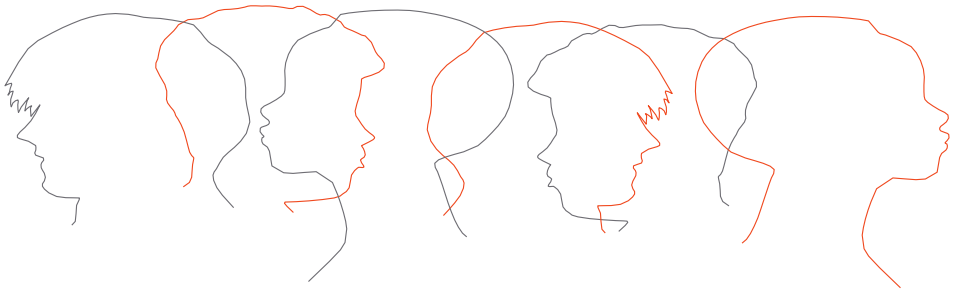
Final Statewide Evaluation Plan of the California Reducing Disparities Project (CRDP) Phase 2



Prepared for:

Office of Health Equity

July 26, 2022

Version 4.0

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Recommended Citation:
Grills, Cheryl; Villanueva, Sandra; Terry, Diane. (2020). Statewide Evaluation Annual Update Version 4.0. Psychology Applied Research Center, Loyola Marymount University.

This report, *Final Statewide Evaluation Report Version 4.0*, was prepared for the California Department of Public Health's Office of Health Equity (CDPH-OHE) by the Psychology Applied Research Center at Loyola Marymount University (PARC@LMU), under CDPH contract number 15-10603. CDPH-OHE and PARC@LMU also thank the CRDP Phase grantees and contractors for their participation in the statewide evaluation plan's development.

Acknowledgements
We would like to thank the following people for their contributions and revisions to this document: Rafael Colonna, Ben Fitzpatrick, Jennifer Abe, Elia De La Cruz Toledo He, Nora Murphy, and Julianne De La Cerda.

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1. BACKGROUND OF CRDP

1.1 California Reducing Disparities Project (CRDP)

The CRDP is funded by the Mental Health Services Act (MHSA, or Proposition 63) that was passed in November 2004. Under the California Department of Public Health's Office of Health Equity (CDPH-OHE). The CRDP is a statewide Prevention and Early Intervention (PEI) demonstration project with the goal of informing statewide policy. Its purpose was to identify and implement solutions to reduce mental health disparities for historically unserved, underserved, and inappropriately served communities in California. The CRDP focused on five priority populations:

- African Americans (AfAm)
- American Indian/Alaska Native Americans (AI/AN)
- Asian American, Native Hawaiian, Pacific Islanders (AANHPI)
- Latinx
- Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ++)

The CRDP consisted of two phases. Phase 1 (2009-2014) focused on population specific needs assessments and the development of a strategic plan to reduce mental health disparities. Phase 2 (2015-ongoing) focuses on the implementation and rigorous evaluation of Community Defined Evidence Practices (CDEP) by 35 funded grantee organizations.

1.2 CRDP Phase 1

In Phase 1, Strategic Planning Workgroups (SPW) were established for each of the five priority populations. These planning groups engaged community members to identify promising CDEPs and make recommendations for reducing mental health disparities in their communities. Each SPW's findings were compiled into population reports and processed into a single, comprehensive CRDP strategic plan to reduce mental health disparities. The Population Reports can be found on PARC@LMU's CRDP Phase II page and the CRDP Strategic Plan can be found on the California Pan-Ethnic Health Network's Publications page.

1.3 CRDP Phase 2

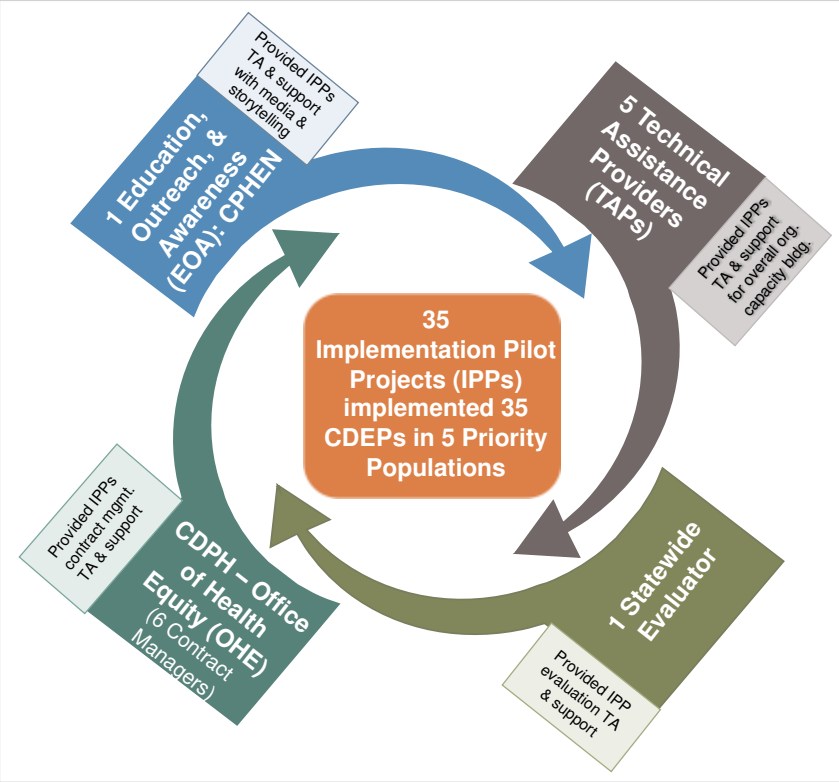
Phase 2 launched in 2016 and was originally funded through April 2022. It builds on and implements the strategies developed in Phase 1 and identified in the CRDP Strategic Plan. This $60 million dollar investment is focused on strengthening and demonstrating effectiveness of CDEPs among the five priority populations and developing and reinforcing organizational infrastructure to effectively deliver mental health services. In 2021, the California State Legislature approved an additional $63.1 million dollars from the State General Fund to extend CRDP Phase 2 through 2026. The CRDP Phase 2 extension continues the funding for implementing and evaluating the CDEPs under the initiative with a focus on scaling the programs at the county level and planning for a potential CRDP Phase 3.

Phase 2 was characterized in the Statewide Evaluation (SWE) solicitation as having four primary "components" with distinct "strategies" and a set of respective Phase 2 grantees (N=35) and contractors (N=7). Phase 2 had five primary components—collectively referred to as the Phase 2 "partners"—each with their own distinct strategies:

- Thirty-five Implementation Pilot Projects (IPPs) – seven per priority population
- Five Technical Assistance Providers (TAPs) – one per priority population
- One Education, Outreach and Awareness (EOA) consultant
- One Statewide Evaluator (SWE)
- Office of Health Equity (OHE)

Each Phase 2 partner (plus CDPH-OHE) implements their component's strategy utilizing their own approach. See Figure 1 for an overview of Phase 2 components, strategies, and partners.

Figure 1: CRDP Phase 2 Components, Strategies, and Partners



The IPPs, TAPs, EOA, and the SWE work closely with CDPH-OHE to coordinate efforts related to Phase 2 activities. The SWE will use this framing of CRDP Phase 2 in its discussion of the initiative's evaluation. See Section 3.2.1 (Table 3) for a full list of Phase 2 partner organizational names.

1.4 Phase 2 Accountability

MHSA established an accountability mandate that must be addressed by all recipients of this $60 million dollar investment. Therefore, CDPH-OHE must demonstrate the extent to which CRDP Phase 2 contributed to:

- Reductions in the severity of mental illness for five priority populations,
- Systems changes in county PEI level operations,
- A return on investment (business case), and

- Changes in state and county mental health policies and practices.

1.5 CDPH-OHE SWE Purpose, Objectives, and Research Questions

1.5.1 Purpose of the SWE

The CDPH Solicitation (15-10603), explicitly outlined the purpose of the SWE.

> *Every component of the CRDP (including IPPs, TAPs, etc.) will be assessed by the Statewide Evaluation contractors to determine if each individual component and the CRDP taken in whole are effective in achieving the goals of CRDP, including developing a business case and evaluating the potential to reduce mental health disparities by expanding effective strategies to a statewide scale. (State of California, California Department of Public Health Office of Health Equity, August 24, 2015)*

Although the parameters of the SWE were predefined, efforts to continue the community based participatory practice begun in Phase 1, were included in refinements to several aspects of the SWE. The CDPH SWE Solicitation are available from CDPH-OHE by request[1].

1.5.2 SWE Objectives and Research Questions

The CDPH-OHE SWE solicitation (pages 18-19) outlines three objectives in the SWE's scope of work. Each objective is aligned with one or more responsibilities that are fulfilled by fifteen SWE deliverables. Three research questions are aligned with Objective 1, while four questions are aligned with Objective 2. These research questions were defined by CDPH in the SWE solicitation. These were later slightly refined by the Statewide Evaluation contractor, the Psychology Applied Research Center at Loyola Marymount University (PARC@LMU) in their accepted SWE bid submitted November 9, 2015. As the full complement of the five TAP organizations and the thirty-five IPPs began in March 2017, active engagement with the SWE began in summer 2017. In response to partner feedback and in consultation with OHE, PARC refined the research questions to ensure that they better aligned with the cultural and community priorities and realities of the IPPs and their respective CDEPs. For example, the original evaluation questions focused solely on the absence or reduction of mental illness. The SWE revisions now include questions regarding the presence of positive mental health (or protective factors), as well as mental health access, awareness, and mental health delivery systems and policies. Further, practical considerations also accounted for some revisions as the SWE determined what data was feasible to collect. The 2015 version of the SWE Questions can be found in Appendix A.

Objective 1 has two high-level questions that are grouped by the following themes: CRDP Phase 2 effectiveness, IPP evaluations, policy/systems changes, fiscal operations, stakeholder perspectives, and initiative improvements. Objective 2 has three high-level questions grouped by the following themes: CDEP effectiveness, validated CDEPs, and evaluation framework. Tables 1 and 2 outline the five revised research questions, highlight a process or outcome evaluation focus, and include accompanying supporting questions. Objective 3 of the SWE (i.e., Support CDPH in developing evaluation systems and guidelines and communicating evaluation results) does not have a set of accompanying evaluation questions.

[1] Requests to CDPH-OHE can be made by email to ohe@cdph.ca.gov.

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

Research Question 1	Research Question 2	Research Question 3
To what extent are CRDP strategies and operations effective at preventing and/or reducing the severity of mental illness in California's historically unserved, underserved and/or inappropriately served communities?	What are vulnerabilities or weaknesses in CRDP's overarching strategies and fiscal operations, and how could they have been strengthened (initiative, addressing mh disparities)?	Do CRDP strategies show an effective Return on Investment?
• To what extent did CRDP Phase 2 employ effective approaches, strategies and structures? Strategies/Approaches (IPPs, EOA, TAPs, SWE, OHE) IPPs = CDEP development & implementation (outreach/recruitment, sustaining participation/community engaged, public communications, fidelity/flexibility) o What approaches and strategies were used to fulfill the goals of Phase 2? - *IPP only* - To what extent did IPPs develop & implement CDEPs that incorporated the unique cultural, linguistic, LGBTQ+, and community context of their priority population? - *IPPs, TAPs, EOA, and SWE* - To what extent was there fidelity and flexibility to approaches, strategies and deliverables? o What conditions supported or hindered implementation of those strategies? TA & Support for IPPs o To what extent did IPPs receive the technical assistance and support from the TAPs, SWE, EOA, and OHE needed to improve mental health and decrease disparities for their specific populations? - What types of TA or support did IPPs receive? - What effect did this have on capacity & infrastructure? - To what extent did IPPs secure additional funding? IPP Local Evaluations o To what extent did CRDP Phase 2 IPP evaluations effectively reflect the unique needs of each priority population, including subpopulations? • What methodological strategies were used by IPPs to incorporate culture and context into their evaluation?		• What is the business case for reducing mental health disparities by expanding CRDP strategies to a statewide scale

• To what extent was there fidelity and flexibility to IPP proposed cultural and community evaluation strategies? • Considering their intended priority population and subpopulations, who did IPPs sample? Advocacy, Systems and Policy Change Efforts o To what extent did CRDP Phase 2 strategies improve alignment between local government and providers to provide culturally responsive, accessible and effective strategies to reduce disparities and improve mental health? • To what extent were policy makers, providers and other key stakeholders better informed about the unique needs of the priority communities and CDEPs? • What collaborative processes emerged as a result of CRDP Phase 2? • To what extent were strategic partnerships secured to improve access, availability and utilization of mental health services?	

Table 2: Objective 2—Determine Effectiveness of Community-Defined Evidence Programs

Research Question 1	Research Question 2	Research Question 3	Research Question 4
To what extent did IPPs prevent and/or reduce severity of prioritized mental health conditions within and across priority populations, including specific sub-populations (e.g., gender, age)?	How cost effective are Pilot Projects? What is the business case for increasing them to a larger scale?	To what extent did CRDP Phase 2 Implementation Pilot Projects validate their Community-Defined Evidence Practices?	What evaluation frameworks were developed and used by the Pilot Projects?
• What positive (protective factors) and negative mental health conditions were prioritized by IPPs for their participants, within and across priority populations, including specific sub-populations (e.g., gender, age, etc.)? • Which CDEP approaches suggest improvements and/or reductions in positive (protective factors) and negative mental health conditions within and across priority populations, including specific sub-populations (e.g., gender, age, etc.)?		• To what extent did IPPs establish credible evidence of the prevention or reduction of priority mental health conditions and/or the promotion of positive mental health conditions (protective factors)?	• What principles best inform the development of evaluation framework(s) best suited for future CDEPs? • What similarities and differences exist in frameworks within and across

• To what extent did IPPs affect mental health access (including availability, utilization, stigma/barriers, and quality)? • How does diversity within and across each priority population affect positive and negative mental health conditions including access to mental health supports and services?	• Where applicable, how many and what types of IPPs meet criteria, apply for, and/or are accepted for identification as evidence-based practices?	priority populations?

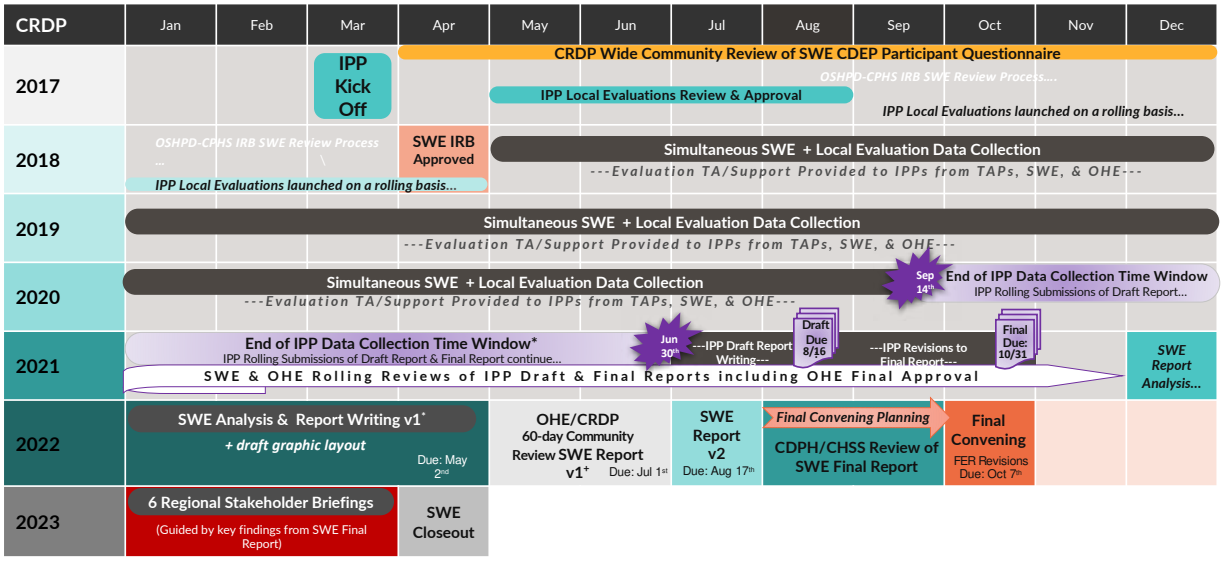
2. STATEWIDE EVALUATION FRAMEWORKS

2.1 SWE Overview

2.1.1 Multi-Year Evaluation

PARC's contract as the SWE covers a six-year period from 2016 through 2022 with the data collection timeframe extending from March 2017-September 2020. Figure 2 presents the SWE multi-year calendar beginning with the IPP kick off in March 2017 and ending shortly after the Regional Stakeholder Briefings in 2023. Appendix B provides a summary of the 15 SWE deliverables.

Figure 2. CRDP Phase 2 SWE Working Multi-Year Calendar



2.1.2 Multi-Site Evaluation

The evaluation also featured a CBPP integrative, multi-year (longitudinal), multi-site approach to the answering the Statewide Evaluation questions. As a multi-site evaluation, the SWE covers 35 IPPs, 5 TAPs, 1 EOA, OHE, and other relevant stakeholders—all part of the SWE's coordinated effort to address the core evaluation research questions outlined in Section 1.5.2. Because of the layered complexity of this evaluation, the SWE addresses process, outcome, and cost benefits questions that extend across three overlapping stages:

- **Stage 1** - Develop the SWE plan, launch the PARC technical assistance (TA) system, and work collaboratively with TAPs and OHE to support IPPs with developing rigorous IPP local evaluation plans.
- **Stage 2** - Implement the SWE plan, provide ongoing evaluation TA and support to Phase 2 partners, including IPPs in the implementation of their respective local evaluations.
- **Stage 3** – Analyze and disseminate SWE findings and practical knowledge to Phase 2 partners and other stakeholders including those in public health, and work collaboratively with TAPs and OHE to support IPPs in finalizing their IPP local evaluation report.

At each stage, PARC employs a collaborative or Community-Based Participatory Practice approach with Phase 2 partners. For more information on CBPP and PARC's approach see Section 2.3.1.

2.2 Flexibility

To align with cultural, contextual, and linguistic realities across the 35 IPPs, the SWE is flexible and adaptive in its methods and approaches to address the three SWE objectives, answer the seven research questions, and complete its fifteen deliverables. As a result, the SWE is dynamic—it is implemented with the understanding that it must incorporate iterative processes and negotiated agreements with Phase 2 partners. Ongoing feedback from Phase 2 partners is essential to vetting the validity and reliability of SWE procedures and measures. For example, as IPPs tailor their CDEPs and local evaluation approaches to contextual and cultural realities in their respective communities, the SWE will also make corollary adjustments. Updates made to the plan annually, therefore, will account for changes in priorities, resources, feasibility issues, emergence of new opportunities, necessary improvements to cultural, contextual and linguistic appropriateness, etc. In fact, the current SWE plan 4.0 update incorporates changes in both the SWE methods and measures in response to feedback from Phase 2 partners.

2.3 SWE Plan Approach

Considerations of culture, context, methodology, and equivalence undergird PARC's evaluation philosophy, praxis, and approach. Accordingly, the SWE Plan is grounded: a) methodologically in the principles and procedures consistent with community-based participatory practice (CBPP), b) theoretically in a social-ecological framework that is culturally- and contextually-oriented, and incorporates an intersectional framework; and c) pragmatically in an orientation of efficiency in the completion of the Phase 2 objectives. The eight elements of this grounding described below include:

1. Community based participatory practice,
2. The social-ecological framework,
3. Culture,
4. Cultural competence,
5. The synthesis of culture and ecology,
6. The Culture Cube,
7. Intersectionality, and
8. The Phase 2 Evaluation Change Model.

2.3.1 Community-Based Participatory Practice (CBPP)

Involving community members and stakeholders in all aspects of health promotion and prevention from conceptualization to implementation is recognized as an effective strategy for sustainably addressing health disparities (Minkler & Wallerstein, 2003; Viswanathan et al., 2004), especially in low-income communities of color (Grills et al., 2014). There are many terms used to describe community-based participation. Most people are familiar with and adopt the phrase Community Based Participatory Research (CBPR). While CBPR is primarily anchored in a research process, the SWE is using the term—Community Based Participatory Practice (CBPP)—that reflects a more expansive array of efforts related to participatory activities that include and extend beyond research. In its broader application, CBPP, like CBPR, offers a set of principles for engagement and participation—typically between communities and entities external to the community (e.g., government agencies such as County Departments of Mental Health, policy makers such as elected officials, institutions, and researchers/program evaluators). It inspires attention to culture, context, trust building, shared meaning, consensus, and equity.

CBPP encompasses the active engagement of community members in identifying, defining, addressing, solving, and evaluating issues in their own community. It can be employed in program design and implementation, program evaluation, and systems and policy change. While the forms of participation vary, a central feature is the inclusion of equitable voices from all parts of a community, and an emphasis on culture and context. CBPP requires trust building, shared meaning, consensus, and equity making space for the active engagement of stakeholders, gatekeepers, and community members to identify, define, address, solve and evaluate issues in their own community. This engagement can occur on a continuum from low to high.

The operative values guiding PARC's approach to CBPP include a commitment to:

- **Shared Vision.** Building on the CBPP efforts in CRDP Phase 1 and extending this into Phase 2 goals and objectives
- **Inclusiveness.** Engaging diverse internal and external stakeholders and those most affected by mental health disparities to create intended change at the local and state levels
- **Collaboration.** Employing joint efforts and willingness to share decision-making as Phase 2 partners pursue CDEPs and mental health delivery systems change
- **Flexibility.** Maintaining an ability to address the unique nature and evolving circumstances of each CDEP and community/population served
- **Empowerment.** Increasing capacity of IPPs and priority communities to foster improvement and self-determination in mental health access and service delivery, as well as evaluation through TA support to the TAPs, SWE, EOA, and CDPH-OHE
- **Cultural Responsiveness.** Viewing the strengths and needs of the five priority populations through a cultural, linguistic, organizational, community, historical, and intersectional lens.

CRDP Phase 2 embodied core principles of CBPP within the context of built-in requirements and external pressures that shaped how CBPP could be applied. In CRDP Phase 1, Priority Population Reports grew out of a variety of community engagement efforts resulting in priority population specific reports steeped in their priority population's perspective. In CRDP Phase 2, the SWE's application of CBPP, among others, included:

- the use of the Phase 1 priority population reports and the Statewide Strategic Plan, which informed the development of the Statewide Evaluation approach and data collection tools

- modifications to two Statewide Evaluation Core Measures based on feedback from Phase 2 stakeholders (IPPs, TAPs) including changes in language, inclusion of additional IPP or TAP generated items, re-ordering of survey items, etc.
- changes to Statewide Evaluation data collection methods in response to individual IPP or priority population hub requests to further address cultural, contextual, or linguistic considerations (i.e., translation and conceptual meaning, response scales, administration strategies with the items, etc.), formation of a data review committee to provide feedback on initiative preliminary findings
- inclusion of a CRDP community review process for feedback on the final evaluation report.

For more information on CBPP in CRDP Phase 2, refer to PARC's document titled, "Best Practices in Community Based Participatory Practice, 2018."

2.3.2 The Social-Ecological Framework

The SWE will examine reductions in mental health disparities and improvements in mental health outcomes from a public health perspective supported by an ecological systems framework (Bronfenbrenner, 1979). This framework posits that individuals' experiences and outcomes must be understood in the context of their ecological systems. In other words, individuals are enmeshed in different ecosystems all at once, from the most intimate home ecological system, moving outward to the larger school or neighborhood/community system to the most expansive system of society and culture. These systems inevitably interact with and influence each other and every aspect of people's lives. This framework is especially critical given that the five priority populations represented in Phase 2 experience a disproportionate share of mental health challenges at every level of the ecosystem, including a high prevalence of untreated mental health problems and related inequities in the social determinants of health.

The social-ecological framework provides a lens for developing a more nuanced understanding of the relationship between mental health and multi-level social and environmental factors (Bronfenbrenner, 1979; Ungar, 2012; Umemoto et al., 2009). It encourages attention to risk and protective factors at several levels that influence mental health, including individual, family, peer, school, neighborhood, community, and systems.

SWE outcomes bridge four critical ecological levels:

- **Individual and Family** - Increased access to culturally, linguistically, and LGBTQ+ competent mental health services and improvements in mental health for community members of the priority populations (CDEPs as implemented by IPPs),
- **Organizational** - Improvements in administration and operations, securing additional resources and building strategic partnerships to better serve communities (IPPs with TA and support from the TAPs, EOA, SWE, and OHE),
- **Community Environment** - Strengthened community capacity that can influence local mental health delivery systems changes (IPPs with support from the TAPs, EOA, SWE, and OHE), and
- **Statewide Systems and Policies** – Improvements in California's public mental health system so it can better recognize and effectively address the different linguistic and cultural needs of

the various unserved, underserved, and/or inappropriately served communities through systems change (EOA, SWE, and CDPH-OHE).

2.3.3 Culture

Closely aligned with the social-ecological framework is culture (Trickett, 2009). For CRDP, CDPH-OHE defines culture as:

> An integrated pattern of human behavior which includes thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, role, relationships and expected behaviors of a racial, ethnic, religious or social group and the ability to transmit this pattern to succeeding generations. (National Center for Cultural Competence, 2001)

The SWE must consider culture and how it influences the evaluation of the CDEPs and CRDP Phase 2 as a whole. Culture is relevant to psychological theory and practice because it provides the foundational frames for developing worldviews, interpreting reality, and acting in the world (Harrell, 2015). It emerges out of interpersonal realities and reflects a dynamic relational process of shared meanings that must be considered in historical, social, political, and economic contexts (Carpenter-Song et al., 2007, Garneau & Pepin, 2015; Gregory et al 2010). More specifically,

> Culture influences the experience, expression, course and outcome of mental health problems, help-seeking and the response to health promotion, prevention or treatment interventions. The clinical [or prevention/early intervention] encounter is shaped by differences between patient and clinician in social position and power, which are associated with differences in cultural knowledge and identity, language, religion and other aspects of cultural identity. Specific ethnocultural or racialized groups may suffer health disparities and social disadvantage as a result of the meanings and material consequences of their socially constructed identities (Kirmayer, 2012, p. 149).

Greater attention to culture is essential in CRDP Phase 2 given the salience of culture highlighted in the Phase 1 priority population reports and the centrality of culture in the community defined evidence practice approaches.

2.3.4 Cultural Competence

Often discussed in the context of discussions of culture in mental health is the concept of cultural competence which highlights the critical need to include cultural considerations in the design and delivery of mental health services. In their widely used framework, Cross et al. (1989) define cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (p. iv). Further, while cultural competence initially focused on providing culturally appropriate care to members of ethnically diverse populations (Cross et al., 1989), it has been expanded for use among other diverse groups (e.g., LGBT individuals, see Boroughs et al., 2015; Israel & Selvidge, 2003) and phenomenon (e.g., providing spiritually competent therapy).

While cultural competence has also been conceptualized on multiple levels, from therapist characteristics, to organizational structures and processes, and system-level issues and policies (Sue, 2001; Betancourt et al., 2003), the majority of empirical research has focused on program characteristics, with the main foci remaining on mental health provider factors (Wendt & Gone, 2011). The SWE is intentionally widening these foci since the goal of CRDP Phase 2 is to demonstrate whether culturally competent PEI programs (i.e., CDEPs), which are community-defined, culturally-based, and community-driven, are effective in reducing mental health disparities across five priority populations.

2.3.5 Synthesis of Culture and Ecology

The SWE integrates culture with the social-ecological framework to develop a conceptual model that is multi-level, community-based, and culturally-situated. Culture is not simply relational and psychological. It is also embedded and expressed in communities. "No one lives in the world in general" (Geertz, 1996, p. 262); that is, everyone lives in the world in a situated context. While the social-ecological framework gives prominence to the complex interplay between individual, relationship, community, and societal factors, it also allows for a deeper examination of culture that changes over time, and is situated and expressed in a particular context. Because culture represents a dynamic, social and ecologically interpretive reality for members of a community, it can also be defined as "shared meaning that develops over time in the common activities of people" (O'Donnell & Tharp, 2012, p. 23). By exploring and examining the multiple factors that influence individual behavior, a more complete picture of the cultural features of a CDEP and the socio-ecological context within which they operate can emerge (Gallimore, Goldenberg, & Weisner, 1993).

More specifically, in this integrated model, the SWE approach is:

- **Multi-level** - Data is collected across individual, organizational, community, and statewide levels.
- **Community-based** - Working in close partnership with TAPs, the EOA, and local evaluators the SWE will identify, describe, and understand the effects of the CDEPs offered by each IPP in their respective communities.
- **Culturally-situated** –Explicit placement of culture, as manifested and expressed in the CDEP, while also considering how cultural, environmental, and historical factors influence the organizational, community, and systems contexts of the CDEP.

Therefore, the social ecological framework, as used in the SWE, is the synthesis of culture and ecology that will be used to represent a nuanced, multidimensional understanding of culture and context in mental health delivery (see Figure 3).

Figure 3: SWE Social Ecological Model

The rings in this SWE social ecological model align with CRDP Phase 2's components and respective strategies.

- At the heart of the ecological system, the CDEPs, which provide services directed towards individuals, families, and groups are situated within the innermost ring.
- The second inner ring of the ecological systems contains the IPPs, who are immersed in the culture and context of their priority population community and develop and implement the PEI programs (including their evaluations).
- In turn, these organizations are located in communities, that are embedded in specific geographic locations and settings (such as schools, workplaces, and neighborhoods, as well as climate, processes and local policies). Although they include the demographic priority populations of interest in CRDP, each community and priority population have their own unique history, social capital, and social identities (Yoshikawa et al 2005), which are examined and described through the lens of intersectionality (e.g., Cole, 2009; Collins, 1999; Crenshaw, 1999). See Section 2.3.7 for more discussion on PARC's intersectionality approach.
- The outermost ring consists of the Statewide Systems (e.g., state laws on data collection and public reporting of mental health utilization and outcomes; public coverage for mental health services; evidence-based practices expectations for mental health service delivery) that incorporate the broad society and policy factors in California that contribute to mental health disparities for the five priority populations.
- Finally, CRDP Phase 2 partners (TAPs, EOA, SWE, CDPH-OHE) traverse the multiple levels of the ecosystem to support, evaluate, and disseminate. The upper half of each ring, depicted with lighter shading, captures the infusion of evaluation, technical assistance, and dissemination/messaging support by the partners across the different levels of the ecosystem.

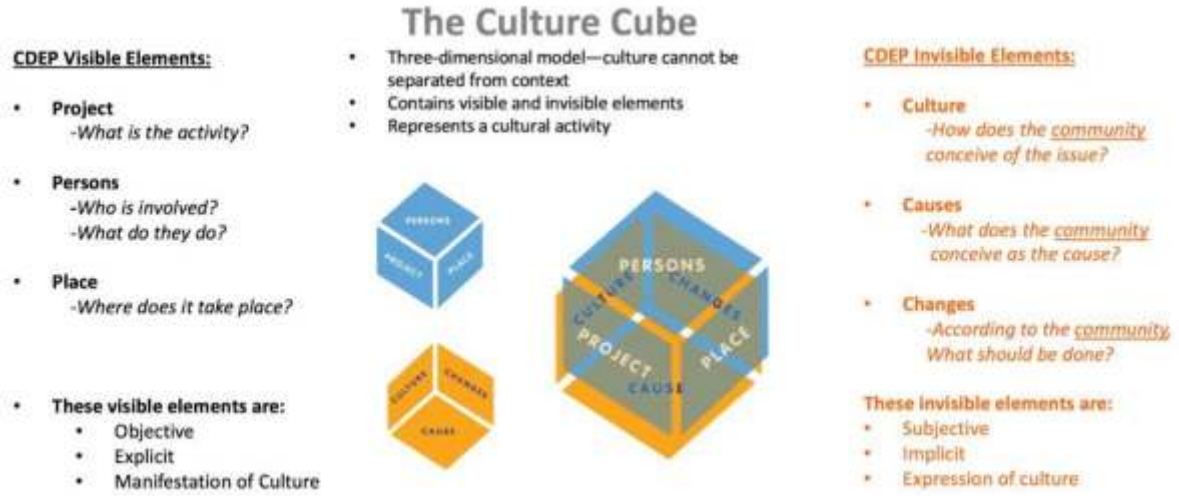
2.3.6 The Culture Cube

PARC developed a conceptual model and tool—The Culture Cube—to assist IPPs, local evaluations, and the SWE in articulating and documenting the cultural features and socio-ecological contexts of their CDEPs (see Figure 4).

The cube is a three-dimensional conceptualization that can:

- Guide descriptions of culture, as manifested and expressed in the CDEP—where culture is placed at the heart of the ecological system, and
- Account for historical factors that influence the organizational, community, and systems contexts of the CDEP. In fact, the cube 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.

Figure 4: The Culture Cube Model and Tool



The CDEP's unique values are captured through an understanding of the dynamic interaction of both visible and invisible aspects of the cube. In other words, communities have at least two levels of "culture", one they share with outsiders (visible) and one that they live with (invisible)—with insiders. The cube is designed to explicate both. More specifically,

- The culture they share with outsiders, represents the "visible" sides of the cube, or the **P**rojects— **P**ersons—and **P**lace (which are bold and prominent in the illustration of the model). These are the more commonly referred to elements of culture.
- The culture they live with—with insiders are the "invisible" parts of the cube, or the **C**ulture—**C**auses—and **C**hanges. 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.[2,3]

The identification of these critical elements of the CDEPs can strengthen IPP local evaluations because they can help IPPs: 1) identify relevant process and outcome measures and methods that flow out of their explanatory models; 2) problem solve ways to capture relevant cultural variables in the evaluation; 3) examine assumptions about the change process required to achieve CDEP goals; 4) develop a clear evidence-based program description that can be included in their final local evaluation report and in the SWE's analysis of IPP data; and 5) discern, cultural variables, outcomes, and measures that might be used across IPPs within a priority population.

2.3.7 Intersectionality

Intersectionality emerged out of a concern for the complex, cumulative ways the many forms of discrimination combine, overlap, and/or intersect. In other words, discrimination does not exist in a bubble; there is no universal person; and people are not one dimensional. Each person belongs to multiple social groups and has a gender, race, sexual orientation, gender identity, social position, experiences of discrimination and inequality, etc. The meaning of each social group membership is co-constructed through the lens of the other social groups (Crenshaw, 1999). For example, a person's understanding of their ethnic group membership is filtered through their gender identity, and their understanding of their gender identity is filtered through their ethnicity. Because social groups ''encapsulate historical and continuing relations of political, material and social inequality'' (Cole, 2009, p. 173), the meaning attached to a social category, and thus, the experiences of advantage and disadvantage based on that category, will depend on the domain being considered. These processes suggest that the same person could be disadvantaged in one context but not in others, based on their intersectional social group memberships. Thus, a person's experiences must be conceptualized as dynamic, fluid, and internally diverse.

For example, a person's understanding of their ethnic group membership is filtered through their gender in one context, which may shift in another context (e.g., at a family gathering, a female is more aware of the prominence of her traditional Mexican gender role, but in the work context, her womanist values characterize her behavior). The shifting and fluid nature of identities provide a more complex view of how social categories shape life outcomes (Warner & Shields, 2013). In keeping with this, the SWE integrated model allows for acknowledgement of and attention to:

- Diversity within cultures (based on multiple identities and intersectionality),
- Similarities across cultures (due to common historical and contemporary experiences of racism and oppression), and
- Differences between cultures (based on meanings attached to different social categories).

[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.

[3] For more information on the Culture Cube conceptual model and its illustration with 3 CDEPs see: Abe, J., Grills, C., & Ghavami, N., Xiong, G., Davis, C., & Johnson, C. (2018). Making the Invisible Visible: Identifying and articulating culture in practice-based evidence. American Journal of Community Psychology, 1-14. The article can be found on PARC's website.

This offers a more textured understanding of the ways in which multiple social group memberships link privilege and disadvantage in people's life experiences and how these may impact mental health and well-being at the organizational, community and systems level.

"Hyperdiversity" has been used to describe a "mosaic-like mix of national origin, ethnicity, race, immigration status, and nativity," within which individuals increasingly claim a "growing multidimensionality of identity" (Good & Hannah, 2015, p. 201). It can also capture gender identity and sexual orientation. At the IPP CDEP and individual level, intersectionality can help us to nuance this within-group diversity, so groups are not stereotyped or essentialized in order to preserve an overly simplistic understanding of culture. At the community and organizational levels, recognizing the diversity among members of a priority population can include a consideration of complex, dynamic, fluid, and evolving community characteristics, compared with older social categories that are based on more static understandings of culture, ethnicity and race. At the local systems level, through the lens of intersectionality, county departments of mental health may discern the relevance of using different methods of service delivery, different assessment tools, and different metrics of effectiveness that better serves the needs of specific priority populations.

2.3.8 The CRDP Phase 2 SWE Change Model

Complementing the social-ecological framework, the SWE change model in Figure 5 delineates the pathways to change in CRDP Phase 2. The model is aligned with goals and strategies outlined in the CRDP Strategic Plan to Reduce Mental Health Disparities[4], including the use of community and culturally-rooted methods to improve access, services, and outcomes for unserved, underserved, and inappropriately served populations.

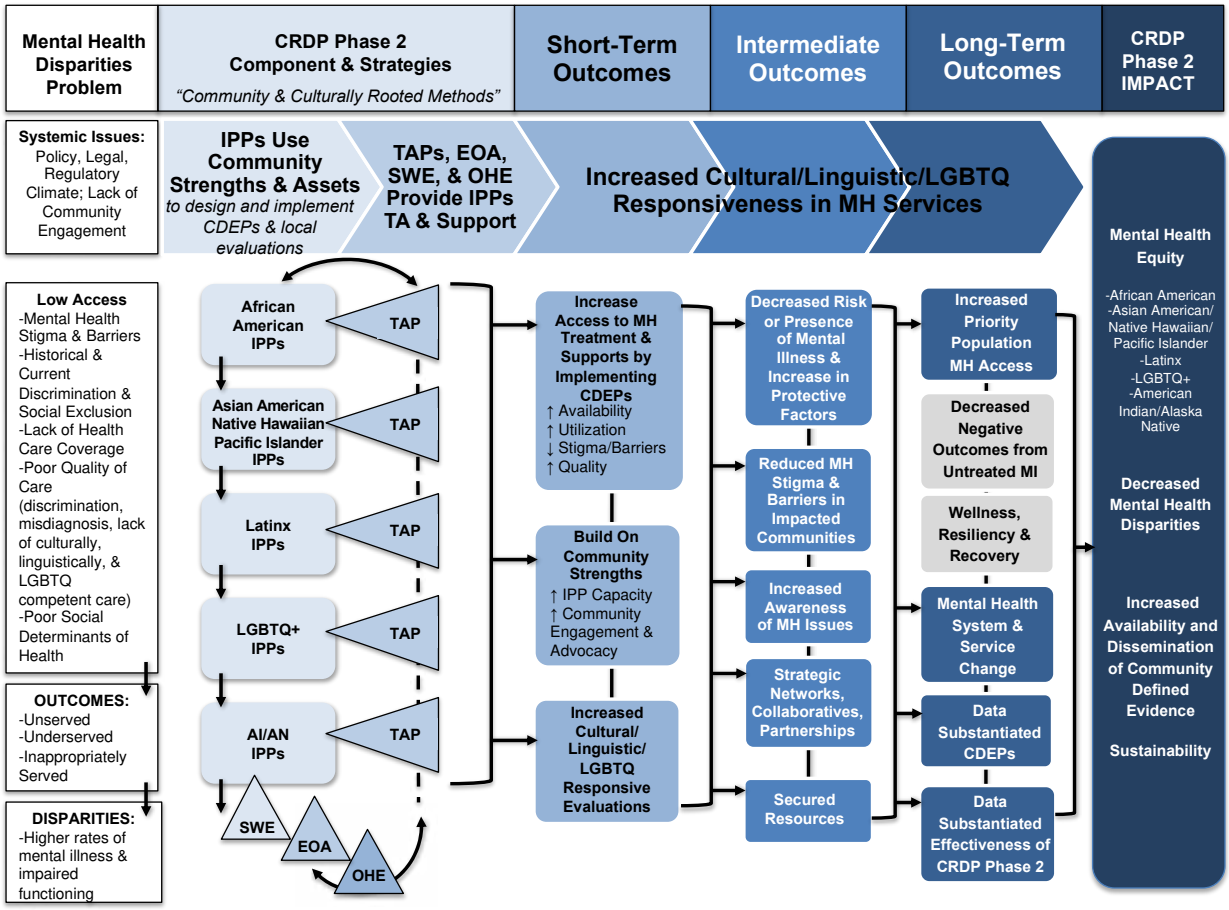
Figure 5 provides a visual representation of the change model:

- The first column illustrates key factors contributing to mental health disparities affecting the five priority populations.
- In the second column, in response to these mental health disparities, the IPPs implement their CDEPs—i.e., a community-focused approach grounded in existing community strengths, culture and context.
- Next, with technical assistance and support provided by the TAPs, SWE, EOA, and CDPH-OHE, the IPPs would continue to strengthen their capacity and efforts to reduce mental health disparities through their CDEPs.
- CDEP efforts contribute to short-term outcomes that include preliminary signs of increased access and utilization of PEI services, decreased stigma associated with mental illness, and improved service quality.
- Continued implementation of the CRDP components and strategies (IPPs, TAPs, EOA, SWE, and CDPH-OHE) subsequently lead to a set of intermediate outcomes at the individual (e.g., continued shifts in access, utilization, and stigma), organizational (e.g., acquisition of resources, strategic networks, and collaborations), and community levels (e.g., increased awareness of mental health issues).

[4] https://cpehn.org/page/california-reducing-disparities-project

- Finally, while individual level change continues over time, additional long-term outcomes also begin to emerge at both the community and statewide/systems level for the five priority populations (e.g., mental health systems change) with continued infusions of support and technical assistance provided by CDPH-OHE, TAPs, EOA, and SWE.

Figure 5. CRDP Phase 2 SWE Change Model



2.3.9 Complexity Theory and the SWE Change Model

The Statewide Evaluation change model in Figure 5 presents a linear illustration with isolated variables. However, the model and accompanying evaluation methodology is grounded in a more nuanced modeling found in complexity theory (Byrne & Callaghan, 2014).

> Complexity theory rejects the mechanistic and deterministic views of traditional science and simple linear models of psychological phenomena in favor of a view that complex phenomenon (such as health and wellness) are not static, do not exist in states of equilibrium, and can never be completely predicted because of the multiple interacting systems simultaneously at play and their self-organizing and emergent properties (Harrell, 2015).

Therefore, despite its linear illustration with isolated variables, the SWE change model and evaluation methodology is intended to capture the more textured story reflected within

complexity theory. The requires sensitivity to the potential influence of organizational, community, cultural, historical, and contextual conditions on any observed changes, focusing attention on filling the gap between the stated importance of culture and the practice of incorporating culture into theory-building, intervention, and evaluation of outcomes. A complexity theory informed approach challenges the fundamental assumptions of experimental research such as the ability to truly isolate independent variables and viewing cultural variability as a problematic in presumed linear relationships. It concurrently encourages the use of mixed methods and triangulation—i.e., verification of findings from two or more sources or types of data. The SWE methodology incorporates this perspective.

3. SWE METHODS

An Important Note on the Implementation of the Statewide Evaluation Plan

It is important to understand the complexity and magnitude of the CRDP Phase 2 Statewide Evaluation Plan. The plan was conceptualized and designed to be a cross-site evaluation capable of demonstrating effectiveness of a large scale, multi-year initiative with numerous components and strategies. Implementation of the CRPD Phase 2 initiative occurred from 2017 to 2021 within a set of contextual and sociopolitical factors that were constantly in flux, often in unpredictable ways (e.g., State IRB requirements, the COVID pandemic, multiple wildfires, etc.). These required that all CRDP components, including the Statewide Evaluation, be adaptive, flexible, and iterative. While implementation of the Statewide Evaluation Plan was successfully implemented, there were a few components that could not be addressed as intended due to external barriers (e.g., inability to access to secondary or administrative data, IPP challenges providing local evaluation meta-data to the SWE). Please refer to the Statewide Evaluation Report Final Report for a detailed overview the implementation of this plan (anticipated for public release by the end of the 2022 calendar year).

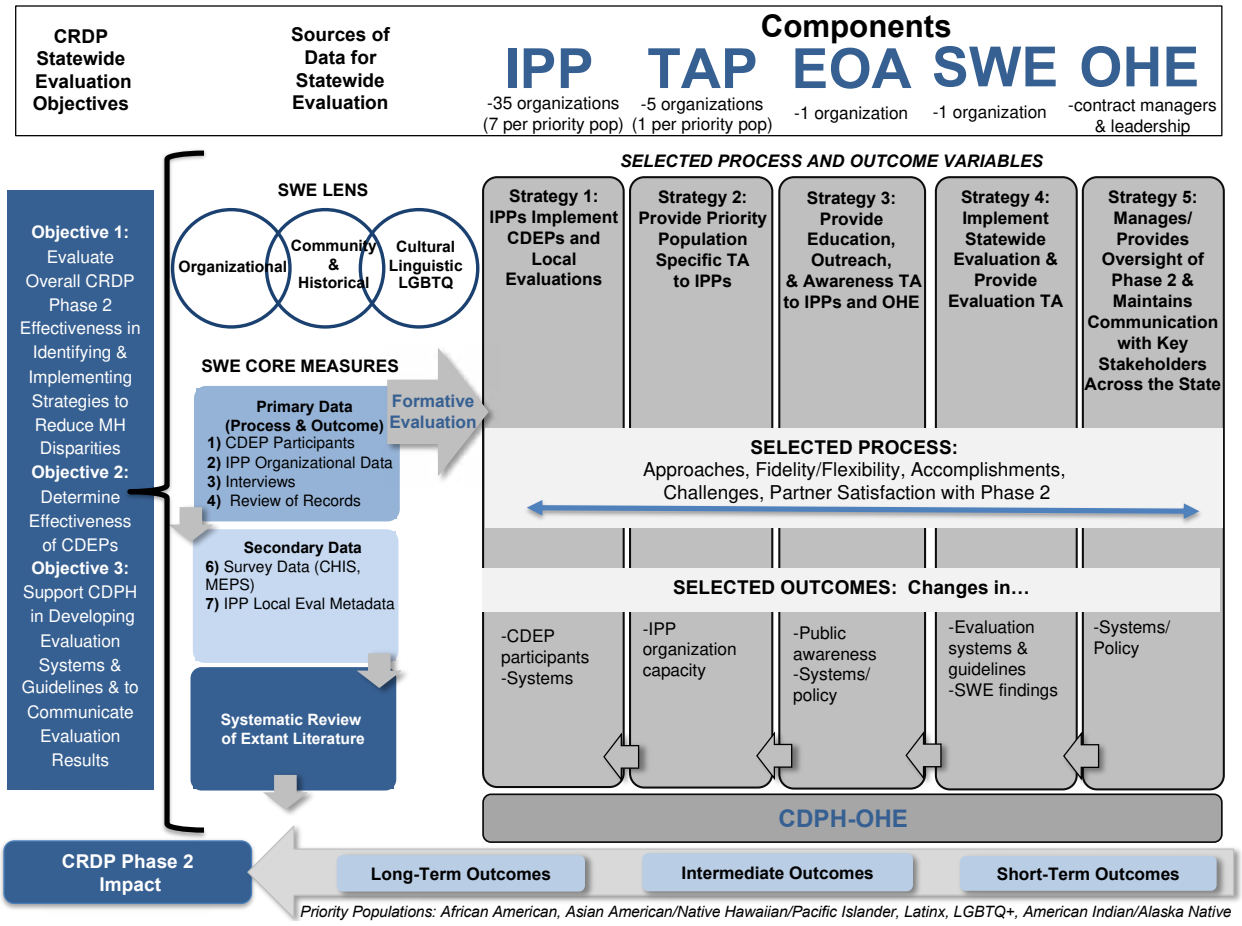
3.1 Design

The SWE uses a CBPP integrative, multi-year, multi-site, and mixed-methods approach to better understand the unique features of culturally defined evidence and practice while addressing the three SWE evaluation objectives. This begins with triangulation of data collected from methodologically diverse primary and secondary data sources to explain the mechanisms and outcomes of Phase 2 strategies. Beyond triangulation, the SWE design has both a summative component and a formative function (i.e., highlighting important success stories in real time, discerning what is and isn't working, and making course corrections). This formative process will yield annual updates to the SWE as Phase 2 unfolds. As a demonstration project, formative evaluation allows the SWE to better meet the objective of highlighting best practices and models in CRDP Phase 2.

The SWE design is illustrated in Figure 6. It visually represents the Phase 2 components and strategies (IPP, TAP, EOA, SWE, and CDPH-OHE), selected SWE process and outcome variables, and SWE data sources (both quantitative and qualitative) to meet its summative and formative functions. It further highlights how PARC will use three unique lenses —i.e., organizational, community (which also includes historical context), and

cultural/linguistic/LGBTQ+ related factors—for each priority population to situate the findings. This nuanced perspective can yield a richer (and intersectional) understanding of how and when these lenses influence changes in mental health disparities among AfAm, AI/AN, AANHPI Latinx, and LGBTQ+ communities.

Figure 6. SWE Schematic of CRDP Phase 2 Components and Strategies



3.2 SWE Sampling

3.2.1 Total SWE Sample

Pre-determined by the CDPH solicitation, the SWE utilizes a non-probability sampling approach. The sample is drawn from the IPPs (N = 35), TAPs (N = 5), PARC (N =1), EOA (N = 1), CDPH- OHE (five priority population contract managers; one SWE contract manager; and OHE leadership including the Lead for CRDP, Chief of Community Development and Engagement, Deputy Director, and Assistant Deputy Director) and other CRDP key stakeholders (e.g., tribal and community leaders, administrators from county DMH's, state policymakers, etc.). These sources provide data for overall statewide evaluation results, priority population results, and when possible, within and across populations.

Table 3: Total SWE Sample

Partners	Priority Populations				
	AfAm (n =7)	AANHPI (n =7)	Latinx (n =7)	LGBTQ+ (n =7)	AI/AN (n =7)
IPPs (N =35)	-California Black Women's Health Project -Catholic Charities of the East Bay -Healthy Heritage Movement -Safe Passages -The Village Project -West Fresno Family Resource Center -Whole Systems Learning	-Hmong Cultural Center of Butte County -Muslim American Society: Social Services Foundation -Cambodian Association of America -East Bay Asian Youth Center -The Fresno Center -HealthRIGHT 360 -Korean Community Services	-Humanidad Therapy and Education Services -Integral Community Solutions Institute -Latino Service Providers -Health Education Council -La Clinica de La Raza -La Familia Community Counseling -Mixteco-Indigena Community Organizing Project	-Center for Sexuality and Gender Diversity -Gender Health Center -San Joaquin County Pride Center, Inc. -San Francisco Community Health Center -Gender Spectrum -On The Move -Openhouse	-Friendship House Association of America -Indian Health Center of Santa Clara Valley -Indian Health Council, Inc. -Native American Health Center -United American Indian Involvement, Inc. -Sonoma County Indian Health Project -Two Feathers Native American Family Services
TAP (N =5)	ONTRACK	Special Service for Groups (SSG)	UC Davis Center for Reducing Health Disparities (UCD)	Center for Applied Research Solutions (CARS)	Pacific Institute for Research and Evaluation (PIRE)
OHE (N =5)	Priority Population Contract Manager	Priority Population Contract Manager	Priority Population Contract Manager	Priority Population Contract Manager	Priority Population Contract Manager
	OHE Leadership (n =4) SWE Contract Manager (n =1)				
SWE (N =1)	PARC@LMU				
EOA (N =1)	California Pan-Ethnic Health Network (CPHEN)				
Other (N=2)	CRDP stakeholders (i.e., the Cross Population Sustainability Steering Committee and the Racial and Ethnic Mental Health Disparities Coalition)				

3.2.2 CDEP Participant Level Sample

IPPs are collecting CDEP participant level data for the SWE using a cross-site questionnaire. The CDEP participant sample size is not pre-determined by PARC but by the IPP and local

evaluators so that sample size aligns with their local evaluation sampling strategy. Outreach methods for and involvement in the local evaluation, and therefore the SWE cross-site questionnaire will vary by IPP and community. Data collection locations will also differ across IPPs because implementation of CDEPs occur across multiple sites and locations, and levels (e.g., school, classroom, students, agencies, community events. etc.). In light of the above variability and the nature of the local IPP evaluation strategies, IPP sampling approaches will primarily be a combination of non-probability techniques—i.e., universal or convenience. Section 5.1.1 addresses the analytical implications of this sampling design.

3.2.3 Inclusion/Exclusion Criteria and Recruitment

Inclusion criteria for the SWE will consist of: a) CRDP Phase 2 partners (IPPs, TAPs, EOA, SWE, and CDPH-OHE); and b) other key stakeholders who have some level of involvement with Phase 1 or 2—i.e., county and state, decision makers, community/tribal leaders, etc. Exclusion criteria for the statewide evaluation are non-CRDP Phase 2 PEI programs or services. Recruitment of the SWE sample will occur through regular contact and communication between PARC and the Phase 2 partners and other key CRDP stakeholders.

3.3 SWE Core Variables and Measures

In order to determine effectiveness of Phase 2 as a whole, a set of SWE core process and outcome variables, as well as measures, were identified and developed to ensure consistency in data across Phase 2 components and strategies. The SWE variables and measures are aligned with the SWE's objectives, research questions, and change model, including the *CRDP Strategic Plan to Reduce Mental Health Disparities*. With feedback and approval obtained from CDPH-OHE, six primary and secondary (or administrative) core measures were identified by PARC that included a combination of qualitative and quantitative measures from internal and external data sources. They constitute only a subset of potential process and outcome measures to answer the research questions. The SWE outcome measures in particular are consistent with evaluation best practices and standard methods to examine changes in PEI programs and strategies (Rand, 2017). Embedded within a portion of the SWE core outcomes measures are a series of comparisons—i.e., comparing CDEP participant data to external populations (e.g. County PEI data and national/state population health survey data)[5]. Tables 5 and 6 present an overview of the SWE core process and outcome variables organized by their operational definition, corresponding measures, data sources, sample, and data collection time points. Sections 3.3.1 to 3.3.6 describe the six core measures.

Using a CBPR process, continuous feedback from Phase 2 partners (IPP, TAP, CDPH-OHE) is solicited and consistently integrated into various SWE core measure instruments and data collection procedures. Improvements to the SWE core measures are often made to account for the unique cultural, linguistic, historical, and contextual factors of each community and priority population. This iterative feedback process facilitates meaningful cross-site measures of progress capable of informing, providing critical feedback, and reinforcing positive change among all Phase 2 partners and their respective strategies and distinct approaches.

[5] Attempts will be made for the comparison populations to have a similar composition to the CDEP priority populations being evaluated to allow for meaningful analysis (i.e., comparability across socio-demographic factors and other relevant covariates).

3.3.1 CDEP Participant Level Data

CDEP Participant Questionnaire consist of items selected and/or modified from national/state population health or other standardized surveys[6], and new items generated by PARC or in collaboration with Phase 2 partners. Questionnaires are collected from either all or a sub-sample of CDEP participants, and are administered at the beginning (pre-test) and/or end (post-test) of the natural CDEP program cycles. There are three age versions of the questionnaire: Adult (18+ years), Adolescent (12-17 years), and Child by Proxy (5-11 years). The Child by Proxy questionnaires are completed on behalf of the child by a parent, guardian, or caregiver. These questionnaires address multiple factors related to individual-level mental health disparities including demographic information. These are:

- Access/utilization to mental health supports and services in the year prior to CDEP involvement (Pre-only),
- Mental health stigma and other barriers to help seeking in the year prior to CDEP involvement (Pre-only),
- Psychological distress, psychological functioning and protective factors (Pre- and Post),
- CDEP satisfaction and quality of service (Post-only), and
- Demographic information (Pre-only).

See Appendix C for paper-pencil copies of the adult, adolescent, and child by proxy questionnaires.

The Application of Intersectionality. While the CDEPs are designed to serve one priority population, it is critical that the SWE not overlook the intersectional identities of the adults, adolescents, and children the CDEPs are serving. For example, the Latinx priority population are not homogenous. They are very diverse on the basis of multiple overlapping factors (e.g., age, ethnicity, gender, sexual orientation, experiences of discrimination and inequality, etc.). The SWE recognizes that people's identities and social positions are shaped by multiple factors, which all contribute towards their unique experiences and perspectives, including a variation of risk and resilience factors in outcomes. To ensure that the experience and needs of all segments of each priority population are adequately addressed in the SWE, the following demographic items were included in the questionnaire: age, race, ethnic identity, sex assigned at birth, gender identity, sexual orientation, English fluency, experiences with temporary refugee settlement or ICE facilities, and number of years living in the United States. Recognizing the current political climate and immigration policies, some individuals may experience discomfort or fear disclosing some or all of this information and a response option of "refuse to answer" is provided. Optional items for use by IPPs also include: perceived health status, experiences of racism and discrimination, and sexual orientation and gender identity discrimination. See Section 2.3.7 for more information on the intersectional data analytic approaches the SWE will be utilizing.

3.3.2 Organizational Level Data

The *IPP Organizational Capacity Assessment* tool assesses organizational capacity strengths and unique or priority capacity building needs at the start of the IPP grant (pre-assessment) and at the end of SWE data collection (post-assessment). It is an adapted version of the Organizational

[6] California Health Interview Survey (CHIS); The National Survey on Drug Use and Health (NSDUH); The Mental Health Statistics Improvement Program (MHSIP) consumer survey; The Consumer-Based Cultural Competency Inventory (CBCI)

Capacity Assessment Tool developed by the Marguerite Casey Foundation that uses a "grading framework" with standardized rating scales. The data will be used to track growth in IPP organizational capacity in the following areas:

- Leadership: to inspire, prioritize, make decisions, provide direction, and innovate;
- Adaptive: to monitor, assess, and respond to internal and external changes;
- Management: to effectively and efficiently use organizational resources;
- Operational: to implement key organizational and programmatic functions; and
- Cultural Competence: to understand/respond to cultural influences, values, needs, and attitudes of their community constituency. (This sub-scale was newly created in collaboration with the TAPs to help explore and assess organizational level cultural responsiveness).

With the assistance of the TAPs, IPPs completed the pre-assessment at the start of their grant. IPPs were encouraged to invite multiple individuals within their organization (e.g., leadership, board of directors, managers, and staff) and other community stakeholders to collectively complete the assessment, discuss their ratings, and reach consensus on one set of ratings that best represents the IPP. The same process will be used at the post-test assessment at the end of the SWE data collection time period. See Appendix D for a paper-pencil copy of the assessment tool.

The IPP Semi-Annual Report (IPP-SAR) summarizes major or significant activities by the IPPs during a six-month time period related to: 1) developing and implementing their CDEPs and local evaluations, including fidelity and appropriate adaption to their original approaches; 2) accomplishments in IPP organizational capacity; 3) community engagement and public communications strategies; 4) advocacy efforts for systems, environmental, and policy change; 5) IPP satisfaction with Phase 2 partner TA and support; and 6) CDEP program participation (e.g., unduplicated or estimated counts of individuals served). This primarily qualitative measure of IPP progress and overall Phase 2 effectiveness, will be collected from the start of the grant to the end of SWE data collection time period. See Appendix E for more information about the SAR, a reporting schedule, and a paper-pencil copy of the most recent IPP SAR.

OHE Progress Reports summarizes TA and support activities provided by the TAPs, EOA, and SWE to IPPs, which is submitted to OHE on a regular basis, and shared with PARC. A template was developed in Year 2 in order to standardize TA reporting across all of the partners. Its development was derived from PARC's internal TA tracking system with input provided by the TAPs and OHE. It documents content of the TA provided to IPPs, mode of delivery (e.g., in person, video conference call), TA type (e.g., consultation, information/resources), and number of TA contacts by IPP. See Appendix F for the TAP's standardized TA reporting template.

3.3.3 Interviews

Phase 2 Partner Interviews and its accompanying survey are conducted annually with TAPs, EOA, SWE, and CDPH-OHE[7] to examine: a) implementation approaches and strategies used by the partners to support the work of the IPPs; b) fidelity and appropriate adaption to their original

[7] Phase 2 Partner Interviews began annually in summer of 2018, and will continue annually until the end of the SWE data collection time period. As EOA's contract started in 2019, they were interviewed for 2019 only.

partner approaches; c) collaboration among the partners to support the work of the IPPs, including how it evolved over time; and d) success, challenges, and lessons learned (IPP specific and priority population and/or CRDP-wide). The interview and survey data will serve as a qualitative measure of progress regarding overall effectiveness of Phase 2. See Appendix G for the interview protocol and the Partners' Brief Survey on TA and Support[8].

3.3.4 Review of Records

CDPH-OHE Phase 1 and 2 Records/Documents include regular and systematic collection, review and extraction of information from pertinent records and documents. These include, but are not limited to:

- Accepted grant proposals and bids,
- Contractor or grantee monthly reports to CDPH-OHE,
- *CRDP Strategic Plan to Reduce Mental Health Disparities* and the Phase 1 Priority Population Reports,
- Approved IPP final evaluation plans* and their annual updates,
- Approved IPP final evaluation reports, and
- Grantee and contractor invoices/budgets.

**The IPP Final Evaluation Plan Template*. Although the IPP grant proposals were an important source document for the SWE, what was originally proposed did not fully capture the detail—i.e., heart, soul, or rational—of the proposed CDEPs and their respective evaluations. In conjunction with SWE Objective 3, PARC developed an IPP local evaluation plan template and evaluation guidelines to assist IPPs with revisiting and refining their CDEP descriptions and local evaluation plans. Elements from the Culture Cube (see Section 2.3.6 for more information) were intentionally built into sections and questions in the local evaluation template to encourage IPPs to explicitly address the visible (project, persons, place) and invisible (e.g., cultural worldviews) elements of their CDEPs in a standardized, narrative format. Formal review and feedback that included external reviewers with research expertise aligned to each specific priority population was provided to each IPP. Where needed, TA was provided by PARC about the technical aspects of their local evaluation plans as well as their application of the culture cube. Their refined local evaluation plans were then subsequently approved by CDPH-OHE. The plans have an added value in that they can be used by both IPPs and the SWE in their respective final evaluation reports to summarize the CDEP's explanatory frameworks. This includes the cultural assumptions that usually remain implicit and unstated in PEI interventions (e.g., articulating the ways in which community context, cultural influences and values, including spirituality, define a CDEP intervention and expected outcomes). This information will be used by the SWE to 1) conceptually understand the CDEPs; 2) understand assumptions in CDEP approaches and strategies; and 3) make necessary course corrections in the SWE and local evaluations. See Appendix H for the Local Evaluation Plan Template and Review Guidelines.

Other Public Records include review of public records to confirm CRDP Phase 2 systems, environmental and policy changes. PARC will seek help from CDPH-OHE and other key stakeholders to obtain records that are not easily accessible.

[8] The Partner's Brief Survey on TA and Support was added in the second year as a qualitative data collection strategy to build on the quantitative information collected in the OHE Progress Reports by the TAPs, EOA, and SWE. It also documents critical TA and support provided by OHE leadership and contract managers to IPPs, including their perceptions of IPP organizational capacity growth.

3.3.5 Secondary or Survey Data (for comparison purposes)

PARC applied and received approval in 2019 to gain access to sensitive mental health data and/or geo-coded data from the California Health Interview Survey (CHIS). Attempts will be made to secure access to County PEI Mental Health Statistics Improvement Program (MHSIP) consumer survey data and demographic groups served data collected by county PEI programs in the same counties in which CDEPs are located. CDPH will be consulted to both facilitate obtaining relevant data sharing agreements with the California Department of Health Care Services (DHCS) and/or county departments of behavioral/mental/public health. This secondary data will be used to understand the magnitude of change or trends related to CRDP Phase 2 strategies, conduct comparisons with IPP participant data, and to make the business case for the effectiveness of CDEPs and CRDP Phase 2. For the business case, PARC will use public use Medical Expenditure Panel Survey (MEPS) data and will request a restricted use version that includes data for California.

3.3.6 Local Evaluation Study Metadata

Along with the SWE's CDEP Participant Questionnaire, PARC will be requesting that IPP submit aggregate meta-data from their local evaluation studies to expand the SWE's capability to demonstrate evidence of CDEP effectiveness on positive (e.g., hope, cultural connectedness) or negative mental health (depression, anxiety) outcomes for participants. Meta-analysis, an analytical technique, will be used to summarize the results of multiple IPP local evaluation studies to assist with determining the effects (or magnitude of change) of the CDEP interventions on participants. The total number of IPP local evaluation studies to be included will vary based on the specific participant outcomes being evaluated by each of the IPPs (and their associated standardized measures), and their ability to be grouped into various categories within and across the five priority populations—e.g., age (adolescent vs. adult CDEPs), PEI focus (e.g., school-based vs. community-based CDEPs), positive (e.g., hope, wellbeing, social support) and negative mental health (e.g., depression, anxiety) constructs, etc. As the changes will be assessed with effect sizes, IPPs will be asked to report aggregate findings on specific outcome measure data in the local evaluation final reports. Table 4 identifies what meta-data IPPs will be asked to report in their local evaluation final reports.

Table 4: IPP Sample Metadata Entry Table

Measure Name	Modified Yes/No	Pre Mean score	Pre score SD	Pre N	Post Mean score	Post score SD	Post N	Correlation between Pre and Post Mean scores (r)	Cohort (if applicable)	Age Group (child/ adolescent/ adult)
Example The Center for Epidemiologic Studies - Depression (CES-D)	N	20.55	2.00	30	18.11	2.00	28	.78	1	Adult

3.3.7 SWE Change Model Core Outcomes by Operational Definition, Measures, Sample, and Data Collection Time Point

Table 5. SWE Change Model Core Outcomes by Operational Definition, Measures, Sample, and Data Collection Time Point

Change Stage	Change Model Constructs /Outcomes		Operational Definition	Measures	Sample	Data Collection Time Points
-Short-Term -Intermediate -Long-Term	Access	Availability	• CDEP setting (e.g., community, faith-based, cultural centers, school-based) • Number of CDEPs implemented by community defined integrated models (integrated, co-location, collaboration) • Cultural/linguistic/LGBTQ+ approaches to CDEP a) outreach and recruitment; b) service provision • Number/type of CDEP referrals/linkages • Number/type of CDEP resource guides	IPP SAR, IPP Local Evaluation Plan	-35 IPPs	IPP SARs (2017 - 2021)
		Utilization	• Number of adult, adolescent, children served by: a) select direct programs; b) unmet need; c) psychological distress & psychological functioning; d) socio-demographics	IPP SAR; CDEP Participant Questionnaire	-33 IPPs -CDEP participant subsample (N=2,415)	-IPP SARs (2017 - 2021) -CDEP PRE Participant Questionnaire (2018 - 2021)
		Stigma/ Barriers	• Number of adult, adolescent, child participants served by stigma/barriers	CDEP Participant Questionnaire	-CDEP participant subsample (N=2,415)	-CDEP Participant Questionnaire (2018 - 2021)
		Quality	• Participant general satisfaction with CDEP: overall, accessibility, quality, cultural/linguistic competency, perceived outcomes • CDEP language assistance provided • Number/type of CDEP workforce responders trained (existing, future) • Cultural, linguistic, and LGBTQ+ approaches to workforce development • Credible evidence of CDEP effectiveness	CDEP Participant Questionnaire; IPP SAR; CDEP Participant Questionnaire; IPP Final Evaluation Report	-33 IPPs -CDEP participant subsample (N=2,415)	-CDEP PRE Participant Questionnaire (2018 - 2021) -IPP SARs (2017 - 2021) -IPP Final Evaluation Reports (11/2021)
-Short-Term -Intermediate	Community Strengths	IPP Capacity	• IPP leadership, adaptive, management, operational, cultural competence, other • Number/type of MHSA PEI and other secured funding	IPP Org. Capacity Assessment; IPP SAR	-35 IPPs CDEP	-CDEP PRE (2017) and POST Org Capacity Assessment (2021) -IPP SARs (2017 - 2021)
		Community	• Parent/family/youth, spiritual leaders/	IPP SAR	-35 IPPs	-IPP SARs (2017 -

Change Stage	Change Model Constructs /Outcomes	Operational Definition	Measures	Sample	Data Collection Time Points
	Engagement	healers, faith-based & other stakeholder involvement with CDEP & Local Evaluation			2021)
Short-Term Intermediate	Cultural and Linguistically Based Evaluation (CDEP, SWE)	• Peer reviewed IPP Local Evaluation Plan & CDPH-OHE approval • Local evaluation outcome data (meta-analysis data)	SWE and CDPH-OHE Records	-35 IPPs	-IPP Local Evaluation Plan Approvals (2018) -IPP Final Evaluation Report Approvals (2021)
Intermediate	Risk/Presence of Mental Health Issues & Protective Factors	• Changes in CDEP participant psychological distress, functioning, cultural connectedness, social exclusion	CDEP Participant Questionnaire	-33 IPPs -CDEP participant subsample (N=2,415)	-CDEP PRE and POST Participant Questionnaire (2018 - 2021) -Ca Health Interview Data (2020)
Intermediate	Awareness of MH Issues (Local, County, State)	• Number/type of audience reached by IPPs • IPP cultural, linguistic, and LGBTQ+ approaches used in public communications messaging	IPP SAR	-35 IPPs	-IPP SARs (2017 -2021)
Intermediate	Networks, Collaboratives, & Partnerships	• Number/level of IPP involvement with mental health networks/collaboratives/ partnerships	IPP SAR	-35 IPPs	-IPP SARs (2017 -2021)
Long-Term	Mental Health System & Services Change	• Number/type of Phase 2 advocacy efforts • Number and type of policy, systems, or environmental change as a result of Phase 2	IPP SAR; Partner Interviews	-35 IPPs -TAPs, EOA, SWE, OHE	-IPP SARs (2017 -2021) -Partner/Stakeholder Annual Interviews

3.3.8 SWE Core Process Variables by Operational Definition, Measures, Sample, and Data Collection Time Points

Table 6. SWE Core Process Variables by Operational Definition, Measures, Sample, and Data Collection Time Points

Process Measures	Operational Definition	Measures	Sample	Data Collection Time Points
IPP Organizational and CDEP Context	• IPP geographic location and CDEP service area • IPP age, CDEP staff, budget, and strengths • Number/type of community mental illnesses & protective factors targeted by CDEPs • CDEP populations of focus • CDEP PEI components	-IPP Phase 2 Proposals; IPP Local Evaluation Plans; IPP SARs; OHE Documents/Records	-35 IPPs	-PP Phase 2 Proposals (2017) -IPP Local Evaluation Plans (2018) -IPP SARs (2017 - 2021) -OHE Documents/Records (ongoing)
Phase 2 Partner (IPP, TAP, EOA, SWE, OHE) Implementation Strategies	• Strategies • Fidelity/flexibility (including implementation barriers/successes both internal/external)	-IPP SAR; Partner Interviews	-35 IPPs -TAPs, EOA, SWE, OHE	-IPP SARs (2017 - 2021) -Annual interviews with TAPs, SWE, EOA, OHE (2018 – 2021)
Phase 2 Technical Assistance Provided to IPPs	• TA provided to IPPs by Phase 2 partners (TAPs, SWE, EOA, OHE)	-OHE Records/Documents	-TAPs, EOA, SWE	-Ongoing (2017 - 2021)
IPP Local Evaluation Strategies	• Cultural, linguistic, and LGBTQ+ methods, measures, and practice • Number & socio-demographics of local evaluation sample size proposed and achieved • Fidelity/flexibility (including implementation barriers/successes both internal/external)	-IPP Local Evaluation Plans; IPP SAR; IPP Final Evaluation Reports	-35 IPPs	-IPP Local Evaluation Plan & Updates (2018 – 2020) -IPP SARs (2017 -2021) -IPP Final Evaluation Reports (2021)
Phase 2 Partner Satisfaction with CRDP Phase 2	• CRDP Phase 2 strategies and operations • Level of support received • Partner collaboration	-IPP Anonymous Survey; Partner Interviews	-35 IPPs -TAPs, EOA, SWE, OHE	-IPP SARs (2017 -2021) -Annual interviews with TAPs, SWE, EOA, OHE (2018 – 2021)
Phase 2 Lessons Learned	• Phase 2 strengths and weaknesses • Recommendations & practical implications for future initiatives	ALL	-35 IPPs -TAPs, EOA, SWE, OHE	-Ongoing (2017 - 2021)

3.4 Translation and Cultural Adaptation of SWE Materials

To date, various SWE materials were translated from English into seven additional languages for use by 16 IPPs:

- SWE Participant Questionnaire,
- IRB-Approved Recruitment Scripts;
- IRB-Approved Consent and Assent Forms, and
- California Participant Bill of Rights for Non-Medical Research.

Table 7 provides a general overview of the languages the SWE materials were translated into by the number of IPPs who will be using these translated and culturally adapted versions of SWE materials.

Table 7: SWE Translation Languages

Languages	# of IPPs	Priority Population
Spanish	10	Latinx (n =7); LGBTQ+ (n =3)
Hmong	3	Asian American, Native Hawaiian and Pacific Islander
Tongan & Samoan	1	
Korean & Vietnamese	1	
Khmer	1	

See Appendix I for a detailed breakdown of IPP translated and culturally adapted versions of SWE materials.

3.4.1 Translation Procedures

To produce English equivalent translations of the various SWE materials, the following procedures were used that are consistent with best practices employed by California Health Interview Survey: 1) initial translation, 2) review by language experts skilled at the level of ATA/CA Court Certified translators/interpreters, 3) translation moderator review, and 4) translation reconciliation. PARC worked collaboratively with IPPs and TAPs to identify certified language translation experts in their respective communities to take the lead on the translation and cultural adaptation of the materials.

PARC aimed for translation equivalence at three levels: construct (do the underlying constructs—stigma, depression, etc.—have the same meaning in different cultural contexts?); method (do the SWE procedures for data collection work for a given population?), and; item (do the SWE items or information provided make sense, not just in terms of grammar structure, but meaning?). Materials were translated and either a) back-translated or b) culturally reviewed by bilingual/bicultural representatives of the IPP or TAP. For many IPPs, the cultural review included a pilot of the materials with CDEP community members, as well as integration of recommendations and final adjustments with the certified language translation expert.

3.5 Institutional Review Board Approval

The Office of Statewide Health Planning and Development's Committee for the Protection of

Human Subjects (OSHPD-CPHS) serves as the institutional review board (IRB) for the California Health and Human Services Agency (CHHSA). On 04/17/2018, a twelve-month approval was granted to PARC@LMU for the SWE (IRB protocol #: 2017-013). Annual re-approval was received on 04/8/2019. Apart from the CDEP Participant Level Data, which is considered research with human subjects, the SWE is considered to be an evaluation. Per requirements outlined in the SWE contract, PARC is adhering to CDPH Information Security Office (ISO) standards for data privacy and protection for all SWE core measure data. For more information on the approved IRB full proposal, contact SWE.SWE@lmu.edu.

CPHS IRB Approved Human Subject Protection Protocol. This research protocol includes standardized procedures and forms for: a) participant recruitment, b) participant consent/assent, c) questionnaire administration, d) data de-identification[4], d) data warehousing (i.e., use of CDPH ISO standards), and e) data submission to PARC. IPPs are responsible for recruiting participants, obtaining consent/assent, collecting data, de-identifying data[9], securing data at their site, and submitting data to PARC using the CPHS approved protocol. See Appendix J for the full protocol.

From 2017 through 2021, a continuous CBPP community review process (which included a pilot of the CDEP Participant Questionnaire) was conducted with Phase 2 partners to strengthen the validity of the participant questionnaire data. In total, PARC successfully submitted 16 CPHS amendments on behalf of 33 IPPs. CPHS approved modifications included changes to item terminology, response scales, visual features of the instrument, administration consent processes, and data submission procedures. Although IPPs consulted with TAPs, PARC, and/or CDPH-OHE on these modifications, they primarily reflect IPP and community wisdom about the particular evaluation strategies and methods that work best for their community.

See Appendix K for an overview of the age-related questionnaire versions in use by each IPP, including general information on administration procedures, data collection settings, and CPHS approved modifications.

4. SWE DATA DOCUMENTATION, VALIDATION, AND VERIFICATION

4.1 Data Dictionary

The SWE includes a Data Dictionary prepared in Microsoft Word that is readily usable as a public use file by Phase 2 Partners, particularly the IPPs, other researchers or key stakeholders. The SWE data dictionary is a "living document" and is regularly updated to ensure that any revisions to the SWE Core Measures are included in the Data Dictionary. To date, Version 3.1 (September 2020) contains detailed data information about the CDEP Participant Questionnaires, IPP-SAR, and TAP/SWE Progress Report. Future versions of the Data Dictionary will include additional SWE Core Measures. Feedback and final SWE Data Dictionary approval will be obtained from CDPH-OHE.

[9] CDEP participant data will be de-identified data by IPPs prior to its submission to PARC, which includes any of the 18 HIPAA identifiers (e.g., participants' name, address, phone number, photographic images, etc. or any other characteristic that could uniquely identify the individual).

The SWE Data Dictionary Version 3.1 contains the following sections:

- CRDP Phase 2 SWE Overview,
- SWE Data Dictionary Overview (how to use it; data dictionary variables list organized alphabetically and also by variable name/label), and
- SWE Data Dictionary (variable name, label, value labels, user missing values, type, format, syntax data, etc.)
    - CDEP Participant Questionnaire by age version
    - IPP Semi-Annual Report (IPP-SAR)
    - TAP and SWE Progress Report (data on TA and support provided to IPP)

For more information on the SWE Data Dictionary Version 3.1, contact SWE.SWE@lmu.edu.

4.2 Data Files

The SWE includes comprehensive data files that meet CDPH ISO standards. All SWE process and outcome data are stored in a variety of data files specific to each CRDP Phase 2 SWE data source and/or Partner (IPP, TAP, EOA, SWE, CDPH-OHE, and other). The data files are created in SPSS Statistics software files, but are available in a variety of data formats, including SAS, STATA, or Excel.

CDPH maintains ownership and all rights to all data collected within the scope of the SWE contract. At the conclusion of the SWE contract, all collected de-identified data, data files, and the data dictionary will be turned over to CDPH. All process and outcome data will be routinely entered and cleaned. At the end of the SWE contract, the database will be transmitted in SPSS and Excel format to CDPH on an external hard drive, including the accompanying Data Dictionary files.

4.3 Data Validation and Verification

Two types of quality control measures are used with SWE core measure data. All data submitted to PARC by IPPs and TAPs undergoes both a validation and verification check to ensure the data is correct, credible, in the correct format, accurate, and error free. Validation procedures include: a) downloading of data submissions from Qualtrics, b) recording data submissions in a master log; c) reviewing data and documenting any errors, inaccuracies or inconsistencies with the submissions, including communication with IPPs or TAPs to discuss and resolve flagged data issues in the master log; and d) processing decisions with the corresponding data and preparing for data entry. A double entry verification method is used to reduce data entry error. Using this method, data is first entered into a data file by one research assistant. The data is then re-entered by a different research assistant and the two data sets are compared for consistency. Discrepancies are brought to the attention of the data management team and they are resolved in real time during data entry. All PARC research assistant staff involved in SWE data validation or verification are supervised by PARC senior researchers and undergo a 2-to-5-hour training depending on their level of involvement with the quality control measures.

5. SWE DATA ANALYSIS

5.1 Overview

Determining the effectiveness of CRDP Phase 2 as a whole, as well as the CDEPs, will involve both qualitative and quantitative analyses of multiple primary and secondary data sources described in Section 3.3.

The SWE data analysis plan is grounded in the following:

- CRDP Phase 2 guiding principles of doing business differently, building community capacity, promoting culturally grounded practice, reducing mental health disparities, and improving mental health systems and policies.
- Inclusion of multiple frameworks that are attentive to the five priority populations, distinct communities, and varied data at hand with particular emphasis on:
- The social and cultural ecological framework represented by the Culture Cube model, elucidating routes to understanding and reducing mental health disparities through the lens of culture, context, intersectionality, and community-defined solutions.
- The CRDP Phase 2 Change Model to demonstrate effectiveness of the CDEPs and CRDP as a whole.

See Section 2 for more information on the SWE framework.

5.1.1 Complexity and Challenges of Multi-Site Data Analysis

PARC is cognizant of and shares the concerns of priority population communities regarding the potential problems associated with the collection and analysis of cross-site data that could be misunderstood, misconstrued, and/or misused. These include, but are not limited to, the use of measures that lack cultural or population validity, apprehension about inappropriate comparisons to other populations or communities, concerns that findings will be incorrectly interpreted, and that findings could advertently pathologize priority populations and communities. The data analysis plan therefore reflects our efforts to acknowledge and address these concerns and to demonstrate the validity of the culturally situated approaches in methods, constructs, and measures that have emerged out of the knowledge base, worldview, and wisdom of the IPPs and their communities. PARC will use a CBPP approach that will involve Phase 2 partners (IPPs, TAPs, EOA, OHE) in the analysis and interpretation of the findings to ensure that the conclusions are accurate and reflective of each community's social and cultural context.

5.1.2 Bayesian Approach to Quantitative and Qualitative Data Analysis

To address SWE Objectives 1 and 2 with quantitative data, an innovative data analysis strategy will be employed to integrate multivariate multi-level statistical models with Bayesian decision theory. Bayesian analysis offers many advantages for program evaluation (Bosworth et al, 1999; Perkins, 1987; Pollard, 1986; Rao and Woolcock, 2003), especially in view of the cultural complexities of the priority populations. Bayes factors will be computed for the comparison outcome measures. Bayes factors compare the posterior likelihood of the CDEP's performance given the evidence (data) collected to the corresponding likelihood for traditional PEI performance. In essence this is an odds ratio for the CDEP and traditional PEI programs.

PARC's Bayesian approach to analyzing CDEP Participant Level Data will be one of evidence

assessment—i.e., providing quantitative information about the extent of CRDP effectiveness. Bayesian methods (Vandekerckhove et al., 2018) made explicit use of prior knowledge and laid out the analytic assumptions for all stakeholders to see. Further, Bayesian approaches permit integration of qualitative and quantitative data, leveraging prior qualitative cultural knowledge and practice into inferential tools. Moreover, the prior probability distribution is a convenient tool for handling latent variables. Structuring the multi- level statistical model includes the observable information about the nature of the project, the people, and the place, as well as the latent variables of conceptualization, causes, and consequences. PARC will work closely with Phase 2 Partners to translate these crucial qualitative elements into prior information that can inform data analysis and ensure accurate cultural representations.

5.1.3 Intersectional Data Analysis

An intersectional lens undergirds the Statewide Evaluation philosophy, praxis, and approach. (see Section 2.7.3) and will be infused into the Bayesian analyses in the following ways to strengthen the modeling robustness:

- The Bayesian multilevel modeling will be structured to align with the Statewide Evaluation's overall social-ecological framework. At the individual level, this includes participants engaged with CDEPs offered by IPPs in their communities. At the hub level, the IPPs will be organized according to race/ethnicity, and LGBTQ++ cultural and community contexts. Within this ecology, intersectionality may connect different, multiple identities of individual participants.
- To address intersectionality within hubs, two modeling approaches will be used: 1) the first model will be applied to hubs where race and priority population hub are strongly associated and 2) the second model will be used for participants for whom racial group affiliation and hub were not intentionally associated, where race was an indicator variable for the participant's race not aligning with that of the hub (e.g., multiracial participants and LGBTQ++ hub participants). This approach will allow for better estimation of intersectional properties of participant identities and hubs for the cross-site analyses.
- The Statewide Evaluation will also employ techniques in robustness analysis with many "competing" models including different combinations of factors. These techniques compare multiple models using the factors they have in common. For example, we may include interaction terms to model intersectionality (ethnicity, gender identity) at the priority population to understand if main effect terms change dramatically with the presence/absence of those model components.

Findings that incorporate these intersectional approaches will be integrated throughout different sections of the report.

5.2 Quantitative Data Analysis

First and foremost, a picture is worth 1000 words. Appropriate data visualization leads to insights much more readily than do tables of numbers. All data analysis will begin with images of the data. Descriptive visuals will highlight aspects of CRDP Phase 2 and IPP efforts that demonstrate the extent to which the SWE objectives were accomplished.

Second, our evaluation, and hence our data analysis, must respect the long-standing challenges

and disparities -- common and unique -- faced by the priority populations. Statistical models and techniques used for SWE objectives need to account for the Culture Cube components and the community knowledge and expertise in the CDEP and its social and cultural context.

For example, the Ncig Teb Chaws intervention of The Fresno Center familiarizes Hmong people with their environment. Traveling with counselors in groups, participants are introduced to people and services in their community. These are the visible cube faces of the intervention: Persons, Place, and Project. Moreover, the Project is intentionally tuned to the obscured faces of Culture, Causes, and Changes, connecting a cultural tradition of relationality, travel and movement with mental and emotional well-being. SWE core measure outcomes, collected pre- and post- intervention, provide insight into the Changes resulting from the CDEP intervention. Therefore, it is essential that interpretation of SWE core measure quantitative findings be understood within the deeper cultural and contextual framing provided by the cube.

Third, we must recognize that "quantitative is qualitative" within the CRDP context. With sampling that is purposive and convenience, the appropriate analysis of Phase 2 data is not classical inferential statistics. Hypothesis testing comparisons of pre- and post-intervention data, program and secondary (or administrative) data, or between IPP data will not provide quantitative insights into CRDP effectiveness. We note that many, if not most, local evaluations do involve such techniques and that these methods form the traditional tools of quantitative program evaluation. From the SWE point of view and its dedication to the principle of doing business differently, we are not planning to deliver p-values and pronouncements of statistical significance for CRDP programs compared to each other or to administrative data.

However, some comparisons with secondary data, particularly CHIS data, will be an important grounding step. For those IPPs providing programs and services for individuals, we have selected several CHIS survey items (access and utilization, Kessler-6, Sheehan Disability Scale) for the SWE Participant Questionnaires, items which are perceived by the broader research community as reliable and valid measures of mental health. Efforts will be made to obtain appropriate subsamples of CHIS data, depending on the demographic and geographic characteristics of IPP priority populations served. These data will allow us to see where the individuals served by the IPPs are, relative to the spectrum of responses for similar populations, at least on these research-based mental health scales. We can also compare IPP participant responses with those of other populations, especially the service seeking items, for a glimpse into existing disparities (and potentially reductions in disparities) in access and utilization of mental health programs and supports.

Since the CHIS data does not follow individual respondents in time, there is no quantitative means of comparing IPP CDEP results to those of non CRDP PEI service providers. Even if such data were available, the nature of the CRDP data would call into question providing any comparisons other than descriptive and visual ones.

To address the basic issue of the effectiveness of the efforts of those IPPs providing services to individuals, the pre- and post-intervention SWE Participant Questionnaire items will help to illuminate progress over time. Our Bayesian view envisions each priority population having a distribution of mental health states that changes as a result of participant involvement in the

CDEP. Defining a quantitative proxy for mental health state will require IPP/TAP/SWE/CDPH-OHE collaboration, considering which SWE Participant Questionnaire items will be folded into single score (or if appropriate multiple scores) like the Kessler-6 or Sheehan Disability Scale. Bayesian analysis relies on a prior distribution, which will be constructed with a combination of secondary (e.g., CHIS) data analysis and discussion among IPPs for community-based prior information. In particular, the IPPs' Culture Cube constructs can help focus the SWE of each IPP with emphasis on SWE core measures relevant to their cube faces. Weighting of SWE core measures appropriate for priority populations (and individual IPPs) will lead to analysis that is attentive to community needs and that illuminates the ways in which IPPs improve the mental health of their populations. In other words, SWE analysis of CDEP specific data will be tailored to the IPPs and communities served. Variables are weighted based on the salience of cultural and contextual factors illuminated in the Culture Cube constructs. The sampled pre- and post-intervention measures provide the observations, and using Bayes' theorem we compute the post- intervention distribution of population mental health states.

The quantitative analysis effort will also be looking at IPP, TAP, EOA, CDPH-OHE, and PARC data for evidence concerning mental health workforce development; mental health referrals, linkages, and navigation; community outreach and engagement; IPP CBPP approaches; public communications; strategic partnership progress; organizational capacity; and policy/systems change. This analysis will largely be of a descriptive nature using the data provided by all Phase 2 Partners.

5.3 Qualitative Data Analysis

CRDP 2 is a new way of doing business to address mental health disparities for priority populations. As a result, PARC will take an inductive approach to analyze data from key informant interview, semi-annual reports, and other documents and records. Given that Phase I identified several important parameters that were further delineated in the state CRDP Strategic Plan (e.g., cultural, linguistic, and LGBTQ+ approaches should be used to conduct community outreach to increase availability to mental health services), these parameters provided an initial framing of some of the SWE variables. In this context, a modified grounded theory approach (Bulawa, 2013) is used to analyze the SWE qualitative data. Qualitative analyses will follow the basic premise of grounded theory emphasizing theory generation rather than theory verification. The strength of this approach is the capacity to conduct exploratory (as opposed to confirmatory) analyses of the data that is free from theoretical constraints with an inductive appeal, while fostering creativity, maintaining conceptualization potential, and its systematic approach to data analysis.

5.3.1 Grounded Theory Methodology

The qualitative approach will use constructivist grounded theoretical methodology (CGT) (Morse, 2009). CGT strives to understand and explain human behavior through inductive reasoning processes (Lazenbatt &Elliot, 2005). CGT does not start with testing an existing hypothesis, but uses the empirical data to generate concepts and theories (Glaser, 1978). CGT allows the research to derive meaning from the data and analysis using creative, inductive processes; it allows for the emergence of original findings from the data (Jones, Kriflik, & Zanko, 2005).

5.3.2 Coding

CGT analysis is focused on coding and analytical memo writing. Three levels of coding will be employed: open coding, axial coding, and theoretical coding (see Charmaz & Belgrave, 2012). The coding stages are consecutive, sequential, and not iterative. The product of each stage guiding the following phase. Using this methodology, the researcher(s) form data into categories of similar phenomena. As categories begin to fill, those that are most dense and/or most theoretically useful/important are identified as core categories (see Charmaz, 2006). Through this process, core categories become the core focus of theoretical articulation through to the development of basic social process (see Charmaz, 2006).

- Open Coding (word-by-word, line-by-line, segment-by-segment, incident-by-incident) –is the part of the analysis concerned with identifying, naming, categorizing and describing phenomena found in the text.
- Axial Coding (links) -- the process of relating codes (categories and properties) to each other.
- Selective Coding (Basic social processes) – is the process of choosing one category to be the core category and relating all other categories to that category.

5.4 Business Case Considerations

As health care costs continue to rise, mental health programs place more emphasis on the economic valuation of outcomes and cost-effectiveness. The economic valuation of CRDP Phase 2 will help assess three different types of impacts:

1. Health impact,
2. Fiscal impact, and
3. Economic impact.

This valuation considers costs and benefits of health and non-health outcomes to determine the return on investment. The business case will explain how changes in health outcomes, such as reductions in psychological distress and functioning, or improvements in protective factors, such as cultural connectedness, can be valued in dollars. This analysis will answer several research questions for both SWE Objectives 1 and 2:

Objective 1: Effectiveness of the CRDP Phase 2

- Do CRDP strategies show an effective Return of Investment?
- What is the business case for reducing mental health disparities by expanding CRDP strategies to a statewide scale?

Objective 2: Effectiveness of the Community-Defined Evidence Programs (CDEP)

- How cost effective are Pilot Projects?
- What is the business case for increasing them to a larger scale?

The CRDP monetary benefits that will be considered are 1) health expenses averted due to improvements in mental health outcomes measured as psychological distress and psychological functioning at the societal level and 2) gains in productivity operationalized as higher gross income from better mental health.

The cost-benefit analysis will included a review of the positive impact of mental health interventions on negative outcomes that can result from untreated mental illness (e.g., reductions in suicides, incarcerations, school failure or drop out, and homelessness). The monetization of these outcomes might not be possible due to data availability. These non-monetary benefits will be included descriptively.

To acknowledge the magnitude of outcomes in PEI efforts, gains in mental health outcomes will be considered in two ways.

1. Gradual or marginal decreases in psychological distress or improvements in functioning for CDEP participants across different levels of severity, from those experiencing early signs of distress to those with acute symptoms of a mental health difficulty and
2. CDEP participants who transitioned out of the threshold for psychological distress or impaired functioning—i.e., in other words, mental health issues were averted or did worsen.

5.4.1 Elements of Health Outcome Valuations

Analytic Horizon

The analytic horizon will consider both the period of CDEP implementation/activities and the period during which mental health (and other) outcomes are projected to improve after the programs end. The horizon will depend on the average age of CDEP participants by priority population.

Intervention Costs

- For IPPs (program administrative costs)
- For Participants (travel costs, leisure lost)
- For CDPH (SWE, TAP, EOA, OHE and other ancillary contractors)

Intervention Benefits

- Improvements in productivity due to an improved mental health (i.e., lower psychological distress or lower psychological functioning),
- Medical costs averted due to improvements in mental health outcomes

For both types of benefits, we will use regression models to calculate the probability of incurring positive medical expenses and the marginal changes for every 1-point change in the psychological distress Kessler-6 measure. Since we did not collect health expenditure data from CDEP participants, we will use Medical Expenditure Panel Survey (MEPS) simulating the population of interest. The steps we will take to calculate the aggregate benefits from a reduction in psychological distress or functioning monetized through health expenditures are the following:

1. Estimating the association between MEPS- Kessler 6 scores and health expenditures for psychological distress or estimating the probability of scoring Kessler 6≥13 and subsequent transitions out of SPD for psychological functioning,

2. Obtaining health expenditure dollar values to point changes in Kessler 6 scores through marginal change models for psychological distress or obtaining health expenditure dollar values to transitions out of SPD status for psychological functioning,
3. Matching pre- and post-CRDP Kessler 6 scores to MEPS Kessler 6 scores, and
4. Multiplying estimated dollar values by the number of corresponding CRDP participants

5.4.2 Costs and Benefits for CRDP Effectiveness (Objective 1)

To calculate CRDP effectiveness, CRDP Phase 2 will be compared to CA County Prevention and Early Intervention (PEI) programming as counterfactuals. To calculate CDEP effectiveness, CDEP participants will be compared to non-CDEP participants as counterfactuals. With the use of counterfactuals, we will calculate the net change that can be attributed to the intervention (i.e., net of the impact of what a comparable program would have achieved or the impact of a "business-as usual" scenario). To evaluate the different hypothesized benefits related to other PEI program (that serve as counterfactuals) the SWE, may seek access to data from county reports, expenditure plans, and other program and evaluation reports.

Data Sources.
The SWE is currently accessing the following data source:

- Medical Expenditure Panel Survey (MEPS)

The SWE will also seek access to the following data sources:

- MHSA PEI county reports that include costs of mental health disorders
- Mental Health Statistics Improvement Program (MHSIP) consumer survey data (by county)
- Mental Health and Substance Use Report on Expenditures and Services (by county)
- Claims data (by county)

5.4.3 Costs and Benefits for CDEP Effectiveness (Objective 2)

To calculate the potential medical expense associated with changes in mental health outcomes we will use regression models that include covariates such as age, gender, English language fluency, whether a person was born in the U.S., household income, and education. The SWE CDEP participant questionnaire does not include health expenditures and we will rely on data from the MEPS to model health expenditures for four of the five priority populations. To model health expenditures for the LGBTQ+ priority population we will request a linkage to the National Health Interview Survey (NHIS).

Our empirical methodology will provide the potential dollar value associated to changes in psychological distress for four of our five priority populations. Through this approach we will be able to quantify health expenditures for individuals with low, moderate, and severe levels indicative of psychological distress as measured by the Kessler 6 scale. In addition, we will be able to observe how point changes in the Kessler 6 scale relate to health expenditures across and within the thresholds. This means that even if post intervention CDEP participants remain above the thresholds of moderate or high distress we will still quantify monetary gains associated to point by point reductions in psychological distress.

Table 8 below shows the (proposed) costs and benefits considered in the analysis, and their hypothesized positive/negative impact on participants and non-participants. The "society"

column indicates the net effect on society which adds/subtracts the total effect of participants and non-participants. One table will be generated per priority population, and one for the CRDP wide initiative that will aggregate the information across.

A second table with monetary values will show how the change in outcomes between the start and end of the CDEP is valued in monetary units. Some hypothesized benefits/costs might not be included if data is not available.

Table 8: Conceptual Monetary Benefits (+) and Costs (-) for CRDP Phase 2

	Total	=	Direct		+	Indirect
	Society		Adult	Youth	Children	Taxpayers / Non-participants
Costs						
IPPs program costs	-		0	0	0	-
CRDP operating costs	-		0	0	0	-
Excess burden for taxpayers	-		0	0	0	-
CDEP participants' travel costs	-		-	0	0	0
Reduction in leisure time for CDEP participants	-		-	0	0	0
Monetary Benefits						
In-program output produced by participants						
Increase in gross earnings	+		+	0	0	0
Tax Payments	0		-	0	0	+
Benefits from a decrease in psychological distress						
Lower health expenditures	+		+	+	+	+
Lower use of public assistance	+		+	+	+	0
Benefits from a proxied decrease in psychological functioning						
Lower health expenditures	+		+	+	+	+
Lower use of public assistance	+		+	+	+	0
Out-of-program output						
Increase in gross earnings	+		+	0	0	0
Tax payments	0		-	0	0	+
Non-Monetary Benefits						
Improvement in cultural connectedness (adults and adolescents) *	+		+	+	0	+
Reduced incarceration/recidivism (adults)*	+		+	+	0	+
Reduction in suicides (adults and adolescents) *	+		+	+	0	0
Net Benefits (benefits - costs)	$\sum_{i=1}^{n}$ **Benefits** $-\sum_{i=1}^{n}$ **Costs**					

*Note: The economic valuation of these measures is dependent on data availability.

Data Sources. To evaluate the possible non-monetary benefits of CDEPs (e.g., reductions in suicide rates, incarceration, and homelessness, etc. as well as improvements in drop-out rates or gains in productivity), a literature review will be conducted to gauge effect sizes.

PARC will use nationally representative health expenditure data from the MEPS for benchmark estimates. However, CRDP pilots are based in California, and we will request restricted-use data from California to produce relevant health expenditure estimates. With the California MEPS data we could estimate expenditure trajectories that are more relevant and adequate for the CRDP analysis. In addition, a linkage of NHIS data will allow us to calculate health expenditures based on different sexual orientations.

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APPENDICES

Appendix A

2015 Version of the SWE Questions

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 and in California's historically unserved, underserved and/or inappropriately served communities?
A. To what extent is CRDP Phase 2 employing effective approaches, strategies and structures?
a. What approaches and strategies were used to fulfill the goals of CRDP Phase 2? (Process) b. What conditions supported or hindered implementation of those strategies? (Process) c. To what extent was there fidelity to approaches, strategies and deliverables by CRDP contractors and grantees and how were these related to outcomes? (Process and Outcome) d. What lessons were learned about addressing mental health disparities? (Process) e. Do CRDP strategies show an effective Return on Investment? What is the business casefor reducing mental health disparities by expanding CRDP strategies to a statewidescale?
B. To what extent do CRDP Phase 2 IPP evaluations effectively reflect the unique needs of each priority population, including subpopulations?
a. As reflected in their evaluation plans, to what extent did IPPs develop plans that reflected the unique cultural and community contextual needs of their priority population? (Process) b. What strategies were used by IPPs to incorporate culture and context into their evaluation? (Process) c. To what extent was there fidelity to IPP proposed cultural and community evaluation strategies? (Process) d. To what extent did IPPs effectively sample the intended priority population and subpopulation? (Process)
C. To what extent did CRDP Phase 2 strategies improve alignment between local government and
providers to provide culturally responsive, accessible and effective strategies to reduce disparities and improve mental health?
a. To what extent were policy makers, providers and other key stakeholders better informed about the unique needs of the priority communities and CDEPs?(Outcome) b. What collaborative processes emerged as a result of CRDP Phase 2 and to what extent was the community engaged? (Outcome) c. To what extent were strategic partnerships secured to improve access, availability and utilization of mental health services? (Outcome)
2. How can CRDP strategies and operations be strengthened?
A. To what extent were funding levels appropriate for each CRDP component?
a. What could additional funding have achieved? (Process) b. Were funded organizations able to scale operations and use funding efficiently? (Process) c. What portion of funding was used to support organizational overhead? (Process)
B. To what extent did IPPs receive the technical assistance and support needed to improve mental health and decrease disparities for their special population?

a. What types of TA or support did IPPs request? (Process) b. What types of TA or support did Pilot Projects receive? (Process, Outcome) c. What effect did this have on capacity & infrastructure)? (Process, Outcomes) d. To what extent did IPPs secure additional funding? (Outcome) e. To what extent were contractors and grantees satisfied with the effectiveness, appropriateness, and efficiency of CRDP Phase 2 in terms of: collaborative processes and partnerships between components; CBPR approach to implementation of strategies and operations; population specific divisions, organization, and coordination of IPPs, TA, and EOA; attention to the cultural and contextual needs of the five specific populations; CDPH administrative guidance and support; and statewide evaluation guidance, assistance, and
3. What are vulnerabilities or weaknesses in CRDP's overarching strategies and operations?
A. What aspects of the strategies and operations raised concerns from thecommunity, policymakers or other stakeholders? (Process) B. What aspects of the strategies and operations were not cost effective?(Outcome) C. To what extent was there fidelity to the cost benefit study by documenting spending? (Process)
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?
A. What mental illnesses were targeted? (Process) B. What strategies were used and at what dosages? (Process) C. To what extent was there fidelity to the IPP interventions? (Process) D. To what extent were the IPPs effective in preventing or reducing the severity of mental illness in the priority populations and where applicable, with specific gender and/or age groups? (Outcome) E. To what extent are Pilot Projects cost effective? What is the business case for increasing them to a larger scale?
2. To what extent did CRDP Phase 2 Implementation Pilot Projects effectively validate Community-Defined Evidence Practices?
A. To what extent where IPPs effective in establishing credible evidence of their prevention and/or reduction of targeted mental health conditions? (Outcome) B. Where applicable, how many and what types of IPPs meet criteria, apply for, and/or are accepted for identification as evidence-based practices? (Outcome)
3. What evaluation frameworks were developed and used by the Pilot Projects?
A. What framework(s) is/are best suited for future CDEPs?
a. What culturally responsive evaluation practices were identified and used by the IPPs? (Outcome) b. How was culture positioned in the framing of evaluation questions, selection of research methods and tools, data collection strategies, and interpretation and use of findings? (Outcome) c. What similarities and differences exist in frameworks within and across specific populations? (Process) d. What aspects of each framework were more or less successful e. What framework(s) is/are best suited for future CDEPs? (Outcome)

Appendix B

SWE CDPH-Defined Deliverables

Deliverable 1: Kickoff Meeting	The Contractor shall attend a kickoff meeting with the CDPH Contract Manager (CM). The Contractor's Project Manager (PM), Contract Administrator and Fiscal Officer shall attend this meeting to discuss the administrative, fiscal and technical aspects of this contract.
Deliverable 2: Progress Reports	The Contractor shall provide a progress report at least monthly. The progress reports must include a written narrative describing of the progress made and including adequate specific details on key aspects of the Workplan to demonstrate fulfillment of the contract. The reports must identify any problems or issues that arise and contain recommendations for resolution.
Deliverable 3: Progress Meetings	The Contractor shall meet with CDPH staff at least monthly to discuss the Progress Report. The meeting will focus on any key issues or risks and coordinate next steps.
Deliverable 4: Quarterly Collaboration Meetings	The Contractor shall meet with CDPH staff and other CRDP contractors/grant recipients at least quarterly. The purpose of these sessions is to provide mutual feedback in a collaborative, team-building fashion and collaborate on activities to the extent possible.
Deliverable 5: Final Evaluation Plan	Upon execution of the Contract, the winning Proposer will meet and confer with CDPH and each of the Technical Assistance Providers to refine the Evaluation Plan submitted in its Proposal. The Final Evaluation Plan must include: • Final Key Research Questions; • Final definition of the elements of the evaluation, inclusive of data requirements; • Final Contractor's approach to addressing Key Research Questions; • Final workplan and schedule; and • Final data collection plan.
Deliverable 6: Best Practices and Acceptable Standards Review	In order to establish clear guidelines regarding culturally and linguistically competent evaluation, the Contractor shall conduct a best practice and acceptable standards review and produce a report, focused on culturally and linguistically appropriate, community-participatory and mixed method evaluation approaches. The review should include both evaluation processes and content and should address each of the five target populations. This review may include a literature review, interviews with key stakeholders and subject matter experts, telephone surveys and/or other suitable methods of review. The review shall be completed within nine months of the contract start date.
Deliverable 7: Evaluation Database	The Contractor will be responsible for defining its data collection plan within the scope of the Evaluation Plan. Subsequently, over the course of the Contract, the Contractor shall collect and validate the data in the manner described in the Evaluation Plan and will develop and maintain a database, which shall be transmitted to CDPH prior to the conclusion of the Contract. In producing the database, the Contractor shall not include any data that could be used to identify specific individuals. CDPH shall retain ownership rights to all data collected within the scope of this Contract. The database shall be operational within six months of the contract start date. The Database must meet the CDPH ISO standards.

Deliverable 8: Other Meetings/Briefings	CDPH anticipates that it will be necessary for the Statewide Evaluator to attend certain meetings to provide updates, briefings or participate in programmatic discussions with entities such as the CRDP

	Advisory Committee, the Mental Health Oversight and Accountability Commission and others. CDPH staff will select which meetings the Contractor shall attend to fulfill this deliverable.
Deliverable 9: Stakeholder Briefings	After the final evaluation report has been delivered to and approved by CDPH, the Contractor shall provide six in-person stakeholder briefings that are supported by presentations and summaries as appropriate. The purpose of the stakeholder briefings will be to present the final evaluation report and the evaluation findings.
Deliverable 10: Closeout Meeting	The Contractor shall compile a closeout report that summarizes the major efforts, findings and lessons learned from CRDP Phase 2 from the perspective of the Contractor. The Contractor shall deliver the closeout report in person during a meeting with CDPH CRDP to ensure thorough knowledge transfer. The Closeout Meeting must be completed before the end of the term of this Agreement. The PM will determine the appropriate meeting participants and particulars.
Deliverable 11: Unanticipated Tasks	The State may add an additional amount in the contract for unanticipated tasks. In the event that additional work must be performed which was wholly unanticipated, and which was identified in neither the State's solicitation document nor the Vendor's bid submitted in response thereto, but which in the opinion of both parties is necessary to the successful accomplishment of the general scope of work. These tasks will be billed at the Contractor's average hourly rate.
Deliverable 12: Subject Matter Expert Services	The Contractor will act as a subject matter expert, available to advise both CDPH staff and the contracted Technical Assistance Providers, as needed, on matters concerning CRDP Phase 2 and Pilot Project evaluations.
Deliverable 13: CRDP Phase 2 Pilot Project Evaluation Guidelines Packet	Each Pilot Project will develop evaluations of their own program, focusing on the unique needs of the project and the community they are serving. Upon receiving guidelines by the Contractor and the population-specific TA Provider, the pilot projects will revise their evaluations with technical support from the TA Provider. To support these efforts and develop a minimum level of consistency acrossthe Implementation Pilot Projects, the Contractor will develop an Evaluation Guidelines Packet.
Deliverable 14: Final Statewide Evaluation	The Contractor shall deliver a final evaluation report to CDPH no later than six months after the end of the Implementation Pilot Project funding period of CRDP Phase 2. The Proposer will define the scope of the evaluation report and its approach to incorporating evaluation methods that are appropriate for the populations and the Pilot Projects' strategies.

Appendix C

Paper-pencil copies of the adult, adolescent, and child by proxy questionnaires

ID	
_____ - _____ - _____ *Priority Pop Code* *IPP Code* *CDEP Participant Code*	**ADULT VERSION (18+)** **PRE**

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. The next questions are about your culture.

At present…	**Strongly Agree**	**Agree**	**I am Neutral**	**Disagree**	**Strongly Disagree**
1. Your culture gives you strength.					
2. Your culture is important to you.					
3. Your culture helps you to feel good about who you are.					
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.					

Instructions: The next questions are about how you have been feeling during the past 30 days

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**
5. …connected to your culture?					
6. …balanced in mind, body, spirit and soul?					
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)					
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond your family, school, and friends.*)					

9. Do you currently have health insurance coverage? (check one)

Yes (GO TO Q10)	**No**	**Refused (GO TO Q11)**	**Don't Know (GO TO Q11)**

Did you have health insurance coverage in the past 12 months?

Yes ☐ No ☐ Refused ☐ Don't Know **(GO TO Q11)**

	Yes	**No**	**Refused**	**Don't Know**
10. Does your insurance cover treatment for mental health problems, such as visits to a psychologist or psychiatrist?				

	Yes	**No**	**Refused**	**Don't Know**
11. 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?				

	Yes	**No**	**Refused**	**Don't Know**	**NA**

ADULT VERSION

12. Because of problems with your mental health, emotions, nerves or your use of alcohol or drugs, was there ever a time during the past 12 months when you FELT LIKE YOU MIGHT NEED to see a…
    a. Traditional helping professional like a culturally-based healer, religious/spiritual leader or advisor
    b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager
    c. Primary care physician or general practitioner
    d. Mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker

	Yes	No	Refused	Don't Know	NA
a.					
b.					
c.					
d.					

13. In the past 12 months, because of problems with your mental health, emotions or your use of alcohol or drugs
    a. HAVE YOU SEEN a traditional helping professional like a culturally-based healer, religious/spiritual leader or advisor
    b. HAVE YOU SEEN a Community helping professional such as a health worker, *promotor*, peer counselor, or case manager
    c. HAVE YOU SEEN a Primary care physician or general practitioner
    d. HAVE YOU SEEN a Mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker

	Yes	No	Refused	Don't Know	NA
a.					
b.					
c.					
d.					

If YES to Q13c OR 13d GO TO Q14. Otherwise, GO TO Q19

GO TO Q19

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

Yes Mental/Emotional Health Problem	*Yes Alcohol-Drug Problem*	*Yes Both Mental & Alcohol-Drug Problems*	*Refused*	*Don't Know*

15. In the past 12 months, how many visits did you make to a mental health professional (counselor, therapist, psychologist, psychiatrist or social worker) for problems with your mental or emotional health, alcohol-drug problem, or both? Do not count overnight hospital stays.

_ # of visits

Yes	No	Refused	Don't Know

ADULT VERSION

16. Are you still receiving treatment for these problems from one or more of these providers?

☐	☐	☐	☐
GO TO	GO TO	GO TO Q19	

17. Did you complete the full course of treatment? In other words, you ended treatment when your counselor, therapist, psychologist, psychiatrist or social worker told you it was ok to end?

☐	☐	☐	☐
GO TO Q19	GO TO Q18	GO TO Q19	

18. What is the **MAIN REASON** you are no longer receiving treatment? (Circle ONE only)
    - 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) _____
    - Refused
    - Don't Know

Instructions: Here are some reasons people have for NOT seeking help from a mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker, even when they think they might need it. Even if you are receiving help now, do you agree or disagree with the following reasons why you might not seek help from a mental health professional?

	Agree	Disagree	Refused	Don't Know
19. You were planning to or already getting help from a…				
a. Traditional helping professional such as a culturally-based healer, religious/spiritual leader or advisor				
b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager				
20. You did not know of or have never heard of these types of mental health professionals (e.g. counselor, therapist, psychologist, etc.)				
	GO TO Q34	GO TO Q21	GO TO Q34	
	Agree	**Disagree**	**Refused**	**Don't Know**
21. You didn't feel comfortable talking with them about your personal problems.				
22. You didn't think you would feel safe and welcome because of your…				
a. limited English				
b. race/ethnicity				
c. age				
d. religious or spiritual practice				
e. gender identity				
f. sexual orientation				
	Agree	**Disagree**	**Refused**	**Don't Know**

ADULT VERSION

23. You were concerned about the cost of treatment				☐
24. You didn't have time (because of job, childcare, or other commitments).	☐	☐	☐	☐
25. You had no transportation, or the program was too far away, or the hours were not convenient.	☐	☐	☐	☐
26. You didn't think you needed mental health counseling or treatment at the time.	☐	☐	☐	☐
27. You thought you could handle the problem on your own.	☐	☐	☐	☐
28. You didn't think mental health counseling or treatment would help.	☐	☐	☐	☐
29. You were concerned that getting mental health treatment or counseling might cause your neighbors or community to have a negative opinion of you.	☐	☐	☐	☐
30. You were concerned that getting mental health treatment or counseling might have a negative effect on your job.	☐	☐	☐	☐
31. You were concerned that the information you gave the counselor might not be kept confidential.	☐	☐	☐	☐
32. You were concerned that you might be admitted to a psychiatric hospital.	☐	☐	☐	☐
33. You were concerned that you might have to take medicine.	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 30 days.

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**
34. … nervous?	☐	☐	☐	☐	☐
35. … hopeless?	☐	☐	☐	☐	☐
36. … restless or fidgety?	☐	☐	☐	☐	☐
37. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
38. … feel that everything was an effort?	☐	☐	☐	☐	☐
39. … worthless?	☐	☐	☐	☐	☐

40. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q34-Q39) match how you would describe those experiences? (Check one)

A Lot ☐ **Somewhat** ☐ **Not At All**

NOW, think about the one month, within the past 12 months, when you were at your worst emotionally.

Did your emotions interfere a lot, some, or not at all with your…	**A Lot**	**Some**	**Not At All**	**Refused**	**Don't Know**
41. …performance at work or school?					
⇒ *Check here if not working and not in school during the past 12 months* ☐					
42. …household chores?	☐	☐	☐	☐	☐
43. …social life?	☐	☐	☐	☐	☐
44. …relationship with friends and family?	☐	☐	☐	☐	☐

45. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q41-Q44) match how you would describe the negative effect of emotions on your life? (Check one)

A Lot ☐ **Somewhat** ☐ **Not At All**

ADULT VERSION

46. How old are you?
- between 18 and 29 years of age
- between 30 and 39 years of age
- between 40 and 44 years of age
- between 45 and 49 years of age
- between 50 and 64 years of age
- 65 or older years of age

47. **VERSION 1**

What is your race and ethnic origin? ***Select only one race category and specify your ethnic origin.***
- American Indian or Alaska Native
- Black or African American**:** Please specify your ethnic origin(s):_____
- Latino, Hispanic, or Spanish: Please specify your ethnic origin(s):_____
- Asian: Please specify your ethnic origin(s): _____
- Native Hawaiian or Other Pacific Islander: Please specify your ethnic origin(s): _____
- White: Please specify your ethnic origin(s):_____
- Other Race: Please specify your race and ethnic origin(s):_____
- Multi-Racial: Please specify your origin(s):_____
- Refused
- Don't Know

VERSION 2

What is your race and ethnic origin(s)? ***Select only one race category; select your ethnic origin(s)***
- American Indian or Alaska Native

- Black or African American:
  Check your ethnic 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: Check your ethnic origin(s):
  - Mexican/Chicano
  - Salvadoran
  - Guatemalan
  - Dominican
  - Honduran
  - Puerto Rican
  - Cuban
  - Peruvian
  - Chilean
  - Colombian
  - Nicaraguan
  - Refused
  - Don't Know
  - Other Latino (Please specify):_____
- Asian:
  Check your ethnic origin(s):
  - Afghan
  - Bangladeshi
  - Burmese
  - Cambodian
  - Chinese
  - Filipino
  - Hmong
  - Indian (India)
  - Indonesian
  - Japanese
  - Korean
  - Laotian
  - Malaysian
  - Pakistani
  - Sri Lankan
  - Taiwanese
  - Thai
  - Vietnamese
  - Refused
  - Don't Know
  - Other Asian (Please specify):_____
- Native Hawaiian or Other Pacific Islander: Check your ethnic origin(s):
  - Samoan
  - Guamanian
  - Tongan
  - Fijian
  - Refused
  - Don't Know
  - Other Hawaiian or Pacific Islander (Please specify):_____
- Multi-Racial: Check all that apply and specify your ethnic origin(s).

- White: (Please specify):_____
- Black/African American (Please specify):_____
- Latino, Hispanic, or Spanish (Please specify):_____
- American Indian or Alaska Native (Please specify):_____
- Asian (Please specify):_____
- Native Hawaiian or Other Pacific Islander (Please specify):_____
- Refused
- Don't Know

- White: Please specify your ethnic origin(s):_____
- Other Race: Please specify your race and ethnic origin(s):_____
- Refused
- Don't Know

48. 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

49. What is your preferred language? _____

50. Were you born:
    - Inside the U.S.
    - Outside the U.S.
    - Refused
    - Don't Know

51. What are the first 3 digits of your ZIP Code? _ _ _ ☐Unstable housing/ no ZIP code ☐ Refused ☐ Don't Know

52. Have you ever spent time in a temporary settlement area for refugees or displaced persons or been held at ICE facilities?
    - Not Applicable
    - Yes
    - No
    - Refused
    - Don't Know

53. 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 Instructions: We use terms like "male" or "female" or "trans" 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. There are no right or wrong answers to these questions. Please be honest and answer as you really think and feel.

54. When I was born, the person who delivered me (e.g., doctor, nurse/midwife, family members), thought I was a:
    Choose the one best answer.
    - Male/Boy
    - Female/Girl
    - Intersex (they were unsure about my sex at birth)
    - I am not sure about my sex assigned at birth
    - My assigned sex at birth (please specify):_____
    - I do not wish to answer this question

55. When it comes to my gender identity, I think of myself as: Choose all that apply.
    - Man/Male
    - Woman/Female
    - Transgender/Trans
    - Non-binary (not exclusively male or female)
    - Two Spirit
    - Intersex (between male and female)

ADULT VERSION

- Trans man/Trans male
- Trans woman/Trans female
- Genderqueer/Gender non-conforming
- I do not wish to answer this question
- I am not sure about my gender identity
- I do not have a gender/ gender identity
- My gender identity is (please specify):_____

Sexual Orientation Instructions: Everyone has a sexual orientation. Some people are straight and are attracted to people of another gender. For example, a straight woman is attracted to men and prefers to date or have sex with men. Other people are gay or lesbian and are attracted to people of the same gender. For example, a gay man is attracted to other men and prefers to date or have sex with other men. Still other people are bisexual and are attracted to both men and women. Some people are attracted to people of all genders including those who do not define their gender within the binary "male or female" framework. Others are unsure about their attractions or are just not attracted to anyone. Just to be clear, who you are attracted to and prefer to date or have sex with is called sexual orientation.

56. What is your sexual orientation? Choose all that apply.

- Straight/heterosexual
- Gay
- Lesbian
- Bisexual
- Queer
- Pansexual/Non-monosexual (I am attracted to all genders)
- Asexual (I am not attracted to anyone sexually)
- I am not attracted to anyone romantically
- I am not sure who I am attracted to sexually
- I am not sure who I am attracted to romantically
- Something else: _____
- I do not wish to answer this question

BELOW ARE OPTIONAL ITEMS
THAT ARE AVAILABLE FOR USE AS PRE-POST MEASURES BY IPPs.
They can be added to the above 56 core items.

Health Status

At present…

	Very Good	Good	Fair	Poor
Would you say your health is Very Good, Good, Fair, or Poor?				

Racism/Discrimination

a. In your day-to-day life how often have any of the following things happened to you? (Would you say almost everyday, at least once a week, a few times a month, a few times a year, less than once a year, never?)

	Almost everyday	At least once a week	A few times a month	A few times a year	Less than once a year	Never
You are treated with less courtesy than other people.						
You are treated with less respect than other people.						
You receive poorer service than other people at restaurants or stores.						
People act as if they think you are not smart.						
People act as if they are afraid of you.						
People act as if they think you are dishonest.						
People act as if you are not as good as they are.						
You are called names or insulted.						
You are threatened or harassed.						

b. What do you think was the main reason for this/these experience(s)? Would you say…?

- Your race or ethnicity
- Your gender
- Your skin color/tone
- Your sexual orientation
- Your religion
- Your immigration status
- Other (Please specify)_____
- Don't know

- Your language or accent
- Refused

SOGI

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? (Choose all that apply.)

- Very feminine
- Mostly feminine
- Somewhat feminine
- Equally masculine and feminine
- Somewhat masculine
- Mostly masculine
- Very masculine
- Androgynous, non-binary, and/or gender nonconforming
- Neither masculine nor feminine

A person's appearance, style, dress, or mannerisms (such as the way they walk or talk) may affect the way other people think of them. On average, how do you think other people would describe your appearance, style, dress, or mannerisms? (Choose all that apply.)

- Very feminine
- Mostly feminine
- Somewhat feminine
- Equally masculine and feminine
- Somewhat masculine
- Mostly masculine
- Very masculine
- Androgynous, non-binary, and/or gender nonconforming
- Neither masculine nor feminine

SOGI Discrimination

How much do the following people in your life accept or reject your gender? *Choose the one best answer.*

	Totally reject	Somewhat reject	Neutral	Somewhat accept	Totally accept	Not applicable
Parents/Guardians						
Siblings						
Extended family						
Children						
Friends						
Partner(s)						
Coworkers						
Neighbors						
Medical providers						
Mental health providers						
Other: _____						

How much do the following people in your life accept or reject your sexual orientation? *Choose the one best answer.*

	Totally reject	Somewhat reject	Neutral	Somewhat accept	Totally accept	Not applicable
Parents/Guardians						
Siblings						
Extended family						
Children						
Friends						
Partner(s)						
Coworkers						
Neighbors						
Medical providers						
Mental health providers						
Other: _____						

ID

____ - ____ - _____

Priority Pop Code *IPP Code* *CDEP Participant Code*

ADULT VERSION (18+)

POST

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. The next questions are about your culture.

At present…	**Strongly Agree**	**Agree**	**I am Neutral**	**Disagree**	**Strongly Disagree**
1. Your culture gives you strength.					
2. Your culture is important to you.					
3. Your culture helps you to feel good about who you are.					
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.					

Instructions: The next questions are about how you have been feeling during the past [IPP selected time period]

About how often during the past [IPP selected time period] did you feel…	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
5. …connected to your culture?					
6. …balanced in mind, body, spirit and soul?					
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)					
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond of your family, school, and friends.*)					

Instructions: During the past [IPP selected time period] 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**
9. … nervous?					
10. … hopeless?					
11. … restless or fidgety?					
12. … so depressed that nothing could cheer you up?					
13. … feel that everything was an effort?					
14. … worthless?					

15. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q9-Q14) match how you would describe those experiences? (Check one)

A Lot	**Somewhat**	**Not At All**

Think about the [IPP selected time period] in the past [IPP selected time period] when you were at your worst emotionally.

Did your emotions interfere a lot, some, or not at all with your…	**A Lot**	**Some**	**Not At All**	**Refused**	**Don't Know**
16. …performance at work or school?					
Check here if not working or in school during the past 12 months ☐					
17. …household chores?					
18. …social life?					
19. …relationship with friends and family?					

ADULT VERSION

20. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q16-Q19) match how you would describe the negative effect of emotions on your life? (Check one)

A Lot	Somewhat	Not At All

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" stands for any program activities or events connected to the program.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
21. I like the services that I received here.						
22. If I had other choices, I would still get services from this agency.						
23. I would recommend this agency to a friend or family member.						
24. The location of services was convenient (parking, public transportation, distance, etc.).						
25. Staff were willing to see me as often as I felt it was necessary.						
26. Services were available at times that were good for me.						
27. When I first called or came here, it was easy to talk to the staff.						
28. The staff here treat me with respect.						
29. The staff here don't think less of me because of the way I talk.						
30. The staff here respect my race and/or ethnicity.						
31. The staff here respect my religious and/or spiritual beliefs.						
32. The staff here respect my gender identity and/or sexual orientation.						
33. Staff are willing to be flexible and provide alternative approaches or services to meet my needs.						
34. The people who work here respect my cultural beliefs, remedies and healing practices.						
35. Staff here understand that people of my racial and/or ethnic group are not all alike.						
36. Staff here understand that people of my gender and/or sexual orientation group are not all alike.						
37. 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
38. I deal more effectively with my daily problems.						
39. I do better in school and/or work.						
40. My symptoms/problems are not bothering me as much.						

ID

	Yes	No	Refused	Don't Know
41. Were the services you received here 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?				

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. The next questions are about your culture.

At present…	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
1. Your culture gives you strength.					
2. Your culture is important to you.					
3. Your culture helps you to feel good about who you are.					
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.					

The next questions are about how you have been feeling during the past 30 days.

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
5. …connected to your culture?					
6. …balanced in mind, body, spirit and soul?					
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)					
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond your family, school, and friends.)*					

	Yes	No	Refused	Don't Know
9. In the past 12 months did you <u>THINK YOU NEEDED HELP</u> for emotional or mental health problems, such as feeling sad, anxious, or nervous?				

	Yes	No	Refused	Don't Know
10. In the past 12 months, have <u>YOU RECEIVED</u> any psychological or emotional counseling from any of the following…				
a. <u>Traditional helping professional</u> such as a culturally-based healer, religious/spiritual leader or advisor?				
b. <u>Community helping professional</u> such as a health worker, *promotor*, or peer counselor?				

	Yes	No	Refused	Don't Know
11. In the past 12 months, have <u>YOU RECEIVED</u> any psychological or emotional counseling from someone <u>AT SCHOOL</u>, such as a school counselor, school psychologist, school therapist, school social worker?	☐ GO TO	☐	☐	☐ GO TO

ID

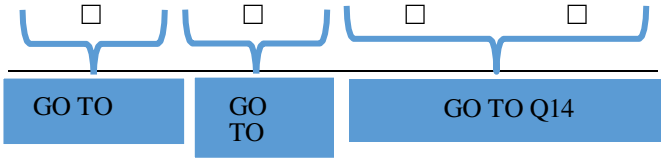
_____ - _____ - _____

Priority Pop Code *IPP Code* *CDEP Participant Code*

ADOLESCENT VERSION (12-17)

PRE

12. Are you still receiving psychological or emotional counseling from someone AT SCHOOL?



ADOLESCENT VERSION

13. If not, what was the **MAIN REASON** you stopped psychological or emotional counseling AT SCHOOL? (Please select **ONE** main reason.)

- ☐ The counselor, therapist, psychologist, psychiatrist or social worker said I finished and/or met my goals
- ☐ Had bad experiences with counselor, therapist, psychologist, psychiatrist or social worker
- ☐ The counselor, therapist, psychologist, psychiatrist or social worker did not understand my problem
- ☐ I ended it because I got better/I no longer needed services
- ☐ Couldn't get appointment
- ☐ I felt discriminated against
- ☐ School ended
- ☐ Not getting better
- ☐ I did not want to go anymore
- ☐ Hours not convenient
- ☐ Didn't have time
- ☐ Wanted to handle the problem on my own
- ☐ I changed schools
- ☐ Other (Specify) _____

14. In the past 12 months, have YOU RECEIVED any psychological or emotional counseling from someone OUTSIDE OF SCHOOL, like a counselor, therapist, psychologist, psychiatrist or social worker?

Yes	No	Refused	Don't Know
☐	☐	☐	☐
GO TO	GO TO		

15. Are you still receiving psychological or emotional counseling from someone OUTSIDE OF SCHOOL?

Yes	No	Refused	Don't Know
☐	☐	☐	☐
GO TO Q17	GO TO	GO TO Q17	

16. What was the **MAIN REASON** you stopped psychological or emotional counseling OUTSIDE OF SCHOOL? (Please select **ONE** main reason.)

- ☐ The counselor, therapist, psychologist, psychiatrist or social worker said I finished and/or met my goals
- ☐ Had bad experiences with counselor, therapist, psychologist, psychiatrist or social worker
- ☐ The counselor, therapist, psychologist, psychiatrist or social worker did not understand my problem
- ☐ I ended it because I got better/I no longer needed services
- ☐ Couldn't get appointment
- ☐ Didn't have transportation
- ☐ Insurance did not cover
- ☐ Not getting better
- ☐ I felt discriminated against
- ☐ Too expensive
- ☐ Didn't have time
- ☐ I did not want to go anymore
- ☐ School ended
- ☐ I moved
- ☐ Wanted to handle the problem on my own
- ☐ Hours not convenient
- ☐ Other (Specify) _____

	Yes	No	Refused	Don't Know
17. In the past 12 months, did you receive any professional help for your use of alcohol or drugs?	☐	☐	☐	☐
18. During the past 12 months, have you take any medication because of difficulties with your emotions, concentration, or behavior?	☐	☐	☐	☐

ADOLESCENT VERSION

Instructions: Here are some reasons youth/teens have for NOT seeking help from a mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker, even when they think they might need it. Even if you are receiving help now, do you agree or disagree with the following reasons why you might not seek help from a mental health professional?

	Agree	Disagree	Refused	Don't Know
19. You were planning to or are already getting help from…				
a. Traditional helping professional such as a culturally-based healer, religious/spiritual leader or advisor				
b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager				
20. You didn't know these types of mental health professionals existed.	GO TO Q34	GO TO Q21		

	Agree	Disagree	Refused	Don't Know
21. You didn't feel comfortable talking with them about your personal problems.				
22. You didn't think you would feel safe and welcome because of your…				
a. limited English				
b. race/ethnicity				
c. age				
d. religious or spiritual practice				
e. gender identity				
f. sexual orientation				
23. You thought you could solve your issue on your own.				
24. You thought your issue wasn't serious enough.				
25. You thought your friends would find out.				
26. You didn't want to talk to a stranger about your issue.				
27. You were worried that your family and others in the community may think differently about you.				
28. You didn't know where to go for help.				
29. You felt embarrassed about what you were going through.				
30. You were worried that your peers and others in school may think differently about you.				
31. You didn't have time because of after-school activities and other commitments.				
32. It was too expensive.				
33. You didn't have transportation to get there.				

Instructions: The next questions are about how you have been feeling during the past 30 days.

During the past 30 days, 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. … nervous?					
35. … hopeless?					
36. … restless or fidgety?					
37. … so depressed that nothing could cheer you up?					
38. … feel that everything was an effort?					
39. … worthless?					

40. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q34-Q39) match how you would describe those experiences? (Check one)

A Lot	Somewhat	Not At All

Okay, you just told me about how you have been feeling the past 30 days. Now I want to know how much your fears and worries have messed things up for you. In other words, how much have they stopped you from doing things you want to do?

How much have your fears and worries messed things up …	**A Lot**	**Some**	**Not At All**
41. …with school and homework?			
42. …with friends?			
43. …at home?			

44. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q41-Q43) match how you would describe the negative effect of emotions on your life? (Check one)

A Lot	Somewhat	Not At All

	Yes	**No**	**Refused**	**Don't Know**
45. In the past 6 months, have you done any volunteer work or community service that you have not been paid for?	☐	☐	☐	☐

46. How old are you? Write in age: _____

47.

VERSION 1

What is your race and ethnic origin? ***Select only one race category and specify your ethnic origin.***

- American Indian or Alaska Native
- Black or African American: Please specify your ethnic origin(s):_____
- Latino, Hispanic, or Spanish: Please specify your ethnic origin(s):_____
- Asian: Please specify your ethnic origin(s): _____
- Native Hawaiian or Other Pacific Islander: Please specify your ethnic origin(s): _____
- White: Please specify your ethnic origin(s):_____
- Other Race: Please specify your race and ethnic origin(s):_____
- Multi-Racial Please specify your origin(s):_____
- Refused
- Don't Know

VERSION 2

What is your race and ethnic origin(s)? ***Select only one race category; select your ethnic origin(s)***

- American Indian or Alaska Native
- Black or African American

  Check your ethnic 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 Check your ethnic origin(s):

  - Mexican/Chicano
  - Salvadoran
  - Guatemalan
  - Puerto Rican
  - Cuban
  - Peruvian
  - Nicaraguan
  - Refused
  - Don't Know

- Dominican
- Honduran
- Chilean
- Colombian
- Other Latino (Please specify):_____

- Asian

Check your ethnic origin(s):

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

- Native Hawaiian or Other Pacific Islander

Check your ethnic origin(s):

- Samoan
- Guamanian
- Tongan
- Fijian
- Refused
- Don't Know
- Other Hawaiian or Pacific Islander (Please specify):_____

- Multi-Racial: Check all that apply and specify your ethnic origin(s).
  - White: (Please specify):_____
  - Black/African American (Please specify):_____
  - Latino, Hispanic, or Spanish (Please specify):_____
  - American Indian or Alaska Native (Please specify):_____
  - Asian (Please specify):_____
  - Native Hawaiian or Other Pacific Islander (Please specify):_____
  - Refused
  - Don't Know

- White: Please specify your ethnic origin(s):_____
- Other Race: Please specify your race and ethnic origin(s):_____
- Refused
- Don't Know

48. 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

49. What is your preferred language? _____

50. Were you born:
- Inside the U.S.
- Outside the U.S.
- Refused
- Don't Know

51. What are the first 3 digits of your ZIP Code? _ _ _ ☐Unstable housing/ no ZIP code ☐ Refused ☐ Don't Know

52. Have you ever spent time in a temporary settlement area for refugees or displaced persons or been held at ICE facilities?
- Not Applicable
- Yes
- No

- Refused
- Don't Know

53. 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 Instructions: We use terms like "male" or "female" or "trans" 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. There are no right or wrong answers to these questions. Please be honest and answer as you really think and feel.

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

- Male/Boy
- Female/Girl
- Intersex (they were unsure about my sex at birth)
- I am not sure about my sex assigned at birth
- My assigned sex at birth (please specify):_____
- I do not wish to answer this question

55. When it comes to my gender identity, I think of myself as: Choose all that apply.

- Man/Male
- Woman/Female
- Transgender/Trans
- Trans man/Trans male
- Trans woman/Trans female
- Genderqueer/Gender non-conforming
- I do not wish to answer this question
- Non-binary (not exclusively male or female)
- Two Spirit
- Intersex (between male and female)
- I am not sure about my gender identity
- I do not have a gender/ gender identity
- My gender identity is (please specify):_____

Sexual Orientation Instructions: Everyone has a sexual orientation. Some people are straight and are attracted to people of another gender. For example, a straight woman is attracted to men and prefers to date or have sex with men. Other people are gay or lesbian and are attracted to people of the same gender. For example, a gay man is attracted to other men and prefers to date or have sex with other men. Still other people are bisexual and are attracted to both men and women. Some people are attracted to people of all genders including those who do not define their gender within the binary "male or female" framework. Others are unsure about their attractions or are just not attracted to anyone. Just to be clear, who you are attracted to and prefer to date or have sex with is called sexual orientation.

56. What is your sexual orientation? Choose all that apply.

- Straight/heterosexual
- Gay
- Lesbian
- Bisexual
- Queer
- Pansexual/Non-monosexual (I am attracted to all genders)
- Asexual (I am not attracted to anyone sexually)
- I am not attracted to anyone romantically
- I am not sure who I am attracted to sexually
- I am not sure who I am attracted to romantically
- Something else: _____
- I do not wish to answer this question

Thank you for taking time to complete this questionnaire. Did any of the questions above upset you? Please check one.

- Yes
- No

If any of the above questions upset you and you want to talk to someone about it, here is a list of referrals for support services.

ADOLESCENT VERSION

BELOW ARE OPTIONAL ITEMS THAT ARE AVAILABLE FOR USE AS PRE-POST MEASURES BY IPPs.

They can be added to the above 56 core items.

Do you currently have health insurance coverage? (check one)

Yes	No → *Did you have health insurance coverage in the past 12 months)*? ☐ Yes ☐ No ☐ Refused ☐ Don't Know	Refused	Don't Know

	Yes	No	Refused	Don't Know
Does your insurance cover treatment for mental health problems, such as visits to a psychologist or psychiatrist?				

Health Status

At present…

	Very Good	Good	Fair	Poor
Would you say your health is Very Good, Good, Fair, or Poor?				

Racism/Discrimination

a. In your day-to-day life how often have any of the following things happened to you? (Would you say almost everyday, at least once a week, a few times a month, a few times a year, less than once a year?)

	Almost everyday	At least once a week	A few times a month	A few times a year	Less than once a year	Never
You are treated with less courtesy than other people.						
You are treated with less respect than other people.						
You receive poorer service than other people at restaurants or stores.						
People act as if they think you are not smart.						
People act as if they are afraid of you.						
People act as if they think you are dishonest.						
People act as if you are not as good as they are.						
You are called names or insulted.						
You are threatened or harassed.						

b. What do you think was the main reason for this/these experience(s)? Would you say…? Check one only.

- Your race or ethnicity
- Your gender
- Your skin color/tone
- Your sexual orientation
- Your language or accent
- Your religion
- Your immigration status
- Other (Please specify)_____
- Don't know
- Refused

SOGI

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? (Choose all that apply.)

- Very feminine
- Mostly feminine
- Somewhat feminine
- Equally masculine and feminine
- Somewhat masculine
- Mostly masculine
- Very masculine
- Androgynous, non-binary, and/or gender nonconforming
- Neither masculine nor feminine

ADOLESCENT VERSION

A person's appearance, style, dress, or mannerisms (such as the way they walk or talk) may affect the way other people think of them. On average, how do you think other people would describe your appearance, style, dress, or mannerisms? (Choose all that apply.)

- Very feminine
- Mostly feminine
- Somewhat feminine
- Equally masculine and feminine
- Somewhat masculine
- Mostly masculine
- Very masculine
- Androgynous, non-binary, and/or gender nonconforming
- Neither masculine nor feminine

SOGI Discrimination

How much do the following people in your life accept or reject your gender? *Choose the one best answer.*

	Totally reject	Somewhat reject	Neutral	Somewhat accept	Totally accept	Not applicable
Parents/Guardians						
Siblings						
Extended family						
Children						
Friends						
Partner(s)						
Coworkers						
Neighbors						
Medical providers						
Mental health providers						
Other: _____						

How much do the following people in your life accept or reject your sexual orientation? *Choose the one best answer.*

	Totally reject	Somewhat reject	Neutral	Somewhat accept	Totally accept	Not applicable
Parents/Guardians						
Siblings						
Extended family						
Children						
Friends						
Partner(s)						
Coworkers						
Neighbors						
Medical providers						
Mental health providers						
Other: _____						

Resiliency (CHIS, 2016)

Instructions: How true do you feel the next statements are about your school and things you might do there?

At my school, there is a teacher or some other adult….

	Not at all true	A little true	Pretty much true	Very much true	Refused	Don't Know
…who really care about me.	☐	☐	☐	☐	☐	☐
…who notices when I'm not there.	☐	☐	☐	☐	☐	☐
…who listens to me when I have something to say.	☐	☐	☐	☐	☐	☐
…who tells me when I do a good job.	☐	☐	☐	☐	☐	☐

ADOLESCENT VERSION

…who always wants me to do my best.	☐	☐	☐	☐	☐	☐
…who notices when I'm in a bad mood.	☐	☐	☐	☐	☐	☐

Instructions: How true do you feel the next statement are about your home?

In my home, there is a parent or some other adult…

	Not at all true	A little true	Pretty much true	Very much true	Refused	Don't Know
…who cares about my school work.	☐	☐	☐	☐	☐	☐
…who listens to me when I have something to say.	☐	☐	☐	☐	☐	☐
…who talks with me about my problems.	☐	☐	☐	☐	☐	☐
…who notices when I'm in a bad mood.	☐	☐	☐	☐	☐	☐
…who always wants me to do my best.	☐	☐	☐	☐	☐	☐
…who believes that I will be a success.	☐	☐	☐	☐	☐	☐
…who expects me to follow the rules.	☐	☐	☐	☐	☐	☐

ID

_____ - _____ - _____

Priority Pop Code *IPP Code* *CDEP Participant Code*

ADOLESCENT VERSION (12-17)

POST

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. The next questions are about your culture.

At present…	**Strongly Agree**	**Agree**	**I am Neutral**	**Disagree**	**Strongly Disagree**
1. Your culture gives you strength.					
2. Your culture is important to you.					
3. Your culture helps you to feel good about who you are.					
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.					

During the past [IPP selected time period], 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**
5. …connected to your culture?					
6. …balanced in mind, body, spirit and soul?					
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)					
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond of your family, school, and friends.*)					

During the past [IPP selected time period], 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**
9. … nervous?					
10. … hopeless?					
11. … restless or fidgety?					
12. … so depressed that nothing could cheer you up?					
13. … feel that everything was an effort?					
14. … worthless?					

15. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q9-Q14) match how you would describe those experiences? (Check one)

A Lot	**Somewhat**	**Not At All**

Okay, you just told me about how you have been feeling during the past [IPP selected time period]. Now I want to know how much your fears and worries have messed things up for you. In other words, how much have they stopped you from doing things you want to do?

How much have your fears and worries messed things up …	**A Lot**	**Some**	**Not At All**
16. …with school and homework?			
17. …with friends?			
18. …at home?			

19. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q16-Q18) match how you would describe the negative effect of emotions on your life? (Check one)

A Lot	**Somewhat**	**Not At All**

ADOLESCENT VERSION

Instructions: Please help our make our program better by answering some questions. Please answer the questions based on the services, program or activities connected to [name of CDEP]. Indicate if you Strongly Disagree, Disagree, are Undecided, Agree, or Strongly Agree with each of the statements below. If the statement 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" stands for any program activities or events connected to [name of CDEP]

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
20. Overall, I am satisfied with the services I received.	☐	☐	☐	☐	☐	☐
21. The people helping me stuck with me no matter what	☐	☐	☐	☐	☐	☐
22. I felt I had someone to talk to when I was troubled	☐	☐	☐	☐	☐	☐
23. I received services that were right for me.	☐	☐	☐	☐	☐	☐
24. The location of services was convenient for me.	☐	☐	☐	☐	☐	☐
25. Services were available at times that were convenient for me.	☐	☐	☐	☐	☐	☐
26. I got the help I wanted.	☐	☐	☐	☐	☐	☐
27. Staff treated me with respect.	☐	☐	☐	☐	☐	☐
28. Staff respected my religious / spiritual beliefs.	☐	☐	☐	☐	☐	☐
29. Staff spoke with me in a way that I understood.	☐	☐	☐	☐	☐	☐
30. Staff were sensitive to my cultural / ethnic background.	☐	☐	☐	☐	☐	☐
31. I am better at handling daily life.	☐	☐	☐	☐	☐	☐
32. I get along better with family members.	☐	☐	☐	☐	☐	☐
33. I get along better with friends and other people.	☐	☐	☐	☐	☐	☐
34. I am doing better in school and/or work.	☐	☐	☐	☐	☐	☐
35. I am better able to cope when things go wrong.	☐	☐	☐	☐	☐	☐
36. I am satisfied with my family life right now.	☐	☐	☐	☐	☐	☐
37. I am better able to do things I want to do.	☐	☐	☐	☐	☐	☐
38. I know people who will listen and understand me when I need to talk.	☐	☐	☐	☐	☐	☐
39. I have people that I am comfortable talking with about my problem(s).	☐	☐	☐	☐	☐	☐
40. In a crisis, I would have the support I need from family or friends.	☐	☐	☐	☐	☐	☐
41. I have people with whom I can do enjoyable things.	☐	☐	☐	☐	☐	☐

	Yes	No
42. Were the services you received here provided in the language you prefer?	☐	☐
43. 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?	☐	☐

Thank you for taking time to complete this questionnaire. Did any of the questions above upset you? Please check one.

Yes | **No** |

ID

____ - ____ - _____

Priority Pop Code *IPP Code* *CDEP Participant Code*

CHILD VERSION (5-11)

PRE

	Yes	No	Refused	Don't Know
1. In the past 12 months did you THINK YOUR CHILD NEEDED HELP for emotional or mental health problems, such as feeling sad, anxious, or nervous?				

	Yes	No	Refused	Don't Know
2. In the past 12 months, has YOUR CHILD RECEIVED any psychological or emotional counseling from any of the following…				
a. Traditional helping professional such as a culturally-based healer, religious/spiritual leader or advisor?				
b. Community helping professional such as a health worker, *promotor*, or peer counselor?				

	Yes	No	Refused	Don't Know
3. In the past 12 months, has YOUR CHILD RECEIVED any psychological or emotional counseling from someone AT SCHOOL, such as a school counselor, school psychologist, school therapist, school social worker?	☐ GO TO	☐ GO TO	☐	☐

	Yes	No	Refused	Don't Know
4. Is YOUR CHILD STILL RECEIVING psychological or emotional counseling from someone AT SCHOOL?	GO TO Q6	GO TO Q5		

5. If not, what was the **MAIN REASON** YOUR CHILD stopped psychological or emotional counseling AT SCHOOL? (Please select **ONE** main reason.)

- ☐ The counselor, therapist, psychologist, psychiatrist or social worker said my child finished and/or met their goals
- ☐ My child had bad experiences with the services
- ☐ School ended
- ☐ Hours not convenient
- ☐ My child changed schools
- ☐ My child got better/My child no longer needed services
- ☐ Couldn't get appointment
- ☐ Not Getting Better
- ☐ Lack of time
- ☐ Other (Specify) _____
- ☐ The counselor, therapist, psychologist, psychiatrist or social worker did not understand my child's problem
- ☐ My child felt discriminated against
- ☐ My child did not want to go anymore
- ☐ We wanted to handle the problem on our own

	Yes	No	Refused	Don't Know
6. In the past 12 months, has YOUR CHILD RECEIVED any psychological or emotional counseling from someone OUTSIDE OF SCHOOL, like a counselor, therapist, psychologist, psychiatrist or social worker?	GO TO Q7	GO TO Q9		

CHILD VERSION

7. Is YOUR CHILD STILL RECEIVING psychological or emotional counseling from someone OUTSIDE OF SCHOOL?

Yes	No	Refused	Don't Know
☐	☐	☐	☐
GO TO Q9	GO TO Q8	GO TO Q9	

8. What was the **MAIN REASON** YOUR CHILD stopped psychological or emotional counseling OUTSIDE OF SCHOOL? (Please select **ONE** main reason.)

- The counselor, therapist, psychologist, psychiatrist or social worker said my child finished and/or met their goals
- My child had bad experiences with counselor, therapist, psychologist, psychiatrist or social worker
- Counselor, therapist, psychologist, psychiatrist or social worker did not understand my child's problem
- My child got better/My child no longer needed services
- Couldn't get appointment
- Didn't have transportation
- Insurance did not cover
- Not Getting Better
- My child felt discriminated against
- Too expensive
- Didn't have time
- My child did not want to go anymore
- Hours not convenient
- We moved
- We wanted to handle the problem on our own
- Other (Specify) _____

	Yes	No	Refused	Don't Know
9. During the past 12 months, has your child taken any medication because of difficulties with their emotions, concentration, or behavior?				

Instructions: The next questions are about how your child has been feeling during the past 6 months.

My child…	**Not True**	**Somewhat True**	**Certainly True**	**Refused**	**Don't Know**
10. is generally well behaved, usually does what adults request					
11. has many worries, or often seems worried.					
12. is often unhappy, depressed or tearful					
13. gets along better with adults than with other children					
14. has good attention span, sees chores or homework through to the end.					

15. The above items are often used to describe experiences with mental or emotional distress for children. To what extent do the above questions (Q10-Q14) match how you would describe those experiences for your child? (Check one)

A Lot	Somewhat	Not At All

Okay, you just told me about how your child has been feeling the past 6 months. Now I want to know how much their feelings have messed things up for them. In other words, how much have they stopped your child from doing things they want to do.

How much have your child's fears and worries messed things up …	**A Lot**	**Some**	**Not At All**	**Refused**	**Don't Know**
16. … with school and homework?					
17. …with friends?					
18. …at home?					

CHILD VERSION

19. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q16-Q18) match how you would describe the effect of emotions? (Check one)

A Lot	Somewhat	Not At All

20. How old is your child? Write in age: _____

21.

VERSION 1

What is your child's race and ethnic origin? ***Select only one race category and specify your child's ethnic origin.***

- American Indian or Alaska Native
- Black or African American**:** Please specify your child's ethnic origin(s):_____
- Latino, Hispanic, or Spanish: Please specify your child's ethnic origin(s):_____
- Asian: Please specify your child's ethnic origin(s): _____
- Native Hawaiian or Other Pacific Islander: Please specify your child's ethnic origin(s): _____
- White: Please specify your child's ethnic origin(s):_____
- Other Race: Please specify your child's race and ethnic origin(s):_____
- Multi-Racial Please specify your child's origin(s):_____
- Refused
- Don't Know

VERSION 2

What is your child's race and ethnic origin(s)? ***Select only one race category; select your child's ethnic origin(s)***

- American Indian or Alaska Native
- Black or African American

  Check your child's ethnic 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

  Check your child's ethnic origin(s):

  - Mexican/Chicano
  - Salvadoran
  - Guatemalan
  - Dominican
  - Honduran
  - Puerto Rican
  - Cuban
  - Peruvian
  - Chilean
  - Colombian
  - Nicaraguan
  - Refused
  - Don't Know
  - Other Latino (Please specify):_____
- Asian

  Check your child's ethnic origin(s):

  - Afghan
  - Bangladeshi
  - Burmese
  - Cambodian
  - Chinese
  - Filipino
  - Hmong
  - Indian (India)
  - Indonesian
  - Japanese
  - Korean
  - Laotian
  - Malaysian
  - Pakistani
  - Sri Lankan
  - Taiwanese
  - Thai
  - Vietnamese
  - Refused
  - Don't Know
  - Other Asian (Please specify):_____
- Native Hawaiian or Other Pacific Islander Check your child's ethnic origin(s):

  - Samoan
  - Guamanian
  - Tongan
  - Fijian
  - Refused
  - Don't Know
  - Other Hawaiian or Pacific Islander (Please specify):_____
- Multi-Racial: Check all that apply and specify your child's ethnic origin(s).

  - White: (Please specify):_____
  - Asian (Please specify):_____

- Black/African American (Please specify):_____
- Latino, Hispanic, or Spanish (Please specify):_____
- American Indian or Alaska Native (Please specify):_____
- Native Hawaiian or Other Pacific Islander (Please specify):_____
- Refused
- Don't Know

- White: Please specify your child's ethnic origin(s):_____
- Other Race: Please specify your child's race and ethnic origin(s):_____
- Refused
- Don't Know

22. How well can your child speak the English language?

- Fluently
- Somewhat fluently; can make themself 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

23. What is your child's preferred language? _____

24. Was your child born:
- Inside the U.S.
- Outside the U.S.
- Refused
- Don't Know

25. What are the first 3 digits of your child's ZIP Code? _ _ _ ☐Unstable housing/ no ZIP code ☐ Refused ☐ Don't Know

26. Has your child ever spent time in a temporary settlement area for refugees or displaced persons or been held at ICE facilities?

- Not Applicable
- Yes
- No
- Refused
- Don't Know

27. 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

Gender Identity Instructions: We use terms like "male" or "female" or "trans" 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 their gender. There are no right or wrong answers to these questions. Please be honest and answer as you really think and feel.

28. When your child was born, the person who delivered them (e.g., doctor, nurse/midwife, family members), thought my child was a: Choose the one best answer.

- Male/Boy
- Female/Girl
- Intersex (they were unsure about my child's sex at birth)
- I am not sure about my child's sex assigned at birth
- My child's assigned sex at birth (please specify):_____
- I do not wish to answer this question

29. When it comes to my child's gender identity, my child thinks of themself as: Choose all that apply.

- Man/Male
- Non-binary (not exclusively male or female)

CHILD VERSION

- Woman/Female
- Transgender/Trans
- Trans man/Trans male
- Trans woman/Trans female
- Genderqueer/Gender non-conforming
- I do not wish to answer this question
- Two Spirit
- Intersex (between male and female)
- I am not sure about my child's gender identity
- My child does not have a gender/ gender identity
- My child's gender identity is (please specify):_____

BELOW ARE OPTIONAL ITEMS
THAT ARE AVAILABLE FOR USE AS PRE-POST MEASURES BY IPPs.
They can be added to the above 29 core items.

Health Insurance

Does your child currently have health insurance coverage? (check one)

Yes | **No** | **Refused** | **Don't Know**

Did your child have health insurance coverage in the past 12 months?
Yes ☐ No ☐ Refused ☐ Don't Know

	Yes	**No**	**Refused**	**Don't Know**
Does your child's insurance cover treatment for mental health problems, such as visits to a psychologist or psychiatrist?				

Health Status

At present…

	Very Good	**Good**	**Fair**	**Poor**
Would you say your child's health is Very Good, Good, Fair, or Poor?				

ID

_____ - _____ - _____

Priority Pop *IPP* *CDEP Participant*

CHILD VERSION (5-11)

Instructions: The next questions are about how your child has been feeling during the past [IPP selected time period].

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.					

6. The above items are often used to describe experiences with mental or emotional distress for children. To what extent do the above questions (Q1-Q5) match how you would describe those experiences for your child? (Check one)

A Lot	**Somewhat**	**Not At All**

Okay, you just told me about how your child has been feeling the [IPP selected time period]. Now I want to know how much their feelings have messed things up for them. In other words, how much have they stopped your child from doing things they want to do.

How much have your child's fears and worries messed things up …	**A Lot**	**Some**	**Not At All**	**Refused**	**Don't Know**
7. … with school and homework?					
8. …with friends?					
9. …at home?					

10. To what extent do the above items (Q7-Q9) reflect how your emotions may have affected your child's life? (Check one)

A Lot	**Somewhat**	**Not At All**

Instructions: Please help our make our program better by answering some questions. Please answer the questions based on the services, program or activities connected to [name of CDEP]. Indicate if you Strongly Disagree, Disagree, are Undecided, Agree, or Strongly Agree with each of the statements below. If the statement 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" stands for any program activities or events connected to [name of CDEP]

	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**Not Applicable**
11. Overall, I am satisfied with the services my child received.	☐	☐	☐	☐	☐	☐
12. The people helping my child stuck with us no matter what.	☐	☐	☐	☐	☐	☐
13. I felt my child had someone to talk to when they were troubled.	☐	☐	☐	☐	☐	☐
14. The services my child and/or family received were right for us.	☐	☐	☐	☐	☐	☐
15. The location of services was convenient for us.	☐	☐	☐	☐	☐	☐
16. Services were available at times that were convenient for us.	☐	☐	☐	☐	☐	☐
17. My family got the help we wanted for my child.	☐	☐	☐	☐	☐	☐
18. My family got as much help as we needed for my child.	☐	☐	☐	☐	☐	☐
19. Staff treated me with respect.	☐	☐	☐	☐	☐	☐

CHILD VERSION POST

20. Staff respected my family's religious / spiritual beliefs.	☐	☐	☐	☐	☐	☐
21. Staff spoke with me in a way that I understood.	☐	☐	☐	☐	☐	☐
22. Staff were sensitive to my cultural / ethnic background.	☐	☐	☐	☐	☐	☐
As a result of the services my child or family received:						
23. My child is better at handling daily life.	☐	☐	☐	☐	☐	☐
24. My child gets along better with family members.	☐	☐	☐	☐	☐	☐
25. My child gets along better with friends and other people.	☐	☐	☐	☐	☐	☐
26. My child is doing better in school and/or work.	☐	☐	☐	☐	☐	☐
27. My child is better able to cope when things go wrong.	☐	☐	☐	☐	☐	☐
28. I am satisfied with my family life right now.	☐	☐	☐	☐	☐	☐
29. My child is better able to do things they want to do.	☐	☐	☐	☐	☐	☐
30. I know people who will listen and understand me when I need to talk.	☐	☐	☐	☐	☐	☐
31. I have people that I am comfortable talking with about my child's problem(s).	☐	☐	☐	☐	☐	☐
32. In a crisis, I would have the support I need from family or friends.	☐	☐	☐	☐	☐	☐
33. I have people with whom I can do enjoyable things.	☐	☐	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
34. Were the services you received here provided in the language you prefer?	☐	☐	☐	☐
35. 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?	☐	☐	☐	☐

Appendix D

Marguerite Casey Foundation IPP Organizational Capacity Assessment Tool

Please refer to this link to view the Marguerite Casey Foundation tool:

https://lmu.box.com/s/yz3ddh8fidc2nji0qpys9n8ay98dh3pf

Alternatively, you may email PARC at "SWE@lmu.edu" for a copy of the tool.

Appendix E

About the IPP Statewide Evaluation Semi-Annual Report (SAR)

LMU|LA
Psychology Applied Research Center
Loyola Marymount University

What is the IPP Statewide Evaluation Semi-Annual Report (SAR)?

The SAR is one of the SWE Core Measures that will be used *every six months* to track and document Phase 2 implementation of IPP strategies and approaches. The SAR is also designed to inform CRDP Phase 2 efforts, provide formative evaluation for Phase 2, and document change across the 35 IPPs, as well as changes within each priority population over the course of the initiative. It serves as a primarily qualitative measure of progress regarding overall effectiveness of Phase 2. "*You can't take credit for positive results if you can't show what caused them.*" (SAMHSA, 2016).

What is the purpose of the SAR?

CRDP Phase 2 must obtain credible evidence about the IPPs and their CDEPs to transform the status quo in the California mental health delivery system. To help demonstrate that CRDP Phase 2 CDEPs are valid, meaningful, and effective in improving mental health and wellness within and across the 5 priority populations, the SAR will document CDEP approaches. Systematic documentation is particularly important because the CDEPs and CRDP Phase 2 as a whole will undoubtedly be viewed in relationship to "business as usual"—i.e., standard Prevention and Early Intervention (PEI) county programs and evaluations.

How can the SAR be of assistance to your IPP?

Over time, these data will help capture your CDEP implementation ***story***, which can help to improve and validate your CDEP. It will provide valuable information and feedback related to your project's specific processes, strategies, and procedures to achieve its goals, and document important accomplishments and challenges encountered during implementation. The SAR can help IPPs with the following:

- qualitatively document important success stories,
- discern what is and isn't working and make course corrections (formative evaluation),
- complete the final local evaluation report,
- identify ongoing technical assistance needs and areas of support,
- provide information useful to sustaining and building upon accomplishments for future organizational growth, program development, and resourceacquisition.

What time period does this IPP Semi-Annual Report (SAR) cover and when is it due?

We recognize that the IPP start date was in March 2017. This SAR covers the six-month time-period from (pre-populated with reporting period). IPPs are welcome to report any critical information or data from March and April 2017 as desired. The SAR is due on (prepopulate with due date). IPPs should submit their SAR on time to allow PARC time to review submissions for data accuracy, completeness, and clarity.

What does the IPP Semi-Annual Report (SAR) cover?

The SAR will primarily consist of *process* data. However, some *outcome* data will be collected qualitatively through this report as well.

- Process Data consists of: 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 consists of: successes/victories associated with community engagement, partnerships/collaboratives, systems transformation, direct service referrals (if applicable), workforce development (if applicable), and organizational capacity/cultural competency.

<<Relevant information about your IPP will be pre-populated from your local evaluation plan and organizational assessment on your SAR Word document to assist you in the completion of the report.>>

The SAR contains the following sections:

- CDEP Purpose
- Outreach/Recruitment & Participation
- CDEP Fidelity/Flexibility
- Local Evaluation Fidelity/Flexibility
- Public Communication Efforts
- Community Engagement
- Networks/Collaboratives/Partnerships
- Systems Change
- Workforce Development
- Direct Service Referrals
- Organizational Capacity/Cultural Competency
- Anonymous Survey on Technical Assistance and Support
- CDEP Reflection

Who should complete the SAR?

Although *one* SAR is submitted on behalf of each IPP, it should be completed jointly by CDEP staff who are involved with program implementation (e.g., program manager, frontline staff, outreach workers) AND your local evaluator (this could include the lead evaluator and evaluation team members involved with data collection). IPPs may also find it useful to have community residents, board members, and other key stakeholders provide feedback to some of the qualitative questions on the SAR. Completion of the SAR using a team approach both improves validity and reduces individual biases. This process also serves as an opportunity for key stakeholders to engage in a rich dialogue about CDEP accomplishments, challenges, goals, and next steps.

<<One section of the SAR—i.e., Anonymous Technical Assistance and Support Survey on Qualtrics—does allow for multiple people from each IPP to complete and submit the survey. Please see that section for specific instructions.>>

Why is the SAR so long? (It actually isn't!)

Given the technical complications with Qualtrics, we decided to go "old school" and use Microsoft Word, offering a more user-friendly format. Because it is in a Word format, the template is lengthier and shows "all" of the SAR questions, regardless of whether each section or question applies to your project. In other words, you must manually skip the questions that do not apply to your CDEP. The SAR template is also long because we built instructions and guidance into the actual template rather than providing you with a separate set of reference instructions.

What is the submission process?

Each IPP will upload the completed SAR as a Word attachment into Qualtrics. To remain in compliance with the ISO data requirements established by CDPH, IPPs will **NOT** be able to submit their SAR via email or mail. The Qualtrics system is dedicated to protecting all data using industry best standards. Submitting your SAR through Qualtrics will ensure the highest security protection and allow IPPs and the SWE to meet the ISO requirements. You will receive a confirmation from Qualtrics indicating successful submission.

Please use the following Qualtrics link to upload your completed SAR (prepopulated with Qualtrics link submission form for the corresponding reporting period)

What and why is there a quality review process?

The PARC team will review all submitted SARs to ensure that the information submitted is understandable, complete, consistent, and accurate. For example, the review will determine whether the information reported is appropriately related to your CRDP Phase 2 effort, uses plain language, correctly responds to queries, does not contain missing information, etc. Once your SAR has undergone the quality review process, you will receive one of two emails:

1) Your SAR is complete! or
2) Additional Information is Requested Re: Your SAR!

In this instance, PARC will send your IPP details about the information needed for your SAR to be considered complete. PARC@LMU will request that you re-submit your SAR if revisions are needed.

Why is data quality important?

Quality data allows the Statewide Evaluation to:

- Adhere to this requirement in the CDPH-OHE grant
- Accurately reflect the work accomplished by your project
- Present a valid and trustworthy story of the collective impact of the IPPs to CDPH-OHE, future funders, decision makers, policymakers, researchers, evaluators,etc.
- Effectively respond to any potential audits of CDPH-OHE or PARC@LMU
- Make the business case that CRDP Phase 2 is a sound basis for programmatic and financial decision-making.

Will the information reported by IPPs be used for comparisons or performance appraisals?

NO! The SAR is **NOT** for comparisons or performance appraisal purposes. The intent is to learn, to grow and to continue to improve the overall functioning of this statewide effort. Neither IPPs nor Priority Populations will be compared to each other. This cross-site evaluation is not a competition. SWE will examine the data within each priority population and across populations to: 1) paint a clear and compelling picture of the CRDP Phase 2 work, 2) inform CDPH-OHE, TAPs, SWE, and other key stakeholders about how they can more effectively provide support, 3) track CRDP Phase 2 change on key outcomes over time, and 4) inform future private and public investments considering similar initiatives (e.g., how funders can invest in and support grantees). If you agree to share your data with your TAP, the SAR data will help the TAPs in their IPP technical assistance.

Who owns the SAR?

As noted in the Statewide Evaluation contract, all data collected as part of the SWE is owned by CDPH. Because the SAR is part of the SWE, it is owned by CDPH. However, as with all data collected related to the SWE, the intended use of this data by CDPH is for the creation of the Final Statewide Evaluation Report. If CDPH wishes to use SWE data for any other purposes in the future, CDPH will consult with IPPs associated with the relevant data.

Will CDPH-OHE get a copy of our SAR?

CDPH-OHE may request to review SAR data to assist with contract management (e.g., identifying TA needs and/or ways CDPH-OHE can improve to provide better support to the IPPs over the course of the initiative). In addition, CDPH-OHE will have access to all of the SAR data through the SWE Database that PARC will provide CDPH-OHE at the

end of CRDP Phase 2 per the SWE Contract, Deliverable 7. However, as noted in the SAR instructions, data collected through the "Anonymous TA and Support Survey" portion of the SAR will remain anonymous and only be reported to CDPH-OHE in aggregate. If CDPH wishes to use the SAR data for any other purposes in the future, CDPH will consult with IPPs associated with the data.

Will the TAPs get a copy of our SAR?

TAPs may request to review data from your SAR to more effectively provide you with support over the course of the initiative. IPPs must give their permission before PARC will share SAR data with the TAPs.

What if we need support completing our SAR?

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. If you have any questions about this report for any reason, the PARC team is here tohelp!

Please contact:
PARC@LMU Email:
diane.terry@lmu.edu
Phone: 310.338.7095

Statewide Evaluation Semi-Annual Report (IPPs)
Reporting Period: November 1, 2020-April 30, 2021

IPP Name: IPP name inserted

We know many of you are continuing to provide COVID-19 community response and recovery services. If you would like to report on these activities in the SAR, you can report this information in the relevant section(s).

In order to demonstrate the impact the CRDP Phase 2 grantees are having on communities that have historically been unserved, underserved, and inappropriately served, we need to document where your CDEP services are being provided. The section below includes the zip codes where your CDEP offers services (e.g., outreach and recruitment, community engagement, workforce development activities, CDEP services, etc.), as reported in your previously submitted SAR. If you've made any changes or expanded to additional service areas for any reason, please update the information below. You may copy and paste additional rows, as needed.

Pre-populated with zip codes or county(s) from SAR 7. Removed the county option for those who report zip codes. Removed the zip code option for those who report counties.
☐ Site #1: Zip Code Click here to enter text, if applicable.)
☐ Site #2: Zip Code Click here to enter text, if applicable.)
☐ Site #3: Zip Code Click here to enter text, if applicable.)

*If your CDEP's geographic territory is vast (e.g., your CDEP reach spans 5+ counties), please indicate the specific counties where your CDEP activities take place, rather than zip code in the spaces below. You may copy and paste additional rows, as needed.

***Inserted in the Native American SARs only**:
If you are unable to provide zip code information for your CDEP due to participant confidentiality concerns, please indicate the specific counties where your CDEP activities take place, rather than the zip code in the spaces below. You may copy and paste additional rows, as needed.

Pre-populated with zip codes or county(s) from SAR 7:
☐ Site #1: County (Click here to enter text.)
☐ Site #2: County (Click here to enter text., if applicable)
☐ Site #3: County (Click here to enter text., if applicable)
☐ Site #4: County (Click here to enter text., if applicable)
☐ Site #5: County (Click here to enter text., if applicable)

CDEP Purpose

In this section let us know if any modifications have been made to your CDEP from November 2020-April 2021 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:

Inserted purpose statement from SAR #7 submission or updates reported in SAR #7.

1. Since November 2020-April 2021, 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.

CDEP Virtual/Remote Pivots. At the beginning of 2020, all IPPs were in full implementation mode with their CDEP logistics in place. The COVID-19 stay-at-home orders (and for some IPPs, the CA wildfires) meant to some degree going back to the drawing board to re-strategize and determine how to deliver your CDEP services and activities virtually/remotely.

2. IPP Core Component #1: Pre-populated based on number of components for each CDEP	2a. Below is list of strategies you indicated using as part of your CDEP service delivery during the SAR 7 reporting period. Did you use any <u>additional</u> strategies to deliver your CDEP services and activities during the SAR 8 reporting period? (select all that apply)

	Pre-populate based on strategies IPP reported in SAR 7.
From November 2020-April 2021, this component was: Please select ONE answer choice. ☐ 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.) ☐ This component was dropped (Describe why it was dropped: Click here to enter text.) ☐ This component ended during this time period (Describe why it ended: Click here to enter text.)	☐ N/A- this component was delivered as originally intended ☐ Phone ☐ Email ☐ Text Message ☐ Video Conferencing (e.g., zoom) ☐ In-person, at your office with social distancing protocols in place ☐ In-person, at other locations (e.g., meeting with clients in outdoor spaces) ☐ Other (specify: Click here to enter text.)
2b. Will you continue implementing this component after your CRDP Phase 2 grant ends in April 2022? ☐ Yes ☐ No	

Please answer each corresponding query for each CDEP component listed in your SAR #7 submission.

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.)

CRDP Phase 2 Reflections

It has been about four years since you launched your CRDP Phase 2 CDEP for your community.
What have you learned as an organization about addressing mental health disparities in your community? What have you learned about your CDEP's ability to address MH disparities?
Click here to enter text.

Based on what you have learned, moving forward what would it take to deepen the impact of your CDEP?
Click here to enter text.

Evidence-Based Practices (EBPs) are interventions for which there is purported scientific evidence showing that they improve client outcomes. EBPs use standardized manuals, guidelines, and training materials with the expectation that there will be 100% adherence to the protocols.

What insights, if any, do you have about how the communities you serve respond to EBPs?
Click here to enter text.

How would you explain to decision makers what the value added is for your CDEPs compared to EBPs for your community?
Click here to enter text.

CRDP is at the forefront of collecting sexual orientation and gender identity (SOGI) data systematically across 5 priority populations via the CDEP Participant Pre-Questionnaire. The information yielded from SOGI data helps promote culturally responsive care and can contribute to the reduction of mental health disparities for LGBTQ individuals and families in each priority population.

In what ways did SOGI data collection inform your understanding of your community, your organizational practices, and the delivery of your CDEP?
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 (often times 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. From November 2020-April 2021, **what places** did you go to conduct outreach and talk to people or groups about your CDEP? Select all that apply.

   ☐ No outreach or recruitment efforts took place during this reporting period (please explain: Click here to enter text.) **(GO TO Q6)**

   ☐ Community resident homes → ☐ in-person ☐ virtual or remote

   ☐ School campuses and classrooms → ☐ in-person ☐ virtual or remote

   ☐ Places where people publicly congregate → ☐ in-person ☐ virtual or remote

   ☐ Local agencies and orgs that offer services to your community → ☐ in-person ☐ virtual or remote

   ☐ Community fairs, social/cultural festivals and events → ☐ in-person ☐ virtual or remote

   ☐ Faith-based, religious or spiritual centers → ☐ in-person ☐ virtual or remote

   ☐ Conferences and convenings → ☐ in-person ☐ virtual or remote

   ☐ Associations and group meetings → ☐ in-person ☐ virtual or remote

   ☐ Businesses → ☐ in-person ☐ virtual or remote

   ☐ Local mental health agencies & other government offices → ☐ in-person ☐ virtual or remote

   ☐ Other (please specify: Click here to enter text.) → ☐ in-person ☐ virtual or remote

5. From November 2020-April 2021, 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 and did not work or challenges here: Click here to enter text.).

☐ Not at all Effective (Please describe what did not work or challenges here: Click here to enter text.).

5a. What types of **barriers or challenges** did you experience with your CDEP 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

☐ COVID-19 Stay-at-home orders (Describe barrier and response: Click here to enter text.)

☐ COVID-19 health impacts (CDEP staff and/or community members) (Describe barrier and response: Click here to enter text.)

☐ Involvement in racial uprisings, mass protests, and/or other social justice activities (Describe barrier and response: Click here to enter text.)

☐ Impact of systemic racism (e.g., police killings of Black and other people of color, anti-Asian racism, ICE enforcement, raids, and transfers) (Describe barrier and response: Click here to enter text.)

☐ Wildfires (Describe barrier and response: Click here to enter text.)

☐ 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.)

6a. From November 2020-April 2021, please rate how effective your strategies were with **sustaining CDEP participation** (in other words, keeping your participants involved over time in your CDEP program events and activities)?

☐ Sustaining CDEP Participation did not take place during this reporting period (Please describe why no efforts took place here: Click here to enter text.). **(GO TO Q7)**

☐ Very Effective (Please describe what worked or successes here: Click here to enter text.).

☐ Somewhat Effective (Please describe what worked and did not work or challenges here: Click here to enter text.).

☐ Not at all Effective (Please describe what did not work or challenges here: Click here to enter text.).

6b. What types of **barriers or challenges** did you experience with sustaining CDEP 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

☐ COVID-19 Stay-at-home orders (Describe barrier and response: Click here to enter text.)

☐ COVID-19 health impacts (CDEP staff and/or community members) (Describe barrier and response: Click here to enter text.)

☐ Involvement in racial uprisings, mass protests, and/or other social justice activities (Describe barrier and response: Click here to enter text.)

☐ Impact of systemic racism (e.g., police killings of Black and other people of color, anti-Asian racism, ICE enforcement, raids, and transfers) (Describe barrier and response: Click here to enter text.)

☐ Wildfires (Describe barrier and response: Click here to enter text.)

☐ 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 programs 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 from November 2020-April 2021. For each CE area listed below, check "Yes" if it was conducted or "No" 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? For IPPs whose community members were engaged in systems transformation, what types of organizing activities were they involved in?

Was the community engaged with making changes/improvements to your CDEP programs or activities? ☐ Yes ☐ No	
If YES, Type of Community Member *(select all that apply & briefly describe)*	
☐ Youth (specify: Click here to enter text.)	☐ Parents (specify: Click here to enter text.)
☐ Community residents (specify: Click here to enter text.)	☐ Families (specify: Click here to enter text.)
☐ Other stakeholders (specify: Click here to enter text.)	☐ Spiritual leaders (specify: Click here to enter text.)
☐ Healers (specify: Click here to enter text.)	☐ Faith-based (specify: Click here to enter text.)
Type of Engagement *(briefly describe)*	

Was the community engaged with carrying out/implementing your CDEP programs or activities? ☐ Yes ☐ No	
If YES, Type of Community Member *(select all that apply & briefly describe)*	
☐ Youth (specify: Click here to enter text.)	☐ Parents (specify: Click here to enter text.)
☐ Community residents (specify: Click here to enter text.)	☐ Families (specify: Click here to enter text.)
☐ Other stakeholders (specify: Click here to enter text.)	☐ Spiritual leaders (specify: Click here to enter text.)
☐ Healers (specify: Click here to enter text.)	☐ Faith-based (specify: Click here to enter text.)
Type of Engagement *(briefly describe)*	

Was the community engaged making changes/improvements to your Local Evaluation Plan? ☐ Yes ☐ No	
Type of Community Member *(select all that apply & briefly describe)*	
☐ Youth (specify: Click here to enter text.)	☐ Parents (specify: Click here to enter text.)
☐ Community residents (specify: Click here to enter text.)	☐ Families (specify: Click here to enter text.)
☐ Other stakeholders (specify: Click here to enter text.)	☐ Spiritual leaders (specify: Click here to enter text.)
☐ Healers (specify: Click here to enter text.)	☐ Faith-based (specify: Click here to enter text.)
Type of Engagement *(briefly describe)*	

Was the community engaged with carrying out/implementing your Local Evaluation? ☐ Yes ☐ No	
Type of Community Member *(select all that apply & briefly describe)*	
☐ Youth (specify: Click here to enter text.)	☐ Parents (specify: Click here to enter text.)
☐ Community residents (specify: Click here to enter text.)	☐ Families (specify: Click here to enter text.)
☐ Other stakeholders (specify: Click here to enter text.)	☐ Spiritual leaders (specify: Click here to enter text.)
☐ Healers (specify: Click here to enter text.)	☐ Faith-based (specify: Click here to enter text.)
Type of Engagement *(briefly describe)*	

Public Communication Efforts

In this section, you will be reporting on public communication efforts conducted from November 2020-April 2021 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", town hall/forum, etc.)
- Coverage by or advertisement in traditional media (TV, radio, print)
- Social networking media (Twitter, Facebook, etc.)
- Informational web sites, etc.
- Resource Guides (e.g., print or online directories designed to facilitate access to culturally and/or linguistically competent service providers)

8. Based on the description above, to what extent was a public communication effort part of your CDEP efforts from November 2020-April 2021.

☐ None **(Skip this section and GO to Networks/Collaboratives/Partnerships section)**

☐ A Little **(GO To Q#9)**

☐ Some **(GO To Q#9)**

☐ A Lot **(GO To Q#9)**

9. Indicate each type of public communication strategy your IPP used November 2020-April 2021. 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:

- Language Capacity: For each strategy you select, indicate which language(s) the associated materials, resources, and/or activities were available in.
- Focus of Messaging: Describe the focus of the messaging or information disseminated, and any cultural, linguistic, and/or LGBTQ-appropriate messaging incorporated into each strategy.
- 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.

This can include public communications that have specific messaging related to COVID-19, and social justice issues (e.g., Black Lives Matter, ICE, anti-Asian racism, etc.)

In SAR (insert), you shared information on a Resource Guide you created related to (insert). Have you made any substantive updates to the guide since you initially distributed it? If yes, please briefly describe and upload a copy of the updated Guide with your SAR submission: Click here to enter text.

Newsletters ☐ Yes ☐ Non-applicable		
If yes, please specify which **language(s)** the resources were made available in: Click here to enter text.		
Focus of Messaging or Information (including cultural or LGBTQ focused messaging)	Type of Audience Reached *(select all that apply)*	SIX MONTH TOTAL Estimated # Reached
Briefly describe:	☐ Youth ☐ Parents ☐ Adults ☐ Community-based orgs ☐ Faith-based orgs ☐ Tribal groups ☐ K-12 schools/districts ☐ Colleges/universities ☐ Govt agencies/departments ☐ Decision makers/policymakers ☐ Other	*If you have a daily or weekly or monthly count, please calculate the estimated reached across the ENTIRE 6-month time period. You can also indicate if you are unable to provide a count.*

Brochures/Leaflets ☐ Yes ☐ Non-applicable		
If yes, please specify which **language(s)** the resources were made available in: Click here to enter text.		
Focus of Messaging or Information (including cultural or LGBTQ focused messaging)	Type of Audience Reached *(select all that apply)*	SIX MONTH TOTAL Estimated # Reached
Briefly describe:	☐ Youth ☐ Parents ☐ Adults ☐ Community-based orgs ☐ Faith-based orgs ☐ Tribal groups ☐ K-12 schools/districts	*If you have a daily or weekly or monthly count, please calculate the estimated reached across the ENTIRE 6-month time period. You can also indicate if you are unable to provide a count.*

	☐ Colleges/universities ☐ Govt agencies/departments ☐ Decision makers/policymakers ☐ Other	

Posters ☐ Yes ☐ Non-applicable		
If yes, please specify which **language(s)** the resources were made available in: Click here to enter text.		
Focus of Messaging or Information (including cultural or LGBTQ focused messaging)	Type of Audience Reached *(select all that apply)*	SIX MONTH TOTAL Estimated # Reached
Briefly describe:	☐ Youth ☐ Parents ☐ Adults ☐ Community-based orgs ☐ Faith-based orgs ☐ Tribal groups ☐ K-12 schools/districts ☐ Colleges/universities ☐ Govt agencies/departments ☐ Decision makers/policymakers ☐ Other	*If you have a daily or weekly or monthly count, please calculate the estimated reached across the ENTIRE 6-month time period. You can also indicate if you are unable to provide a count.*

Toolkits ☐ Yes ☐ Non-applicable		
If yes, please specify which **language(s)** the resources were made available in: Click here to enter text.		
Focus of Messaging or Information (including cultural or LGBTQ focused messaging)	Type of Audience Reached *(select all that apply)*	SIX MONTH TOTAL Estimated # Reached
Briefly describe:	☐ Youth ☐ Parents ☐ Adults ☐ Community-based orgs ☐ Faith-based orgs ☐ Tribal groups ☐ K-12 schools/districts ☐ Colleges/universities ☐ Govt agencies/departments ☐ Decision makers/policymakers ☐ Other	*If you have a daily or weekly or monthly count, please calculate the estimated reached across the ENTIRE 6-month time period. You can also indicate if you are unable to provide a count.*

Public Event (e.g., press conference, kick off, townhall/forum) ☐ Yes ☐ Non-applicable (INCLUDING VIRTUAL EVENTS CONDUCTED DURING THIS REPORTING PERIOD)		
If yes, please specify which **language(s)** the resources were made available in: Click here to enter text.		
Focus of Messaging or Information (including cultural or LGBTQ focused messaging)	Type of Audience Reached *(select all that apply)*	SIX MONTH TOTAL Estimated # Reached

Briefly describe:	☐ Youth ☐ Parents ☐ Adults ☐ Community-based orgs ☐ Faith-based orgs ☐ Tribal groups ☐ K-12 schools/districts ☐ Colleges/universities ☐ Govt agencies/departments ☐ Decision makers/policymakers ☐ Other	*If you have a daily or weekly or monthly count, please calculate the estimated reached across the ENTIRE 6-month time period. You can also indicate if you are unable to provide a count.*

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		
If yes, please specify which **language(s)** the resources were made available in: Click here to enter text.		
Focus of Messaging or Information (including cultural or LGBTQ focused messaging)	Type of Audience Reached *(select all that apply)*	SIX MONTH TOTAL Estimated # Reached
Please check the type of traditional media used and briefly describe focus of the messaging): ☐ TV News story/Interview: Click here to enter text. ☐ Radio Announcement/Interview: Click here to enter text. ☐ Ethnic/Bilingual radio Click here to enter text. ☐ Newspaper article: Click here to enter text. ☐ Other (please specify): Click here to enter text.	☐ Youth ☐ Parents ☐ Adults ☐ Community-based orgs ☐ Faith-based orgs ☐ Tribal groups ☐ K-12 schools/districts ☐ Colleges/universities ☐ Govt agencies/departments ☐ Decision makers/policymakers ☐ Other	*If you have a daily or weekly or monthly count, please calculate the estimated reached across the ENTIRE 6-month time period. You can also indicate if you are unable to provide a count.*

Social Networking Media (Twitter, Facebook, etc.) ☐ Yes ☐ Non-applicable		
If yes, please specify which **language(s)** the resources were made available in: Click here to enter text.		
Focus of Messaging or Information (including cultural or LGBTQ focused messaging)	Type of Audience Reached *(select all that apply)*	SIX MONTH TOTAL Estimated # Reached
Briefly specify and describe the type of social media used: ☐ Twitter: Click here to enter text. ☐ Facebook: Click here to enter text. ☐ Instagram: Click here to enter text.	☐ Youth ☐ Parents ☐ Adults ☐ Community-based orgs ☐ Faith-based orgs ☐ Tribal groups ☐ K-12 schools/districts ☐ Colleges/universities	*If you have a daily or weekly or monthly count, please calculate the estimated reached across the ENTIRE 6-month time period. You can also indicate if you are unable to provide a count.*

☐ Other Social Media (please specify): Click here to enter text.	☐ Govt agencies/departments ☐ Decision makers/policymakers ☐ Other	

Informational Web Pages ☐ Yes ☐ Non-applicable		
If yes, please specify which **language(s)** the resources were made available in: Click here to enter text.		
Focus of Messaging or Information (including cultural or LGBTQ focused messaging)	Type of Audience Reached *(select all that apply)*	SIX MONTH TOTAL Estimated # Reached
Briefly describe:	☐ Youth ☐ Parents ☐ Adults ☐ Community-based orgs ☐ Faith-based orgs ☐ Tribal groups ☐ K-12 schools/districts ☐ Colleges/universities ☐ Govt agencies/departments ☐ Decision makers/policymakers ☐ Other	*If you have a daily or weekly or monthly count, please calculate the estimated reached across the ENTIRE 6-month time period. You can also indicate if you are unable to provide a count.*

Resource Guide ☐ Yes ☐ Non-applicable		
If yes, please specify which **language(s)** the resources were made available in: Click here to enter text.		
Focus of Messaging or Information (including cultural or LGBTQ focused messaging)	Type of Audience Reached *(select all that apply)*	SIX MONTH TOTAL Estimated # Reached
Briefly describe:	☐ Youth ☐ Parents ☐ Adults ☐ Community-based orgs ☐ Faith-based orgs ☐ Tribal groups ☐ K-12 schools/districts ☐ Colleges/universities ☐ Govt agencies/departments ☐ Decision makers/policymakers ☐ Other	*If you have a daily or weekly or monthly count, please calculate the estimated reached across the ENTIRE 6-month time period. You can also indicate if you are unable to provide a count.*

Other ☐ Yes (specify: Click here to enter text.) ☐ Yes ☐ Non-applicable		
If yes, please specify which **language(s)** the resources were made available in: Click here to enter text.		
Focus of Messaging or Information (including cultural or LGBTQ focused messaging)	Type of Audience Reached *(select all that apply)*	SIX MONTH TOTAL Estimated # Reached

Briefly describe:	☐ Youth ☐ Parents ☐ Adults ☐ Community-based orgs ☐ Faith-based orgs ☐ Tribal groups ☐ K-12 schools/districts ☐ Colleges/universities ☐ Govt agencies/departments ☐ Decision makers/policymakers ☐ Other	*If you have a daily or weekly or monthly count, please calculate the estimated reached across the ENTIRE 6-month time period. You can also indicate if you are unable to provide a count.*

Note: When uploading your SAR in Qualtrics, please attach PDF files, electronic links, audio files, etc. to any of your public communication materials of significance to your CDEP.

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 from November 2020-April 2021?

☐ 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 (November 2020-April 2021), including joint efforts. In this section, you can also document work you have completed with other IPPs. For **each** group you are involved in, please answer the following:

- Group Type: Select if it is a network, collaborative, or formal partnership.
- Phase 2 Joint Efforts: Indicate whether or not the network, collaborative, or formal partnership involved other Phase 2 IPPs, and provide the names(s) of the IPP(s) if applicable.
- 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.

We have provided tables for previously reported groups, and additional tables for you to report new networks, collaboratives, or partnerships your IPP was involved in from November 2020 – April 2021.

—Tables for Previously Reported Groups (SAR 7)—

The following tables have been prepopulated with data from your previous SAR. Please ~~strikethrough~~ any information that is no longer relevant. If group involvement and/or purpose have changed or was missing from your last SAR, please insert the information and highlight it in yellow. Information that was missing on the previous SAR is highlighted in Green. Please be sure to complete this section for this reporting period.

Prepopulated Group Type #1: → : ☐ Network ☐ Collaborative ☐ Formal partnership *If applicable*, provide the group's formal or informal name: Click here to enter text.
Are other CRDP Phase 2 IPPs involved? ☐ No ☐ Yes → Write in IPP names: Click here to enter text.
→ **When did you become involved with this group?** ☐ Before Phase 2 ☐ During Phase 2 → **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.)
Prepopulated Group #1 Purpose in Relation to CDEP Goals *(Briefly describe)*

Are you still involved with this group? ☐ No→ Skip to **next group** ☐ Yes → Go to **CHALLENGES & ACCOMPLISHMENTS**
Please be sure to note any accomplishments and/or challenges experienced with these groups from November 2020-April 2021.

What **CHALLENGES AND BARRIERS** did you experience with this group during the reporting period?	What **ACCOMPLISHMENTS OR SUCCESSES** did you experience with this group during the reporting period?

---Tables for New Groups since SAR 7---

If you have any new partnerships or collaborations to report, please use the tables below to provide that information. *Additional tables can be copied and pasted as necessary to report new groups.*

Prepopulated NEW Group #1: → **:** ☐ Network ☐ Collaborative ☐ Formal partnership *If applicable*, provide the group's formal or informal name: Click here to enter text.
Are other CRDP Phase 2 IPPs involved? ☐ No ☐ Yes → Write in IPP names: Click here to enter text.
→ **When did you become involved with this group?** ☐ Before Phase 2 ☐ During Phase 2 → **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.)
New Group #1 Purpose in Relation to CDEP Goals *(Briefly describe)*
Please be sure to note any accomplishments and/or challenges experienced with these groups from November 2020-April 2021.

What **CHALLENGES AND BARRIERS** did you experience with this group during the reporting period?	What **ACCOMPLISHMENTS OR SUCCESSES** did you experience with this group during the reporting period?

Prepopulated NEW Group #2: → **:** ☐ Network ☐ Collaborative ☐ Formal partnership *If applicable*, provide the group's formal or informal name: Click here to enter text.
Are other CRDP Phase 2 IPPs involved? ☐ No ☐ Yes → Write in IPP names: Click here to enter text.
→ **When did you become involved with this group?** ☐ Before Phase 2 ☐ During Phase 2 → **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.)
New Group #2 Purpose in Relation to CDEP Goals *(Briefly describe)*

What **CHALLENGES AND BARRIERS** did you experience with this group during the reporting period?	What **ACCOMPLISHMENTS OR SUCCESSES** did you experience with this group during the reporting period?

Prepopulated NEW Group #3: → : ☐ Network ☐ Collaborative ☐ Formal partnership *If applicable*, provide the group's formal or informal name: Click here to enter text.
Are other CRDP Phase 2 IPPs involved? ☐ No ☐ Yes → Write in IPP names: Click here to enter text.
→ **When did you become involved with this group?** ☐ Before Phase 2 ☐ During Phase 2 → **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.)
New Group #3 Purpose in Relation to CDEP Goals *(Briefly describe)*

What **CHALLENGES AND BARRIERS** did you experience with this group during the reporting period?	What **ACCOMPLISHMENTS OR SUCCESSES** did you experience with this group during the reporting period?

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 designed to capture advocacy efforts and systems change work your IPP has conducted from November 2020-April 2021. **Advocacy** involves any actions taken on behalf of OR with underrepresented individuals, communities, or populations to advance social and economic change to improve quality of life, and ultimately, reduce mental health disparities. **Systems change** work pertains to ways in which clinics, schools, school districts, counties, tribal governments/councils, etc. are **formally transforming their system** to more appropriately serve or support your priority population. Advocacy and systems change work can result in changes at one or more of the following levels:

Changes to…	Examples…
Policy: Laws, regulations, ordinances, rules	Tribal council, legislative bodies, school boards city councils, board of supervisors ***Example: A high number of API youth involved in the foster care system reside in our district. Over the last year, we've strategically engaged our city council in discussions about how to better meet the mental health needs of these young people. In response, our city council recently passed a motion to create a wellness center in our area, as the first step in helping these youth heal from their trauma.***
Systems: Existing processes of an org, institution or system	Worksites, schools, community organizations, health institutions ***Example: Our CDEP is involved in a partnership designed to increase culturally competent mental health services for Latino families in the county. As a result of our efforts, our local behavioral health agency now requires***
	regular trainings for their staff on culturally responsive strategies for serving Latino families.

Environmental: Physical or social spaces or places where people live, learn, work, and play	Shared community spaces, housing, parks, streets ***Example: During this reporting period, the high school where we provide our CDEP services allowed us to begin using an empty classroom as our official on-campus office space. This change directly stemmed from youth advocacy efforts, which helped the school recognize the value and necessity of our program within the school setting.***

12. Based on the description above, were you involved in any advocacy efforts for **policy change**, **system change**, or **environmental change** from November 2020-April 2021? This includes any advocacy work your CDEP was involved in as a response to COVID-19, the racial uprising, other social justice related efforts, and/or the wildfires. Select all that apply.

☐ No, we did not participate in any advocacy efforts during this reporting period **(GO To Q#14)—Skip logic modified accordingly for each IPP**

☐ Policy advocacy **(GO To Q#12a)**

☐ Systems advocacy **(GO To Q#12a)**

☐ Environmental advocacy **(GO To Q#12a)**

12a. Which type(s) of advocacy effort(s) did you engage in as part of your systems/policy or environmental work? This includes any advocacy work your CDEP was involved in as a response to COVID- 19, the racial uprising, other social justice related efforts, and/or the wildfires.

Individual level — Acting with or on behalf of a CDEP participant to resolve an issue, obtain a needed support or service or promote a change in the practices, policies and/or behaviors of third parties	(Please describe: Click here to enter text.)
Civic engagement— Participation in activities that promote community awareness and involvement in civic, community, & political life (e.g., ballot organizing, voter turnout activities)	(Please describe: Click here to enter text.)
Grassroots community organizing— Building community power to address social inequities and achieve social and political change (e.g., leadership development, power analyses, base-building activities)	(Please describe: Click here to enter text.)
Public testimony/commentary with decision makers (e.g., public testimony at a Board of Supervisors meeting; petition-gathering efforts)	(Please describe: Click here to enter text.)
Media campaign— Use of the media, including the arts, for strategic messaging and framing of social justice issues; can	(Please describe: Click here to enter text.)

involve messaging related to root causes and potential solutions (e.g., press conferences, op-eds, etc.)	
Research campaigns— Community-driven, participatory, action research and evaluation activities used to inform community organizing initiatives (e.g., research conducted on a topic to help prepare a policy brief in support of a campaign; community polling to inform policy initiatives)	(Please describe: Click here to enter text.)
Education and awareness activities with the general public and/or decision makers	(Please describe: Click here to enter text.)
Mass mobilization activities (e.g., rally, protest, marches)	(Please describe: Click here to enter text.)
Community actions (e.g., townhall meetings, community forum)	(Please describe: Click here to enter text.)
Partnerships— Group (formal or informal) of organizations and individuals that come together for a period of time to collaborate specifically to achieve changes in policy, law, programs, or funding streams for a particular issue	(Please describe: Click here to enter text.)
Other	(Please describe: Click here to enter text.)

12b. Was the community engaged in any of these advocacy efforts?

☐ No **(GO TO Q#13)**

☐ Yes **(GO TO Q#12c)**

12c. Type of **Community Members Engaged in Advocacy Efforts** ***(select all that apply & briefly describe)***

☐ Youth (What role did they play: Click here to enter text.)
☐ Parents (What role did they play: Click here to enter text.)
☐ Community residents (What role did they play: Click here to enter text.)
☐ Families (What role did they play: Click here to enter text.)
☐ Spiritual leaders (What role did they play: Click here to enter text.)
☐ Healers (What role did they play: Click here to enter text.)
☐ Faith-based (What role did they play: Click here to enter text.)
☐ Other stakeholders (What role did they play: Click here to enter text.)

13. We know that policy, systems, or environmental changes can take a long time to accomplish. Did your advocacy efforts lead to any policy, systems, or environmental level changes?

☐ Yes, there was a policy change (i.e. Changes to laws, regulations, ordinances, rules). Please describe: Click here to enter text.

☐ Yes, there was a systems-level change (i.e. Changes to existing processes of an org, institution of system). Please describe: Click here to enter text.

☐ Yes, there was an environmental change (i.e. Changes to physical or social spaces/places where people live, learn, work and play). Please describe: Click here to enter text.

☐ No, but steps have been taken that could lead to future policy, systems, and/or environmental change in the next 6 months. Please describe: Click here to enter text.

If the IPP indicated that they took steps in SAR 7 that could lead to future systems change for item 13 or 13A on SAR 7 the following item was included:

13a.
In your SAR dated (prepopulated date), you reported that steps have been taken that could lead to future policy systems and/or environmental change related to: prepopulated. Was any formal change implemented during this reporting period?

☐ Yes, a formal change was adopted and implemented (Please describe: Click here to enter text.

☐ Yes, a formal change was adopted but has not yet been implemented (Please describe: Click here to enter text.

☐ No (Please describe the reason for the delay in implementation: Click here to enter text.)

Local Evaluation Plan Update (COVID-19 Modifications, SAR 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.

14. Your local evaluation plan has been:

☐ Implemented exactly as planned

☐ Implemented with low/moderate change

Please describe all changes made to your local evaluation plan including changes made in relation to COVID-19.

(Click here to enter text.)

☐ Implemented with a lot of change

Please describe all changes made to your local evaluation plan including changes made in relation to COVID-19.

(Click here to enter text.)

☐ Not conducted at all

Please describe all changes made to your local evaluation plan including changes made in relation to COVID-19.

(Click here to enter text.)

Workforce Development Programs or Strategies

****IMPORTANT NOTE****

This next section pertains to Workforce Development Programs or Activities 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 (TA) to strengthen and/or develop the skills, knowledge base, and capacity of individuals, agencies, organizations, and institutions to *increase the number of culturally, linguistically, LGBTQ competent workers*.

The workforce development population typically includes:

- **Mental/Behavioral Health Workers** who provide *direct* services (e.g., counselors, psychologists, therapists, social workers, case managers, etc.) to your priority population, and may or may not reflect your priority population's lived experience, cultural, or community context
- **First Responders** who are in frequent contact with your priority population, are not mental/behavioral health workers, but are often the first to see signs of mental health issues; they provide critical services or supports, including referrals (e.g., health care workers—e.g., doctors, nurses, etc.; faith-based community and/or spiritual leaders, and traditional healers; probation, parole, or police officers; teachers, administrators, school guidance counselors; etc.)
- **Community Participants** or indigenous members of the community (e.g., *promotores*, health workers, peer navigators or counselors, etc.) who formally and informally engage with individuals or families by outreaching to link people to services, provide information, facilitate support groups, conduct community triage, etc.

Workforce development typically includes the following sectors:

- **Existing Local Workforce** - strengthening the capacity of the current workforce (mental/behavioral health workers; first responders, etc.) to work appropriately with your priority population
- **Future Community-Based Workforce** - building the future mental/behavioral workforce in your community (e.g., youth, community residents, etc.)

Workforce development program or activity strategies typically involve:

- **"On-The-Job" Training/Education and Technical Assistance** – can occur one time or over a set period of time usually in an organizational or community setting to increase knowledge or specific skills of current workers; it is typically delivered in small or large group settings; it can also involve TA to provide targeted support to an organization with a development need or problem
- **"Pipeline"/Extensive Training** – typically a formal program for credit or certification that includes the following: goal directed and in-depth training guidelines or standards (e.g., training modules; set number of workshops/classes, established curriculum and evaluation process); graduation requirements (e.g., completion of courses or hours in the field, skills practice, etc.); extensive training materials; ongoing supervision; and may involve a cadre or cohort of individuals.

The workforce includes, but is *NOT* limited to:

- Marriage and family therapists, mental health/professional counselors, psychologists, and social workers

- Case managers, 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 counselors/mentors/navigators
- School personnel (including teachers and non-teachers)
- Psychiatrists and psychiatric aides and technicians
- Primary care providers (e.g., physicians, nurses, etc.)
- Probation and parole officers

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 Activities

In this section you will be reporting on the workforce development programming or activities your CDEP completed during November 2020 through April 2021. Please report the following information for each program or activity:

- Workforce Population: Indicate whether the workforce population was mental/behavioral health workers, community participants, or first responders (refer to definitions provided above to help you determine which population to select)
- Workforce Sector: Indicate whether the workforce sector is the existing local workforce or future community-based workforce.
- Workforce Strategy: Indicate if the program or activity is "on-the-job" training/education or TA or "pipeline" extensive training.
- Ethnicity of Workers Engaged: If applicable, indicate which CRDP priority populations the workers you engaged with represent.
- Background Information of Workers Engaged: Provide detailed demographic or other background information of the workers engaged as possible.
- Multilingual Capacity of Workers Engaged: If known, languages represented among workers engaged other than English.
- Number of Unduplicated Workers Served: Unduplicated refers to a worker who is counted **only once** during the past 6 months (November 1, 2020 – April 30, 2021). A worker who receives repeated workforce development activities 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 (November 1, 2020 – April 30, 2021).
- Topic Area: Training or TA topic area(s) including any cultural, linguistic, or LGBTQ specific content.

16. Do you have a certification component to your workforce development program or activity?

☐ YES

☐ NO → Are you interested in developing a certification component? ☐ YES ☐ NO

16a. Did you obtain certification during CRDP Phase 2? ☐ YES ☐ NO

17. Please tell us the type of workforce development programming or activities your CDEP completed during the period, November 2020-April 2021. **Use a separate row for each distinct type of workforce program or activity**.

NOTE: DO NOT REPORT YOUR CDEP DIRECT SERVICES IN THIS TABLE (e.g., support groups, 1-on-1 counseling/therapy sessions, recreational activities, etc.)

Population **1=**Mental/ Behavioral Health Workers **2=**First Responders **3=**Community Participants ***SEE ABOVE for Full Definitions***	**Sector** **1=**Existing Workforce **2=**Future Workforce ***SEE ABOVE for Full Definitions***	**Strategy** 1="On-the-Job" Training/ Ed & TA 2="Pipeline" Extensive Training ***SEE ABOVE for Full Definitions***	**Priority Population of Workers Engaged** 1= AA 2=API 3=Latino 4=LGBTQ 5=NA 6=Other 7=Unknown	**Background Information of Workers Engaged** (demographics, name/type of organization, etc.)	**Multilingual Capacity of Workers**	**# Workers Served Unduplicated**	**# Sessions/ # of Hours Per Session**	**Topic Areas** (including Cultural, Linguistic, & LGBTQ specific content)
EXAMPLES								
2	**1**	**1**	**1, 3, 6**	**Teachers, Counselors, Administrators from Apple High School**	**Spanish**	**10**	**5 sessions; 7 hours per session**	**Foundations of gender, including critical information about gender and strategies for creating gender inclusive schools**
2	**1**	**1**	**5, 6**	**Teachers and Staff from Davis Joint Unified School District**	**Unknown**	**8**	**3 sessions; 2 hours each**	**Mental Health, Trauma Informed Care, Native American Mental Health**
3	**2**	**2**	**3**	**Latino youth Promotores ages 17-25 from Riverside County**	**Spanish**	**12**	**16 sessions; 1 hour each**	**Stress and Anxiety Reduction**
1	**1**	**1**	**2, 3, 6**	**Clinical and case manager staff from a community-based mental health provider in Bayview**	**Spanish Vietnamese**	**20**	**2 sessions; 8 hours each**	**Complex Trauma in Communities of Color- What Works?**

Population **1=**Mental/ Behavioral Health Workers **2=**First Responders **3=**Community Participants ***SEE ABOVE for Full Definitions***	**Sector** **1=**Existing Workforce **2=**Future Workforce ***SEE ABOVE for Full Definitions***	**Strategy** 1="On-the-Job" Training/ Ed & TA 2="Pipeline" Extensive Training ***SEE ABOVE for Full Definitions***	**Priority Population of Workers Engaged** 1= AA 2=API 3=Latino 4=LGBTQ 5=NA 6=Other 7=Unknown	**Background Information of Workers Engaged** (demographics, name/type of organization, etc.)	**Multilingual Capacity of Workers**	**# Workers Served Unduplicated**	**# Sessions/ # of Hours Per Session**	**Topic Areas** (including Cultural, Linguistic, & LGBTQ specific content)

18. Please describe any notable successes or outcomes experienced from November 2020-April 2021 with your workforce development program in general, or with strengthening/improving the cultural, linguistic, and LGBTQ competence of the workforce you engaged with during this reporting period.

Click here to enter text.

19. If not already mentioned in the CDEP section earlier, please describe any notable challenges or obstacles experienced from November 2020-April 2021 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.

This section also applies to CDEPs who don't typically provide DIRECT referrals and/or linkages and/or navigation, but did from November 2020-April 2021 in response to COVID- 19, the racial uprising, and/or the wildfires.

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 only one option.

☐ We don't typically provide DIRECT referrals and/or linkages and/or navigation, but did during this reporting period in response to COVID-19, the racial uprising, and/or the wildfires. **(GO To Q#21)**

☐ We provide DIRECT referrals and/or linkages and/or navigation and CAN report this data in SAR 7. **(GO To Q#21)**

☐ We provide DIRECT referrals and/or linkages and/or navigation but did **NOT** work on this during this reporting period. **(GO To Q#24)**

☐ We provide DIRECT referrals and/or linkages and/or navigation, but we don't have a tracking system in place and are unable to report this data in SAR 7. **(GO To Q#24)**

☐ Our CDEP does not do this work. **(GO To Cultural-, Linguistic-, LGBTQ-, & Other Community-Affirming Approaches section)**

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 Individuals Who Received Referrals Only (no linkages or navigation provided)	*If applicable,* # of Individuals Who Received Referrals + Linkages Only (no navigation provided)	*If applicable,* # of Individuals Who Received Referrals + Linkages + Navigation	*Optional:* # of Individuals who Accessed the Service Referral

Adolescents (12-17): ☐ Yes ☐ Non-applicable				
Subpopulation Demographics *(briefly describe)*	# of Individuals Who Received Referrals Only (no linkages or navigation provided)	*If applicable,* # of Individuals Who Received Referrals + Linkages Only (no navigation provided)	*If applicable,* # of Individuals Who Received Referrals + Linkages + Navigation	*Optional:* # of Individuals who Accessed the Service Referral

Adults (18+): ☐ Yes ☐ Non-applicable				
Subpopulation Demographics *(briefly describe)*	# of Individuals Who Received Referrals Only (no linkages or navigation provided)	*If applicable,* # of Individuals Who Received Referrals + Linkages Only (no navigation provided)	*If applicable,* # of Individuals Who Received Referrals + Linkages + Navigation	*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	
Mental Health Services (e.g., counseling, therapy)	

Substance Abuse (e.g., alcohol/drug treatment)	
Sexual Assault	
Domestic Violence	
Psychiatric Care	
Other Mental Health Click here to enter text.	
Health	
Primary Health Care (e.g., well-check, vaccines, etc.)	
Specialty Health Care (HIV/AIDS, dialysis)	
Dental/Optometry/Prescription	
Nutrition	
Other Health Click here to enter text.	
Basic Needs	
Clothing and Furniture Assistance	
Financial Assistance	
Food Assistance (e.g., food bank)	
Housing and Rent Assistance	
Transportation	
Other Basic Needs Click here to enter text.	
Personal Growth & Development	
Faith-Based or Spiritual Services	
Social/Cultural Enrichment Programs	
Volunteer Services	
Other Personal Growth & Development Click here to enter text.	
Education	
Academic Support (e.g., college applications, school placement assistance)	
Tutoring	
Other Education Click here to enter text.	
Legal/Advocacy	
Immigration Services	
Other Legal/Advocacy Click here to enter text.	
Parenting & Child Care (including early child care supports)	
Special Needs, Disability and Personal Care Services	
Employment (e.g., job training, job skills)	

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 from November 2020-April 2021. Click here to enter text.

Cultural-, Linguistic-, LGBTQ-, & Other Community- Affirming Approaches

In order to demonstrate how CRDP Phase 2 uniquely contributed to reducing disparities for unserved, underserved, and inappropriately served populations, the SWE will continue to document the type of cultural, linguistic, LGBTQ, and other community affirming approaches IPPs have used in their Phase 2 efforts.

Based on our quality review of previous SARs, as well as important feedback received from IPPs and the TAPs about the challenges with reporting cultural, linguistical, and LGBTQ approaches in your CRDP Phase 2 efforts, PARC has done the following:

- **Seven questions were REMOVED** that specifically asked about cultural, linguistic, and LGBTQ approaches. These questions were originally scattered throughout SAR 1-4, but are now located in this one section of SAR. *Two questions still remain in the Workforce Development section.*
- ***Developed specific CATEGORIES & SUB-CATEGORIES*** for you to select from to help make it easier to provide descriptive information related to culture, language, LGBTQ, and other community affirming approaches used by your CDEP. It is broken down into three areas:
    - Practices and Traditions: Arts (music, dance, visual arts, oral storytelling), Food, Dress/Regalia, Celebrations/remembrances (can include marking important historical events), Faith-based/Spiritual, Places and Spaces (can include non-traditional/cultural specific sites), and Language (can include terminology, use of pronouns, cultural slang, sayings, proverbs, idioms)
    - Education and History: Sharing specific knowledge and history related to Ethno-Cultural, LGBTQ, and Social Movement
    - Underlying Principles, Values, or Beliefs: Social justice, Intersectional Lens, Collectivism/Communalism, Spiritual, Age-Centric Focus (e.g., youth, elders), Cross-Generational (across the ages), Community Based Participatory Approaches (CBPR)
- Asking you respond to this section separately for Outreach/Recruitment Efforts vs. CDEP Implementation Activities vs. Local Evaluation Activities (see below for definitions).
    - **Outreach/Recruitment:** (i.e., reaching out to your community in spaces and places—e.g., homes, public parks, schools, etc.—where they are located). It can include raising awareness of key mental health issues or existing services, as well as used to enroll or identify community members to formally participate in your CDEP programming/services efforts.
    - **CDEP Implementation Activities** – Delivering key programming and services to community participants who are formally involved in your CDEP. It can include case management; support groups; individual counseling; talking circles; school-based or after-school programs; referrals, linkages, and navigation; and other non- outreach/recruitment activities.
    - **Local Evaluation Activities** – Data collection strategies used or involving your community members with making course-corrections to your evaluation design or instruments, including interpretation and dissemination of findings.

A. Thinking about your work from November 2020-April 2021, please share *anywhere from 1 to 5 EXAMPLES* of the type of cultural, linguistic, LGBTQ, or other community affirming approaches that were used in your **OUTREACH/RECRUITMENT EFFORTS** for CRDP Phase 2. If you would like to provide more than 5 examples, please add additional rows as needed.

	CODES		**DESCRIPTION**
	Practices/Traditions/Ed/History (for each example listed, type in all codes that apply from **#1a-k)**	**Core Principles/Values/Beliefs** (for each example listed, type in all codes that apply from **#2a-k)**	(please provide a detailed description including an explanation of the core principle, value, or belief that is underlying the example)
EXAMPLE	1c, 1d, 1f	2a, 2d, 2e, 2f	We intentionally conducted outreach during large cultural events happening in the community to highlight the cultural features of our CDEP, and to reinforce the message that mental health is an important component of our overall community wellness. For example, we set up a booth at a South Asian cultural festival in September, and our staff members wore traditional attire to help draw people over. This strategy was particularly important because mental health stigma is high in our community, and we realized that people may not come to booth that explicitly advertises mental health services. As people came over, we shared information about our CDEP, and how our program draws on culturally-based values and practices (e.g., deference to and honoring of elders for their wisdom; love and respect for parents and guardians; the importance of doing good deeds, etc.) to deliver services. Our outreach staff consists of individuals who are also a part of the South Asian community, so they were able to talk about these values in a way that was relatable and meaningful. We started and ended the outreach event with a prayer of blessings over the community.
1.			
2.			
3.			
4.			
5.			

----------**CODES**----------

1. Practices & Traditions/Education & History:
- a. Arts (music, dance, visual arts, oral storytelling)
- b. Food
- c. Dress/Regalia
- d. Celebrations/remembrances (can include marking important historical events, festivals, etc.)
- e. Faith-based/Spiritual (e.g., prayers, altars, hymns, etc.)
- f. Places and Spaces (can include non-traditional/cultural specific sites)
- g. Language (can include terminology, use of pronouns, cultural slang, sayings, proverbs, idioms)
- h. Sharing "Ethno-Cultural" knowledge and history
- i. Sharing "LGBTQ community" knowledge and history
- j. Sharing "Social Movement" knowledge and history
- k. Other activities/exercises (please specify Click here to enter text.)

2. Guiding Core Principles, Values, or Beliefs:
- a. Ethnic-Cultural
- b. Social Justice
- c. Intersectional Lens
- d. Collectivism/Communalism (can include familism)
- e. Relational
- f. Religious/Spiritual
- g. Age-Centric Focus (e.g., youth, elders)
- h. Cross-Generational (across the ages)
- i. Community Based Participatory Approaches (CBPR)
- j. LGBTQ Inclusion
- k. Other principles, values, or beliefs (please specify: Click here to enter text.)

B. Thinking about your work from November 2020-April 2021, please share *anywhere from 1 to 5 EXAMPLES* of the type of cultural, linguistic, LGBTQ, or other community affirming approaches that were used in your **CDEP IMPLEMENTATION ACTIVITIES** for CRDP Phase 2. If you would like to provide more than 5 examples, please add additional rows as needed.

	CODES		**DESCRIPTION**
	Practices/Traditions/Ed/History (for each example listed, type in all codes that apply from **#1a-k)**	**Core Principles/Values/Beliefs** (for each example listed, type in all codes that apply from **#2a-k)**	(please provide a detailed description including an explanation of the core principle, value, or belief that is underlying the example)
EXAMPLE	1h, 1j	2a, 2b, 2g	For our last cohort of youth participants who enrolled in May, we purposefully framed the lack of mental health access within our communities as a social justice issue. We taught them about the healing practices traditionally used by our ancestors, and helped them understand that ultimate healing comes in the form of action and liberation from oppressive systems. Many of the youth we work live at the margins because of their involvement with foster care and the juvenile justice system, and they don't think they have the power to change their conditions. So not only were we teaching youth specific healing practices they could use to deal with their own trauma, we were also linking mental health access to the larger fight for social justice. This helped them to stay motivated and engaged in the program, as they began to dream and imagine new possibilities for their futures and their communities.
1.			
2.			
3.			
4.			
5.			

----------**CODES**----------

1. Practices & Traditions/Education & History:

a. Arts (music, dance, visual arts, oral storytelling)
b. Food
c. Dress/Regalia
d. Celebrations/remembrances (can include marking important historical events, festivals, etc.)
e. Faith-based/Spiritual (e.g., prayers, altars, hymns, etc.)
f. Places and Spaces (can include non-traditional/cultural specific sites)
g. Language (can include terminology, use of pronouns, cultural slang, sayings, proverbs, idioms)
h. Sharing "Ethno-Cultural" knowledge and history
i. Sharing "LGBTQ community" knowledge and history
j. Sharing "Social Movement" knowledge and history
k. Other activities/exercises (please specify Click here to enter text.)

2. Guiding Core Principles, Values, or Beliefs:

a. Ethnic-Cultural
b. Social Justice
c. Intersectional Lens
d. Collectivism/Communalism (can include familism)
e. Relational
f. Religious/Spiritual
g. Age-Centric Focus (e.g., youth, elders)
h. Cross-Generational (across the ages)
i. Community Based Participatory Approaches (CBPR)
j. LGBTQ Inclusion
k. Other principles, values, or beliefs (please specify: Click here to enter text.)

C. Thinking about your work from November 2020-April 2021, please share *anywhere from 1 to 5 EXAMPLES* of the type of cultural, linguistic, LGBTQ, or other community affirming approaches that were used in your **CDEP LOCAL EVALUATION ACTIVITIES** for CRDP Phase 2. If you would like to provide more than 5 examples, please add additional rows as needed.

	CODES		**DESCRIPTION**
	Practices/Traditions/Ed/History (for each example listed, type in all codes that apply from **#1a-k)**	**Core Principles/Values/Beliefs** (for each example listed, type in all codes that apply from **#2a-k)**	(please provide a detailed description including an explanation of the core principle, value, or belief that is underlying the example)
EXAMPLE	1b, 1h, 1i	2a, 2b, 2c, 2d, 2j	During this last reporting period, we invited some of our program alumni to help with data collection for our new cohort of participants. We hosted a series of data collection trainings for these volunteers, and intentionally grounded our training activities in the larger history of research within LGBTQ communities. For example, we spent time discussing how data has been misused in ways that further perpetuate systemic oppression against our people. This helps set a foundation for everyone to understand the importance of collecting data that truly represents our histories and experiences, and ultimately, how it can be used as a form of resistance against misinformed narratives about LGBTQ communities. We also made a point of serving food at our trainings. Our program alumni are a racially diverse group, but the idea of breaking bread together is one cultural thread that unites everyone in the room. Different people took turns preparing food for the group, and they shared the reason why they chose that particular dish, including any personal, familial, and/or cultural meanings attached to it. We then ate together before starting the formal training activities.
1.			
2.			
3.			
4.			
5.			

----------CODES----------

1. Practices & Traditions/Education & History:

a. Arts (music, dance, visual arts, oral storytelling)
b. Food
c. Dress/Regalia
d. Celebrations/remembrances (can include marking important historical events, festivals, etc.)
e. Faith-based/Spiritual (e.g., prayers, altars, hymns, etc.)
f. Places and Spaces (can include non-traditional/cultural specific sites)
g. Language (can include terminology, use of pronouns, cultural slang, sayings, proverbs, idioms)
h. Sharing "Ethno-Cultural" knowledge and history
i. Sharing "LGBTQ community" knowledge and history
j. Sharing "Social Movement" knowledge and history
k. Other activities/exercises (please specify Click here to enter text.)

2. Guiding Core Principles, Values, or Beliefs:

a. Ethnic-Cultural
b. Social Justice
c. Intersectional Lens
d. Collectivism/Communalism (can include familism)
e. Relational
f. Religious/Spiritual
g. Age-Centric Focus (e.g., youth, elders)
h. Cross-Generational (across the ages)
i. Community Based Participatory Approaches (CBPR)
j. LGBTQ Inclusion
k. Other principles, values, or beliefs (please specify: Click here to enter text.)

Organizational Capacity (including Cultural/Linguistic Competency)

Did your organization obtain additional non-CRDP funding to expand and support continued sustainability of your CDEP?

☐ No
☐ No, but we are working on it
☐ Yes

Which type of funding did you receive? (Select all that apply)
☐ Public→ (please indicate which type) ☐ City ☐ County ☐ State ☐ Federal

→ Did this include MHSA PEI funding? ☐ Yes ☐ No

☐ Private→ (please indicate which type) ☐ Foundation(s) ☐ Private donor(s)

Will any of the new funding you received help sustain your CDEP beyond the end of your CRDP Phase 2 grant (April 2022)? ☐ Yes ☐ No

25. In this section you will continue to report on the **organizational capacity elements** identified by your organization (in collaboration with your TAP) at the beginning of your grant. **Please Select only ONE level of change per element.**

Prepopulated only if an IPP reported previously that a capacity element was resolved.

Element X was resolved in the previous reporting period.

a. Is this element still resolved?
   ☐ Yes (Please move on to the next element.)
   ☐ No **(GO to b.)**
b. If no, do you need additional TA support in this area?
   ☐ Yes **(GO to c.)**
   ☐ No (Please move on to the next element)
c. Describe what type of support is needed and from whom.
   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 only if an IPP reported previously that a capacity element was no longer a priority:

Pre-populated Element X was reported as no longer a priority in the previous reporting period.

a. Is this element still no longer a priority?
   ☐ Yes (Please move on to the next element.)
   ☐ No **(GO to b.)**
b. If no, do you need additional TA support in this area?
   ☐ Yes **(GO to c.)**
   ☐ No (Please move on to the next element)
c. Describe what type of support is needed and from whom.
   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 element

☐ This element is no longer a priority

We understand that IPPs may experience problems or natural delays with making progress towards completing their capacity-building objectives due to internal reasons (e.g., hiring staff; technology issues, staff turnover, etc.) and external reasons (e.g., natural disasters, community crises, political events, competing demands of participants, etc.) that may require a shift in your organizational priorities. If the element above is no longer a priority for your IPP please use this space to briefly explain why:
Click here to enter text.

☐ 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. Did any CRDP Phase 2 supports or resources contribute to this change (e.g., your TAP connected you to a consultant with particular expertise; your contract manager worked with you to problem-solve a grant-related issue, etc.)?
      ☐ No
      ☐ Yes, please describe: Click here to enter text.
   c. ☐ The element is now resolved
☐ Large/significant change
   a. What type of change occurred? Click here to enter text.

   b. Did any CRDP Phase 2 supports or resources contribute to this change (e.g., your TAP connected you to a consultant with particular expertise; your contract manager worked with you to problem-solve a grant-related issue, etc.)?
      ☐ No
      ☐ Yes, please describe: Click here to enter text.
   c. ☐ The element is now resolved

Is there a new or different area of organizational capacity that you worked on during this reporting period?
☐ No

☐ Yes → If Yes, indicate what that new area is below and any type of change that occurred as a result of Phase 2 capacity-building supports and resources (i.e., TAP technical assistance, support from OHE/CDPH, consultation with PARC@LMU).

New organizational capacity area: Click here to enter text.

☐ 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. Did any CRDP Phase 2 supports or resources contribute to this change (e.g., your TAP connected you to a consultant with particular expertise; your contract manager worked with you to problem-solve a grant-related issue, etc.)?

☐ No

☐ Yes, please describe: Click here to enter text.

c. ☐ The element is now resolved

☐ Large/significant change

a. What type of change occurred? Click here to enter text.

b. Did any CRDP Phase 2 supports or resources contribute to this change (e.g., your TAP connected you to a consultant with particular expertise; your contract manager worked with you to problem-solve a grant-related issue, etc.)?

☐ No

☐ Yes, please describe: Click here to enter text.

c. ☐ The element is now resolved

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 element**

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)** Click here to enter text, if applicable

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. 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. During November 2020-April 2021, 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. During November 2020-April 2021, 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.

CDEP Participants Served by Direct Programs or Supports

In this section you will be reporting information on the number of individuals who are receiving or have received services from the ***DIRECT*** programs or supports of the CDEPs from November 2020-April 2021 (See below for definitions of direct program or supports). In this report, please indicate the unduplicated counts of NEW PARTICIPANTS served by your CDEP from 11/1/2020 to 4/30/2021. In other words, report the number of participants who became involved on or after 11/1/2020 and up to 4/30/2021. **Do NOT include any participants who were served before 11/1/20, even if they continued to receive services during this SAR reporting time period.**

- **What are direct programs or supports?** Individuals (and sometimes their family) enroll in a voluntary program that provides a broad range of services, treatment, or supports that are provided to improve their mental health or increase their resiliency by:
  - Reducing risk factors and stressors that contribute to the development of mental health issues, while also building and strengthening protective factors (*otherwise known as prevention*).

    ☑ Programs or supports can include **counseling, therapy, support groups, case management, and other culturally specific approaches.**
  - Engaging individuals experiencing early onset of mental health symptoms to assist in reducing those symptoms before they progress (*otherwise known as early intervention*).

    ☑ A wide range of treatments and supports can include **screenings, assessments, individual and family counseling or therapies, and other culturally specific approaches.**

- **What are NOT direct programs or supports?**
  - ☒ Activities that increase access to timely and appropriate mental health services and other supports via referrals, linkages, and/or navigation. *(These are reported in the DIRECT REFERRALS section of the SAR)*
  - ☒ Activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families. This includes community outreach, recruitment, or engagement through a variety of activities (e.g., cultural or community events/celebrations, wellness fairs, other social/recreational activities, talking circles/*platicas*) *(These are reported in the Outreach/Recruitment and Community Engagement section of the SAR)*
  - ☒ Workforce development programs or activities which is defined as any training, education, and/or technical assistance to strengthen and/or develop the skills, knowledge base, and capacity of individuals, agencies, organizations, and institutions. *(These are reported in the Workforce Development section of the SAR)*

What is an unduplicated count? This is a participant who is counted *only* *ONE TIME*, no matter how many services or supports the participant receives from your CDEP. A participant who receives services or supports throughout the reporting period should be counted and reported no more than one time.

Example #1: S.J. participated in 1) College Prep Classes and 2) Resilience Workshops, and 3) Life Skills Workshop. S.J. is counted as 1 participant served. **This is the unduplicated count, regardless of how many total program components or activities they participated in.** In an effort to decrease the burden on IPPs to report these counts we do NOT need you to report the frequency or type of services each participant received (e.g., S.J. participated in 4 group mentoring activities, 10 weekly peer counseling sessions, and 4 workshops)

Working in collaboration with your CDPH-OHE Contract Manager (and based on a review of your CDEP local evaluation plan and SAR 1 – 7), we have identified the following direct programs or supports for your CDEP:

[Note age group]: *Participants in "A" may also be involved in "B" and/or "C" programs or activities.*

A. [Inserted IPP Component]
B. [Inserted IPP Component]
C. [Inserted IPP Component]

[If applicable: Families]. (these participants do not participate in "A" through "C" programs or activities)

D. [Inserted IPP Component]

Is this understanding correct?

☐ Yes
☐ No. ***If no, please clarify here*** → *Click here to enter text.*

The first table below reflects an unduplicated count of participants involved in your CDEP's Direct Services through the last reporting period (through SAR 6). Please use the **second** table below to report the following:

- **In section 1**, write in the unduplicated count of participants served summed across the above CDEP direct programs components or activities for the following time period: 11/1/2020 to 4/30/2021. *If you are only able to provide an estimate of the total unduplicated served, please check the "estimate" box.*
- **In section 2 (optional)**, please provide a count or estimate of total unduplicated served by "*age group"* in the appropriate column(s). *If you are only able to provide an estimate of the unduplicated served by age group, please check the "estimate" box.*

The table below includes the unduplicated count of participants involved in your CDEP direct services from 3/23/17 (start of the grant) through 10/31/20, as reported in SAR #7:

CDEP Direct Program Components		A. **[Inserted IPP Direct Service Components]**
		Section 1
		(prepopulated based on previous SARs): #_____☐ *Check here if this number is an estimate*
		Section 2 – Optional

SAR 1-7	**3/23/17—10/31/20**	Older Adults (60+ years)	Adults (25-59 yrs)	TAY (18-24 yrs)	Adolescents (12-17 yrs)	Children (5-11)
		#_____ ☐ *Check here if this number is an estimate*	#_____ ☐ *Check here if this number is an estimate*	# _____ ☐ *Check here if this number is an estimate*	#_____ ☐ *Check here if this number is an estimate*	#_____ ☐ *Check here if this number is an estimate*

Please provide unduplicated data counts for the SAR #8 reporting period in the table below. **Do NOT include any participants who were served before 11/1/20, even if they continued to receive services during this SAR reporting period.**

CDEP Direct Program Components		A. **[Inserted # of IPP Direct Service Components]**				
SAR 8	**11/1/20-4/30/21**	***Section 1***				
		How many NEW unduplicated participants have you served in "A" through "X" (i.e., individuals that participated at least one time in at least one component, and weren't involved prior to this reporting period)? #_____☐ *Check here if this number is an estimate*				
		Section 2 – Optional				
		Older Adults (60+ years)	Adults (25-59 yrs)	TAY (18-24 yrs)	Adolescents (12-17 yrs)	Children (5-11)
		#_____ ☐ *Check here if this number is an estimate*	#_____ ☐ *Check here if this number is an estimate*	# _____ ☐ *Check here if this number is an estimate*	#_____ ☐ *Check here if this number is an estimate*	#_____ ☐ *Check here if this number is an estimate*

Did you provide any direct service components in a non-English language during this reporting period?

☐ No

☐ Yes→ Please indicate which language(s): *Click here to enter text.*

Did you provide oral interpretation or written translation for your direct service components during this reporting period?

☐ *We did not provide oral interpretation or written translation.* **(STOP here)**

☐ Yes

→ Please indicate which language(s): *Click here to enter text.*

Check the type of language access services that were provided: (Check all that apply)
☐ Written translation ☐ Oral interpretation

If oral interpretation services were provided, who provided the interpretation? (Check all that apply)
☐ Bilingual staff
☐ Staff interpreters
☐ Contract interpreters
☐ Telephone interpreter lines
☐ Community volunteers
☐ Family members or friends
☐ Other: *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:

[Hyperlink]

*****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 November 2020-April 2021, 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 2022?

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:

[Hyperlink]

Appendix E

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. The following table provides an overview of IPP semi-annual reporting periods, and dates when semi-annual reports will be submitted to PARC@LMU.

SWE Semi-Annual Reporting Schedule

Semi-Annual Reporting Periods	Semi-Annual Submission to the SWE
#1: 5/1/2017 – 10/31/2017	#1: 5/14/2018
#2: 11/1/2017 – 4/30/2018	#2: 6/1/2018
#3: 5/1/2018 – 10/31/2018	#3: 12/1/2018
#4: 11/1/2018 – 4/30/2019	#4: 6/1/2019
#5: 5/1/2019 – 10/31/2019	#5: 12/1/2019
#6: 11/1/2019 – 4/30/2020	#6: 6/1/2020
#7: 5/1/2020 – 10/31/2020	#7: 12/1/2020
#8 11/1/2020 – 4/30/2021	#8: 6/1/2021

Appendix F

Statewide Evaluation Semi-Annual Report (IPPs)
Special Report

IPP Name: Insert IPP name

We recognize COVID-19 has upended your CDEP activities and priorities in 2020. We have also been inspired by how quickly the IPPs adapted to this current and chaotic time. We know it has been stressful working remotely, while simultaneously juggling the needs of your family, staff and community. The purpose of this special report is to systematically document the important work of all 35 IPPs to meet the critical needs of your communities to help them stay safe, secure, and healthy in their own homes during this crisis. This information will be used by the SWE to both contextually ground the SWE findings (e.g., CDEP Participant Pre- and Post-Questionnaire) and uplift the vital role the IPPs and their CDEPs have played.

Do you grant permission for OHE to access this special report on the impact of the crises (COVID-19, CA Wildfires, racial uprisings) on your CDEP and IPP?
☐ Yes ☐ No

- **As you complete this section of the SAR, please keep in mind that there is space for you to reflect on how COVID-19, the racial uprising, and/or the wildfires have uniquely affected your staff, CDEP implementation, and needs of the communities you serve. There is also space for you to report on these events in relevant sections of the regular section of the SAR.**
- **It may be helpful to involve multiple stakeholders (e.g., staff members, local evaluator, Board members, community advisory committee members, etc.) to help document this critical part of your CDEP story. There are specific sections of this special report where the local evaluators may have valuable insights to share.**

The timeline below, with key time points inserted, can serve as a reference point as you reflect on your work.

Mar 2020	**Apr 2020**	**May 2020**	**Jun 2020**	**Jul 2020**	**Aug 2020**	**Sep 2020**	**Oct 2020**
COVID Crisis and Adjustment Period	*Deepening of the Stay at Home Orders*	*Truncated CA Reopening* *Continued COVID Crisis and Adjustment* --- *George Floyd murder/BLM Protests begin*		*Wildfire season begins* *Continued BLM protests*			
Community Impact							

COVID-19

- The pandemic is a great threat to our 35 CRDP communities. We know it has disproportionately impacted Black, Indigenous and People of Color (BIPOC) and the LGBTQ community—e.g., higher numbers of infection, hospitalizations, and deaths; lower access to health care and COVID-19 testing, higher numbers of essential workers, to name a few.
- Each of the 35 CRDP communities are uniquely challenged and impacted by COVID-19 due to varying economic and health care situations, historical and current experiences of racism/oppression, cultural mistrust, language barriers, miscommunication and misinformation on the spread of COVID-19 and related public health directives, chronic illness bred by limited food and living choices, varied lived experiences, etc.
- It's important to understand how the pandemic and stay at home orders have impacted the *physical, emotional, psychological, and spiritual wellbeing* of your CDEP community members, and document any *unique challenges faced by your community*.

Approximately, what percentage of your CDEP participants are deemed to be part of the essential workforce per the state of California's designated list (e.g., health care providers/caregivers, food manufacturing/distribution, emergency services, retail, manufacturing, construction, sanitation workers, etc.)?

☐ A few (25% or less)
☐ Somewhat less than half (more than 25% but less than 50%)
☐ About half (50%)
☐ Somewhat more than half (more than 50% but less than 75%)
☐ Most (over 75%)

Based on staff observations/interactions with CDEP participants, or on evaluation or anecdotal evidence, has the COVID-19 pandemic increased CDEP participants' out-of-pocket healthcare spending (i.e., healthcare office visits, in patient hospitalizations, prescription medications, and/or mental health care visits)?

☐ Not that we know of
☐ Yes. Please describe. (Click here to enter text.)

How has the COVID-19 pandemic impacted the physical, emotional, psychological, and spiritual wellbeing of your CDEP participants, including any unique challenges faced by your community?
(Click here to enter text.)

Pre-populated item only for those IPPs administering the SWE CDEP Participant Questionnaire—remove this item after pre-populating, then change the text below back to black:
What kinds of things (caveats, cautions, possible explanations etc.) might we want to take into consideration when looking at the findings from your pre and post CDEP Participant Questionnaire? *Your local evaluators may have valuable insights to share for this question.*
(Click here to enter text.)

What types of resiliency and strengths have you observed among your community members as it relates to COVID-19?
(Click here to enter text.)

Community Response and Recovery Efforts. We know IPPs are working tirelessly to protect, support and lead your communities through the developing COVID-19 pandemic. The convergence of COVID-19 pandemic and the California wildfires put an additional burden on some of our IPPs and the communities they serve (e.g., homes destroyed, thousands of evacuations, toxic air quality, more deaths, increased risk of COVID-19 transmission, etc.).

Please check all of the Community Response and Recovery Efforts your IPP has engaged in from **March 2020 through October 2020** and indicate whether these efforts were in response to COVID-19 and/or the California wildfires. *If your IPP did not provide response or recovery efforts for the CA Wildfire please select N/A, and only complete the COVID-19 response and recovery effort section.*

COVID 19 Response and Recovery Efforts (March – October 2020) *Please be as specific as possible when describing your efforts in each area.*	**CA Wildfire Response and Recovery Efforts (July - October 2020)** *Please be as specific as possible when describing your efforts in each area.* ☐ Not applicable to our CDEP community
☐ Food and water distribution (specify: Click here to enter text.)	☐ Food and water distribution (specify: Click here to enter text.)
☐ Clothing/household goods (specify: Click here to enter text.)	☐ Clothing/household goods (specify: Click here to enter text.)
☐ Technology equipment (e.g., cell phones, computers, tablets) (specify: Click here to enter text.)	☐ Technology equipment (e.g., cell phones, computers, tablets) (specify: Click here to enter text.)
☐ Internet connectivity (e.g., Wi-Fi) (specify: Click here to enter text.)	☐ Internet connectivity (e.g., Wi-Fi) (specify: Click here to enter text.)
☐ Personal Protective Equipment (e.g., masks, hand sanitizer, face shields) (specify: Click here to enter text.)	☐ Personal Protective Equipment (specify: Click here to enter text.)

COVID 19 Response and Recovery Efforts **(March – October 2020)** *Please be as specific as possible when describing your efforts in each area.*	**CA Wildfire Response and Recovery Efforts** **(July - October 2020)** *Please be as specific as possible when describing your efforts in each area.* ☐ Not applicable to our CDEP community
☐ ER financial resources for food and bills including rent (e.g., cash stipends, cash grants, loans, hotel vouchers, burial expenses) (specify: Click here to enter text.)	☐ ER financial resources for food and bills including rent (e.g., cash stipends, cash grants, loans, hotel vouchers, burial expenses) (specify: Click here to enter text.)
☐ English language COVID-19-related information/education (e.g., pamphlets, brochures, County websites) (specify: Click here to enter text.)	☐ English language wildfire-related information/education (e.g., pamphlets, brochures, County websites) (specify: Click here to enter text.)
☐ Non-English COVID-19-related information/education (e.g., pamphlets, brochures, County websites, etc.) (specify: Click here to enter text.)	☐ Non-English wildfire-related information/education (e.g., pamphlets, brochures, County websites, etc.) (specify: Click here to enter text.)
☐ Housing advocacy/tenant rights support (specify: Click here to enter text.)	☐ Housing advocacy/tenant rights support (specify: Click here to enter text.)
☐ Family needs assessments (specify: Click here to enter text.)	☐ Family needs assessments (specify: Click here to enter text.)
☐ Transportation access (specify: Click here to enter text.)	☐ Transportation access (specify: Click here to enter text.)
☐ Navigating CA unemployment benefits or other govt benefits (specify: Click here to enter text.)	☐ Navigating CA unemployment benefit or other govt benefits (specify: Click here to enter text.)
☐ Educational support (e.g., tutoring, education tech support) (specify: Click here to enter text.)	☐ Educational support (e.g., tutoring, education tech support) (specify: Click here to enter text.)
☐ Grief/bereavement counseling and support (specify: Click here to enter text.)	☐ Grief/bereavement counseling and support (specify: Click here to enter text.)
☐ Wellness (e.g., stress management, emotional support, social activities) (specify: Click here to enter text.)	☐ Wellness (e.g., stress management, emotional support, social activities) (specify: Click here to enter text.)
☐ Service referrals, linkages, or navigation to other community supports (specify: Click here to enter text.)	☐ Service referrals, linkages, or navigation to other community supports (specify: Click here to enter text.)
☐ Other (specify: Click here to enter text.)	☐ Other (specify: Click here to enter text.)

Based on staff observations/interactions with CDEP participants, or evaluation and/or anecdotal evidence, how has your IPP community response efforts made a difference in the lives of your CDEP participants? Please feel free to share stories or highlights of your community response and recovery efforts.
(Click here to enter text.)

Has your organization secured additional funding (e.g., additional grants, emergency funding) to support COVID-19, the racial uprisings, and/or CA wildfire response efforts? If you have, can you provide some details?

☐ No

☐ Yes. Can you please describe? (Click here to enter text.)

Black Lives Matter (BLM) Racial Uprisings.

How has the racial uprising impacted the physical, emotional, psychological, and spiritual wellbeing of your CDEP participants, including any unique challenges faced by your community?

Pre-populated item only for those IPPs administering the SWE CDEP Participant Questionnaire:
What kinds of things (caveats, cautions, possible explanations, etc.) might we want to take into consideration when looking at the findings from your pre and post CDEP Participant Questionnaire? *Your local evaluator may have valuable insights to share for this question.*
(Click here to enter text.)

How has your CDEP strategy, program activities, and/or approach been influenced or impacted by the BLM racial justice uprisings this year?
(Click here to enter text.)

Even though it's been stressful to pivot in response to the Stay-at-Home orders, we know IPPs are using innovative and creative strategies to implement their CDEPs. As you reflect on your CDEP efforts since March, what lessons/accomplishments would be important to uplift or highlight for the prevention/early intervention field, county departments of behavioral health/public health, decision-makers, private funders, etc.?
(Click here to enter text.)

How has the COVID-19 pandemic, racial uprising, and/or wildfires impacted your overall organizational capacity in the last six months?
(Click here to enter text.)

Appendix G

TA Activity & Training Chart

[INSERT TAP ORGANIZATION NAME HERE] IPP TECHNICAL ASSISTANCE AND TRAINING REPORT REPORTING PERIOD: **[INSERT REPORTING PERIOD HERE]**

TECHNICAL ASSISTANCE AND TRAINING ACTIVITIES TABLE:

IPP	Mode	Month	Date	Type	Content	Recipients LE, staff, community members	Collaborators OHE PP contract mgr, OHE SWE contract mgr, other TAP, PARC	Notes

Appendix G

TA Activity Chart
Codes

TA Mode Codes:
1. Site Visit/In-Person
2. Telephone/Video Conference Call *(month or specific date as possible)*
3. Optional: Email (month only)
4. Other: (please specify)

TA Type Codes:
1. Information and Resources (i.e., sending helpful resources/tools; raising awareness/providing updates on issues relevant to CRDP, IPPs, CDEPs, etc.)
2. Relationship Building with IPPs (i.e., establishing rapport/trust; checking in)
3. TA Planning and Review (i.e., increasing awareness/understanding of CDEP, organizational infrastructure, community context/history, IPP priorities/strengths, etc.)
4. TAP Facilitated Relationship Building with External Stakeholders
5. Consultation/Coaching (i.e., problem solving, comprehensive guidance to troubleshoot and resolve challenges or issues)
6. Formal Training (i.e., didactic trainings to build new knowledge & skills in specific areas)
7. Other: (please specify)

TA Content
1. Structured Organizational Assessment (develop/refine IPP assessment; review results/findings)
2. TA Goals/Activities/Expectations
3. CDEP
    a. Development
    b. Implementation
    c. Community outreach and engagement (please specify)
    d. Policy/Systems Change
4. Local evaluation
    a. Evaluation planning and design
    b. Evaluation implementation (i.e., data collection and analysis)
    c. Evaluation modification and revisions (once implementation has begun)

   d. CBPR - Engaging community members in the evaluation process
   e. Seeking recognition as an evidence-based practice or program
   f. Obtaining Institutional Review Board approval of research protocols
   g. Other:
5. SWE (please specify)
6. Organizational infrastructure development (please specify)
7. OHE CRDP Phase 2 (e.g., initiative-wide updates, convening, etc.)

Appendix H

Phase 2 Partner Interview & Questionnaire

LMU | LA
Psychology Applied Research Center

Loyola Marymount University

About the SWE CRDP Partners Interview Year 2 Reporting Period: May 2018 to May 2019

What is the Statewide Evaluation CRDP Partners Interview?

The CRDP Partners Interview is a qualitative approach based on a group interview with all CRDP Partners (OHE cross-site team, OHE contract managers, TAPs, EOA, SWE) that will be used each year to track and assess the effectiveness of CRDP approaches, strategies, and structures in the implementation of Phase 2 and working with IPPs. The CRDP Partners Interview process also specifically examines the approaches and strategies that are used by CRDP Partners to facilitate the work of the IPPs in refining and implementing their CDEPs, as well as to support and inform IPP efforts to demonstrate their CDEP effectiveness (that is, through local and statewide evaluation). This information will be gathered through a brief rating scale that will be sent to each CRDP Partner prior to the scheduling of the group interview, and will provide general ratings of the intensity of TA and support provided to each IPP, as well as the impact on IPPs' (a) capacity and infrastructure, (b) CDEP improvement/implementation, (c) local evaluation improvement/ implementation, (d) IPP implementation of the SWE, (e), ability to secure additional funding, (f) establishing relationships with decisionmakers, (g) advocating for mental health delivery systems/policy changes, and (h) dissemination of IPP successes/stories.

For the TAPs, OHE, the SWE, and EOA (which will not be included in the Year 2 interview given that there were no EOA activities during the reporting period in question), the CRDP Partners Interview represents a qualitative measure of progress, documenting the issues that emerged each year as well as the strategies used by CRDP partners to adapt to these circumstances as well as to adhere to their own Year 2 goals. The CRDP Partners interview fosters reflection on issues emerging in the CRDP that affect the overall effectiveness of Phase 2. "*You can't take credit for positive results if you can't show what caused them.*" (SAMHSA, 2016).

The goal is to interview all CRDP Phase 2 partners (OHE leadership, OHE CMs, PARC, TAPs) by **Aug 15, 2019.**

What is the purpose of the CRDP Partners Interview?

In addition to gathering credible evidence about how the CDEPs of participating IPPs are valid, meaningful, and effective in improving mental health and wellness within and across the 5 priority populations (the first big area of evaluation responsibility for the Initiative), CRDP Phase 2 must also describe the implementation strategies and approaches used by the Initiative to support the work of the IPPs and how partners (TAPs, SWE, EOA, CDPH-OHE) collaborated with each other and with IPPs over the life of the Initiative. It is critical to note that this does NOT represent a "report card" for each partner, but rather:

1. A way to understand the broader story of **what** the Initiative did to support the IPPs,
2. H***ow*** and **by whom** this support was delivered, and
3. To describe how the strategies and approaches used by the TAPs, the SWE, EOA, and even OHE itself, evolved over time.

For all the partners in the Initiative, then, *the CRDP Partners Interview helps address the questions about how the Initiative was implemented, that is the overarching story of the infrastructure and support for the work of the Initiative—*

what strategies worked and didn't work? What were the initial plans for support vs. what actually happened for support activities over time? And, what internal and external challenges emerged and how they were addressed by partners?

The focus will be describing how the work of Initiative partners reflected both ***fidelity*** to their original strategies and approaches proposed for working with the IPPs, as well as ***flexibility*** in making the necessary adjustments to these original strategies and approaches in response to changing circumstances, needs, and issues under consideration. Note that while the work of CRDP Partners with respect to the dualities of both fidelity and flexibility will be examined, **the purpose of the CRDP Partners Interview is to be descriptively accurate regarding these issues, not to make summative judgments about them.** That is, in trying to tell the sorry of the Initiative, it is important to capture both *what was initially intended*, and then *what was actually done* (including by **whom, how**, and **why**) to facilitate the work of the IPPs.

How can the CRDP Partners Interview be of assistance to your organization?

The CRDP Partners Interview is implemented as a group interview with a member of the SWE team. This means that members of your team will sit down together and reflect on the past reporting period. In creating this format, the hope is that multiple perspectives and the richness of various team members' experiences are able to emerge. **It is NOT about providing the right answers or giving a single narrative or response**. So, the group interview is meant to be a broader reflection about the team's approach and experiences with IPPs [and/or other CRDP partners] on a yearly basis, which means it represents a valuable opportunity for each CRDP Partner team to pause and listen to each other voice observations, experiences, questions regarding their particular role and work with the IPPs and other CRDP partners. In doing so, these regular times for reflection can serve as a way for each CRDP Partner team to gain perspective, affirm positive movement, and identify areas for further attention.

How will the information reported by CRDP Partners be used by PARC?

The information from the CRDP Partners interviews will be recorded and transcribed by PARC to prepare for qualitative analysis of themes and issues which will eventually become part of the final evaluation report which is to be submitted to CDPH at the end of the Initiative.

PARC will summarize key themes that emerge from the CRDP Partners Interview and include as part of the SWE final report and possible the final convening. Note that the information for the CRDP Partners Interview is **NOT** for comparisons across CRDP Partners and is not used for performance appraisal purposes. No single CRDP Partner (or IPP as a result of any work with them) will be "called out" in any way that calls attention to their performance, either positively or negatively. The intent is to describe what happened in each reporting period from the perspective of each CRDP Partner, in order to continue to learn, grow and improve the overall functioning of this statewide effort. As part of this shared story, the focus is on describing what has happened, what we are doing, how we are doing it, and what the impact of our efforts seems to be. *In addition, all data related to CRDP partners gathered through the CRDP Partners Interview will be shared with partners prior to the convening (indeed, each year), so that there is an opportunity to provide corrections and to give feedback before the information is shared more broadly.*

Will CRDP Partners get a copy of their CRDP Interview?

CRDP Partners may request a transcript of their group reflection for use in their own process and it will be provided by PARC when completed. A summary of the group interview will be available within a week or two of the interview and will be sent to each CRDP Partner for review and corrections of fact before analysis proceeds.

Please contact:
PARC@LMU Email:
diane.terry@lmu.edu
Phone: 310.338.7095

Appendix H

Statewide Evaluation CRDP Partners EOA Interview Protocol

CRDP Partner Name:_____**Interview Date**: _____

CRDP Partner Staff/Consultant(s) and Title/Role Present During Interview:

CRDP Partner Name	Title/Role(s)

Changes in Staff/Consultants: If there have been any changes with your staff and/or consultants during the past year, please briefly explain the reason for the change.

Review of CRDP Partner interview purpose (as needed).

1. What was your overall philosophy, approach, or communication strategies this past year (May 2018-19) in yourrole as the EOA?
    - With IPPs?
    - What other Phase 2 partners?

2. What were the major activities and support needed during in your role during this past year?
    - By IPPs?
    - By other Phase 2 partners (e.g., SWE, TAPs, CMs)?

3. How did you align your activities and support to address these needs?

4. In what ways did culture (including LGBTQ), language, and community or organizational context impact your activities and support strategies or approaches this past year? Please provide specific examples.

CRDP Partner Fidelity in Approaches/Strategies

5. To what extent did your actual activities and approach align (Fidelity) with your proposed bid and/or intended plans during May 2018 through May 2019?

    ___Very aligned ____Somewhat aligned ___Not at all aligned

    PROBES:
    - If very or somewhat aligned: In what areas was your actual work closely aligned with your proposed work?
    - Any examples of this with IPPs?

CRDP Partner Flexiblity in Approaches/Strategies

6. To what extent did you adapt (Flexibility) your proposed bid and/or intended plan(s) during May 2018 through May 2019?

   ___Very adapted ____Somewhat adapted ___Not at all adapted

   PROBES:
   - If very or somewhat adapted: In what areas did your actual work reflect an adaptation of your proposed work during the reporting period?
   - Any examples of this with IPPs?

7. For what reasons did you adapt your plans in Year 2?
   PROBES:
   - What IPP-specific factor or issue(s) affected your work most?
   - What CRDP-wide factors or issue(s) affected your work most?

CRDP Partner Perceived Impact of TA and Support on IPPs

8. What effect do you think your approach and strategy have on IPPs and the other CRDP partners from May 2018 through May 2019?

CRDP Partner Perceptions of IPP Challenges

9. What type of challenges did you encounter in Year 2 in working with IPPs and other CRDP partners? Any "lessons learned" stories that stand out?

CRDP Partner Perceptions of CRDP Phase 2

10. From your organizational role and perspective as the EOA, what has gone well or been particularly successful as you have begun your work with CRDP Phase 2?

11. What are some lessons learned about being a partner in a statewide demonstration project during your start-up period that your organization will carry with you into next year?

12. What are some lessons your organization is learning about addressing mental health disparities through a CDEP statewide approach following your initial experience this past year?

Statewide Evaluation CRDP Partners Interview Protocol
Reporting Period: May 2018 through May 2019

CRDP Partner Name:_____**Interview Date**: _____

CRDP Partner Staff/Consultant(s) and Title/Role Present During Interview:

CRDP Partner Name	Title/Role(s)

Changes in Staff/Consultants: If there have been any changes with your staff and/or consultants during the past year, please briefly explain the reason for the change.

Review of CRDP Partner interview purpose (as needed).

CRDP Partner Organizational Approach/Strategy

11. What changes, if any, were made to your overall philosophy, approach, or communicationstrategies this past year (May 2018-19) in your role as a [CM/TAP/SWE/OHE lead]?
    - What changes were made with IPPs and in response to what issues?
    - What changes were made with other Phase 2 partners and in response to what issues?

12. What were the major TA or areas of support needed during this past year?
    - By IPPs?
    - By other Phase 2 partners (e.g., SWE, TAPs, CMs)

13. How did you align your TA and support services to address these needs?

14. In what ways did culture (including LGBTQ), language, and community or organizational context impact your TA and support strategies or approaches this past year? Please provide specific examples.

CRDP Partner Fidelity in Approaches/Strategies

15. To what extent did your TA or support services and approach align (Fidelity) with your proposed bid and/or intended plans during May 2018 through May 2019?

___Very aligned ____Somewhat aligned ___Not at all aligned

PROBES:

- If very or somewhat aligned: In what areas was your actual work closely aligned withyour proposed work?
- Any examples of this with IPPs?

CRDP Partner Flexiblity in Approaches/Strategies

16. To what extent did you adapt (Flexibility) your proposed bid and/or intended plan(s) duringMay 2018 through May 2019?
___Very adapted ____Somewhat adapted ___Not at all adapted

PROBES:

- If very or somewhat adapted: In what areas did your actual work reflect an adaptation ofyour proposed work during the reporting period?
- Any examples of this with IPPs?

17. For what reasons did you adapt your plans in Year 2?
PROBES:
    - What IPP-specific factor or issue(s) affected your work most?
    - What CRDP-wide factors or issue(s) affected your work most?

CRDP Partner Perceived Impact of TA and Support on IPPs

18. What effect did your TA or support approach and strategy have on IPPs from May 2018through May 2019? In other words, please describe any successes or highlights related to:
    - Organizational capacity and infrastructure
    - Improvements to CDEP or its implementation
    - Improvements to IPP local evaluations or its implementation?
    - Improvements to IPP implementation of the SWE?
    - Other (e.g., CDEP sustainability, policy/systems

change) Please describe any IPP specific success stories that stand

out.

CRDP Partner Perceptions of IPP Challenges

19. What type of challenges did you encounter in Year 2 in providing TA and support to IPPs? Any "lessons learned" stories in working with IPPs that stand out?

CRDP Partner Perceptions of CRDP Phase 2

20. From your organizational role and perspective (i.e., as TAP, SWE, or OHE), what has gone well or been particularly successful in Year 2 with CRDP Phase 2?

21. What are some lessons learned about being a partner in a statewide demonstration project during year 2 that your organization will carry with you into Year 3?

22. What are some lessons your organization is learning about addressing mental health disparities through a CDEP statewide approach following your experiences in Year 2?

SWE CRDP Partners Interview Year 2_African American Priority Population (EXAMPLE)

Start of Block: Default Question Block

Q2
SWE CRDP Partners Brief Survey on TA and SupportAfrican American Priority Population Reporting Period: May 2018 to May 2019

The purpose of this brief survey is to assess perceptions about the intensity of TA and support delivered to IPPs during this reporting period. The survey is IPP-specific, meaning you will provide separate responses for each IPP in your priority population.
We know that many TAPs assign team members to work with different IPPs. Any team members who have this link can select the IPPs they work with and answer the associated questions.
Survey ratings will supplement information provided during your Partner Interview with PARC.

IPP_Name Please indicate which IPPs you provided technical assistance for during this reporting period.

- ☐ California Black Women's Health Project
- ☐ Healthy Heritage
- ☐ Whole Systems Learning
- ☐ Catholic Charities
- ☐ Safe Passages
- ☐ The Village Project
- ☐ West Fresno Family Resource Center

Display This Question:

If Please indicate which IPPs you provided technical assistance for during this reporting period. = California Black Women's Health Project

CBWHP_TA_Support Please rate the amount of TA or support you provided to ${IPP_Name/ChoiceDescription/1} in the following areas:

	Not at all	Minimal	Moderate	High	Extremely High
Strengthening capacity and infrastructure	○	○	○	○	○
Bolstering CDEP improvement/implementation	○	○	○	○	○
Furthering CDEP local evaluation improvement/implementation	○	○	○	○	○
Advancing IPP implementation of the SWE	○	○	○	○	○
Improving ability to secure additional funding	○	○	○	○	○
Establishing relationships with decision makers	○	○	○	○	○
Advocating for mental health delivery systems/policy changes	○	○	○	○	○
Promoting/publicizing IPP successes	○	○	○	○	○
Other Technical Assistance (please specify):	○	○	○	○	○

Display This Question:

If Please indicate which IPPs you provided technical assistance for during this reporting period. = California Black Women's Health Project

CBWHP_TA_Success What is one success/accomplishment experienced specifically with ${IPP_Name/ChoiceDescription/1} as it relates to technical assistance and support?

_____

_____

_____

_____

_____

Display This Question:

If Please indicate which IPPs you provided technical assistance for during this reporting period. = California Black Women's Health Project

CBWHP_TA_Challenge What is one challenge experienced specifically with ${IPP_Name/ChoiceDescription/1} as it relates to technical assistance and support?

_____

_____

_____

_____

_____

Thank_You
Thank you for your time and feedback!

End of Block: Default Question Block

Appendix I

Local Evaluation Plan & Rubric

CRDP PHASE 2 CDEP EVALUATION PLAN REVIEW TEMPLATE

IPP Name:
CDEP Name:

THIS SECTION TO BE COMPLETETED BY CDPH ONLY	
CDPH Contract Manager:	Date:
Recommended Evaluation Plan Status ☐ Approved ☐ Approved with recommendations for improvement ☐ Needs further development/revisions prior to approval	
Final Comments:	

THIS SECTION TO BE COMPLETETED BY SWE PRINCIPAL INVESTIGATOR ONLY	
IPP Name:	Date Evaluation Plan Submitted:
CDEP Name:	
Recommended Evaluation Plan Status ☐ Approved ☐ Approved with recommendations for improvement ☐ Needs further development/revisions prior to approval	
Overall Comments on the IPP CDEP Evaluation Plan	

----------THIS SECTION BELOW TO BE COMPLETED BY PARC@LMU RATERS---
----

Reviewed by:	Date reviewed:

Instructions: *Please have on hand the assigned CDEP Evaluation Plan. For each section in the review template, you will do the following:*

- *Check a "Yes" box ☒ OR "No" box ☒ to answer a reviewquestion*
- *Check a box ☒ to indicate if certain criteria are either present or absent*
- *In some instances, you will be required to write in information or explain your response*

At the END of each section, provide the following in the comments section:

- *Mini summary of the section being reviewed*
- *Include both strengths and recommendations ("fixes") for improvement or to strengthen the plan*

At the END of the Review Template, please address the following:

- *IRB approval*
- *Alignment between NREPP requirements and EBP status*
- *Overall comments*

1. Introduction	
Does the CDEP thoroughly and clearly describe the problem ?	☐ YES ☐ NO
Introduction clearly describes the following: ☐ Mental Health problem (incl. magnitude, causes, trends) ☐ Relevant literature or other data How problem is understood from: ☐ Historical context ☐ Community values ☐ Community practices ☐ Things that concern/bother the community	
Comments on Introduction (please include strengths and recommended modifications):	
2. Purpose	
Does the CDEP address the community problems noted in the Introduction?	☐ YES ☐ NO
Purpose clearly addresses the following elements: ☐ Type of prevention/intervention project ☐ Type of mental health issue/problem(s) being addressed ☐ Outcomes they hope to decrease ☐ Outcomes they hope to increase ☐ Phase 1 priority population strategies being addressed	
For those pursuing EBP, did they include previous evaluation results and/or cite previous published literature on their CDEP?	☐ YES ☐ NO
Comments on Purpose (please include strengths and recommended modifications):	
3. CDEP Description	
Type of MHSA Program/Strategy: *(Pre-populated by PARC prior to rater review)* Direct: ☐Prevention ☐Early Intervention Indirect: ☐Access/Linkages ☐Outreach ☐Stigma/Discrimination Reduction ☐Suicide Prevention	
Intervention Level(s) To Reduce Mental Health Disparities: *(Pre-populated by PARC prior to rater review)* ☐ Individual ☐Community ☐Systems	
Type of CDEP Cycles: *(Pre-populated by PARC prior to rater review)* ☐ Continuous ☐Multiple ☐Both ❼ *If applicable, # ofcycles:*	

Number and Name of CDEP components *(Pre-populated by PARC prior to rater review)*	
Was EACH CDEP component clearly described with sufficient detail?	☐ YES ☐ NO
Which component(s) are in NEED of revision and in what areas? *For those checked, please include the component number(s) that need revision in the areas below. Also, make sure to include a description of what the issue and/or recommended fix is the "Comments" section below.* ☐ CDEP activities (write in component(s) numbers here:) ☐ Cultural/linguistic values, beliefs, practices, and access included in description (write in component(s) numbers here:) ☐ CDEP duration, # of activities, frequency, length (write in component(s) numbers here:) ☐ Number of Participants (write in component(s) numbers here:) ☐ Demographics (write in component(s) numbers here:) ☐ Geographic/physical location (write in component(s) numbers here:) ☐ Who is implementing the CDEP and how (write in component(s) numbers here:) ☐ Timing and if applicable, the relationship of the components to each other (write in component(s) numbers here:) ☐ If applicable, community contextual considerations (write in component(s) numbers here:)	
Does the IPP sufficiently identify the "core" (indispensable) elements of their CDEP?	☐ YES ☐ NO
Comments on CDEP Description (please include strengths and recommended modifications):	
4. Evaluation Questions and Measures	
EBP Aspirations (according to IPP) *(Pre-populated by PARC prior to rater review)* ☐ YES	
Are there too many evaluation questions?	☐ YES ☐ NO
Are the evaluation questions clear?	☐ YES ☐ NO
Do the evaluation questions reflect their CDEP purpose, description, and level of intervention (individual, community, systems change)?	☐ YES ☐ NO
Do the evaluation questions include both process and outcome questions?	☐ YES ☐ NO
Are the CDEP's evaluation focus (priorities) reflected in their questions?	☐ YES ☐ NO
Do the key indicators match each evaluation question?	☐ YES ☐ NO
Do the instruments/data sources match key indicators?	☐ YES ☐ NO
Do the selected instruments/data sources include sufficient information such as: title, year, authors, sources, etc.?	☐ YES ☐ NO
Do the questions, indicators, and measures reflect cultural and linguistic factors and/or unique population-specific needs? *(This includes modifications to existing instruments or development of new instruments.)*	☐ YES ☐ NO
Will the evaluation questions contribute to the evidence base?	☐ YES ☐ NO
Do the evaluation questions contribute to program improvement?	☐ YES ☐ NO
Comments on Evaluation Questions and Measures (please include strengths and recommended modifications):	
5. Evaluation Design	
Type of Evaluation Method: *(Pre-populated by PARC prior to rater review)* ☐ Quantitative (type(s):) ☐ Qualitative (type(s):) ☐ Mixed-Methods (type(s):)	
Does the design match the evaluation questions?	☐ YES ☐ NO
Is the design feasible given the project scope?	☐ YES ☐ NO
Is the intervention group (and if applicable, control and/or comparison groups) adequately described?	☐ YES ☐ NO
Is there evidence of priority population involvement (i.e., CBPR) in the design and/or implementation?	☐ YES ☐ NO

Does the IPP adequately describe how intersectionality will be addressed in the evaluation?	☐ YES ☐ NO
Comments on Evaluation Design (including strengths and recommended modifications):	

6. Sampling Plan

Evaluation Sub-Populations *(Pre-populated by PARC prior to rater review)*
Language:
Age:
Racial/Ethnic Group:
Education Level:
Gender Identity:
Sexual Orientation:
Geography:
Homeless/Transient:
Immigrants/Refugees:
Religion:
Tribal Groups:
Non•Native English Speakers:
SES/Income:
Disabilities (cognitive or physical):
Uninsured/Underinsured:
Length of residence in the community:
Other(s):

Evaluation Sample Size *(Pre-populated by PARC prior to rater review)*

Method *(Pre-populated by PARC prior to rater review)*
☐ Random selection (random sampling) ☐Stratified sampling ☐Systematic random sampling ☐Purposive sampling
☐ Convenience sampling ☐Snowball sampling ☐Quota sampling ☐ Multi•stage random sampling ☐Other:

Power Analysis *(Pre-populated by PARC prior to rater review)*
☐ Yes (Sufficiently powered description:)

Is the sampling plan adequate for the evaluation questions?	☐ YES ☐ NO
If applicable, the sample size has enough power to detect a statistically significant outcome?	☐ YES ☐ NO
If applicable, an adequate explanation for why the intended sample size is not sufficiently powered?	☐ YES ☐ NO
Are evaluation recruitment and retention strategies, including the use of CBPR and cultural and/or linguistic strategies, adequately addressed?	☐ YES ☐ NO
Comments on Sampling Plan (please include strengths and recommended modifications):	

7. Data Collection Plan

Are the data collection time points appropriate for each instrument/data source?	☐ YES ☐ NO
Was the data collection protocol for each instrument/data source sufficiently described?	☐ YES ☐ NO
Are the data storage and security measures adequate?	☐ YES ☐ NO
Is the staff training plan adequate for each instrument/data source?	☐ YES ☐ NO
Are the SWE Core Questionnaire Items for CDEP participants incorporated appropriately into the local evaluation plan?	☐ YES ☐ NO
Comments on Data Collection Plan (strengths including recommended modifications):	

8. Informed Consent & Confidentiality	
Need for IRB Approval (according to IPP) *(Pre-populated by PARC prior to rater review)* ☐ Yes	
Are informed consent and/or assent procedures clearly and sufficiently explained?	☐ YES ☐ NO
If applicable, was the IRB submission/approval status adequately described?	☐ YES ☐ NO
Comments on Informed Consent and Confidentiality (please include strengths and recommended modifications):	

9. Data Analysis Plan	
Plan ☐ Quantitative ☐Qualitative ☐Mixed-Methods	
If applicable, the quantitative analysis plan is sufficiently described (e.g., descriptive analyses, inferential analyses)?	☐ YES ☐ NO
If applicable, the qualitative analysis plan is sufficiently described (e.g., procedures to review, organize, code, and interpret data)?	☐ YES ☐ NO
If applicable, the mixed-methods analysis plan is sufficiently described (e.g., procedures to review, organize, code, and interpret data)?	☐ YES ☐ NO
The data analysis plan is appropriate for answering the evaluation questions?	☐ YES ☐ NO
Comments on Data Analysis Plan (please include strengths and recommended modifications):	

10. Fidelity Assessment	
Fidelity Dimensions Being Examined *(Pre-populated by PARC prior to rater review)* ☐ Adherence ☐Exposure ☐Quality of Delivery ☐Participant Responsiveness ☐Program Differentiation	
Do the criteria, measurement tool, and protocol match each dimension being examined?	☐ YES ☐ NO
Overall, the fidelity assessment is adequate for measuring the extent to which the CDEP was implemented with fidelity.	☐ YES ☐ NO
Comments on Fidelity Assessment (please include strengths and recommended modifications):	

11. Dissemination Plan	
Peer Reviewed Manuscript *(Pre-populated by PARC prior to rater review)* ☐**Yes** ☐**No** ☐**Unsure**	
Is sufficient detail provided for each of the following: ☐ Audience/stakeholders ☐Utilization of the findings ☐Community engagement ☐Dissemination methods	
Is the dissemination plan accessible and relevant to priority population and key stakeholders?	☐ YES ☐ NO
Comments on Dissemination Plan (please include strengths and recommended modifications):	

12. Final Reviewer Comments
In your opinion, does this IPP need IRB approval for their CDEP evaluation? ☐ No (please explain:) ☐ Yes (please explain:)
According to NREPP requirements (see attachment), does this CDEP evaluation meet criteria for: Check one ☐ EBP (please explain:) ☐ Promising Practice (please explain:) ☐ Community Defined Evidence (please explain:)

Overall

PARC@LMU Evaluation Plan Template 2017

IPP GENERAL INFORMATION

~~CRDP Phase 2: CDEP Evaluation Plan~~

The CDEP Evaluation Plan template should be completed jointly between IPP lead staff and the local evaluator. ~~Please have on hand the following resources and information as you complete this template:~~

A hard copy of Section 11 of the Statewide Evaluation Guidelines (technical instructions and guidance for completing the template) Your CDEP original bid and other background information A list and electronic copy of all of your CDEP instruments, tools, and data sources (e.g., citations of all instruments, tools and government and administrative data sources) Information collected from the SWE cube exercise Other materials/information relevant to your local evaluation

IPPs will receive written feedback on their plans from PARC@LMU within about **4 weeks** of submission. To help IPPs clarify or strengthen their evaluation plans, reviewers will provide any relevant feedback and where possible offer ideas and recommendations. Where changes are recommended, IPPs will also have the opportunity to receive technical assistance from the TAPs and PARC@LMU as needed.

CDPH will provide final approval of IPP evaluation plans. CDPH recognizes that evaluation plans may continue to evolve and be revised/updated in order to meet local circumstances and needs.

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
email: diane.terry@lmu.edu

Navigating the Template

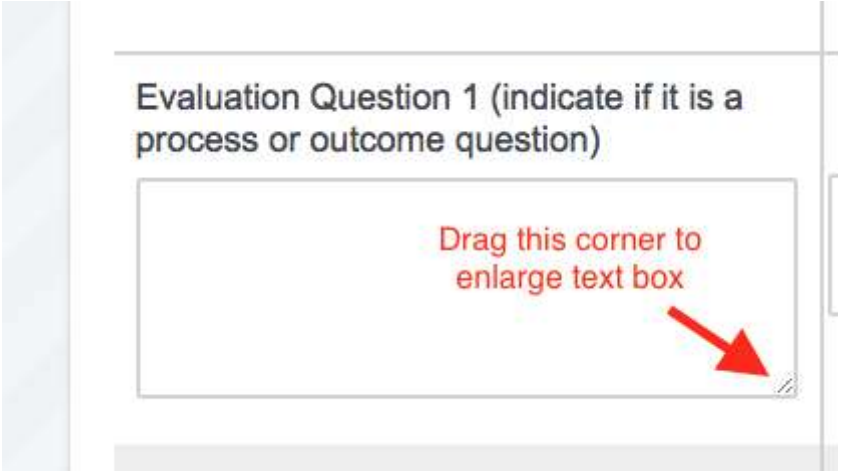
- The “Next” button allows you to move forward to subsequent sections.
- The “Back” button allows you to easily return to previous sections.
- A progress bar at the bottom of the page will show your progress in the completion of your template.

Saving and Closing Your Work

- 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 must **use the same computer and web browser**.
- Click on the link to return to where you left off.

Qualtrics Helpful Hint!

If at any point, you would like to make any text box larger, drag the bottom right corner of each respective box with your mouse.



IPP GENERAL INFORMATION

IPP and CDEP Name

IPP Organization Name:

CDEP Name:

Priority Population

Provide the name, title, email address, and phone number for up to three primary IPP contact person(s). Additionally, provide the name, email address, and phone number for your local evaluator.

IPP Contact Information #1

IPP Contact Name:

Title:

Email Address:

Phone Number:

IPP Contact Information #2

IPP Contact Name:

Title:

Email Address:

Phone Number:

IPP Contact Information #3

IPP Contact Name:

Title:

Email Address:

Phone Number:

IPP Local Evaluator Contact Information

Local Evaluator Contact Name:

Email Address:

Phone Number:

Click to write the question text

Click to write the question text

Introduction

\

Refer to the "Introduction" instructions in Section 11 of the SWE Guidelines to guide what to write in this section.

Please keep your introduction to a maximum of 3 single-spaced pages (approx. 1,500 words).

CDEP PURPOSE

Refer to the "CDEP Purpose" instructions in Section 11 of the SWE Guidelines for guidance on how to write your statement.

Purpose Statement

This statement should be no more than 3-4 sentences.

***For those pursuing EBP only**

If your CDEP was piloted and evaluated, briefly describe previous evaluation results and cite any published literature on your CDEP.

CDEP DESCRIPTION

Refer to Section 3 for more information about MHSA PEI.

MHSA PEI Programs specify two broad types of program categories: Direct and Indirect. Some CDEPs might only be Direct or Indirect, while others might be both.

MHSA Direct Programs intend to reduce negative outcomes that may result from untreated illness or individuals with risk or early onset of mental illness.

If you have a Direct PEI program, select all that apply.

- [ ] Prevention to reduce MHSA negative outcomes among people with greater than average risk of mental illness
- [ ] Intervention to reduce MHSA negative outcomes among people with early onset of mental illness

MHSA Indirect Programs/Strategies include early and prompt access to treatment and other mental health services and supports and/or changes in someone's attitudes, common knowledge, and/or behavior that are likely to facilitate access to mental health services. *If you have an Indirect PEI program, select all that apply.*

- [ ] Timely access to services for underserved populations to improve access among people from underserved populations with risk, early onset, or experience of mental illness
- [ ] Access and linkage to treatment to improve access and reduce duration of untreated mental illness among people with a serious mental illness
- [ ] Outreach to increase recognition of early signs of mental illness to engage people who can identify signs and symptoms to help people with risk or early onset of mental illness (Most workforce development/career pathways/training strategies fall under this category.)
- [ ] Stigma and discrimination reduction to produce changes in attitudes, knowledge, or behaviors to help people with risk, early onset, or experience of mental illness
- [ ] Suicide prevention to produce changes in attitudes, knowledge, or behavior to help people with risk of suicide as a consequence of mental illness
- [ ]

CDEP DESCRIPTION CONTINUED

Level of Intervention

At which level does your CDEP aim to reduce mental health disparities? Select all that apply.

- [ ] *Individual-focused practice*: Changes knowledge, attitudes, beliefs, practices, and behaviors of individuals. This practice level is directed at individuals, alone or as part of a family, class, or group.
- [ ]

☐ *Community-focused practice*: Changes community norms, community attitudes, community awareness, community practices, and community behaviors. They are directed toward entire populations within the community or occasionally toward target groups within those populations. Community-focused practice is measured in terms of what proportion of the population actually changes.

☐ *Systems-focused practice*: Changes organizations, policies, laws, and power structures. The focus is not directly on individuals and communities but on the systems that impact health. Changing systems is often a more effective and long-lasting way to impact population health than requiring change from every single individual in a community.

CDEP DESCRIPTION CONTINUED

Refer to "CDEP Description" in Section 11 of the SWE Guidelines for guidance.

Number of CDEP Cycles

Will your CDEP have one continuous cycle or multiple cycles?

**Note: A cohort is a group of participants who go through the CDEP together from start to finish.*

- ◯ Continuous (rolling basis)
- ◯ Multiple (different cohorts)
- ◯ Both continuous and multiple cycles

Multiple Program Cycles

How many program cycles do you plan to offer?	
How many participants per program cycle?	
What is your anticipated **start** date for cycle #1 (mm/dd/yyyy)	
What is your anticipated **end** date for cycle #1 (mm/dd/yyyy)	

How long does one cycle last? (e.g., 1 day, 6 weeks, 6 months):

CDEP DESCRIPTION CONTINUED

In this next section please provide detailed information on the individual components/elements/strategies that make up your CDEP, hereafter referred to as ***Components****. First, enter a brief name for each CDEP component.*

For example:
Component #1: Group Sessions with Parents
Component #2: Group Sessions with Children
Component #3: A Family Session
Component #4: Access and Linkages
Component #5: Mental Health Workforce Training
We have provided space for up to 10 components, although you may have fewer.

Component #1
Component #2
Component #3
Component #4
Component #5
Component #6
Component #7
Component #8
Component #9
Component #10

CDEP Components

Refer to the "CDEP Components" in Section 11 of the SWE Guidelines for guidance and examples on how to write your component description.

Include the following information for EACH individual component:

- length and duration of each component and its activities (e.g., 6 weeks, 2 times per week; 8 hours per day)
- 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)

Component #1 **${q://QID115/ChoiceTextEntryValue/1}**

Now, copy and paste into this box the "core" elements of #1 that you think are indispensable to your CDEP.

> Based on component example #1 in Section 11, the following text would be copied/pasted in this box.
> *"the use of "dichos" (proverbs) in the group sessions with parents" (a core element).*

*Drinking "cafecito" (coffee) together would NOT be copied/pasted, because it is considered optional to your CDEP component.

Component #2 **${q://QID115/ChoiceTextEntryValue/2}**

Copy and paste the "core" elements of #2 that are indispensable to your CDEP.

Component #3 **${q://QID115/ChoiceTextEntryValue/3}**

Copy and paste the "core" elements of #3 that are indispensable to your CDEP.

Component #4 **${q://QID115/ChoiceTextEntryValue/4}**

Copy and paste the "core" elements of #4 that are indispensable to your CDEP.

Component #5 **${q://QID115/ChoiceTextEntryValue/5}**

Copy and paste the "core" elements of #5 that are indispensable to your CDEP.

Component #6 **${q://QID115/ChoiceTextEntryValue/6}**

Copy and paste the "core" elements of #6 that are indispensable to your CDEP.

Component #7 **${q://QID115/ChoiceTextEntryValue/7}**

Copy and paste the "core" elements of #7 that are indispensable to your CDEP.

Component #8 **${q://QID115/ChoiceTextEntryValue/8}**

Copy and paste the "core" elements of #8 that are indispensable to your CDEP.

Component #9 **${q://QID115/ChoiceTextEntryValue/9}**

Copy and paste the "core" elements of #9 that are indispensable to your CDEP.

Component #10 **${q://QID115/ChoiceTextEntryValue/10}**

Copy and paste the "core" elements of #10 that are indispensable to your CDEP.

EVALUATION QUESTIONS AND MEASURES

EBP Status

Do you plan to submit your CDEP to a nationally-recognized registry for evidence-based practices (EBP)?

- Unsure
- No
- Yes (please list which one(s)):

EVALUATION QUESTIONS AND MEASURES CONTINUED

Evaluation Focus

If you have multiple programs and/or strategies (or multiple cycles of your CDEP), indicate which ones will be the focus of your local evaluation. Keep in mind, that you may not be able to evaluate all of them due to time or cost constraints. You may need to prioritize which ones are most important and feasible to evaluate.

EVALUATION QUESTIONS AND MEASURES CONTINUED

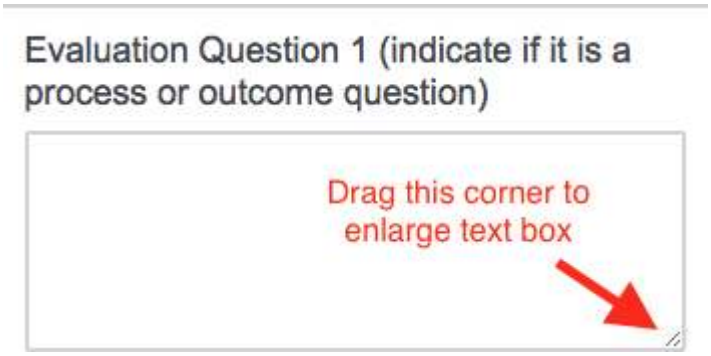
Evaluation Questions, Indicators and Measures

Please include the following:

- Evaluation questions (include both process and outcome)
- Indicators to address each question
- Instruments and/or data sources

Refer to the *"Evaluation Questions, Indicators and Measures"* in Section 11 of the SWE Guidelines for additional guidance and examples of how to complete this table.

Don't forget, if you would like to make the text boxes larger, drag the bottom right corner of each respective box.



We have provided space for up to 7 questions, although you may have fewer. ***If you have more than 7 evaluation questions, please contact PARC@LMU.***

	Indicators List indicators for each question here:	**Instruments/data sources used to measure key indicators** Provide a brief description for each question here:	**New instruments or modifications to existing instruments due to cultural and linguistic considerations** Provide a brief description for each question here:
Evaluation Question 1 (indicate if it is a process or outcome question)			
Evaluation Question 2 (indicate if it is a process or outcome question)			
Evaluation Question 3 (indicate if it is a process or outcome question)			
Evaluation Question 4 (indicate if it is a process or outcome question)			
Evaluation Question 5 (indicate if it is a process or outcome question)			
Evaluation Question 6 (indicate if it is a process or outcome question)			
Evaluation Question 7 (indicate if it is a process or outcome question)			

EVALUATION DESIGN

What type of evaluation methods will you be using?

- ◯ Quantitative Methods
- ◯ Qualitative Method
- ◯ Mixed-Methods

What type of **Quantitative** design will be utilized? Select one.

- ◯ Randomized Control Trial: Pre- and post- with randomly assigned intervention and control groups
- ◯ Quasi-experimental: Pre- and post- with comparison group design
- ◯ Quasi-experimental: Interrupted time series with a comparison community
- ◯ Non-experimental: Pre- and post- with single-group design
- ◯ Non-experimental: Interrupted time series
- ◯ Other (please specify):

Quantitative Design Continued

Please describe random assignment into the treatment or control group—i.e., how participants will be selected into either the intervention or control group (e.g., lottery draw).

If there will be random selection into the CDEP, please describe how participants will be selected from the priority population.

Quantitative Design Continued

Who will serve as the comparison group and how will they be selected? (program/group name, demographics, geographic location, motivation/incentive to participate)

If there will be random selection of CDEP participants into the evaluation, please describe how random selection be done.

Quantitative Design Continued

Please provide more information related to your use of your interrupted time series design. What type of data will be collected? How many time points will be observed before and after your CDEP intervention? Who will serve as your comparison community or group and why were they selected? (please describe)

Quantitative Design Continued

If there will be random selection of CDEP participants into the evaluation, please describe how they will be selected.

Quantitative Design Continued

Please describe your "Interrupted time series" design. What type of data will be collected? How many time points will be observed before and after your CDEP intervention?

What type of **Qualitative** design will you use? Please select all that apply.

- [ ] Phenomenological studies
- [ ] Ethnographic studies
- [ ] Grounded Theory studies
- [ ] Historical studies
- [ ] Case studies
- [ ] Action Research studies
- [ ] Other (please specify):

Please describe your Qualitative design.

EVALUATION DESIGN CONTINUED

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

Evaluation Sub-Populations

Check the sub-population(s) that will be represented in your CDEP evaluation sample.

Above and beyond your CRDP Phase II Priority Population, make sure to describe intersectional sub-populations that will participate in your CDEP:

Language (please describe):

Age (please describe):

Racial/Ethnic Group (please describe):

Education Level (please describe):

Gender Identity (please describe):

Sexual Orientation (please describe):

Geography (urban, rural or frontier) (please describe):

Homeless/Transient (please describe):

Immigrants/Refugees (please describe):

Religion (please describe):

Tribal Groups (please describe):

Non-Native English Speakers (please describe):

SES/Income (please

describe):

Disabilities (cognitive or physical) (please describe):

Uninsured/Underinsured (please describe):

Length of residence in the community (please describe):

Other(s) (please describe):

SAMPLING PLAN CONTINUED

Evaluation Sample Size

Indicate your intended sample size. If you have program cycles, list the intended evaluation sample size for each cycle.

Sampling Method

Refer to Section 6 of the SWE Guidelines for a description of different types of sampling methods and techniques. Select the type of sampling technique you will be using in your local evaluation.

- [ ] Random selection (random sampling)
- [ ] Stratified sampling
- [ ] Systemic random sampling
- [ ] Purposive sampling
- [ ] Convenient sampling
- [ ] Snowball sampling
- [ ] Quota sampling
- [ ] Multi-stage random sampling

☐ Other (please specify):

Describe your rationale/reasoning for using a ${q://QID24/ChoiceGroup/SelectedChoices} technique. If you selected more than one sampling technique, please indicate the rationale for each and note which program or strategy it is associated with. Finally, note any limitations to your sampling technique.

SAMPLING PLAN CONTINUED

Power Analysis

Was a power analysis conducted?

Yes

○ No

○

Is your intended sample size sufficiently powered?

- ◯ Yes (please explain):
- ◯ No (please explain):

SAMPLING PLAN CONTINUED

Recruitment/Retention Plan

How will you identify, access, and recruit participants to the evaluation (including comparison/control group if applicable)? Please include CBPR approach and other cultural/linguistic recruitment strategies.

DATA COLLECTION PLAN

Name of Instrument(s)/Data Source(s)

List out your instruments/data sources

~~Instrument/Data Source #1~~	
Instrument/Data Source #2	
Instrument/Data Source #3	
Instrument/Data Source #4	
Instrument/Data Source #5	
Instrument/Data Source #6	
Instrument/Data Source #7	
Instrument/Data Source #8	
Instrument/Data Source #9	
Instrument/Data Source #10	

DATA COLLECTION PLAN CONTINUED

Data Collection Timing, Protocol, Storage, and Training

If you would like to make the text boxes larger, drag the bottom right corner of each respective box.

	Timing of Data Collection	Data Collection Protocol	Data Storage	Training
		How will the data be collected? Who will administer or collect data? How long will it take to administer?	What data security measures will you take to store data?	How will you train data collectors to ensure data are collected accurately and reliably?
» Instrument/Data Source #1				
» Instrument/Data Source #2				

	Timing of Data Collection	Data Collection Protocol How will the data be collected? Who will administer or collect data? How long will it take to administer?	Data Storage What data security measures will you take to store data?	Training How will you train data collectors to ensure data are collected accurately and reliably?
» Instrument/Data Source #3				
» Instrument/Data Source #4				
» Instrument/Data Source #5				
» Instrument/Data Source #6				
» Instrument/Data Source #7				
» Instrument/Data Source #8				
» Instrument/Data Source #9				
» Instrument/Data Source #10				

Please upload established or newly developed instruments and/or tools described on the previous page.

Instrument #1

Instrument #2

Instrument #3

Instrument #4

Instrument #5

Instrument #6

Instrument #7

Instrument #8

Instrument #9

Instrument #10

INFORMED CONSENT AND CONFIDENTIALITY

Informed Consent

Explain the informed consent procedure (e.g., if written informed consent/assent will be obtained; if youth assent/guardian consent is also needed).

IRB Approval

Do you require IRB approval?

- ○ Unsure
- ○ No
- ○ Yes

For what reason are you unsure?

Where will you be submitting for IRB approval?

What is the status of IRB approval/process?

DATA ANALYSIS PLAN

DATA ANALYSIS PLAN

What type of data analysis will you be conducting?

- Quantitative
- Qualitative
- Mixed-Methods

Quantitative Analysis

Describe the descriptive analyses to be performed.

Describe the inferential analyses to be conducted to answer "each" evaluation question.

Qualitative Analysis

Describe the procedures that will be used to review, organize, code, and interpret your data.

FIDELITY ASSESSMENT

Please select all of the fidelity dimensions you will be examining:

- [ ] Adherence
- [ ] Exposure
- [ ] Quality of Delivery
- [ ] Participant Responsiveness
- [ ] Program Differentiation

Fidelity Dimensions

Refer to Section 11 of the SWE Guidelines for additional guidance and examples of how to complete this table.

	Criteria for each dimension Please describe:	**Measurement tools for each dimension** Please describe:	**Protocol for each dimension** Please describe:
» Adherence			
» Exposure			
» Quality of Delivery			
» Participant Responsiveness			
» Program Differentiation			

DISSEMINATION PLAN

Audience/Stakeholders

List all audiences/stakeholders for this evaluation.

Utilization of the Findings

Describe how your findings could be put into action.

Community Engagement

How will the community be engaged in the interpretation and dissemination of findings?

Dissemination Methods

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

Peer Reviewed Manuscript

Do you plan to develop a peer-reviewed manuscript based on this evaluation?

- ○ Yes

- ◯ No
- ◯ Unsure

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.

Thank you for completing the Evaluation Plan!

WARNING

Once you click "Next" your evaluation plan will be submitted.

Appendix J

Translated SWE Materials

IPP	Language Translation	SWE Translated Materials
Priority Population: Asian & Pacific Islander		
HCCBC TFC	Hmong	• IRB forms (Consent form (18+), Participant Bill of Rights, Recruitment Script) • Adult questionnaires
EBAYC		• IRB Forms: (Recruitment Script, Participant Bill of Rights • Adolescent questionnaires
HR360/AARS	Tongan	• IRB forms (Recruitment Script, Consent form (18+), Participant Bill of Rights) • Adult questionnaires
HR360/AARS	Samoan	• IRB Forms (Consent form (18+), Recruitment Script, Participant Bill of Rights) • Adult questionnaires
CAA	Khmer	• Recruitment Script (Consent form (18+), Adolescent Assent, Parent consent (12-17), Participant Bill of Rights) • Adult & youth questionnaires
KCS	Korean	• IRB forms (Recruitment Script, Consent form (18+), Participant Bill of Rights) • Adult questionnaires
KCS	Vietnamese	• IRB forms (Consent form (18+), Recruitment script) • Adult questionnaires
Priority Population: LGBTQ		

GHC	Spanish	• IRB forms (Consent form (18+), Youth CONSENT, Youth ASSENT, Parent Consent (12-17), Recruitment Script, Participant Bill of Rights • Adult and Youth questionnaires
OTM		• IRB Forms (Youth CONSENT, Youth ASSENT, Parent Consent (12-17), Recruitment Script, Participant Bill of Rights) • Youth questionnaires
SJPC		• IRB Forms: Youth CONSENT, Adolescent ASSENT, Parent Consent (12-17), Recruitment Script, Participant Bill of Rights • Youth questionnaires
Priority Population: Latino		
ICSI	Spanish	• IRB Forms (Adolescent ASSENT, Parent Consent (12-17), Recruitment Script, Participant Bill of Rights) • Youth questionnaires
LSP		• IRB Forms (Consent form (18+), Parent Consent (12-17), Adolescent ASSENT, Recruitment Script, Participant Bill of Rights • Adult & Youth questionnaires
HEC		• IRB Forms (Consent form (18+), Recruitment Script, Participant Bill of Rights) • Adult questionnaires
La Clinica		• IRB Forms (Consent form (18+), Adolescent ASSENT, Parent Consent (12-17), Recruitment Script, Participant Bill of Rights) • Adult & Youth questionnaires
La Familia		• IRB Forms (Consent form (18+), Recruitment Script, Participant Bill of Rights)
MICOP		• IRB Forms (Consent form (18+), Recruitment Script, Participant Bill of Rights) • Adult questionnaires

Appendix K

Agenda for IRB Procedures for SWE Core Measure Item Data

Purpose of the Webinar

- Review new IRB procedures
- Answer questions
- For specific IPP needs, a separate one-on-one meeting will be held

Final CPHS required changes to the SWE evaluation protocols and procedures

All IPPs administering the SWE Core measure items must use the following IRB approved materials or procedures:

- SWE Recruitment Script
- SWE Consent Forms
- Procedures for De-identifying the SWE Data (paper-pencil; Qualtricsversion)
- IPP designated SWE Data Gatekeepers
- IPP and Staff Data Privacy and Protection Agreements

SWE Recruitment Script (see recruitment script)

Per the request of the IRB committee, prior to obtaining consent/assent, IPPs will use the following script with CDEP participants in the locations where recruitment into the CDEP is already occurring. Per their request, it includes more detailed information and language about the SWE and is written at a 5th grade reading level.

Hello, my name is _. I am a member of (name of the CDEP project). Our project is part of a larger CA State Department of Public Health, CA Reducing Disparities Project, Phase 2 to increase access to and use of mental health services in the state. The state study is done by the Psychology Applied Research Center in Los Angeles. The state study wants to understand how projects like (CDEP name) are useful to communities like ours. I am inviting you to participate because you will be a part of our (CDEP name). If you say yes to the state study you will take a survey when you start our project and then again at the end of the project. The survey will ask about your mental health and mental health services you might have used or need, and basic background information about you like your age, gender, sexual orientation, and what you think about (CDEP name). The first survey will take approximately 15 minutes. If you agree to do the second survey when you are done with our project, that will take approximately 10 to 15 minutes. If you do this survey and the survey at the end of the project, your total time will be between 25 – 30 minutes. You do not have to participate in the study. If you do not participate, this will not affect your ability to participate in (CDEP name). You can also refuse to answer specific questions in the survey. You may also withdraw from the study at any time.

Appendix K

SWE Consent and Assent Forms (see attached consent and assent forms- 6 in total)
Per the request of the IRB committee, separate SWE consent and assent forms must be used with CDEP participant (separate from the local evaluation consent forms). Per the IRB committee, they include language describing in detail: the purpose of the SWE; types of questions asked in the pre-and post- tests; length of time to complete the pre-and post-test and; procedures for maintaining participant confidentiality. Table 1 provides a breakdown of which forms are required for each age group.

Procedures
The consent process and procedure for obtaining consent will occur before CDEP participants receive any services/programming with:

1. adults (18+ years of age) capable of providing consent;
2. one or both parents when the participant is a child (5 to 17 years of age); or in the absence of a parent, a person other than a parent authorized under applicable law to consent on behalf of the child or adolescent to participate in the SWE questionnaire. Child assent will also be obtained (described in detail below).

Trained and supervised team members at each IPP will use the following guidelines to obtain informed consent/assent from CDEP participants. The IPP designated staff member(s) responsible for consenting CDEP participants will ensure that the following procedures are carriedout:

1. Conduct all discussions for consent in a private and quiet setting;
2. Provide a copy of the consent/assents forms to the participant/representative. Whenever appropriate, provide the consent form to the participant/representative in advance of the consent discussion;
3. If the participant/representative understands more than one language, conduct the consent process in the preferred language of the participant/representative; provide adequate information about the SWE and the participant questionnaire in a language understandable to the participant;
4. If the participant/representative cannot speak English, obtain the services of an interpreter fluent in both English and the language understood by the participant/representative. The witness may be a member of the IPP team, a family member, or friend of the participant/representative.
5. If the participant/representative cannot read, a verbal consent may be appropriate or they may need to have a witness present during the consent discussion. The witness may be a member of the IPP team, a family member, or friend of the participant/representative.
6. Read the consent document (or have an interpreter read the translated consent document) with the participant/representative.
7. Explain the details in such a way that the participant/representative understands what it would be like to take part in the SWE questionnaire. Provide adequate opportunity for the participant to consider all options and respond to participants' questions.
8. When obtaining consent is completed, a signed copy will be offered to the participant/representative. The participant/representative is not obligated to take the document but it will be offered.
9. Continue to provide information as the participant requires. If at any point a participant/representative indicates that they do not want to take part in the SWE questionnaire, the process stops.

Appendix K

If the parent and/or legal representative of the child consents to complete the SWE questionnaire on behalf of their child OR consents for their adolescent to take part in the SWE questionnaire the following procedures will also be used to obtain child assent:

1. Whenever possible, the SWE questionnaire will be explained using language that is age appropriate and/or cognitively consistent with the child's ability to understand.
2. For children 5 to 11 years of age, it will be explained to them that their parent or legal representative will be completing the SWE questionnaire on their behalf; while it will be explained to adolescents 12 to 17 years of age that they (not their parents) will be completing the SWE questionnaire.
3. The assent (affirmative agreement) of the child/adolescent will be requested unless the capability of the child is so limited that the child cannot reasonably be consulted.
4. Whenever possible, children 7+ will be assented in writing and verbally when literacy limitations would prohibit it. Whenever possible, children under age 7 will be verbally assented (see below).
5. Once a child indicates that they do not want their parent or legal guardian to take part in the SWE questionnaire (i.e., complete the SWE questionnaire on their behalf), this process stops.

Table 1 provides a breakdown of which forms are required for each age group.

Table 1: SWE Consent and Assent Forms by Age Group

If you need consent for…	Use	Description
Adults (ages 18+)	Adult Consent Form (ages 18+)	Standard consent form explaining the nature of the evaluation
Adolescents (ages 12-17)	Adolescent Assent Form (ages 12-17) AND Parent Consent to Participate (ages 12-17)	12-17 year olds will be fully informed about the SWE and will give signed assent to their own participation in the evaluation. The assent form is very similar to the parent consent form. Parents will also sign a Consent Form granting their permission for their child's participation.
Child (ages 7-11)	Child Informed Assent Form (ages 7-11) AND Parent Consent to Participate by Proxy (ages 5-11)	In most cases, 7-11 year olds will be able to participate in the assent process using a simplified assent form. The child should sign the form if possible. If not, the form will document that verbal assent was obtained. Parents will also sign a Consent by Proxy Form.
Child (ages 5-6)	Child Oral Assent Form (ages 5-6) AND Parent Consent to Participate by Proxy (ages 5-11)	For 5-6 year olds, the oral assent script will be used to explain the project and ask for their assent. Children in this age range may not be able to participate in a written assent process, or if very young or otherwise incapable, in any meaningful assent process. In such cases, only a consent form from the parents or legal representative will be required. In some cases, the IPP team member may deem a child younger than 7 years old capable of being involved in the assent process. If so, the child will be given a simple explanation of what their parent will answer about them in the SWE questionnaire, and that there will be documentation on the parent consent form that this was done. Parents will also sign a Consent by Proxy Form.

Appendix K

SWE Data Gatekeeper
In general, a SWE data gatekeeper(s) is defined as key senior CDEP staff assigned within each IPP, such as the CEO/ED, local evaluator, senior program manager, and program manager. The IPP SWE data gatekeeper(s) will ensure that all SWE date security, storage, and submission to PARC procedures are followed as outlined below.

SWE Data De-Identification Procedures

PARC has developed a Unique Number System to ensure that we not receive any personal identifying information related to CDEP participants consisting of the following:

Priority Population Code: This refers to the unique identifier for each priority population in CRDP Phase 2. Implementation Pilot Project (IPP) Code: This # is the unique identifier for each IPP in CRDP Phase 2.

CDEP Participant Code: Numbers are assigned by each IPP to CDEP participants who are eligible and assent/consent to participate in the SWE pre and post-test questionnaire. IPPs will assign a participant ID number to each individual person, starting with 01. This number, combined with the corresponding Priority Population and IPP Code, will serve as a Participant ID Number that will allow IPPs to label either their paper-pencil version or web-based version with this number to indicate the CDEP participant from which data was collected. PARC@LMU will only see these codes and no actual correspondingnames.

Other Codes: Due to the variability and uniqueness of each CDEP, some IPPs may need additional codes, associated with some feature of their CDEP (e.g., location, staff member). These other codes can be used as needed by IPPs; The PARC team will work closely with the local evaluator to create these additional codes.

Participant ID Number Format – Illustration/Example
The ID Number format will define CDEP participants in the SWE pre and post-test as follows – the two digit number of the Priority Population (assigned by PARC to each IPP), the two digit number of the IPP Code (assigned by PARC to each IPP), and the CDEP Participant # (assigned by each IPP to each CDEP participant):

_____	-	_____	-	_____
Priority Pop Code		IPP Code		CDEP Participant Code

For example, the first Center for Sexuality and Gender Diversity CDEP participant who has assented/consented to participate in the SWE pre and post-test questionnaire, would have the following participant ID number assigned to them:

Priority Population #– **04**
IPP # – **01**
For the first participant – **01**
The SWE participant ID number therefore would be: **04-01-01**

Table 2 below contains the unique participant codes for each IPP, by priority population.

Table 2: PARC Unique Number System

Priority Population Code	IPP Name	IPP Code
01	California Black Womens' Health Project	01
01	Healthy Heritage	02
01	Whole Systems Learning	03
01	The Villlage Project	04
01	Catholic Charities of the East Bay	05
01	West Fresno Family Resource Center	06
01	Safe Passages	07
02	MAS-SSF	01
02	Hmong Cultural Center of Butte County	02
02	East Bay Asian Youth Center	03
02	Korean Community Services:	04
02	Cambodian Association of America	05
02	HealthRight 360	06
02	Fresno Center for New Americans:	07
03	Humanidad Therapy & Education Services	01
03	Integral Community Solutions Institute	02
03	Latino Service Providers	03
03	Health Education Council	04
03	La Familia Counseling Center Inc.	05
03	La Clinica de la Raza	06
03	Mixteco/Indigena Community Organizing Project	07
04	Center for Sexuality and Gender Diversity	01
04	San Joaquin Pride Center	02
04	Gender Health Center	03
04	OpenHouse	04
04	Gender Spectrum	05
04	San Francisco Community Health Center	06
04	On the Move	07
05	United American Indian Involvement	01
05	Friendship House	02
05	Indian Health Council	03
05	Indian Health Center of Santa Clara Valley	04
05	Native American Health Center	05
05	Sonoma County Indian Health Project	06
05	Two Feathers	07

IRB Amendment: COVID-19 Modifications

The following IPPs were included in a CPHS SWE IRB approval to collect consent, assent, and/or participant data remotely and/or virtually during the COVID-19 stay-at-home orders.

Table 3: IPP Inclusion in SWE IRB Amendments related to COVID-19

Priority Population	IPP
Amendment 11 (Approval Date: May 5, 2020)	
African American	Whole Systems Learning California Black Women's Health Project Catholic Charities of the East Bay Safe Passages West Fresno Family Resource Center
Native American	Sonoma County Indian Health Project Indian Health Center of Santa Clara Valley
API	Hmong Cultural Center of Butte County The Fresno Center AARS/Health Right 360 Korean Community Services
Latino	Humanidad Therapy and Education Services Latino Service Providers Health Education Council La Clinica de la Raza La Familia Counseling Center
LGBTQ	Center for Sexuality and Gender Diversity OpenHouse Gender Health Center San Francisco Community Health Center
Amendment 12 (Approval Date: June 18, 2020)	
African American	Healthy Heritage
Native American	UAII Sonoma County Indian Health Project
API	EBAYC CAA
Latino	MICOP
LGTBQ	On the Move
Amendment 13 (Approval Date: July 8, 2020)	
Native American	Native American Health Center
LGTBQ	San Joaquin Pride Center
Amendment 14 (Approval Date: September 28, 2020)	
LGTBQ	Openhouse
Amendment 15 (Approval Date: November 24, 2020)	
Native American	Indian Health Council

Approved modifications include the ability to obtain electronic and/or verbal consent (in alignment with previously approved IPP-specific SWE IRB modifications). Please contact PARC and your TAP if you have specific questions regarding your inclusion in the SWE IRB Amendment approval. Details regarding each approach are outlined in Table 4 below.

Table 4: COVID-19 Modified SWE Electronic and Verbal Consent and Assent Procedures

Consent Type	Approved Change	Application
Electronic signature	IPPs can collect CDEP participant e-signatures using any of the following (3) platforms designated as meeting the CDPH ISO data security and storage standards: 1) Qualtrics, 2) Adobe Cloud, and 3) DocuSign.	1) E-Signature via Qualtrics **Step 1:** PARC sets up a Qualtrics Basic account for the IPP. **Step 2:** The primary IPP SWE data gatekeeper will receive a Qualtrics-generated account verification email. The data gatekeeper will then forward this to PARC at: swe.swe@lmu.edu . **Step 3:** Upon receipt of the account verification email, PARC will upload the IPP's consent/assent forms to the account, which will generate a second email from Qualtrics to the IPP data gatekeeper requesting permission to collaborate on a Qualtrics project. The data gatekeeper will then forward this email to PARC at swe.swe@lmu.edu to finalize the account set up. **Step 4:** PARC will alert the IPP data gatekeeper via email once the account is ready, and the gatekeeper can take over as the account administrator. *The account password should be changed at that time to ensure that PARC no longer has access.* **Step 5:** CDEP staff can email and/or text CDEP participants a Qualtrics link to the electronic consent/assent forms. CDEP participants who consent/assent to participate in the SWE will e-sign the form, which will then be stored in the IPP's Qualtrics account. **Step 6:** CDEP staff will write the participant's name on the paper-pencil version of the SWE consent/assent form, document that electronic consent was provided, sign their name as the witness that consent was provided, and store the hard copy form in a secure physical or virtual location (e.g., locked file cabinet, Qualtrics, encrypted hard drive). 2-3) E-Signature via Adobe Sign and DocuSign: *The steps are identical for these two platforms.* **Step 1:** The IPP sets up the account independent of PARC and uploads their consent/assent forms to the account. **Step 2:** CDEP staff can email and/or text CDEP participants a Qualtrics link to the electronic consent/assent forms. CDEP participants who consent/assent to participate in the SWE will e-sign the form, which will then be stored in the Adobe or DocuSign cloud. **Step 3:** CDEP staff will write the participant's name on the paper-pencil version of the SWE consent/assent form, document that electronic consent was provided, sign their name as the witness that consent was provided, and store the hard copy form in a secure

Consent Type	Approved Change	Application
		physical or virtual location (e.g., locked office, Qualtrics, encrypted hard drive).
Verbal consent	IPPs can collect verbal consent from participants who are unable to provide written or electronic consent.	**Step 1:** CDEP staff will ask IPPs to provide verbal consent or assent to participate in the SWE. **Step 2:** CDEP staff will document on the paper-pencil version of the SWE consent/assent forms that verbal consent was provided and store the hard copy form in a secure physical or virtual location (e.g., locked office, Qualtrics, encrypted hard drive).
Best Practice: IPPs should make every effort to mail or email participants a copy of the SWE consent/assent forms prior to or after data collection occurs, if at all possible.		

SWE Data Submission, Storage, Security Procedures

Table 5 provides an overview of the procedures for data submission, security and destruction (if applicable) that the IRB has requested each IPP adhere to. ***IPP local evaluators can consult with their TAP and CDPH-OHE for assistance with these procedures, as needed.***

Table 5: Submission, Storage, Security, and Destruction of SWE Records and Data by Type

Version Type	Submission to SWE	IPP Storage/Security	Destruction of Data
Paper-Pencil Questionnaires (pre and post)	IPPs will scan and submit a PDF version of the Questionnaire via a PARC provided Qualtrics link within 20 days after administration.	Securely stored (e.g., locked office, laboratory, filing cabinet) separate from the SWE Master Participant Code List and Consent/Assent Forms	Questionnaires must be shredded within 24 hours upon confirmation of receipt from PARC, as well a permanent deletion of the PDF scanned files
Electronic: Qualtrics Questionnaires (pre and post)	NA	NA	NA
Records: SWE Master Participant Code List	**IPP store the code list; It is NOT submitted to PARC**	Stored securely in locked cabinet or room, separately from the SWE Questionnaires. If the master code list is in an electronic format, the data must be stored in password-protected computers or files. The electronic file of the master code list must remain closed on computers when left unattended, while the paper-pencil version in a locked cabinet or room when left unattended.	**The master code list should be the only document that links participants' names and unique participant codes.** It must be destroyed by the IPP SWE gatekeeper at the conclusion of Phase 2 data collection (Nov 2020). The data gatekeeper will oversee compliance with these procedures and the contract managers will verify these procedures have been followed in the site visits.

Records: Paper Consent and Assent Forms	Stored securely in a locked cabinet or room, separately from the SWE Questionnaire. CDPH Contract Managers will verify that consent/assent procedures were followed and the appropriate SWE consent/assent forms are on file and under secure, locked conditions. The IPP stored consent and/or	The consent/assent forms must be destroyed by the IPP SWE gatekeeper at the conclusion of CRDP Phase 2. The data gatekeeper will oversee compliance with these procedures and the contract managers will verify these procedures have been followed in the site visits.

Version Type	Submission to SWE	IPP Storage/Security	Destruction of Data
		assent forms will not contain the CDEP participant's SWE unique code.	
Electronic Consent/Assent Storage		Stored securely in the cloud when obtaining consent via Qualtrics, Adobe Sign and DocuSign. Paper consent and assent forms noting that electronic consent was received should be stored in a secure physical or virtual location (e.g., locked cabinet, Qualtrics, encrypted hard drive), separately from any paper-pencil SWE questionnaires.	The consent/assent forms must be destroyed by the IPP SWE gatekeeper at the conclusion of CRDP Phase 2. The data gatekeeper will oversee compliance with these procedures and the contract managers will verify these procedures have been followed in the site visits.
Verbal Consent/Assent Storage		Paper consent and assent forms noting that verbal consent was received should be stored in a secure physical or virtual location (e.g., locked cabinet, Qualtrics, encrypted hard drive), separately from any paper-pencil SWE questionnaires.	The consent/assent forms must be destroyed by the IPP SWE gatekeeper at the conclusion of CRDP Phase 2. The data gatekeeper will oversee compliance with these procedures and the contract managers will verify these procedures have been followed in the site visits.

----- ADDITIONAL NOTE ABOUT DATA SUBMISSION VIA QUALTRICS -----

PARC will provide each IPP with their own unique Qualtrics link to submit SWE participant data. The steps for data submission are as follows:

- **Step 1:** SWE Core Measures Submission Upload Portal Page – This is the main page you will see after clicking the Qualtrics link. To begin the data submission process, click "Next Page."
- **Step 2:** Data Gatekeeper page – Enter the name and email of your IPP's data gatekeeper.
- **Step 3:** Contact Information page – Enter information related to your priority population, IPP and CDEP name, and contact information for your IPP staff and local evaluator.
- **Step 4**: Checklist page – Complete a checklist confirming that your IPP is following the IRB procedures for securing, de-identifying, storing, and submitting SWE participant data.
- **Step 5:** Data upload page – Indicate the # and type of surveys you are uploading. Then upload your survey(s) into Qualtrics by attaching or dragging the files into the appropriate box(es).

Once you've uploaded your data, the data gatekeeper information you provided will receive 2 follow-up emails:

  - #1-An automatically generated email from Qualtrics confirming that the data was uploaded
  - #2- An email from PARC confirming that we've reviewed the quality of the scanned surveys, and your data gatekeeper can move forward with destroying the hard-copy and/or electronic SWE participant data files. **PLEASE DO NOT DESTROY YOUR SWE PARTICIPANT DATA UNTIL YOU HAVE RECEIVED THIS CONFIRMATION EMAIL FROM PARC.**

SWE Data Agreements (see 3 attached Agreement Forms)

To ensure that grantees follow best and required practice, all IPPs will be required to sign agreements that indicate compliance with maintaining a secure data storage environment and security procedures that are consistent with CDPH ISO standards:

1) The Data Privacy and Protection Agreement
2) The IPP Confidentiality Statement
3) The IPP Staff Confidentiality Statement

LMU|LA
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Tel 310.568.6634
www.lmu.edu

Data Privacy and Protection Agreement

I. Purpose and Scope

This Data Privacy and Protection Agreement forms part of the master agreement between [IPP name] and the Psychology Applied Research Center at Loyola Marymount University (PARC@LMU) to set forth the parties' privacy agreement related to data handling and warehousing, and security requirements, in accordance with the standards set by the California Department of Public Health Information Systems Office (CDPH ISO) for the California Reducing Disparities Project Phase 2.

The CDPH ISO standards provide a universal set of requirements mandated by the CDPH ISO for projects governed and/or subject to the policies and standards of CDPH. PARC@LMU will use these standards for all SWE related data collection, including the SWE evaluation questionnaires collected by IPPs at the local sites. These standards intend to assist CDPH and its service customers in understanding the criteria CDPH will use when evaluating, certifying the systems design, security features, and protocols used by project solutions utilizing CDPH services in five categories:

- Administrative/Management Safeguards
- Technical and Operational Safeguards
- Solution Architecture
- Documentation of Solution
- ISO Notifications and Approvals

II. Safeguards

The IPP shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the privacy, security, integrity, and availability of Community Defined Evidence Practice (CDEP) participants' personal and confidential information (PCI), including electronic or computerized CDEP participants' PCI. At each location where CDEP PCI exists under IPP's control, the IPP shall develop and maintain a written information privacy and security protocol that includes administrative, technical and physical safeguards appropriate to the size and complexity of the IPP's operations and the nature and scope of its CDEP activities in performing its agreement, including this Agreement, and which incorporates the requirements of the Security Section, below.

III. Security

The IPP shall take any and all steps reasonably necessary to ensure the continuous security of all computerized data systems containing CDEP PCI. These steps shall include, at a minimum, complying with all of the data system security precautions listed in the Data Security Standards set forth by CDPH ISO document: https://otis.catcp.org/utilities/tcforFileFetch.cfm?docID=559

IV. IPP SWE Data Gatekeeper(s)

Each location where CDEP PCI is located, the IPP shall designate an IPP SWE Data Gatekeeper(s) to oversee compliance with the Data Security Standards set forth by CDPH ISO. An IPP SWE data gatekeeper(s) is defined as key senior CDEP staff assigned within each IPP, such as the CEO/ED, local

evaluator, senior program manager, and program manager. The IPP SWE data gatekeeper(s) is authorized to: 1) de-identify the SWE questionnaire by using PARC's "Unique Number System", 2) instruct SWE questionnaire administrators how to code the questionnaire with the unique participant code, 3) securely store and protect the master code listand the consent/assent forms in a secure location, 4) if applicable, scan, upload and submit PDF files of the SWE questionnaire physical copy data using a Qualtrics form within 7 days of collecting the data, and 5) destroy the physical copy questionnaires and PDF files within 24 hours upon confirmation of receipt from PARC@LMU of the electronically submitted data using a cross-cut shredder. A secure location is defined as a place (e.g., office, laboratory, filing cabinet) for storing personal identifiers. The gatekeeper(s) has access to the secure locations through lock and key (either physical or electronic keys are acceptable). The master code list and consent/assent forms must be destroyed by the IPP SWE gatekeeper by the end of the SWE data collection period of September, 2023.

V. Training

The IPP shall provide in-service training on its obligations under this agreement and in accordance with Data Security Standards set forth by CDPH ISO to all IPP staff. The IPP local evaluator will be responsible for ensuring IPP Data Security Standards training and ongoing compliance with best practices in data security. The local evaluator can consult with both PARC@LMU and their technical assistance provider, for assistance with data security CDPH ISO standards.

VI. IPP Responsibilities

The IPP will undertake the following activities during the duration of the California Reducing Disparities Project Phase 2:

- Train and supervise staff who will collect the SWE questionnairedata
- Utilize best practices strategies to receive, analyze, transfer and preserve confidential evaluation data to ensure the highest level of security is in place
- Take reasonable precautions to ensure protection of data from unauthorized access, tampering or destruction
- Take reasonable precautions to ensure the safekeeping of research supportedhardware/software
- Oversee reasonable workflow that allows IPP to abide by the PARC guidelines for data security, maintenance, and shredding and consistent with California Department of Public Health Security ISO standards
- Assign responsibility to an official (known as the IPP SWE Data Gatekeeper) on the California Reducing Disparities Project Phase 2 to ensure the compliance of the above responsibilities

VII. Signatures and Dates

This Data Privacy and Protection Agreement will be effective upon the signatures of all IPP official and PARC Principle Investigator. It will be enforced until the completion of the California Reducing Disparities Project Phase 2.

We, [name of IPP], have the responsibility for the security of the data being obtained, stored, and/or used for the California Reducing Disparities Project Phase 2: Statewide Evaluation.

We certify that [name of IPP] is in compliance with all applicable administrative, physical, and electronic safeguards as detailed in the California Department of Public Health Information Systems Security Requirements for Projects (ISO/SR1).

Signature and Dates

IPP:_____

Printed Name of IPP SWE Data Gatekeeper	Signature of IPP SWE Data Gatekeeper	Date

Printed Name of IPPCEO/ED	Signature of IPP CEO/ED	Date
Printed Name of PARC@LMU PI	Signature of PARC@LMU PI	Date

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Confidentiality Statement

We, [name of Implementation Pilot Project (IPP)], agree to abide by the standards set by the California Department of Public Health Information Systems Office (CDPH ISO) for the California Reducing Disparities Project (CRDP) Phase 2 to protect the confidentiality of the data provided and the privacy of the human subjects under this initiative. These standards prohibit the following:

1. The delivery of SWE Questionnaire confidential information to other persons, stakeholders, organizations, etc.

2. Use of vital record information and/or other records provided by the Community Defined Evidence Practice (CDEP) evaluation participants in any way that may violate the privacy of any individual affiliated with CRDP Phase 2 including but not limited to any of the 18 Health Insurance Portability and Accountability Act (HIPAA) identifiers. HIPAA identifiers include: participants' name, any geographical subdivision smaller than a state (e.g., zip code, street, address, etc.), phone number, fax number, email address, medical record numbers, health plan beneficiary numbers, account numbers, certificate/license numbers, vehicle identifiers and serial numbers, device identifiers and serial numbers, web universal resource locators (i.e., URLs), IP addresses, biometric identifiers (e.g., finger prints), full face photographic images, or any other unique identifying number, characteristic, or code

3. The use of identifying information by the contractor and its employee, agents, or subcontractors for any purpose other than carrying out the obligations under the California Department of Public Health, Office of Health Equity (CDPH-OHE) solicitation

We understand the requirements and agree to maintain the confidentiality of the SWE questionnaire and evaluation data or other records (e.g., consent forms). We agree to use the CDPH ISO/SR1 document as well as other industry best practices as a guideline to ensure the security of the SWE data to appropriately protect all electronic and hard copy recorded data for the duration of the CDRP Phase 2 initiative. IPPs will limit access to identifiable information by assigning a unique code to each participant developed by the Psychology Applied Research Center at Loyola Marymount University (PARC@LMU) as outlined in the SWE Guidelines Document. For insurance, all IPP staff will be trained, vetted, and (Collaborative Institutional Training Initiative) CITI certified. All personally identifiable information provided by CDEP evaluation participants will be destroyed upon completion of the evaluation. We understand that IPPs that collect the data using paper- pencil methods will: 1) store that data in a secure location (i.e., locked room in locked file cabinets with no identifying information contained on the actual protocols) and 2) submit information electronically to PARC@LMU within 7 days of data collection. Once submitted, the

hardcopy versions of the data will be destroyed via a cross-cut shredder within 24 hours of confirmation of receipt of the electronically submitted data. We further agree to submit to CDPH-OHE/PARC@LMU, immediately upon the conclusion of the initiative and the destruction of records, a written statement setting forth the specific date and the method of destruction used to destroy the vital records. At the conclusion of the statewide evaluator's contract, PARC@LMU will turn over all collected de-identified data, databases, and data dictionary and codebook to CDPH. At a minimum, all IPPs will comply with all of the data system security and confidentiality precautions listed in the Data Security Standards set forth by CDPH ISO document: https://otis.catcp.org/utilities/tcforFileFetch.cfm?docID=559

Signatures and Dates

Printed Name of IPP SWE Data Gatekeeper	Signature of IPP SWE Data Gatekeeper	Date
Printed Name of IPP CEO/ED	Signature of IPP CEO/ED	Date
Printed Name of PARC@LMU PI	Signature of PARC@LMU PI	Date

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Staff Confidentiality Statement

Purpose and Scope

The purpose of the Staff Confidentiality Statement is to clearly identify the roles and responsibilities of each IPP staff member related to data handling, data warehousing and storage, submission, the confidentiality of the data provided by human participants under the California Reducing Disparities Project Phase 2 (CRDP 2) initiative.

Staff Confidentiality Acknowledgment

I have read the Confidentiality Statement and Privacy and Protection Agreement, and will comply with the security and privacy requirement indicated in both documents. Also, I understand the need to:

1.) Adopt CDPH ISO standards (https://otis.catcp.org/utilities/tcforFileFetch.cfm?docID=559) and utilize best practice strategies for receiving, transferring, and preserving confidential research and evaluation data to ensure the highest level of security are in place.
2.) Take reasonable precautions to ensure protection of data from unauthorized access, tampering or destruction.
3.) Ensure and abide by all procedures and protocols for electronic and physically obtained data outlined in the SWE guidelines.
4.) Ensure that all electronic and physically obtained PID is properly disposed within 24 hours of confirmation of receipt of electronic submission through confidential means (e.g., cross-cut shredding).
5.) Notify my supervisor or SWE Data Gatekeeper of a possible or actual information security incident including, but not limited to:
    a. Theft, loss, damage, unauthorized destruction, unauthorized modification, misuse, or unintentional or inappropriate release of any classified or PID data associated with CRDP 2.
    b. Inappropriate use and unauthorized access – this includes actions of IPP staff or non-IPP individuals that involve tampering, interference, damage, or unauthorized access to computer systems, file cabinets, etc.
    c. Theft, damage, destruction, or loss of IPP-owned information technology equipment including mobile computing devices, or any electronic devices containing or storing confidential, sensitive, or PID data.
    d. Any other incident that violates privacy, protection, and/or confidentiality of humanparticipants under CRDP 2 set forth by CDPH-OHE

Effective Date and Signature

This Staff Confidentiality Statement will be effective upon the signature of IPP staff member and IPP Staff Supervisor. It will be enforced until the completion of CRDP 2. IPP staff member and IPP Staff Supervisor indicate agreement with this Staff Confidentiality Statement by theirsignatures.

Appendix K

Signatures and Dates

Printed Name of IPP Staff Member	Signature of IPP Staff Member	Date

Printed Name of IPP Staff Supervisor	Signature of IPP Staff Supervisor	Date

Recruitment Script

"Hello, my name is___. I am a member of (name of the CDEP project). Our project is part of a larger CA State Department of Public Health, CA Reducing Disparities Project, Phase 2 to increase access to and use of mental health services in the state. The state study is done by the Psychology Applied Research Center in Los Angeles. The state study wants to understand how projects like (CDEP name) are useful to communities like ours. I am inviting you to participate because you will be a part of our (CDEP name).

If you say yes to the state study you will take a survey when you start our project and then again at the end of the project. The survey will ask about your mental health and mental health services you might have used or need, and basic background information about you like your age, gender, sexual orientation, and what you think about (CDEP name). The first survey will take approximately 15 minutes. If you agree to do the second survey when you are done with our project, that will take approximately 10 to 15 minutes. If you do this survey and the survey at the end of the project, your total time will be between 25 – 30 minutes.

You do not have to participate in the study. If you do not participate, this will not affect your ability to participate in (CDEP name). You can also refuse to answer specific questions in the survey. You may also withdraw from the study at any time."

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INFORMED CONSENT FORM – 18+ Years of Age
California Reducing Disparities Project Phase 2 Statewide Evaluation
Principal Investigator: Dr. Cheryl Grills, Loyola Marymount University (LMU)

The California Reducing Disparities Project is a statewide project to improve mental health services. _____[Program name] is one of 35 programs funded by this project. The Psychology Applied Research Center in Los Angeles is doing a study of the project. The California Department of Public Health funds the study. The study will be used to report on the usefulness of programslike _____[program name]. You can be in the study because you will be a part of _____[program name]. If you take part in the study, you will be one of about _____[local sample size] people for_____[program name] and 9000 statewide.

If you say yes to the study, you will take two surveys. One survey when you start _____[program name]. Another survey at the end of the program. The surveysask about your mental health; services you have used or need for mental health, alcohol or drugs; and what you think about _____[program name]. The survey also asks for details like your age, gender, and sexual orientation. One example of a question is, "Did you seek help for your mental or emotional health or for an alcohol or drug problem?" Another example is, "About how often during the past 30 days did you feel nervous?" The first survey should take 15 minutes. The second survey should take 10 to 15 minutes. Both surveys should take 25 to 30 minutes. Program staff can read questions and help you fill out the surveys.

Being in the study is optional. You will not be paid or receive any direct benefits. Saying no will not affect you being in _____[program name]. If you say yes to the study, you will take two surveys. You can ask questions before you decide if you want to be in thestudy.

The surveys ask some questions that may cause discomfort. You can choose to not answer for any reason. You can also withdraw from the study at any time by saying, "I do not want to be in the study anymore." Nothing bad will happen if you withdraw. Withdrawing will not affect you being in _____[program name].

If you feel upset after you do the survey, the_____[program group] can refer you to support services. If you want more support, you can contact Dr. Cheryl Grills at LMU, 310-338-3016.

To protect your data, paper surveys are stored in locked file cabinets and destroyed once put on computers. Computer data is stored on secure servers. However, there is a small chance of a data security breach that could cause loss of privacy. The law requires us to report child abuse, elder abuse, or plans to hurt yourself or others.

If you have any questions, you can contact_____[program contact and number]. You can also contact Dr. Cheryl Grills at LMU, 310-338-3016 or cheryl.grills@lmu.edu. If you want to know more about your rights in research, contact the Committee for the Protection of Human Subjects, 916-326-3660 or cphs-mail@oshpd.ca.gov. You will also get a copy of the Participant's Bill of Rights for Non-Medical Research.

Signing below [or clicking the yes button below] means that:

- I understand all of the above information.
- I have received the Participant's Bill of Rights for Non-Medical Research.

- I consent to being in the study.

Signature:_____ Date: _____

Verbal Consent Obtained (if participant is unable to provide written consent): ☐ Yes ☐ No

Witness Signature if Verbal Consentwas Obtained:_____ Date: _____

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INFORMED ASSENT FORM – 12-17 Years of Age
Principal Investigator: Dr. Cheryl Grills, Loyola Marymount University (LMU)
California Reducing Disparities Project Phase 2

This_____[program] is part of a statewide project to improve mental health services. _____[Program name] is one of 35 programs funded by this project. The Psychology Applied Research Center in Los Angeles is doing a study of the project. The California Department of Public Health funds the study, which it will use to report on the usefulness of programs like _____ [program name]. You can be in the study because you will be a part of _____ [program name]. If you take part in the study, you will be one of about_____[local sample size] people for_____[program name] and 9000 statewide.

If you say yes to the study, you will take two surveys. One survey when you start _____[program name]. Another survey at the end of the program. The surveys ask about your mental health, services you have used or need for mental health, alcohol or drugs, and what you think about _____[program name]. The survey also asks for details like your age, gender, and sexual orientation. One example of a question is, "In the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" Another example is, "About how often during the past 30 days did you feel nervous?" The first survey should take 15 minutes. The second survey should take 10 to 15 minutes. Both surveys should take 25 to 30 minutes. Program staff can read questions and help you fill out the surveys if you need help.

Being in the study is optional. You will not be paid or get any direct benefits. Saying no will not affect you being in _____[program name]. If you say yes to the study, you will take two surveys. You can ask questions before you decide if you want to be in the study.

The surveys ask questions that may cause discomfort. You can choose to not answer. You can withdraw from the study at any time. You can withdraw by saying, "I do not want to be in the study anymore." Nothing bad will happen if you withdraw. Withdrawing will not affect you being in_____[program name].

If you feel upset after you do the survey, the_____[program group] can refer youto support services. If you want more support, you can contact Dr. Cheryl Grills at LMU, 310-338-3016.

To protect your data, paper surveys are stored in locked file cabinets. Paper surveys are destroyed once put on computers. Computer data is stored on secure servers. However, there is a small chance of a data security break that could cause loss of privacy. The law requires us to report child abuse, elder abuse, or plans to hurt yourself or others.

If you have any questions, you can contact_____[program contact and number]. You can also contact Dr. Cheryl Grills at LMU, 310-338-3016 or cheryl.grills@lmu.edu. If you want to know more about your rights in research, contact the state of California, 916-326-3660 or cphs-mail@oshpd.ca.gov. You will also get a copy of the Participant's Bill of Rights.

Signing below [or clicking the yes button below] means that:

- I understand all of the above information.
- I have received the Participant's Bill of Rights.
- I agree to be in the study.

Your Signature:_____ Date: _____

Verbal Consent Obtained (if participant is unable to provide written consent): ☐Yes ☐No

Witness Signature if Verbal Consentwas Obtained:_____ Date: _____

Appendix K

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INFORMED ASSENT FORM – 7 to 11 Years of Age
Principal Investigator: Dr. Cheryl Grills, Loyola Marymount University (LMU)
California Reducing Disparities Project Phase 2

We are doing a survey to learn aboutprograms like_____[program name]. We want to learn how_____[program name] might be helpful for you, your family, and other families like yours. You can be in the study since you will be in_____[program name].

If you want to be in the study, your parent(s) or guardian will fill out a survey. The survey will ask things about how you have been feeling. It will also ask how you are doing in school. It will also ask about programs you have been in at school and in your neighborhood. When_____[program name] ends, we will ask them the same questions about you again. We will also ask how you likedbeing in_____ [program name].

After the study, we will write a report about what we learned. Your name, or your family's name, will not be in the report.

It is okay if you do not want to be in the study. No one will be in trouble. You still get to be in _____[program name] if you say no. You do not get anything special if you sayyes.

Do you have questions? If so, you can ask them now. If you think of any later, ask your parent(s) or guardian. We gave your parent(s) or guardian ways to ask us things later.

Writing my name below means that:

- I understand all of the above information.
- I agree for my parent(s) or guardian to do the surveys.
- I agree to be in the study.

Child's Name: _____
Child's Signature:_____ Date:_____

Verbal assent obtained (if child is unable to sign): ☐ Yes ☐ No

Witness Signature if Verbal Consentwas Obtained:_____ Date: _____

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PARENT CONSENT TO PARTICIPATE – 12 to 17 Years of Age
California Reducing Disparities Project Phase 2 Statewide Evaluation
Principal Investigator: Dr. Cheryl Grills, Loyola Marymount University (LMU)

The California Reducing Disparities Project is a statewide project to improve mental health services._____[Program name] is one of 35 programs funded by this project. The Psychology Applied Research Center in Los Angeles is doing a study of the project. The California Department of Public Health funds the study, which it will use to report on the usefulness of programs like_____[program name]. Your child can be in the study because they willbe in_____[program name]. If your child takes part in the study, they will be one of about_____[local sample size] people for_____[program name] and 9000 statewide.

If you say yes to the study, your child will take two surveys. One survey when your child starts_____[program name]. Another survey at the end of the program. The surveys ask about your child's mental health, services they have used or need for mental health, alcohol or drugs, and what your child thinks about_____[program name]. The survey also asks for details like your child's age, gender, and sexual orientation. One example of a question is, "In the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" Another example is, "About how often during the past 30 days did you feel nervous?" The first survey should take 15 minutes. The second survey should take 10 to 15 minutes. Both surveys should take 25 to 30 minutes. Program staff can read questions and help your child fill out the surveys if they need help.

Being in the study is optional. You and your child will not be paid or receive any direct benefits. Saying no will not affect your child being in_____[program name]. If you say yes to the study, your child will take two surveys. You can ask questions before you decide if you want your child to be in the study.

The surveys asks some questions that may cause discomfort. They can choose to not answer for any reason. Your child can withdraw from the study at any time by saying, "I do not want to be in the study anymore." Nothing bad will happen if your child withdraws. Withdrawing will not affect your child being in_____ [program name].

If your child feels upset after they do thesurvey, the_____[program group] can refer them to support services. If you want more support, you can contact Dr. Cheryl Grills at LMU, 310-338-3016.

To protect your child's data, paper surveys are stored in locked file cabinets and destroyed once put on computers. Computer data is stored on secure servers. However, there is a small chance of a data security break that could cause loss of privacy. The law requires us to report child abuse, elder abuse, or plans to for someone to hurt themselves or others.

If you have any questions, you can contact_____[program contact and number]. You can also contact Dr. Cheryl Grills at LMU, 310-338-3016 or cheryl.grills@lmu.edu. If you want to know more about your child's rights in research, contact the Committee for the Protection of Human Subjects, 916-326-3660 or cphs-mail@oshpd.ca.gov. You will also get a copy of the Participant's Bill of Rights for Non-Medical Research.

Signing below [or clicking the yes button below] means that:

- I understand all of the above information.

- I have received the Participant's Bill of Rights for Non-Medical Research.
- I consent to my child being in the study.

Youth's Name: _____
Signature: _____ Date: _____

Adolescent Assent Form on File: ☐ Yes ☐ No

Verbal Consent Obtained (if participant is unable to provide written consent): ☐ Yes ☐ No

Witness Signature if Verbal Consentwas Obtained: _____ Date: _____

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PARENT CONSENT TO PARTICIPATE BY PROXY – 5 to 11 Years of Age
California Reducing Disparities Project Phase 2 Statewide Evaluation
Principal Investigator: Dr. Cheryl Grills, Loyola Marymount University (LMU)

The California Reducing Disparities Project is a statewide project to improve mental health services._____[Program name] is one of 35 programs funded by this project. The Psychology Applied Research Center in Los Angeles is doing a study of the project. The California Department of Public Health funds the study. The study will be used to report on the usefulness of programs like_____[program name]. You can be in the study for your child because they will be in_____[program name]. If you take part in the study for your child, they will be one of about_____[local sample size] people for_____[program name] and 9000 statewide.

If you say yes to the study, you will take two surveys. One survey when your child starts_____[program name]. Another survey at the end of the program. The surveys ask about your child's feelings, behavior, mental health services they have used or need, and what youthink about_____[program name]. The survey also asks for details like your child's age, gender, and other personal details. The first survey should take 15 minutes. The second survey should take 10 to 15 minutes. Both surveys should take 25 to 30 minutes. Program staff can read questions and help you fill out the surveys if you need help.

Being in the study is optional. You and your child will not be paid or receive any direct benefits. Saying no will not affect your child being in_____[program name]. If you say yes to the study, you will take two surveys. You can ask questions before you decide if you want to be in the study.

The surveys ask for some details that may cause discomfort. You can choose to not answer. You can also withdraw from the study at any time by saying, "I do not want to be in the study anymore." Nothing bad will happen to you or your child if you withdraw. Withdrawing will not affect your childbeing in_____[program name].

If you feel upset after you do the survey, the_____[program group] can refer you to support services. If you want more support, you can contact Dr. Cheryl Grills at LMU, 310-338-3016.

To protect your data, paper surveys are stored in locked file cabinets and destroyed once put on computers. Computer data is stored on secure servers. However, there is a small chance of a data security break that could cause loss of privacy. The law requires us to report child abuse, elder abuse, or plans to hurt yourself or others.

If you have any questions, you can contact_____[program contact and number]. You can also contact Dr. Cheryl Grills at LMU, 310-338-3016 or cheryl.grills@lmu.edu. If you want to know more about your rights in research, contact the Committee for the Protection of Human Subjects, 916-326-3660 or cphs-mail@oshpd.ca.gov. You will also get a copy of the Participant's Bill of Rights for Non-Medical Research.

Signing below [or clicking the yes button below] means that:

- I understand all of the above information.
- I have received the Participant's Bill of Rights for Non-Medical Research.
- I consent to take part in the study on my child's behalf.

Child's Name: _____
Signature: _____ Date: _____

Child Verbal Assent (ages 5-6) Document on File: ☐ Yes ☐ No ☐ NA

Child Informed Assent (ages 7-11) Document on File: ☐ Yes ☐ No ☐ NA

Verbal Consent Obtained (if participant is unable to provide written consent): ☐ Yes ☐ No

Witness Signature if Verbal Consentwas Obtained: _____ Date: _____

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ORAL INFORMED ASSENT FORM – 5 to 6 Years of Age
Principal Investigator: Dr. Cheryl Grills, Loyola Marymount University (LMU) California Reducing Disparities Project Phase 2

Hi, my name is_____[CDEP staff name]. I want to learn more about this_____[program]. I would like to ask for your help. I will ask your parent(s) or the people who take care of you questions. For example, how you have been feeling. Also, what you like about this_____[program]. I will ask the same questions again at the end of the____[program].

It is okay if you do not want to help. If you say no, you still get to be in_____[program name].
Do you have any questions? Would you like to help me?

Name of Child: _____
Date: _____

Child's Voluntary Response to Participation: ☐ Yes ☐ No Parental Permission on File:

☐ Yes ☐ No

Verbal Consent Obtained (if participant is unable to provide written consent): ☐ Yes ☐ No
Witness Signature if Verbal Consentwas Obtained: Date: _____

Appendix L

IPP-specific age version, administration procedures, data collection setting, and modifications to SWE materials

(A) IPP	(B) Population Focus	(C) Sample Size	(D) PEI Program Type	(E) SWE Questionnaire Administration	(F) Data Collection Setting	COVID-19 Modifications	(G) Ongoing Modifications to SWE CDEP Questionnaire (See Addendum 1 for Rationales)			
							P	RS	I	C
PRIORITY POPULATION: AFRICAN AMERICAN										
California Black Women's Health Project (CBWHP)	African American adult women	100nn	Workforce Development, Direct Referrals	SWE items will be administered as a part of the program intake process Self-administered; Paper-pencil	Private, secure space in local community rooms, local recreational centers, libraries, religious and spiritual institutions, college campus, community-based organizations	Electronic consent procedures Staff- administered survey, electronically from a remote location	X			X
Healthy Heritage Movement	African American adult women	180	Workforce Development, Direct Referrals, Programs/Services	Self-administered, Paper-pencil	Private, secure space in community meeting room in local target churches with attention to privacy, safety, confidentiality	Electronic consent procedures Staff- and self-administered survey,	X		X	

(A) IPP	(B) Population Focus	(C) Sample Size	(D) PEI Program Type	(E) SWE Questionnaire Administration	(F) Data Collection Setting	COVID-19 Modifications	(G) Ongoing Modifications to SWE CDEP Questionnaire (See Addendum 1 for Rationales)			
							P	RS	I	C
						electronically from a remote location				
Whole Systems Learning	Adjudicated African American youth, ages 18-24	40-50	Direct Referrals, Programs and Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Staff-administered; Electronically via Qualtrics and paper-pencil	Reserved classrooms or private meeting rooms on college campuses with attention to privacy, safety, confidentiality	Verbal consent procedures Staff-administered survey, electronically from a remote location	X			X
Catholic Charities of the East Bay	African American middle and High school students	105	Workforce Development	SWE items will be administered as part of the local evaluation pre- and post-tests. Self-administered; electronically via Qualtrics	Schools or by phone. When not in session→Organization offices or other community locations where the participants feel comfortable with attention to privacy, safety, confidentiality	Electronic and verbal consent procedures Staff-and self-administered survey, remotely	X			X
Safe Passages	African American adjudicated youth ages 16 to 21	126	Direct Referrals Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Self-administered, Paper-pencil	Public partner agency offices, community-based organizations meeting rooms, Alternative Education; School sites and Safe Passages office with attention to privacy, safety, and confidentiality	Electronic and verbal consent procedures Staff-and self-administered survey, electronically from a remote location	X			X

(A) IPP	(B) Population Focus	(C) Sample Size	(D) PEI Program Type	(E) SWE Questionnaire Administration	(F) Data Collection Setting	COVID-19 Modifications	(G) Ongoing Modifications to SWE CDEP Questionnaire (See Addendum 1 for Rationales)			
							P	RS	I	C
The Village Project	Children from Kindergarten to 4th grade	120	Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Staff-administered, Paper-pencil	Administered to parents at school auditorium, classrooms and offices with attention to privacy, safety, confidentiality	NA				
West Fresno Health Care Coalition	African American youth ages 12-15	70	Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Staff-administered, Electronically via Qualtrics	School meeting rooms, organization offices with attention to privacy, safety, confidentiality	Electronic consent procedures Self-adminstered, remotely				
Priority Population: ASIAN PACIFIC ISLANDER										
Hmong Cultural Center of Butte County	Hmong Elders	50	Direct Referrals	SWE items will be administered as part of the local evaluation pre- and post-tests. Staff administered; Paper-pencil	Organization offices, community center meeting spaces with attention to privacy, safety, confidentiality	Verbal consent procedures Staff- administered survey, electronically or paper-pencil, via phone Administered over 2 sessions if needed	X	X	X	X
Muslim American Society: Social Services Foundation	South Asian Muslim adults	24	Workforce Development, Programs and Services, Direct referrals	Not using the SWE Questionnaire	NA	NA	X		X	

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							P	RS	I	C
Cambodian Association of America	Cambodian ages 16+ Evaluation: Cambodian adults ages 18+ only	325	Direct Referrals, Programs/Services	SWE items will be administered alongside the local evaluation. Staff-administered; paper-pencil	Meeting spaces at churches, temples, community Center meeting rooms, and other Cambodian-serving establishments with attention to privacy, safety, confidentiality	Verbal consent procedures Staff-administered, electronically, from a remote location	X	X	X	X
East Bay Asian Youth Center	Hmong and Southeast Asian youth	100	Direct Referrals	SWE items will be administered as part of the local evaluation pre- and post-tests. Self-administered; Paper-pencil	EBAYC offices, school meeting spaces, Youth Detention facility meet Center meeting rooms, and other Cambodian-serving establishments with attention to privacy, safety, confidentiality, and neighborhood meeting spaces with attention to privacy, safety, confidentiality.	Staff- and self-administered, paper or electronically, in person or from a remote location	X		X	
The Fresno Center **(Formally Fresno Center for New Americans)**	Hmong adults 18+	Minimum of 100	Direct Referrals	SWE items will be administered as part of the local evaluation pre- and post-tests. Self-administered; Paper-pencil	In a community organization room/office with attention to privacy, safety, confidentiality	Verbal consent procedures Staff- administered survey, electronically or paper-pencil, via phone	X	X	X	X

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							P	RS	I	C
						Administered over 2 sessions if needed				
HealthRIGHT 360	Samoan and Tongan youth (12-17) and adult caregivers (18+)	200	Direct Referrals, Programs and Services	SWE questionnaire will be administered 1:1 separate from the local evaluation in meetings with participants Self-administered; Paper-pencil	Health Right office/center	Verbal consent procedures Staff- administered survey, electronically or paper-pencil, via phone Administered over 2 sessions if needed	X	X	X	X
Korean Community Services	Korean and Vietnamese adults (18+)	325	Direct Referrals	SWE items will be administered as part of the local evaluation pre- and post-tests. Self-administered AND Staff-administered, Paper-pencil	Organization office	Verbal consent procedures Staff- administered survey, electronically or paper-pencil, via phone Administered over 2 sessions if needed	X	X	X	X
Priority Population: LATINO										
Humanidad Therapy and Education Services	Latino Adults	384	Programs/Services	SWE core items will be administered separately from the local evaluation in 1:1 meetings with participants Self-administered, Paper-pencil	Humanidad office	Verbal consent procedures Staff-and self-administered survey, electronically and remotely				

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							P	RS	I	C
Integral Community Solutions Institute	Latino youth aged 14-19	60	Direct Referrals, Programs and Services	SWE core items will be administered separately Self-administered, Paper-Pencil	School meeting spaces and classrooms with attention to privacy, safety, confidentiality	NA				
Latino Service Providers	Latino Youth and adults (16-25)	48 (Approximately 15 of which are over 18 years old)	Workforce Development, Programs/Services	SWE core items will be administered separately from the local evaluation in 1:1 meetings with participants Self-administered, Electronically via Qualtrics	High Schools/Community colleges meeting spaces with attention to privacy, safety, confidentiality	Electronic consent procedures Self-administered, remotely	X			
Health Education Council	Latino adults (18+)	60	Workforce Development, Direct Referrals, Programs/Services	SWE core items will be administered separately from the local evaluation in 1:1 meetings with participants Staff-administered; electronically	Mexican Consulate meeting room space	Electronic and Verbal consent procedures Staff-administered survey, electronically remotely	X			
La Clinica de La Raza	Latinos of all ages	150	Workforce Development, Direct Referrals, Programs/Services	SWE core items will be administered separately from the local evaluation in 1:1 meetings with participants Staff-administered; Electronically	Meeting spaces at community locations such as schools, churches, senior centers, community service agencies with attention to privacy, safety, and confidentiality.	Verbal consent procedures Staff-administered survey, remotely	X	X	X	X
La Familia Counseling Center	Latino Adults	150	Direct Referrals, Programs/Services	SWE core items will be administered separately from	La Familia office/center meeting space	Paper, verbal and electronic consent procedures	X			X

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							P	RS	I	C
				the local evaluation in 1:1 meetings with participants Staff-administered; Paper-pencil		Staff-administered, remotely				
Mixteco-Indigena Community Organizing Project	Indigenous Mexican adults (ages 18-60)	360-432	Workforce Development	SWE core items will be administered separately from the local evaluation in 1:1 meetings with participants Staff-administered; Paper-pencil	Local community organization meeting spaces the agency collaborates with, with attention to privacy, safety, confidentiality.	Staff-administered, during a single 1:1 session	X		X	X
Priority Population: LGBTQ										
Center for Sexuality & Gender Diversity **(Formerly Gay & Lesbian Center of Bakersfield)**	Youth (ages 13-17) and adult LGBTQ (18+)	300	Workforce Development, Direct Referrals, Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Staff-administered AND self-administered based on participant preference Paper-pencil AND Electronically via Qualtrics	Gay & Lesbian Center of Bakersfield office, at private locations, and at the newest RISE program offices.	Verbal and electronic consent procedures Staff and self-administered, remotely	X			X
Gender Health Center	LGBTQ youth and adults (ages 5-74 with an emphasis on ages 13+)	728 (Approximately 70 children ages 5-11, 210 youth	Workforce Development, Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Staff-administered AND self-administered based on participant preference	Gender Health Center office	Verbal and electronic consent procedures Staff and self-administered, electronically, remotely	X		X	X

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							P	RS	I	C
		ages 12-17)		Paper-pencil AND Electronically via Qualtrics						
San Joaquin County Pride Center, Inc.	LGBT+ youth (ages 7-18) and their parents/family members (ages 18+)	450	Workforce Development, Programs/Services	SWE core items will be administered separately from the local evaluation in 1:1 meetings with participants Staff-administered AND self-administered based on participant preference, Paper-pencil	School meeting spaces and classrooms with attention to privacy, safety, confidentiality; Organization office	Verbal and electronic consent procedures Staff and self-administered, electronically or remotely	X			X
SF Community Health Center (Formally API Wellness Center)	LGBTQ transition age youth (18-24) and adults	312	Direct Referrals, Programs/Services	SWE items will be folded into the local evaluation pre- and post-tests. Self-administered, Electronically	API Wellness office; LGBT Center office meeting space; Point Bonita YMCA meeting space	Verbal consent procedures	X	X	X	X
Gender Spectrum	Adults	1655	Direct Referrals	Not using the SWE Questionnaire	NA	NA				
On The Move - LGBTQ Connection	LGBTQ youth aged 14-24	150 (75 adults; 75 youth)	Workforce Development, Direct Referrals, Programs/Services	Not specified Staff-administered paper-pencil	Meeting spaces at community centers the agency has relationships with, with attention to privacy, safety, confidentiality	Verbal and written consent procedures Staff- and self-administered, electronically, remotely	X		X	X
OpenHouse	LGBTQ older adults	100-150	Direct Referrals, Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests.	OpenHouse offices and meeting spaces at community centers with attention to	Verbal and electronic consent procedures Staff- and self-administered,	X		X	X

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							P	RS	I	C
				Staff-administered, Paper-pencil and Electronically via Qualtrics	privacy, safety, confidentiality.	electronically, remotely Staff-and self-administered survey, remotely				
Priority Population: NATIVE AMERICAN										
Friendship House Association of American Indians Inc	American India/Alaska Native adults	180 minimum	Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Staff-administered, Paper-pencil	Residential treatment center offices (San Francisco & Oakland); Inipi (Sweat Lodge); Friendship House office (San Francisco)	NA				
Indian Health Center of Santa Clara Valley	American Indian/Alaska Native youth ages 8-17	60-90	Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Staff-administered, Electronically	Community meeting space in downtown San Jose; at community Pow Wow in secure area set aside for surveys with attention to privacy, safety, confidentiality.	Electronic consent	X			
Indian Health Council, Inc.	American Indian/Alaska Native youth	120	Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Self-administered; Paper-pencil	Private meeting space in La Jolla. Local Evaluator attends to ensure proper administration with attention to privacy and confidentiality.	Staff- and self-administered, remotely and/or electronically	X	X	X	X

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							P	RS	I	C
Native American Health Center	Urban Indian youth and adults (ages 12-17 and 18-65+)	300-840	Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Self-administered, Electronically via Qualtrics AND Paper-pencil	Private space at the retreat center with attention to privacy, safety, confidentiality.	Verbal consent procedures Staff- and self-administered electronically, remotely	X		X	
Sonoma County Indian Health Project	TAY youth	140 (minimum)	Workforce Development, Direct Referrals, Programs/Services	Staff-administered, Electronically via Qualtrics AND Paper-pencil	Intervention is at large community events. Data collection will occur at community events in a secure area set aside for surveys with attention to privacy, safety, confidentiality. These include Community Wellness Gatherings (e.g., Big Time), Talking Circles, and other community events, participating schools (two middle schools and three high schools); tribal community meeting spaces; partner community-based organizations serving Native Americans.	Electronic consent procedures Self-administered, remotely	X		X	

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							P	RS	I	C
United American Indian Involvement, Inc.	Urban American Indian/Alaskan Native all ages	100	Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Staff-administered, Paper-pencil	Urban American Indian Involvement Center offices	Verbal consent procedures Staff- and self-administered, electronically, remotely				
Two Feathers	American Indian youth and adults	378 (176 youth; 202 adults)	Programs/Services	SWE items will be administered as part of the local evaluation pre- and post-tests. Staff-administered; paper-pencil	Intervention is at large community events. Data collection will occur at community events in a secure area set aside for surveys with attention to privacy, safety, confidentiality.	NA			X	