The California Reducing Disparities Project Phase 2

Statewide Evaluation Report
Executive Summary

Psychology Applied Research Center

COMMUNITY BASED RESEARCH ACTIVISM
AND EVALUATION

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The findings and conclusions in this report are those of the authors and do not necessarily represent the views or opinions of the California Department of Public Health or the California Health and Human Services Agency.

PRIORITY POPULATION	AFRICAN AMERICAN	AMERICAN INDIAN/ALASKA NATIVE	ASIAN AMERICAN NATIVE HAWAIIAN PACIFIC ISLANDER	LATINX	LGBTQ+
TAPs	OnTrack Program Resources	PIRE	SSG Special Services for Groups, Inc.	UC Davis Health Center for Reducing Health Disparities	CARS Center for Applied Research Solutions
IPPs	California Black Women's Health Project	Friendship House	Cambodian Association of America	Health Education Council	San Francisco Community Health Center
	Catholic Charities of the East Bay	Indian Health Center of Santa Clara Valley	EBAYC East Bay Asian Youth Center	Humanidad Therapy & Education Services	The Center For Sexuality & Gender Diversity
	Healthy Heritage Movement		The Fresno Center	Integral Community Solutions Institute	Gender Health Center
	Safe Passages	Native American Health Center Serving the community since 1972	health RIGHT 360 A Family of Programs	La Clínica a california health center	gender spectrum
	The Village Project, Inc.	Sonoma County Indian Health	Cultural Center of Butte County CA	La Familia Counseling Center	LGBTQ Connection Napa • Sonoma Community Driven Action
	West Fresno Health Care Coalition Inc.	United American Indian Involvement, Inc.	Korean Community Services	Latino Service Providers	openhouse
	Whole Systems Learning	Two Feathers Native American Family Services	MAS Muslim American Society	Mixteco Indigena Community Organizing Project MIXTECO.ORG	SJPC San Joaquin Pride Center
EOA AND CULTURAL BROKER		California Pan-Ethnic Health Network	REMHDCO Racial and Ethnic Mental Health Disparities Coalition		

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" As a Black woman, this has been one of the most affirming experiences that I've had, to be able to come together beyond our differences and connect on what's important to us as Black women has been priceless...What I really, really, loved was that they created a safe space. It was a space that was non-judgmental and you were able to show who you really were authentically."

African American Adult CDEP participant[3]

[3]All CDEP quotations are taken from IPP Local Evaluation Reports or Statewide Evaluation Semi-Annual Reports.

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THE CALIFORNIA REDUCING DISPARITIES PROJECT EXECUTIVE SUMMARY

The California Reducing Disparities Project (CRDP) provides a way forward in the commitment to reduce mental health disparities in California. The statewide evaluation found:

- The CRDP **increased access to mental health services** and **improved the mental health among participants** in unserved, underserved, and inappropriately served communities.
- The CRDP approach also **strengthened the capacity of communities** to respond to their own mental health needs more and more over time.
- Because the CRDP approach prioritizes prevention and early intervention, **it is cost effective**. For every dollar spent during a four-year implementation period, about five dollars were saved. The net estimated financial benefit to the state exceeded $450 million.

WHAT IS CRDP PHASE 2?

In 2009, California responded to a standing call from U.S. Surgeon General David Satcher for national action to reduce mental health disparities experienced by "historically unserved, underserved, and inappropriately served groups." Under the leadership of the California Department of Public Health's Office of Health Equity (CDPH-OHE), CRDP is a statewide mental health prevention and early intervention (PEI) initiative to improve outcomes through access to appropriate services among five populations: African American/Black (AfAm), Asian American Native Hawaiian Pacific Islander (AANHPI), Latinx, American Indian/Alaska Native (AI/AN), and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ+) communities.

Currently in its second phase, CRDP is a $60 million investment that aims to implement and validate community-driven mental health solutions. Originally funded from 2016-2022 by the 2004 Mental Health Services Act, CRDP Phase 2 was renewed in 2021 for an additional four years with $63.1 million from the state general fund.

THE BUSINESS (AS USUAL) OF MENTAL HEALTH

"A public health organization may struggle to promote healthy habits in a community if it does not take into account how other factors play into the behavior of the community as a whole.[4]"

It's pretty straightforward. If we want to meet the needs of unserved, underserved, and inappropriately served communities, we must change the way we do the business of mental health.

Despite the extraordinary efforts, expertise, and dedication of California's mental health professionals, current approaches across the state too often fail to address key determinants of mental health needs and challenges, including housing, employment, health care, education, transportation, and systemic racism.

While mental health disorders are common everywhere, rates of serious mental illness – and our response – vary across lines of race, gender, and socioeconomics. For example, AfAm, AANHPI, AI/AN, and Latinx people are less likely to receive the services they need than people in other groups. People in the LGBTQ+ community experience worse mental health outcomes than heterosexual and cisgender people.[5] In each of these communities, access to care is impeded by financial constraints, stigma related to mental illness, and lack of culturally relevant services.

[4] Poux, 2017 https://borgenproject.org/social-ecological-model/
[5] Moagi, van Der Wath, Jiyane, & Rikhotso, 2021 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7876969/

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None of this is news. Researchers have documented mental health disparities for decades. Still, they persist, in part because current standards of prevention and early intervention, although grounded in state-of-the-art evidence-based practices (EBPs), do not address three critical questions:

- How can we support communities to design and implement contextually grounded, culturally-driven interventions that reflect their own lived experience and understanding of mental health?
- How can we increase the role of communities in gathering and vetting evidence to evaluate the programs that serve them?
- How can standards of evidence originate in the community and reflect the culture and values of the populations served?

Until we answer these questions, the chasm of disparity across communities will continue to widen. We suggest a community-centered mental health approach, built on culture, history, knowledge, praxis, and values. Call it "community-defined evidence practice."
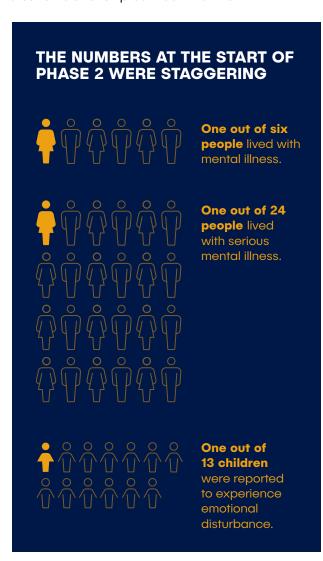
DEFINE EVIDENCE

Viewed as the gold standard for mental health service delivery, EBPs are intended to incorporate the best available research into the shaping and delivery of interventions. Less known is that community leaders, members, and organizations are typically left out of the conversation as the cultural considerations of interventions are sorted out. This top-down approach creates barriers between mental health service providers and their clients and can even result in an adversarial relationship between the two.

As an alternative or complement to EBPs, community-defined evidence practices (CDEPs) offer culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve. CDEPs represent the cornerstone of the CRDP initiative.

During CRDP Phase 2, the CDEP approach to prevention and early intervention (PEI) upended business-as-usual by employing a community-driven response to an array of persistent challenges, including:

- Rising numbers of people with mental illness who are underserved, unserved, or marginalized.
- Cultural differences in how mental illness is understood, described, and manifested.
- Lack of spiritually and culturally-grounded mental health services and providers.
- Poor housing, toxic pollution, substandard education, unemployment, lack of health care, historical trauma, and stress related to systemic racism.
- Lack of attention to defining elements of diverse communities, including language, culture, spirituality, gender identity, and sexual orientation.
- Deficit/punishment models of treating mental illness.

THE NUMBERS AT THE START OF PHASE 2 WERE STAGGERING

One out of six people lived with mental illness.

One out of 24 people lived with serious mental illness.

One out of 13 children were reported to experience emotional disturbance.

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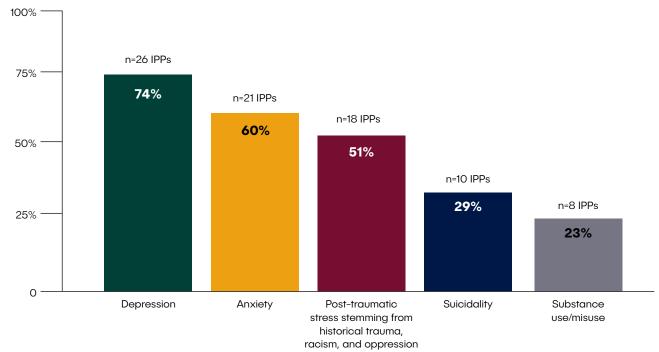COST-BENEFITS

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During Phase 2, community-based organizations called Implementation Pilot Projects (IPPs) developed and implemented CDEPs using culturally-informed approaches in 36 of California's 58 counties where they had established community relationships and credibility based on several components, including:

71% Lived experience in IPP mental health workforce

71% Linguistic competency in IPP mental health workforce

68% Community culture brokers, who bridge, link, and mediate between agencies and the community

54% Filling the gap in mental health care for unserved and underserved communities

54% Leveraging strategic partnerships and collaborations

31% Strengthening CDEPs through community-based participatory practices

23% Community-wide events designed to build a sense of connection and improve wellbeing

AS THEIR WORK BEGAN, IPPS IDENTIFIED THE FOLLOWING MENTAL HEALTH PROBLEMS IN THE COMMUNITIES THEY SERVED.

Priority Mental Health Problems

Information derived from: IPP Local Evaluation Plans 2018

Bar chart — Priority Mental Health Problems:
- Depression: 74% (n=26 IPPs)
- Anxiety: 60% (n=21 IPPs)
- Post-traumatic stress stemming from historical trauma, racism, and oppression: 51% (n=18 IPPs)
- Suicidality: 29% (n=10 IPPs)
- Substance use/misuse: 23% (n=8 IPPs)

One-third of IPPs identified isolation as a contributing risk factor for depression among the populations they served. This is important given the foundational role of social connectedness in mental health among communities of color. Involving communities in mental health approaches helps destigmatize mental illness and strengthens resistance to risk factors.

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IPPS COLLECTIVELY USED SIX DIRECT-SERVICE STRATEGIES IN RESPONSE TO THE ISSUES ABOVE

Social/ Recreational Activities

Healing Justice

Case Management and Screening Assessment

Ethno-Cultural Awareness and Celebrations

Life/Skills or Personal/ Career Development

Family Wraparound Supports

In all, the IPPs provided direct services to California CDEP participants in 15 languages. Fourteen IPPs also engaged in workforce development focused on training, education, and/or technical assistance to strengthen and/or develop the skills, knowledge base, and capacity of individuals, agencies, organizations, and institutions to work with the CRDP priority populations. Their three primary strategies were:

- **Pipeline**: To promote opportunities to work in community health and mental health, IPPs trained community members to become peer counselors, health workers, youth leaders, etc.
- **Capacity-building**: IPPs trained internal CDEP staff (e.g., program managers, advocates, therapists, counselors, psychologists), community volunteers, and staff from partner organizations.
- **Community-wide capacity**: IPPs provided training and technical assistance to non-CDEP mental health workers in private and public agencies (e.g., therapists, counselors, psychologists, graduate-level mental health interns) and first responders (e.g., school personnel, law enforcement, health providers).

An AfAm youth illustrates the importance of CDEPs to behavior change and cultivation of the cultural principle of connection to community, a protective factor for many communities of color:

"

I didn't think I was going to pass 8th grade. I was getting bad grades kind of, but more so I was giving up. After participating, I try at least. I try. You can outreach to the community and you can give back to the community and you will get back from the community."

"

At its core, a culturally competent health care system is one that provides care to clients with diverse values, beliefs, and behaviors, and tailors services to meet clients' social, cultural, and linguistic needs."

(California Pan-Ethnic Health Network, 2018)

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The rich diversity of strategy and ethos of CDEPs is at the heart of CRDP's work. Consider the following five examples.[6]

AN AFRICAN AMERICAN CDEP

The Emanyatta Project was designed for Black children and their families in Monterey County. It provides clinical assessments and workshops that teach African American and African history. The idea is that a strong sense of ethnic pride leads to a strong sense of identity and community, and can help counter common disorders, such as depression and anxiety.

An AfAm youth participant's mother illustrates the transformative power of an African–centered CDEP that instilled a positive sense of identity for her child:

"

'Mommy I want a ponytail down here' and I'm, like, 'we're not going to get a ponytail like that.' She's in 1st grade now and my mom had bought her this handmade African skirt and head wrap, and so she was, like, 'I wanna wear my hair natural (afro),' and she wanted to wear her hair scarf and everything and her mission was just to tell everybody where the skirt was from, why her head was wrapped, why her hair looks like that. And so there's this little girl, her mom was, like, 'Where do you get Kennedy's hair braided? She's begging me to get her hair braided.'... I think the influence has been reversed and that's really nice to hear.... She doesn't feel so defeated about being different.... She feels more empowered to be different and she's, like, accepting that it's okay to be different and you can still be a leader, you can still be someone of influence even though you're different."

[6]Note that detailed descriptions of all IPPs' CDEPs are available in the statewide evaluation final report.

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AN AI/AN CDEP

The Stick Game and Flower Dance projects were created to help the AI/AN communities (tribal groups primarily from the Northwest California region including the Yurok, Hupa, Karuk, Tolowa, and Wiyot) recover from historical trauma associated with forced assimilation and genocide. The goal is to help American Indians strengthen connections to family, community, and spirituality through ancestral, culturally-based wellness practices. The Stick Game, an athletic activity, integrates cultural teachings with game play. The Flower Dance is a celebratory acknowledgement of young girls' transition into womanhood. Year-long preparations for both events involve the entire community in activities such as tool making, mindfulness exercises, and singing.

A youth participant's comment illustrating the importance of culture to positive youth development:

"Culture is important to me because it's made me more mature, and it's helped me with a lot of things in life and will help me in the future. It's important for more youth to grow up with their culture so they can carry on that knowledge to future generations. Culture can help out people in our communities that are struggling."

Community Advisory Committee member comment illustrating the healing power of cultural practices:

"Our ceremonies heal. This is told in our very first stories. And we know that our ceremonies can resonate and heal our mind and body."

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AN AANHPI CDEP

Integrated Care Coordinators (ICC) project provides referrals and linkages to the Korean and Vietnamese communities in Orange County. Through referrals and linkages, ICC increases access to culturally and linguistically appropriate services. ICC works to understand the unique service needs of its clients and uses approaches such as "no wrong door," "whatever it takes," and "the warm handoff," to ensure they connect with appropriate providers.

An adult participant's comment illustrating the importance of cultural attunement between staff and clients:

"

The ICC staff had a good understanding of Korean culture. She understood how Korean pastors like me often feel ashamed to disclose emotional problems to others. The ICC staff said, 'Pastor is a human too.' Pastors can have depression or panic attacks too. She made me feel understood. It was good to have a counselor who not only speaks the language but understands the culture fully."

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A LATINX CDEP

Cultura y Bienestar (CyB) works to decrease mental health stigma by improving mental health awareness and increasing service usage for Alameda County's Latinx community. Distrust of public mental health systems, barriers to accessibility, and a lack of culturally-grounded services result in a persistent under-utilization of services in the community. CyB serves as a bridge between Latinx community members and providers by promoting cultural connectedness and values. Trained *promotores* (health educators) provide wellness education, assess needs, and connect participants to services.

An adult participant's comment illustrating the ripple effect of cultural trust that engages other family and friends with mental health services:

"This had a great impact on my family. When I go here from my country, I stayed with my sister, and I witnessed a lot of domestic violence. After a few sessions, my sister came to therapy to see if she could abandon that life she was living. Now my sister is better, she looks much better and is healthier emotionally."

AN LGBTQ+ CDEP

Community Engagement Program (CEP) uses a holistic approach to address social isolation, depression, anxiety, and trauma experienced by LGBTQ+ seniors living in the San Francisco Bay area. The program increases social connectedness and engagement by hosting social activities and providing support services. The "friendly visitor" component matches program volunteers with seniors to provide ongoing companionship and emotional support, meeting them where they are in a way that normalizes their experience.

An adult participant's comment illustrating the power of identifying with one's CDEP staff based on shared identities that aids behavior change:
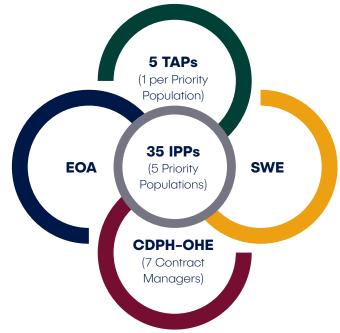
" For me, I love the Saturday outing because for almost a year, I never went out on the weekend. So it was big. I remember the first day that I met up with [a friendly visitor]. I felt a little anxiety because I had not been out on a Saturday. I don't like crowds. And all of the sudden, I found myself thrust into crowds. But they were so good, they were so nice. I decided to talk about it. I decided to say, 'I'm feeling a little anxious, but I want to do this.' So, it was just great. After that, I've started getting out on Saturdays."

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COMMUNITY-BASED ORGANIZATIONS AT THE TABLE, NOT ON THE MENU

CRDP's structure was designed to help the 35 participating IPPs demonstrate the effectiveness of CDEPs in their communities through a series of partnerships and steps.

- The IPPs implemented and evaluated their local CDEPs.

- Five technical assistance providers extended organizational capacity and evaluation support to the IPPs.

- The statewide evaluator consultant evaluated the overall initiative and provided evaluation support.

- The education, outreach, and awareness consultant helped IPPs with media and storytelling.

- The California Department of Public Health Office of Health Equity managed the overall initiative and maintained communication with key stakeholders across the state.

5 TAPs
(1 per Priority Population)

35 IPPs
(5 Priority Populations)

EOA

SWE

CDPH–OHE
(7 Contract Managers)

For CDPH–OHE, "doing business differently" was not just a tagline. It was a goal to create a tangible and demonstrable difference between CRDP Phase 2's design and implementation and those of other state-funded initiatives. For example, CDPH–OHE leadership, in consultation with community leaders from Phase 1, designed Phase 2 of the initiative with a capacity-building phase to help increase the number of eligible organizations with CDEPs. Recognizing that new organizations could not weather months-long delays in receiving payments, CDPH–OHE worked with the state to change invoicing practices so the organizations could receive advance payments. IPP funds were provided with maximal flexibility so they could roll over from year to year and could be used to address unanticipated community needs, as happened during the COVID-19 pandemic.

IPP deliverables and deadlines were also adjusted to streamline reporting requirements without losing key information or diminishing accountability, a degree of flexibility not found in other state initiatives.

The Hub Structure. The IPPs were organized into different "hubs" based on race and LGBTQ+ populations. The hub structure was designed to create affinity groups for shared learning and collaboration.

Community-Based Participatory Practice (CBPP). CBPP was key to doing business differently. CBPP engenders the active engagement of community members in identifying, defining, and addressing issues in their communities.

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HOW WAS CRDP EVALUATED?

Central to CRDP Phase 2 was the rigorous evaluation of CDEPs and the initiative's overall strategies to reduce mental health disparities. Robust data collection increases the chances of substantiating the merits of CRDP and the CDEP approach to PEI and leads to increased credibility and future funding for priority populations.

First, culturally and contextually grounded local evaluations of each CDEP were designed and implemented by each IPP through a community-based participatory research approach. IPPs had flexibility in the design of their local evaluations to develop evidence for intervention strategies that were culturally anchored.

Second, CRDP conducted a cross-site, statewide evaluation to assess the overall effectiveness of the PEI initiative in designing and implementing initiative-wide strategies to reduce mental health disparities. Statewide evaluation objectives and research questions were predefined by the CDPH-OHE.

STATEWIDE EVALUATION OBJECTIVES AND RESEARCH QUESTIONS

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

- To what extent were 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 were vulnerabilities or weaknesses in CRDP's overarching strategies and fiscal operations, and how could they have been strengthened?

- To what extent did CRDP strategies show an effective return on investment?

Objective 2: Determine Effectiveness of CDEPs

- To what extent did IPPs prevent and/or reduce the severity of prioritized mental health conditions within and across priority populations, including specific sub-populations (e.g., gender, age)?

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

- To what extent did CRDP Phase 2 Implementation Pilot Projects validate their CDEPs?

- What evaluation frameworks were developed and used by the Pilot Projects?

Considerations of culture, context, methodology, and equivalence undergirded the statewide evaluation's philosophy and approach. Culture is not simply relational and psychological. It is also embedded and expressed in communities. To this end, the statewide evaluation approach was:

- Multi-level: Data was collected at individual, organizational, community, and statewide levels.
- Community-based: Working closely with CRDP partners, the statewide evaluation team identified and described the impact of the CDEPs offered by each IPP in their respective communities.
- Culturally-driven: Cultural, contextual, and historical factors were considered essential in the design and implementation of the research approach.

The statewide evaluation included five qualitative and quantitative measures of evaluation:

Organizational-level data.	CDEP participant level data.	Semi-structured interviews with CRDP partners.	Review of CRDP-related documents and records.	Secondary data, such as state and national-level survey sources.

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OUTREACH AND RECRUITMENT

Outreach and recruitment were central to CRDP's commitment to increasing access to mental health services. It was clear that the traditional approach of using infomercials, leaflets, and presentations to tell communities what they need would not help to build trust or to design effective interventions. Instead, community members were invited to develop CDEPs. In that process, IPPs engaged a broad spectrum of community members at their homes, schools, businesses, faith-based settings, public events, government offices, and local agencies.

Meeting people where they live their lives was important, but how IPPs showed up there was crucial. So, they came to listen and connect.

AANHPI IPP: Staff report on outreach illustrating the importance of connecting through shared understanding of cultural practices, shared language, and willingness and ability to be flexible in addressing potential obstacles to participation:

"Many Southeast Asian youth, both male and female, have responsibilities at home that keep them from attending out-of-school functions. Home visits allow youth counselors to talk to youth and their families about the benefits of joining [CDEP] where they are comfortable. Counselors can also communicate in the parents' native language and anticipate and address many of their concerns in a culturally responsive way. For example, Hmong girls are often not allowed to do extra-curricular activities. [Staff] can convince parents of the benefits as well as assure them of their safety, driving girls to [CDEP] activities if necessary."

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AfAm IPP: Staff report on outreach illustrating the value of using local talent in outreach efforts, food, art work, Black history, and Black music as a powerful engagement strategy:

"At [CDEP events] staff hired a Black woman-owned caterer to provide vegan soul food, which instantly became a popular topic of conversation and an ice-breaker to staff to meet with the over 60 sisters in attendance. Sisters spoke to the caterer about the recipe and creating traditional dishes in a healthy way. The event took place at OakStop, and the striking art honoring Black history, women and artistic expression of our people similarly became a source of conversation and helped to affirm that the Information Session is a safe space for Black women to express and see themselves reflected in the food, art, and music. Songs like Andra Day, 'Rise Up,' Anita Baker, 'You Bring Me Joy,' and Ms. Lauren Hill, 'I Gotta Find Peace of Mind-Live,' caused both pause, reflection, and sparked a call-and-response to how music vocalizes the shared struggle and journey we face as Black women."

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AI/AN IPP: Staff report on outreach illustrating the importance of connecting through cultural tools and practices, aided by program participants, and in atypical spaces such as a professional sports game:

"

We presented at Native American Heritage Night at the Oakland A's game. Staff and program participants shared powwow songs and demonstrated powwow dancing while in powwow regalia. This is an outreach event that simultaneously reaches the Native community present at the game and shares Native culture with non-Natives. Many youth dancers participated in this event. Indian Health Center programming was announced and information about Native families fostering Native American children was promoted on the jumbo screen. Powwow is an inter-tribal gathering that unites tribes across the United States. The event is put on by the Native community for the Native community and is a time to celebrate Native culture. We outreached about our CDEP with CDEP participants and with three critical CDEP components (powwow song, dance, and cultural arts regalia), highlighting the youth and carrying on of these important inter-tribal traditions. Youth were also emphasized by our promoting the needs of Native youth in the foster system."

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Latinx IPP: This IPP demonstrates the importance of addressing the linguistic needs of their priority population using familiar, colloquial language forms and the relational benefits of doing so:

"We do much of our recruitment at the Mexican consulate where [our CDEP is] co-located [with their preventative health program]. We believe this co-location is a key and integral part of our model because we can outreach to a population that is hardly reached with direct services from other health providers. We know that when participants arrive at the consulate the Spanish that they are serviced with is a more bureaucratic Spanish that may not be the one they communicate normally, it is not the Spanish our [CDEP] staff uses at home either. We make sure that in our outreach presentations to the general waiting area we speak in a Spanish that we are comfortable with, with simple terms for health topics just as [staff] learned and heard in our own homes growing up. This Spanish resonates with much of the audience and we believe is the start to building the trust that will motivate them to step into our office and learn about our services."

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DID CDEPs MAKE A DIFFERENCE TO MENTAL HEALTH ACCESS?

THE SHORT ANSWER: YES.

According to community feedback, participants felt strongly that their cultural beliefs and healing practices were respected (97% strongly agree/agree), that providers understood their gender and sexual orientation diversity (97% strongly agree/agree), and that providers respected their spiritual diversity (95% strongly agree/agree).

We examined CDEP's impact in several areas, including **availability**, **utilization**, and **stigma/barriers.**

LGBTQ+ IPP: In this example, staff report on outreach illustrating the importance of understanding the stressors faced by their priority population, and the need to encourage their participation by responding to their socio-emotional needs:

"[CDEP staff] has listened to community members who have shared their fears about what it would be like for them to leave their home and move into a nursing home. Research tells us that LGBTQ seniors face discrimination and mistreatment in long-term care facilities. In an effort to find a solution to ensure our community members can age as who they are with dignity and support, [IPP] has partnered with [a local organization] to create the first LGBTQ Community Day Service Center where more frail LGBTQ seniors can continue to participate in programming. These seniors require transportation to and from our center, which is critical to keeping them connected to programs and community, aging safely in their homes. In an effort to encourage more participation in programming, we began bi-monthly workshops to highlight the benefits of staying engaged and enrolling into the Community Day Service Center to be able to have their health needs met and participate in social and social-support groups. We also encourage being matched up with a 'friendly visitor.'"

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AVAILABILITY

Difficulty accessing treatment can discourage individuals from seeking help and can ultimately lead to lower service-utilization rates and more severe or persistent mental health conditions. Where mental health services are situated matters when it comes to expanding service access and usage. People in communities of color and other marginalized groups are more apt to seek help in culturally-relevant spaces (e.g., faith-based settings, community-based organizations) during times of distress. In other words, traditional clinical settings are not the only places mental health services can or should be offered.

CDEPs were implemented across 74 locations spanning a variety of settings. Nearly two in three IPPs provided CDEP services in their agency offices. Other settings included schools, social service institutions, and public spaces. A small group of IPPs provided services in faith-based settings and at participants' homes (particularly when core service approaches involved home visits).

People in need of comprehensive services often face a patchwork of service providers in different program areas. To ease that burden, several IPPs used creative methods of streamlining services.

- Nine IPPs used a *holistic in-house* approach. For example, an AI/AN CDEP promoted whole-person wellness and healing within the IPP agency and in sacred outdoor locations using a unique blend of traditional healing methods coupled with best practices in trauma-informed services.

- Twelve IPPs used a *communication* approach that directed individuals to external services and resources to meet any needs extending beyond their CDEP service scope. For example, a Latinx CDEP created a warm, trusting environment within its agency's space to provide therapeutic support services for individuals and families in the area. The CDEP's clinical staff and community health workers used a "warm handoff" to connect individuals experiencing serious distress to long-term service providers and other support systems.

- Seven IPPs used a *co-location and collaboration* approach. For example, an LGBTQ+ CDEP created a community of support for LGBTQ+ youth and their families. This effort included school-based resources offered directly to youth and technical assistance for school staff and administration focused on providing competent LGBTQ+ services.

- Seven IPPs used an *integrated team and/or partnership* approach. For example, one AANHPI CDEP represented a partnership of five organizations that came together with the shared value of promoting physical and mental wellness using culturally relevant, trauma-informed care. Services were integrated across partner sites ensuring that participants received seamless, consistent treatment.

As a component of their CDEP strategies, 24 IPPs provided service referrals, linkages, and/or service navigation to 17,599 individuals to improve access mental health services.

Referrals connected participants to mental health care (counseling, therapy, wellness), basic needs (food, financial assistance, transportation), and health care (primary health care, nutrition, COVID-related health).

Linkages involved timely "warm handoffs," meaning that someone personally connected a participant to a service provider.

Service navigation entailed ongoing guidance for participants as they sought care, support, and advocacy across the mental health system.

24 IPPs from 5 hubs provided   **17,599** unique individuals   **1+** referrals (total of 21,902)

89% adult   **10%** adolescent   **1%** children

ABOUT CRDP

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OUTREACH

MENTAL HEALTH ACCESS

MENTAL HEALTH OUTCOMES

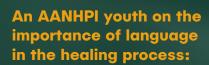COST-BENEFITS

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In total, 24 IPPs issued 21,902 CDEP referrals. While mental health and health care accounted for the largest number of referrals, the high frequency of basic-needs referrals reflected the importance of addressing the social determinants of health and mental health. Where people are born, live, learn, work, play, worship, and age affect mental health outcomes.

UTILIZATION

Between May 2017 and April 2021, IPPs directly served approximately 15,322 individuals. Eighteen CDEPs served older adults (60+ years), 23 served adults (25-59 years), 21 served transitional-age youth (18-25 years), 21 served adolescents (12-17 years), and 12 served children (5-11).

CDEPs served a cross-section of sub-populations (e.g., adolescents, older adults, limited English-speakers, immigrants, refugees) that are typically at a higher risk for mental health problems and may be less likely to use mental health services due to stigma related to mental health care.
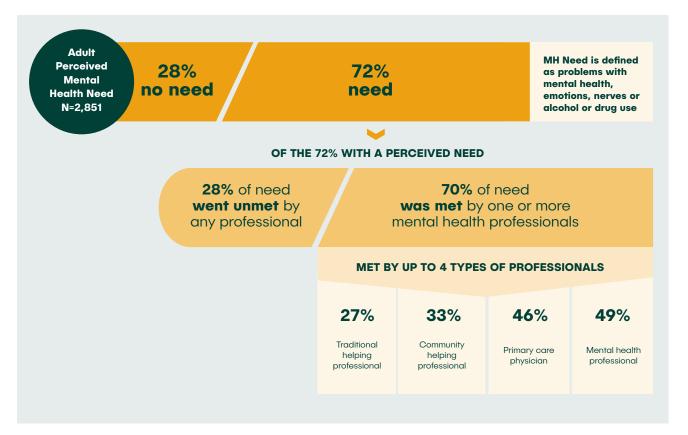
Health insurance, or lack of it, also impacts utilization. People with insurance have greater access to services. More than one in three CDEP participants with mental health coverage accessed services compared with just one in ten participants without coverage.

An AANHPI youth on the importance of language in the healing process:
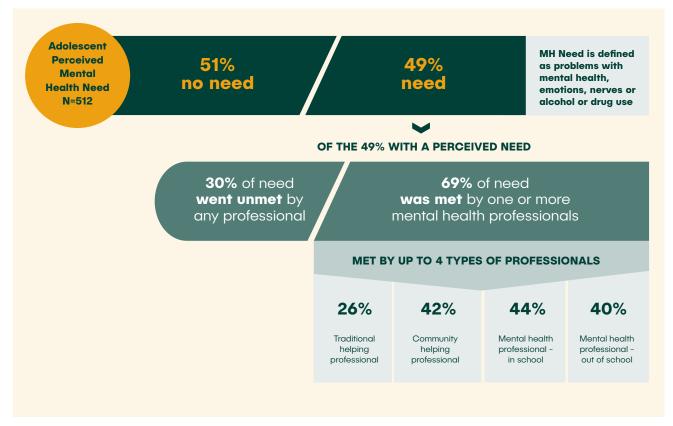
"I don't usually go to mentors at school because I don't like opening up to people. I don't know. I'm not sure why I opened up with [CDEP staff]. Maybe it's because they'll understand me more if they're more the same language as we speak and culture."

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Among those who completed the participant questionnaire, 72% of adults and 49% of adolescents had a perceived mental health need (e.g., depression, anxiety, addiction) in the year prior to receiving CDEP services. Of those participants, 28% of adults and 30% of adolescents had an unmet mental health need before their CDEP participation. Levels of unmet need fell by 7 percentage points for adults and 6 points for adolescents after their help-seeking options were expanded beyond mainstream services to include culturally informed or community-based care.

Adult Perceived Mental Health Need N=2,851

28% no need

72% need

MH Need is defined as problems with mental health, emotions, nerves or alcohol or drug use

OF THE 72% WITH A PERCEIVED NEED

28% of need **went unmet** by any professional

70% of need **was met** by one or more mental health professionals

MET BY UP TO 4 TYPES OF PROFESSIONALS

27%	**33%**	**46%**	**49%**
Traditional helping professional	Community helping professional	Primary care physician	Mental health professional

Adolescent Perceived Mental Health Need N=512

51% no need

49% need

MH Need is defined as problems with mental health, emotions, nerves or alcohol or drug use

OF THE 49% WITH A PERCEIVED NEED

30% of need **went unmet** by any professional

69% of need **was met** by one or more mental health professionals

MET BY UP TO 4 TYPES OF PROFESSIONALS

26%	**42%**	**44%**	**40%**
Traditional helping professional	Community helping professional	Mental health professional – in school	Mental health professional – out of school

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An AANHPI IPP: Staff shared a case example that illustrates the importance of connecting through shared experience, engendering hope, and providing support in the healing process:

"A young, single mother with two young children who just divorced from her abusive and controlling husband told me that she felt that she was trapped in the welfare system. She is working for minimum wage and has no education or college degree and did not think she could break out of the cycle and provide a better standard of living for her children. She wants to go to college, but she did not know how to start or whom she could talk to. After I listened to her story, I shared my own story, how I was able to go from a brand-new immigrant who spoke very little English working at 7-Eleven to hold a master's degree in Early Childhood Education within ten years. I told her that she has all the potential and power to make this happen because she is a strong and intelligent young woman. I reassured her that she can survive and provide for her family without her ex-husband. She is now enrolled at Los Angeles City College majoring in nursing and is starting in January 2018. She is still in her recovery stage from the emotionally abusive relationship, but she now knows that she is not going through this alone and things will get better."

Among CDEP participants surveyed, three-in-four adults experienced serious or moderate psychological distress 30 days prior to CDEP involvement. Two out of three adults reported impaired functioning at home, school, work, or in personal relationships.

Almost two-in-three adolescents experienced serious or moderate psychological distress 30 days prior to CDEP involvement. More than half reported impaired functioning at home and school.

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> **A Latinx youth provides a case example of the behavior change that comes through CDEP support:**
>
> " Honestly, when I came, I didn't like it. I just wanted to go back to my home school, but then I started talking. I met [my therapist] and other teachers that saw me as a bright student, and they even told me. Ever since, from the first day I came to this day now, I have no suspensions here. No suspensions, no referrals, or anything."

These findings illustrate the crucial role that CDEPs can play in addressing gaps in access to mental health services. But identifying an individual's mental health needs (also thought of in terms of risk factors) is only a part of the story. Protective factors, including cultural strengths and community assets, can and should be leveraged to help decrease an individual's risk of mental illness. **IPPs provided insight into salient risk and protective factors in communities they served.**

- At the start of CDEP program participation, most adults and adolescents said their culture was protective and stabilizing.

- One out of two adults said they felt marginalized or isolated from the broader society.

- One out of two adolescents had a risk factor for loneliness and one out of three felt isolated from the broader society.

> **An AfAm CDEP participant illustrates the power of culturally- grounded intervention that decreased isolation and distress and increased connection and acceptance:**
>
> " One word I would use to capture my experience is the word 'free' because I have been free to show up as myself and not have to pretend like I'm okay when I'm not.... Before I started with [CDEP], I was pretty isolated, I was dealing with depression and anxiety. Still am, but now it doesn't feel as painful to say that those are some of the things I'm dealing with... and so it's been culturally affirming because there aren't too many spaces for Black women to come together and bare their truth and not be judged or expected to hide their feelings. And so we were in this space and you can see the passion, you can see the joy, and you can see the tears and the laughter and the humor... You can see all of who we are... And so I appreciate being able to be in community. I feel that nurturing, love, and support."

STIGMA/BARRIERS

The reasons shared by participants for not seeking mental health care varied.

- Nearly half of adults and two-thirds of adolescents said they could handle their problems on their own.

- Other barriers to mental health care for adults were financial and logistic, such as cost of services or lack of time.

- The second most common barrier to mental health treatment for adolescents was stigma and the fear of judgement from friends and family.

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DID CDEPS IMPROVE OUTCOMES?

YES. CDEPS HELPED IMPROVE MENTAL HEALTH OUTCOMES REGARDLESS OF PARTICULAR CDEP CHARACTERISTICS OR COMMUNITY DEMOGRAPHICS.

The statewide evaluation examined the prevalence of positive changes to psychological distress and functioning, increases of protective factors, and reductions of risk factors for individuals during their participation. The five mental health outcomes gleaned from the participant questionnaire were:
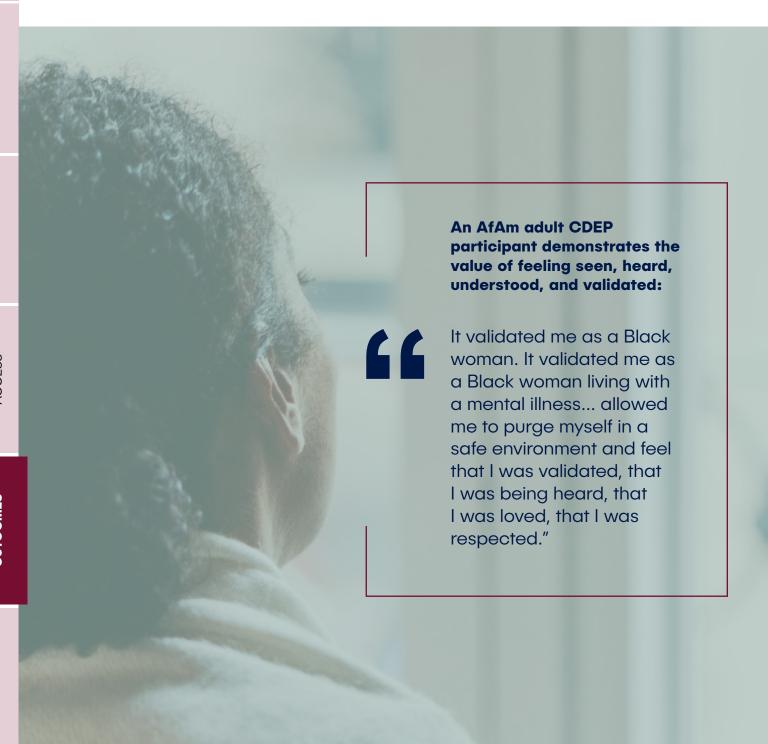
- Psychological distress.
- Functional impairment.
- Cultural protective factor (perceived connectedness and strength).
- Cultural protective factor (connected and balanced).
- Social isolation risk factor (marginalized/isolated).

The statewide evaluation found strong quantitative evidence supporting CDEP prevention and early intervention effectiveness among a sample of adult and adolescent participants, with most maintaining decreased levels of distress by the end of services. Perhaps most remarkable was that among participants who began with severe psychological distress, 80% of adults and 70% of adolescents were at or below pre-involvement levels of distress at the end of services. Moreover, 66% of adults and 49% of adolescents reported that their participation in CDEP services resulted in lower states of distress.

An AANHPI adult CDEP participant shares the value of incremental change:

"Before I joined the program, I had a heart problem, and when I get mad I cannot breathe. Since joining the program, I've learned to not get mad right away and to re-think why I'm mad. I no longer have the problem of not being able to breathe. I used to have an inhaler to help me breathe when I'm mad, but the program gave me a stress ball and I've been using that instead, so I don't have to use the inhaler anymore."

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Overall, adult CDEP participants experienced improvements in psychological distress and functioning, increased cultural protective factors, and reduced marginalization and isolation.

In particular, adults who reported the highest levels of distress pre-intervention had the greatest decreases of distress at post-intervention. Similarly, adults whose mental health interfered with functioning at home, work, or school experienced fewer disruptions after receiving CDEP services.

An AfAm adult CDEP participant demonstrates the value of feeling seen, heard, understood, and validated:

" It validated me as a Black woman. It validated me as a Black woman living with a mental illness... allowed me to purge myself in a safe environment and feel that I was validated, that I was being heard, that I was loved, that I was respected."

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Adolescent participants showed modest reductions of psychological distress but overall held steady in psychological functioning, cultur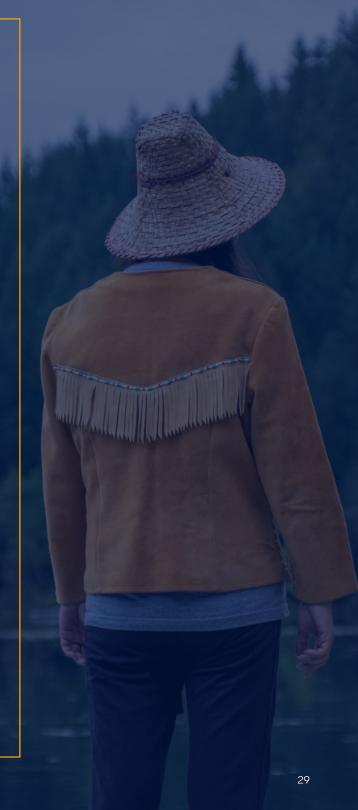al protective factors, and marginalization and isolation. From a prevention standpoint, these findings are promising. Youth who reported the highest levels of distress pre-intervention showed the greatest improvements to mental health over time.

Overall, these findings suggest that IPPs were serving persons with the highest levels of need. That participants maintained low or moderate levels of distress from pre- to post-intervention is an encouraging finding and a win for prevention.

An AI/AN youth CDEP participant illustrates the healing power of a culturally grounded experience:

"I found it (CDEP event) to be beneficial to be able to sit with elders and other cultural people from my community to support me and the ideas I had for my future. It was comforting to hear stories from people I see in my community as leaders and to hear what they have gone through in their own journey. Those stories were reminders that we are all still people, regardless of the good and bad we go through. I believe that other Native youth could benefit from hearing these personal stories to help motivate each one of us to walk in a good way... to be humble and kind while staying true to our culture and traditions."

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A Latinx youth CDEP participant and promotor shares the value of cultural grounding:

" I learned Spanish when I was younger, but then I tried to hide it because I felt like I shouldn't speak it, like it was wrong. But with this, I felt really empowered speaking Spanish because I can help people. I understand them. I understand their needs and I'm able to communicate with them better."

An LGBTQ+ CDEP participant shares how hope was restored through their CDEP:

" People throw around the word hope a lot and when you think about the rest of your life it can be quite daunting, but to have a little glimpse of something that's possible is probably the biggest gift I've gotten from here."
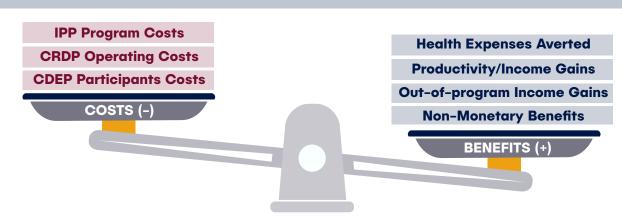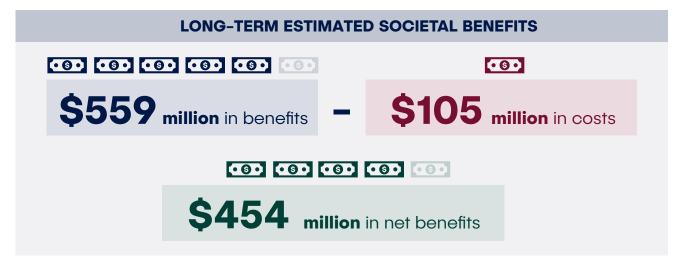
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WHAT DOES ALL OF THIS COST?

THE QUESTION THAT SHOULD BE ASKED IS, HOW MUCH DOES ALL OF THIS SAVE?

Even small improvements in mental health and wellbeing yielded positive financial benefits for the state of California, and therefore for taxpayers. The economic value of CRDP Phase 2 was calculated using a cost-benefit analysis of health and non-health initiative outcomes to determine the return on investment (ROI). After subtracting the costs from the benefits, CRDP Phase 2 yielded an estimated net benefit of $454,260,069. From a prevention standpoint, for every dollar invested in the CRDP Phase 2 initiative, there were cost savings between $4.32 to $5.67.

CRDP COSTS AND BENEFITS

IPP Program Costs
CRDP Operating Costs
CDEP Participants Costs

COSTS (–)

Health Expenses Averted
Productivity/Income Gains
Out-of-program Income Gains
Non-Monetary Benefits

BENEFITS (+)

LONG-TERM ESTIMATED SOCIETAL BENEFITS

$559 **million** in benefits **–** **$105** **million** in costs

$454 **million** in net benefits

$$\text{Return on Investment} = \frac{(\text{Benefits} - \text{Cost})}{\text{Cost}}$$

CRDP ROI = 4.32 to 5.67

*Note: The net benefits reflected in this illustration are for the main scenario. The range for the CRDP ROI reflects calculations for the main scenario and for the sensitivity analysis.

Analyses of CDEP's cost effectiveness show that financial benefits stem most often from improvements to prevention and early intervention practices. These findings are in line with CDRP's core mission: developing and implementing culturally anchored, community-defined approaches to treatment that address mental health issues before they become too damaging and expensive to confront.

The extraordinary estimated return on investment outlined here validates CDEPs as a strategy that warrants serious consideration of expanding similar programs.

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CDRP statewide evaluation findings led to five key recommendations for consideration by lawmakers, researchers, county mental health systems, and mental health practitioners. In the full report, we highlight further questions and potential avenues to pursue in future work.

> **An AANHPI CDEP participant shares about the liberatory value of her CDEP:**
>
> "I felt that I had a dark life, like a pigeon in a bird cage, when I first came here. Now my dreams are coming true and I can be more honest and see the world being much brighter now."

1 **Recognize CDEPs as innovative, effective, community-driven PEI approaches to reducing mental health disparities, especially in unserved, underserved, and inappropriately served communities.**

The CDEP approach to PEI represents a viable, culturally responsive alternative or complement to EBPs and should be recognized as such by federal, state, and county mental health services (e.g., MediCal, and other ongoing behavioral health funding streams). CDEPs developed in communities using culturally, linguistically, and LGBTQ+–affirming evaluation approaches represent effective, inclusive, and responsive approaches to reducing mental health disparities.

2 **Use a Capacity-Building Pilot Project approach as a health equity tactic more widely and maintain flexibility and openness to a wide range of potential CDEP approaches considered for funding.**

The variety of CDEPs could not be easily categorized within CRDP Phase 2 (e.g., workforce development, direct service, school-based programs, youth development, etc.) and there was no single model that was adopted by all communities, so it is important to be flexible in defining what CDEPs look like and how they provide programs and services.

Organizations in unserved, underserved, and inappropriately served communities may have creative, substantive ideas, but would benefit from organizational capacity building to help develop their CDEPs and meet eligibility requirements for grants. Specifically, support for organizational capacity development around issues of fiscal management, leadership development, community engagement, and evaluation could make a big difference for potential CDEPs.

Other resources to support these organizations can be developed, including CDEP toolkits to strengthen community engagement and aid decision making, implementation, adaptation, and evaluation processes.

3 **Make disaggregated data more widely available in large-scale secondary datasets, increase access to county level PEI data, and oversample certain populations and sub-populations.**

These will permit better examination of intersectionality issues and assist stakeholders and policy makers to understand and reduce mental health disparities.

For example, for LGBTQ+ populations, the lack of access to disaggregated data with robust sample sizes means that it is not yet possible to establish a business case with credible evidence for LGBTQ+ populations. Note that these barriers have nothing to do with the actual effectiveness of CDEPs for LGBTQ+ populations but instead have to do with the lack of secondary data available to analyze the cost effectiveness of these approaches.

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Importantly, the lack of disaggregated data blocks the capacity to complete analyses that are more nuanced and better able to identify which gaps in services exist for which populations. Without appropriate items and the capacity to link datasets, existing datasets cannot contribute to the examination of intersectionality or the needs of priority populations with more fine-grained analyses. Instead aggregate categories found in many datasets perpetuate category-based assumptions about priority populations, hiding the unique cultural, linguistic, and historical differences among diverse communities such as AANHPI, AI/AN, LGBTQ+.

At the county and state levels, PEI program data was not uniformly available at the level required to provide comparable estimates of a credible counterfactual to the CRDP Phase 2 CDEPs as mental health PEI programs.

4 While fidelity has its purpose, it is important to recognize the value of diverse PEI approaches and the need for flexibility in their implementation and responsiveness to community.

Mission fidelity centers IPP relationships with their communities. From this perspective, the community and its ecology are not simply background context for program implementation, but a guide for ensuring that programs are responsive to the community's needs and cultural values. As such, flexibility is instrumental to ensuring fidelity, and in this case, construed as adherence to mission rather than deviation from a program template or a manualized intervention.

CDEPs were prevention and early intervention approaches for adults and youth representing various communities, identities, languages, and cultural experiences. What does it mean to value and honor this CDEP diversity when EBPs, which are manualized and standardized, tend to be held as an unquestioned standard? PEI approaches primarily reflect youth populations and support for PEI programs for older adults is lean. CRDP findings encourage the application of PEI approaches across a wide age range, especially with adults and older adults in the priority populations served by CRDP Phase 2.

5 Expand use of community-based participatory practices (CBPP) and evaluation strategies for services and programs offered for unserved, underserved, and inappropriately served populations.

The findings from the statewide evaluation of CRDP Phase 2 would not have been possible without the high level of community engagement during the initiative, even as IPPs and TAPs tended to perceive statewide evaluation efforts as "top down" in nature. But community-engagement strategies were key to the success of every aspect of CRDP Phase 2, including the evaluation. Developing CDEPs, measuring results, and sharing the stories of these efforts with stakeholders and other audiences were collaborative undertakings by IPPs and communities. The results demonstrate extraordinary success in expanding access to mental health care while the processes by which they were achieved and measured were healing and empowering in themselves.

The CRDP Phase 2 Extension and continued CDEP funding would not have been possible without the IPP's self-mobilization around continued sustainability and advocacy through the work of the IPP-formed Cross-Population Sustainability Steering Committee CPSSC.

Community members repeat the mantra, "nothing about us, without us," yet how often do funding efforts and research endeavors focus on communities without authentic, meaningful, sustained community engagement? Several factors would help to strengthen initiative partnerships, including the creation of data use and sharing agreements to clarify data ownership, data use, and data sharing, and generous time allocated for community review processes, especially to honor tribal review processes. Additionally, a planning phase that creates time and space for building relationships and establishing trust among contractors and grantees would strengthen collaboration and promote sustainability at a human level.

CRDP Phase 2 has shown that CDEPs are indeed innovative and effective PEI strategies that reduce mental health disparities in priority populations. As such, we recommend that CDEPs be uplifted, supported, and expanded for use in unserved, underserved, and inappropriately served communities in California and beyond.