, noncitizens), more flexible and/or collaborative methods may be needed. The table below provides an overview of methods that can assist with:

- obtaining in-depth understandings of how communities in different cultures and sub cultures make sense of their lived reality,
- understanding complex socio-political problems where cultural diversity is great,
- collaboratively working with communities who have historical and current experiences of oppression and exploitation,
- providing opportunities for community members to actively pinpoint issues impacting individual lives, families and their communities,
- describing and explaining individual experiences, relationships and other social phenomena, such as community/cultural norms, and
- evoking responses that are meaningful and culturally salient to the community.

Overview of Flexible and Collaborative Methods

Method/Approach	Rationale & Advantages	Additional Resources
Community-Based Participatory Research (CBPR) Community-based participatory research (CBPR) is a "collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community, has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities." —WK Kellogg Foundation Community Health Scholars Program	CBPR advances the development of culturally centered research designs and public health interventions. CBPR has several advantages to conventional research paradigms. • Community members are not passive "research subjects," but equal partners and active participants in the development of research questions, program design and implementation, and dissemination of findings. • Researchers are better able to see and understand the complex factors that influence health. By engaging in true partnerships with community, they learn about strengths and values, different ways of knowing, and policy and systems barriers that are often obscured within conventional research frameworks	**University of Washington:** Developing and Sustaining Community-based Participatory Research Partnerships: A Skill-building Curriculum (https://depts.washington.edu/ccph/cbpr/index.php) **Community-Campus Partnerships for Health (CCPH):** Community-Based Participatory Research (https://ccph.memberclicks.net/participatory-research) What is CBPR? (http://www.detroiturc.org/about-cbpr/what-is-cbpr.html) **Detroit Urban Research Center:** What is CBPR?
Ethnography "Critical ethnography is an approach to ethnography that attempts to link the detailed analysis of ethnography to wider social structures and systems of power relationships." —Madison, D.S., 2004, Critical Ethnography: Method, ethics, and performance	Ethnography helps us understand culture through representation of the "insider perspective." Ethnographic research explores social phenomena in the setting it takes place in. Through the use of participant observation, in-depth interviews, focus groups, etc., ethnographers gain rich insights about culture and community (i.e., the social and physical location of communities, individual viewpoints and values, etc.) that would be hard to ascertain using other methods.	**Community Tool Box:** Gathering and Interpreting Ethnographic Information (http://ctb.ku.edu/en/table-of-contents/evaluate/evaluate-community-interventions/ethnographic-information/main)
Mixed Methods "Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the purpose of breadth and depth of understanding and corroboration." —Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. Journal of Mixed Methods Research, 1(2), 112-133.	Using multiple methods can improve the quality of your data. Both quantitative and qualitative research have weaknesses. Quantitative research (e.g., surveys) is weak in understanding the context or setting in which data is collected. Qualitative research (e.g., interviews) may include biases and does not lend itself to certain statistical analysis and generalization. A mixed method approach can offset these weaknesses by integrating both quantitative and qualitative methods to provide a better understanding of the research question than either approach alone. Researchers using a mixed methods approach will be able to use all the tools available to them and collect more comprehensive data which can generate results that have a broader perspective of the overall problem, and ultimately tell a more complete and accurate story.	**Association for Psychological Science:** Mixed Methods Research (https://www.psychologicalscience.org/observer/mixed-methods-research#.WMm2w2_yupo)

Method/Approach	Rationale & Advantages	Additional Resources
Triangulation "Triangulation involves using multiple data sources in an investigation to produce understanding. Some see triangulation as a method for corroborating findings and as a test for validity. This, however, is controversial. This assumes that a weakness in one method will be compensated for by another method, and that it is always possible to make sense between different accounts. This is unlikely. Rather than seeing triangulation as a method for validation or verification, qualitative researchers generally use this technique to ensure that an account is rich, robust, comprehensive and well-developed." —Robert Wood Johnson Foundation	Triangulation combines multiple methods (or data sources) to study one phenomenon. Because a single method can never fully shed light on a social problem or issue, triangulation attempts to understand it from more than one standpoint. There can be triangulation between methods and triangulation within methods, each providing different types of insight about your potential findings and the utility of various methods for your priority population. In fact, within qualitative research several types of triangulation methods are possible (e.g., Data Triangulation, Method Triangulation, Investigator Triangulation, Theory Triangulation, and Multiple Triangulation which uses two or more triangulation techniques in one study). (Akomolafe, 2016)	**Robert Wood Johnson Foundation Qualitative Research Guidelines Project:** Triangulation (http://www.qualres.org/HomeTria-3692.html) **Better Evaluation:** Triangulation (http://www.betterevaluation.org/en/evaluation-options/triangulation)
Qualitative "Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them." —Denzin and Lincoln, 2005, p. 3	Qualitative methods (e.g., case study, personal experience, interview, observational, visual texts, etc.) tend to be more flexible than quantitative methods because they allow greater spontaneity and adaptation of the interaction between the researcher and the participant. For example, qualitative methods ask mostly "open-ended" questions that are not necessarily worded in exactly the same way with each participant. With open-ended questions, participants are free to respond in their own words, and these responses tend to be more complex than simply "yes" or "no." An advantage of qualitative methodology is that it provides nuanced, rich, and complex descriptions of how people experience a given phenomenon. It is effective in identifying intangible factors such as social norms.	**Community Tool Box:** Qualitative Methods to Assess Community Issues (http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/qualitative-methods/main) **Robert Wood Johnson Foundation Qualitative Research Guidelines Project:** What is Qualitative Research? (http://www.qualres.org/HomeWhat-3513.html)

"Sexual minorities are likely to be present in many evaluation populations; however, evaluators may be unaware of their inclusion because of the stigma attached to 'outing' oneself…Because of the sensitivity of the issues surrounding LGBTQ status, evaluators need to be aware of safe ways to protect such individuals' identities and ensure that discriminatory practices are brought to light in order to bring about a more just society."
— Mertens & Wilson, 2012

Alternative and Innovative Approaches

There are some cultural, linguistic, and contextual situations where conventional methods won't work. For example, focus groups, interviewing, observations, cultural adaptations of measures, can be alienating and insensitive to certain communities. In these instances, it is critical that your CDEP evaluation explores and uses alternative and innovative methods.

Innovative and Alternative Methods	
Method	Description
Community Narratives	This method elicits personal or community stories by asking story-based questions (e.g., Tell me about a high point in your childhood, a time you remember feeling extremely positive emotions; Tell us a low point in your community?). More value- or belief-based questions often follow once a participant has warmed up to story-based questions. Themes that emerge across participants become part of the community narrative. Collective themes serve as a barometer of transformative and positive changes occurring for individuals and communities.
Storytelling (Re-storying)	Storytelling is an oral tradition that involves skilled vocal and body expression (e.g., intonation, verbal imagery, facial animation, plot and character development, and authentic recall of the story (First Nations Pedagogy, 2009). Storytelling is often accompanied with song, music, spoken word, and dance as a way to heighten the senses and enhance feelings of interconnectedness. Storytelling frequently involves the use of testimonios—urgent spoken and/or written narratives that are situated in the context and lived experiences of the storyteller. Storytelling serves to preserve tribal history and culture, and also honor and prioritize Indigenous experiences, values, and ways of knowing. It is grounded in the understanding that narratives about Indigenous, marginalized communities typically reflect dominant western/colonial perspectives that perpetuate false, harmful images of communities. Storytelling allows Indigenous people to reframe and re-tell their stories. It emphasizes truth-telling and self-determination, and is thus viewed as a tool for resistance against western patriarchy, capitalism, and colonialism.
Photovoice (Photoethnography)	This method involves participants taking pictures based on a prompt or issue to be explored (e.g., What do you like about your neighborhood? What would you like to change?). Respondents spend several weeks exploring the question by taking photos that express their behavior, attitudes, and emotions. These photos allow participants to discuss: 1) the meanings of their lived experiences through visual symbols; 2) their own stories; and 3) their sensitive and private issues. After several group discussions, participants then categorize their photos and accompanying narratives by themes. The photos and narratives serve as data points.
Sharing Circle	Similar to focus groups, sharing circles use group discussions to gather information on a particular topic. Sharing circles differ depending on the indigenous groups' culture and are used as a healing method often times as part of a ritualistic practice. Through ceremonial recognition of the presence and guidance of the ancestors, circle participants share all aspects of themselves – heart, mind, and spirit – with permission given to the facilitator to report on discussions. Other aspects of the sharing circle may include speaking in a counter clockwise direction, only speaking when holding an object like a speaking stick, or beginning the circle with a smudging ceremony, ridding the circle of negativity.
Photoelicitation	This method uses photographs to understand how the community sees the world, and how they express their own definitions and meanings. For example, after looking at a series of pictures depicting emotional pain, participants may be asked the following questions: What is happening to the people in the picture? Is anyone in the pictures in pain? With whom do you identify most?
Reflexive Photography	In this method, participants take photographs of themselves or localities. This method has been used successfully with Americans Indian/Alaska Natives and African Americans. The self-generated images symbolize and make visible their identities in social and/or physical environments, and highlight what's important for their cultural group. Participants are asked to describe what the photo represents and why it was taken, which can often lead to spontaneous storytelling.
Audio/Video Diaries	This method draws on the tradition of personal narratives and storytelling but is audio or video recorded. For example, children suffering from asthma were asked to record their daily lives and world. The diary-like approach revealed situations unknown to the researcher, for example, their social isolation and relationship problems with their parents.
Draw and Write	This method combines drawings and writing. It has mostly been used with children and youth as it 1) gives them a voice, 2) provides insight of how they make sense of the world, and 3) reveals their wealth of knowledge. It is recommended that this method be integrated with other social science methods. For example, one study used a 'visual life-line' with LGBTQ homeless youth, where they viewed a large sheet of flip-chart paper with a line down the middle with a smiling baby on the left-hand side, a mark in the middle, and a smiling person on the right-hand side was placed in the room. Youth were invited to draw or write text about important moments and events in their life wherever they wanted along the line.
Written Diaries	In this method, participants record their feelings, experiences, observations and thoughts about a particular aspect of their lives. It provides an in-depth understanding of sensitive issues for hidden and hard-to-reach populations.

Examples of Culturally Based Quantitative Measures

While CRDP Phase 2 local evaluations face a challenge and an opportunity there is no need to throw the baby out with the bath water as decisions are made regarding the selection of methods and measures. In other words, there is no need to reject all Western methods and measures. In some instances, adaptations may be appropriate and beneficial by the local community (Simmons and Christopher, 2013). In other instances, you might employ methodological triangulation allowing comparisons of different methods to strengthen the argument for more culturally defined approaches to evaluation and research. The table below offers a sample list of culturally-based quantitative measures currently in use for each priority population.

Sample List of Culturally-Based Quantitative Measures by Priority Population

Citation	Scale	Population	Psychometric Score
AFRICAN AMERICAN			
Utsey, S.O., Bolden, M.A., Williams, O., Lee, A., Lanier, Y., & Newsome, C. (2007). Spiritual well-being as a mediator of the relationship between culture-specific coping and quality of life in a community sample of African Americans. Journal of Cross-Cultural Psychology, 38(2), 123-136. doi: 10.1177/0022022106297296	Spiritual Well-Being Scale	African American adults	Cronbach's alphas were calculated for each of the subscales and were as follows: connection with God, .82; satisfaction with God and day-to-day living, .73; future/life contentment, .72; personal relationship with God, .54; and meaningfulness, .49.
ASIAN AND PACIFIC ISLANDER			
Yoon, E., Jung, K. R., Lee, R. M., & Felix-Mora, M. (2012). Validation of Social Connectedness in Mainstream Society and the Ethnic Community Scales. Cultural Diversity and Ethnic Minority Psychology, 18(1), 64.	Social Connectedness in Mainstream Scale & Social Connectedness in the Ethnic Community Scales	Mexican American students from California & Asian international students from the Midwest	the alphas for Mexican American students were .92 for the SCMN and .95 for the SCETH; alphas for Asian students were .90 for the SCMN and .95 for the SCETH.
LATINO			
Steidel, A. G. L., & Contreras, J. M. (2003). A new familism scale for use with Latino populations. Hispanic Journal of Behavioral Sciences, 25(3), 312-330.	Attitudinal Familism scale	Latino adults in the Midwest (Cleveland)	Cronbach's alphas for the factors were .83 for the overall scale, .72 for Familial Support, .69 for Familial Interconnectedness, .68 for Familial Honor, and .56 for Subjugation of Self for Family
LGBTQ			
Steidel, A. G. L., & Contreras, J. M. (2003). A new familism scale for use with Latino populations. Hispanic Journal of Behavioral Sciences, 25(3), 312-330.	Attitudinal Familism scale	Latino adults in the Midwest (Cleveland)	Cronbach's alphas for the factors were .83 for the overall scale, .72 for Familial Support, .69 for Familial Interconnectedness, .68 for Familial Honor, and .56 for Subjugation of Self for Family
NATIVE AMERICAN			
Snowshoe, A., Crooks, C.V., Tremblay, P. F., Craig, W. M., & Hinson, R. E. (2015). Development of a Cultural Connectedness Scale for First Nations youth. Psychological assessment, 27(1), 249.	Cultural Connectedness Scale	First Nation, Metis, and Inuit youth	3 Subscales: Identity: .872 Traditions: .791 Spirituality: .808

"The debate about criteria for credible evidence is neither academic nor trivial. How we as a nation deal with issues of evidence will shape the nature of social innovation, programs, and policies—what is and what is not allowed, promoted, and incentivized—for years to come."

— Schorr & Farrow, 2011

This is our defining moment—the challenge and the opportunity.

— (PARC)

"Sometimes people hold a core belief that is very strong. When they are presented with evidence that works against that belief, the new evidence cannot be accepted. It would create a feeling that is extremely uncomfortable, called cognitive dissonance. And because it is so important to protect the core belief, they will rationalize, ignore and even deny anything that doesn't fit in with the core belief."

— Frantz Fanon

8. Designing an Evidence-based Practice Study

This section will be useful to IPPs who wish to establish their CDEP as anevidenced-based practice (EBP).

Evidence-Based Practice and Mental Health PEI Programming

One classic definition of EBP refers to "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Council of Representatives, 2005). The intent of an EBP is to close the gap between research and practice. In addition to practice-based findings (i.e., knowledge gained from their professional experience with clients), with EBPs service providers have access to the best available research evidence to inform their client interventions.

MHSA PEI evidenced-based practices refer to treatments and services that are backed by scientific evidence—i.e., at the end of the study, if the treated participants are better off than the control participants, there is evidence that the treatment "worked" (MedicineNet.com, 2016). This simply means that an intervention was effective in alleviating or improving a condition based on a randomized controlled trial (RCT).

The movement towards EBP in mental health is partly due to the concern that the use of strategies and techniques that are uninformed, outdated, and ineffective, are harmful to clients. **This is particularly important for the five CRDP priority populations.** Historically, these communities have not had access to mental health interventions that speak to their specific cultural, contextual, and linguistic needs, but rather have been subject to generic EBPs not designed with their culture or context in mind or validated in their communities. In addition, not having culturally relevant and responsive services has contributed to distrust of the mental health system and ultimately, untreated mental health needs, and negative outcomes resulting from untreated mental illness (i.e., homelessness, substance abuse, incarceration, prolonged suffering, removal of children from their homes, etc.). **Advancing CDEPs to EBP status can begin to fill a very large vacuum**.

Acceptance into an EBP registry means 1) an increased likelihood that other organizations can more effectively serve your population and 2) greater access to resources and better mental health outcomes for your priority population.

Applying to an Evidence-based Registry

IPPs can apply to a number of EBP registries. A frequently used registry for mental health and substance abuse programs is the National Registry of Evidence-based Programs and Practices (NREPP) (https://www.samhsa.gov/nrepp). Developed by Substance Abuse and Mental Health Services Administration (SAMHSA), NREPP is designed to increase public awareness of available EBPs. All interventions in the registry have met NREPP's minimum requirements for review and have been independently assessed and rated for "Quality of Research and Readiness for Dissemination".

For more details, please visit the following links to learn about requirements for and benefits of having your CDEP included in this registry.

- NREPP Review Process
  (http://nrepp.samhsa.gov/review_process.aspx)
- NREPP Submission Requirements
  (http://nrepp.samhsa.gov/reviews_submission.aspx)

Establishing Your CDEP as an EBP

Below are some points to consider if you are interested in applying to the registry to establish your CDEP as an EBP.

MHSA PEI programs typically consist of a range of interventions that have documented evidence of effectiveness. The figure below shows three categories of practice and the level of evidence each provides (the Continuum of Evidence).

Community-Defined Evidence

A set of practices shown to yield positive results as determined by community consensus over time, and which may or may not have been measured empirically, but have reached a level of acceptance by the community

Promising Practice

Innovations in clinical or administrative practice that respond to critical needs of a particular program, population or system and which seem to produce good outcomes but do not have enough research or replication to support generalized outcomes

Evidence-Based Practice

A range of treatment and services that have documented effectiveness according to the following criteria: 1) quantitative and qualitative data showing positive outcomes, but does not yet have enough research or replication to support generalized positive outcomes; and 2) has been subject to expert/peer review that has determined that a particular approach or strategy has a significant level of evidence of effectiveness in research literature

Some CDEPs are ready to advance to a Promising Practice while others may be ready to move to the stage of an EBP. Consider the following questions, to determine whether or not you should apply for EBP status for your CDEP.

- Where does your CDEP currently fall on this continuum of evidence?
- What type of evidence has been used to demonstrate effectiveness for your CDEP?
- Are there ways your CDEP could benefit from using a randomized control study?
- Do you have the capacity to conduct a randomized control study?
- Are there benefits to establishing your CDEP as an EBP?
- How could you use CRDP Phase 2 resources to help establish your CDEP as an EBP?

Designing an EBP

Following these basic procedures will help ensure that your plan will produce findings that meet EBP criteria. This is a helpful but not exhaustive list. Consult the registry you intend to submit for EBP status.

Explicitly describe the intervention, comparison, and/or control group. The intervention should be described in detail and a carefully developed protocol should explain how the treatment group will receive the intervention. Instructions and protocols for your CDEP should be standardized across participants to be sure that no one receives special or different treatment. The only difference in the experience of participants in treatment or control groups is the intervention itself; all other aspects of the intervention should be the same.

Checkpoint: You are required to describe the details of your CDEP in your local CDEP evaluation plan. See Section 11 for examples of details to include when writing your program description.

☐ Can you describe your CDEP in a way that is easily understandable to others?

Ensure that you select measures that will yield valid outcomes. Outcomes refer to the behavior, reaction, or effect that is expected to improve or change as a result of your CDEP intervention. For example, if a CDEP expects that their intervention will reduce depression, the outcome that is expected to change should be related to depression. A depression tool that has demonstrated validity and reliability with your priority population should be used to measure changes among CDEP participants.

Checkpoint: You are required to describe your CDEP outcomes, associated measures, and how they relate to your evaluation questions in your CDEP local evaluation plan. See Section 11 for the type of detail you will need to provide.

☐ Do you have clearly defined outcomes that should result from participation in your CDEP?

☐ Have you selected valid measures that are related to your anticipated outcomes?

Report effect size and use of statistical tests. Inferential statistics indicate the probability of a particular set of findings; if there is low probability, the results are unlikely due to chance and you can safely conclude that you have statistically significant results. In addition to the statistical significance of results, examine the effect size (i.e., the magnitude of your findings), which indicates how closely two variables are related or how different two group means are from one another. This is an important distinction from statistical significance — you want to be able to conclude that two variables are related, and how closely the variables are related. Effect size can be calculated in various ways. Two common indicators are the 1) correlation coefficient r (referred to simply as r) which indicates how closely two variables are related and 2) Cohen's d (referred to as d) which describes how much two groups differed on a measured outcome. See the box below for an example that illustrates the difference between these two statistical concepts.

Statistical Significance versus Effect Size

A CDEP involving Mi'kmaw youth is focused on enhancing resiliency among its participants. A primary component of their program is the talking circle, which provides space for youth to discuss issues that are bothering them. The CDEP wants to compare their outcomes to another program that also serves Mi'kmaw youth, but uses a standard Western-centric therapy intervention. After six weeks of one group of Mi'kmaw youth participating in the traditional talking circle and another group of Mi'kmaw youth participating in the Western-centric technique, community resiliency is assessed for all youth. Statistical significance (e.g., $p < .05$), was detected, indicating a difference between the two groups; in other words, the traditional talking circle is better for enhancing community resiliency among Mi'kmaw youth. However, this statistic does not tell us the magnitude of the difference. In other words, how much more effective was the traditional talking circle than the conventional Western approach?

To determine the magnitude of this differencae, the next step was to use a measurement of effect size. Evaluators calculated a Cohen's d of 0.7, which means that the traditional talking circle had a moderate sized effect on resiliency compared to the conventional Western approach. Taken together, the statistical significance and the effect size tell a more complete story about the difference between the two intervention approaches.

Here is a great resource for interpreting Cohen's d: http://rpsychologist.com/d3/cohend/

For additional information on how to calculate and interpret effect sizes for your CDEP data, refer to these links below. TAPs may also consult the SWE for assistance in how to calculate such effects.

- How to Select, Calculate, and Interpret Effect Sizes (http://psych.colorado.edu/~willcutt/pdfs/Durlak_2009.pdf)
- Effect Size Calculator (http://www.cem.org/effect-size-calculator)
- Vacha-Haase and Thompson (2005) (http://www2.fiu.edu/~blissl/Effectsizethompson.pdf)

Helpful hint: The basic format for group comparison with effect size is to provide: the size (n) for each sample (e.g., Group 1 n = 100, Group 2 n = 105), mean (M) and standard deviation (SD) for each sample, the statistical value (t or F), degrees freedom (df), significance (p), and confidence interval (CI.95). In general, with this information, an effect size can be calculated from most data..

Create implementation materials, training and support resources. This involves developing things like the following to guide others in the implementation of your CDEP.

- Set up a CDEP training protocol for staff regarding model adherence
- Create training materials as quick reference guides and for use in staff training on implementation of the CDEP
- Develop an ongoing technical support process to assist with staff development and adherence to CDEP procedures
- Establish a plan for assessing CDEP implementation fidelity

Ensure quality assurance and implementation fidelity. It is critical to understand the effectiveness of the EBP itself and the effectiveness of your implementation of the EBP. Also known as program fidelity, this type of analysis allows programs to explore how well their execution of the EBP matches the intended design. The following table provides an overview of the key elements of a fidelity study.

Element	Question	Measurements/Tools
Adherence	Are you delivering your program components in the manner intended?	Ask your local evaluator to directly observe and rate each component of your CDEP for appropriate length, duration, demographic features, timing and/or any other adherence delivery indicators
Dosage	Are participants receiving the right amount of services?	A CDEP that hosts weekly support groups might create an Excel sheet that allows them to track for each participant: # of services offered, # of services attended, length of each service received
Quality	What quality of services are participants receiving?	Administer a brief client satisfaction survey over the phone where clients can provide feedback about the quality of services received from the CDEP
Responsiveness	How engaged are participants in the program services?	Ask your local evaluator to randomly observe your CDEP activities and take notes about how involved, interested, and alert the participants are.
Differentiation	What parts of your program produce certain outcomes? Are your program components different from each other?	Observations, satisfaction surveys, focus groups, and interviews can provide data about the effectiveness of specific program components

EBP Examples

The following hyperlinks:

The following are a few examples of individual, school, and family-based PEI programs.

- Ecological-Based Family Therapy (EBFT): A family systems therapy designed to support positive family connections as well as communication and problem-solving skills (http://www.urban.org/sites/default/files/family-interventions-for-youth-experiencing-or-at-risk-of-homelessness-appendix.pdf)
- HIV Outreach for Parents and Early Adolescents (HOPE) Family Program: A shelter-based preventive intervention designed to decrease youth risk-taking related to HIV infection and mental health (http://www.urban.org/sites/default/files/family-interventions-for-youth-experiencing-or-at-risk-of-homelessness-appendix.pdf)
- Promoting Alternative Thinking Strategies (PATHS): A classroom intervention program for children with behavioral and emotional deficits (http://k12engagement.unl.edu/strategy-briefs/Resources%20for%20Social%20Skills%20Curricula%209-22-2014_0.pdf)
- Strengthening Families Program (SFP): A family skills training program designed to improve parenting skills and family relationships, and reduce problem behaviors, delinquency and alcohol and drug abuse in children (http://www.urban.org/sites/default/files/family-interventions-for-youth-experiencing-or-at-risk-of-homelessness-appendix.pdf)
- Mindful Parenting Groups (MFG): A development-driven, relationship-focused approach to the cultivation of resilient, healthy and secure parent-child bonds among parents, infants, toddlers or preschoolers (http://reflectivecommunities.org/programs/mindful-parenting-groups-mpg/)

Other Helpful Resources

Muñoz, R. F., Ying, Y., Bernal, G., Pérez-Stable, E. J., Sorensen, J. L., Hargreaves, W. A., & ... Miller, L. S. (1995). Prevention of depression with primary care patients: A randomized controlled trial. *American Journal Of Community Psychology*, 23(2), 199-222. doi:10.1007/

Chassin, L., Knight, G., Vargas-Chanes, D., Losoya, S. H., & Naranjo, D. (2009). Substance use treatment outcomes in a sample of male serious juvenile offenders Journal of Substance Abuse Treatment, 36, 183-194. http://dx.doi.org/10.1016/j.jsat.2008.06.001 (http://dx.doi.org/10.1016/j.jsat.2008.06.001)

"Let us put our minds together and see what life we can make for our children."

—Sitting Bull

9. Human Subjects Protection

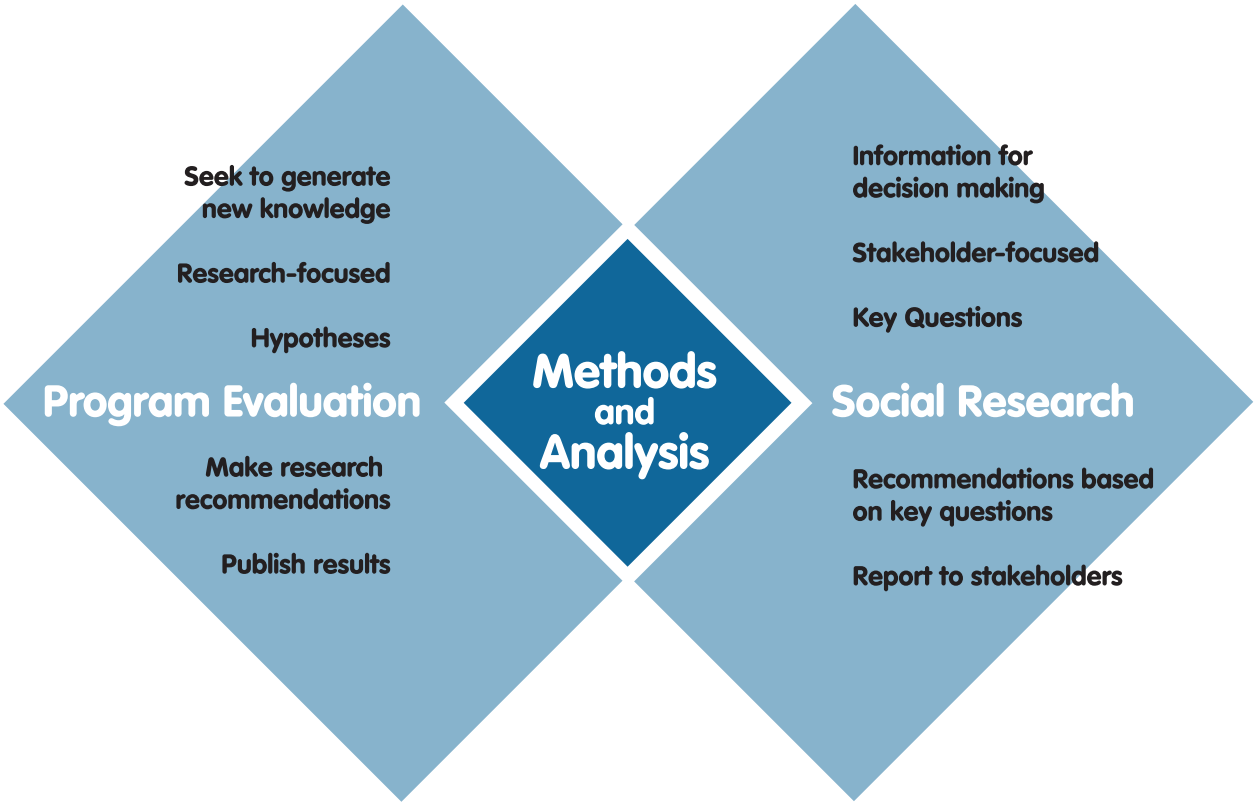
The guidelines and definitions related to "human subjects research" are often vague and unclear, leaving many organizations wondering if their evaluation is considered research, and what steps they should take to protect the privacy of their participants. This section provides IPPs with basic information about what constitutes human subjects research, along with a framework for understanding the types of evaluation research that might require Institutional Review Board (IRB) approval. A set of frequently asked questions and answers to help navigate the IRB application process are also provided.

Research
The Office for Human Research Protections (2016) defines research as "a systematic investigation including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge."

- "Generalizable knowledge" refers to information that can be used to understand a social condition, problem, topic, or population at large.
- "Generalizable" means that the research findings have a broad scope; although the study might have involved a particular group of people, the findings are useful for understanding other groups of people who share similar characteristics or circumstances.

Evaluation
Evaluation refers to the "systematic application of scientific methods to assess the design, implementation, improvement or outcomes of a program" (Rossi & Freeman, 1993; Short, Hennessy, & Campbell, 1996). The information generated from an evaluation is specialized and intentionally focused on informing future program development. In contrast to research findings, evaluation findings are not generalizable to a larger audience, but are specifically tailored to the particular program being evaluated.

Though they use similar methods to meet their intended goals, research and evaluation studies have distinct differences related to their purpose, audience, types of questions asked, and final recommendations and conclusions. These differences are illustrated below.



Defining "Human Subject"

A human subject is "a living individual about whom a research investigator (whether a professional or a student) obtains data through intervention or interaction with the individual or from individually identifiable information." (Office for Human Research Protections, 2017). In simpler terms, you are working with a human subject if you:

- intervene in some way with a person or his/her environment,
- have personal contact or communication with a person, or
- obtain private information (i.e., information that wouldn't normally be observed, recorded, or made public) from someone that is identifiable (i.e., their identity can be connected to the information provided).

Human Subjects Protection

Why the need for human subjects protection? Reflect for a moment on the following historical events.

Indian Health Service: In the 1960s and 1970s, thousands of American Indian women were sterilized without their consent by the Indian Health Service, who was operating under racist assumptions that Native people and people of color were morally, mentally, and socially defective. Most of the women were under the false assumption they were being treated for illnesses such as appendicitis.

Willowbrook Hepatitis Experiment: In the 1960s, scientists purposely injected a group of "mentally retarded" children residing in a New York state hospital with the hepatitis virus as part of a study that examined the causes and treatments for the disease. Their rationale was based on the idea that youth at the facility were highly likely to contract the virus at some point, and it would be beneficial to study their experience under "carefully controlled research conditions".

Tearoom Trade: In the 1960s, a sociologist conducted his dissertation research on the bathroom behaviors of gay men in an effort to combat negative stereotypes held by the public and law enforcement. His methods included stationing himself in public restrooms where sex acts took place and notifying participants if the police were nearby, and showing up to men's homes and obtaining personal information by pretending to be a health service interviewer. Despite his intentions to help the gay community, his research raised concerns about invasion of privacy and participant confidentiality.

The case examples described above provide a powerful rationale for why human subjects protection is needed. Even when programs and researchers perceive themselves as helping the community, it is *unethical and harmful* to involve people in research without their permission. This is particularly true for communities of color who historically have suffered various forms of institutional maltreatment and abuse. The National Research Act of 1974 established the Institutional Research Board (IRB) system as a way of providing oversight for any research involving human subjects.

Additionally, federal guidelines mandate that special considerations must be made when research involves groups who face medical, economic, cognitive, institutional, and/or social vulnerabilities. Special care must be given as a result of their ability to provide consent for themselves, the potential for risk and/or reward in the study, and the potential of coercion. This includes but is not limited to:

- Children (ages 18 and below)
- Veterans
- Incarcerated individuals
- Individuals with cognitive impairments
- Pregnant women

IRB Approval

An IRB is a committee that comes together to review, approve, and monitor research activities involving human subjects. An IRB assures that human subjects research is conducted ethically and in line with federal and institutional requirements. Studies usually require IRB approval if they involve research and human subjects, however certain exceptions to this rule exist. If you are uncertain about whether or not your study requires IRB review, Appendix 7 contains a helpful flow chart to help you think through the process.

How to Obtain IRB Approval

The application process for IRB approval can be lengthy depending on when and where you apply. Upon review, your application may receive immediate approval, or you may be asked to edit and then re-submit your application for final approval. IPPs should work closely with their local evaluator to complete their IRB application process.

> *Helpful hint:* Many of the sections of the IRB application overlap with what you are required to submit in your CDEP Evaluation Plan to CDPH. A carefully delineated evaluation plan prepares you for submission of an IRB application.

IRB boards are usually located within community-based organizations or university settings. The type of IRB you apply to will depend on the type of research or evaluation you are proposing and the populations participating in the research. Be sure to ask your IRB how frequently they review applications, how long the approval is valid, and what type of research they review. This can have a direct impact on the timing of your evaluation and therefore the timetable of your CDEP roll out.

Community-Based IRBs

School districts often have IRB committees available for groups who are conducting research involving students. Their review process can take up to a few months and approvals are valid for a 12 month period only. For example, the Los Angeles Unified School District reviews research applications for studies concerned with

- Improving educational outcomes across all or selected subgroups of students
- Improving the design and delivery of services that promote learning
- Improving the management of the school environment
- Improving parent involvement in education

Non-profit agencies often have IRB committees available for groups who are conducting research with community members. For example

- *Special Service for Groups (SSG)* (API TAP) is an LA based non-profit organization dedicated to providing community-based solutions to social and economic issues including mental health, housing, criminal justice, and substance abuse. Their research and evaluation team accepts IRB applications on a quarterly basis for review. For more information related to applying to SSG's IRB for your IPP evaluation, please visit: www.ssgresearch.org

- *Pacific Institute for Research and Evaluation (PIRE)* (American Indian/Alaska Native TAP) is a nonprofit organization merging scientific knowledge and proven practice to create solutions that improve the health, safety and well-being of individuals, communities, and nations around the world. In collaboration with the Prevention Research Center, PIRE provides IRB review for both academic and community-based research and evaluation studies. More information about their services can be found at http://www.prev.org

- *The California Rural Indian Health Board (CRIHB)* was formed to provide a central focal point in the Indian health field in California for planning, advocacy, funding, training, technical assistance, coordination, fund raising, education, development and for the purpose of promoting unity and formulating common policy on Indian health care issues. The purpose of their IRB is to ensure that the rights and welfare of individuals and communities participating in research are protected which includes reviewing documents and establishing conditions and requirements for approval to ensure that the activities and documents are both culturally sensitive and relevant to the American Indian individuals and communities who participate. https://crihb.org/

University-Based IRBs

- Educational institutions (i.e., colleges and universities) typically have IRB committees that regularly review a range of physical and social science research studies. Generally, one must be a faculty, staff, or student of the university to apply for approval from those IRBs. *Depending on the nature of their evaluation, IPPs may have more difficulty going through a university IRB as a result of this requirement, and may find a community-based IRB to be most fitting for their work.*

Regardless of where the IRB is located, all IRB committees will require some type of application process typically containing the following elements.

- IRB electronic or paper application
- Study proposal document (e.g., study purpose, literature review, methods, strategies for protection of human subjects involved with the study)
- Consent forms
- Recruitment materials (e.g., outreach scripts)
- Data collection instruments (e.g., surveys, interview questions, etc.)
- Research personnel list for study
- Letters of support

FAQs

1. How do I know if my human subject research is "Exempt?"

Exempt research is based on a study that is low risk to the participant, and generally has a faster response time from the IRB. An example of exempt research is an anonymous survey, either online or on paper, with no identifying data (e.g., name, date of birth, address). Guidance from your local evaluator and TAP can help you determine whether your study meets criteria for being "exempt" from IRB approval.

2. If I want to do research at a local school, what is the procedure for obtaining consent?

Generally, you must obtain the consent from the following individuals

- The Administrator of the school district where the research is to be performed
- The Principal of the school where the research is to be performed
- The Teacher(s)
- The Parent(s)/Legal Guardian(s)—"Informed Consent" written at a 6th grade reading level
- The child—"Assent" written to the child's level of understanding

3. If my intervention is working with vulnerable populations or sensitive topics, will it take longer for approval?

Generally yes. It is customary to allow an IRB at least 30 days to consider an application. When vulnerable populations and/or research with sensitive topics are involved, it often takes longer than the standard time frame for an application to move through the approval process. Sometimes these projects are deemed as "full board review," and can take up to 8 weeks or longer to be considered, so plan accordingly!

4. Do I have to keep my subjects' identities confidential?

Protection of your participants' privacy is of utmost importance. There are varieties of ways to do this, such as assigning identification numbers or pseudonyms to participants. Researchers must generally keep electronic and paper documents secure as well, for example in a locked file cabinet or a password-protected electronic file. However, some research projects can't be conducted without revealing subjects' identities. In these situations, you must fully explain and justify this need for the purposes of your research (i.e., using photos and names simply to enhance the entertainment value of a public presentation would not, in most cases, be allowed). Subjects must consent to have this information made public. If the project involves collecting sensitive information, the IRB will generally weigh the risk of making this information public against the value of your research project, and determine whether the benefits of doing the study outweighs the risk of harm.

5. Is there a difference between confidentiality and anonymity?

Confidentiality means having knowledge of the participants, directly or indirectly, and not being allowed to identify the participants or attribute private or restricted information about a participant. Thus, the researcher is able to correlate data with a specific participant; however, this correlation is never revealed to anyone outside of the research team. Most research is of a confidential nature.

Anonymity means that the researchers cannot ever identify participants. Thus, the researcher, at any point in the research, is unable to correlate the data with a specific participant.

"We're all human, aren't we?
Every human life is worth
the same, and worth saving."

—J.K. Rowling

10. Developing A Business Case

IPPs are required to develop a business case for their CDEP to document its "return on investment." This section provides a general overview of what a business case is and what information is needed to establish your business case.

Introduction to the Business Case

A business case measures the cost effectiveness of your CDEP—the "value added." It answers two main questions.

- What are the benefits and costs of your CDEP?
- How does your CDEP compare to similar programs in some other hypothetical scenario?

The process for establishing the business case involves the following steps.

Step One. The business case gives number values to all the positive benefits that emerge from your CDEP programs, services, and/or activities. It considers all the IPP costs to provide these services, programs, and activities. As part of your CDEP evaluation plan, you will be collecting most of the data to help answer: 1) what are the benefits (which you will assess through your outcomes) and 2) what are the costs (which for many sites may simply be your operating budget).

Second Two. Once you have an analysis of all the benefits relative to the costs, you can compare this cost-benefit picture to what would have happened if, for instance, there were no programs in place, or, if a different type of program had been in place. The SWE will be responsible for the second part. PARC@LMU will gather the information needed for comparison between the cost-benefit picture for your CDEP to two different "what if" scenarios.

- Populations NOT receiving services (counterfactual group #1)
- Populations receiving traditional PEI services (counterfactual group #2)

This comparison of your CDEP's cost-benefit picture to that of these "counterfactual" groups provides a theoretical financial assessment that will help contextualize the benefits resulting from your CDEP. The intent of the business case is to fully capture the implications of these programs for the well-being of the community so that decision makers can have as complete a picture as possible.

Doing a *Business Case* Differently

In creating the CRDP business case, we want to make sure that the community gets to have their say in answering this question ("What was the return on investment?"). So, in order to do this, we need to find out from each IPP, out of all the outcomes you measure, which represent the most important and valued benefits for your community? Some benefits are so positive and valuable to a community that even if they cost a lot, your community might be very clear that the costs are worth it. This is critical for CDPH (as well as other potential funders) to know. Your IPP business case not only provides the cost and benefit information for your CDEP-related activities, it will also provide information about what benefits are viewed as most valuable for your community which may have implications for future funding and programs.

The business case will attempt to evaluate the effectiveness of the program from the point of view of the priority populations. This is part of doing business differently. Rather than assume that all people value aspects of mental and community health the same, we want to ensure that the measures of effectiveness are community-based and culturally responsive. Thus, it will be important to not only assess what was accomplished, but also what the community values.

Why the Business Case is Important

Money does not grow on trees, and even politicians want to make sure that taxpayers' money is well spent. If done correctly, the business case will be able to demonstrate the effectiveness of the CDEPs to anyone who might be skeptical.

A poorly done business case may either fail to represent just how valuable your CDEP is, or may raise additional doubts about its validity.

Making the Case
If you are nervous about evaluating the business case for your own CDEP, don't worry. We, at PARC@LMU, are here to help. Here are the parts to creating your business case:

The business case does not require extra data collection on your part. The information you need to put together your business case is already included in the data collection plan. Specifically, the data that all sites will be asked to collect as part of the SWE will be used to create aggregate measures of mental health for IPPs. As a reminder, the SWE Core Outcome Questionnaire Items include the following:

1. Access and Utilization
2. Barriers to Help-Seeking and Stigma/Discrimination
3. Psychological Distress
4. Sheehan Disability Scale
5. Social Isolation and Marginalization
6. Subjective Spirituality & Religiosity
7. Spiritual Wellness
8. Community/Social Connectedness
9. Cultural Connectedness
10. Health (optional)

As part of your CDEP evaluation, you will also select additional mental health and other outcome measures. You already are planning on how you want to evaluate progress in these measures. Such site-specific outcomes could include some of the issues that you identified as important issues in your initial grant applications, for instance: stigma, poor health, suicide, social exclusion/isolation, in school behavioral problems (youth), substance abuse, community violence, discrimination, homelessness, family problems, adult criminal justice involvement, prolonged suffering, youth criminal justice involvement, domestic violence, unemployment, child welfare system, education inequality, non-help-seeking, and poverty.

PARC@LMU will help you convert changes in mental and community health into dollar values. Once you have your outcomes measured at the end of data collection, we will provide you with the "conversion rates" or formulas you will need to transform your outcomes into the "cost-benefit" figures you need for your business case. **The conversion rate that PARC@LMU works out for you, will be different for each IPP, because it will take into account the values and priorities of your community**. That is, what your community members regard as the most important, valued outcomes for themselves are weighted more heavily, and so will be reflected in your particular conversion rate.

As the data are collected, PARC@LMU will be able to make preliminary estimates of the dollar value of each of the SWE Core Outcome Measures that are assessed across all IPPs. This way, if you notice a significant decrease in psychological distress for 50 people, for instance, and the SWE estimates that this is worth $20,000 per person, then that service provided $1 million dollars in benefit for that result alone.

You do not need to turn in receipts for the business case. The aggregate numbers you report to CDPH will include costs data. This will simply be your operating budget. For IPPs that provide multiple types of programs/services, it would be helpful to assess roughly what percent of the effort was spent on CDEPs and then divide the total costs appropriately.

Business Case Example
You will be given an Excel spreadsheet that will resemble the table below. The numbers listed below are completely arbitrary and are just used to illustrate an example.

Common Mental Health Outcomes	Pre	Post	People	Value	Benefit
Psychological Distress (K6)	5.28	6.01	200	$8,249	$1,216,095
Sheehan Disability Scale (SDS)	3.53	9.47	200	$6,883	$8,177,749
Social Isolation and Marginalization	8.76	5.77	200	$6,200	-$3,706,858
Subjective Spirituality & Religiosity	2.01	8.53	200	$4,490	$5,852,949
Spiritual Wellness	4.53	4.90	200	$4,684	$346,244
Community/Social Connectedness	4.23	8.10	200	$8,118	$6,274,716
Cultural Connectedness	3.04	10.00	200	$9,623	$13,396,903
Health	6.20	8.57	200	$4,397	$2,083,725
Site-Specific Outcomes					
Stigma	4.69	8.70	200	$3,896	$3,124,451
Suicide	6.49	5.24	200	$6,879	-$1,720,783
Substance Abuse	5.54	8.10	200	$9,251	$4,736,601
Total					$39,781,790

Tips for Reading & Using the Spreadsheet

1. The only data you will need to provide to PARC@LMU will be site-specific out comes from your CDEP evaluation.

2. The "Pre" column measures baseline values (i.e., prior to CDEP intervention) for each of the outcomes of interest averaged across participants, while the "Post" column measures the values at the end of the intervention. In this example, there was a big increase in the level of "cultural connectedness" for CDEP participants from baseline to the end of the program.

3. The "People" column simply tracks how many participants were served by the CDEP.

4. The "Value" column will be calculated by PARC@LMU and provided to you. Again, these numbers will be site-specific to represent the community-identified priority values. In this example, all of the values are listed as positive because it is assuming the categories are coded such that a higher value is better. In the case that a lower number is better (such as if suicides were measured as number per year), then that value number would be negative.

5. The final column, "Benefit," is calculated by taking the change in each outcome multiplied by the number of people served multiplied by the value of that outcome. This yields an estimate of the net benefit achieved in that category. Note that it is OK that some of the numbers are negative. It makes sense that sometimes measures will decline. Keep in mind, the gains may far exceed the losses.

6. PARC@LMU will also be working with this data to ask other counterfactual questions. If we did see a worsening of the substance abuse rate in a community, did this reflect a wider trend? Is it possible that the IPP was effective in making sure that substance abuse did not go up even more given a local shift in policies related to alcohol availability?

Remember, this is a long term collaborative process. You are not alone. If you run into trouble, the TAPs and PARC@LMU are here to help.

“Write what should not be forgotten.”

— Isabel Allende

11. IPP Evaluation Plan Instructions

CDPH requires grantees to submit an evaluation plan for their CDEP. A strong evaluation plan is the foundation of a successful evaluation. When thoughtfully developed, it provides a roadmap for every step of your evaluation. Grantees will use the IPP Local Evaluation Plan Template (found in Qualtrics) to complete and submit their required evaluation plan to CDPH.

IPP Evaluation Plan Submission

IPPs can submit their Evaluation Plan Templates Using the personalized link from **PARC**. IPPs will submit their evaluation plan no later than **May 26th, 2017** and will receive written feedback from PARC@LMU within about 4-6 weeks of submission.

IPPs will have an opportunity to receive Technical Assistance from their TAP and PARC@LMU before receiving final approval of their evaluation plan by CDPH. Even with final approval, CDPH recognizes that evaluation plans may continue to evolve and be revised/updated in order to meet local circumstances and needs.

This section will cover:

- Technical instructions for opening and submitting your local evaluation plan using the Qualtrics template.
- Guidance for completing the different sections of the template. Additionally, examples and helpful hints/questions are provided to assist you with thinking through what should be included in each section.

If you need any technical assistance with Qualtrics or guidance with completing the template, please contact:

Diane Terry, Ph.D.,
Project Coordinator
310.338.7095
diane.terry@lmu.edu

IPPs can submit their Evaluation Plan Templates

**Using the personalized link from PARC.
IPPs will submit their evaluation plan no later than
May 26th, 2017 and will receive written feedback
from PARC@LMU within about 4–6 weeks of submission.**

Technical Instructions

System Requirements

The Qualtrics link can be opened on most major web browsers (Internet Explorer, Mozilla Firefox, Google Chrome, Safari). The template can also be opened on smart mobile devices, but it will be more prone to errors. Avoid completing the Qualtrics template on mobile devices if possible.

Opening the Template

To complete the template, simply click on the link provided to you from PARC.

Navigating the Template

Qulatrics is user-friendly.

- The "Next" button allows you to move forward to subsequent sections.
- The "Back" button allows you to easily return to previous sections.
- A progress bar at the bottom of the page will show your progress in the completion of your template.

Saving and Closing Your Work

Qualtrics will automatically save any text that is entered once you click the "Next" button. If you are unable to complete the template in one sitting, follow the instructions below:

Closing and Re-Opening a Partially Completed Template

- Make sure that Qualtrics cookies are enabled on your browser so that partial data you have entered may be saved. The method for enabling cookies will depend on which browser you are using. Contact your IT Department if you are unsure or need help determining if cookies are already enabled.
- If you have partially completed the template and you want to close out and return to it at a later point in time, make sure you click the "Next" button to ensure that any text you have entered is saved.
- To resume filling out the template, you can click on the link provided to you from PARC to return to where you left off.

Submitting the Evaluation Plan

As you get to the end of the template, you will see an "alert" signaling that you have completed the template with a query asking if you are ready to print and submit. We recommend that you print a copy of your completed evaluation plan for your records. Once you click the "Next" button on this screen, your evaluation plan will be officially submitted. PARC will send you a confirmation email upon submission of your template. We recommend printing and/or saving your confirmation email for your records as well.

Once the template has been submitted, you cannot go back to make changes or finish incomplete sections. If you re-open the link, you will notice that the entire template is blank. If you need to change/revise any section(s) of your template, please contact Dr. Diane Terry at PARC@LMU.

Printing Your Evaluation Plan

After you have submitted your evaluation plan, you will be able to view a summary report of your responses and you will have the option to print and/or save your template as a PDF. We recommend printing and/or saving your evaluation plan for your records.

Guidance for Completing the Template

Template Overview

- The Cube (Section 7) provides a framework for how to think about, organize, and describe much of the information to be addressed in the evaluation plan. Working through the Cube with project staff, the evaluator, and community stakeholders prior to writing the evaluation plan will provide the details and nuance to capture the unique cultural, programmatic, and contextual features of your CDEP.

Did you?:

- ☐ Describe how the principles of CBPR will be incorporated in the design, implementation, and dissemination of your evaluation plan and findings?
- ☐ Address how context, culture, and language are reflected across the different elements of your evaluation plan?

IPP General Information

This section requests information about the primary contact persons for your CDEP and the type of technical assistance and support you may want from PARC@LMU.

IPP Organization Name and CDEP Name: Provide the names of your IPP and CDEP.

Priority Population: Select which CRDP Phase 2 priority population your CDEP belongs to.

IPP Contact Information: Provide name, title, email address, and phone number for primary contact person(s) responsible for your CDEP.

IPP Local Evaluator Contact Information: Provide name, email address, and phone number for primary contact person(s).

Introduction

Here you will establish the context for your CDEP by summarizing the problem your project is addressing.

- Identify the mental health problem(s) the CDEP is trying to address (i.e., magnitude, causes, and trends of the issue).
- Discuss relevant literature; administrative data (e.g., county crime or education data); White Papers produced by organizations, funders, state, federal, and other sources; community focus group, mapping, or needs assessment data, etc.
- Describe how the problems are understood a) in a historical context, b) through

the lens of the community's values, c) through community practices, and d) things that concern or bother the community.

CDEP Purpose
Your CDEP purpose statement (no more than 3-4 sentences) should reflect: a) CDPH defined CDEP goals to prevent and/or reduce the severity of selected mental health conditions, b) desired outcomes that are of importance to your community from a cultural perspective, and c) CDEP relationship to Phase I priority population strategies. Be specific, precise, clear, and goal oriented with desired outcomes that logically connect to the purpose of your CDEP.

A mini-template and example are provided below to help you construct your statement.

Purpose Statement: The [insert name of CDEP] is a [insert program type—i.e., prevention and/or early intervention program] that aims to prevent and/or reduce [insert mental health issue(s) or problem(s)] for [insert specific priority and/or sub-populations] by decreasing [insert outcomes(s)] and/or increasing [insert outcome(s)]. It is

Example:

The "Storytellers" intervention is a prevention program that aims to prevent depressive symptoms among children of depressed parents for Mexican immigrant families by decreasing internalizing behaviors in the child, increasing resilience in the child and improving family functioning. This CDEP is designed to address the following Phase I priority population strategy: family psycho-educational curricula as a means to increase family and extended family involvement and promote health and wellness.

**For those pursuing EBP only:*
Previous CDEP Evaluation Results: If your CDEP was previously piloted and evaluated, briefly describe evaluation results and cite any published literature on your CDEP.

CDEP Description
This section requests information about the specific type of PEI program to be evaluated and detailed information (including cultural, linguistic, and contextual nuances) about your CDEP and priority population. Helpful questions and examples are also provided.

Helpful Questions:

- How does your CDEP reflect the needs of the priority population, cultural values, and issue(s)?
- What are the roles of CDEP-specific staff and how are they connected to the priority population and/or community?
- What community partners will be involved in CDEP implementation (collaborations, networks, etc.?) and how are they connected to the priority population and/or community?
- How will the community be involved in its implementation and how does their involvement reflect the cultural values, linguistic needs, and key issue(s) of your priority population(s)?
- How does the CDEP facilitate cultural, geographic, physical, and/or linguistic access to the CDEP for your priority population?
- How do the physical characteristics of the setting reflect the community's cultural values and priority issues?

- What resources are available within this setting (for example: characteristics of physical space, time, technology, staff and/or partners, other?)
- What types of evidence do you have to support your CDEP (for example: literature, articles, formal reports, cultural wisdom)?

Type of MHSA PEI Program(s)/Strategy(s): Type of MHSA PEI Program(s)/Strategy(s): Select which program(s) or strategy(ies) best describes your CDEP (e.g., direct, indirect).

Level of Intervention: Indicate at what level your CDEP is attempting to reduce mental health disparities (e.g., community-focused, systems focused, individual focused).

Number of Program Cycles: Here you will identify whether or not your CDEP has continuous and/or multiple cycles.

For multiple program cycles: Provide the following information:
- Number of program cycles you plan to offer during the grant period
- Number of participants per program cycle
- Anticipated start date for cycle 1
- Anticipated end date for cycle 1
- Length of each cycle (e.g., 6 weeks, 6 months)

CDEP Components: In this section, you will provide detailed information for EACH of the individual components/elements/strategies that make up your CDEP:
- Component name (e.g., A Family Session, Access and Linkages)
- Component description: duration (e.g, 3 week CDEP); # of activities (e.g., 6 activities in total); frequency (e.g., 2 times per week); and length of activities (e.g., 3 hours for each activity); number of participants; participant demographic features; setting (geographic/physical location); who is implementing the CDEP and how; the timing of each component, and if applicable, their relationship to each other (e.g., if they are in sequential order and/or build on previous components). Be sure to describe how your CDEP reflects the cultural values, practices, and beliefs of your community. When possible, provide relevant citations. *Remember the Cube. It should help ensure that you capture the cultural/linguistic/contextual depth and rich features of your CDEP and priority population.*

- "Core" and "Optional" Elements: "Core" elements are indispensable to your CDEP components—they embody the theory, internal logic, and core values of your intervention and most likely produce the intervention's main effects (Kelly et al., 2000; McKleroy et al., 2006). The core elements are what make your program "work." (In other words, if you don't add cream to your macaroni and cheese, you don't have southern style mac and cheese.)

  "Optional" elements are discretionary, meaning they can be deleted or changed without having an impact on the desired outcome. Simply, while important, these elements are not as strongly related to your intervention's positive outcomes. (For example, paprika is optional – some like it, some don't…but the dish is still southern style mac and cheese.)

  Component #2 as an example, the warm hand-off is a "core" element while meeting on a Saturday morning is an optional element.

CDEP Components Example #1

Component #1: Group Sessions with Parents—Platicas
Four psychoeducation group sessions (1.5 hours each) will be conducted with 12 Mexican farmworker parents. Sessions will be focused on: 1) providing information about depression and serious mood disorders, and 2) uncovering culturally-based coping strategies (family and community strengths and resources) specific to and across parents through the use of "Dichos" (i.e., proverbs and sayings that capture wisdom). A Latino staff counselor and a peer parent counselor (who is Spanish language dominant of Mexican origin) will co-facilitate the group in Spanish, and will also self-disclose about their own cultural heritage, education, and experience in working with Latino children and families. This cultural exchange process results in a greater integration between the ethnic culture of the families and the psychoeducational knowledge base of the counselor. All sessions will be held on Saturdays in a private room at the Community Center. The room has couches and cultural artifacts on the walls. Coffee (cafecito) and light snacks will be available.

Component #2: Group Sessions with Children—Cuentitos
Four group sessions (1.5 hours each) will be conducted with elementary aged children (6 to 8 years of aged) of the parent participants simultaneously as the Platicas. Sessions will be focused on reading cuentos (i.e., Mexican folktales) to the children and discussing the life lessons through various activities. The cuentos will feature characters with similar family experiences and attributes to those of the child. This trauma-reduction approach has been found to reduce symptoms of anxiety and depression in children (Altarriba and Santiago-Rivera, 1994). One to two Latino college-aged staff counselors (who are both English and Spanish language dominant and of Mexican origin) will guide the children to: share the meaning of the tales with each other, role play the characters in the stories, and discuss the relationship of the role-play to their personal lives. Depending on the number of child participants, either 1 to 2 groups will be conducted with no more than 6 children per group. All sessions will be held on Saturdays in a private room(s) at the Community Center. The room has toys, books, drawing board, and kid friendly art on the walls. Juice and light snacks will be available.

Three sessions (1 hour each) will be held with each family (parent and child) after the Platicas and Cuentitos sessions are over. This phase is meant to gain and build family trust, cooperation, rapport, and cohesion between the parent and child. The insights gained from the psychoeducational sessions with parents will be used by the counselor to help the family build on and encourage the use of existing cultural resources/supports during times of stress. Although family discussions will be held about parental depression (i.e., with help from the counselor, parents talk about their depression, possible culturally inferred origins—spiritual elements—and answer questions from their children), the focus will be on recognizing the parent's/family's cultural strengths (protective factors). This will assist with replacing the imagery of parent mental illness/deficits with one of strength and resilience. All sessions will be held in the participating family's home at a day and hour that is most convenient.

CDEP Components Example #2

Component #1: Client Assessment—A one-hour family needs assessment will be conducted with 50 Cambodian relative caregiver grandparents. The assessment will be used to identify 1) mental health needs within the family; and 2) needs in other domains relevant to mental health including physical health, child development, and basic living needs. Efforts are made throughout the assessment process to honor aspects of Cambodian culture including values, practices, beliefs, and historical experiences. For example, the first section of the assessment tool provides space for participants to identify family strengths, spiritual beliefs, and cultural practices. Additionally, caregivers are encouraged to provide an oral account of their family's history including historical and current trauma experiences related to immigration and the acculturation processes. All assessments are conducted by CDEP staff who are also Cambodian or who have a deep understanding of Cambodian culture. Sessions are held in the language of choice of the grandparents, and are conducted in a recreation room at the IPP agency. Various cultural and spiritual elements are utilized throughout the assessment including prayer and meditation exercises conducted at the beginning and end of each session.

Component #2: Access and Linkages—The Saturday morning following their assessment, participants are invited back to the IPP agency to discuss a family action plan. This plan includes tailored services and supports to help ensure that each family's unique needs are met. Participants are given specialized referrals to highest need services including 1) the name of the agency providing the service; 2) specific contact person at the agency who will be expecting the participants' call; and 3) the best time of day to call. Providing this specific referral detail results in a "warm hand-off" where participants are directly linked to a service provider who is already familiar with the family and their needs, and is committed to providing them with services that are timely and meaningful (Richter et al., 2009). Referrals will not be considered "activated" until the warm hand-off has occurred. The family meeting is held in the same recreation room at the IPP agency where the client assessment took place. Immediately following the meeting, participants are invited to eat breakfast and socialize with other relative caregivers, and/or to participate in any of the Cambodian arts/crafts/music and dance classes held at the IPP agency that day. In line with the collectivist nature of the Cambodian culture, the goal of these activities is to promote a sense of community, family, and support amongst CDEP participants.

Component #3: Peer Navigator—All 50 participants will be assigned to a "Peer Navigator" – a seasoned relative caregiver who is knowledgeable about the challenges related to kinship care and can: 1) assist participants with navigating the mental health system and accessing services they were referred to; 2) provide ongoing peer and emotional support via weekly phone calls and in-person visits at the participants' homes; and 3) provide practical forms of assistance such as giving rides to appointments. All Peer Navigators are Cambodian and will be able to demonstrate sensitivity to the cultural/linguistic/historical experiences of the participants. Peer Navigators will have weekly contact with participants until their case is closed (approximately 6 weeks).

Evaluation Questions and Measures

Here you will list your evaluation focus, questions, indicators, and measures, including whether you plan to submit for an EBP. Below are a few helpful hints and examples about how to complete this section.

Helpful hints:

- Evaluation questions lay the foundation for the findings you will share that inform the community-defined evidence base and/or contribute to program improvement. Answering your evaluation questions will allow you to demonstrate your program's merit, worth, and significance. Take the time to ensure you are asking the right questions for your CDEP.
- Outcome evaluation questions address the impact of your CDEP on specific positive and negative mental health outcomes.
- Evaluation indicators and measures can reflect mental health risks and protective factors either at the individual, family, systems, or community level. Culturally-anchored evaluation questions and outcome indicators reflect the community's values and perspectives on expected outcomes of a successful program.
- The instruments selected should respect and respond to the cultural values and priorities of the community.
- Having multiple indicators for each evaluation question will provide more complete evidence and an accurate picture of program impact.
- Process evaluation questions address how program activities were delivered. This provides information about how closely the intervention was implemented as planned and how well it reached the priority population. It will be important to decide what process evaluation questions are most pertinent to your CDEP to avoid overcommitting yourself to too many process evaluation tasks.
- If you plan to use any of the SWE core measures for your local evaluation, include the name of the SWE core measure.

EBP Status: Indicate if you plan to submit your CDEP to a nationally-recognized registry for evidence-based practices (e.g., SAMHSA's National Registry of Evidence-Based Programs and Practices).

Evaluation Focus: Your CDEP may encompass multiple programs or strategies. Keep in mind that you may not be able to evaluate all of them and may need to prioritize which ones are most important and feasible to evaluate. Your TAP along with PARC@LMU will be available to consult with you about if/what aspects of your CDEP should be prioritized in your local evaluation.

☐ List which program and/or strategy(s) will be the focus of your CDEP evaluation.

Evaluation Questions, Indicators and Measures: Please list each of your evaluation questions. Make sure to include both process and outcome evaluation questions. You will be prompted to list a) one or more process or outcome indicators that may need to be measured to address each question, b) your instruments, and/or c) the data sources. They can include observations, surveys/questionnaires, interviews, focus groups, administrative/secondary data (e.g., county/neighborhood crime rates, substance use arrests), other records review, etc. Describe any new instruments developed and/or modifications or adaptions made to any established original instruments to make them culturally/linguistically appropriate for your priority population. The following table provides a brief example of how this information (Evaluation Questions, Indicators and Measures) could be reported.

Please include available instruments as attachments to your Qualtrics template when you submit your evaluation plan to PARC@LMU; drafts are acceptable.

Evaluation Questions, Indicators and Measures Example

Evaluation Questions (please indicate whether it is process or outcome)	Indicators	What instruments/data sources will be used to measure your key indicators? Provide a brief description.	New instruments or modifications to existing instruments due to cultural/linguistic considerations
To what extent did youth's personal resilience and self-concept change? (Outcome)	#1: Peer problems #2: Overall resilience #3: Adherence to cultural practices, values & beliefs #4: Involvement in meaningful social justice experiences	#1: Peer Problems Subscale from the Strengths and Difficulties Questionnaire (SDQ); Solantaus et al. (2010); youth and parent self- report #2: Child and Youth Resilience Measure (CYRM-28); youth version; youth self-report #3: Modified Phinney MEIM Scale; Phinney and Rotherman (2016) #3 and 4: Focus group with youth; data used for instrument development by IPP evaluator and youth members	#2: Child and Youth Resilience Measure (CYRM-28): A focus group with LGBTQ youth in the community was held to create the 10 site-specific items that make up Section B of the tool. The final items represent specific challenges and coping strategies relevant to LGBTQ youth #3: 6 culture specific items added to Phinney MEIM to reflect local cultural traditions related to family, spirituality, and community responsibility of the primary ethnocultural groups reflected in our CDEP #3-#4: Focus group protocol developed by IPP evaluator and IPP LGBTQ youth members
To what extent was the CDEP implemented as designed in the priority community? (Process)	#1: Number, type, and frequency of youth participation #2: Number and type of outreach/recruitment conducted	#1: Sign in sheets with demographics and activity codes #2: Outreach/recruitment sheets	All sign-in sheets will be translated into the languages spoken by our CDEP participants including Spanish and Thai

Evaluation Design

Now you will describe your overall evaluation design and how CBPR contributed to its design and implementation.

Evaluation Design: Identify the type of evaluation design and methods you will be using (e.g., qualitative, quantitative, mixed methods); and, if applicable, a description of the control group (e.g., procedures for random assignment, random selection, and demographic similarities); if applicable, description and selection of comparison group (e.g., demographic similarities); and whether you will collect data from the same individuals over time or from independent samples at each time point; if applicable, description of qualitative design

Community Based Participatory Research: Describe how your priority population has or will assist with the design and implementation of this evaluation plan. Examples include community members serving on planning team or as external reviewers, assisting with collecting data, interpreting findings, receiving results, etc.

Intersectional Approach: Describe how your local evaluation will incorporate issues of intersectionality.

Sampling Plan
In this section, list the sub-populations that will be represented in your local evaluation, the sample size, sampling method, use of power analysis, and recruitment plan. Helpful links are provided.

Evaluation Sub-populations: Describe the sub-populations (i.e., subset of your population that shares one or more additional characteristics such as 9th and 11th grade LGBTQ youth; out of school LGBTQ youth etc.) that will be represented in your evaluation sample. Above and beyond your CRDP Phase II Priority Population, make sure to describe intersectional sub-populations that will participate in your CDEP.

Evaluation Sample Size: Indicate your intended sample size. If you have program cycles, list the intended sample size for each cycle.

Sampling Method: Select the type of sampling method (probability or non-probability), its associated technique, and your rationale/reasoning for using that technique. If you selected more than one sampling technique, please indicate the rationale for each and note which program/strategy it is associated with. Also note any limitations to your sampling technique(s).

Power Analysis: Indicate if a power analysis was conducted and indicate if your sample size is sufficiently powered; if applicable, explain why your sample is not sufficiently powered.

Helpful hint:
- Power analysis is a calculation to determine the size of a sample needed to reach a statistically significant result at a given effect size (Rosenthal & Rosnow, 1991). There are many online power analysis calculators that can help determine an appropriate sample size for various research designs (e.g., www.powerandsamplesize.com; www.statpages.info/index.html). Consider the benefits of a power analysis to help you think through decisions about your sample.

Recruitment/Retention Plan: Describe how you will recruit and retain participants in the evaluation (including comparison/control group, if applicable). Please include CBPR approach and other cultural/linguistic recruitment strategies.

Data Collection Plan

Here you will describe the data collection plan for each of your instruments/data sources including such details as the name of your instruments or data sources, timing of data collection, the protocol, data storage etc. An example of how to complete this section is also provided.

Name of Instrument(s)/Data Source(s): List out your instruments/data sources. If more than one instrument has the same data collection plan, list all of these instruments/data sources together and complete the required information once only. If some instruments/data sources have different data collection plans, list them separately and complete the required information separately.

Timing for Data Collection: The timing of data collection may differ for some of your instruments and data sources. Describe the timing of data collection for each of them. For example, quantitative instruments might be administered before (pre) and after (post) your CDEP intervention. A direct observation might occur repeatedly throughout the program. Case management records and/or attendance rosters might be collected daily, weekly, or monthly. Satisfaction surveys might be collected at the end of the program (post). Census data, vital statistics from local health departments, and school data might be collected annually or semi-annually, etc.

Data Collection Protocol: Describe how the data will be collected (e.g., self-administered vs. administered, in-person vs. online, archival data downloaded from public data set or provided via email, etc.) and from whom (e.g., CDEP participants, CDEP staff, county health department, etc.); who will administer or collect the data (e.g., frontline staff, evaluator, etc.) and if applicable, how long will it take to administer.

Data Storage/Security Plan: Indicate what data security measures will be taken to ensure the safe handling and storage of your data. Your plan should address who has access to the data, whether electronic or hard copies will be kept, where data will be stored, and what types of protections will be in place (e.g., hard copies are stored in a locked filing system, electronic copies are password protected/encrypted, etc.). Additionally, describe what procedures are in place to protect confidentiality of participants.

Training of Data Collection Team: Supervisors, team leaders, staff, and evaluators should receive different training, tailored to their roles in the data collection process. Describe how you will train data collectors to ensure data are collected accurately and reliably.

After completing the required information, please upload established or newly developed instruments and/or tools described in this section.

Data Collection Plan

Name of Instrument/ Data Source	Timing of Data Collection	Data Collection Protocol	Data Storage/ Security	Training
1. Columbia-Suicide Severity Rating Scale (C-SSRS) 2. Patient Health Questionnaire (PHQ-9) 3. Alcohol Use Disorders Identification Test (AUDIT	Pre and Post	Pre- and post-assessments will be completed (self-administered, paper/pencil, 20 minutes in total) by CDEP participants in a group setting at the Community Center, within 1 week of program intake. Frontline staff will welcome participants and provide information about the assessment purpose and content, and instructions for completing the tool. Participants will have an opportunity to ask questions and provide their verbal or written consent to participate in the evaluation. Staff will be available during the assessment to answer any questions that arise. Participants will return to the Community Center within 1 week of program completion to do the post-assessment (self-administered, paper/pencil, 20 minutes in total). Frontline staff will remind participants of the purpose of the assessment and provide instructions for completion.	Assessment data will be input to Microsoft Excel. Assessments will be tracked with a unique client identifier rather than by respondent name (e.g. initials + last 4 digits of phone number). All hard-copy surveys will be stored in a locked cabinet in the data analyst's office to which only select IPP personnel will have access.	All CDEP staff regardless of their role in data collection will participate in a comprehensive training detailing 1) the purpose of the evaluation; 2) data collection protocols; 3) frequently asked participant questions that can arise during survey administration; and 4) the proper procedures for the handling and storage of the surveys once they've been collected. During the training, staff will have an opportunity to practice administering and taking the survey so they can troubleshoot any potential administration challenges.
4. Focus Group	Within two weeks of the program start	The CDEP evaluator will facilitate two separate focus groups with newly enrolled CDEP participants in a private room at the IPP facility. Hand held tape recorders will be used to audio record the focus group discussion. An additional staff member will be present to take hand written notes. Before the group starts, the evaluator will explain the purpose of the focus group and shared agreements for participation. Focus groups should take about 1 hour each.	All audio recordings will be transcribed and merged with the handwritten notes. Afterwards, the recordings and notes will be stored in a locked cabinet in the evaluator's office. Pseudonyms will be used in any written reports generated from the focus group findings.	The evaluator has over 15 years of qualitative data collection experience, including the facilitation of focus groups. The evaluator will train the staff member on how to take notes during the focus group discussion.
5. Program Records (attendance rosters)	Monthly	Frontline staff who facilitate the monthly group sessions will ask attendees to sign-in at each session. The sign-in sheet will include participants' names, phone number, and date and time of the event. Monthly CDEP meetings last about 1.5 hours each.	The attendance sheets will be stored in a locked cabinet in the IPP office to which only key staff will have access.	All frontline staff that facilitate monthly CDEP meetings will be trained on the importance of consistent and complete gathering and filing of attendance data. The evaluator will periodically review the sign-in sheets to ensure they are being filled out properly.
6. Death Statistical Data Tables	Annually	Data tables will be retrieved from the CDPH website.	All data files will be stored on the evaluator's password protected computer.	The evaluator has 6 years of quantitative data training, with specific expertise in secondary data analysis.

Informed Consent and Confidentiality

In this section, explain the informed consent procedures that will be used in your evaluation and whether IRB approval is needed.

Informed Consent: Describe your informed consent procedures (e.g., how written informed consent/assent will be obtained; if consent is needed from parents, legal guardians, etc.).

IRB Approval: Indicate whether your evaluation plan requires IRB approval, where you will be submitting, and your status in the submission/approval process. If applicable, explain why you are unsure if your evaluation requires IRB approval.

Data Analysis Plan

Describe your data analysis plan for all of the evaluation questions by describing descriptive and inferential analyses to be conducted and/or qualitative data analysis procedures.

Fidelity Assessment

In this section, you will describe methods to assess the degree to which your CDEP is implemented with fidelity—the extent to which the delivery of your project/program adheres to the protocols that were originally put in place.

Fidelity Dimension: Fidelity is often examined across at least five dimensions: adherence, exposure, quality of delivery, participant responsiveness, and program differentiation. Indicate which dimensions you will be examining in your local evaluation.

Fidelity Criteria: Describe the criteria you will use for each dimension

Fidelity Measurement Tools: Describe how you will measure adherence to your criteria for each dimension. Common measurement tools include ratings based on direct observations, project documentation, and client records; and surveys or interviews completed by program staff or participants (Mowbray et al, 2003).

Fidelity Protocol: Describe the protocol that will be followed to measure fidelity in each of the dimensions you listed previously.

Dissemination Plan

Dissemination of your findings represents a critical step in the evaluation process. Once data analyses are complete, there are two major final steps in the evaluation process: 1) engaging the community in the interpretation of the data and/or development of key recommendations; 2) dissemination and utilization of the findings. This is an opportunity to meaningfully contribute to the evidence base and make decisions/recommendations that reduce mental health disparities for your priority population.

Audience/Stakeholders: List all audiences/stakeholders for this evaluation. Consider what individuals and groups have an interest in the outcomes of your evaluation. Examples include program participants, staff, decision makers, and even critics. Some questions to consider are: What might they be most interested in knowing? For example, cost/benefits, program effectiveness, important culture/language considerations, etc.?

Utilization of the Findings: Describe how your findings can be put into action. What programmatic changes will you implement/incorporate based on your findings? What specific policies or actions do your findings support?

Community Engagement: Describe how the community will be engaged in both the interpretation and dissemination of the findings.

Dissemination Methods: Apart from the Phase 2 Final Convening, how will findings be disseminated (e.g., detailed reports, news releases, press conferences, seminars, or email-based list serves, website, community meetings/town halls, etc.)?

- How will you ensure dissemination is culturally/linguistically/contextually accessible and relevant to your priority population and other key stakeholders?

Peer Reviewed Manuscript: Indicate if you plan to develop a peer-reviewed manuscript based on this evaluation.

Technical Assistance: Indicate the type of TA or support you are interested in receiving from PARC@LMU related to evaluation and research.

Updating/Revising Evaluation Plans

Your evaluation plan may be revised/updated upon receiving feedback from PARC, your assigned TAP, and/or CDPH. In addition, your plan may continue to evolve over the grant period in order to meet local circumstances and the needs of your community.

Upon receipt of your local evaluation plan, you will receive an electronic link from PARC that will allow you to revise/update your plan as needed.

"Until the lion can tell his own stories,
tales of the hunt will be told by the hunter."

— African proverb

12. IPP Evaluation Report

The final evaluation report describes how you monitored and evaluated your program. It presents findings, conclusions, and recommendations from your CDEP evaluation. Since evaluation is an ongoing process, this outline can be used to prepare drafts of your final report over the life of your CDEP. You can then use this outline to update and refine your findings at the culmination of your local evaluation data collection. You will receive the due date for the Final Evaluation Report once it is finalized by CDPH.

The final CDEP evaluation report will make the case that CRDP Phase 2 brings value added approaches to reducing mental health disparities. This is our opportunity to make a noticeable difference (i.e., "move the needle") and expand the range of credible prevention and early intervention (PEI) options for our priority populations. The case must balance the creativity of our mixed methods approaches and the standards of evidence expected by champions of EBPs. Therefore, in making the case, we must speak to multiple audiences, including those who may not see the value of culturally, linguistically, and contextually grounded approaches to PEI.

A variety of research groups have created standards on how to report evaluation research findings. One of the most well-known is the Consolidated Standards of Reporting Trials report (CONSORT; Moher, Schulz, & Altman, 2001), adopted by many professional international organizations and journals. Though the CONSORT Checklist (http://www.consort-statement.org/checklists/view/32-consort/66-title) is primarily aimed at medical research, the checklist is a valuable resource to other researchers writing research reports.

Other standards detailed by professional organizations include:

- CDC Developing An Effective Evaluation Report(2013) (https://www.cdc.gov/eval/materials/Developing-An-Effective-Evaluation-Report_TAG508.pdf)
- Transparent Reporting of Evaluations With Non-experimental Designs (includes a 22-item checklist; (TREND; Des Jarlais, Lyles, Crepaz, & the TREND Group, 2004), (https://www.cdc.gov/trendstatement/)
- Reporting Standards for Research in Psychology (American Psychological Association Publications and Communications Board Working Group on Journal Article Reporting Standards, 2008), (http://www.apastyle.org/manual/related/apa-jars-2008.pdf) and
- Standards for Reporting on Empirical Social Science Research in American Educational Research Association Publications (American Educational Research Association, 2006) (https://www.jstor.org/tc/accept?origin=/stable/pdf/3876756.pdf)

The outline below provides the structure and information that should be included in your final evaluation research report. Because the CDEP evaluation will have already been conducted, use past-tense to describe the project. Bear in mind the general principles of transparency, accuracy, precision, and consistency when writing your report.

The report sections include:

1. **Title Page**
2. **Executive Summary**
3. **Introduction**
4. **CDEP Purpose and Description**
5. **Evaluation Questions**
6. **Methods**
   - **a. CDEP Implementation**
   - **b. Evaluation Participants and Recruitment**
   - **c. Evaluation Measures and Data Collection Procedures**
   - **d. Evaluation Fidelity and Flexibility**
   - **e. Statistical Analyses**
7. **Results**
8. **Discussion**
9. **Conclusion**
10. **References**
11. **Appendices**
    - **a. Tables, Charts, Figures, Acronyms**

1. Title Page
The title page presents the IPP organization name, CDEP name, priority population, time period covered by the local evaluation, acknowledgement of CRDP Phase 2, and acknowledgement of CDPH funding.

2. Executive Summary
The executive summary provides a brief synopsis of the CDEP purpose and description, evaluation questions, evaluation research design, and key findings.

3. Introduction
You have already written this in your evaluation plan. (See Section 11) Simply copy and paste it here and edit for any relevant updates.

A literature review is required for IPPs pursuing EBP, and is recommended for all other IPPs. The reader should understand the logic and rationale as to why that information is being presented in relation to your CDEP evaluation report. The literature review provides context and grounding for the "what" and "why" of your CDEP purpose and findings.

EBP Literature Review Helpful Hint:

Begin with a general introduction to the topic and explain why the topic is important to the study. Briefly describe related literature and previous studies on the topic, particularly more recent studies as those will be the most relevant. When describing previous studies provide enough detail so readers understand the general idea and relevant findings. Avoid providing unnecessary details or irrelevant information from previous studies (the reader can always locate the previous study by using the information provided in the Reference section). Click on the following citation generator link to help cite sources accurately when describing the background and any previous studies on a topic: http://www.citationmachine.net/apa/cite-a-book

4. CDEP Purpose and Description
You have already written this information in your evaluation plan (See Section 11). Simply copy and paste, and make relevant edits to reflect any modifications to how you conceptualized and implemented your CDEP.

5. Evaluation Questions
You have already written this information in your evaluation plan. State the evaluation research questions that were made at the beginning of the project, regardless of whether these were supported or not in the results. If your evaluation questions were refined or modified, indicate what these changes were and why they were made.

6. Methods
CDEP Implementation
This section describes the CDEP implementation as it was offered with enough detail so another reader could replicate it based on your description.

- Describe how program activities were delivered
- Indicate how closely the intervention was implemented as planned, including changes or modifications that were made
- Describe the extent to which the CDEP reached the priority population
- Provide descriptive statistics reflecting the full complement of program participants across all cycles or the length of your CDEP
- Provide information about how many participants dropped or left the CDEP project and why

Example:

Structured Psychotherapy for Adolescents Responding to Stress (SPARCS) is an adapted 6-week, peer-led group intervention designed to address the needs of adolescent girls chronically exposed to trauma or severe stress who may be living with ongoing stress and experiencing problems in several areas of functioning. With 6 core elements, introduced in separate sessions, each technique was aimed to improve adolescent and young girls' ability to accurately gauge their emotions and cope more effectively with stressful situations. As a part of a larger pilot program, SPARCS was implemented in three community organizations. Participants were 74 African-American girls between the ages of 14 and 19 from three community organizations (HOPE center, Youth Organizing, and Center for Adolescent Health) from Baltimore City, Maryland. All participants have been chronically exposed to trauma or severe stress and living with ongoing stress and experiencing problem in several areas of functioning. After the first meeting, sessions were reduced from 2-hour sessions to 1-hour sessions to accommodate for time conflicts and other commitments with group participants. This modification allowed for a 100% attendance rate of all group participants, resulting in no attrition.

Evaluation Study Participants and Recruitment

In this section you will report the following as it relates specifically to the evaluation of your CDEP. Describe the following:

- Any decisions made about sample size before the evaluation began. For those that used power analysis, you should report all pieces of information used to calculate your sample size. For example, we needed 64 subjects in each of our two groups to have 80% power for detecting a medium sized effect when employing the traditional .05 criterion of statistical significance.
- Participant eligibility criteria
- Your sampling strategy
- How participants were recruited, the dates of recruitment for each cycle, and the number of participants in the evaluation per cycle (if cycles are applicable for your CDEP).
- The number of participants who participated in the evaluation including descriptive demographic information (e.g., average age, ethnicity, etc.).
- Indicate the extent to which the evaluation sample is representative of the broader CDEP project.
- The setting and location of the measure processes (e.g., participants completed the assessments online, at home, on a cell phone app, in a group administration etc.).
- Information as to how many participants dropped or left the evaluation, and why.
- Any payment participants received for participating in the evaluation.
- Consent procedures. If you are pursuing an IRB, indicate IRB approval

Helpful hint:

Refer to the following links for examples of how this information has been presented in other evaluation reports:

Final Evaluation Report Example #1 (http://cccstudentmentalhealth.org/docs/evaluation/CCCSMHP_PIRE_FinalEvalReport_May2015.pdf)

Final Evaluation Report Example #2 (http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20F/PDF%20FUHSIEvaluationReport.pdf)

Data Analysis Plan
Describe your data analysis plan for all of the evaluation questions by describing descriptive and inferential analyses to be conducted and procedures to test assumptions and/or qualitative data analysis procedures.

Measures and Data Collection Procedures
In general, describe your procedures with enough detail so another reader could replicate the study based on your description. In this section you should describe:

- Quantitative or qualitative measures (and any modifications to the tools) and data sources used to assess outcomes
- Procedure participants followed to complete the assessments (e.g., self or other administered; paper and pencil vs online)
- Where data collection took place
- Who collected the data
- If administrative data, what procedure followed to sample that data? Describe the basic procedures used by the administrative data source (e.g., how often they collect this information; what periods were collected for your evaluation; at what level is the data aggregated etc.)
- What steps were taken to triangulate your data?

Fidelity and Flexibility
Fidelity is often examined across at least five dimensions: adherence, exposure, quality of delivery, participant responsiveness, and program differentiation. It will be important to consider issues of flexibility—how did your measurement tools and protocols capture changes to your program or evaluation to meet local circumstances? In this section please describe:

- Your fidelity and flexibility dimension and criteria
- Your fidelity and flexibility measurement tools (e.g., direct observations, videotaped sessions, project documentation and client records, surveys or interviews etc.)
- Protocols used (e.g., ratings by specialists based on direct observations 2 times per week for 6 consecutive weeks, sample of program activities/sessions videotaped and reviewed by subject-matter raters, collection of project documentation and client records on a weekly basis, surveys or interviews completed by program staff or participants at the end of every program cycle, etc.)

Data Analyses

- For quantitative data briefly describe the statistical procedures that were used and identify the specific inferential tests, effect-size metrics, and comparisons tested.
- For qualitative data, describe the procedures that were used to review, organize, code, and interpret your data and any inter-rater reliability methods used.

7. Results

The results section is where analysis information is reported; interpretations or implications of the findings generally are reserved for the Discussion section.

Quantitative. This section requires the following: 1) general descriptive statistics of measured outcomes (e.g., mean scores on a test with corresponding SD), 2) detailed statistical analysis and general patterns of findings, 3) corresponding Ns, p-values, and effect sizes for any inferential statistics, and 4) all other findings, regardless of statistical significance. Include a final section in the results focused on the findings from your fidelity assessment.

Qualitative. IPPs using qualitative methods should think carefully about the presentation of their findings. Rather than simply presenting quotes or narratives, your reporting of qualitative findings should "tell a vivid story from authoritative and credible sources in an organized manner so the audience can draw, in parallel with the evaluator, conclusions that are grounded in the data" (Miles & Huberman, 1998). For qualitative data briefly describe the procedures that were used to review, organize, code, and interpret your data.

The power of the vivid story is often forgotten in the presentation of quantitative data. These data need to be contextualized so that stakeholders and decision makers can relate, hold onto the ideas presented, and thus act upon the information (Heath & Heath, 2007).

A variety of strategies can be used to report your data. The strategy you choose depends on your evaluation questions, data gathering approach, and the analyses undertaken. Below are a few points to keep in mind when reporting qualitative data findings:

- Report key qualitative findings by theme or category, using appropriate verbatim quotes to illustrate any repeating ideas or emerging themes that were expressed by different respondents. Quote one or two responses that exemplify the repeating idea. Quotes are "raw data" and should be compiled and analyzed, not just listed.

- You may also want to quote a response that was an exception to illustrate a minority opinion or highlight a noteworthy idea. If so, you should state that it is only one person's response.

8. Discussion

Remember to pay particular attention to the relevance of culture, language, context, and CBPR, and avoid repeating statistical information in this section.

In this section you will indicate:

1) Whether the results supported your evaluation questions. If they were not supported, briefly speculate as to how/why.
2) The cultural and theoretical importance of the results.
3) How the findings relate to the overall objectives or purpose of the evaluation, as well as how your results relate to previous findings (including those that may have been cited in the Introduction).
4) Include a short section on potential limitations of the study, such as methodological weaknesses or inconsistencies. Usually 2-3 limitations are identified with an explanation as to why the limitation was a problem, how it may have affected results, and what could be done to avoid such problems in the future. Briefly and simply acknowledge that some limitations existed, as they do in all program evaluations and research studies.

9. Conclusion
Conclude the report by reiterating the important findings and/or implications of results. Summarize one or two critical take-away messages from the project.

"The 'Why It Matters' (sometimes referred to as the 'So What' question) provides the rationale for your program and its impact on public health. The ability to demonstrate that your program has made a difference is crucial to program sustainability." (CDC 2013)

This is an opportunity to reflect on and share the contributions gleaned from your CDEP for the field of PEI, mental health services, state and county policy and practice, and CBPR, particularly as these relate to your priority population.

10. References
Provide complete references for all cited sources in your final report.

11. Appendices
Include any necessary tables, charts, or figures as appendices.

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Appendices

APPENDIX 1:

Improving school conditions by changing public policy in South Los Angeles: The Community Coalition partnership

"[The campaign's success] was a combination of good, solid, strategic community organizing backed by hard data they collected to substantiate the claim regarding the need for redistribution of funds." —Academic Partner

Case Study #7:

Improving school conditions by changing public policy in South Los Angeles:
The Community Coalition Partnership

With an estimated 694,000 students in a public school system second in size only to New York City's, Los Angeles, California, has long faced gross disparities in the physical environments in which youth receive an education (1). This disparity has rarely been more apparent than in a dramatic CBPR effort in the late 1990s to study and bring attention to the deplorable condition of schools in South Los Angeles, and the fact that a large, newly passed school bond would likely exacerbate the disparities between affluent and poor neighborhood schools.

Bordered on two sides by freeways and home to more than half a million people, South Central LA (now called South Los Angeles or South LA) is perhaps best known for civil unrest in the spring of 1992, following the acquittal of white police officers in the racially charged Rodney King beating case. The court's decision sparked the looting and burning down of some 200 of the area's 728 liquor stores (2). This tragedy also created a valuable opportunity for a community-based organization that had been established two years earlier to address alcohol and drug problems and to effect policy change in South LA through grassroots community organizing.

The Community Coalition for Substance Abuse Prevention and Treatment, or CCSAPT (now known simply as the Community Coalition), began the "Campaign to Rebuild South Central LA without Liquor Stores," which in turn was credited with preventing the rebuilding of 150 alcohol outlets and helping spur the conversion of 44 liquor outlets to community-friendly businesses such as laundromats. Most of these continue to thrive today (2). The campaign also helped establish the Community Coalition as a powerful voice for health-promoting public policy. Now boasting 5,000 dues-paying members, the Community Coalition frequently has combined CBPR with grassroots organizing to achieve larger policy change objectives (3). The successful Coalition-led campaign to study conditions in South LA schools and to get $153 million—most of it from a recent school bond—reallocated for repairs and other improvements in South LA schools exemplifies these efforts (4).

The Partnership: Since its founding in 1990, the Community Coalition has worked closely with an evaluation team at Imoyase Research Group Inc., a nonprofit program evaluation and consultation organization, and its CEO/founder, a professor of psychology at Loyola Marymount University. Community-based participatory research has been a central part of the partnership's mode of operation, with "community-driven research" described by the Coalition and its academic partners as central to the success of their collaborative work. The partners also share a commitment to youth development and empowerment, and the Coalition's youth group, South Central Youth Empowered through Action (SC-YEA), has played a key role in several partnership efforts.

Research Methods: The Community Coalition partnership has used a variety of research methods, including randomly sampled, door-to-door neighborhood needs assessments; GIS mapping; and secondary data analysis. The schools improvement project involved a survey administered by SC-YEA youth to 1,500 public school students, focus groups with parents, and a modified Photovoice project (5). As part of the data collection process, 60 students were given inexpensive cameras to document

"I think they have altered the process of decision making. When [policymakers] get ready to do things they say, 'What do you think the Coalition is going to say? Maybe we should run this by [the Coalition].'" —Academic Partner

risks in the school environment. The students then discussed the photos and selected pictures for later use in policy action (6). Taking advantage of the opportunity provided by a recently passed school bond measure, Proposition BB, in-house, policy-focused research was conducted as well to understand key city and state agencies responsible for implementing the legislation and the policy environment in which it would be implemented.

Findings: The survey of 1,500 teens was expected to identify racism, the quality of education, and teacher-student relationships as key areas of student concern. Instead, by far the greatest issue identified was the physical condition of the schools, many of which had leaky roofs and bathrooms with nonfunctioning sinks and toilets. In one high school, a single working toilet served the entire student body of 3,000. The "Photovoice" project, which produced more than 200 pictures, vividly portrayed many of these problems—overflowing toilets, exposed wires, missing cement tiles, and corroded water fountains (6). The youth conducted additional research in the schools and developed a detailed list of plant and grounds problems.

Lastly, the partnership's policy research revealed that, while most of the Proposition BB money had been allocated for air conditioning in the wealthier San Fernando Valley schools (leading critics to dub the measure "Proposition AC"), the small amount set aside for inner-city schools was earmarked mainly for security guards and window bars.

Getting to Action: Soon after the data-gathering phase of the project, the partnership used its findings to create public and policymaker awareness of twin issues: the terrible condition of South LA schools and the grossly inequitable resource distribution under the new school bond measure. Many of the 200 pictures from the SC-YEA Photovoice project were displayed as part of a demonstration at a meeting of the school district's oversight committee. In the words of a local political figure overseeing the meeting, "The students were very effective. They were angry, but they didn't come across as angry. They created a presentation, and they did it very respectfully" (4). Since part of the Coalition's strategy was, in the words of a journalist, "to shame the school district into doing the right thing," the group reached out to the media by writing numerous press releases and arranging school "walk-arounds" for a *Los Angeles Times* columnist accompanied by SC-YEA students. The Photovoice project garnered national coverage of the issue when it was featured in *People* magazine (6). Numerous meetings with government officials or staffers were held to share study findings and advocate for change. Coalition staff and SC-YEA youth testified more than a dozen times at hearings and committee and school board meetings.

The Coalition and its partners' policy advocacy was effective in part because of the careful preparatory research that preceded it. They consequently did a careful mapping of the policy environment, along with key players and pressure points. Although the academic partners' role was less visible in the policy advocacy aspects of the work, they held trainings for Coalition staff and youth members throughout the process, participated in a detailed strategic planning process, collected needed policy-related information that was sometimes difficult for community partners to gather, and used a detailed archiving system to compile relevant information from newspapers and other sources. The academic partners also worked with the Coalition to develop short-, middle-, and long-term goals to guide the organization's future work.

Policy Change Outcomes: The Coalition and its partners' documentation of the deteriorating conditions in South LA schools, together with their background research on the planned use of Proposition BB monies, effective organizing, and media and policy advocacy, was widely credited with the reopening of repair and construction contracts made in conjunction with the $2.4 billion bond. Roughly $100 million was reallocated for repairs in schools in South LA and other inner-city neighborhoods, supplemented by $153 million from other sources. Media accounts and local political figures cited the role of the Coalition and teenagers involved in the partnership's project as having played a major role in bringing about this investment (5). Approximately 1,800 repairs

"[The Coalition] did a lot of investigative work to understand who the key players were in the process, where there were points of potential impact from a policy perspective, [and] what needed to be done both from an organizing standpoint and from a research standpoint to make some type of inroad into that pressure point." —Academic Partner

were made to address the problems brought to light by the Coalition study. These efforts in turn helped lay the groundwork for a subsequent bond measure and a successful lawsuit that brought $750 million to low-income communities in and around Los Angeles for new school construction.

The Coalition's victories also contributed to youth empowerment. In the words of one SC-YEA participant, "For us to go down there and protest and talk to people…the Community Coalition showed me I can make a difference around my neighborhood."

The school district also made changes in its operating procedures in the wake of the campaign, hosting an annual gathering of hundreds of interested students and also regularly having students present their concerns at school board meetings (3). In the end, the successful schools campaign enhanced the perception of the Coalition as a major player in the local political arena. As one observer commented, "When [policymakers] get ready to do things, they ask, 'What do you think the Coalition is going to say? Maybe we should run this by the Coalition.'"

Barriers and Success Factors: The Coalition's work was not without obstacles. "Publicly available" information (e.g., municipal budget allocations) was sometimes withheld from the community partner despite repeated efforts to obtain it; sometimes access to information required the intervention of the academic partner. Several students involved in exposing poor conditions at their school faced retaliation by their principal, and in one case, a senior's transcripts were held up, potentially jeopardizing his admission to college. Although adult intervention ended this standoff in the student's favor, the incident was a reminder of the personal obstacles that may be confronted in such work.

Counterbalancing such challenges, however, was the very visible and powerful role of the Coalition, its history of success on important community-driven issues (2, 7), its large membership base, and increasingly, its youth program. Several policymakers, prominent business leaders, and the mass media commented on the significant role of the SC-YEA youth in the budget reallocation decision and the school improvements that followed (4). Regular youth involvement at city council meetings and in other venues and the Coalition's adept use of media advocacy also contributed to the group's success.

Summary Reflections: Education and school quality have strong links to health, with recent studies suggesting that education is indeed even more important than income as a contributor to adverse health outcomes, including lower life expectancy (8). The Community Coalition's efforts to improve the deteriorating South LA schools for and with youth helped improve the physical environments in which children grow up and learn, in the process improving their chances for leading healthy and productive lives.

The Coalition continues to work in a variety of areas, from kinship care policy through land use to social services delivery, welfare reform, and community economic development. Further, and as a testament, in part, to its broad base of community support, the organization's former executive director, Karen Bass, stepped down to run for State Assembly—and was elected by a wide margin in November 2004. Assemblywoman Bass, who went on to become the first African American woman Speaker of the House in 2008, stated that her decision to run for public office signaled not only her belief in the strength and sustainability of the Coalition, but also in the need to provide another avenue for the organization and the broader community to have access to power and to keep lawmakers' "feet to the fire" in being responsive to their base.

Contact Information:

Marqueece Harris-Dawson
Executive Director
Community Coalition
8101 S. Vermont Avenue
Los Angeles, CA 90044
323.750.9087
marqueece@southla.org

Cheryl Grills, PhD
Professor
Loyola Marymount University
University Hall 4747
310.338.3016
cgrills@lmu.edu

APPENDIX 2:

Overview of SWE Core Measures: Quick Reference Guide

Appendix 2
Overview of SWE Core Outcome Measures: Quick Reference Guide

OVERVIEW OF CLIENT COMPLETED DATA – Adult Version

In order to accomplished the goals of the cross-site evaluation, 72 items have been selected by the PARC SWE team that are aligned with the SWE change model and CDPH research questions, for inclusion into the local evaluation of outcomes with CDEP served individuals. A majority of these items were selected from population health surveys: 1) California Health Interview Survey (CHIS), 2) National Survey on Drug Use and Health (NSDUH), and 3) Mental Health Statistics Improvement Program (MHSIP)) to serve as a comparison with state, county and other data source and make the CRDP Phase 2 Business Case. 26 items are asked at pre-only (see Table 1, yellow highlighted areas), 24-items at both pre-and post (see Table 1, green highlighted areas), and 22-items at post-only (see Table 1, blue highlighted areas).

This breaks down to:

- 50 total items at pre-assessment (26 pre-only items + 24 pre- and post-items)
- 46 total items at post-assessment (24 pre- and post-items + 22 post- only items)
- 11 demographic items at pre-assessment

Table 1: SWE Core Measures for CDEP Served Individuals: Pre- and/or Post

(blue font indicates item additions or deletions based on TAP & CDPH feedback)

Questionnaire Areas *(administered to CDEP Participants and submitted to SWE on a rolling basis)*		**Number of Items**	**Question #**	**Pre**	**Post**
Pre items	*Access/Utilization/Barriers to Help Seeking*				
	Access/Utilization (CHIS)	10	Q#1-10	X	
	Barriers to Help-Seeking, incl. Stigma/Discrimination (CHIS, NSUDH)	11 + 5 = 16	Q#11-23a-d	X	
	Ethnicity, Sexual Orientation, Gender Identity, Age, Language, Immigrant/Refugee Status	11 **+ 13 optional**	Q#48-58	X	
Pre- & Post-items	*Psychological Distress and Functioning*				
	Psychological Distress (K6)	6	Q#1-6	X	X
	Sheehan Disability Scale (SDS)	+4	Q#7-10	X	X
	Social Isolation and Marginalization	+2	Q#11-12	X	X
	Protective Factors				
	Subjective Spirituality & Religiosity	4	Q#1-4	X	X
	(Spiritual) Wellness	+1	Q#5	X	X
	Community/Social Connectedness	4	Q#6-9	X	X
	Cultural Connectedness	+3	Q#10-12	X	X
	OPTIONAL -- Health	1	Q#13	X	X
Post items	*Quality of CDEP*				
	General Satisfaction	3	Q#1-3		X
	Access	4	Q#4-7		X
	Quality & Cultural Appropriateness	12 -2 = 10	Q#8-17		X
	Perceived Outcomes	3	Q#18-20		X
	Cultural Competence	2	Q#21-22		X
	Total # of Outcome Items	**72 + 1 optional**			

SWE Core Outcome Measures for CDEP Served Individuals – Adult Version (18+ years)

PRE-Assessment Items Only

ACCESS/UTILIZATION (CHIS) and STIGMA/BARRIERS TO HELP-SEEKING (CHIS, NSUDH)

1. **Who are the respondents?** CDEP served adult individuals (18+)
2. **When and how often?** At first contact (i.e., intake, first day of program, etc.); one time only basis!
3. **When is data submitted to PARC@LMU?** Data will be submitted on an ongoing basis based on each CDEP program cycle using Qualtrics, a web-based survey service; PARC will work with TAP and IPPs to determine data submission schedules
4. **What level of SWE Outcomes do they capture?** Immediate and intermediate outcomes
5. **How many items are there?** 26 items
6. **Specifically, what will the SWE be able to answer with these items?** See Table 2

Table 2: Access/Utilization and Stigma/Barriers to Help-Seeking

Items Will Answer The Following:	***Item Analysis***	***SWE Outcomes***
Extent of help-seeking behaviors prior to first contact with CDEP	Pre scores: Q3-6	Short-term: Increased Cultural and Linguistic Competence of MH Services
Extent of unmet mental health needs prior to first contact with CDEP	Pre Scores: Unserved = yes to Q1, no to Q3, no to Q4 Underserved = Yes to Q1, Yes to Q3 or Q4, No to Q8	
Extent of help-seeking barriers encountered prior to first contact with CDEP	Pre Scores: Cost = Q11 Structural Barriers = Q#12-13 Low Perceived Need = Q#14-15 Not Helpful = Q#16 Stigma/Discrimination = Q17-22 Discrimination = Q23a-c	
Total number of unduplicated individuals served by CDEPs who had previous unmet needs and perceived stigma/discrimination with help-seeking	Submission of data for each participant = 1 unduplicated count	
Extent that "help seeking" stigma and other barriers were reduced and help seeking behaviors increased in the priority communities over time	Examination of pre-scores over Y1, Y2, Y3, and Y4	Intermediate: Reduced Stigma and Discrimination

These are the 23 specific pre-assessment items of access, utilization, stigma and barriers to help-seeking:

	Yes	No	Refused	Don't Know
1. Was there ever a time during the past 12 months when you felt like you might need to see a professional because of problems with your mental health, emotions, or nerves or your use of alcohol or drugs?	☐	☐	☐	☐
2. Does your insurance cover treatment for mental health problems, such as visits to a psychologist or psychiatrist?	☐	☐	☐	☐
3. In the past 12 months, have you seen your primary care physician or general practitioner for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?	☐	☐	☐	☐

4. In the past 12 months, have you seen any other professional such as a counselor, psychiatrist or social worker for problems with your mental health, emotions, nerves, or your use of alcohol or drugs? ☐ ☐ ☐ ☐

5. Did you seek help for your mental or emotional health or for an alcohol or drug problem? (*Circle one*)

Not Applicable (N/A)	*Mental/Emotional Health Problem*	*Alcohol-Drug Problem*	*Both Mental AND Alcohol-Drug Problems*	*Refused*	*Don't Know*

6. In the past 12 months, how many visits did you make to a professional (counselor, psychiatrist or social worker) for problems with your: 1) Mental or Emotional Health, 2) Alcohol-Drug Problem, 3) Both Mental & Alcohol-Drug Problem? ☐ *Not Applicable (N/A)* _____ # of visits

	Not Applicable	**Yes**	**No**	**Refused**	**Don't Know**
7. Are you still receiving treatment for these problems from one or more of these providers?	☐	☐	☐	☐	☐
8. Did you complete the full course of treatment? In other words, you ended treatment when your counselor, psychiatrist or social worker told you it was ok to end.	☐	☐	☐	☐	☐

9. What is the **MAIN REASON** you are no longer receiving treatment? (Circle one)

-Not Applicable (N/A) -Therapist ended treatment/ goals met
-Got better/No longer Needed -Not Getting Better -Wanted to handle the problem on own
-Had bad experiences with treatment -Lack of time/Transportation -Too expensive
-Insurance does not cover -Other (Specify)

_____

	Yes	**No**	**Refused**	**Don't Know**
10. During the past 12 months, did you take any prescription medications, such as an antidepressant or an antianxiety medication almost daily for two weeks or more, for an emotional or personal problem?	☐	☐	☐	☐

STIGMA/DISCRIMINATION/OTHER BARRIERS- *Instructions: Here are some reasons people have for not seeking help from a professional such as a counselor, psychiatrist, or social worker, even when they think they might need it. Please tell me "yes" or "no" for whether each statement has applied to you.*

	Yes	**No**	**Refused**	**Don't Know**
11. You were concerned about the cost of treatment. *order changed as this is more of a structural barrier. (CHIS – cost)	☐	☐	☐	☐
12. You didn't have time (because of job, childcare, or other commitments) . (NSUDH – structural barrier)	☐	☐	☐	☐
13. You had no transportation, or treatment was too far away, or the hours were not convenient. (NSUDH – structural barrier)	☐	☐	☐	☐
14. You didn't think you needed mental health counseling or treatment at the time. (NSUDH – low perceived need)	☐	☐	☐	☐
15. You thought you could handle the problem without treatment. (NSUDH – low perceived need)	☐	☐	☐	☐
16. You didn't think mental health counseling or treatment	☐	☐	☐	☐

would help. *order changed (NSUDH – structural barrier) (NSUDH – not helpful)

17. You were concerned that getting mental health treatment or counseling might cause your neighbors or community to have a negative opinion of you. (NSUDH – stigma)	☐	☐	☐	☐
18. You were concerned that getting mental health treatment or counseling might have a negative effect on your job. (NSUDH – stigma)	☐	☐	☐	☐
19. You were concerned that the information you gave the counselor might not be kept confidential. (NSUDH – stigma)	☐	☐	☐	☐
20. You were concerned that you might be admitted to a psychiatric hospital. (NSUDH – stigma) *double barrel item modified to one element	☐	☐	☐	☐
21. You were concerned that you might have to take medicine. *double barrel item modified to one element (NSUDH – stigma)	☐	☐	☐	☐
22. You did not feel comfortable talking with a professional such as a counselor, psychiatrist, or social worker about your personal problems. (CHIS – stigma)	☐	☐	☐	☐
23. You didn't think you would feel safe and welcome because of your… (*new items by CARS - discrimination)				
a. limited English	☐	☐	☐	☐
b. race/ethnicity	☐	☐	☐	☐
c. sexual orientation/gender identity	☐	☐	☐	☐
d. religion and spiritual practices	☐	☐	☐	☐

AGE, RACE/ETHNICITY, LANGUAGE, IMMIGRATION/REFUGEE STATUS, SEXUAL ORIENTATION AND GENDER IDENTITY

1. **Who are the respondents?** CDEP served adult individuals (18+)
2. **When and how often?** At first contact (i.e., intake, first day of program, etc.); one time only basis
3. **When is data submitted to PARC@LMU?** Data will be submitted on an ongoing basis based on each CDEP program cycle using Qualtrics, a web-based survey service; PARC will work with TAP and IPPs to determine data submission schedules
4. **What level of SWE Outcomes do they capture?** Immediate outcomes
5. **How many items are there?** 11 required demographic items +4 optional items (See Table 3)
6. **Why are there so many demographic questions, especially connected to gender identity and sexual orientation?** An intersectional analytic framework (e.g., Collins, 1999; Crenshaw, 1995) is incorporated in the statewide evaluation. To ensure that the experience and needs of all segments of each population are adequately addressed in the evaluation, it is necessary for each IPP to collect data on these population groups. We recognize that sexual minority and gender minority statuses are stigmatized in certain communities. Therefore, some individuals may not feel comfortable disclosing their sexual orientation or gender identity to program staff prior to developing trusting personal relationships with them. Hesitation about disclosing sexual orientation or gender identity may further be exacerbated if these questions are asked in a public setting, such as a common waiting, without guarantee of protecting confidentiality. At the same time, including these questions on participant intake forms is critical to obtain comparative data related to program engagement and retention across different priority populations (CARS, 2016). One solution is to collect the data once at intake, and again a month or so later (depending on the frequency and quality of program involvement) once trust in confidentiality has been established (CARS, 2016). All IPPs are responsible for collecting data on sexual orientation, gender identity, and ethnic/racial background. After consulting with multiple experts (including The Williams Institute and CARS), IPP recommendations for collecting data on gender, gender identity, sexual orientation, race/ethnicity, preferred language, and immigration and refugee status have been developed. SWE also created a minimum and maximum number of items IPPs would ask participants related to sexual orientation and gender identity. The minimum number can be utilized by IPPs who serve communities with high LGBTQ stigma, while the maximum number can be asked in IPPs with a larger LGBTQ community or where stigma would not be as much of an issue. TAPs and IPPs can work together to determine which

set of questions are best suited for their community. SWE also included a response option of "refuse" and "not comfortable answering this question" for all of the demographic questions.

7. **Specifically, what will the SWE be able to answer with these items?** While each of the CDEPs is designed to serve a particular priority population, it is understood that many people are members of multiple priority population groups. For example, while a CDEP may serve the Latino/a community, it is critical to acknowledge that the population is not homogenous. Rather, there is great diversity within this population on the basis of gender, gender identity, sexual orientation and immigration and so on which would contribute to variation of risk and resilience factors in outcomes.

Table 3: Age, Race/Ethnicity, Language, Immigration/Refugee Status, Sexual Orientation and Gender Identity

Items Will Answer The Following:	***Item Analysis***	***SWE Outcomes***
Age	Q1	Short-term: Increased Cultural and Linguistic Competence of MH Services
Race/ethnicity	Q2	
Language	Q3-4	
Immigration/refugee status and housing	Q5-8	
Gender Identity	Q9-10; OPTIONAL: Q11 & Q12	
Sexual Orientation	Q14; OPTIONAL: Q13(a-h) & Q15	

These are the 11 specific demographic items +4 optional items in blue:

AGE

1. **IF YOU ARE 18 AND OLDER**: Are you between 18 and 29, between 30 and 39, between 40 and 44, between 45 and 49, between 50 and 64, or 65 or older?

☐ between 18 and 29
☐ between 30 and 39
☐ between 40 and 44
☐ between 45 and 49
☐ between 50 and 64
☐ 65 or older
☐ Refused
☐ Don't Know

RACE/ETHNICITY

For each racial category, CDEPs can select either "a" or "b for "Origin". Option "a" is a fill-in response, while option "b" is a pre-populated checklist. CDEPs can also consult with PARC to create a hybrid of options "a" and "b" (e.g., fill for some racial categories pre-populated response categories for others).

2. *What is your race and origin?*

☐ White

*Please specify your ethnic origin(s):*_____

☐ Black or African American

*a) Please specify your origin(s):*_____

---OR---

b) Check your origin(s):

☐ African American
☐ Caribbean
☐ Egyptian
☐ Kenyan
☐ South African
☐ Ghanaian
☐ Nigerian
☐ Ethiopian
☐ Refused
☐ Don't know
☐ Other Black or African American (Please specify):_____

☐ Latino, Hispanic, or Spanish

a) *Please specify your ethnic origin(s):*_____

---OR---

b) *Check your origin(s):*

☐ Mexican/ Chicano
☐ Salvadoran
☐ Guatemalan
☐ Dominican
☐ Honduran
☐ Puerto Rican
☐ Cuban
☐ Peruvian
☐ Chilean
☐ Columbian
☐ Nicaraguan
☐ Refused
☐ Don't know
☐ Other Latino (Please specify):_____

☐ American Indian or Alaska Native

*Please list tribe[s] you are from(please describe):*_____

☐ Asian

a) *Please specify your ethnic origin(s):*_____

---OR---

b) *Check your origin(s):*

☐ Afghan
☐ Bangladeshi
☐ Burmese
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Indian (India)
☐ Indonesian
☐ Japanese
☐ Korean
☐ Laotian
☐ Malaysia
☐ Pakistani
☐ Sri Lankan
☐ Taiwanese
☐ Thai
☐ Vietnamese
☐ Refused
☐ Don't know
☐ Other Asian Please specify):
_____

☐ Native Hawaiian or Other Pacific Islander

a) *Please specify your ethnic origin(s):* _____

---OR---

b) *Check your origin(s):*

☐ Samoan
☐ Guamanian
☐ Tongan
☐ Fijian
☐ Refused
☐ Don't know
☐ Other Hawaiian or Pacific Islander Please specify):_____

☐ Other Race
*Please specify your race and origin(s):*_____

☐ Multi-Racial
Check all that apply and specify your origin(s).

☐ White
☐ Black/African American
☐ Latino, Hispanic, or Spanish
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Refused
☐ Don't know

*Please specify your origin(s):*_____

☐ Refused
☐ Don't know

LANGUAGE

3. How well can you speak the English language?

☐ Fluently
☐ Somewhat fluently; can make myself understood but have some problems with it
☐ Not very well; know a lot of words and phrases but have difficulties communicating
☐ Know some vocabulary, but can't speak in sentences
☐ Not at all

4. What is your preferred language? _____

IMMIGRANT/REFUGEE/HOUSING STATUS

5. *Were you born:*

☐ Inside the U.S.
☐ Outside the U.S.
☐ Don't know
☐ Refused

6. What is your Zip Code? _____ ☐Unstable housing/ no zip code ☐ Refused
☐ Don't know

7. When you came to the United States, did you spend time in a refugee camp?

☐ Not Applicable
☐ Yes
☐ No
☐ Refused
☐ Don't know

8. About how many years have you lived in the United States? [*For less than a year enter 1 year*]

Number of years_____ ☐ Not Applicable

GENDER IDENTITY ***(Optional items in blue font)***

Instructions: Gender is complex and has many different facets. Here we focus on three aspects, namely, sex assigned at birth, gender identity (label), gender expressions and behavior. The items below reflect these different aspects.
Just so that everyone is on the same page, let's start with a general definition of gender. Some people are born a male and others are born a female. Still other people are born intersex. Sometimes, however, an individual's sex assigned at birth does not correspond with the way a person identifies their gender. For example, an individual who is assigned male at birth might feel that they are a female, on the inside. Such individuals may think of themselves as transgender. There are also individuals who are not sure about their gender. These are just a few examples. We recognize that each person has their own sense of gender and we want to know about you and your experiences. There are no right or wrong answers.

9. When I was born, the person who delivered me (e.g., doctor, nurse/midwife, family members), thought I was a:

☐ Male
☐ Female
☐ Intersex
☐ I am not sure about my sex assigned at birth
☐ Another description (please specify)
_____
☐ I do not wish to answer this question

10. When it comes to my gender identity, I think of myself as:

☐ Man/Male
☐ Woman/Female
☐ Transgender male/Transgender man/Female to Male
☐ Transgender female/Transgender woman/Male to Female
☐ Genderqueer/Gender non-conforming
☐ Two Spirit
☐ I am not sure about my gender identity
☐ I do not have a gender/ gender identity
☐ Another description (please specify):_____
☐ I do not wish to answer this question

11. Above, we used terms like "male/female" or "Transgender/FtM" as a short-hand way to capture the gender of individuals. We fully understand, however, that people use a wide range of labels – some prefer other terms such as Genderfluid, Agender, Enby, Androgynous, etc. To help us understand you personally, please tell us the term that you personally prefer to describe your gender.

Please tell us what term that you personally prefer to describe your gender: _____

12. A person's appearance, style, dress, or mannerisms (such as the way they walk or talk) may affect the way they think of themselves. On average, how would you describe your appearance, style, dress, or mannerisms?
☐ Very feminine
☐ Mostly feminine
☐ Somewhat feminine
☐ Equally masculine and feminine
☐ Somewhat masculine
☐ Mostly masculine
☐ Very masculine

SEXUAL ORIENTATION ***(Optional items in blue font)***

51. ***Individuals often develop romantic attractions toward others. For example, some men are attracted to women, while other men are attracted to both women and men. Still other men might be attracted to female identified individuals in general, for example, transgender women as well as cisgender women. Some women are attracted to other women but want to kiss, hold hands with and be in relationships with men. Other women may daydream and think about other women. Still other individuals may not develop attractions toward anyone or are unsure about whether they are attracted to women or men. Just to be clear, we are not talking about how you feel toward your friends. We are talking about who you want to get emotionally and physically close to, in a romantic way. Please answer the questions below about your experiences in <u>the past year (12 months).</u>***

There are no right or wrong answers to any of these questions. Please be honest and answer as you really think and feel.

	ONLY Men/Male identified individuals	MOSTLY Men/ Male identified individuals	BOTH men/ Male identified individuals and women/female identified individuals equally	MOSTLY women/ female identified individuals	Only women/ female identified individuals	No one	I am not sure	Other (please specify)
a. I am attracted to (e.g., get crushes on, get excited about)	☐	☐	☐	☐	☐	☐	☐	_____
b. I daydream about….	☐	☐	☐	☐	☐	☐	☐	_____
c. I would want to hold hands with, kiss and hug	☐	☐	☐	☐	☐	☐	☐	_____
d. I have held hands with, kissed and hugged…	☐	☐	☐	☐	☐	☐	☐	_____
e. I would want to have intimate physical relationships with....	☐	☐	☐	☐	☐	☐	☐	_____
f. I have had intimate physical relationships with…	☐	☐	☐	☐	☐	☐	☐	_____
g. I would want to be in a romantic relationship with…	☐	☐	☐	☐	☐	☐	☐	_____
h. I have been in a romantic relationship with….	☐	☐	☐	☐	☐	☐	☐	_____

Instructions: Everyone has a sexual orientation. Some people are straight and are attracted to people of the other gender. For example, a straight woman "likes" men and gets crushes on men. Other people are gay or lesbian and attracted to the same gender. For example, a gay man "likes" other men and gets crushes on other men. Still other people are bisexual and "like" both men and women. Some people are unsure about their attractions or are just not attracted to anyone. Just to be clear, who you "like" and are attracted to is called sexual orientation. What is your sexual orientation?

☐ Straight
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Queer
☐ I have started to question my sexual orientation
☐ I am not attracted to anyone
☐ I am asexual
☐ Another label: _____
☐ I do not wish to answer this question

☐ I am not sure who I am attracted to

13. What is your sexual orientation?

Instructions: ***Above, we used terms like "straight" or "gay/lesbian" as a short-hand way to capture the experiences of individuals who are attracted to people of the other sex or of the same sex. We fully understand, however, that individuals use a wide range of labels – some prefer other terms such as queer, homosexual, same-gender loving, etc. To help us understand you personally, please tell us the term that you personally prefer to describe yourself?***

14. Please tell us what term that you personally prefer to describe yourself: _____

PRE-POST-Assessment Items Only

Psychological Distress & Functioning Items (Kessler 6-CHIS; Sheehan Disability Scale-CHIS)

1. **Who are the respondents?** CDEP served adult individuals (18+)
2. **When and how often?** At first contact and final contact; two times
3. **When is data submitted to PARC@LMU?** Data will be submitted on an ongoing basis based on each CDEP program cycle using Qualtrics, a web-based survey service; PARC will work with TAP and IPPs to determine data submission schedules
4. **How many items are there in Psychological Distress & Functioning section?** 12 items
5. **What level of SWE Outcomes do they capture?** Immediate and intermediate outcomes
6. **Specifically, what will the SWE be able to answer with these items?** See Table 4

Table 4: Kessler 6, Social Isolation/Marginalization items, and the Sheehan Disability Scale

Items Will Answer the Following:	***Item Analysis***	***SWE Outcomes***
Level of psychological distress prior to first contact with CDEP	Pre scores: Q1-6	Short-term: Increased Cultural and Linguistic Competence of MH Services
Total number of unduplicated individuals served by CDEPs who had psychological distress prior to first contact with CDEP	Submission of data for each participant = 1 unduplicated count	
Improvement in psychological distress for participants from pre to post	Pre and Post Scores: Q 1-6	Intermediate: Decreased Risk or Presence of Mental Illness and Symptoms
Improvement in psychological distress for CDEP participants who scored above the clinical cut-off at the pre and at/below the clinical cutoff at the post	Pre and Post Scores: Q 1-6	
Absence of psychological distress for CDEP participants from pre to post (i.e., scored below the clinical cut-off at the pre and post)	Pre and Post Scores: Q 1-6	
Functional impairment in performance	Pre and Post Score: Q 7-10	

at work, ability to do household chores, social life and personal relationships		
Social Isolation/Marginalization	Pre and Post Score: Q 11-12	

These are the 10 specific pre- and post-assessment items of psychological distress and functioning:

Instructions: During the past 12 months how often did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
1. … nervous?	☐	☐	☐	☐	☐
2. … hopeless?	☐	☐	☐	☐	☐
3. … restless or fidgety?	☐	☐	☐	☐	☐
4. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
5. … feel that everything was an effort?	☐	☐	☐	☐	☐
6. … worthless?	☐	☐	☐	☐	☐

Think about the month in the past 12 months when you were at your worst emotionally. (Sheehan Disability Scale-CHIS)

	N/A	A Lot	Some	Not At All	Refused	Don't Know
7. Did your emotions interfere a lot, some, or not at all with your performance at work/school?	☐	☐	☐	☐	☐	☐
8. Did your emotions interfere a lot, some, or not at all with your household chores?	☐	☐	☐	☐	☐	☐
9. Did your emotions interfere a lot, some, or not at all with your social life?	☐	☐	☐	☐	☐	☐
10. Did your emotions interfere a lot, some, or not at all with your relationship with friends and family?	☐	☐	☐	☐	☐	☐

During the past 12 months, how often did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
11. …marginalized or excluded from society? *new item	☐	☐	☐	☐	☐
12. …isolated and alienated from society? *new item	☐	☐	☐	☐	☐

PROTECTIVE FACTORS

15. **Who are the respondents?** CDEP served adult individuals (18+)
16. **When and how often?** At first contact and final contact; Two times
17. **When is data submitted to PARC@LMU?** Data will be submitted on an ongoing basis based on each CDEP program cycle; PARC will work with TAP and IPPs to determine data submission schedules
18. **How many items are there in Protective Factors section?** 10 items + 1 optional item
19. **What level of SWE Outcomes do they capture?** Intermediate outcomes
20. **Specifically, what will the SWE be able to answer with these items?** See Table 5

Table 5: Protective Factors

Items Will Answer the Following:	*Items*	*SWE Outcomes*
Extent to which CDEP participants' subjective	Pre-Post Scores: Q#1-4	Intermediate:

spirituality and religiosity was strengthened		Increased Protective Factors
Extent to which CDP participants' (spiritual) wellness was strengthened	Pre-Post Scores: Q#5	
Extent to which CDEP participants' social/community connectedness was strengthened	Pre-Post Scores: Q#6-9	
Extent to which CDEP participants' cultural connectedness was strengthened	Pre-Post Score: Q#10	
OPTIONAL ITEM --Extent to which CDEP participants' perceived health status was improved	Pre-Post Scores: Q#11	

These are the 11 specific pre- and post-assessment items of protective factors:

Subjective Spirituality & Religiosity Items

	Not at all	Somewhat	Quite a bit	Very
1. How religious are you?	☐	☐	☐	☐
2. How spiritual are you?	☐	☐	☐	☐
3. How important is religion in your life?	☐	☐	☐	☐
4. How important is spirituality in your life?	☐	☐	☐	☐

(Spiritual) Wellness Item (adapted from Davis, 2012)

	Not at all	Somewhat	Quite a bit	Very
5. To what extent do you feel that in your life you are in balance physically, emotionally, mentally, and spiritually?	☐	☐	☐	☐

Community/Social Connectedness Items (MHSIP)

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
6. I am happy with the friendships I have.	☐	☐	☐	☐	☐	☐
7. I have people with whom I can do enjoyable things.	☐	☐	☐	☐	☐	☐
8. In a crisis, I would have the support I need from family or friends.						
9. I feel I belong to a community.	☐	☐	☐	☐	☐	☐

Cultural Connectedness Items

Instructions: Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
10. My culture gives me strength.	☐	☐	☐	☐	☐	☐
11. My culture is important to me.	☐	☐	☐	☐	☐	☐
12. My culture helps me to feel good about who I am.	☐	☐	☐	☐	☐	☐

OPTIONAL - Health Item (CHIS)

	Very Good	Good	Fair	Poor	Refused	Don't Know
13. Would you say your health is Very Good, Good, Fair, or Poor? (*Circle one*)	☐	☐	☐	☐	☐	☐

POST-ASSESSMENT ITEMS ONLY

Quality of CDEP Services Items (MHSIP, CBCI)

1. **Who are the respondents?** CDEP served adult individuals (18+)
2. **When and how often?** At final contact (e.g., end of program graduation); one time only basis
3. **When is data submitted to PARC@LMU?** Data will be submitted on an ongoing basis based on each CDEP program cycle using Qualtrics, a web-based survey service; PARC will work with TAP and IPPs to determine data submission schedules
4. **What level of SWE Outcomes do they capture?** Immediate and intermediate outcomes
5. **When is data submitted to PARC@LMU?** Data will be submitted on an ongoing basis based on each CDEP program cycle; PARC will work with TAP and IPPs to determine data submission schedules
6. **How many items are there?** 22 items
7. **Specifically, what will the SWE be able to answer with these items?** See Table 7

Table 7: Quality of CDEP Services

Items Will Answer the Following:	***Items***	***SWE Outcomes***
General satisfaction with CDEP Services	Post Scores: Q#1-3	Short Term: Increased Cultural and Linguistic Competence of MH Services
Accessibility of CDEP Services	Post Scores: Q#4-7	
Quality & Cultural Appropriateness of CDEP services	Post Scores: Q#8-17	
Perceived outcomes of CDEP services	Post Scores: Q#18-20	
Cultural competence of CDEP services	Post Scores: Q#21-22	

These are the 22 specific post-assessment items of CDEP quality:

*Instructions: Please answer the following questions based on the services you have received so far. Indicate if you **Strongly Agree, Agree,** are **Neutral, Disagree,** or **Strongly Disagree** with each of the statements below. If the question is about something you have not experienced, check the box for **Not Applicable** to indicate that this item does not apply to you. **Please note: the word "service" stand for any program activities or events connected to the program.***

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
General Satisfaction						
1. I like the services that I received here. (MHSIP)	☐	☐	☐	☐	☐	☐
2. If I had other choices, I would still get services from this agency. (MHSIP)	☐	☐	☐	☐	☐	☐
3. I would recommend this agency to a friend or family member. (MHSIP)	☐	☐	☐	☐	☐	☐
Access	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
4. The location of services was convenient (parking, public transportation, distance, etc.). (MHSIP)	☐	☐	☐	☐	☐	☐
5. Staff were willing to see me as often as I felt it was necessary. (MHSIP)	☐	☐	☐	☐	☐	☐
6. Services were available at times that were good for me. (MHSIP)	☐	☐	☐	☐	☐	☐
7. When I first called or came here, it was easy to talk to the staff. (CBCI)	☐	☐	☐	☐	☐	☐
Quality and Cultural Sensitivity						
8. The staff here treat me with respect. (CBCI)	☐	☐	☐	☐	☐	☐
9. The staff here don't think less of me because of the way I talk. (CBCI)	☐	☐	☐	☐	☐	☐
10. The staff here respect my race and/or ethnicity. (CBCI)	☐	☐	☐	☐	☐	☐
11. The staff here respect my religious and/or spiritual beliefs. (CBCI)	☐	☐	☐	☐	☐	☐
12. The staff here respect my gender identity and/or sexual orientation. (CBCI)	☐	☐	☐	☐	☐	☐
13. Staff are willing to be flexible and provide alternative approaches or services to meet my needs. (CBCI)	☐	☐	☐	☐	☐	☐
14. The people who work here respect my cultural beliefs, remedies and healing practices and remedies. (CBCI)	☐	☐	☐	☐	☐	☐
15. Staff here understand that people of my racial and/or ethnic group are not all alike. (CBCI)	☐	☐	☐	☐	☐	☐
16. Staff here understand that people of my gender and/or sexual orientation group are not all alike. (CBCI)	☐	☐	☐	☐	☐	☐
17. Staff here understand that people of my religious and spiritual background are not all alike. (CBCI)	☐	☐	☐	☐	☐	☐
Outcomes	☐	☐	☐	☐	☐	☐
As a direct result of the services I received:						
18. I deal more effectively with my daily problems. (MHSIP)	☐	☐	☐	☐	☐	☐
19. I do better in school and/or work. (MHSIP)	☐	☐	☐	☐	☐	☐
20. My symptoms/problems are not bothering me as much. (MHSIP)	☐	☐	☐	☐	☐	☐

Cultural Competence	Yes	No	Refused	Don't Know
21. Were the services you received here in the language you prefer? (MHSIP)	☐	☐	☐	☐
22. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available in the language you prefer? (MHSIP)	☐	☐	☐	☐

----Refer to Appendix 3 for the Paper and Pencil Version of Pre- and Post-Assessment (Adult Version) ----

Overview Of IPP COMPLETED DATA

With the exception of organizational capacity/cultural competency, IPPs will also be asked submit other program outcome data to the SWE on a semi-annual basis (see Table 6 for a full breakdown of required core indicators and measures).

Table 6: Other SWE Core Outcome Data

Area	Indicator	Measure/Data Administration
Workforce Development (see Tracking Tool below)	-Number and type of workforce gaps in the mental health workforce for each IPP -Number and type of a) Training and Technical Assistance, b) Mental Health Career Pathway Programs, c) Residency and Internship Programs completed; Unduplicated number of people served by sector -Percentage estimates of individuals served by priority population and multilingual capacity -Number and type of workforce development successes or outcomes	Workforce Development Tracking Tool -Completed by subset of IPPs doing workforce development; submitted to SWE on a semi-annual basis
Access: Service Referrals (see Tracking Tool below)	-Number of referrals provided for children, youth, adults -Number of referrals provided for mental health (e.g., depression, suicide, etc.), substance abuse, domestic violence, sexual assault, primary care, non-health care services (e.g., housing, education, job training, etc.), social/cultural enrichment programs	Access (Service Referral) Tracking Tool -Completed by subset IPPs doing access/linkages; submitted to SWE on a semi-annual basis
Organizational Capacity and Cultural Competence (See Appendix 6)	-Changes in organizational capacity in priority areas identified by IPPs at the start of the grant	-Marguerite Casey Foundation Organizational Capacity Assessment Tool administered by TAPs and/or SWE at beginning and end of contract -Semi-structured interviews with IPPs administered by TAPs and/or SWE beginning and end of contract SWE Semi-Annual Report (IPPs and TAPs)- qualitative updates on progress attained on each of the IPP prioritized capacity areas including unanticipated benchmarks/outcomes
	-Strengths in IPP organizational cultural competence at start of the grant including changes/improvements made	
	-IPP progress on organizational capacity or cultural competence throughout the grant period	
Collaborative Processes and Community Engagement (See SWE Semi-Annual Report)	-Number and type of community engagement efforts (including use of CBPR), networking activities, and informal collaborations (e.g., sharing of resources and space for a common goal)	-SWE Semi-Annual Report (IPPs only)
Local Strategic Partnerships (See SWE Semi-Annual Report)	-Number and type of local level partnerships with contracts or memorandums of understanding (MOUs) with established structures and partnership roles and responsibilities	-SWE Semi-Annual Report (IPPs only)
Community Driven	-Number and type of expanded use of CDEPs with	SWE Semi-Annual Reports

Mental Health Systems Changes (See SWE Semi-Annual Report)	priority populations by non-CRDP organizations, agencies, & local mental health systems -Number and type of local MH service delivery improvements using community recommendations—i.e., practices, rules, laws, regulatory changes -Number and type of data sharing agreements obtained and implemented with local county systems	(IPPs only)

SWE Core Outcome Measures for IPPs

WORKFORCE DEVELOPMENT

1. **Who are the respondents?** IPPs who have a workforce development program/strategy as part of their CDEP
2. **When is it completed?** Every 6 months
3. **How is the data submitted to PARC@LMU?** Via Qualtrics, a web-based survey service
4. **What level of SWE Outcomes do they capture?** Immediate outcomes
5. **How many items are there?** 6 items
6. **Specifically, what will the SWE be able to answer with these items?** See Table 7

Table 7: Workforce Development

Items Will Answer The Following:	***Item Analysis***	***SWE Outcomes***
Number and type of workforce gaps in the mental health workforce for each IPP	Q1	Short-term: Increased Cultural and Linguistic Competence of MH Services
Number and type of Training and Technical Assistance completed; Unduplicated number of people served by sector	Q1, 1a, 1b	
Number and type of Mental Health Career Pathway Programs completed; Unduplicated number of people served by sector	Q2, 2a, 2b	
Number and type of Residency and Internship Programs completed; Unduplicated number of people served by sector	Q3, 3a, 3b	
Percentage estimates of individuals served by priority population and multilingual capacity	Q4, 5	
Number and type of workforce development successes or outcomes	Semi-AnnualQ6	

WORKFORCE DEVELOPMENT (Complete this section only if your CDEP has a workforce development component)

Please indicate the workforce gaps, shortages and deficiencies in the mental health workforce in your community that your CDEP is trying to meet: Check all that apply.

€ Cultural competency gap € Linguistic capacity gap € Poor representation of consumers and family members in workforce € Lack of career pathways for public	€ Ethnic representation gap € Need for first responder competencies € Increased ethnic representation € Lack of career pathways for high school students

sector employees € Training/education programs that are not aligned with CRDP Phase 2 principles	€ Training/education programs that did not teach competencies needed for public sector work
€ Need for personnel specializing in services for: (Check all that apply) __ Older Adults __ Transitional Age Youth	€ Shortages with: (Check all that apply) __ Psychiatrists (M.D.) __ Physician Assistants (P.A.) __ Masters level Therapists (MFT/LCSW) __ Clinical Psychologists (Ph.D.)
€ Other gap (fill in): _____	€ Other gap (fill in): _____

18. Please tell us the type of workforce development programming or activities your CDEP completed during the past 6 months [*insert actual time period here*]. In other words, these programs or activities are not currently running but were completed during the past 6 months.

18a. Training and Technical Assistance – i.e., training/TA to increase *skills* and *knowledge base* of workforce

€ No (If no, skip to question #18b)
€ Yes (If yes, answer questions 18a.1 and 18a.2 below)

a.1. What Training and TA need areas were *completed* in the past 6 months? (check all that apply)

€ CRDP and CDEP core values and principles including design/implementation of CDEPs
€ Resources/services networks for underserved and unserved communities
€ Pre training for workforce entry and advocacy roles
€ Supporting consumers with lived experiences and their family
€ Community outreach, engagement and collaboration
€ Cultural competence (please describe_____)
€ Linguistic competence (please describe_____)
€ Wellness, recovery and resilience (please describe:_____)
€ Other: (please describe):
_____)

a.2. How many were served by the training and TA in the past 6 months? Write in the unduplicated number of people served for each category that applies. Place a zero (0) in the space where no one was served in a particular category.

Types of Individuals/Groups	# Served – UNDUPLICATED
€ Consumers with lived experience	€ _____
€ Parents/family of those with lived experiences	€ _____
€ K-12 schools/school districts	€ _____
€ Adult schools, regional occupation centers/ programs	€ _____
€ Community colleges	€ _____

€ 4-year colleges/universities	€ _____
€ Graduate schools/professional schools	€ _____
€ County DMH or Public Health employees	€ _____
€ Other county or GOV employees (e.g., Employment, Probation, Parole, CPS)	€ _____
€ Community organizations, agencies employees	€ _____
€ Health care workers (e.g., psychiatrist P.A., nurse, etc.)	€ _____
€ Other (please describe: _____)	€ _____
€ Other (please describe: _____)	€ _____

18b. Mental Health Career Pathway Programming or Activities

€ No (If no, skip to question #18c)
€ Yes (If yes, answer questions 18b.1 and 18b.2 below)

b.1. What type of career pathways programming was *completed* in the past 6 months? (check all that apply)

€ Entry level professional training for individuals who aren't currently in the mental health workforce
€ Advocacy training (e.g., community outreach, leadership development, public speaking, navigating systems, resources supports etc.)
€ Advancement and retention of existing mental health staff (e.g., advice, coordination, financial assistance, job training, mentoring, tutoring, information sharing, advocacy)

€ Graduation of enrolled students in the academic pipeline program(s). If you selected this response, provide follow-up information below

Graduation academic pipeline: Check all that apply and indicate the unduplicated # of students served in the past 6 months.

Student Type	**# Served – UNDUPLICATED**
€ High Schools	€ _____
€ Adults Schools/Regional Occupation Centers	€ _____
€ Community Colleges	€ _____
€ 4-Year Colleges/Universities	€ _____
€ Graduate/Professional Schools	€ _____
€ **Total # served**	€ _____

€ Partnerships with educational institutions for students to become employed within the mental health system (e.g., establishing academic pipeline programs, aligning curriculums, designing field placements, etc.) If you selected this response, provide follow-up information below

Partnerships: Check all that apply and indicate the unduplicated # of students served in the past 6 months.

Institution Type	# Served – UNDUPLICATED
€ High Schools	€ _____
€ Adults Schools/Regional Occupation Centers	€ _____
€ Community Colleges	€ _____
€ 4-Year Colleges/Universities	€ _____
€ Graduate/Professional Schools	€ _____
€ **Total # served**	€ _____

€ Other- does not fit any of the other pathways [please describe]:

_____

_____

_____

If you selected this response, provide follow-up information below:

Other Categories: Write-in other category type(s) and indicate the unduplicated # of students served in the past 6 months.

Other Category Type(s)	# Served – UNDUPLICATED
€ _____	€ _____
€ _____	€ _____
€ _____	€ _____
€ _____	€ _____
€ _____	€ _____
€ **Total # served**	€ _____

18c. Residency and Internship Programs

€ No (If no, skip to question #19)
€ Yes (If yes, answer questions 18c.1 and 18c.2 below)

c.1. What type of residency and internship programming was *completed* in the past 6 months? (check all that apply)

Student Type	# Served – UNDUPLICATED
€ Internships and placements for individuals at the BA and Masters level	€ _____
€ Residency programs with graduate or professional educational institutions to expand the number of psychiatrists,	€ _____

psychiatric nurse practitioners, MSWs, MFTs, LVNs, RNs, and OTs	
€ Externships for high school and college students seeking more education about mental health or developing a mental health service career	€ _____
€ Other (please describe)	€ _____
€ Total # served	€ _____

If you selected "Externships for high school and college students," please provide follow-up information below:

Institution Type	**# Served – UNDUPLICATED**
€ High School Students	€ _____
€ Community College Students	€ _____
€ Community Colleges	€ _____
€ 4-Year Colleges/University Students	€ _____
€ Other (please describe)	€ _____
€ **Total # served**	€ _____

If you answered 'Yes', to 18a, 18b, or 18c:

19. Among the [total # of individuals served – excluding institutions], please estimate the percentage for each of the following categories:

Priority Populations	% of Participants
African American	
Asian Pacific Islander	
Latino	
LGBTQ	
Native American	
Multi-Race/Other	

20. Among the [total # of individuals served], please estimate the percentage of participants served who have multilingual capacity (fluent in language other than English):

Languages	% of Participants
Multilingual Capacity	

21. Predominately, what languages are represented other than English:

_____

_____

22. Please select any notable successes or outcomes experienced in the last 6 months, with your workforce development program.

- € Other (describe): _____
- € Other (describe): _____

SECTION 5: Access and Linkages (This section should be completed only by CDEPs that include an access and linkages component)

Please record the following data for the past 6 months of service referrals provided to your CDEP participants. The term "referral" is used to describe a process of assisting participants in obtaining services by connecting them to culturally and linguistically competent providers and support services.

Referral Month and Year _____/_____

mm yyyy

# of CDEP Participants Served	Unduplicated Counts
€ Children (0-11)	€ # served _____
€ Youth (12-17)	€ # served _____
€ Adult (18+)	€ # served _____

# of Service Referrals Provided to CDEP Participants by Type:	
€ Mental Health (e.g. depression, suicide, etc.)	€ # _____
€ Substance Abuse	€ # _____
€ Domestic Violence	€ # _____
€ Sexual Assault	€ # _____
€ Primary Care (e.g. well check, vaccines, etc.)	€ # _____
€ Non-health Care Services (e.g. housing, education, job training, etc.)	€ # _____
€ Social/cultural Enrichment Programs	€ # _____
€ Other (please describe): _____	€ # _____

APPENDIX 3:

Sources, Core Process Measures

Appendix 3
Sources, Core Process Measures, & Data Collection Points

Process Indicators	SWE Strategy
CDEP Cultural, Linguistic, Organizational, Community, and Historical Context; Special Population Report Recommendations	SWE will conduct qualitative analysis of IPP proposals, special population reports, evaluation plans, and final reports
CDEP Implementation Approaches & Strategies **and** **CDEP Implementation Fidelity and Flexibility**	Step 1: Using SWE evaluation guidelines, IPP and local evaluator will develop fidelity study in their evaluation plan. Step 2: In semi-annual reports to SWE, IPPs will share adherence ratings related to their: a) core intervention component ("the what"—processes and strategies) and b) core implementation strategy ("the how"—staff, training, partnerships, etc.), including a brief narrative regarding divergence from 100% adherence (e.g., elements that were maintained, modified, eliminated, and added, including rationale for changes) Step 3: At end of program, SWE will assign a final fidelity/flexibility rating to each IPP
TAP & EOA Implementation Approaches & Strategies **and** **TAP & EOA Implementation Fidelity and Flexibility**	Step 1: Using Qualtrics at beginning of Year 1, TAPs and EOAs will list their: a) core intervention component and b) core implementation strategy Step 2: In semi-annual reports to SWE, TAPs and EOAs will share adherence ratings related to their: a) core intervention component ("the what"—processes and strategies) and b) core implementation strategy ("the how"—staff, training, partnerships, etc.), including a brief narrative regarding divergence from 100% adherence (e.g., elements that were maintained, modified, eliminated, and added, including rationale for changes) Step 3: At end of program, SWE will assign a final fidelity/flexibility rating to each TAP and EOA
Internal Implementation Barriers & Successes: Number & Type	In SWE semi-annual reports, IPPs, TAPs, and EOA will select from a pre-populated checklist the types of organizational barriers and successes encountered with implementation (will include internal successes/barriers related to capacity building, use of CBPR and cultural/linguistic competency strategies)
External Implementation Barriers & Successes: Number & Type	In SWE semi-annual reports, IPPs, TAPs, and EOA will select from a pre-populated checklist the types of major issues that surfaced in the community, political, or public system that supported or served as barriers to implementation (will include external successes/barriers related to capacity building, use of CBPR and cultural/linguistic competency strategies)
Lessons Learned **and** **-Satisfaction with CRDP 2**	Semi-structured survey and interview on Qualtrics (Provo, UT)[1] with IPPs, TAPs, EOAs, CDPH in Years 3 and 4 related to: a) collaboration between components; b) population and geographical divisions; c) IPP strategies and operations; d) TAP strategies and operations; e) EOA strategies and operations; f) SWE strategies and operations; g) CDPH strategies, operations and administrative support
CBPR and Cultural Competency in IPP's Local Evaluations **and** **Evaluation Implementation Fidelity and Flexibility**	Step 1: With input from the TAPs and The Alliance, SWE will create a "CBPR/Cultural Competency Evaluation Framework" with a standardized rating scale to assess the appropriateness of the IPPs local evaluation plan (approach and strategies) to the priority population and their respective community context Step 2: In SWE semi-annual reports, IPPs will check off what core elements were maintained, modified, eliminated, and added, including rationale for changes Step 3: Using CBPR/Cultural Competency Evaluation Framework, SWE will rate the IPPs final evaluation report Step 4: SWE will assign a final evaluation fidelity/flexibility rating
-IPP CDEP Outreach & Recruitment	Step 1: In semi-annual reports to SWE, IPPs will rate the extent of their CDEP outreach and recruitment effort (none, moderate, high) including rationale for rating Step 2: At end of program, SWE will assign a final CDEP outreach/recruitment score to each IPP
-IPP Evaluation Sample Population	SWE will analyze number and socio-demographics of participants in IPP local evaluations plan (targeted) versus final evaluation report (participated)
-IPP TA Requests and Received	Step 1: In SWE semi-annual reports, IPPs and TAPs will report the number, type of

(TAPs): Number & Type	TA requested and the number, type, and method of TA delivered Step 2: SWE will analyze TA requests in comparison to TA received
-IPP TA Requests and Received (TAPs + SWE collaboration): Number & Type	Step 1: In SWE semi-annual reports, IPPs and TAPs will report the number, type of TA requested and the number, type, and method of TA delivered in collaboration with the SWE Step 2: SWE will analyze TA requests in comparison to TA received
Mental Health Awareness Efforts (To be determined with EOA & IPPs)	To be determined in consultation with the EOA
Mental Illness Targets: Number & Type	SWE will analyze the number and type of mental illnesses targeted in IPP local evaluations plans
SWE Process Data	Via Qualtrics and monthly reports to CDPH, SWE will track requests and response for TA/subject matter expertise from CDPH, TAPs, IPPs, and the EOA related to a) subject matter expert services, b) implementation approaches and strategies and fidelity, and c) challenges, successes and opportunities, and d) stakeholder dissemination

APPENDIX 4:

Adult, child, and adolescent core measures

ADULT VERSION PRE

	Yes	No	Refused	Don't Know
1. Was there ever a time during the past 12 months when you felt like you might need to see a professional because of problems with your mental health, emotions, or nerves or your use of alcohol or drugs?	☐	☐	☐	☐
2. Does your insurance cover treatment for mental health problems, such as visits to a psychologist or psychiatrist?	☐	☐	☐	☐
3. In the past 12 months, have you seen your primary care physician or general practitioner for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?	☐	☐	☐	☐
4. In the past 12 months, have you seen any other professional such as a counselor, psychiatrist or social worker for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?	☐	☐	☐	☐

5. Did you seek help for your mental or emotional health or for an alcohol or drug problem? (*Circle one*)	*Not Applicable (N/A)*	*Mental/Emotional Health Problem*	*Alcohol-Drug Problem*	*Both Mental AND Alcohol-Drug Problems*	*Refused*	*Don't Know*

6. In the past 12 months, how many visits did you make to a professional (counselor, psychiatrist or social worker) for problems with your: 1) Mental or Emotional Health, 2) Alcohol-Drug Problem, 3) Both Mental & Alcohol-Drug Problem?

☐ *Not Applicable (N/A)* # of visits_____

	Not Applicable	Yes	No	Refused	Don't Know
7. Are you still receiving treatment for these problems from one or more of these providers?	☐	☐	☐	☐	☐
8. Did you complete the full course of treatment? In other words, you ended treatment when your counselor, psychiatrist or social worker told you it was ok to end?	☐	☐	☐	☐	☐

9. What is the **MAIN REASON** you are no longer receiving treatment? (Circle one)

-Not Applicable (N/A) -Therapist ended treatment/ goals met
-Got better/No longer Needed -Not Getting Better -Wanted to handle the problem on own
-Had bad experiences with treatment -Lack of time/Transportation -Too expensive
-Insurance does not cover -Other
(Specify)_____

	Yes	No	Refused	Don't Know
10. During the past 12 months, did you take any prescription medications, such as an antidepressant or an antianxiety medication almost daily for two weeks or more, for an emotional or personal problem?	☐	☐	☐	☐

Instructions: Here are some reasons people have for not seeking help from a professional such as a counselor, psychiatrist, or social worker, even when they think they might need it. Please tell me "yes" or "no" for whether each statement has applied to you.

	Yes	No	Refused	Don't Know
11. You were concerned about the cost of treatment.	☐	☐	☐	☐
12. You didn't have time (because of job, childcare, or other commitments).	☐	☐	☐	☐
13. You had no transportation, or treatment was too far away, or the hours were not convenient.	☐	☐	☐	☐
14. You didn't think you needed mental health counseling or treatment at the time.	☐	☐	☐	☐
15. You thought you could handle the problem without treatment.	☐	☐	☐	☐
16. You didn't think mental health counseling or treatment would help.	☐	☐	☐	☐
17. You were concerned that getting mental health treatment or counseling might cause your neighbors or community to have a negative opinion of you.	☐	☐	☐	☐
18. You were concerned that getting mental health treatment or counseling might have a negative effect on your job.	☐	☐	☐	☐
19. You were concerned that the information you gave the counselor might not be kept confidential.	☐	☐	☐	☐
20. You were concerned that you might be admitted to a psychiatric hospital.	☐	☐	☐	☐
21. You were concerned that you might have to take medicine.	☐	☐	☐	☐
22. You did not feel comfortable talking with a professional such as a counselor, psychiatrist, or social worker about your personal problems.	☐	☐	☐	☐
23. You didn't think you would feel safe and welcome because of your…				
e. limited English	☐	☐	☐	☐
f. race/ethnicity	☐	☐	☐	☐
g. sexual orientation/gender identity	☐	☐	☐	☐
h. religion and spiritual practices	☐	☐	☐	☐

Instructions: During the past 12 months how often did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
24. … nervous?	☐	☐	☐	☐	☐
25. … hopeless?	☐	☐	☐	☐	☐
26. … restless or fidgety?	☐	☐	☐	☐	☐
27. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
28. … feel that everything was an effort?	☐	☐	☐	☐	☐
29. … worthless?	☐	☐	☐	☐	☐

Think about the month in the past 12 months when you were at your worst emotionally.	N/A	A Lot	Some	Not At All	Refused	Don't Know
30. Did your emotions interfere a lot, some, or not at all with your performance at work/school?	☐	☐	☐	☐	☐	☐
31. Did your emotions interfere a lot, some, or not at all with your household chores?	☐	☐	☐	☐	☐	☐
32. Did your emotions interfere a lot, some, or not at all with your social life?	☐	☐	☐	☐	☐	☐

33. Did your emotions interfere a lot, some, or not at all with your relationship with friends and family?	☐	☐	☐	☐	☐	☐

During the past 12 months, how often did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
34. …marginalized or excluded from society?	☐	☐	☐	☐	☐
35. …isolated and alienated from society?	☐	☐	☐	☐	☐

	Not at all	Somewhat	Quite a bit	Very
36. How religious are you?	☐	☐	☐	☐
37. How spiritual are you?	☐	☐	☐	☐
38. How important is religion in your life?	☐	☐	☐	☐
39. How important is spirituality in your life?	☐	☐	☐	☐
40. To what extent do you feel that in your life you are in balance physically, emotionally, mentally, and spiritually?	☐	☐	☐	☐

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
41. I am happy with the friendships I have.	☐	☐	☐	☐	☐	☐
42. I have people with whom I can do enjoyable things.	☐	☐	☐	☐	☐	☐
43. In a crisis, I would have the support I need from family or friends.	☐	☐	☐	☐	☐	☐
44. I feel I belong to a community.	☐	☐	☐	☐	☐	☐

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
45. My culture gives me strength.	☐	☐	☐	☐	☐	☐
46. My culture is important to me.	☐	☐	☐	☐	☐	☐
47. My culture helps me to feel good about who I am.	☐	☐	☐	☐	☐	☐

	Very Good	Good	Fair	Poor	Refused	Don't Know
Would you say your health is Very Good, Good, Fair, or Poor? (*Circle one*)	☐	☐	☐	☐	☐	☐

48. **IF YOU ARE 18 AND OLDER**: Are you between 18 and 29, between 30 and 39, between 40 and 44, between 45 and 49, between 50 and 64, or 65 or older?

☐ between 18 and 29
☐ between 30 and 39
☐ between 40 and 44
☐ between 45 and 49
☐ between 50 and 64
☐ 65 or older
☐ Refused
☐ Don't Know

Instructions: Mark an 'X' in one box and circle all origins that apply.

49. What is your race and origin?

☐ White
*Please specify your ethnic origin(s):*_____

☐ Black or African American
*Please specify your ethnic origin(s):*_____
---OR---
Check your origin(s):
☐ African American
☐ Caribbean
☐ Egyptian
☐ Kenyan
☐ South African
☐ Ghanaian
☐ Nigerian
☐ Ethiopian
☐ Refused
☐ Don't know
☐ Other Black or African American (Please specify):_____

☐ Latino, Hispanic, or Spanish
*Please specify your ethnic origin(s):*_____
---OR---
Check your origin(s):
☐ Mexican/ Chicano
☐ Salvadoran
☐ Guatemalan
☐ Dominican
☐ Honduran
☐ Puerto Rican
☐ Cuban
☐ Peruvian
☐ Chilean
☐ Columbian
☐ Nicaraguan
☐ Refused
☐ Don't know
☐ Other Latino (Please specify):_____

☐ American Indian or Alaska Native
*Please list tribe[s] you are from:*_____

☐ Asian
*Please specify your ethnic origin(s):*_____
---OR---
Check your origin(s):
☐ Afghan
☐ Bangladeshi
☐ Burmese
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Indian (India)
☐ Indonesian
☐ Japanese
☐ Korean
☐ Laotian
☐ Malaysia
☐ Pakistani
☐ Sri Lankan
☐ Taiwanese
☐ Thai
☐ Vietnamese
☐ Refused
☐ Don't know
☐ Other Asian Please specify):
_____

☐ Native Hawaiian or Other Pacific Islander
Please specify your ethnic origin(s):

_____

---OR---

Check your origin(s):

☐ Samoan
☐ Guamanian
☐ Tongan
☐ Fijian
☐ Refused
☐ Don't know
☐ Other Hawaiian or Pacific Islander
Please specify):_____

☐ Other Race
*Please specify your race and origin(s):*_____

☐ Multi-Racial
Check all that apply and specify your ethnic origin(s).

☐ White
☐ Black/African American
☐ Latino, Hispanic, or Spanish
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Refused
☐ Don't know

*Please specify your origin(s):*_____

☐ Refused
☐ Don't know

50. How well can you speak the English language?

☐ Fluently
☐ Somewhat fluently; can make myself understood but have some problems with it
☐ Not very well; know a lot of words and phrases but have difficulties communicating
☐ Know some vocabulary, but can't speak in sentences
☐ Not at all

51. What is your preferred language? _____

52. *Were you born:*

☐ Inside the U.S.
☐ Outside the U.S.
☐ Refused
☐ Don't know

53. What is your Zip Code? _____ ☐Unstable housing/ no zip code ☐ Refused ☐ Don't know

54. When you came to the United States, did you spend time in a refugee camp?

☐ Not Applicable
☐ Yes
☐ No
☐ Refused
☐ Don't know

55. About how many years have you lived in the United States? [*For less than a year, enter 1 year*]

Number of years_____ ☐ Not Applicable

Individuals often develop romantic attractions toward others. For example, some men are attracted to women, while other men are attracted to both women and men. Still other men might be attracted to female identified individuals in general, for example, transgender women as well as cisgender women. Some women are attracted to other women but want to kiss, hold hands with and be in relationships with men. Other women may daydream and think about other women. Still other individuals may not develop attractions toward anyone or are unsure about whether they are attracted to women or men. Just to be clear, we are not talking about how you feel toward your friends. We are talking about who you want to get emotionally and physically close to, in a romantic way. Please answer the questions below about your experiences in the past year (12 months).

There are no right or wrong answers to any of these questions. Please be honest and answer as you really think and feel.

	ONLY Men/Male identified individuals	MOSTLY Men/ Male identified individuals	BOTH men/ Male identified individuals and women/female identified individuals equally	MOSTLY women/ female identified individuals	Only women/ female identified individuals	No one	I am not sure	Other (please specify)
i. I am attracted to (e.g., get crushes on, get excited about)	☐	☐	☐	☐	☐	☐	☐	_____
j. I daydream about….	☐	☐	☐	☐	☐	☐	☐	_____
k. I would want to hold hands with, kiss and hug	☐	☐	☐	☐	☐	☐	☐	_____
l. I have held hands with, kissed and hugged…	☐	☐	☐	☐	☐	☐	☐	_____
m. I would want to have intimate physical relationships with....	☐	☐	☐	☐	☐	☐	☐	_____
n. I have had intimate physical relationships with…	☐	☐	☐	☐	☐	☐	☐	_____
o. I would want to be in a romantic relationship with…	☐	☐	☐	☐	☐	☐	☐	_____
p. I have been in a romantic relationship with….	☐	☐	☐	☐	☐	☐	☐	_____

Instructions: Everyone has a sexual orientation. Some people are straight and are attracted to people of the other gender. For example, a straight woman "likes" men and gets crushes on men. Other people are gay or lesbian and attracted to the same gender. For example, a gay man "likes" other men and gets crushes on other men. Still other people are bisexual and "like" both men and women. Some people are unsure about their attractions or are just not attracted to anyone. Just to be clear, who you "like" and are attracted to is called sexual orientation. What is your sexual orientation?

56. What is your sexual orientation?

☐ Straight
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Queer
☐ I am not sure who I am attracted to romantically
☐ I have started to question my sexual orientation
☐ I am not attracted to anyone
☐ I am asexual
☐ Another label: _____
☐ I do not wish to answer this question

Instructions: Above, we used terms like "straight" or "gay/lesbian" as a short-hand way to capture the experiences of individuals who are attracted to people of the other sex or of the same sex. We fully understand, however, that individuals use a wide range of labels – some prefer other terms such as queer, homosexual, same-gender loving, etc. To help us understand you personally, please tell us the term that you personally prefer to describe yourself?

Please tell us what term that you personally prefer to describe yourself: _____

Instructions: Gender is complex and has many different facets. Here we focus on three aspects, namely, sex assigned at birth, gender identity (label), gender expressions and behavior. The items below reflect these different aspects.
Just so that everyone is on the same page, let's start with a general definition of gender. Some people are born a male and others are born a female. Still other people are born intersex. Sometimes, however, an individual's sex assigned at birth does not correspond with the way a person identifies their gender. For example, an individual who is assigned male at birth might feel that they are a female, on the inside. Such individuals may think of themselves as transgender. There are also individuals who are not sure about their gender. These are just a few examples. We recognize that each person has their own sense of gender and we want to know about you and your experiences. There are no right or wrong answers.

57. When I was born, the person who delivered me (e.g., doctor, nurse/midwife, family members), thought I was a:
☐ Male
☐ Female
☐ Intersex
☐ I am not sure about my sex assigned at birth
☐ Another description (please specify)
_____
☐ I do not wish to answer this question

58. When it comes to my gender identity, I think of myself as:

☐ Man/Male
☐ Woman/Female
☐ Transgender male/Transgender man/Female to Male
☐ Transgender female/Transgender woman/Male to Female
☐ Genderqueer/Gender non-conforming
☐ Two Spirit
☐ I am not sure about my gender identity
☐ I do not have a gender/ gender identity
☐ Another description (please specify):_____
☐ I do not wish to answer this question

Above, we used terms like "male/female" or "Transgender/FtM" as a short-hand way to capture the gender of individuals. We fully understand, however, that people use a wide range of labels – some prefer other terms such as Genderfluid, Agender, Enby, Androgynous, etc. To help us understand you personally, please tell us the term that you personally prefer to describe your gender.

Please tell us what term that you personally prefer to describe your gender:
_____

A person's appearance, style, dress, or mannerisms (such as the way they walk or talk) may affect the way they think of themselves. On average, how would you describe your appearance, style, dress, or mannerisms?

☐ Very feminine
☐ Mostly feminine
☐ Somewhat feminine
☐ Equally masculine and feminine
☐ Somewhat masculine
☐ Mostly masculine
☐ Very masculine

ADULT VERSION POST

During the past 12 months how often did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
1. … nervous?	☐	☐	☐	☐	☐
2. … hopeless?	☐	☐	☐	☐	☐
3. … restless or fidgety?	☐	☐	☐	☐	☐
4. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
5. … feel that everything was an effort?	☐	☐	☐	☐	☐
6. … worthless?	☐	☐	☐	☐	☐

Think about the month in the past 12 months when you were at your worst emotionally.

	N/A	A Lot	Some	Not At All	Refused	Don't Know
7. Did your emotions interfere a lot, some, or not at all with your performance at work/school?	☐	☐	☐	☐	☐	☐
8. Did your emotions interfere a lot, some, or not at all with your household chores?	☐	☐	☐	☐	☐	☐
9. Did your emotions interfere a lot, some, or not at all with your social life?	☐	☐	☐	☐	☐	☐
10. Did your emotions interfere a lot, some, or not at all with your relationship with friends and family?	☐	☐	☐	☐	☐	☐

During the past 12 months, how often did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
11. …marginalized or excluded from society?	☐	☐	☐	☐	☐
12. …isolated and alienated from society?	☐	☐	☐	☐	☐

	Not at all	Somewhat	Quite a bit	Very
13. How religious are you?	☐	☐	☐	☐
14. How spiritual are you?	☐	☐	☐	☐
15. How important is religion in your life?	☐	☐	☐	☐
16. How important is spirituality in your life?	☐	☐	☐	☐
17. To what extent do you feel that in your life you are in balance physically, emotionally, mentally, and spiritually?	☐	☐	☐	☐

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
18. I am happy with the friendships I have.	☐	☐	☐	☐	☐	☐
19. I have people with whom I can do enjoyable things.	☐	☐	☐	☐	☐	☐
20. In a crisis, I would have the support I need from family or friends.	☐	☐	☐	☐	☐	☐
21. I feel I belong to a community.	☐	☐	☐	☐	☐	☐

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
22. My culture gives me strength.	☐	☐	☐	☐	☐	☐
23. My culture is important to me.	☐	☐	☐	☐	☐	☐
24. My culture helps me to feel good about who I am.	☐	☐	☐	☐	☐	☐

Instructions: Please answer the following questions based on the services you have received so far. Indicate if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each of the statements below. If the question is about something you have not experienced, check the box for Not Applicable to indicate that this item does not apply to you. Please note: the word "service" stand for any program activities or events connected to the program

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
25. I like the services that I received here.	☐	☐	☐	☐	☐	☐
26. If I had other choices, I would still get services from this agency.	☐	☐	☐	☐	☐	☐
27. I would recommend this agency to a friend or family member.	☐	☐	☐	☐	☐	☐
28. The location of services was convenient (parking, public transportation, distance, etc.)	☐	☐	☐	☐	☐	☐
29. Staff were willing to see me as often as I felt it was necessary.	☐	☐	☐	☐	☐	☐
30. Services were available at times that were good for me.	☐	☐	☐	☐	☐	☐
31. When I first called or came here, it was easy to talk to the staff.	☐	☐	☐	☐	☐	☐
32. The staff here treat me with respect.	☐	☐	☐	☐	☐	☐
33. The staff here don't think less of me because of the way I talk.	☐	☐	☐	☐	☐	☐
34. The staff here respect my race and/or ethnicity.	☐	☐	☐	☐	☐	☐
35. The staff here respect my religious and/or spiritual beliefs.	☐	☐	☐	☐	☐	☐
36. The staff here respect my gender identity and/or sexual orientation	☐	☐	☐	☐	☐	☐
37. Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	☐	☐	☐	☐	☐	☐
38. The people who work here respect my cultural beliefs, remedies and healing practices and remedies.	☐	☐	☐	☐	☐	☐
39. Staff here understand that people of my racial and/or ethnic group are not all alike	☐	☐	☐	☐	☐	☐
40. Staff here understand that people of my gender and/or sexual orientation group are not all alike.	☐	☐	☐	☐	☐	☐
41. Staff here understand that people of my religious and spiritual background are not all alike.	☐	☐	☐	☐	☐	☐

As a direct result of my involvement in the program:

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
42. I deal more effectively with my daily problems.	☐	☐	☐	☐	☐	☐
43. I do better in school and/or work.	☐	☐	☐	☐	☐	☐
44. My symptoms/problems are not bothering me as much.	☐	☐	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
45. Were the services you received here in the language you prefer?	☐	☐	☐	☐
46. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available in the language you prefer?	☐	☐	☐	☐

ADOLESCENT VERSION PRE

1. In the past 6 months did you think you needed help for emotional or mental health problems, such as feeling sad, anxious, or nervous?	☐	☐	☐	☐
2. When you had your last routine physical exam, did you and a doctor talk about your emotions or moods?	☐	☐	☐	☐
3. In the past 6 months, have you received any psychological or emotional counseling? This can be from psychologists, therapist, psychiatrists, or social workers.	☐	☐	☐	☐
4. Are you still in counseling?	☐	☐	☐	☐
5. In the past 6 months, did you receive any professional help for your use of alcohol or drugs?	☐	☐	☐	☐
6. Are you still receiving professional help?	☐	☐	☐	☐

	Not Applicable	Yes	No	Refused	Don't Know
7. Did you complete the full course of treatment? In other words, you ended treatment when your counselor, psychiatrist or social worker told you it was ok to end?	☐	☐	☐	☐	☐

8. What was the **MAIN REASON** you stopped counseling or professional help? (Please select one)

☐ Not Applicable (N/A)
☐ Therapist ended treatment/ goals met
☐Got better/No longer needed
☐Insurance did not cover
☐Had bad experiences with treatment
☐Hours not convenient
☐Couldn't get appointment
☐Not Getting Better
☐Lack of time/Transportation
☐ I moved
☐Other (Specify)
☐Too expensive
☐Provider did not understand what my problem was
☐ I felt discriminated against
☐I did not want to go anymore
☐Wanted to handle the problem on own

	Yes	No	Refused	Don't Know
9. During the past 12 months, have you taken any medications because of difficulties with your emotions, concentration, or behavior?	☐	☐	☐	☐

Instructions: Here are some reasons people have for not seeking help from a professional such as a counselor, psychiatrist, or social worker, even when they think they might need it. Please tell me "yes" or "no" for whether each statement has applied to you

	Yes	No	Refused	Don't Know
10. I thought I could solve my problems on my own.	☐	☐	☐	☐
11. I didn't think my problem was serious enough.	☐	☐	☐	☐
12. My friends might find out.	☐	☐	☐	☐
13. I didn't want to talk to a stranger about my problem.	☐	☐	☐	☐
14. I was worried my family and others (e.g., in the community) may think differently about me.	☐	☐	☐	☐
15. I don't know where to go for help.	☐	☐	☐	☐
16. I felt embarrassed about what I am going through.	☐	☐	☐	☐
17. I don't trust therapists.	☐	☐	☐	☐
18. I do not think that seeing a professional will help.	☐	☐	☐	☐
19. I didn't seek help because…				
a. I don't have time because of school, after-school	☐	☐	☐	☐

activities, and other commitments.				
b. I cannot afford it.	☐	☐	☐	☐
c. I don't have a way to get there.	☐	☐	☐	☐
20. I did not think I would feel safe and welcomed because of my…				
a. race/ethnicity	☐	☐	☐	☐
b. religious/spiritual belief	☐	☐	☐	☐
c. sexual orientation/gender identity	☐	☐	☐	☐

Instructions: About how often during the past 30 days did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
21. … nervous?	☐	☐	☐	☐	☐
22. … hopeless?	☐	☐	☐	☐	☐
23. … restless or fidgety?	☐	☐	☐	☐	☐
24. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
25. … feel that everything was an effort?	☐	☐	☐	☐	☐
26. … worthless?	☐	☐	☐	☐	☐

Instructions: Young people have a lot of fears and worries. The following questions ask how much your fears and worries have messed things up for you in your life.

	A lot	Some	Not at all	Refused	Don't know
27. How much have your fears and worries messed things up with school and homework?	☐	☐	☐	☐	☐
28. How much have your fears and worries messed things up with friends?	☐	☐	☐	☐	☐
29. How much have your fears and worries messed things up at home?	☐	☐	☐	☐	☐

During the past 12 months, how often did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
30. …marginalized or excluded from society?	☐	☐	☐	☐	☐
31. …isolated and alienated from society?	☐	☐	☐	☐	☐

	Not at all	Somewhat	Quite a bit	Very
32. How religious are you?	☐	☐	☐	☐
33. How spiritual are you?	☐	☐	☐	☐
34. How important is religion in your life?	☐	☐	☐	☐
35. How important is spirituality in your life?	☐	☐	☐	☐

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
36. I am happy with the friendships I have.	☐	☐	☐	☐	☐	☐
37. I have people with whom I can do enjoyable things.	☐	☐	☐	☐	☐	☐
38. In a crisis, I would have the support I need from family or friends.	☐	☐	☐	☐	☐	☐
39. I feel I belong to a community.	☐	☐	☐	☐	☐	☐

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
40. My culture gives me strength.	☐	☐	☐	☐	☐	☐
41. My culture is important to me.	☐	☐	☐	☐	☐	☐
42. My culture helps me to feel good about who I am.	☐	☐	☐	☐	☐	☐

	Very Good	Good	Fair	Poor	Refused	Don't Know
Would you say your health is Very Good, Good, Fair, or Poor? (*Circle one*)	☐	☐	☐	☐	☐	☐

43. ***IF YOU ARE UNDER 18:*** Are you between 0 and 5, between 6 and 10, between 11 and 15, or between 16 and 17?
- ☐ between 0 and 5
- ☐ between 6 and 10
- ☐ between 11 and 15
- ☐ between 16 and 17
- ☐ Refused
- ☐ Don't Know

Instructions: Mark an 'X' in one box and circle all origins that apply.

44. What is your race and origin?

☐ White

*Please specify your ethnic origin(s):*_____

☐ Black or African American

*Please specify your ethnic origin(s):*_____

---OR---

Check your origin(s):

- ☐ African American
- ☐ Caribbean
- ☐ Egyptian
- ☐ Kenyan
- ☐ South African
- ☐ Ghanaian
- ☐ Nigerian
- ☐ Ethiopian
- ☐ Refused
- ☐ Don't know
- ☐ Other Black or African American (Please specify):_____

☐ Latino, Hispanic, or Spanish

*Please specify your ethnic origin(s):*_____

---OR---

Check your origin(s):

- ☐ Mexican/ Chicano
- ☐ Salvadoran
- ☐ Guatemalan
- ☐ Dominican
- ☐ Honduran
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Peruvian
- ☐ Chilean
- ☐ Columbian
- ☐ Nicaraguan
- ☐ Refused
- ☐ Don't know
- ☐ Other Latino (Please specify):_____

☐ American Indian or Alaska Native

*Please list tribe[s] you are from:*_____

☐ Asian

*Please specify your ethnic origin(s):*_____

---OR---

Check your origin(s):

- ☐ Afghan
- ☐ Bangladeshi
- ☐ Burmese
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysia
- ☐ Pakistani
- ☐ Thai
- ☐ Vietnamese
- ☐ Refused
- ☐ Don't know
- ☐ Other Asian Please specify):

☐ Hmong ☐ Sri Lankan
☐ Indian (India) ☐ Taiwanese

☐ Native Hawaiian or Other Pacific Islander
Please specify your ethnic origin(s): _____
---OR---
Check your origin(s):
☐ Samoan ☐ Refused
☐ Guamanian ☐ Don't know
☐ Tongan ☐ Other Hawaiian or Pacific Islander
☐ Fijian Please specify):_____

☐ Other Race
*Please specify your race and origin(s):*_____

☐ Multi-Racial
Check all that apply and specify your ethnic origin(s).
☐ White ☐ Asian
☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander
☐ Latino, Hispanic, or Spanish ☐ Refused
☐ American Indian or Alaska Native ☐ Don't know

*Please specify your origin(s):*_____

☐ Refused
☐ Don't know

45. How well can you speak the English language?

☐ Fluently
☐ Somewhat fluently; can make myself understood by have some problems with it
☐ Not very well; know a lot of words and phrases but have difficulties communicating
☐ Know some vocabulary, but can't speak in sentences
☐ Not at all

46. What is your preferred language? _____

47. Were you born:

☐ Inside the U.S.
☐ Outside the U.S.
☐ Refused
☐ Don't know

48. What is your Zip Code? _____ ☐Unstable housing/ no zip code ☐ Refused

49. When you came to the United States, did you spend time in a refugee camp?
☐ Not Applicable
☐ Yes
☐ No
☐ Refused
☐ Don't know

50. About how many years have you lived in the United States? [*For less than a year enter 1 year*]

Number of years_____ ☐ Not Applicable ☐ Don't Know

Individuals often develop romantic attractions toward others. For example, some men are attracted to women, while other men are attracted to both women and men. Still other men might be attracted to female identified individuals in general, for example, transgender women as well as cisgender women. Some women are attracted to other women but want to kiss, hold hands with and be in relationships with men. Other women may daydream and think about other women. Still other individuals may not develop attractions toward anyone or are unsure about whether they are attracted to women or men. Just to be clear, we are not talking about how you feel toward your friends. We are talking about who you want to get emotionally and physically close to, in a romantic way. Please answer the questions below about your experiences in the past year (12 months).
There are no right or wrong answers to any of these questions. Please be honest and answer as you really think and feel.

	ONLY Men/Male identified individuals	MOSTLY Men/ Male identified individuals	BOTH men/ Male identified individuals and women/female identified individuals equally	MOSTLY women/ female identified individuals	Only women/ female identified individuals	No one	I am not sure	Other (please specify)
q. I am attracted to (e.g., get crushes on, get excited about)	☐	☐	☐	☐	☐	☐	☐	_____
r. I daydream about….	☐	☐	☐	☐	☐	☐	☐	_____
s. I would want to hold hands with, kiss and hug	☐	☐	☐	☐	☐	☐	☐	_____
t. I have held hands with, kissed and hugged…	☐	☐	☐	☐	☐	☐	☐	_____
u. I would want to have intimate physical relationships with....	☐	☐	☐	☐	☐	☐	☐	_____
v. I have had intimate physical relationships with…	☐	☐	☐	☐	☐	☐	☐	_____
w. I would want to be in a romantic relationship with…	☐	☐	☐	☐	☐	☐	☐	_____
x. I have been in a romantic relationship with….	☐	☐	☐	☐	☐	☐	☐	_____

Instructions: Everyone has a sexual orientation. Some people are straight and are attracted to people of the other gender. For example, a straight woman "likes" men and gets crushes on men. Other people are gay or lesbian and are attracted to the same gender. For example, a gay man "likes" other men and gets crushes on other men. Still other people are bisexual and "like" both men and women. Some people are unsure about their attractions or are just not attracted to anyone. Just to be clear, who you "like" and are attracted to is called sexual orientation.

51. What is your sexual orientation?

☐ Straight
☐ Gay
☐ Lesbian
☐ I have started to question my sexual orientation
☐ I am not attracted to anyone
☐ I am asexual

☐ Bisexual
☐ Queer
☐ I am not sure who I am attracted to romantically
☐ Another label: _____
☐ I do not wish to answer this question

Instructions: Above, we used terms like "straight" or "gay/lesbian" as a short-hand way to capture the experiences of individuals who are attracted to people of the other sex or of the same sex. We fully understand, however, that individuals use a wide range of labels – some prefer other terms such as queer, homosexual, same-gender loving, etc. To help us understand you personally, please tell us the term that you personally prefer to describe yourself?

Please tell us what term that you personally prefer to describe yourself: _____

Instructions: Gender is complex and has many different facets. Here we focus on three aspects, namely, sex assigned at birth, gender identity (label), gender expressions and behavior. The items below reflect these different aspects.
Just so that everyone is on the same page, let's start with a general definition of gender. Some people are born a male and others are born a female. Still other people are born intersex. Sometimes, however, an individual's sex assigned at birth does not correspond with the way a person identifies their gender. For example, an individual who is assigned male at birth might feel that they are a female, on the inside. Such individuals may think of themselves as transgender. There are also individuals who are not sure about their gender. These are just a few examples. We recognize that each person has their own sense of gender and we want to know about you and your experiences. There are no right or wrong answers.

52. When I was born, the person who delivered me (e.g., doctor, nurse/midwife, family members), thought I was a:

☐ Male
☐ Female
☐ Intersex
☐ I am not sure about my sex assigned at birth
☐ Another description (please specify)
_____
☐ I do not wish to answer this question

53. When it comes to my gender identity, I think of myself as:

☐ Man/Male
☐ Woman/Female
☐ Transgender male/Transgender man/Female to Male
☐ Transgender female/Transgender woman/Male to Female
☐ Genderqueer/Gender non-conforming
☐ Two Spirit
☐ I am not sure about my gender identity
☐ I do not have a gender/ gender identity
☐ Another description (please specify):_____
☐ I do not wish to answer this question

Above, we used terms like "male/female" or "Transgender/FtM" as a short-hand way to capture the gender of individuals. We fully understand, however, that people use a wide range of labels – some prefer other terms such as Genderfluid, Agender, Enby, Androgynous, etc. To help us understand you personally, please tell us the term that you personally prefer to describe your gender.
Please tell us what term that you personally prefer to describe your gender: _____

A person's appearance, style, dress, or mannerisms (such as the way they walk or talk) may affect the way they think of themselves. On average, how would you describe your appearance, style, dress, or mannerisms?

☐ Very feminine
☐ Mostly feminine
☐ Somewhat feminine
☐ Equally masculine and feminine
☐ Somewhat masculine
☐ Mostly masculine
☐ Very masculine

ADOLESCENT VERSION POST

About how often during the past 30 days did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
1. … nervous?	☐	☐	☐	☐	☐
2. … hopeless?	☐	☐	☐	☐	☐
3. … restless or fidgety?	☐	☐	☐	☐	☐
4. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
5. … feel that everything was an effort?	☐	☐	☐	☐	☐
6. … worthless?	☐	☐	☐	☐	☐

Instructions: Young people have a lot of fears and worries. The following questions ask how much your fears and worries have messed things up for you in your life.

	A lot	Some	Not at all	Refused	Don't know
7. How much have your fears and worries messed things up with school and homework?	☐	☐	☐	☐	☐
8. How much have your fears and worries messed things up with friends?	☐	☐	☐	☐	☐
9. How much have your fears and worries messed things up at home?	☐	☐	☐	☐	☐

During the past 12 months, how often did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
10. …marginalized or excluded from society?	☐	☐	☐	☐	☐
11. …isolated and alienated from society?	☐	☐	☐	☐	☐

	Not at all	Somewhat	Quite a bit	Very
12. How religious are you?	☐	☐	☐	☐
13. How spiritual are you?	☐	☐	☐	☐
14. How important is religion in your life?	☐	☐	☐	☐
15. How important is spirituality in your life?	☐	☐	☐	☐

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
16. I am happy with the friendships I have.	☐	☐	☐	☐	☐	☐
17. I have people with whom I can do enjoyable things.	☐	☐	☐	☐	☐	☐
18. In a crisis, I would have the support I need from family or friends.	☐	☐	☐	☐	☐	☐
19. I feel I belong to a community.	☐	☐	☐	☐	☐	☐

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
20. My culture gives me strength.	☐	☐	☐	☐	☐	☐
21. My culture is important to me.	☐	☐	☐	☐	☐	☐
22. My culture helps me to feel good about who I	☐	☐	☐	☐	☐	☐

am.

Instructions: Please answer the following questions based on the services you have received so far. Indicate if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each of the statements below. If the question is about something you have not experienced, check the box for Not Applicable to indicate that this item does not apply to you.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
23. Overall, I am satisfied with the services I received.	☐	☐	☐	☐	☐	☐
24. If I had other choices, I would still comeback to [Name of Project].	☐	☐	☐	☐	☐	☐
25. I would recommend [Name of Project] to a friend or family member.	☐	☐	☐	☐	☐	☐
26. The location of services was convenient for me.	☐	☐	☐	☐	☐	☐
27. Services were available at times that were convenient for me.	☐	☐	☐	☐	☐	☐
28. When I first called or came here, it was easy to talk to the staff.	☐	☐	☐	☐	☐	☐
29. The staff here treat me with respect.	☐	☐	☐	☐	☐	☐
30. The staff here don't think less of me because of the way I talk.	☐	☐	☐	☐	☐	☐
31. The staff here respect my race and/or ethnicity.	☐	☐	☐	☐	☐	☐
32. The staff here respect my religious and/or spiritual beliefs.	☐	☐	☐	☐	☐	☐
33. The staff here respect my gender identity and/or sexual orientation**.**	☐	☐	☐	☐	☐	☐
34. Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	☐	☐	☐	☐	☐	☐
35. The people who work here respect my cultural beliefs, remedies and healing practices and remedies.	☐	☐	☐	☐	☐	☐
36. Staff here understand that people of my racial and/or ethnic group are not all alike.	☐	☐	☐	☐	☐	☐
37. Staff here understand that people of my gender and/or sexual orientation group are not all alike.	☐	☐	☐	☐	☐	☐
38. Staff here understand that people of my religious and spiritual background are not all alike.	☐	☐	☐	☐	☐	☐

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
As a direct result of my involvement in the program:						
39. I am better at handling daily life.	☐	☐	☐	☐	☐	☐
40. I do better in school and/or work.	☐	☐	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
41. Were the services you received here provided in the language you prefer?	☐	☐	☐	☐
42. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available in the language you prefer?	☐	☐	☐	☐

CHILD VERSION PRE

1. In the past 6 months did you think your child needed help for emotional, behavioral or mental health problems, such as feeling sad, anxious, or nervous?	☐	☐	☐	☐
2. When your child had his/her last routine physical exam, did you and your child's doctor talk about his/her emotions or moods?				
3. In the past 6 months, did your child receive any psychological or emotional counseling? This can be from psychologists, therapists, psychiatrists, or social workers.	☐	☐	☐	☐

	Not Applicable	Yes	No	Refused	Don't Know
4. Is your child still receiving any psychological or emotional counseling?	☐	☐	☐	☐	☐
5. Did your child complete the full counseling program? In other words, your child ended counseling when your child's counselor, psychiatrist or social worker told you it was okay for him/her to end.	☐	☐	☐	☐	☐

6. What is **MAIN REASON** your child stopped counseling?

☐ Not Applicable (N/A)	☐I or my child had a bad experience with this "provider"	☐Too expensive
☐Therapist ended treatment/ goals met	☐I or my child felt discriminated against	☐We moved
☐My child improved so stopped going	☐"Provider" was no longer available (moved or left setting)	☐Refused
☐ I felt "provider" did not understand what my child's the problem was	☐Child did not want to go anymore	☐Don't know
☐ I disagreed with "provider" about what should be done for my child	☐Insurance/ managed care company limited treatment	☐Other (Specify)

	Yes	No	Refused	Don't Know
7. DURING THE PAST 12 MONTHS, has your child taken any medication because of difficulties with his or her emotions, concentration, or behavior?	☐	☐	☐	☐

The following is a list of items that describe children. During the past 6 months, how true have the following items been for your child?

My child…	Not True	Somewhat True	Certainly True	Refused	Don't Know
8. is generally well behaved, usually does what adults request	☐	☐	☐	☐	☐
9. has many worries, or often seems worried.	☐	☐	☐	☐	☐
10. is often unhappy, depressed or tearful	☐	☐	☐	☐	☐
11. gets along better with adults than with other children	☐	☐	☐	☐	☐
12. has good attention span, sees chores or homework through to the end.	☐	☐	☐	☐	☐

	No	Yes, Minor	Yes,	Yes, Severe	Refused	Don't

		Difficulties	Definite Difficulties	Difficulties		Know
13. Overall, do you think that your child has difficulties in any of the following areas: emotions, concentration, behavior, or being able to get along with other people?	☐	☐	☐	☐	☐	☐

Instructions: Young people have lot of worries and fears. The following questions as how much your child's fears and worries have messed things up for your child in his/her life.

	A lot	*Some*	*Not at all*	*Refused*	*Don't know*
14. How much have your child's fears and worries messed things up with school and homework?	☐	☐	☐	☐	☐
15. How much have your child's fears and worries messed up things at home?	☐	☐	☐	☐	☐
16. How much have your child's fears and worries messed things up with friends?	☐	☐	☐	☐	☐

	Very Good	Good	Fair	Poor	Refused	Don't Know
Would you say your child's health is Very Good, Good, Fair, or Poor? (*Circle one*)	☐	☐	☐	☐	☐	☐

17. ***IF YOUR CHILD IS UNDER 18***: Is your child between 0 and 5, between 6 and 10, between 11 and 15, or between 16 and 17?

☐ between 0 and 5
☐ between 6 and 10
☐ between 11 and 15
☐ between 16 and 17
☐ Refused
☐ Don't Know

Instructions: Mark an 'X' in one box and circle all origins that apply for your child.

18. *What is your child's race and origin?*

☐ White
*Please specify your child's ethnic origin(s):*_____

☐ Black or African American
*Please specify your child's ethnic origin(s):*_____
---OR---
Check your child's origin(s):

☐ African American
☐ Caribbean
☐ Egyptian
☐ Kenyan
☐ South African
☐ Ghanaian
☐ Nigerian
☐ Ethiopian
☐ Refused
☐ Don't know
☐ Other Black or African American (Please specify):_____

☐ Latino, Hispanic, or Spanish
*Please specify your child's ethnic origin(s):*_____
---OR---
Check your child's origin(s):

☐ Mexican/ Chicano
☐ Salvadoran
☐ Guatemalan
☐ Dominican
☐ Honduran
☐ Puerto Rican
☐ Cuban
☐ Peruvian
☐ Chilean
☐ Columbian
☐ Nicaraguan
☐ Refused
☐ Don't know
☐ Other Latino (Please specify):_____

☐ American Indian or Alaska Native
*Please list tribe[s] your child are from:*_____

☐ Asian
*Please specify your child's ethnic origin(s):*_____
---OR---

Check your child's origin(s):

☐ Afghan
☐ Bangladeshi
☐ Burmese
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Indian (India)
☐ Indonesian
☐ Japanese
☐ Korean
☐ Laotian
☐ Malaysia
☐ Pakistani
☐ Sri Lankan
☐ Taiwanese
☐ Thai
☐ Vietnamese
☐ Refused
☐ Don't know
☐ Other Asian
Please specify):
_____

☐ Native Hawaiian or Other Pacific Islander

Please specify your child's ethnic origin(s): _____

---OR---

Check your child's origin(s):

☐ Samoan
☐ Guamanian
☐ Tongan
☐ Fijian
☐ Refused
☐ Don't know
☐ Other Hawaiian or Pacific Islander
Please specify):_____

☐ Other Race

*Please specify your child's race and origin(s):*_____

☐ Multi-Racial

Check all that apply and specify your child's ethnic origin(s).

☐ White
☐ Black/African American
☐ Latino, Hispanic, or Spanish
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Refused
☐ Don't know

*Please specify your child's origin(s):*_____

☐ Refused
☐ Don't know

19. How well can your child speak the English language?

☐ Fluently
☐ Somewhat fluently; can make himself/ herself understood but have some problems with it
☐ Not very well; know a lot of words and phrases but have difficulties communicating
☐ Know some vocabulary, but can't speak in sentences
☐ Not at all

20. What is your child's preferred language? _____

21. Was your child born:

☐ Inside the U.S.
☐ Outside the U.S.
☐ Don't know
☐ Refused

22. What is your child's ZIP Code? _____ ☐Unstable housing/ no ZIP code ☐ Refused

23. When your child came to the United States, did he/she spend time in a refugee camp?

- ☐ Not Applicable
- ☐ Yes
- ☐ No
- ☐ Refused
- ☐ Don't know

24. About how many years has your child lived in the United States? [*For less than a year enter 1 year*]

Number of years_____ ☐ Not Applicable ☐ Don't Know

Instructions: Gender is complex and has many different facets. Here we focus on three aspects, namely, sex assigned at birth, gender identity (label), gender expressions and behavior. The items below reflect these different aspects.
Just so that everyone is on the same page, let's start with a general definition of gender. Some people are born a male and others are born a female. Still other people are born intersex. Sometimes, however, an individual's sex assigned at birth does not correspond with the way a person identifies their gender. For example, an individual who is assigned male at birth might feel that they are a female, on the inside. Such individuals may think of themselves as transgender. There are also individuals who are not sure about their gender. These are just a few examples. We recognize that each person has their own sense of gender and we want to know about your child and your child's experiences. There are no right or wrong answers.

25. When my child was born, the person who delivered my child (e.g., doctor, nurse/midwife, family members), thought my child was a:

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ I am not sure about my child's sex assigned at birth
- ☐ Another description (please specify)
  _____
- ☐ I do not wish to answer this question

26. Which option best describes your child's gender identity?

- ☐ Man/Male
- ☐ Woman/Female
- ☐ Transgender male/Transgender man/Female to Male
- ☐ Transgender female/Transgender woman/Male to Female
- ☐ Genderqueer/Gender non-conforming
- ☐ Two Spirit
- ☐ I am not sure about my child's gender identity
- ☐ My child does not have a gender/ gender identity
- ☐ Another description (please specify):_____
- ☐ I do not wish to answer this question

Above, we used terms like "male/female" or "Transgender/FtM" as a short-hand way to capture the gender of individuals. We fully understand, however, that people use a wide range of labels – some prefer other terms such as Genderfluid, Agender, Enby, Androgynous, etc. To help us understand your child personally, please tell us the term that your child personally prefers to describe your child's gender.

Please tell us what term that your child personally prefer to describe your child's gender:
_____

A person's appearance, style, dress, or mannerisms (such as the way they walk or talk) may affect the way they think of themselves. On average, how would your child describe your child's appearance, style, dress, or mannerisms?

- ☐ Very feminine
- ☐ Mostly feminine
- ☐ Somewhat feminine
- ☐ Equally masculine and feminine
- ☐ Somewhat masculine
- ☐ Mostly masculine
- ☐ Very masculine

CHILD VERSION POST

Instructions: Read the list of items below that describe children. For each item, please tell me if it has been NOT TRUE, SOMEWHAT TRUE, OR CERTAINLY TRUE for your child in the past 6 (12)months …

My child…	Not True	Somewhat True	Certainly True	Refused	Don't Know
1. is generally well behaved, usually does what adults request	☐	☐	☐	☐	☐
2. has many worries, or often seems worried.	☐	☐	☐	☐	☐
3. is often unhappy, depressed or tearful	☐	☐	☐	☐	☐
4. gets along better with adults than with other children	☐	☐	☐	☐	☐
5. has good attention span, sees chores or homework through to the end.	☐	☐	☐	☐	☐

	No	Yes, Minor Difficulties	Yes, Definite Difficulties	Yes, Severe Difficulties	Refused	Don't Know
6. Overall, do you think that your child has difficulties in any of the following areas: emotions, concentration, behavior, or being able to get along with other people?	☐	☐	☐	☐	☐	☐

Instructions: Young people have lot of worries and fears. The following questions as how much your child's fears and worries have messed things up for your child in his/her life.

	A lot	*Some*	*Not at all*	*Refused*	*Don't know*
7. How much have your child's fears and worries messed things up with school and homework?	☐	☐	☐	☐	☐
8. How much have your child's fears and worries messed up things at home?	☐	☐	☐	☐	☐
9. How much have your child's fears and worries messed things up with friends?	☐	☐	☐	☐	☐

Instructions: Please answer the following questions based on the services you have received so far. Indicate if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each of the statements below. If the question is about something you have not experienced, check the box for Not Applicable to indicate that this item does not apply to you.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
10. Overall, I am satisfied with the services my child received.	☐	☐	☐	☐	☐	☐
11. If I had other choices, I would still bring my child back to [Name of Project].	☐	☐	☐	☐	☐	☐
12. I would recommend [Name of Project] to a friend or family member.	☐	☐	☐	☐	☐	☐
13. The location of services was convenient for us.	☐	☐	☐	☐	☐	☐
14. Services were available at times that were convenient for us.	☐	☐	☐	☐	☐	☐
15. When I first called or came here, it was easy to talk to the staff.	☐	☐	☐	☐	☐	☐
16. The staff here treat my child with respect.	☐	☐	☐	☐	☐	☐
17. The staff here don't think less of my child because of the way he/she talks.	☐	☐	☐	☐	☐	☐
18. The staff here respect my child's race and/or ethnicity.	☐	☐	☐	☐	☐	☐

19. The staff here respect my child's religious and/or spiritual beliefs.	☐	☐	☐	☐	☐	☐
20. The staff here respect my child's gender identity and/or sexual orientation.	☐	☐	☐	☐	☐	☐
21. Staff are willing to be flexible and provide alternative approaches or services to meet my child's needs.	☐	☐	☐	☐	☐	☐
22. The people who work here respect my child's cultural beliefs, remedies and healing practices and remedies.	☐	☐	☐	☐	☐	☐
23. Staff here understand that people of my child's racial and/or ethnic group are not all alike.	☐	☐	☐	☐	☐	☐
24. Staff here understand that people of my child's gender and/or sexual orientation group are not all alike.	☐	☐	☐	☐	☐	☐
25. Staff here understand that people of my child's religious and spiritual background are not all alike.	☐	☐	☐	☐	☐	☐

As a direct result of the services my child received:

	Strongly Agree	**Agree**	**I am Neutral**	**Disagree**	**Strongly Disagree**	**Not Applicable**
26. My child is better at handling daily life.	☐	☐	☐	☐	☐	☐
27. My child does better in school and/or work.	☐	☐	☐	☐	☐	☐

	Yes	**No**	**Refused**	**Don't Know**
28. Were the services your child received here provided in the language he/she prefers?	☐	☐	☐	☐
29. Was written information (e.g., brochures describing available services, your child's rights as a consumer, and mental health education materials) available in the language you prefer?	☐	☐	☐	☐

APPENDIX 5:

SWE Semi-Annual Evaluation Report

Appendix 5

Statewide Evaluation Semi-Annual Report (IPPs)
Reporting Period: May 2017 through October 2017

IPP Name: (prepopulated)

CDEP Staff/Consultant(s) and Title/Role:
Please list out all of names of your CDEP staff/consultants and include a brief description of their title/role. If you are still currently in the hiring process for certain staff, write in "still hiring" and briefly describe their designated role.

Name of CDEP Staff Member or Consultant	Title/Role(s)

IPP Contact Information:
Below is a list of primary contact names identified in your local evaluation plan dated (prepopulated). If there have been any changes with your IPP staff and/or local evaluator, please update the contact list below.

Staff Person(s)
(prepopulated)

Local Evaluator
(prepopulated)

If IPP primary contact names have changed since (prepopulated date), please write in new contact person's name and briefly explain the reason for the change. If no changes occurred, write in "Not Applicable."
Click here to enter text.

CDEP Purpose

In this section let us know if any modifications have been made to your CDEP in the past 6 months that would require changes to your CDEP Purpose Statement. If modifications have been made, please include the revised purpose statement below and describe your rationale for the change(s) you have made to either the mental health issue(s) being addressed, priority or sub-populations, desired outcomes, and/or Phase 1 priority population strategy.

Purpose Statement:
(prepopulated CDEP purpose statement here)

1. In the past 6 months, have you made any modifications to your CDEP that impacts your purpose statement?
   ☐ No **(GO TO Q2)**
   ☐ Yes **(GO TO Q1a and Q1b)**

   1a. Include your revised purpose statement here: Click here to enter text.

   1b. Please explain your rationale for the changes that were made: Click here to enter text.

CDEP Fidelity/Flexibility

In this section, you will use data from your ongoing fidelity assessment from your local evaluation to report the extent to which each of your CDEP components were:

- Implemented as intended, OR
- Adapted to meet local circumstances, AND
- Reasons for modification(s) to your CDEP if applicable.

Reasons for modifications may include things such as a need to simplify due to time or resource constraints, adapting your CDEP to strengthen its cultural or linguistic appropriateness, lack of responsiveness by participants, meeting needs of the organization, etc.

Please answer each corresponding query for each CDEP component listed in your local evaluation plan (prepopulated date).

2. [Prepopulated IPP core component #1 --- each component will get their own set of queries based on # of components identified in the evaluation plan]
   This component was:
   - ☐ Implemented exactly as planned
   - ☐ Implemented with low/moderate change
     (Describe change and reason for change: Click here to enter text.)
   - ☐ Implemented with a lot of change
     (Describe change and reason for change: Click here to enter text.)
   - ☐ Not implemented but plan to at some point
     (Describe why it was not conducted: Click here to enter text.)
   - ☐ This component was dropped
     (Describe why it was dropped: Click here to enter text.)

3. Were any **new core components** added to your CDEP?
   - ☐ No **(GO TO Q4)**
   - ☐ Yes (**If YES**, please describe your new component(s) and core elements here: Click here to enter text.)

CDEP Outreach/Recruitment & Participation

All organizations must work to attract and sustain community involvement in their programs. Participation in your CDEP activities may be high or low at times for various reasons—some that are internal to your organization, and some that are external (and oftentimes due to circumstances beyond your control). The next three questions will identify successes, challenges and lessons learned related to community outreach, recruitment, and participation for your CDEP. This information is important for both capturing your story and developing recommendations and lessons learned regarding how to best implement outreach and recruitment for CDEPs for future efforts such as these.

Outreach/recruitment is defined as reaching out to others or becoming involved in a community project or effort. Often times, outreach is not stationary, but mobile; in other words, you are meeting in spaces and places where your community is located. **Important note: outreach and recruitment is NOT community engagement.** Refer to the Community Engagement Section of the SAR for further information on the distinction between the two.

4. In the past 6 months, **what places** did you go to conduct outreach and talk to people or groups about your CDEP? Select all that apply.
   - ☐ Community resident homes
   - ☐ School campuses and classrooms
   - ☐ Places where people publicly congregate (e.g., parks, outside of schools, barber shops, markets, etc.)
   - ☐ Local agencies and organizations that offer services to your community
   - ☐ Community fairs, social/cultural festivals and events
   - ☐ Faith-based, religious or spiritual centers
   - ☐ Conferences and convenings
   - ☐ Associations and group meetings (e.g., PTA, block clubs, etc.)
   - ☐ Businesses
   - ☐ Local mental health agencies & other government offices (e.g., police department, social services, etc.)
   - ☐ Other (please specify: Click here to enter text.)

5. In the past 6 months, how effective were your **CDEP outreach/recruitment strategies**? (In other words, recruiting community members to participate or become involved in your CDEP events and activities)
   - ☐ Very Effective (Please describe what worked or successes here: Click here to enter text.).
   - ☐ Somewhat Effective (Please describe what worked or successes here: Click here to enter text.).
   - ☐ Not at all Effective (Please describe what didn't work or challenges here: Click here to enter text.).

5a. What types of **barriers or challenges** did you experience with outreach/recruitment and what, if anything, was done in response? Select all that apply and provide an explanation.
   - ☐ No particular barriers or challenges experienced during this time
   - ☐ Program marketing/messaging (Describe barrier and response: Click here to enter text.)
   - ☐ Staffing changes/staff capacity (Describe barrier and response: Click here to enter text.)
   - ☐ Cultural/linguistic factors (Describe barrier and response: Click here to enter text.)
   - ☐ Program visibility/accessibility (Describe barrier and response: Click here to enter text.)

- ☐ Community buy-in/trust/interest (Describe barrier and response: Click here to enter text.)
- ☐ Relationship building with stakeholders (Describe barrier and response: Click here to enter text.)
- ☐ Competing time demands for participants (Describe barrier and response: Click here to enter text.)
- ☐ Stigma (Describe barrier and response: Click here to enter text.)
- ☐ Community is very transient – moves in and out quickly (Describe barrier and response: Click here to enter text.)
- ☐ Geography/weather/transportation (Describe barrier and response: Click here to enter text.)
- ☐ Budget/resources (Describe barrier and response: Click here to enter text.)
- ☐ Other (Describe barrier and response: Click here to enter text.)

6. In the past 6 months, please rate how effective your strategies were in **sustaining participation** in your CDEP (in other words, keeping your participants involved over time in your CDEP program events and activities)?
   - ☐ Very Effective (Please describe what worked or successes here: Click here to enter text.).
   - ☐ Somewhat Effective (Please describe what worked or successes here: Click here to enter text.).
   - ☐ Not at all Effective (Please describe what didn't work or challenges here: Click here to enter text.).

6a. What types of **barriers or challenges** did you experience with sustaining participation and what, if anything, was done in response?

Select all that apply and provide an explanation.

- ☐ No particular barriers or challenges experienced during this time
- ☐ Program marketing/messaging (Describe barrier and response: Click here to enter text.)
- ☐ Staffing changes/staff capacity (Describe barrier and response: Click here to enter text.)
- ☐ Cultural/linguistic factors (Describe barrier and response: Click here to enter text.)
- ☐ Program visibility/accessibility (Describe barrier and response: Click here to enter text.)
- ☐ Community buy-in/trust/interest (Describe barrier and response: Click here to enter text.)
- ☐ Relationship building with stakeholders (Describe barrier and response: Click here to enter text.)
- ☐ Competing time demands for participants (Describe barrier and response: Click here to enter text.)
- ☐ Stigma (Describe barrier and response: Click here to enter text.)
- ☐ Community is very transient – moves in and out quickly (Describe barrier and response: Click here to enter text.)
- ☐ Geography/weather/transportation (Describe barrier and response: Click here to enter text.)
- ☐ Budget/resources (Describe barrier and response: Click here to enter text.)
- ☐ Other (Describe barrier and response: Click here to enter text.)

Community Engagement (including Community-Based Participatory Research)

Community engagement (CE) is a process that promotes the participation of individuals, who have been historically excluded and isolated from community life, by engaging them to have an active role in shaping program and policies that affect the mental health and wellness of residents in their community.

- Your priority community (i.e., youth residents, adult residents, families, elders, etc.) is engaged when they are actively involved in deliberations and discussions of community strengths, assets, aspirations, and issues/problems affecting them, including generating ideas, acting in their own interests, and identifying solutions to community concerns.
- CE can vary in different community contexts, is fluid and dynamic, and has the power to impact multiple systems and to create lasting community change.

The 3 main CE areas you will be reporting on in this section include:

- Designing, planning and decision-making related to your CDEP and its implementation;
- Designing, planning and decision-making related to your local evaluation and its implementation; and
- Community members who you are working with directly (e.g., community advisory board members) having a seat at the decision-making table for systems transformation (e.g., county mental health delivery systems, schools and school districts, tribal councils, etc.).

It is important to note that Outreach is NOT Community Engagement.

7. Indicate each type of CE area your IPP used during the past 6 months. For each CE area listed below, check "Yes" if it was conducted or "Non-applicable" if it was not conducted.

   For **EACH** CE activity checked "**YES**," please complete the following:
   - Type of Community Member: Select types of the community members engaged and briefly describe any critical sub-population background information
   - Type of Engagement: Briefly describe how and when community members were involved. For example: Did they help conceptualize CDEP, establish project goals, and develop or plan the project? How did community members help assure that the program or intervention is culturally sensitive? How are community members involved in implementing the CDEP? Did they assist with the development of materials or the implementation of project activities or provide space? How are community members involved in program evaluation or data analysis? Did they help create tools, methods, interpret or synthesize data and conclusions? Did they help develop or disseminate materials? Are they coauthors on a publication or products?
   - IPP Cultural and Linguistic Policies and Structures: Briefly describe how IPP cultural and linguistic (C/L) processes and structures allowed for all voices to be heard and equally valued. For example, offering cultural food and social spaces/times, giving elders a special role, providing child care, having interpreters present (or staff serve as interpreters), arranging transportation, etc.

CDEP Development ☐ Yes ☐ Non-applicable
Type of Community Member *(select all that apply & briefly describe)* ☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)
Type of Engagement *(briefly describe)*
IPP Cultural/Linguistic Processes & Structures *(briefly describe)*

CDEP Implementation ☐ Yes ☐ Non-applicable
Type of Community Member *(select all that apply & briefly describe)* ☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)

Type of Engagement *(briefly describe)*
IPP Cultural/Linguistic Processes & Structures *(briefly describe)*

Local Evaluation Plan Development ☐ Yes ☐ Non-applicable
Type of Community Member *(select all that apply & briefly describe)* ☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)
Type of Engagement *(briefly describe)*
IPP Cultural/Linguistic Processes & Structures *(briefly describe)*

Local Evaluation Plan Implementation ☐ Yes ☐ Non-applicable
Type of Community Member *(select all that apply & briefly describe)* ☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)
Type of Engagement *(briefly describe)*
IPP Cultural/Linguistic Processes & Structures *(briefly describe)*

Systems Transformation *(refers to CDEP work related to changes in local mental health delivery systems and policies)* ☐ Yes ☐ Non-applicable
Type of Community Member *(select all that apply & briefly describe)* ☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)
Type of Engagement *(briefly describe)*
IPP Cultural/Linguistic Processes & Structures *(briefly describe)*

Public Communication Efforts

In this section, you will be reporting on public communication efforts conducted in the past 6 months related to:

- Increasing awareness and understanding of mental health;
- Promoting emotional health and wellness; and
- Increasing access to mental health services or other resources and supports.

These campaigns or efforts use the media and messaging to shape attitudes, values or behaviors among the broader community (i.e., large numbers of individuals in your community). Public communications most commonly include:

- Newsletters
- Brochures/leaflets
- Posters
- Toolkits

- Public Events (e.g., press conference, event "kick-offs", townhall/forum, etc.)
- Coverage by or advertisement in traditional media (TV, radio, print)
- Social networking media (Twitter, Facebook, etc.)
- Informational web sites, etc.

8. Based on the description above, to what extent was a public communication effort part of your CDEP efforts during the past 6 months?
   - ☐ None **(Skip this section and GO to Networks/Collaboratives/Partnerships section on p.10)**
   - ☐ A Little **(GO To Q#8)**
   - ☐ Some **(GO To Q#8)**
   - ☐ A Lot **(GO To Q#8)**

9. Indicate each type of public communication strategy your IPP used during the past 6 months. For each strategy listed below, check "Yes" if it was used or "Non-applicable" if it was not used.

   For **EACH** strategy checked "**YES**," please complete the following:
   - Focus of Messaging: Describe the focus of the messaging or information disseminated
   - Type of Audience: Select all of the types of audiences reached and briefly describe any critical sub-population background information
   - Total Estimated Number Reached: Indicate the TOTAL estimated number of individuals reached (across audience types), if applicable.

Newsletters ☐ Yes ☐ Non-applicable		
Focus of Messaging or Information *(briefly describe)*	Type of Audience Reached *(select all that apply and briefly describe your audience)*	Total Est. # Reached
	☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Community-based orgs (specify: Click here to enter text.) ☐ Faith-based orgs (specify: Click here to enter text.) ☐ Tribal groups (specify: Click here to enter text.) ☐ K-12 schools/districts (specify: Click here to enter text.) ☐ Colleges/universities (specify: Click here to enter text.) ☐ Govt agencies/departments (specify: Click here to enter text.) ☐ Decision makers/policymakers (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)	

Brochures/Leaflets ☐ Yes ☐ Non-applicable		
Focus of Messaging or Information *(briefly describe)*	Type of Audience Reached *(select all that apply and briefly describe your audience)*	Total Est. # Reached
	☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Community-based orgs (specify: Click here to enter text.) ☐ Faith-based orgs (specify: Click here to enter text.) ☐ Tribal groups (specify: Click here to enter text.)	

	☐ K-12 schools/districts (specify: Click here to enter text.) ☐ Colleges/universities (specify: Click here to enter text.) ☐ Govt agencies/departments (specify: Click here to enter text.) ☐ Decision makers/policymakers (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)	

Posters ☐ Yes ☐ Non-applicable		
Focus of Messaging or Information *(briefly describe)*	Type of Audience Reached *(select all that apply and briefly describe your audience)*	Total Est. # Reached
	☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Community-based orgs (specify: Click here to enter text.) ☐ Faith-based orgs (specify: Click here to enter text.) ☐ Tribal groups (specify: Click here to enter text.) ☐ K-12 schools/districts (specify: Click here to enter text.) ☐ Colleges/universities (specify: Click here to enter text.) ☐ Govt agencies/departments (specify: Click here to enter text.) ☐ Decision makers/policymakers (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)	

Toolkits ☐ Yes ☐ Non-applicable		
Focus of Messaging or Information *(briefly describe)*	Type of Audience Reached *(select all that apply and briefly describe your audience)*	Total Est. # Reached
	☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Community-based orgs (specify: Click here to enter text.) ☐ Faith-based orgs (specify: Click here to enter text.) ☐ Tribal groups (specify: Click here to enter text.) ☐ K-12 schools/districts (specify: Click here to enter text.) ☐ Colleges/universities (specify: Click here to enter text.) ☐ Govt agencies/departments (specify: Click here to enter text.) ☐ Decision makers/policymakers (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)	

Public Event (e.g., press conference, kick off, townhall/forum) ☐ Yes ☐ Non-applicable		
Focus of Messaging or Information *(briefly describe)*	Type of Audience Reached *(select all that apply and briefly describe your audience)*	Total Est. # Reached
	☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Community-based orgs (specify: Click here to enter text.)	

	☐ Faith-based orgs (specify: Click here to enter text.) ☐ Tribal groups (specify: Click here to enter text.) ☐ K-12 schools/districts (specify: Click here to enter text.) ☐ Colleges/universities (specify: Click here to enter text.) ☐ Govt agencies/departments (specify: Click here to enter text.) ☐ Decision makers/policymakers (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)	

Coverage by/Advertisement in Traditional Media (e.g., TV news story, Radio announcement/interview, Newspaper article such as an Op-Ed piece, etc.) ☐ Yes ☐ Non-applicable

Focus of Messaging or Information *(briefly describe)*	Type of Audience Reached *(select all that apply and briefly describe your audience)*	Total Est. # Reached
	☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Community-based orgs (specify: Click here to enter text.) ☐ Faith-based orgs (specify: Click here to enter text.) ☐ Tribal groups (specify: Click here to enter text.) ☐ K-12 schools/districts (specify: Click here to enter text.) ☐ Colleges/universities (specify: Click here to enter text.) ☐ Govt agencies/departments (specify: Click here to enter text.) ☐ Decision makers/policymakers (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)	

Social Networking Media (Twitter, Facebook, etc.) ☐ Yes ☐ Non-applicable

Focus of Messaging or Information *(briefly describe)*	Type of Audience Reached *(select all that apply and briefly describe your audience)*	Total Est. # Reached
	☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Community-based orgs (specify: Click here to enter text.) ☐ Faith-based orgs (specify: Click here to enter text.) ☐ Tribal groups (specify: Click here to enter text.) ☐ K-12 schools/districts (specify: Click here to enter text.) ☐ Colleges/universities (specify: Click here to enter text.) ☐ Govt agencies/departments (specify: Click here to enter text.) ☐ Decision makers/policymakers (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)	

Informational Web Pages ☐ Yes ☐ Non-applicable

Focus of Messaging or Information	Type of Audience Reached	Total Est.

(briefly describe)	*(select all that apply and briefly describe your audience)*	# Reached
	☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Community-based orgs (specify: Click here to enter text.) ☐ Faith-based orgs (specify: Click here to enter text.) ☐ Tribal groups (specify: Click here to enter text.) ☐ K-12 schools/districts (specify: Click here to enter text.) ☐ Colleges/universities (specify: Click here to enter text.) ☐ Govt agencies/departments (specify: Click here to enter text.) ☐ Decision makers/policymakers (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)	

Other ☐ Yes (specify: Click here to enter text.) ☐ Yes ☐ Non-applicable		
Focus of Messaging or Information *(briefly describe)*	Type of Audience Reached *(select all that apply and briefly describe your audience)*	Total Est. # Reached
	☐ Youth (specify: Click here to enter text.) ☐ Parents (specify: Click here to enter text.) ☐ Adults (specify: Click here to enter text.) ☐ Community-based orgs (specify: Click here to enter text.) ☐ Faith-based orgs (specify: Click here to enter text.) ☐ Tribal groups (specify: Click here to enter text.) ☐ K-12 schools/districts (specify: Click here to enter text.) ☐ Colleges/universities (specify: Click here to enter text.) ☐ Govt agencies/departments (specify: Click here to enter text.) ☐ Decision makers/policymakers (specify: Click here to enter text.) ☐ Other (specify: Click here to enter text.)	

Networks/Collaboratives/Partnerships

In this section, you will be reporting on your IPP's participation or involvement with networks, collaboratives or formal partnerships as part of your CDEP.

There are some meaningful differences between a network, collaborative, or formal partnership. Below are some key definitions to help you complete this section.

- **Network**: stakeholders come together to exchange information to strengthen and improve their efforts

- **Collaborative**: stakeholders come together to find solutions for issues/problems and share resources; it is typically an open and inclusive process in which parties are not bound contractually
- **Formal Partnership**: a formal commitment between two or more stakeholders who join together to achieve a common goal, and combine their resources to accomplish the goal; usually involves a formal agreement or relationship, such as a binding, legal contract (e.g., MOU)

Networks, collaborative and formal partnerships commonly involve the following types of stakeholders:

- **Community-based**: Non-profit organizations working alongside you on the front lines of your community even if they are offering different types of programs or services
- **Faith-based**: Local faith-based or religious institutions or centers often regarded as important supports and resources for your community, who have diverse congregations with various skills
- **Institution-based**: Local institutions, in particular, schools, school districts, hospitals, etc. who provide access, services, or resources to the populations your CDEP serves
- **Tribal-based**: Tribal governments, councils, or organizations who provide access, services, or resources to the populations your CDEP serves
- **Government-based (County or City)**: Local government groups, in particular, agencies/departments, etc. who provide services or resources to the populations your CDEP serves

10. Has your IPP been involved in a network, collaborative or formal partnership during the past 6 months?
    - ☐ NO **(GO To Q#12)**
    - ☐ YES **(GO To Q#11)**

11. If you selected YES, in this section, you will report on your IPP's involvement in network(s), collaborative(s), or formal partnership(s) in the past 6 months. We have provided up to 3 tables for you to report this information separately for each network, collaborative, or partnership your IPP has been involved in. If you need additional box(es), copy/paste as many as you need.

    For **EACH** group you are involved in, please complete one box and answer the following:
    - Group Type: Select if it is a network, collaborative, or formal partnership.
    - Group Name: If applicable, write in the official name of the group (e.g., The Transformative Schools Network)
    - When: Select if you became involved with this group before Phase 2 funding or after Phase 2 funding
    - Purpose: Briefly describe the purpose of this group and how it related to your CDEP goals
    - Accomplishment/Challenges:
        - If applicable, briefly describe the accomplishments of this group (e.g., secured access to CDEP population, sharing of resources, obtained critical information, etc.).
        - If applicable, briefly describe the challenges in this group.

Group Type #1: Choose an item.
→ *If applicable*, Name of Group: Click here to enter text.
→ When did you become involved with this group? Choose an item.
→ Stakeholders Involved *(Select all that apply)*
☐ Community-based groups ☐ Faith-based groups ☐ Institution-based groups

☐ Tribal-based groups ☐ Govt-based groups ☐ Other (specify: Click here to enter text.)	
Group #1 Purpose in Relation to CDEP Goals *(Briefly describe)*	Group #1 Accomplishments and Challenges
	☐ Accomplishments (specify: Click here to enter text.) ☐ Challenges (specify: Click here to enter text.)

Group Type #2: Choose an item.

→ *If applicable*, Name of Group: Click here to enter text.
→ When did you become involved with this group? Choose an item.
→ Stakeholders Involved *(Select all that apply)*
☐ Community-based groups ☐ Faith-based groups ☐ Institution-based groups
☐ Tribal-based groups ☐ Govt-based groups ☐ Other (specify: Click here to enter text.)

Group #2 Purpose in Relation to CDEP Goals *(Briefly describe)*	Group #2 Accomplishments and Challenges
	☐ Accomplishments (specify: Click here to enter text.) ☐ Challenges (specify: Click here to enter text.)

Group Type #3: Choose an item.

→ *If applicable*, Name of Group: Click here to enter text.
→ When did you become involved with this group? Choose an item.
→ Stakeholders Involved *(Select all that apply)*
☐ Community-based groups ☐ Faith-based groups ☐ Institution-based groups
☐ Tribal-based groups ☐ Govt-based groups ☐ Other (specify: Click here to enter text.)

Group #3 Purpose in Relation to CDEP Goals *(Briefly describe)*	Group #3 Accomplishments and Challenges
	☐ Accomplishments (specify: Click here to enter text.) ☐ Challenges (specify: Click here to enter text.)

Systems Transformation

CDPH Phase 2 goals include supporting changes in statewide and local mental health delivery systems and policies that will reduce mental health disparities among unserved, underserved and inappropriately served populations.

This section is related to any work your IPP conducted in the past 6 months that resulted in clinics, schools, school districts, counties, tribal governments/councils, etc. **formally transforming their system** to more appropriately serve or support your priority population (e.g., through changes in law, regulation, procedure, administrative action, incentive, or voluntary practice that is adopted and/or implemented). It may also be reflected in resource allocations and can include securing important data sharing agreements.

12. Based on the description above, to what extent was a systems change effort a part of your CDEP during the past 6 months?
    - ☐ None **(Skip this section and GO to Local Evaluation Fidelity/Flexibility section)**
    - ☐ A Little **(GO To Q#13)**
    - ☐ Some **(GO To Q#13)**
    - ☐ A Lot **(GO To Q#13)**

13. Did any ***systems change*** occur as a result of the work of your CDEP in the past 6 months?

☐ No (If applicable, please describe any important benchmarks or steps taken that could lead to *future* systems change(s). (s): Click here to enter text.)
☐ Yes, a systems level change was adopted and will be implemented at a later point in time (Please specify type of change and who adopted it: Click here to enter text.)
☐ Yes, a systems level change was adopted and also implemented (Please specify type of change and who implemented it: Click here to enter text.)

SKIP 13a: This will be for subsequent report

13a. [Prepopulated with SAR data, when applicable]
In your SAR dated (prepopulate date), you indicated that a systems change was adopted but not yet implemented. Was it implemented during this reporting period?
☐ Yes
☐ No (Please describe reason for the delay in implementation: Click here to enter text.)
☐ N/A (This question does not apply)

Local Evaluation Fidelity/Flexibility

In this section, you will report on the extent to which your local evaluation was:
- Implemented as intended, OR
- Adapted to meet local circumstances, AND
- Reasons for modification(s) to your local evaluation if applicable.

Examples of reasons for modification(s) include: revisions to your evaluation questions, measures/instruments to better reflect the community's cultural values and context, data collection methods to reflect the community context, more diverse stakeholders to participate in the interpretation of data, etc.

14. Your local evaluation plan has been:
☐ Implemented exactly as planned
☐ Implemented with low/moderate change (Describe change and reason: Click here to enter text.)
☐ Implemented with a lot of change (Describe change and reason: Click here to enter text.)
☐ Not conducted at all (Describe reason: Click here to enter text.)

Workforce Development Programs or Strategies

****IMPORTANT NOTE****

This next section pertains to Workforce Development Programs or Strategies used by your CDEP. Please read the text in the box below AND respond to Question #15 to determine if this section should be skipped or completed.

Workforce development includes any training, education, and/or technical assistance to strengthen and/or develop the skills, knowledge base, and capacity of individuals, agencies, organizations, and institutions to increase any of the following:

- The number of culturally and/or linguistically competent mental/behavioral health workers that provide direct services (e.g., counselors, psychologists, therapists, etc.)
- The number of mental/behavioral health workers that provide direct services who reflect your priority population's lived experience or community context (e.g., counselors, psychologists, therapists, etc.)
- Cultural and linguistic competence of "community guardians" to provide appropriate supports and referrals for services on an ongoing basis (i.e., indigenous members of the community who have formal or informal influence and regular contact with your priority population)
- Cultural and linguistic competence of "first responders" to provide appropriate supports and referrals especially during emergencies or other crisis situations (e.g., individuals who are in frequent contact with your priority population, such as probation officers, teachers, suicide counselors, police and others)

The workforce includes, but is *NOT* limited to:

- Marriage and family therapists, mental health/professional counselors, psychologists, and social workers
- *Promotores*/health workers, case managers, homeless outreach specialists, parent aides, etc.
- Certified prevention specialists or addiction counselors
- Faith-based or spiritual leaders or advisors (e.g., ministers, pastors, tribal chief, etc.)
- Culturally-based traditional healers (e.g., curandero, kennekuk, etc.)
- Peer mentors and support specialists, recovery coaches
- School personnel (including teachers and non-teachers)
- Psychiatrists and psychiatric aides and technicians
- Primary care providers (e.g., physicians, nurses, etc.)

15. Based on the description above does your CDEP have a workforce development program or strategy?
    - ☐ NO **(Skip this section and GO To the "Direct Referrals" section)**
    - ☐ YES **(GO To Q#16)**

Workforce Need

16. Please indicate the reason(s) or need for a mental health workforce program or strategy in your CDEP:

a. Our community is… (Check all that apply)

- ☐ Unaware of available mental health services in the community
- ☐ Unlikely to seek out mental health services because of stigma of distrust
- ☐ More likely to seek services from CDEPs like ours that uses a cultural/community-based approach

b. In our community, there is a lack of… (Check all that apply)

- ☐ Mental health workers
- ☐ Mental health workers that represent the lived experiences of our community
- ☐ Culturally/linguistically competent mental health workers

☐ Trained and competent "community guardians" (e.g., indigenous members of the community who have formal or informal influence and contact with the priority population)
☐ Trained and competent "first responders" (probation officers, teachers, suicide counselors, police and others who are in frequent contact with your priority population)

c. In our community, there is a need for workers specializing in services for: (Check all that apply)

☐ Racial and ethnic specific populations (Please specify racial/ethnic sub-populations: Click here to enter text.)
☐ Language specific populations (Please specify languages: Click here to enter text.)
☐ Native or Tribal groups (Please specify Native or Tribal groups: Click here to enter text.)
☐ LGBTQ+ (Please specify LGBTQ+ sub-populations: Click here to enter text.)
☐ Age specific populations (Please specify ages: Click here to enter text.)
☐ Adolescents (Please specify youth sub-populations: Click here to enter text.)
☐ Other population(s) (Please specify: Click here to enter text.)

d. Is there another reason not mentioned already? (Please specify: Click here to enter text.)

Workforce Activities

In this section you will be reporting on the workforce development programming or activities your CDEP completed during May 2017 through October 2017. Please report the following information:

- Participant Background Information: Provide as much detailed demographic or other background information as possible
- Number of Unduplicated Individuals Served: Unduplicated refers to a CDEP participant who is counted **only once**, no matter how many direct services they received during the past 6 months. A participant who receives services throughout the 6-months should be counted and reported **no more than one time**
- Number of Training/Technical Assistance (TA) Sessions and Hours Offered: Unduplicated refers to the number of sessions and hours provided in total during the past 6 months regardless of level of participation by participants
- Topic Area: Training or TA topic area(s)
- Multilingual Capacity: If known, languages represented among participants other than English; this does not have to be an exact count
- CRDP Phase 2 Priority Populations Served: If known, Phase 2 priority populations served
- **Use a separate row for each distinct type of workforce representative or member.**

Here are some examples.

Phase 2 Priority Population(s) Served	Participant Background Information	# Served Unduplicated	# Sessions Unduplicated/ # of Hours Unduplicated	Topic Areas	Multilingual Capacity
African American	African American women ages 18+	10	5 sessions; 36 total hours	Support group	Unknown
-African American -Latino -API	-Jefferson Middle School academic counselors & vice-principals -Washington High School teachers and non-teaching staff	20	2 sessions; 16 hours	Trauma-informed de-escalation, restorative practices	Spanish Vietnamese
API Latino	Pacific Asian Counseling Services MFT staff and management	8	3 sessions; 6 hours	Culturally competent outreach with family and community, risk and culturally based protective	Hmong Korean Vietnamese

				factors	
NA	Native youth ages 14 to 18	12	-16 sessions; 16 hours	Eating well; staying active; managing stress	N/A

17. Please tell us the type of workforce development programming or activities your CDEP completed during the period, May 2017 through October 2017.

Phase 2 Priority Pop(s) Served	Participant Background Information	# Served Unduplicated	# Sessions Unduplicated/ # of Hours Unduplicated	Topic Areas	Multilingual Capacity

18. Please describe any notable successes or outcomes experienced in the last 6 months with your workforce development program.
Click here to enter text.

19. If not already mentioned in the CDEP section earlier, please describe any notable challenges or obstacles experienced in the last 6 months with your workforce development program.
Click here to enter text.

Direct Referrals (including Linkages and Navigation)

****IMPORTANT NOTE****

This next section pertains to Direct Referral Programs or Strategies used by your CDEP. Please read the text in the box below AND respond to Question #20 to determine if this section should be skipped or completed.

Coordination with and referrals for mental health or other community resources and supports outside of your CDEP is a possible outcome of some of your work, even if such coordination and referrals are not an explicit CDEP goal. For example, CDEP staff may DIRECTLY refer participating individuals/families to places in their community to receive mental health services (or even other services such as health, financial, basic living, education, etc.).

We recognize that IPPs may not always provide DIRECT REFERRALS, but that frequent exposure to your CDEP may have the INDIRECT result of motivating participating individual/families to seek these services on their own. In this section we will be asking you to report numbers related to any *direct* service referrals provided by your CDEP. For those IPPs

who may have *indirect* results of your CDEP motivating individuals/families to seek services on their own, we will have a space for you in this section to report stories.

- Referral: Directing an individual/family to outside provider/agency for appropriate services or treatment. This may involve a formal or informal assessment, in which the individual/family provides input.
- Linkage: Connecting a client to another provider/agency for appropriate services—i.e., this may be in the form of a "warm hand-off" or accompaniment to a service appointment
- Navigation: Providing follow-up services to help clients navigate complex systems and/or barriers to accessing services. This may be in the form of weekly/monthly contact for a set period of time to ensure that participation in services is happening, ongoing accompaniment to a service appointment, and/or advocacy when barriers to service access emerge.

Service referrals include, but are *NOT* limited to:

- Mental Health (e.g. depression, suicide, etc.)
- Substance Abuse
- Domestic Violence
- Sexual Assault
- Primary Care (e.g. well check, vaccines, etc.)
- Non-Health Care Services (e.g. housing, education, job training, etc.)
- Social/Cultural Enrichment Programs

20. Based on the description above, select the category below that best fits your CDEP. Select all that apply.
    - ☐ We provide DIRECT referrals and/or linkages and/or navigation. **(GO To Q#21)**
    - ☐ We INDIRECTLY motivate individual/families to seek services on their own. **(GO To Q#24)**
    - ☐ Our CDEP does not do this work. **(GO To Q#25)**
21. For each age group (children, adolescents, adults) that your CDEP provided direct service referrals or coordination during the past 6 months, check "Yes" we provided referrals or "Non-applicable" if they were not provided referrals.

    For **EACH** age group checked "**YES**," please complete the following:
    - Critical Sub-Population Demographics: Briefly describe any critical sub-population background information for the individuals or families your CDEP provided referrals to.
    - Number of Unduplicated Individuals Served: Unduplicated refers to an individual that is counted **only once,** no matter how many direct referrals, linkages or navigations services they received during the past 6-months. A participant who receives referrals throughout the 6-months should be counted and reported **no more than one time.**
        - Number Who Received Linkages: If applicable, total number of referrals provided by service type for the reporting period.
        - Number Who Received Navigation: If applicable, total number of referrals provided by service type for the reporting period.
        - OPTIONAL - Number Who Accessed the Service Referral: Total number of individuals who accessed the service referral at least once. (The IPP should confirm the number with the referral agency or organization.)

Children (0-11): ☐ Yes ☐ Non-applicable

Subpopulation Demographics *(briefly describe)*	# of Unduplicated	# of Individuals Who Received	# of Individuals	*Optional:* # of

	Individuals Served	Linkages *(if applicable)*	Who Received Navigation *(if applicable)*	Individuals who Accessed the Service Referral

Adolescents (12-17): ☐ Yes ☐ Non-applicable				
Subpopulation Demographics *(briefly describe)*	# of Unduplicated Individuals Served	# of Individuals Who Received Linkages *(if applicable)*	# of Individuals Who Received Navigation *(if applicable)*	*Optional:* # of Individuals who Accessed the Service Referral

Adults (18+): ☐ Yes ☐ Non-applicable				
Subpopulation Demographics *(briefly describe)*	# of Unduplicated Individuals Served	# of Individuals Who Received Linkages *(if applicable)*	# of Individuals Who Received Navigation *(if applicable)*	*Optional:* # of Individuals who Accessed the Service Referral

22. Across ALL age groups, indicate the number of direct referrals provided by service type. If you would like to report the number of direct referrals separately by age group, copy and paste this table 3 times and specify age group. Otherwise report TOTAL numbers.

Service Referral Type	# of TOTAL Referrals Provided by Category
Mental Health (e.g. depression, suicide, etc.)	
Substance Abuse	
Domestic Violence	
Sexual Assault	
Primary Care (e.g. well check, vaccines, etc.)	
Non-Health Care Services (e.g. housing, education, job training, etc.)	
Social/Cultural Enrichment Programs	
Other (please describe):	

23. Briefly describe what IPP cultural and linguistic processes and structures were used in the past 6 months to support individuals and families with connecting to providers to improve their mental health and wellbeing. For example, offering cultural food and social spaces/times, giving elders a special role, providing child care, having interpreters present (or staff serve as interpreters), arranging transportation, etc. In other words, how are you doing business differently from other direct referral programs?

Click here to enter text.

24. If you have any stories you'd like to share of how your CDEP INDIRECTLY motivated individual/families to seek services on their own in the past 6 months Click here to enter text.

Organizational Capacity (including Cultural/Linguistic Competency)

25. In this section you will report on the **4 organizational capacity elements** prioritized by your IPP in the organizational capacity assessment conducted earlier this year with your TAP.

Priority elements (prepopulate)
1. #1
2. #2
3. #3
4. #4

[Prepopulated priority element #1]
In the past 6 months, what type of change occurred in this element as a result of Phase 2 capacity-building supports and resources (i.e., TAP technical assistance, support from OHE/CDPH, consultation with PARC@LMU)?

- ☐ No change
  - a. Why did no change occur? *(e.g., this includes challenges or obstacles faced)* Click here to enter text.
- ☐ Low/moderate change
  - a. What type of change occurred? Click here to enter text.
  - b. What contributed to this change? *Please indicate if any CRDP Phase 2 supports or resources contributed to this change* Click here to enter text.
- ☐ Large/significant change
  - a. What type of change occurred? Click here to enter text.
  - b. What contributed to this change? *Please indicate if any CRDP Phase 2 supports or resources contributed to this change* Click here to enter text.
  - c. The element is now resolved
    - ☐ Yes
    - ☐ No

[Prepopulated priority element #2]
In the past 6 months, what type of change occurred in this element as a result of Phase 2 capacity-building supports and resources (i.e., TAP technical assistance, support from OHE/CDPH, consultation with PARC@LMU)?

- ☐ No change
  - a. Why did no change occur? *(e.g., this includes challenges or obstacles faced)* Click here to enter text.
- ☐ Low/moderate change
  - a. What type of change occurred? Click here to enter text.
  - b. What contributed to this change? *Please indicate if any CRDP Phase 2 supports or resources contributed to this change* Click here to enter text.
- ☐ Large/significant change
  - a. What type of change occurred? Click here to enter text.
  - b. What contributed to this change? *Please indicate if any CRDP Phase 2 supports or resources contributed to this change* Click here to enter text.
  - c. The element is now resolved
    - ☐ Yes

☐ No

[Prepopulated priority element #3]
In the past 6 months, what type of change occurred in this element as a result of Phase 2 capacity-building supports and resources (i.e., TAP technical assistance, support from OHE/CDPH, consultation with PARC@LMU)?

☐ No change
a. Why did no change occur? *(e.g., this includes challenges or obstacles faced)* Click here to enter text.

☐ Low/moderate change
a. What type of change occurred? Click here to enter text.
b. What contributed to this change? *Please indicate if any CRDP Phase 2 supports or resources contributed to this change* Click here to enter text.

☐ Large/significant change
a. What type of change occurred? Click here to enter text.
b. What contributed to this change? *Please indicate if any CRDP Phase 2 supports or resources contributed to this change* Click here to enter text.
c. The element is now resolved
☐ Yes
☐ No

[Prepopulated priority element #4]
In the past 6 months, what type of change occurred in this element as a result of Phase 2 capacity-building supports and resources (i.e., TAP technical assistance, support from OHE/CDPH, consultation with PARC@LMU)?

☐ No change
a. Why did no change occur? *(e.g., this includes challenges or obstacles faced)* Click here to enter text.

☐ Low/moderate change
a. What type of change occurred? Click here to enter text.
b. What contributed to this change? *Please indicate if any CRDP Phase 2 supports or resources contributed to this change* Click here to enter text.

☐ Large/significant change
a. What type of change occurred? Click here to enter text.
b. What contributed to this change? *Please indicate if any CRDP Phase 2 supports or resources contributed to this change* Click here to enter text.
c. The element is now resolved
☐ Yes
☐ No

26. In the next 6 months, in which organizational capacity elements will you need **continued TA or support**, AND what type of support is needed? *Check all that apply and describe what type of support is needed and from whom. If it is a new area(s), please select "New area(s)" and specify what it is and type of support desired and from whom.*

☐ (prepopulated e.g., Org Cap Element 1.03)
Please specify type of TA or support needed: Click here to enter text.
Please indicate who you would like support from:
☐ Your Assigned TAP ☐ PARC@LMU ☐ CDPH-OHE Contract Manager ☐ Other: Click here to enter text.

☐ (prepopulated e.g., Org Cap Element 1.03)
Please specify type of TA or support needed: Click here to enter text.

Please indicate who you would like support from:
☐ Your Assigned TAP ☐ PARC@LMU ☐ CDPH-OHE Contract Manager ☐ Other: Click here to enter text.

☐ (prepopulated e.g., Org Cap Element 1.03)
Please specify type of TA or support needed: Click here to enter text.
Please indicate who you would like support from:
☐ Your Assigned TAP ☐ PARC@LMU ☐ CDPH-OHE Contract Manager ☐ Other: Click here to enter text.

☐ (prepopulated e.g., Org Cap Element 1.03)
Please specify type of TA or support needed: Click here to enter text.
Please indicate who you would like support from:
☐ Your Assigned TAP ☐ PARC@LMU ☐ CDPH-OHE Contract Manager ☐ Other: Click here to enter text.

☐ New area(s)
Please specify type of TA or support needed: Click here to enter text.
Please indicate who you would like support from:
☐ Your Assigned TAP ☐ PARC@LMU ☐ CDPH-OHE Contract Manager ☐ Other: Click here to enter text.

27. For the areas of continued or new support identified in the above question (Q#26), do you grant permission to PARC@LMU to share this information with CRDP Phase 2 partners so we can connect you to appropriate TA and supports?
☐ Yes ☐ No

28. In the past 6 months, did any **unexpected or unanticipated changes** occur in organizational capacity not already mentioned in earlier sections as a result of CRDP Phase 2 capacity-building supports and resources? *If none occurred, write in "None."* Click here to enter text.

29. In the past 6 months, what challenges or barriers occurred in organizational capacity not already mentioned in earlier sections of this report as a result of CRDP Phase 2 capacity-building supports and resources? *If none occurred, write in "None."* : Click here to enter text.

Anonymous Technical Assistance (TA) and Support Survey

In this section, we want to provide IPPs with an opportunity to express their views on the TA and support provided by CRDP Phase 2 Partners:

- Your assigned TAP
- PARC@LMU
- Your assigned CDPH-OHE Contract Manager
- Other CDPH-OHE Staff Member (e.g., SWE contract manager, lead CRDP Phase 2)
- Other priority population TAP

- **Why is it anonymous?**
  - We wanted to give IPPs an opportunity to provide candid feedback and insights about a major component of Phase 2—TA and Support. Oftentimes, those who feel they "have nothing to say" are the best resources in this type of evaluation.
- **What is the purpose of this portion of the SAR?**

- The intent is to learn, to grow and to continue to improve the overall functioning of this initiative. It will also serve to inform future efforts such as this. This evaluation is NOT a performance appraisal or about blaming partners. It will not be used against any Phase 2 grantee or contractor.

- **How will this data be reported?**
  - This data will be aggregated and reported by priority population and across the 35 groups. It cannot be linked to any one IPP.
- **Is my IPP expected to complete this link?**
  - Yes. The expectation is that at minimum 1 person per IPP will complete this survey. However, multiple people from your organization (including your local evaluator) can complete this link as long as they participated in some type of TA or support from a partner (TAP, PARC@LMU, CDPH OHE). This will not only help preserve anonymity but also provide balance.

30. Please click on the Qualtrics link below to complete the *Anonymous TA and Support Survey*. Feel free to disseminate this link to other members of your IPP CDEP team.

Anonymous TA and Support Survey:
http://mylmu.co1.qualtrics.com/jfe/form/SV_e3EhoIvBOnCAPXv

*****Don't forget to respond to the Q#31 and Q#32 below. *****

31. We need to confirm that there is full representation across the 35 IPPs with the anonymous survey. Please confirm that at least one person in your organization completed the anonymous survey.
    - ☐ Yes, at least 1 person in our organization completed the survey.

CDEP Reflection

32. Thinking about the last 6 months, what's the headline story? In other words, what important things were accomplished, learned, overcome, or will be important to keep in mind when we tell your particular IPP-CDEP story in 2021?
    Click here to enter text.

SAR Submission

Please submit your SAR using the Qualtrics link below. E-mail submissions cannot be accepted.

SAR Submission Form:
http://mylmu.co1.qualtrics.com/jfe/form/SV_0jIMgGIe2muFRml

Thank you for completing this report! ☺

APPENDIX 6:

Organizational Capacity Assessment Tool

CRDP Phase 2: Organizational Capacity Assessment Tool

(Adapted From The Marguerite Casey Foundation Tool)

INTRODUCTION

The mission of the California Reducing Disparities Project (CRDP) Phase 2 aims to help individuals and families receive quality mental health prevention, treatment, and early intervention delivered in a culturally and linguistically competent manner. Strong, sustainable community-based organizations are essential to this work, and this is why the Statewide Evaluator (SWE) and Technical Assistance Provider (TAP) staff felt it was necessary to also invest in supporting capacity building so Implementation Pilot Projects (IPPs) can advance their mission related to their Community Defined Evidence Practices (CDEPs).

HOW WILL THE DATA BE USED BY IPPs & TAPs

This Organizational Capacity Assessment Tool is a self-assessment instrument that will be used two times by your organization (start and end of grant). The assessment will assist with the following: 1) identify the capacity strengths your organization already has coming into the grant, 2) identify your unique and top areas of capacity need within your organization, 3) help guide the development of a Technical Assistance plan to address them, and 4) assist with tracking organizational growth in capacity over time including using the data to explicate program outcomes. Please note there is no adverse connotation/stigma associated with selecting lower score values reflecting areas that are opportunities for growth—your honest responses are valued and encouraged. The assessment will facilitate understanding of which areas to allocate more technical assistance and support from the TAP. One of the key purposes is to identify areas in which to support your organization throughout the project.

HOW WILL THE DATA BE ANALYZED & USED BY THE SWE & CDPH

The SWE will examine the data within each organization to: 1) paint a clear and compelling picture of capacity strengths that Phase 2 grantees already bring to the table from the start, 2) help California Department of Public Health (CDPH) learn about capacity needs of Phase 2 grantees so that CDPH, TAPs, SWE, and other key stakeholders can more effectively provide support, 3) track initiative-wide growth in capacity over time, 4) assess the effectiveness of Phase 2 capacity building support provided to individual IPPs, and 5) inform future private and public investments in technical assistance and programming plans in similar initiatives (e.g., how funders can support grantee capacity so they can make bigger impacts).

Please note: Public reporting of any capacity data will be reported in aggregate form only (data summaries), and no organization will be identified individually. This data will NOT be used against any individual Phase 2 grantee or contractor. The data will only be used to evaluate capacity building efforts in this initiative. Grantees along with their TAP team will assist the SWE with interpreting the findings and/or using the data to improve their CDEP. If you need any assistance filling this out, feel free to contact your TAP.

Please proceed to the Instructions tab for more details.

INSTRUCTIONS

Print out a hard copy of these instructions help you complete the worksheets!

WHAT DOES THE TOOL ASSESS

There are several worksheets for you to complete in this Excel spreadsheet:

a) **General Information Worksheet (see tab below)**: Organization name, name/title of person completing form, contact information, and names of other stakeholders involved.

b) **Leadership Worksheet (see tab below)**: the capacity of organizational leaders to inspire, prioritize, make decisions, provide direction, and innovate

c) **Adaptive Worksheet (see tab below)**: the capacity of a nonprofit organization to monitor, assess, and respond to internal and external changes

d) **Management Worksheet (see tab below)**: the capacity of a nonprofit organization to ensure the effective and efficient use of organizational resources

e) **Operational Worksheet (see tab below)**: the capacity of a nonprofit organization to implement key organizational and programmatic functions

f) **Cultural Competence Worksheet (see tab below)**: the capacity of a nonprofit organization to understand/respond to cultural influences, values, needs, and attitudes of their community members

g) **Summary Table (see tab below)**: Review your scores for all 46 capacity elements and then indicate the FOUR your organization is most interested in strengthening.

HOW TO COMPLETE THE WORKSHEETS

To input your selections, click on the yellow cell to the right of each capacity element. Then select the down arrow and choose from the list that appears. If a capacity element does not apply to your organization (e.g., some organizations do not have revenue generation activities or the intention to create them), select "N/A". Be sure to provide a capacity rating (or select "N/A") for each capacity element, as failing to do so will produce incomplete summary scores. A section for comments about your ratings is included at the bottom of each capacity dimension worksheet. Use this section to include any clarifying information about the selections you made.

Helpful Hint: It is better to underestimate rather than overestimate your organization's capacity in a particular area. With an accurate portrait of the capacity of your organization, you will be better equipped to identify the most critical areas for improvement.

WHO SHOULD COMPLETE THE ASSESSMENT?

The Assessment is intended for self-guided use by nonprofit organizations. Many organizations will find it useful to have other staff, board members, and/or community members complete the assessment as well. Completing the Assessment using a team approach both improves validity and reduces individual biases. This process also serves as a catalyst for key stakeholders to engage in a rich dialogue about the organization. We recommend a two-step process for completing this assessment: 1) at least TWO people playing a leadership role on the CRDP project complete this assessment separately, with input from staff and community members (including ED/CEO) when applicable; 2) Upon completing the Assessment on an individual basis, the two (or more) participants should gather to discuss their ratings and reach consensus on one set of ratings that best represents the organization.

Please proceed to the General Information worksheet to begin.

GENERAL INFORMATION

Organization	
Name of Person Compiling Final Assessment Ratings	
Title of Person Compiling Final Assessment Ratings	
Length of Time in Organization	
Phone Number of Person Compiling Final Assessment Ratings	
Email of Person Compiling Final Assessment Ratings	
Date Final Assessment Ratings Completed	

Others Involved with the Capacity Assessment Process	
Name	
Title	
Length of Time in Organization	
Name	
Title	
Length of Time in Organization	
Name	
Title	
Length of Time in Organization	
Name	

Please proceed to the Leadership Worksheet

LEADERSHIP CAPACITY: In this section, you will be rating your organization on the capacity of the organizational leaders to inspire, prioritize, make decisions, provide direction, and innovate. For each capacity element, identify the description that best describes your organization's status or level of performance. For some elements, your organization's capacity will not fully match any of the descriptions; in these instances, simply identify the description that is most suitable for your organization.

Capacity Elements (1.01-1.06)		LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Input capacity rating in this column
1.01	Organizational Culture: Shared Beliefs & Values	No common set of basic beliefs and values (e.g., social, cultural, etc.) exists within organization	Common set of basic beliefs and values exists in some groups within organization, but is not shared broadly; beliefs and values are only partially aligned with organizational purpose and community members' norms (that is, the community's expectations or rules), or are rarely harnessed to produce impact	Common set of basic beliefs and values held by many people within organization; helps provide a sense of connection to organization; beliefs and values are aligned with organizational purpose and community members' norms (that is, the community's expectations or rules), and are occasionally harnessed to produce impact	Common set of basic beliefs and values exists and is widely shared within organization; helps provide a sense of connection to organization and a clear direction for behavior; beliefs and values embodied by leader but are also timeless and stable across leadership changes; beliefs and values clearly support organizational purpose, are in line with community members' norms (that is, the community's expectations or rules), and are consistently harnessed to produce impact	
1.02	Board Composition & Commitment	Membership with limited diversity in fields of practice and expertise; drawn from a narrow spectrum of community members relevant to the organization; little or no relevant experience; commitment to organization's success, vision, and mission is unclear; meetings are sporadic and/or attendance is sometimes poor	Some diversity in fields of practice and expertise; membership represents a few different community members relevant to organization; some evidence of commitment to organization's success, vision, and mission; regular meetings are well-planned and attendance is adequate; occasional subcommittee meetings	Good diversity in fields of practice and expertise; membership represents most community members relevant to the organization; solid evidence of commitment to organization's success, vision, and mission; regular, purposeful meetings are well-planned and attendance is consistently good; regular subcommittee meetings	Membership with broad variety in fields of practice and expertise, and drawn from the full spectrum of community members relevant to the organization; includes functional and issue area expertise; proven track record of learning about the organization and addressing its issues; consistently demonstrated commitment to the organization's success, mission, and vision; regular, purposeful meetings are well-planned and attendance is consistently strong; regular meetings of focused subcommittees	
1.03	Board Governance	Roles of legal board, advisory board, and management are unclear; board rarely scrutinizes budgets, holds CEO/ED accountable, or operates according to formal procedures	Roles of legal board, advisory board, and management are clear; board functions according to by-laws, reviews budgets, and occasionally sets organizational direction and targets, but does not regularly review CEO/ED performance, monitor potential conflicts of interest, scrutinize audits, or review IRS and state filings	Roles of legal board, advisory board, and management are clear and function well; board reviews budgets, audits, IRS and state filings; size of board set for maximum effectiveness with formal nomination process; board co-defines performance targets and actively encourages CEO/ED to meet targets; annual review of CEO/ED's performance, but board not prepared to hire or fire CEO/ED	Legal board, advisory board, and management work well together from clear roles; board fully understands and fulfills fiduciary duties; size of board set for maximum effectiveness with rigorous nomination process; board actively defines performance targets and holds CEO/ED fully accountable; board empowered and prepared to hire or fire CEO/ED if necessary; board periodically evaluated	
1.04	Board Involvement & Support	Provide little direction, support, and accountability to leadership; not fully informed about material and other major organizational matters; largely "feel-good" support	Provide occasional direction, support, and accountability to leadership; generally informed about all material matters in a timely manner; input and responses often solicited	Provide direction, support, and accountability to leadership; fully informed about all material matters; input and responses actively sought and valued; full participant in major decisions	Provide strong direction, support, and accountability to leadership and engaged as a strategic resource; communication between board and leadership reflects mutual respect, appreciation for roles and responsibilities, shared commitment, and valuing of collective wisdom	
1.05	Board & CEO/ED Appreciation of Power Issues	No explicit attention given to power issues (e.g., race, class, sexual orientation, gender identity, etc.) within the orenization and the community being served	Power issues (e.g.,race, class, sexual orientation, gender identity, etc.) within the orenization and the community being served occasionally acknowledged and discussed; policies and/or procedures developed on an ad hoc basis to address these issues	Power issues e.g.,race, class, sexual orientation, gender identity, etc.) within the orenization and the community being served regularly acknowledged and discussed; basic policies and/or procedures exist to address these issues	Power issues e.g.,race, class, sexual orientation, gender identity, etc.) within the orenization and the community being served regularly acknowledged and discussed; well-established policies & procedures exist to address these issues, and are routinely reviewed and revised	
1.06	Ability to Motivate & Mobilize Community Members	Community members with potential to be most affected by organization's work have limited knowledge of organization; organization programs are sporadic and poorly attended; organization has difficulty motivating community members into action	Community members with potential to be most affected by organization's work have some knowledge of organization; programs held regularly, but attendance varies widely; organization has ability to motivate a small core group of community members into action	Community members with potential to be most affected by organization's work are knowledgeable and likely to be engaged with organization; programs held regularly and are generally well-attended; organization has ability to motivate a segment of community members into action	Community members with potential to be most affected by organization's work see organization as inspiring and motivating; they are excited to be involved; programs held regularly and are routinely well-attended; organization has ability to motivate a broad range of community members into action	
	Comments:	Type comments here.				

Please proceed to the Adaptive Worksheet.

ADAPTIVE CAPACITY: In this section, you will be rating your organization on the capacity to monitor, assess, and respond to internal and external changes.

	Capacity Elements (2.01-2.13)	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Input capacity rating in this column
2.01	Strategic Planning (that is, a process to confirm the organizational mission, establish long term and short-term action plan to achieve goals)	Limited ability and tendency to develop strategic plan, either internally or via external assistance, if strategic plan exists, it is rarely or never referenced	Some ability and tendency to develop high-level strategic plan either internally or via external assistance; strategic plan sometimes directs management decisions	Ability and tendency to develop and refine concrete, realistic strategic plan; some internal expertise in strategic planning or access to relevant external assistance; strategic planning carried out on a near-regular basis; strategic plan used to guide management decisions	Ability to develop and refine concrete, realistic, and detailed strategic plan; critical mass of internal expertise in strategic planning, or efficient use of external, sustainable, highly qualified resources; strategic planning exercise carried out regularly; strategic plan used extensively to guide management decisions	
2.02	Program Evaluation / Performance Measurement (process and outcome data)	Very limited measurement and tracking of performance and progress; all or most evaluation based on anecdotal evidence; no external performance comparisons made; organization collects some process data on program activities and outputs (e.g., number of children served), but has no measurement of outcomes (e.g., how much better off are the participants, or society as a whole, as a result of the organization or program activities)=OR	Performance partially measured and progress partially tracked; some external performance comparisons made; organization regularly collects solid process data on program activities and outputs, and has begun to measure outcomes (e.g., how much better off are the participants, or society as a whole, as a result of the organization or program activities)	Performance measured and progress tracked in multiple ways on a regular basis; effective internal and external benchmarking occurs (that is, comparing to a standard) but may be confined to select areas; multiple indicators used in evaluation, with primary focus on outcomes; some attention paid to cultural appropriateness of evaluation process/methods; social impact measured (e.g., changes in crime rates), but longitudinal (long-term) evaluation is missing or evaluation not conducted by independent third party	Comprehensive, integrated system (e.g., balanced scorecard) used for measuring organization's performance and progress on continual basis; internal and external benchmarking part of the organizational culture and used by staff in target-setting and daily operations; clear and meaningful outcomes-based performance indicators exist in all areas; careful attention paid to cultural appropriateness of evaluation process/methods; measurement of social impact based on longitudinal studies with independent evaluation	
2.03	Program Evaluation & Organizational Learning Environment	Evaluation data rarely used to improve program and organization; little experience with evaluation beyond capturing information to report to funders; information systems not in place	Evaluation data occasionally used by staff and/or board to improve organization and programs; some staff time devoted to evaluation efforts, as required by funders, however staff and board do not typically see evaluation as integral to organization's work; information systems not in place	Learnings from evaluation data distributed throughout organization, and often used by staff and/or board to make adjustments and improvements; some staff time devoted to documenting organization's work; some information systems in place to support ongoing evaluation	Systematic staff and/or board practices of making adjustments and improvements on basis of evaluation data; resources are devoted to thoroughly documenting organization's work and capturing the complete story of its impact; evaluation processes fully integrated into information systems	
2.04	Use of Research Data to Support Program Planning & Advocacy (that is, use of research to develop a program or influence your target audience)	Sporadic use of data from external sources to support proposals or program decisions; limited capacity to work with research data; little understanding of where to find useful outside data or how to assess its quality	Basic data from external or internal data used to support significant proposals and major advocacy; ability to read external research reports and evaluate quality of data exists, but data is not relied upon as part of regular decision making; familiarity with one or two external sources of data especially relevant to organization's work; little capacity to analyze raw data or present it in graphical, engaging ways	Familiarity with useful external data sources in relevant issue areas; data used to support decisions, proposals, and advocacy; employs staff with research and data skills, although they may not conduct analysis full time; capacity to manipulate data from existing data sets, merge data sets, and make assessments about relevance and cultural appropriateness of findings for its community or clients; ability to present data from outside sources using charts, tables, and graphics	Respected by peers as both consumer and producer of data; dedicated research staff capable of working with complex data and making assessments about relevance and cultural appropriateness of findings for its community or clients; external research regularly scanned for relevant data to support decisions, proposals, and advocacy; important organizational questions answered through research; ability to effectively present data using charts, tables, and graphics for a variety of audiences	
2.05	Program Relevance & Integration	Core programs and services vaguely defined and lack clear alignment with mission and overarching goals; programs seem scattered and largely unrelated to each other	Most core programs and services well-defined and solidly linked with mission and overarching goals; program offerings may be somewhat scattered and not fully integrated into clear strategy	Core programs and services well-defined and aligned with mission and overarching goals; program offerings fit together well as part of clear strategy	All programs and services well-defined and fully aligned with mission, overarching goals, and community being served; program offerings are clearly linked to one another and to overall strategy; synergies across programs are captured	
2.06	Program Growth & Replication	No assessment of possibility of scaling up existing programs; no ability to scale up or replicate existing programs	Limited assessment of possibility of scaling up existing programs and, even when judged appropriate, action rarely taken; limited ability either to scale up or replicate existing programs	Occasional assessment of possibility of scaling up existing programs and, when judged appropriate, action occasionally taken; able to scale up or replicate existing programs	Frequent assessment of possibility of scaling up existing programs, and when judged appropriate, action consistently taken; efficiently and effectively able to grow existing programs to meet needs in local area or other geographies	
2.07	Monitoring of Program Landscape	Minimal knowledge and understanding of other players as well as alternative and complementary models in program area	Basic knowledge of other players as well as alternative and complementary models in program area, but limited ability to adapt behavior based on acquired understanding	Solid knowledge of other players as well as alternative and complementary models in program area; good ability to adapt behavior based on acquired understanding and cultural appropriateness, but only carried out on occasion	Extensive knowledge of other players as well as alternative and complementary models in program area; refined ability and systematic tendency to adapt behavior based on acquired understanding and cultural appropriateness	
2.08	Assessment of External Environment & Community Needs	Planning not supported by systematically collected information about community needs or external opportunities and threats; organization has very few connections to community members and opinion leaders that can provide information about evolving community needs	Information about community needs or external opportunities and threats used to inform planning, although collection is haphazard; organization has a few connections to community members and opinion leaders that can provide information about evolving community needs	Information about community needs and external opportunities and threats used to inform planning; organization has many connections to community members and opinion leaders with whom they communicate about evolving community needs	Clear, established systems regularly used to assess community needs and external opportunities and threats; information systematically collected and used to support and improve planning efforts; organization has numerous connections to community members and opinion leaders with whom they regularly communicate about evolving community needs	

ADAPTIVE CAPACITY: In this section, you will be rating your organization on the capacity to monitor, assess, and respond to internal and external changes.

Capacity Elements (2.01-2.13)		LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Input capacity rating in this column
2.09	Organizational Influencing of Systems (e.g., school, school district, county dept.) and Policies (city, county, state level)	No ability or awareness of possibilities to influence systems or policies; never called on to participate in substantive systems or policy discussions	Aware of possibilities to influence systems and policies; some readiness and skill to participate in policy discussion, but rarely invited to substantive systems or policy discussions	Fully aware of possibilities to influence systems and policies; one of several organizations active in systems or policy discussions at the local, state, and/or national level (as relevant and appropriate)	Proactively influences systems and policies in a highly effective manner at the local, state, and/or national level (as relevant and appropriate); always ready for and often called on to participate in substantive systems or policy discussions	
2.10	Partnerships & Alliances	No partnerships or alliances with other for-profit, nonprofit, or public sector entities	Early stages of building relationships and collaborating with other for profit, nonprofit, or public sector entities; if relations do exist, some may be precarious or not fully "win-win"	Some key relationships with a few types of relevant entities (e.g., for-profit, nonprofit, public sector) have been built and leveraged; action around common goals is generally short term	Strong, high-impact, relationships with variety of relevant entities (local, state, and federal government as well as for-profit, other nonprofit, and community agencies) have been built, leveraged, and maintained; relationships anchored in stable, long-term, mutually beneficial collaboration	
2.11	Community Presence & Standing	Community presence either not recognized or organization is generally not regarded as a player in the community; few members of the community (e.g., other nonprofit leaders, government representatives, and academics) engage with organization; community leaders rarely call on organization for its input on issues important to organization	Community presence somewhat recognized, and organization is generally regarded as a player in the community; some members of the community actively engage with organization; community leaders occasionally call on organization for its input on issues important to organization	Known within the community beyond community members; perceived as open and responsive to community needs; the larger community (including some highly respected members, such as decision makers) actively engage with organization; community leaders often call on organization for its input on issues important to organization	Widely known within the community, and perceived as actively engaged with and extremely responsive to it; the larger community (including many highly respected members, such as decision makers) actively engage with organization; community leaders always call on organization for its input on issues important to organization	
2.12	Community Member Involvement with Organization	Community member involvement is limited; planning involves little community input; community not trained or supported in their involvement	Community members offered a range of roles in the organization; volunteer positions of leadership open to community, but rarely filled by them; paid staff responsible for planning; community member work mostly task-oriented; community members trained or supported in their work on an ad hoc basis	One or two systems in place to actively recruit and involve community members; they take on a variety of roles in organization, including volunteer positions of leadership; paid staff take a large role in planning, but community members are involved and help define some desired outcomes; training provided to community members in some of the skill areas needed to affect change	Variety of systems in place to actively recruit and involve community members; they take on a wide variety of roles in organization, including volunteer positions of leadership; paid staff work collaboratively with community members to plan and lead much of the organization's work and define desired outcomes; training is provided to community members in all of the skill areas needed to affect change	
2.13	Grassroots Community Organizing (that is, empower residents poor and working class communities to play an active role in shaping policies that affect their health, well-	Grassroots advocacy work is focused only on short-term achievements; long-term strategy does not exist; campaign targets are sometimes vague; organizing tactics may not be those best suited to the priority community	Some understanding of the need to grow the community's capacity and social capital to tackle issues/problems; grassroots advocacy work generally promotes short-term gains rather than long-term capacity building; community organizing tactics are engaged in without a detailed plan of how they will lead to long-term change	Broad understanding of the need to grow community member capacity and social capital to tackle issues/problems; grassroots advocacy work is directed toward that end, but could be better aligned; a strategy for long-term change exists, with appropriate campaign targets and community organizing tactics	Primary focus is on growing the community's capacity and social capital to tackle issues/problems; grassroots advocacy work is aligned with that focus; a carefully developed strategy for long-term change exists, with appropriate campaign targets and community organizing tactics	
	Comments:	Type comments here.				

Please proceed to the Management Worksheet.

MANAGEMENT CAPACITY: In this section, you will be rating your organization's capacity to ensure effective and efficient use of organizational resources.

Capacity Elements (3.01-3.10)	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Input capacity rating in this column
3.01 Goals / Performance Targets	Specific/concrete milestones are non-existent or few, vague or confusing, or either too easy or impossible to achieve; not clearly linked to overarching goals and strategy; milestones largely unknown or ignored by staff	Realistic milestones exist in some key areas, and are mostly aligned with overarching goals and strategy; may lack aggressiveness, specificity/ concreteness, or are short-term; they are known and utilized by some staff	Achievable yet demanding milestones exist in most areas, and are aligned with overarching goals and strategy; primarily quantifiable and focused on outcomes; typically multi-year milestones; they are known and utilized by most staff who use them to broadly guide work	Realistic yet demanding milestones exist in all areas; milestones are tightly linked to overarching goals and strategy, quantifiable, outcome-focused, have annual milestones, and are long-term in nature; all staff consistently utilize them and work diligently to achieve them	
3.02 Funding Model	Strong dependence on a few funders, largely of same type (e.g., government, foundations, corporations, or individuals)	Multiple types of funding sources with only a few funders in each type, or many funders within only one or two types of funders	Solid base of funders from many types of funding sources; some ability to guard against market instabilities (e.g., operating reserves, small endowment) and/or has developed some sustainable revenue-generating activity	Highly diversified funding streams; organization stable in face of potential market instabilities (e.g., sufficient budget or donor base to cover short-term funding losses) and/or has developed sustainable revenue-generating activities; other nonprofits try to imitate organization's fundraising activities and strategies	
3.03 Fund Development Planning	No systems in place for long-term planning, diversifying revenue streams, or outlining and managing to target goals; fundraising is reactive; fund development strategy not well-articulated and focuses on one type of activity such as grants	Recognize need to develop systems for long-term planning, revenue diversification, and outlining and managing to target goals; fund development includes several activities, but is not connected to organization's long-term strategic plan and budget projections	Some systems in place for long-term planning, revenue diversification, and outlining and managing to target goals; fund development strategy includes multiple activities and is loosely connected to organization's long-term strategic plan and budget projections	Well-developed systems for long-term planning, revenue diversification, and outlining and managing to target goals; multi-pronged fund development strategy is proactive and integrated into organization's long-term strategic plan and budget projections	
3.04 Financial Planning / Budgeting	No or very limited financial planning; general budget developed; only one budget for entire organization; performance-to-budget loosely or not monitored	Limited financial plans, updated on an ad hoc basis; budget utilized as operational tool; used to guide/assess financial activities; some attempt to isolate divisional (program or geographical) budgets within central budget; performance-to-budget monitored periodically	Solid financial plans, updated regularly; budget integrated into most operations; reflects organizational needs; solid effort made to isolate divisional (program or geographical) budgets within central budget; performance-to-budget monitored regularly	Very solid financial plans, continuously updated; budget integrated into all operations; used as strategic tool; budget developed from process that incorporates and reflects organizational needs and objectives; well-understood divisional (program or geographical) budgets within overall central budget; performance-to-budget closely and regularly monitored	
3.05 Operational Planning & Organizational Processes	Operations run purely on day-to-day basis with no short- or longer-term planning activities; no experience in operational planning; Limited set of organizational processes (e.g., planning, reviews, internal information dissemination) for ensuring effective functioning of the organization	Some ability and tendency to develop high-level operational plan either internally or via external assistance; operational plan loosely or not linked to strategic planning activities and used roughly to guide operations; Basic set of organizational processes in core areas for ensuring efficient functioning of organization	Ability and tendency to develop and refine concrete, realistic operational plan; some internal expertise in operational planning or access to relevant external assistance; operational planning carried out on a near-regular basis; operational plan linked to strategic planning activities and used to guide operations; Solid, well-designed set of organizational processes in place in core areas to ensure smooth, effective functioning of organization	Concrete, realistic, and detailed operational plan developed and regularly refined; critical mass of internal expertise in operational planning, or efficient use of external, sustainable, highly qualified resources; operational planning exercise carried out regularly; operational plan tightly linked to strategic planning activities and systematically used to direct operations; Robust, lean, and well-designed set of organizational processes in place in all areas to ensure effective and efficient functioning of organization	
3.06 Decision Making Processes	Decisions made largely on an ad hoc basis by one person and/or whomever is accessible; highly informal; authority is vague and changing; staff is unaware of social/cultural power differences between themselves and their community	Appropriate decision makers known; decision making processes fairly well established, but often break down and become informal; social/cultural power differences addressed in a limited fashion (e.g., a one-day training)	Transparent and structured lines/systems for decision making exist; dissemination of decisions generally good; general awareness of social/cultural power differences and on-going plans to address them	Transparent and structured lines/systems for decision making exist, and involve broad participation as practical and appropriate (sometimes including community); dissemination and interpretation of decisions is both good and consistent; specific awareness of social/cultural power differences and established systems in place to address them	
3.07 Knowledge Management	No formal systems to capture and document internal knowledge	Systems exist in a few areas but are either not user-friendly or not comprehensive enough to have an impact; systems known by only a few people, or only occasionally used	Well-designed, user-friendly systems in some areas; not fully comprehensive; systems are known by many people within organization and often used	Well-designed, user-friendly, comprehensive systems to capture, document, and disseminate knowledge internally in all relevant areas; all staff are aware of systems and trained in their use; systems used frequently	
3.08 Recruiting, Development, & Retention of Management	Standard career paths in place without considering staff/managerial development; very limited training, coaching, and feedback; infrequent performance appraisals; no systems/processes to identify promising new managers and staff	Partially tailored development plans for some promising staff members; personal annual reviews incorporate development plan for each manager; some formal recruiting networks in place	Recruitment, development, and retention of key managers is priority and high on CEO/ED's agenda; individually tailored development plans for some promising staff members; relevant training, coaching/feedback, and consistent performance appraisals are institutionalized; well-connected to potential sources of promising new managers; attention paid to recruitment and promotion of managers that reflect the diversity of the community	Well-planned process to recruit, develop, and retain key managers; CEO/ED takes active interest in managerial development; individually tailored development plans for all promising staff members; relevant and regular internal and external training, coaching/feedback, and consistent performance appraisals are institutionalized; well-connected to potential sources of promising new managers; recruitment and promotion methods ensure that management team reflects the diversity of the community	
3.09 Recruiting, Development, & Retention of General Staff	Standard career paths in place without considering staff development; limited training, coaching and feedback; no regular performance appraisals; no initiatives to identify promising new staff	No active development tools/programs; feedback and coaching occur sporadically; performance evaluated occasionally; sporadic initiatives to identify promising new staff	Limited use of active development tools/programs; frequent formal and informal coaching and feedback; performance regularly evaluated and discussed; regular concerted initiatives to identify promising new staff; attention paid to the recruitment of staff that reflect the diversity of the community	Management actively interested in general staff development; thoughtful and targeted development plans for key employees/positions; frequent, relevant training, coaching/feedback, and consistent performance appraisals are institutionalized; continuous, proactive initiatives to identify promising new staff; recruitment methods ensure that staff reflect the diversity of the community	

MANAGEMENT CAPACITY: In this section, you will be rating your organization's capacity to ensure effective and efficient use of organizational resources.

Capacity Elements (3.01-3.10)		LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Input capacity rating in this column
3.10	Volunteer Management	No active recruitment of volunteers (only passive recruitment such as people who walk in the door); no defined roles for volunteers to fill; few systems in place to train and support volunteers	Some active recruitment of volunteers; volunteer roles involve a range of time commitments and skill levels; volunteer work is mostly task-oriented; basic training to volunteers provided, generally on an ad hoc basis	Active recruitment of volunteers on a regular basis; wide range of volunteer roles available; written job descriptions for most common volunteer positions; some systems exist to track and manage volunteers; volunteer orientations and trainings take place periodically, with attention paid to both skills and cultural competency; staff trained on how to manage volunteers	Volunteer recruitment systems successfully fill organizational needs with appropriate volunteers; wide range of volunteer roles available, including positions of leadership; written job descriptions for all volunteer positions; robust volunteer management systems in place; volunteer orientations and trainings take place on a regular basis, with attention paid to both skills and cultural competency; staff experienced and/or extensively trained in volunteer management	
	Comments:	Type comments here				

OPERATIONAL CAPACITY: In this section, you will rate your organization's capacity to implement key organizational and programmatic functions.

Capacity Elements (4.01-4.09)		LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Input capacity rating in this column
4.01	Skills, Abilities, & Commitment of Volunteers	Volunteers not working up to their potential or ill-equipped for work with organization; may be unreliable or have low commitment	Many volunteers working up to their potential; mostly reliable, loyal, and committed to organization's success	Capable set of individuals that bring required skills to organization; culturally competent, reliable, loyal, and generally committed to organization's success and to "making things happen"; work easily with most staff, but do not generally play core roles without staff supervision	Extremely capable set of individuals that bring complementary skills to organization; culturally competent, reliable, loyal, highly committed to organization's success and to "making things happen"; often go beyond call of duty; able to work easily with wide range of staff and play core roles without special supervision	
4.02	Fundraising and Revenue Generation	Generally weak fundraising skills and lack of expertise (either internally or accessible externally); No internal revenue-generation activities (e.g., cause-related marketing, fee-for-services, retailing)	Main fundraising needs covered by some combination of internal skills & expertise, and access to external fundraising assistance (When needed); Some internal revenue generation activities; financial net contribution is marginal; activities may distract from programmatic work and often tie up senior management team	Fundraising needs adequately covered by well-developed internal fundraising skills; occasional access to some external fundraising expertise (When needed); Some proven internal revenue generation activities that provide substantial additional funds, but occasionally distract from programmatic work; require extensive senior management attention	Highly developed internal fundraising skills and expertise in all funding source types to cover all needs; access to external fundraising expertise for additional extraordinary needs; Significant internal revenue generation; experienced and skilled in cause-related marketing, fee-for-services, and retailing; activities support, but don't distract from, focus on creating social impact	
4.03	Board Involvement & Participation in Fundraising	Most board members do not recognize fundraising as one of the board's roles and responsibilities; no goals or plans for board-driven fundraising activities exist; board members do not generally make financial contributions to organization	Board members accept that the board has some fundraising responsibilities, but some concerns exist regarding ability of board to be successful in this area; board fundraising activities are limited; some board members make a personally significant annual financial contribution to organization based on their individual means	Many board members embrace fundraising as one of the board's core roles and responsibilities, and participate with fundraising endeavors; realistic and appropriate board fundraising goals and plans exist; fundraising activities are underway; most board members make a personally significant annual financial contribution to organization based on their individual means	All board members embrace fundraising as one of the board's core roles and responsibilities; realistic and appropriate board fundraising goals and plans in place; board actively fundraises and has achieved measurable progress towards goals; all board members make a personally significant annual financial contribution to organization based on their individual means, and some contribute more financially	
4.04	Communications Strategy & Outreach	No communications plan or articulated communications strategy in place; key messages not defined or articulated; audiences not identified; information messages about organization are inconsistent; No marketing materials, or outdated materials; strictly internally-focused and little to no outreach to community members	No communications plan or articulated communications strategy in place, but key messages defined and audiences identified; communications to community members are fairly inconsistent; Loose collection of materials used for marketing; generic documents and not always updated to reflect current programs, activities, and outcomes; materials have a minimal degree of professionalism or consistent look and feel; a few key materials are provided in multiple languages as needed; and some outreach to community members; unclear about its effectiveness	Communications plan and strategy in place; key messages defined and audiences identified; communications to community members are generally consistent and coordinated; Packet of marketing materials used on a consistent basis; information contained in the materials is up to date and reflects current programs, activities, and outcomes; materials reasonably professional in presentation and aligned with established standards for font, color, logo placement, etc.; most materials are provided in multiple languages as needed; able to; and ongoing somewhat effective outreach to community members	Communications plan and strategy in place and updated on a frequent basis; audiences and their values identified, and communications to each of these community members customized; communications always carry a consistent and powerful message; Packet of marketing materials used consistently and easily updated on a regular basis; materials extremely professional in appearance and appeal to a variety of community members all materials consistently adhere to established standards for font, color, logo placement, etc.; all materials are provided in multiple languages as needed; and consistent effective outreach to community members	
4.05	Computers, Applications, Network, & Email	Limited/no use of computers or other technology in day-to-day activity and/or staff don't use or rarely use computers or other existing technology	Adequately equipped at central level, incomplete/limited infrastructure at locations aside from central offices; equipment sharing may be common; satisfactory use of IT infrastructure by staff; periodic training provided to some staff members	Solid hardware and software infrastructure that contributes to increased efficiency; no or limited sharing of equipment is necessary; regular use of IT infrastructure by staff, though some accessibility challenges for front-line program deliverers may exist; periodic training provided to all staff members	State-of-the-art, fully networked computing hardware with comprehensive range of up-to-date software applications; greatly enhances efficiency; all staff have individual computer access and e-mail; high usage level of IT infrastructure by staff; regular training provided to all staff members	
4.06	Website	No individual website	Basic website containing general information, but little information on current developments; site maintenance is a burden and performed only occasionally	Comprehensive website containing basic information on organization as well as up-to-date latest developments; most information is organization-specific; easy to maintain and regularly maintained	Sophisticated, comprehensive, and interactive website, regularly maintained and kept up to date on latest area and organization developments; praised for its user-friendliness and depth of information; includes links to related organizations and useful resources on topic addressed by organization	
4.07	Databases / Management Reporting Systems	No systems for tracking program participants or clients; staff volunteers, program outcomes and financial information	Electronic databases and management reporting systems exist in only few areas; systems perform only basic features, are awkward to use, or are used only occasionally by staff	Electronic database and management reporting systems exist in most areas for tracking program participants or clients, staff, volunteers, program outcomes, and financial information; commonly used and help increase information sharing and efficiency	Sophisticated, comprehensive electronic database and management reporting or systems exist for tracking program participants or clients, staff, volunteers, program outcomes, and financial information; widely used and essential in increasing information sharing and efficiency	
4.08	Buildings & Office Space	Inadequate physical infrastructure, resulting in loss of effectiveness and efficiency (e.g., unfavorable locations for clients and employees, no possibility of confidential discussions, insufficient workspace for individuals, no space for teamwork)	Physical infrastructure can be made to work well enough to suit organization's most important and immediate needs; a number of improvements could increase effectiveness and efficiency	Fully adequate physical infrastructure for the current needs of the organization; infrastructure does not impede effectiveness and efficiency; decor partially reflects cultural traditions of community members	Physical infrastructure well-tailored to organization's current and anticipated future needs; well-designed to enhance organization's effectiveness and efficiency; favorable locations for clients and employees; plentiful space encourages teamwork; layout increases critical interactions among staff; decor clearly reflects and affirms cultural traditions of community members	
4.09	Management of Legal & Liability Matters	Legal issues not anticipated; issues addressed individually when they arise; property insurance includes some liability coverage	Legal support resources identified, readily available, and employed on "as needed" basis; major liability exposures managed and insured (including property liability and workers compensation)	Legal support regularly available and consulted in planning; routine legal risk management and occasional review of insurance	Well-developed, effective, and efficient internal legal infrastructure for day-to-day legal work; additional access to general and specialized external expertise to cover peaks and extraordinary cases; continuous legal risk management and regular adjustment of insurance	
	Comments:	Type comments here.				

CULTURAL COMPETENCE: In this section, you will rate your organization's understanding of and responsiveness to your community's cultural influences, values, needs, and attitudes.

	Capacity Elements (5.01-5.08)	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Input capacity rating in this column
5.01	Expressed Organizational Commitment to Cultural Competence	No common set of basic cultural competence beliefs and values exists within organization; values not expressed in mission or vision	Common set of basic cultural competence beliefs and values exists by some people within organization; they are not formally expressed in mission or vision	Common set of cultural competence basic beliefs and values held by many people within organization, and formally expressed in the mission or vision	Common set of basic cultural competence beliefs and values exists in mission or vision, and are widely shared within organization	
5.02	Cultural Competence Policies/ Procedures/ Governance	No explicit attention given to cultural competency issues within organizational policies and/or procedures	Basic policies and/or procedures exist to address these issues; issues occasionally acknowledged and discussed	Basic policies and/or procedures exist, and additional policies and/or procedures are created on an ad-hoc basis to address these issues; issues regularly acknowledged and discussed	Well-established written policies and procedures exist; are routinely reviewed and revised	
5.03	Planning/ monitoring/ evaluation	Very limited measurement and tracking of demographic data (e.g., age, race, ethnicity, gender, sexual orientation, etc.); organization collects performance and/or outcome data but does not analyze it by key demographics	Demographic data measured and partially tracked on select indicators (e.g., age, race, ethnicity, gender, sexual orientation, etc.); organization has begun to pay attention to demographics when it comes to program involvement or (e.g., comparisons by groups); analyzing outcomes by demographics is missing; some attention is paid to setting realistic goals and action plans using this data	Demographic data measured and regularly tracked for some select indicators; some key demographics are still missing; some attention is paid to analyzing both performance and outcomes by key demographics as a means of identifying cultural competence needs or gaps in service access/utilization for certain groups; attention is paid to setting realistic goals and action plans using this data, but strengths-based planning is missing	Demographic data measured and tracked on a continual basis on a wide-range of indicators; careful attention is paid to analyzing performance and outcomes by demographics as a means of identifying cultural competence needs or gaps in service access/utilization for certain cultural groups; engages in strengths-based planning; setting realistic goals and action plans using this data	
5.04	Communication	Messaging and marketing materials that incorporate culturally specific attitudes and values of community being served are missing; decision making processes with the community do not reflect their cultural values and communication styles (e.g., involvement of family, building rapport with elders, etc.)	Messaging and marketing materials do not always incorporate culturally specific attitudes and values of community being served; a few key materials are linguistically accessible to priority population(s); decision making processes with community do not always reflect their cultural values and communication styles (e.g., involvement of family, building rapport with elders, etc.)	Messaging and marketing materials reasonably incorporate culturally specific attitudes and values of the community being served as needed; most materials are linguistically accessible to priority population as needed; decision making processes with community reasonably reflect their cultural values and communication styles (e.g., involvement of family, building rapport with elders, etc.)	Messaging and marketing materials consistently incorporate culturally specific attitudes and values of the community being served and are all linguistically accessible to priority population(s); decision making processes with community reflect their cultural values and communication styles (e.g., involvement of family, building rapport with elders, etc.)	
5.05	Human Resources	Standard processes for recruitment, development, and retention of staff based on skills and qualifications only; infrequent or no cultural competency education and training for staff	Partial processes for recruitment, development, and retention of staff with diverse backgrounds/experiences and (e.g., community members, professionals, paraprofessionals, peer mentors, etc.); occasional cultural competency education and training for staff that is standard	Some process in place for recruitment, development, and retention of staff with diverse backgrounds/experiences (e.g., community members, professionals, paraprofessionals, peer mentors, etc.); cultural competency education and training for some staff on an ad hoc basis tailored to the unique needs of priority population	Well-planned process of recruitment, development, and retention of staff with extraordinarily diverse backgrounds/experiences (e.g., community members, professionals, paraprofessionals, peer mentors, etc.); continual cultural competency education and training for staff at all levels tailored to the unique needs of priority population	
5.06	Cultural Factors in Engagement with Community	No familiarity with the culture(s) of the priority population(s) served; there are no staff employed who reflect the population(s) being served	Some organization and staff familiarity with the culture(s) of the priority population(s) served; limited integration of cultural beliefs/practices into program activities and engagement with community; designing programs with community input is missing; a few staff employed who reflect the population(s) being served	Organization and staff are familiar with the culture(s) of the priority population(s) served; cultural beliefs/practices are partially integrated into engagement with community and program activities; programs occasionally designed with community input; good number of staff employed who reflect the population(s) being served	Organization and staff are immersed in the culture(s) of the priority population(s) served to support organizational purpose and strengthen program impact; cultural beliefs/practices are fully integrated into engagement with community and program activities; programs are consciously designed with community input; staff employed primarily reflect the population(s) being served	
5.07	Service Array and Responsiveness to Community Context	Programs and services don't reflect the needs of the community; systems and practices to make services accessible to the community are missing and needed (e.g., program locations; hours of operation, membership; welcoming physical environment; linguistic competency and welcoming attitude at appointment desk, advice lines, written materials, etc.)	Programs and services don't always reflect the needs of the community; limited systems and practices in place to make services accessible to the community but a lot more are needed (e.g., program locations; hours of operation, membership; welcoming physical environment; linguistic competency and welcoming attitude at appointment desk, advice lines, written materials, etc.)	Programs and services partially reflect the needs of the community; some practices in place to make services accessible to the community but a few more are needed (e.g., program locations; hours of operation, membership; welcoming physical environment; linguistic competency and welcoming attitude at appointment desk, advice lines, written materials, etc.)	Programs and services reflect the unique needs of the community; variety of practices in place to make services accessible to the community (e.g., program locations; hours of operation, membership; welcoming physical environment; linguistic competency and welcoming attitude at appointment desk, advice lines, written materials, etc.)	
5.08	Linguistic Competency	Limited/no use of linguistic support services and resources (translation and interpretation) in day-to-day activity with community being served	Linguistic support services/resources occasionally available in day-to-day activity for community served; Friends, family members or bilingual staff primarily serve as translators/interpreters on an ad-hoc basis for language in priority community; limited education/training for staff related to linguistic competence; challenges with accurate translation of information and quality/trustworthiness of interpretation	Linguistic support services regularly available in day-to-day activity for community served; bi-lingual/bi-cultural staff are effective translators/ interpreters for priority languages; partial dissemination strategy in place to inform community of these services; some education/training for staff related to linguistic competence; accurate translation of information and good quality/trustworthiness of interpreter services	Linguistic support services widely used in day-to-day activity and essential for community being served; bi-lingual/bi-cultural staff serve as highly effective translators/interpreters for priority languages; access to highly qualified interpreters for non-priority languages; signs posted and dissemination strategy in place to inform community of these services; continual education and training for staff at all levels related to linguistic competence; highly accurate translation of information and high quality/trustworthiness of interpreter services	
	Comments:	Type comments here.				

Organizational Capacity Assessment Summary: On this worksheet, select the four capacity elements that your organization is most interested in strengthening over the next one to two years. Mark an "X" in the "priority" column next to the four capacity elements you chose as top priorities for your organization.

		Capacity Element Rating Levels	Prioritization of Capacity Elements	
Click on any Capacity Element link below to return to that section in the Assessment		NOTE: A ZERO (0) SCORE INDICATES A MISSING RESPONSE FROM WORKSHEETS 1-5	INDICATE THE FOUR (OUT OF 46 TOTAL) CAPACITY ELEMENTS YOUR ORG. IS MOST INTERESTED IN STRENGTHENING (PLACE AN 'X' IN THE APPROPRIATE CELLS)	Capacity Dimension Averages
1. LEADERSHIP CAPACITY				
1.01	Shared Beliefs & Values	0		0.00
1.02	Board Composition & Commitment	0		
1.03	Board Governance	0		
1.04	Board Involvement & Support	0		
1.05	Board & CEO/ED Appreciation of Power Issues	0		
1.06	Ability to Motivate & Mobilize Community Members	0		

Organizational Capacity Assessment Summary: On this worksheet, select the four capacity elements that your organization is most interested in strengthening over the next one to two years. Mark an "X" in the "priority" column next to the four capacity elements you chose as top priorities for your organization.

Click on any Capacity Element link below to return to that section in the Assessment		Capacity Element Rating Levels	Prioritization of Capacity Elements	Capacity Dimension Averages
		NOTE: A ZERO (0) SCORE INDICATES A MISSING RESPONSE FROM WORKSHEETS 1-5	INDICATE THE FOUR (OUT OF 46 TOTAL) CAPACITY ELEMENTS YOUR ORG. IS MOST INTERESTED IN STRENGTHENING (PLACE AN 'X' IN THE APPROPRIATE CELLS)	
2. ADAPTIVE CAPACITY				
2.01	Strategic Planning	0		0.00
2.02	Evaluation / Performance Measurement	0		
2.03	Evaluation & Organizational Learning	0		
2.04	Use of Research Data to Support Program Planning & Advocacy	0		
2.05	Program Relevance & Integration	0		
2.06	Program Growth & Replication	0		
2.07	Monitoring of Program Landscape	0		
2.08	Assessment of External Environment & Community Needs	0		
2.09	Influencing of Policy-making	0		
2.10	Partnerships & Alliances	0		
2.11	Community Presence & Standing	0		
2.12	Community Member Involvement	0		
2.13	Organizing	0		

Organizational Capacity Assessment Summary: On this worksheet, select the four capacity elements that your organization is most interested in strengthening over the next one to two years. Mark an "X" in the "priority" column next to the four capacity elements you chose as top priorities for your organization.

Click on any Capacity Element link below to return to that section in the Assessment		Capacity Element Rating Levels	Prioritization of Capacity Elements	Capacity Dimension Averages
		NOTE: A ZERO (0) SCORE INDICATES A MISSING RESPONSE FROM WORKSHEETS 1-5	INDICATE THE FOUR (OUT OF 46 TOTAL) CAPACITY ELEMENTS YOUR ORG. IS MOST INTERESTED IN STRENGTHENING (PLACE AN 'X' IN THE APPROPRIATE CELLS)	
3. MANAGEMENT CAPACITY				
3.01	Goals / Performance Targets	0		0.00
3.02	Funding Model	0		
3.03	Fund Development Planning	0		
3.04	Financial Planning / Budgeting	0		
3.05	Operational Planning	0		
3.06	Decision Making Processes	0		
3.07	Knowledge Management	0		
3.08	Recruiting, Development, & Retention of Management	0		
3.09	Recruiting, Development, & Retention of General Staff	0		
3.10	Volunteer Management	0		

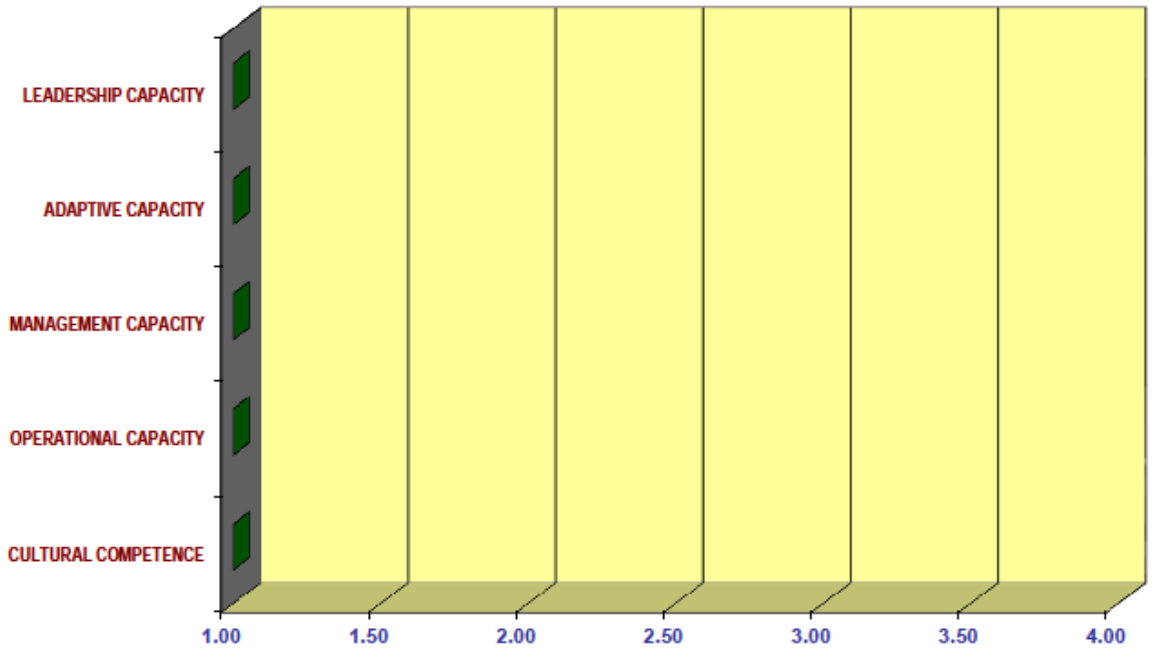
Organizational Capacity Assessment Summary: On this worksheet, select the four capacity elements that your organization is most interested in strengthening over the next one to two years. Mark an "X" in the "priority" column next to the four capacity elements you chose as top priorities for your organization.

		Capacity Element Rating Levels	Prioritization of Capacity Elements	
Click on any Capacity Element link below to return to that section in the Assessment		NOTE: A ZERO (0) SCORE INDICATES A MISSING RESPONSE FROM WORKSHEETS 1-5	INDICATE THE FOUR (OUT OF 46 TOTAL) CAPACITY ELEMENTS YOUR ORG. IS MOST INTERESTED IN STRENGTHENING (PLACE AN 'X' IN THE APPROPRIATE CELLS)	Capacity Dimension Averages
4. OPERATIONAL CAPACITY				
4.01	Skills, Abilities, & Commitment of Volunteers	0		0.00
4.02	Fundraising	0		
4.03	Board Involvement & Participation in Fundraising	0		
4.04	Communications Strategy	0		
4.05	Computers, Applications, Network, & Email	0		
4.06	Website	0		
4.07	Databases / Management Reporting Systems	0		
4.08	Buildings & Office Space	0		
4.09	Management of Legal & Liability Matters	0		

Organizational Capacity Assessment Summary: On this worksheet, select the four capacity elements that your organization is most interested in strengthening over the next one to two years. Mark an "X" in the "priority" column next to the four capacity elements you chose as top priorities for your organization.

Click on any Capacity Element link below to return to that section in the Assessment		Capacity Element Rating Levels	Prioritization of Capacity Elements	Capacity Dimension Averages
		NOTE: A ZERO (0) SCORE INDICATES A MISSING RESPONSE FROM WORKSHEETS 1-5	INDICATE THE FOUR (OUT OF 46 TOTAL) CAPACITY ELEMENTS YOUR ORG. IS MOST INTERESTED IN STRENGTHENING (PLACE AN 'X' IN THE APPROPRIATE CELLS)	
5. CULTURAL COMPETENCE				
5.01	Expressed Organizational Commitment to Cultural Competence	0		0.00
5.02	Cultural Competence Policies/Procedures/Governance	0		
5.03	Planning/monitoring/evaluation	0		
5.04	Communication	0		
5.05	Human Resources	0		
5.06	Cultural Factors in Engagement with Community	0		
5.07	Service Array and Responsiveness to Community Context	0		
5.08	Linguistic Competency	0		

CRDP Phase 2: Organizational Capacity Assessment Summary



APPENDIX 7:

IRB Decision Tree

Appendix 7

Human Subjects Protection: IRB Decision Tree

Do I need Human Subjects Protection? Let's find out.

Research is a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes.

Does your CDEP incorporate a research component (answer should be yes)?

A human subject is a living individual about whom an investigator (whether professional or student) conducting research obtains

1. Data through intervention or interaction with the individual, or
2. Identifiable private information.

Does your CDEP collect any of this kind of information?