

Loyola
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Psychology Applied Research Center



The California Reducing Disparities Project Phase 2

Statewide Evaluation Report



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Psychology Applied Research Center

COMMUNITY BASED RESEARCH ACTIVISM
AND EVALUATION

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PRIORITY POPULATION	AFRICAN AMERICAN	AMERICAN INDIAN/ALASKA NATIVE	ASIAN AMERICAN NATIVE HAWAIIAN PACIFIC ISLANDER	LATINX	LGBTQ+
TAPs					
					
					
IPPs					
					
					
					
					
EOA AND CULTURAL BROKER					

KEY TERMS

The racial, ethnic, sexual, and gender-identity labels originally used by CDPH-OHE for the priority population hubs were.

- **African American**
- **Asian Pacific Islander**
- **Latin**
- **Lesbian, Gay, Bisexual, Transgender, Queer & Questioning**
- **Native American**

The process of self-definition after generations of being defined by others is important. PARC@LMU understands that discourse related to these terms is complicated by differences in perspective, power, and politics. Language is complicated. Identities are not a monolith and are intersectional and complex.

With such complexities in mind, PARC uses the following terms and acronyms in this report because they are in alignment with CRDP's values of equity, inclusion, and dignity for all.

- **African American (AfAm)**
- **American Indian/Alaska Native (AI/AN)**
- **Asian American Native Hawaiian Pacific Islander (AANHPI)**
- **Latinx**
- **Lesbian, Gay, Bisexual, Transgender, Queer & Questioning (LGBTQ+)**¹

PARC uses these umbrella terms while also acknowledging that there is no universal priority-population experience. Individuals within each community may be linked because of a shared cultural ethos that inspires a sense of community connectedness, or they may have less in common despite sharing an externally imposed label. The priority populations are often viewed as monoliths, despite having significant cultural differences (e.g., language, worldview, spiritual practices and traditions, historical experiences), this point may be particularly critical for AI/AN, AANHPI, and LGBTQ+ communities. Further, priority population categories themselves are not mutually exclusive.

It is also worth noting that it is the IPPs, not individual community members, that are categorized into priority populations and hubs. Individuals within and across hubs may hold separate and distinct identities based on ethnic background, economic circumstance, immigration

experience, etc. These factors uniquely shape their narratives and lived experiences with regard to mental health and wellness.

The following sexual orientation and gender identity terms² are used in this report and are aligned with our values.

- **Sex:** A multidimensional construct based on a cluster of anatomical and physiological traits. Sex is usually assigned as female or male at birth based on visual inspection of external genitalia.
- **Intersex:** People whose sex traits do not all correspond to a single sex. Some individuals no longer use the term "intersex conditions" and instead prefer "disorders of sex development." (See ISNA.org.) Others identify as intersex and do not have bodies the medical establishment would label "intersex."
- **Cisgender:** A person whose current gender identity corresponds to the sex they were assigned at birth (e.g., someone who is assigned female at birth and who lives as a woman).
- **Transgender:** A person whose current gender identity is different from the sex they were assigned at birth. Also, an umbrella term which includes all people whose genders are not traditionally associated with their sex at birth.
- **Trans:** An inclusive term referring to the many ways one can transcend or even transgress gender or gender norms (e.g., individuals who may identify as transgender, transsexual, gender diverse, etc.). In some cases, the term is followed by a sex or gender identity label (i.e., trans female, trans women, trans male, trans man). In other instances, trans is not followed by a sex or gender term, which can indicate that not all trans people identify with an established sex or gender label.
- **Transmasculine:** Someone assigned female at birth and who identifies as masculine but may not identify as a man. The phrase "masculine of center" may be used to indicate where people who identify as transmasculine see themselves in relation to other genders.
- **Transfeminine:** Someone assigned male at birth and who identifies as feminine but may not identify as a woman. The phrase "feminine of center" may be used to indicate where people who identify as transfeminine see themselves in relation to other genders.

¹ As the variety and richness of identities for gender and sexual orientation continue to grow and evolve, LGBTQ-serving organizations increasingly add "+" to the list of people as shorthand to acknowledge the multitude of personal identities used by those they serve.

² The gender identity and sexual orientation terms and definitions used in this report are drawn or adapted from several sources. (Human Rights Campaign n.d.; National Academies of Sciences, Engineering and Medicine, 2022; and Einhaus et al., 2018)

KEY TERMS & ACRONYMS

- **Gender non-conforming:** Someone who looks and/or behaves in ways that don't conform to, or are atypical of, society's expectations of how a person of that gender should look or behave.
- **Genderqueer:** Someone who identifies outside of, or wishes to challenge, the two-gender (i.e., man/woman) system; may identify as multiple genders, a combination of genders, or "between" genders.
- **Non-binary:** Similar to genderqueer, an umbrella term for gender identities that lie outside the gender binary (i.e., man/woman) system and/or challenge that system.
- **Two-spirit:** Someone who embodies the gender spirit of both men and women. The term has roots in the traditions of the indigenous nations and peoples of North America and is used by some indigenous people to describe their sexual, gender, and/or spiritual identity.
- **Transgender/Gender Non-binary (TGNB):** An umbrella term used when reporting on gender identity referring to individuals with gender identities different from the sex assigned at birth and/or that fall outside of or challenge the gender binary system.
- **Heterosexual/Straight:** Sexually oriented toward people of the opposite, usually binary, gender.
- **Gay or Lesbian:** Sexually oriented toward people of the same, usually binary, gender.
- **Queer:** An umbrella term for belonging to the LGBTQ+ community; also used to refer to a person who is sexually oriented toward people of more than one gender.
- **Bisexual:** Sexually oriented toward both men and women.
- **Pansexual:** Sexually oriented toward people of any gender.
- **Asexual:** A complete or partial lack of sexual attraction or lack of interest in sexual activity with others. Asexuality exists on a spectrum, and asexual people may experience no, little, or conditional sexual attraction.
- **Aromantic:** A person with little or no romantic attraction to others. They may or may not feel sexual attraction.
- **Questioning:** A person who is unsure of, or still exploring, their sexual orientation and/or gender identity.
- **LGBQ+:** An acronym used when reporting sexual orientation referring to individuals with sexual orientations that are not exclusively heterosexual or straight.

We recognize that the inclusion of various terms to signify gender identity, sexual orientation, race, and ethnicity may differ for various groups and from commonly used terms in the general population or within social justice movement efforts.

AfAm	African American/Black
AI/AN	American Indian/Alaska Native
AANHPI	Asian American/Native Hawaiian Pacific Islander
APA	American Psychological Association
CalHHS	California Health and Human Services Agency
CBO	Community-Based Organization
CBPP	Capacity Building Pilot Project
CBPR	Community-Based Participatory Research
CDC	Centers for Disease Control and Prevention
CDEP	Community-Defined Evidence Practice
CDPH	California Department of Public Health
CM	Contract Manager
CRDP	California Reducing Disparities Project
CPEHN	California Pan-Ethnic Health Network
CPSSC	Cross-Population Sustainability Steering Committee
DMH	Department of Mental Health
EBP	Evidence-Based Practice
EOA	Education, Outreach, & Awareness
IPP	Implementation Pilot Project
IRB	Institutional Review Board
LGBQ+	Lesbian, Gay, Bisexual, Queer
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
NIH	National Institute of Health
NIMH	National Institute of Mental Health
OHE	Office of Health Equity
PARC@LMU	Psychology Applied Research Center at Loyola Marymount University
PEI	Prevention and Early Intervention
RFP	Request for Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SOGI	Sexual Orientation and Gender Identity
SPW	Special Planning Workgroup
SWE	Statewide Evaluator
TA	Technical Assistance
TAP	Technical Assistance Provider
TGNB	Transgender and Non-Binary
WET	Workforce Education and Training

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Statewide Evaluation Executive Summary

“

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 participant³

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

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 socioeconomic status. 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/>

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.

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

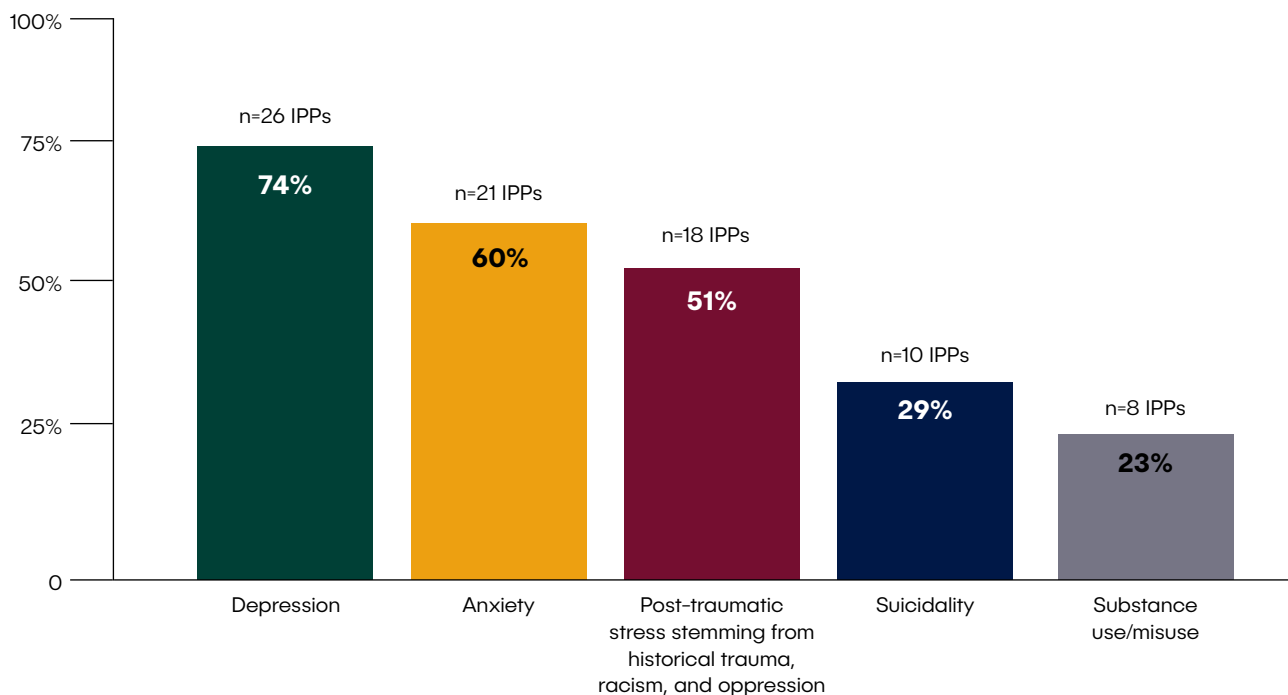
23%

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.

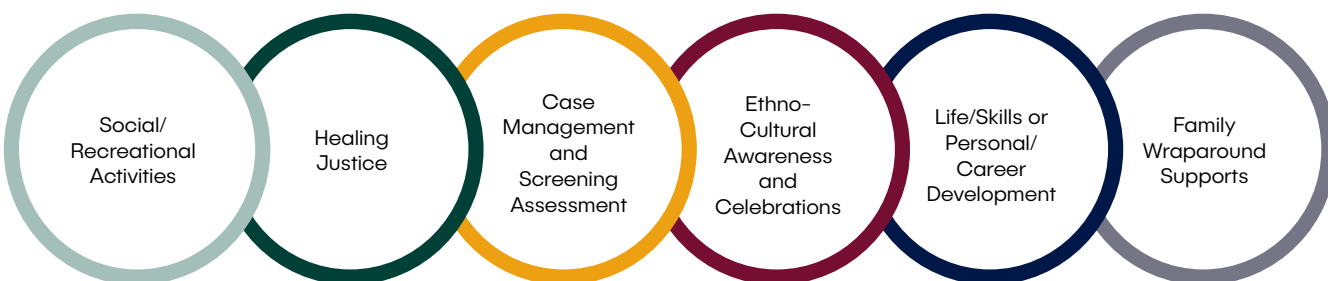
Priority Mental Health Problems

Information derived from: IPP Local Evaluation Plans 2018



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.

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



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)

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."

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

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.”

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.”

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:

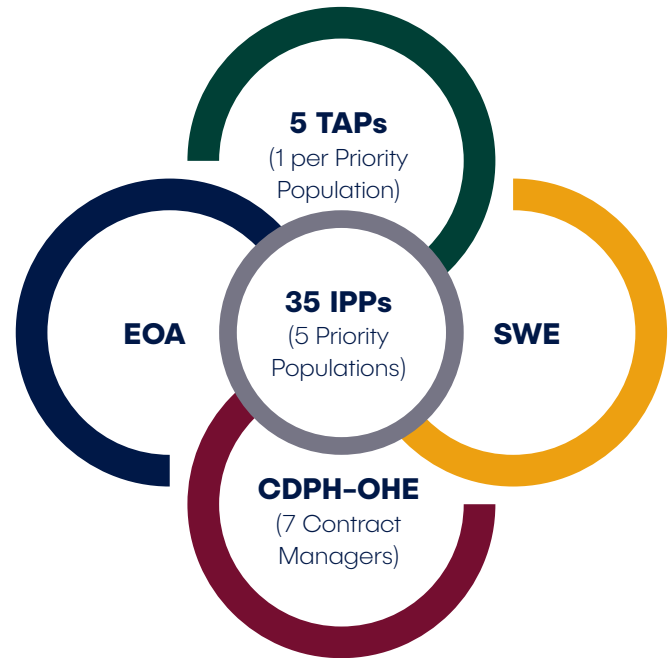
“

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.”

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.



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.



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.

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.”

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.”

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.”

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.”

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.’”

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

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.

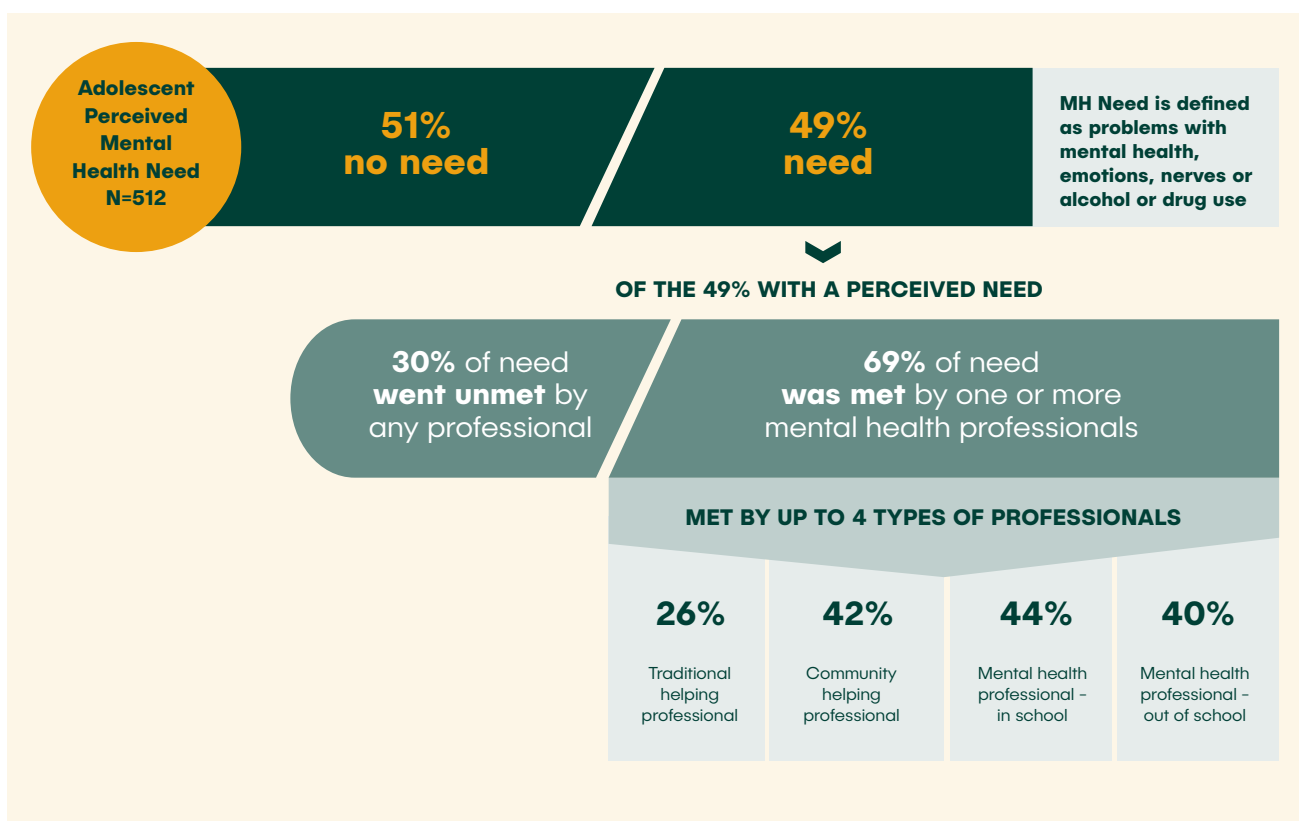
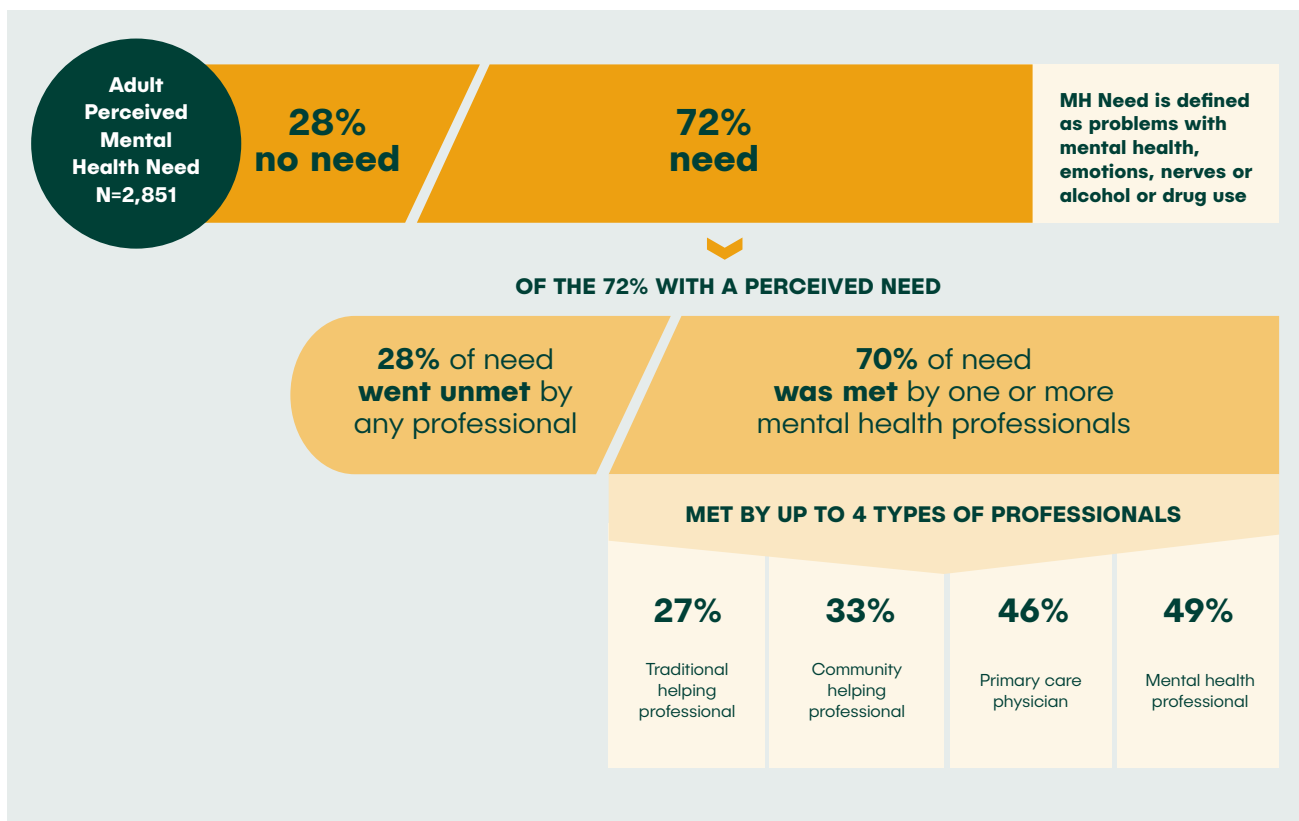
Health insurance, or lack of it, also impacts utilization. People with insurance have greater access to services. More than one in three CDEP participants with mental health coverage accessed services compared with just one in ten participants without coverage.

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.”

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.



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.

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.

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.”

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.”

Adolescent participants showed modest reductions of psychological distress but overall held steady in psychological functioning, cultural 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.”





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.”

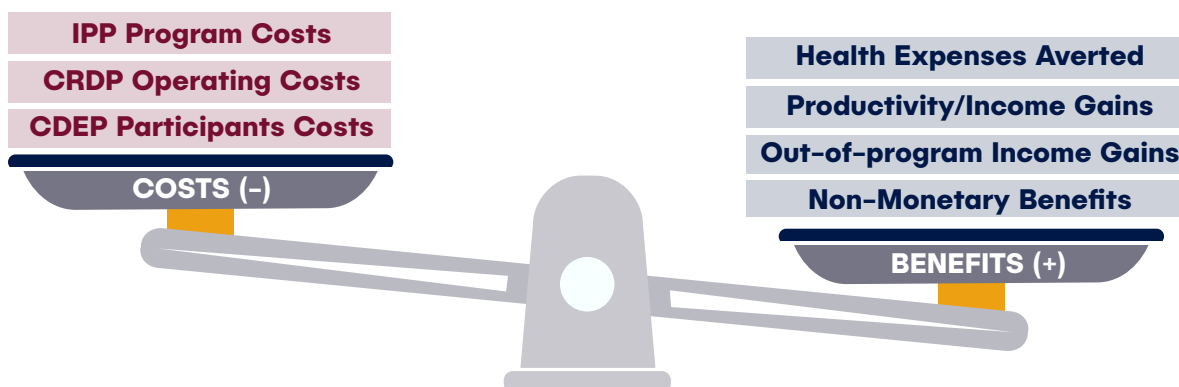


WHAT DOES ALL OF THIS COST?

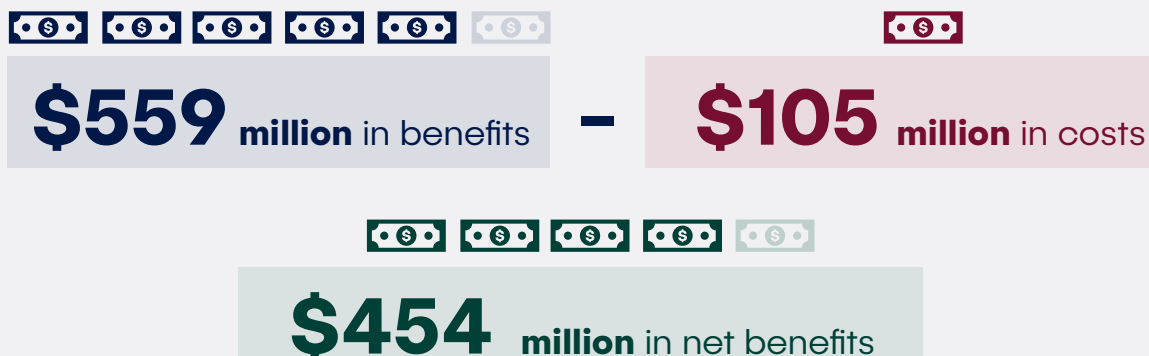
THE QUESTION THAT SHOULD BE ASKED IS, HOW MUCH DOES ALL OF THIS SAVE?

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



SOCIETAL BENEFITS



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

$$\text{CRDP ROI} = 4.32 \text{ to } 5.67$$

***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.

RECOMMENDATIONS

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.

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.

Chapter 1

Introduction

INTRODUCTION

LAUNCHED IN 2009, THE CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP) EMERGED FROM THREE IMPORTANT FACTORS.

FIRST

U.S. Surgeon General David Satcher's call for national action to reduce mental health disparities experienced by historically unserved, underserved, and inappropriately served racial and ethnic groups, and the release of the supplemental research report released by his office in 2001 titled, *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services). Along with associated research, it made the case for the creation of CRDP.

SECOND

The passage of the Mental Health Services Act (MHSA) through California Proposition 63 in 2004. The MHSA, which places a 1% tax on all California incomes over \$1 million, funds services to improve mental health conditions and mental health systems in California. Most funds are distributed at the county level, of which 20% are allocated to prevention and early intervention efforts related to mental health. It is important to note that PEI is likely the component of the MHSA that holds the most potential and promise to racial/ethnic/LGBTQ+ communities. The MHSA funded CRDP Phase 1 and the original scope (2015–2022) of CRDP Phase 2.

THIRD

The third factor was strong stakeholder mobilization to address mental health disparities in California. CRDP exists due to a long history of community participation that included community demands to meet with Dr. Stephen Mayberg, then director of the now dissolved Department of Mental Health (DMH), to address mental health disparities in the state. Dr. Mayberg's response led to the DMH's initiation of the CRDP. In 2012, when the DMH was dissolved, the CRDP was transferred to the newly founded 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 is to identify and implement solutions to reduce mental health disparities for historically unserved, underserved, and inappropriately served communities in California. The CRDP focuses on five priority populations⁷:

- 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⁺)

Phase 1 (2009–2015) focused on population-specific needs assessments and the development of a strategic plan to reduce mental health disparities. Strategic planning workgroups, one for each priority population, engaged their respective communities in a needs assessment process (e.g., surveys, focus groups, town halls, etc.) to:

- Assess community mental health needs and service access.
- Make recommendations for reducing community mental health disparities.
- Identify practices that could effectively address mental health and wellness in CRDP Phase 2.

The findings were compiled into five priority population reports, which were synthesized into a single, comprehensive CRDP strategic plan to reduce mental health disparities.

The original scope of Phase 2 (2015–2022) focused on the implementation and rigorous evaluation of community-defined evidence practices (CDEPs) by 35 funded grantee organizations (constituting 7 CDEPs for each priority population identified in Phase 1). Phase 2 began with a \$60 million dollar investment focused on strengthening and demonstrating the effectiveness of the 35 CDEPs implemented by the five priority populations and developing and reinforcing organizational infrastructure to effectively deliver mental health services.

⁷ In addition to the five-priority population listed, CRDP Phase 1 also supported statewide advocacy efforts for additional populations including, Arabic-Speaking, Russian-speaking, Armenian, and the Deaf and Hard of Hearing community.

The CRDP Phase 2 was originally intended to end in April 2022. At the time of writing this report, through the leadership and efforts of the IPP-led Cross-Population Sustainability Steering Committee (CPSSC), the California State Legislature approved an additional \$63.1 million dollars from the state's general fund to continue CRDP Phase 2 through 2026. (See Chapter 5 for additional information on the CPSSC and its efforts to sustain the CRDP.)

This report presents an overview of the CRDP Phase 2 (2016 – 2021) Statewide Evaluation and its findings. The evaluation was conducted by the Psychology Applied Research Center at Loyola Marymount University (PARC@LMU). This report does not reflect any activities occurring as part of the extended CRDP Phase 2.

1.1 THE MENTAL HEALTH DISPARITIES CONTEXT



Nearly one in six California adults experience a mental illness of some kind, and one in 24 have a serious mental illness that makes it difficult to carry out major life activities. One in 13 children has an emotional disturbance that limits participation in daily activities."

(California Health Care Foundation, 2018, p.2).

This finding is remarkable on its own. But consider the experience of racial, ethnic, and LGBTQ+ populations, and a striking picture of mental health disparities emerges.

It is also remarkable that, after considering 165 different health disparity conditions, the Federal Collaborative for Health Disparities Research chose mental health disparities as one of four topics warranting its immediate national research attention (Safran et al., 2009). The Institute of Medicine and the National Institutes of Health (NIH) have also prioritized mental health disparities in their research agendas.

Mental health disparity is defined in various ways depending on agency focus and expertise, and the purpose and context of the definition. For example, the Mental Health Science Group at the National Institute of Mental Health (NIMH) defines mental health disparity as a significant disparity in the overall rate of mental illness incidence or prevalence, morbidity, mortality, or survival in a health-disparity population as compared with the health status of the general population (Safran et al., 2009). The Substance Use and Mental Health Services Administration (SAMHSA) defines health disparity as the power imbalances that impact practices influencing access, quality, and outcomes of behavioral health care, or a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival in a specific group of people defined along racial and ethnic lines, as compared with the general population (Safran et al., 2009). These and similar definitions describe mental health disparities as differences associated with health, health services, or health determinants.

Cutting across such distinctions is the Center for Disease Control and Prevention's (CDC) definition, which associates mental health disparities as disparities present within the field of public health, health systems, and society. By the CDC's definition, mental health disparities often fall into one of three categories:

- Disparities between the attention given to mental health and that given to other public health issues of comparable magnitude.
- Disparities between the health of persons with mental illness compared to those without.
- Disparities between populations with respect to mental health and the quality, accessibility, and outcomes of mental health care.



The CDC often considers social determinants, such as employment, income, and housing, as factors that can influence mental health and access to care. When mental health disparities are not reduced, even when causal mechanisms are understood, they qualify as inequities, and are unfair (Coman et al., 2018).

Mental health disorders are among the most common health conditions faced by Californians (California Health Care Foundation, 2018). National data on mental health disparities, particularly related to access to and use of mental health services, align with California trends (Safran et al., 2009).

Mental health disparities look different for different populations. For example, although rates of depression are lower for African American/Black (24.6%) and Latinx (19.6%) compared to Whites (34.7%), their depression is likely to be more persistent (Budhwani et al., 2015). LGBTQ+ communities must contend with multiple marginalized identities contributing to worse health from double discrimination (Robertson et al., 2021), likely a contributing factor to their higher levels of mental health distress than heterosexuals (Hsieh, 2019). Disparities for this population may be even worse for LGBTQ+ youth. In a large-scale national study, transgender and non-binary (TGNB) youth reported significantly higher rates of depressive mood, seriously considered suicide, and attempted suicides compared with cisgender LGBTQ+ youth (Price-Feeney et al., 2020).

In California, rates of adult serious mental illness differ across racial groups. For example, 7% for Native Americans, 6% African American, 5% Latinx, 4% White, 2% Pacific Islander and 2% Asian American. A slightly different picture emerges with respect to serious emotional disturbance among children by race in the state (8% Latinx, 8% African American, 8% Native American, 8% Pacific Islander American, 7% Asian American, and 7% White) (California Health Care Foundation, 2018). Latinx and Asian Americans born abroad have the highest rates of unmet need. Latinx and Asian American Native Hawaiian Pacific Islanders born in the U.S. have the highest rates of inadequate treatment. African Americans, Asian American Native Hawaiian Pacific Islanders, Latinos, and Native Americans are more likely to have unmet needs compared to other subgroups. Native Hawaiians, Pacific Islanders, and multiracial groups experience the highest rates of inadequate treatment and after adjusting for age, gender, income, and education. The percentage of adults with mental health needs among LGBTQ+ (17.9%) was more than double the rate of mental health needs among heterosexuals (7.9%) (California Pan-Ethnic Health Network, 2018).

THE REASONS FOR THESE DISPARITIES INCLUDE BUT ARE NOT LIMITED TO:

- Health care providers delivering services with an inadequate cultural understanding of diverse communities, which contributes to the underdiagnosis and/or misdiagnosis of mental illness in people from racially and ethnically diverse populations.
- Lack of access to culturally competent and quality care.
- A potential preference for CDEPs rather than EBPs by communities of color and the LGBTQ+ communities.
- Lack of language access for non-English speakers (e.g., lack of written materials in clients' primary languages and bilingual service providers; no comprehensive statewide plan to address language access in county mental health departments).
- Affordability and accessibility of services.
- Stigma of mental illness.
- Historical factors.
- Cultural differences in how mental illness is understood, described and manifested.
- Systemic racism (e.g., a disproportionate number of people of color with mental health needs ends up in the criminal justice system rather than in the mental health care system; between 50% and 75% of youth in the juvenile justice system meet criteria for a mental health disorder but rather than receiving treatment they are incarcerated) (Underwood & Washington, 2016).
- Psychiatric and behavioral problems among youth of color often result in punishment at school or incarceration, neither of which typically include adequate mental health care (Marrast et al., 2016).
- The behavioral health workforce does not substantively reflect the diverse demographic characteristics of the communities it serves (Coffman et al., 2018).

Barriers to mental health service use vary by population and were discussed in each of the five CRDP Phase 1 Priority Population Reports.

For example:

- For **Latinx** populations, language barriers can make communicating with providers difficult. A lack of cultural understanding between clients and therapists, can lead to mental health providers misunderstanding and misdiagnosing Latinx clients. For example, an individual might describe symptoms of depression as “*nervios*” (nervousness), tiredness, or as a physical ailment. These are common symptoms consistent with depression, but providers untrained on culture might miss them as symptoms of depression. For immigrants who arrive to the U.S. without documentation, the fear of deportation can prevent them from seeking help. Even though millions of children of undocumented immigrants are eligible for health insurance under the Affordable Care Act, individuals may not know they are eligible, or might be afraid to register due to fear of separation from their families (Ford-Paz et al., 2020; Rhodes et al., 2015; Roche et al., 2018).
- Barriers for **AfAms** often include stigma associated with mental illness, distrust of the health care system, lack of providers from diverse racial/ethnic backgrounds, lack of culturally competent providers, lack of insurance, inadequate insurance, and fear of judgment or stereotyping (Chapman et al., 2013; Drwecki et al., 2010).
- Traditional behavioral health services do not reflect the cultural, linguistic, and geographical diversity of **Native American** communities. Further, factors known to contribute to mental health disparities within Native American communities (e.g., historical and intergenerational trauma, loss of culture) are often overlooked, misunderstood, or misdiagnosed by western providers. These factors contribute to stigmatization of Native American communities and can discourage individuals from seeking mental health support. Also, western mental health services, which focus on individual-level behaviors, are misaligned with Native American practices, which center on community wellness and holistic healing. For these reasons, indigenous people experiencing psychological distress are much more likely to seek help from a spiritual and/or traditional healer than from mental health or medical specialists.
- Discrimination, lower levels of social support and systemic exclusion from healthcare services contribute to mental health disparities in **LGBTQ+** communities (Steele et al., 2017). Low clinical practitioner knowledge of LGBTQ+ issues, concerns about therapists linking LGBTQ+ status to mental health issues, and experiences of discrimination during consultation, are a few examples of LGBTQ+-specific barriers to mental health care services (McCann & Sharek, 2014).
- **AANHPI** is a diverse population that is underserved, overlooked and not well understood. Consisting of more than 50 distinct ethnicities in the U.S., AANHPIs are typically lumped into an umbrella racial category obfuscating important distinctions in language, culture, history, experience that should inform mental health care. For example, in Native Hawaiian communities, there is an absence of culturally responsive treatments that honor and integrate traditional healing practices. Vietnamese, Cambodian, and Laotian refugee men reported several risk factors for depression and anxiety, including having a large family in the U.S. (which led to more financial pressures), difficulty adjusting to American culture, and traumatic life events (Chung & Bemak, 2002). Chinese and Vietnamese males reported more problems with alcohol than their female counterparts, whereas Korean females tended to have more problems with alcohol than Korean men (Kim et al., 2014). Providers must understand such distinctions in order to offer appropriate treatment.

Historical and contextual factors matter for understanding the causes of mental health disparities. “Racism, bigotry, heterosexism, transphobia, ageism, and other discrimination in the United States is a constant source of stress which can lead to feelings of invalidation, negation, dehumanization, disregard, and disenfranchisement” (California Pan-Ethnic Health Network, 2018). Consistent with a social ecological perspective, Alegria et al. (2003) argue that ultimately, “ethnic and racial disparities in mental health are driven by social factors such as housing, education, and income,” and that “many of these social factors are different for minorities than they are for Whites.” In other words, mental health disparities cannot be solved solely within the mental health context; the social determinants must also be addressed. For example, following the release of video footage of George Floyd being murdered by police, the share of Black people suffering from different forms of psychological distress such as depression and anxiety jumped from 36% to 41% (Altiraifi & Rapfogel, 2020).

The American Psychological Association (APA, 2017) recommends the following to address mental health disparities:

- “Increase the availability of culturally and linguistically competent mental and behavioral health services accessible to diverse racial/ethnic groups.”
- “Increase research examining the complexities and intersections of multiple statuses/identities (e.g., socioeconomic status, disability, and immigrant status) and how these may contribute to psychological health.”
- “Foster positive relationships and programs within racial and ethnic minority communities to increase awareness of mental health issues and prevent environmental factors that may place individuals at risk.”

Although the APA does not explicitly address mental health disparities across LGBTQ+ communities in its recommendations, the APA guidance holds true for this population as well.

In 2021, the APA issued an apology in which it acknowledged:

“

Since its origins as a scientific discipline in the mid-19th century, psychology has, through acts of commission and omission, contributed to the dispossession, displacement, and exploitation of communities of color. This early history of psychology, rooted in oppressive psychological science to protect Whiteness, White people, and White epistemologies, reflected the social and political landscape of the U.S. at that time. Psychology developed under these conditions, helped to create, express, and sustain them, continues to bear their indelible imprint, and often continues to publish research that conforms with White racial hierarchy.”

(Cummings Center, 2021; Helms 2003; Luther et al., 1996; Santiago-Rivera et al., 2016).

(APA, 2021, [apa.org/about/policy/racism-apology](https://www.apa.org/about/policy/racism-apology)) This acknowledgement further inspires the need for CDEPs that reflect the culture, context, social determinants of health, and historical realities of California’s diverse communities.

1.2 COMMUNITY-DEFINED EVIDENCE PRACTICES FOR REDUCING MENTAL HEALTH DISPARITIES

Efforts to ameliorate mental health disparities should build on community assets, culture, and resilience. CRDP and its community-defined evidence practices (CDEPs) touch upon all these recommendations.

CDEPS ARE “...A SET OF PRACTICES THAT COMMUNITIES HAVE USED AND DETERMINED TO YIELD POSITIVE RESULTS **BY COMMUNITY CONSENSUS OVER TIME** AND WHICH MAY OR MAY NOT HAVE BEEN MEASURED EMPIRICALLY BUT HAVE REACHED A LEVEL OF ACCEPTANCE WITHIN THE COMMUNITY” (MARTINEZ, 2008, PP. 9-10).

As an alternative or complement to evidenced-based practices (EBPs), which are based on randomized clinical control trials, CDEPs offer community-defined, culturally anchored interventions that reflect cultural values, practices, and worldviews of the communities they serve. Truly innovative, CDEPs can take many shapes and forms, such as *pláticas* (i.e., warm and friendly facilitated conversations about issues of importance to particular communities); after-school meditation classes; gardening activities; *Ncig Teb Chaws* (i.e., guided walks that introduce participants to a range of cultural principles and community resources); harvesting and selling sweet potatoes; or “warm hands” guidance in navigating complex health systems. Such programs can improve the mental health of community participants who generally would not have contact with formal mental health services, suggesting that CDEPs can increase access to needed care for unserved, underserved, and inappropriately served populations.

CDEPs are grounded in the lived experience, wisdom, worldview, and historical context of a community or ethnocultural group. They are rooted in the cultural knowledge and traditions of treatment in a particular community. They are not limited to western conceptions of psychological functioning or resulting forms of mental health treatment or interventions. In contrast, EBPs are grounded in empirical research that is often conducted without consultation with community members; neglectful of the culture, worldview, and the historical experience of the population being served; and overly narrow in their definition of evidence used to establish credibility (Martinez et al., 2010; Nebelkopf et al., 2011; Yeganeh et al., 2004). Moreover, interventions that claim they are culturally adapted EBPs often do not have cultural depth in their adaptation. They do not challenge the fundamental cultural assumptions underlying the provision of mental health services, or include culturally appropriate, relevant, and community-defined interventions (Lyon et al., 2015).

Marginalized and oppressed communities have historically been denied control over the mental health care of their members by the predominantly White, male mental health establishment, resulting in services that are cost-prohibitive, scarce, coercive, and lacking resonance (Altiraifi & Rapfogel, 2020). The empirical studies that legitimize EBPs are commonly based on research studies that use adequate sample sizes. (Aisenberg, 2008; Hall, 2001; Sue et al., 2009).


Ultimately, EBPs have not improved mental health care for unserved, underserved, and inappropriately served populations. EBPs’ lack of cultural grounding has led some of the national ethnic psychological associations to push back against such heavy reliance on EBPs and move to give local stakeholders a greater role in meeting the needs of their own communities. The CDEPs implemented by CRDP grantees evolved out of community wisdom that was not restricted to EBP practices. Mental health systems need to invest time to understand lived mental health experiences in diverse communities (Aronowitz et al., 2015). This is what the CRDP Implementation Pilot Projects (IPP) have done in their implementation of CDEPs.

This report provides an overview of the CRDP Phase 2, including key findings related to processes and outcomes, such as:

- CRDP initiative strategies.
- Mental health access (availability, utilization, stigma/barriers, quality).
- Mental health improvements.
- Advocacy, policy and systems change.
- The business case.
- Organizational capacity of CDEP organizations.
- CDEP local evaluation strategies and credible evidence.

The report concludes with selected recommendations grounded in insights derived from the evaluation of CRDP Phase 2.



A background image of a smiling man with glasses, partially obscured by a large orange overlay. The man is wearing a light-colored shirt and has a friendly expression.

Chapter 2

Overview of the Initiative

EXECUTIVE
SUMMARY

CHAPTER 1

CHAPTER 2

CHAPTER 3

CHAPTER 4

CHAPTER 5

CHAPTER 6

CHAPTER 7

CHAPTER 8

CHAPTER 9

CHAPTER 10

CHAPTER 11

REFERENCES

APPENDICES

2.1 CRDP PHASE 2 (2016–ONGOING)

Phase 2 launched in 2016 and was originally funded through April 2022. The CDPH CRDP Statewide Evaluator Solicitation (15–10603) delineated the goals for CRDP Phase 2:

- Demonstrate through a rigorous, community-participatory evaluation process that selected CDEPs are effective in preventing or reducing the severity of mental illness.
- Increase funding for validated CDEPs by other, non-CRDP sources, including county mental health agencies upon completion of Phase 2.
- Support changes in statewide and local mental health delivery systems and policies that will reduce mental health disparities among unserved, underserved and inappropriately served populations (Burch, 2015).

This \$60 million investment was meant to strengthen and demonstrate effectiveness of CDEPs among the five priority populations, and develop and reinforce organizational infrastructure to effectively deliver mental health services.

Through the leadership and efforts of the IPP-led CPSSC, the CRDP Phase 2 received an additional \$63.1 million dollars from the state general fund to extend CRDP Phase 2 through 2026. The CRDP Phase 2 extension continues 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 Phase 3.

2.2 PHASE 2 PARTNERS

Phase 2 originally had five primary components, 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).

At the heart of the initiative were the IPPs, community-based organizations with an average organizational age of 26.6 years. They applied their rich history of community-based services to develop, expand, implement, and evaluate CDEPs using culture, language, and LGBTQ+-responsive approaches. Through a competitive statewide public request for proposals (RFP) process, 35 community-based organizations were awarded five-year CDEP implementation grants in 2017 (each totaling \$1.14 million). The IPPs, TAPs, EOA, and SWE worked closely with CDPH-OHE to coordinate efforts related to Phase 2 activities and provided technical assistance and support to the IPPs to build their capacity to implement, evaluate, and tell the stories of their CDEPs.

In addition to these original components, a Cultural Broker component was later added to the initiative structure. This was an emergent strategy led by the Racial Ethnic Mental Health Disparities Coalition (REMHDCO) that is discussed in greater detail in Chapter 5.



NOTE ABOUT THE CAPACITY BUILDING PILOT PROJECT (CBPP) PHASE

In 2016, eleven Phase 2 organizations were involved in a six-month Capacity Building Pilot Project (CBPP) process. They each received an additional \$40,000 and technical assistance support prior to the CDEP implementation phase. The CBPP grants provided enhanced support for smaller community-based organizations with annual operating budgets under \$500,000 to better situate their capacity alongside larger, more established organizations. This included a streamlined application process to minimize capacity issues for organizations with less grant writing experience.

See Figure 2.1 for a brief overview of all Phase 2 components and strategies. See Table 2.1 for a detailed overview of Phase 2 components, strategies, and partners. See Chapter 3 for more information about the IPPs, their CDEPs and priority communities.

Figure 2.1: Original Phase 2 Components and Strategies



Table 2.1: Overview of Original Phase 2 Components, Strategies, and Partners

Component: Implementation Pilot Projects (IPPs)				
Strategy: Developed, implemented, and evaluated their PEI ODEPs using cultural, linguistic, and LGBTQ+ responsive approaches.				
AfAm hub	AANHPI hub	AI/AN hub	Latinx hub	LGBTQ+ hub
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Friendship House Assoc. of American Indians 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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

Component: Technical Assistance Providers (TAPs)				
Strategy: Supported the IPPs to improve administration and operations, identify and secure additional resources, and build strategic partnerships.				
AfAm hub	AANHPI hub	AI/AN hub	Latinx hub	LGBTQ+ hub
<ul style="list-style-type: none"> ONTRACK Program Resources 	<ul style="list-style-type: none"> Special Service for Groups (SSG) 	<ul style="list-style-type: none"> Pacific Institute for Research and Evaluation (PIRE) 	<ul style="list-style-type: none"> UC Davis Center for Reducing Health Disparities (UCD) 	<ul style="list-style-type: none"> Center for Applied Research Solutions (CARS)

Component: Education, Outreach, and Awareness (EOA)	Component: Statewide Evaluator (SWE)	Component: Office of Health Equity (OHE)
Strategy: Implemented key components of the CRDP Strategic Plan and provided IPPs with technical assistance and support with media and storytelling	Strategy: Supported the IPPs to develop and implement local evaluations and demonstrated the extent to which Phase 2 and the CDEPs, were effective in achieving CRDP goals. ⁸	Strategy: Provided oversight of Phase 2 components, contract management, technical assistance, and support, and maintained communication with partners and other key stakeholders across the state.
<ul style="list-style-type: none"> California Pan-Ethnic Health Network (CPEHN) 	<ul style="list-style-type: none"> Psychology Applied Research Center at Loyola Marymount University (PARC@LMU) 	<ul style="list-style-type: none"> 5 Contract Managers (One contract manager per priority population) Program Lead Evaluation Lead

⁸ The SWE also helped CDPH develop evaluation systems and guidelines, communicate evaluation results, review the adequacy of IPP evaluation plans, maintain communication with CDPH, organize and present at the Phase 2 Final Convening, and served as a subject matter expert to the community-based organizations.

Chapter 3

Implementation Pilot Projects

3.1 OVERVIEW OF IMPLEMENTED PILOT PROJECTS

At its core, CRDP Phase 2 was comprised of 35 community-based organizations known as Implementation Pilot Projects (IPPs). IPPs developed and implemented innovative approaches to reducing mental health disparities for five unserved, underserved, and inappropriately served populations in California. All IPPs were competitively selected from a grantee applicant pool based on a rigorous review of proposals submitted to CDPH; these groups did not represent a random sample of CDEPs in California.

The CDPH IPP Solicitation (15-10648) for each priority population delineated the following⁹ on page three:

IPPs for this grant program are focused on the priority population and will provide mental health prevention and early intervention services, defined to include approaches that show promise in preventing and/or reducing the severity of mental illness. The primary goal of the IPP program is to validate community-defined evidence practices (CDEPs) in order to support further funding and expansion of their efforts. Secondary program goals include the development of infrastructure and business practices to expand and improve existing efforts in order to provide quality mental health services to more at-need community members.

This section presents information about the non-profit, community-based organizations funded in CRDP Phase 2 including:

- Number of years in operation at start of the initiative.
- Size of organizational budget at start of the initiative.
- CDEP staff size at start of the initiative.
- Organizational strengths at start of the initiative.
- CDEP service location from start to end of the initiative.
- Implemented MHSA PEI and Workforce Education and Training (WET) approaches Descriptions of CDEPs funded under CDRP Phase 2.

NOTE ABOUT THE USE OF TERM “POPULATION HUB” VS “PRIORITY POPULATION”

While the CRDP prioritized five unserved, underserved or inappropriately served populations in California, Phase 2 grantees did not represent – nor were they intended to represent – each of their respective populations at large. In other words, the individuals CDEPs served did not include every relevant group from the larger priority population in proportion to their numbers in the state based on race, gender, age group, socioeconomic status, region, community, etc. As a result, IPPs and the community members served by their CDEPs represent a convenience sample. Because they are a convenience sample, it is important to not give the impression that findings are generalizable to specific racial groups in the state.

Similarly, the statewide evaluation is NOT a population-based study (e.g., case-control study, cross-sectional study etc.). Instead, it is a study designed to demonstrate the extent to which population-specific interventions, or CDEPs, were effective. The findings identify and describe mental health disparities within the CRDP Phase 2 initiative, and the strategies and approaches used to contribute to their reductions.

The Statewide Evaluation uses the term “population hub” instead of “priority population” to contextualize all findings and conclusions to shed light on the extent to which population specific PEI strategies might reduce mental health disparities for five unserved, underserved or inappropriately served populations in California.

⁹ IPPs (or grantees) were also tasked with evaluating their programs’ effectiveness utilizing both quantitative and qualitative approaches and employing community-based participatory research (CBPR) forms of community participation.

Data points 1-5 were examined in an aggregate fashion, anonymized, and presented below at the CRDP overall, hub, and/or IPP level. Although indicators such as years in operation, budget size, and CDEP staff size help to paint a broad picture of the community-based organizations participating in CRDP Phase 2, it is important to note that these data points are insufficient to fully characterize the developmental life stage of an organization at the start of the initiative. It also did not predict or reflect any one grantee's capacity to make an impact in its respective communities. Irrespective of size, some grantees were focused on making a broad impact across a community, while others focused on making a deep impact with a small number of people. More importantly, the grantees that organizations selected not only emerged from the communities they served but were also important stakeholders in the mental health system. They provided numerous, often highly valued programs and services to members of their community, particularly those who have historically been poorly served, if at all, by mainstream mental health service delivery systems. Not only did the grantee organizations understand their local communities, but they also brought their expertise and indigenous wisdom to the process. Therefore, these data assist with understanding the organizational makeup of Phase 2 grantees. They help answer:

- Who did CDPH-OHE partner with at the community level and to what extent was there CDEP reach?
- To what extent did Phase 2 funds support an inclusive and diverse set of grantee organizations?
- Which existing strengths did the grantees bring to the table?
- Which CDEPs were implemented by the IPPs in each priority population (and to what extent did they reflect MHSA programs)?

3.2 PHASE 2 STRATEGIES TO FUND AND SUPPORT AN INCLUSIVE AND DIVERSE SET OF GRANTEEES

The CRDP Phase 2 grantee solicitation process provided important context for understanding the organizational characteristics described in this chapter. In particular, the grantee solicitation included several nonstandard practices to align it with the initiative's strategic efforts to improve the diversity of funded organizations with an emphasis on improving the capability of organizations with historically less access to government funding to competitively apply and participate in CRDP.

These practices were informed by recommendations from the *CRDP Strategic Plan for Reducing Mental Health Disparities* report and through a pre-draft solicitation feedback process where, prior to the official grantee solicitation release, draft solicitations were released for public comment and discussion. The pre-draft solicitations were also presented and discussed in person at community townhalls throughout California. Prior to CRDP, releasing pre-draft solicitations for community review was not a common practice for CDPH and reflected stakeholder feedback and recommendations for the rollout of Phase 2.

Three strategies informed the nonstandard practices incorporated into the CRDP grantee solicitation process.

- First, pilot project (PP) eligibility was limited to community-based organizations and not open to county-based entities including county behavioral health departments. Most MHSA funds are allocated directly to county behavioral health departments that either directly provide local services or do so through contractors. By directly funding local community-based organizations that have historically had limited access to county-based MHSA funding, the CRDP Phase 2 aimed to pilot and build evidence for promising CDEPs that were generally not funded by the existing mental health system.
- Second, to avoid excluding small organizations with promising CDEPs, two different types of grants were developed: a standard PP grant and then Capacity Building Pilot Project (CBPP) grants. The CBPP grants were intended for smaller community-based organizations with annual operating budgets under \$500,000 to reduce competition with larger, more established organizations. The African American CBPP solicitation (#15-10614) describes the intent of these grants. Historically small, CBOs had difficulty competing for funding against more established CBOs and government entities that have the infrastructure to prepare more effective applications. CBPP grants helped overcome these historical shortcomings by not forcing small CBOs to compete with larger CBOs and government entities, helping ensure that CRDP funding is not limited to the same

organizations that typically receive mental health funding. The CBPP application process was streamlined to minimize capacity issues for organizations with less grant writing experience. CBPPs also began six months prior to the IPP kick-off in March 2017 to give them a head start to work with their population-specific technical assistance provider on building organizational infrastructure and completing components included in the standard IPP application that were not required in the initial CBPP applications, including a five-year workplan, a budget, an evaluation plan, and an organizational growth and sustainability plan. Upon successful completion of these components, CBPPs graduated to IPP status. Funding for up to 15 CBPPs (three for each priority population hub) were included in CRDP Phase 2. However, based on successful applications received, 11 CBPPs were funded (three AfAm, three Latinx, three LGBTQ+, and two AANHPI).

- Third, the CBPP and IPP solicitation applications and scoring processes emphasized the importance of applicants embedded in the communities served by the grant. To this end, application materials included community endorsement letters and the solicitation process included a telephone interview stage. Application scorers and interview panel members also received training on community based participatory research and culturally and linguistically responsive services to better assess these aspects of the applications.

In addition to strategies embedded into the solicitation process, two additional strategies were embedded in CRDP's fiscal and administrative management to improve the initiative's capacity for supporting grantee organizations with smaller operating budgets and fewer funding streams beyond CRDP.

- CDPH-OHE implemented an advance-payment option for CRDP grantees. The advance-payment option allowed grantees to request up to 25% of their annual grant funds at the start of each fiscal year. This option helped to mitigate grant payment challenges for organizations with smaller operating budgets disproportionately impacted by the length of time it can take for the state to process invoices (i.e., the state of California defines timely payment as within 45 days of invoice submission). The CRDP's advance-payment option was a first of its kind for CDPH that required approval from the California State Legislature and the creation of new departmental accounting processes.
- CDPH-OHE utilized a high-touch approach to CRDP grant management and monitoring. Each CRDP priority population (consisting of seven grantees and one population-specific technical assistance provider each) had a dedicated contract manager with experience working with that population. In addition to standard grant oversight, CRDP contract managers also provided intensive technical assistance related to program design, evaluation, and organizational developments. To accommodate this higher workload per contract, each CRDP contract manager was primarily responsible for only eight contracts (seven grantees and the population specific technical assistance provider), a significantly smaller load than usual for state contract managers.



3.3 PHASE 2 COMMUNITY-DEFINED EVIDENCE PRACTICE (CDEP) SERVICE AREA

This section provides an overview of Phase 2 CDEP service areas by county and/or zip code in California (i.e., geographic areas where CDEPs focused their PEI programming – direct mental health services, community outreach and recruitment, community engagement, advocacy efforts, workforce development, training, and technical assistance with community stakeholders). If a CDEP's geographic territory was vast (e.g., reach spanned multiple counties), IPPs listed in their semi-annual report the specific counties where activities took place instead of zip codes. Some IPPs were unable to provide zip code information for their CDEP due to participant confidentiality concerns, and only indicated the specific counties where their CDEP took place. Below is a summary of this data presented by California region, county, and zip code at the priority population and/or the overall CRDP level.

CDEP service areas were categorized according to the [California Complete Count Office's](#) grouping of the state's 58 counties into 10 regions based on hard-to-count populations, like-mindedness of the counties, and capacity of community-based organizations within the counties (State of California, 2022).

The following was found:

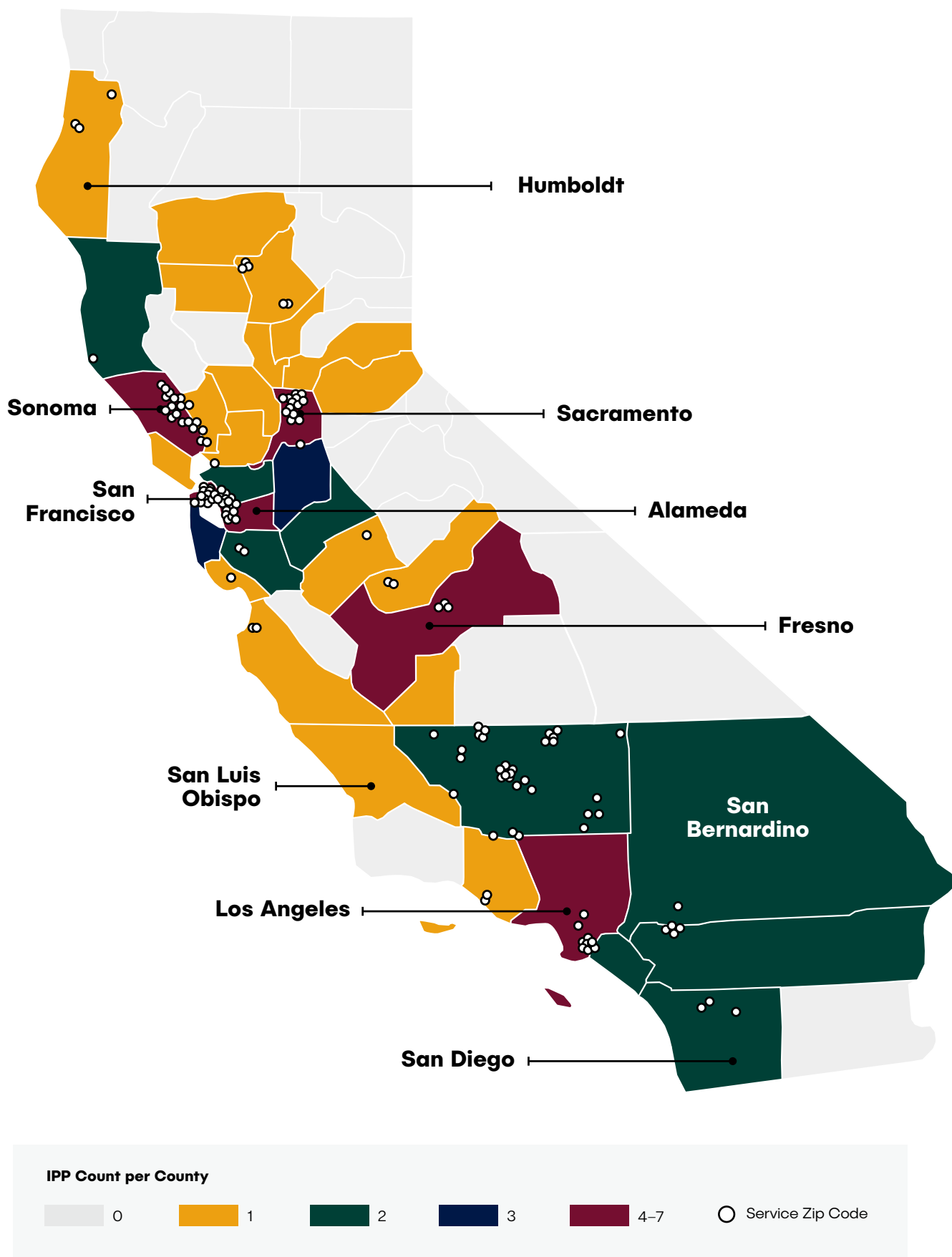
- CDEP service areas encompassed all 10 regions and were present in 36 of the 58 counties in the state.
- San Francisco/Bay Area (n=12 CDEPs), Superior California (n=8 CDEPs), and Central Coast (n=6 CDEPs) were the top regions served by CDEPs.
- On average, IPPs implemented their CDEPs in two counties (range: 1 to 12 counties).
- Almost half of IPPs (49%; n=26) implemented their CDEPs in seven counties; these counties also had the highest CDEP service area presence:
 - › Alameda (n=7 IPPs)
 - › Sacramento (n=7 IPPs)
 - › San Francisco (n=6 IPPs)
 - › Fresno (n=5 IPPs)
 - › Los Angeles (n=5)
 - › Sonoma (n=5 IPPs)
- When examining CDEP reach by priority population we found that out of the 58 counties in the state:
 - › AfAm: 14 counties (24%)
 - › AI/AN: 18 counties (31%)
 - › AANHPI: 10 counties (17%)
 - › Latinx: 18 counties (31%)
 - › LGBTQ+: 19 counties (33%)
- At least one IPP from each priority population had CDEP activity in Fresno and Sacramento counties.
- Four of the five priority populations offered CDEP services in Alameda and Los Angeles counties.
- Considering service area by zip codes, 28 of 35 IPPs reported 226 unique zip codes in which most CDEP participants were served. Of note, four zip codes in Sonoma County (North Coast region) had the highest number of IPP CDEP presence (n=4): 95403, 95401, 95405 and 95407.

See Table 3.1 for a detailed overview of this information by California region/county and priority population hub. See Figure 3.1 for a visualization of IPP service location by county and zip code (for those IPPs that reported unique zip codes).

Table 3.1: CDEP Service Areas by County, Location Type, and Priority Population (CDEPs can serve multiple regions and counties)

California Region	CDEP Service Area by County	AfAm # CDEPs	AI/AN # CDEPs	AANHPI # CDEPs	Latinx # CDEPs	LGBTQ+ # CDEPs	Total # CDEPs
1. Superior CA (9 counties served by 8 CDEPs)	Butte	-	-	1	-	-	1
	El Dorado	-	-	-	1	-	1
	Glenn	-	-	-	1	-	1
	Placer	-	-	-	1	-	1
	Sacramento	1	1	2	2	1	7
	Sutter	-	-	-	1	-	1
	Tehama	-	-	-	1	-	1
	Yolo	-	-	-	1	-	1
	Yuba	-	-	-	1	-	1
	#of Unique CDEPs Per Region	1	1	3	2	1	8
2. North Coast (5 counties served by 6 CDEPs)	Del Norte	-	1	-	-	-	1
	Humboldt	-	1	-	-	-	1
	Mendocino	-	1	-	-	1	2
	Napa	-	-	-	-	1	1
	Sonoma	-	1	-	2	2	5
	#of Unique CDEPs Per Region	-	2	-	2	2	6
3. San Francisco/Bay Area (6 counties served by 12 CDEPs)	Alameda	3	2	-	1	1	7
	Contra Costa	1	1	-	-	-	2
	Marin	-	-	-	1	-	1
	San Francisco	-	2	1	-	3	6
	San Mateo	-	1	1	-	1	3
	Santa Clara	-	1	-	-	1	2
	#of Unique CDEPs Per Region	3	3	1	2	3	12
4. Northern San Joaquin Valley (4 counties served by 5 CDEPs)	Madera	-	-	-	1	-	1
	Merced	-	-	1	-	-	1
	San Joaquin	-	-	1	1	1	3
	Stanislaus	-	-	-	1	1	2
	#of Unique CDEPs Per Region	-	-	1	2	2	5
5. Central Coast (5 counties served by 6 CDEPs)	Kern	1	-	-	-	2	3
	Monterey	1	-	-	-	-	1
	San Luis Obispo	-	-	-	-	1	1
	Santa Cruz	-	1	-	-	-	1
	Ventura	-	-	-	1	-	1
	#of Unique CDEPs Per Region	2	1	-	1	2	6
6. Southern San Joaquin Valley (2 counties served by 5 CDEPs)	Fresno	1	1	1	1	1	5
	Kings	-	1	-	-	-	1
	#of Unique CDEPs Per Region	1	1	1	1	1	5
7. Inland Empire (2 counties served by 2 CDEPs)	Riverside	2	-	-	-	-	2
	San Bernardino	2	-	-	-	-	2
	#of Unique CDEPs Per Region	2	-	-	-	-	2
8. Los Angeles County (served by 5 CDEPs)	Los Angeles	2	1	1	-	1	5
	# of Unique CDEPs Per Region	2	1	1	-	1	5
9. Orange County (served by 2 CDEPs)	Orange	-	-	1	-	1	2
	# of Unique CDEPs Per Region	-	-	1	-	1	2
10. San Diego – Imperial (served by 2 CDEPs)	San Diego	-	-	2	-	-	2
	# of Unique CDEPs Per Region	-	2	-	-	-	2
Total: 35 CDEPs served 10 Regions and 36 Counties							

Figure 3.1: CDEP Service Areas by Zip Code (196 Zip Codes; N=28 IPPs)



3.4 GRANTEE ORGANIZATIONAL CHARACTERISTICS AT CRDP GRANTEE KICKOFF

3.4.A GRANT PARTNERSHIP STRATEGY

IPPs were funded to use a single-organization strategy or a grant-partnership strategy involving two or more organizations. While the majority (80%; n=28) of Phase 2 grantees operated independently, seven (20%) grantees used a grant-partnership strategy to deliver their CDEP (i.e., two or more organizations shared costs and/or resources and worked together to address the mental health needs in their community to achieve greater efficiency and effectiveness. While 35 grantees were funded to be part of Phase 2, when including partner organizations, the number of community-based groups supported by Phase 2 resources increased to 49.

- Twenty-eight IPPs had a single-organization service delivery strategy.
- Seven IPPs had a grant-partnership service delivery strategy. (It is important to note that each collaborative/partnership had a designated lead organization.)
 - › Mean: three groups
 - › Range: two-five groups
- Forty-nine community-based organizations were a part of Phase 2 (single plus grant-partner organizations).

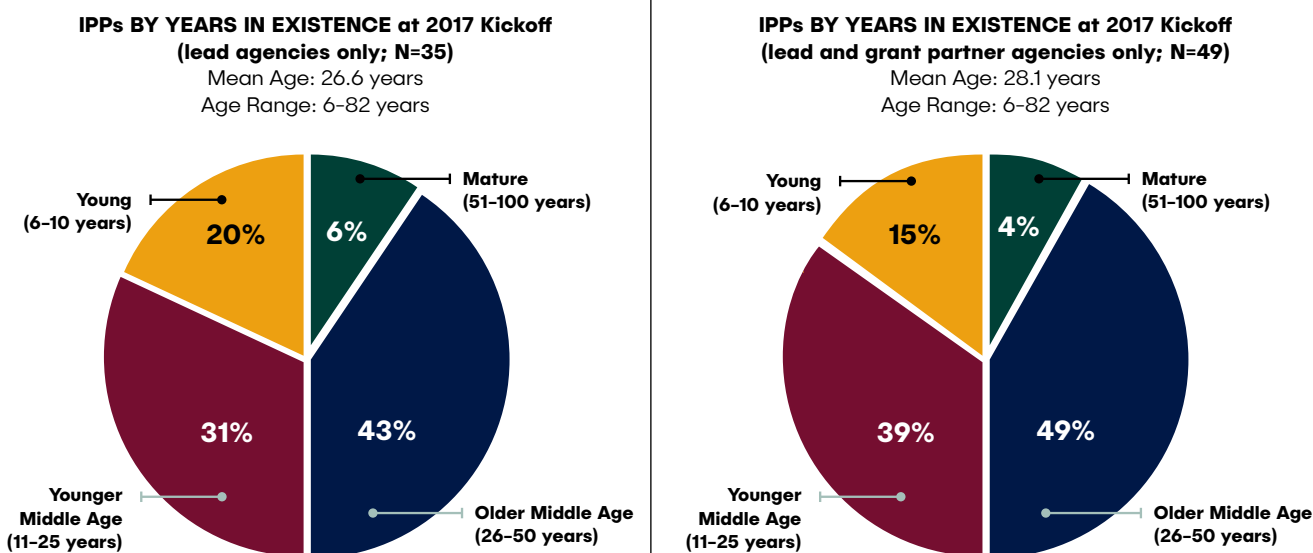
3.4.B ORGANIZATIONAL AGE

On average, grantees' organizational age (length of time functioning as an organization, whether as an independent non-profit or under the support of a fiscal agent) was 26.6 years (single plus lead grantee).

- This reflects a range from six years to 82 years in operation.
- Younger organizations (6 to 10 years) made up 20% of Phase 2 grantees, reflecting the CRDP goal to fund organizations that were typically unable to access government funding.

No major shifts were observed with this data with the inclusion of partners in the analysis. See Figure 3.2.

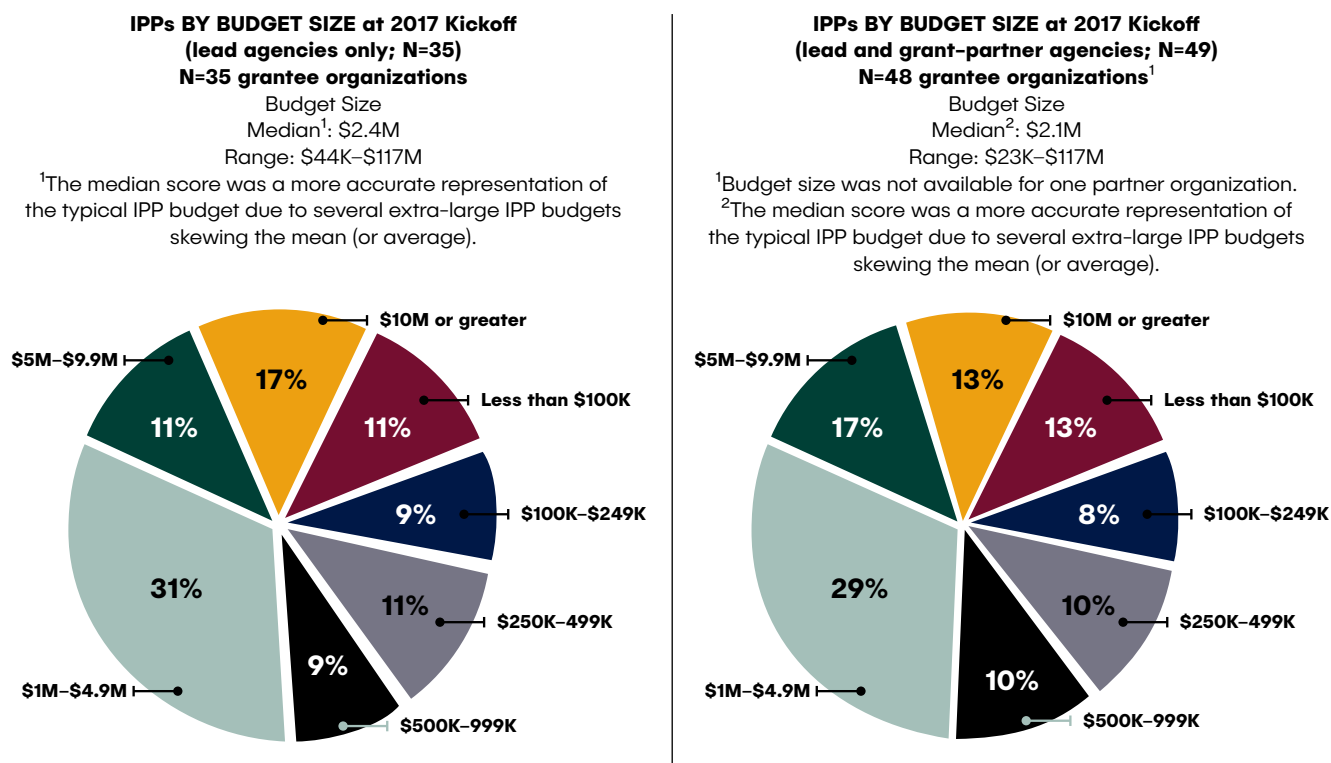
Figure 3.2: Grantee Organizational Age at Grantee Kick-off (March 2017)



3.4.C ORGANIZATIONAL BUDGET

The median (midpoint) size of organizational budget (single plus lead grantee) was \$2.4M. This included a range from \$44,000 to \$117 million. When including the partner organizations into the analysis, the number of grantees with smaller size budgets (\$999,000 or less) slightly increased, with the smallest budget dropping to \$23,000 and the largest budget remaining at \$117 million. See Figure 3.3.

Figure 3.3: Grantee Organizational Budget Grantee Kick-off (March 2017)



3.4.D CDEP STAFF SIZE

On average, CDEPs had four full-time and part-time staff (combined) with a range of two to nine staff. CDEPs had more part-time staff (average: 2.4) than full-time staff (average: 1.6).

On average, CDEPs had about two subcontractors (or independent contractors). This included a range from one to six subcontracted staff. The most common subcontractor across CDEPs was an external evaluator. CDEPs had more part-time subcontractors (average: 1.7) than full-time contractors (average: .08). See Figure 3.4.

Figure 3.4: CDEP Staff Size at Grantee Kick-off (March 2017)

**IPPs BY CDEP Staff Size at Phase 2 Launch (2017)
N=35 grantee organizations¹**

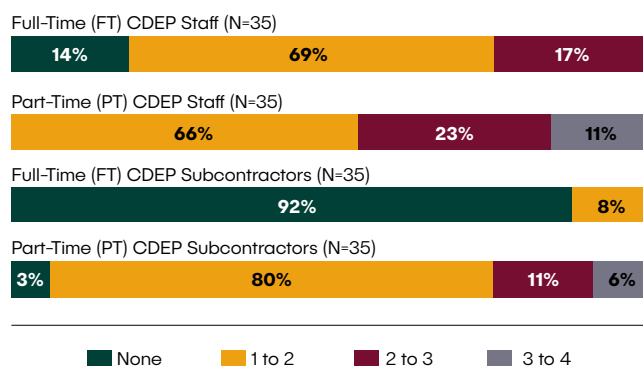
CDEP Staff Combined (FT/PT) Mean: 4 (range: 2 to 9)

- FT mean only: 1.6 staff (range: 2 to 9 staff)
- PT mean only: 2.4 staff (range: 2 to 9 staff)

CDEP Subcontractors Combined (FT/PT) Mean: 1.7 (range: 1 to 6)

- FT mean only: .08 subcontractors (range: 0 to 1)
- FT mean only: 1.7 subcontractors (range: 1 to 6)

¹Note: Counts reflect total number of CDEP staff/subcontractors for all IPPs including the seven IPPs using a collaborative/partnership strategy.



3.4.E IPP STRENGTHS

Grantees came to the CRDP initiative with established community relationships and credibility as well as a strong track record of providing innovative mental health services and programs. Through a rigorous, open competition, the 35 grantees were selected to be among the most promising community partners to contribute to the elimination of mental health disparities among the five priority populations.

Based on self-reported data obtained from IPP local evaluation plans, Table 3.2 provides a thematic description of IPP strengths. See Chapter 7 for additional information on how IPP organizational capacity strengths grew through the life of the initiative.

Table 3.2: IPP Organizational Strengths at the Launch of the Initiative (2017)

IPP 2017 Self-Reported Strengths	Description	% (N)
1. Lived Experience in IPP Mental Health Workforce	Seventy-one percent of IPPs had staff who were community members with relevant lived experience, enhancing the quality of their community services and programs. Among others, staff shared the following lived experience with their focal community: demographic characteristics (e.g., race, ethnicity, sexual orientation, language); neighborhood/community context and norms; personal histories (e.g., immigrant/refugee experiences, health/mental health issues, family backgrounds); cultural realities (e.g., norms, values, and practices); and/or deep understanding of the various health and mental health stressors and needs affecting the community. This shared lived experience uniquely situated IPPs to quickly develop rapport and trusting relationships with the community, relate with and respond to community members' needs, foster dialogue and critical healing processes in safe and affirming spaces, and ultimately sustain community participation in critical CDEP activities.	71% (n=25 IPPs)
2. Linguistic Competency in IPP Mental Health Workforce (Language Access)	Many IPPs had the capacity to provide multilingual support and interpretation to their non-English-speaking community members (e.g., Samoan, Punjabi, Sindhi, Spanish, Korean, Hmong, Vietnamese, Mixteco, and Khmer) via their bilingual and bicultural staff; this includes dissemination of multicultural mental health information, both verbal and written, that was appropriate to the literacy levels of those being served. This further facilitated IPPs ability to deepen trust and rapport with the community, create a safe and welcoming space/ environment, and reduce access and utilization barriers to mental health services for non-native English speakers.	71% (n=25 IPPs)
3. Community Culture Brokers	Over two-thirds of IPPs had earned reputations as culture brokers steeped in community norms, knowledge, values, worldviews, and practices. They were often called upon by other stakeholders/providers to deliver technical assistance and training to school districts, community-based organizations, behavioral health providers, and private mental health agencies. These efforts strengthened the mental health workforce's skillset and knowledge base, better equipping them and other first responders to identify and respond to the mental health needs of the broader community.	68% (n=24 IPPs)
4. Strategic Partnerships/ Collaborations	Fifty-four percent of IPPs had established histories of partnership, collaboration, and communication with other groups in the regions they served (e.g., community-based organizations, schools, probation departments, county behavioral health departments, hospitals). These organizations leveraged their legacy of community-driven work to earn community trust and strengthen the mental health social safety net. Working together, these multi-sector groups shared data and information about local community needs and priorities, and advanced efforts to increase community access to culturally, linguistically, and/or LGBTQ+-responsive services in mental health and other areas.	54% (n=19 IPPs)
5. Bridging the Gap in Mental Health Care for Specific Communities	Fifty-four percent of IPPs self-identified as the sole (or one of a handful) of community-based organizations serving a specific population(s) (e.g., LGBTQ+ youth, Hmong elders, indigenous migrant communities) and/or geographic region(s) (e.g., Central Valley serving the LGBTQ community). Prior to the launch of these IPPs, the community frequently found it difficult to access cultural, linguistic, or LGBTQ+- responsive mental health care and often did not receive the services they wanted or needed. IPPs developed traditional and/or culturally unique solutions (i.e., CDEPs) to their service provision in these underserved areas, thus becoming an oasis of safe, welcoming, competent, and respectful care for the community.	54% (n=19 IPPs)
6. Strengthening CDEPs Through Community-Based Participatory Practices	Nearly one-third of IPPs used participatory practices to develop and/or implement their CDEP approach. Community engagement strategies included: instituting Community Advisory Boards (CABs); collaborating with community members in the design of project materials; engaging CDEP alumni in outreach, recruitment, and planning efforts; and regularly seeking feedback from participants for program improvement. These efforts helped ensure that the CDEPs were centered in the knowledge, wisdom, voices, and perspectives of their community members.	31% (n=11 IPPs)
7. Community-Wide Events to Build Sense of Community and Improve Wellbeing	Eight IPPs noted the importance of community-wide approaches to de-stigmatize mental health, normalize mental health services/supports, and reinforce wellness and other protective factors (e.g., sense of community, belonging, and resilience). Experience with the following types of community-wide events were noted: cultural celebrations/festivals, conferences, expositions, wellness gatherings, recreational activities, pláticas (i.e., conversations). These events were explicitly centered in the culture, language, needs, traditions/rituals, and experiences of the community, with a focus on mental health promotion, behavior change, and social connectedness.	23% (n=8 IPPs)

3.5 IMPLEMENTED PREVENTION AND EARLY INTERVENTION (PEI) APPROACHES

Two of five MHSA components, PEI and WET, are represented among the CDEP approaches implemented in CRDP Phase 2. The [California Department of Health Care Services](#) (2021b) defines the PEI and WET components as follows:

On average, grantees' organizational age (length of time functioning as an organization, whether as an independent non-profit or under the support of a fiscal agent) was 26.6 years (single plus lead grantee).

"The PEI component funds programs designed to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for underserved populations."

It has six state-defined programs:

- › [Prevention Program](#)
- › [Early Intervention Program](#)
- › [Outreach for Increasing Recognition of Early Signs of Mental Illness](#)
- › [Stigma and Discrimination Reduction Program](#)
- › [Access and Linkage to Treatment Program](#)
- › [Suicide Prevention Program](#)

"The WET component funds are used to fund programs designed to enhance the public mental health workforce." It contains five funding categories:

- › [Training and Technical Assistance](#)
- › [Mental Health Career Pathway Programs](#)
- › [Residency and Internship Programs](#)
- › [Financial Incentive Programs](#)
- › [Workforce Staffing Support](#)

Nearly all IPPs (n=34) had an MHSA PEI formal component in their CDEP. (One IPP had a WET component only.) In examining which six state-defined PEI programs (see above) were best represented among these 34 CDEPs, the following was found:

- Eleven CDEPs had a prevention program.
- Four CDEPs had an early intervention program.
- Eighteen CDEPs had both a prevention and early intervention program.
- One CDEP had an access/linkage to treatment program.

In addition, 14 CDEPs that had a PEI program also had an access/linkage to treatment program.

More than one in three IPPs (n=14 IPPs) had a formal MHSA WET component in their CDEPs. They were best represented in the following WET programs:

- Six CDEPs had a Mental Health Careers Pathway program.
- Seven CDEPs had a Workforce Staffing Support program.
- Six CDEPs had a Training and Technical Assistance program.

Notably, a majority of IPPs (n=30) engaged in mental health advocacy strategies (i.e., advocacy aimed at increasing funding and resources or transforming institutional rules and practices, physical environments, public policy, etc.) at the local and state legislative and organizational levels. While mental health advocacy is not a formal MHSA component, it is nonetheless an integral part of CRDP Phase 2 efforts to reduce mental health disparities for the unserved, underserved, and inappropriately served among the five priority populations. Please refer to Chapter 5 for additional information about the IPPs' implementation of mental health advocacy strategies, and Chapter 6 for information related to their prevention and early intervention programs, access/linkages to treatment programs, and workforce, education and training programs.

3.6 CDEP DESCRIPTIONS

See Table 3.3 for an overview of CDEP Key Populations Served, Geographic Service Areas, CDEP Description, and MHSA Approaches.

Table 3.3: CDEP Key Populations Served, Geographic Service Areas, CDEP Description, and MHSA Approaches

IPP Name/Website / Key Populations	CDEP Service Area by Region/County	PEI Community Defined Evidence Practice Description	CDEP MHSA and Other Program Approaches
AFRICAN AMERICAN			
WHOLE SYSTEMS LEARNING wholesystemlearning.org Key Population: African American youth and young adults ages 15-29	Region/County: Los Angeles	The <i>Turning Resilience into Brilliance for Eternity</i> (TRIBE) program was created to combat oppressive societal factors that contribute to mental illnesses among adjudicated or fostered African American male youth and young adults in Los Angeles County. The program components include, college preparation, Know Thyself resilience workshops, and somatic and hip-hop approaches to relieving trauma. Utilizing an African-centered, ecological, and brain-based learning approach, TRIBE helps transform how young men see themselves, and nurtures their inherent gifts so they can walk in greater alignment with their overall purpose.	Early intervention Program Mental Health Advocacy Strategy
WEST FRESNO FAMILY RESOURCE CENTER wfresnofrc.org Key Population: African American youth ages 12-15	Region: Southern San Joaquin Valley County: Fresno	The <i>Sweet Potato Project</i> works directly with African American youth ages 12-15 in Southwest Fresno to reduce and prevent school drop-out, gang involvement, and substance use initiation. This culturally responsive program stems from the historical and cultural roots of Black farmers. By teaching youth how to plant seeds, harvest crops, and apply entrepreneurial and business skills to market and sell their products, the Sweet Potato Project decreases internalized oppression and hopelessness, while increasing a positive Black identity, collective economic activity, college intentions, and leadership development.	Prevention Program Mental Health Advocacy Strategy
THE VILLAGE PROJECT villageprojectinc.org Key Population: African American children (K-4th grade) and their families	Region: Central Coast County: Monterey	The <i>Emanyatta Project</i> was designed for Black children from K-4th grade and their families in Monterey County. It consists of clinical assessments, as well as Saturday and summer school workshops. The workshops teach youth African American and African history to instill strong ethnic pride that supports the prevention of (or overcoming of) depression and anxiety among Black children. Emanyatta aims to build pride in cultural and ethnic heritage as a strategy for achieving academic achievement and positive self-esteem in Black children, strengthen their resiliency, and increase familial understanding and awareness of mental health issues and support services.	Prevention Program Early Intervention Program Mental Health Advocacy Strategy
SAFE PASSAGES safepassages.org Key Population: African American youth ages 16-21 and their families.	Region: San Francisco/Bay Area County: Alameda	The <i>Law and Social Justice Life Coaching Project</i> (LSJ Life Coaching Project) utilizes culturally responsive approaches to uplift and educate adjudicated Black youth (ages 16-21) and their families in Oakland, CA. The staff is racially, culturally, and linguistically representative, and experienced in a variety of disciplines. Youth and their families learn about their rights and how to access resources and are provided one-on-one coaching to stop the trajectory established by generations of trauma, mental illness, and prison overpopulation faced by the African American community.	Prevention Program Early Intervention Program Access and Linkages to Treatment Program Mental Health Advocacy Strategy
HEALTHY HERITAGE MOVEMENT healthyheritage.org Key Population: African American women	Region: Inland Empire, Southern San Joaquin Valley Counties: Kern, Riverside, San Bernardino	The <i>Broken Crayons...Still Color Project</i> (BCSCP) tapped into the historical pillars of the Black community to reduce mental health disparities among African American women ages 18 and older in San Bernardino and Riverside counties. By working within Black church settings, BCSCP uses a faith-based approach to assist Black women in increasing their knowledge of core mental health issues affecting the African American community and their root causes, as well as reducing stigma associated with seeking mental health treatment. The BCSCP team informs, encourages, and provides safe spaces for Black women to dialogue about their mental health needs, with the overarching goal of shifting perceptions about mental health treatment in the broader community.	Prevention Program

IPP Name/Website / Key Populations	CDEP Service Area by Region/County	PEI Community Defined Evidence Practice Description	CDEP MHSA and Other Program Approaches
CATHOLIC CHARITIES OF THE EAST BAY cceb.org Key Population: African American students (middle and high school)	Region: San Francisco/ Bay Area Counties: Alameda, Contra Costa	<i>Experience Hope for Teens</i> (EHT) is a school-based intervention program for middle and high school African American students in Oakland and Richmond to address disproportionately high levels of trauma-related behaviors. They increase access to mental health services (individual and group treatment sessions), provide nonclinical restorative groups, and provide training/technical assistance for their staff and school personnel to increase institutional capacity for healing-focused responses. All services are infused with traditional African American principles of cultural discourse, healing, and community. This program aims to increase access to trauma-informed services, decrease students' trauma symptoms, and increase the capacity of schools to respond in a healing-focused, restorative, and culturally appropriate manner.	Prevention Program Early Intervention Program WET: Workforce Staffing Support Program; Training and Technical Assistance Program Mental Health Advocacy Strategy
CALIFORNIA BLACK WOMEN'S HEALTH PROJECT cabwhp.org Key Population: African American women	Region: San Francisco/ Bay Area, Los Angeles, Inland Empire, Superior CA Counties: Alameda, Los Angeles, Riverside, Sacramento, San Bernardino	<i>Sisters Mentally Mobilized</i> (SMM) is a community-driven program designed to prevent and reduce the severity of mental illness in Black women. SMM incorporates foundational advocacy and empowerment principles through two key initiatives, The Advocate Training Program and Sister Circles. By blending advocacy training and support/engagement circles, SMM builds the capacity of Black women across the state to improve mental health conditions at both the individual and community levels. SMM is focused on the health and wellness needs of Black women, concretizing this dedication through trainings and culturally responsive group circles.	Prevention Program WET: Mental Health Careers Pathway program Mental Health Advocacy Strategy
AMERICAN INDIAN/ALASKA NATIVE (AI/AN)			
UNITED AMERICAN INDIAN INVOLVEMENT uaii.org Key Population: AI/AN families	Region/ County: Los Angeles	<i>The Native American Drum, Dance and Regalia</i> (NADDAR) program recognizes the need to reduce mental health disparities among urban American Indian/ Alaska Native Families in Los Angeles County by incorporating culturally sensitive and community-based methods to address mental health issues (e.g., depression, anxiety, isolation, and substance use), and strengthen community/ cultural connectedness, spirituality, cultural identity, and family cohesion. The workshops are centered around important healing practices of AI/AN culture and history (e.g., drumming, dancing, regalia making) that have been utilized for many centuries among indigenous populations to promote wellness and self-expression.	Prevention Program
TWO FEATHERS NATIVE AMERICAN FAMILY SERVICES twofeathers-nafs.org Key Population: AI youth ages 6-18 including their families and community at large	Region: North Coast Counties: Del Norte, Humboldt	<i>The Stick Game and Flower Dance</i> projects were created to help the Native American community recover from the historical trauma associated with forced assimilation, genocide, and disconnection from family, community, and spirituality by connecting American Indians with 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 preparation for both events involve the entire community in activities such as stick game, tool making, team exercises, cultural mindfulness, and singing.	Prevention Program Mental Health Advocacy Strategy
SONOMA COUNTY INDIAN HEALTH PROJECT scihp.org Key Population: Native American Transitional Aged Youth (TAY)	Region: North Coast Counties: Mendocino, Sonoma	The Aunties and Uncles Program aims to prevent suicide among transitional-aged youth (TAY) by decreasing depressive symptoms and increasing mental health awareness and knowledge, cultural identity, and involvement in traditional practices. Historically related factors (i.e., destructive colonialism) coupled with social isolation/ exclusion, and distrust in health care systems, have contributed to mental health needs and disparities in the Native American community in Sonoma County. At the core is the special role that extended family members play in Native American Cultures where "aunties and uncles" (i.e., trained TAY, key tribal members, traditional medicine people, and elders) provide support, guidance, teachings, and protection for youth. Community wellness gatherings serve to promote awareness of mental wellness, discuss stigma associated with mental illness, and teach ways to access services. Talking Circles, a method for planning and solving problems in many Native American communities, provides education and awareness for suicide prevention, referrals for mental health screenings, and comprehensive mental health assessments and treatment.	Prevention Program Early Intervention Program Access and Linkages to Treatment Program Mental Health Advocacy Strategy

IPP Name/Website / Key Populations	CDEP Service Area by Region/County	PEI Community Defined Evidence Practice Description	CDEP MHSA and Other Program Approaches
NATIVE AMERICAN HEALTH CENTER (lead agency) nativehealth.org Grant Partners: Fresno Indian Health Project; San Diego Indian Health Project Key Population: Urban Indian youth and their families	Region: San Francisco/ Bay Area, Southern San Joaquin Valley, Superior CA, San Diego - Imperial Counties: Alameda, Contra Costa, Fresno, King, Sacramento, San Diego, San Francisco, San Mateo	<i>Gathering of Native Americans</i> (GONA) addresses mental health stigma, family health, violence, suicide, and other mental health conditions, including the strengthening of protective factors in Urban Indian communities. The GONA brings youth and their families together for a four-day retreat to guide their experiences in healing from historical, intergenerational trauma that has led to increased mental illness and trauma among Native communities. GONA participants actively work to identify approaches to healing the community, a process that results in self-reflection, increased understanding of the root causes of health disparities in Native communities and increased individual healing and resiliency.	Prevention Program Mental Health Advocacy Strategy
INDIAN HEALTH COUNCIL indianhealth.com Key Population: Native American youth and families	Region: San Diego - Imperial County: San Diego	<i>REZolution</i> was designed to increase healthy self-expression through the performing and fine arts among individuals and families who may be at risk for early onset mental illness. Through a series of community-wide events, REZolution integrates cultural practices, tribal traditions, and tribal values into mental health prevention and early intervention services. REZolution restores wellness and balance to families and youth, and reduces high rates of domestic abuse, suicide, school failure, and severe mental illness among Native American families.	Prevention Program
INDIAN HEALTH CENTER OF SANTA CLARA VALLEY indianhealthcenter.org Key Population: Youth and young adults ages 12-25	Regions: San Francisco/ Bay Area, Central Coast Counties: Santa Clara, Santa Cruz	<i>The Strengthening Youth and Families Project</i> addresses mental health disparities among American Indian people in Santa Clara County by increasing community connectedness and knowledge, and sustainment of cultural traditions, practices, and ceremonies to help preserve traditional beliefs, values, and culture. Cultural traditions/practices and ceremonies include the Traditional Song Class, Traditional Dance Class, San Jose Native Youth Empowerment Group, Cultural Arts Classes, Mini-Powwows, and The Gathering. These activities promote mental health wellbeing and increase protective factors for the American Indian community in Santa Clara County.	Prevention Program Access and Linkages to Treatment Program Mental Health Advocacy Strategy
FRIENDSHIP HOUSE friendshiphousesf.org Key Population: AI/AN adults	Region: San Francisco/ Bay Area Counties: Alameda, San Francisco	<i>The American Indian Traditional Treatment and Recovery Healing Model</i> (Friendship House Model) aims to prevent and/or reduce substance abuse and the underlying social and mental health issues experienced by American Indian/Alaska Native (AI/AN) community members. In recognition of the historical trauma and mental health inequities resulting from state-enforced relocation and assimilation policies, this residential recovery program integrates American Indian healing practices with evidence-based methods to address the complex needs of its residential clients. Through engaging residents in Talking Circles Ceremonies, Sweat Ceremonies, Traditional Healer therapeutic practices, and community-wide Gathering of Native American activities, participants will experience "whole person" (physical, emotional, spiritual, and mental wellbeing) healing, greater cultural connectedness, and decreases in substance abuse, depression, anxiety, and criminal justice involvement.	Prevention Program Early Intervention Program
ASIAN AMERICAN, NATIVE HAWAIIAN, PACIFIC ISLANDER (AANHPI)			
MUSLIM AMERICAN SOCIETY muslimamericansociety.org Key Population: South Asian Muslim adults	Region: Superior CA County: Sacramento	<i>The Shifa for Today</i> ("healing" in Arabic) program addresses the historical and current trauma faced by Muslims in the U.S. by recruiting, training, and engaging peer counselors to lead individual counseling sessions with clients from the community. The peer counselor-led sessions utilize traditional and contemporary Islamic and Muslim content along with peer counseling practices to assist clients in identifying their strengths, developing skills, and developing a support system to cope with an anti-Muslim political climate, and help them address trauma, anxiety and other forms of psychological distress.	Early Intervention Program WET: Mental Health Careers Pathway Program Mental Health Advocacy Strategy

IPP Name/Website / Key Populations	CDEP Service Area by Region/County	PEI Community Defined Evidence Practice Description	CDEP MHSA and Other Program Approaches
KOREAN COMMUNITY SERVICES (lead agency) kcsinc.org Grant Partner: Southland Integrated Services Key Population: Korean and Vietnamese immigrants	Region/County: Orange	The <i>Integrated Care Coordinators</i> (ICC) project provides clients from the community referrals and linkages to service providers and conducts ongoing follow up through an in-depth linkage process to address trauma and mental illness among Korean and Vietnamese immigrant communities in Orange County. ICC increases client access to culturally and linguistically appropriate services using multiple approaches such as “no wrong door,” “whatever it takes,” and “the warm hand off” to understand each client’s individual case and address their need for culturally sensitive services.	Access and Linkages to Treatment Program Mental Health Advocacy Strategy
HMONG CULTURAL CENTER OF BUTTE COUNTY hmongculturalcenter.net Key Population: Hmong elders	Region: Superior CA County: Butte	<i>Zoosiab</i> (“happy” in Hmong) works with Hmong elders in Butte County to improve their mental health and address trauma by facilitating social group interactions within the community, connecting elders with health and mental health services, and implementing culturally based wellness practices in efforts to educate elders on ways to improve their wellness, address mental illness, and provide access to new community spaces. Staff facilitate individualized services in the Hmong language to reduce stigma and improve mental wellbeing for this community.	Early Intervention Program Access and Linkages to Treatment Program Mental Health Advocacy Strategy
HEALTH RIGHT 360 ASIAN AMERICAN RECOVERY SERVICES healthright360.org/agency/asian-american-recovery-services Key Population: Samoan and Tongan families	Regions: San Francisco/ Bay Area Counties: San Francisco, San Mateo	The <i>Essence of MANA</i> serves Samoan and Tongan families in Northern San Mateo County, which has the highest proportion of Native Hawaiian and Pacific Islander families among all counties in California. It provides a space for families to discuss culturally tailored topics, socialize, and increase their community involvement. Additional outreach activities help raise awareness surrounding mental health conditions through engagement with individuals and families, distribution of bilingual materials, and facilitation of access to mental health resources. MANA aims to improve communication skills among family members, build leadership skills and community involvement, increase knowledge of mental health issues, reduce stigma surrounding mental health challenges, and increase access to culturally supportive care and services.	Prevention Program Access and Linkages to Treatment Program Mental Health Advocacy Strategy
THE FRESNO CENTER (lead agency) fresnocenter.org Grant Partners: Stockton Lao Family, Merced Lao Family Community Key Population: Hmong adults and elders	Regions: Superior CA, Northern San Joaquin Valley, Southern San Joaquin Valley Counties: Fresno, Merced, San Joaquin	The <i>Hmong Helping Hands Intervention’s</i> culturally and linguistically based services are designed to meet the community and mental health needs of adults and elders in the Hmong community. Culturally based components include inspirational talks, exploring their environment, engaging in cultural arts activities, spiritual healing practices, and workshops on personal beauty and self-esteem. It aims to reduce depression, anxiety, and acculturation issues related to difficulties assimilating to Western culture and lifestyles, the cumulative effects of untreated chronic medical conditions, and the impact of relocation and displacement from their homelands.	Prevention Program Early Intervention Program Mental Health Advocacy Strategy
EAST BAY ASIAN YOUTH CENTER ebayc.org Key Population: Southeast Asian high school aged youth and their families	Region: Superior CA County: Sacramento	<i>GroundWork</i> focuses on low-income Southeast Asians (Hmong, Iu-Mien, and/or Lao backgrounds) high-school aged youth who are at high-risk for, or are exhibiting, school failure, juvenile justice involvement, or suicidal ideation. Their mental health needs are uniquely overlooked and misunderstood within local public education and further compounded by familial and community-level risk factors, resulting in high rates of depression, suicide, substance abuse, and incarceration. GroundWork provides youth and families with culturally responsive counseling, mentoring, and case management services resulting in strengthened protective factors and a positive bicultural identity, improved relationships with caregiving adults, and healthy self-management skills. They also provide their staff with ongoing professional supervision and support to effectively provide services within school and juvenile justice settings.	Prevention Program Early Intervention Program Access and Linkages to Treatment Program WET: Workforce Staffing Support Program Mental Health Advocacy Strategy

IPP Name/Website / Key Populations	CDEP Service Area by Region/County	PEI Community Defined Evidence Practice Description	CDEP MHSA and Other Program Approaches
CAMBODIAN ASSOCIATION OF AMERICA (lead agency) cambodianusa.com Grant Partners: Families in Good Health, United Cambodian Community, The Cambodian Family, Khmer Parent Association Key Population: Cambodian adults	Region/ County: Los Angeles	The <i>Community Wellness Program</i> (CWP) utilizes peer-led engagements, cultural practices, workshops, and mental health service referrals to serve Cambodian participants who experience unaddressed historical trauma and mental illness. Located in Long Beach and Santa Ana, CWP integrates traditional Cambodian principles and values with mental health care and wellness through group engagement activities such as water ceremonies, meditation, group therapy, and case management. The CWP breaks generational cycles of trauma by encouraging participants to seek help when facing distress, educating community members about where and how to find available resources, and destigmatizing mental health illness and treatment.	Prevention Program Early Intervention Program Access and Linkages to Treatment Program Mental Health Advocacy Strategy
LATINX			
MIXTECO INDIGENA COMMUNITY ORGANIZING PROJECT mixteco.org Key Population: Mexican adult immigrants, primarily of Mixtec origin	Region: Central Coast County: Ventura	<i>Living with Love</i> (LwL) addresses depression, anxiety, domestic violence, and socio-cultural and linguistic isolation among Mexican immigrants, primarily of indigenous origin (Mixtec), in Ventura County using a culturally responsive framework. Trained Program <i>Promotoras</i> (health educators) who are fluent in Spanish and Mixteco, and knowledgeable about indigenous, collectivist culture and traditions, educate LwL participants using a four-week structured curriculum on mental health stressors and positive coping strategies. LwL participants gain information about how to better manage their daily life stressors and have increased knowledge, awareness, and access to mental health services and supports. All <i>Promotoras</i> participate in an 80-hour training focused on mental health, domestic violence, responding to emotional crises, and how to teach LwL.	Prevention Program Early Intervention Program Access and Linkages to Treatment Program WET: Workforce Staffing Support Program; Mental Health Careers Pathway Program; Training and Technical Assistance Program Mental Health Advocacy Strategy
LATINO SERVICE PROVIDERS latinoserviceproviders.org Key Population: Latino Youth and young adults	Regions: San Francisco/ Bay Area, North Coast Counties: Marin, Sonoma	The <i>Testimonios</i> project (also known as the Youth <i>Promotor</i> Internship) is a mental health and workforce development project in Sonoma County. The goals of the project are to work with the Latinx community to 1) increase mental health knowledge; 2) decrease mental health stigma; 3) increase mental health service-seeking behaviors; 4) increase career readiness and workforce skills among youth; 5) increase the number of bilingual-bicultural mental health providers; and 6) improve mental health outcomes and reduce disparities. The heart of the program is the identification, recruitment, selection, training, and engagement of bilingual-bicultural Youth <i>Promotores</i> , ages 16 to 25, who present mental health education and resources to the Latinx community.	Prevention Program Early Intervention Program WET: Mental Health Careers Pathway Program Mental Health Advocacy Strategy
LA FAMILIA COUNSELING CENTER, INC. lafamiliacounseling.org/housing Key Population: Latinx adults	Region: Superior CA County: Sacramento	<i>Centro de Apoyo Latino</i> (CAL) is a community mental health program designed to increase mental health service access and utilization among Latinos in Sacramento County. Latino families residing in this region have felt the disproportionate impact of social, political, economic, and racial isolation, yet have lacked access to safe spaces to disclose and seek assistance for their stressors. CAL aims to fill this gap through a service delivery model grounded in the <i>Cultura de Salud</i> (Culture of Health), or culturally responsive principles (e.g., collectivism, respect, and family) (Fernandez and Barnes, 1978). Services include extensive community outreach and education aimed at dispelling myths about mental health care and reducing cultural barriers that impede access to care; <i>Promotor</i> -led navigation services designed to facilitate families' connection to mental health resources; and individual and group therapeutic services for individuals with critical symptoms of mental illness and family stress care needs. CDEP staff participate in trainings designed to increase their capacity as community health workers.	Prevention Program Early Intervention Program Access and Linkages to Treatment Program WET: Workforce Staffing Support Program Mental Health Advocacy Strategy

IPP Name/Website / Key Populations	CDEP Service Area by Region/County	PEI Community Defined Evidence Practice Description	CDEP MHSA and Other Program Approaches
LA CLINICA DE LA RAZA (lead agency) laclinica.org Grant Partners: La Familia Counseling Services–East Bay/Hayward ¹⁰ , Tiburcio Vazquez Health Center Key Population: Latinx adults	Region: San Francisco/Bay Area County: Alameda	<i>Cultura y Bienestar's</i> (CyB) goal is to improve mental health knowledge, decrease mental health stigma, and increase mental health service usage among Latinos in Alameda County. Community distrust of the public mental health system, accessibility barriers, and the absence of culturally grounded services that are strengths-based, results in persistent under-utilization of mental health services. Cyb serves as a bridge between Latinx community members and providers by promoting a set of culturally relevant values (e.g., <i>compadrazgo</i> or becoming part of the extended family) to address mental health needs. Trained <i>Promotores</i> (Health Educators) provide mental health and wellness education, assess individual/family needs, and connect participants to needed services. CyB also offers individual counseling, group interventions (e.g., support groups, ceremonies, and traditional healing events), and mental health technical assistance and training for leaders and organizations in the broader community.	Prevention Program Early Intervention Program Access and Linkages to Treatment Program WET: Mental Health Careers Pathway Program Mental Health Advocacy Strategy
INTEGRAL COMMUNITY SOLUTIONS INSTITUTE icsi.solutions Key Population: Latinx youth ages 14-19 years	Regions: Northern San Joaquin Valley, Southern San Joaquin Valley Counties: Fresno, Madera	In lieu of school-based standard disciplinary measures, this program uses Latino-based wellness therapies (<i>Pláticas</i> and <i>Atención Plena</i>) with Latinx youth ages 14-19 residing in Fresno and Madera Counties who are at risk for mental health challenges and school failure. <i>Pláticas</i> , or, conversations, are grounded in Latinx indigenous wisdom traditions and are used to communicate cultural knowledge, promote healing, and create safe spaces for people to engage in dialogue about mental health challenges. <i>Atención plena</i> , also referred to as mindfulness, is a progressive relaxation technique and guided meditation activity. Both techniques are merged with hip-hop counseling, which draws upon music, poetry, and lyrics to share stories and life experiences, establish rapport, and facilitate discussions regarding student's culture, identity, and behavioral health issues. Through its emphasis on integrating cultural values with psychotherapeutic techniques, it decreases unwanted school behavior, school absenteeism, and academic disinterest, and improves positive school behavior, school engagement, and academic achievement.	Prevention Program Early Intervention Program Mental Health Advocacy Strategy
HUMANIDAD THERAPY AND EDUCATION SERVICES srosahtes.org Key Population: Latinx adults	Region: North Coast County: Sonoma	<i>Convivencia</i> bridges a historical cultural practice with modern counseling services to address stigma around seeking mental health services among low-income Latino adults living in Sonoma County. <i>Convivencia</i> decreases barriers to access and utilization of mental health services by increasing awareness about mental health issues and resources; engaging Latinos prior to the development of serious mental illness or serious emotional disturbances; and strengthening personal, familial, and community relationships. The strategies include culturally relevant community events and group counseling services to increase a sense of belonging, self-esteem, quality of life, and appreciation of being together to share stories of support and previous experiences..	Prevention Program Early Intervention Program Mental Health Advocacy Strategy
HEALTH EDUCATION COUNCIL (lead agency) healtheducouncil.org Grant Partners: El Hogar, The Mexican Consulate Key Population: Mexican adults	Region: Superior CA County: Yolo, Yuba	The <i>Ventanilla De Salud</i> (VDS)/ <i>Mente Sana, Vida Sana</i> (MSVS) (Health Window/Healthy Mind) increases access and utilization of culturally appropriate mental health services and reduces the stigmatization and discrimination related to mental illness through programs and services located at the Mexican Consulate in Sacramento. Mobile services are also offered in San Joaquin, Stanislaus, and Yolo Counties. Preventative mental health screenings are offered and co-located with regular health screenings, as well as referrals and linkages to culturally appropriate services. VDS/ MSVS hosts culturally informed health fairs in comfortable, familiar environments to the Latino community, and educational events where VDS staff members who share similar backgrounds as the program participants provide culturally appropriate information on health, mental illness, treatment resources, and stigma reduction. Sessions were led by MSW interns as part of HEC's ongoing effort to equip bilingual/cultural mental health professionals with tools needed to effectively serve the Latino community's mental health needs.	Prevention Program Access and Linkages to Treatment Program WET: Mental Health Careers Pathway Program; Training and Technical Assistance Program Mental Health Advocacy Strategy

¹⁰ La Familia Counseling Services – East Bay/Hayward is not the same agency as the CRDP IPP La Familia Services, Incorporated.

IPP Name/Website / Key Populations	CDEP Service Area by Region/County	PEI Community Defined Evidence Practice Description	CDEP MHSA and Other Program Approaches
LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, AND QUESTIONING (LGBTQ+)			
ON THE MOVE/LGBTQ CONNECTION onthemovebayarea.org Key Population: LGBTQ youth and young adults	Region: North Coast Counties: Napa, Sonoma	<i>Oasis Model</i> combats the dishearteningly high reports of depression, anxiety, and suicide among LGBTQ youth and young adults in the North Bay Area. Their stressors are distinctly connected to long histories of economic, racial, and geographic oppression, and an absence of youth-friendly resources and gathering spaces in the area. As a result, many youth self-isolate and remain invisible for fear of rejection or for their safety. Oasis provides safe meeting spaces for youth, helps them develop positive peer networks, and engages them in youth-led advocacy projects to address the social, economic, and racial disparities experienced by LGBTQ youth. Oasis also offers youth-informed workplace and social service-provider trainings to increase the availability of LGBTQ, culturally, and linguistically affirming health and wellness services in the region.	Prevention Program Early Intervention Program Access and Linkages to Treatment Program WET: Mental Health Careers Pathway Program; Training and Technical Assistance Program Mental Health Advocacy Strategy
SAN JOAQUIN PRIDE CENTER communityconnections.ssjc.org/programs/details/sjpc Key Population: LGBTQ+ Youth (high schoolers), allies, and families	Region: Northern San Joaquin Valley County: San Joaquin	<i>The Cultivating Acceptance Program (CAP)</i> supports San Joaquin County LGBTQ+ youth (high schoolers), allies, families, and engages various agencies/institutions (e.g., public school and foster care systems) throughout San Joaquin County to become more welcoming, accepting, and supportive of San Joaquin's LGBTQ+ youth. A long history of anti-LGBTQ+ sentiment exists throughout the community, with school settings in particular serving as a place where youth experience severe harassment and bullying, resulting in an increased vulnerability to suicide, depression, and substance-use issues compared to their straight and cisgender peers. Through gender-affirming support services and counseling with LGBTQ+ youth, cultural diversity trainings for behavioral health workers, empowerment and educational campaigns, and enrichment events, CAP aims to cultivate a spirit of safety, acceptance, and wellness among LGBTQ+ youth in the county. SJPC also has a mental health training program for graduate student interns.	Prevention Program Early Intervention Program WET: Workforce Staffing Support Program Training and Technical Assistance Program Mental Health Advocacy Strategy
SAN FRANCISCO COMMUNITY HEALTH CENTER (lead agency) sfcommunityhealth.org Grant Partner: SF LGBT Center Key Population: Transgender persons and LGBTQ TAY youth	Regions: San Francisco/ Bay Area Counties: San Francisco	<i>Let's Connect</i> serves LGBTQ+ adults residing in San Francisco. The city is home to the largest proportion of transgender individuals in the state, many of whom come to the area fleeing discrimination, making them susceptible to poverty, substance use, isolation, and poor mental health outcomes. LGBTQ+ TAY experience many of the same mental health challenges, along with a host of educational and economic challenges unique to their young age (e.g., school bullying, family ostracization, and homelessness). The core of Let's Connect is a series of eight two-hour sessions focused on various mental health topics. Other activities include culturally and linguistically appropriate community outreach and engagement efforts addressing the social determinants of health through the provision of wraparound services, and quickly identifying and assessing mental health needs in the community. Let's Connect seeks to empower participants, reduce stigma, and eliminate barriers to care.	Prevention Program Early Intervention Program Access and Linkages to Treatment Program
OPENHOUSE openhousesf.org Key Population: LGBTQ older adults	Region: San Francisco/ Bay Area County: San Francisco	<i>The Community Engagement Program (CEP)</i> is a holistic and comprehensive program that addresses social isolation and loneliness, as well as depression, anxiety, and long-standing trauma for LGBTQ+ older adults. It increases social connectedness and engagement by providing social support activities to connect elder LGBTQ+ residents with each other and to needed services and supports. The CDEP hosts social activities and implements both one-on-one and group support services. It is designed to reduce harm from discrimination, shame, rejection, inequality, and other prejudices, and work within the specific themes of directly and indirectly providing cultural and linguistic competence and responding to the social and environmental determinants of health.	Early Intervention Program Access and Linkages to Treatment Program Mental Health Advocacy Strategy

IPP Name/Website / Key Populations	CDEP Service Area by Region/County	PEI Community Defined Evidence Practice Description	CDEP MHSA and Other Program Approaches
GENDER SPECTRUM genderspectrum.org Key Population: Transgender (TG) and gender expansive (GE) youth (K-12)	Regions: Central Coast, Los Angeles, North Coast, Northern San Joaquin Valley, Orange, San Francisco/Bay Area, Southern San Joaquin Valley Counties: Alameda, Fresno, Kern, Los Angeles, Mendocino, Orange, San Francisco, San Luis Obispo, San Mateo, Santa Clara, Sonoma, Stanislaus	This program addresses the mental health needs of transgender (TG) and gender expansive (GE) youth by delivering technical assistance and trainings to educators, mental health professionals, and administrators, including supporting staff from organizations that work with schools (e.g., mental health organizations, non-teaching staff, such as bus-drivers, campus supervisors, clerical staff, cafeteria workers, coaches, and after-school program providers). As schools are the main institution where, outside of the family, many young people spend most of their time, creating gender inclusive, respectful, and understanding spaces where TG and GE youth can feel safe, affirmed, and supported is crucial for supporting their mental health and wellness needs.	WET: Training and Technical Assistance Program Mental Health Advocacy Strategy
GENDER HEALTH CENTER genderhealthcenter.org Key Population: LGBTQ+	Region: Superior CA County: Sacramento	This program addresses the sequelae of mental illness resulting from systemic violence, such as suicide, depression, isolation, and anxiety, among other negative life factors burdening LGBTQ+ populations. This is done by decreasing stigma and social isolation, and increasing access to affirming relationships, including cultural and community connections and mental health care using Queer-Informed Narrative Therapy (QINT) and advocacy-focused case management approaches. Strategies start at the community level to meet specific needs of gender minorities, particularly people of color, and folks living in poverty and/or without insurance. It addresses the lack of access to mental health services, is focused on improving quality of mental health services, and builds on community strengths to increase capacity and empowerment. Health Center staff, volunteers, advocates, and interns participate in ongoing advocacy and therapy trainings to ensure competency in providing QINT.	Prevention Program Early Intervention Program WET: Workforce Staffing Support Program Mental Health Advocacy Strategy
CENTER FOR SEXUALITY AND GENDER DIVERSITY thecenterbak.org Key Population: LGBTQ		The <i>Reducing Isolation through Support and Empowerment</i> (RISE) program addresses depression, anxiety, self-harm, and post-traumatic stress disorders resulting from isolation in the LGBTQ+ community in Kern County. RISE provides support workshops (specifically the Gender Rebels and Bi+/Pan workshops) one-on-one advocacy, community activities and events, and trainings for behavioral health providers in Kern County. RISE's tailored programming increases social connectedness and engagement, sense of community, and access to LGBTQ+-affirming mental health services. It reduces harm from discrimination, shame, rejection, and inequality experienced by LGBTQ+ community members and supports the development of positive coping skills and resiliency.	Prevention Program Early Intervention Program WET: Training and Technical Assistance Program Mental Health Advocacy Strategy



Chapter 4

The Statewide Evaluation Design

4.1 STATEWIDE EVALUATION PURPOSE

The purpose of the statewide evaluation was delineated in the [CDPH Statewide Evaluator Solicitation \(15-10603\)](#) which stated:



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 statewide evaluation were predefined, efforts to ensure the continuity of community-based participatory practices that began in Phase 1 were included through refinements to several aspects of the evaluation including the research questions, core measures, and data collection methods. The CDPH Statewide Evaluation Solicitation is available from CDPH-OHE by request. For more information related to refinements made to the Statewide Evaluation, please see the Statewide Evaluation Plan v4.0 (Psychology Applied Research Center, 2017).

4.2 STATEWIDE EVALUATION OBJECTIVES AND RESEARCH QUESTIONS

The CDPH-OHE Statewide Evaluator Solicitation (pg. 18-19) outlined three objectives for the statewide evaluation's scope of work. This report will address Statewide Evaluation Objectives 1 and 2 with their respective evaluation questions. Three research questions are aligned with Objective 1, while four questions are aligned with Objective 2. These seven research questions include both process and outcome evaluation foci.

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 Community-Defined Evidence Programs

- 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 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 Community-Defined Evidence Practices?
- What evaluation frameworks were developed and used by the Pilot Projects?

The statewide evaluation had a third objective which was to “Support CDPH in developing evaluation systems and guidelines and in communicating evaluation results.” This objective did not have a set of accompanying evaluation questions. It focused on advising CDPH on the adequacy of the IPP evaluation plans; planning, coordinating, organizing, and presenting at the Phase 2 Final Convening; serving as a subject matter expert; and maintaining regular communication with CDPH. The primary deliverables were:

- Development and dissemination of the Statewide Evaluation Guidelines, a reference document that provided an overview of the statewide evaluation and a framework for conducting high-quality, meaningful, culturally responsive local evaluations.
- Development and dissemination of a local evaluation plan template for IPPs to guide the completion and submission of their plan to OHE for approval. PARC also conducted a systematic review of IPP evaluation plans using a standardized rubric with defined criteria to evaluate the plans’ strengths, rigor, and attention to cultural, linguistic, and/or LGBTQ+ factors.
- Development and dissemination of an IPP final evaluation report checklist (e.g., most important areas to include in each section: executive summary, introduction, methods, etc.).

4.3 STATEWIDE EVALUATION APPROACH

Considerations of culture, context, methodology, and equivalence undergirded PARC’s evaluation philosophy, praxis, and approach. The Statewide Evaluation Plan was grounded:

- Methodologically in the principles and procedures consistent with community-based participatory practice (CBPP).
- Theoretically in a social-ecological framework that was culturally- and contextually oriented and incorporated an intersectional framework.

4.3.A COMMUNITY BASED PARTICIPATORY PRACTICE (CBPP)

A central feature of CRDP Phase 1 and 2 was the application of varying degrees of CBPP in all facets of the initiative. 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 uses CBPP to reflect a more expansive array of efforts related to participatory activities that include and extend beyond research. For more information on CBPP and how it was applied in CRDP, please refer to PARC’s publication: **Best Practices in Community Based Participatory Practice (2018)**.

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.

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 statewide evaluation’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 a statewide evaluation core measure based on feedback from Phase 2 stakeholders (IPPs, TAPs) including changes in language, inclusion of additional IPP or TAP-generated items, reordering 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 (e.g., translation and conceptual meaning, response scales, administration strategies with the items, etc.).
- Formation of a data review committee to provide feedback on the initiative's preliminary findings.
- Inclusion of a CRDP community review process for feedback on the final evaluation report.

4.3.B CULTURE

The statewide evaluation considered culture and how it influenced not only the evaluation of the ODEPs but CRDP Phase 2 overall. 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 was 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.

4.3.C THE SOCIAL-ECOLOGICAL FRAMEWORK

The statewide evaluation examined 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 multiple nested ecological systems. In other words, individuals are enmeshed in different ecosystems simultaneously, 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 influence and interact with each other and every aspect of people's lives. This framework was 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.

4.3.D INTERSECTIONALITY

Intersectionality emerged out of a concern for the complex, cumulative ways the many forms of discrimination combine, overlap, and/or intersect. 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, 1995). Thus, a person's experiences must be conceptualized as dynamic, fluid, and internally diverse.

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 statewide evaluation acknowledged and paid attention to the following:

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

To protect against stereotyping or essentializing communities and to examine the nuance of culture and diversity within and across the priority populations, an intersectional lens was used.

For more information on the statewide evaluation approach and the elements that make up this grounding (CBPP, the social-ecological framework, culture, cultural competence, the synthesis of culture and ecology, and intersectionality) see the Statewide Evaluation Plan v4.0 (June 2022).

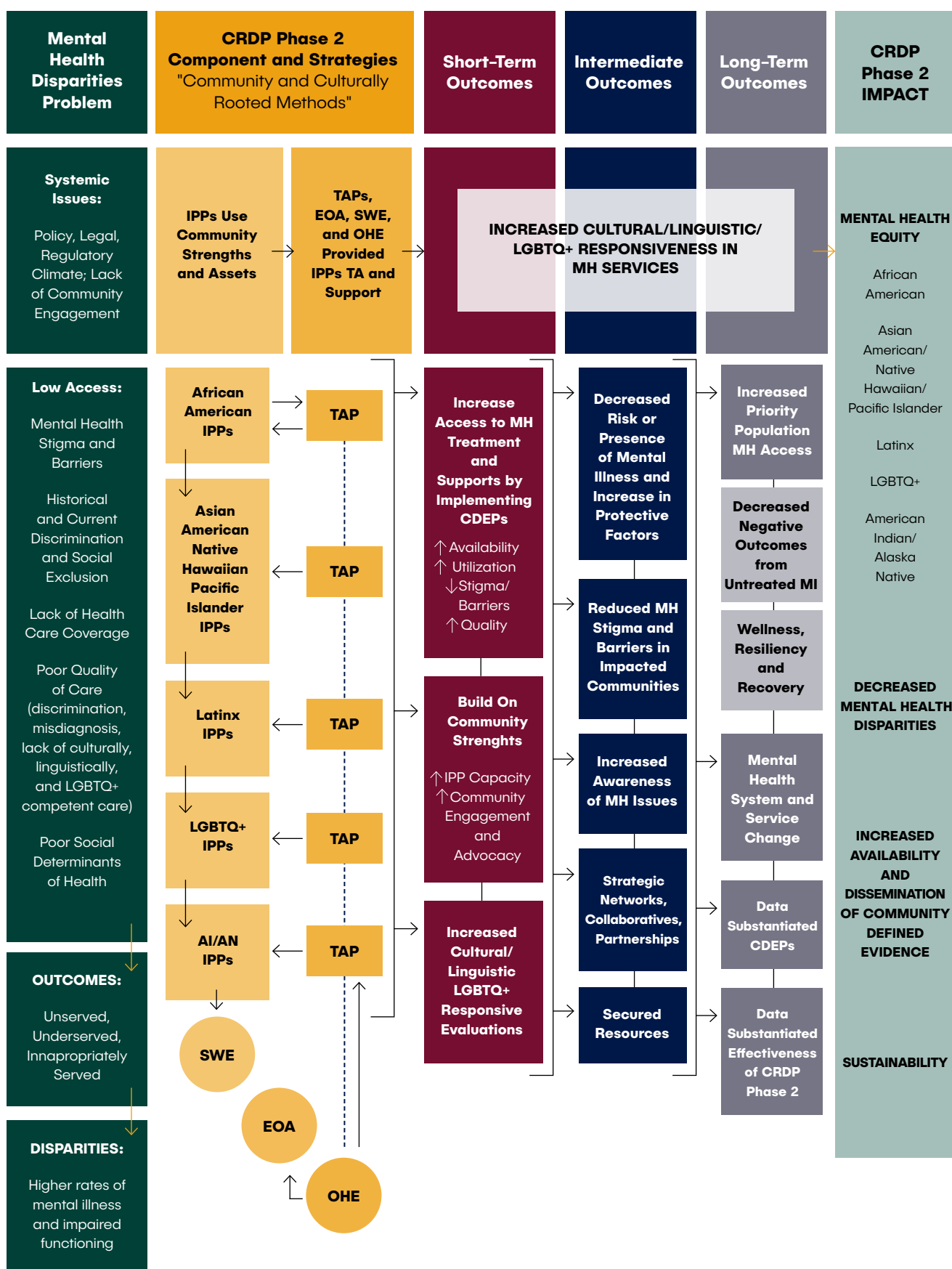
4.4 STATEWIDE EVALUATION CHANGE MODEL

The Statewide Evaluation Change Model (Figure 4.1) delineates the pathways to change in CRDP Phase 2. The model is aligned with the CRDP Strategic Plan to Reduce Mental Health Disparities, as well as community and culturally rooted methods to improve access, services, and outcomes for unserved, underserved, and inappropriately served populations.

Figure 4.1 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).
- With technical assistance and support provided by the TAPs, SWE, EOA, and CDPH-OHE, the IPPs 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 quality of service.
- Continued implementation of the CRDP components and strategies (IPPs, TAPs, EOA, SWE, and CDPH-OHE) lead to a set of intermediate outcomes at the individual level (e.g., continued shifts in access, utilization, and stigma), organizational level (e.g., acquisition of resources, strategic networks, and collaborations), and community level (e.g., increased awareness of mental health issues).
- Finally, while changes at the individual level continue over time, additional long-term outcomes also begin to emerge at both the community and statewide/systems-levels 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 4.1: CRDP Phase 2 Statewide Evaluation Change Model



4.4.A COMPLEXITY THEORY

The Statewide Evaluation Change Model in Figure 4.1 presents a linear illustration with isolated variables. However, the model and accompanying evaluation methodology was grounded in a more nuanced modeling found in complexity theory (Byrne & Callaghan, 2014)¹¹. The statewide evaluation was sensitive to the potential influence of organizational, community, cultural, historical, and contextual conditions on any observed change. It focused 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 or viewing cultural variability as merely a problem in presumed linear relationships. The statewide evaluation methodology incorporated this perspective by using mixed methods and data triangulation.

4.5 STATEWIDE EVALUATION METHOD

4.5.A DESIGN

To ensure equity, fairness, humanity, and transparency within the initiative, the statewide evaluation did not use a randomized control trial experimental design with assignment of CDEPs or their participants to treatment or control groups. In a demonstration project aimed at reducing mental health disparities among communities in California that have historically been unserved, underserved, and inappropriately served, it would have been unethical to assign one group of community participants to CDEP interventions while withholding such interventions from other community members. It also did not include a cohort study structure with non-treatment (i.e., non-CDEP PEI) service providers who collected statewide evaluation core measure data (i.e., CDEP Participant Questionnaire) on individuals with similar characteristics to CRDP Phase 2 participants.

Given that the statewide evaluation was mandated to evaluate both the effectiveness of the CDEPs and CRDP Phase 2 overall, a concurrent triangulation mixed-methods design was used to meet the two statewide evaluation objectives. Methodologically diverse qualitative and quantitative data sources were concurrently collected to explain the mechanisms and outcomes of Phase 2 strategies and to capture the more textured story reflected in the findings. The evaluation also featured a CBPP-integrative, multi-year (longitudinal), multi-site approach to the answering the statewide evaluation questions. In addition, in the absence of comparison data using control or comparison groups, the SWE gained access to mental health survey items from the California Health Interview Survey (CHIS) and Medical Expenditure Panel Survey (MEPS) databases. This California comparative data assisted the SWE with determining the effectiveness of IPP CDEPs in preventing and/or reducing the severity of mental health conditions for their priority populations.

4.5.B SAMPLE

Inclusion criteria consisted of CRDP Phase 2 partners (IPPs, TAPs, EOA, SWE, and CDPH-OHE), CDEP community participants (children, adolescents, and adults), and other key stakeholders who had some level of involvement with Phase 1 or 2. Exclusion criteria for the statewide evaluation were non-CRDP Phase 2 PEI programs or services. Recruitment of the statewide evaluation sample occurred through regular contact and communication between PARC, the Phase 2 partners and other key CRDP stakeholders.

¹¹ "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)".

The statewide evaluation utilized a non-probability sampling approach comprised of:

- Thirty-five IPPs (including a sample of CDEP participants from 32 IPPs).
- Five TAPs.
- One statewide evaluation consultant.
- One EOA consultant.
- CDPH-OHE (five priority population contract managers; one statewide evaluation contract manager; OHE leadership: lead for CRDP, chief of community development and engagement, deputy director, and assistant deputy director).
- Two CRDP stakeholders (i.e., the Cross Population Sustainability Steering Committee and the Cultural Broker).

4.5.B.I CDEP PARTICIPANT SAMPLE¹²

The cross-site core measure (i.e., the CDEP Participant Questionnaire) was collected by 32 of 35¹³ IPPs from either all or a sub-sample of their participants and were administered at the beginning (pre-test) and/or end (post-test) of their natural program cycles. The questionnaire was available for three age groups (adult: 18+ years, adolescent: 12-17 years, and child by proxy: 5-11 years). See Table 4.1 for an overview of the number of IPPs that collected data for each age-related sample.

Table 4.1: Number of IPPs Collecting Age Specific CDEP Participant Data from 06/15/2018 to 06/30/2021

# IPPs (N=32)	Adult	Adolescent	Child by Proxy
15	✓	–	–
6	–	✓	–
6	✓	✓	–
3	–	✓	✓
1	–	–	✓
1	✓	✓	✓

In total, 3,746 individuals completed pre-and/or-post questionnaires (adult: 2,945, adolescent: 694, child by proxy: 107). Overall, 3,657 pre-tests and 2,504 post-tests were collected, with a final matched pre-and post-test sample size of 2,415 (a matched response rate of 66%).



¹² The CDEP participant sample size was not pre-determined by PARC but by the IPPs and local evaluators so that it aligned with their local evaluation sampling strategy as well as outreach methods for and involvement in IPP local evaluations. As a result, the statewide evaluation cross-site questionnaire sample varied by IPP and community. Data collection locations also differed across IPPs because implementation of CDEPs occurred across multiple sites, locations, and levels (e.g., school, classroom, students, agencies, community events, etc.). Sampling approaches were primarily a combination of non-probability techniques—i.e., universal or convenience due to the variability of the design and methods of the local IPP evaluations.

¹³ Two IPPs had a CDEPs focused on mental health workforce development and therefore did not administer the CDEP Participant Questionnaire. One IPP's participant data was not included because CDPH-OHE was not able to secure a data sharing agreement with the communities participating in that program

Table 4.2: CDEP Participant Sample Size by Priority Population and CRDP Overall Collected from 06/15/2018 to 06/30/2021

Questionnaires Collected/ (pre-and-post-test)	AfAm N=661 individuals	AI/AN N=672 individuals	AANHPI N=990 individuals	Latinx N=909 individuals	LGBTQ+ N=514 individuals	CRDP Overall N=3,746 individuals
CRDP Overall: (n=2,945 Adults)						
# of Pre-tests	n=441 (4 grantees)	n=396 (3 grantees)	n=930 (5 grantees)	n=750 (6 grantees)	n=378 (4 grantees)	n=2,895 (22 grantees)
# of Post-tests	n=254 (4 grantees)	n=168 (3 grantees)	n=754 (5 grantees)	n=597 (6 grantees)	n=179 (4 grantees)	n=1,952 (22 grantees)
Matched Sample Size	n=243 (55%) (4 grantees)	n=144 (36%) (3 grantees)	n=752 (81%) (5 grantees)	n=590 (79%) (6 grantees)	n=173 (46%) (4 grantees)	n=1,902 (66%) (22 grantees)
CRDP Overall: (n=694 Adolescents)						
# of Pre-tests	n=164 (4 grantees)	n=166 (5 grantees)	n=58 (1 grantee)	n=145 (3 grantees)	n=126 (3 grantees)	n=659 (14 grantees)
# of Post-tests	n=111 (3 grantees)	n=109 (5 grantees)	n=45 (1 grantee)	n=131 (2 grantees)	n=79 (3 grantees)	n=475 (12 grantees)
Matched Sample Size	n=110 (67%) (3 grantees)	n=86 (52%) (5 grantees)	n=45 (77%) (1 grantees)	n=124 (86%) (2 grantees)	n=75 (60%) (3 grantees)	n=440 (67%) (14 grantees)
CRDP Overall: (n=107 Child by Proxy)						
# of Pre-tests	n=43 (2 grantees)	n=60 (3 grantees)	-	-	-	n=103 (5 grantees)
# of Post-tests	n=38 (2 grantees)	n=39 (3 grantees)	-	-	-	n=77 (5 grantees)
Matched Sample Size	n=37 (86%) (2 grantees)	n=36 (60%) (3 grantees)	-	-	-	n=73 (71%) (5 grantees)
CRDP FINAL SAMPLE SIZE						
# of Pre-tests	648	622	988	895	504	3,657 (32 grantees)
# of Post-tests	403	316	799	728	258	2,504 (32 grantees)
Matched Sample Size	390 (60%)	266 (43%)	797 (81%)	714 (80%)	248 (49%)	2,415 (66%) (32 grantees)

NOTE ABOUT THE CHILD BY PROXY (5-11 YEARS) CDEP PARTICIPANT QUESTIONNAIRE SAMPLE

The term “Child by Proxy” refers to data from all children (ages 5-11) for whom participant data was reported by other people (e.g., parents, legal guardians, etc.). While the original intent of CRDP Phase 2 was to include information from participants of all ages, including children, given the small statewide evaluation child-by-proxy sample size (e.g., $n=73$ for the overall matched pre- post-sample; $n=68$ for IPPs with $>10\%$ of the sample), a CRDP-wide or hub analysis of the CDEP Participant Questionnaire for this sample was not possible. Consequently, CRDP overall and hub findings of the CDEP Participant Questionnaire are reported for the adult and adolescent samples only.

What were the specific limitations of the child-by-proxy sample in CRDP Phase 2? Only five IPPs collected child-by-proxy data for the statewide evaluation. The sample is primarily represented by two IPPs, including one African American IPP (with a direct service component exclusively serving children) and one AI/AN IPP (with a direct service component serving families and individuals of all ages, including 3+ years). The other three IPPs reporting child-by-proxy data had sample sizes that represented 10% or less of the child-by-proxy sample. This pattern suggests that these were children involved in their CDEP ancillary services. That is, ancillary services were provided to younger children (11 years or younger) when they accompanied a parent, older sibling (12-17 years), or other family member enrolled formally in a direct service component. While some IPPs had CDEP components that served entire families, including younger children, this mostly occurred through community level activities (e.g., large social/cultural gatherings in the community). Consequently, most CDEP direct services were primarily designed to serve adults (18+ years) and adolescents (12-17 years). In the case of direct CDEP services that were designed for participants of all ages, including children, the primary age groups that subsequently enrolled were adolescents and/or adults.

Additional explanations for the small sample size for the child-by-proxy data may include:

1. The numbers of younger children expected to be served by the CDEPs was smaller than what was initially projected by the IPPs in their local evaluations.
2. CDEP interventions involving children were longer in duration resulting in a smaller number of eligible participants for the statewide evaluation.

Recruiting and enrolling eligible participants into the statewide evaluation might have been proved challenging (i.e., response burden too high given that the respondents were parents or legal guardians responding on behalf of their child).

See Table 4.3 for an overview of the child-by-proxy sample for the CDEP Participant Questionnaire.

Table 4.3: Child by Proxy Sample Size at Pre-Test, Post-Test, and Matched Pre-and Post-Test

HUB	Child by Proxy						
	# IPPs	Pre-Tests		Post-Tests		Matched Pre-and Post-Tests	
		Size	Range Per IPP	Size	Range Per IPP	Size	Range Per IPP
AfAm	2 ¹	$n=43$	3 to 35	$n=38$	3 to 35	$n=37$	3 to 34
AI/AN	3 ²	$n=60$	1 to 34	$n=39$	1 to 34	$n=36$	1 to 34
Total (all IPPs)	5	$N=103$		$N=77$		$N=73$	
Total (IPPs with $>10\%$ sample)	2	$N=69$		$N=69$		$N=68$	

¹The AfAm hub sample was representative of one of two IPPs across all three samples. (One IPP represented less than 5% of the sample.)

²The AI/AN hub sample was representative of one of three IPPs across all three samples. (Three IPPs represented 10% of the sample or less.)

4.5.C VARIABLES

Seven construct/outcome variables and six process variables were developed to ensure consistency in data across Phase 2 components and strategies. The variables were aligned with the Statewide Evaluation's objectives, research questions, change model, and the CRDP Strategic Plan to Reduce Mental Health Disparities (California Pan-Ethnic Health Network; 2018). See Table 4.4.

Table 4.4: Process and Outcome Variables with Examples of Associated Operational Variables

Outcome Constructs/Variables	Examples of Operational Variables
1.Mental Health Access (Availability, Utilization, Stigma/Barriers, Quality)	<ul style="list-style-type: none"> Cultural, linguistic and LGBTQ+ approaches to CDEP service provision and outreach/recruitment (Availability) Number of adults, adolescent, children served by unmet need (Utilization) Number of adults, adolescent, and children served by stigma/barriers (Stigma/Barriers) Number and type of CDEP workforce responders trained (Quality)
2.Community Strengths (IPP Capacity, Community Engagement)	<ul style="list-style-type: none"> Changes in IPP leadership capacity Community engagement strategies
3. Cultural and Linguistically Based IPP Evaluations	<ul style="list-style-type: none"> Peer reviewed IPP Local Evaluation Plans CDPH-OHE review/approval
4. Risk/Presence of Mental Health Issues and Protective Factors in CDEP Participants	<ul style="list-style-type: none"> Changes in cultural connectedness Changes in psychological distress
5. Awareness of Mental Health Issues	<ul style="list-style-type: none"> Number/type of audiences reached by IPPs in public communications
6. Mental Health Services Networks/Collaboratives and Strategic Partnerships	<ul style="list-style-type: none"> Number/type of IPP involvement in networks
7. Mental Health System and Services Change	<ul style="list-style-type: none"> Number/type of Phase 2 advocacy efforts
Process Constructs/Variables	Examples of Operational Variables
1. IPP Organizational and CDEP Context	<ul style="list-style-type: none"> IPP geographic location CDEP service area
2. Phase 2 Partner (IPP, TAP, EOA, SWE, OHE) Implementation Strategies	<ul style="list-style-type: none"> Strategies and approaches used by each partner
3. Phase 2 Technical Assistance Provided to IPPs	<ul style="list-style-type: none"> Number/type of technical assistance and support provided by TAPs, EOA, OHE, and SWE
4. IPP Local Evaluation Strategies	<ul style="list-style-type: none"> Cultural, linguistic, CBBP, and LGBTQ+ methods, measures, and practices
5. Phase 2 Partner (IPP, TAP, EOA, SWE, OHE) Satisfaction with CRDP Phase 2	<ul style="list-style-type: none"> Satisfaction with CRDP Phase 2 strategies and operations
6. Phase 2 Lessons Learned	<ul style="list-style-type: none"> Phase 2 strengths and weaknesses

See Statewide Evaluation Plan 4.0 for more information on the process and outcome variables.

4.5.D CORE MEASURES

Six primary and secondary statewide evaluation core measures, both quantitative and qualitative, were identified, developed, and aligned with the process and outcome variables. The statewide evaluation core measures consisted of only a subset of potential process and outcome measures to answer the research questions but are consistent with evaluation best practices and standard methods to examine changes in PEI programs and strategies (Rand, 2017). Using a CBPP process, continuous feedback from Phase 2 partners (IPP, TAP, CDPH-OHE) was solicited and consistently integrated into modifications to the various statewide evaluation core measure instruments and data collection procedures. Improvements to the statewide evaluation core measures were often made to account for the unique cultural, linguistic, historical, and contextual factors of each community and priority population. See Figure 4.2 for information on the six Statewide Evaluation core measures.

Figure 4.2: The Six Statewide Evaluation Core Measures (Qualitative and Quantitative)

OUTCOME		INSTRUMENTS AND AREAS OF ASSESSMENTS	
1	CDEP PARTICIPANT LEVEL DATA Quantitative pre-and post-tests addressed multiple factors related to CDEP individual-level mental health disparities.	CDEP Participant Questionnaire: Adult (N=2,945; 22 IPPs), Adolescent (N=712; 14 IPPs), Child by Proxy (N=107; 5 IPPs) <ul style="list-style-type: none"> Access/utilization to mental health services in the 12 months (pre-only items). Mental health stigma and other barriers to help seeking involvement (pre-only items). Psychological distress, functioning and protective factors (matched pre-and post-test items). CDEP satisfaction & quality of service (post-only items). Demographic information (pre-only items). 	
PROCESS AND OUTCOME		INSTRUMENTS AND AREAS OF ASSESSMENTS	
2	ORGANIZATIONAL LEVEL DATA Quantitative and qualitative reports that summarized major or significant Phase 2 partner (IPP, TAP, EOA, SWE) activities.	IPP Organizational Capacity Assessment: Pre-and Post-Assessment (N=70; 35 IPPs) <ul style="list-style-type: none"> Organizational capacity strengths and capacity building needs (pre-and post-test assessments in five areas: leadership, adaptive, management, operational, and cultural competence). The IPP Semi-Annual Report (IPP-SAR): 279 Reports (across 8 reporting periods) <ul style="list-style-type: none"> CDEP and local evaluation development/implementation (including fidelity and flexibility). Progress in strengthening IPP organizational capacity. Community engagement and public communications strategies. Systems, environmental, and policy advocacy and change efforts. IPP satisfaction with Phase 2 technical assistance/support. Direct service referrals, linkages and navigation. Direct service unduplicated counts served for select CDEP components. Cultural, linguistic, LGBTQ+ affirming strategies in CDEP and/or local evaluation. Partner (TAP, EOA, SWE) Progress Reports Submitted to OHE <ul style="list-style-type: none"> TA and support activities provided by the TAPs, EOA, and SWE to IPPs. 	
PROCESS AND OUTCOME		INSTRUMENTS AND AREAS OF ASSESSMENTS	
3	SEMI-STRUCTURED INTERVIEWS Qualitative measure of progress regarding overall effectiveness of Phase 2.	Phase 2 Partner Interviews with TAPs, EOA, SWE, and OHE: 2018 (N=8 interviews); 2019 (N=9 interviews); 2020 (N=10 interviews); 2021 (N=10 interviews) <ul style="list-style-type: none"> Implementation approaches and strategies to support the work of the IPPs (including fidelity and flexibility). Partner collaboration to support the work of the IPPs. Success, challenges, and lessons learned. 	
PROCESS AND OUTCOME		INSTRUMENTS AND AREAS OF ASSESSMENTS	
4	REVIEW OF RECORDS Regular and systematic collection, review and extraction of information from pertinent records and documents.	CDPH-OHE Phase 1 and 2 Records/Documents <ul style="list-style-type: none"> Accepted grant proposals and bids. CRDP strategic plan to reduce mental health disparities Phase 1 priority population reports. Approved IPP final evaluation plans and reports. Grantee and contractor invoices/budgets. 	
OUTCOME		INSTRUMENTS AND AREAS OF ASSESSMENTS	
5	SECONDARY DATA Large scale survey data to understand the magnitude of changes/trends related to CRDP Phase 2 strategies, conduct comparisons with CDEP participant data, and to make the business case for the effectiveness of CDEP's and CRDP Phase 2.	California Health Interview Survey (CHIS, 2020) <ul style="list-style-type: none"> Severe psychological distress. Medical Expenditure Panel Survey (MEPS, 2017-2019) <ul style="list-style-type: none"> Health insurance, out-of-pocket health expenditures, Medicaid health expenditures, Medicare health expenditures, health insurance payments, public assistance payments, yearly household income, wage income, marital status, job occupation, family size, age, race, sex at birth, whether a person was born in the U.S., how well a person speaks English, highest level of schooling, Kessler-6 score. 	
OUTCOME		NOT CONDUCTED	
6	IPP LOCAL EVALUATION METADATA Analysis of aggregate meta-data from IPP local evaluation studies to demonstrate evidence of CDEP effectiveness on positive or negative mental health outcomes for participants.		

Note for participant-level and organizational-level data: All data submitted to PARC by IPPs and TAPs underwent a validation and verification check to ensure the data was correct, credible, properly formatted, accurate, and error free. Validation procedures included downloading of data submissions from Qualtrics; recording data submissions in a master log; reviewing data and documenting any errors, inaccuracies, or inconsistencies, including communication with IPPs or TAPs to discuss and resolve flagged data issues in the master log; and processing decisions with the corresponding data and preparing for data entry.

NOTE ABOUT IPP LOCAL EVALUATION METADATA

IPPs were invited, but not required, to submit meta-data for all standardized, quantitative measures on positive or negative mental health outcomes in their final evaluation reports. Because only three IPPs provided this data, a local evaluation meta-analysis could not be conducted for CRDP overall or by hub.

See the Statewide Evaluation Plan v4.0 (June 2022) for more information on the six statewide evaluation core measures.

4.6 DATA ANALYSIS PLAN

The data analysis plan applied the CRDP Phase 2 guiding principles as defined in the CDPH CRDP Statewide Evaluator Solicitation (15-10603):

- “Doing business differently” by obtaining and considering input from communities and CRDP Phase 2 partners.
- Building and supporting community capacity to sustain efforts to reduce mental health disparities beyond Phase 2.
- Ensuring fairness (and not perpetuating disparities).
- Using statewide evaluation findings to contribute to local and state-level policy and systems change within the larger mental health care delivery system.

Understanding not only the promise but also the challenges these principles embodied, the statewide evaluation data analysis plan included multiple frameworks across a spectrum, from traditional to highly innovative.

4.6.A OBJECTIVES 1 AND 2 DATA ANALYSIS PLAN

The analytic approach for Objective 1 (evaluate overall CRDP Phase 2 effectiveness in identifying and implementing strategies to reduce mental health disparities) and aspects of Objective 2 (evaluate the effectiveness of community-defined evidence practices) included a mixed-methods “parallel combination” approach for four of the six statewide evaluation core measures:

- Pre-test CDEP participant-level data (adult and adolescent).
- Organizational and CDEP program-level data (all data sources).
- Semi-structured interviews.
- Review of all records.

If data from two or more core measures answered the same question, the findings were triangulated to verify findings and generate a more nuanced and complete explanation of the findings. When the statewide evaluation core measures answered different questions, data were analyzed separately and the results were combined or synthesized in the final evaluation report.

4.6.A.I QUANTITATIVE DATA

Quantitative data analysis involved the use of frequency counts of data collected at one point in time or on a longitudinal basis. Descriptive statistics and cross tabulations were also conducted for select variables.

4.6.A.II QUALITATIVE DATA

A content analysis was used to quantify and analyze the presence of words, themes, and concepts from qualitative data collected by the statewide evaluation at one point in time or longitudinally. Textual information was also extracted from key Phase 1 and 2 documents and reports. Manifest content analysis (e.g., data that were easily recognized and counted by the coding team without the need to discern intent or identify deeper meaning) was conducted most often (e.g., IPP CDEP location, prot

Multiple researchers developed codebooks which were systematically reviewed and updated to identify patterns, trends, and themes, and were then grouped together in relation to the larger constructs being analyzed. Qualitative data was converted into either narrative or numerical data for descriptive analysis. In instances where there was insufficient text to generate a code, the statewide evaluation team consulted with IPPs, the statewide evaluation contract manager, and the priority population contract managers to confirm and vet understanding of the data.

4.6.B OBJECTIVE 2 QUANTITATIVE DATA ANALYSIS PLAN

The analytic approach for Objective 2 (evaluate the effectiveness of community-defined evidence practice in improving mental health and reducing disparities) involved one of the six statewide evaluation core measures:

- Pre-and-post-test CDEP participant-level data (matched adult and adolescent sample).

To obtain usable and useful qualitative and quantitative information, the data analysis plan included several statistical best practices, including:

- Generating descriptive statistics.
- Visualizing and summarizing data.
- Identifying relationships between variables.
- Comparing variables.
- Examining differences between variables.
- Modeling outcomes in the presence of explanatory variables.

These best practices helped PARC assess whether assumptions tied to the analytic methods were met by the data collected and were then used to select more appropriate methods based on those results.

Despite the diversity found in CDEP populations, intervention strategies, and IPP approaches, specific questions were common across IPPs that helped determine the extent to which CRDP Phase 2 met its objectives. The challenge was to define and measure effectiveness or success in ways that honored communities' cultural perspectives, values, and priorities. PARC recognized that "quantitative is qualitative" within the CRDP context. With purposive and convenience sampling approaches used by most IPPs, the appropriate analysis of Phase 2 cross-site evaluation data for Objective 2 was not classical inferential statistics. Hypothesis testing comparisons of pre-and post-intervention data, program, and administrative data, or between IPP data would not provide quantitative insights into the overall effectiveness of CRDP. From the SWE point of view and its dedication to the principle of doing business differently, the research questions for CRDP were not framed as "did this work?" but as "to what extent did this work?" Therefore, empirical data analysis of outcomes included use of Bayesian data analysis. PARC did not deliver p-values and pronouncements of statistical significance for CDEPs compared to each other or to administrative data. Rather, using a Bayesian analysis paradigm, the statewide evaluation assessed the extent to which CRDP Phase 2 units (i.e., priority populations and the IPPs embedded within them) delivered results via credible intervals on effect sizes of relevant variables.

PARC's Bayesian approach to analyzing CDEP Participant Level Data was 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. Analysis products included ranges of effectiveness reflective of the uncertainties that arise not only from "sampling variation" that dominates traditional statistical thinking, but also from prior information and modeling assumptions. Much more than a binary outcome of whether "it worked" or not, the evidence base encoded in the posterior information of this statewide evaluation analysis (i.e., the probability an event will occur after all evidence or background information has been considered) showed how well the different components worked.

4.6.B.I USE OF SECONDARY DATA: CALIFORNIA HEALTH INTERVIEW SURVEY (CHIS)

The Statewide Evaluation initially intended to use sensitive mental health data and/or geo-coded data from the California Health Interview Survey (CHIS) to understand the magnitude of change or trends related to CRDP Phase 2 strategies, conduct comparisons with IPP participant data, and to make the case for the effectiveness of CDEPs and CRDP Phase 2. The Statewide Evaluation Plan proposed using CHIS data to create a comparison group of non-CRDP individuals with similar demographics to CRDP CDEP-served individuals to identify commonalities and distinctions among shared access and utilization measures shared between the CHIS and the statewide evaluation CDEP Participant Questionnaire (Statewide Evaluation Plan v4.0). However, following exploratory analysis, the SWE determined that including the CHIS in the statewide evaluation was not appropriate due to limited representative data reflecting CRDP participants from which to create an accurate comparison group. See Appendix 3 for more information on this exploratory analysis.

BUSINESS CASE DATA ANALYSIS PLAN

The economic valuation of the CRDP Phase 2 assessed the health, fiscal, and economic impacts of the 35 CDEPs and Phase 2 overall. It considered costs and benefits of health and non-health outcomes to determine the return on investment. The CRDP Phase 2 business case explains 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.

Potential medical expenses associated with changes in mental health outcomes were calculated using regression models that included covariates such as age, gender, English-language fluency, whether a person was born in the U.S., household income, and level of education. Given that our CDEP Participant Questionnaire did not include health expenditures, data from the Medical Expenditure Panel Survey (MEPS) was used to model health expenditures for four of the five hubs. To model health expenditures for the LGBTQ+ priority population, sexual orientation data was linked from the National Health Interview Survey (NHIS).

The Statewide Evaluation empirical methodology provided the potential dollar value associated with changes in psychological distress. Through this approach, health expenditures were quantified for individuals with low, moderate, and severe levels indicative of psychological distress as measured by the Kessler-6 (K6) scale. In addition, point changes in the K6 scale were observed related to health expenditures across and within the thresholds. This means that even if post intervention CDEP participants remained above the thresholds of moderate or high distress, monetary gains were quantified associated with point-by-point reductions in psychological distress. To estimate differences in the prevalence of psychological distress in the general population of California in comparison to the CRDP Phase 2 CDEP participants, weighted adjustment to the estimates were conducted.

For the economic valuation of CRDP overall, we originally aimed to compare the costs and benefits from CRDP CDEPs to other California-based PEI programs. To estimate government expenditures associated to PEI programs, we accessed county annual MHSA Revenue and Expenditure Reports compiled by the Mental Health Services Oversight and Accountability Commission (MHSOAC). However, there was no county data on benefits from PEI programs or participant costs that would be comparable to our calculations for CRDP Phase 2.

4.7 LIMITATIONS

PARC 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 within and between priority populations; concerns that findings will be incorrectly interpreted; and that findings could inadvertently pathologize priority populations and communities. The data analysis plan reflects PARC's 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.

4.8 FOCUS OF THE FINDINGS

The remainder of this report summarizes the CRDP Phase 2 statewide evaluation findings.

Chapter 5 provides a broad narrative of the initiative and its impact through the lens of the contractors, or CRDP partners, who were selected to support the IPPs and the overall Initiative. How CRDP partners collaborated with each other and with IPPs over the life of the initiative is examined first, followed by data from IPPs to provide a context for the work of CRDP partners. Key challenges faced during the initiative (COVID-19, racial unrest, California wildfires) are addressed as well.

Chapter 6 answers research questions connected to Objective 1 (i.e., overall CRDP Phase 2 effectiveness in identifying and implementing strategies to reduce mental health disparities). It is divided into three sections. Section 1 presents findings related to mental health access with a focus on four key topics: availability, utilization, stigma/barriers, and CDEP quality. Section 2 provides findings on CDEP mental health priorities. Section 3 shares findings related to improvements in mental health.

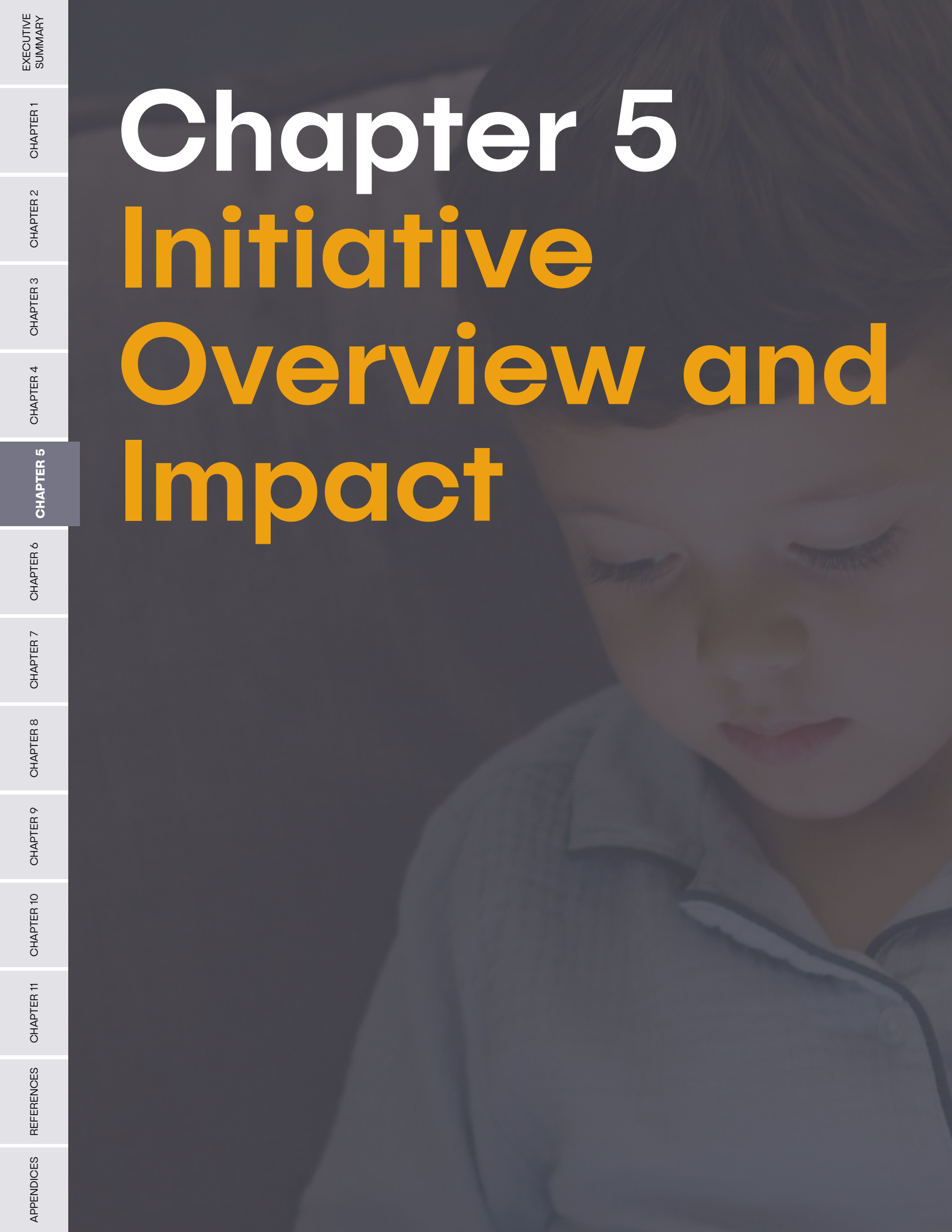
Chapter 7 focuses on organizational impacts, presenting findings related to outreach and recruitment, community engagement, public communications, culturally responsive service delivery, fidelity/flexibility, and organizational capacity. The chapter concludes with a discussion of technical assistance and support during the initiative.

Chapter 8 addresses findings related impacts on policy, communities, and the larger society. The chapter also looks at the networks, collaborations, and partnerships formed by IPPs, their advocacy efforts, and environmental, systems, and policy changes that occurred over the life of the initiative. Chapter 8 concludes with a presentation of the CRDP and CDEP business case.

Chapter 9 includes a discussion of three topics: CBPR forms of community engagement, culture, and context in IPP methodological strategies, and fidelity and flexibility related to both program implementation and local IPP evaluations. Given the rich diversity of racial/ethnic groups, contexts, and strategies characterizing the CRDP initiative, information about forms of bias contained within the cross-site participant survey and the types of adaptations made to resolve or minimize these methodological biases within the statewide evaluation for specific IPPs and their communities are also presented. Chapter 9 concludes with an analysis of fidelity and flexibility in CDEP delivery and local evaluation, and what constitutes credible evidence for demonstrating CDEP effectiveness.

Chapter 10 and 11 conclude the report with a summative discussion about the SWE objectives, practical recommendations, and implications for future initiatives like the CRDP.





Chapter 5

Initiative

Overview and

Impact

EXECUTIVE
SUMMARY

CHAPTER 1

CHAPTER 2

CHAPTER 3

CHAPTER 4

CHAPTER 5

CHAPTER 6

CHAPTER 7

CHAPTER 8

CHAPTER 9

CHAPTER 10

CHAPTER 11

REFERENCES

APPENDICES

5.1 PHASE 2 APPROACHES AND STRATEGIES

This chapter provides a broad narrative overview of CRDP Phase 2 through the lens of the contractors (or CRDP partners) who were selected to support the IPPs and the overall initiative. Qualitative interviews with CRDP partners supplemented the Statewide Evaluation Semi-Annual Report (SWE-SAR) to describe how CRDP Phase 2 was implemented and to help tell the overarching story of the initiative.

This chapter first examines how CRDP partners collaborated with each other and with IPPs over the life of the initiative. This is not a report card for each partner, but rather a way to understand the broader story of how the initiative supported IPPs and how approaches used by the TAPs, SWE, EOA, and OHE evolved to meet challenges over time.

This chapter also highlights data from IPPs to provide a context for the work of CRDP's partners. Those data are included below in text boxes and an extensive insert focused on IPP reports detailing the impact on communities stemming from COVID-19, the California wildfires, racial injustice, and racial uprisings related to the Black Lives Matter (BLM) movement.

5.1.A CRDP PARTNERS AND INTERVIEW METHODOLOGY

5.1.a CRDP Partners and Interview Methodology:

- Technical Assistance Providers (TAPs, n=5), one for each priority population.
- Statewide Evaluator consultant (SWE, n=1).
- Education, Outreach, and Awareness consultant (EOA, n=1).
- Office of Health Equity (OHE, n=2).
- Two entities which were not part of the original CRDP Phase 2 design but emerged over time and played important roles during the initiative included: a cultural broker (the Racial and Ethnic Mental Health Disparities Coalition, or REMHDCO) and an IPP-led volunteer group called the Cross-Population Sustainability Steering Committee (CPSSC).
- At OHE, CRDP administrative leadership (e.g., community development and engagement section chief, CRDP program lead, CRDP evaluation lead) comprised one team. All CRDP contract managers comprised the other.

The methodology consisted of four annual interviews with CRDP partners between 2018–2021. Topics covered in the semi-structured interview were:

- Changes in staff/consultants during past year.
- Organizational approach/strategy.
- Fidelity in approaches/strategies.
- Flexibility in approaches/strategies.
- Organizational successes and challenges.
- Lessons learned about addressing mental health disparities through the ODEP approach.
- Other observations.

Interviews with the CPSSC and REMHDCO were less structured and more focused on telling the stories of how they engaged with the initiative, how they perceived their purpose, their day-to-day activities, and their most important achievements.

The year-to-year narratives below give an aerial view of the initiative. Additionally, summaries of overall observations across Phase 2 are provided in “spotlight” text boxes to provide specific details related to strategy and implementation.

5.2 YEAR 1: LAUNCH (MAY 2017–2018)

CRDP Phase 2 began amid an extraordinary confluence of factors. Expectations were high. Program visibility was high. Political stakes were high. And unmet mental health needs in communities across California were through the roof. The climate at launch was, to say the least, fraught.

But Phase 2 was an unprecedented opportunity to demonstrate the effectiveness of community-driven prevention and early intervention approaches to mental health in unserved, underserved, and inappropriately served communities. Moreover, it was a chance to achieve a lasting impact at the public-policy level.

For IPP grantees, CRDP Phase 2 was a rare funding stream aimed at designing and implementing their CDEPs and developing their organizational capacities. At the launch, IPPs reflected a wide range of organizational reach, from newly emerging community-based organizations with CDEPs as their primary focus to highly established organizations for which CDEPs represented one of many funded programs.

At the CRDP convening in March 2017, the director of CDPH and deputy director of OHE delivered welcoming remarks, while representatives from CRDP Phase 1 strategic workgroups gave presentations to help initiate Phase 2 grantees and contractors into the CRDP work. OHE's Deputy Director at the time, Wm. Jahmal Miller, unexpectedly left OHE in 2018 and his position was not filled until 2021. At the time, however, there was a palpable sense of excitement among participants about the unprecedented opportunity to demonstrate the value of community-based and community-driven approaches to addressing mental health disparities in California. The diversity of the room was notable for its broad representation from all priority populations, a rare experience for participants to have diverse representation as the norm among grantees and contractors.

The launch phase was intense. OHE leaders described the experience as “exhilarating,” “exhausting,” and akin to “building the plane while it is flying.” Statewide cross-site participant measures were developed. Best practices for technical assistance and community-based participatory practices were established. CDEPs were implemented. Evaluation plans were refined. Contracts were formalized. Grants were reported. All told, Year 1 was a bold collaboration to wrangle a daunting array of interconnected deliverables on tight timelines. Building relationships was key to making it happen. How else do you get 35 IPPs, five TAPs, and SWE, five OHE contract managers, and multiple members of the OHE leadership team on the same page?

The TAPs, SWE, and OHE coordinated communication with each other and defined their roles in supporting IPPs. The SWE also offered technical assistance to the IPPs and TAPs, and developed a collective framework for refining local evaluation plans and infrastructure for data review.

Two structural issues, however, threatened to create an overwhelming workload for CRDP partners. First, the sheer number of CRDP deliverables, and their deadlines, did not facilitate effective coordination and sharing of information between partners. Second, the absence of a planning phase made it difficult to enable community engagement, build relationships among partners, and develop a shared understanding of CRDP's goals before the initiative was in motion. For example, the need for community-based engagement, especially tribal-based processes of review and approval, was not given adequate time within the CRDP timeline.

While CRDP and its partners were working through these challenges, an important but unexpected and time-consuming step in the process surfaced: all CDEP local evaluations and the statewide evaluation would have to undergo individual review by the California Health and Human Services Agency's (CalHHS) Committee for the Protection of Human Subjects. Although this step was in line with state policy, it was not considered in the original design and timeline of the initiative.

The IPPs scrambled to ramp up their programs, designing services, building community relationships, and negotiating complex state procedures and policies. They did this work largely in isolation from each other, which contributed to a sense of burden and uncertainty. Some IPPs believed CRDP had placed

unreasonable demands on them. The complex, unrelenting nature of the work was most challenging for smaller and newer IPPs, especially former CBPPs with few or no financial reserves. Delays in invoicing and payment felt to them not just simply inconvenient, but personal.

Some partners felt they were singled out to take on additional work and accountability. For example, IPPs that worked with communities requiring language translation and interpretation faced significant additional tasks related to the statewide evaluation. TAPs played an advocacy role in calling out such issues, which created a perception that OHE and SWE were operating in a top-down manner, a challenging schism that continued throughout the initiative.

CRDP PARTNER YEARS 1-4 SPOTLIGHT: FIDELITY AND FLEXIBILITY

- There was a wide range of IPP organizational capacity needs, and preferences for communication and contact. Flexibility was needed for TA tailored to each IPP, with variation in the level/type of TA provided according to need (e.g., equity), rather than similar services for all (e.g., equality).
- In response to feedback from the initial all-grantee annual convening, TAPs rotated responsibility for designing annual convenings to center IPP needs/experiences. This continued until 2020, when the COVID-19 pandemic made in-person meetings impossible. At that time, OHE took the lead on organizing fully digital annual convenings.
- SWE designed a cross-site participant questionnaire to address initiative-wide variables and outcomes across populations, which also had to be highly tailored with IPP-specific adaptations. SWE continually balanced the need to demonstrate overall effectiveness of the CRDP and CDEPs with IPP-specific community feedback and data collection concerns during COVID. SWE flexibility was manifested through waves of IPP-specific IRB amendments. Semi-Annual Reports (SARs) continually evolved and became a critical source of data to help IPPs tell their story.
- EOA deliverables were adapted from the beginning of their work due to IPP and CRDP partner feedback. A later EOA start date and compressed timeline also influenced EOA's need to focus on building trust with partners while adapting deliverables in a responsive manner (e.g., mental health survey methodology and unplanned creation of a CRDP website). The EOA worked closely with the CPSSC, an IPP-led group that became the de facto EOA advisory committee on sustainability-related issues.
- OHE added the Cultural Broker contract with REMHDCO, which had worked closely with CRDP Phase 1 but was not part of the original design of CRDP Phase 2. REMHDCO partnered closely with the IPP-led CPSSC on IPP sustainability matters, resulting in an extension of CRDP Phase 2 funding.
- OHE responded to heavy IPP workloads with flexibility, streamlining deliverables, adjusting timelines, and allowing delays related to deadlines when needed. OHE adjusted IPP deliverables to minimize reporting requirements without loss of information. OHE contract managers found it increasingly challenging to manage their own workloads with IPPs missing deadlines, especially in the latter part of Phase 2.
- Over time, fidelity was increasingly regarded in terms of responsiveness to community needs, rather than precise program or workplan implementation (see Chapter 7 for CDEP fidelity and Chapter 9 for fidelity of local evaluations). For example, the IPP pivot to food distribution, social-distancing messaging, and COVID testing and vaccination efforts, for example, were consistent with IPP goals, even if CDEP implementation was impacted for a time by some IPPs. OHE demonstrated flexibility to support IPP activities through flexibility in use of funds, deadlines, and streamlining IPP deliverables to minimize reporting requirements. SWE showed support by leading IRB amendment efforts with each IPP when they needed modifications to successfully participate in the statewide evaluation during the pandemic.

From the start, CRDP and OHE were committed to “doing business differently,” and literally changed state policies and practices to address the needs of grantees and contractors. Some of these changes were baked into the initiative from the beginning (e.g., advanced payment practices), while others emerged over time (e.g., adjustments to deadlines and deliverables). IPPs, however, perceived CRDP as not being “different” in the way that they had hoped, especially in their understandable desire to focus primarily on the implementation of CDEPs. Negative perceptions emerged most strongly in regard to the statewide evaluation, which came with high expectations for the maximum level of participatory research practices and low recognition of the evaluation’s participatory efforts to varying degrees across the initiative. During the launch phase, cross-site evaluation was largely viewed by IPPs as an extra burden that took away precious time from the development and implementation of CDEPs. This reflected a lack of recognition that evaluation was an essential part of the initiative itself.

Indeed, it was a challenge for CRDP partners to grasp the scope and complexity of the CRDP statewide evaluation. The statewide evaluation agenda was somewhat at cross-purposes with itself, developing and demonstrating the effectiveness of local, population-specific CDEPs, while also determining how CDEP approaches address traditional MHSA PEI priorities, such as outcomes and cost-effectiveness. The focus on cost and outcomes consistently competed with the IPPs’ immediate and resource intensive task to build capacity to respond to community needs and launch their CDEPs. The complexity, expectations, and negative perceptions of the evaluation process created a lack of buy-in from partners regarding overarching CRDP goals and posed a challenge throughout the life of the initiative.

Despite these obstacles, the most important Year 1 tasks were completed, including, but not limited to the following:

- Successful launch of all CDEPs.
- Increased capacity of IPPs.
- Development of TAP and SWE resources and tools for IPPs.
- Creation of shared spaces for TAPs in each priority population to support IPPs.
- Review and refinement of all local evaluation plans.
- Revisions to the SWE core measures through IPP and community feedback processes.
- Submission of local and statewide evaluation plans for CalHHS IRB approval.
- Coordination, translation, and adaptation of statewide evaluation core measures across multiple languages and communities.
- Increased visibility for mental health issues in vulnerable communities as part of the state’s health equity agenda.

5.3 YEAR 2: IMPLEMENT (MAY 2018–MAY 2019)

By the end of Year 1, CRDP partners collectively felt that the major infrastructure for the initiative had been developed and the heavy lift to get CRDP off the ground had been successful. In Year 2, IPPs would focus on implementing their CDEPs. To support this work, CRDP partners established strong relationships with their IPPs and created robust communication channels with each other, including a monthly roundtable call between OHE, SWE, and TAPs, and informal TAPs-only calls each month. The TAPs-only monthly call became a primary source of support, encouragement, and communication for TAPs for the remainder of CRDP Phase 2 and built a strong sense of collective identity among them.

OHE refined some of the expectations around roles, placing more emphasis on OHE contract managers as the primary point of contact for IPPs. OHE also tried to promote wider ownership for the CRDP Phase 2 goals and purpose, and the role of evaluation in the initiative. This was accomplished in several ways. Some TAPs collaborated with OHE to organize pre-pandemic, in-person annual grantee meetings to make them more IPP-centric. They also organized monthly roundtable calls between CRDP partners to increase information sharing and to help counter the perception of a top-down structure. While OHE convened and

facilitated each monthly roundtable meeting, the agenda was collectively determined at the start of each meeting. (The meetings were voluntary, not a contract requirement).

For the SWE, the intense evaluation activity in Year 1 to develop and refine the cross-site measures gave way in Year 2 to consultations with individual IPPs and their respective TAP teams. This resulted in additional rounds of IRB amendments to further tailor the cross-site measures to IPP-specific needs. Many of the IPP requests for modifications emerged as they either began to utilize the SWE cross-site participant questionnaire or piloted the questionnaire during the launch period while they waited for SWE IRB approval. For example, pilot administration of the SWE participant questionnaire for some AANHPI hub IPPs revealed that with translation and explanation of unfamiliar concepts (e.g., related to sexual orientation and gender identity) required more than two hours for some CDEP participants. IRB amendments allowed IPPs change how they asked questions or how they administered the questionnaires to reduce the burden on participants. (See Chapter 9 for an in-depth discussion of these evaluation modifications.) Near the end of Year 2, the California Pan Ethnic Health Network (CPEHN) joined CRDP as the Education, Outreach, and Awareness (EOA) provider. Despite a tight timeline, ambitious workplan, and late start relative to other partners, the EOA decided make relationship development and trust building its highest priority in response to feedback from CRDP partners.

During Year 2, OHE and CDPH operated with interim leadership or no leadership in several key department roles. This impacted both CDPH employee workload and external perceptions of leadership instability at CDPH. Nonetheless, OHE and CRDP staff provided consistent guidance to CRDP Phase 2 implementation.

Other Year 2 challenges included:

- Delays in initiative timelines due to the unforeseen and prolonged process of state IRB review through CalHHS.
- High levels of IPP staff turnover in many hubs (and the resulting loss of institutional/initiative memory).
- CRDP partners reported challenges related to a lack of time. For example, TAPs reported that some IPPs did not request technical assistance because they simply did not have enough bandwidth to receive and implement it. The SWE team initiated a participatory process for verifying evaluation data that included all CRDP partners, but it was too time-consuming for them to manage.
- EOA staff were expected to design and implement a statewide mental health poll as part of their contract, but the unexpectedly high level of communication and extensive collaboration required to complete this work was very time-consuming.
- OHE leadership and contract managers were pulled away from CRDP to serve as subject matter experts for other state projects and initiatives, and felt the strain of the additional workload.
- Difficulties simply and effectively communicating the big picture of the many parts of CRDP, even with CRDP partners, persisted in Year 2. This occurred at the same time that sustainability emerged as a major issue. Sustainability efforts would require clear, simple, and convincing communication about CRDP and CDEPs.

In response to the IPPs' extensive workloads, OHE provided flexibility regarding deadlines and adjusted IPP deliverables to minimize reporting requirements without a loss of information (e.g., eliminating a separate annual evaluation update by consolidating it with an evaluation narrative already included in the quarterly IPP reports). This level of flexibility is not characteristic of other statewide initiatives. A challenge for OHE contract managers, however, was that a significant number of IPPs began missing deadlines, a feature of their experience of CRDP that was also not typical of other statewide initiatives.

Major accomplishments of Year 2 included:

- IPPs continued to implement CDEPs and serve communities.
- Local and statewide evaluation data collection was tailored to the needs of each IPP, with attention to corresponding required IRB amendments.
- IPP-specific technical assistance was provided by all CRDP partners. For TAPs, this included a greater focus on sustainability and analysis of evaluation data, especially local data, organizational capacity building and leadership development, engaging Community Advisory Boards, and building

networks. TAPs reported being more strategic in devoting time and resources for the specific needs of each IPP. Rather than providing the same set of services or approaches for all IPPs in a priority population, TAPs tended to treat each IPP as a distinct unit. This resulted in wide-ranging levels of technical assistance based on each IPP's need (e.g., an emphasis on equity) rather than the provision of similar services across IPPs (e.g., an equality approach).

CRDP PARTNER YEARS 1-4 SPOTLIGHT: CHALLENGES, BARRIERS, AND SOLUTIONS

Partners experienced:

- Continual challenges developing and sustaining a broader understanding of CRDP's overall goals while managing multiple partners, constant staff turnover, and competing agendas.
- With respect to statewide evaluation efforts, challenges included building understanding around a complex evaluation agenda, aligning local and cross-site evaluation efforts, and clarifying interdependent and sometimes overlapping partner roles around supporting IPP evaluation efforts.
- Disruption and distress due to COVID-19 and the global racial reckoning.
- Many hubs experienced high turnover of IPP staff and leadership, difficulty onboarding online, and disruptions in institutional memory. TAPs, SWE, and OHE offered some consistency in staffing to aid institutional memory for the initiative and IPPs, except for turnover in OHE contract managers for some populations.
- A leadership vacuum at higher levels of CDPH and OHE existed for extended periods. Further, CRDP staff, especially contract managers, pulled out to support state COVID responses at a critical time for all. In response, IPPs took the lead in organizing and advocating for sustainability through the formation of a Cross-Population Sustainability Steering Committee (CPSSC) in close partnership with REMHDCO. The CPSSC represented an IPP-led space within the initiative, which supported "doing business differently" in an inclusive, participatory manner. Neither CPSSC nor REMHDCO were part of the original design of Phase 2.
- Questions regarding evaluation data ownership, community review/approval, and data sharing emerged early and were not fully resolved during Phase 2. An Internal Data Review Policy Committee was established to inform the work of the SWE, while OHE continued to elevate these issues and explore mechanisms for addressing them at the state level.
- Multiple partners, demanding workloads, tight deadlines, high expectations, high visibility, and external pressure all contributed to complex dynamics between CRDP partners. They experienced continual challenges related to trust, constructive communication, and effective collaboration. Partners contended with all these factors while keeping IPPs central to the work and guarding against overburdening them.
- Political polarization, wildfires, police violence, unrest over racial injustice, and the COVID-19 pandemic cast long shadows across the work of IPPs. Trauma was salient across the populations served. With so much to address, many IPPs reported insufficient bandwidth to engage in TA. TAPs responded by being "supportive but not burdensome" with a focus on trauma-informed and healing-centered approaches to IPP leadership support and organizational development.
- Concerns over the perceived inadequacy of initiative timelines for critical community processes, especially with the lack of a planning period needed to develop trust, role clarity, and collaboration between CRDP partners, as well as for TAPs to engage IPPs in organizational capacity building. Also, greater time would have helped with community engagement, review, and decision-making processes, especially for tribal communities. The CBPP phase prepared emerging organizations to meet grant eligibility requirements ("teaching to the test") but was not perceived as adequate time for capacity building.
- The added focus on sustainability: Sustainability had multiple meanings within CRDP, and raised questions about who advocates for IPP sustainability. CPSSC, in partnership with REMHDCO and supported by TAPs, turned its attention to engaging MHSOAC, state behavioral health agencies, and the California State Legislature to advocate for funding to continue CRDP. While state behavioral health agencies signed CPSSC's letter of support, the MHSOAC did not. Nonetheless, CPSSC-led efforts resulted in securing \$63 million from California's general fund.

Overall, the work of the CRDP transitioned from a primary emphasis on statewide evaluation infrastructure and development in Year 1 to CDEP implementation and IPP capacity-building and leadership development in Year 2. In response to IRB-related delays from Year 1, which resulted in delays in implementing the statewide and local evaluations, OHE began working on a strategy to extend the window for evaluation data collection by nine months (i.e., from September 2020 to June 2021). Coordinating the data extension meant that OHE leadership had to sort through complicated CRDP timeline logistics (e.g., implications for contracts, payments, scheduled events etc.), identifying where additional dollars would be needed, obtaining approval from higher echelons of state leadership, including the Governor's Office, and completing a series of contract amendments for CRDP partners. To ensure that IPP and CRDP partner goals were met, Year 2 activities kept an eye on the endgame of CRDP Phase 2. TAPs reported that IPPs began to see the value of their evaluation findings, which was especially true for IPPs that were able to begin leveraging their findings toward the sustainability of their CDEPs. For the SWE, the endgame meant crafting the shape and structure of the final evaluation report to tell the CRDP story. For the TAPs and the EOA, it meant working with IPPs to continue to build their capacity and leadership, to use evaluation to tell their story effectively, and to link them to external stakeholders with whom they could build partnerships and leverage resources.

5.4 YEAR 3: PIVOT (MAY 2019–MAY 2020)

In March 2020, the COVID-19 pandemic upended life across the globe and led to a dramatic pivot to remote work. At the same time, the effect of the pandemic on health and the economy had a disproportionate impact on communities of color and marginalized populations (Grills et al., 2021). In Year 3, those realities collided, and the challenges of CRDP Phase 2 grew exponentially.

The pandemic, as life-altering as it has been for so many, accentuated existing trauma and hardship experienced by people in unserved, underserved, and inappropriately served communities. In the fall of 2019, before the onset of the pandemic, IPPs were acutely aware of triggering events affecting their priority populations, (e.g., the shooting deaths of 23 Latinx shoppers at a Walmart in El Paso, Texas, by a white, far-right extremist, and a devastating wildfire season in California that destroyed entire neighborhoods).

Racial disparity writ large exacted a deadly toll in the early months of the pandemic as incidences of anti-Asian violence spiked and disproportionate rates COVID-19-related mortality swept across communities of color.

At the end of Year 3, the murder of George Floyd, and recognition of Breonna Taylor, Ahmaud Arbery, and other innocent Black people killed by police violence, sparked a global movement against systemic racism, especially anti-Black racism. The trauma stemming from these events were compounded by a notable absence of state-level solidarity with those most affected. The sting was felt by CRDP and its partners, and it informed their work.

Year 3 also marked the largest OHE staff turnover to date for the CRDP team, including the departure of the CRDP lead and two contract managers. Although these positions were filled by the end of Year 3, the disruption stretched the OHE team's capacity leading into the early days of the pandemic. Once the full impact of COVID-19 hit the state in March 2020, the focus of all CRDP partners became oriented toward moving operations online, supporting IPPs in responding to community needs, and drawing attention to health inequities and racial disparities. The IPPs pivoted from just implementing their CDEPs to also serving immediate community needs related to the pandemic. Several OHE staff were pulled from their CRDP work and deployed by the state for COVID-19-related emergency responsibilities. The SWE worked with IPPs and TAPs to submit IRB amendments for each IPP to address shifts to virtual service delivery and data collection.

As IPPs faced the enormous challenge of moving their services and CDEPs to remote work conditions, many chose to expand the focus of their work to respond to the pandemic-related needs of their communities, including food delivery, translation of COVID-19 materials, culturally responsive contact tracing, housing and financial assistance, and COVID-19 messaging. OHE provided flexibility in the use of CRDP funds. Some IPPs paused their CDEPs to respond to immediate community needs. Some shifted

their interventions to focus on essential workers. Others adapted their CDEPs to phone-based services or moved them completely online. Technology infrastructure, internet access, and the “techno-literacy” of the priority populations all impacted the ways IPPs adapted to pandemic conditions.

For IPPs in remote areas, technology alone was not enough. Spotty internet access often constrained their capacity to work online. In cases where IPPs worked with populations less adept at navigating the internet and other technologies, IPPs served individuals with phone calls and socially distanced visits. IPPs serving socially isolated and marginalized populations, such as transition-age youth, were unable to maintain contact with them, necessitating a shift in their priority population focus.

OHE adapted and supported IPP responses to their communities by loosening timelines, employing electronic signatures for the first time, providing budget flexibility, and supporting expectations that IPPs would respond to community needs first. All of this enabled IPPs to feel reassured that they could do the work they believed was most urgent. Many IPPs also worked with CDPH COVID-19-response workgroups, providing the department guidance related to engaging underserved communities. At the same time, COVID-19-related adaptations led to further evaluation challenges for both the statewide and local evaluations. The SWE and OHE worked on examining opportunities and strategies for addressing cross-site modifications and ensuring alignment with state IRB parameters, while TAPs continued to work with IPPs on issues specific to their local evaluations.

IPP SPOTLIGHT: IPP SUPPORT OFFERED FOR COMMUNITIES DURING COVID-19

IPPs offered various forms of support to help their participants and communities weather the pandemic and prevent untoward mental and physical distress. They:

- **Distributed...**

- › personal protective equipment (n=24 IPPs)
- › food and water (n=23 IPPs)
- › clothing/household goods (n=17 IPPs)
- › technology equipment (n=15 IPPs)

- **Provided...**

- › wellness services and support (n=27 IPPs)
- › English-language COVID-19 information/education (n=18 IPPs)
- › grief/bereavement counseling (n=17 IPPs)
- › financial assistance (n=17 IPPs)
- › family needs assessments (n=12)
- › support for internet access (free hot spots to support distance learning) (n=11 IPPs)
- › housing advocacy/tenant rights support (n=10 IPPs)
- › referrals to other services (n=3 IPPs)

- **Supported...**

- › the educational needs of their communities (n=16 IPPs)
- › navigating access to California unemployment benefits or other government benefits (n=10 IPPs)
- › ways to access transportation (n=8 IPPs)

After a later start than other partners, EOA was fully brought into CRDP Phase 2 during the first part of Year 3. They had a compressed contract of approximately two years to accomplish an ambitious agenda. In addition to their general role of increasing awareness and messaging about CRDP, they were to create a statewide mental health poll and an advisory committee. For the TAPs, especially, the value added from the EOA's work was not always apparent considering the increased demand and workload for IPPs. Some TAPs viewed their responsibility as "buffering" IPPs from the seemingly endless requests from the EOA. On the other side, the EOA experienced the TAPs as serving an unexpected gatekeeping function that made their work more difficult. A contributing factor to this challenging dynamic was that EOA engagement was not built into IPP workplans. As a result, responses to the EOA tended to be viewed as extra uncompensated labor. In addition, the EOA's mandate to develop an advisory committee overlapped with the emergence of the IPP-led CPSSC, which led to confusing expectations over the roles. This took time to unravel. Eventually, the CPSSC assumed the role of de facto EOA advisory committee, helping to shape the EOA's work.

During this period, CRDP leadership expanded the purview of an external contractor, the Racial and Ethnic Mental Health Disparities Coalition (REMHDCCO), to fill a "cultural broker" role that could provide more support for CRDP sustainability efforts. Although the cultural broker was not part of the original CRDP design, OHE's first deputy director realized early on the importance of having an external pool of subject matter experts in cultural and linguistic competence, and mental health inequities and disparities, to support OHE's ongoing work not only with the CRDP, but with the larger mental health community.

The purpose of the cultural broker contract was to keep OHE staff informed and engaged with external mental health partners looking to advance mental health equity efforts. The cultural broker also served as a key resource and connector for the CRDP IPPs, providing them with guidance on how to partner and navigate county-level behavioral health systems and understand county cultural competence plans. Additionally, the cultural broker developed reports to inform the state and the general public on current events impacting the mental health of multicultural communities, provided guidance on important MHSA funding policy changes, and conducted educational briefings with key policy makers on mental health equity for vulnerable communities in California. As the initiative progressed, these activities led the cultural broker to work closely with IPPs, primarily through the CPSSC, on their education and outreach efforts related to sustainability.

The CPSSC led sustainability efforts in the absence of executive OHE leadership and in response to initial perceptions that EOA efforts were not, as one CPSSC member said, "turning out what we thought we needed in terms of sustainability and representing the work that the IPPs are doing." So, while their initial focus was to work with OHE and the EOA to shift EOA's scope of work to better address their needs (e.g., website, materials), the committee also saw itself as providing a different kind of infrastructure to engage in systems change within CRDP. Its goal was to help IPPs learn how to be sustainable beyond CRDP Phase 2.

Under the co-leadership of two IPP leads within the African American hub, the CPSSC opened the space for the IPPs to assume a significant leadership role in the CRDP in relation to sustainability. Members voluntarily met monthly as a full group, and weekly as an advocacy subcommittee. The committee composition eventually expanded to include representation from all IPPs, supported by TAPs, the EOA, and the OHE CRDP lead. From its inception, this group became the embodiment of the CRDP's initial vision of "doing business differently," with a highly inclusive IPP-led space that felt psychologically safe, responsive to intersectionality, and supportive of concerns cutting across the priority populations hubs.

The continuing absence of executive OHE leadership, however, made it harder to make clear headway on data use and sharing (DUSA) efforts, another significant issue that grew in importance over the life of the initiative. Specifically, data issues had to be addressed with greater nuance and understanding, with distinctions made between data ownership (e.g., related to how contract language is used across various CRDP grantees and contractors), community review and/or approval (e.g., having to do with how community data is vetted for inclusion in presentations and reports), and data sharing (e.g., related to how interrelationships between statewide and local evaluation data are handled in IRB agreements). Confusion around these concepts, IRB issues, OHE practices, and the sheer complexity of intersecting processes related to original contract language required time consuming state review processes that have not yet led to clear resolution. This further complicated CRDP dynamics around evaluation.

In sum, adaptability, innovation, and flexibility were major strengths demonstrated by all CRDP partners during the pandemic, with resilience and resourcefulness taking priority over fidelity to existing workplans and processes. OHE, despite its many challenges, supported IPPs' responses to their communities' needs, and demonstrated its own resourcefulness by changing infrastructure to respond flexibly to IPP adaptations during a difficult period. For TAPs, fidelity was reframed as a consistent commitment to community rather than the strict implementation of a specific CDEP program.

During Year 3, IPPs and their CDEPs were positioned to respond to community needs in ways that publicly funded mental health agencies could not. IPPs built relationships with their communities grounded in trust and credibility, as well as language capacities and cultural responsiveness, which increased their ability to address community needs.

Despite the tremendous stress and extraordinary effort required in Year 3, there was a sense of pride in how IPPs and CRDP partners came together creatively and constructively to elevate and sustain the work of the initiative in ways that were responsive to community needs. Collaborations included submitting IPP-specific IRB amendments in response to COVID-19, the development of a CRDP website (which includes a map of tribal lands), and the emergence of the CPSSC. The CPSSC seemed to embody the original vision of the CRDP as an IPP-driven participatory approach for "doing business differently." At the same time, the sole focus on IPP sustainability revealed a tension between two different, fundamental goals that fueled the initiative: the goal of CRDP to demonstrate the effectiveness of the CDEP approach for reducing mental health disparities, and the goal of IPPs to provide services that respond to community needs. None of these developments were part of the original workplan in a year that was not "business as usual" for any CRDP partner.



COVID-19 IMPACT

How did COVID-19 affect CDEP participants, and in what ways? (N=34 IPPs)

COVID-19 particularly threatened participants' mental wellbeing, income, physical wellbeing, spiritual wellbeing, family dynamics, and technology dependence (see below). These findings closely mirror national and California-specific COVID-19 findings from the National Urban League and Alliance of National Psychological Association for Racial Equity (see [NUL website](#) for population-specific reports).

#1

Threats to Mental Wellbeing (n=33 IPPs): The COVID-19 pandemic caused strain to mental and emotional health.

“

Remote learning has led to feelings of isolation, loss of socialization, learning loss, anxiety, and feeling of depression among participants.”

AfAm (n=6 IPPs)

“

Our TAY participants have experienced increased anxiety, depression, and stress due to COVID-19.”

AI/AN (n=6 IPPs)

“

For the majority of our former CRDP participants whom we talked to, the impact was more emotional and psychological in nature where they reported feeling depressed, anxious, and fearful of the disease.”

AANHPI (n=7 IPPs)

“

High levels of anxiety, depression, elevated stress, alcohol abuse, and domestic violence has been observed as a result of the pandemic.”

Latinx (n=7 IPPs)

“

Due to prolonged isolation from friends, family, and community, as well as lack of access to outdoor recreational activities regarding public parks, recreational areas, hiking trails, we have seen an increase in mental health crises and an increased need for mental and physical health support from our CDEP participants.”

LGBTQ+ (n=7 IPPs)



#2

Loss of, or Threats to, Income (n=17 IPPs): The COVID-19 pandemic resulted in job loss or loss of income.

“

There are widespread job losses in our communities where daily wage earning is also high, so we are working and potentially at more risk for exposure.”

AfAm (n=4 IPPs)

“

Families were concerned about their financial future. Many parents had lost their jobs or were worried about losing their job in the near future.”

AI/AN (n=4 IPPs)

“

They are also facing challenges with managing family and work schedules. Employment challenges have also been brought as well.”

AANHPI (n=2 IPPs)

“

The two main reasons have been the isolation brought on by the prevention of the spread of COVID and the economic hardships due to loss of income.”

Latinx (n=7 IPPs)

#3

Threats to Physical Wellbeing (n=16 IPPs): The pandemic heightened risk associated with in-person contact (e.g., essential workers required to go to work). Also, restrictions inhibited community members from physically visiting their doctors or going to the gym.

“

Physically, there has been a trend in the AfAm community to improve their health journey via gym memberships and physical fitness. With COVID-19, local gyms have been ordered to comply with the statewide lockdown, preventing members from engaging in their ideal fitness experience.”

AfAm (n=3 IPPs)

“

Elders in our community seem to have suffered more than others (physically, emotionally, psychologically) due to isolation, whether that isolation was at home alone to avoid infection, isolated in the hospital where visitors were not allowed...”

AI/AN (n=2 IPPs)

“

A large majority of our participants are older and at high risk for COVID-19 complications. Many participants are afraid to leave their homes because they are scared of contracting the virus and/or of racial discrimination due to the racially charged rhetoric about the origins of the virus.... Some participants delay healthcare visits during the pandemic, which has had an impact on their physical health.”

AANHPI (n=2 IPPs)

“

By this they share that being unable to participate in outdoor activities and school sports has made them gain weight and develop unhealthy eating habits.”

Latinx (n=6 IPPs)

“

Many in our community are considered high risk because of chronic medical conditions so they are unable or unwilling to venture into public spaces.”

LGBTQ+ (n=3 IPPs)

#4

Technology Challenges (n=15 IPPs): Transitions to online learning and/or work from home proved challenging for community members as they navigated technology.

“

For a number of the students and their parents, learning through use of technology has been extremely challenging with some parents feeling inept and even angry that they are not able to give their children the in-home support they feel they need.”

AfAm (n=4 IPPs)

“

TAY [transition-aged youth] who live in our remote tribal reservations have challenges with remote learning and reliable internet access.”

AI/AN (n=3 IPPs)

“

It was tough for our CDEP to move our recreational groups virtually as many of our elders do not have the technological equipment and have no internet connection at their home.”

AANHPI (n=4 IPPs)

“

A unique challenge we saw among many participants of all ages is that most did not have the technology to get through the pandemic. For example, they lacked accessibility to technology.”

Latinx (n=3 IPPs)

“

Other things participants said they need help with include assistance with transition to using Zoom...”

LGBTQ+ (n=1 IPP)

#5

Threats to Spiritual Wellbeing (n=14 IPPs): Inability to physically attend places of worship, engage in culturally significant rituals, etc.

“

Spiritually, the African American community is no longer able to physically visit their houses of worship.”

AfAm (n=3 IPPs)

“

Challenges specific to our community were inability to take part in community events such as powwows.”

AI/AN (n=2 IPPs)

“

The community are very social and have many gatherings and to not be able to do so impacted them significantly as these are their source of support in maybe dealing with what we would call mental health symptoms and of course also for their spiritual well-being.”

AANHPI (n=4 IPPs)

“

Isolation having a negative impact on emotional, psychological, and spiritual wellbeing.”

Latinx (n=3 IPPs)

“

COVID-19 has negatively impacted the physical, psychological, and spiritual wellbeing of our CDEP participants and other community members.”

LGBTQ+ (n=2 IPPs)

#6

Turbulence in Family Dynamics (n=10 IPPs): COVID-19 pandemic quarantine requirements caused strain on family relationships.



There is also increased familial stress as households adapt to fluctuating COVID-19 restrictions, changing school modalities, and the general psychological effects of the pandemic."

AI/AN (n=1 IPP)



The biggest impact it had on our community is having to shelter in place and it's more difficult when there are multiple families and or generations in one household in smaller dwellings. They've lost that ability to have their own space or me-time when at school, work, or at community spaces."

AANHPI (n=3 IPPs)



Between parents having to still go to work, sharing small spaces with other relatives, stressing out about putting food in the table, etc., now parents have to assist their kids with getting online and support their education the best they can, sometimes for more than one child."

Latinx (n=3 IPPs)



Unique challenges faced by our community are being forced to quarantine with unsupportive family..."

LGBTQ+ (n=3 IPPs)

COMMUNITY STRENGTHS AND RESILIENCE IN THE FACE OF COVID-19 (N=35 IPPS)

While communities were clearly negatively impacted by the pandemic, IPPs noted that COVID-19 also revealed community resilience and strengths. Community connectedness remained strong despite shelter-in-place orders. IPPs also noted perseverance, spirituality, cultural grounding, adaptability, community and family responsibility, financial assistance, and willingness to be vulnerable and ask for help.

In the midst of crisis, the cultural values that engender senses of community and responsibility for the greater good took primacy. Coming together was among the most highly cited forms of resilience observed by the IPPs. This included unity among families and communities.

By grounding themselves in cultural values of adaptability and community connectedness, many participants stayed engaged. In fact, some IPPs reported that CDEP service engagement rose during the pandemic and that community members and IPPs offered financial support to others struggling because of the COVID-19 pandemic.

Community Connectedness (n=22): A great source of resilience for communities was the act of coming together to support each other. Both community members and families banded together to uplift each other during this difficult time.



Sisters have also rallied around each other individually and collectively."

AfAm Hub



Community members are finding ways to connect safely and/or remotely. LGBTQ+ youth, especially, are utilizing social media platforms in new ways to share non-physical space. [They] are even connecting across county/state lines."

LGBTQ+ Hub

Perseverance (n=19): Many IPPs discussed that despite challenges they did not stop offering important services to the community, often resulting in an increase in service engagement. Furthermore, community members continued to try their best to participate in activities and services.



We did not stop. Our CDEP did not stop. We continued on because we know our services and our education are important. We wanted our community to stay informed amongst the pandemic. Our participants continued to push on because they wanted to ensure the safety of themselves and their families."

AANHPI Hub

Spirituality and/or Culture (n=9): During the pandemic, many groups leaned on their spirituality and culture as a source of strength.



The Hmong have a very strong belief system as one of their strengths, whether it is traditional belief in animism, ancestral workshopping, or Christianity in times like this, their faith remains very strong."

AANHPI Hub

Vulnerability (n=5): In the face of pandemic challenges, IPPs reported that community members allowed themselves to be more vulnerable and transparent about their needs for support.



One of the greatest strengths we have seen from our sisters is the ability to be vulnerable to reach out to ask for help."

AfAm Hub

Mutual Financial Aid (n=8): IPPs or community members banded together to support others financially. This included providing monetary support, essential items, or support for small businesses.



A community member noticed families struggling because some of their income came from selling products in the community and they could no longer do this.[They] organized a way to promote [their] products so that they continued to sell."

Latinx Hub

Adaptability (n=10): Many IPPs described their community members' ability to quickly adapt to the changes brought about by the pandemic as a source of resilience (e.g., adapting to going remote). IPPs also described their ability to adapt services to meet the needs of community.



We have seen an adaptation of ceremonial practices to help protect our communities during this time. Ceremonial leaders came together to ensure that our World Renewal ceremonies were still held in various regions."

AI/AN Hub

Sense of Responsibility (n=5): Many community members moved forward through the pandemic inspired by a sense of responsibility to their children, family, loved ones, and community.

“

A number of young women's coming-of-age ceremonies were postponed [due to the] pandemic.... Several community leaders helped to host these ceremonies so that they would meet pandemic guidelines [and] still be able to show support to the young women.”

AI/AN Hub

“

Many of our community members lived through the AIDS pandemic.... [They] tapped into the model of care they helped create during that time such as checking in with friends more locally in their building/neighborhood, attending... support groups, running errands for frailer peers...”

LGBTQ+ Hub

COVID-RELATED LESSONS LEARNED (N=34 IPPS)

As you reflect on your CDEP efforts since March, what lessons and accomplishments would be important to uplift or highlight for the prevention and early intervention field, county departments of behavioral health and public health, decision makers, private funders, etc.?

Thirty-four IPPs responded to this question. Most focused on COVID-19, which is why these findings are included in this section. In a qualitative thematic analysis of examples provided, four themes emerged: adaptability and innovation, contextualized services and aid, perseverance in services, and strength in coming together. The following section provides an overview of those themes and exemplary IPP quotes.

#1

Adaptability and Innovation (n=25): Many IPPs detailed the accomplishment of their ability to quickly pivot and adapt their efforts to meet the needs of their community during this time. This included adapting to online platforms and offering innovative services and aid.

“

It is important to showcase how efficient our IPPs were able to make a quick turnaround for the changes due to COVID-19. We adapted quickly our service delivery approach to phone and cloud-based.”

AANHPI Hub

“

In response to COVID-19, we were able to successfully transfer all efforts of our CDEP from in-person to online without sacrificing the quality of our CDEP delivery, and we also recruited a larger number of participants.”

AfAm Hub



#2 Contextualized Services and Aid (n=24): IPPs detailed the importance of their ability to not only address their community's needs, but deeply understand the needs of their community on a contextual level (e.g., culturally, economically, socially). In dealing with the COVID-19 pandemic, California wildfires, and racial uprisings, the ability to disseminate information and offer aid in a contextual and relevant manner was key to uplifting and supporting their communities.

“

As a provider of community-based services, looking to public health models for guidance seemed like a good approach. Yet, missing from the public health model is an understanding of how nonprofits and community-based organizations respond to crisis in their communities. In times of crisis, there is so much community activity going on that is informal and fueled by word-of-mouth. And these approaches/services are not captured in a public health model. This in part, explains the disparities: If you do not know what the community really needs, and if you are not working at a level where you can see and experience the actual community-level response (which is always outweighed by the needs of that community), then you will likely not provide that community with enough money to do what it needs to do to be culturally responsive in times of crisis.”

AI/AN Hub

#3 Perseverance in Services (n=22): IPPs reported that despite challenges they did not stop offering important services to the community. This often resulted in an increase in service engagement.

“

Our agency switched to Zoom almost immediately after the stay-at-home orders went into effect, even though using Zoom was not yet common and our community had not yet asked for online programming. Although our team was unfamiliar with Zoom, we learned on the go, which was a difficult learning curve. Our team had to make a lot of decisions about whether or not to do programmatic elements that were previously exclusively in-person. Some programs were not conducive to online programming or had to be significantly adjusted. Staff have improved in online programming over time.”

AI/AN Hub

#4 Strength in Coming Together (n=8): A great source of resilience for communities was the act of coming together to support each other. Community members, organizations, and families banded together to uplift each other during this difficult time.

“

The community has come together to seek strength and support from each other and from their culture. This is a community that gives more than it takes.”

Latinx Hub

IMPACT OF RACIAL UNREST

To assess how the racial uprisings impacted CDEP participants the following qualitative question was asked: 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?

29 IPPs responded to this question. In a qualitative thematic analysis of examples, several themes emerged, including threats to mental wellbeing, threats to physical wellbeing, spirituality as a source of strength, advocacy, activism, and anti-Asian xenophobia.

Threats to Mental Wellbeing (n=23): Racial uprisings strained mental and emotional health. Commonly mentioned challenges included feelings of stress, fear, depression, anxiety, frustration, and anger. Many groups also mentioned the traumatic impact images of police brutality and violence have on them mentally.



The stress and fear resulting from the Black Lives Matter mass demonstrations served to compound the stress and fear already being experienced by the larger Black community."

AfAm Hub



Shock, anger, and insecurity. Many community members talked about feeling shocked or numb regarding the killing of Floyd George during an arrest by...police force. Some individuals talked about the 'insecurity of even stepping out their door' due to aggressive treatment or stare-downs they received from strangers when outside in public."

AI/AN Hub

Threat to Physical Wellbeing (n=9): During particularly heightened times of unrest related to the racial uprisings, many groups reported not feeling physically safe as a person of color. Others reported that ongoing demonstrations threatened their physical wellbeing.



There are increasing experiences with physical violence, emotional strain, and burnout, and a collective hypervigilance impacting the wellbeing of our ODEP participants."

LGBTQ+ Hub

Spiritual Wellbeing as a Source of Strength (n=3): During these challenging times, many groups turned toward their spirituality as a source of strength.



The same spiritual resources used by Black people in our community continued to be a source of strength and wellbeing for Black people during this period."

AfAm Hub

Advocacy and Activism (n=18): In response to the racial uprisings IPPs and their communities mobilized to learn more and help where they could.



This racial uprising has highlighted the systemic inequities and somehow has given permission to the communities of color to feel and protest these inequities."

Latinx Hub

Solidarity: Many IPPs reported standing in solidarity with communities of color during this time.



Our agency, which is a central hub within the community, held a kneel-in in solidarity with George Floyd and Black Lives Matter on June 9."

AI/AN Hub

Anti-Asian Xenophobia (n=3): Related to the COVID-19 pandemic, groups mentioned a rise in anti-Asian Xenophobia and hate stoked by anti-Asian rhetoric blaming the pandemic on China.

“

Current xenophobic acts against Hmong and other Asian Americans are concerning because racism, a known social determinant of health, can exacerbate mental health disparities already present in the Hmong and other Asian American populations. There has been anxiety and worry by some family caregivers about the ongoing Anti-Asian xenophobia during COVID-19 that can unintentionally lead to harm for the Hmong older adult participants if they go out to the community alone. Program staff and family caregivers also worry that Hmong older adults (and also themselves) might not be able to protect themselves from others in the community from Anti-Asian verbal or physical harm if they go out alone.”

AANHPI Hub

Police Interaction Training: In response to ongoing police brutality many IPPs deployed police interaction training in an effort to lessen escalated, negative interactions between community members and police.

“

Our youth expressed concern with the current uprising. Through our sessions, staff talked about our history and past experience with the police. Some youth expressed harassment from the police officers. Staff also engaged in training if youth were approached by the police.”

AfAm Hub



5.5 YEAR 4: SUSTAIN (MAY 2020–APRIL 2021)

In Year 4, America went to the edge.

As deaths from COVID-19 continued to increase, California, once again, burned – this time to the tune of 8,835 fires across 2,568,948 acres – and caused compounded trauma in several IPP-served communities.

The mayhem around the bitterly contested 2020 presidential election dragged on for months and culminated in shocking display of mass violence at the nation's Capital on January 6, 2021.

A racial reckoning led by the Black Lives Matter movement sparked a global protest against anti-Blackness and structural racism, but some Americans remained in denial. They pushed back against reform, and some began carrying assault rifles in public spaces, including government buildings.

It felt like the brink and the country was divided like it had not been since the Vietnam War.

IPP SPOTLIGHT: CALIFORNIA WILDFIRES

The California wildfires created a major crisis that directly impacted the communities served by IPPs. Support was provided to communities in critical ways. IPPs:

- **Distributed...**

- › food and water (n=7 IPPs)
- › clothing/household goods (n=6 IPPs)
- › PPE including N95 masks (n=4 IPPs)

- **Provided...**

- › English language wildfire related information/education (n=5 IPPs)
- › non-English language wildfire related information/education (n=4 IPPs)
- › service referrals, linkages, or navigation to other community support (n=3 IPPs)
- › financial resources for food and bills (n=2 IPPs)
- › transportation access (n=2 IPPs)
- › housing advocacy/tenant rights support (n=1 IPP)
- › family needs assessments (n=1 IPP)
- › educational support (n=1 IPP)
- › internet access (n=1 IPP)

- **Supported** community members through...

- › grief/bereavement counseling and support (n=2 IPPs)
- › wellness support services (n=6 IPPs)

- **Secured...**

- › additional funding to support delivery of these services (n=31 IPPs)

While that division was evident in the rising debate over racial and social justice in the wake of the murder of George Floyd, there was an upside: more Americans than ever began to recognize systemic racism as a public health concern. The issues of health equity and racial disparity garnered increased visibility, which resulted in more federal and state funding to address them.

As part of CRDP Phase 2, IPPs were well-positioned to receive additional funds to support their critical work. In this context, CPSSC's actions pivoted to engage IPPs in advocating for additional funds from

the state legislature (in close partnership with REMHDCO and with support from TAPs). IPPs presented and testified to the Mental Health Services Oversight and Accountability Commission (MHSOAC), state behavioral health agencies, and the California State Legislature. While the state behavioral health agencies signed a letter of support to back CPSSC-led efforts, MHSOAC did not. The California Legislature approved \$63.1 million in general funds to support a four-year extension of CRDP Phase 2 in spring 2021.

During Year 4, a new CDPH director, Dr. Tomás Aragón, and a new OHE deputy director, Dr. Rohan Radhakrishna, were finally appointed by Governor Gavin Newsom. The new leaders had deep, nuanced, understandings of issues affecting underserved communities and helped cultivate palpable culture shifts at CDPH and OHE.

In December 2020, the first COVID-19 vaccine was authorized for emergency use. Availability was limited, however, to older individuals, those with high-risk medical conditions, and essential workers. For the next several months, most CRDP operations continued online, including the first virtual all-grantee convening held in April 2021.

IPP SPOTLIGHT: THE BLACK LIVES MATTER (BLM) MOVEMENT FOR RACIAL JUSTICE

In the Semi-Annual Reports, IPPs shared how their CDEP strategy, program activities, and/or approach was influenced or impacted by the BLM racial uprisings. The following highlights were drawn from responses reported by 30 IPPs.

IPP concerns included...

- Racial uprisings fueled by images of police brutality, and violence deeply impacted the mental health of many community members. Many reported feeling angry, stressed, anxious, fearful, and depressed
- IPP reports that their community members had either experienced physical threats or were fearful of leaving their homes due to physical threats
- Some community members turning toward their spirituality as a source of strength
- Rise in anti-Asian Xenophobia and hate co-occurring with anti-Black racial justice problems

IPPs responded in the following ways...

- 7 IPPs adapted their CDEP services to include more cultural and race centered strategies specifically in response to the BLM racial uprisings
- 18 IPPs strengthened or adapted their services and curriculum to incorporate racial justice and anti-racist training, including hosting critical conversations about race
- 18 IPPs and community members mobilized with advocacy and activism efforts. Many stood in solidarity with people of color. In response to the threat of police brutality, a subset of IPPs initiated police interaction training for community members to lessen escalated, negative interactions between community members and police

In communities served by CRDP and IPPs, elevated consciousness of systemic racism, extreme political polarization, and racial and LGBTQ+ disparities in COVID-19-related morbidity and mortality contributed to heightened levels of stress and trauma.

These factors had an especially painful impact in LGBTQ+ communities, where COVID-19 re-triggered trauma related to the devastating AIDS epidemic in the 1980s. Meanwhile, growing action and solidarity around racial justice led to organizational self-reflection for LGBTQ+ IPPs. These discussions transformed the leadership of LGBTQ+ IPPs as they addressed disconnects between leadership representation of LGBTQ+ service providers and the demographics of populations served. One result was more inclusion of transgender individuals and persons of color in positions of IPP leadership.

The isolation of seniors and rise in anti-Asian hate crimes became key focal points for AANHPI IPPs during the pandemic. The effects of COVID-19 also hit Latinx, Black, Native American, and Pacific Islander communities particularly hard.

For the Latinx hub (which served the state's largest ethnic group), for example, COVID-19 represented a major threat. Latinx individuals were contracting the virus and dying at much higher rates than Whites.

AI/AN communities were also hit hard. As older individuals continued to die from COVID-19, the losses were felt not just personally but on cultural and political levels by members of the communities. They worried that their losses were not being fully accounted for by a state data system that often misclassified them as Latinx or multiracial. In response, TAPs made efforts to be “supportive but not burdensome” in their work. Many explicitly focused on trauma-informed approaches to leadership and organizational development. Some TAPs felt the need to add healing-centered approaches to address high levels of trauma and burnout. Support for IPP leadership around these issues was prominent in Year 4.

Evaluations and data collection also continued to pose challenges in Year 4. In their advocacy efforts, the CPSSC and IPPs wanted more IPP-specific evaluation data from the SWE, perhaps because the SWE data was designed to include (as well as test) commonly used, standardized measures that might appeal to decision makers (e.g., legislators, state agencies, and county departments of mental health). In some cases, IPPs fell behind in reporting their local evaluation findings because they were still finishing data collection and analysis.

The SWE was in a similar position due to the complexities of cross-site data cleaning, data verification, and data review processes. CRDP developed an internal data review policy during Year 4 and a committee was formed in response to specific concerns about how SWE data would be presented and disseminated.

CRDP PARTNER YEAR 1-4 SPOTLIGHT: INITIATIVE AND PARTNER STRENGTHS/ACCOMPLISHMENTS

- Completion of Phase 2 by all IPPs with expanded reach, increased capacity, and greater networks. By Year 4, increased visibility of mental health equity issues in state, especially reduction of mental health stigma. The successful implementation of CRDP Phase 2 with funded IPPs, some of which would not otherwise have had access to state funding, was also an important marker and accomplishment.
- A high level of IPP commitment to communities and CDEPs. IPPs reached communities to support a wide variety of needs. This was especially seen during COVID-19 as IPPs disseminated COVID-19-related information to their communities in culturally and linguistically appropriate ways.
- Highly successful IPP-led sustainability efforts mobilized by the CPSSC with REMHDCO partnership led to the extension of CRDP Phase 2 with an additional \$63.1 million in funding from California's general funds.
- A greater recognition of the value of CDEPs and IPPs during COVID-19 through CRDP participation. There was greater recognition of IPPs as cultural brokers who have access to, and the trust of, underserved communities (evidenced in funding and relationships with counties); were positioned to increase community vaccine access and use; and able to counter vaccine misinformation. Many IPPs were well-positioned to get resources. Some IPPs are now represented on mental health county oversight boards, “at the table,” representing CDEPs.
- A greater response to the racial justice movement in society with notable changes in IPPs (especially in LGBTQ+ hubs) and state leadership (CDPH-OHE). There was an increase of people of color and transgender people in leadership representation, culture shifts and organizational transformation. Racism became recognized as a public health issue, with increased visibility for mental health disparities and recognition/visibility for the role of CDEPs in underserved communities.
- Despite the daunting nature and complexity of the work, successful implementation of CDEPs and collection of local and cross-site evaluation data to help tell the CRDP story.
- Increased visibility and funding resulting from CRDP-related advocacy to reduce mental health disparities through a CDEP approach.

The policy resulted in a community review process that created an extended time frame for the SWE to share any evaluation findings. While the SWE was responsible for providing cross-site evaluation findings, the SWE team was not resourced or contracted to provide IPP-specific evaluation findings. This caused tension when IPPs wanted the data to help make the case to expand funding. The SWE adapted by creating a stakeholder presentation deck of preliminary findings that could be used for sustainability efforts.

That each IPP contracted with its own evaluator to conduct local evaluations presented an opportunity, and a set of challenges. While local evaluation plans were free to creatively prioritize and represent the cultural underpinnings of CDEPs in their measurement approaches (which would carry the associated risks of operating outside of the boundaries of commonly used research approaches), the local plans remained largely aligned with conventional boundaries of empirical research best practices. The intention of CRDP Phase 2 was to encourage non-western, culturally grounded research strategies, as explained in the local evaluation guidelines. Yet IPPs perceived that the local evaluation plans were constrained by the use of a standardized evaluation plan template and review process. The template was provided to ensure consistency in the description of an evaluation plan. The template did not require any particular research design or method.

Another local evaluation issue concerned accountability. How, and to whom, were local evaluators accountable for their efforts? To the IPPs who contracted them? The TAPs? The SWE, with whom they could potentially coordinate their data collection efforts? For some IPPs, SWE data was incorporated as the primary local evaluation strategy. For others, there was little to no SWE data collection at all due to a primary or exclusive emphasis on local evaluations, especially in the AI/AN hub.

One consequence of the uneven participation of priority population hubs in the SWE data collection was the loss of the data needed to examine outcomes within and across priority populations. At the same time, aggregation of data within priority populations was not necessarily a desired goal for CRDP Phase 2. Aggregation issues became problematic due to significant identity, cultural, and/or linguistic differences between populations served by IPPs within the same hub, and differences in the nature, location, and types of CDEPs offered by IPPs within the same hubs. Consequently, while the CRDP Phase 2 was originally organized by racial/ethnic and LGBTQ+ priority population hubs, these categories were not always helpful in the evaluation process, especially with serious concerns about SWE presentations that might involve population-level comparisons or the highlighting of specific IPP examples.

Despite these challenges, CRDP stayed focused on sustainability throughout Year 4. IPPs were recognized as valued cultural brokers that had earned tremendous community access by building trust within their priority populations. In addition to meeting community needs and implementing their CDEPs during COVID-19, IPPs served as critical local community partners for state and federal agencies working to counter COVID-19 misinformation and provide greater vaccine access in their communities. IPP leaders, specifically Josefina Alvarado Mena and Nina Moreno from the AfAm hub, were instrumental in creating an inclusive, IPP-centered, TAP-supported space, and partnering with REMHDCO director, Stacie Hiramoto, to advocate for funds to extend CRDP Phase 2. CPSSC-led efforts resulted in the approval of \$63.1 million dollars from the state's general funds for a CRDP Phase 2 extension.



5.6 LOOKING AHEAD

The goal of CRDP Phase 2 was to identify and implement approaches to reducing mental health disparities in historically unserved, underserved, and inappropriately served communities in California. The initiative demonstrated its success using a broad range of research and evaluation strategies that left no question regarding the effectiveness of CRDP's central approach: community-defined evidence practices.


Despite a series of extraordinary and unanticipated challenges (a global pandemic, catastrophic wildfires, extreme political division, heightened racial tension), CRDP Phase 2 also demonstrated the dedication and creativity of California's mental health professionals, and their commitment to working with the individuals and communities most commonly left out.

Over the four years, the initiative faced all of the obstacles familiar to those in and around mental health care and social services – funding, logistics, staff retention, regulatory constraints, service mandates – and faced them on a grand scale. That the initiative accomplished its core mission anyway shows that, despite all the rugged terrain along the way, the journey toward real health equity in California is worth the investment of time and money.

In the end, Phase 2 was an argument in favor of diversity, innovation, and forward motion in mental health care. From homes and faith-based settings to nonprofits and county agencies to the halls of state government, everyone involved in Phase 2 took bold chances and tried new things in the pursuit of better, more community-based, more culturally informed mental health approaches.

Looking ahead, our hope and expectation is that the findings and accomplishments of the CRDP, its partners, and its communities will resonate with policy makers and shift the state's mental health strategies toward more equitable mental health care across California.





Chapter 6

Individual Impact

EXECUTIVE
SUMMARY

CHAPTER 1

CHAPTER 2

CHAPTER 3

CHAPTER 4

CHAPTER 5

CHAPTER 6

CHAPTER 7

CHAPTER 8

CHAPTER 9

CHAPTER 10

CHAPTER 11

REFERENCES

APPENDICES

Chapter 6 covers three key process and outcome findings related to the initiative's overall impact at the individual level. It includes three main areas:

- Mental Health Access (operationalized by four variables: availability, utilization, stigma/barriers, and quality).
- Mental Health Priorities (operationalized by two variables: mental health protective factors and mental health problems).
- Improvements in Mental Health.

6.1 MENTAL HEALTH ACCESS

The findings in this section describe the extent to which the CDEPs increased access to mental health services for unserved, underserved, and inappropriately served populations by making mental health services more available in need in their respective communities. Specifically, findings related to mental health services are organized by:

- **Availability** (setting, community-defined integrated settings, service referrals, linkages, service navigation, and resource guides).
- **Utilization** (individuals served by select direct services/programs; demographics of CDEP participants served; individuals served with unmet mental health need; individuals served by psychological distress and functional impairment; and number of persons served by protective factors and risk factors).
- **Stigma/barriers** (number of persons served by stigma/barriers).
- **Quality** (participant satisfaction, language assistance provided, and workforce development).

Data sources for this chapter include:

- IPP Semi-Annual Report data (May 2017 to April 2021).
- Baseline (i.e., pre-test) and post-test data from the CDEP Participant Questionnaire for Adults and Adolescents (June 2018 to June 2021).

Findings from these two data sources were used to examine and summarize mental health access trends for CDEP served communities (i.e., the extent to which cultural, linguistic, and LGBTQ+ responsive services were made more accessible by the CDEPs). For more information on how the statewide evaluation operationalized mental health access and supporting variables, please refer to Figure 4.1 (SWE Change Model) and Table 4.4 (Operational SWE Process and Outcome Variables).

See Chapter 6: Improvements in Mental Health for pre and post-test analyses on select CDEP participant questionnaire items.

NOTE ABOUT THE CDEP PARTICIPANT QUESTIONNAIRE SAMPLE (GENERALIZABILITY AND MISSING DATA)

- The SWE CDEP pre and post participant questionnaires were incorporated into most of the IPP local evaluation data collection strategies. Purposive and convenience sampling approaches were used by all IPPs. Because it is a convenience sample of the CDEP communities served, it is important to not assume that the findings are generalizable to specific racial, ethnic, and LGBTQ+ populations in the state.
- The rates of missing item values for the CRDP overall pre test (or baseline) participant sample were low. About 2% to 3% for most demographic items, 3% to 5% for SOGI items, 1% to 2% for cultural protective factors/risk factors, and 2% to 8% for mental health distress and functioning items. These missing rates for the baseline sample were not high enough to be considered as consequential for data analysis (Schafer, 1999; Bennett, 2001). Moreover, sensitive items tend to have higher rates of missingness, which was not observed in the CRDP Phase 2 case.

6.1.A AVAILABILITY

Baseline availability findings are organized into the following categories: setting; community-defined integrated settings; service referrals, linkages, and service navigation; and resource guides.

6.1.A.I SETTING

The priority population communities served by the CRDP Phase 2 IPPs faced significant barriers to mental health service use including (but not limited to):

- Stigma associated with mental health illness.
- A lack of knowledge and awareness about signs and symptoms of mental health conditions.
- Fragmented and costly mental health care systems.
- Routine mistreatment in traditional mental health care settings (e.g., inaccurate diagnoses, prejudice and discrimination, the absence of providers experienced in working with diverse ethnocultural and LGBTQ+ individuals and families, communication barriers arising from the lack of bilingual providers).
- Lack of transportation to obtain services.

The inability to access treatment can discourage individuals from seeking help and can ultimately lead to lower service utilization rates and more severe and persistent mental health conditions.

The mental health field has become increasingly aware that *where* mental health services are situated matters when it comes to expanding service access and usage (Wakida et al., 2018). People whose needs have been unmet in more western-centered spaces (e.g., medical and psychiatric settings) may be reluctant to return to these settings during times of need. Moreover, ample research has found that communities of color and other marginalized groups are apt to seek help in culturally and community-relevant places and spaces (e.g., faith-based settings, community-based organizations) during times of distress (Brewer & Williams, 2019; Zamudio et al., 2020).

Taken together, these factors suggest that traditional clinical settings are not the only places where mental health services can or should be offered. In recognition of this fact, the CRDP Strategic Plan explicitly calls for greater diversity in mental health settings as an important strategy for making mental health services more available to communities in need.

Goal 1, Strategy 1:



Increase Opportunities for co-Location of services and integration: Locating mental health services in community facilities, faith-based organizations, cultural centers, and other entities where people are comfortable will increase access and combat stigma.”

(California Pan-Ethnic Health Network, 2018, p. 26)

This section demonstrates how the 35 IPPs enhanced access to mental health care by providing CDEP prevention and early intervention services in a diverse array of community-rooted locations. The IPPs were uniquely poised to know where and how to engage community members in services. They came into the CRDP initiative with established community relationships and credibility, as well as a strong track record of leading innovative, culturally and community-grounded mental health programs. This work afforded them unique insights into:

- Indigenous and community knowledge about why mental health challenges exist in their communities, and ideal settings for fostering healing.
- How to dialogue with community members about mental health issues in ways that resonate with community and cultural norms.
- The value of meeting community members in the spaces where they live, work, and socialize to build trusting relationships that are necessary for effective engagement in mental health and wellness services.

Findings are based on a thematic analysis of IPP's CDEP service setting and service delivery descriptions obtained from their local evaluation plans and final local evaluation reports.

- The 35 CDEPs were implemented in seven types of settings.
 - › IPP offices (e.g., IPP agency) (n=22).
 - › Schools (e.g., K-12 schools, community colleges, four-year institutions) (n=14).
 - › Public and social service institutions (e.g., other nonprofit organizations or social service providers extending beyond IPP agency offices) (n=13).
 - › Public community spaces (e.g., museums, libraries) (n=8).
 - › Outdoors (e.g., tribal lands, farms, parks) (n=8).
 - › Participant homes (e.g., CDEPs whose core service approaches involved home visits) (n=5).
 - › Faith-based locations (e.g., churches, spiritual institutions) (n=4).
- Over one-third (37%; n=13) of CDEPs were delivered in one setting, and 62% (n=22) were delivered in two or more settings.
 - › Among the 13 CDEPs implemented in one setting only, services were held primarily in IPP agency offices (n=6). Other service settings included public and social service institutions (n=3), schools (n=2), outdoor locations (n=1), and faith-based settings (n=1).
 - › Among the 22 CDEPs implemented in two or more settings, the average number was three (range of two to four). These were:
 - ◆ IPP agencies (n=16), schools (n=12), public and social service institutions (n=10), public spaces (n=8), outdoor locations (n=7), participant homes (n=5), and faith-based settings (n= 3).

6.1.A.II COMMUNITY-DEFINED INTEGRATED SETTINGS

People needing comprehensive services often face a patchwork of service providers in different program areas (e.g., physical/mental health services, transportation, housing assistance, etc.). Siloed programs often serve the same populations but with little direct interaction, sharing of information, or coordination of service delivery, requiring individuals and families to navigate multiple and often complex systems on their own, contributing to disjointed care (Davie & Rataj, 2018). Research supports service integration as one strategy for overcoming the challenges of siloed approaches.

Integrated service models aim to eliminate these barriers and simplify service access by coordinating services across multiple providers and settings. In this client-centered, holistic approach, providers from diverse health and human service organizations work collaboratively to streamline services, strengthen systems efficiency, and enhance quality of care for those they serve (Fallon, 2017; McGregor, et al., 2019). Integrated models have demonstrated considerable success in narrowing treatment gaps and strengthening health and wellness outcomes including improvements in behavioral and emotional health, family functioning and stability, and service utilization rates (McGregor, et al., 2019; Pomerantz et al., 2008).

Service integration models can vary by the level of collaboration between providers and the time points at which integration occurs (World Health Organization, 2016). Below are four examples of integrated models, with the level of collaboration between providers increasing in intensity from the single-provider model to the full or partial integration model (Rural Health Information Hub, n.d; Fallon, 2017).

- Single-provider model: information-sharing about an individual/family with no coordination among the providers (e.g., accessing client records from another agency).
- Care coordination model: communication between providers on treatment goals and service delivery planning for an individual or family (e.g., coordination around client referrals or development of a care plan).
- Co-located model: collaboration between providers who share a physical space occurring at specified time points with an individual or family (e.g., enhanced, face-to-face consultation and communication related to client needs).

- Full or partial integration model: joint planning and execution of services among providers throughout the entire service period for an individual or family.

The IPPs via their CDEPs further improved access to mental health programming by using integrated service model strategies. While the strategies were grounded in the existing research, CDEPs articulated unique approaches to service integration in CRDP Phase 2. In a thematic analysis of CDEP service delivery descriptions from their local evaluation plans, these four strategies included:

- Holistic “in-House” approach.
- Communication approach.
- Co-Location and collaboration.
- Integrated team and/or partnership.

Strategy 1: Holistic “in-house” approach (n=9 IPPs): The IPP is the sole provider of services for participants. Support is focused on the whole person, meaning the CDEP provides services that address participants' social, cultural, spiritual, and/or emotional needs, with a focus on promoting longer-term stability and growth. Below are a few examples of CDEP holistic service models.

- An AfAm CDEP focused its efforts on culturally attuned mental health wellness and advocacy support for African American women in a variety of community-based locations (e.g., homes, churches, schools). The CDEP delivered all of the services and created a safe, affirming space for healing, information-sharing, and activism.
- An LGBTQ+ CDEP offered comprehensive on-site workshops, social and recreational activities, and individual advocacy to support LGBTQ+ individuals with personal struggles and increase their connection to a supportive, affirming community.
- An AI/AN CDEP provided multilevel, in-house services to treat individual mental health and health related challenges. The 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.

Strategy 2: Communication approach (n=12 IPPs): IPPs obtained specialized consultation support from external multidisciplinary care providers to address individuals and families' comprehensive needs. This included directing individuals to external services and resources to meet any needs extending beyond their CDEP service scope. In some instances, IPPs used a “warm hand-off” to directly connect participants to their referred external service provider or provided service navigation (e.g., assistance with transportation, language interpretation or translation, scheduling assistance, physical accompaniment, case plan review, documentation) to increase service utilization and engagement. Below are a few examples of CDEP communication approaches.

- An AANHPI CDEP strengthened mental health and social connectedness by facilitating educational and wellness activities at their agency and in a variety of community-based places and spaces. Through these activities, the CDEP identified individuals who could benefit from enhanced mental health support and used a warm handoff and/or concentrated service navigation to connect them to needed resources.
- Guided by a set of culturally specific principles that center family, relationships, and respect, a Latinx CDEP created a warm, trusting environment within its physical agency 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 more serious distress to long-term service providers and other support systems.
- An LGBTQ+ CDEP's service model used a blend of case management, information and referrals, and caregiver support to connect elder participants to LGBT-affirming mental health services and peer supports. Comprehensive health and wellness assessments were conducted in participants' homes, while social engagement programming was offered onsite and in senior-specific sites in the community to create a bridge into social services and programs that are both geographically accessible and welcoming to LGBT+ older adults.

Strategy 3: Co-Location and collaboration approach (n=7 IPPs): IPPs worked closely with multidisciplinary providers, and shared a space at the IPP agency, the provider's site, and/or in other community settings. Each provided separate but collaborative care services to meet the unique needs of the individuals and families. Additional collaboration occurred through cross-agency referrals (e.g., the provider referred individuals and families to the CDEP) and through technical assistance/training provided by the CDEP related to culturally and/or LGBTQ+-responsive care for the priority population communities being served. Below are a few examples of CDEP Co-Location and collaboration approaches.

- One CDEP's school-based intervention created spaces for culturally responsive healing for Latinx youth directly in the schools. The CDEP established partnerships with local schools and used these sites as a base for participant recruitment (i.e., worked with the school to identify and assess eligible youth), service provision, and parent engagement.
- An LGBTQ+ CDEP used a multipronged approach to create a community of support for LGBTQ+ youth and their families. This included school-based resources offered directly to youth and technical assistance for school staff and administration focused on LGBTQ+ competent service delivery, along with individual and family counseling housed within their center.

Strategy 4: Integrated team and/or partnership approach (n=7 IPPs): IPPs worked in coordination with other multidisciplinary providers (or partners) using a team-based approach or collaborative/partnership service delivery strategy. The team or partnership communicated about the individual or family's care and concerns and worked together to solve or address the issue(s). In most instances they shared a space. This level of integration often resulted in organizational systems change for the provider including adaptations to organizational processes, practices, and procedures. Below are a few examples of CDEP integrated team and/or partnership approaches.

- One AI/AN CDEP provided a structured, culturally specific framework and process for Native persons to address and heal from historical trauma, substance abuse, and other risk factors impacting their health and wellness in a variety of outdoor spaces. This multisite collaborative developed out of a need to systematically build evidence of effective culturally based practices for addressing mental health and substance abuse. Through peer-to-peer sharing, joint learning activities regarding CDEP implementation, and collaborative data collection practices, the partnership collectively promoted community healing and demonstrated the value of culturally informed mental health interventions.
- 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 and trauma informed care. As a multi-site IPP, services were highly integrated and were implemented evenly across partner sites ensuring that participants received seamless, consistent treatment. Partners worked collaboratively on community outreach and engagement, educational workshops, case management, and social and spiritual activities, with each partner facilitating and hosting CDEP events and activities.

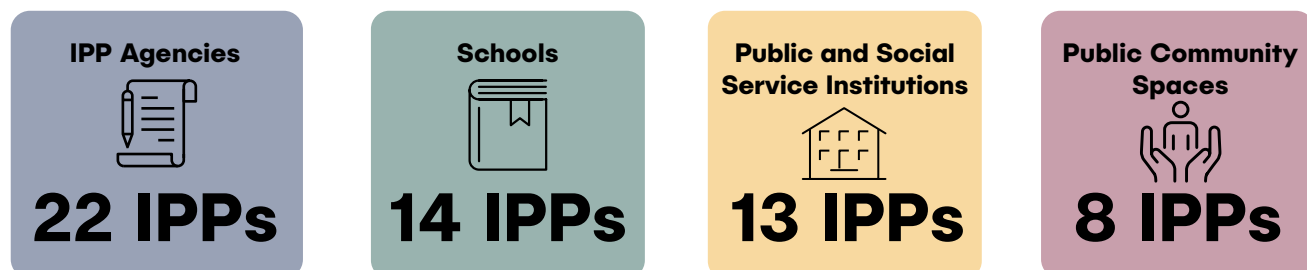
See Figure 6.1 for a visual overview of CDEP top settings and integrated service approaches.



Figure 6.1: CDEP Settings and Integrated Service Approaches

TOP 4 CDEP SERVICE SETTINGS

Data period: 2017-2021



IPPs increased the availability of culturally and LGBTQ+-responsive mental health supports by integrating their CDEPs into a variety of community-based locations that were easily accessible to community members.

**Holistic (In House)
(n=9 CDEPs)**

Provider: IPPs (via their CDEPs).

Type of Care: Direct services and programming focused on addressing the “whole person” (e.g., social, cultural, spiritual support), and promoting long-term stability and growth.

Provider: IPPs (via their CDEPs) with specialized consultation support from multidisciplinary providers (or partners).

Type of Care: Direct services and linkages to external providers for needs extending beyond the scope of the CDEP; use of a “warm hand-off” or transfer of care to eliminate access barriers.

**Communication
(n=12 CDEPs)**

**Co-Location & Collaboration
(n=7 CDEPs)**

Provider: IPPs (via their CDEPs) working closely with multidisciplinary providers or partners.

Type of Care: Collaboration with multidisciplinary providers, including use of a shared space (e.g., services offered at another agency or community-based site) to easily facilitate individuals’/ families’ access to care.

Provider: IPPs (via their CDEPs) in coordination with other multidisciplinary providers (or partners).

Type of Care: Use of a team-based or service-partnership approach to collectively address individual or family concerns; this model facilitated organizational-level systems change (e.g., transformation of practices and procedures to better serve the priority population)

**Integrated Team/
Partnership
(n=7 CDEPs)**

6.1.A.III SERVICE REFERRALS, LINKAGES, AND SERVICE NAVIGATION

Service referrals, linkages, and service navigation data were gathered from the IPP semi-annual report across four years from May 2017 to April 2021. These strategies reflect CDEP approaches used to direct individuals to culturally, linguistically, and LGBTQ+ affirming mental health services and other resources that could meet their needs.

Twenty-four IPPs¹⁴ worked to improve availability of mental health services using the following three CDEP strategies

Strategy 1: Referral: Provided information to increase an individual's knowledge and awareness of where they could access additional needed resources and supports in the community that fell outside the scope of the CDEP.

Strategy 2: Linkage: A subset of individuals who received a referral were also provided a timely “warm handoff” or direct connection to their external service provider (which may have included transfer of case information) to increase access to needed resources and/or supports.

Strategy 3: Navigation: A subset of individuals who received the referral and linkage were also provided ongoing guidance, care, support, and/or advocacy to improve outcomes and address barriers to service utilization and engagement (e.g., assistance with transportation, language interpretation or translation, scheduling assistance, physical accompaniment, case plan review, documentation).

Individuals who were most vulnerable were further assisted through client “linkage” and “navigation” services. This is especially important to help them connect with and/or navigate complex medical, mental health, and social systems. Linkages and navigation are much more labor intensive, with navigation requiring the greatest amount of effort by IPPs.

Twenty-four IPPs provided one or more referrals to 17,599 unique individuals (Strategy 1: Referrals). Of these individuals:

- 89% (n=15,701) were adults.
- 10% (n=1,723) were adolescents.
- 1% (n=175) were children.

Twenty-four IPPs provided linkage and navigation support. In other words, in addition to a referral:

- 32% (n=5,632 of 17,599) of individuals received a linkage.
- 17% (n=2,994 of 17,599) of individuals received linkage and service navigation.

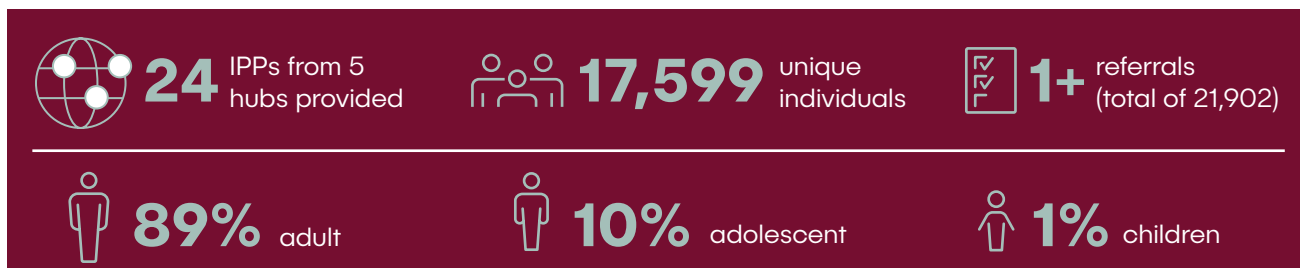
Figure 6.2 provides a detailed summary of the number of unique individuals who received referrals, linkage, and navigation by age.



¹⁴ Fifteen of the 24 IPPs who provided service referrals had a formal “referral system” strategy as part of their CDEP.

Figure 6.2: CRDP Overall Number of Unique Individuals who Received Referrals, Linkage and Navigation by Age (N=24 IPPs)

Data period: 2017-2021

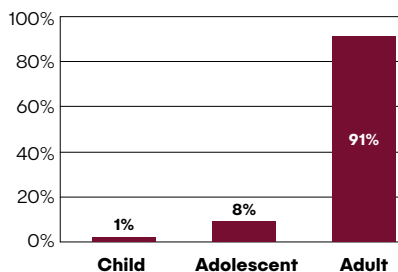


IPPs worked to improve availability of mental health services using 3 CDEP strategies...

**STRATEGY 1:
REFERRALS ONLY
(n=8,973 unique individuals)**



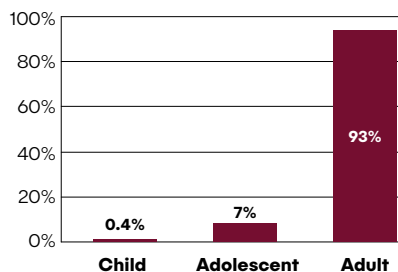
Information provided about where to go for needed resources & supports.



**STRATEGY 2:
REFERRALS + LINKAGE
(n=5,632 unique individuals)**



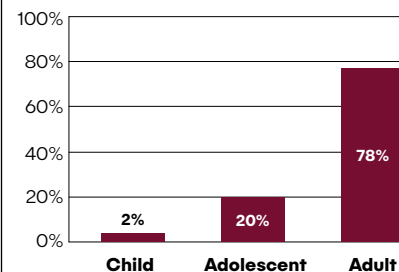
A timely "warm handoff" or direct connection to their referred external service provider.



**STRATEGY 3:
REFERRAL + LINKAGE
+ SERVICE NAVIGATION
(n=2,994 unique individuals)**



Ongoing guidance, care, support, and/or advocacy.



While adults were the primary group supported by the referrals, linkage, and navigation, among the adolescent and child's data:

- Over one in two (58%; n=1,007 of 1,723) adolescents received a referral and linkage (23%; n=401) or referral, linkage, and navigation (35%; n=606). This is notable given the amount of time, resources, and care involved in the provision of linkage and navigation supports.
- Nearly one in two (46%; n=80) children received a referral and linkage (12%; n=21) or referral, linkage and navigation (34%; n=59).

Table 6.1 provides the number of unique individuals supported by each strategy and by age.

Table 6.1: CRDP Overall Number of Unique Individuals Supported by Strategy and by Age (N=24)

Strategy (N=24 IPPs)	# Unique Adults (%)	# Unique Adolescents (%)	# Unique Children (%)
#1 Referral only	8,162 (52%)	716 (42%)	95 (54%)
#2 Referrals + Linkage	5,210 (33%)	401 (23%)	21 (12%)
#3 Referrals + Linkage + Navigation	2,329 (15%)	606 (35%)	59 (34%)
Total	15,701	1,723	175

NOTE ABOUT REFERRALS BY CATEGORY AND SUB-TYPE

Referrals by category were reported in aggregate counts in the IPP semi-annual report. Therefore, these data are duplicative (i.e., one individual may have received two or more referrals within and across categories). They provide a snapshot of the number of referrals provided in each category and sub-type. They do not reflect the number of unique individuals who received a referral by category and sub-type.

The 21,902 CDEP referrals fall into three broad referral categories: mental health care, basic needs, and health care. The largest number of referrals were to mental health care.

- **Mental Health Care.** 6,439 referrals were provided. Sub-types included:
 - › Counseling/therapy/wellness.
 - › Specialty mental health referrals related to:
 - ◆ Substance abuse.
 - ◆ Sexual assault.
 - ◆ Psychiatric care (for those experiencing serious mental illness).
 - ◆ Domestic violence.
- **Basic Needs.** 4,775 referrals were offered. Sub-types included:
 - › Food assistance.
 - › Financial assistance.
 - › Housing/rent/utilities.
 - › Transportation.
 - › Clothing and furniture assistance.
- **Health Care.** 4,392 referrals occurred. Sub-types included:
 - › Primary health care.
 - › Nutrition.
 - › COVID-19-related health supports.
 - › Dental/optometry/prescription.
 - › Medical benefits/insurance.
 - › Illness specific (e.g., HIV/AIDs, dialysis).
 - › Transgender health care.

See Figure 6.3 for the number of referrals by category and sub-type and the number of IPPs providing them. See Appendix 1 for more referral type and sub-type details.

While mental health care and health care accounted for a larger number of referrals, the high frequency of basic needs referrals reflected the critical importance of the social determinants of health (SDOH) impacting CDEP participants. It is well established that the SDOH or the environmental conditions where people are born, live, learn, work, play, worship, and age affect a wide range of health (including mental health), functioning, and quality-of-life outcomes and risks. The CDEP approach to referrals reflects a holistic, client-centered approach to referral provision that recognizes unmet social needs which can impact mental health and health disparities.

In addition to referrals focused on basic needs, IPPs also provided referrals related to personal growth, legal and advocacy assistance, education, parenting/childcare, and specialty care.

“

(California Pan-Ethnic Health Network, 2018)

Data period: 2017-2021



MENTAL HEALTH/HEALTH + SOCIAL DETERMINANTS OF HEALTH (SDOH)

MENTAL HEALTH			BASIC NEEDS			LEGAL ADVOCACY		
n=6,439 Referrals	24 IPPs		n=4,775 Referrals	20 IPPs		n=1,707 Referrals	19 IPPs	
Top Sub-Types	# Referrals	# IPPs	Top Sub-Types	# Referrals	# IPPs	Top Sub-Types	# Referrals	# IPPs
Counseling, Therapy, Wellness	5,247	24	Food Assistance	2,070	17	Immigration Services	1,164	13
Substance Abuse	416	20	Financial Assistance	922	14	Other (free legal services, tenant rights, etc.)	191	13
Sexual Assault	282	15	Housing, Rent, Utilities	869	17	Legal Mediation (e.g., divorce, custody)	35	3
Psychiatric Care	229	9	Transportation	367	13	Child Welfare	8	3
Domestic Violence	220	13	Clothing and Furniture Assistance	339	8			
HEALTH			PERSONAL GROWTH			EDUCATION		
n=4,392 Referrals	18 IPPs		n=2,188 Referrals	15 IPPs		n=537 Referrals	20 IPPs	
Top Sub-Types	# Referrals	# IPPs	Top Sub-Types	# Referrals	# IPPs	Top Sub-Types	# Referrals	# IPPs
Primary Health Care	2,691	17	Social/Cultural Enrichment Programs	1,365	11	Academic Support	291	12
Nutrition	482	4	Support/ Mentoring	326	3	Tutoring	151	8
COVID-Related Health Supports	379	4	Faith-Based/ Spiritual Services	230	7	Adult Education	18	2
Dental/ Optometry/ Prescription	356	8	Other (e.g., entrepreneurial training, police athletic league)	136	4			
Medical Benefits and Insurance	140	5	Volunteer Services	120	9	EMPLOYMENT CAREER (job training, skills)	n=507 Referrals	13 IPPs
Illness Specific (HIV/AIDS, dialysis)	77	4				PARENTING CHILD CARE	n=141 Referrals	7 IPPs
Transgender Healthcare	49	1				SPECIALTY CARE	n=73 Referrals	9 IPPs

93

Mental health was one of the top three referral types for all five hubs reflecting its critical importance to the CRDP priority populations. (See Table 6.2.) At the same time, there was some diversity of needs reflecting the importance of appreciating the unique needs and circumstances of different racial/ethnic groups. Basic needs were in the top three referral types for four out of five hubs signaling the vital role of the social determinants of health for the populations served by CDEPs. Finally, the types of referrals for different IPPs may also be influenced by the nature of their CDEPs (e.g., the AANHPI hub had a number of navigation-focused CDEPs and immigrant populations in their communities that may have required more legal/advocacy supports).

Table 6.2 Top Three Referral Types Across Hubs

Hub	Top Three Referral Types	# Referrals Provided	# IPPs
AfAm	Basic Needs	174	3
	Education	160	4
	Mental Health	141	5
AANHPI	Health	3,261	5
	Mental Health	2,531	7
	Legal/Advocacy	1,342	7
AI/AN	Mental Health	1,272	3
	Personal Growth and Development	222	2
	Basic Needs	166	2
Latinx	Mental Health	1,781	6
	Basic Needs	1,677	5
	Health	772	6
LGBTQ+	Basic Needs	772	3
	Mental Health	714	2
	Health	296	3

6.1.A.IV RESOURCE GUIDES

CRDP Strategic Plan Goal 1, Strategy 2 (i.e., develop resource guides to facilitate access to services) calls for the development of resource guides that:



...list community clinics and health centers, social service agencies, community programs, and other service providers that are culturally and linguistically competent and LGBTQ-sensitive and affirming for each of the five targeted populations, as well as other underserved populations who reach a language threshold in their respective jurisdiction.”

(CPEHN, Strategic Plan, 2018)

- In total, 17 resource guides were developed and disseminated to the community by 14 IPPs representing all five hubs. As highly reputable and trusted sources of information, IPPs used their experiential knowledge of their communities’ needs to develop the content of the guides:
 - › Fifteen guides listed mental health and other resources available in their communities (e.g., phone numbers, websites, physical addresses of community clinics, social service providers, etc.). Six of these guides also included educational information designed to strengthen community members’ understanding and awareness of mental health and wellness.
 - › Two guides were focused solely on promoting emotional health and wellness, including increasing awareness of mental health.
 - › With the onset of COVID-19 in 2020, seven IPPs developed and disseminated resource guides to help their communities navigate pandemic-related challenges and stressors.

- › IPPs distributed their resource guides to a broad range of community stakeholders. Most guides (n=11) were distributed to specific audiences within their CDEPs, school settings, and/or community-based organizations, while a few (n=6) distributed their guides community-wide (e.g., residents, schools, community-based organizations, decision makers, youth).

- The estimated reach for nine resource guides ranged from 10 to 3,964. (Resource guide audience reach was available for 76% (n=13) of the resource guides).
- In total, six resource guides were made available in English only, two were Spanish only, and nine in both English and a non-English language (i.e., nine Spanish, one Korean, one Vietnamese).

See Table 6.3 for more information about the resource guides by priority population hubs.

Table 6.3: CDEP resource guides reach (17 guides produced by 14 IPPs)

Hub	# IPPs	# Guides	Resource Guide Examples	Non-English Languages	Est. # Reached: Range
AfAm	4	6	One guide included information and referrals in relation to the COVID-19 pandemic (tips for managing infection; financial and mutual aid resources; free or discounted Wi-Fi; mental health services; advice on self-care and spirituality for essential workers, at-risk shoppers, families, children, and students).	Spanish	24-2,000 (2 missing)
AI/AN	2	2	One guide included resource referrals for housing and rental assistance; also included COVID-19 safety information and mental health coping strategies during the pandemic (e.g., anxiety management, maintaining social distancing, and shelter in place).	Spanish	60-1,525
AANHPI	1	1	One guide provided a comprehensive list of health and mental health resources and information available in for Korean and Vietnamese community members in Orange County.	Korean, Spanish, Vietnamese	200-3,964
Latinx	5	6	One guide included information on how to cope with stress and maintain wellness, along with bilingual resources on suicide prevention and domestic violence.	Spanish	75-500 (2 missing)
LGBTQ+	2	2	One guide included information on health and well-being resources for LGBTQ youth, LGBTQ Latinx youth, LGBTQ seniors and their support networks.	Spanish	10-1,398
Total	14 IPPs	17 resources guides	--	3 non-English languages	Range: 10-3,964

*Only five resources guides were submitted to the statewide evaluation for content analysis. Data for this section came primarily from IPP self-reported descriptions about their resource guides in the IPP semi-annual report.

CRDP PHASE 2 RESOURCE GUIDE SPOTLIGHT

Health Education Council (HEC) created a resource guide that included the types of resources and information envisioned in Goal 1 of the CRDP strategic plan. Written entirely in Spanish, this guide is an engaging resource, providing information on topics like physical health, mental health, nutrition, HIV, tuberculosis, and preventive measures. In addition, the guide provides contact information for community members in Sacramento, San Joaquin, Stanislaus, and the Yolo counties of California who are looking for Spanish-speaking family counseling, substance abuse resources, or Catholic-centered services directed to the Latinx community. The value of this resource goes beyond the information it provides. It is a culturally informed and linguistically competent product to reduce the stigma of mental health issues with which this community often grapples. The guide addresses difficult topics with an openness and sensitivity that is crucial to helping community members overcome the stigma that surrounds so many health-related topics. The guide addresses suicidal ideations and self-harm behavior, sexual problems due to diabetes, and ways to prevent the transmission of HIV, to name just a few. HEC developed this resource with a deep understanding and centering the needs of their community, providing a valuable tool for the Latinx population reached. See resource guide visual layout and content below.

DIRECTORIO DE SALUD	
Mente Sana, Vida Sana	
Condado de Sacramento	
El Hogar Community Services, Inc.	
3780 Rosin Court, Suite 110 Sacramento, CA 95811	
916-702-9032	
La Familia Counseling Center, Inc.	
5523 34 th Street Sacramento, CA 95820	
916-702-9032	
Sacramento County Division of Behavioral Health Services	
7001 A East Parkway Suite 400 Sacramento, CA 95882	
Mental Health Access Team: 916-875-1055 y 888-881-4581	
Llamar al equipo Access para ser referidos a un terapeuta que acepta Medi-Cal	
Condado de San Joaquín	
El Concillio	
Latino Behavioral Health and Recovery Services	
1755 W. Hammer Lane, Suite 1 Stockton, CA 95209	
209-444-8910	
Clinica La Familia-Servicios Psicosociales	
1149 N. El Dorado Street Stockton, CA 95202	
209-331-2070	
Catholic Charities of Stockton	
1106 North El Dorado Stockton, CA 95202	
209-444-5900 y 209-340-3218	
Condado de Stanislaus	
El Concillio	
Latino Behavioral Health and Recovery Services	
1314 H Street Modesto, CA 95354	
209-338-5715	

VENTANILLA DE SALUD	3
EL PLATO DEL BIEN COMER	4
LA JARRA DEL BUEN BEBER	5
MEDICINA PREVENTIVA	6
DIABETES	7
OBEESIDAD	8
HIPERTENSIÓN	9
INFLUENZA	10
VH	11
TUBERCULOSIS	12
ENFERMEDADES TRANSMITIDAS POR VECTOR	13
SALUD DEL HOMBRE	14
SALUD DE LA MUJER	15
SALUD MENTAL	16
SALUD OCUPACIONAL	17
CALENDARIO DE ACTIVIDADES DEL MES DE OCTUBRE	18
ACTIVIDADES DEL MES DE LA SALUD	20
DIRECTORIO DE SALUD	

SALUD MENTAL

#SALUDMENTAL

De acuerdo con la Organización Mundial de la Salud (OMS), la salud mental se define como el bienestar emocional, psíquico y social de un individuo.

La salud mental se caracteriza por lo siguiente:

- Estar consciente de nuestras propias capacidades
- Trabajar de forma productiva y fructífera
- Afrontar tensiones normales de la vida
- Ser capaces de contribuir a nuestra comunidad

Tu estado emocional afecta la forma en cómo piensas, sientes y actúas en tu vida cotidiana. Infiere en cómo manejas el estrés, las relaciones sociales y la forma de tomar decisiones.

Las afecciones de la salud mental son **padecimientos multifactoriales que afectan nuestra manera de pensar, comportamiento y humor**. Estos padecimientos son comunes y se presentan en diversas formas, por lo que es importante aprender a reconocer sus manifestaciones con el propósito de buscar programas de tratamiento disponibles.

Una de las barreras más importantes que sufren los individuos afligidos por padecimientos de salud mental y sus familiares es la estigmatización. Suelen ser marginados socialmente y no reciben la atención, los servicios o el apoyo que necesitan para desarrollar una vida plena en la comunidad.

La discriminación es particularmente marcada en el área de la educación, el empleo y la vivienda. Como comunidad, es importante detectar estos prejuicios y trabajar en cambiar actitudes para mejorar la sensibilización.

Debemos empoderar a las personas con salud mental y sus familias.

DEPRESIÓN

De acuerdo a la OMS, es la enfermedad mental más frecuente en el mundo. Se estima que aproximadamente 6 de cada 100 mexicanos sufren depresión. La depresión se distingue de otras emociones habituales y de respuestas emocionales breves a problemas de la vida cotidiana. Es un padecimiento multifactorial, que incluye causas sociales (historia de abuso, violencia doméstica, desempleo, etc.), psicológicos (estrés, soledad, ansiedad, fallecimiento de un ser querido, etc.) y biológicos (enfermedades como obesidad, diabetes y antecedentes familiares).

Algunos síntomas de la depresión son:

- Sentimientos de tristeza, melancolía, ira, frustración y abatimiento
- Alteraciones del sueño
- Alteraciones del apetito
- Baja autoestima
- Sentimientos de culpa
- Dificultades de concentración
- Ideas de automutilación y/o ideas suicidas

Si tú o algún conocido presentan estos síntomas o hay sospechas de padecer depresión, es importante acudir con un especialista (consejero, trabajador social o psicólogo) para recibir ayuda inmediata. En casos de emergencia (Intento de suicidio, auto laceración, etc.) llamar al 911.

Por lo general, simples modificaciones en el estilo y forma de vida pueden ser un tratamiento suficiente para la depresión leve. En casos de depresión moderada o grave es necesario acudir con un especialista, quien determinará la necesidad de acceder a una terapia psicológica y/o la atención de un médico especialista en psiquiatría.

6.1.B UTILIZATION AND STIGMA/BARRIERS

This section of Chapter 6 presents mental health disparities baseline (pre-test) data for CDEP participants in the year prior to receiving CDEP services. Mental Health Access findings are presented for CDEP utilization and stigma/barriers. Findings are presented for individuals served based on their demographics, perceived need for mental health care and unmet need, psychological distress and functional impairment, and protective factors and risk factors, and stigma/barriers.

These data provide an important snapshot of the mental health status (including barriers to mental health care) of adult and adolescent participants in CRDP overall prior to their involvement with CDEP services. See Appendix 2 for detailed data for each of the five priority population hubs.

6.1.B.I NUMBER SERVED BY SELECT DIRECT SERVICES/PROGRAMS

Direct services included a broad range of supports, services, or treatment for individuals (and at times their families) to improve mental health or increase 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).
- Engaging individuals experiencing an early onset of mental health symptoms to mitigate symptoms before they progress (otherwise known as early intervention).

Utilization data was derived from IPP semi-annual reports spanning a four-year period from May 2017 to April 2021.

The findings summarized below DO NOT include counts or information related to any of the following CDEP activities: community outreach/recruitment; service referrals, linkages, and/or navigation; systems/policy advocacy efforts; and workforce development. These other CDEP activities are reported separately in other sections of this report.

NOTE ABOUT NUMBER SERVED BY CDEP DIRECT SERVICES



Everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted."

William Bruce Cameron

Although there are similarities across IPPs (and their CDEPs) within and across priority populations, there were striking differences related to:

- Interventions (e.g., settings, types, length of intervention cycles, size of cohorts, number served, etc.).
- Community demographics and contexts (e.g., cultural, linguistic, historical, and subcultural perspectives and contexts, including intersectional identities).
- Prevailing social and political conditions (e.g., ICE immigrant deportations, anti-LGBTQ+ discrimination, anti-Black racism, anti-Asian violence, Afghan refugee crisis, etc.).

Given the vast diversity of populations served, strategies employed, and specific program designs used, a wide array of possibilities existed for the number of community members served by CDEP direct services.

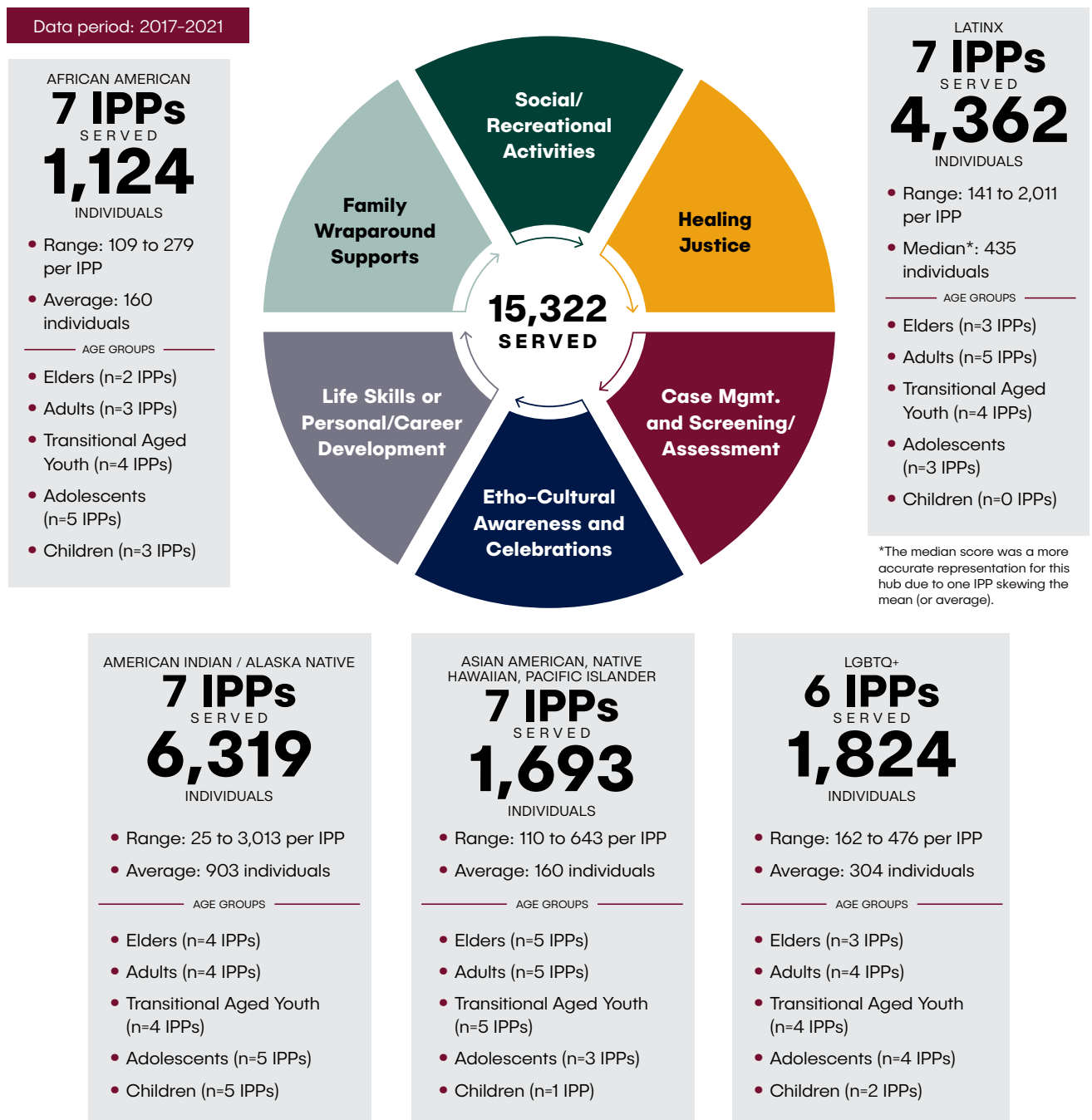
For example, while one IPP may have served what appears to be a smaller number of participants, their CDEP may have been designed to provide a more intensive intervention over a longer period (e.g., multiple years), while other IPPs may have conducted community-wide interventions that involved many community participants for a single point in time. **Therefore, priority population comparisons are neither appropriate nor valid.**

Between May 2017 and April 2021, 34¹⁵ IPPs directly served approximately 15,322 individuals.

- In their direct service activities, 18 CDEPs served elders (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). Figure 6.4 provides a summary of CDEP direct services by priority population and PEI strategies.
- In a thematic analysis of IPP local evaluation plans and semi-annual report data (Direct Services section), six primary PEI direct services strategies were identified. These overlapping/intersecting PEI strategies were: healing justice, case management/assessment, ethnocultural awareness activities and celebrations, life skills or personal/career development, family wraparound supports, and social recreational activities.

See Table 6.4 for thematic description of the six overlapping/intersecting PEI strategies.

Figure 6.4: CRDP CDEP Direct Services by Priority Population



¹⁵ One IPP had a workforce development component only.

Table 6.4: Six Primary Strategies Used to Deliver CDEP Direct Services

CDEP Direct Service Strategies (designed & implemented using ethnic, cultural, spiritual, LGBTQ+ and other community affirming approaches)	
Healing Justice (including counseling, therapy, wellness services)	Provided space for CDEP participants to discuss and/or heal from mental health challenges. These multilayered services involved several approaches including short-term therapy grounded in specific psycho-therapeutic modalities; group-oriented work providing opportunities for individuals to bond over shared experiences and discuss coping strategies; and/or spiritually grounded activities that promote health and healing. Regardless of setting or technique, the cultural and/or LGBTQ+ affirming nature of these services fostered a sense of safety, belonging, acceptance, and support.
Case Management and Screening/Assessment	Examined CDEP participant mental health needs through the lens of education, empowerment, and advocacy. The assessment process began with the development of trusting relationships and expanded to include personalized life coaching; and/or education that incorporates the root causes of challenges to mental health within the context of systems of oppression; and/or provided advocacy strategies for navigating mental health systems. As a result, community members felt empowered and capable of accessing the services they needed.
Ethno-Cultural Awareness Activities and Celebrations	Transmission of cultural wisdom, rituals/practices, values, and beliefs to strengthen protective factors to support mental health of CDEP participants. Operating from the principle of " <i>cultura cura</i> " ("culture cures"), these services reignited, celebrated and preserved cultural identity, indigenous wisdom and values, spiritually based traditions, and the arts as strengths-based strategies for nurturing individual, family, and community wellness. Examples included education about specific cultural teachings and traditions; culturally grounded arts-based programming; cultural celebrations; and large-scale community gatherings.
Life Skills or Personal/ Career Development	Cultivation of relevant skills, knowledge, and psychosocial competencies that supported academic and future career achievement of CDEP participants. For youth in particular, these skills helped build resilience and filled a critical gap in their academic and personal development. Services included academic support (including college preparation and tutoring), career guidance, and leadership development. It may also have included workforce development—training participants as community resources who can identify mental health symptoms and supportive resources for community members in need.
Family Wraparound Supports	Honored the ways in which family members (e.g., grandparents, parents, siblings, chosen family, etc.) serve as important collaborators in the maintenance and support of mental health of individuals enrolled in the CDEP. Particularly present among youth serving CDEPs, these culturally grounded activities recognized the critical role families play in supporting the mental health and wellbeing of individual family members. Activities included educating family members on various mental health symptoms and conditions; identifying and resolving sources of stress within the family; screenings and assessments to connect families to basic needs and other supports, and/or engaging the family in programs and activities designed to strengthen family cohesion and connectedness.
Social/Recreational Activities	Grounded in a cultural and/or LGBTQ+-related worldview, these activities were aligned with how strength, resilience, and healing emerge when individuals have opportunities to be in community with one another. Recognizing that social isolation can contribute to poor mental health outcomes, particularly in communities of color due to their communal orientation, these services focused on enhancing social connectedness, expanding social support networks, and creating opportunities for fun and joy among CDEP participants.

6.1.B.II DEMOGRAPHICS OF CDEP PARTICIPANTS SERVED

All baseline items were administered at the beginning (pre-test) of a natural CDEP program cycle. The number of pre-tests included in this analysis are:

- N=2,895: Adults (18+ years)
- N=659: Adolescents (12-17 years)

For the adult sample, 63% of IPPs (n=22) collected pre-test data with a range of three to six IPPs per hub (See Table 6.5).

Table 6.5: Adult (18+ years) IPP Representation and Sample Size at Baseline (Pre-Test) by Hub and CRDP Overall

HUB	IPP Distribution by Hub		Adult Sample Size		
	#	% of the Hub Represented	Sample Size	% CRDP Overall Representation	Survey Range Per Hub
AfAm ¹	4	57%	n=441	15%	n=14 to n=189
AI/AN ²	3	43%	n=396	14%	n=26 to n=261
AANHPI ³	5	71%	n=930	32%	n=61 to n=392
Latinx ⁴	6	86%	n=750	26%	n=24 to n=374
LGBTQ+ ⁵	4	57%	n=378	13%	n=37 to n=143
CRDP Overall	n=22 IPPs		N=2,895		

¹ While four IPPs are noted for the AfAm hub, one of these four IPPs contributed to less than 10% of the sample.

² While three IPPs are noted for the AI/AN hub, one IPP contributed to less than 10% of the sample.

³ While five IPPs are noted for the AANHPI hub, one IPP contributed to less than 10% of the sample.

⁴ While six IPPs are noted for the Latinx hub, one IPP contributed less than 5% of the sample.

⁵ While four IPPs are noted for the LGBTQ+ hub sample, one IPP contributed less than 10% of the sample.

While all five priority populations collected adolescent pre-test data, there was lower overall IPP representation compared to the adult sample (See Table 6.6). Forty percent of IPPs (n=14) collected adolescent pre-test data with a range of one to five IPPs per hub.

Table 6.6: Adolescent (12-17 years) IPP Representation and Sample Size at Baseline (Pre-Test) by Hub and CRDP Overall

HUB	IPP Distribution by Hub		Adolescent Sample Size		
	#	% of the Hub Represented	Sample Size	% CRDP Overall Representation	Survey Range Per Hub
AfAm ¹	4	57%	n=164	25%	n=2 to n=66
AI/AN	5	71%	n=166	25%	n=18 to n=78
AANHPI	1	14%	n=58	9%	-
Latinx ²	3	43%	n=145	22%	n=1 to n=112
LGBTQ+	3	43%	n=126	19%	n=16 to n=91
CRDP Overall	n=16 IPPs		N=659		

¹ While four IPPs are noted for the AfAm hub, one IPP contributed to just about 1% of the sample.

² While three IPPs are noted for the Latinx hub, one IPP contributed to less than 1% of the sample.

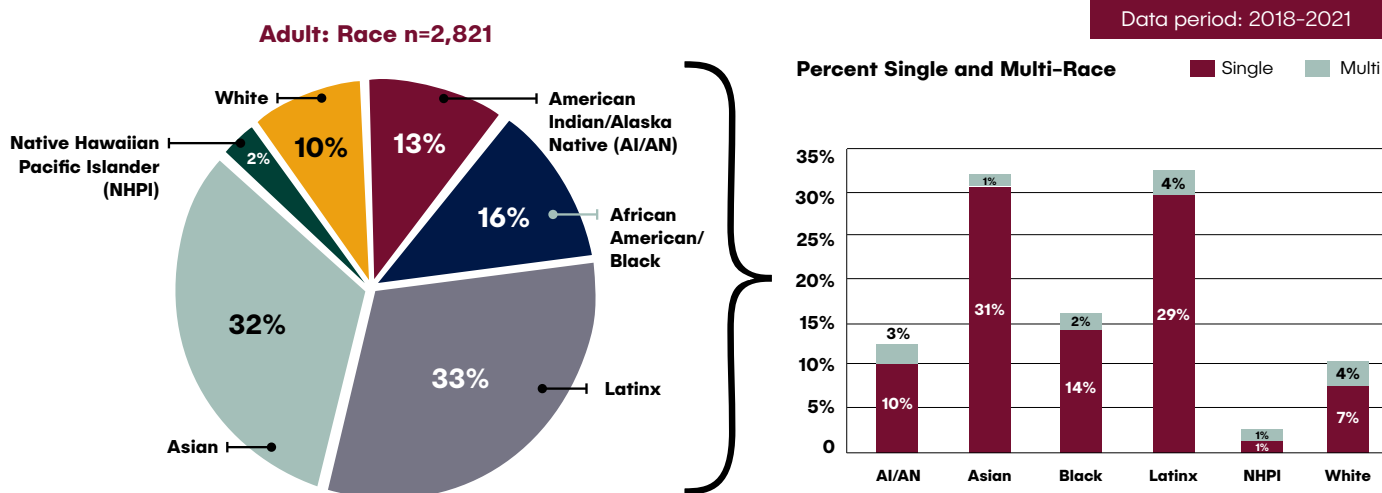
NOTE ABOUT PERCENTAGES OF TOTAL COUNTS

- All percentages were calculated using valid responses (e.g., excludes missing or refused).
- Percentage decimals were rounded up or down.
- Rounding of percentage decimals may result in the same percent for slightly different n's.

Baseline (pre-test) CDEP participant findings suggest that the IPPs served communities from all five priority populations intended to be served by the CRDP. Among those served:

- 33% of adults identified as Latinx, 32% Asian, 16% African American/Black, 13% American Indian/Alaska Native, 10% White, and 2% Native Hawaiian/Pacific Islander. (See Figure 6.5).
- 39% of adolescents identified as Latinx, 28% African American/Black, 23% American Indian/Alaska Native, 15% Asian, 15% White, and 1% Native Hawaiian/Pacific Islander. (See Figure 6.6).

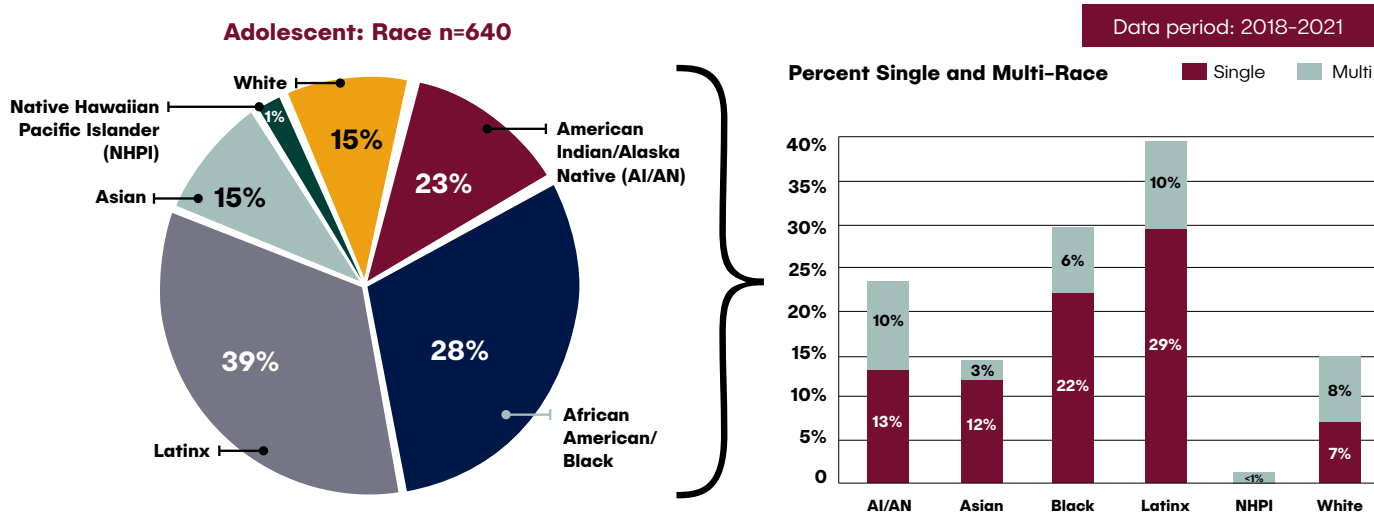
Figure 6.5: Racial Makeup Among CDEP Adult Sample at Baseline (Pre-Test)



*One percent of adults identified as "other" or "multi-racial" but did not specify a racial group.

**Individuals who selected two or more multiracial categories (6%) were aggregated with the corresponding single race categories. As a result, the total percent is greater than 100%. The bar graph reflects the percent of single and multi-race individuals for each race category.

Figure 6.6: Racial Makeup Among CDEP Adolescent Sample at Baseline (Pre-Test)



*12% of all adolescents identified as "other" or "multi-racial" but did not specify a racial group.

**Individuals who selected two or more multiracial categories (15%) were aggregated with the corresponding single race categories. As a result, the total percent is greater than 100%. The bar graph reflects the percent of single and multi-race individuals for each race category.

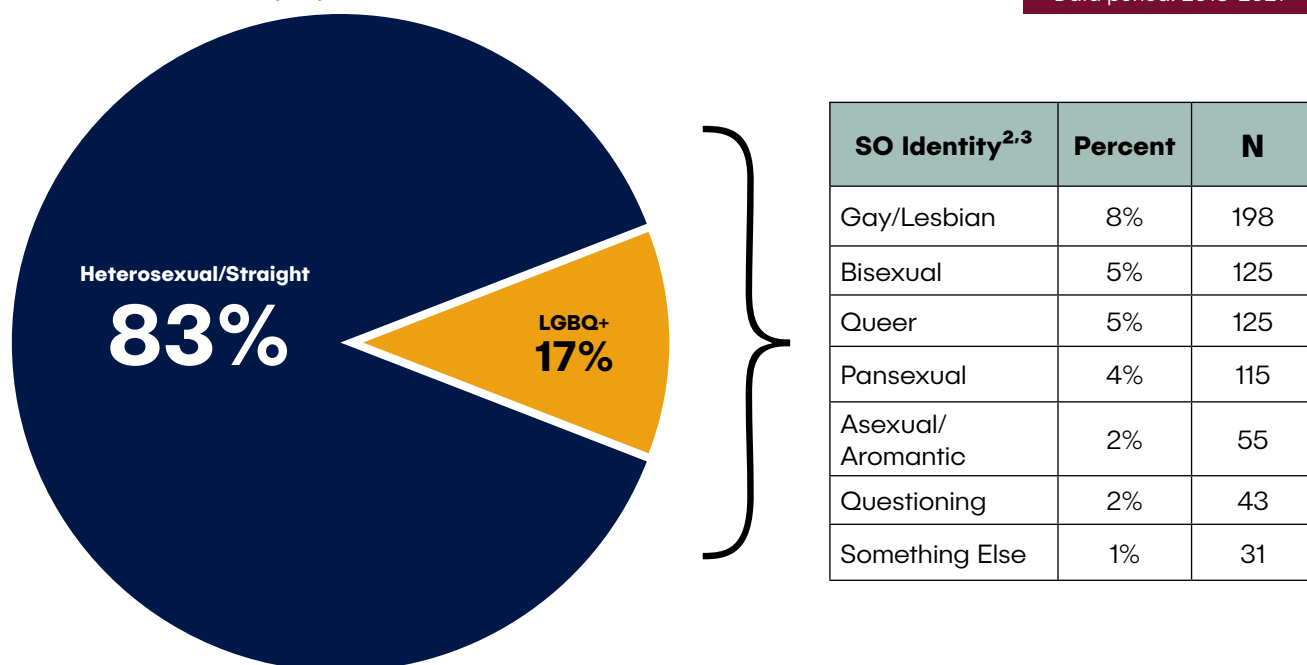
Of those served:

- 17% of adults and 29% of adolescents reported an LGBTQ+ sexual orientation. (See Figure 6.7 and Figure 6.8).
- In terms of gender identity, 9% of adults and 12% of adolescents identified as transgender and gender non-binary, while 2% of both age groups identified as questioning/unsure. (See Figure 6.9 and Figure 6.10).

Figure 6.7: Sexual Orientation Identities Among CDEP Adult Sample at Baseline (Pre-Test)

Sexual Orientation¹ (SO) n=2,621

Data period: 2018-2021



¹ Sexual orientation is a multiple response item; participants selected all categories that were true for them at baseline (pre-test); percentages are unique for straight/heterosexual and LGBTQ+.

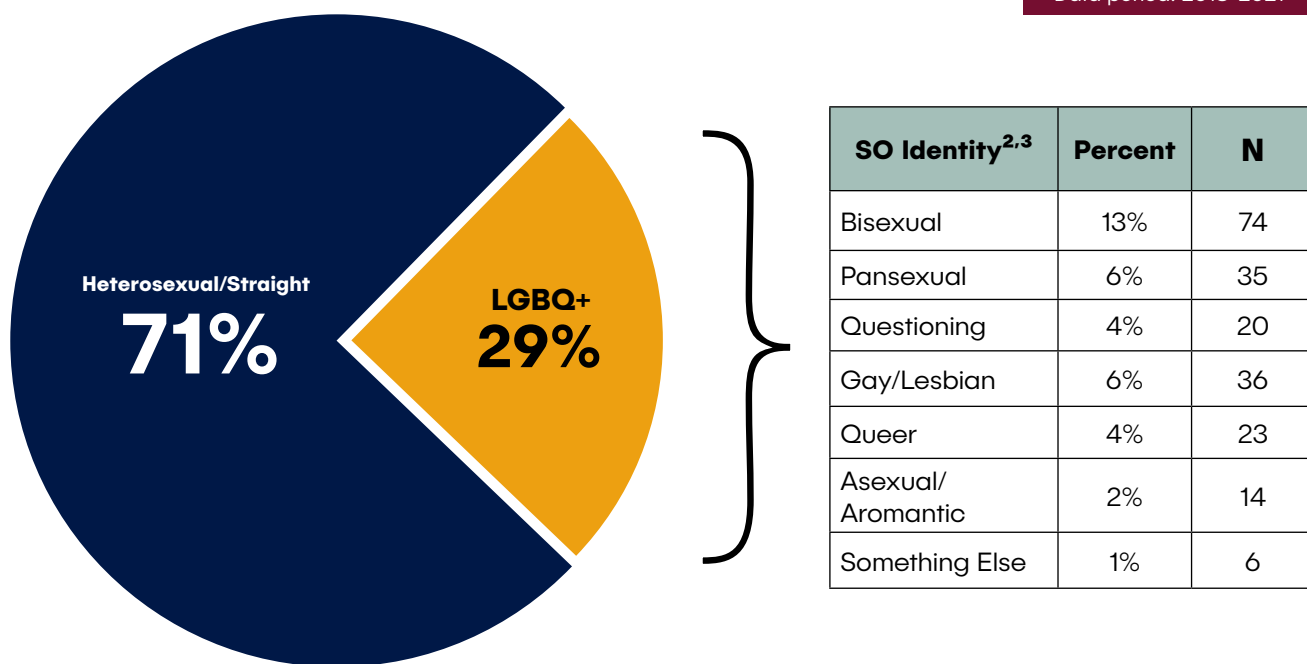
² 5% of both LGBTQ+ adults and adolescents selected two or more identities, therefore percentages overlap.

³ 3a) Percentages were calculated using valid responses (e.g., excludes missing or refused); b) Percentage decimals were rounded up or down; c) Rounding of percentage decimals may result in the same percent for slightly different n's.

Figure 6.8: Sexual Orientation Identities Among CDEP Adolescent Sample at Baseline (Pre-Test)

Sexual Orientation¹ (SO) n=573

Data period: 2018-2021



¹ Sexual orientation is a multiple response item; participants selected all categories that were true for them at baseline (pre-test); percentages are unique for straight/heterosexual and LGBTQ+.

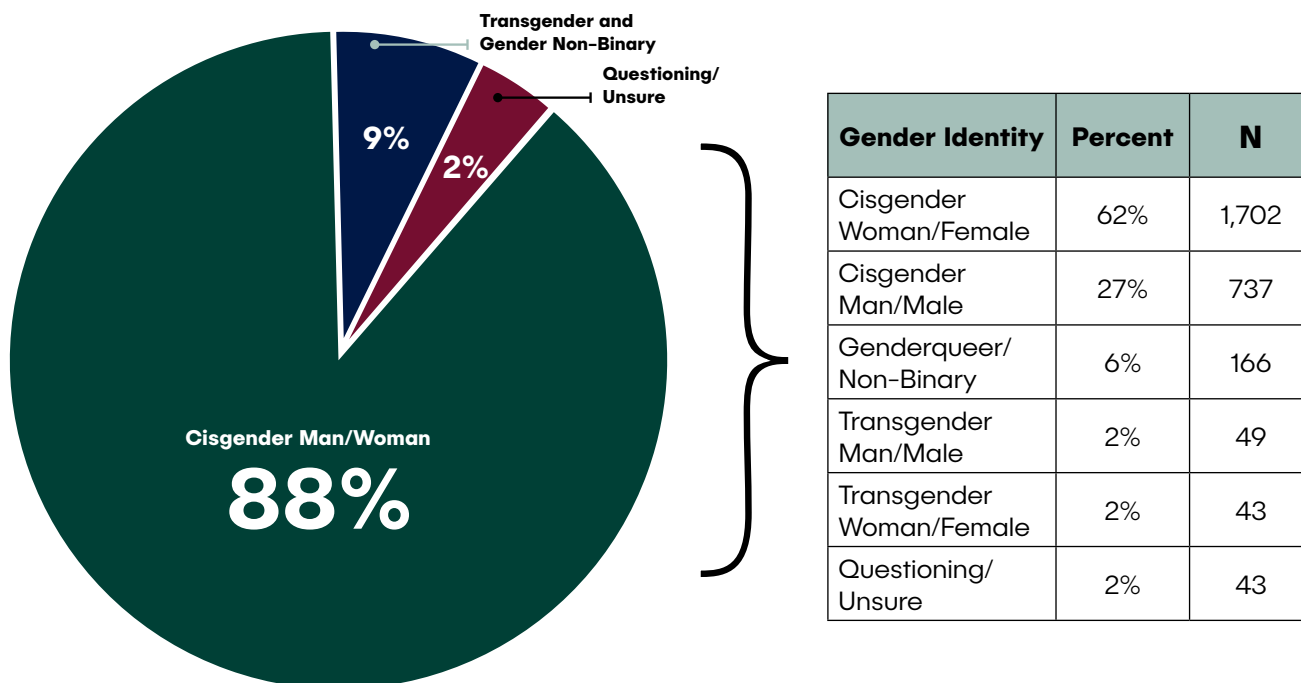
² 5% of both LGBTQ+ adults and adolescents selected two or more identities; therefore, percentages overlap.

³ 3a) Percentages were calculated using valid responses (e.g., excludes missing or refused); b) Percentage decimals were rounded up or down; c) Rounding of percentage decimals may result in the same percent for slightly different n's.

Figure 6.9: Gender Identities Among CDEP Adult Sample at Baseline (Pre-Test)

Gender Identity^{1,2} n=2,764

Data period: 2018–2021



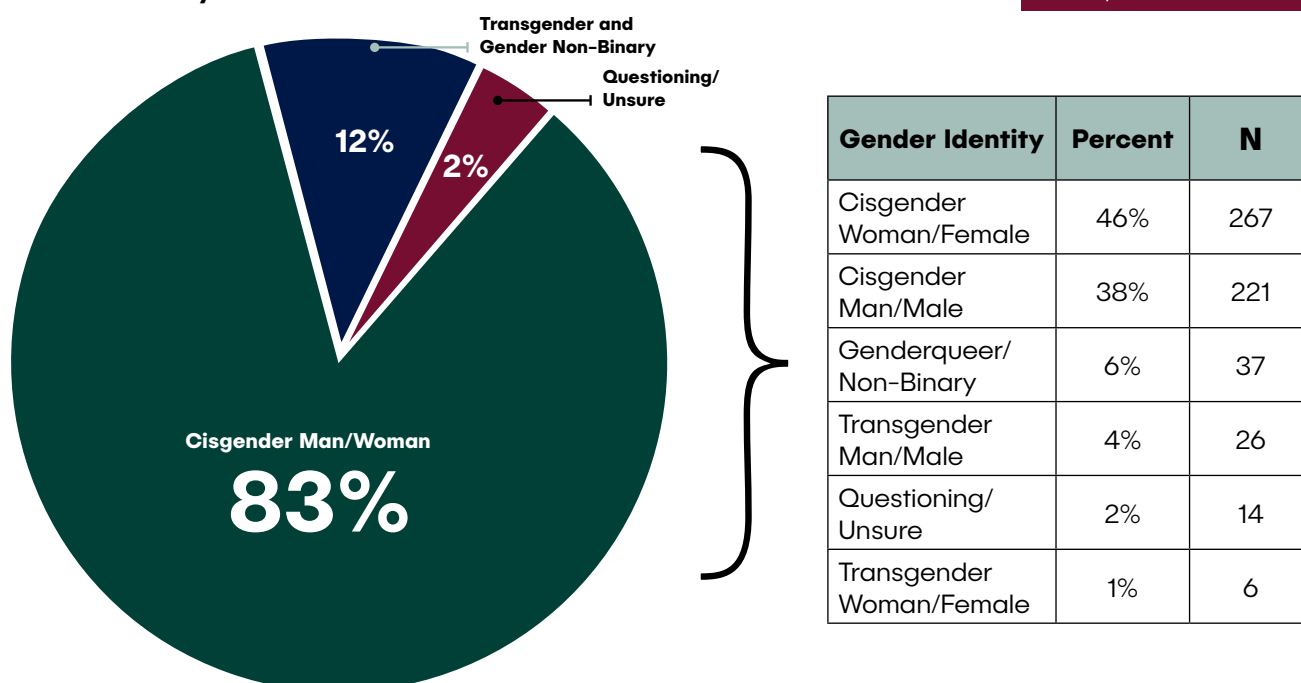
¹ Gender identity is a multiple response item; participants selected all categories that were true for them at baseline (pre-test).

² Percentages are unique for cis woman/female, cis man/male, transgender woman/female, and transgender man/male. Percentages overlap for genderqueer/non-binary and questioning/unsure.

Figure 6.10: Gender Identities Among CDEP Adolescent Sample at Baseline (Pre-Test)

Gender Identity^{1,2} n=586

Data period: 2018–2021



¹ Gender identity is a multiple response item; participants selected all categories that were true for them at baseline (pre-test).

² Percentages are unique for cis woman/female, cis man/male, transgender woman/female, and transgender man/male. Percentages overlap for genderqueer/non-binary and questioning/unsure.

INTERSECTIONAL SPOTLIGHT: SEXUAL ORIENTATION GENDER IDENTITY (SOGI) AND RACE

According to a 2021 brief titled “The State of Mental Health in LGBTQ+ Communities of Color” (Human Rights Campaign Foundation, 2021) LGBTQ+ people of color:

- Experience higher rates of mental health challenges than the LGBTQ+ community broadly (largely due to stigma, discrimination, and bias compounded by decades of harm inflicted by the medical community).
- Face significant gaps in receiving adequate health and mental health care with various social determinants of health worsening the mental health status of LGBTQ+ people of color (e.g., lack of health insurance coverage, economic inequality, racism/discrimination, community violence, etc.).

At the intersection of race, sexual orientation, and gender identity within CRDP Phase 2, the LGBTQ+ hub served adults and adolescents of color who have often been stigmatized for their sexual orientation, gender identity and expression, and their different lived racial/cultural realities.

LGBQ+ and Race

Within the CRDP overall sample, 17% of adults and 29% of adolescents identified as LGBQ+.

- Nearly two in three LGBQ+ adults (61%) and nearly three in four LGBQ+ adolescents (72%) were people of color or multiracial.

Nearly three in four (73%) of LGBQ+ participants were served by the LGBTQ+ hub. Of the six IPPs in the LGBTQ+ hub who submitted CDEP participant questionnaires, the racial breakdown of the LGBQ+ participants were the following:

- 39% White, 19% Multiracial, 14% Latinx, 6% Asian Am, 3% AfAm, 1% NHPI, and 1% AI/AN.

Transgender Non-Binary (TGNB)+ Questioning or Unsure (Q/U) and Race

Within the CRDP overall sample, 11% of adults and 14% of adolescents identified as TGNB and/or Q/U:

- Two in three adults (67%) and one in two adolescents (52%) were people of color or multiracial.

Over three in four (82%) of TGNB and 77% of Q/U participants were served by the LGBTQ+ hub. Of the six IPPs in the LGBTQ+ hub who submitted CDEP participant questionnaires, the racial breakdown of the LGBQ+ participants were the following:

- 22% White, 16% Multiracial, 8% Latinx, 5% Asian Am, 2% AfAm, 1% NHPI, and 1% AI/AN.

Here are a few examples of how LGBTQ+ CDEPs improved the care environment for LGBTQ+ people of color.

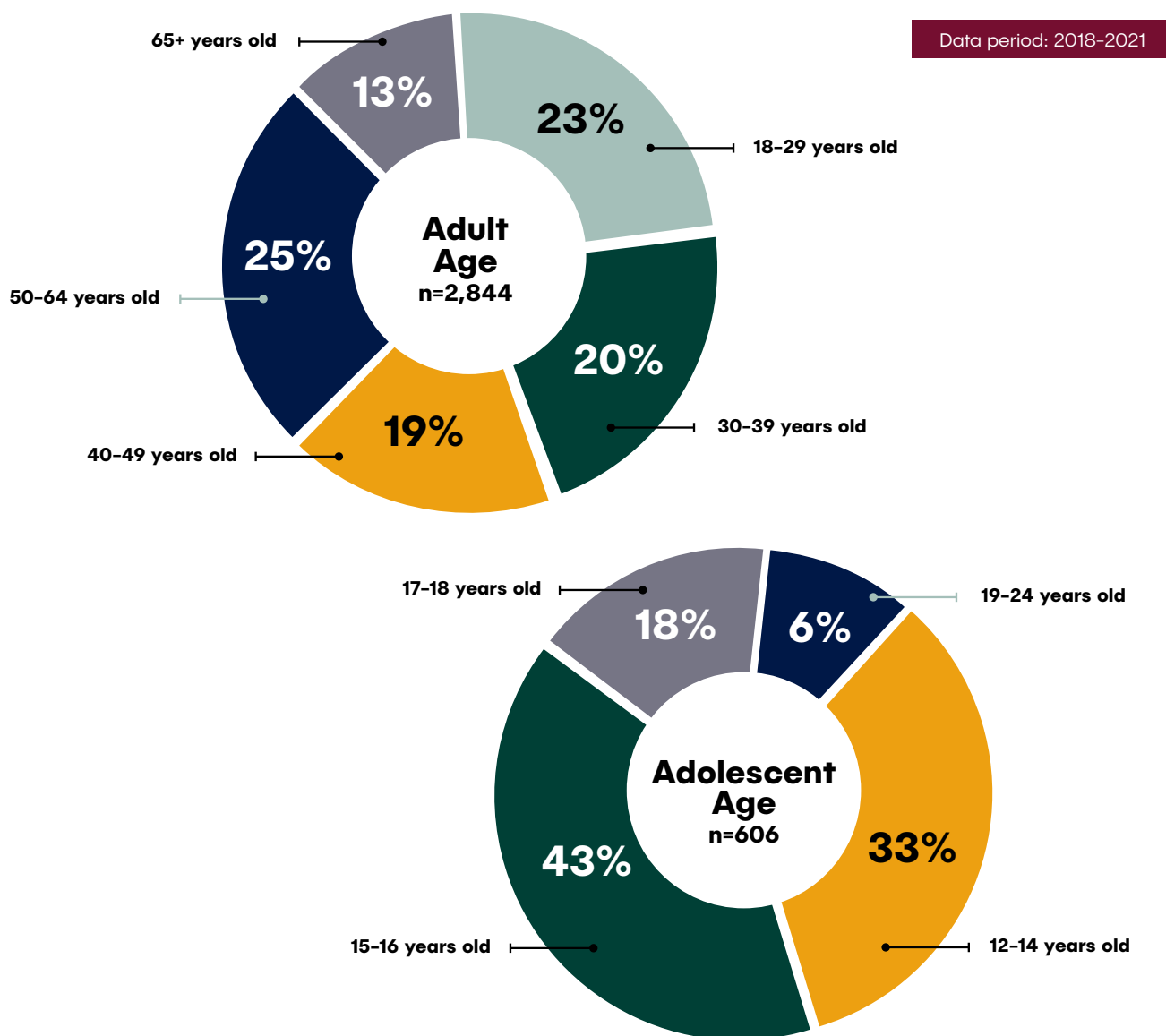
One CDEP launched monthly social/support group events for their queer and trans youth of color and one each for some of their smaller geographic communities. These youth centric events were designed by youth leaders and included themes of cultural and linguistic significance. The central activities of each social event encouraged personal story sharing, cultural education, resource sharing, and just having fun. Following the George Floyd killing and subsequent racial uprising, this CDEP also facilitated conversations with youth about how to authentically support Black Lives Matter and racial justice, building in an explicit focus on racial justice in all programming moving forward.

Another CDEP developed the “Community to You” community outreach campaign to raise awareness for LGBTQ+ seniors, including seniors of color. They delivered 600 Pride bags/backpacks which contained a custom fabric mask, hand sanitizer, t-shirt with Pride parade chant, “Still here, Still Queer, Seniors are the reason you’re here!” They also delivered homemade soul food meals from a Black-owned caterer for our transgender and gender non-conforming (TGNC) and people of color elders.

Baseline (pre-test) demographic data also suggest that CDEPs served a cross section of sub-populations (i.e., adolescents, elders, limited English fluency, immigrant, or refugee status) which places them at an elevated risk for mental health problems, and/or may make them less likely to use mental health services due to stigma, attitudes about mental health care, and other institutional and structural barriers. See Chapter 1, Mental Health Disparities Context, for more information on mental health disparities affecting the five priority populations and sub-populations. For a more extensive discussion of these issues, refer to the **Phase 1 Priority Population reports**. Of those served:

- Adults were almost equally represented across four age groups: 18-29 years (23%), 30-39 years (20%), 40-49 years (19%), and 50-64 (25%). Of note, 13% of the adult sample were aged 65 and older.
- Adolescents were primarily distributed among middle school or high school: 15-16 years (43%) and 12-14 years (33%). One-in-four (24%) were older youth: 17-18 years (18%) or 19-24 years (6%). (See Figure 6.11).

Figure 6.11: Baseline (Pre-Test) Adult and Adolescent Age Distribution

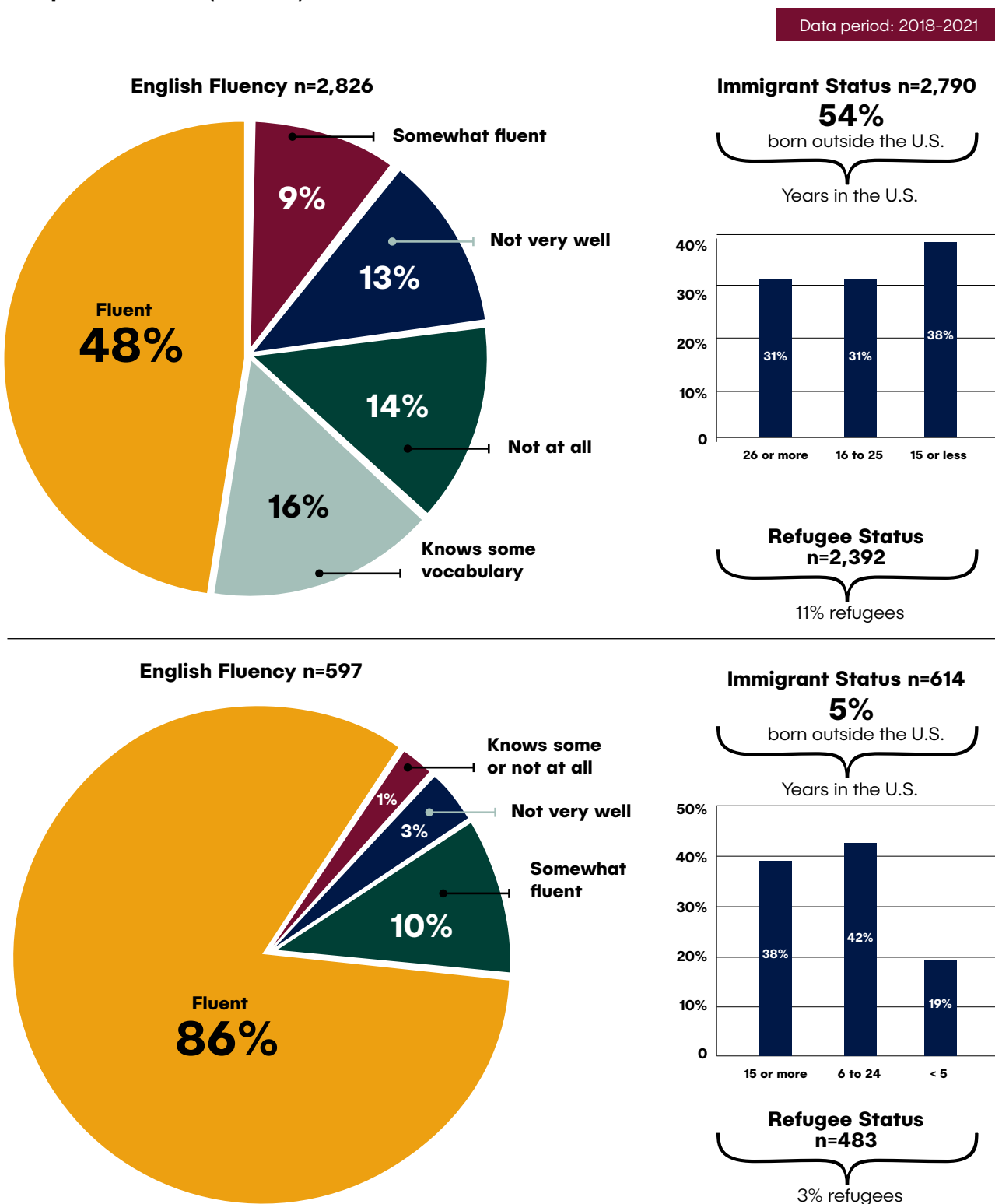


*The CRDP had no clear guidelines for defining age ranges for adolescents or youth. There is also a lack of consensus among researchers in the U.S. and internationally as to what age parameters best define youth. The World Health Organization categorizes “young people” as adolescents and young people ages 10 to 24 years. Since there was no prescribed youth definition in CRDP, the SWE used the same definition as the California Health Interview Survey (ages 12-17 years), from which many of the SWE participant questionnaire items were drawn and/or adapted. However, an exception was made to include one individual age 11 and 36 individuals ages 19-24 years into the SWE adolescent sample based on the CDEP’s own definition of youth. These age groups were served by three IPPs from three different hubs (AI/AN, AANHPI, & LGBTQ+). The one participant aged 11 is not featured in the age figure.

In addition, of those served:

- 52% of adults had limited English fluency (85% of Latinx adults; 81% of Asian American adults) in contrast to 14% of adolescents.
- 54% of adults were born outside of the U.S. (88% of Asian American adults; 91% of Latinx adults), compared to 5% of adolescents.
- 11% of adults were refugees (27% of Asian American adults; 9% of Latinx adults), while 3% of adolescents were refugees. (See Figure 6.12).

Figure 6.12: English Fluency, Immigrant, and Refugee Status Among CDEP Adult and Adolescent Sample at Baseline (Pre-Test)



INTERSECTIONAL SPOTLIGHT: ELDERS (65 OR OLDER)

In 2019, nearly one in four (24%) adults ages 65 years or older were members of racial or ethnic minority populations in the U.S., with California having the highest percentage of older populations (Administration of Aging, 2021). While seniors/elders play an important role in many of the communities served by the IPPs, some are at risk for developing mental health and health conditions, such as mood disorders, depression, dysthymia, and anxiety (Byers et al., 2010), as well as dementia, which has been found to be higher for those of African American, Latinx, American Indian/Alaska Native, and Pacific Islander descent (Alzheimer's Association, 2021). Further, older adults of color and/or from other marginalized communities have likely experienced discriminatory treatment for longer durations, and possibly more severe forms of it, that have affected their health and/or mental health (Aaron, et al., 2021; Applewhite, 2021; Kum, 2017; Lui & Suyemoto, 2011; Routledge, 2021). In 2011, Fredriksen-Goldsen found that LGBTQ+ older adults had higher levels of isolation or loneliness compared to cisgender, straight older adults, with about one-third reporting symptoms meeting a depression diagnosis.

In a subsample of adults served by CDEPs, 13% (n=366) were ages 65 or older. Twenty-two CDEPs representing all five hubs (4 AfAm IPPs; 5 AANHPI IPPs; 3 AI/AN IPPs; 6 Latinx IPPs; 4 LGBTQ+ IPPs) provided PEI services to elders who may not typically come to the attention of the mental health and aging service delivery systems. For example,

- Over one in two (63%) identified racially as AANHPI; this was followed by 13% White, 11% AfAm, 8% Latinx, and 2% AI/AN.
- Nearly one in five (18%) identified as LGBTQ+, while 3% identified as TGNB.
- Nearly three in four (73%) had limited English fluency.
- Over two in three (68%) were born outside of the United States, while 18% were refugees.

CDEP PEI services were provided to elders in ways that resonated with their culture and historical experiences. For example:

In one AANHPI CDEP, the staff communicates in-language with Hmong elders and seeks their input on the types of cultural foods they would prefer for their meals. Staff will ask the Hmong elders for their traditional recipes and seek guidance on how to prepare the food. In community exchanges, the elders intentionally speak and practice the Hmong language with CDEP staff and the younger generations to keep the language and culture alive. They also attend cultural events, such as Hmong weddings, funerals, and spiritual events (*hu plig*-soul calling, *ua neeg kho*-spiritual healing, etc.).

One IPP in the LGBTQ+ hub, listened to their senior community members who shared their safety concerns about leaving their home (e.g., risks connected to falls or injuries) and having to move into a nursing home where they are likely to face discrimination and mistreatment in long-term care facilities. Therefore, the CDEP provided seniors transportation to and from their center, which was critical for keeping them connected to support programs and community, as well as allowing them to age safely in their homes.



6.1.B.III INDIVIDUALS SERVED WITH PERCEIVED NEED FOR MENTAL HEALTH CARE AND UNMET NEED

An unmet mental health need exists when someone has a mental health problem but doesn't receive formal care (i.e., unserved), or when the care received is insufficient (i.e., underserved) or inadequate (i.e., inappropriately served). To better understand the mental health needs among CDEP participants, items measuring perceived need, unmet need, and help seeking from the California Health Interview Survey (Mental Health section – Access and Utilization) were used in the statewide evaluation CDEP participant questionnaire (pre-test).

CORE DEFINITIONS

- **Perceived Mental Health Need:** Self-reported need to see a professional for problems with mental health, emotions, nerves, or use of alcohol and/or drugs in the past 12 months prior to receiving CDEP services. In other words, perceived need (PN) is an estimate of adults who felt they had a need for mental health services.
- **Unmet Need for Mental Health Care:** Two approaches were used to calculate unmet need for mental health care among individuals with a perceived need in the statewide evaluation.
 - › California Health Interview Survey approach: Self-reports of not seeing two types of professionals in the 12 months prior to CDEP involvement for mental or behavioral health problems among individuals with a perceived need. These two types only include mainstream sources of mental health care (i.e., mental health care providers and medical providers only) to estimate unmet need. This is considered the typical standard of measurement in epidemiological studies and other population surveys such as the California Health Interview Survey (CHIS) and the National Survey on Drug Use and Health (NSDUH).
 - › PARC approach: Self-reports of not seeing four types of professionals in the 12 months prior to CDEP involvement for mental or behavioral health problems among individuals with a perceived need. This includes non-western mainstream sources of mental health care such as spiritually based healer or *promotor*.
- **Mental Health Help-Seeking:** Self-report of seeing up to four types of professionals in the 12 months prior to CDEP involvement for mental or behavioral health problems among individuals with a perceived need.
- **Mental Health Visits:** If yes to mental health help-seeking, self-reports of the number of visits to a mental health professional (counselor, therapist, psychologist, psychiatrist, or social worker) for problems with mental or emotional health, alcohol-drug problem, or both during the past 12 months (overnight hospital stays not counted).
- **Mental Health Prescription:** Self-report of taking any prescription medications, such as an antidepressant or an antianxiety medication, almost daily for two weeks or more, for an emotional or personal problem, during the past year.



The Statewide Evaluation expands on the CHIS items measuring perceived and unmet mental health needs by accounting for an expanded range of mental health supports stemming from traditional and community-based sources of care. These additional supports were identified through recommendations from the CRDP Partners and the IPPs. See Table 6.7 for the provider types used in the PARC vs. CHIS approach in the statewide evaluation. For an estimate of adults and adolescents with a perceived need for mental health care with serious or moderate psychological distress, please see the Individuals Served by Psychological Distress & Functional Impairment section of the report.

Table 6.7: Mental Health Care Professionals Types Used to Estimate Unmet Need in the Statewide Evaluation

Sources of Mental Health Care	Adult Provider Types	Adolescent Provider Types
MAINSTREAM CARE (Used in both PARC & CHIS approach)	Primary care physician or general practitioner.	At school: school counselor, school psychologist, school therapist, or school social worker.
	Mental health care provider, such as a counselor, therapist, psychologist, psychiatrist, social worker.	Outside of school: counselor, therapist, psychologist, psychiatrist, or social worker.
TRADITIONAL & COMMUNITY-BASED CARE (Used in PARC approach)	Holistic/spiritual provider, such as a culturally based healer, religious/spiritual leader, or advisor.	
	Community helping professional such as a health worker, promotor, peer counselor, or case manager.	

Baseline (pre-test) findings revealed that:

- Nearly three in four (72%) adults and nearly one in two (49%) adolescents had a perceived mental health need (indicated they needed help with emotional, mental, alcohol, or drug problems) in the year prior to receiving services from the CDEP (See Figures 6.13 and 6.14).

Estimates were also calculated for individuals with a perceived need who did NOT seek help from any of the four types of mental health care professionals (PARC approach). This included mainstream sources of care, as well as traditional/community-based sources of care.

- Just over one in four (28%) adults and nearly one in three (30%) adolescents who had a perceived mental health need were unserved in the year prior to receiving services from the CDEP (See Figures 6.13 and 6.14). That is, they had an unmet need for mental health care in the year prior to receiving CDEP services.

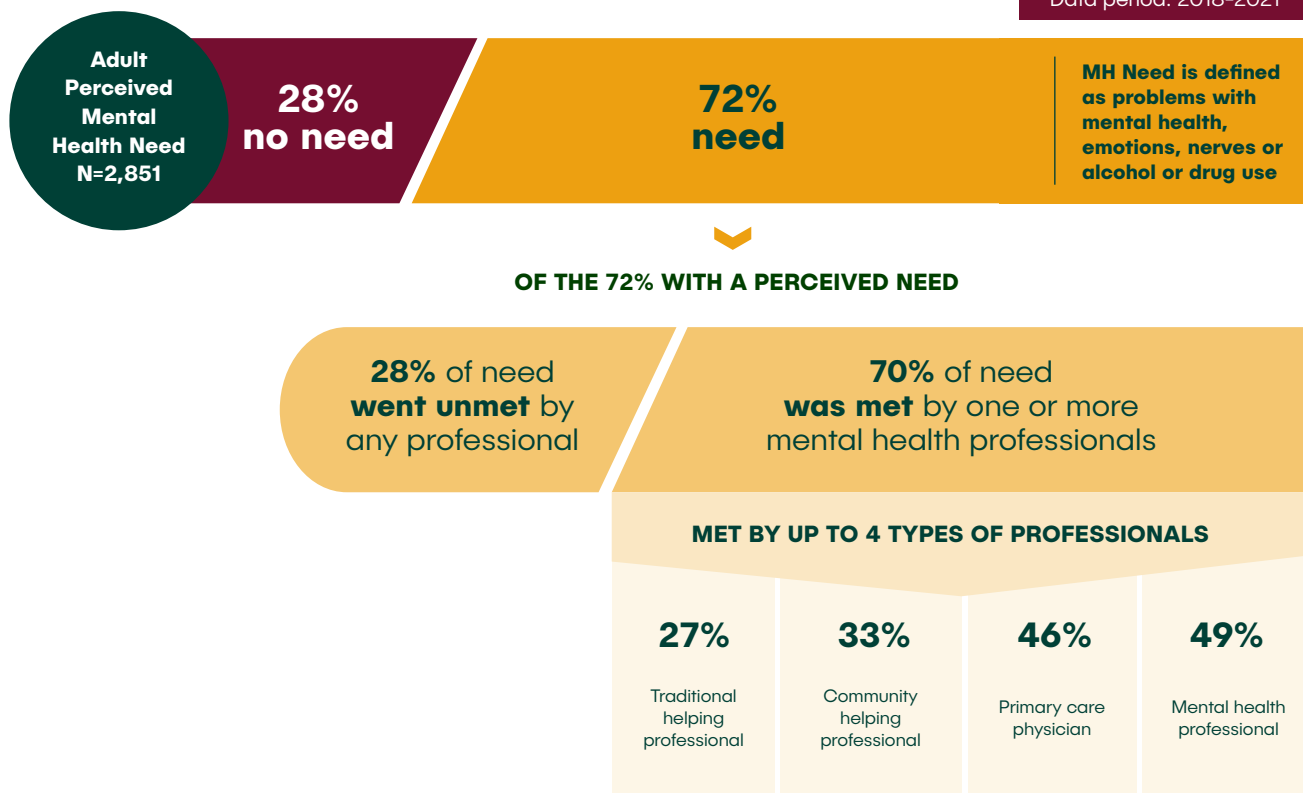
When traditional and community-based care are excluded from the analysis of unmet need (the CHIS approach), the amount of unmet need is even more striking (i.e., individuals with a perceived need who did NOT seek help from mainstream sources of mental health care).

- When examining only mainstream sources of care (mental health or medical provider only), the number of unserved adults and adolescents increased by seven and six percentage points respectively (See Figures 6.13 and 6.14). Specifically, 35% of adults (compared to 28%) and 36% (compared to 30%) of adolescents were unserved in the year prior to CDEP involvement using the more restricted list of possible sources of professional help.



Figure 6.13: Perceived Need for Mental Health Care and Unmet Need Among CDEP Adult Sample in the 12 Months Prior to Receiving CDEP Services (PARC approach compared to CHIS approach)

Data period: 2018–2021



There was 28% unmet need in the PARC approach (top figure – examination of four provider types) compared to 35% unmet need using CHIS approach (bottom figure – examination of two provider types). In other words, when adult CDEP participants accessed a broader variety of professionals in their community, **unmet need was reduced by seven percentage points**.

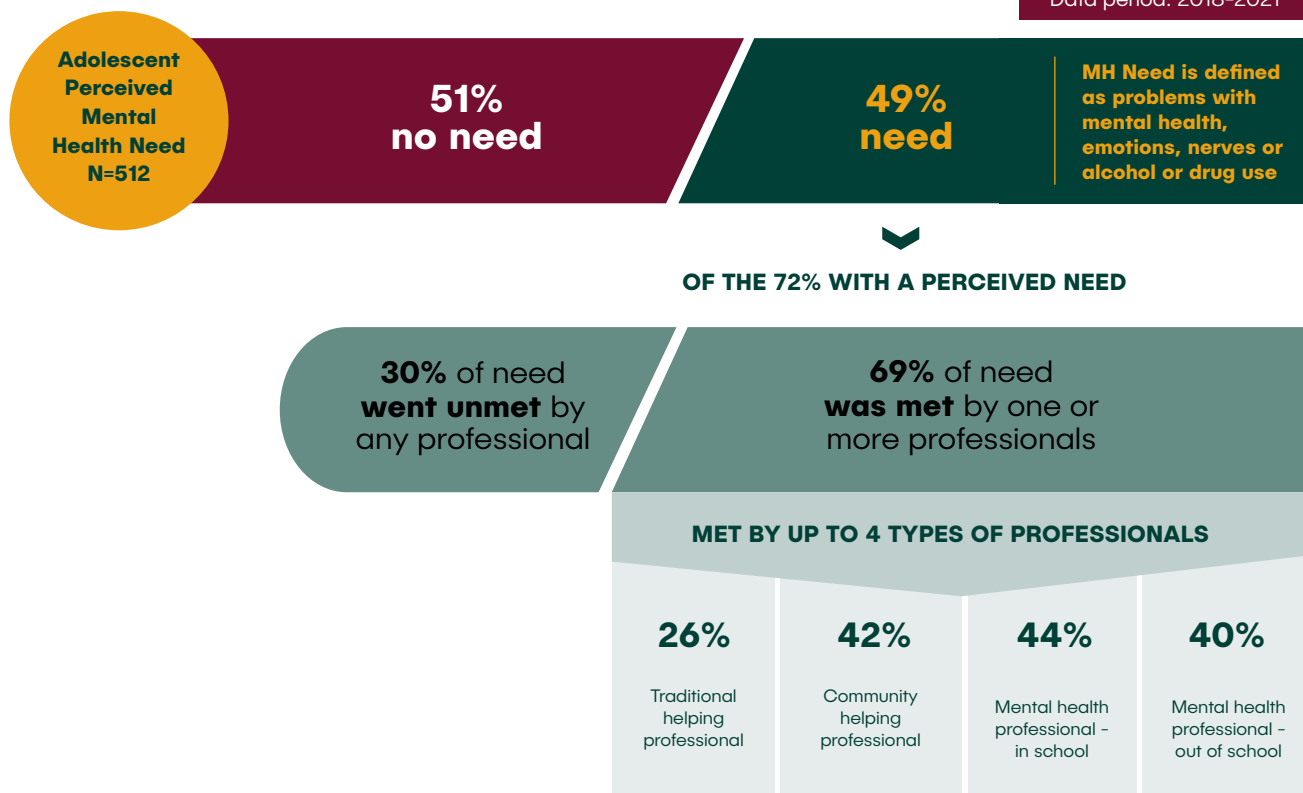
Perceived Need for Mental Health Care and Unmet Need in the 12 Months Prior to Receiving CDEP Services Using the California Health Interview Survey (CHIS) Approach*

(*Two provider types ONLY – i.e., primary care physician and/or mental health professional)



Figure 6.14: Perceived Need for Mental Health Care and Unmet Need Among Adolescent Sample in the 12 Months Prior to Receiving CDEP Services (PARC approach compared to CHIS approach)

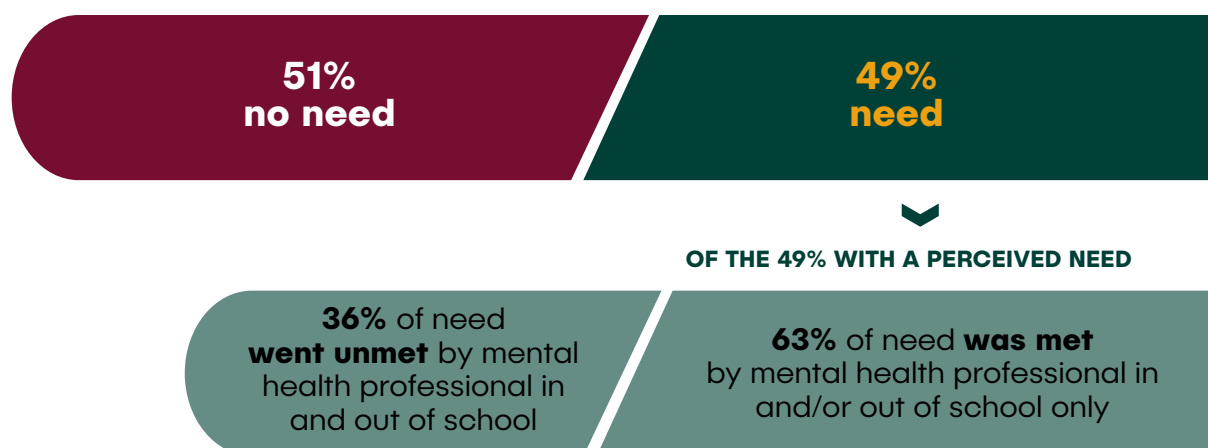
Data period: 2018-2021



There was 30% unmet need in the PARC approach (top figure – examination of four provider types) compared to 36% unmet need using CHIS approach (bottom figure – examination of two provider types). In other words, when adult CDEP participants accessed a broader variety of professionals in their community, **unmet need was reduced by seven percentage points**.

Perceived Need for Mental Health Care and Unmet Need in the 12 Months Prior to Receiving CDEP Services Using the California Health Interview Survey (CHIS) Approach*

(*Two provider types ONLY - i.e., primary care physician and/or mental health professional)



*Participants were able to select up to four mental health care professional types who met their PN in the past year; since this is a multiple response item, percentages do not add up to 100.

In relation to mental health help-seeking for individuals with a perceived need the following was found:

- Nearly three in four (70%) adults and over two in three adolescents (69%) had their need met by one or more professionals in the year prior to receiving CDEP services (See Figure 6.13 and 6.14 above). This suggests high levels of help-seeking behavior with a wide variety of professionals including community helping professionals.
- Close to one in three (35%) adults sought help from at least one mainstream professional (mental health or primary care physician) and at least one holistic (culturally based healer, religious/spiritual leader, or advisor) or community-based helping professional (health worker, promotor, peer counselor, case manager). (See Appendix 2).

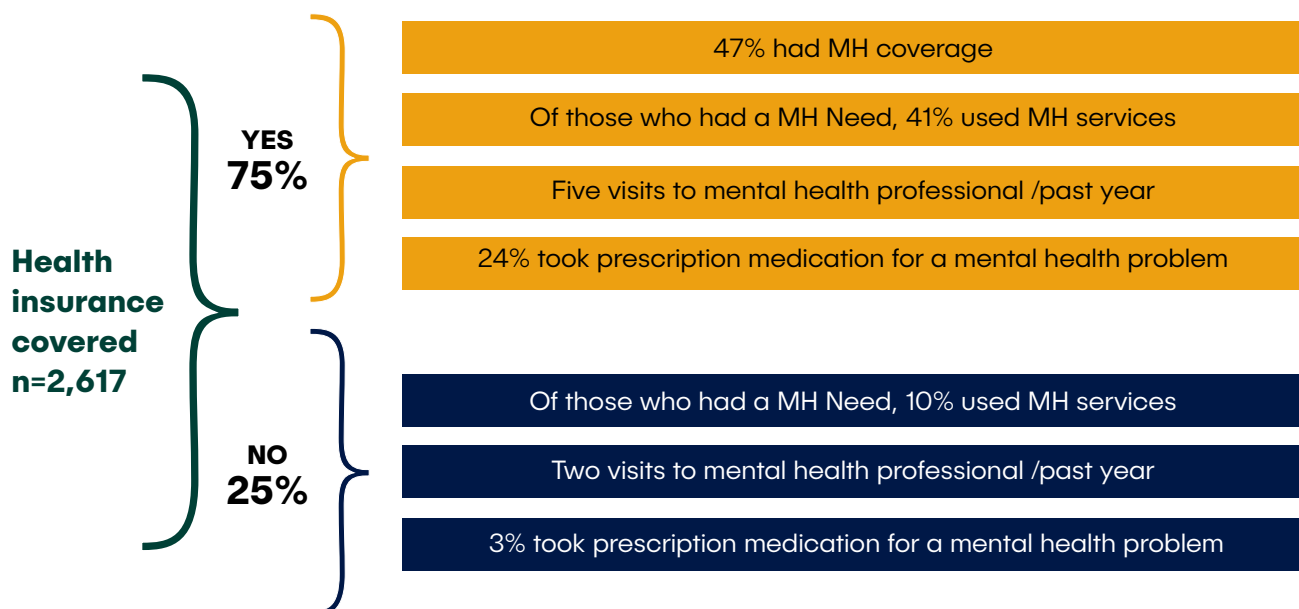
To further understand access, health insurance coverage queries were included in the adult baseline (pre-test) questionnaire. Three in four (75%) adults had health insurance, while one in four did not. Nearly one in two adults who had health insurance stated they had mental health coverage. It is important to note that the percent acknowledging having health insurance may be an overestimation as CDEP participants from two hubs (AI/AN & AANHPI) may have confused other resources (e.g., services provided through Indian Health Services) with actual health insurance coverage (See Figure 6.15).

Forty-seven percent of adults who had health insurance had mental health coverage and over one in three of them used mental health services with a median number of five visits in the past year. Among adults with no coverage, only one-in-ten used mental health services, with median number of five visits in the past year (See Figure 6.15). Twenty-four percent of adults with health insurance took prescription medication (e.g., antidepressant or antianxiety medication) for an emotional or personal problem, compared to 3% of people who were uninsured (See Figure 6.15).

Figure 6.15: Mental Health Service Utilization, Visits, & Prescription Use Among a Sample of CDEP Adult Participants with and without Health Care Insurance Coverage

Data period: 2018-2021

Insurance, Visits to MH Professional, and Service Utilization in the Past Year (Prior to CDEP Services)



For those with health insurance:

- Over one in three used mental health service (median visits = 5).
- Mental health coverage is nearly one in two.
- Nearly one in four took prescription medication for a MH need.

For those with no health insurance:

- One in 10 used mental health services (median visits = 2).
- 3% took prescription medication for a MH need.

6.1.B.IV INDIVIDUALS SERVED BY PSYCHOLOGICAL DISTRESS AND FUNCTIONAL IMPAIRMENT

To further understand CDEP participants' mental health needs, items measuring psychological distress (the Kessler-6, or K6) and functional impairment (the Sheehan Disability Scale, or SDS) from the California Health Interview Survey were embedded into the Statewide Evaluation Adult and Adolescent CDEP Participant Questionnaires.

CORE DEFINITIONS

- **Moderate Psychological Distress (past month):** An estimate of individuals with moderate mental distress that likely warrants mental health intervention. The Kessler-6 (K6) assesses six symptom areas associated with mental health conditions such as depression and anxiety. Estimates are based on the number and frequency of symptoms (i.e., K6 scores of 5-12) reported in the past 30 days prior to receiving CDEP services.
- **Serious Psychological Distress (past month):** An estimate of individuals with serious mental distress that is clinically relevant and warrants mental health intervention. The Kessler-6 (K6) assesses six symptom areas associated with mental health conditions such as depression and anxiety. Estimates are based on the number and frequency of symptoms (i.e., K6 scores ≥ 13) reported in the past 30 days prior to receiving CDEP services.
- **Functional Impairment (past year):** An estimate of functional impairment for adults experiencing serious or moderate psychological distress. The four-item Sheehan Disability Scale (SDS) measures the extent to which emotions interfered with their performance at work/school, at home, in one's social life, and in one's personal relationships in the year prior to CDEP involvement. Adolescents take a three-item SDS that measures the extent to which their emotions interfered with their performance with school and homework, and relationships with friends and at home. Adults and adolescents are asked to think about the one month, within the past 12 months, when they felt at their worst emotionally.

Baseline (pre-test) findings among a CDEP adult participants revealed that:

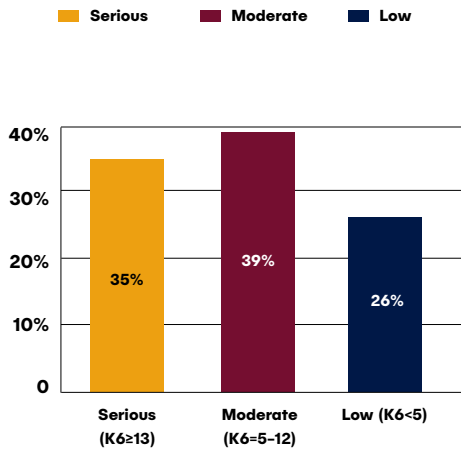
- Nearly three in four (74%) adults experienced serious or moderate psychological distress in the 30 days prior to CDEP involvement (See Figure 6.16). Specifically, 35% of adults had serious psychological distress, while 39% had moderate psychological distress.
 - Serious psychological distress was eight times higher (89%) among adults with a perceived need for mental health services than adults with no need (11%).
 - Moderate psychological distress was nearly three times higher (74%) among adults with a perceived need for mental health services than adults with no need (26%).
- Two in three adults with serious psychological distress reported "a lot" of impaired functioning at home/school, at work, in social life, and in personal relationships (See Figure 6.17). About one in four adults with moderate psychological distress reported "a lot" of impaired daily functioning.



Figure 6.16: Psychological Distress Among a CDEP Adult Sample in the Past 30 Days Prior to Receiving CDEP Services

Data period: 2018-2021

Adult: Psychological Distress in the Past 30 Days n=2,745



Adult: Perceived Mental Health Need by Psychological Distress (Past Month) n=2,581

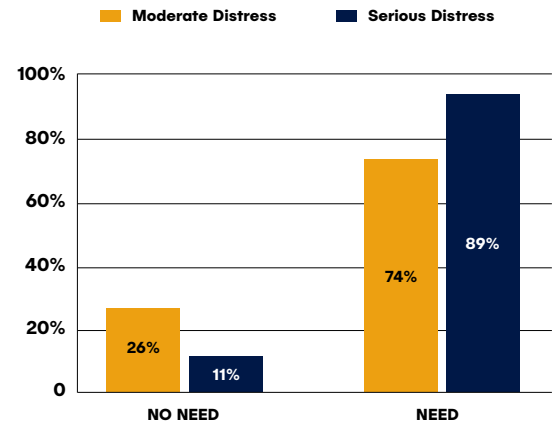
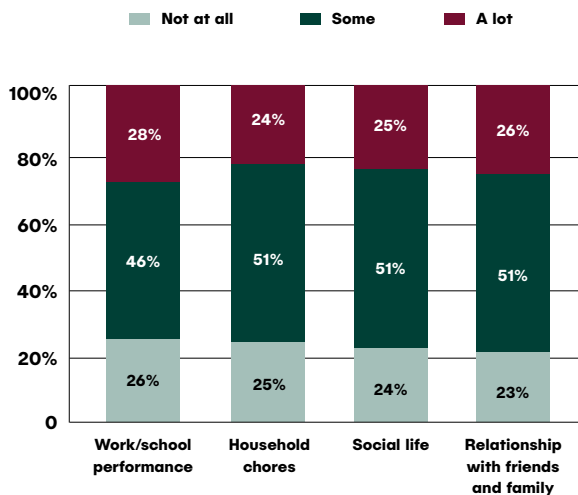


Figure 6.17: Psychological Distress by Functional Impairment Among a CDEP Adult Sample in the Past Year Prior to Receiving CDEP Services

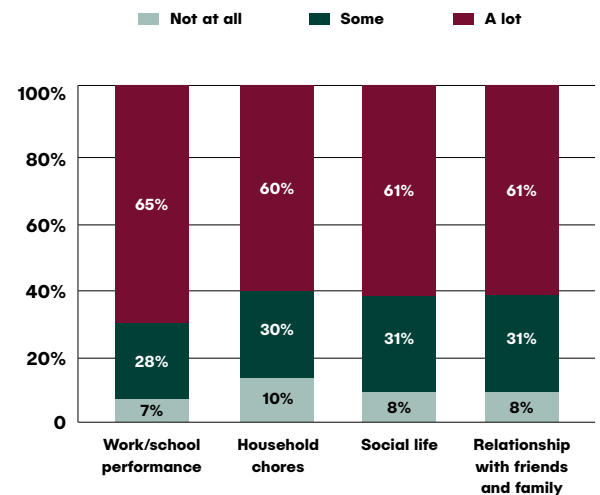
Data period: 2018-2021

Reported impairment in the worst month emotionally in the past year for CDEP adult participants meeting criteria for:

Moderate Psychological Distress (K6=5-12) n=1,068



Serious Psychological Distress (K6≥13) n=961



The proportion of participants with "a lot" of impairment in the serious mental distress group is over twice as high as those in the moderate mental distress group.

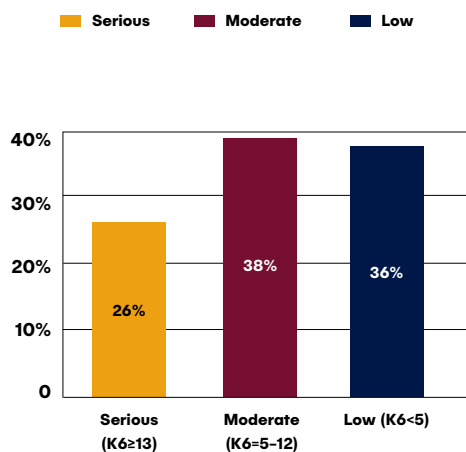
Baseline (pre-test) findings among CDEP adolescent participants revealed that:

- About two-thirds (64%) of adolescents experienced serious or moderate psychological distress in the 30 days prior to CDEP involvement (See Figure 6.18). Specifically, 26% had serious psychological distress, while 38% had moderate psychological distress.
- Serious psychological distress was almost double (93%) among adolescents with a perceived need for mental health services compared to adolescents with no need (46%).
- 61% of adolescents with serious psychological distress reported "a lot" of impaired functioning at school; 42% in social life; and 55% at home (See Figure 6.19).

Figure 6.18: Psychological Distress Among a CDEP Adolescent Sample in the Past 30 Days Prior to Receiving CDEP Services

Data period: 2018–2021

Adolescent: Psychological Distress in the Past 30 Days n=576



Adolescent: Perceived Mental Health Need by Psychological Distress in the Past Month n=512

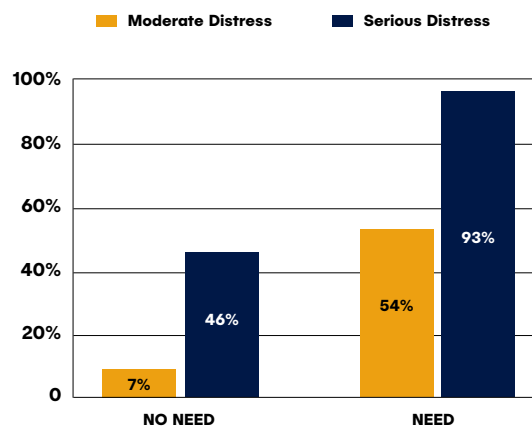
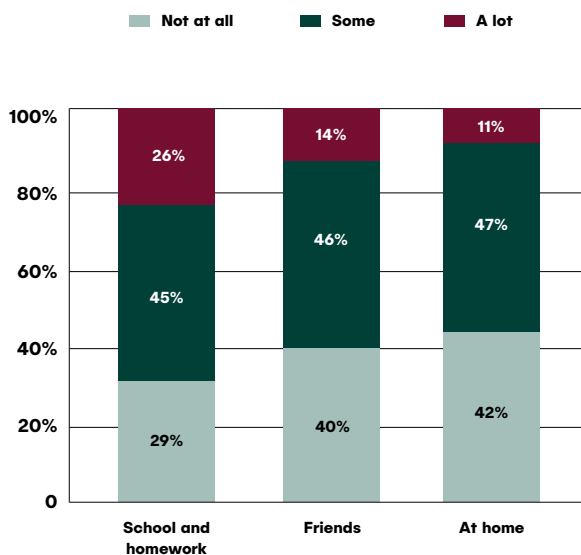


Figure 6.19: Psychological Distress by Functional Impairment Among a CDEP Adolescent Sample in the Past Year Prior to Receiving CDEP Services

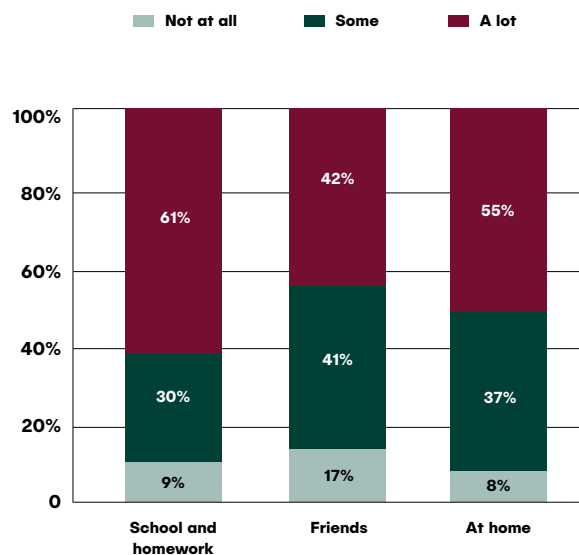
Data period: 2018–2021

Reported impairment in the worst month emotionally in the past year for CDEP adolescent participants meeting criteria for:

Moderate Mental Distress (K6=5–12) n=220



Serious Mental Distress (K6≥13) n=149



The proportion of participants with “a lot” of impairment in the serious mental distress group is over twice as high compared to those in the moderate mental distress group.

These findings further illustrate the importance of CDEPs in meeting gaps in access to mental health services for individuals who had a perceived need at baseline but also for those who were experiencing moderate or serious levels of psychological distress and impaired functioning that warranted a mental health intervention. The statewide evaluation was not able to estimate the number of individuals with a met need who were underserved or inappropriately served in the year prior to receiving CDEP services. However, given the high levels of help seeking reported previously, these findings suggest that this may be the case for some CDEP participants experiencing moderate or serious psychological distress or impaired daily functioning.

6.1.B.V PROTECTIVE AND RISK FACTORS AMONG INDIVIDUALS SERVED

While risk factors were once thought to be fixed, specific circumstances or life stressors, the field's understanding has shifted to reflect a broader, more general phenomenon that is malleable and developmentally influenced. The presence of risk factors for a given individual increases the possibility that individual will develop a mental health challenge compared to someone selected at random from the general population. Risk factors also cut across the social ecological levels and can reside within the individual, the family, the community, or institutions.

Protective factors can modify or alter an individual's response to potential hazards emanating from various potential risk factors. They too can reside within the individual, the family, the community, or institutions (Mrazek & Haggerty, 1994).

CORE DEFINITIONS

- **Risk Factors:** Factors which predispose individuals to mental illness (<https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders>).
- **Protective Factors:** Factors which protect individuals from developing mental disorders (<https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders>).
- **Culture as a Protective Factor:** Culture (and language) play an important role in maintaining health and reducing risk factors for mental health crises. Belief systems, values, customs, and traditions transmitted from generation to generation and encapsulated in ceremonies, customs, rules for community behavior, the gathering and use of traditional medicines and diets, spiritual practices, leisure activities, community rituals, and more serve to define and protect healthy behavior and community relations which undergird well-being. As such, culture creates the conditions to build resilience and buffers against the negative effects of various risk factors. For more information, please refer to Molvor et al. (2009).
- **Culture:** The following statement preceded the protective factor items in the statewide evaluation's CDEP participant questionnaire (adult and adolescent versions): "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."

IPPs provided important insights into the salient risk and protective factors in their communities. Baseline (pre-test) findings of protective and risk factors among CDEP adult participants revealed that:

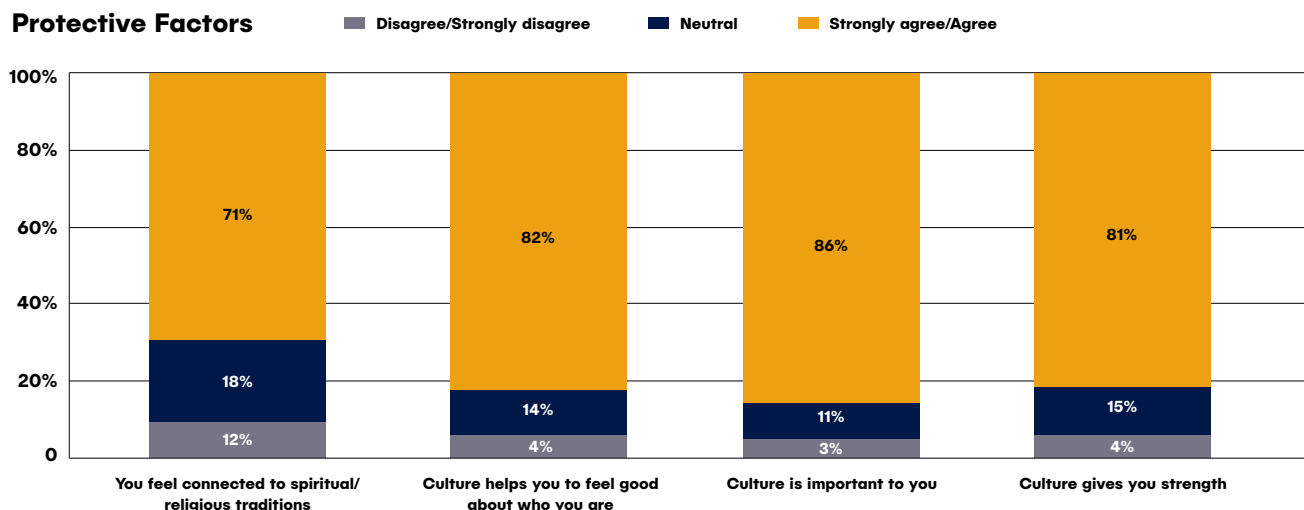
- At CDEP program entry, most adults indicated that their culture was protective and stabilizing. Adults agreed/strongly agreed that culture: is important to them (86%), helps them feel good (82%), and gives them strength (81%) (See Figure 6.20). While fewer adults endorsed feeling highly connected to their spiritual/religious traditions (71%), it remained a protective factor for many adults.
 - When considering the past 30 days, adults felt less balanced in mind/body/spirit (46% all or most of the time) and connected to their culture (58% all or most of the time) (See Figure 6.20).
- Approximately, one-in-two adults had a risk factor for feeling socially marginalized or isolated from the broader society. Specifically, 56% felt marginalized/excluded from society and 50% felt isolated/alienated from society all/most/some of the time (See Figure 6.20). These are important risk factors from the historical context of multigenerational oppression faced by many of the CDEP-served communities and ongoing racial and LGBTQ+ discrimination occurring today.

Figure 6.20: Protective and Risk Factors Among a Sample of CDEP Adult Participants

At present...

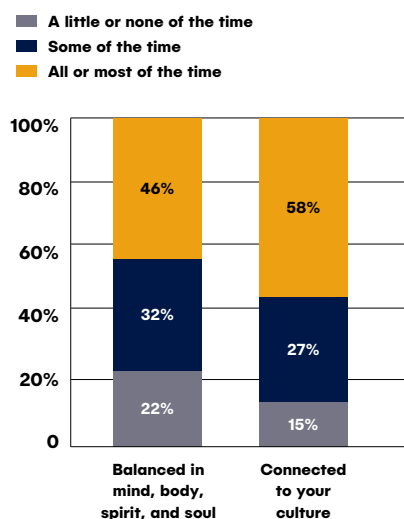
Data period: 2018-2021

Protective Factors

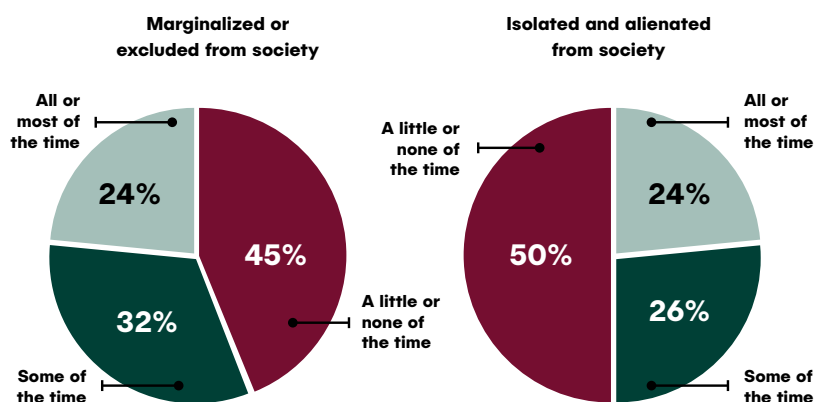


About how often during the past 30 days did you feel...

Protective Factors



Risk Factors



Baseline (pre-test) findings of protective and risk factors among a sample of CDEP adolescent participants revealed that:

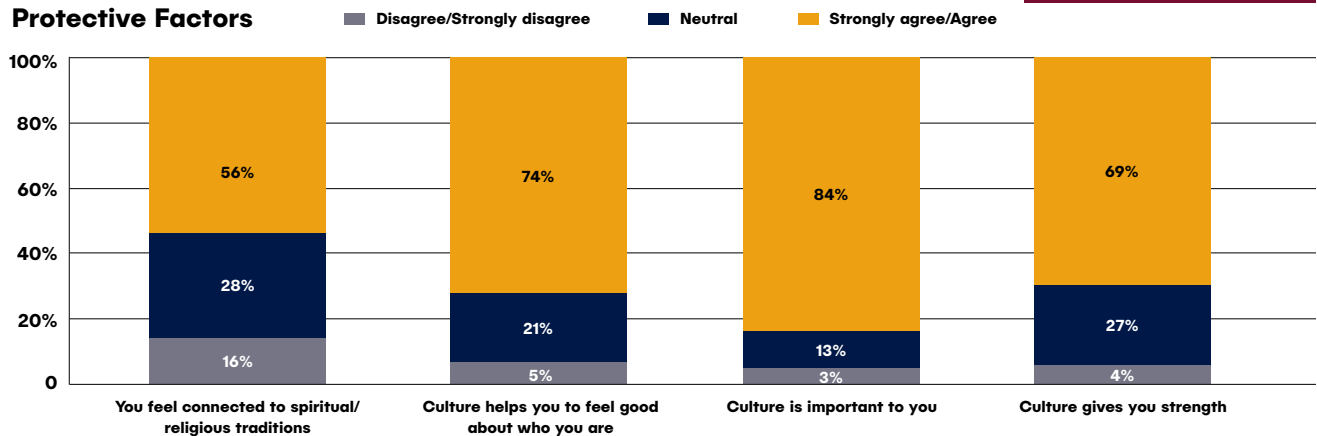
- At CDEP program entry, most adolescents indicated that their culture was protective and stabilizing. Adolescents agreed/strongly agreed that culture is important to them (84%) and helps them feel good about who they are (74%) (See Figure 6.21). Conversely, fewer adolescents endorsed that their culture gives them strength (69%) or that they felt connected to their spiritual/religious traditions (56%).
 - When considering the past 30 days, adolescents felt less balanced in mind/body/spirit (38% all or most of the time) and less connected to their culture (50% all of most of the time). (See Figure 6.21).
- Nearly one in two adolescents had a risk factor for loneliness while one in three felt isolated from the broader society. Specifically, 46% felt marginalized/excluded and 42% felt isolated/alienated from society all/most/some of the time (See Figure 6.21). Again, in the context of communal culture, these indices of disconnection are critical risk factors that can undermine wellbeing and mental health.

Figure 6.21: Protective and Risk Factors Among a Sample of CDEP Adolescent Participants

At present for Adolescent...

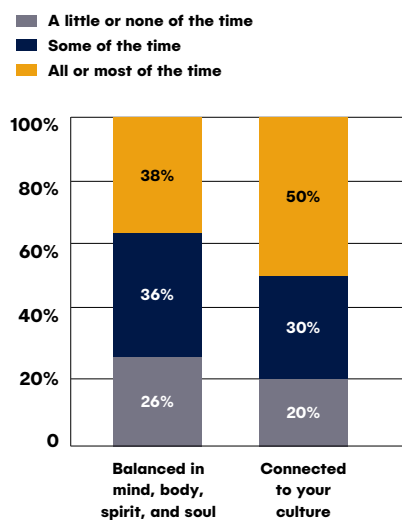
Data period: 2018-2021

Protective Factors

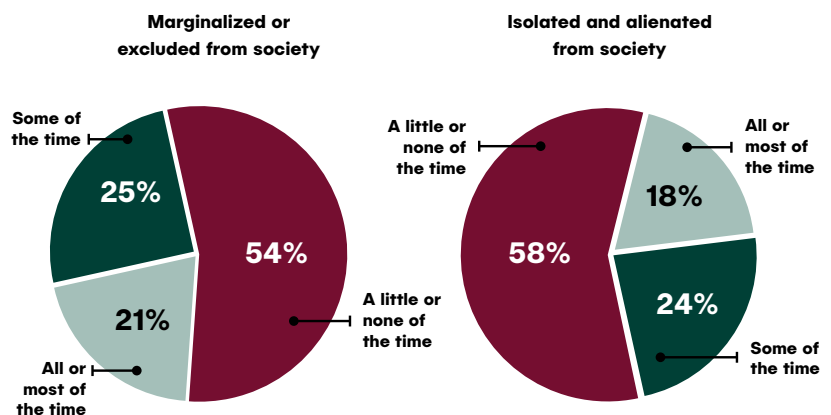


About how often during the past 30 days did you feel...

Protective Factors



Risk Factors



6.1.B.VI MENTAL HEALTH STIGMA/BARRIERS AMONG INDIVIDUALS SERVED

Barriers to mental health treatment services were assessed by asking adult and adolescent participants about their reasons for NOT seeking help from a mental health professional such as a counselor, therapist, psychologist, psychiatrist, or social worker, even when they thought they might need it. When relevant, barrier questions were asked of individuals who had a met or unmet need for mental health treatment. This is noted because researchers tend to ask about barriers only for those who have an unmet need and not of individuals who have reported a met need. It is important to note that respondents could select “yes” to multiple barrier items. Participants were also not asked to rank items in order of importance.

Barriers or reasons for not seeking mental health treatment were organized into four groups:

- Structural (includes financial cost)
- Attitudinal
- Stigma
- Prejudice and discrimination

Most of the statewide evaluation mental health barrier items were selected from the National Survey on Drug Use and Health (NSDUH). They are primarily connected to items in the structural, attitudinal, and stigma categories for not seeking help. New items (e.g., prejudice and discrimination) were constructed in collaboration with Phase 2 partners (IPPs, TAPs, IPPs) or from qualitative studies focused on the types of barriers adolescents face when seeking mental health services.

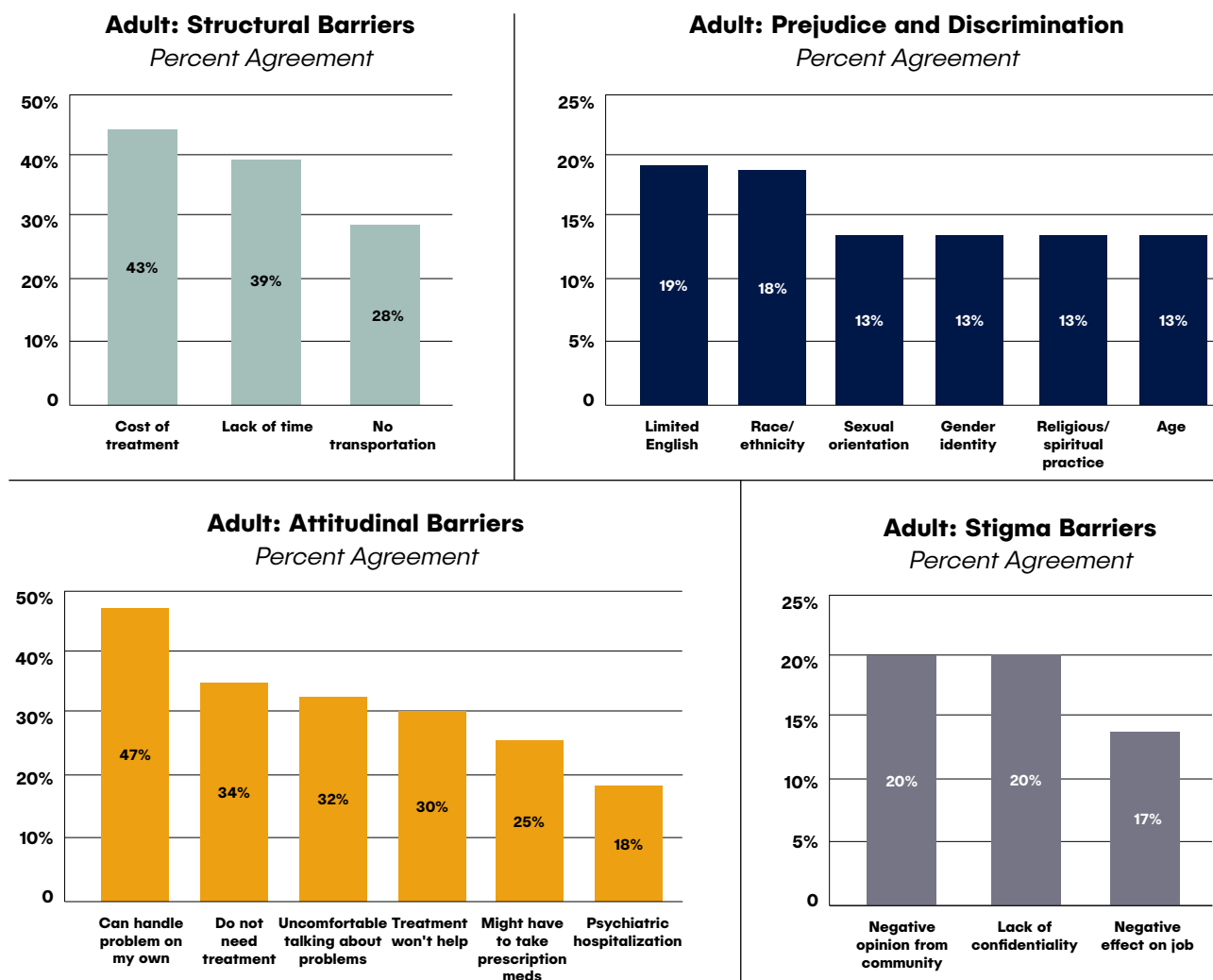
The statewide evaluation recognizes that researchers organize mental-health-barriers survey items into different groups. See Chen et al. (2013) for more information on what informed the statewide evaluation grouping of the NSUDH barriers items.

- The most common reason for not seeking mental health treatment for both adults and adolescents was an attitudinal barrier.
 - › Nearly one in two (47%) adults “can handle the problem on my own.”
 - › Nearly two in three (65%) adolescents “can solve the issue on my own.”
- For adults, the second most common reason for not seeking mental health treatment was related to structural barriers.
 - › Over one in three adults endorsed “cost of treatment” (43%) or “lack of time” (39%) as barriers.
- For adolescents, the second most common mental health treatment barriers for adolescents were stigma-related. One in three (33%) worried about receiving a “negative opinion from friends/family” and another 33% “felt embarrassed.”

These findings are important because they shed light on the tendency to assume stigma is a primary driver in deferring help seeking among adults and youth of color or LGBTQ+ adults and youth. Greater attention is needed on attitudinal and structural factors as well. (Refer to Figures 6.22 and 6.23 for more details.)

Figure 6.22: Barriers to Mental Health Care Services Among a Sample of CDEP Adult Participants

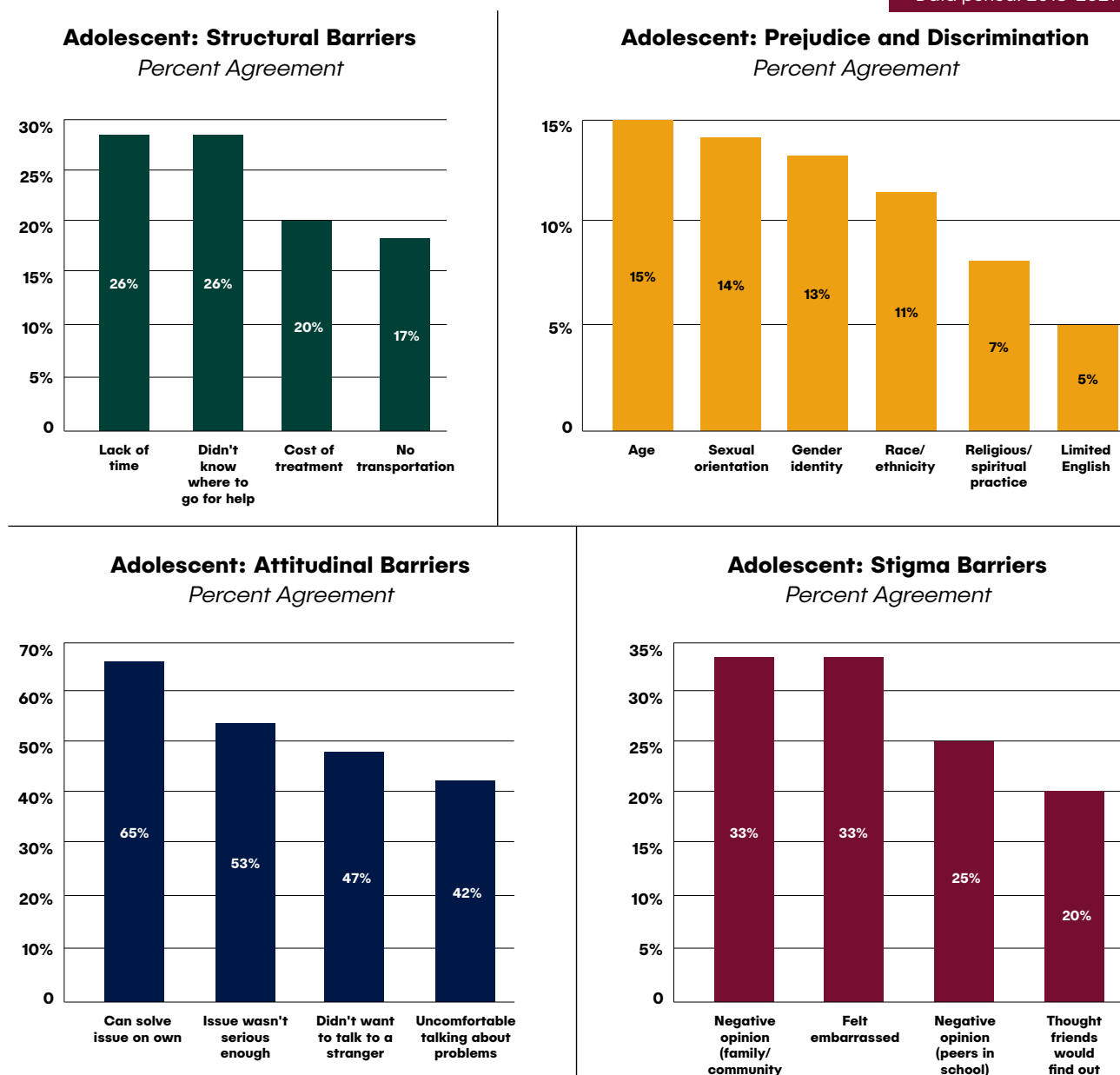
Data period: 2018–2021



*Due to skip sequencing embedded in the “stigma/barriers” section of the pre-test questionnaire, the adult sample size varied for each item (the lowest “n” for the was equal to 1,493 and the highest “n” equal to 1,570).

Figure 6.23: Barriers to Mental Health Care Services Among a Sample of CDEP Adolescent Participants

Data period: 2018–2021



*Due to skip sequencing embedded in the “stigma/barriers” section of the pre-test questionnaire, the adolescent sample size varied by item (the lowest “n” for the adolescent sample was equal to 368 and the highest “n” equal to 407).



6.1.C QUALITY

6.1.C.I PROGRAM SATISFACTION

Goal 2 of the CRDP Strategic Plan to Reduce Mental Health Disparities is to:



Improve the Quality of Mental Health Services for Unserved, Underserved and Inappropriately Served Populations.”

(California Pan-Ethnic Health Network, 2018)

Program satisfaction data was obtained from the statewide evaluation CDEP participant questionnaire post-test administered from June 2018 to June 2021. The post-test satisfaction data includes items from the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey and the Consumer-Based Cultural Competency Inventory (CBCI) (Cornelius, et al., 2004).

The MHSIP has been used for over 20 years nation-wide. It assesses concerns that are important to consumers of publicly funded mental health services. In California, the MHSIP is part of the mandated State Performance Outcomes System used with all outpatient and day treatment providers (i.e., directly operated and contracted programs) in every county (Department of Health Care Services, 2021a). Counties typically collect this data on a semi-annual basis for the purpose of service planning and quality improvement.

The MHSIP Consumer Survey was designed to measure consumer satisfaction (children, youth, adults, families) across seven domains established at the national level by Substance Abuse and Mental Health Services Administration (SAMHSA). These subscale domains are:

- General Satisfaction
- Perception of Access
- Perception of Quality and Appropriateness
- Perception of Participation in Treatment Planning
- Perception of Outcomes
- Perception of Functioning
- Perception of Social Connectedness

To reduce CDEP participant and IPP organization response and administration burden, only four subscale domains were identified as most essential through a CRDP-wide community review process and included in the statewide evaluation CDEP participant questionnaire. All MHSIP subscales items were vetted during a Phase 2 community review process. Three adult subscale domains consisting of nine items and four adolescent subscale domains consisting of 18 items were used. Table 6.8 provides an overview of the specific MHSIP domains selected (and their corresponding number of adult and adolescent subscale items).

Table 6.8: Evaluation’s CDEP Participant Questionnaire by Age Group

MHSIP Domains (# of items)	Number of MHSIP Subscale Domain items included in Statewide Evaluation CDEP Participant Questionnaire by Age (# of items included)	
	Adult	Adolescent
General Satisfaction – Consumers’ satisfaction with services received	3 of 3 items	5 of 6 items
Access – Consumers’ perception of service accessibility	3 of 6 items	2 of 2 times
Access – Consumers’ perception of treatment outcomes as a result of receiving services	3 of 12 items	7 of 7 items
Access – Consumer’s perceptions of treatment and its impact on their social support network	N/A	4 of 4 items

MHSIP items from a total of 2,427 post-questionnaires were included in this analysis:

- Adult (18+ years): N=1,952
- Adolescent (12-17 years): N=475

Among the adult sample 1,952 MHSIP post-tests were collected from 63% (n=22) of all IPPs. The number of IPPs completing the MHSIP for adults ranged from four to six IPPs per hub. (See Table 6.9).

Table 6.9: Post-Test: Adult (18+ years) IPP Representation and Sample Size by Hub and CRDP Overall

HUB	IPP Distribution by Hub		Adult Sample Size (Highest n's and percentages highlighted in green)		
	#	% of the Hub	Sample Size	% CRDP Overall Representation	Range Per IPP
AfAm ¹	4	57%	n=254	13%	12 to 99
AI/AN ²	3	71%	n=168	8%	10 to 93
AANHPI ³	5	71%	n=754	37%	51 to 353
Latinx ⁴	6	85%	n=597	31%	21 to 338
LGBTQ+ ⁵	4	57%	n=179	9%	16 to 82
CRDP Overall	22 IPPs		N=1,952		

¹ While four IPPs are noted for the AfAm hub, one of these four IPPs contributed to less than 10% of the sample.

² While three IPPs are noted for the AI/AN hub, one IPP contributed to less than 10% of the sample.

³ While five IPPs are noted for the AANHPI hub, one IPP contributed to less than 10% of the sample.

⁴ While six IPPs are noted for the Latinx hub, one IPP contributed less than 5% of the sample.

⁵ While four IPPs are noted for the LGBTQ+ hub sample, one IPP contributed less than 10% of the sample.

While adolescent MHSIP data were collected by IPPs from all five priority population hubs, there was lower overall IPP adolescent representation compared to adults. One to five IPPs per hub (40% of IPPs totaling 14 IPPs) collected MHSIP adolescent data. (See Table 6.10).

Table 6.10: Post-Test: Adolescent (12-17 years) IPP Representation and Sample Size by Hub and CRDP Overall

HUB	IPP Distribution by Hub		Adult Sample Size (Highest n's and percentages highlighted in green)		
	#	% of the Hub Representation	Sample Size	% CRDP Overall Representation	Range Per IPP
AfAm	3	43%	n=111	23%	25 to 59
AI/AN ¹	5	71%	n=109	23%	1 to 42
AANHPI	1	14%	n=45	9%	N/A
Latinx	2	29%	n=131	28%	25 to 106
LGBTQ+ ²	3	43%	n=79	17%	2 to 68
CRDP Overall	14 IPPs		N=475		

¹ While five IPPs are noted for the AI/AN hub, one IPP contributed less than 10% of the sample and one IPP less than 1% of the sample.

² While three IPPs are noted for the LGBTQ+ hub, one IPP contributed less than 5% of the sample.

The four domain subscales were measured on a 5 Point Likert scale with 1 = Strongly Disagree, 2 = Disagree, 3 = I am Neutral, 4 = Agree and 5 = Strongly Agree. Scale reliability was assessed using the Cronbach’s coefficient alpha. The value for Cronbach’s Alpha for the MHSIP survey items ranged from $\alpha = .86$ to $.90$ for adults and $\alpha = .86$ to $.92$ for adolescents. Mean scores and standard deviations were calculated for all four subscales. SAMHSA’s Center for Mental Health Services (CMHS) recommends calculating the percent of scores greater than 3.5 (i.e., percent agree and strongly agree) for each domain and for individual scale items. Prompts for items were: “Please answer the questions based on the services, program, or activities connected to [name of CDEP]” or “As a direct result of my involvement in the program...”

The mean scores were 4.52 for Adult General Satisfaction, 4.44 for Access, and 4.06 for Outcomes. The highest percentage of adult respondents scoring 3.5 or above was found for General Satisfaction at 96% and Access at 93%.

Subscale items with the highest and lowest percentage of Strongly Agree/Agree included:

- I like the services that I received here: 97% (General Satisfaction).
- I would recommend this agency to a friend or family member: 97% (General Satisfaction).
- Services were available at times that were good for me: 95% (Access).
- I do better in school and/or work: 81% (Outcomes).
- My symptoms/problems are not bothering me as much: 76% (Outcomes).

See Table 6.11 for a detailed summary of item scores by subscale domain.

The mean scores were 3.88 for Adolescent General Satisfaction, 3.76 for Access, 3.59 for Outcomes, and 3.92 for Social Connectedness. (See Table 6.11).

Table 6.11: CRDP Overall Percentage of CDEP Respondents Scoring 3.51 or above on Four MHSIP* Subscale Domains

MHSIP Domains	Adult (N=1,952)			Adolescent (N=475)		
	Mean (SD)	Percentage Scoring $\geq 3.5^*$	#IPPs	Mean (SD)	Percentage Scoring $\geq 3.5^*$	#IPPs
General Satisfaction	4.52 (0.56)	96%	n=22	3.88 (0.92)	74%	n=14
Access	4.44 (0.61)	93%		3.76 (1.00)	68%	
Outcomes	4.06 (0.72)	80%		3.59 (0.90)	62%	
Social Connectedness	N/A	N/A		3.92 (0.97)	77%	

*Note: All MHSIP items use a 5-point Likert scale (1 = Strongly Disagree and 5 = Strongly Agree). SAMHSA’s Center for Mental Health Services (CMHS) recommends calculating the percent of scores greater than 3.5 (i.e., percent agree and strongly agree) for each domain and for individual scale items.

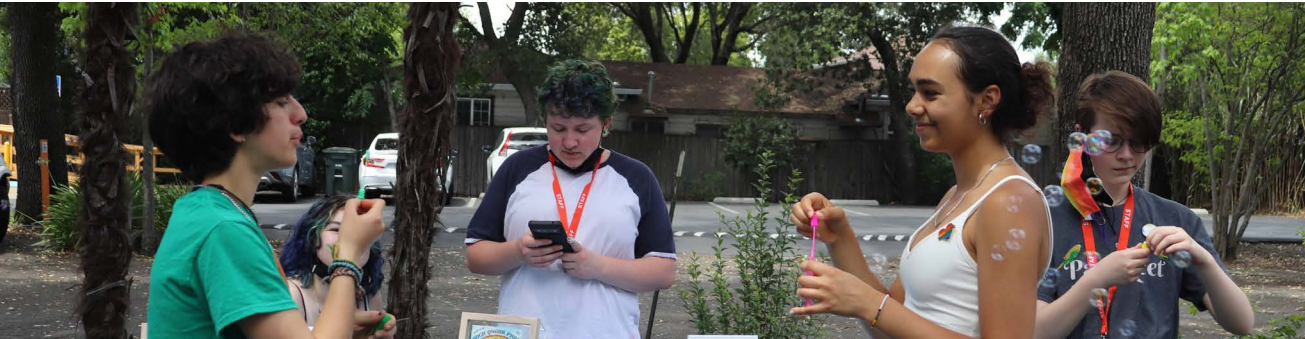


Table 6.12: CRDP Overall Percentage of CDEP Respondents Scoring 3.51 or above on MHSIP Subscale Items

Subscale Domains	MHSIP Adult Items (N=1,952)	% Strongly agree/ agree	MHSIP Adolescent items (N=475)	% Strongly agree/ agree
--Highest and lowest percentages across subscale items are in bold--				
General Satisfaction Subscale (Please answer based on the CDEP services, program, or activities)	I like the services that I received here.	97%	Overall, I am satisfied with the services I received.	75%
	If I had other choices, I would still get services from this agency.	95%	The people helping me stuck with me no matter what.	76%
	I would recommend this agency to a friend or family member.	97%	I felt I had someone to talk to when I was troubled.	71%
			I received services that were right for me.	73%
			I got the help I wanted.	74%
Access Subscale (Please answer based on the CDEP services, program, or activities)	The location of services was convenient.	91%	The location of services was convenient for me.	69%
	Services were available at times that were good for me.	95%	Services were available at times that were convenient for me.	68%
	Staff were willing to see me as often as I felt it was necessary.	95%		
Outcomes Subscale (As a direct result of my involvement in the program...)	I deal more effectively with my daily problems.	84%	I am better at handling daily life.	63%
	I do better in school and/or work. ¹	81%	I am doing better in school and/or work.	59%
	My symptoms/ problems are not bothering me as much.	76%	I get along better with friends and other people.	66%
			I get along better with family members.	58%
			I am better able to cope when things go wrong.	62%
			I am satisfied with my family life right now.	55%
			I am better able to do things I want to do.	68%
Social Connectedness Subscale (As a direct result of my involvement in the program...)			I know people who will listen and understand me when I need to talk.	74%
			I have people that I am comfortable talking with about my problem(s).	75%
			In a crisis, I would have the support I need from family or friends.	76%
			I have people with whom I can do enjoyable things.	83%

¹ The valid sample size for "I do better in school and/or work" was N=1,506 as 20% (n=387) of adult respondents selected "Not Applicable" indicating they were not presently in work or school.

The highest percentage of adolescent scores at 3.51 or above were in the subscale domains of Social Connectedness at 77%, followed by General Satisfaction at 74% and Access at 68%. The highest percent of endorsed Strongly Agree/Agree subscale items were:

- I have people with whom I can do enjoyable things: 83% (Social Connectedness).
- In a crisis, I would have the support I need from family or friends: 76% (Social Connectedness).
- The people helping me stuck with me no matter what: 76% (General Satisfaction).
- I have people that I am comfortable talking with about my problem(s): 75% (Social Connectedness).

From a cultural perspective, the above finding is noteworthy for communities of color that are often communal in nature. Communal cultures stress the interdependence of members of the community, attribute success to loved ones, and highlight that success was achieved as a group with the assistance of many people. As such, relational ties form the foundation for health and well-being. Establishing strong relationships is essential as seen by the high levels of endorsement of social connectedness endorsed by both youth and adults. These relational ties (social connectedness) serve as the foundation for other behavioral and psychological changes.

The lowest percentage of adolescent scores at 3.51 or above were in the outcomes subscale at 62%. The lowest percent of endorsed Strongly Agree/Agree subscale items were:

- I am doing better in school and/or work: 59% (Outcomes).
- I get along better with family members: 58% (Outcomes).
- I am satisfied with my family life right now: 55% (Outcomes).

The MHSIP includes only a handful of items that assess consumer cultural and linguistically appropriate service provision satisfaction. As a result, only two items were added to the SWE participant questionnaire post-test related to language assistance. Nearly all adult respondents reported that the services they received were in the language they preferred (99%), and that written information was available to them in the language they preferred (98%) (see Table 6.13). Based on responses to these items, only 2% or less of adults did not receive language assistance. While still quite high, adolescent respondents had slightly lower levels of agreement with these two items (91% and 90% respectively). Nonetheless, most adolescents concurred that the CDEPs provided both oral and written language assistance (10% or less did not receive language assistance).

Table 6.13: MHSIP Language Assistance Items (written, oral)

Items	Adult (N=1,952)	Adolescent ¹ (N=430)
Were the services you received [CDEP program] in the language you prefer?	99%	91%
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?	98%	90%

¹ Note: Data for the adolescent sample is reflective of 12 IPPs; two IPPs used a modified version of the CDEP Participant Questionnaire that did not include these items.

While the MHSIP is a widely used, reliable measure that assesses many important dimensions of service and care, it does not examine a consumer's experience with receiving effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices and other communication needs. PARC considered this to be an essential component to assessing CDEP quality (i.e., to what extent did CDEPs render culturally responsive services to culturally and ethnically diverse clients, including other marginalized communities?) The Consumer-Based Cultural Competency Inventory (CBCI) (Cornelius, et al., 2004) is a 52-item scale with eight subscales. It was identified by the Statewide Evaluation as a reliable and valid measure to assess CDEP cultural and linguistically responsive service provision. The measures' eight subscales are:

- Awareness of Patients' Culture subscale
- Respectful Behaviors subscale
- Language Interpreter Issues subscale
- Understanding of Indigenous Practices subscale
- Consumer Involvement subscale
- Acceptance of Cultural Differences subscale
- Community Outreach subscale
- Patient-Provider-Organization Interactions subscale

Like the MHSIP, only a select number of CBCI subscales were included in the statewide evaluation cross-site measure to reduce survey administration and response burden. Subscales and items deemed most essential for measuring CDEP cultural responsiveness were selected during the community feedback process. Adaptations were made to some of the CBCI items including the development of new items. Table 6.14 provides an overview of the CBCI subscales (and the number of items) included in the statewide evaluation's CDEP participant questionnaire post-test by age group.

Table 6.14: CBCI Subscale Domains Included in the Statewide Evaluation's CDEP Participant Questionnaire by Age

CBCI Subscale (# of items)	Subscale Domains included by Age (# of items included)	
	Adult	Adolescent
Respectful Behavior: Consumers' perception of feeling respected.	3 of 8 items (+2 new items developed)	2 of 8 items (+2 new items developed)
Patient-Provider-Organization Interactions: Consumers' perception that the care provided is client-centered.	1 of 8 items	N/A
Understanding of Indigenous Practices: Consumers' perception of a provider being aware of culturally relevant healing practices.	1 of 4 items	N/A
Acceptance of Cultural Differences: Consumer's perceptions of a provider being sensitive and responsive to cultural differences.	2 of 6 items (+2 new items developed)	N/A

The CBCI subscales were all measured on a 5-Point Likert scale with 1 = Strongly Disagree, 2 = Disagree, 3 = I am Neutral, 4 = Agree and 5 = Strongly Agree. Given the small number of items used for each subscale, scale reliability was not assessed, nor were mean scores or standard deviations calculated for each subscale. Percent of scores greater than 3.5 (i.e., percent Agree and Strongly Agree) were calculated for all individual scale items. Prompts for items were: "Please answer the questions based on the services, program, or activities connected to [name of CDEP]."

In general, the adult sample rated CDEPs high on respectful behaviors. Particularly high ratings (percent Strongly Agree/Agree) in the adult sample were found for all five items. The adolescent sample had more variability than adults related to respectful behaviors by the CDEP. The highest and lowest percents for Strongly Agree/Agree for the adolescent sample were:

- The staff here treat me with respect: 82%.
- Staff were sensitive to my cultural/ethnic background: 66%.

Table 6.15 provides a summary of Respectful Behavior subscale item scores for both adult and adolescent age groups.



Table 6.15 CRDP Overall Percentage of CDEP Respondents Scoring 3.51 or above on (1) CBCI Subscale Items by Age Group

Subscale Domains	CBCI Adult Items (N=1,952)	% Strongly agree/agree	CBCI Adolescent items (N=433 ¹)	% Strongly agree/agree
Respectful Behavior (Please answer based on the CDEP services, program, or activities)	The staff here treat me with respect.	97%	Staff treated me with respect.	82%
	The staff here don't think less of me because of the way I talk.	95%	Staff spoke with me in a way that I understood.	79%
	The staff here respect my race and/or ethnicity.	98%	Staff were sensitive to my cultural/ethnic background.	66%
	The staff here respect my religious and/or spiritual beliefs.	96%	Staff respected my religious/spiritual beliefs.	77%
	The staff here respect my gender identity and/or sexual orientation.	97%		

¹ Data for the adolescent sample is reflective of 13 IPPs; one IPP used a modified version of the CDEP participant questionnaire that did not include the CBCI items.

In general, the adult sample rated CDEPs high on patient-provider-organization interactions, understanding of indigenous practices, and acceptance of cultural differences. Participants felt their cultural beliefs, remedies and healing practices were respected (97% Strongly Agree/Agree); CDEP staff understood their affinity group's gender and/or sexual orientation diversity (97% Strongly Agree/Agree); and that CDEP staff their group's religious and spiritual diversity (95% strongly agree/agree). (See Table 6.16).

Table 6.15 CRDP Overall Percentage of CDEP Respondents Scoring 3.51 or above on (1) CBCI

Subscale Domains	CBCI Adult Items (N=1,952)	% Strongly agree/agree
--Highest and lowest percentages across subscale items are in bold--		
Patient-Provider-Organization Interactions (Please answer based on the CDEP services, program, or activities)	When I first called or came here, it was easy to talk to the staff.	95%
Understanding of Indigenous Practices (Please answer based on the CDEP services, program, or activities)	Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	96%
Acceptance of Cultural Differences (Please answer based on the CDEP services, program, or activities)	The people who work here respect my cultural beliefs, remedies, and healing practices.	97%
	Staff here understand that people of my racial and/or ethnic group are not all alike.	96%
	Staff here understand that people of my gender and/or sexual orientation group are not all alike.	95%
	Staff here understand that people of my religious and spiritual background are not all alike.	95%

6.1.C.II LANGUAGE ASSISTANCE PROVIDED

Goal 2, Strategy 10 of the CRDP Strategic Plan (i.e., Build and Sustain a Culturally, Linguistically, and LGBTQ+- Competent Workforce) is designed to



Ensure Linguistic Access to Mental Health Services: The CRDP Partners recommend the state legislature provide additional resources for DHCS to fund – and county departments of mental health and local service providers to implement – comprehensive approaches to improve linguistic access for all clients of all MHSA-funded programs.”

(California Pan-Ethnic Health Network, 2018)

Data for these findings were derived from IPP semi-annual reports spanning a four-year period from May 2017 to April 2021.

Within the CRDP Phase 2 initiative, 49% (n=17) of IPPs formally contributed to improving the quality of mental health services for unserved, underserved, and inappropriately served populations by providing direct services to CDEP participants in 15 languages. As seen in Table 6.17, all five priority population hubs provided linguistic access (AfAm=1 IPP, AANHPI=5 IPPs, AI/AN=1 IPP, Latinx=7 IPPs, LGBTQ+=3 IPPs).

Specifically:

- Three hubs (AfAm, Latinx, LGBTQ+) provided CDEP direct services in Spanish.
- The AANHPI hub provided direct services in eight languages.
- The AI/AN and Latinx hubs provided direct services for four native/indigenous languages.
- The LGBTQ+ hub provided direct services in American Sign Language.

Table 6.17: Non-English Languages Served by Priority Population

Priority Population	# of Non-English Languages (# of IPPs)	Non-English Languages Served by Age Groups
AfAm	2 (n=1 IPP)	Arabic (Age groups: TAY, Adolescent) Spanish (Age groups: TAY, Adolescent)
AANHPI	8 (n=5 IPPs)	Arabic (Age groups: Adult, TAY, Adolescent) Dari (Age groups: Adult, TAY, Adolescent) Hmong (Age groups: Adult, TAY) Khmer (Age groups: Adult, TAY) Korean (Age groups: Adult) Pashto (Age groups: Adult, TAY, Adolescent) Urdu (Age groups: Adult, TAY, Adolescent) Vietnamese (Age group: Adult)
AI/AN	2 (n=1 IPP)	Lakota (Age group: Adult) Navajo (Age group: Adult)
Latinx	3 (n=7 IPPs)	Spanish (Age groups: Adult, TAY, Adolescent) Mixteco (Age group: Adult) Maya-mam (Age group: Adult)
LGBTQ+	2 (n=3 IPPs)	American Sign Language (Age groups: Adult, Adolescent) Spanish (Age groups: Adult, TAY, Adolescent, Children)
Total	14 languages (n=17 IPPs)	

6.1.C.III WORKFORCE DEVELOPMENT

Goal 2, Strategy 8 of the CRDP Strategic Plan (i.e., Build and Sustain a Culturally, Linguistically, and LGBTQ+ Competent Workforce) states the following:



To improve the cultural and linguistic competence of mental health services, the CRDP Partners recommend that the state legislature fund OSHPD to focus on creating and supporting a well-trained and culturally, linguistically, LGBTQ+-responsive workforce, through promoting careers to youth and parents; ensuring cultural competency training in mental health career training; resources for staff to attend training; and expanded opportunities for community health workers.”

(California Pan-Ethnic Health Network, 2018)

Data for these findings were derived from IPP semi-annual reports spanning a four-year period from May 2017 to April 2021.

Within the CRDP Phase 2 initiative, 40% (n=14) of IPPs formally contributed to improving the quality of mental health services for unserved, underserved, and inappropriately served populations by including a formal¹⁶ workforce development component in their CDEP. Four priority population hubs consisting of 14 IPPs (AfAm=2 IPPs, AANHPI=2 IPPs, Latinx=5 IPPs, LGBTQ+=5 IPPs) offered workforce development. These 14 IPPs built and sustained a culturally, linguistically, and LGBTQ+-responsive workforce using three primary strategies described below. Nine of the 14 IPPs used one strategy, four IPPs used two strategies, and one IPP used all three.

Strategy 1: Pipeline (n=6 IPPs): Promoted careers or expanded opportunities in community health/mental health with youth, parents, and/or adults with lived experience from the priority communities by providing formal training to become a peer counselor, community *promotor*/health worker, youth leader, etc.

Strategy 2: IPP/Partner Capacity (n=7 IPPs): Trained internal CDEP staff (e.g., program managers/coordinators, advocates, therapists, counselors, psychologists, and graduate-level mental health interns/trainees), as well as community volunteers or organizational partner staff.

Strategy 3: Community-wide Capacity (n=7 IPPs): Provided training and/or technical assistance to non-CDEP mental health workers in private or public agencies (e.g., therapists, counselors, psychologists, graduate-level mental health interns/trainees) or first responders (e.g., school personnel, law enforcement, health providers, other service providers) located in the communities served by the CDEPs.

In total, 14 IPPs offered 311 workforce activities from May 2017 to April 2021. Workforce development was an especially prominent strategy for the LGBTQ+ hub, which offered 61% of the total number of the workforce development activities.

Figure 6.24 provides an overview of the formal CRDP Phase 2 workforce development activities. In summary:

- Nearly two-thirds (65%) of the activities were held with external non-CDEP workers, 32% were in-house with CDEP staff, and 4% were held with both.
- IPPs engaged CDEP and non-CDEP workers in 12,143 program touchpoints (i.e., workers were counted each time they participated in a training and/or technical assistance activity).
 - › These workforce activities and program touchpoints reflected approximately 1,243 sessions and 22,922 hours of training or technical assistance.

¹⁶ The 14 IPPs designated as having a “formal” workforce development component was based on IPP CDEP self-descriptions in their OHE-approved IPP local evaluation plans.

- Close to one-third (30%) of those engaged were community members, while over half (52%) were mental health workers (e.g., therapists, counselors, psychologists, graduate-level mental health interns/trainees) or first responders (59%).
 - The primary types of first responders included: 29% school personnel, 26% service providers, 7% health workers, and 3% law enforcement.
- There was considerable multilingual diversity spanning 18 languages (e.g., Hindi, Spanish, Zapoteco, Pashto).
- The racial backgrounds of the workforce trained represented all five Phase 2 priority populations: 71% Latinx, 50% LGBTQ+, 43% AANHPI, 42% AfAm, and 9% AI/AN.
- The top training and technical assistance topics covered were cultural attunement (9 IPPs), mental health issues (9 IPPs), LGBTQ+ response (7 IPPs), and mental health/health career development (7 IPPs).

Figure 6.24: CRDP Overall Formal Workforce Development Activity Summary (n=14 IPPs)

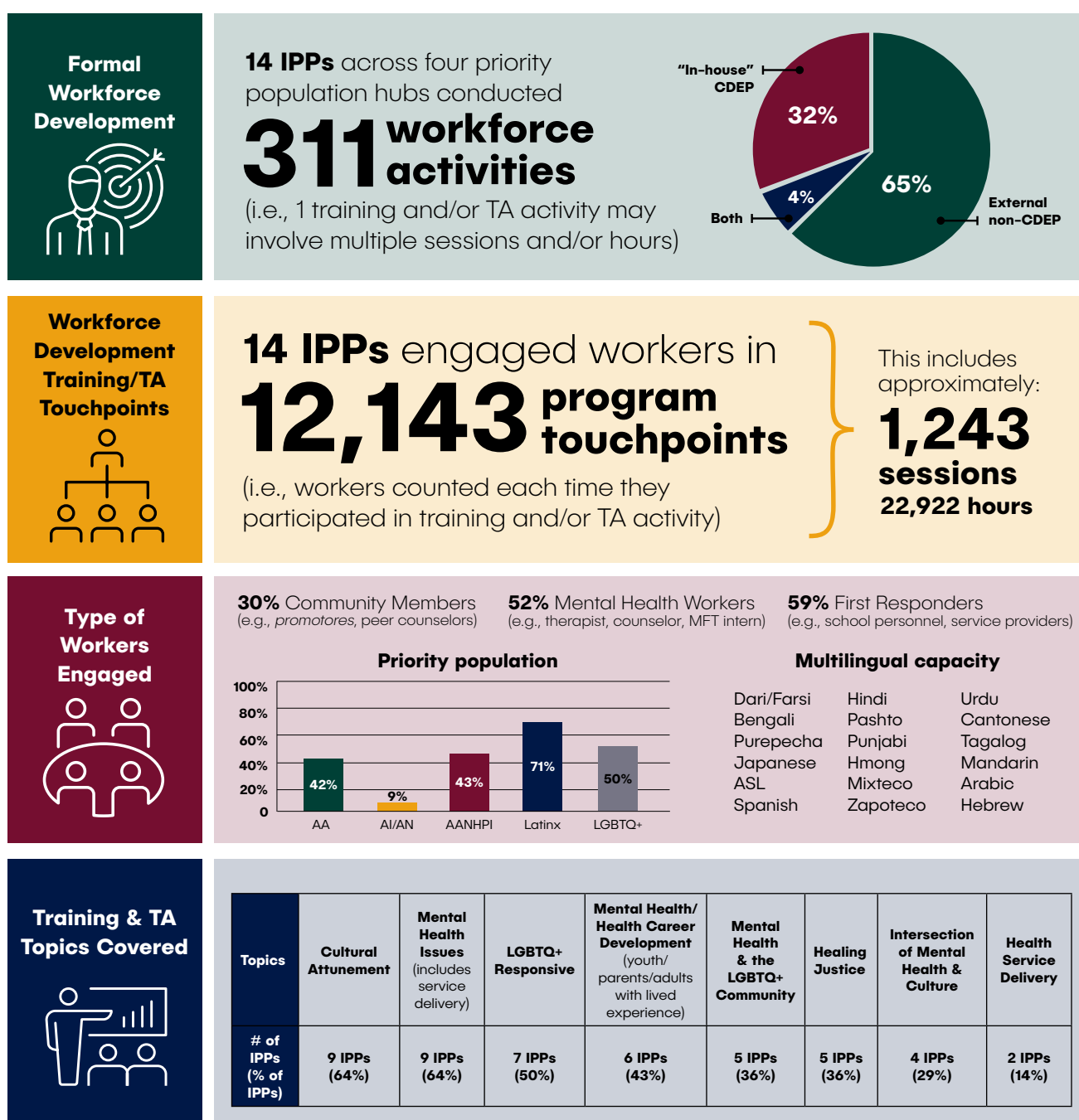


Table 6.18 provides a summary of the eight primary training and technical assistance topics.

Table 6.18: Examples of Formal Training & TA Topics Covered in Workforce Development Sessions (N=14)

Topics	# of IPPs (% of IPPs)	Examples of Topics Covered
Cultural Attunement	9 (64%)	Black parent outreach/engagement; building an inclusive school climate for Black students; street outreach with Black youth; Black community, culture, and environment; Building trust/social capital in the Asian American community; Conducting effective outreach in the Asian American community; Outreach strategies with Latinx farm workers and their families; Farmworker labor rights; Latinx migrant indigenous community needs; Integrating physical health and mental health prevention in working with the Latinx community; Cultural humility.
Mental Health Issues (including Service delivery)	9 (64%)	Issues: Trauma 101; Understanding suicide and self-harm; Somatic awareness and strategies for supporting and treating anxiety in clients; Anxiety/depression; Stress-reduction; Building self-esteem; Conflict resolution/communication skills; Substance use challenges including co-occurring recovery; Crisis response services; Signs of addiction and mental health problems; Cycle of domestic violence; Parenting stress; Suicide prevention (including Question, Persuade, Refer training); Mental health first aid certificate training. Service Delivery: Used case logs/data tracking systems/action plans; Conducted intakes; Mandated reporting 101; Assessment/screening tools (suicide, depression); Integrated care; Partnership with other providers; Motivational interviewing for substance use; Local mental health services and other resources.
LGBTQ+ Responsive	7 (50%)	Affirming care/affirming interactions; SOGI 101; foundations of gender; Understanding LGBTQ+ persons/experience; Trans healthcare basics; Creating inclusive schools; Using inclusive language; Connecting LGBTQ+ persons to local resources; Reaching and serving LGBTQ youth and seniors; Family acceptance; LGBTQ terms and issues in Spanish; Reaching and serving LGBTQ youth and seniors in Spanish; Best practices for SOGI data collection; Best practices for schools and medical providers; Understanding LGBTQ terms and identity; LGBTQ Latinos/as and family issues; LGBTQ rights; Needs of LGBTQ residents of long-term care facilities.
Mental Health/Health Career Development (youth/parents/adults with lived experience)	7 (50%)	Panelists/storytelling skills; Peer counseling skills; Leadership skills; Class/groups facilitation and teaching skills; Role of community health workers 101; Careers/professions in health and mental health; Self-care and boundary setting.
Mental Health & the LGBTQ+ Community	5 (36%)	LGBTQ+-centric mental health management; Queer informed narrative therapy; Assessing readiness for surgery, including writing surgery clearance letters; Mental health issues surrounding the LGBTQ community; Motivational interviewing for the LGBTQ older adult community.
Healing Justice	5 (36%)	Restorative practices in the classroom for Black students; Community-building activities in the African American community; Implicit bias training; LGBTQ+ historical trauma; Mind-body-spirit healing; Building resiliency for healing of systemic and intergenerational trauma.
Intersection of Mental Health & Culture	4 (29%)	Complex trauma in communities of color; Suicide awareness and assessment training for African American and Latinx communities; Creating more culturally and linguistically appropriate services; Immigrant communities and their mental health status; Enhancing cultural humility in a mental health setting with Latinx community; Use of a depression screening tool in the Latino population.
Health Service Delivery	2 (14%)	Health care navigation; Diabetes risk assessment screening and education; Blood pressure screenings; Nutrition education and physical activity demonstrations for outreach and education; Incorporating mental health into conversation about health with patients.

While the Workforce Development Section in the IPP Semi-Annual Report was primarily intended to document formal workforce development activities from the 14 grantees who had workforce development as a formal component in their CDEP, it also remained open to other grantees to report these efforts conducted on an informal or ad-hoc basis. An additional eight grantees reported conducting workforce development activities on an informal basis. (Both approaches are summarized in Table 6.19).

Table 6.19: CRDP Overall Workforce Development Summary – Formal Only (N=14) and Formal/ Informal Combined (N=22)

	Formal	Combined Formal/Informal
Number of Hubs	4 hubs	5 hubs
Number of IPPs	14 IPPs	22 IPPs (Formal=14 IPPs + Informal=8 IPPs)
Number of Workforce Activities	311	384
Foci	65% External (non-CDEP) 32% Internal ("in-house" CDEP) 4% Both	57% External (non-CDEP) 37% Internal ("in-house" CDEP) 6% Both
Type of Workers Engaged	30% Community Members 52% Mental Health Workers 59% First Responders Type of First Responders: 29% school personnel; 26% service providers; 7% health workers; 3% law enforcement	30% Community Members 58% Mental Health Workers 55% First Responders Type of First Responders: 27% school personnel; 23% service providers; 9% health workers; 2% law enforcement
Number of Program Touchpoints	12,140	13,882
Number of Sessions	1,240	1,490
Cumulative Hours	22,922.2	23,808.2
Racial Workforce Populations Engaged	42% AfAm 9% AANHPI 71% Latinx 50% LGBTQ+	36% AfAm 14% AI/AN* 45% AANHPI 64% Latinx 44% LGBTQ+
Multilingual Capacity of Workers**	Dari/Farsi, Bengali, Purepecha, Japanese, American Sign Language, Spanish, Hindi, Pashto, Punjabi, Hmong, Mixteco, Zapoteco, Urdu, Cantonese, Tagalog, Mandarin, Arabic, Hebrew	

*While no AI/AN IPPs self-reported having a formal workforce development component, two AI/AN IPPs reported conducting informal workforce activities and are reflected in the combined data column in Table 6.19.

**Multilingual capacity of workers was only conducted for IPPs who had a formal workforce development component.

Appendix 2 provides a detailed breakdown of formal workforce development activity within each priority population hub, including a summary of formal and informal efforts combined.

6.2 MENTAL HEALTH PRIORITIES

The findings in this section present contextual information about the mental health foci of CDEP interventions (i.e., mental health problems and protective factors). It has been widely established in the literature that effective PEI programs reduce risk factors (or stressors), strengthen protective factors that can help decrease mental illness symptoms, improve impaired functioning, and stop the onset of mental disorders (World Health Organization, 2004).

These findings were derived from a qualitative thematic analysis of IPP local evaluation plans' descriptions of their CDEP purpose (see Local Evaluation Plan Spotlight). In a few cases where it was unclear or not well established in their evaluation plan, the IPP's local evaluation report was used to identify or confirm a mental health problem or protective factor.

IPP LOCAL EVALUATION PLAN SPOTLIGHT: CDEP PURPOSE

IPPs were provided guidance on how to construct a CDEP purpose statement to reflect CDPH-defined CDEP goals to prevent and/or reduce the severity of selected mental health conditions; desired outcomes of importance to their respective communities from a cultural perspective; and CDEP relationship to Phase 1 priority population strategies.

A mini template (and example) was provided to the IPPs to help them construct a statement.

Purpose Statement: The [insert name of CDEP] is a [insert program type—i.e., prevention and/or early intervention program] that aims to prevent and/or reduce [insert mental health issue(s) or problem(s)] for [insert specific priority and/or sub-populations] by decreasing [insert outcome(s)] and/or increasing [insert outcome(s)]. It is designed to address [insert recommended Phase 1 priority population strategy(s)].

The top five mental health problems IPPs focused on to prevent and/or reduce symptoms for individuals and families were:

- Depression (74%; n=26 IPPs).
- Anxiety (60%; n=21 IPPs).
- Post-traumatic stress (including historical trauma and past/current experiences of racism, prejudice, and oppression) (51%; n=18 IPPs).
- Suicidality (29%; n=10 IPPs).
- Substance use and misuse (23%; n=8 IPPs).

Table 6.20 provides a summary overall and by priority population hub.

Table 6.20: Mental Health Problems Prioritized by the CDEPs Overall and by Priority Population Hub

Mental Health Problems	% CRDP Overall (# IPPs)	AfAm (# IPPs)	AI/AN (# IPPs)	AANHPI (# IPPs)	Latinx (# IPPs)	LGBTQ+ (# IPPs)
Depression	74% (n=26)	4	3	6	7	6
Anxiety	60% (n=21)	3	2	4	6	6
Post-Traumatic Stress	51% (n=18)	4	3	5	3	3
Suicidality	31% (n=11)	-	4	3	1	3
Substance Use	23% (n=8)	2	4	1	1	-
Grief and Loss	11% (n=4)	1	2	-	1	-
Schizophrenia	3% (n=1)	-	-	-	1	-
Adjustment Disorder	3% (n=1)	-	-	-	-	1

Mental health problems have multiple determinants. While an in-depth qualitative analysis of risk factors as described by the IPPs was not conducted, IPPs described a multitude of social, environmental, and economic determinants influencing/contributing to the onset of the mental health problems for their communities. These included:

- Poverty or low wage jobs.
- Experiences of war.
- Racial injustice.
- Prejudice and discrimination.
- Historical oppression.
- Community violence.
- Alcohol and drug availability.
- Food insecurity.
- Housing instability.

Eleven IPPs identified isolation as a contributing risk factor for depression. This is important given the discussion earlier in this chapter regarding the importance of social connectedness as foundational to mental health for communities of color.

CDEPs also focused on mental health promotion (i.e., enhancing positive mental health or protective factors) to improve people's resistance to risk factors and mental illness disorders. The protective factors were organized into four ecological spheres (i.e., community, school, family, and individual/peer). Among the CDEPs:

- Nearly half (46%; n=16 IPPs) addressed community-level protective factors.
 - › The primary factor within this sphere was community connectedness (n=12 IPPs).
- About one in 10 (11%; n=4 IPPs) addressed school protective factors.
 - › Primary factors within this sphere were LGBTQ+-affirming school climate (n=2 IPPs) and youth connection/commitment to school (n=2 IPPs).
- A little over one in three (34%; n=12 IPPs) promoted family level protective factors. This protective factor promoted positive family relationships/functioning (e.g., cohesion, engagement, stability, communication, values).
- Nearly all (97%; n=34 IPPs) addressed individual/peer level protective factors
 - › Primary among these were: social support/connectedness (n=26 IPPs), cultural connectedness (n=22 IPPs), and self-system (n=13 IPPs).

See Figures 6.25 and 6.26 for a summary of the mental health problems and protective factors prioritized by the IPPs' CDEP interventions and Table 6.21 for a summary by priority population hub.

Figure 6.25: CRDP Overall Mental Health Problems Prioritized in IPP CDEP Interventions

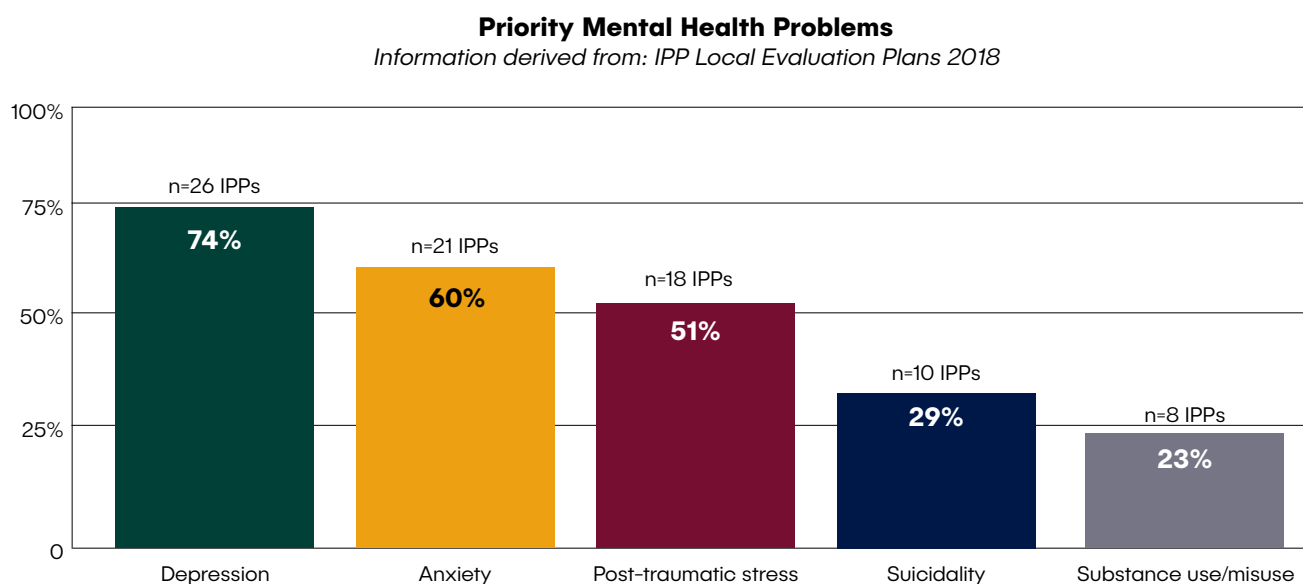


Figure 6.26: CRDP Overall Mental Health Protective Problems Prioritized in IPP CDEP Interventions

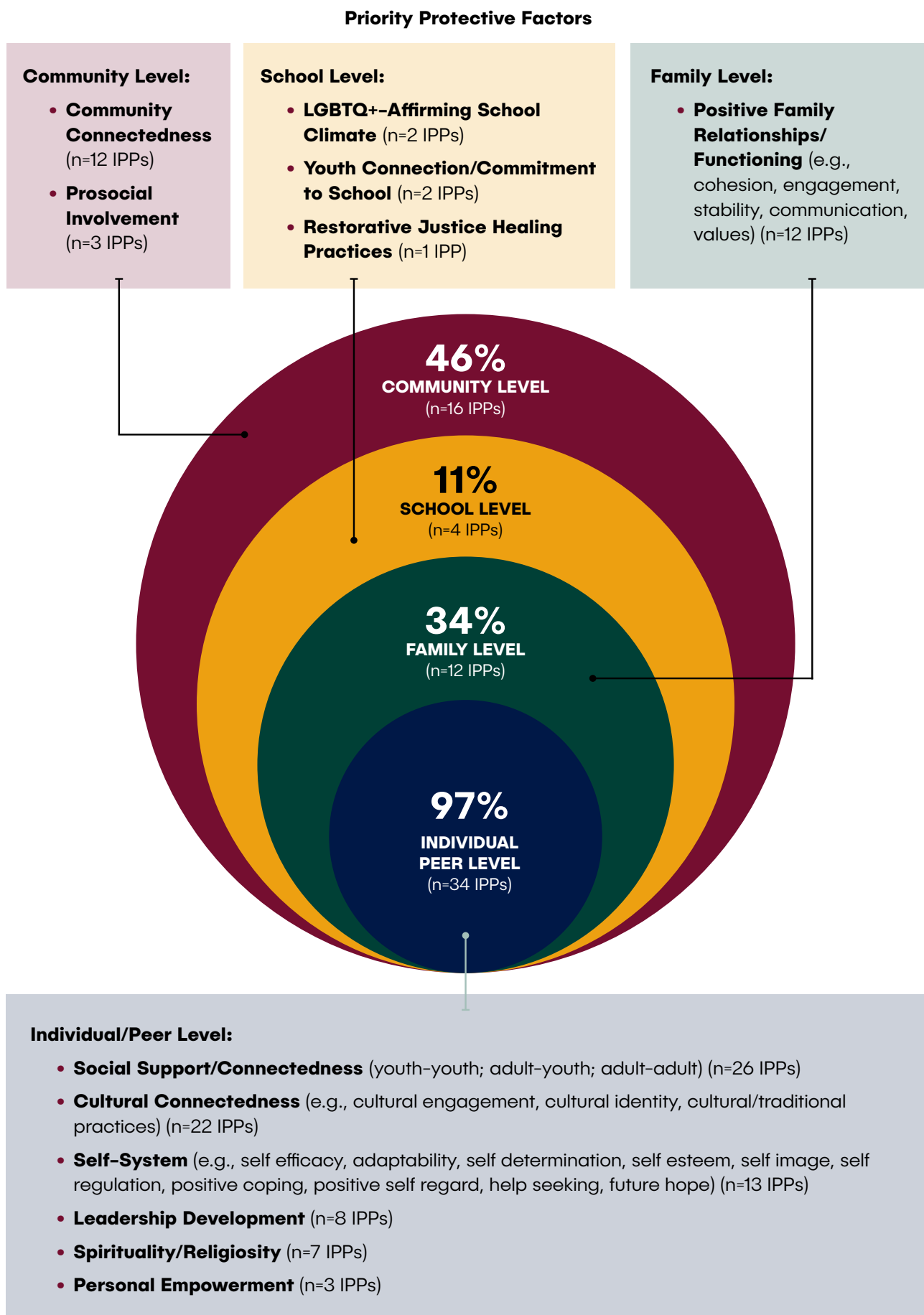


Table 6.21: Protective Factors Prioritized by the CDEPs Overall and by Priority Population Hub

Protective Factor Level	% (# IPPs)	Protective Factor Type	Total # IPPs	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
Community Level	46% (n=16)	Community Connectedness	14	-	4	4	2	4
		Prosocial Involvement	3	2	-	1	-	-
School Level	11% (n=4)	Youth Connection/ Commitment to School	3	1	-	-	1	1
		LGBT Affirming School Climate	2	-	-	-	-	2
		Restorative Justice Healing Practices	1	1	-	-	-	-
Family Level	34% (n=12)	Positive Relationships/ Functioning (cohesion, engagement, stability, communication, values)	12	2	4	1	4	1
Peer/ Individual Level	97% (n=34)	Social Support/ Connectedness (one-on-one, youth to youth, adult-youth, adult-to-adult)	26	6	3	6	5	6
		Cultural Connectedness (engagement, identity, cultural/ traditional practices)	22	4	6	5	6	1
		Self-System (self-efficacy, adaptability, self-determination, self-esteem, self-image, self-regulation, positive coping, positive self-regard, help-seeking, future hope)	13	5	2	1	3	2
		Leadership Development	8	2	-	3	3	-
		Spirituality/ Religiosity	7	1	-	6	-	-
		Personal Empowerment	3	2	-	-	-	1

6.3 IMPROVEMENTS IN MENTAL HEALTH

This section provides an overview of the improvements in mental health outcomes for individuals served by the CDEPs. In other words, the statewide evaluation examines the extent to which there were changes in psychological distress and functioning, as well as strengthening of protective factors or reduction of risk factors, for individuals before and after receiving CDEP services. Assessing outcomes of PEI efforts in mental health care is both important and challenging. For a state-funded demonstration project like the CRDP, which attempted to “do business differently” in its support of CDEPs, these findings are critical.

Findings from this section address the following statewide evaluation objective and question:

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

- 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)?
 - › 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)?

The findings in this section furthers Goal 4 of the CRDP Strategic Plan: “Develop, fund, and demonstrate the effectiveness of population-specific and tailored programs.” It aligns with Strategy 17: “Fund culturally-specific research,” and Strategy 20, “Conduct culturally congruent evaluation of community-defined practices.”

To preserve the report’s readability for a range of audiences, the main report will provide an overview of the mental health outcome conceptual framework, methodology, and results. The complete, technical write-up of the Bayesian analysis including supporting literature, methodology, analysis, and findings is found in Appendix 3.

FREQUENTLY ASKED QUESTIONS (FAQ) ABOUT THE BAYESIAN APPROACH:

Dealing with Uncertainty, Statistically Speaking

Q1: How did the statewide evaluation determine the extent to which IPPs prevented and/or reduced severity of mental health conditions for CDEP Participants?

A: The statewide evaluation’s quantitative analysis approach uses the Bayesian statistical framework (Gelman et al, 2014; McElreath, 2020; Perkins, 1987; Pollard, 1986; Spiegelhalter, Abrams, and Myles, 2004).

- This quantitative analysis focused on measuring differences in five key mental health outcome measures pre-intervention (before CDEP) to post-intervention (after CDEP) for youth and adult participants.
- These differences are called effect sizes (Cummings and Calin-Jageman, 2017). The magnitudes of these effect sizes are direct assessments of the amount of improvement in mental health conditions. All the statewide evaluation analyses are based on effect sizes.

Q2: What are the five key mental health outcome measures?

- Psychological Distress: Kessler 6 (K6).
- Functional Impairment: Sheehan Disability Scale (SDS).
- Cultural Protective Factor: Perceived Connectedness and Strength.
- Cultural Protective Factor: Connected and Balanced.
- Social Isolation Risk Factor: Marginalized/Isolated.
- For more information on these 5 key measures, refer to the section below titled Mental Health Outcome Findings.

WHAT'S WITH ALL THE STATISTICS ANYWAY?

Q3: Why does the statewide evaluation involve such complicated statistical modeling to answer its questions?

A: In Steps 1 and 2 (see below) descriptive statistical analyses describe and summarize the experiences of the actual CDEP participants, people we collectively call “the sample.” If the state’s only goal in CRDP Phase 2 was to assess only the participants recruited and served by the CDEPs, the statewide evaluation would really have no need for anything beyond descriptive statistics.

Confidence intervals and p-values are about generalizing from the actual sample (Phase 2) to a larger population (beyond Phase 2) represented by the sample. Several places in this report caution about generalizing from CRDP served participants to a larger population. The nature of CDEP participant recruiting (primarily convenience and purposive sampling) make it difficult to determine what that population might be. However, if the state seeks to expand the use of CDEPs (that are culturally, linguistically, and LGBTQ+-competent) across more unserved, underserved, and inappropriately served communities, some form of generalization can provide evidence to support such an expansion. For this reason, we need the tools of inferential statistics (see Step 3 below).

WHERE ARE THE P-VALUES?

Q4: Why does the statewide evaluation avoid the use of p-values that are so common in the scientific literature?

A: P-values are used to address a very specific question: is the effect size zero or not? The p-value provides a probability that future replication studies, conducted in such a way that the effect size is truly zero, would give results at least as strong as those found in the statewide evaluation. Given the statewide evaluation research question is “to what extent,” providing evidence that the CRDP effect is not zero does not address the evaluation objective.

Q5 Why were classical or frequentist statistics not used?

A: Frequentist statistical analysis relies heavily on the idea of replication (see the p-value question above). We flip a coin repeatedly. The fraction of times we see “heads” over the long run gives the meaning of probability in the frequentist setting. Much of the historical motivation for probability came from gambling. Card shuffling and dice rolling represent perhaps the best randomized replication humankind has devised.

When the statewide evaluation discusses quantitative data analysis results, all statements about effects are directly probabilistic. What are the likely effect sizes overall and with respect to specific factors? In classical statistics, 95% confidence intervals are used to respond to these questions, but the interpretation of these probabilities is quite different for Bayesian approaches.

CLASSICAL OR FREQUENTIST STATISTICS

The foundation of classical or frequentist statistics is built on replication and a fixed underlying truth. For example, in classical approaches, if we could replicate a study many times, the confidence interval would contain the truth in 95% of those replications.

In the film *Groundhog Day*, a weatherman, Phil Connors, becomes trapped in a time loop, forcing him to relive February 2nd repeatedly. Imagining or predicting day-after-day observations of tomorrow’s weather is using a frequentist analysis. The fraction of times the storm appears gives the probability of rain.

VS

BAYESIAN ANALYSIS

In contrast, for Bayesian analysis, there is no such appeal to future studies of what might happen. The posterior probabilities (which are the conditional probabilities of the effects based on the observed data) give our assessment of an effect’s likely values.

In other words, like the weatherman’s assessment of the likelihood of rain tomorrow, the question answered using Bayesian analysis is: Given what we observe, will it likely rain or not?

Q6: So, if the statewide evaluation outcomes findings are not reported in terms of statistical significance, how are they presented?

A: Bayesian findings focus on two things:

- What are the effect sizes that are consistent with the observed data?
- How likely do we think these effect sizes are?

Presenting these two pieces of information usually takes the form of estimates and credible intervals, which are Bayesian versions of confidence intervals.

- The estimate is the value of the effect size that is most consistent with the observations.
- The credible interval is a range of effect sizes plausibly consistent with the data. Credible intervals can go out from the estimate to capture the best 50% of plausible effect sizes (illustrated with the thick bars in the figures), or a larger range of 95% of the effect sizes (illustrated with the thin bars in the figures) that are at least somewhat plausibly consistent with the data.

Since outcomes findings presented below may feel new to some, then the way to think about outcomes from a Bayesian approach is something like this:

What is the range of effect sizes that are consistent with our data?

Q7: How is the Bayesian analysis aligned with the statewide evaluation plan?

A: The Bayesian multilevel modeling was structured to align with the statewide evaluation's overall social-ecological framework:

- At the individual level, participants engaged with CDEPs offered by IPPs in their communities.
- At the hub level, the IPPs were organized according to race, ethnicity, and LGBTQ+ cultural and community contexts.

Within this ecology, intersectionality may connect different, multiple identities of individual participants.

Q8: How many IPPs contributed data for this analysis?

A: The cross-site core measure (i.e., the CDEP participant questionnaire) was collected by 32 of the 35 IPPs from either all or a sub-sample of their participants and were administered at the beginning (pre-test) and/or end (post-test) of their natural program cycles.

Q9: What was the final matched sample size for this quantitative analysis?

A: The matched pre and post-test sample size was 2,342.

Age Group	Pre-Tests	# IPPs	Post-Tests	# IPPs	Final Matched Sample	# IPPs
Adult	n=2,895	22	n=1,952	22	n=1,902	22
Youth	n=659	14	n=475	12	n=440	14
Total Matched Sample Size for Adults and Youth					N=2,342	32

See Chapter 4 (Statewide Evaluation Methods – CDEP Participant Sample) for a detailed breakdown of the number of IPPs that collected this data and the sample size by each hub and CRDP overall. Descriptive analyses on the matched pre/post data were conducted on all demographic variables. The difference between the characteristics of the baseline (pre only) and matched sample were small enough to be negligible. See Demographics of CDEP Participants Served for a summary of CDEP participant demographic information for adults and adolescents at baseline.

Q10: What statistical software was used to conduct the Bayesian analysis of CDEP participant outcome data?

A: The models that are delineated further below in this section of the report were analyzed within a Bayesian statistical framework, using the R statistical computing environment (R Core team, 2021) and the Bayesian multilevel modeling package *brms* (Bürkner, 2017). Missing data were imputed using the *mice* package (van Buuren and Groothuis-Oudshoorn, 2011) that implements Rubin's multiple imputation method (Rubin, 1987, 1996).

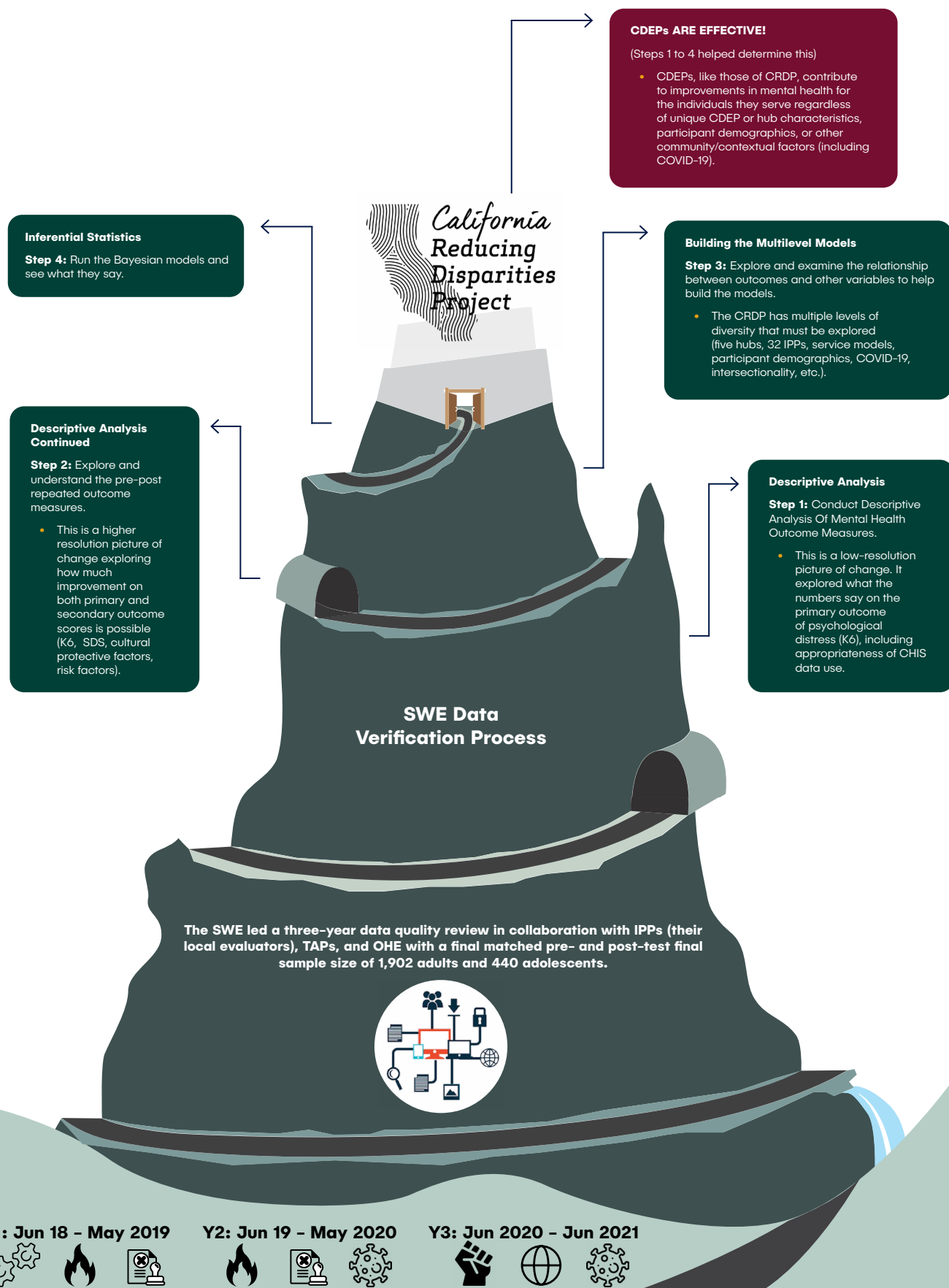
6.3.A GUIDE ON HOW TO READ THE FINDINGS

The guide presented in a visual format outlines three general steps that the SWE took to build and run the Bayesian multilevel modeling to help determine the extent to which CDEPs were effective in improving mental health outcomes for their CDEP participants. As one can see in Figure 6.27, conducting a Bayesian quantitative analysis was a long uphill journey and was a collective effort among all Phase 2 partners.

- The journey began with the 32 IPPs that collected CDEP participant questionnaires across three years (2018–2021). These data are referred to in this section as pre-intervention (before CDEP) and post-intervention (after CDEP) mental health outcome data. CDEP staff and their local evaluators engaged in a tremendous data collection effort with their adult and youth participants through internal Phase 2 challenges (e.g., staff transitions, IRB, etc.) and external challenges (e.g., wildfires, racial uprisings; ICE arrests, detention centers, and deportations, the COVID-19 global pandemic and pivot to virtual service delivery).
- The journey continues with the SWE-led quality review process that was conducted in collaboration with IPPs (and their local evaluators), TAPs, and OHE. This resulted in a matched pre and post-test final sample size of 1,902 adults and 440 youth. This part of the uphill journey culminated in a lengthy and involved data verification process between PARC staff and our statistician.
- As we begin to travel a little bit higher in our Bayesian journey, we see that the SWE launched Steps 1 and 2. These two steps are descriptive statistical analysis, with Step 1 providing a low-resolution description and summarization of change for CDEP participants, while Step 2 is higher in resolution. While they informed the building of the Bayesian models, they also generated preliminary evidence of CDEP effectiveness. Step 3 is the most important section of the report.
- As we move up to the highest level, Step 4 (the actual multilevel modeling) is what determined “to what extent” CDEPs were effective in improving mental health outcomes for the sample of CDEP participants, and what can be said about future participants or even other non-Phase 2 CDEPs. This latter consideration offers evidence that may help in expanding CRDP efforts more broadly across California. The findings of this analysis are presented in the form of regressions, estimates, and credible intervals, for it is with these complex models that overall CRDP effectiveness stands out in the presence of the great diversity of participants and CDEPs.



Figure 6.27: PARC Steps to Making Bayesian Inferences About CDEP Effectiveness



6.3.B MENTAL HEALTH OUTCOME FINDINGS

NOTE ON THE TWO PRIMARY MEASURES OF MENTAL HEALTH OUTCOMES IN THE STATEWIDE EVALUATION

The statewide evaluation Bayesian modeling and analysis of mental health changes uses the Kessler 6 (K6, Kessler et al, 2002), a measure of psychological distress, and the Sheehan Disability Scale (SDS, Sheehan, 2000), a measure of functional impairment. Many studies have demonstrated the reliability and validity of these scales (see, e.g., Kessler et al, 2002; Olfson et al, 1996), and they have both been employed by the California Health Interview Survey (CHIS, Padilla Frausto, Grant, and Aguilar Gaxiola, 2007) and the National Survey of Drug Use and Health (NSDUH, Substance Abuse and Mental Health Services Administration, 2021). Thus, these two scales offer well understood constructs to support the assessment of CRDP Phase 2 Statewide Evaluation Objective 2.

Among the five key mental health outcome measures in the statewide evaluation, the two primary measures of mental health outcomes are:

- Kessler 6 (K6) of Psychological Distress (Past 30 days). The range for summed responses across the 6-items is zero to 24, with zero suggesting the lowest level of psychological distress and 24 suggesting the highest level of psychological distress. A score of 13 or greater indicates more serious mental health problems. K6 scores are typically used in conjunction with research-validated cut-points to indicate levels of psychological distress. (Note that scores are not used to diagnose specific psychological disorders). These cut-points or categories of psychological distress are:
 - Severe psychological distress: scores of 13 or higher.
 - Moderate psychological distress: scores ranging between 5 and 12.
 - None/low distress: scores less than 5.

Because these categories are widely used and recognized in the field (Prochaska et al., 2012), we compare pre- and post-intervention K6 scores using these categories:

A low-resolution picture of change in improvement of the K6 scores pre- and post-intervention is included in the Step 1 descriptive analysis below.

- Sheehan Disability Scale (Past 12 months): The original SDS uses five items to assess levels of functional impairment in three areas by measuring “the extent to which a patient’s disability due to an illness or health problem interferes with work/school, social life/leisure activities, and family life/home responsibilities.” (Sheehan, 2000). The statewide evaluation used a four-item version of the SDS developed by the California Health Interview Survey (CHIS), that summed scores assessing impairment with chores at home, in social life, and in relationships with friends and family as the basis for analysis. The response scale across the four items is: 0= not at all; 1= some, and 2=a lot. Scores for youth are based on a three-item SDS that summed scores assessing impairment with their performance with school and homework, friends, and at home. Adults and youth are asked to think about the one month, within the past 12 months, when they felt at their worst emotionally.

Secondary mental health outcomes include measures of protective and risk factors. The CDEP participant questionnaire contained eight items connected to cultural protective factors and a social isolation risk factor. Three outcomes were created from three different groupings of these items. These were:

- Cultural Protective Factor 1 (CPF1): Perceived Connectedness and Strength: This score is a sum of four items anchored at the present time (culture: gives you strength, is important to you, helps you to feel good about who you are, and helps you feel connected to spiritual/religious traditions). Items in Connectedness and Strength were answered on a five-point frequency scale of: 0=strongly agree to 5=strongly disagree and the scale scores formed from them. Lower scores indicate higher levels of cultural connectedness and strength.

- **Cultural Protective Factor 2 (CPF2): Connected and Balanced:** This score is the sum of two items anchored in the past 30 days (feeling connected to culture, feeling balanced in mind-body-spirit). Items in Connected and Balanced were answered on a five-point frequency scale of: 0=all of the time to 4=none of the time and the scale scores formed from them. Lower scores indicate higher levels of connection and balance.
- **Social Isolation Risk Factor (SIRF): Marginalized/Isolated:** This score is a sum of two items anchored in the past 30 days (feeling marginalized/excluded or isolated/alienated) on a five-point frequency scale of 4=all of the time to 0=none of the time. Lower scores indicate low levels of feeling marginalized/isolated

A higher-resolution picture of mental health improvement on all primary and secondary score pre- and post-intervention are included in Step 2 Descriptive Analysis below.

STEP 1: DESCRIPTIVE ANALYSIS A LOW-RESOLUTION PICTURE OF IMPROVEMENT IN PSYCHOLOGICAL DISTRESS (K6) AMONG A SAMPLE OF CDEP PARTICIPANTS

First, we looked at all CDEP participants' K6 scores **before** they began a CDEP service/program (i.e., how they would be classified in one of these categories pre-intervention) to see how their levels of psychological distress changed over time after they completed the CDEP (i.e., their post-intervention K6 score). We report these changes as percentages for each K6 category of distress.

Adult Participants: What do the numbers say about their experience of change?

Key Takeaway from Step 1: Strong evidence begins to emerge supporting CDEP prevention and early intervention effectiveness among a sample of adult participants, with many maintaining lower levels of distress or decreasing their level of distress by the end of services. Specifically: The Bayesian multilevel modeling was structured to align with the statewide evaluation's overall social-ecological framework:

- Most adult participants who started with *none/mild distress* stayed in this same category post-intervention (71%), although about a quarter of them (26%) moved to a higher level of distress at the post.
- For adults reporting *moderate distress* before CDEP participation, most (40%) moved in a positive direction (i.e., to the low category) at the post or stayed in the same category (49%) (i.e., did not worsen).
- A notable finding is that adult participants who reported the highest levels of distress pre-intervention (66%) had the greatest shifts at the post. Specifically, among adults who started with severe psychological distress:
 - › 50% moved one K6 category down (from severe to moderate distress) at the post.
 - › 16% moved two K6 categories down (from severe to mild) at the post
- Among *severely distressed* adults at pre-intervention, 34% remained in this category post-intervention. This required some additional investigation. That is, these participants were severely distressed before their CDEP participation and did not shift categories from pre- to post-intervention, but this finding at first glance also masks the presence of improvement within this category.
 - › In other words, despite remaining in the severe category, these adults showed movement in the positive direction. Specifically, the mean K6 improvement dropped by 2.3 points within this category, with over 80% of participants reporting post-intervention K6 at or below their pre- K6 value.

See Figure 6.28 for a big-picture overview of changes in psychological distress for each category pre- to post-intervention for a sample of adult participants.

Figure 6.28: Changes in Psychological Distress Category, Pre- to Post-intervention, all CRDP Adult Participants with Matched Pre/Post K6 responses. (N=1,773)

ADULT (N=1,773): PSYCHOLOGICAL DISTRESS (Kessler-6) BY THE NUMBERS



Among a sample of **CDEP-Served Adults** who had **"none"** or **"mild"** (K6=5 or lower) psychological distress at pre-CDEP intervention:

- **7 in 10** maintained none or at a mild state of distress at post-test.



Key takeaway

71%

Stayed the same, providing strong evidence that CDEP **prevention** efforts work for many adults.

Among a sample of **CDEP-Served Adults** who had **"moderate"** (K6=5 to 12) psychological distress at pre-CDEP intervention:

- **4 in 10** had less distress at post-test, while **5 in 10** maintained at the same state at post-test.



Key takeaway

89%

Improved or stayed the same, providing strong evidence that CDEP **prevention AND early intervention** efforts prevent some adults from developing more serious symptoms.

Among **CDEP-Served Adults** who had **"severe"** (K6=13 or higher) psychological distress at pre-CDEP intervention:

- **Nearly 7 in 10** had less distress at post-test; while 3 in 10 maintained serious distress at both time points.



80% of post-test distress levels were at or below pre-test levels

Key takeaway

100%

Improved (i.e., dropping from severe to moderate distress) or remained at or below their pre-test severe state providing strong evidence that CDEP **early intervention** efforts help adults with serious symptoms.

First, we looked at all CDEP participants' K6 scores **before** they began a CDEP service/program (i.e., how they would be classified in one of these categories pre-intervention) to see how their levels of psychological distress changed over time after they completed the CDEP (i.e., their post-intervention K6 score). We report these changes as percentages for each K6 category of distress.

Youth Participants: What do the numbers say about their experience of change?

Key Takeaway from Step 1: Strong evidence begins to emerge supporting CDEP prevention and early intervention effectiveness among a sample of youth participants, with many maintaining lower levels of distress or decreasing their level of distress by the end of services.

Specifically:

- Most youth who started with *none/mild distress* stayed in this same category post-intervention (67%), although about a third (33%) moved to a higher level of distress at the post.
- For youth reporting *moderate distress* before CDEP participation, one-quarter (28%) shifted in a positive direction (to the low category) at the post or stayed in the same category (62%) (i.e., did not worsen).
- Like the adults, youth participants who reported the highest levels of distress pre-intervention (49%) had the greatest shifts (49%). Specifically, among youth participants who started with severe psychological distress:
 - 44% moved one K6 category down (from severe to moderate distress) at the post.
 - 5% moved two K6 categories down (from severe to mild) at the post.
- 51% of *severely distressed* youth at pre-intervention remained in this category post-intervention. Like the adults, despite remaining in this category, over 70% had post-intervention distress levels at or below their pre-intervention state, showing movement in the positive direction (i.e., lower distress). Specifically, the mean K6 improvement dropped by 3.95 points within this category.

See Figure 6.29 for a big-picture overview of changes in psychological distress for each category pre- to post-intervention for a sample of youth participants.



Figure 6.29: Changes in Psychological Distress Category, Pre- to Post-intervention, all CRDP Youth Participants with Matched Pre/Post K6 responses. (N=317)

YOUTH (N=317): PSYCHOLOGICAL DISTRESS (Kessler-6) BY THE NUMBERS



Among a sample of **CDEP-Served YOUTH** who had **"none"** or **"mild"** (K6=5 or lower) psychological distress at pre-CDEP intervention::

- Nearly **7 in 10** maintained none or a mild state of distress at post-test.



Key takeaway

67%

Stayed the same, providing strong evidence that CDEP **prevention** efforts work for many young people.

Among a sample of **CDEP-Served YOUTH** who had **"moderate"** (K6=5 to 12) psychological distress at pre-CDEP intervention:

- Nearly **3 in 10** had less distress at post-test, while **6 in 10** maintained at the same state at post-test.



Key takeaway

90%

Improved or stayed the same, providing strong evidence that CDEP **prevention AND early intervention** efforts prevent some youth from developing more serious symptoms.

Among **CDEP-Served YOUTH** who had **"severe"** (K6=13 or higher) psychological distress at pre-CDEP intervention:

- Nearly **5 in 10** had less distress at post-test; while 5 in 10 maintained serious distress at both time points.



70% of post-test distress levels were at or below pre-test levels

Key takeaway

100%

Improved (i.e., dropping from severe to moderate distress) or remained at or below their pre-test severe state providing strong evidence that CDEP **early intervention** efforts help youth with serious symptoms.

STEP 2: DESCRIPTIVE ANALYSIS

A HIGHER-RESOLUTION PICTURE OF IMPROVEMENT IN K6, SDS, AND PROTECTIVE/RISK FACTORS

Step 1 observations led directly into Step 2 in the statewide evaluation's quantitative analysis. This step is a higher-resolution view of the pre- to post-intervention changes for a sample of CDEP participants. It helped the statewide evaluation understand the mental health outcome data so we can build an appropriate experiential model. It answers the following question: how do we understand all the variables and the impact they might have on improvement?

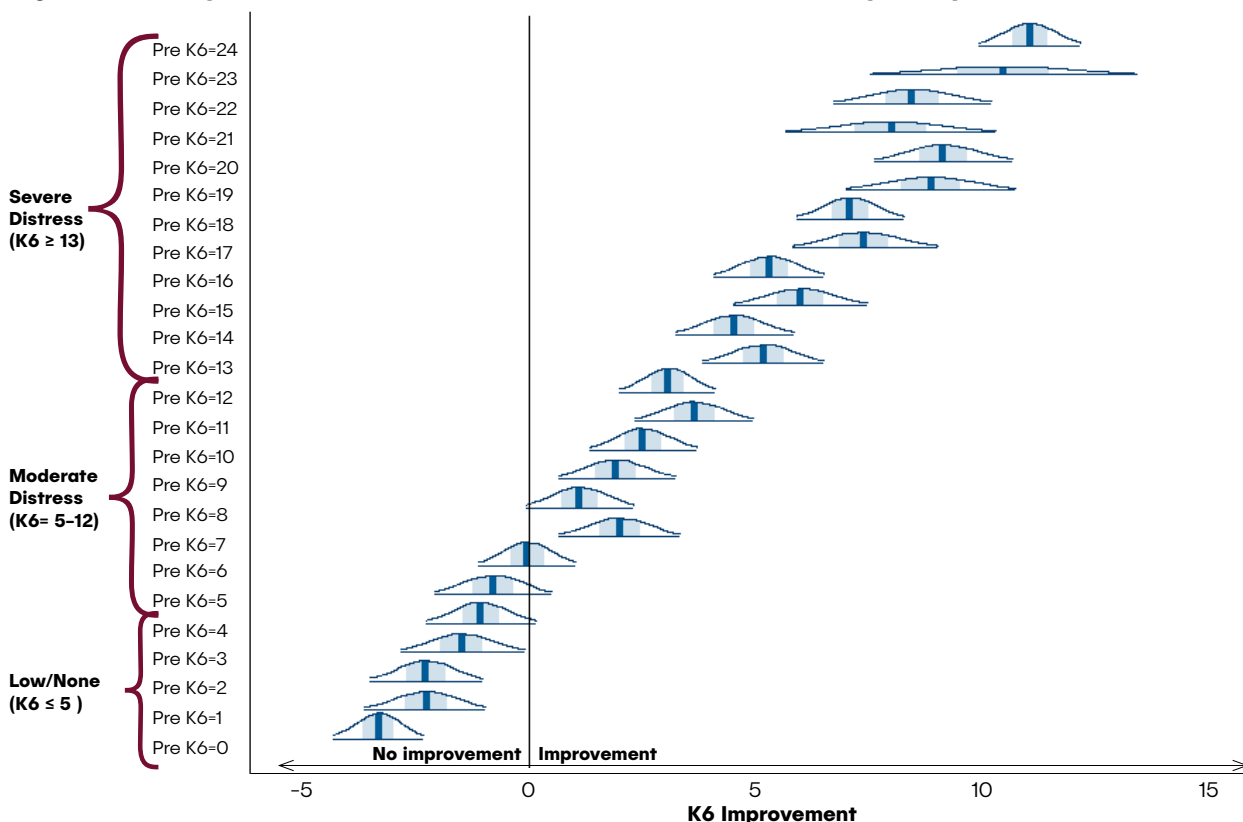
CRDP Overall: What do exploratory analysis of pre-post repeated measures on the K6 say about the amount of improvement for the overall sample?

Key Takeaway on the K6 from Step 2: For CRDP overall, the change in K6 depended linearly on the pre-intervention score K6. In other words, the amount of improvement CDEP participants had depended on how distressed they were when they began CDEP services. The pre-intervention K6 measure therefore must be treated as an independent variable. Specifically:

- For those participants who maintained low or moderate levels of distress from pre- to post-intervention, this is a positive finding, and considered a win for prevention.
- A high proportion of participants served by CDEPs had high levels of psychological distress. This indicated that IPPs were successful in reaching and serving individuals with high levels of mental health need in their communities via their CDEPs.
- Participants who reported high levels of psychological distress prior to their participation in CDEPs tended to show the highest levels of improvement. This suggests that IPPs were also effective in providing early intervention services to participants with the highest levels of need.

See Figure 6.30 for a visual representation of this pattern of improvement in psychological distress for CRDP overall.

Figure 6.30: Improvement in K6 vs. Pre-Intervention K6, all CRDP participants



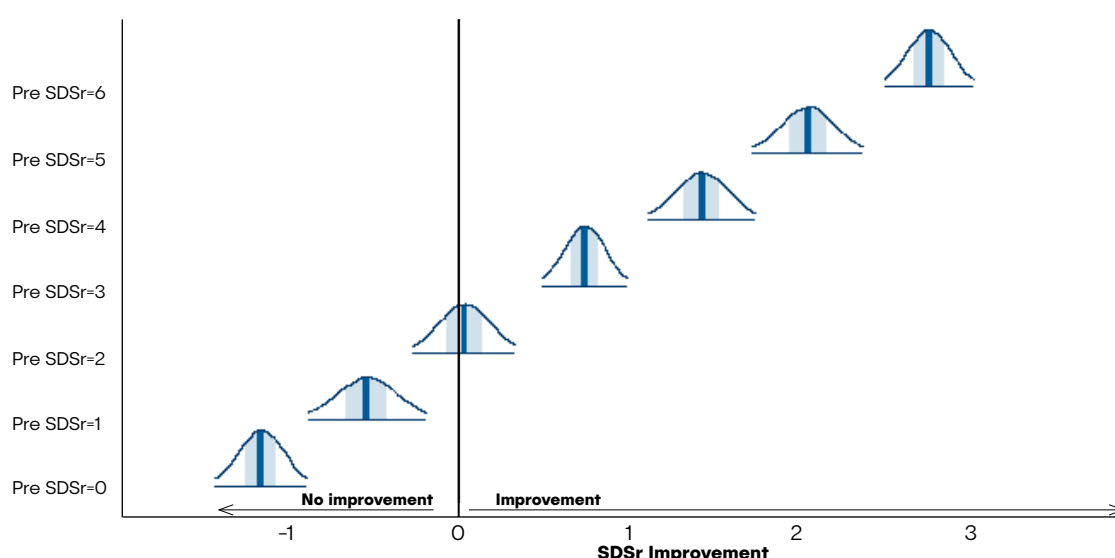
*Error bars represent 95% CI around the mean K6 improvement at each pre-intervention K6 value.

CRDP Overall: What do exploratory analysis of pre-post repeated measures on the SDS say about the amount of improvement for the overall sample?

Key Takeaway on the SDS from Step 2: In a higher resolution examination of SDS findings, the improvement-in-SDS measure exhibits a similar pattern of dependence on the pre-intervention score as the K6. In other words, greater improvement was associated among CDEP participants who had higher levels of functional impairment pre-intervention. Specifically, individuals whose emotions had strongly interfered with their performance at work/school, at home, in one's social life, and in one's personal relationships pre-intervention, had less disruptions in managing their personal and work life after receiving CDEP services.

See Figure 6.31 for a visual representation of this pattern of improvement in functional impairment for CRDP overall.

Figure 6.31: Improvement in SDS vs. Pre-Intervention SDS, all CRDP participants



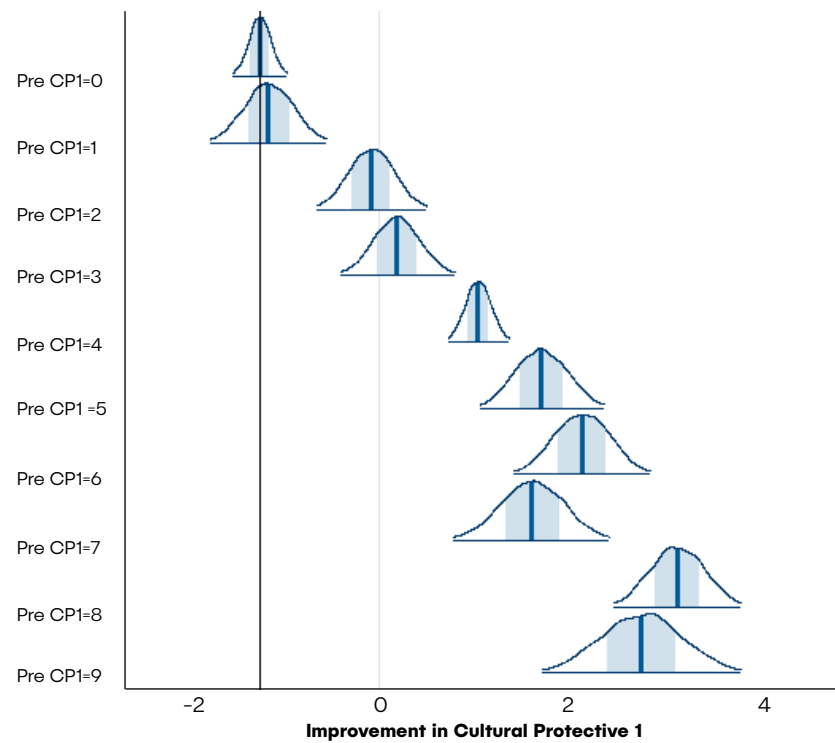
*Error bars represent 95% CI around the mean SDS improvement at each pre-intervention SDS value.

CRDP Overall: What do exploratory analysis of pre-post repeated measures on the cultural protective factors (CPF1-2) and social isolation risk factors (SIRF) say about the amount of improvement for the overall sample?

Key Takeaway on Cultural Protective Factors and Social Isolation Risk Factors from Step 2: Each of the three secondary outcomes (e.g., two CPFs and one SIRF score) exhibited the same linear relationship between the pre-intervention score and improvement in pre- to post-scores. In other words, greater improvement was associated among CDEP participants who had lower levels of cultural protective factors and higher levels of risk factors pre-intervention.

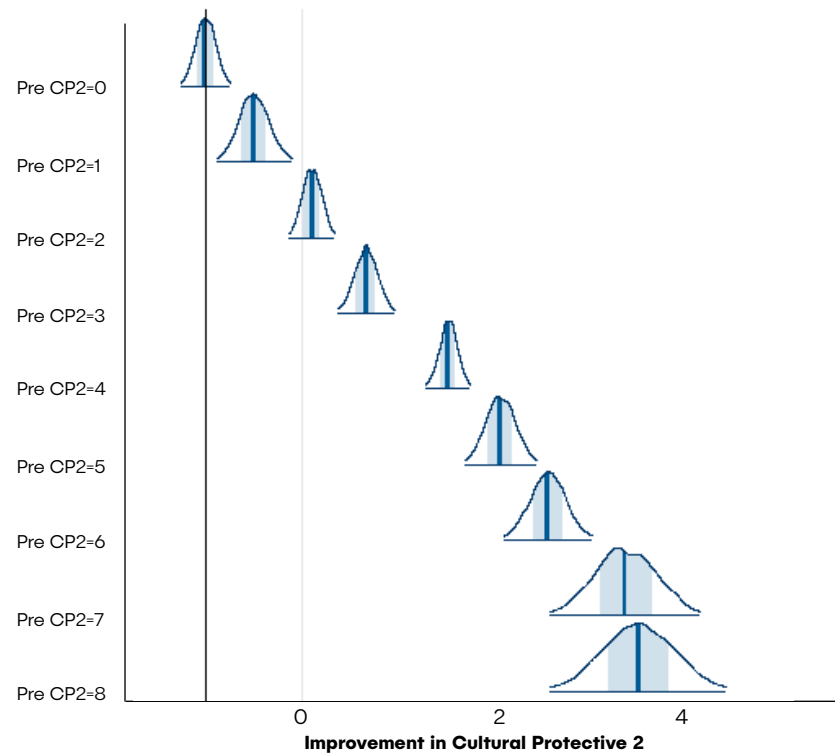
- Cultural Protective Factor 1 (CPF1): Perceived Connectedness and Strength: (culture: gives you strength, is important to you, helps you to feel good about who you are, and helps you feel connected to spiritual/religious traditions). In Figure 6.32, lower scores indicate high levels of CPF1 at pre-test, while higher scores indicate low levels of CPF1 at post-test.
- Cultural Protective Factor 2 (CPF2): Connected and Balanced (feeling connected to culture, feeling balanced in mind-body-spirit). In Figure 6.33, lower scores indicate high levels of CPF1 at pre-test, while higher scores indicate low levels of CPF1 at post-test.
- Social Isolation Risk Factor (SIRF): Marginalized/Isolated: (feeling marginalized/excluded or isolated/alienated). In Figure 6.34, high scores indicate high levels of SIRF (or high risk) at pre-test, while higher scores indicate low levels of CPF1 at post-test.

Figure 6.32: Improvement in CPF1 vs. Pre-Intervention CPF1, all CRDP participants



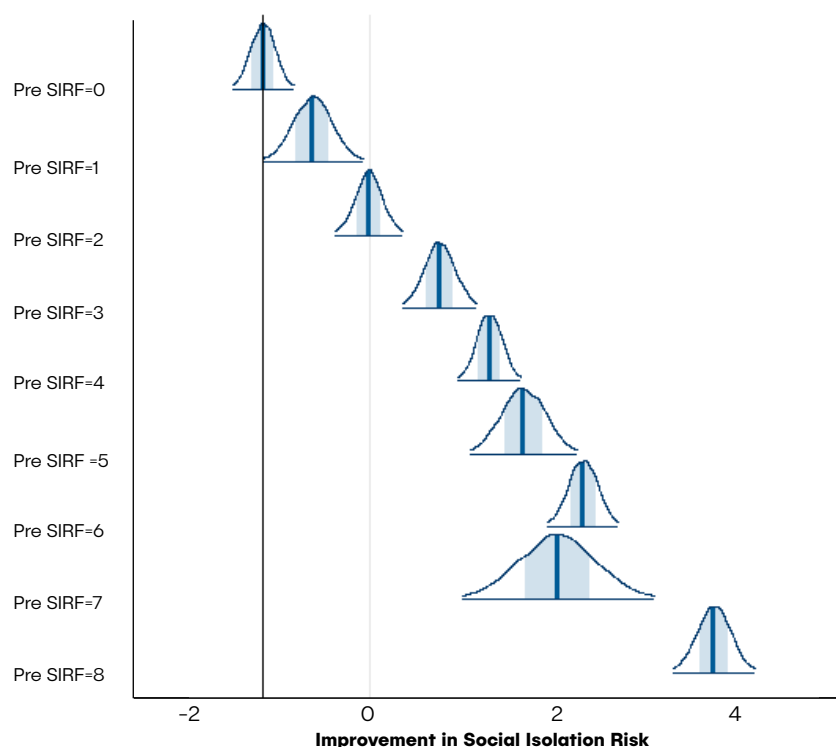
*Error bars represent 95% CI around the mean CPF1 improvement at each pre-intervention CPF1 value.

Figure 6.33: Improvement in CPF2 vs. Pre-Intervention CPF2, all CRDP participants



*Error bars represent 95% CI around the mean CPF2 improvement at each pre-intervention CPF2 value.

Figure 6.34: Improvement in SIRF vs. Pre-Intervention SIRF, all CRDP participants



*Error bars represent 95% CI around the mean CPF1 improvement at each pre-intervention SIRF value.

SPOTLIGHT: VALUE OF PHASE 2 COMMUNITY-DEFINED EVIDENCE PRACTICE FOR EARLY INTERVENTION

Within Phase 2 overall, what was the percentage of serious psychological distress (“severe” K6 category) among the five priority populations at the start of CDEP services?

Key Takeaway: CDEPs filled a critical service gap in their local communities by serving individuals who were members of the five CRDP priority populations who had high need (i.e., severe levels of distress). The findings suggest that these individuals had an unmet need (i.e., were unserved) and for those who had received prior care, the care was inadequate (underserved or inappropriately served).

If high levels of distress at pre-intervention were the most important factor in influencing the amount of positive change reported at the post, it could be helpful to understand demographic characteristics of CDEP participants who reported distress in the “severe” K6 range. This is particularly important given that early intervention efforts are widely perceived as beneficial, with mental health services/supports limiting or even stopping unfavorable outcomes, reducing the need for costly and more intense treatments in the future.

Among a sample of adult CDEP participants, 36.6% were classified as “severely” distressed at pre-intervention.

- 51.1% of Latinx adults reported severe distress, accounting for 44.5% of the total.
- 43.1% of LGBTQ+ adults reported severe distress, accounting for 11.1% of the total.
- 31.2% of AANHPI adults reported severe distress, accounting for 34.1% of the total.
- 29.3% of AI/AN adults reported severe distress, accounting for 6.0% of the total.
- 14.1% of AfAm adults reported severe distress, accounting for 4.3% of the total.

Among a sample the youth CDEP participants, 31.3% were classified as “severely” distressed at pre-intervention.

- 51.4% of LGBTQ+ youth reported severe distress, accounting for 37.5% of the total.
- 26.6% of Latinx youth reported severe distress, accounting for 31.3% of the total.
- 32.5% of AANHPI youth reported severe distress, accounting for 13.5% of the total.
- 13.9% of AI/AN youth reported severe distress, accounting for 10.4% of the total.
- 7.3% of AfAm youth reported severe distress, accounting for 7.1% of the total.

SPOTLIGHT: STEP 2: FUNCTIONAL IMPAIRMENT (SHEEHAN DISABILITY SCALE – SDS)

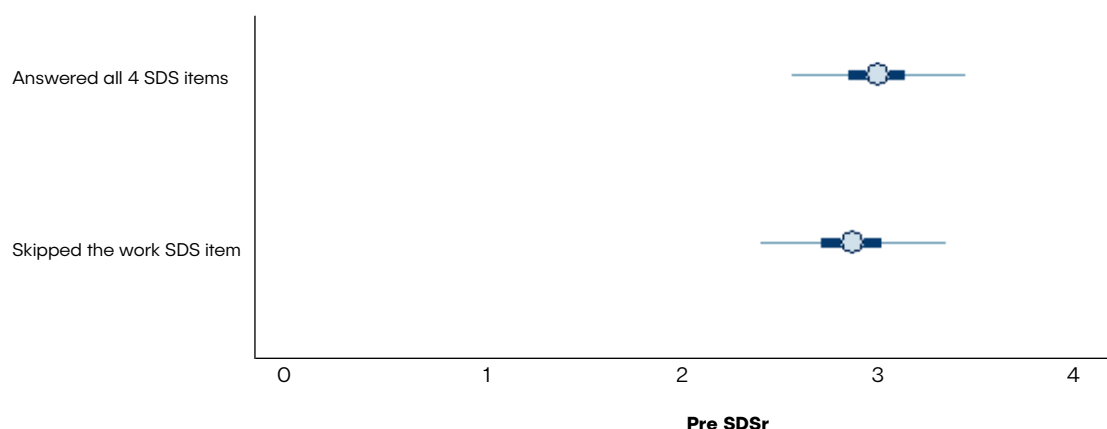
Among the Phase 2 adult sample, was functional impairment the same in adults who were not working/in school as those who were working/in school?

Key Takeaway: Adult (including older adults) mental health matters. For adult individuals who were not in school/work, their functional impairment in daily life was only slightly better than individuals who reported working/in school, indicating that older adults are also benefitting from CDEPs and have a need for CDEP services.

A major challenge to the analysis of the SDS outcome measure was missing data. Only 1,220 of the 1,902 matched pre-post respondents provided complete data for the four items. Specifically, 437 participants checked a box indicating that they “were not working or in school during the past 12 months” and therefore did not respond to the “performance at work/school” SDS item. In total, 1,697 respondents provided complete data for the three remaining items. The SWE chose to focus analysis on a “reduced” SDS: the “SDSr” sums the items concerning household chores, social life, and relationships with friends and family. The SDSr sample is comprised of CDEP participants from 21 IPPs across the five priority population hubs. Some key demographic information for this reduced sample were the following: tend to be older (43% were 50 year or older) and 63% were either Latinx (34%), AANHPI (37%), or LGBTQ+ (8%).

What we found was a very slight difference between the SDSr scores of the participants who only answered three items (i.e., were not working or in school) in comparison with those who answered all four (i.e., were working or in school). See Figure 6.35.

Figure 6.35: SDS Scores for “Reduced” SDS Sample



*At baseline, the SDS asks respondents to think about the one month, within the past 12 months, when they felt at their worst emotionally. The response scale for each of the four items is: 0= none at all; 1=some; and 2=a lot. Adding the three non-work items leads to the SDSr outcome that ranged from 0 to 6.

STEP 3: BAYESIAN MULTILEVEL MODELING: VARIABLES, RELATIONSHIPS, AND STRUCTURES

Now that we know what is going on (from Step 1 and Step 2), the SWE builds the model.

There are several higher-level considerations related to variables, interactions, and missing data that need to be made, including decisions about what to include and how to include.

How did the statewide evaluation's Bayesian multilevel modeling handle issues related to varying sample sizes, missing data, and intersectionality?

The high-level view of the K6 primary outcome measure discussed above suggests the presence of improvement effects at the CRDP initiative level. Of course, this perspective may miss some of the nuances associated with individual participant, IPP, and community characteristics at other levels of analysis. For instance, how is intersectionality represented in the analyses? Two additional complexities of the CRDP dataset relate to the handling of unbalanced designs and the treatment of missing data.

- Unbalanced designs arise when the different factor levels in a model have different sample sizes. Lack of balance can create several estimation difficulties. To illustrate with an extreme example, if one IPP served 90% of the CRDP participants, then this sample might overwhelm the effects of other IPPs. In practice, lack of balance across the different factors included in a model generally leads to varying amounts of uncertainty in estimators and correlations among estimated quantities. To investigate the potential impact of sample size variation across IPPs and hubs, the SWE implemented a weighting process that equalizes the IPPs' impacts on the model parameter estimation (see, e.g., Milhken and Johnson, 1984).
- For the problem of missing data, non-response issues enter in several ways, with participants skipping items completely or selecting "prefer not to answer" or "I don't know" for other items. For the CRDP Phase 2 participant sample, these missing data were treated in two ways: the simple "complete case only" approach and Rubin's multiple imputation method (Rubin, 1987, 1996). The analysis presented here uses multiple imputation method on the matched sample. Refer to Appendix 3 for more information.
- To address intersectionality issues, we note that for four hubs (e.g., AfAm, Latinx, AI/AN, and AANHPI), race and hub associated quite strongly by design. A second modeling approach was 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. Multiracial participants and LGBTQ+-hub participants, for example, represented instances of "not matched" cases with respect to hubs. This complexity reduction allowed for better estimation of intersectional properties of participant identities and hubs for the CRDP analyses.

How did the SWE build the Bayesian multilevel models? With the mental health outcome and independent variables identified, multilevel regression models were built to estimate overall CRDP effects while controlling for the many factors arising in a cross-cultural, multi-site real-world evidentiary study. Specifically, with multiple outcome measures (e.g., K6, SDS, two types of culture protective factors, one type of risk factor) for analysis, two different kinds of models were developed:

1. Univariate models that operate with each of the four specific change outcomes already described (e.g., K6, SDS, protective factors, risk factor) as a single dependent variable.
2. A single multivariate model using all the above outcomes simultaneously since these outcomes are correlated.

The data analysis is based on the univariate, baseline, unweighted, multiple imputation model for CDEP adult and youth participant samples. Modeling details are synthesized in Table 6.22 below.

Table 6.22: Statewide Evaluation Model Adjustments

Age Group	Outcome Approaches	Model Structures	Missing data
Adult	Univariate, separate by outcome	Baseline	Complete cases only
Youth	Multivariate, all outcomes	Complete Race	Multiple imputation
	Multivariate, K6+SDSr	Interactions	

All variables included in these models are summarized in Table 6.23 below.

Table 6.23: Variables for Bayesian Quantitative Data Analysis

Variables	Variable Use	Variable Type	Variable Value Range
Change in K6	Outcome	Continuous	(-24,24)
Change in SDS	Outcome	Continuous	(-9,9)
Change in Culture-at-Present	Outcome	Continuous	(-16,16)
Change in Culture-Past-30-Days	Outcome	Continuous	(-8,8)
Change in Marginalization/Isolation	Outcome	Continuous	(-8,8)
Pre K6	Independent	Continuous	(0,24)
Pre SDS	Independent	Continuous	(0,9)
Pre-Culture-at-Present	Independent	Continuous	(0,16)
Pre-Culture-Past-30-Days	Independent	Continuous	(0,8)
Pre-Marginalization/Isolation	Independent	Continuous	(0,8)
Hub	Independent	5-level factor	AI/AN, AfAm, API, Latinx, LGBTQ+
Age	Independent	6-level factor*	18-29,30-39,40-44,45-49,50-64,65+
Race	Independent	8-level factor	None given, AI/AN, AfAm, Latinx, Asian, NHPI, W, Multi
Race Alignment with Hub	Independent	2-level factor	Yes, No
Gender Identity	Independent	5-level factor	no GI given, cis-male, cis-female, trans, non-binary
Sexual Orientation	Independent	2-level factor	hetero, LGBTQ+
Unmet Need for Mental Health Services	Independent	2-level factor	Yes, No
IPP Service Model	Independent	4-level factor	Holistic, Communication, Co-Located/Collab, Integrated
COVID Timing	Independent	3-level factor	pre/post before 2020-03-19, pre before and post after, pre/post after
IPP	Independent	random effect	22 IPPs with Adult samples pre-post, 12 IPPs with Youth samples
Age in Youth Model	Independent	4-level factor	<=14, 15-16, 17-18, 19+

Appendix 3 contains details of the multilevel regression equations, weighting, multiple imputation, and software implementation used for inference while Table 6.24 summarizes the variables and modeling structures applied to the CDEP Participant Questionnaire database. These are technical details that represent the parameters of the analyses conducted.

Table 6.24: Baseline quantitative model structure: Example layout for K6 endpoint

Variables	Variable Use	Variable Type	Variable Value Range
Change in K6	Outcome	1	Intercept
Pre K6	Independent	1	Slope
Hub	Independent	5	4 intercept adjustments
Age	Independent	6	5 intercept adjustments
Race Alignment with PP	Independent	2	1 intercept adjustment
Gender Identity	Independent	5	4 intercept adjustments
Sexual Orientation	Independent	2	1 intercept adjustment
Unmet Need for Mental Health Services	Independent	2	1 intercept adjustment
IPP Service Model	Independent	4	3 intercept adjustments
COVID Timing	Independent	3	2 intercept adjustments
IPP	Independent	22	covariance – random effect
Hub: Pre K6 Interaction terms	Independent	5	4 slope adjustments
Age in Youth Model	Independent	4	3 intercept adjustments
Model complexity			27 coefficients + random effects

STEP 4: BAYESIAN MULTILEVEL MODELING: FINDINGS FROM MODEL REGRESSIONS (INFERENTIAL STATISTICS)

Step 3 helped build the model. Step 4 focuses on the adult and youth K6 model results for all modeled effects to illustrate how findings are represented and interpreted using Bayesian approaches. The regression analyses conducted are meant to:

- Estimate how much improvement (if any) can be expected from CDEP interventions,
- Determine the extent to which characteristics of the participants, the hubs, or other relevant factors may impinge upon effectiveness estimates.

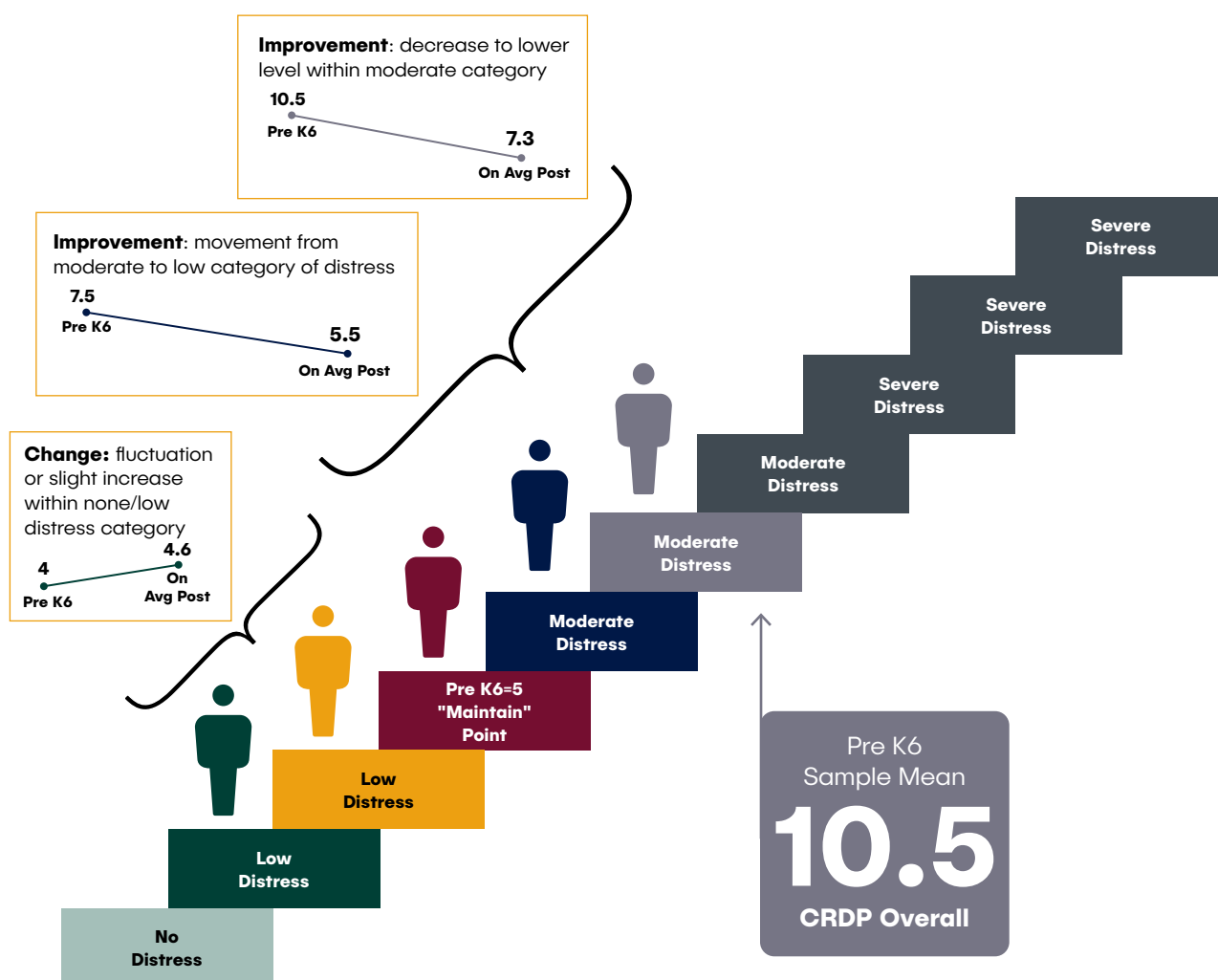
For each of the five outcomes, we estimated the effects of the factors tabulated in Table 6.24 (variables for Quantitative Analyses). The main findings are that adult CDEPs like those in CRDP can be expected to have positive impacts on clients in terms of psychological distress and functional impairment, cultural protective factors, and marginalization and isolation, with clients at higher levels of distress, impairment, etc., experiencing more benefit. Age, race, sexual orientation, gender identity, and, remarkably, even the pandemic, had small impacts in comparison to the overall CRDP-wide gains. Figure 6.33 illustrates the estimated overall effect as well as the impacts on the K6 as an example due to these additional factors. The K6 model for youth looked similar to the model for adults, with the variables demonstrating more modest effects compared with the adult model.

Our primary findings for the CRDP sample are that:

- Adult participants experienced overall improvement in K6, SDSr, protective factors, and marginalization and isolation.
- Youth participants held steady overall in K6, SDSr, protective factors, and marginalization and isolation.
- The diverse characteristics of participants, hubs, and CDEPs, for the most part, had very small impact on the overall effects.
- The pre-intervention levels of the outcomes did show a strong and consistent impact on the level of improvement.
- Our estimates of adult improvements, together with their 95% credible intervals, are given in Table 6.25.
- Our estimates of youth improvements, together with their 95% credible intervals, are given in Table 6.26.

Figure 6.36 below illustrates the relationship between on-average improvement and pre-intervention outcome.

Figure 6.36: Illustration of the Relationship Between CRDP K6 On-Average Improvement and Pre-Intervention Outcome

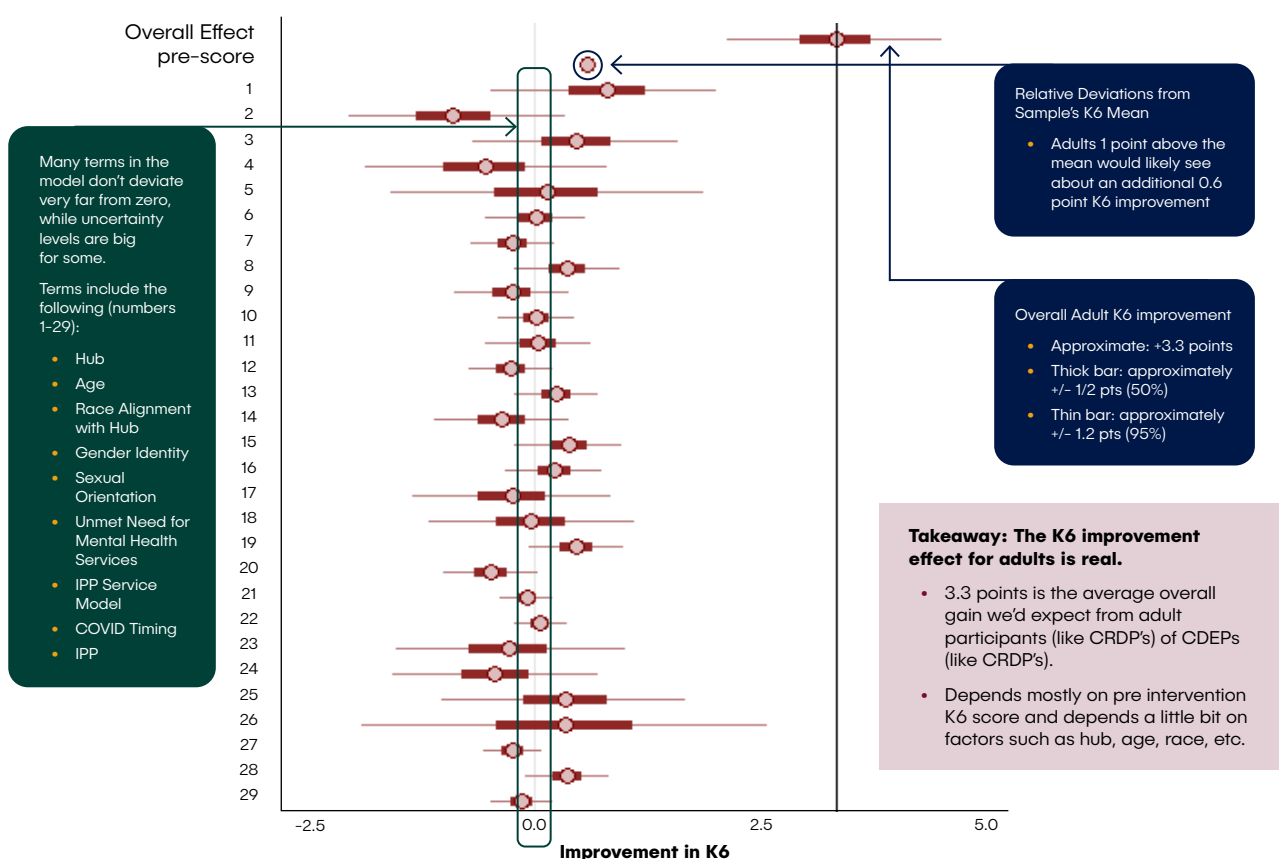


ADULT REGRESSION FINDINGS

CRDP Overall K6 and SDS Outcomes. Both K6 and SDS show large CRDP-wide improvements.

- The K6 sample means for adults were 10.6 (pre-) and 7.2 (post-), respectively. For the K6, the overall improvement is around 3.2 points, with a 95% credible interval of about ± 1 point. That is, we see a 3.2-point overall positive effect pre-to-post for the K6. Additional improvement is demonstrated for participants who are more psychologically distressed, with about 0.6 points of additional K6 improvement for every additional K6 point of distress. All other factors in the model (hub, age, race, and SOGI) show small and uncertain impacts to K6. In other words, the K6 improvement was robust across the board (see Figure 6.37 below).

Figure 6.37: The Bayesian Approach to Modeling Univariate Outcomes: Adult K6 Outcomes Example



Other Univariate Outcome Highlights.

- For SDS, the overall improvement is about one point, ± 0.5 points. Like the K6 result, participants with more SDS-measured impairment saw greater gains, with additional improvement of 0.5 points for every point of additional impairment. Also, like the K6 result, all other factors showed small effects with relatively wide credible intervals.
- The Perceived Connectedness and Strength score, based on four items, also showed CRDP-wide gains of approximately two to three points from pre- to post- measurements. For those reporting lower levels of perceived cultural connectedness and strength pre-CDEP participation, a gain of nearly .75 points for each initially (low) point rating was observed. Again, this reflects a pattern of greater gain for those reporting less perceived cultural connectedness and strength at baseline.

For the most part, the other variables in the model showed small effects with wide credible intervals (e.g., high levels of uncertainty; see Figure 6.37 for all univariate outcomes). One interesting nuance is that the AI/AN participants showed even stronger cultural connectedness improvements from pre- to post-, with an approximately one additional point above the .75-point gains seen in CRDP participants overall. Thus, gains in culture connectedness and strength were a notable outcome of CDEP participation for the AI/AN hub. LGBTQ+ hub participants and White participants (most of whom were served by LGBTQ+ IPPs), however, ended up with slightly decreased cultural connectedness, approximately .3 points below their pre-intervention status.

- The two-item (Connected/Balance score) results also showed overall improvement, with additional gains for those with lower pre-intervention scores. This score showed a great deal more variability across the factors but was similar to the patterns observed in the Culture Connectedness and Strength Regression scores.
- The two-item (Marginalized/Isolated score) results also showed overall improvement (.5-point decrease in Marginalized/Isolated scores from pre-test to posttest), with additional improvements among those who reported high levels of marginalization/isolation pre-intervention.

How was COVID-19 accounted for in the statistical analyses?

The pandemic resulted in a nationwide shutdown and move to remote work in March 2020, with IPPs at different points in their data collection process. A variable called "COVID Timing" was created, with three different options or levels: (1) "Pre-COVID" was the first option and used to categorize IPPs who completed their pre- and post- CDEP Participant Questionnaire data collection prior to March 19, 2020; (2) "Trans-COVID" described IPPs who had collected their "pre-" data prior to March 19, 2020 but had not yet collected their "post-" data, and; (3) "Post-COVID" was the category used to identify IPPs who had not yet started their "pre-" data collection and, by extension, had also not collected their "post-" data by this same date. The resulting 3-level variable was included in all analyses to control for differences in findings due to the timing of CDEP data collection in relation to the pandemic.

What was notable is that this "COVID timing" variable did not have much of an effect in the analyses. That is, the occurrence of COVID did not affect CDEP effectiveness, either separately or considered together with all other variables.

Table 6.25: Adult Estimate Overall Improvement with 95% CI-s for K6, SDSr, CP1, CP2, and SIRF

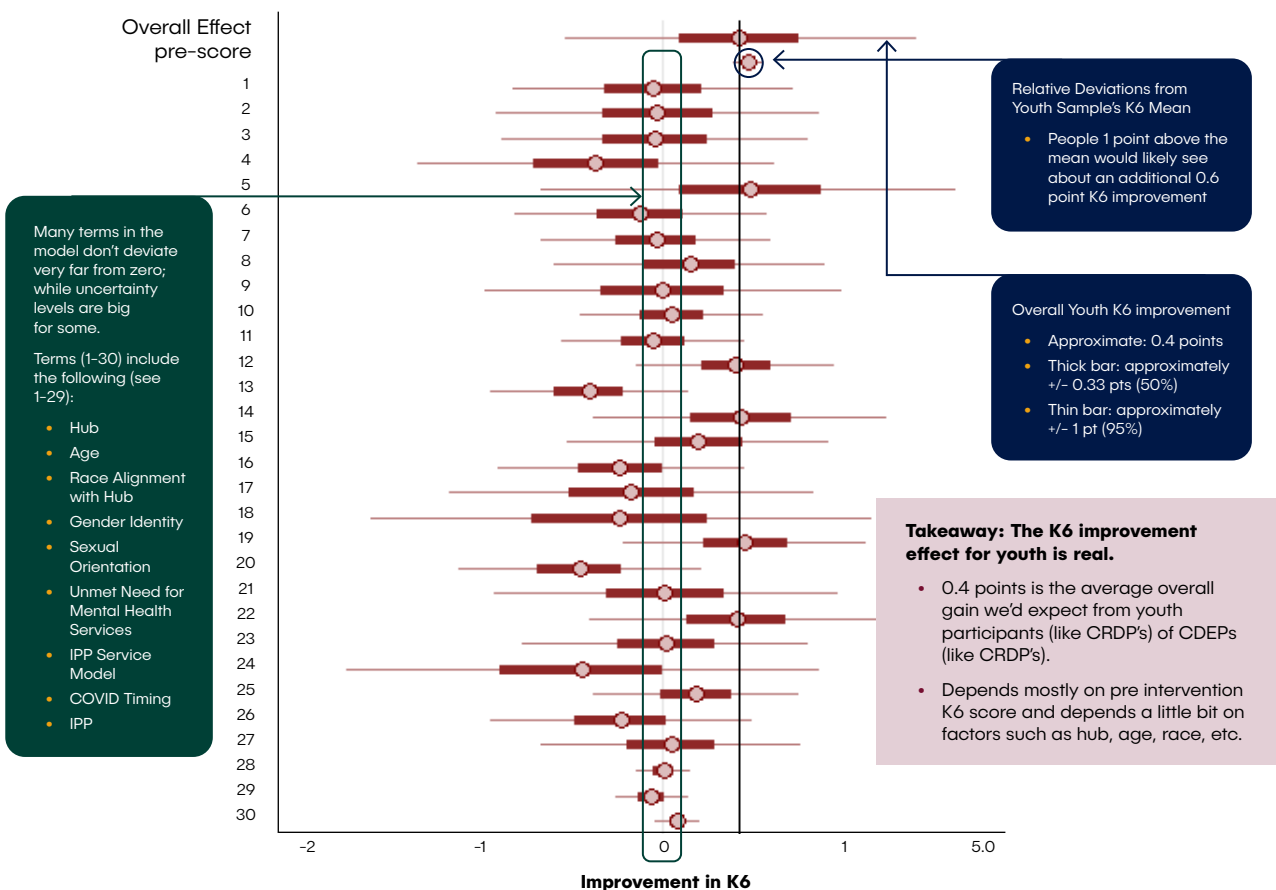
Outcome measure	Estimated overall improvement	Credible interval
K6 Improvement	3.31	(2.13,4.49)
SDS Improvement	1.34	(0.88,1.80)
SDSr Improvement	1.01	(0.63,1.38)
CP 1 Improvement	0.60	(0.03,1.16)
CP 2 Improvement	0.33	(-0.03,0.69)
SIRF Improvement	0.51	(0.04,0.97)



YOUTH REGRESSION FINDINGS

In contrast to the adult findings which highlight the importance of early intervention, the youth regression analysis results are more indicative of the importance of prevention. The youth outcomes did not show CRDP-overall evidence of change from pre-intervention to post-intervention, with credible intervals for overall effects centered near zero and wide credible intervals (see Figure 6.38).

Figure 6.38: The Bayesian Approach to Modeling Univariate Outcomes: Youth K6 Outcomes Example



- The sample means K6, pre- and post-intervention, of the youth K6 were 8.4 and 7.8 respectively. For youth, the pre- and post-difference of 0.6 points is consistent with what would be predicted for a pre-intervention K6 score of 8.4 at baseline. Youth sample means for the SDS outcome, pre- and post-intervention, were 2.3 and 2.2 respectively.
- Perceived Connectedness and Strength (an 8-point scale) also showed no discernable CRDP-wide gain. Again, consistent with the adult findings, the youth participants in the AI/AN hub showed approximately one-point gain on this measure.
- The 2-item past-30-days Connected/Balanced results remained unchanged pre- to post-intervention. Youth from the Latinx hub improved by roughly one unit on this eight-point scale.
- The 2-item risk factor of Marginalization and Isolation score results told a similar overall story. The only specific characteristics of the youth sample that indicated improvement were the 17-18 years of age range and multi-racial youth, both of which showed about 1/2 point improvements.
- Our estimates of youth improvements, together with their 95% credible intervals, are given in Table 6.26.

Table 6.26: Youth Estimate Overall Improvement with 95% CI-s for K6, SDS, CP1, CP2, and SIRF

Outcome measure	Estimated overall improvement	Credible interval
K6 Improvement	0.42	(-0.54,1.41)
SDS Improvement	-0.04	(-0.52,0.42)
CP 1 Improvement	-0.15	(-0.81,0.53)
CP 2 Improvement	-0.28	(-0.87,0.29)
SIRF Improvement	0.03	(-0.51,0.58)

The multilevel models with all outcome variables included were completed for both adults and youth. The findings did not show deviations from what was found in the univariate models presented in this chapter.

The need for a spotlight of Bayesian findings of mental health outcomes emerged after seeing that 36% of adult participants with [a pre-post-matched complete case] K6 data had severe psychological distress (n=649 out of 1,773) at baseline. The SWE took a deeper dive into this sub-sample of adult participants. One of the hubs that was dramatically over-represented was the Latinx hub, which made up 45% of the severe cases (n=1,773), with 51% of the Latinx participants reporting severe psychological distress in the month prior to receiving any CDEP services. Consequently, we provide a Spotlight on Latinx Adult K6 findings.

SPOTLIGHT: LATINX ADULT K6 FINDINGS

Latinx refers to individuals living in the United States that identify their origin, descent, or background as coming from any of 20 Latin American nations (Mexico, Central America, South America, Puerto Rico, Cuba) and Spain.

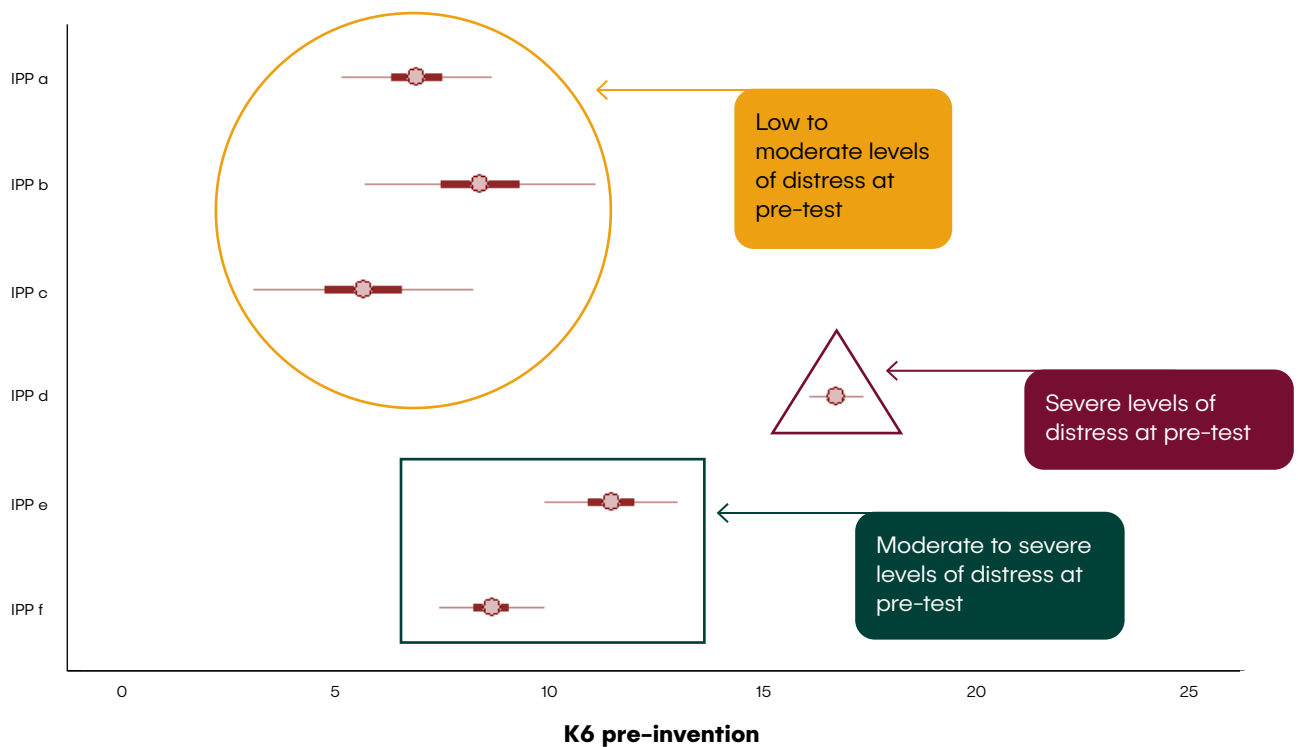
- Within the CRDP, 98% of participants from the matched sample Latinx hub (n=590) identified as Latino, Hispanic, or Spanish, with the remaining 2% identifying their racial origin as White and Multi-racial.
 - » In terms of ethnic origin, 84% identified as Mexican/Chicano, while 7% were Central American (Guatemala, Honduras, Salvadoran, Nicaraguan).
- 85% of Latinx adults had limited English fluency, 89% were born outside of the US, and 8% were refugees.

While the CRDP Latinx adult sample is represented primarily by Mexican/Chicano/a, the statewide evaluation acknowledges the importance of recognizing the variability within the Latinx, and especially the Mexican/Chicano/a, community in our sample. Mendez and Cortina (2021) found that a substantial amount of psychological research on Latinx communities is centered on Mexican/Chicano/a communities, and the focus is primarily through the lens of acculturation and immigrant cultures. We discovered that the findings for this hub are heavily IPP-dependent and analyzing the data for this hub alone illustrates some important aspects of our analysis.

While all six of the Latinx hub IPPs that collected pre- and post-tests for adult participants had both a prevention and early intervention focus in their CDEPs, as one can see in Figure 6.39, the levels of psychological distress at baseline (pre-test) among the participants varied considerably.

- Three IPPs served CDEP participants ranging from the low to moderate levels of distress at pre-intervention (see circle in Figure 6.39). This suggests that these IPPs had more of a prevention focus.
- Two IPPs served participants with moderate to severe level of distress at baseline (see rectangle in Figure 6.39). This suggests that these IPPs had both a prevention and early intervention focus.
- One IPP served participants with high levels of psychological distress at baseline (see triangle in Figure 6.39). This suggests that this IPP had more of an early intervention focus.

Figure 6.39: Diversity of Pre-Intervention Psychological Distress Across Latinx IPPs



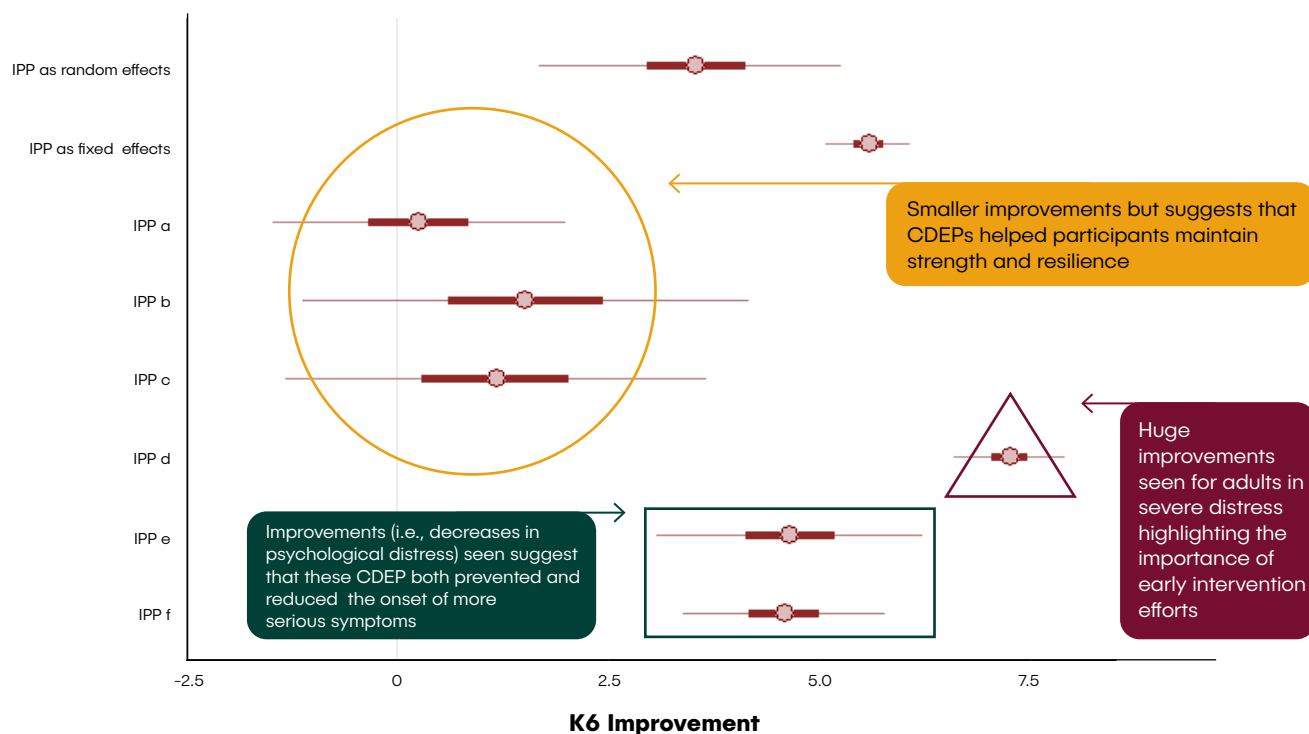
*Note: The range for summed responses for the K6 is zero to 24, with zero suggesting the lowest level of psychological distress and 24 suggesting the highest level of psychological distress, with a score of 13 or greater indicating more serious mental health problems.

In the baseline Bayesian model (see Figure 6.40) the top two credible intervals are mean K6 improvement for the whole Latinx hub.

- At the top of the model, you can see that IPPs are first treated as random effects. In this model, we think of the IPPs as having been sampled from a population of possible Latinx service providers. The mean estimate and credible intervals capture the additional uncertainty of imagining the expected improvement of a client of this larger pool of service providers.
- The second treats IPPs as fixed effects, meaning the credible intervals cover the K6 improvement one might expect for clients in general of these six service providers.
- The remaining intervals are the mean K6 improvement (pre- to post-intervention changes) for each of the six IPPs in the Latinx hub.

It is important to remember that pre-intervention K6 had a strong impact on the amount of change that can be expected. In the figure below, we see that the IPPs with higher K6 pre-scores tended to show the largest improvements. Admittedly there is a lot to unpack in this figure.

- We see that the IPPs whose participants were in higher levels of distress saw greater improvement.
- We also see the impact of the random-effects vs. fixed-effects modeling.
 - › The mean for the fixed effects model is larger than all the IPP means but one (this IPP also had one of the largest sample sizes). Differences in sample sizes of the individual IPPs had a larger impact on the fixed effects model, for each IPP's mean contributes to the overall mean in proportion to its sample size. Therefore, this IPP had a strong effect on the fixed-effect hub mean estimate and its interval width (see triangle in Figure 6.40).
 - › The random-effects model is more conservative in that it attempts to account for the fact that each IPP was sampled from a pool of potential organizations, which adds to the uncertainty in the data and model inferences. The overall hub mean computed this way is larger than all IPP means. Even using a conservative model, we see that this hub collectively contributed to improvements in mental health for their adult participants.

Figure 6.40: Latinx Credible Intervals for Mean K6 improvement**Takeaway**

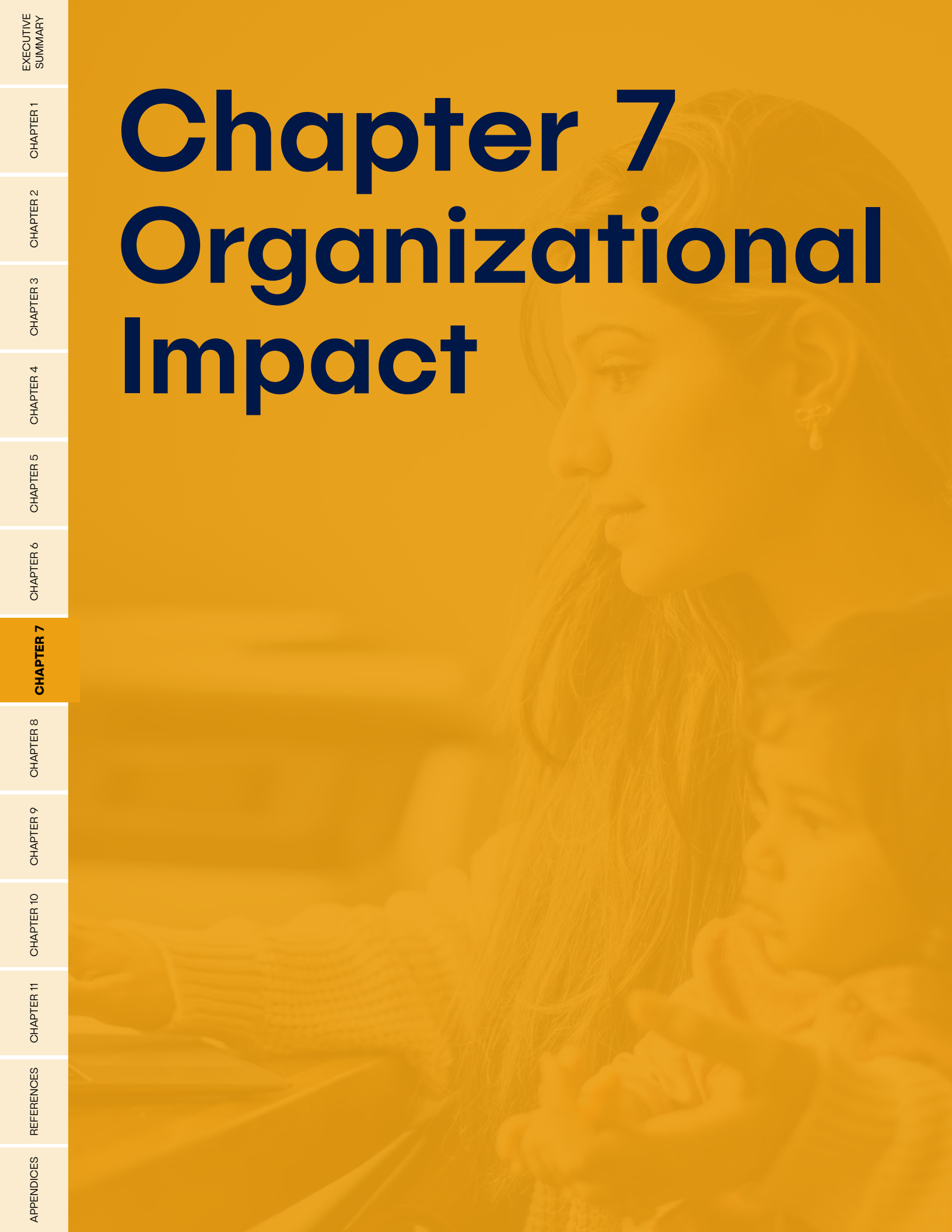
During the span of CRDP Phase 2, Latinx people endured the cumulative impact of various hardships. It began with Donald Trump's presidency, particularly by his anti-immigration stance/policies and racist rhetoric that especially targeted individuals of Mexican origin. This was followed by the California wildfires, with many Latinx IPPs serving communities operating in some of the most extreme wildfire risk areas. This culminated with the COVID-19 pandemic. As one can see from these findings, the model showcases both the resilience of the participants served by the CDEPs and the large psychological cost (e.g., symptoms of depression and anxiety) experienced by a subset of Latinx adults. It also speaks to the important role that the Latinx hub played in providing culturally and linguistically appropriate mental health services during a stressful, traumatic time for Latinx communities. The CDEPs helped maintain/strengthen mental wellbeing for their community members, while helping to reduce psychological distress for others. The diversity in the mental health pre-intervention K6 scores underscores the value of using CDEPs in the provision of mental health services as opposed to a "one size fits all" intervention like evidence-based practices.

These findings suggest that further hub-level analyses could be fruitful to dig more deeply into the meaning of these initial observations.



Chapter 7

Organizational Impact



7.1 IMPLEMENTATION PILOT PROJECT APPROACHES AND STRATEGIES

7.1.A OUTREACH AND RECRUITMENT

Goal 1 of the CRDP Strategic Plan was to increase access to mental health services (CPEHN, Strategic Plan, 2018). One step in reducing mental health disparities and making services more available to those in need is by developing and implementing culturally, linguistically, and LGBTQ+ appropriate outreach. Within CRDP Phase 2, CDEP outreach/recruitment was defined as reaching out to different types of community members in spaces and places where they are naturally located to raise awareness and/or connect individuals with mental health needs to community resources and information and invite and encourage community members to become involved in CDEPs.

During eight six-month reporting periods, from May 2017 to June 2021, IPPs reported the places and spaces in which CDEP outreach and recruitment efforts occurred. For this analysis, longitudinal frequencies were conducted to calculate both the number of IPPs engaging in community outreach and recruitment activities by type, as well as percent effort across the life of the initiative. Outreach and recruitment occurred primarily in ten spaces and places:

- Community resident homes
- School campuses and classrooms
- Places where people publicly congregate
- Local agencies and organizations that offer services to your community
- Community fairs, social/cultural festivals, and events
- Faith-based, religious or spiritual centers
- Conferences and convenings
- Associations and group meetings
- Businesses
- Local mental health agencies & other government offices

NOTE ON HOW TO INTERPRET/READ DATA

Percent effort considers both consistency of activities across time (over 8 periods) in combination with the number of IPPs involved in the specific outreach activity. For example, a 100% effort score for outreach effort at a given place/space would indicate that 7 out of 7 IPPs in a hub conducted outreach activities at each of the 8 periods of analysis.

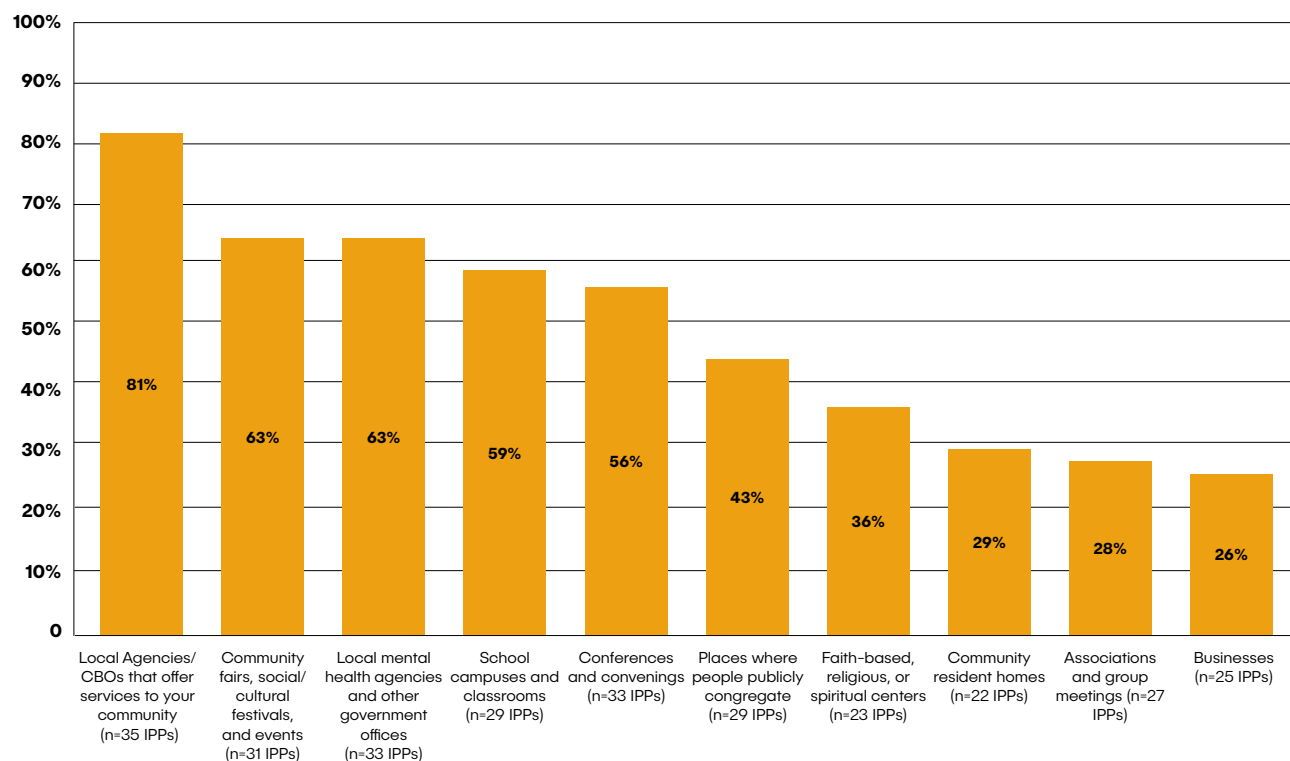
7.1.A.I OVERALL CRDP TRENDS

The most common places/spaces for a majority of IPPs (≥ 29 grantees or 80%+) over the course of the initiative were:

- 81% - local agencies/organizations that offer services to their communities (n=35 IPPs).
- 63% - community fairs, social/cultural festivals, and events (n=31 IPPs).
- 63% - local mental health agencies and other government offices (n=33 IPPs).
- 59% - school campuses and classrooms (n=29 IPPs).
- 56% - conferences/convenings (n=33 IPPs).

Figure 7.1 details the places/spaces where outreach and recruitment occurred. Here, the effort is identical in community fairs, social/cultural festivals, and local mental health agencies (63%). Fewer IPPs conducted outreach activities at community fairs, social/cultural festivals (n=31) in comparison to local mental health agencies (n=33). This example captures the nuances in percent effort and the relevance of consistent outreach/recruitment activities conducted across time.

Figure 7.1: CRDP Overall Outreach and Recruitment Percent Effort by Number of IPPs (May 2017 – June 2021)



7.1.A.II FLOW OF OUTREACH ACTIVITIES THROUGH THE INITIATIVE

The percent effort to conduct CDEP outreach/recruitment across the above listed ten spaces or places was higher in the earlier period of the initiative, with IPPs reaching out more to their communities to increase awareness and participation in their CDEPs. During the last months of the initiative, percent effort and number of grantees involved in CDEP outreach/recruitment in any given space or place naturally decreased and likely was also impacted by the wildfires, COVID-19 and the subsequent shelter in place, and the racial uprisings.

7.1.A.III PRIORITY POPULATION TRENDS

Local agencies were the one place/space used by all priority populations. Latinx and LGBTQ+ hubs reported a percent effort of 89% and 91%, respectively. AfAm, AANHPI and AI/AN hubs reported a percent effort that ranged from 74% to 77%. In addition, the percent effort in the top three places/spaces by hub were:

- **AfAm:** local agencies (76%), mental agencies (63%), and schools (59%).
- **AI/AN:** local agencies (77%), community fairs and social/cultural events (56%), and conferences/ convenings (50%).
- **AANHPI:** local agencies (74%), community fairs and social/cultural events (59%), and mental health agencies (58%).
- **Latinx:** local agencies (89%), schools (85%), and community fairs and social/cultural events (76%)
- **LGBTQ+:** local agencies (91%), community fairs and social/cultural events (79%), and mental health agencies (70%).

Below are exemplary IPP quotes highlighting cultural, linguistic, and LGBTQ+ CDEP outreach approaches.

Table 7.1: CDEP Outreach Examples

CDEP Outreach Examples	
AfAm	<p>"We participated in a Juneteenth event with canopy with our name on it, the kids had their t-shirts on. The kids created a sweet potato shake. We had all 30 kids there, so we asked them to work in shifts. We had a 5x7 coupon for the sweet shakes, so we sent kids out to distribute them in the crowd and talk about the program. Other kids stayed at the booth. We had educational information, a wheel about sweet potatoes, prizes, and kids actually making the sweet shakes. When people came to buy the sweet shakes, I would hear things like, 'man this kid really sold me on the shake.' He talked about the program and I just had to come over here and buy the shake.' So, the kids were prepared in talking about the program and the work. We made over \$300 that day selling sweet shakes. The success was due to the kids and their marketing of the product. And you can see the sense of pride in the kids when people came up to the booth. They were anxious and excited to talk about the program. They were able to implement all they had learned through the program."</p>
AfAm	<p>"As a signature to [CDEP] events, [IPP] 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 the 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-in response to how music vocalizes the shared struggle and journey we face as Black women."</p>
AI/AN	<p>"A majority of outreach was conducted at school campuses, local agencies, and community events. At school campuses we provided cultural arts, medicine wheel teachings, traditional songs, and suicide prevention training for Native American clubs at four local high schools. Through engaging students at the Native American clubs, we increased their awareness of our CDEP and their interest in attending our wellness events. We conducted outreach at a community event hosted by Santa Rosa Junior College called Native American Awareness Day. We tabled throughout the event to engage community members and college students in our program and share our event information. Our staff participated in a panel discussion that included local tribal members who shared insight on growing up Native American, health challenges in tribal communities that include mental health, violence, and suicide. Outreach was also conducted at local health agencies including St. Joseph Health, NAMI Sonoma County, Buckelew Programs, and the Indian Child and Family Preservation Program. Staff attended a planning meeting organized by St. Joseph Health to promote mental health resources to hospital staff during Mental Health Month in May. From the planning meeting came potential collaboration opportunities with the health agencies mentioned above."</p>
AI/AN	<p>"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. [IPP] 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."</p>
AI/AN	<p>"We conducted outreach during large events which we designed and implemented that included community dinners, community activities, and festivals. We strategically put together opportunities for youth to engage with our staff and for parents and other community members to see us as part of the community. Our events, like the Harvestival, where we provided a dinner and music, our Halloween event where we provided activities, and our community music gathering, where we featured a local band that includes one of our staff members, all helped community members to get to know us so that we can build trust and relationship with potential clients and also potential future employees. This helps us to create a fun and engaged atmosphere with our community members. As part of these events, we are also able to share flyers and other information about our programs and projects."</p>

CDEP Outreach Examples

AANHPI

"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 [IPP] 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. [IPP] can convince parents of the benefits as well as assure them of their safety, driving girls to [IPP] activities if necessary."

AANHPI

"We conducted outreach at two major Pacific Islander events: Pacific Islander Day at the San Mateo County Fair and the Aloha Fest. We had a spinning wheel with questions about perceptions of mental health in the PI community and types of services offered. It was our way of getting people to interact with us in a festive manner. We were able to conduct brief demographic surveys after engaging with them. We provide simple prizes for those who participated. We employ Pacific Islander staff and were dressed in festive Island clothing. These were weekend events so some family members attended and some children were present. Having families behind the booth made it less intimidating to approach us as it was a familial environment compared to the Red Cross table next to us who were just sitting behind their table. We also have staff in front of the booth to greet people and engage them in conversation and guide them to our spinning wheel. Our staff was also able to go around and meet other Pacific Islander providers and businesses and invited them to our monthly Journey to Empowerment event."

AANHPI

"Due to the historical negative stigma of mental health and lack of knowledge about mental health services and resources in the Hmong community, our outreach/recruitment efforts are centered on the unique guiding principles, values, beliefs, and practices of the Hmong people. Our approaches are sensitive and individualized toward each of the generations, genders, and religious beliefs and practices. We rely on ethnic specific practices when outreaching and going to their homes or places of worship, which means we make sure we respect and first get permission from the main decision maker before proceeding. For example, we just don't enter a person's place without asking for permission and taking off our shoes. This is a sign of respect not only for the family but house spirits. Also, we are strategic with our use of the media and primarily utilized ethnic media that we know will reach our Hmong community. For our older Hmong we partnered with local well-known radio and TV channels, then with our younger adults and youths we utilize Facebook to help educate our community about CRDP and our [CDEP Intervention]. Furthermore, we employed ethnic cultural recruitment approaches like in "Cog Phoojywg" or creating a meaningful friendship with participants so that they can be our "outreach specialist" and "recruiters." We also go out to cultural events like the Hmong New Year to help with informing the community about CRDP and our CDEP."

Latinx

"[IPP] also continues to visit the local swap meet with the Pan y Café strategy in an effort to conduct outreach in areas where our community is present. The swap meet is a very common place, where our priority population gathers to walk around for distraction and shopping. [IPP] takes advantage of this opportunity to interact with community members who walk by the informational table, where sweat bread and coffee is served and *Radio Indígena* 94.1FM is played. Community members feel connected with the Chilenas playing, which are well-recognized traditional songs, and the information being announced in Mixteco and Spanish that grabs their attention to the informational table. Team members walk around distributing informational pamphlets and inviting community members to stop by to get their sweat bread and coffee."

Latinx

"[IPP] celebrated Latinx Behavioral Health Week by hosting a community event with community collaborators and partners to discuss the social injustice occurring among Latinx community in the U.S. Attendees were also provided a Latinx luncheon, in which the Latinx population places a strong cultural component on serving food. One of the panelists, a member of the Vida Church, discussed her challenges with immigration in her parking lot and other offensive political maneuvers. Other panelists discussed the political climate and what they were doing to assist, and mental health representatives discussed the mental health challenges Latinx community members face. Collectivism is one of our eight principles in which we recognize that Latinx place high priority on the family and extended family and their relationship within the community. They are not as individualistic culture whereby their emphasis is not on the self but on the self in relation to others. The acculturation levels of Latinx's are various, with the younger generation more acculturated generally due to the social impetus of the social systems within which they live, in contrast to the adults who are generally more traditional from the values of their ancestors and family members. The evaluation reports that our local evaluators are creating will share the stories of the Latinx's that we served and show the strength of the collectivist approach."

CDEP Outreach Examples

Latinx	<p>"We do much of our recruitment at the Mexican Consulate where we are co-located along with the [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 from 10 years of administering the [program] that the population that accesses the Consulate services is overwhelmingly medically uninsured and may not have access to health services. We have encountered many cases of men who took a day off from work, in occupations where taking days off doesn't happen often, to access an urgent service from the Consulate. These are often the same men who have not seen a doctor in a decade or more. Our co-location and ability to do outreach at the Mexican Consulate provides these participants with valuable and often lifesaving resources and insight into their current health status. We pay special attention to the messages and language we use to recruit participants to the health screenings during the monthly health fairs. 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 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 we (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."</p>
LGBTQ+	<p>"We participated in several outreach events that were designed to be an open, safe space for the LGBTQ+ community, such as Bakersfield Pride. Additionally, we had an outreach table at large community events to increase visibility and to inform the public about the services our organization provides for the LGBTQ+ community. We intentionally set-up at events that one may not traditionally find "out" community members and where we may or may not be welcomed to share who we are. For example, we participated in the Veterans Stand Down, an event to uplift our veterans. All of the folks who were at our booth are both veterans and part of the LGBTQ+ community or allies of the community. While many of the participants celebrated our attendance at this event, others were dismissive and rude. We find that just being present at these events help to decrease the stigma regarding the LGBTQ+ community in Bakersfield."</p>
LGBTQ+	<p>"Trans day of remembrance is a large cultural event held annually in November. This was the first time this event was held during the pandemic. We set up an outdoor space with social distancing in mind. This strategy was important, and especially so during the pandemic, as honoring our transcestors (trans ancestors) lost in the past year and gathering as a community was integral in addressing social isolation. The event was held in front of a mural of Chyna Gibson, a transgender woman killed in 2017. Community members utilized this space to process grief, loss, and collectively mourn during a period where mental health symptoms were incredibly exacerbated."</p>
LGBTQ+	<p>"[IPP] has listened to community members who have shared their fears about what it would be like for them to leave their home and to 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 On Lok to create the first LGBTQ Community Day Service Center where more frail LGBTQ seniors can continue to participate in [IPP] programming (CDEP). 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 [IPP] 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."</p>



7.1.B. COMMUNITY ENGAGEMENT WITH CDEP PROGRAMS

Goal 3 of the CRDP Strategic Plan was to build on community strengths to empower and increase the capacity of unserved, underserved, and inappropriately served communities (CPEHN, Strategic Plan, 2018). To reduce mental health stigma and to develop and implement pathways to wellness in the communities, it is important that spiritual leaders, the faith-based community, parents, and families in the development, implementation, and evaluation of services be engaged. Within CRDP Phase 2, CDEP community engagement was defined as 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.

To gauge CDEP community engagement within CRDP Phase 2, information was collected on:

- Type of community members engaged.
- Type of engagement.
- IPP cultural, linguistic, and LGBTQ+ appropriate strategies.

Over eight six-month periods, IPPs reported community engagement focused on implementing or making improvements to CDEP programs or activities. Longitudinal frequencies were conducted to calculate the percent effort across the life of the initiative and the number of IPPs reporting type of community members engaged in the implementation or development of CDEP programs or activities.

The types of community members engaged included:

- Youth
- Parents
- Families
- Community residents
- Spiritual leaders
- Healers
- Faith-based leaders
- Other stakeholders (e.g., community leaders, educators, board members, government officials, etc.)

NOTE ON HOW TO INTERPRET/READ DATA

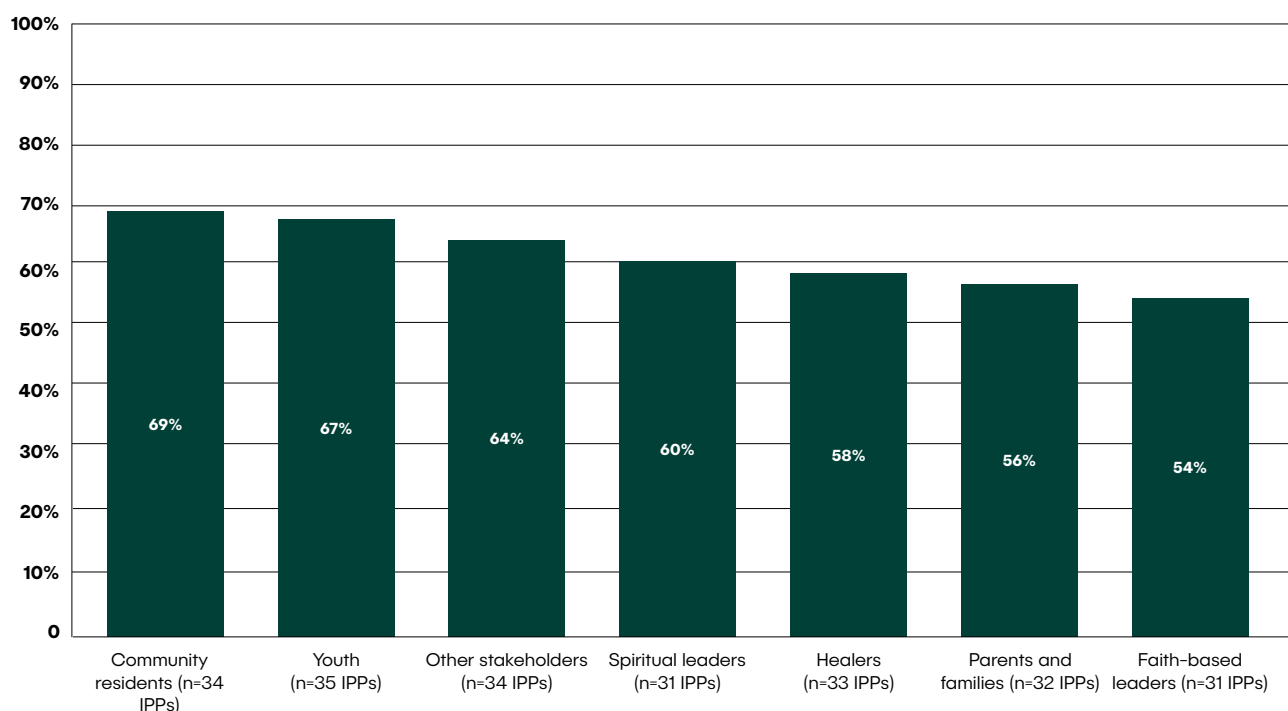
Percent effort considers both consistency of involvement through time (over 8 periods) in combination with the number of IPPs reporting a specific community engaged member. For example, a 100% effort score for engagement from a given community member would indicate that 7 out of 7 IPPs in a hub had that community member involved at each of the 8 periods of analysis.

7.1.B.I CRDP-WIDE TRENDS

Community members were involved in designing, planning, and decision-making across all hubs. The majority of IPPs (34 of 35 grantees) reported consistent community engagement with youth, community residents, and other stakeholders (64% to 69% effort) over the course of the initiative. Parents and families were involved across 32 IPPs with an effort of 56%. Faith-based leaders and spiritual leaders were engaged in CDEP development and implementation across 31 IPPs with an effort of 54% and 60%, respectively. Healers were engaged across 33 IPPs with an effort of 58%.

Figure 7.2 below illustrates all community members engaged in CDEP development and implementation. Effort in engagement from parents and families (56%) was below that of spiritual leaders (60%), even though more IPPs reported parental involvement (n=32 IPPs) compared to leaders (n=31 IPPs). The estimation of percent effort is important because it shows the consistency in community involvement with IPPs through the different reported periods

Figure 7.2: CRDP Overall Community Engagement Percent Effort by Number of IPPs (May 2017 – June 2021)



7.1.B.II PRIORITY POPULATION HUB TRENDS

Youth were involved in community development and implementation across all priority population hubs and IPPs. Even though youth were engaged across 35 IPPs, the percent effort varied by hub. AfAm, LGBTQ+ and AI/AN hubs reported effort that ranged from 72% to 81%, while AANHPI and Latinx hubs reported an effort of 48% to 56%. Community residents were engaged in community development and implementation (ranging from 55% to 83%) across 34 of 35 IPPs. Levels of percent effort were similar across hubs for healers (50% to 84%) and spiritual leaders (53% to 80%). Although healers were engaged across 33 IPPs and spiritual leaders in 31 IPPs, involvement from faith-based leaders was more uniform across hubs with an effort that ranged from 53% to 61% across 31 IPPs.

These findings show that IPPs welcomed the involvement of different types of community members in the development, implementation, and evaluation of services across the entire initiative and throughout the different hubs. Within this engagement, community members actively participated in planning and decision-making to improve the effectiveness of the CDEPs.



Below are sample quotes of IPP reports related to community engagement.

Table 7.2: CDEP Community Engagement Examples

CDEP Community Engagement	
AfAm	“We are always looking for more people who can provide 1:1 support/work with the students. So, we get college and high school students to come in and volunteer. Most recently we had a group of basketball players come and sit with the kids and sometimes share stories with the kids. They come almost every week. This is helpful because there are so few Black people left in the community. So, they help make the experience of the children a positive one.”
AfAm	“Students: We also ask students to serve as leaders during the group. We also invite them to play key roles like serving as an editor of a newly created CDEP newsletter. We identified this role for one of our youths in particular based on his particular skillset and interests. School district: Fresno Unified, which is the fifth largest school district in the state of California, has purchased 3000 pounds of our sweet potatoes, and they are using them to make empanadas to sell as part of the school lunch in the cafeteria. We now have a second school district planning to purchase the sweet potatoes for their cafeteria as well. Both schools have students who are part of our program. Police department: Our local police department came to our end-of-the-year celebration and has donated bicycles for two years in a row, and last year donated tablets to the kids at our program graduation. Their Police Activity League (PAL) sponsored a shopping spree for each of the 30 youth in our program. They also come to serve as guest speakers for our program from time to time to discuss topics such as gang activity.”
AfAm	“In February 2019, our local evaluator conducted a focus group with 12 program participants. The purpose of the focus group was to gather participant input both on the program and on the evaluation tools and procedures. During this session, focus group participants indicated that they wanted more time with [IPP] staff, and that the 35-minute program session was too short. The [IPP] team brought this feedback to school administrators in April and May 2019. One proposed solution was to use the advisory class, but there were too many students in the room for this to be effective. Instead, the administration restructured the schedule to extend therapeutic and restorative sessions to 50 minutes. Through this process, student voice helped to improve the structure and design of the program. In another area of community engagement, the [IPP] team met with school administrators and asked them to weigh in on what they felt were the underlying causes of the racial disparity in the school's suspension data. School administrators identified a need for professional development for school personnel, including training in how to dismantle implicit racial bias. Our team delivered a preliminary professional development session on this topic, after which our team conducted a needs assessment of professional development priorities. Additional implicit bias training, as well as restorative classroom management, were identified, and 10.5 hours of training was delivered to the entire faculty during the current reporting period.”
AI/AN	“Feedback was received from traditional healers and discussions were also held with residents regarding their needs. Feedback is generated through post-ceremony participant feedback, follow-up meetings, and post-ceremony facilitator survey. Information is shared and modifications are made as needed through the decisions at [IPP] monthly grant meetings and/or quarterly quality assurance meetings. As a result of feedback provided, adjustments were made to schedules to accommodate both community and resident needs. Traditional Healers were provided additional ceremony support [and at an additional site]. In addition, technical support is ongoing through [IPP] to assist the site in conducting Traditional Healer Ceremonies.”
AI/AN	“Planning and executing La Jolla and Santa Ysabel [CDEP] events. Youth were responsible for planning and creating all elements for the La Jolla and Santa Ysabel [CDEP] events, respectively). Santa Ysabel Youth Coordinators also made suggestions for best practice when working with their youth and these youth coordinators also helped brainstorm ideas for the event. Youth planners from Santa Ysabel were involved in every aspect of planning the [CDEP] event, from creating the theme of ‘CULTURE’ for the event, designing t-shirts featuring traditional rattle, creating an event flyer featuring bird singers, and writing/directing a promotional video centered around the powerful wisdom of ancestors. A community elder attended several [CDEP] meetings to help the youth with their tasks. This elder also participated as an actor for the promotional video. Community residents also performed at the [CDEP] event”.

CDEP Community Engagement

AI/AN

"Our community advisory board is made up of community members and spiritual/cultural leaders. They worked diligently to revise and approve the cultural activities and programs. Our cultural consultants are also community members local to this region. They designed the program based on their expertise and knowledge of our tribal peoples and places. At each of the events, youth are asked to fill out an evaluation form. Questions on this form include an opportunity for them to reflect on the program and what they liked or what they would like to see changed. We read through these surveys after each event and use them to improve upon the program for the next event. In addition, we meet with all staff members and college-age mentors to discuss each program after it is completed. This one-hour qualitative evaluation helps to shape the next event as well. Cultural consultants, college mentors, community leaders, youth parents, and community advisory board members all attend our events. They are able to help assist with the implementation of activities and also help to contribute to the cultural information that is shared with our youth."

AANHPI

"The [CDEP] staff convenes a quarterly [CDEP advisory committee] meeting with community stakeholders to discuss updates to the program activities and evaluation, current issues that require [CDEP advisory committee] member input, and to seek guidance on how to improve the program content and format. [CDEP advisory committee] has six committed members including leaders from the local Hmong community, service providers, county officials, and [CDEP] participants."

AANHPI

"The leadership team and [community health workers (CHWs)] continue to play a key role in deciding what activities to include in the [CDEP] that would be most culturally relevant. We also engage CHWs in determining if activities would be well received by participants and if they would be feasible to carry out due to the ongoing challenges (e.g., lack of transportation). As reported previously, we work with partners and agencies outside of the [CDEP] collaborative to create a repository of health and social service referrals for participants. These partners include Orange County Social Service Agency for benefits enrollment, Asian Americans Advancing Justice for legal assistance, and Susan G. Komen-Orange County for mammograms. Our recently completed community garden was made possible through in-kind support from a youth program (Educating Men with Meaningful Messages [EM3]). Other examples of engaging the community in program implementation include in-kind support from participants themselves, who often cook the food that is offered to Buddhist monks during water blessings and visits to the Buddhist temple, and who help to provide transportation for other participants."

AANHPI

"In July we welcomed two new CAB Members. Both are Pacific Islanders, active community members, and have participated in the parent workshops as well as other events. They have volunteered at various events helping us carry out some of our activities. They've also helped us with the administration of the SWE Surveys, making themselves available to help explain a question and how to respond to it."

Latinx

"Feedback from our six participants was used to set up the Therapeutic [CDEP] Group to fit clients' expressed needs in order to attend. Graton Center participants were immigrants and day laborers. Their direct feedback about their interest was that services needed to be open to their inconsistent ability to meet weekly due to late-night and long-hour demanding jobs, free of charge. They requested to have the information provided in Spanish and given orally versus in paper format. They asked directly if men and women would be allowed as well, that they liked being in a group with both and would like more of that sharing. At the end of [CDEP] they all expressed that they liked the gathering and wished they had brought a friend along. Some expressed they had never shared so openly about their struggles."

Latinx

"The Santa Rosa Junior College (SRJC) and Sonoma State University (SSU) staff were instrumental in the [CDEP] team's recruitment efforts. They allowed space for the team to give presentations to certain classes and encouraged students to apply for the program. The Roseland Community has become increasingly supportive of the [CDEP], which has led to many invitations to participate in Roseland Community events, like mini-conferences and health fairs. Parents from the ELAC and DELAC communities have also provided the Youth Promotores to conduct pláticas in their spaces and are often engaged during the presentations. Our April Noche de Padres y Amigos was also an opportunity for the Youth Promotor parents to engage with [CDEP] staff as well as receive a group therapy session for another partner organization called Humanidad Therapy and Education Services."

CDEP Community Engagement

Latinx	<p>"Partner agency TVHC organized a series of groups for youth as well as [IPP] in Livermore using curriculum Joven Noble. In addition, we engaged a group of Indigenous leaders called Grupo Desarrollo Maya who met regularly with educator and manager to advise our program and plan activities to engage Indigenous communities. We also had a series of presentations at ASPIRE high school in Oakland and participated in their annual careers in public health conference. We engaged traditional healers and organized nine traditional healing events. Additionally, in December we joined forces with an organization called Street Level Health to provide hygiene kits, information and outreach to clients during their Christmas event and during the high of last winter's COVID surge. Other stand-alone workshops were also organized by our program including on traditional healing, medicinal herbs, gratitude, and spirituality."</p>
LGBTQ+	<p>"Stakeholders representing each of our target populations (primary trans and gender non-conforming adults and transitional age youth) provided feedback into the adaptation and tailored curriculum development of the intervention, which was adapted from an established intervention to improve communication among Asian and Pacific Islander women. We solicited feedback specifically related to cultural sensitivity, relevance to the target population, and intersectionality."</p>
LGBTQ+	<p>"The school principals and admin at our three testing sites have acknowledged the value of services and have made efforts to integrate our program into more school activities. Youth, community members, and parents have given feedback through surveys that have resulted in modifications to our program. Youth continued to support improving school climates. Parents, and community members participated in our two stakeholder committees, Education and Foster Youth and faith-based organizations and spiritual leaders support through our non-profit collaborative. Faith-based and spiritual leaders also facilitated and participated in our Family Day at the Park event."</p>
LGBTQ+	<p>"For CDEP Component One (connections to peers and appropriate resources), youth who facilitated or attended support groups debriefed successes and challenges after each meeting. This feedback was then used to make immediate adjustments to program implementation and inform the future development of the component. Youth leaders in CDEP Component Two worked with peer coaches from the community to identify community issues, which are then prioritized and addressed through the team's chosen advocacy project. The coaches or mentors that advise the projects are also residents of the community the project aims to impact. For CDEP Component Three (youth-informed workforce training), youth and community residents that served as panelists during trainings debriefed with staff to identify successes and challenges from the training. Community residents were further engaged in CDEP Component Three by responding to a survey for training attendees at the end of training and provided feedback on their experience. The feedback from the panelists and community resident attendees was then used to refine future training delivery and content."</p>



7.1.C PUBLIC COMMUNICATIONS

To increase awareness and understanding of mental health, promote emotional health and wellness, and increase access to mental health services or other resources and supports, IPPs used public communication campaigns. Various forms of media and messaging were used to shape attitudes, values, or behaviors among the broader community. The following public communication types were reported:

- Newsletters
- Brochures/leaflet
- 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)

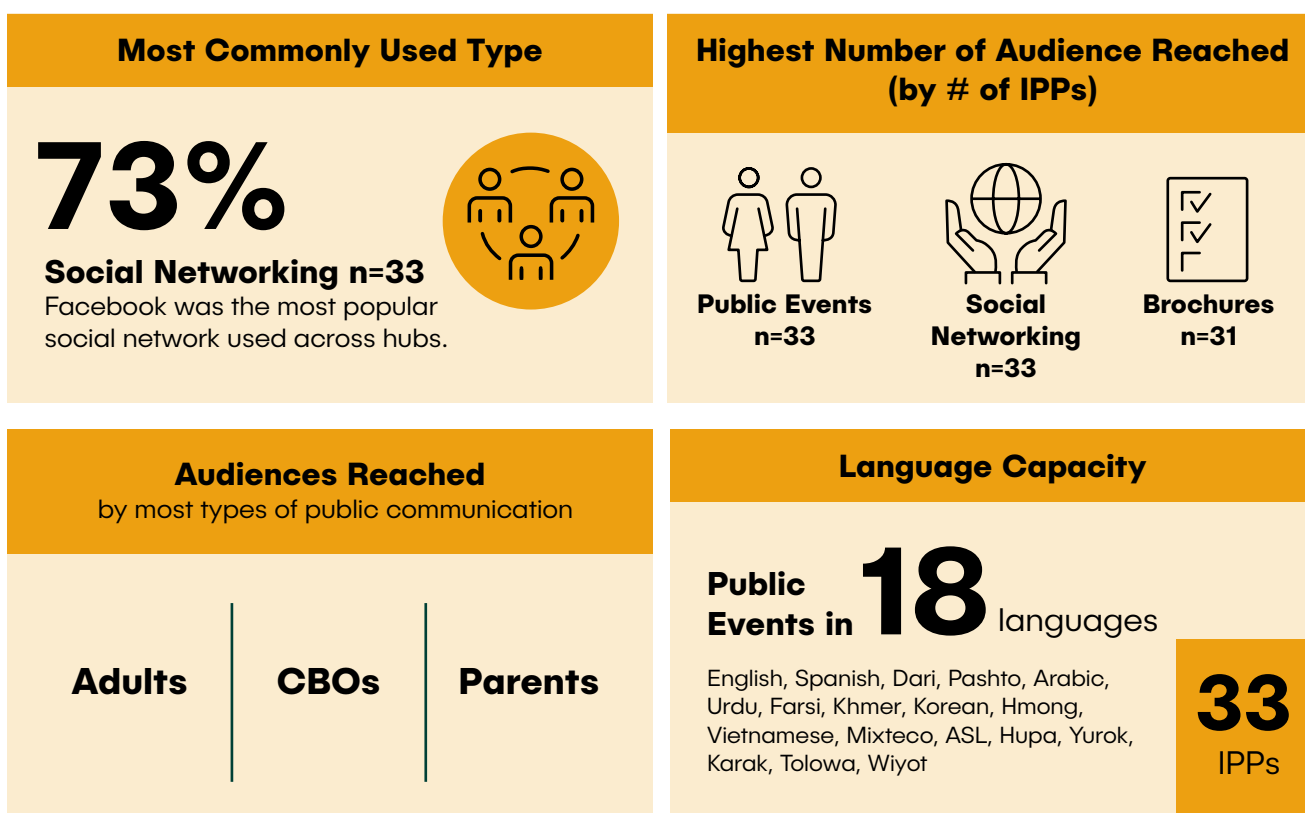
NOTE ON HOW TO INTERPRET/READ DATA

Percent effort considers both consistency of activities over time (over 8 periods) in combination with the number of IPPs involved in the specific public communication strategy. For example, a 100% effort score for a public communication strategy would indicate that 7 out of 7 IPPs in a hub used this strategy at each of the 8 SAR reporting periods.

IPPs applied their breadth of knowledge and skills to reach their priority populations. (See Figure 7.3). Social networking was the most often cited form of public communication used by all hubs (33 of 35 IPPs). Across the eight reporting periods, IPPs reported a percent effort of 73% in social networking. Among the different types of audiences, IPPs reached out with the greatest frequency to adults, community-based organizations (CBOs), and parents. Most IPPs (31 to 33) reached out to large audiences through public events, social networking, and brochures. The cultural and linguistic diversity of CRDP is reflected in the diverse set of languages used across public communication efforts. Further, 18 languages were used at public events.



Figure 7.3: Type of Public Communication, Audience Reached, Language Capacity

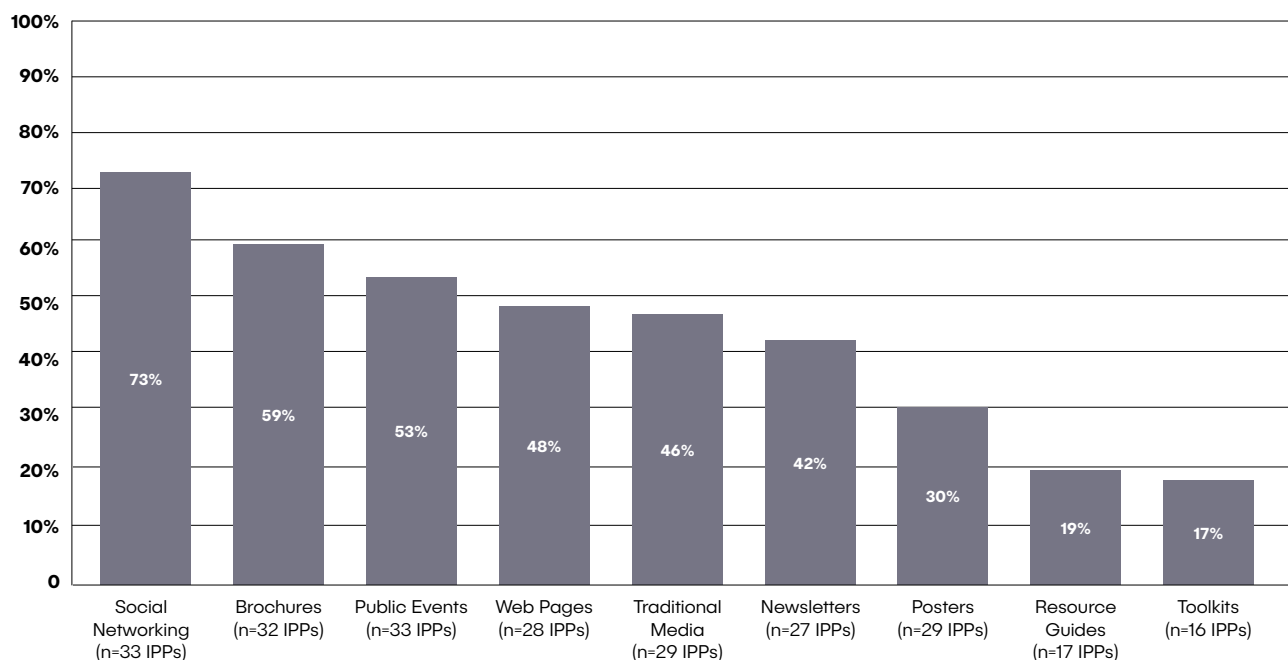


7.1.C.I TYPE OF PUBLIC COMMUNICATION STRATEGY

Across the eight six-month reporting periods, 33 IPPs used public events and social networking as their chief strategies, followed by brochures (n=32). Social networking showed the highest percent effort (73%) across both IPPs and time periods. Figure 7.4 illustrates the types of public communication efforts, the associated percent effort, and the number of IPPs using each type.

Figure 7.4: Use of Public Communication Strategies

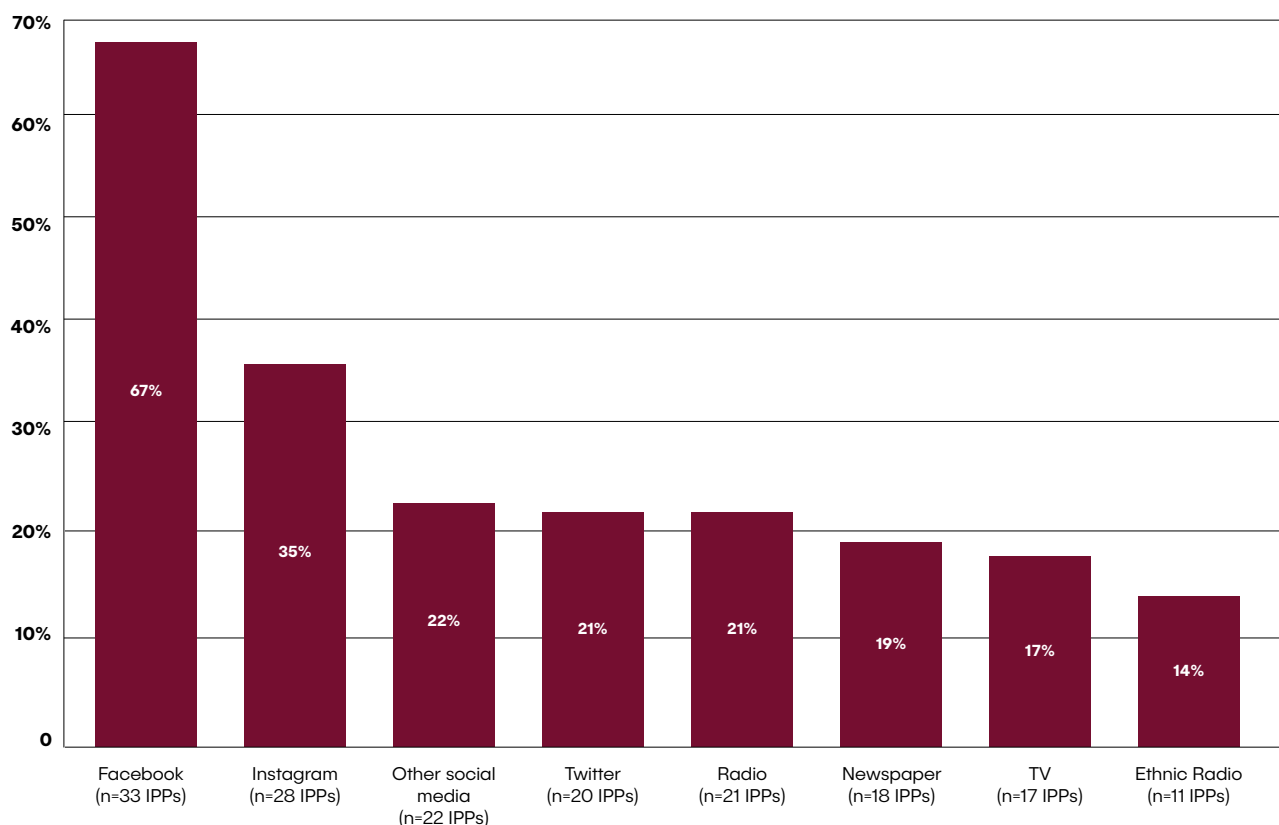
(May 2017 – June 2021)



Social networking and traditional media were highly used. Figure 7.5 disaggregates these broad categories. Social networking played a key role in IPP communications. Facebook was used by 33 IPPs with an effort of 67% across IPPs and time periods. Instagram was used by 28 IPPs with an effort of 35%; 22 IPPs used other social media (e.g., YouTube, Snap Chat, Tumblr, and others) at 22% effort, and 20 IPPs used Twitter at 21% effort. Traditional media was not as widely used but was very important in communicating IPPs' message: 21 IPPs used mainstream radio; 18 used newspapers, 17 used TV, and 11 participated in ethnic radio shows.

Figure 7.5: Social Networking and Traditional Media Use

(May 2017 – June 2021)



7.1.C.II TYPE OF AUDIENCE REACHED AND LANGUAGE CAPACITY

Public communication strategies reached a variety of audiences. IPPs reported reaching youth, parents, adults, community-based organizations, faith-based organizations, tribal groups, K-12 schools/districts, colleges/universities, government agencies/departments, and decision makers/policymakers. Most IPPs (n=34) reached out to adults/parents (n=33) and CBOs (n=32). These groups were accessed mostly at public events and through social networking.

In terms of language capacity, English and Spanish were the two most often used languages across all types of public communication strategies. Depending on the type of public communication, 15 to 32 IPPs used English and eight to 15 IPPs used Spanish. Across hubs, public events had the highest language diversity with 18 languages that included (in no order): American Sign Language (ASL), Arabic, Dari, English, Farsi, Hmong, Hupa, Karak, Khmer, Korean, Mixteco, Spanish, Pashto, Tolowam Urdu, Vietnamese, Wiyot, and Yurok.

7.1.C.III TOTAL NUMBER OF AUDIENCES REACHED

A majority of IPPs (n=33) used public events and social networking to increase awareness and understanding of mental health. On average, 2,242 people were reached at public events and 12,297 were reached via different social networks. It is important to note that IPPs estimated the total number of audiences reached as accurately as possible, but for some strategies the numbers are approximate and reflect some uncertainty. (See Table 7.3).

Table 7.3: Total and Average Number of Audiences Reached CRDP Wide

Type of public communication effort	Average	Total	Number of IPPs
Public Events	2,242	11,210	33
Social Networking	12,297	61,485	33
Brochures	735	3,677	31
Posters	397	1,984	27
Newsletters	988	4,941	23
Informational Web Pages	2,774	13,870	23
Traditional Media	40,256	201,280	22
Toolkits	213	1,066	14
Resource Guides	147	735	13

NOTE ON TRADITIONAL MEDIA AND SOCIAL NETWORKING NUMBERS

On some occasions, the number of people reached through traditional media may have been overestimated. For example, if an IPP appeared on a TV show segment, the reported estimated audience reached was the network's global estimate of viewers. Audience reached through radio shows was reported similarly. Because it is hard to estimate the actual number of people listening to an IPP on a radio show, the reported estimates were based on global radio listeners for a given radio station. For those reasons, the total and average audience numbers reached for traditional media are significantly higher when compared to other types of traditional media (as shown in the table above).

In the case of social networking, there were some differences in the way public communication efforts were reported. For example, to estimate audience reached for Facebook, some IPPs reported number of "likes" on a post while other IPPs counted comments as a proxy for engagement, and others reported number of people connecting to a "live." Numbers were included as reported by IPPs.

7.1.D CULTURALLY RESPONSIVE SERVICE DELIVERY



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)

IPPs implemented their CDEPs using cultural, linguistic, LGBTQ+, and other community-affirming approaches to ensure their CDEPs were respectful of and relevant to the diverse worldviews, experiences, and needs of their communities. The examples below illustrate how these approaches manifested across the five priority population hubs, with a specific focus on the core practices and traditions, and guiding principles, values, and beliefs guiding their efforts.

Table 7.4: CDEP Culturally Responsive Service Delivery

CDEP Culturally Responsive Service Delivery	
AfAm	“The [CDEP] LA graduates decided to wear white as a recognition of the ancestors and bringing their love and legacy into the celebrations. Through music and soul food, the SMM extended community was brought together to celebrate the dedication and intentionality of each sister in advancing her understanding and need for mental health wellness, not just for herself, but community. As a tribute to the sisters and as part of the opening of the graduation, [IPP] staff asked permission of the elders to begin the celebration which then commenced with libations conducted by [CDEP] guest speaker Misty Powell honoring the ancestors and calling their presence into the ceremony. The graduation incorporated African traditions of storytelling through the [CDEP LA group] testimonial video which provided insights from each sister on the experience they had from [CDEP] and a call-and-response program format that allowed family and friends to share with their own testimonies and stories highlighting the importance of mental health wellness and awareness in the Black community. [CDEP LA group] graduates shared poetry, spoken word, and made sister bracelets/regalia as a tribute to the sisterhood and connection to each other.”
AfAm	“We use African-centered indigenous practices in our delivery of service during groups. We meet in circle and use a talking-piece to support the distribution of power and level of the playing field between adults and youth. We use culturally relevant artifacts, music, and food, and education to support engagement of youth and to debunk the myth of African American inferiority.”
AI/AN	“It is customary that each activity held at [IPP] provides food. Each [CDEP] session includes a communal dinner. Before dinner is served the community is invited to stand if that is their tradition or remain seated if that is their tradition to prepare for prayer. Native American regalia is a component of the cultural education program. The instructors wear full regalia for the introduction session and the final session. Regalia making workshops are available. Lender shawls are available for use for one of the types of dancing styles. Drum sticks are provided for those who come to learn to drum.”
AI/AN	“The [CDEP] curriculum and key fidelity elements addresses several codes listed here. For the purposes on keeping this brief as a multi-site [CDEP], on the topic of ‘what broke our Indian world apart?’ and ‘what can bring it together?’ helped us untangle intergenerational trauma and the impact it has on our people, with multiple vantage points and methods of implementation. Some covered alcohol and drug dependence, traditional uses of tobacco, importance of clean land and water, how colonization has impacted down to the way we eat, etc. There were also cultural teachings around the ribbon skirt for the Bay Area. During the water walk, elders brought additional skirts so that young girls can present themselves to the earth and ceremony in a good way. Many girls were seen pulling their skirts down to be in touch with the earth as a means to generate connection with the woman as a divine being and the earth. Many young girls and boys learned traditional songs and were found singing them throughout arts-and-crafts time.”
AI/AN	“During the month of November, we celebrated Native American Heritage Month with special virtual programming in our CDEPs. We created the Red Dress Special, Virtual Speaker Series to highlight Native American women/femme educators, advocates, artists, and healers in the community. The Red Dress Special series was dedicated to the MMIWG2S (Missing & Murdered Indigenous Women/ Girls/Two-Spirit). Throughout the Native American Heritage Month. Each component of the CDEP had guest speakers join virtually to share cultural knowledge, stories, arts. The San Jose Native Youth Empowerment group learned how to decorate feathers and make gourd rattles. Traditional song and dance guest speakers shared their different tribes’ styles of music, dance, and their personal experience creating and recording music.”
AANHPI	“Program staff provided cultural foods and social spaces/times for elders to gather around during recreational group days. Participants were able to converse with their peers and enjoy learning new topics taught by program staff. Participants were able to decrease their stress and increase their mental wellbeing when surrounded by their peers. For the past six months, program staff gave participants a special role within the community garden. Participants collaborated to tend the garden and plant any crops they liked. The community garden served as a therapeutic garden to help participants with their physical, psychological, social, and spiritual needs. Program staff accompanied participants to their provider appointments and provided interpretation when necessary. Staff also transported participants to and from their appointments and during recreational group days as well.”

7.1.E CDEP FIDELITY AND FLEXIBILITY

Fidelity and flexibility assessments were conducted during CRDP Phase 2 to assess the degree to which CDEP components, protocols, and procedures were delivered as intended. In contrast to traditional intervention fidelity studies which primarily focus on the extent to which an intervention maintains its original form (Carroll et al., 2007), fidelity assessments in the context of community-based interventions view programmatic adaptations as necessary, especially when changes are made to enhance participant outcomes, program fit, and integration of the intervention into practice in real world settings (Cohen et al., 2008). Very few interventions are delivered with 100% implementation fidelity in community settings, and this poses an opportunity for service providers to implement program adaptation and flexibility that enhance community-based program delivery. Interventions that feature innovation, adaptation, and flexibility in implementing programs have improved program outcomes in some settings (Durlak & DuPre, 2008).

For CRDP Phase 2, fidelity became increasingly framed in relation to an IPP's mission and goals, rather than simple adherence to the plan for CDEP implementation (see Chapter 5 for a discussion of fidelity among CRDP partners). In responding to COVID-19, for example, all CDEPs had to shift to online, regardless of whether their original design included this element. Yet, the IPP commitment to their communities remained steadfast even as the manifestations of this commitment took different forms over the course of CRDP Phase 2. Consequently, an expanded understanding of fidelity, or mission fidelity, is proposed and defined as the extent to which IPPs adhered to their core mission, including their commitment to be responsive to the cultural values and community contexts of their priority populations. For the purposes of this assessment, a more focused understanding of fidelity is also useful. The implementation fidelity is operationalized as the extent to which IPPs adhered to the core structure and planned execution of their CDEP components as originally described in their local evaluation plans.

CDEPs that demonstrate fidelity to major CDEP program components (implementation fidelity) as well as flexibility in developing adaptations that enhance ecological fit (mission fidelity) can lead to improved outcomes for CRDP. For these reasons, the CRDP Phase 2 fidelity assessment situates IPPs' adherence and fidelity to their core CDEP implementation strategies alongside responsiveness and flexibility that reflect IPPs' commitment to their core mission.

For the evaluation of implementation fidelity, major changes to CDEPs are defined as changes to the overall structure of the CDEP (e.g., components added or dropped), which impact implementation fidelity. Minor modifications are defined as changes within CDEP program components; when these changes result in improved capacity or ability of CDEPs to be implemented, then these changes constitute implementation fidelity. External contextual factors (including the onset and impact of COVID-19, racial uprisings, and California wildfires) challenged IPPs' capacity to adhere to their initial CDEP program implementation strategy, yet also provided opportunities to address the immediate needs and well-being of their communities considering these factors. We assessed the impact of these external factors that necessitated many programmatic shifts over time. When these shifts were made to enhance CDEP capacity to respond to community concerns we framed them in terms of mission fidelity. See Table 7.5 for a summary of these types of fidelity.

Table 7.5: Fidelity and Flexibility Definitions within CRDP Phase 2

Types of Changes	Types of Fidelity within CRDP Phase 2	
	Implementation Fidelity Adherence to CDEP core structure and execution.	Mission Fidelity Adherence to CDEP core mission and community context.
Major Modifications	Changes to overall CDEP structure.	Changes to CDEP purpose and goals.
Minor Modifications	Changes within CDEP components.	Changes to CDEP objectives and strategies (i.e., changes in activities to help the CDEP to achieve its purpose and goals).
Flexibility: How are changes viewed?	Flexibility viewed as changes that enhance CDEP implementation.	Flexibility viewed as changes that enhance CDEP responsiveness to community context.

Shifts that affect mission fidelity will also impact implementation fidelity, but the converse may not necessarily occur; changes that affect implementation fidelity may not necessarily affect mission fidelity. For example, a CDEP may add a CDEP program component in response to feedback (major modification), affecting its implementation fidelity. Unless this program component addition affects CDEP purpose, goals, objectives, or strategies, it would not affect its mission fidelity. The focus of the present assessment is on the implementation fidelity of the CDEPs, but the concept of mission fidelity is helpful to keep in mind.

Data for the implementation fidelity analyses were extracted from two sources:

- CDEP component descriptions documented in each IPP's local evaluation plan, which provided the criteria to monitor implementation fidelity associated with each program component.
- IPP semi-annual reports (collected from May 2017 to April 2021) noting modifications, adaptations, disruptions, and/or other changes made to CDEP components (e.g., number of program components at the start and end of the initiative; new components added; components dropped; component duration; unplanned delays.)

NOTE ABOUT CDEP CORE COMPONENTS

IPPs provided detailed information in their local evaluation plans about the individual elements comprising their CDEPs. This included:

- Component name (e.g., a family session, access and linkages).
- Description: (e.g., primary goals and activities).
- Duration (e.g., three-week CDEP).
- Number of activities (e.g., six activities in total).
- Frequency (e.g., two times per week) and length of activities (e.g., three hours for each activity).
- Number and demographic features of participants.
- 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).
- How each component reflected the cultural values, practices, and beliefs of their communities.

CDEP component types ranged from mental health outreach, education, and awareness, to workforce development, to family wraparound supports. Most IPPs reported an average of four components to their CDEPs. As an example of the types of components reported, one IPP outlined the following five primary CDEP components: Aunties and Uncles Training and Intervention; Community Wellness Gatherings; Talking Circles; Mental Health Prevention and Education Campaign; and PHQ-9 & PHQ-A Depression Screenings. Detailed information on CDEP component development is available in the CRDP Statewide Evaluation Guidelines (Psychology Applied Research Center, 2017).

Analysis involved a quantitative and qualitative thematic examination across three different time periods¹⁷:

- CRDP Phase 2 Launch (March 2017 to April 2018)
- CRDP Phase 2 implementation and Pivot (May 2018 to April 2020)
- CRDP Phase 2 Sustain (May 2020 to April 2021)

7.1.E.I IDENTIFICATION OF CDEPS AND THEIR COMPONENTS

A total of 133 CDEP components across the 35 IPPs were defined and planned for implementation at the start of the observation period. Fifty-three percent (n=71) of CDEP program components were launched by 10 IPPs (29%) with adherence to the CDEP as described in IPPs' local evaluation plans (e.g., in the IPP timeline specified and with no major or minor changes to implementation reported).

¹⁷ These three time periods are aligned with four year-by-year themes identified in Chapter 5: Launch (2017-18); Implement (2018-19); Pivot (2019-20), and Sustain (2020-21).

Most CDEP components, (114 of the initial 133 CDEP program components or 86%) were initiated at some point during the launch period (March 2017 to April 2018).

- Twenty-five IPPs (71%) reported delays in launching at least one program component.
- Two CDEP program components (for two IPPs) were never implemented across the entire observation period.

Some of the reasons that CDEP components were delayed and therefore launched beyond the launch period include:

- Planned program component deferment or updates to timelines.
- Staffing turnover, shortage, or training needs.
- IRB review process delays.
- Community-engaged program review delays (e.g., community advisory group review and feedback)
- Delays due to changes in program component structure or format (e.g., change from group activity to workshop format).

IPPs defined an average of four components (range of 1–7) in their CDEPs. Overall, IPPs demonstrated a high level of implementation fidelity regarding adherence to key CDEP component structures. On average, IPPs made less than one major change to their core CDEP structure (e.g., component addition, component dropped); 26 IPPs made no major CDEP program changes. However, all IPPs made minor changes to at least one CDEP program component. For the purposes of this assessment, program flexibility refers to modifications or adaptations made in implementing program components. Often, these changes were adaptations or modifications made to accommodate participant needs, strengthen the quality of their CDEP service provision, and/or adjust to external conditions in the broader community.

Early during the Launch and Implementation phases, the nature of programmatic changes pertained to research-related modifications (e.g., delays or adjustments to program launches due to IRB review of evaluation activities), personnel challenges (e.g., hiring, training, and staffing issues), and culturally responsive measures taken to promote community engagement (e.g., priority population served) and program effectiveness. Early attention given to these adaptations yielded fewer IPPs reporting these changes across the implementation phase.

Later in the implementation and pivot phase, into the onset of the COVID-19 pandemic, all IPPs reported making at least some changes to their CDEP program components directly in response to statewide mandates and measures taken to ensure safe social distancing. COVID-19-related changes to CDEP program components was the most prominent theme that emerged in our analysis. IPPs reported these changes throughout the pivot and sustain phases. Most of the COVID-19-related programmatic shifts resulted in either pauses or delays to program component timelines and were also linked to changes in program delivery modality (e.g., change from in-person to virtual or telephone-based program delivery). The COVID-19 pandemic alongside other contextual factors, such as the racial uprisings, California wildfires, etc., often required culturally responsive shifts to CDEP implementation and program delivery. Many IPPs also made programmatic modifications incorporating community-focused COVID-19 responses (see Chapter 5 insert for more information about IPP responses to these contextual issues).

Major changes to CDEP implementation were made through components added, dropped, or never implemented:

- Components added: 11 (n=8 IPPs)
 - › Most new CDEP programmatic components consisted of entirely new program areas (e.g., new workshop offerings, cultural gatherings).
 - › Some new CDEP program components were expansions of programs due to increased external funding, increased capacity through partnerships, or expanded IPP operations (e.g., case management).
- Components dropped: 4 (n=3 IPPs)
 - › Two CDEP components were dropped and subsequently merged into other CDEP components.

- › One component was dropped due to staffing issues related to the inability to provide culturally responsive and relevant services.
- › One component was not launched and subsequently dropped due to unanticipated IRB and program planning setbacks.
- Components never implemented: 2 (n=2 IPPs)
 - › CDEP component's scheduled launch was disrupted by COVID-19.
 - › CDEP component was delayed by research process throughout the duration of the evaluation period.

All 35 IPPs reported making at least one change to a program component during the four-year implementation period spanning across five primary categories.

- **Program Delivery:** Changes to a component's modality (e.g., changes in number of sessions offered; changes in staff responsible for delivering program content).
- **Research:** Changes to the implementation of the program components in response to research and evaluation-related activities.
- **Programmatic:** Changes to the content, structure, or timing of CDEP components.
- **Personnel:** Changes to resolve challenges related to CDEP staff hiring, training, and overall capacity.
- **Cultural Responsiveness:** Accommodations for participant needs, circumstances, or preferences.

Table 7.6 presents an overview of the five types of programmatic changes, the number of IPPs making each type of change, along with illustrative examples.

Table 7.6: CDEP Changes Over Time: Themes and Examples

Themes	# of IPPs	Examples
Program Delivery Changes to a component's modality.	24	<ul style="list-style-type: none"> • Component delivered to a more expansive or restricted catchment area. • Number of program sessions increased or decreased. • Frequency or timing of program delivery modified. • Program was restricted or expanded to include participants involved in local evaluation. • Program delivered to fewer or more participants or different participant profile than intended.
Research Changes made in response to research and evaluation-related challenges.	15	<ul style="list-style-type: none"> • Delays in program participant recruitment while evaluation procedures were finalized, or informed consent was acquired. • IRB approval of evaluation plans delayed program component implementation, potentially impacting program cycle timeline and activities.
Programmatic Changes made to the content, structure, or timing of CDEP components.	14	<ul style="list-style-type: none"> • Program content or modality added, eliminated, or otherwise modified. • Changes in program format (e.g., activities to workshops/webinars). • Increased social media engagement for program component. • New programming due to addition of a component.
Personnel Changes made to resolve challenges related to CDEP staff hiring, training, and overall capacity.	14	<ul style="list-style-type: none"> • Components delayed or modified to address staffing shortages and staff recruitment and/or retention challenges. • Program component facilitated by a different staff role (e.g., from staff to paid consultant). • Components delayed due to insufficient or delayed training of dedicated staff. • Other CDEP delays (e.g., IRB delays and delayed component implementation) impacted IPP's hiring processes and timelines.

Themes	# of IPPs	Examples
Cultural Responsiveness Accommodations for participant needs, circumstances, or preferences.	11	<ul style="list-style-type: none"> • Program curricular changes to increase cultural relevance (e.g., images, dietary recommendations, etc.). • Program offerings adapted to multiple languages to accommodate the community served. • Program component renamed and designed to incorporate a culturally affirming element. • Decrease/increase in culture-affirming activities to meet immediate needs of community in the context of COVID-19. • Expanded program offering to a new community site to address transportation issues of hard-to-reach participants from priority population. • Modified an element of program delivery to be more culturally congruent.

Outside of these changes, the COVID-19 pandemic (and its devastating impact on communities served by the CRDP Phase 2 IPPs) required all IPPs to change aspects of their service delivery content and/or approach. For example, changes were made to ensure safe social distancing to comply with stay-at-home orders in California, and to respond to other limitations and challenges presented by the COVID-19 pandemic. Commonly mentioned adaptations included (see also Chapter 5 insert on IPP responses to COVID-19):

- Transitioning all or part (e.g., hybrid) of CDEP component delivery to online, virtual, or COVID-19- safe distancing format (e.g., tele-health, virtual convenings).
- Limited/restricted program delivery capacity to accommodate safe social distancing requirements.
- Pauses, cancellations, and delays to regroup or restructure component for COVID-19-safe implementation.
- Component(s) de-prioritized as IPPs shifted focus toward a community-centered COVID-19 programmatic response (that is, re-structuring of program priorities to focus on COVID-19 community response efforts).
- Program component modified or expanded to incorporate elements in response to COVID-19-related community needs (e.g., meal program, mask distribution, etc.).

For CRDP Phase 2, mission fidelity represents an expanded view of fidelity that considers the alignment of CDEP processes with IPP mission and goals in relation to their communities served. That is, mission fidelity centers IPP relationships with their communities, rather than solely focusing on how they implement their programs. From this perspective, the community and its ecology are not simply a background context for program implementation, but a guide for ensuring that programs are responsive to community needs and cultural values. As such, flexibility is instrumental to ensuring fidelity and, in this case, construed as adherence to mission rather than deviations from a program template. This reflects an expanded understanding of flexibility that may be more culturally attuned to the needs of diverse communities.

While IPPs maintained a high level of CDEP implementation fidelity, they also exhibited flexibility in making modifications and adaptations that often-yielded improved capacity or ability to pursue the missions of their CDEP components for the communities they served. The deep connection to and engagement with community, as well as IPPs' knowledge of the priority populations engaged through CDEP implementation, situated the CRDP IPPs to address the specific, urgent needs of the communities they served. They did so in the context of the broader impacts of pressing external factors and by incorporating flexibility and adaptation into their implementation strategy reflecting a high level of fidelity to their core missions.

7.2 CULTURALLY RESPONSIVE TECHNICAL ASSISTANCE

Technical assistance (TA) offered to community-based organizations often relies on conventional approaches to capacity building that involve providing resources and supports to help organizations develop, expand, and sustain their work. While the five priority-population technical assistance providers (TAPs) in CRDP Phase 2 were tasked with providing these supports, they were also clear that effective technical assistance provision for community-defined evidence projects should also:

- Demonstrate an understanding of historical and contemporary challenges experienced uniquely within each of the priority population hubs.
- Resonate with their specific communities' cultural lens, cues, and practices.
- Prioritize relationship-building between TAPs and their assigned IPPs.

The section below summarizes the culturally responsive approaches each priority population TAP used to deliver technical assistance and support during CRDP Phase 2.

African American TAP Conversations with ONTRACK

Reflections on Culturally Responsive TA Support

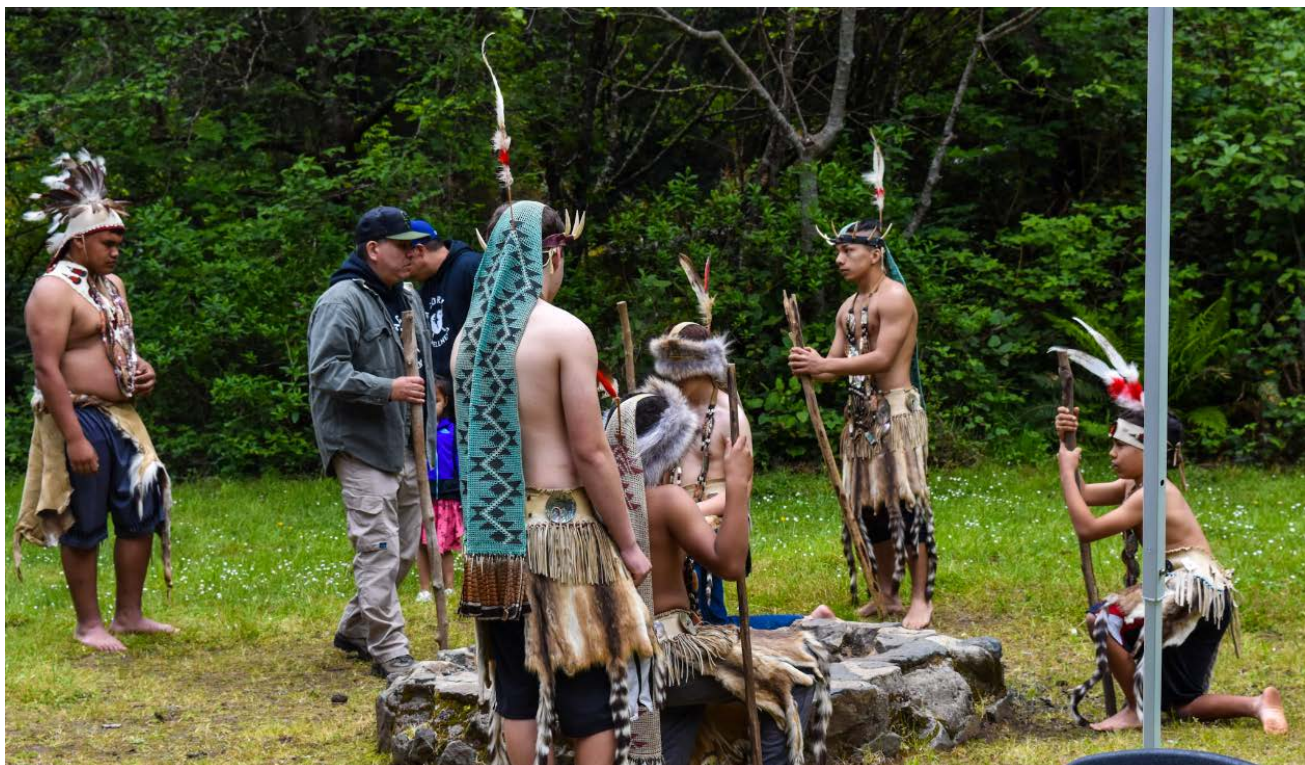
"Culturally sensitive and responsive TA for IPPs in the African American hub includes the creation of safe spaces for the expression of hurt, pain, and anger in response to multigenerational racial trauma and systemic racism. In such a space, responses to historically rooted, ongoing trauma expressed as feelings of anger, woundedness, and frustration can be seen, accepted, and understood safely, and compassionately held as deep manifestations of a shared collective reality. This manner of TA support not only encourages IPP leadership to engage in self-care and personal development, but also challenges them to use their emotional responses to social inequities and injustices to help fuel constructive work on behalf of their community. During the pandemic, IPPs in the African American hub were acutely aware of, and attentive to, racial disparities in COVID-related mortality and vulnerability as yet another manifestation of the broader historical pattern of systemic oppression. The murder of George Floyd, Breonna Taylor, Ahmaud Arbery and others ("say their names") amplified the trauma of racism and racial violence, renewing community mobilization around these issues. But it also evoked profound weariness and rage in recognition of the longstanding nature and deep familiarity of these assaults on Black humanity. Supporting IPP leadership meant recognizing, always with deep compassion and empathy, that in the face of this trauma, many IPP leaders are resilient and at the same time may be 'wounded healers' in their personhood and work with their communities.

The TA team was small, with three individuals with one person brought in specifically for CRDP Phase 2 to provide evaluation TA expertise. The other two individuals worked as primary TA providers dividing the seven IPPs, while the evaluation TA consultant worked with all IPPs, as needed. Together, this TA team helped facilitate a strong sense of shared identity and support in this hub. The collective meaning and purpose of CDEP work, along with a strong sense of solidarity in the face of shared experiences of continuing racial injustice and systemic racism, also contributed to an ethos of shared history, struggle, and solidarity in this hub. Solidarity brought expressions of joy and love, with laughter and sense of community as reliable features of hub-specific breakout sessions in all-grantee meetings. As the lyrics to the M.A.Z.E. song states: "Joy and pain are like sunshine and rain." Steeped in the African cultural tradition of the balance of opposites, breakouts for this hub were sure to be a space where joy and pain could be found, sprinkled with tears and laughter, debate and community. Indeed, a sense of unity and shared racial identity was a striking characteristic of this priority population."

American Indian and Alaska Native TAP Conversations with PIRE

Reflections on
Culturally Responsive
TA Support

For the American Indian Alaska Native (AI/AN) hub, attention to process, communication, relationship building, and treatment of time were especially critical. A legacy of continuing historical trauma and broken treaties between Tribal communities and the U.S. and California state governments meant that a restorative approach, centering Indigenous voices and honoring their direction and guidance, would be key to successful TA provision. The AI/AN IPPs included many well-established organizations, with deep expertise in Indigenous evaluation research and practice. The TA provider was a large multi-site organization whose work was not limited to AI/AN health projects. The team was led by investigators who, although well-experienced in AI/AN research and with long-standing relationships with California Native health providers, were non-Native. The team therefore included AI/AN key consultants and experts from within and outside the organization. The model was to connect two team members to each IPP, while the team collectively provided stability in the TA liaison relationships to the other CRDP partners. Structural issues emerged as key issues for this hub. High turnover in OHE Contract Managers, some of whom lacked experience in AI/AN community work, contributed to perceptions of insufficient attention and lack of awareness of culturally issues and historical contexts of importance to the AI/AN priority population. Lack of explicit agreements related to data ownership with the CRDP partners prior to beginning the work, together with insufficient time for community review/approval processes, and uneven collaboration between the AI/AN IPPs and other CRDP partners in creating a strengths-oriented approach to evaluation were also unexpected challenges for the TA provider in their role as liaison. As a result, the focus of TA support shifted over the Phase 2 years increasingly to facilitate constructive dialogue within CRDP about the importance of strengths-based methods and measures, such as a sense of hope and cultural connectedness, which are in turn hypothesized by the AI/AN IPPs to improve mental health for AI/ANs; and to provide on-going upstream TA on culturally-competent practices within AI/AN communities and organizations.



Asian American Native Hawaiian and Pacific Islander American TAP Conversations with SSG

Reflections on
Culturally Responsive
TA Support

"For the Asian American Native Hawaiian and Pacific Islander American (AANHPI) hub, it became increasingly evident that lumping AANHPI IPPs into a single hub was not meaningful for this priority population, as communities which did not share common languages, cultures, values, or identities. As such, a primary concern that emerged for these IPPs was the critical need for disaggregation of their data so that their distinctive cultural and community realities did not get hidden, masked, or rendered invisible within the cross-site evaluation. At the same time, the original creation of this hub reflects the reality that highly diverse AANHPI communities are often grouped together in ways that do not reflect their individual community and cultural realities. Indeed, the lack of societal differentiation between different AANHPI groups by others also created its own shared reality in terms of having to respond to increased xenophobia and acts of violence against members of different AANHPI communities. Political framing of COVID-19 in grossly damaging and inflammatory language such as "China virus" and "Kung flu" contributed to continuing perceptions of Asian Americans as perpetual foreigners, undistinguishable from each other, and blamed for the pandemic. At the same time, due to high proportions of immigrants in many of these communities, most IPPs had to engage in time-consuming, labor-intensive, cultural and linguistic translations of cross-site measures, representing invisible and substantial time and energy for IPPs and TAP alike, efforts that were not necessary in many of the other hubs.

In this context, culturally responsive TA requires delicate balancing of professional and personal boundaries, with high cultural expectations for anticipating the needs of IPPs and advocating for their expressed (and sometimes unexpressed) concerns and stressors, along with an understanding of the strong sense of obligation and conscientiousness that can easily lead to overwork and burnout for IPP leadership and staff. The TA team, co-led by two TA providers, included assignments of two, maybe three IPPs (mostly by region) per team member, with another member assigned as back-up support, as needed. This configuration, along with a highly inclusive leadership duo, offered flexibility, support, and continuity for the TA team. Culturally responsive TA and being present to community members were expressed in concrete gestures of thoughtful care, concern, and, always, appreciation, including simple acts (such as celebrating personal milestones, sharing conversations with food, offers to help each other) that help build a sense of community, shared burden, and common purpose. Such expressions became a vehicle for the TA team to support each other as well as their IPPs, especially during COVID."



Latinx TAP Conversations with UCD

Reflections on Culturally Responsive TA Support

"For the Latinx hub, culturally responsive TA provision meant a simultaneous recognition of within-group differences along with shared cultural values. On the one hand, a common language and values are not assumed (for instance, many in the Mixteco communities served in this hub do not speak Spanish). Therefore, a high level of humility and openness to learning from each IPP about what their culture means to them was consistently evident among members of the TA team. TA members took care to follow through on every commitment and to work with great intentionality to build credibility and trust, never assuming, presuming, or over promising in their work with IPPs. On the other hand, they identified elements important to work with Latinx communities, including (a) affirming the community's resiliency through hardships, (b) cultivating a strong sense of *familialismo* and belonging for all, (c) strengthening a commitment to the community, and (d) building *confianza*, or trust and a sense of safety in relationships. The TA team took care to build and model "with and for" each other, as well as for their IPPs. They met regularly with each other and worked in a decentralized manner as individuals with their own assigned IPPs. While the team was deferential to its most senior, experienced leaders, reflecting cultural values of respect and dignity, TA processes were also highly attentive and inclusive of other TA team members. A strong sense of connectedness and community characterized this team. At the center of their loosely organized structure was the administrative coordinator who kept all members in sync through regularly scheduled meetings and communication.

During CRDP Phase 2, the Latinx community faced an almost continual sense of collective trauma, with hostile federal government policies prior to the 2020 presidential election that include ICE raids and crises at the border, as well as events such as the El Paso shooting, which made this population feel highly vulnerable and fearful. This population thus experienced COVID as part of an ongoing, multi-faceted trauma, and the TAP raised particular concern about the ongoing mental health repercussions, especially considering increases in suicidality, particularly among younger people. Cultural responsiveness in TA provision has meant understanding the negative repercussion of this sociopolitical context and responding with empathy, respect, and compassion. The centrality of relationship building and honoring commitments in ways that honor each IPP's organizational culture was part of being culturally responsive in TA support for this priority population."



<div> <div> <div>LGBTQ+ TAP</div> <div>Conversations with CARS</div> <div>Reflections on Culturally</div> <div>Responsive TA Support</div> </div> </div>	<p>“There is no single culture for the various communities under the LGBTQ+ umbrella, yet an emphasis on a shared sense of identity, common struggles, and experiences of exclusion and oppression can lead to a strong sense of community. As such, the IPPs in the LGBTQ+ hub could not be culturally grouped together across different organizations and populations in a meaningful way. Here, cultural responsiveness to the needs of the priority population meant recognition not only of the diversity and intersectionality of groups within the hub (e.g., race, ethnicity, transgender populations, etc.), but also sensitivity to trauma concerns and issues of representation. For instance, the COVID-19 pandemic re-triggered trauma related to the AIDS crisis for many in the LGBTQ+ hub, including feelings of profound loss and intense vulnerability. Issues of intersectionality arose in CRDP Phase 2 in relation to IPPs: who gets to serve whom, both across IPPs (which identity is most salient in considering which IPP serves which constituency) and, eventually, within IPPs (what are the identities of the IPP leadership in relation to the populations served)? Consequently, the LGBTQ+ hub collectively had a deep engagement with intersectionality, in both CDEP implementation and local evaluation, through multiple co-articulations of identity (e.g., sexual orientation, gender identity, race, ethnicity, housing status, age, language, ability, etc.). One challenge was that while intersectionality was recognized as important for the initiative to address as relevant for every priority population and hub, the scope and depth of that intersectional work varied greatly, especially regarding sexual orientation and gender identity. This varied engagement with sexual orientation and gender identity across the initiative left the LGBTQ+ hub with the feeling that this was an issue for the LGBTQ+ hub to address for all.</p> <p>For the TA team, which consisted of two individuals working autonomously with different IPPs, in conjunction with a wide range of specialized consultants called in on an “as needed” basis, culturally responsive TA at the IPP level meant helping IPPs create inclusive, welcoming spaces for any LGBTQ+ person having contact with them. The shared goal was for all LGBTQ+ persons to feel welcome, comfortable, accepted, and understood from their first point of contact with a CDEP program. At the hub level, TA support meant creating a space for different styles of leadership within the hub. Some IPP leaders primarily emphasized the provision of safe spaces and places for community members to simply “be” as their priority while other IPP leaders centered activism and resistance (e.g., ‘speaking out and against’) in their leadership approaches. Both ‘being’ and ‘doing,’ and attention to ‘resistance’ and ‘refuge,’ are important elements of work and identity for all the IPPs in this hub. TA support meant finding common ground to provide an inclusive space and sense of community across these differences. Further, over time, the focus of TA attention and IPP concerns moved to issues of representation in IPP leadership, especially in relation to gaps/disconnects that emerged between IPP leadership and the populations served by CDEPs. For this hub, significant increases in people of color representation as well as transgender representation in IPP leadership, led to the transformation of organizational cultures, programs, and communities served within this hub.”</p>
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NOTE ON CROSS-SITE DATA COLLECTION WITH PARTNERS

The TAPs, EOA, and SWE consisted of seven diverse organizations, with not only distinct approaches to technical assistance delivery but also processes for documenting technical assistance efforts with their respective hubs or cross-hub (in the case of the EOA and SWE). When evaluating technical assistance, evaluators often rely either on information that the provider already has from existing reports or on administrative data. In this case, the statewide evaluation had to rely on administrative data made available by OHE (via the OHE Contractor Reporting Form). This form was used by TAPs, EOA, and SWE to document technical assistance activities on either a monthly/quarterly basis and submitted to each partner's contract manager. This tool was neither a process tool capable of measuring each partner's technical assistance activities and output, nor was it an outcome tool capable of measuring the expected effects/changes from technical assistance in the short, intermediate, or long term. For this reason, the information it yielded for the cross-site evaluation was limited.

To assist with improving the quality of information being reported by the TAPs (and eventually the EOA who came on board during Year 3), the statewide evaluation recommended that changes be made to the OHE progress report to obtain standardized quantitative metrics on technical assistance activities from all partners. The changes introduced into the technical assistance progress reports in Year 2 involved a few basic quantitative indicators of technical assistance activities: mode of delivery, type of technical assistance provided, and content of technical assistance activities, which were consistent metrics already being used by the SWE to document PARC technical assistance efforts. While this helped to some degree, technical assistance data submitted to the cross-site evaluation continued to vary in quality and quantity from partner to partner.

The findings in this section do not measure the effectiveness of technical assistance in all the components needed to make such a determination (e.g., technical assistance activity dosage, IPP use, IPP learning, etc.). Instead, the findings represent more of a snapshot or window into the contributions of each partner when it came to provision of technical assistance/support with the IPPs. Comparisons across partners, especially as it relates to number of technical assistance activities, should not be conducted. It is not possible to determine the intensity or depth of the technical assistance delivered for each activity reported to the statewide evaluation (e.g., one activity could have been an email with information while one activity could have been a two-day in-person site visit).

7.2.A TAP TECHNICAL ASSISTANCE

The five CDPH CRDP Technical Assistance Provider (TAP) Solicitations (#15-10605, #15-10608, #15-10609, #15-10610, #15-10611) delineated the role of the population-specific TAPs as supporting the IPPs by working to improve their administration and operations, identify and secure additional resources, and build strategic partnerships to better serve communities during the Phase 2 implementation phase. TAPs were selected for having a deep understanding and demonstrable record of building trusting relationships with their respective priority population, including conducting technical assistance in a culturally, linguistically, and/or LGBTQ+ affirming manner. The TAPs were also expected to support and work collaboratively with other CRDP Phase 2 partners as appropriate (i.e., SWE, EOA, OHE).

Across the 3,943 technical assistance activities conducted by the five TAPs with the IPPs, the following was found:

- The top technical assistance delivery modes were telephone/video conference calls (54%) and email (30%).
- The top types of technical assistance provided were information and resources (43%) and consultation/coaching (42%).

- The top content areas addressed were CDEP (55%) and local evaluation (48%) related.
 - › Within CDEP, the top content areas were implementation (26%), community outreach (12%), and development (12%).
 - › Within local evaluation, the top content areas were implementation (26%), planning/design (13%), and modifications and revisions (8%).
- Capacity building goals/activities/expectations was the third most common content area for the TAPs, followed by organizational infrastructure development (21%), and statewide evaluation (17%).

(See Tables 7.7–7.9 for a detailed overview of this data by hub).

Table 7.7: TAP TA Delivery Mode for CRDP Overall and by Individual Hub (2017–2021)

Mode of Technical Assistance Delivery	CRDP Overall N=3,943*	AfAm Hub n=496*	AI/AN Hub n=510*	AANHPI Hub n=674*	Latinx Hub n=1,252*	LGBTQ+ Hub n=1,011*
	%	%	%	%	%	%
Telephone/Video Conference Call	54%	59%	43%	64%	47%	58%
Email	30%	4%	25%	21%	40%	40%
Site Visit/In-Person	7%	6%	11%	11%	7%	1%
Written Materials	1%	<1%	2%	1%	2%	–
Multimode	8%	30%	19%	3%	4%	1%

*This “N” represents the valid number of TA activities included in the analysis for TA delivery mode.

Table 7.8: TAP Type of TA Provided for CRDP Overall and by Hub (2017–2021)

Type of Technical Assistance	CRDP Overall N=3,943*	AfAm Hub n=496*	AI/AN Hub n=510*	AANHPI Hub n=674*	Latinx Hub n=1,252*	LGBTQ+ Hub n=1,011*
	%	%	%	%	%	%
Information and Resources	43%	52%	55%	55%	48%	22%
Consultation/Coaching	42%	71%	51%	51%	36%	38%
Relationship Building with IPPs	34%	42%	36%	36%	40%	30%
TA Planning and Review	34%	40%	31%	31%	34%	39%
Formal Training	6%	16%	5%	5%	5%	4%
TAP Facilitated Relationship Building with External Stakeholders	5%	1%	2%	2%	8%	4%
Other	5%	–	5%	5%	6%	9%

*This “N” represents the valid number of TA activities included in the analysis for TA type.



Table 7.9: TAP Content Area Addressed in TA for CRDP Overall and by Hub (2017–2021)

TA Content	CRDP Overall N=3,943*	AfAm Hub n=496*	AI/AN Hub n=510*	AANHPI Hub n=674*	Latinx Hub n=1,252*	LGBTQ+ Hub n=1,011*
	%	%	%	%	%	%
CDEP	55%	74%	25%	45%	75%	46%
Implementation	26%	49%	6%	24%	30%	27%
Community Outreach	12%	5%	14%	7%	15%	11%
Development	12%	19%	4%	7%	22%	5%
Policy/Systems Change	4%	1%	1%	2%	7%	3%
Other	1%	–	–	5%	1%	–
Local evaluation	48%	46%	25%	39%	62%	51%
Implementation	15%	8%	8%	10%	16%	23%
Planning & design	13%	23%	6%	14%	14%	12%
Modification/revisions	8%	9%	3%	5%	12%	8%
Institutional Review Board	4%	5%	5%	2%	5%	5%
CBPR	2%	–	1%	1%	5%	1%
Evidence-Based Practices	2%	–	–	1%	5%	–
Cultural/linguistic and LGBTQ+ considerations	1%	–	–	–	2%	–
Other	3%	1%	2%	6%	3%	2%
Capacity Building Goals/Activities/Expectations	45%	64%	30%	34%	58%	32%
Structured Organizational Assessment	11%	13%	6%	14%	16%	5%
Organizational infrastructure development	21%	43%	10%	17%	12%	30%
Statewide Evaluation	17%	8%	10%	26%	8%	10%
CRDP Phase 2 Information Sharing	11%	–	12%	30%	6%	11%

*This “N” represents the valid number of TA activities included in the analysis for TA content area.

7.2.B EDUCATION, OUTREACH, AND AWARENESS (EOA) TECHNICAL ASSISTANCE

The ODPH CRDP EOA Solicitation (#18-10144) delineated the role of technical assistance for the EOA consultant as consisting of the following elements: media training (e.g., understanding reporter protocols and media industry etiquette, forming and articulating messages); storytelling (e.g., helping the IPP tell their stories through different mediums that could be shared within their communities and/or the general population); facilitating relationship building between IPPs and other key stakeholders (e.g., key decision makers such as county mental health departments); and creating collateral media that would help IPPs communicate to key stakeholders about CRDP. All technical assistance would also need to be conducted in a manner that was culturally, linguistically, and LGBTQ+ affirming. The EOA consultant was also expected to support and work collaboratively with the other elements of CRDP Phase 2 as appropriate (i.e., TAPs,

SWE, OHE). Due to unexpected delays in the EOA contract, this consultant did not officially come on board until Year 3 (2019) of the initiative for a compressed contract of two years.

Across the 52 technical assistance activities the EOA conducted with the IPPs, the following was found:

- The top technical assistance delivery mode was telephone/video conference call (98%).
- The top types of technical assistance provided were relationship building (60%), consultation and coaching (48%), and facilitated relationship building with external stakeholders (42%).
- The top content areas addressed were CDEP-related (87%). Specifically, 56% was community outreach and 31% policy/systems change.
- Other top content areas for the EOA with IPPs were communication methods/materials (56%), strategic messaging (44%), storytelling (44%), CRDP Phase 2 EOA contract (42%), and program sustainability (35%).

See Tables 7.10–7.12 for a detailed overview of this data.

Table 7.10: EOA Technical Assistance Delivery Mode (2019–2021)

Mode of Technical Assistance Delivery (N=52)	%
Telephone/Video Conference Call	98%
Site Visit/In-Person	2%

*This “N” represents the valid number of TA activities included in the analysis for TA delivery mode.

Table 7.11: EOA Type of Technical Assistance Provided to IPPs (2019–2021)

Type of Technical Assistance Provided (N=52)*	%
Relationship Building with IPPs	60%
Consultation/Coaching	48%
Facilitated Relationship Building with External Stakeholders	42%
Information and Resources	27%
Formal Training	8%
TA Planning and Review	2%

*This “N” represents the valid number of TA activities included in the analysis for TA type.

Table 7.12: EOA Content Area Addressed in Technical Assistance with IPPs (2019–2021)

Content of Technical Assistance Provided (N=52)*	%
CDEP	87%
Community Outreach	56%
Policy/Systems Change	31%
Communication Methods & Materials	56%
Strategic Messaging (e.g., toolkits)	44%
Storytelling	44%
CRDP Phase 2 EOA Contract	42%
Program Sustainability	35%
Structured Organizational Assessment	2%

*This “N” represents the valid number of technical assistance activities included in the analysis for technical assistance content area.

7.2.C STATEWIDE EVALUATION TECHNICAL ASSISTANCE

The CDPH CRDP Statewide Evaluator (SWE) Solicitation (#15-10603) delineated the role of technical assistance for the SWE consultant as making themselves available to advise (and provide training where needed) CDPH, the TAPs, and IPPs, on matters concerning CRDP Phase 2 and IPP local evaluations. The SWE was tasked with reviewing each IPPs evaluation plan (including IRB processes) and final report; proposing recommendations for strengthening evaluation plans and reports; and establishing clear guidelines and best practices regarding culturally and linguistically competent, yet rigorous, evaluations. The SWE consultant was also expected to support and work collaboratively with the other elements of CRDP Phase 2 as appropriate (i.e., TAPs, EOA, OHE).

Across the 278 technical assistance activities the SWE conducted with the IPPs, the following was found:

- The top technical assistance delivery mode was telephone/video conference call (67%).
- The top types of technical assistance provided were consultation/coaching (67%) and formal training (63%). While the SWE was the primary lead on these technical assistance activities, they were often conducted in collaboration with the TAPs and/or OHE.
 - SWE consultation and coaching activities involved TAPs 45% of the time and OHE 41% of the time.
 - SWE formal training involved TAPs 37% of the time and OHE 30% of the time.
- The top content areas addressed were the statewide evaluation (70%) and local evaluation (44%).
 - Within the statewide evaluation, the top content areas were: 36% implementation (e.g., data collection, administration, consent, storage, security, confidentiality/anonymity, inclusion in IPP local evaluations), 20% cultural/linguistic/LGBTQ+ considerations, and 14% IRB-related issues.
 - Within local evaluation, the top content areas were 59% planning (e.g., evaluation design, evaluation questions, sampling) and 58% implementation (e.g., data collection, fidelity, quantitative methods/analysis, qualitative methods/analysis administration, submission, storage, confidentiality, and consent).

See Tables 7.13–7.15 for a detailed overview of this data.

Table 7.13: SWE Technical Assistance Delivery Mode with IPPs (2017–2021)

Mode (N=278)*	%
Telephone/Video Conference Call	67%
Email	28%
Written Materials	3%
Site Visit/In-Person	2%

*This “N” represents the valid number of technical assistance activities included in the analysis for technical assistance delivery mode.



Table 7.14: EOA Type of Technical Assistance Provided with IPPs (2017–2021)

Type (N=28)*	%
Consultation/Coaching	67%
Collaborators	–
TAP	45%
OHE	41%
Formal Training	63%
Collaborators	–
TAP	42%
OHE	35%
Information and Resources	52%
Collaborators	–
TAP	37%
OHE	30%
EOA	<1%

*This “N” represents the valid number of technical assistance activities included in the analysis for technical assistance type. Total percentage for technical assistance type distribution exceeds 100% due to instances where activities involved two different types (81%).

Table 7.15: SWE Content Area Addressed in Technical Assistance with IPPs (2017–2021)

Content (N=278)*	%
Statewide Evaluation	70%
Implementation	36%
Cultural, Linguistic, and LGBTQ+ Considerations	20%
Institutional Review Board	14%
Semi-Annual Report	11%
Inclusion in Local Evaluation	10%
Translation	6%
Analysis	3%
Sustainability Efforts	<1%
Local Evaluation	44%
Planning	59%
Implementation	58%
Cultural, Linguistic and LGBTQ+ Considerations	15%
IRB Approval of Research Protocols	13%

*This “N” represents the valid number of technical assistance activities included in the analysis for technical assistance content area. Total percentage for Local Evaluation and SWE exceeds 100% due to instances where activities involved both Local Evaluation and SWE topics (6%).

7.3 ORGANIZATIONAL CAPACITY AND INFRASTRUCTURE

To achieve the mission of the CRDP Phase 2 to help unserved, underserved, and inappropriately served individuals from the five priority populations the CRDP understood that strong, sustainable, community-based organizations were essential. CRDP Phase 2 therefore invested in supporting organizational capacity building so IPPs could advance their CDEP missions.

Findings in this section examine the extent technical assistance and support provided to the IPPs by the partners (TAPs, OHE, EOA, SWE, hub contract manager/other staff) or Phase 2 resources strengthened IPP organizational capacity. See Chapter 8 for more information on how IPPs built their capacity at the network level and systems level to address complex challenges such as reducing mental health disparities.

A mixed method analysis was conducted using two statewide evaluation data sources to discern changes in IPP organizational capacity and barriers to capacity change. The quantitative instrument was the IPP Organizational Capacity Assessment (OCA), while qualitative data was derived from the IPP semi-annual report. For more information on each tool, see descriptions below.

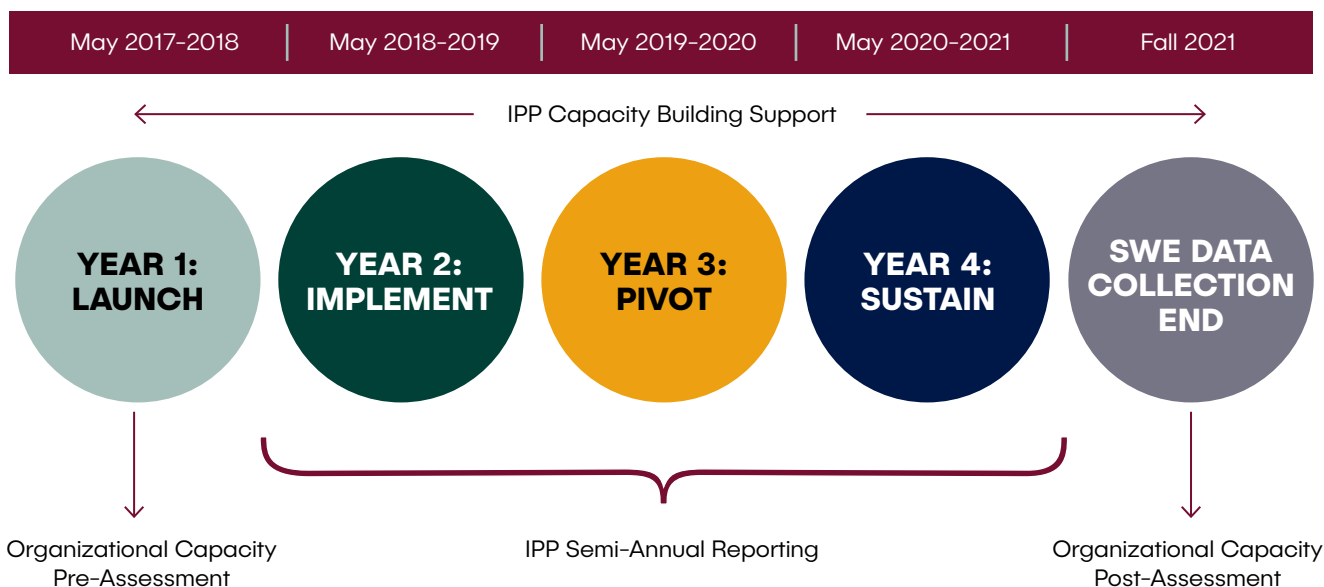
SWE IPP Organizational Capacity Assessment: This tool quantitatively assessed organizational capacity strengths and capacity building priorities at the start of the IPP grant (pre-assessment) and at the end of SWE data collection (post-assessment). Capacity growth in five domains and corresponding sub-elements were numerically rated on a response scale from Level 1 (none to very limited capacity) to Level 4 (high to maximum capacity). Average pre and post scores were calculated for each domain by hub and CRDP overall. The five capacity domains were:

- **Leadership:** to inspire, prioritize, make decisions, provide direction, and innovate (sub-elements: shared beliefs/values; board composition/commitment; board governance; board involvement and support; board and CEO/ED appreciation of power; ability to motivate and mobilize constituents).
- **Adaptive:** to monitor, assess, and respond to internal and external changes (sub-elements: strategic planning; evaluation/performance measurement; evaluation and organizational learning; use of research to support program planning and advocacy; program relevance and integration; program growth and replication; monitoring of program landscape; assessment of external environment and community needs; influencing of policy-making; partnerships and alliances; community presence and standing; constituent involvement; organizing).
- **Management:** to use organizational resources effectively and efficiently (sub-elements: goals/performance targets; funding model; fund development planning; financial planning/budgeting; operational planning; decision making processes; knowledge management; recruiting, development, and retention of management; recruiting, development, and retention of general staff; volunteer management).
- **Operational:** to implement key organizational and programmatic functions (sub-elements: skills, abilities, and volunteer commitment; fundraising; board involvement and participation in fundraising; communications strategy; computers, applications, network, and email; website; databases/management reporting system; buildings and office space; management of legal and liability matters).
- **Cultural Competence:** to understand/respond to cultural influences, values, needs, and attitudes of their community constituency (sub-elements: expressed commitment to cultural competence; cultural competence policies, procedures, governance; planning, monitoring, evaluation; communication; human resources; cultural factors in engagement with community).

SWE IPP Semi-Annual Report (IPP-SAR): Across a four-year period, IPPs qualitatively described benchmarks to change or actual changes on areas of need prioritized by IPPs in their baseline assessment including any new capacity building needs that emerged during the life of the Initiative. These qualitative data were thematically coded to identify IPP benchmarks to capacity change (i.e., indicators of progress), organizational capacity changes, and capacity change barriers experienced by IPPs. Findings are reported by CRDP overall and by hub.

Figure 7.6 illustrates how data collection unfolded alongside CDEP implementation and the provision of capacity building supports.

Figure 7.6: CRDP Overall IPP Capacity Building Timeline and SWE Data Sources



NOTE ABOUT QUANTITATIVE DATA, QUALITATIVE DATA, AND ORGANIZATIONAL CAPACITY CHANGE

"Numbers are a poor substitute for the richness and color of the real world." (Fry, 2021).

While the organizational capacity assessment (quantitative data) presents a picture of growth with respect to IPP capacity, it does not reflect the richness of this change. Qualitative findings fill in this gap, illustrating how personal growth in capacity had a deep effect on IPP organizations. While averaging pre/post test scores is an important indicator of change, it did not capture the meaning and depth of multiple capacity journeys and growth IPPs may have experienced (and are still experiencing).

The qualitative data from the IPP-SAR brought a more holistic understanding of the process of organizational change for the IPPs that was not readily discerned from the findings from the quantitative organizational assessment tool. The IPP-SAR provided a more expansive accounting of:

- How IPPs used the TA/support received to strengthen specific aspects of their work.
- Real-time capacity changes occurring within their organizations during specific periods.
- Relevant milestone/benchmark achievements necessary for more substantive change in specific areas.
- Areas of organizational challenge and resiliency in the face of larger external conditions (e.g., the COVID-19 pandemic).



7.3.A MIXED METHODS FINDINGS

In a quantitative analysis of OCA, scores statistically significant changes were found in four of five capacity domains.

- Operational Capacity (Pre Mean=2.50 vs Post Mean=2.71) ($p<0.05$)
- Adaptive Capacity (Pre Mean=2.69 vs Post Mean=3.01) ($p<0.05$)
- Management Capacity (Pre Mean=2.42 vs Post Mean=2.73 ($p<0.05$))
- Cultural Competence Capacity (Pre Mean=2.96 vs Post Mean=3.15) ($p<0.05$)
- Leadership Capacity (Pre Mean=2.83 vs Post Mean=2.93)

In an analysis of qualitative data obtained from the IPP semi-annual report, IPPs reported 97 capacity changes and 94 benchmarks to change. From highest to lowest, these were:

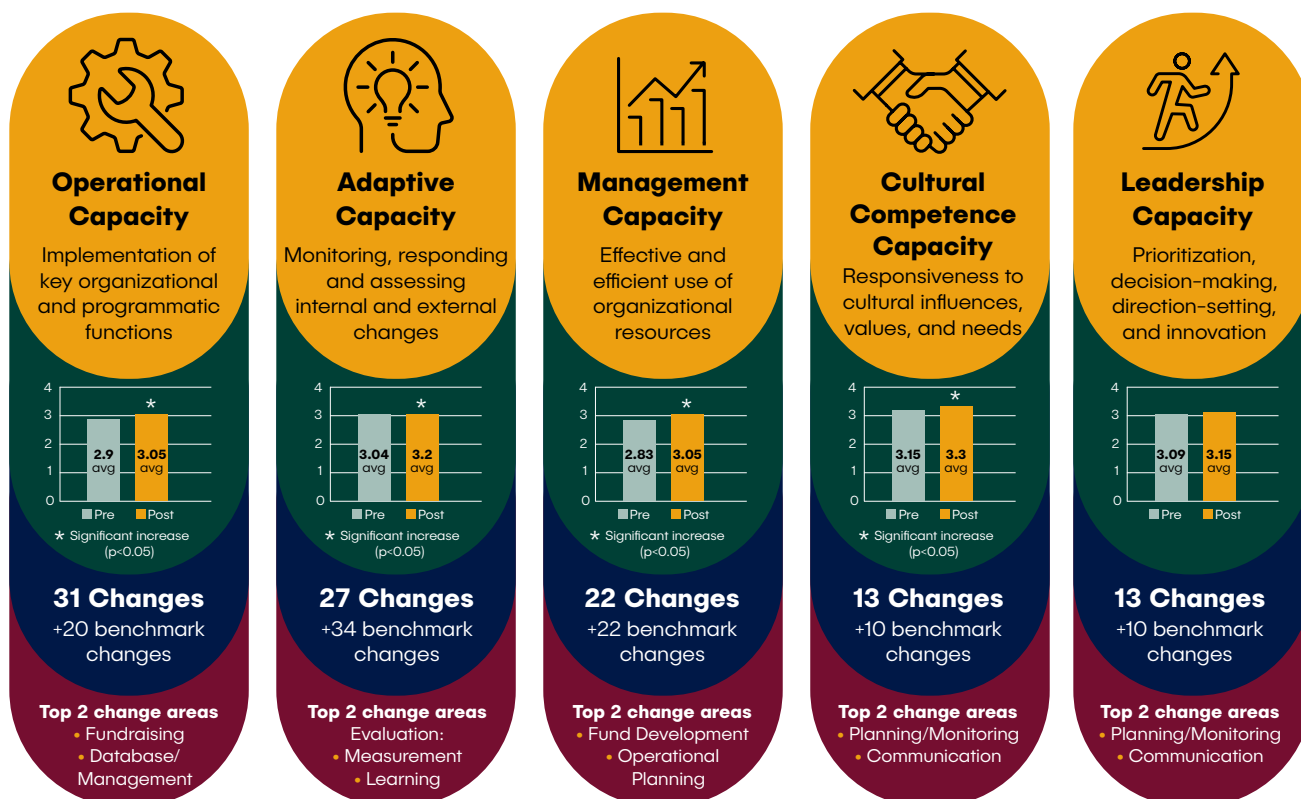
- Operational Capacity (31 changes) (+20 additional benchmarks of change)
- Adaptive Capacity (27 changes) (+34 additional benchmarks of change)
- Management Capacity (22 changes) (+23 additional benchmarks of change)
- Cultural Competence Capacity (13 changes) (+10 additional benchmarks of change)
- Leadership Capacity (4 changes) (+8 additional benchmarks of change)

A high degree of alignment was found between the OCA scores in relation to IPP semi-annual report data (i.e., the qualitative data validated the quantitative findings). Both data sources showed top areas of growth across capacity domains, while the qualitative data confirmed and further illustrated the depth of change within each domain.

Figure 7.7 illustrates the number of changes identified from both data sources for each capacity building domain.

Figure 7.7: IPP Organizational Capacity Growth During CRDP Phase 2

Data period: 2017-2021



*Organizational Capacity Assessment Scale: 1= non/very limited capacity to 4=high/maximum capacity.

Tables 7.16–7.20 provide information and examples related to the top areas of change within each capacity domain. See Appendix 2 for capacity growth within each hub.

Table 7.16: IPP Changes in Operational Capacity

OPERATIONAL CAPACITY (to implement key organizational and programmatic functions) Capacity assessment score (Pre): 2.50 Capacity assessment score (Post): 2.71 Mean Difference: +0.21*			EXAMPLES
Changes Reported by 25 IPPs	Changes	Benchmarks	
Fundraising (n=10 IPPs)	8	4	Fundraising Benchmarks: <ul style="list-style-type: none"> Developed new fundraising goals. Applied for new grants. Created a fundraising committee to identify new funding opportunities. Changes: <ul style="list-style-type: none"> Secured new funding. Increased organizational budget. Implemented new Medi-Cal billing system. Fundraised enough money to enroll new CDEP participants.
Databases / Management Reporting Systems (n=8 IPPs)	6	5	
Communications Strategy (n=6 IPPs)	4	4	
Website (n=5 IPPs)	4	1	
Board Involvement & Participation in Fundraising (n=3 IPPs)	3	3	
Buildings & Office Space (n=4 IPPs)	3	1	Databases/Management Reporting Benchmarks: <ul style="list-style-type: none"> Secured new funding. Increased organizational budget. Implemented new Medi-Cal billing system. Fundraised enough money to enroll new CDEP participants. Changes: <ul style="list-style-type: none"> Designed & implemented new database (e.g., to store local evaluation data; streamline communication; facilitate data tracking; manage grant deliverables)..
Computers, Applications, Network, & Email (n=3 IPPs)	2	2	
Management of Legal & Liability Matters (n=1 IPP)	1	-	
Total	31	20	

*Significant at $p < 0.05$.



ADAPTIVE CAPACITY (to monitor, assess, and respond to internal and external changes) Capacity assessment score (Pre): 2.69 Capacity assessment score (Post): 3.01 Mean Difference: +0.32			EXAMPLES
Areas of Growth Reported by 25 IPPs	Changes	Benchmarks	<p>Evaluation/Performance Measurement</p> <p>Benchmarks:</p> <ul style="list-style-type: none"> Trained staff on data collection and management protocols. Initiated discussions about community-based participatory research strategies. Clarified evaluation goals and objectives. <p>Changes:</p> <ul style="list-style-type: none"> Implemented culturally and linguistically responsive local evaluation. <p>Evaluation & Organizational Learning</p> <p>Benchmarks:</p> <ul style="list-style-type: none"> Hired consultant to support advanced statistical analyses. Established a system for reviewing evaluation data and making necessary program refinements. <p>Changes:</p> <ul style="list-style-type: none"> Refined data collection methods based on preliminary review of the data. Facilitated data reflection meetings with key stakeholders to review preliminary data findings, and establish priorities for the upcoming year.
Evaluation/Performance Measurement (n=11 IPPs)	6	9	
Evaluation & Organizational Learning (n=8 IPPs)	5	7	
Strategic Planning (n=5 IPPs)	3	4	
Program Growth & Replication (n=4 IPPs)	3	3	
Partnerships & Alliances (n=4 IPPs)	3	2	
Influencing of Policy-making (n=3 IPPs)	2	2	
Use of Research Data to Support Program Planning & Advocacy (n=2 IPPs)	2	1	
Program Relevance & Integration (n=2 IPPs)	1	2	
Assessment of External Environment & Community Needs (n=2 IPPs)	1	2	
Constituent Involvement (n=2 IPPs)	1	2	
Total	27	34	

198

Table 7.18: IPP Changes in Management Capacity

MANAGEMENT CAPACITY (to use organizational resources effectively and efficiently) Capacity assessment score (Pre): 2.42 Capacity assessment score (Post): 2.73 Mean Difference: +0.31*			EXAMPLES Fund Development Planning Benchmarks: <ul style="list-style-type: none"> Hired a consultant to support with fundraising strategies. Identified and applied for new sources of funding. Attended a Medi-Cal readiness webinar. Changes: <ul style="list-style-type: none"> Established a reserve fund. Held 2 successful fundraising events. Secured monies from multiple, diverse funding sources. Operational Planning Benchmarks: <ul style="list-style-type: none"> Began working with an organizational development consultant. Initiated development of a 5-year strategic plan. Hired an operations team to develop and strengthen systems and infrastructure. Changes: <ul style="list-style-type: none"> Formally instituted organizational policies and procedures. Hired additional people so the organization is now fully staffed and able to operate efficiently.
Areas of Growth Reported by 20 IPPs	Changes	Benchmarks	
Fund Development Planning (n=12 IPPs)	8	10	
Operational Planning (n=4 IPPs)	3	3	
Funding Model (n=3 IPPs)	2	3	
Financial Planning/Budgeting (n=3 IPPs)	2	2	
Recruiting, Development, & Retention of General Staff (n=3 IPPs)	3	1	
Recruiting, Development, & Retention of Management (n=2 IPPs)	2	1	
Volunteer Management (n=2 IPPs)	2	1	
Knowledge Management (n=1 IPP)	-	1	
Total	22	22	

*Significant at p<0.05.

Table 7.19: IPP Changes in Cultural Competence Capacity

CULTURAL COMPETENCE CAPACITY (to understand/respond to cultural influences, values, needs, and attitudes of their community constituency) Capacity assessment score (Pre): 2.96 Capacity assessment score (Post): 3.15 Mean Difference: +0.19*			EXAMPLES
Areas of Growth Reported by 11 IPPs	Changes	Benchmarks	Planning/Monitoring/Evaluation Benchmarks: <ul style="list-style-type: none"> • Learned strategies for virtual program implementation during COVID that were appropriate for the community served. • Initiated data collection to better understand community members' needs. Changes: <ul style="list-style-type: none"> • Hired staff with bilingual capacity. • Created a program and evaluation steering committee. • Hired employees with extensive research expertise. Communication Benchmarks: <ul style="list-style-type: none"> • Hired marketing consultant to help develop communications strategy. • Created new CDEP marketing materials. Changes: <ul style="list-style-type: none"> • Leveraged social media and program events to expand organizational outreach efforts. • Translated materials (e.g., instructional videos, flyers) into multiple languages.
Planning/Monitoring/Evaluation (n=5 IPPs)	4	6	
Communication (n=4 IPPs)	3	2	
Human Resources (n=2 IPPs)	2	1	
Linguistic Capacity (n=2 IPPs)	2	-	
Expressed Organizational Commitment to Cultural Competence (n=2 IPP)	1	1	
Cultural Factors in Engagement with Community (n=1 IPP)	1	-	
Total	13	10	

*Significant at p<0.05.

Table 7.20: IPP Changes in Leadership Capacity

LEADERSHIP CAPACITY (to inspire, prioritize, make decisions, provide direction, and innovate) Capacity assessment score (Pre): 2.83 Capacity assessment score (Post): 2.93 Mean Difference: +0.10			EXAMPLES
Areas of Growth Reported by 7 IPPs	Changes	Benchmarks	Board Governance Benchmarks: <ul style="list-style-type: none"> • Hired and trained new board members. Changes: <ul style="list-style-type: none"> • Board increased in size, diversity, and leadership capacity. Shared Beliefs & Values Benchmarks: <ul style="list-style-type: none"> • Acquired information about possible new funding sources. Changes: <ul style="list-style-type: none"> • Sought information about possible new funding sources aligned with organizational purpose.
Board Governance (n=2 IPPs)	2	2	
Shared Beliefs & Values (n=1 IPP)	1	1	
Board Composition & Commitment (n=2 IPPs)	1	2	
Board Involvement & Support (n=2 IPPs)	-	2	
Board & CEO/ED Appreciation of Power Issues (n=1 IPP)	-	1	
Total	4	8	

*Significant at p<0.05.

7.3.A.I BARRIERS TO ORGANIZATIONAL CAPACITY GROWTH


While IPPs documented several ways in which their capacities improved during CRDP Phase 2, they also identified specific challenges that hampered aspects of their progress. Thematic analysis of reported barriers revealed 92 challenges in total clustered into eight categories. The top three reported barriers are described below.

- COVID-19 (37%) (n=15 IPPs): Capacity building activities paused so IPPs could tend to the needs of the community and their staff during the pandemic (41%); forced to pivot to virtual service delivery impacted organizational and programming operations (21%).
- Shifting organizational needs and priorities (16%; (n=15 IPPs): IPPs determined it was necessary to prioritize one element over another) (64%); IPPs unable to make progress on an element due to time constraints (36%).
- Staffing (15%; n=9 IPPs): Staff turnover and/or limited staff capacity (57%); additional time spent on recruitment, hiring, training new staff in response to staff turnover (29%).

Table 7.21 provides a complete list of capacity challenges reported by IPPs.

Table 7.21: IPP Organizational Capacity Challenges

Challenge	% (n)
1. COVID-19 (e.g., capacity building activities paused so IPPs could tend to community and staff needs during the pandemic; forced to pivot to virtual service delivery impacted programming, client access, and client engagement; staff wellbeing negatively impacted)	37% (34)
2. Shifting Organizational Needs and Priorities (e.g., IPPs determined it was necessary to prioritize one element over another; IPPs unable to make progress on an element due to time constraints)	16% (15)
3. Staffing Capacity (e.g., Staff turnover; additional time spent on recruitment, hiring, and training new staff; loss of key executive staff)	15% (14)
4. Funding (e.g., Funding delays hindered implementation; limited funding impeded efforts to hire staff needed to support capacity growth)	13% (12)
5. Evaluation (e.g., IRB delays hindered evaluation progress; challenges providing evaluation incentives)	9% (8)
6. Shortcomings with External Sources of Support (e.g., cancelled meetings; promised commitments not carried out)	4% (4)
7. Bureaucratic Challenges & Obstacles (e.g., bureaucratic "red tape" prevented organization from securing new office space)	3% (3)
8. External Community Conditions and Events (e.g., California wildfires and racial uprisings interrupted or delayed progress on elements)	2% (2)
Total #	92



Chapter 8

Community, Societal, and Policy Impact

EXECUTIVE
SUMMARY

CHAPTER 1

CHAPTER 2

CHAPTER 3

CHAPTER 4

CHAPTER 5

CHAPTER 6

CHAPTER 7

CHAPTER 8

CHAPTER 9

CHAPTER 10

CHAPTER 11

REFERENCES

APPENDICES

This chapter summarizes IPP involvement in advocacy, environmental, systems, and policy changes during CRDP Phase 2. IPPs worked together with the objective of improving mental health service access, quality, and utilization by forming strategic collaborations such as networks, collaboratives, and formal partnerships. Both quantitative and descriptive information reported in the SARs are included to reveal the color and nuance within the collaborative story that unfolded. We report on the who, how, and why IPPs formed collaborations, which include the types of groups IPPs were involved with, the nature of the groups they formed (networks, collaboratives, or partnerships), and the primary goals. Challenges and accomplishments of the IPPs are discussed followed by a discussion of advocacy and systems change efforts. Finally, we present the business case for CRDP Phase 2 which considered averted health expenses and increased productivity linked to improvements in mental health. The net benefit for CRDP Phase 2 was calculated using health expenditure models, CRDP statewide evaluation data, and large-scale survey data.

8.1 STRATEGIC COLLABORATIONS: NETWORKS, COLLABORATIVES, AND PARTNERSHIPS

CRDP Strategic Plan Goal 5, Strategy 25 (Develop new community/county partnerships) recommends that:



County mental health departments work more closely and develop partnerships with community-based organizations funded to implement the strategies identified for Phase II of the CRDP. These collaborations should include providing technical assistance and evaluation support to each other and sharing promising practices and successes.”

(CPEHN; Strategic Plan, 2018)

In this strategy, the onus falls on the counties to initiate collaborations with local community-based organizations to enhance the breadth and depth of community participation in local mental health PEI decision making. However, IPPs could not wait for the counties to take the lead. Instead, they took on this strategy and engaged in community-level work, often involving a collective impact approach to reduce mental health disparities for unserved, underserved, and inappropriately served communities. A collective impact approach refers to:

“...the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem at scale” (Center for Community Health and Development, n.d.).

This approach moves away from the traditional, more isolated ways that service organizations contribute to solving complex issues, and instead is an intentional way of working and sharing information with similar and/or diverse stakeholders.

In the semi-annual reports in May 2017 to April 2021, IPPs provided quantitative and qualitative information related to the extent of their involvement in three types of strategic collaborations:

- **Networks:** Groups formed with the goal of exchanging information to strengthen and improve mental health service provision.
- **Collaboratives:** Open and inclusive groups formed to share resources and identify solutions for mutual issues or challenges related to mental health service provision.
- **Formal Partnerships:** A formal commitment (i.e., involving a binding legal contract such as a memorandum of understanding, or MOU) between two or more stakeholders who combined resources to achieve a common goal.

IPPs were also asked to provide information related to a strategic collaboration’s purpose, sectors involved, collective accomplishments, and challenges from engaging in a collective impact approach to reducing mental health disparities in their respective communities.

8.1.A MIXED METHODS FINDINGS

A summary of quantitative and qualitative findings revealed the following:

Thirty-four IPPs across all five hubs engaged in 332 strategic collaborations (an average of 10 collaborations per IPP (range=1 to 32 collaborations). Seventy-three percent of IPP involvement in these strategic collaborations occurred during Phase 2; 27% occurred prior to the initiative’s launch but continued into Phase 2.

Forty of the 332 strategic collaborations were internal to CRDP Phase 2 (i.e., IPP to IPP)

- Twenty-eight were collaborations within hubs, while 16 were cross-hub collaborations (See Figure 8.2).

**STRATEGIC COLLABORATION SPOTLIGHT:
CROSS-POPULATION SUSTAINABILITY STEERING COMMITTEE (CPSSC)**

An example of a large and influential internal strategic collaboration formed during Phase 2 that included not only IPP representation, but OHE and TAPs, was the Cross-Population Sustainability Steering Committee (CPSSC). Its purpose was to raise awareness of CRDP efforts with an overarching goal of initiative sustainability. See Chapter 5 for more information about the CPSSC and its accomplishments.

As shown in Figure 8.1, strategic collaborations included:

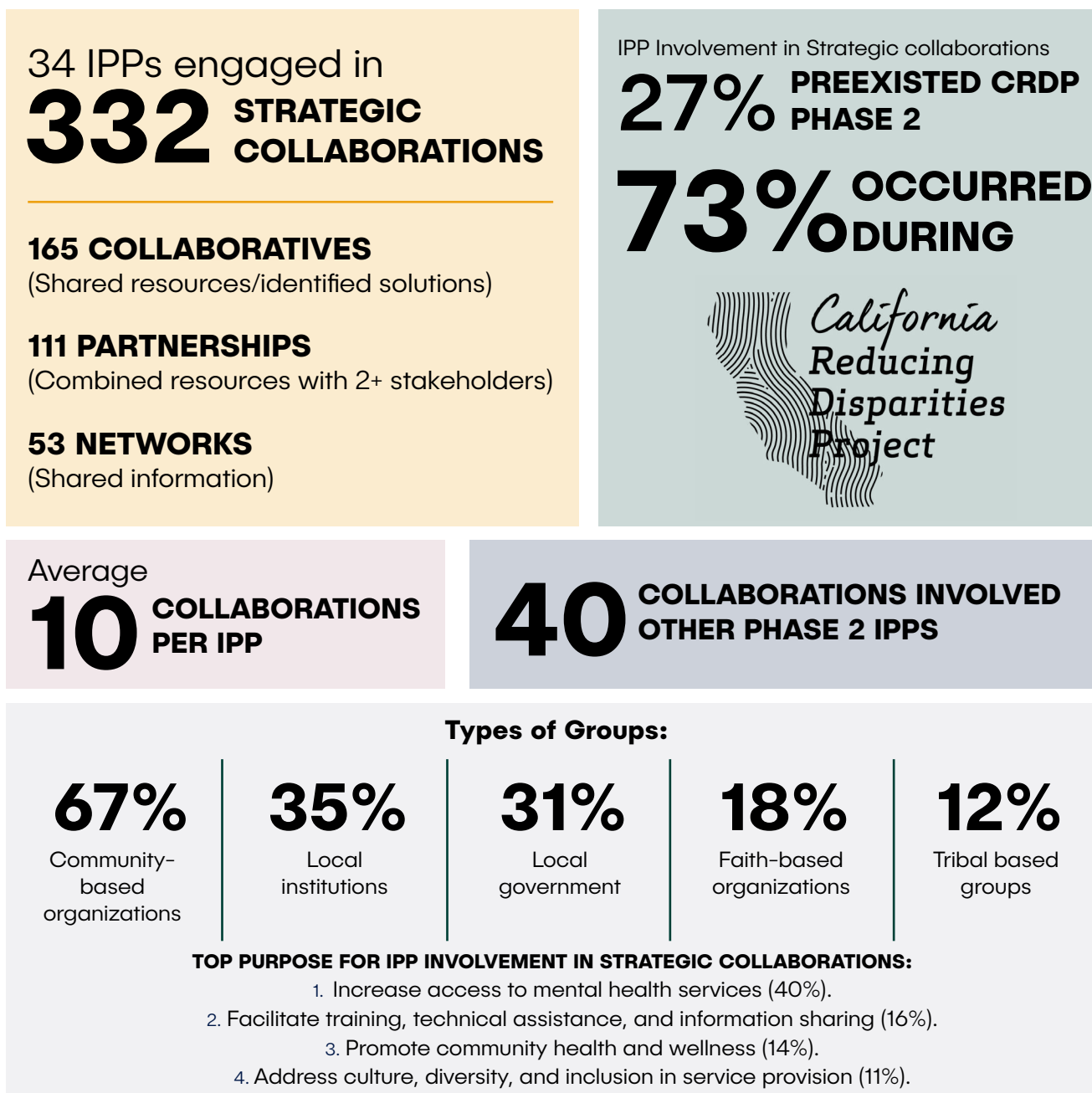
- Collaboratives (i.e., shared resources/identified solutions) (50%; n=165).
- Formal partnerships (i.e., MOU with 2+ stakeholders) (33%; n=111).
- Networks (i.e., exchanged information) (16%; n=53).

On average, 32 IPPs were involved in five collaboratives (range=1 to 27).	On average, 31 IPPs were involved with three partnerships (range=1 to 12).	On average, 24 IPPs were involved with two networks (range=1 to 5).
Examples of IPP collaboratives: BHC Health Access Action Team Capitol Health Network Navigator Academy Committee Love Our Vulnerable and Elderly (LOVE) SEARAC’s California Southeast Asian American Collaborative Stomp the Stigma Steering Committee	Examples of IPP partnerships: Alameda County Social Services Agency Coastal Roots Farms McDowell Family Resource Center Sacramento City Unified School District Native American Cultural Leaders Subcontractors	Examples of IPP networks: California Urban Indian Health Organizations County Parks and Recreation Services Kids and Family Together Los Angeles Alliance for Community Health and Aging Teen Health Advocacy Coalition

Two in three (67%) strategic collaborations involved alliances with other community-based organizations. (See Figure 8.1). This was followed by: local institutions (e.g., hospitals, schools) (35%; n=116), governmental groups (e.g., county mental health departments) (31%; n=103), faith-based groups (18%; n=60), and tribal-based groups (12%; n=40).

Figure 8.1: CRDP Phase 2 Overall IPP Participation in Strategic Collaborations and Sectors Involved

Data period: 2017–2021



Increasing access to mental health services (40%; n=190) was the most common purpose for an IPP's involvement in a strategic collaboration. A few examples of collaboration activities included cross-agency service referrals, joint community outreach to increase awareness of service availability, and client recruitment. (See Figure 8.1). The other two most common reasons for strategic collaborations were:

- Training, technical assistance, and information sharing (e.g., best practices in mental health service provision, community *promotor* trainings, staff trainings related to culturally responsive care) (22%; n=74).
- Community health and wellness promotion (e.g., joint wellness events, increasing health care enrollment, elevating issues related to health and mental health inequities) (20%; n=66).

Figure 8.2: CRDP Overall Strategic Collaborations Internal to CRDP Phase 2 (IPP to IPP)

Data period: 2017–2021

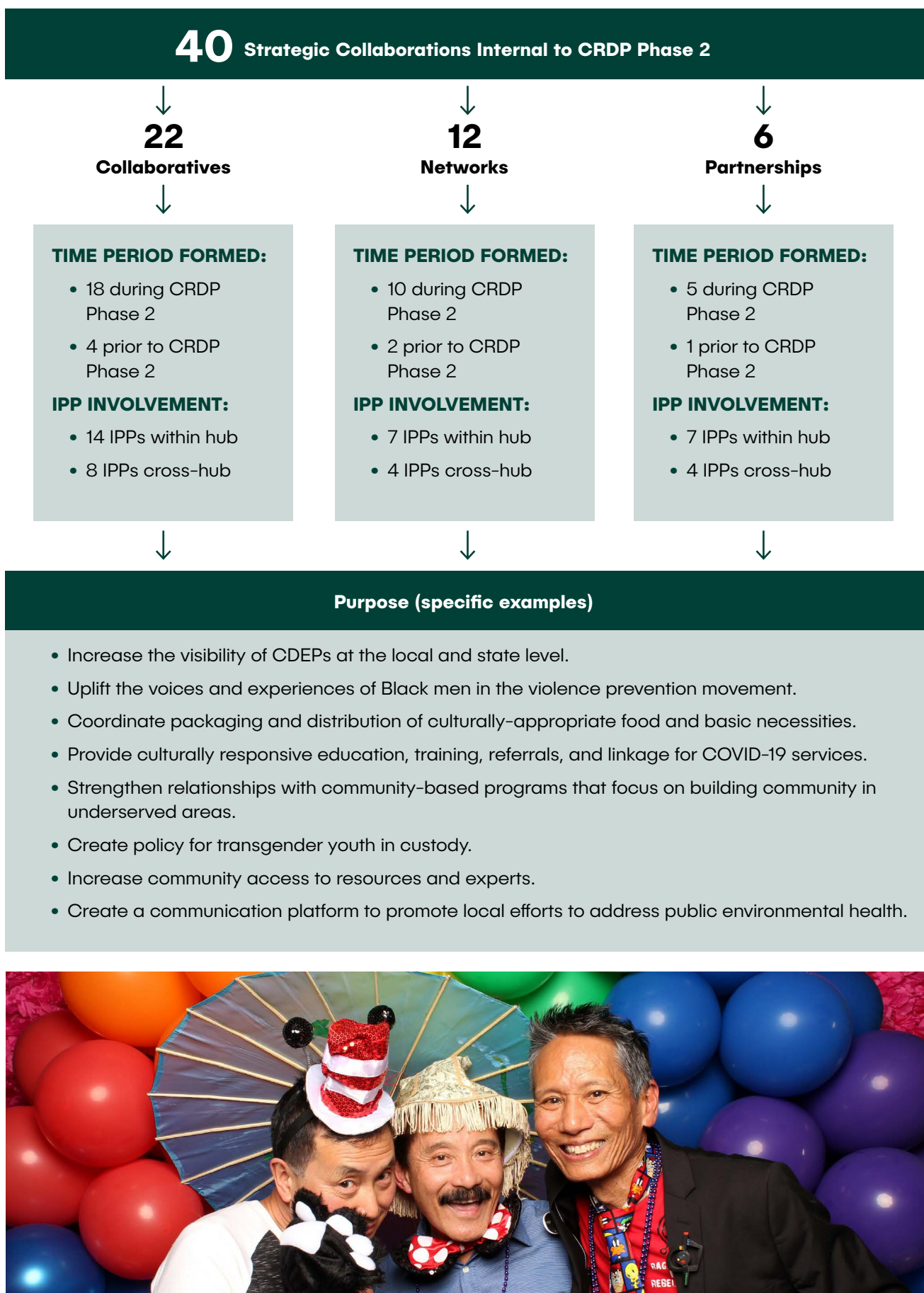


Table 8.1 provides a summary of the major reasons IPPs became involved in strategic collaborations.

Table 8.1: CRDP Overall – Purpose of the Strategic Collaborations (Collaboratives, Partnerships, Networks)

Major Themes	Collaboratives #	Formal Partnerships #	Networks #	CRDP Overall Total #
Increase Access to Mental Health Services (e.g., cross-agency service referrals, joint community outreach, and recruitment of clients/participants)	87	78	25	190
Facilitate Training/TA or Information Sharing (e.g., best practices in mental health service provision, community <i>promotor</i> trainings, culturally responsive care training for staff)	30	11	33	74
Community Health and Wellness Promotion (e.g., wellness events, increasing health care enrollment, increasing awareness of health/mental health inequities)	35	16	15	66
Culture, Diversity, and Inclusion in Service Provision (e.g., advocacy for transgender individuals, increasing availability of linguistically responsive services)	25	13	15	53
Sustainability Efforts (e.g., increasing funding opportunities)	8	12	7	27
Mental Health Systems and Policy Change (e.g., recommending priorities to funders, local and county mental health departments)	10	2	8	20
Facilitate Evaluation Activities (e.g., establishing data sharing between agencies)	8	8	1	17
Provide COVID-19 Support Services (e.g., basic needs, educational, wellness)	10	4	-	14
Census 2020 (e.g., providing information; increasing participation)	0	8	1	9
Total	213	152	105	470

Using a community-collective impact approach with other stakeholder groups resulted in 852 accomplishments. (See Figure 8.3). The top three types of accomplishments were:

- Increased and/or strengthened mental health programming in IPPs collective service areas (n=300).
- Increased knowledge and awareness of mental health needs, experiences, and services among the communities served by the ODEPs (n=219).
- New connections/deepened relationships with community stakeholders to advance mental health PEI efforts (n=187).

Despite the many benefits of engaging in strategic collaborations, IPPs also reported several barriers (n = 587) that impeded progress towards achieving their shared purposes/goals. The most frequently encountered challenges pertained to:

- Unequal member involvement (n=178),
- COVID-19 disruptions (n=171), and
- Limited resources to do the work (n=107).

Figure 8.3 provides a summary of accomplishments and challenges reported by IPPs from their involvement in strategic collaborations.

Figure 8.3: CRDP Overall – IPP Reported Accomplishments and Challenges Resulting from Strategic Collaborations

Data period: 2017-2021

NUMBER & TYPE OF STRATEGIC COLLABORATION ACCOMPLISHMENTS						
#1 Increased/strengthened mental health services/programming n=300 (e.g., obtained funding or in-kind donations to augment CDEP programs, co-facilitated community-level healing events; coordinated COVID-19 relief packages)	#2 Increased knowledge/awareness of mental health issues and service availability n=219 (e.g., raised awareness about priority population mental health needs; strengthened knowledge about culturally-responsive service provision)	#3 Created new connections & deepened relationships to advance mental health PEI efforts n=187 (e.g., created communication channels; shared information about services and programs; built connections between agencies)	#4 Influenced policy and systems change n=71 (e.g., advocated for the county department of mental health to allocate priority population-specific resources; garnered support for an Assembly Bill to be passed)	#5 Strengthened evaluation capacity & resources n=51 (e.g., secured a data sharing agreement; collected participant data to inform county-level decision making; created space to share evaluation findings to inform organizational learning)	#6 Expanded funding opportunities n=13 (e.g., applied for additional funds through the County Board of Supervisors)	#7 Improved organizational & strategic collaboration functioning n= 11 (e.g., developed strategies for virtual service delivery; created special committees focused on improving the group's governance structure)
NUMBER & TYPE OF STRATEGIC COLLABORATION CHALLENGES						
#1 Unequal member involvement n=178 (e.g., uneven levels of commitment/participation; lack of follow-through on agreed upon expectations; time needed to build trust)	#2 COVID-19 disruptions n=171 (e.g., delays in service provision; time needed to pivot to virtual service/program delivery)	#3 Limited resources for the work n=107 (e.g., limited financial/tech/human resources that last long and can contribute to community change)	#4 Impacted services/programming n=76 (e.g., difficulties conducting outreach/recruitment; community need exceeded service availability)	#5 Lack of cultural competencies n=26 (e.g., members lacked information, awareness, or skills to conduct cultural, linguistic, or LGBTQ+ competent care)	#6 Bureaucratic impediments n=15 (e.g., delays with solidifying MOU contracts; lack of external investment in sustaining/supporting the collaborations)	#7 Shifting priorities n=14 (e.g., group needed to modify its shared purpose and/or goals)

The complete list of accomplishments and challenges related to collaboratives, networks, and partnerships can be found in Tables 8.2 and 8.3.

Table 8.2: IPP-Reported Accomplishments Resulting from Strategic Collaborations

Major Themes	Collaboratives #	Formal Partnerships #	Networks #	CRDP Overall Total #
Increased/or strengthened mental health services/programming (e.g., expanded CDEP programs; co-facilitated community-level healing events; coordinated COVID-19 relief packages for community)	136	135	29	300
Increased knowledge/awareness of mental health issues and service availability (e.g., raised awareness about mental health needs within their respective priority populations; strengthened knowledge about culturally responsive service provision; co-created mental health public awareness materials)	114	72	33	219
Created new connections and deepened relationships to advance mental health PEI efforts (e.g., created communication channels; shared information about services and programs, built connections between agencies)	94	50	43	187
Influenced policy and systems change (e.g., advocated for the county department of mental health to allocate priority population-specific resources; garnered community support for an assembly bill to be passed)	37	19	15	71
Strengthened evaluation capacity and resources (e.g., secured a data sharing agreement; collected participant data to inform county-level decision making; created space to share evaluation findings to inform organizational learning)	21	21	9	51
Expanded funding opportunities (e.g., applied for additional funds through the County Board of Supervisors)	6	6	1	13
Improved organizational and collaboration functioning (e.g., developed strategies for virtual service delivery; created special committees focused on improving governance structure)	3	7	1	11
Total	411	310	131	852

*The total number of accomplishments is duplicative, meaning that any one group may have reported multiple achievements during the initiative period.

Table 8.3: IPP Reported Challenges Resulting from Strategic Collaborations

Major Themes	Collaboratives #	Formal Partnerships #	Networks #	CRDP Overall Total #
Unequal member involvement (e.g., uneven level of commitment and participation; lack of follow-through on agreed upon expectations; communication challenges; extensive time needed to build trust)	72	62	44	178
COVID-19 disruptions (e.g., delays in service provision; time needed to pivot to virtual service/program delivery)	92	62	17	171
Limited resources to do the work (e.g., limited financial, human, technology, and other sustainable resources that can contribute to community change)	48	34	25	107
Impacted service provision (e.g., outreach and recruitment challenges; participants unable to access services virtually; insufficient services to meet community need)	45	29	7	76
Lack of cultural competencies by group members (e.g., partners lacking cultural, linguistic, and/or LGBTQ+ awareness)	12	6	8	26
Bureaucratic impediments (e.g., delays with solidifying MOU contracts; lack of external investment in sustaining/supporting the group)	8	7	-	15
Shift in priorities (e.g., group needing to modify its shared purpose and/or goals)	10	4	-	14
Total	287	204	101	587

*The total number of accomplishments is duplicative, meaning that any one group may have reported multiple achievements during the initiative period.

8.1.A.I ACCOMPLISHMENTS

IPPs reported a total of 852 accomplishments stemming from their involvement in strategic collaboratives, partnerships, or networks. The top successes emerging from their collective efforts were:

- Increased and/or strengthened mental health programming (300 accomplishments). (This finding is particularly important given that increasing service provision was the most frequently mentioned reason for IPPs forming alliances with other groups).
- Increased knowledge and awareness of mental health needs, experiences, and services across the five priority populations (219 accomplishments).
- Deepened relationships with community stakeholders to advance mental health work (187 accomplishments).

8.1.A.II CHALLENGES

Despite the staggering number of successes IPPs achieved toward advancing their mission around mental health equity for their community members, many encountered internal barriers that impeded progress towards their objectives. IPPs reported 587 challenges across seven primary categories. The most frequently encountered challenges pertained to:

- Partner engagement (178 challenges)
- COVID-19 (171 challenges)
- Limited resources (107 challenges)

See Figure 8.3 for the top accomplishments and challenges reported by IPPs from their group involvement. See Appendix 2 for a full list of accomplishments and challenges for collaboratives, networks, and partnerships respectively for each of the priority populations hubs.

Appendix 2 provide a detailed breakdown of IPP involvement in strategic groups within each of the five priority population hubs. Please note that IPPs may have reported involvement in the same group, and for this reason the total number of groups reported across priority populations exceeds the total number of groups formed.

8.2 IPP ADVOCACY EFFORTS

The CDPH CRDP IPP Solicitation (15-10603), explicitly delineated one of its goals for CRDP Phase 2 as:



Support changes in statewide and local mental health delivery systems and policies that will reduce mental health disparities among unserved, underserved and inappropriately served populations.”

(State of California, California Department of Public Health Office of Health Equity, August 24, 2015)

IPPs often pursued collective impact strategies with other organizations, agencies, and institutions to help move the CRDP mission forward. At other times, IPPs worked independently from each other (but often in tandem with their community members) to address issues that mattered most to them. This work was reflected in their community advocacy efforts to influence outcomes and drive change with and on behalf of their respective communities. This section of the report provides an overview of the advocacy activities IPPs participated in during Phase 2. Findings were derived from the IPP's self-reported advocacy descriptions in the IPP semi-annual reports from March 2017 to April 2021.

Through their participation in advocacy activities, IPPs raised awareness and generated much needed attention at the local and state levels related to:

- Community members' mental and behavioral health needs.
- Inadequate availability of culturally, linguistically, and LGBTQ+-appropriate mental healthcare for their communities.
- The importance of the social determinants of health (e.g., education, social and community context, economic stability, health care access) on the mental health and health of individuals in vulnerable populations.



Nearly all IPPs (88%) engaged in community advocacy during CRDP Phase 2. See Figure 8.4.

- Thirty-one IPPs representing all five hubs (with a range of five to seven IPPs per hub) were involved in 396 advocacy activities on behalf of, or in collaboration with, their communities.

IPPs meaningfully engaged communities to ensure that the perspectives of those most affected by the problems were part of the process. See Figure 8.4.

- 87% (n=28 IPPs) engaged community members (families, parents, youth, adults).
- 37% (n=12 IPPs) engaged community healers/spiritual leaders.
- 22% (n=7 IPPs) engaged CDEP staff, who often had lived experience with mental health challenges.
- 50% (n=16 IPPs) worked with community partners (e.g., schools, community-based organizations).
- 12% (n=4 IPPs) worked with county agencies/departments (e.g., hospitals, child welfare).

The top three IPP advocacy activities were:

- Community actions, including public testimony/commentary (n=91 activities).
- Mental health education and awareness (n=71 activities).
- Collective impact approach for change (n=57 activities).

See Figure 8.4.

Figure 8.4: IPP Advocacy Activities and Community Engagement

Data period: 2017–2021

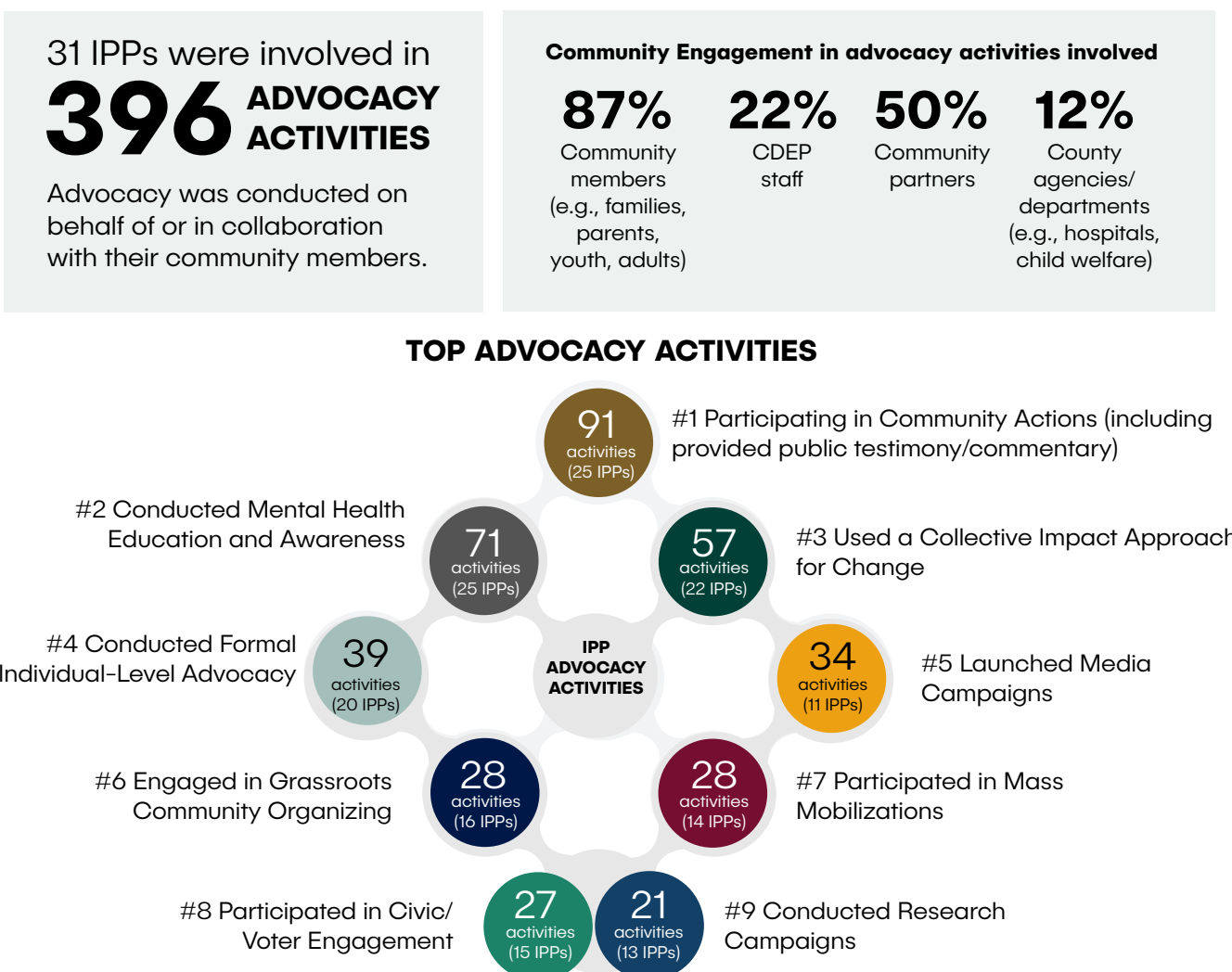


Table 8.4 provides a description of IPP advocacy activities with accompanying examples.

Table 8.4: CRDP Overall – IPP Advocacy Activities and Examples

Major Themes Advocacy Activities	Examples
<p>Participated in community actions (e.g., visible participation in townhall meetings, community forums, school board or city council meetings, <u>including provided public testimony and commentary</u>).</p> <p><i>91 activities reported by 25 IPPs</i></p>	<p>Lodi Unified School Board meeting regarding the concerns community members had about Lodi School Board's attitudes and intentions toward teaching LGBT+ History in Lodi schools; participated in violence intervention and prevention rally; provided public comment at the Sacramento Behavioral Health Cultural Competence Committee to advocate for more dedicated services for the African-American community and to highlight challenges with accessing both private and community mental health services; CDEP staff presented about the effectiveness of the CDEP on behalf of Assembly Bill 512 at the California State Capitol; educated community members and decision makers on deportation, census outreach, and language access services via community forums and legislative visits.</p>
<p>Conducted mental health education and awareness (e.g., with the general public, community members, and/or decision makers).</p> <p><i>71 activities reported by 25 IPPs</i></p>	<p>Facilitated educational and awareness activities focused on: mental health disparities in LGBTQ communities; funding for children and youth-serving programs; equitable educational resources; impact of COVID-19 in the Latinx community; inclusive health access system for Mexican indigenous communities; census participation; protecting the health and safety of underserved communities during COVID-19; COVID-19 testing and vaccinations; sexual assault prevention; tobacco prevention; mental health; self-care; nurturing parenting; Anti-Asian American violence.</p>
<p>Used a collective impact approach for change (e.g., strategic collaborations, advocated for changes in practices, regulations, policies, programming, or funding streams).</p> <p><i>57 activities reported by 22 IPPs</i></p>	<p>Co-organized a Trans Job Fair with another local organization (Sol Collective) to tackle the lack of access, job discrimination, and unsafe work environments; partnered with Roseville City School District to work with parents and teachers to reduce mental health stigma among families. This has included a parent workshop on mental health, connecting school staff to mental health trainings, and mental health awareness activity with after-school program students; partnered with other local tribal agencies to advocate on a county-wide level for systems change in child welfare and mental health.</p>
<p>Conducted formal individual-level advocacy (e.g., spoke out and advocated on behalf of a community member to resolve an issue, obtain a needed support/service, or promote a change in the practices, policies and/or behaviors of third parties).</p> <p><i>39 activities reported by 20 IPPs</i></p>	<p>One IPP's resources and referrals navigation team, CDEP staff, and community wellness services staff advocated for individual community members within housing, aging services, and other social services; assisted with navigation for a client to meet with the workman's compensation department and empowered the client to follow through with services which ultimately resulted in the client receiving an award and compensation; clinicians, support coordinators, and advocates work regularly with their assigned youth and families to address systemic barriers to wellness.</p>
<p>Launched media campaigns (e.g., used the media, including the arts, for strategic messaging and framing of social justice issues; involved messaging related to root causes and potential solutions).</p> <p><i>34 activities reported by 11 IPPs</i></p>	<p>Posted several "get out to vote" and "filling out the census" posts on social media platforms; participated in art and mural production to promote social justice; started a podcast and radio program to address mental health issues and health equity; created a Spanish language video called "La Importancia del Censo 2020" to engage the community in filling out their census.</p>
<p>Engaged in grassroots community organizing (e.g., building of community power to address social inequities and achieve social and political change).</p> <p><i>28 activities reported by 16 IPPs</i></p>	<p>Established a youth advisory committee to help inform outreach to LGBTQ+ youth; organized community members to help renovate a classroom in a park to make the classroom available for public use; canvassed neighborhoods and promoted the initiative at community events in the run-up to the March 2020 primary election.</p>

Major Themes Advocacy Activities	Examples
Participated in mass mobilization activities (e.g., rally, protest, marches). <i>28 activities reported by 14 IPPs</i>	Community members, participants, and CDEP staff organized a rally at the state Capitol to protest the injustices imposed on Roxsana Hernandez, a trans community member who died in ICE detention; IPP and community members attended and spoke at Black Lives Matter rallies and town hall meetings; partnered with Councilmember Saro to host anti-hate vigil in Cambodia Town in response to the tragic Atlanta spa mass shooting; coordinated rallies around tenant rights.
Participated in civic/voter engagement activities (e.g., activities that promoted community awareness of and involvement in civic, community, and political life, such as ballot organizing, voter turnout activities, to name a few). <i>27 activities reported by 15 IPPs</i>	Led voter registration efforts; provided voting and census sites and marketed both to encourage Latinx people to vote and complete the census; organized and assisted resident leaders in participating in census meetings and educated community members about the importance of the census and civic participation.
Conducted research campaigns (e.g., community-driven, participatory action research and evaluation activities used for advocacy). <i>21 activities reported by 13 IPPs</i>	Participated in research groups with Kern Behavioral Health and Research Services to make changes in health care management and services to the LGBTQ+ community; engaged in a youth-participatory qualitative research project examining the lived experiences of Latinx youth and young adults in the Sonoma County area who lived through multiple crises (Covid-19, political unrest, and/or wildfires).

8.3 IPP ENVIRONMENTAL, SYSTEMS & POLICY CHANGE EFFORTS

From March 2017 to April 2021, IPPs reported on environmental, systems, or policy changes (including benchmarks) accomplished in Phase 2. This entailed:

- Environmental change: to physical or social spaces or places where people live, learn, work, and play.
- Systems change: to existing processes of organizations, institutions, and formal systems.
- Policy change: to laws, regulations, ordinances, and rules.
- Benchmarks: meaningful steps or progress made toward environmental, systems, or policy change.

A CAVEAT ABOUT EVALUATING ENVIRONMENTAL/SYSTEMS/POLICY CHANGE

Several approaches and frameworks have been used to assess environmental/systems/policy change(s) resulting from community-led advocacy efforts. Two common approaches/frameworks include:

- Evaluating community change: A framework for grantmakers (Grantmakers for Effective Organizations, 2014).
- Evaluating power building: Concepts and considerations for advocacy evaluators (Post, 2021).

At minimum, the statewide evaluation approach would answer the following questions:

- What was the problem or core issue that needed to be addressed (including its root causes and the baseline conditions) and the proposed solution(s)?
- Who was involved in the advocacy effort? For example, was it one organization or a partnership of community-based organizations? Did ally organizations provide support along the way? Was the community engaged and to what extent? What specific role did each stakeholder group play and what resources did each bring to the table?

- What advocacy tactics and strategies were used, and did they help create the conditions necessary for change (e.g., built community power and influence)? (This also includes assessing the contributions of external groups working on the same issue and assessing any coordinated response to stakeholder groups in opposition.)
- What type of change occurred and to what extent were there multiple coordinated pathways that led to positive outcomes? Was the change adopted and was it implemented? Which stakeholder groups were at the table with decisionmakers during the adoption or implementation process? To what extent is there public documentation related to the advocacy group's contribution to the adopted or implemented change?

This type of change work is complex, challenging, and can occur slowly over time. Due to the number of research questions and objectives to address, the statewide evaluation did not have the resources or capacity to conduct an evaluation consistent with the above environmental, systems, or policy change frameworks. Additional changes may have occurred after CRDP data collection ended and these would not be captured in this report of findings.

When reading the findings in this section, it is important to note that the statewide evaluation does not:

- Provide evidence of a causal pathway between IPP self-reported advocacy activities and any environmental, systems, or policy changes.
- Determine the extent to which IPPs contributed to environmental, systems, or policy changes, especially those at the state level (e.g., individual vs. collective partnership effort, extent of community involvement, etc.).

Nonetheless, CRDP Phase 2 evaluation findings yielded important evidence that IPPs contributed to the realignment of policies, processes, power, and infrastructure, all of which are necessary to address the complex and inequitable systems that affect mental health for the five priority populations. A natural next step for further CRDP statewide evaluation efforts would be to design an evaluation approach that more systematically explores environmental, systems, and policy changes in ways that can address the four questions noted above, especially those at the state level (e.g., individual vs. collective partnership effort, extent of community involvement, etc.).

Of the 32 IPPs that were involved in community advocacy efforts, 21 contributed to 55 environmental, systems, or policy changes and 12 benchmarks to change. (See Figure 8.5) Specifically:

- Seven IPPs contributed to 10 environmental changes.
- Fifteen IPPs contributed to 33 systems changes and 10 system benchmarks to change.
- Eight IPPs contributed to 12 policy changes and 2 policy benchmarks to change.

Some IPPs engaged in multiple change efforts:

- Thirteen IPPs contributed to change in one area only (primarily at the systems level).
- Seven IPPs contributed to changes in two areas.
- One IPP contributed to changes in all three areas.

The absence of information in Figure 8.5 below for any given priority population hub should not be interpreted as a lack of expected CDEP contributions to this statewide evaluation variable. IPP contributions to environmental, systems, and policy changes were not a central component of all CDEPs. Further, many contributions in this area represent IPP efforts that went above and beyond their CDEP deliverables. In general, this domain can be used to signify a value-added consequence, not a central goal, for CDEP implementation in CRDP Phase 2.

Figure 8.5: Environmental, Systems, and Policy Change Efforts by Hub and CRDP Overall

IPP CONTRIBUTIONS TO ENVIRONMENTAL, SYSTEMS, & POLICY CHANGES

Data period: 2017-2021

CRDP Overall (21 IPPs)	AfAm (6 IPPs)	AI/AN (4 IPPs)	AANHPI (2 IPPs)	Latinx (5 IPPs)	LGBTQ+ (4 IPPs)
Environmental (7 IPPs): 10 changes Systems (15 IPPs): 33 changes (+10 Benchmarks) Policy (8 IPPs): 12 changes (+2 Benchmarks)	Environmental (2 IPPs): 3 changes Systems (4 IPPs): 7 changes (+3 Benchmarks) Policy (3 IPPs): 3 changes	Environmental (2 IPPs): 2 changes Systems (4 IPPs): 4 changes (+3 Benchmarks) Policy (2 IPPs): 2 changes	Systems (1 IPP): 4 changes (+2 Benchmarks) Policy (2 IPPs): 6 changes (+2 Benchmarks)	Environmental (3 IPPs): 5 changes Systems (2 IPPs): 3 changes Policy (1 IPP): 1 change	Systems (4 IPPs): 14 changes (+2 Benchmarks)

EXAMPLES OF CHANGES IPPs CONTRIBUTED TO BY HUB:

ENVIRONMENTAL	Changes in physical or social spaces or places where people live, learn, work, and play	Farmers market space created as part of a neighborhood revitalization effort. Created social justice-oriented murals in schools as part of a school beautification effort.	Secured agreement to use sacred land for annual Memorial gathering and other community events.		Co-located parent support services in schools. Received grant award to assist farm workers testing positive for COVID-19 to receive temporary shelter, food and housing supports.
SYSTEMS	Changes in the existing processes of an organization, institution or system	Culturally responsive trauma informed practices established in six schools. Mobile crisis response unit opened in response to demands to shift funding from law enforcement into mental health service provision.	Community feedback incorporated into the Mental Health Services Act 3-Year Plan. IPP became a billable Medi-Cal provider.	Racial equity framework formed with the city of Long Beach. Resolution adopted by Los Angeles County to fund Asian & Pacific Islander organizations.	Changed discipline policies from punitive to supportive in several schools. Mental health, local government, law enforcement, & child welfare organizations now refer community members to IPP & call IPP for support services.
POLICY	Changes in laws, regulations, ordinances, rules	Reauthorized funding from the Oakland Fund for Children and Youth. CDEP included in the Mental Health Services Act 3-Year Plan.	Passage of the Missing and Murdered Indigenous Women Awareness month.	Housing ordinance passed for relocation assistance & eviction moratorium in Long Beach during COVID-19. State adopted & implemented close to \$9 million in federal CARES Act money for youth services.	Passage of Peer Support Certification bill which establishes statewide requirements for counties to use in developing certification programs for peer support specialists.

Appendix 2 provides hub specific descriptions of advocacy activities and systems, policy, and environmental changes by hub.

8.4 BUSINESS CASE: COST-BENEFIT ANALYSIS OF CRDP PHASE 2



An ounce of prevention is worth a pound of cure.”

Benjamin Franklin

This section outlines the business case for CRDP Phase 2 by demonstrating the value of CDEPs as a prevention and early intervention mental health approach to reduce mental health disparities for the five priority populations. The economic value of CRDP Phase 2 is calculated through a cost-benefit analysis (CBA) of health and non-health initiative outcomes to determine the return on investment (ROI). In other words, the business case explains how changes in CDEP participant mental health outcomes, measured as changes in psychological distress and functioning, can be valued in dollars.

This business case answers the following statewide evaluation questions.

Objective 1: **Effectiveness of the CRDP Phase 2.**

- Do CRDP strategies show an effective return on 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 implementation pilot projects?
- What is the business case for increasing them to a larger scale?

In demonstrating the economic value of CRDP Phase 2 strategies, including CDEPs, the business case furthers Goal 4 of the CRDP Strategic Plan: “Develop, fund, and demonstrate the effectiveness of population-specific and tailored programs.” It also aligns with Strategy 17: “Fund culturally specific research.” (CPEHN, Strategic Plan, 2018).

To preserve the main report’s readability for a range of audiences, this section provides only an overview of the business case’s conceptual framework, methodology, and results. See Appendices 4.1 to 4.6 for additional technical details on the business case methodology and supporting literature.

8.4.A METHODS

8.4.A.I CONCEPTUAL FRAMEWORK AND APPROACH

The business case for CRDP Phase 2 considered medical expenses and costs averted, and increased productivity linked to improvements in mental health. In CBAs, costs are compared to the benefits of health- and non-health-related outcomes and are expressed in monetary units (Boardman et al., 2018). This analysis adopted a societal perspective to determine direct benefits accrued to CDEP participants and indirect benefits accrued to everyone else in the society, mostly in their role as taxpayers (Garfinkel et al., 2022). Initiative costs were calculated using CRDP Phase 2 budgetary costs (i.e., IPP grants, CRDP technical assistance and evaluation contracts, OHE’s administrative costs), as well as participant costs (i.e., travel expenses and lost leisure time due to CDEP participation).

The CRDP monetary benefits considered were:

- Health expenses averted due to improvements in mental health outcomes measured as psychological distress and psychological functioning at the societal level.
- Gains in productivity operationalized as higher gross income from better mental health.

For non-monetary benefits, a section is included that describes the 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). These outcomes were not monetized in this analysis due to data limitations (i.e., the outcomes were not collected in the participant questionnaire or in the available large-scale survey data used in these analyses).

The listed benefits do not encapsulate the full range of potential benefits from the CRDP Phase 2 (e.g., decreases in homelessness and school drop-out or increases in school instruction time). In this analysis we had to balance economic pertinence and data availability in the inclusion of all monetary and non-monetary benefits.

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

- 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.
- CDEP participants who transitioned out of the threshold for psychological distress or impaired functioning (i.e., mental health issues were averted or did not worsen).

Table 8.5 shows the potential monetary benefits and costs of CRDP Phase 2. Estimated costs are subtracted from benefits to derive the net benefit or dollar gains from CRDP Phase 2 PEI efforts. Direct benefits and costs are received by participants after their involvement in CDEP activities. Indirect benefits are received by everyone else in the society, mainly as tax gains.

The top panel of Table 8.5 shows IPP program costs and CRDP operating costs. This panel also includes costs accrued to CDEP participants, including travel costs to attend CDEP activities, a reduction in leisure time from involvement in CDEP activities, and excess burden for taxpayers. This last cost comes from a distortionary effect from taxes that leads to a loss of welfare and is typically calculated in CBAs.

The bottom panel of Table 8.5 shows the monetary benefits from increases in productivity from better mental health, valued as higher gross earnings. Increases in beneficiaries' earnings lead to higher tax payments, which are a cost to beneficiaries and represent an indirect benefit for taxpayers (non-participants). Another set of benefits for CDEP participants come from lower health expenditures associated with better mental health (measured in lower psychological distress and positive psychological functioning). Improvements in mental health also resulted in lower dependence of public assistance. Important benefits that could not be monetized are discussed in further sections.

Table 8.5: 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					
SWE	-	0	0	0	-
TAPs	-	0	0	0	-
EOA	-	0	0	0	-
OHE	-	0	0	0	-
Ancillary contractors	-	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

	Total=	Direct + Indirect			
	Society	Adult	Youth	Children	Taxpayers / Non-participants
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 (out-of-pocket, public, and private insurance)	+	+	+	+	0
Lower use of public assistance	0	-	-	-	+
Benefits from a proxied decrease in psychological functioning					
Lower health expenditures (out-of-pocket, public, and private insurance)	+	+	+	+	0
Lower use of public assistance	0	-	-	-	+
Out-of-program output					
Increase in gross earnings	+	+	0	0	0
Tax Payments	0	-	0	0	+
Net Benefits (benefits - costs)	$\sum_{i=1}^n \text{Benefits} - \sum_{i=1}^n \text{Costs}$				

The analytic horizon of this evaluation considered both the period of CDEP activities and the period during which mental health and other outcomes were projected to continue improving after the programs ended. The horizon for out-of-program benefits varied by hub depending on the average age of participants. All monetary estimates are net of inflation and represent real dollars. Costs and benefits were deflated using the Consumer Price Index from the Bureau of Labor Statistics, base period 2019.

8.4.A.II CALCULATING BENEFITS ASSOCIATED WITH CHANGES IN PSYCHOLOGICAL DISTRESS AND FUNCTIONING

Improved or sustained mental health, measured through changes in psychological distress and functioning, was assessed and associated with monetary benefits in the business case. Research shows that healthcare expenditures are consistently higher among individuals with greater psychological distress. Pirraglia et al., (2011) found that individuals presenting higher psychological distress had greater subsequent healthcare expenditures and more outpatient visits even after adjusting for mental health conditions. Dismuke et al. (2011) found that among adults in the U.S., serious psychological distress (SPD) was associated with significant increases in total health expenditures and higher office visits, emergency department visits, and inpatient visits. This study found that symptoms associated with SPD were linked to \$1,735 higher total expenditures compared to people not experiencing SPD.

Two data sources are used to calculate monetary benefits resulting from changes in CDEP participant changes in psychological distress and functioning: the statewide evaluation CDEP participant questionnaire and the Medical Expenditure Panel Survey (MEPS). The statewide evaluation CDEP participant questionnaire was used to measure changes in mental health outcomes, particularly psychological distress and functioning pre and post CDEP intervention. Nationally representative MEPS data was used to calculate a monetary benefit per increment change in psychological distress for the racial and ethnic groups represented in the CRDP hubs and for LGBTQ+ individuals. Together, the statewide evaluation CDEP participant questionnaire and the MEPS data allowed for estimates in the monetary gains from the improved or sustained mental health of CDEP participants.

Statewide evaluation CDEP participant questionnaire¹⁸ data was collected pre and post intervention from CDEP participants. The questionnaire measured participant psychological distress using the Kessler-6 (K6) scale and psychological functioning using an adapted version of the Sheehan Disability Scale (SDS). The business case only used the matched sample pre and post interventions with complete K6 cases. This means that only participants that answered all K6 items in the pre and post questionnaire were considered as part of the analytic sample. Participants with missing values were dropped from the sample to avoid biased estimates. The total matched adult sample size was 1,784. This sample was used to estimate average K6 scores pre and post interventions. Subsequent changes in K6 scores were used to inform our health and income models.

MEPS data was used to estimate several monetary benefits of the CRDP business case. The MEPS is a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States. These data, managed by the Federal Agency for Healthcare Research and Quality (AHRQ), are released yearly, and include information on disaggregated health expenditures, income, public assistance, family and individual characteristics, and mental health indicators, including the K6 and PHQ9. K6 data is only collected for adults. We pooled the three most recent years of consolidated available data (2017, 2018, and 2019) for a sample size of 68,688 adults. Pooled weights were used to account for the sampling structure and to obtain estimates representative of the national population.

The MEPS does not collect information on psychological functioning using the SDS. The SDS measures functional impairment in work, school, home, social life, and relationships. The strategy to estimate changes in psychological functioning for this CBA consisted of exploring changes around the K6 cutoff for symptoms associated with SPD. Mental health problems derived from SPD can be severe enough to cause moderate to serious impairment in social, occupational, or school functioning (Weissman et al., 2015). In the CRDP data, a majority of adults with SPD (96%) had an impairment in one or more activities of daily living (e.g., psychological functioning).

Four steps were used to calculate the aggregate health expenses associated with changes in psychological distress and functioning:

- Estimating the association between MEPS K6 scores and health expenditures for psychological distress or estimating the probability of scoring $K6 \geq 13$ and subsequent transitions out of SPD for psychological functioning.
- Obtaining health expenditure dollar values associated to point changes in K6 scores through marginal change models for psychological distress or obtaining health expenditure dollar values to transitions out of SPD status for psychological functioning.
- Matching pre and post changes in CRDP K6 scores to MEPS K6 scores and their associated dollar values.
- Multiplying estimated dollar values by the number of corresponding CRDP participants.

The resulting estimates were considered the aggregate benefits from a reduction in psychological distress or functioning monetized through out-of-pocket health expenditures. The process was replicated for Medicare/Medicaid health expenditures, health insurance expenditures, and use of public assistance dollars. Please refer to Appendix 4.1 for a technical description of the steps used to estimate changes in psychological distress and Appendix 4.2 for a technical description of the steps used to estimate proxied changes in psychological functioning.



¹⁸ See chapter 4 for additional information on the Statewide Evaluation CDEP Participant Questionnaire.

LIMITATIONS OF MEPS REPRESENTATIVENESS FOR THE CRDP PHASE 2 BUSINESS CASE

The MEPS data has four notable limitations in relation to the CRDP business case. First, the complexity of accessing required data limited the analyses that could be completed for the report. State-level data with finer geographic details are only available in restricted MEPS files. The SWE requested access to use MEPS data for California. The process to access these restricted data required submitting a project proposal, background checks, and approval from the Federal AHQR and the U.S. Census Bureau. After receiving approval from both agencies, model estimation and analyses could only be done from a secure Federal Statistical Research Data Center (FRDC) location, and output removal required a disclosure process review. Given the complexity of modeling and process to disclose results, only nationally representative health expenditure data for adults in the MEPS were used in the estimates for this report.

Second, the MEPS does not include sexual orientation or gender identity information. To address this limitation, we requested access to National Health Interview Survey (NHIS) data linked to the MEPS to incorporate sexual orientation to calculate health expenditure models. The NHIS includes the variable sexual orientation with the following response categories: gay/lesbian, straight, bisexual, something else, I don't know the answer, refused, and not ascertained. From a 2020 public access version of the NHIS data, we observed that, at the national level, 93% of respondents reported being straight. Considering these numbers, we proposed to use a "heterosexual" and "LGBQ+" categorization for our models to have enough power to detect differences by sexual orientation. We acknowledge this categorization does not account for the diversity of LGBQ+ populations and does not include gender identity measures to account for transgender and gender non-binary (TGNB) populations. However, despite the limitations of these national datasets, NHIS-linked data allowed us, to a limited extent, to estimate some of the mental health monetary benefits for the LGBTQ+ hub in our analysis.

Third, the main analyses only include estimates on adult benefits and costs because the MEPS does not collect K6 information for individuals under the age of 18 years. A supplemental assessment in the sensitivity analysis section accounts for adolescent benefits and costs. Those estimates should be interpreted cautiously as those have more uncertainty due to inferences that had to be made about K6 changes for adolescents using models with adult MEPS K6 and adult outcome means.

Fourth, the AI/AN and AANHPI samples are representative at the national level using probability weights, but each population has a small sample in the MEPS and differs greatly from the diverse CRDP sample. In the case of the AANHPI MEPS sample, the data includes NHPI individuals, but it mostly represents AA individuals.

8.4.A.III INCREASE IN GROSS EARNINGS (PRODUCTIVITY IMPROVEMENTS)

Economic costs of mental illness included direct health expenses and provision of services as well as the opportunity cost of the foregone output. Individuals struggling with mental health issues are less likely to participate in the labor market, have higher unemployment rates and show diminished productivity at work (Bubonya et al., 2017). Bubonya and colleagues estimated that the odds that workers in poor mental health reported diminished job productivity because of "emotional issues" was six times higher when compared to similar workers in good mental health.

Research has shown that health-related productivity costs tend to be greater than medical and pharmacy costs (Loepke et al., 2009). In the U.S., half of the overall cost of depression is attributable to lost productivity of workers and premature death due to suicide (Greenberg et al., 1993; Greenberg et al., 2003). There is growing evidence that effective mental health treatments lead to productivity improvements (Goetzel et al., 2002).

Four steps were used to calculate the aggregate income gains associated with changes in psychological distress.

- Estimating an income model that included K6 as one of the predictors.
- Obtaining income values associated to point changes in K6 scores through marginal change models.
- Matching pre and post changes in CRDP K6 scores to MEPS K6 scores and their associated dollar values.
- Multiplying estimated dollar values by the number of corresponding CRDP participants.

The resulting estimates were considered the aggregate value of benefits from an increase in productivity (operationalized through gross income) derived from lower psychological distress. Please see Appendix 4.3 for a technical description of the steps used to calculate productivity gains.

8.4.A.IV CRDP PHASE 2 OPERATING COSTS

OHE provided information on the operating costs of the CRDP initiative. These included IPP's program costs and CRDP operating costs. CRDP Phase 2 planning started in fiscal year 2014–2015. By fiscal year 2016–2017 the IPPs and the stakeholders started operating and costs accrued until 2021–2022.

Appendix 4.4 provides an in-depth discussion of the derivation of CRDP operating costs.

8.4.A.V CDEP PARTICIPANTS' TRAVEL COSTS

To take part or become involved in CDEP activities or events, participants incurred travel costs. We did not directly collect information from CDEP participants or IPPs, but we used several pieces of information to calculate potential travel costs for the different hubs. The main data sources were the California Communities Mental Health Services Survey (CCMHSS) questions on travel distance and the IPP local evaluation reports which identified the duration and frequency of CDEP activities.

Appendix 4.4 provides an in-depth discussion of the derivation of CDEP participant travel costs.

8.4.A.VI REDUCTION IN LEISURE TIME FOR CDEP PARTICIPANTS

Interventions often generate intangible effects such as foregone leisure while participating in programs. Intangible effects are difficult to measure, but not accounting important intangible costs and benefits is a recurring issue in conducting CBAs of social programs (Boardman et al., 2018).

Appendix 4.4 provides an in-depth discussion of a valuation in leisure reductions.

8.4.A.VII MARGINAL EXCESS TAX BURDEN

Every additional dollar of tax revenue generates a loss in social surplus. This distortionary effect is known as the marginal excess tax burden (METB). Some researchers argue that no correction for METB is needed in the case of optimal taxation or when a public good is financed in a distribution-neutral case (Jacobs, 2018). However, in the U.S. it is customary to account for this distortion, and in the case of CRDP, it is especially important considering the funding source that potentially created a distortionary effect on the elasticity of income. Income taxes distort the incentive to earn more income and reduce the incentive to report income (Garfinkel et al., 2022).

As noted previously, the CRDP initiative was funded by the voter-approved Mental Health Services Act (MHSA). This legislation is funded by a 1% income tax on personal income in excess of \$1 million per year.

An estimate of 19 cents to 23 cents per dollar is considered a reasonable value for the METB for federal projects funded by income taxes (Boardman et al., 2018). We considered an METB of 23 cents per tax dollar raised for CRDP.¹⁹ According to Boardman and colleagues (2017), all program costs that represent a government's expenditures should be multiplied by the METB. We multiplied the total costs for CRDP Phase 2, \$65,855,624, by 0.23 resulting in a total excess burden of \$15,146,794 dollars. This is the value of the distortionary effect from taxation that leads to a loss of welfare for taxpayers. In future analyses of PEI or other mental health-focused programs, METB should be adjusted if the funding source impacts the elasticity of income differently, or if the program is financed through property or other types of taxes.

8.4.A.VIII NON-MONETARY BENEFITS (HYPOTHESIZED BENEFITS NOT MONETIZED)

PEI programs funded by the MHSA are expected to emphasize strategies to reduce the negative

¹⁹ This estimate is also the average midpoint for studies that calculate METBs across the U.S. (Dahlby, 2008)

outcomes associated with untreated mental illness that include suicide, incarcerations, school failure or drop-out, unemployment, prolonged suffering, homelessness, and removal of children from their homes. Evidence from the Full-Service Partnership (FSP) program evaluation in Los Angeles County found that FSP participation was indeed associated with improvements in homelessness, criminal justice detention, behavioral health inpatient stays, and employment among adults (McBain et al., 2018).

Broadly, CDEP goals were to reduce risk (early signs) or presence (symptoms) of mental illness for CDEP participants so that the negative outcomes that result from mental illness were reduced. We were not able to measure the effects of CRDP on some of the hypothesized negative outcomes, but we conducted a literature review that summarizes a range of cost-benefit values for mental health interventions focused on reducing suicide risk for youth and adults, and incarceration and recidivism for adults. Three examples that focused on suicide prevention programs (described in Appendix 4.5) showed that targeted efforts supporting suicide prevention programs can be cost-effective (e.g., a positive ROI of \$4.50 and gains in Quality of Adjusted Life Years). Most of the times estimates represented conservative calculations due to the savings not considered. Studies that focused on the mental health of jail detainees, defendants, and probationers showed that mental health treatments can be cost-effective and can reduce recidivism. Although the CDEPs did not engage with detainees or probationers, the evidence shows the reach of programs that focus on treating mental illness under the adverse circumstances.

We found positive evidence connecting cultural connectedness and mental health outcomes, but the studies did not include economic valuations.²⁰ The literature reviews summarizing the range of cost-benefit values for suicide prevention programs, mental health interventions for detainees and probationers and evidence from cultural connectedness on mental health are included in Appendix 4.5.

8.4.B COST-BENEFIT ESTIMATES

8.4.B.I MONETARY BENEFITS FOR REDUCED PSYCHOLOGICAL DISTRESS AND FUNCTIONING

Using health expenditure models, CRDP statewide evaluation data (i.e., statewide evaluation CDEP participant questionnaire data) and MEPS data, we estimated reductions in health expenditures associated with a decrease in psychological distress and a proxy decrease in psychological functioning, measured as the probability of transitioning out of the SPD status. From a societal perspective, costs and benefits from CDEP participants and non-participants were considered.

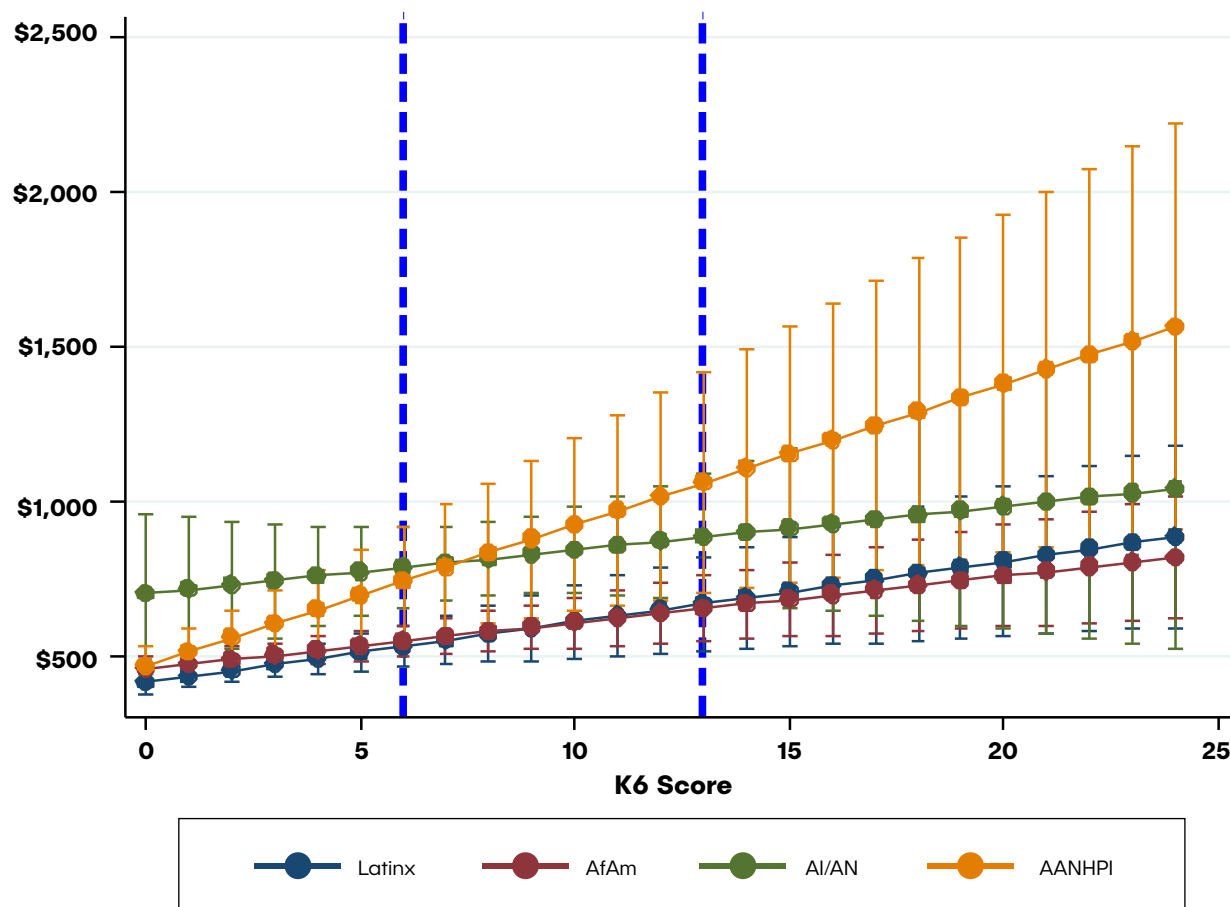
Some relevant findings include:

- National longitudinal MEPS data showed an average year-to-year 1 point drop in K6 scores for adults. CRDP statewide evaluation data showed an average 3 point drop in adult K6 scores from pre- to post-interventions, with a range of 1.5-to-5.6-points.
- Dollar value changes associated with changes in the composite K6 score were not linear and varied by hub. The largest drops in K6 scores did not yield the largest benefits in out-of-pocket health expenditures.
- CRDP statewide evaluation data showed that the probability of reporting symptoms associated with SPD dropped across all hubs from pre to post interventions. For example, while it was estimated that participants in one hub had a 50% probability of scoring $K6 \geq 13$ pre-intervention, that probability dropped to 19% post-intervention. That equaled a -32% in the probability of experiencing symptoms associated with SPD.

Figure 8.6 shows the trajectory of health expenditures for a national MEPS sample stratified by race and ethnicity. This sample includes pooled data from 2017 to 2019. The MEPS K6 point estimates used to calculate benefits from improvements in mental health are graphed here. A positive relationship was found between K6 scores and out-of-pocket health expenditures, as previously outlined in the literature (Dismuke et al, 2011; Pirraglia et al., 2011). Another important observation is that there are no evident changes in the trajectory of this relationship at the moderate ($K6=5$) and serious ($K6=13$) thresholds.

²⁰ We also conducted a systematic literature review and found evidence (with no dollar value or CBA estimates) of positive effects of treating mental illness on other outcomes that included, socioemotional development and dropout rates for adolescents.

Figure 8.6: Predicted Out-of-Pocket Health-Related Expenditures for Different Levels of K6 Using MEPS Data



Source: 2017–2019 Medical Expenditure Panel Survey Data

The economic valuation of changes in psychological distress and functioning show that maintaining participants at low levels of distress is as important as procuring large changes across thresholds of K6 scores. And even small improvement in mental health translated into positive dollar gains (measured as health expenditure savings).

Please see Appendix 4.6 for the full calculation of monetary benefits from gross earnings (in-program and out-of-program benefits); increases in health expenditure benefits from a decrease in psychological distress; health expenditure benefits from a proxied decrease in psychological functioning; and lower dependence of public assistance.

8.4.B.II VALUE OF MONETARY BENEFITS AND COSTS OF THE CRDP PHASE 2 INITIATIVE

Table 8.6 shows discounted values of monetary costs and benefits. There are three major columns: participants (adults, youth, and children), non-participants, and the society (this represents the aggregate monetary gain or cost across both participants and non-participants). The table shows present discounted values of aggregate benefits and costs. The top panel shows the costs, including program operating costs, CDEP participants' travel costs, CDEP participants' reduction in leisure time, and excess burden for taxpayers. The mid panel shows the monetary benefits from increases in productivity (valued as higher gross earnings); health expenditure benefits from a decrease in psychological distress; health expenditure benefits from a proxied decrease in impaired psychological functioning; and lower dependence of public assistance. The bottom panel shows the hypothesized non-monetary benefits. A "+" was used when we were not able to calculate a dollar value to indicate the potential positive impact on the CBA.

Table 8.6: Aggregate Benefits and Costs for CRDP Phase 2

		CDEP Participants / Beneficiaries			
	Society	Adults	Youth	Children	Non-Participants / Taxpayers
COSTS					
IPPs program costs	(\$39,479,073)	0	0	0	(\$39,479,073)
CRDP operating costs					
SWE	(\$4,583,928)	0	0	0	(\$4,583,928)
TAPs	(\$12,160,788)	0	0	0	(\$12,160,788)
EOA	(\$1,836,874)	0	0	0	(\$1,836,874)
OHE	(\$6,527,470)	0	0	0	(\$6,527,470)
Ancillary contractors	(\$1,267,491)	0	0	0	(\$1,267,491)
Excess burden for taxpayers	(\$15,146,794)	0	0	0	(\$15,146,794)
CDEP participants' travel costs	(\$12,459,688)	(\$12,459,688)	0	0	0
Reduction in leisure time	(\$11,649,127)	(\$11,649,127)	0	0	0
MONETARY BENEFITS					
In-program output produced by participants					
Increase in gross earnings	\$11,796,675	\$11,796,675	0	0	0
Tax Payments	0	(\$3,539,002)	0	0	\$3,539,002
Benefits from a decrease in psychological distress					
Lower out-of-pocket health expenditures	\$776,799	\$776,799	+	+	0
Lower Medicare/Medicaid health expenditures	\$13,620,176	0	0	0	\$13,620,176
Lower health insurance expenditures	\$2,134,265	0	+	+	\$2,134,265
Lower use of public assistance	0	(\$146,554)	+	+	\$146,554
Benefits from a proxied decrease in psychological functioning					
Lower out-of-pocket health expenditures	\$258,422	\$258,422	+	+	0
Lower Medicare/Medicaid health expenditures	\$6,092,030	0	0	0	\$6,092,030
Lower health insurance expenditures	\$99,861	0	0	0	\$99,861
Lower use of public assistance	0	(\$53,571)	+	+	\$53,571
Out-of-program output					
Increase in gross earnings	\$524,593,073	\$524,593,073	0	0	0
Tax Payments	0	(\$157,377,922)	0	0	\$157,377,922
NON-MONETARY BENEFITS					
Improvement in cultural connectedness (adults)	+	+	+	+	+
Reduced incarceration/recidivism (adults)	+	+	+	0	+
Reduction in suicides (adults and adolescents)	+	+	+	0	0
Net Benefits (benefits - costs)	\$454,260,069				

Notes: 1. Estimates represent present discounted values in constant dollars deflated using 2019 as the base year.

8.4.B.III NET ESTIMATED BENEFITS AND RETURN ON INVESTMENT

After subtracting the costs (including the excess burden) from the benefits (see figure 8.7), we calculated a net benefit for the CRDP Phase 2 initiative of \$454,260,069 (see figure 8.8). There are no comparable cost-benefit evaluations of community-based projects focusing on mental health PEI. However, Cook et al. (2015) found that reducing the gap in mental health services was a cost-effective approach to reducing mental health disparities. Cook and colleagues used a simulation to model an elimination of disparities in mental health care access and psychotropics (with MEPS data). They found that for Black and Latinx Americans the potential savings from reducing disparities in inpatient medical expenditure were as much as \$1 billion.

Figure 8.7: CRDP Costs and Benefits

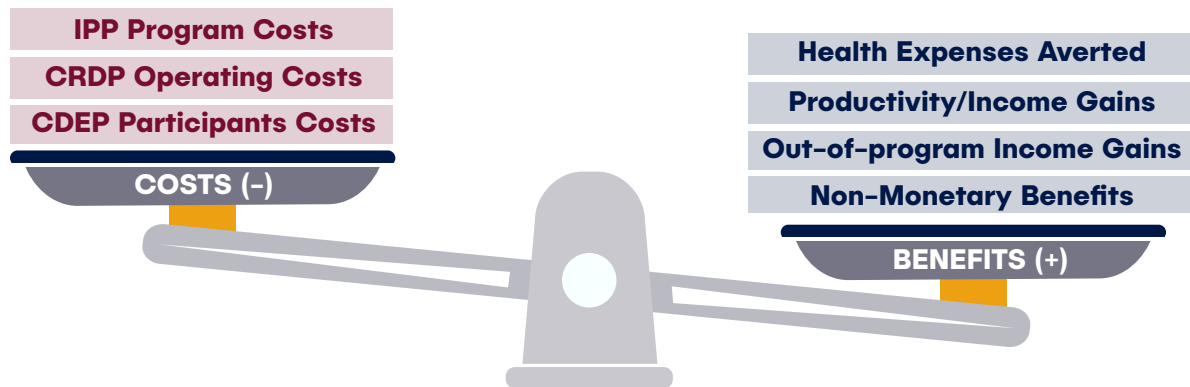
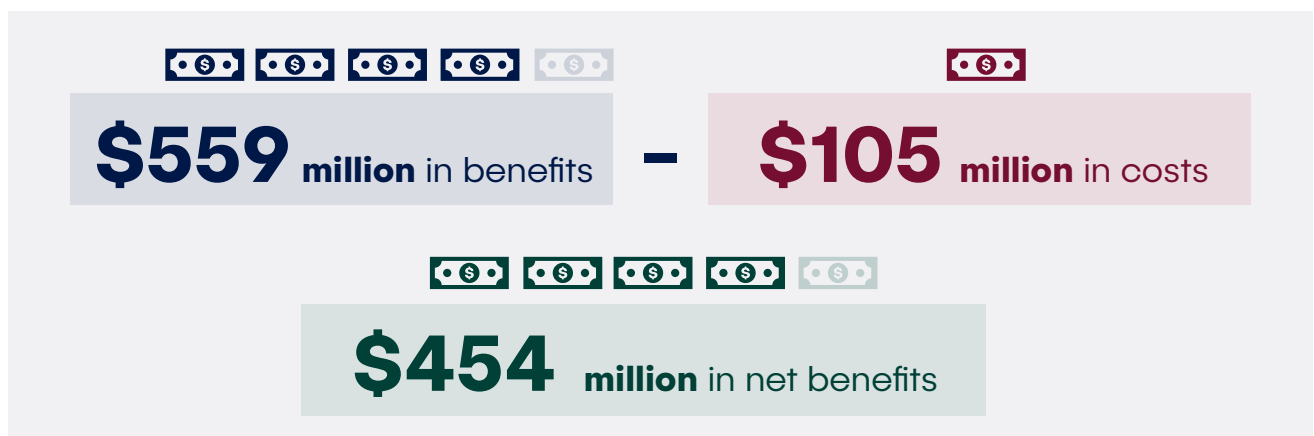


Figure 8.8: Long-term Societal Benefits



A positive net value indicates that benefits outweighed costs and that the CRDP Phase 2 was cost-effective. It can be difficult to grasp the relationship between the investment of tax-payer dollars and the benefits accrued by participants and non-participants. For that reason, we calculated the ROI using the following formula:

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

Plotting in the numbers previously estimated, the ROI= (\$559,371,301 – \$105,111,232)/ \$105,111,232 = 4.32. This is the ROI under the most conservative scenario, that is assuming an 80.5% employment rate for CRDP participants and that only 35% of CDEP participants can transition out of SPD status.²¹ Under a more relaxed scenario, assuming 100% employment (and the corresponding gains in gross earnings) and 100% of CDEP participants having the possibility of transitioning out of SPD, the ROI would be 5.67.

²¹ See appendices 4.2 and 4.3 for a discussion of the rationale for these assumptions.

Based on these calculations, for every dollar invested in the CRDP Phase 2 initiative there was an estimated return between \$4.32 and \$5.67 dollars.

It is important to note that we are not accounting for all possible benefits (due to limited availability of data) which could potentially make the return of investment even larger. The cost-effectiveness and positive ROI of implementing CDEPs in California validates the CDEPs as a PEI strategy that warrants consideration for expanding similar programs.

The CRDP Phase 2 findings stand comparable in relation to the CBA of a large national suicide prevention program that calculated a ROI of \$4.50 and a simulation study using MEPS data that showed savings of \$1 billion from a hypothesized reduction in racial-ethnic disparities in mental health treatment (Godoy et al., 2009; Cook et al., 2015).

SENSITIVITY ANALYSIS

It is critical to understand that the values discussed above are predicted values based on assumptions that carry some uncertainty. All results presented have only considered adult estimates to minimize that uncertainty and to provide conservative estimates. Due to the large number of youth served in the CRDP, the main net benefit and ROI reported may be underestimated. For that reason, we examined the sensitivity of our results to alternative assumptions.

In an alternative CBA, we included the benefits and costs accrued to CDEP adolescent participants. Among CDEP adolescent participants, we observed an average drop of 0.65 points in K6, with a range of a 0.32 increase to a drop of 1.66 points. Extrapolating the models that associated health expenditures for adults in the MEPS and adult health expenditures to changes in CRDP K6 for adolescents, we obtained benefits from reductions in psychological distress (\$16,943,227) and psychological functioning (\$6,882,998). We obtained estimates for a reduction in public assistance (\$196,709). We also incorporated the travel costs incurred by parents of adolescent participants to calculate an updated value for CDEP participants' travel costs (\$12,459,688). The resulting net benefit in this scenario was \$455,105,236. Under these assumptions, the ROI remained in a similar range of \$4.33 to \$5.69 range. Although this combined adult/adolescent analysis carries more uncertainty than the adult analysis, it does point to the fact that even small improvements in mental health wellbeing yield positive monetary benefits.

8.4.C OVERVIEW OF BUSINESS CASE FINDINGS

The CRDP Phase 2 business case provided an estimate of potential savings from CRDP strategies and demonstrated the impact and value of the initiative. Through a combination of CRDP participant data from pre and post interventions and MEPS administrative data that included health expenditures and a measure for psychological distress, this CBA provided an economic valuation of better mental health outcomes valued in lower health expenditures and productivity gains. This CBA also calculated costs incurred by CDEP participants (e.g., travel costs and lost leisure).

The economic valuation of CRDP Phase 2 showed the cost effectiveness of CDEPs for improving the mental health of unserved, underserved, and inappropriately served communities. In doing so, we adjusted traditional CBA methodologies to account for the uniqueness of the populations served by CRDP while always being conservative to not overstate benefits. Of note were the following findings:

- After subtracting the costs from the benefits, a net benefit for CRDP Phase 2 of \$454,260,069 was found.
- From a prevention standpoint, for every taxpayer dollar invested in CRDP, there was a return of \$4.32 to \$5.67 dollars. This constitutes a conservative (lower bound) estimate as we did not monetize all benefits (e.g., reductions in the incidence of suicide, strength of cultural connectedness).
 - › Once benefits and costs for adolescents were included, in a sensitivity analysis, we observed larger net benefits, but the ROI remained in a similar range.

- › The cost-effectiveness and ROI of implementing CDEPs in California warrant consideration for expanding similar programs.

- Average year-to-year change in psychological distress at the national level (from MEPS data) is about 1 point in the K6 composite score for adults. Among CRDP adult CDEP participants, we observed an average 3-point drop in the K6 composite score (i.e., a decrease in psychological distress) across the CRDP hubs with a range of 1.5 to 5.6 points.
- For adults, in some cases, larger monetary gains were observed by remaining at low levels of stress, compared to sustaining large point drops in K6 or to changes from severe to moderate levels of stress. For instance, a hub with an almost 6-point drop in average K6 scores translated into a per capita benefit of \$96, and a score change from a serious to a moderate distress. But for another hub, a 2.2-point drop in K6 scores (and remaining in a moderate score range) translated into a \$126 per capita benefit.
 - › This means that important money savings come from improvements among individuals who started with worse mental health but also from preventing mental health issues and maintaining low levels of stress. These findings are in line with the value of PEI programs in preventing serious mental health issues, and it shows that these programs have an important value for individuals already experiencing mental health issues.
- For adolescents we observed subtle changes in scores from pre to post interventions. In the sensitivity analysis, we observed that an absence of change (e.g., remaining in the moderate or low levels) generates positive monetary benefits. Both this and the adult results make the case for preventative interventions.
 - › Extrapolating the models that associated health expenditures for adults in the MEPS and adult health expenditures to changes in CRDP K6 for adolescents, additional benefits from reductions in psychological distress (\$16,943,227) and functioning (\$6,882,998) were noted. In addition, estimates for a reduction in public assistance totaled \$196,709.
 - › While the combined adult/adolescent analysis carries more uncertainty than the adult analysis, it does suggest that even small improvements in mental health wellbeing can yield positive monetary benefits.

8.4.D LIMITATIONS AND RECOMMENDATIONS FOR FUTURE WORK

CBA can be a powerful tool for government planning and for the capacity building of local organizations. The CRDP Phase 2 business case provided an estimate of potential savings from CRDP strategies. Through a combination of CRDP participant data and MEPS administrative data, this CBA provided an economic valuation of positive mental health outcomes measured as health expenditures and productivity gains, as well as costs incurred by CDEP participants. This CBA also showed the cost effectiveness of IPP approaches that improve mental health for unserved, underserved, and inappropriately served communities. However, this analysis is limited in several ways.

At the CRDP level, our analysis was limited in the sense that we used approximate measures where participant data was not available, relying on high quality, nationally representative survey data related to health expenditures and mental health outcomes. Invaluable participant information was provided through the statewide evaluation CDEP participant questionnaire. This was coupled with data obtained from the SARs and through engagement with IPPs and TAPs. However, additional information on CDEP participant willingness to pay for healthy years, personal preferences to value leisure, travel costs, health expenditures, education levels, and income would have allowed us to refine our estimates to decrease uncertainty. For example, if we were able to know which individuals are willing to give up more leisure for extra income, we would be able to measure the income elasticity and more precisely monetize lost leisure. Another example is if we had been able to connect IPP level data with CDEP participant health expenditures or mental health outcomes, then we would have been able to specifically account for the uniqueness of CDEP program components.

Although CDEP participants provided valuable information to inform the business case, additional information is needed to improve the precision of the cost and benefit estimates. Future iterations of the CRDP (or programs emulating the CRDP model) could incorporate additional CDEP questionnaire items on participants' willingness to pay for a healthy life, costs and time incurred in travel to CDEP activities, personal valuation of leisure, and other relevant pieces of data. These additional pieces of data would strengthen the evidence for CRDP and similar mental health initiatives moving forward.

At the county and state levels, PEI program data was not uniformly available to the degree required to provide comparable estimates of a credible counterfactual to the CRDP Phase 2 CDEPs as mental health PEI programs. In cost-benefit analyses, counterfactuals are needed to fully calculate the net change that can be attributed to an intervention, net of the impact of what a comparable program would have achieved or the impact of a "business-as usual" scenario. To fully calculate CDEP effectiveness, CDEP participants could be compared to non-CDEP participants as counterfactuals. In other words, the ideal counterfactual for CRDP would be other California-based county mental health PEI programs.

In the absence of detailed mental health PEI program data, this business case used estimated government expenditures associated with PEI programs reported in annual MHSA revenue and expenditure reports completed by counties and compiled by the Mental Health Services Oversight and Accountability Commission (MHSOAC). However, the calculation of potential benefits for specific or individual PEI programs was more challenging. We could not find formal or informal cost-effective estimates for PEI programs. McBain (2018) provided a cost-benefit analysis of selected L.A. County FSP programs but those are not necessarily comparable to PEI programs or to CRDP. McBain's report recommended strengthening data collection efforts in this area, and we echo this suggestion.

Comparability among programs and county data from PEI programs is necessary to understand where the CRDP stands. Moving forward, standardized information reported by counties for each mental health PEI program, including accurate and up-to-date counts of beneficiaries, expenses, and possible benefits, would allow for comparisons across PEI programs. This information would not only improve future costs-benefit calculations for the CRDP (or similar efforts) but could assist counties in conducting their own CBAs using their administrative data. In particular, the availability of more nuanced data at the CRDP, county, state, and national levels would be beneficial for future work calculating the costs and benefits for CDEPs and, more broadly, mental health PEI programs.

Finally, at the state and national level, the lack of health expenditure data linked to detailed SOGI data and youth mental health outcomes limited the extent to which the CRDP Phase 2 business case could account for CDEP benefits to LGBTQ+ and youth populations more precisely. This resulted in a potential undercount of the net benefits and ROI for CRDP. Given these limitations, two data-related actions are recommended:

First, promote or fund the inclusion of SOGI items in surveys that include health expenditure data. Due to the ongoing health and mental health disparities experienced by LGBTQ+ populations, items reporting sexual orientation and gender identity are instrumental for implementing programs and policies to meaningfully address them (Institute of Medicine, 2011).

Second, further efforts are needed at the state and national level to report youth mental health outcomes and link them to health expenditure data. This could be helpful in more accurately calculating the cost-effectiveness of youth-based mental health programs. In both cases, these data gaps can be addressed through additional funding to sponsor additional items on existing surveys, such as the MEPS or the CHS. Additional efforts can also be made at the state level to link health care administrative data with data collected from other state departments relevant to assessing the impact of mental health PEI programs and CDEPs. For example, in 2020, the MHSOAC released an electronic dashboard assessing the potential impact of mental health services on criminal justice involvement by linking mental health FSP data collected by the Department of Health Care Services with arrest data from the Department of Justice.²² The CDPH also began in 2020 a Comprehensive Suicide Prevention Program utilizing multiple statewide data sources, including suicide rates, self-harm emergency department rates, and California Violent Death Reporting System data, to identify counties accounting for a significant portion of the State's suicide burden and provide those counties in-depth training and technical assistance to adopt and implement suicide prevention strategies. Continued and expanded efforts such as these are needed to fully inform the costs and benefits of mental health PEI programs and CDEPs.

²² <https://mhsoac.ca.gov/transparency-suite/criminal-justice/>

Chapter 9

Culturally and Contextually Responsive Evaluation Methods and Credible Evidence

9.1 CULTURE AND CONTEXT IN CRDP PHASE 2 EVALUATION METHODS

The need to pay attention to culture and language as a strategy for working with communities that are vulnerable to health and mental health inequities has been continually reinforced by the work of CRDP Phase 2. In 2000, the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) developed the national standards for Culturally and Linguistically Appropriate Services in health and health care (CLAS Standards) to provide guidance on developing a more consistent and comprehensive approach to cultural and linguistic competence in health care. These standards were further refined in 2013 to include specific directives for how health care organizations can implement culturally and linguistically appropriate services that advance health equity, improve service quality, and help reduce health care disparities. In California, cultural competence plan requirements for county public mental health systems are based on the CLAS Standards.

In outlining the vision for CRDP Phase 2, the CRDP Strategic Plan advocated for continued support and use of the CLAS Standards in service delivery and recommended that funding be awarded to community-defined evidence programs that value: “Culturally competent and linguistically appropriate services and adherence to federal CLAS standards in service delivery at a minimum,” including LGBTQ+ communities (California Pan-Ethnic Health Network, 2018). The strategic plan further outlined a vision for how CLAS Standards should be applied to the evaluation of these programs, advocating for the use of stakeholder-driven, culturally congruent evaluation methodologies to effectively demonstrate CDEPs’ value and in promoting positive outcomes and reducing disparities among unserved, underserved, and inappropriately served communities.

This section provides a detailed overview of the cultural, linguistic, LGBTQ+, and community-inclusive strategies used in the design and implementation of the statewide evaluation and IPP local evaluations. It includes examples of where adaptations were needed to strengthen the cultural responsiveness of various evaluation elements and describes the participatory practices used to engage community stakeholders in addressing areas of concern. These examples offer lessons for the field on how attention to culture and context can strengthen the external validity of research conducted with diverse ethnocultural and LGBTQ+ communities. The intent of the chapter is to provide a detailed picture of what culturally responsive evaluation can look like in practice, addressing both the need for scientific rigor in evaluation method and measurement approaches, as well as flexibility in responding to community concerns and cultural issues. For the CRDP Phase 2 statewide evaluation, a key principle was that “culture drives methodology, methodology follows culture.” That is, responsiveness to community, contextual, and cultural concerns was treated as the primary driver for the evaluation process, resulting in creative and innovative statewide evaluation methods and measures.

Community engagement is key to this process, since it is not only the *what* of an evaluation that changes with responsiveness to cultural and contextual issues, but how the evaluation proceeds, which attends to and honors community members’ feedback and concerns. For the statewide evaluation process, community engagement resulted in identifying different forms of potential bias (e.g., construct bias, method bias, item bias) that required adaptations to the cross-site participant questionnaire. The process of developing the cross-site participant questionnaire and the subsequent culturally and contextually responsive modifications made are reported here.

IPPs engaged their own evaluators to design, implement, and report findings on local evaluation activities in independent local evaluation final reports. IPPs were supported by the TAPs, OHE, and SWE in these efforts. See Chapter 5 for a description of the some of the issues that emerged in coordinating cross-site and local evaluation efforts. Information about the implementation and focus of local evaluation activities from these written local evaluation reports were used, post-hoc, to develop an evaluation tool to help consider what credible evidence might look like for CDEPs. Specifically, findings from these local evaluation final reports were used to develop a Credible Research Evidence Domains (CRED) mapping tool to identify key domains representing the infrastructure and processes needed for establishing credible evidence for CDEPs. This mapping tool was used to sketch a broad picture of the infrastructure and processes, as well as types of outcomes, that CDEPs identified for their local evaluation efforts.

9.2 IPP LOCAL EVALUATIONS

9.2.A COMMUNITY ENGAGEMENT IN EVALUATION

Community engagement in the evaluation of services is key to the reduction of mental health stigma and the development and implementation of long-lasting pathways to wellness. Within the CRDP Phase 2 context, CDEP community engagement was defined as a process that promoted residents' engagement in defining programs and policies that affect the mental health and wellness in their communities. Community engagement in local evaluation efforts includes designing, planning and decision-making.

Local evaluation samples provide the basis for understanding the nature of who was reached by IPPs, and who were the community participants in CDEPs. Tables 9.1–9.3 provide an overview of the number and type of populations sampled across IPP local evaluations, for both quantitative and qualitative data sources. Data were extracted from IPP local evaluation reports.

Table 9.1: IPP Pre-Test, Post-Test, and Cross-Sectional Survey Sample Sizes by Participant Type

Survey Type	Total Sample	Survey Participants					
		Adults (n=23 IPPs)	Youth (Includes TAY) (n=13 IPPs)	Child (n=2 IPPs)	CDEP Staff (n=1 IPP)	School Staff (n=1 IPP)	Unspecified Age (n=6 IPPs)
Pre	6,437 (n=34 IPPs)	4,548 (n=23 IPPs)	1,162 (n=13 IPPs)	82 (n=2 IPPs)	45 (n=1 IPP)	531 (n=1 IPP)	69 (n=1 IPP)
Post	3,997 (n=33 IPPs)	2,570 (n=23 IPPs)	789 (n=10 IPPs)	68 (n=2 IPPs)	19 (n=1 IPP)	482 (n=1 IPP)	69 (n=1 IPP)
Matched ¹	2,747 (n=28 IPPs)	1,452 (n=17 IPPs)	619 (n=8 IPPs)	36 (n=1 IPP)	9 (n=1 IPP)	482 (n=1 IPP)	149 (n=2 IPPs)
Cross-Sectional	3,751 (n=10 IPPs)	1,209 (n=5 IPPs)	-	-	-	-	2,542 (n=5 IPPs)

¹ Reported sample sizes for 7 IPPs reflect summed participant counts across all measures (i.e., participants were counted each time they completed a measure and the sample sizes reported may include duplicated counts. For these reasons, the total sample size reported for these IPPs may reflect a slight overcount).

Table 9.2: IPP Focus Group Sample Sizes by Participant Type

# Conducted	# of Participants	Adults	Youth	Parents	CDEP Staff	Community Advisory Board	Community Partners	Unspecific Type
72 (n=21 IPPs)	531	336 (n=12 IPPs)	82 (n=6 IPPs)	7 (n=1 IPP)	10 (n=1 IPP)	15 (n=2 IPPs)	48 (n=3 IPPs)	33 (n=2 IPPs)

Table 9.3: IPP Interview and Observation Sample Sizes by Participant Type

# Conducted	# of Participants	Adults	Youth	Parents	CDEP Staff	Key Informants	Unspecific Type
391 (n=19 IPPs)	377	175 (n=7 IPPs)	56 (n=5 IPPs)	44 (n=3 IPPs)	40 (n=7 IPPs)	47 (n=3 IPPs)	11 (n=1 IPP)
1 (n=1 IPP)	18	18 (n=1 IPP)	-	-	-	-	-

Whereas the above tables represent overall local evaluation data samples that describe the number and type of community members who engaged in individual CDEP evaluations, the semi-annual reports (SARs) were used to provide information from IPPs regarding the community members who participated in developing and implementing local evaluation efforts for these CDEPs. This information was critical to identify the level of community engagement in the CDEP evaluation process, and therefore to ensure that community voices were centered at all stages of the evaluation. Over eight six-month periods (from May 2017 to May 2021), IPPs reported community engagement that contributed to changes or improvements to local evaluation plans or their implementation. For this analysis, longitudinal frequencies were conducted to calculate the percent effort across the life of the initiative and the number of IPPs reporting various types of community members engaged in local evaluations and plans. The types of community members engaged included:

- Youth
- Parents
- Families
- Community residents
- Spiritual leaders
- Healers
- Faith-based leaders
- Other stakeholders (e.g., community leaders, educators, board members, government officials, etc.)

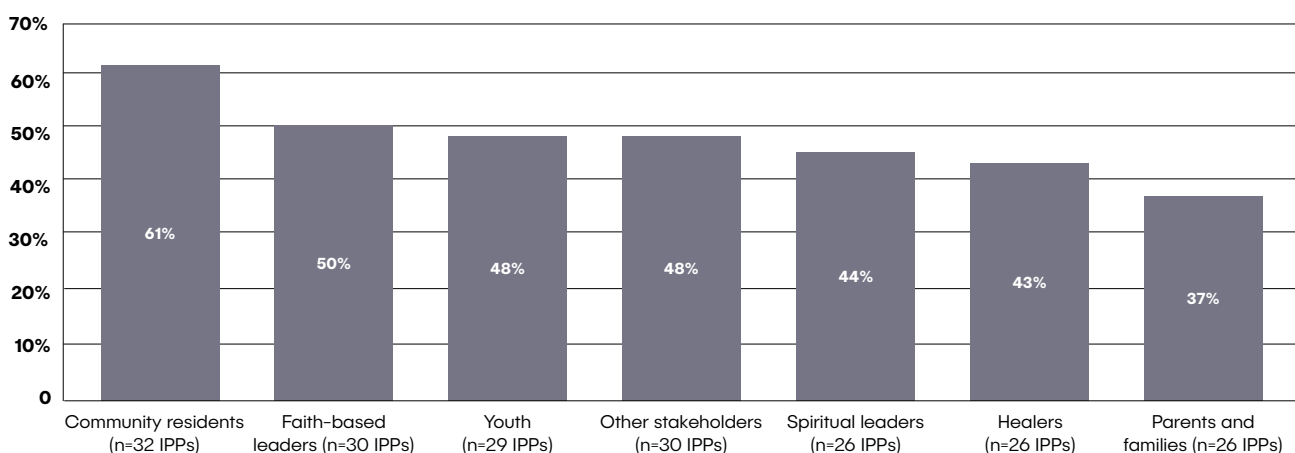
NOTE ON HOW TO INTERPRET/READ DATA

Percent effort considers both consistency of involvement across time (over 8 SAR periods) in combination with the number of IPPs reporting a specific community engaged member. For example, a 100% effort score for engagement from a given community member would indicate that 7 out of 7 IPPs in a hub had that community member involved at each of the 8 periods of analysis.

9.2.A.I OVERALL CRDP TRENDS

Community members were involved in designing, planning and decision-making for local evaluation plans across all hubs. The majority of IPPs (32 IPPs) reported consistent adult involvement over the course of the initiative (with 61% effort). Across 30 IPPs, faith-based leaders and other stakeholders were engaged in local evaluation planning and implementation with an effort of 48% to 50%. Youth were engaged across 29 IPPs with an effort of 48%. Parents and families, spiritual leaders, and healers were involved across 26 IPPs with an effort of 37% to 44%. (See Figure 9.1).

Figure 9.1: Overall CRDP Community Engagement Percent Effort by Number of IPPs (May 2017 – June 2021)



9.2.A.II PRIORITY POPULATION TRENDS

CRDP community members actively participated in local evaluation planning and decision making to improve the effectiveness of the CDEPs. Participating in a variety of roles, community residents were consistently involved in local evaluations across all hubs with five to seven IPPs per hub reporting this type of engagement (32 IPPs total). The percent effort varied across hubs, ranging from 50% to 76%.

All IPPs in the AfAm hub reported community resident involvement across all involvement types. Six AfAm IPPs reported community involvement of youth, parents, families, spiritual leaders, healers, and faith-based leaders. A majority of AI/AN IPPs reported community involvement with, on average, six to seven IPPs reporting engagement of all types of involvement. In the AANHPI hub, on average, five to seven IPPs reported the involvement of community residents, faith-based leaders, and other stakeholders in local evaluation activities. In the Latinx and LGBTQ+ hubs, on average, six to seven IPPs reported involvement of youth, community residents, faith-based leaders, and other stakeholders in their local evaluations.

9.3 STATEWIDE AND LOCAL EVALUATION PARTICIPANT DATA COLLECTION

Both the statewide and local evaluations were expected to include community-based participatory practices (Grills et al., 2018) to ensure that community members' voices were centered in each stage of the process including the design, implementation, and interpretation of data collected. Participatory practices took place across specific, overlapping time points outlined in Table 9.4.

Table 9.4: Community Based Participatory Practices Used Within Statewide and Local Evaluation Development

Statewide Evaluation	Local Evaluation
<p>Stage 1 began in summer of 2016 with a review of IPP applications to identify mental health issues addressed by their proposed CDEPs and subsequent initial item generation by the SWE team informed by several sources (e.g., the Initiative's OHE-defined cross-site research questions, CRDP Phase 1 priority population reports, and academic and grey literature). In December 2016, CDPH-OHE and TAPs provided feedback on a draft statewide evaluation plan and core measures.</p> <p>Stage 2 began in June 2017 and involved a more extensive review of the cross-site questionnaire by the IPPs and their community members, TAPs, and CDPH-OHE. An updated cross-site questionnaire based on community feedback was approved by CDPH-OHE in December 2017. Stage 2 also included completing an IRB review process with CalHHS's Committee for the Protection of Human Subjects. The statewide evaluation received IRB approval in April 2018.</p> <p>Stage 3 began in January 2018 and continued until the end of CRDP evaluation data collection in June 2021. During this stage, evaluation instruments were refined over time to address emerging contextual issues, as well as linguistic, cultural, LGBTQ+, and community concerns, and IRB amendments tailored for each IPP.</p>	<p>Stage 1 of Local Evaluation Plan development began prior to CRDP Phase 2 implementation with each IPP providing a tentative evaluation plan as part of their initial grant application. For IPPs that started as Capacity Building Pilot Projects (CBPPs), the development of an initial evaluation plan was part of a six-month capacity building phase that occurred before the launch of CRDP Phase 2 in March 2017.</p> <p>Stage 2 began in April 2017 and involved IPPs refining their local evaluation plans based on the local evaluation guidelines and technical assistance from the SWE, TAPs, and OHE. Stage 2 also included IPPs completing an IRB review process with CalHHS's Committee for the Protection of Human Subjects. Although the period for stage 2 varied among IPPs, the majority of IPPs completed their local evaluation refinements and had received either IRB exemption or approval by January 2018.</p> <p>Stage 3 began in January 2018 and continued until the end of CRDP evaluation data collection in June 2021. During this stage, IPPs revised their plans to respond to emerging contextual (e.g., COVID-19, community) issues, and worked with the SWE, TAPs, and OHE to develop IRB amendments as needed.</p>

This section highlights the different types of evaluation adaptations made in response to feedback from TAPs and IPPs (for statewide evaluation processes) and from communities themselves (for local evaluation processes) as part of community-based participatory practices across the three stages of collaborative evaluation. These adaptations were made in relation to linguistic, cultural, LGBTQ+, organizational, and community contextual issues.

- Reflected a value for both the etic perspectives (i.e., with standardized data used to conduct comparisons with mainstream services) and the emic perspectives (i.e., indigenous, culture-specific meanings reflecting community contexts and realities) which needed to be upheld in CRDP Phase 2 evaluations.
- Provided a unique opportunity to privilege community-defined wisdom over customary western-centric research and evaluation practice for collecting mental health-related data.
- Helped ensure that community and cultural considerations drove the process to generate solutions to concerns.
- Were aligned with CRDP Strategic Plan recommendations for centering culture, language, and LGBTQ+ perspectives when developing and implementing evaluation activities.

In this section, the cultural and contextual issues addressed in both statewide and local evaluation processes are described along with examples of specific adaptations made in response to these concerns. In doing so, we underscore the importance of designing and implementing evaluation methodologies that recognize, honor, and engage communities, including how their values, locations, cultures, members, and concerns impact CDEP structures, processes, and outcomes.

9.4 CULTURE AND CONTEXT IN THE STATEWIDE EVALUATION

A major focus of the statewide evaluation was the development of the cross-site participant questionnaire. The CDEP participant questionnaire was a cross-site, self-report instrument administered by IPPs to their entire sample or sub-sample of CDEP participants before (pre-test) and after (post-test) receiving services. The questionnaire addressed multiple domains related to individual-level mental health disparities and was organized by five key domains plus demographics.

- **Mental health access/utilization** in the year prior to CDEP involvement.
- **Stigma and barriers** to mental health help seeking in the year prior to CDEP involvement.
- **Psychological distress** and functioning prior to CDEP involvement and at the end of CDEP services.
- **Protective factors** prior to CDEP involvement and at the end of CDEP services.
- **CDEP satisfaction and quality** at the end of CDEP services.

Demographic information (e.g., immigration/refugee status, English language fluency) included two state-mandated queries about sexual orientation and gender identity (SOGI) along with racial and ethnic background and identification.



Within these five key domains, three types of potential bias were identified through community-based participatory processes including CRDP Partner and IPP feedback, especially in stages one and two of evaluation activities.

- Construct bias:** Bias that emerged when the mental health construct being measured in the cross-site instrument lacked equivalency across cultures and/or languages. In other words, one could not assume that the language, behaviors, or characteristics included in the construct held the same meaning when translated or assessed across the diverse cultural groups served within the CRDP.
- Method bias:** Bias pertaining to the following elements:
 - Instrument: Participants having different levels of experience and familiarity with test-taking or with the structural features of the instrument (e.g., instruments administered via paper and pencil or electronically).
 - Administration: Difficulties pertaining to how, when, and in what manner the instrument was administered due to perceptions of the process (i.e., consent), ambiguous instructions, or interactions between administrator and respondents.
 - Response styles: Participant tendencies to answer positively due to social desirability or lack of familiarity with Likert-scaled responses regardless of the item content.
- Item bias:** bias occurring when the meaning of one or more items was not identical or lacked applicability across different cultures, languages, and/or communities.

Cultural, linguistic, and LGBTQ+-affirming refinements to the CDEP participant questionnaire were made during all stages of the evaluation in response to community feedback. Changes were made at one or more of the following levels:

- IPP-level changes** to address IPP-specific challenges or concerns.
- Hub-level changes** to address concerns relevant for one or more priority population hubs.
- CRDP-level changes** impacting all 33 IPPs using the cross-site instrument.

Table 9.5 provides a summary of the biases that emerged within each section of the instrument, the types of adaptations made, and the level at which these changes were applied.

Table 9.5 Adaptations Made to Resolve Bias in the Statewide Evaluation Instrument

Evaluation Domains and Adaptation Focus	Biases Present	Adaptation Types	Level of Adaptation Changes
Methods	1. Instrument 2. Administration 3. Response styles	1. Instrument 2. Administration 3. Response options	1. IPP: 9 IPPs 2. Hub: 4 IPPs 3. CRDP wide: 33 IPPs
Demographic Information	1. Item 2. Administration 3. Construct 4. Instrument 5. Response style	1. Items 2. Administration 3. Instrument 4. Response options	1. IPP: 10 IPPs 2. Hub: 6 IPPs 3. CRDP wide: 33 IPPs
Protective Factors	1. Construct	1. Items	1. IPP: 4 IPPs 2. Hub: 33 IPPs 3. CRDP wide: 33 IPPs
Mental Health Access and Utilization (including Stigma/Barriers)	1. Construct 2. Item	1. Items 2. Response options 3. Instrument	1. IPP: 3 IPPs 2. CRDP wide: 33 IPPs
Psychological Distress and Functioning	1. Construct 2. Item	1. Items	1. IPP: 2 IPPs 2. CRDP wide: 33 IPPs
CDEP Satisfaction	1. Construct 2. Item	1. Items	1. IPP: 2 IPPs

9.4.A CULTURALLY AND CONTEXTUALLY RESPONSIVE STRATEGIES TO ADDRESS BIAS

Bias can occur when the way an evaluation instrument is constructed and administered is not aligned with the lived experiences, modes of engagement, and cultural values of a community. The community members served by CRDP Phase 2 IPPs held a diverse range of intersectional identities and backgrounds (e.g., age, race and ethnicity, sexual orientation, English fluency, immigrant experiences, etc.). The CDEPs themselves were equally diverse in terms of their service type (e.g., support groups, service referrals and linkages, community-wide events, etc.) duration (e.g., cohort vs. ongoing services); setting (e.g., schools, community-based agencies, community events, outdoor locations, etc.), and sample size. For these reasons, the cross-site evaluation measure needed to be sensitive to a range of cultural and contextual issues. Indeed, if the statewide evaluation data collection procedures required uniformity across IPPs (i.e., all IPPs mandated to collect data in the exact same manner), this would have introduced the following forms of methodological bias.

- Instrument bias:** Community members served by the CDEPs had varying levels of familiarity with self-reported, standardized test-taking procedures in either paper/pencil or electronic formats. For example, elders, participants with lower literacy levels, and monolingual speakers all encountered challenges with navigating the CDEP participant questionnaire (e.g., understanding skip logic patterns). In some instances, even with staff assistance, completion of the instrument took nearly two hours, resulting in fatigue for both CDEP staff and participants. IPPs in these scenarios worried that the immense survey burden might lead to lower response rates and lower quality of data received, as participants either refused to complete the full instrument or rushed or skipped over items to expedite the process.
- Administration bias:** Certain communities were also vulnerable to challenges associated with how the cross-site instrument's administration context (i.e., perceptions of the process, staff respondent interactions, unclear instructions). For example, IPPs working in communities with high levels of mental health stigma had to consider participants' comfort level with responding to queries about their psychological distress and functioning. Others were concerned that participants would be hesitant to disclose personal information via a survey during the prevailing political climate (e.g., disclosing immigrant status during a period of intensive immigration raids). Others voiced that the written consent/assent requirements would pose barriers for participants with lower literacy levels who were unable to write their names; those with limited access to technology who would be unable to provide electronic signatures; and/or those who wanted their CDEP involvement to remain private (e.g., LGBTQ+ minors who had not yet disclosed their sexual orientation or gender identity to their parents or guardians).
- Response style bias:** The cross-site instrument included items from standardized measures, many of which included Likert-scale response options. Traditional survey approaches using Likert scales were ineffective for IPPs whose community members had lower literacy rates, those who had difficulty distinguishing numeric values, or those who found the inclusion of numerous response options to be cumbersome and/or confusing. In one instance, an IPP worried that differences in responses with varied degrees of agreement (e.g., strongly agree, agree, neutral, disagree, strongly disagree) or frequency (e.g., all of the time, most of the time, some of the time, none of the time) stemmed from participants' tendencies to endorse moderate or extreme options, rather than from actual differences in the constructs being assessed.

The examples in Table 9.6 illustrate the types of adaptations made to resolve or minimize these forms of methodological biases within the statewide evaluation CDEP participant questionnaire for specific IPPs and their communities.

Table 9.6: Examples of Adaptations Made to Address Methodological Bias in the CDEP Participant Questionnaire

Types of Adaptations	Areas Requiring Cultural, Linguistic, LGBTQ+ Responsive Adaptations
Specific Examples	
Cultural adaptations to administration procedures	<p>Timing and Mode of instrument administration:</p> <ul style="list-style-type: none"> While most IPPs administered the CDEP participant questionnaire during a single session prior to the start of CDEP services, six IPPs opted to administer the instrument over the first two sessions, allowing more time for staff to build trust and rapport with participants before engaging them in data collection activities. All IPPs were able to select the administration method appropriate for their CDEP community and context (self-and/or staff-administered; paper-pencil or electronic; telephone or in-person).
Linguistic adaptations to administration procedures	<p>Administration for communities with non-written languages/oral traditions:</p> <ul style="list-style-type: none"> One IPP served an indigenous immigrant community whose members primarily spoke non-written, indigenous languages. Even after using the Spanish-language translation of the CDEP participant questionnaire, staff noticed that participants could not always discern the meaning of various survey items, leading to confusion and frustration for both staff and participants. To strengthen participant comprehension, IPP staff translated items in real time from the written Spanish-language questionnaire into the oral languages spoken by their community members, and then recorded participants' verbal responses onto the cross-site instrument.
LGBTQ+ adaptations to the administration procedures	<p>Sensitivity to privacy and coming out issues for LGBTQ+ adolescents:</p> <ul style="list-style-type: none"> Requiring parent or guardian consent could have jeopardized the welfare and violated the privacy of LGBTQ+ minors who were enrolled in LGBTQ+-affirming CDEPs but had yet to disclose their sexual orientation or gender identity to their parents or guardians. Excluding participation of LGBTQ+ youth from the statewide evaluation would have resulted in detrimental sampling bias and a missed opportunity to better understand CDEPs' effectiveness for this population. To rectify this issue, four youth-serving LGBTQ+ IPPs instituted a modified consent process whereby trained mental health professionals at each IPP assessed incoming participants to determine if the parental consent requirement would jeopardize their wellbeing. If significant risk was detected and minors were deemed mature enough to participate in the consent process, youth provided their own consent to participate. Parental consent was still required for youth who did not meet both criteria.
Cultural adaptations to response options	<p>Likert scales and cultural/linguistic appropriateness:</p> <ul style="list-style-type: none"> To improve ease of administration for community members struggling with Likert scales, three IPPs replaced the 5-point frequency scale (all of the time, most of the time, some of the time, a little of the time, and none of the time) with a 3-point scale (all of the time, some of the time, and none of the time), which better aligned with participants' linguistic and cognitive schemas for meaningfully distinguishing between categories. One of the three IPPs also used visual aids (i.e., pictures) in place of numbers to ensure that the response options were more easily understood by their low-literate and monolingual participants.

9.4.B CULTURAL AND CONTEXTUAL ADAPTATIONS RELATED TO SEXUAL ORIENTATION AND GENDER IDENTITY (SOGI)

The use of sexual orientation and gender identity (SOGI) questions is critical for systematically documenting and addressing health and mental health disparities affecting LGBTQ+ people. For this reason, CDPH-OHE mandated the inclusion of SOGI data collection in the statewide evaluation. The SWE, in collaboration with the LGBTQ+ priority population IPPs, the LGBTQ+ TAP, and CDPH-OHE, developed three core SOGI items and instructions to be administered across IPPs.

The selection of these items reflected a balancing of the diverse needs of all IPPs, including those that had reservations about asking SOGI items within their respective communities and those that felt strongly about assessing the mental health needs of LGBTQ+ community members. Ultimately, CDEP participants across all five priority populations and their respective subpopulations were willing to answer the SOGI items, with low response rates (3%–11%) obtained for “refuse to answer” and “don’t know.” The SWE, LGBTQ+ TAP, and CDPH-OHE continued providing technical assistance to individual IPPs and priority populations to make additional cultural, linguistic, and/or LGBTQ+–related adaptations as data collection ensued.

- **Sexual Orientation:** Conceptually, sexual orientation (SO) has three major dimensions (self-identification, sexual behavior, and sexual attraction). The statewide evaluation measures, however, included only a single item for self-identification to reduce the data collection burden for IPPs and survey fatigue for the participants. This item, however, was comprised of 11 multiple response options (i.e., check all that apply) or terms to describe specific sexual orientation identities and expressions (e.g., straight/heterosexual, Queer, Asexual, aromantic), including both a “write in” and “refuse to answer” option. Measuring SO presented challenges and concerns for all five priority populations that led to specific adaptations to address the following biases:
 - › **Item Bias:** The prompts and terminology used for the diverse sexual orientation identities must be understood equally by CDEP participants who identify as LGBTQ+ and those who do not. The terminology and concepts used to develop the prompts for the item and the 11 multiple response options were not only Western and U.S.-centric and grounded in the English language, but also relatively new for some communities represented in the CRDP (especially those who were immigrants/refugees or non-English speakers). In addition, other cultures including individuals in the LGBTQ+ community may use different terms/labels and have other conceptions of sexual orientation resulting in differences in how sexual orientation is understood across diverse ethnic, sexual, cultural, language, or religious groups.
 - › **Administration Bias:** During the item development phase, IPPs from several priority populations reported that the SO items would be the most sensitive or uncomfortable (e.g., topic is considered personal or a cultural taboo) for both self and proxy responses from their community members. Some IPPs shared that their respective community members would refuse to answer or have concerns about answering this item due to privacy/confidentiality (especially those working in small, rural communities). Others worried about the sensitivity of asking this question for fear it would be used for discrimination purposes given the political climate at the time of data collection. Therefore, considerations were given to mode and physical context of data collection, along with the age and language of respondents sampled to increase the overall response rate.
- **Gender Identity:** The statewide evaluation measure for gender identity involved a two-step process: one item asked about an individual’s sex assigned at birth and one item asked about their self-determined, present gender identity. The two items were analyzed in conjunction to identify the number of individuals who fall into the constructs of cisgender, transgender, genderqueer/non-binary, as well as those who were questioning/unsure. The second item related to self-determined gender identity included 11 multiple-response options or terms to describe specific gender identities and expressions (e.g., gender non-binary, trans male, intersex, Two Spirit), including both a “write in” and “refuse to answer” option. This allowed individuals to select as many responses as they desired to document a gender identity representative of their multiple experiences and expressions.

This gender-inclusive and non-binary measurement approach presented a set of challenges for all five priority populations that led to specific adaptations to address some of the following biases.

- › **Construct Bias:** While empirical evidence affirms that gender is a nonbinary spectrum, many assumptions continue to be made in the general population that gender is a binary identity consisting of two discrete categories (women and men). Such a binary perspective on gender excludes the experiences and rights of transgender and other non-binary individuals, resulting in a “hidden population.”
- › **Instrument and Response Scale Bias:** The general population is still accustomed to responding to questions of gender in a binary manner using one single response question (i.e., are you male or female?) in large scale surveys, as well as everyday forms/applications. They are therefore less familiar and experienced with the two-step process of measuring gender identity (sex assigned at birth and gender identity at present), including the multiple response (i.e., select all that apply) option.
- › **Item Bias:** Like sexual orientation, the terminology and concepts used to develop the prompts for both items and the 11 multiple response options for the second item were not only western and U.S.-centric, and grounded in the English language, but were also relatively new for many in the general population, especially those who were immigrants/refugees or non-English speakers. In addition, other cultures, including individuals in the LGBTQ+ community, may use different terms/labels and have other conceptions of gender resulting in differential survey responses for individuals across different ethnic, sexual, cultural, or religious groups.

Table 9.7 below illustrates the types of adaptations made to resolve or minimize SOGI biases within the statewide evaluation CDEP participant questionnaire.

Table 9.7: Specific Examples of Sexual Orientation and Gender Identity (SOGI) Related Adaptations

Sexual Orientation	
Cultural adaptations to administration procedures	<p>Timing of SOGI administration:</p> <ul style="list-style-type: none"> • One IPP opted to ask participants about their SO and GI during the post- rather than the pre-questionnaire administration. This change in timing afforded CDEP staff the opportunity to build rapport and trust with participants while engaging them in CDEP services, which made it easier for them to ask questions deemed as highly sensitive or personal once services concluded.
Linguistic adaptations to administration and items	<p>Explanation of SOGI terms:</p> <ul style="list-style-type: none"> • Administration procedures were adapted for nine IPPs who noted that due to literacy, translation, and differences in cultural expressions of sexuality, some of the categorical response options lacked an appropriate term in-language, resulting in staff having to spend an inordinate amount of time explaining the meaning of each response choice. To ensure cultural sensitivity and reduce translation-related challenges, these IPPs modified the item prompts with simpler wording, and implemented a two-step administration process: <ul style="list-style-type: none"> › Step 1: Participants provided open-ended responses to indicate their SO and GI using their preferred terminology. › Step 2: After reading the participant’s response, staff selected the corresponding response options from the categorical responses listed on the cross-site instrument. See SWE Evaluation Plan 4.0 Appendices (CDEP Participant Questionnaire) for more information on the response options for SOGI.

Gender Identity

Cultural adaptation to items**Word choices to be more sensitive to earlier traumas/circumstances:**

- The item asking about sex assignment at birth was reworded for six API IPPs that noted that the original item wording lacked sensitivity to the experiences of many refugee and immigrant adults who may not have had a medical professional or midwife present at their birth and/or have been forcibly separated from family members who were present at the time of their birth. To rectify these concerns, IPPs modified the item wording as follows:

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

Revised: "My sex at birth was..."

Language (translation, terminology) adaptations to items**Word choices made to create space for personal terms:**

- One LGBTQ+ IPP reconfigured the response options associated with the item, "When it comes to my gender identity, I think of myself as...", to better reflect their participants' preferred terminology. For example, they removed the terms "intersex" and "transgender/trans" and added an open-ended response option, which allowed participants to document their gender identity using terms that were meaningful for them. The items were revised as follows:

Original: (examples of response options): a) Man/male b) Woman/female c) Transgender/trans d) Non-binary e) Two Spirit f) I am not sure g) Intersex

Revised: (examples of response options): a) Man/male b) Woman/female c) ~~Transgender/trans~~ d) Two Spirit e) I am not sure f) Intersex Another description (please specify)

LGBTQ+-affirming adaptations to items**Word choices to respond to transgender concerns:**

- The item asking about sex assignment at birth was reworded for two LGBTQ+ IPPs that raised two concerns. First, the person who delivers a baby is not always the person who labels the baby's sex (e.g., scenarios where individuals gave birth in non-hospital settings). Second, the item wording did not reflect the institutional power of sex assignment. Given the distinct ramifications for transgender individuals based on sex assignment, the opinion of the person who delivered the baby matters less than the sex they were assigned by the institutions that wield power over their lives. The items were modified as follows:

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

Revised: "When I was born, I was labeled a..."

9.4.C CULTURAL AND CONTEXTUAL ADAPTATIONS RELATED TO MENTAL HEALTH OUTCOMES

The statewide evaluation CDEP participant questionnaire also addressed two key domains related to mental health disparities, including mental health access and utilization and psychological distress and functioning. Mental health access/utilization was assessed in the year prior to CDEP involvement while psychological distress/functioning was assessed at two time points, pre- and post-CDEP involvement. Types of bias and adaptations are described below.

- **Mental Health Access and Utilization:** An explicit goal of the CRDP was to increase access and utilization of mental health supports among California's unserved, underserved, and inappropriately served communities. Accordingly, the statewide evaluation CDEP participant questionnaire included several items asking participants about their need for and usage of various mental health supports, along with perceived barriers to accessing mental health care in the year prior to their involvement with the CDEPs. The items used to assess this construct came from the California Health Interview Survey (CHIS) (a standardized survey administered to California residents). The CHIS assesses various health topics, including participants' experiences with accessing primary care physicians or general practitioners and mental health professionals. IPPs and TAPs raised several concerns about how the framing of these items would result in the following biases in the statewide evaluation data:
 - › **Construct and Item bias:** The CHIS items reflected western-centered forms of mental health care and discounted the community- and culturally based resources more frequently used by CRDP community members (e.g., religious/spiritual leaders, *promotores*, peer counselors, etc.). IPPs were concerned that this narrow framing of mental health support would result in confusion for participants who lacked familiarity with these types of professionals, or those who did not seek help from these individuals because they were more apt to seek out culturally or community-based healers or professionals for healing and help.
- **Psychological Distress and Functioning:** The statewide evaluation participant questionnaire assessed changes in psychological distress and functioning before and after participants' CDEP involvement using standardized items from the Kessler-6 Psychological Distress (K-6) scale and an adapted version of the Sheehan Disability Scale (SDS). The focus on mental health symptomology posed challenges for several CRDP priority populations, resulting in adaptations to address the following biases:
 - › **Construct and Item bias:** Construct bias surfaced with regard to the conceptualization of mental illness in the instrument. The focus on mental illness and negative symptomatology seemed at odds with CRDP's goal of uplifting culturally and community-rooted perspectives on how mental health should be operationalized and measured. Some IPPs cautioned that while western mental health measures typically focused on individual-level functioning as a measure of mental health, non-western worldviews typically reflect a more community-oriented, strengths-based understanding of mental health and wellness. Rather than asking participants "what's wrong," indigenous wisdom calls for communities to assess "what's right" by examining protective factors such as cultural connectedness, hope, and spirituality. From this perspective, it is through the strengthening of such protective factors that positive mental health is achieved.

The examples in Table 9.8 below illustrate the types of adaptations made to resolve or minimize these biases.



Table 9.8: Specific Examples of Adaptations Made for Mental Health Access and Utilization

<p>Linguistic and cultural adaptations to items, response scales, instrument</p>	<p>Changes included:</p> <ul style="list-style-type: none"> • Additional items allowing participants to indicate help received from community- and/or culturally-based helping professionals alongside the CHIS items. • New items allowing participants to document culturally relevant reasons for not seeking help from western professionals. • Descriptors to clarify the term “mental health professional.” • Skip logic and “refused/don’t know” answer choices allowing participants to opt out of answering questions not applicable to their experiences or knowledge base. <p>Examples:</p> <p>“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...</p> <ul style="list-style-type: none"> • “Primary care physician or general practitioner.” • “Mental health professional.” • “Traditional helping professional like a culturally-based healer and/or religious/spiritual leader or advisor.” (NEW ITEM). • “Community helping professional such as a health worker, promotor, peer counselor, or case manager.” (NEW ITEM).
<p>Specific Examples of Adaptations for Psychological Distress and Functioning</p>	
<p>Cultural adaptations to items</p>	<p>A set of community-vetted protective factors were added to the statewide evaluation participant questionnaire, allowing for a more balanced assessment of both positive and negative mental health conditions.</p> <ul style="list-style-type: none"> • For example, instead of solely assessing how often participants felt “nervous” or “hopeless” in the past 30 days, items were added measuring how often participants felt “connected to [their] culture” or “balanced in mind, body, spirit, and soul.” • One IPP excluded the K-6 and SDS scales altogether on their version of the SWE instrument, as the deficit-oriented nature of these items were too misaligned with their strengths-based evaluation methodology.
<p>LGBTQ+ adaptations to items</p>	<p>One LGBTQ+ IPP modified the highlighted item below from the SDS scale: “Think about the one month in the past 12 months when you were at your worst emotionally. Did your emotions interfere a lot, some, or not at all with your”:</p> <ul style="list-style-type: none"> • “Performance at work or school.” • “Household chores.” • “Social life.” • “Relationship with friends and family.” <p>The inclusion of this item in a measure of psychological functioning lacked sensitivity to LGBTQ+ community members whose poor relationships with their family of origin stem from prejudice rather than their mental health status. As written, the item inaccurately implies LGBTQ+ identity as the cause of one’s impaired psychological functioning. Moreover, chosen family networks serve as a unique cultural characteristic of LGBTQ+ communities and consolidating “friends and family” into a single response was confusing to participants. The IPP ultimately decided to delete this item from the instrument to prevent inaccurate conclusions from being drawn about psychological functioning among LGBTQ+ participants.</p>

9.5 CULTURE AND CONTEXT IN IPP LOCAL EVALUATIONS

The IPPs were keenly aware of the need to use community-grounded strategies to drive the development and implementation of their local evaluations. This included incorporating local, indigenous knowledge about how mental health and wellness are experienced by priority population communities, the types of outcomes that should be measured, and the most appropriate measurement strategies.

In addition to administering the statewide evaluation CDEP participant questionnaire, IPPs also engaged in local evaluations of their CDEPs, in partnership with their chosen local evaluators. These local evaluation designs prioritized community wisdom and perspectives at each phase of the evaluation process (e.g., research question development, instrument development, recruitment and sampling, analysis and interpretation) and strove to bolster the capacity of CDEPs and community members to effectively participate in and/or facilitate evaluation protocols. An analysis of IPP local evaluation reports revealed five core strategies.

- **Strategy 1: CBPR/Representation:** Intentionally embedding participatory practices in all data collection activities to ensure that community voice guided each aspect of the evaluation.
- **Strategy 2: Cultural/Community Norms:** Ensuring that evaluation activities reflected community context, customs, and knowledge.
- **Strategy 3: Community Capacity Building:** Strengthening the capacity of community members (including CDEP staff) to understand and/or facilitate evaluation activities.
- **Strategy 4: Intersectionality:** Ensuring that data collection approaches were sensitive and responsive to participants' multiple intersecting identities.
- **Strategy 5: Linguistic Responsiveness:** Centering language access in evaluation activities.

A sixth strategy cuts across the first five and relates to a broad conception of **accessibility**, or creating the conditions that enable community members to feel welcome, respected, and included in the CDEPs. A primary dimension of accessibility was linked specifically to linguistic issues (e.g., how did participating in CDEP services/program in a language familiar to participants help them feel more connected to these programs and services?) Another dimension of accessibility occurred when CDEP services were impacted by COVID-19 social distancing requirements. Here, many IPPs moved their services to online, called their participants to check in on them, or transitioned to programs that made use of an online platform to increase their reach and enhance participants' access to CDEPs. See Chapter 7 for more examples of these CDEP adaptations.

Table 9.9 below provides an overview of the strategies used. The narrative and additional tables provide illustrative examples from IPP local evaluation reports showing how these strategies were applied at various evaluation touchpoints.



Table 9.9: Overview of Local Evaluation Adaptations

Evaluation Strategies	Number of Times Strategies were Applied				
	Questions/ Design/Method	Instrument	Recruitment/ Sampling	Administration	Analysis/ Reporting
CBPR/ Representation 55 adaptations made by 16 IPPs	9	17	5	11	13
Culture/ Community Norms 30 adaptations made by 16 IPPs	7	14	4	5	-
Capacity Building 17 adaptations made by 4 IPPs	2	4	3	6	2
Intersectionality 17 adaptations made by 7 IPPs	9	3	-	-	5
Accessibility 19 adaptations made by 9 IPPs	-	3	4	6	2
Linguistic 19 adaptations made by 10 IPPs	-	10	-	9	-
Total	27	51	16	37	22

9.5.A COMMUNITY-BASED PARTICIPATORY RESEARCH AND REPRESENTATION STRATEGIES

The CRDP Strategic Plan explicitly calls for community-based participatory research practices to be embedded into evaluations of mental health PEI programs. Participatory practices that involve community members and stakeholders in all aspects of health promotion and prevention work 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). IPPs engaged in two forms of participatory practices in their local evaluation efforts: Community-Based Participatory Research (CBPR), which is primarily anchored in a research process, and Community-Based Participatory Practice (CBPP), which reflects an 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 that inspire attention to culture, context, trust building, shared meaning, consensus, and equity (see Grills et al., 2018). The use of both strategies was necessary for ensuring that the cultural and experiential knowledge of community members most impacted by mental health challenges addressed by the CDEPs was prioritized throughout the local evaluation design and implementation.

The examples in Table 9.10 below provide further context about the use of these strategies in the development and implementation of the IPP local evaluations.

Table 9.10: Community-Based Participatory Research and Representation Strategies

CBPR/ Representation	Areas Requiring Cultural, Linguistic, LGBTQ+ Responsive Adaptations				
	Questions/ Design/Method	Instrument	Recruitment/ Sampling	Administration	Analysis/ Reporting
	n=7 IPPs	n=11 IPPs	n=3 IPPs	n=9 IPPs	n=9 IPPs
Specific Examples of Adaptations Made for CBPR and Representation Strategies					
Instrument Development	<p>IPP partners provided valuable insight on culturally relevant measures of mental health status and on culturally acceptable methods of data collection. For example:</p> <ul style="list-style-type: none"> Partners shared that sleep quality and social isolation were more appropriate measures of mental health status than validated scales found in extant literature. The Harvard Trauma Questionnaire (Mollica et al., 1992) was used to assess trauma, but partners believed that using the questionnaire in its entirety would trigger an emotional response due to questions asking about specific traumatic events. As such, the evaluation only assessed trauma symptoms by using one part of the questionnaire. By working closely with partners, the IPP evaluation team was able to design data collection instruments and data collection activities that were culturally responsive to the unique characteristics of immigrant and refugee groups. In initial evaluation design work, data collection tools were co-created with LGBTQ+ youth participants to establish buy-in for evaluation activities. During the pilot period, LGBTQ+ youth were invited to give feedback on all evaluation tools after completing them. Feedback was compiled and shared across program sites and adjustments to tools were made based on feedback. Another IPP partner developed community-centered questions to assess how community members' relationships with their identity and the larger LGBTQ+ community have been impacted by participating in CDEP activities. Also, given the historical violence inflicted upon LGBTQ+ people in a particular region of the state, committee members added questions to assess participants' experiences with discrimination and perceptions of their environment and community. 				
Administration	<ul style="list-style-type: none"> Community members assisted in the administration of surveys and in the troubleshooting process when barriers arose. They helped translate survey questions into understandable language for participants and used the cultural practices and traditions of call-and-response, as needed. Translation and call-and-response were also utilized when acquiring parent agreement/consensus. The CDEP incorporated community leaders into recruitment activities to help engage families. For example, community advisory board members, community members and past participants were often invited to participate in orientations for new cohorts to assist with data collection and welcome individuals to the cohort. The practice was engaging because it enhanced feelings of trust for participants. 				
Analysis	<ul style="list-style-type: none"> Throughout the project, one CDEP shared summary evaluation results and qualitative feedback with cohort members who graduated from the program and engaged them in dialogue on the meaning of the results from their perspective and provided space for them to weigh in on program improvements. These conversations help to facilitate the CBPR principle of fostering co-learning and capacity building among all partners. CDEP alumni were invited back to dialogue about the meaning of evaluation findings from their perspectives as former participants and to provide input on areas of program improvement. 				

9.5.B CULTURAL AND COMMUNITY NORMS

The tension between cultural specificity and standardization is inherent in any project that seeks to respond to the particularity of community lived experience, while also seeking to respond to an explicit or implicit scientific mandate to rely on western-centric validated instruments that enable comparisons across studies and samples (Beals et al., 2003). These fundamental tensions are based on different methodological assumptions underlying each approach. A reliance on evidence-based practices requires standardized, validated measures and careful comparisons across intervention strategies. CDEPs, on the other hand, tend to favor highly qualitative, descriptive approaches and diverse epistemologies that are validated by community values, norms, wisdom, culture, and experience. CRDP Phase 2 provided IPPs with a unique opportunity to redefine what constitutes appropriate methodologies that reflect culturally responsive and indigenous research and evaluation approaches. Table 9.11 below offers some specific examples.

Table 9.11: IPP Local Evaluation Strategies Used to Incorporate Cultural and Community Norms

Cultural/ Community Norms	Areas Requiring Cultural, Linguistic, LGBTQ+ Responsive Adaptations			
	Questions/Design/Method	Instrument	Recruitment/Sampling	Administration
	n=6 IPPs	n=11 IPPs	n=4 IPPs	n=4 IPPs
Specific Examples of Adaptations to Address Cultural and Community Norms				
Instrument Development	<p>Perceptions of one's color:</p> <ul style="list-style-type: none"> The perception of how one's color impacts one's self-concept is a topic that has plagued African Americans since enslavement, and according to research, has persisted through the decades. Clark and Clark's infamous doll test conducted in 1947 showing that Black children prefer white dolls was used in the seminal 1954 Brown vs. Board of Education. More recently CNN commissioned University of Chicago child psychologist Margaret Beale Spencer to replicate the Clark Study. Her pilot study (133 participants were used) found many of the same prejudices among white children but seemed to show that some African American children now have a more positive attitude toward children of their own race. A version of the doll study was created for one CDEP evaluation to see how students perceived color and if being part of the CDEP would shift these perceptions. The second measure used in this research was created to assess the student's perception of color and was conceived as an indirect measure of self-esteem. <p>Hope:</p> <ul style="list-style-type: none"> The Herth Hope Index was modified with the author's permission to increase inclusivity for Native spirituality and to replace a word that triggered trauma for some participants. Specifically, the word "faith" used in the original tool was linked to organized European religions which led to the genocide and dehumanization of California Natives for centuries. This word was changed to "spiritual" to be more in alignment with indigenous spiritualities that are not organized religions but can also apply to people participating in organized religions. 			
Questions/ Design/Methods	<p>Oral tradition and kinship:</p> <ul style="list-style-type: none"> The qualitative methods for one CDEP evaluation were designed to support and complement inter-related cultural dynamics for the Black community: the oral tradition and kinship. Deeply rooted and inherited from African ancestral wisdom, the oral tradition (spoken word, storytelling, testifyin', signifyin', etc....) serves as a powerful medium for the Black community to transmit culture and values, exchange knowledge, make meaning of life experiences, and, perhaps most importantly, to serve as a protective barrier and salve against the pain and oppression that many Black people experience. <p>Intergenerational relationships and hierarchies:</p> <ul style="list-style-type: none"> To respectfully adhere to the diverse social complexities of their Pacific Islander American participants, the local evaluator considered the cultural appropriateness of all evaluation methods and protocols by discussing and involving the CDEP staff in developing and implementing the evaluation plan. <ul style="list-style-type: none"> All data collection instruments were carefully crafted with culturally appropriate language that was mindful of gender, age, generation (parent versus grandparent as a caretaker), religious/spirituality, mixed ethnic identity, and sexual identity. They also acknowledged the traditional family hierarchy within Samoan and Tongan communities, which elects who gets to speak and use their voice, and created a safe, respectful space that afforded all participants the opportunity to speak and communicate. In creating this safe space, the CDEP demonstrated to the community an understanding of deeply rooted layers of trauma or mental health issues that parents, caregivers, and youth may have experienced. Such efforts showed they were mindful of the intergenerational differences and hierarchical tradition during class sessions and when engaging with the community. 			

CBPR/ Representation	Areas Requiring Cultural, Linguistic, LGBTQ+ Responsive Adaptations			
	Questions/Design/Method	Instrument	Recruitment/Sampling	Administration
	n=6 IPPs	n=11 IPPs	n=4 IPPs	n=4 IPPs
Specific Examples of Adaptations to address Cultural and Community Norms				
Recruitment and Sampling	<ul style="list-style-type: none"> Since there is a definite cultural stigma related to mental illness and mental health in one CDEP's AANHPI population, the sampling methods needed to be adaptable, accessible, and open to encourage potential participants to feel safe and welcome to enter an environment previously viewed in a negative manner. Evaluators for a Latinx IPP used the CDEP's referral support staff to recruit participants for the evaluation because there was already a high level of trust [<i>confianza</i>] between the staff and former program participants. 			

9.5.C COMMUNITY CAPACITY BUILDING

Community engagement was critical to the design and implementation of CDEP program and evaluation activities including the interpretation and dissemination of evaluation findings (see Credible Evidence section later in this chapter). To do so, it was helpful to build the capacity of CDEP participants, program staff, and/or community members to understand evaluation issues, from research design and the development of appropriate instruments to problem solving issues with survey administration and data interpretation. Evaluation capacity building for community members was critical for IPPs as they worked to develop a robust approach to empowering community members, including their community advisory boards, to fully engage in community-based participatory research and community-based participatory practices (Grills et al., 2018). It also ensured CDEP evaluation participants understood the value and purpose of the data they provided, improving trust and comfort with the evaluation process, and increasing data validity. As part of this engagement, IPPs also sought community feedback as they worked with PARC to adapt the SWE participant measure to the cultures, contexts, and needs of the priority populations served by their CDEPs. See Table 9.12 for specific examples.

Table 9.12: Areas Requiring Cultural, Linguistic, LGBTQ+ Responsive Adaptations

Community Capacity Building	Questions/Design/Method	Instrument	Recruitment/Sampling	Administration	Analysis/ Reporting
	n=2 IPPs	n=2 IPPs	n=1 IPP	n=4 IPPs	n=1 IPP
Examples of adaptations: Questions/Design/Method + Administration <ul style="list-style-type: none"> For one IPP partner, staff and managers were provided training designed to increase research literacy and capacity among community members (such as <i>promotoras</i>/community mental health workers). The training was designed for individuals who are engaged in providing direct services but are called upon to assist with the design, implementation, and reporting of community health research. For example, this training helped CDEP staff to understand how research is designed and implemented, and to appreciate what was needed to properly support the research study. Instrument <ul style="list-style-type: none"> For a youth-focused IPP, during the initial evaluation design work, CDEP staff co-created all data collection tools with LGBTQ+ youth participants to establish buy-in for evaluation activities. During the pilot period, youth offered feedback on all evaluation tools after completing them and adjustments to tools were made based on feedback. Changes included a full color graphic redesign of survey instruments (including Pre/Post Core Measures) and demographic forms and redesigned elements of the youth participant focus group protocols to make them more youth friendly. Administration <ul style="list-style-type: none"> As part of the CDEP's recruitment and orientation sessions, the evaluator facilitated conversations and training activities to query attendees about their current and prior knowledge of evaluation processes. Evaluation word games developed by the evaluator were played to increase awareness of evaluation terminology while simultaneously highlighting terminology that was already known by attendees. 					

9.5.D INTERSECTIONALITY

Standard 11 of the CLAS calls for health and healthcare organizations to: “Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery” (Office of Minority Health, n.d).

IPPs used an intersectional framework to guide their collection of CDEP participant demographic data. Intersectionality acknowledges the fact that people are multi-dimensional beings who belong to multiple identity groups. For example, each participant has a race, gender, social orientation, social position, etc. Membership within each of these groups influences how participants perceive and influence the world. These processes suggest that a 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. Collecting demographic data through an intersectional lens is necessary for nuancing within-group diversity, so groups are not stereotyped or essentialized in ways that preserve an overly simplistic understanding of culture and identity. This point is particularly important when trying to discern the relevance of different assessment tools and metrics of effectiveness to better serve the needs of specific priority populations.

The examples below in Table 9.13 illustrate how IPPs infused an intersectional framework into multiple aspects of their evaluations to better distinguish the nuanced mental health needs and outcomes of their CDEP participants.

Table 9.13: Strategies Used to Incorporate Intersectionality Frameworks into IPP Local Evaluations

Intersectionality	Areas Requiring Cultural, Linguistic, LGBTQ+ Responsive Adaptations			
	Questions/Design/Method	Instrument	Reporting	Analysis
	n=6 IPPs	n=2 IPPs	n=1 IPP	n=4 IPPs
Specific Examples of Adaptations to Address Intersectionality				
Questions, Design, Method and Analysis	<ul style="list-style-type: none"> During program enrollment, youth participants in an AA CDEP had an opportunity to identify the multiple ways they defined themselves, including gender, ethnicity, cultural identity, class, national origin, LGBTQ+ affiliation, and neighborhood affiliation. Using a community-based participatory research frame, the evaluation design incorporated surveys, interviews, focus groups, and observations with/of youth, family, community members, and program staff, inclusive of questions to track the ways the program served youth with intersectional identities, and how services were perceived by participants, family, and community members. The evaluation team presented preliminary findings to program staff during quarterly program meetings to encourage a participatory feedback process that continuously examined and adjusted program strategies to ensure that programming attracted the range of ways African American youth identified and explored ways to fill existing gaps in services. The community advisory board (CAB) for an LGBTQ+ CDEP was instrumental in ensuring that the evaluation was infused with an intersectional approach to data collection and analysis. The overall evaluation followed a mixed-methods, observational study design. CAB members helped design questions to understand how experiences of the CDEP participants are shaped by their multiple identities, such as: “When you think about your multiple identities, what do you think is most important in terms of how you access health care?” CAB members also helped structure tools to measure the degree to which intern trainings had an impact on attitudes, beliefs and intended behaviors of interns as they began to serve transgender and gender nonconforming participants. In all of the tools, demographic questions were intentionally designed to collect adequate data to analyze for variations by various points of identity. This analysis was then brought to the CAB for exploration. Qualitative data collection questions were also informed by CAB concerns based on emerging findings from initial quantitative data collection. All data collection protocols for an AANHPI CDEP were crafted with language that was mindful of the multiple, intersecting identities held by participants (e.g., religious, generational, gender). CDEP staff intentionally created data collection spaces that were attuned to cultural worldviews and practices within Samoan and Tongan communities (e.g., acknowledgement of the traditional family hierarchy used to determine who gets to speak and use their voice). At the same time, they demonstrated mindfulness of intergenerational differences within the room (e.g., different trauma and mental health challenges experienced by different generations participating in the CDEP). 			
Instrument	<ul style="list-style-type: none"> The Community Research Group for an LGBTQ+ CDEP that served elders was instrumental in shaping two key components in population outreach for the evaluation. First, beyond age, the CDEP recognized and affirmed that LGBTQ+ older adults live at the intersections of race, ethnicity, class, culture, HIV status, sexual orientation, gender, gender identity and expression, spirituality, ability, and other identities, all of which intersect to shape individuals’ experience in the CDEP. Alongside CDEP staff, the community research group developed demographic questions and categories, using specific, intentional language so that the evaluation could capture nuances in intersectional experiences. 			

9.5.E LINGUISTIC RESPONSIVENESS

Language access for individuals with lower English proficiency goes beyond simply translating words into the languages spoken by community members. It must also ensure that community members fully understand the meaning of all questions asked of them. Sometimes, careful translations are not adequate when concepts do not easily translate or when there are no comparable counterparts to a concept in another language. In such cases, evaluation protocols require adaptation to deal with these issues of construct bias, which may also involve extra support in administering measures. Creating a comfortable environment for participants to ask questions and to respond to the evaluation measures is part of being linguistically responsive. Table 9.14 provides specific strategies to strengthen the linguistic responsiveness of IPP local evaluations.

Table 9.14: Strategies to Strengthen Linguistic Responsiveness of IPP Local Evaluations

Linguistic	Areas Requiring Cultural, Linguistic, LGBTQ+ Responsive Adaptations	
	Instrument	Administration
	n=8 IPPs	n=6 IPPs
Specific Examples of Adaptations for Linguistic Responsiveness		
Instrument	<ul style="list-style-type: none"> CDEP staff presented potential survey items to the community advisory board to get feedback on how items would be translated into indigenous languages, and whether community members would grasp the intended meaning of the concepts being assessed. Guidance from these community experts revealed that having multiple Likert-type response options was confusing and would be challenging to translate. 	
Instrument and Administration	<ul style="list-style-type: none"> Surveys were translated into Hmong, and a facilitator read aloud each survey question while a trained bilingual staff in each location sat alongside and assisted participants with penciling in their answers and, if needed, staff reinterpreted and/or reinstated the questions in Hmong for the participants again. 	
Administration	<ul style="list-style-type: none"> Focus groups were conducted by a native Spanish speaker to allow students to code-switch in Spanish and English in their responses, and for the researcher to ask probing questions related to the code-switched dialogue when necessary. Additionally, because of the close relationships that participants had with their therapists, the therapists were invited to sit in on these focus groups to maximize the level of comfort and confidence by the participants. Although the COVID-19 pandemic necessitated the use of technology-based data collection, a bilingual/bicultural member of the evaluation team always served as an interface between the subjects and the data collection technologies. In addition to the language, accessibility and community trust, appropriate interpretation became very important especially when many Spanish terms did not have a direct interpretation to Mixteco (e.g., mental health, stigma, and other labels associated with mental disorders). Therefore, CDEP <i>Promotoras</i> became key in identifying and defining the appropriate interpretation for these terms. Prior to their interactions with the community, <i>Promotoras</i> identified concepts and worked together with more experienced <i>Promotoras</i> to determine the best interpretation approach. Because terms do not have a direct interpretation to Mixteco, <i>Promotoras</i> had to exert mental effort to organize words and provide simple descriptions or examples of the meaning and context of a term or relevant ideas to get their point across clearly. For example, when trying to interpret the term mental health, the <i>Promotoras</i> had to be knowledgeable of symptoms or signs associated with psychological distress such as <i>nervios o latido</i>, which are well known terms in the Latino indigenous community. Once there was an understanding of the context and purpose, <i>Promotoras</i> asked community members for their input and suggestions regarding the best approach to, and interpretation of, such terms, and reached community consensus. 	

9.6 LOCAL EVALUATION FIDELITY AND FLEXIBILITY

What does fidelity mean in the context of evaluating CDEPs? In this section, we examine areas of continuity and change in IPP local evaluation implementation. In Chapter 7, we emphasized the point that fidelity encompasses two dimensions: mission fidelity, which considers the alignment of CDEP processes with IPP mission and goals in relation to their communities served, and implementation fidelity, which includes changes to the structure or internal workings of CDEP components to better meet participants needs. Our analysis revealed that IPPs' ability to demonstrate flexibility in *how* they delivered their CDEPs ultimately enabled them to maintain fidelity and demonstrate responsiveness to their larger CDEP objectives and goals.

We use this same lens as in Chapter 7 to discern the extent to which IPPs remained faithful in their commitment to implementing culturally responsive evaluations in CRDP Phase 2, particularly considering changes occurring in the larger ecosystems in which IPPs were operating. In the same way IPPs adjusted their CDEPs to align with important community and organizational realities, changes made to their evaluation strategies occurred in response to broader challenges happening at one or more interconnected ecological levels.

- **Micro-level:** Individual IPP concerns necessitating refinements to evaluation protocols.
- **Meso-level:** CRDP-wide activities and events that impacted evaluation implementation across IPPs.
- **Macro-level:** Community and societal level changes that impacted evaluation implementation across IPPs.

This fidelity assessment thus involved an examination of the degree to which IPPs' local evaluation plans were executed as intended, and the measure of flexibility used to improve the effectiveness of their evaluation practices considering these contextual factors.

Data for these analyses were extracted from three sources.

- IPP local evaluation plans, which described the evaluation questions, instruments, measures, study design, methodology, and analysis plan.
- IPP Semi-Annual Reports (collected from May 2017–April 2021) noting modifications, adaptations, disruptions, and/or other changes made to the local evaluation plan. The semi-annual reports contained both qualitative and quantitative data which indicated the following:
 - › Intensity of local evaluation modifications where IPPs described their local evaluation plan implementation status, and any notable changes,
 - › Changes to sample size obtained from IPPs' accounts of sample size changes,
 - › Sampling strategies used by IPPs to address their local evaluation plan objectives. COVID sampling strategies were also measured, given the onset and impact of the COVID-19 pandemic, and
 - › Impact of external factors impacting implementation on their local evaluation implementation.
- Administrative data from CDPH-OHE containing information about IPP local evaluation launch dates and other contextual factors impacting evaluation implementation during the initiative.

Qualitative thematic analysis and quantitative descriptive analysis were conducted with a focus on patterns occurring across three different time periods: CRDP Phase 2 Launch (March 2017 to April 2018); CRDP Phase 2 Implementation and Pivot (May 2018 to April 2020); and CRDP Phase 2 Sustain (May 2020 to April 2021). Themes that emerged through iterative coding procedures were applied as codes representing cross-site local evaluation changes.

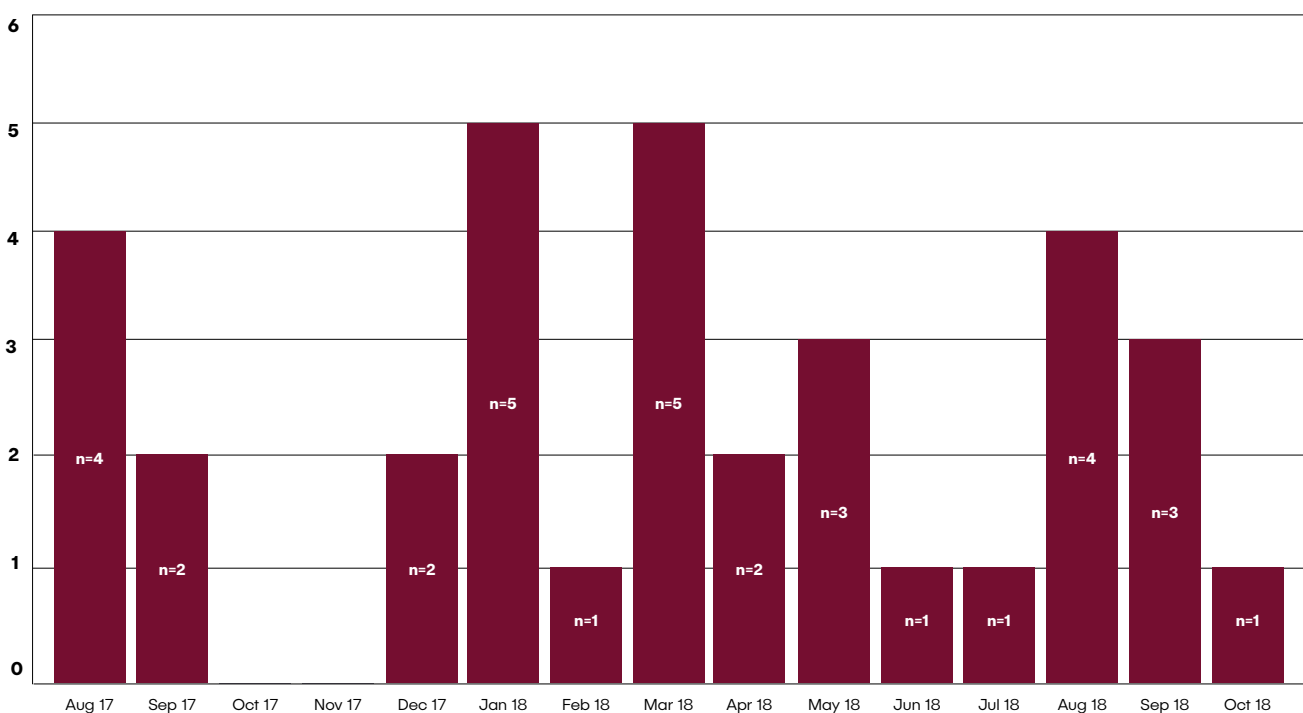
NOTE ABOUT MESO-LEVEL CHANGES IMPACTING EVALUATION IMPLEMENTATION

Two pivotal meso-level events occurred within the CRDP during the Phase 2 launch period. Both had far-reaching impacts on all 35 IPPs and framed a large part of the context in which evaluation activities occurred:

- **Institutional Review Board (IRB) Approvals:** An unanticipated requirement for IRB approval or exemption by the California Health and Human Services Agency's Committee for the Protection of Human Subjects had a ripple effect on statewide and local evaluation implementation. Reviews were conducted for all 35 IPPs and for the statewide evaluation beginning in 2017 and concluding in 2018, and interrupted evaluation procedures in the following ways:
 - › Local evaluation IRB approvals took (on average) 6 months and impacted IPPs differentially, varying from IPPs experiencing no delays (due to exempt project status and methodology allowing for retroactive use program data) to IPPs experiencing delays up to 14 months.
 - › IRB approvals for the statewide evaluation took nine months. However, IPP administration of the statewide evaluation CDEP participant questionnaire was further delayed because of: time needed to train IPPs on new IRB-mandated protocols; completion of IPP-specific amendments including translated versions of the instrument; and IPP program timing. These delays in their entirety ranged from nine to 22 months.
 - › IPPs whose local evaluation elements were directly linked to the statewide evaluation (i.e., IPPs using the CDEP Participant Questionnaire to answer their own local evaluation questions) were greatly impacted by changes in the statewide evaluation timeline and, consequently, their local evaluation launch was contingent upon IRB approval of the statewide evaluation. See Figure 9.2.

Figure 9.2: IRB Impact on Launch of Local Evaluations

Distribution of IPP Local Evaluation Start Times



- **CRDP Evaluation Extension:** IRB approval delays for the statewide evaluation and IPP local evaluations resulted in a shorter data collection window and reduced opportunity for IPPs to reliably demonstrate their CDEP effectiveness.

- › At the request of several CRDP partners, the CalHHS approved an evaluation extension allowing for an additional nine months of participant data collection, along with more time for IPPs analysis, reporting, and CDEP quality improvement informed by evaluation findings. These adjustments were particularly important for IPPs with fewer program cycles and/or those whose recruitment and sampling efforts were greatly hampered by the unforeseen IRB delays.
- › Thirty-four of the 35 IPPs opted to take advantage of this extended data collection period.

Examples of changes made in response to both factors are reported below.

9.6.A IPP LOCAL EVALUATION IMPLEMENTATION

Nine IPPs reported implementing their local evaluations exactly as planned in the first six months of the CRDP launch period (e.g., in the IPP-specified timeline and with no major or minor changes to implementation reported). By the end of the start-up phase (April 2018), 77% of IPPs (n= 26) had initiated local evaluation activities either as planned or with low/moderate changes. IPPs that did not launch evaluations during this period reported challenges related to:

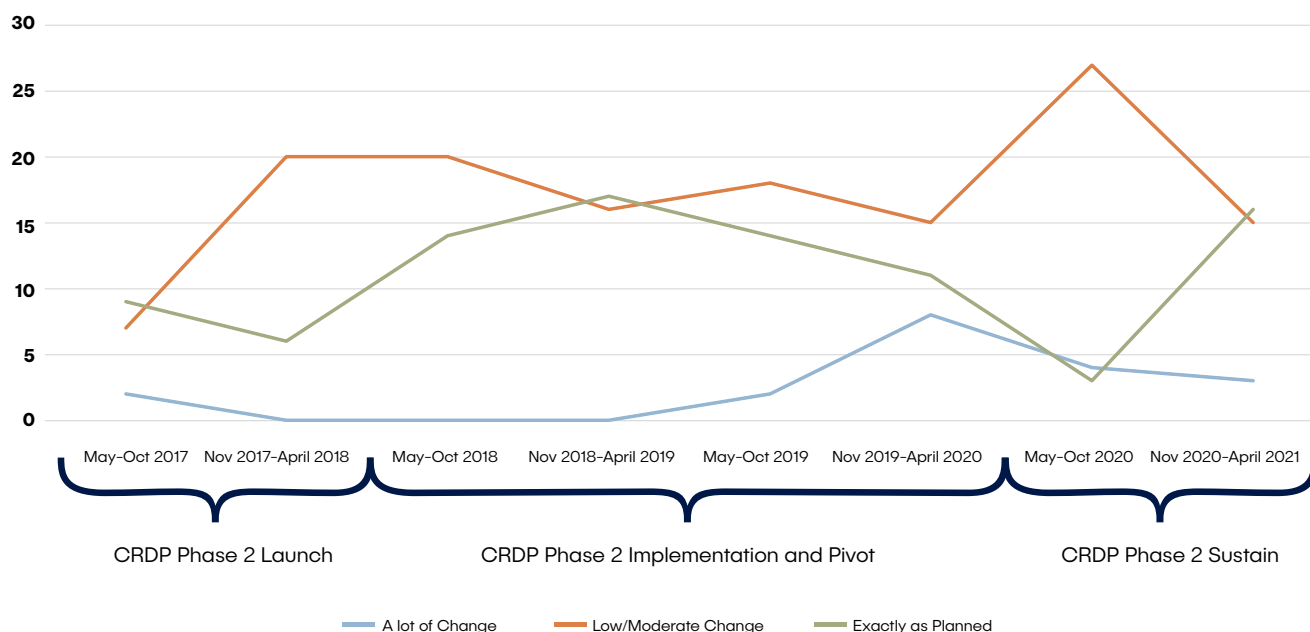
- Prolonged IRB approvals for the statewide evaluation measures which subsequently impacted their local evaluation implementation (for IPPs who integrated these measures into their local research design).
- Extensive revisions made to initial local evaluation plans after receiving consultation and technical assistance from Phase 2 partners (TAPs, SWE, OHE).
- Delays in CDEP component implementation also delayed the time frame for evaluating those components.

Figure 9.3 illustrates changes to the implementation of IPP local evaluation plans across the launch, implementation, pivot, and sustain time periods.



Figure 9.3: Local Evaluation Implementation Status by Time Period

IPP Local Evaluation Implementation Level Across Time Periods



9.6.B IPP LOCAL EVALUATION MODIFICATIONS

All IPPs made some type of adjustment to their proposed local evaluation activities at least once during the initiative. Qualitative thematic analysis revealed seven types of changes in total, with the top changes pertaining to:

- COVID-19: (n=30 IPPs) (e.g., converting all data collection protocols to electronic formats).
- IRB (n=20 IPPs) (e.g., delays in implementing specific measures due to IRB review).
- Data collection strategies (n=19 IPPs) (e.g., changes in data collection frequency in response to participants' needs or convenience).
- Metrics and instruments (n=19 IPPs) (e.g., modifications to instruments to address cultural responsiveness of evaluation such as translation of instruments into different languages or inclusion of racism-related measures).

Certain types of changes were more prominent during specific time periods in the initiative.

- Modifications to local evaluation implementation were common during the launch period, especially as IPP organizations navigated research-related processes (e.g., IRB) and refined their evaluation instruments.
- By early in the implementation phase, most IPPs were implementing their local evaluation plans with either high fidelity or with low to moderate level changes IPP-level changes relevant for their evaluation needs and context (e.g., sample size updates, adjustments to data collection strategies).
- At the end of the implementation phase and leading into the pivot phase, all IPPs reported making changes in direct response to COVID-19 mandates, most commonly emerging as modifications to data collection methods.

Table 9.15 provides a complete list of evaluation modifications, the levels at which these modifications were aimed, and illustrative examples.

Table 9.15: Local Evaluation Plan Fidelity Themes and Examples (N=35 IPPs)

Themes	Change Level	# of IPPs	Examples
COVID-19	Macro	30	<ul style="list-style-type: none"> Data collection activities, assessments and instruments were converted to online/virtual formats, or by telephone. Evaluation instruments/surveys were shortened or otherwise modified to reduce the time spent by participants completing evaluation activities. Delays due to IRB review of COVID-19-related changes to evaluation protocols. Modifications to data collection procedures to adhere to COVID-19 restrictions and safe-distancing practices. COVID-19-related pause in data collection activities.
Institutional Review Board (evaluation changes requiring IRB approval)	Meso	20	<ul style="list-style-type: none"> Initial delays in launching local evaluation plans related to IRB review and approval. Delays in implementing specific measures due to IRB review.
Data collection strategies (changes to the way data were collected)	Micro	19	<ul style="list-style-type: none"> Changes in frequency of data collection in response to participants' needs (e.g., allowing more time for participants to complete pre- and post-tests to elicit more substantive responses). More streamlined data collection approach due to time restrictions and limited availability of staff. Eliminated recording of data collection sessions to cultivate richer discussion. Modifications to data collection procedures (e.g., change from interviews to focus group).
Metrics and Instruments (modifications to the tools and criteria for evaluation)	Micro	19	<ul style="list-style-type: none"> Changes made to measures/instruments because of feedback from stakeholders, community, OHE, or TAP/SWE review. Streamlined language and number of questions to limit burden on administration. Modifications to instruments to address cultural responsiveness of evaluation (e.g., translation of instruments into different languages; inclusion of racism-related measures; culturally validating and/or developmentally appropriate language). Addition of items to evaluate a new program component, or new measurement of a component (e.g., addition of quantitative items).
Sampling and Sample Size (modifications to sampling methods or sample size)	Macro Micro	9	<ul style="list-style-type: none"> Culturally relevant changes to sample/sample size (e.g., political tensions reduced participation; challenges reaching adults of a cultural group during COVID-19; including all participants from a cultural group to reduce experiences of distrust upon being excluded). Changes in recruitment and sampling strategies to increase participation.
Organizational delays and challenges (changes to accommodate or respond to IPP organizational circumstances)	Macro Micro	8	<ul style="list-style-type: none"> Wildfires, racial tensions/volatile political landscape, and other external factors led to IPPs shifting focus from local evaluation activities to address urgent needs in the community. Staff turnover impacted capacity to fully execute all evaluation activities. Participant attrition (e.g., graduation of participants).
Data analysis (changes in the analysis approach)	Micro	4	<ul style="list-style-type: none"> Restructured analysis procedures to better operationalize a construct. Focused analysis on a smaller selection of evaluation items.

9.7 DEVELOPMENT OF THE CREDIBLE RESEARCH EVIDENCE DOMAINS (CRED) MAPPING TOOL

Within CRDP, CDEPs are a set of holistic practices that communities have used and determined to yield positive or promising results in addressing mental health. CDEPs may or may not have been measured empirically but have reached a level of acceptance by the community (Martinez, 2008). Two statewide evaluation questions are addressed in this section.

- To what extent did CRDP Phase 2 implementation pilot projects validate their community-defined evidence practices?
- 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)?

To answer these questions, we must look at how CRDP Phase 2 CDEPs demonstrated credible evidence of their effectiveness. Credible evidence must demonstrate a valuing of cultural and community practices in how programs are designed, implemented, and evaluated, including methods for defining, gathering, and interpreting evidence (Abe et al., 2018). The issue of credible evidence for CDEPs directly addresses Goal 4 of the CRDP Strategic Plan “to develop, fund, and demonstrate the effectiveness of population-specific and tailored programs,” and especially the following specific strategies (CPEHN, 2018):

- Strategy 17: Fund culturally specific research.
- Strategy 18: Develop culturally specific mental health practice models.
- Strategy 20: Conduct culturally congruent evaluation of community-defined practices.

How can we understand what made their CDEPs credible and effective from the perspective of their communities? This section describes an approach for mapping CRED for CDEPs, contextualizes the use of a CRDP Phase 2 CRED mapping tool within the “culture cube” conceptual framework, and examines CRED findings for CRDP Phase 2 CDEPs.

9.7A OPERATIONALIZING AND MAPPING CREDIBLE RESEARCH EVIDENCE DOMAINS (CRED)

To operationalize what credible evidence means for participating CDEPs, the IPP local evaluation final reports were reviewed to identify ways in which CDEP services/programming incorporated cultural, linguistic, and/or LGBTQ+ affirming and inclusive characteristics. A tool for mapping CRED was developed in alignment with the local evaluation reports to describe CDEP characteristics in five domains:

- CDEP services/programming characteristics (e.g., capacity to deliver services, culturally, linguistically, and/or LGBTQ affirmative/inclusive approach).
- CDEP process indicators (e.g., participation rate, level of participant satisfaction).
- CDEP Outcomes.²³
 - › Mental health (e.g., status, knowledge, attitudes, service access, utilization).
 - › Cultural, community, and social (e.g., cultural and community protective factors, workforce capacity to provide culture-informed and LGBTQ+ affirming care, quality of life or social determinants of health, and community-level norms/perceptions).

²³ Given the wide range of outcomes assessed and reported by CDEPs, a program received “full credit” for this domain only if they reported outcome data that indicated improvements in at least two areas, including outcomes directly related to mental health issues and/or services, as well as outcomes related to cultural, community, workforce, and/or social determinant/quality of life issues. For the other four domains, CDEPs had to include relevant data or narratives in their report to receive a full score.

- CDEP program research design and implementation (e.g., clear and appropriate quantitative, qualitative or mixed methods design; clear and appropriate evaluation implementation and reporting).
- CDEP community engagement (e.g., in development/design, program improvement, data gathering/interpretation/dissemination).

These five domains comprise the infrastructure and processes needed to establish credible evidence for evaluating CDEP effectiveness, with IPP local evaluation final reports used as the sole source of data and unit of analysis.

NOTE ABOUT THE CRED MAPPING TOOL IN CRDP PHASE 2

- The CRED mapping tool provides insight into the extent to which IPPs have developed the necessary infrastructure for providing credible evidence for their CDEPs.
- The CRED mapping tool does NOT provide information regarding the quality of data or judgments about the presence or absence of credible evidence.
- Because the five domains were identified and drawn from data provided in the IPP local evaluation final reports, the IPPs had no explicit guidelines to address them when they wrote the reports. Consequently, it would not be accurate to equate the absence of a reported score with the absence of CDEP activity on a domain, as the reports varied in comprehensiveness, length, and level of detail provided.
- If an IPP did not receive a full score, it primarily means its local evaluation final report did not include this information.

Given these limitations, the CRED map is more useful for giving a minimum or conservative report of the data provided for a domain (e.g., there could be more, but there is not less than what is reported) than for interpreting the absence of information. To give a hypothetical example:

- If 25% of IPPs report they are working with community members to strengthen their CDEPs, then the 25% becomes the minimum percentage of IPPs engaged in this work, not the final word (because there could be more).
- Conversely, it would be inaccurate to state that 75% of IPPs are not engaged in this work. They may just not have reported it.

9.7.B CONTEXTUALIZING CREDIBLE RESEARCH EVIDENCE DOMAINS WITHIN A CULTURE CUBE FRAMEWORK

The Culture Cube is a conceptual tool that helps articulate how cultural and community values and worldviews are reflected in an IPP's CDEP design, implementation, and outcomes to help inform their local evaluation design and selection of measures. Within the Culture Cube model:

- The visible elements of a CDEP include the "three Ps," which describe CDEP activities (project), personnel (persons), and geographic, physical, and community contexts (place) of the program.
- The invisible/less visible dimensions ("three Cs") bring to explicit awareness of the cultural worldviews and values (culture) that influence how problems and their root causes are viewed from a community's perspective (causes) and what the community regards as desired changes and expected outcomes that should follow from these conceptions (changes) (Abe et al., 2018).

An understanding of these elements is needed to ensure that evaluation design, data collection, and interpretation are aligned with a CDEP's cultural underpinnings to establish credible and culturally relevant evidence for their effectiveness. Credibility, it should be noted, cuts multiple ways. When the question "Credibility for whom?" is asked of CDEPs, it is critical that the response centers community perspectives even as CDEPs also address scientific principles and standards.

As such, a central element required for CDEPs to establish credible evidence was the presence of robust community engagement informing both CDEP programming/services and research/evaluation activities. Indeed, without community engagement, it is simply not possible to create a community-defined intervention. Here, CDEPs are more distinctive for the way in which community-based participatory practices inform decision making processes for program and evaluation design and implementation, rather than simply to create highly distinctive programs. Rather, "the overlap would depend on the extent to which each of their conceptualizations of the problem, appropriate intervention, and perception of desirable outcomes are aligned with a Western perspective or [a different cultural] worldview" (Abe et al., 2018, p. 123). The use of the Culture Cube was helpful for identifying and articulating a CDEP's distinctive cultural elements, while the CRED mapping tool assisted in identifying the extent to which CDEPs had the infrastructure and processes needed to establish their credible evidence.

Specifically, the CRED mapping tool affirmed the presence of the essential CDEP elements and processes for ensuring that community engagement, cultural, linguistic and LGBTQ+ affirming approaches were embedded in program structures, processes, and outcomes. The CRED map does NOT provide any indicator of program quality but signals the extent to which a CDEP developed the infrastructure and processes needed to establish credible evidence. As a next step (not conducted as part of the statewide evaluation here), CDEPs can develop a case for their effectiveness based on the quality of their outcome data as credible evidence.²⁴

WHY USE THE CRED MAPPING TOOL?

- It indicates whether a program has the infrastructure and processes, including community engagement, necessary for gathering CDEP evidence. However, it does not, in itself, provide credible evidence of CDEP effectiveness.
- It provides critical information about CDEP infrastructure and process using simple scores for five key domains.
- It does not necessarily require filling out extra forms, since it can be used with existing written evaluation reports.

9.7.C CREDIBLE RESEARCH EVIDENCE DOMAINS FOR CDEPS IN CRDP PHASE 2

We next examined the use of the CRED to identify and describe the essential elements and processes needed to establish credible evidence of effectiveness. The mapping tool was developed using Phase 2 CDEPs as a template. They serve as exemplars, with the focus being on the potential usefulness of the CRED mapping tool for providing information on CDEPs. Therefore, CRED findings are NOT a "report card" of the CDEP quality, but instead, test the "fit" of the five domains with their work, as reported in their local evaluations. The main question answered is: how well do the five CRED domains describe the infrastructure and processes needed to establish credible evidence for CDEPs? With these assumptions in mind, CRED scores are expected to show that CDEPs in the CRDP Phase 2 are on the higher end of the scale (e.g., successful CDEP implementation is assumed) and show evidence of a limited range in scores (given that CDEPs are expected to vary in their implementation success, which would also avoid a "ceiling effect" for the CRED²⁵).

²⁴ Please note that it was not within the scope of the statewide evaluation to report on or evaluate individual IPP CDEP outcomes. Readers interested in a deeper exploration of individual CDEP outcomes can review the 35 CDEP local evaluation reports conducted by the IPPs as part of CRDP Phase 2. Local evaluation reports will be available on the CRDP website (www.cultureishealth.org) in early 2023.

²⁵ A ceiling effect occurs when an instrument has too low of an upper limit, or ceiling, for scores so that all entries get bunched together with the highest scores possible. This indicates that the instrument cannot distinguish between "good" and "excellent" because its ceiling or highest score is too low.

Scoring for the CRED: Each of the five domains were rated with a score ranging from 0–2 (0=not met; 1=partially met; 2=fully met), with a maximum total score of 10. CDEP total scores ranged between 7–10, with 83% of CDEPs scoring 9–10 and 17% scoring 7–8. The majority of CDEPs (69%) had perfect scores (10/10) across all dimensions. The tight range of scores (7–10) and the fact that most CDEPs had high CRED scores suggests that it is providing a robust overview of CDEP functioning. The breakdown of scores for each dimension is reported in Table 9.16.

Table 9.16: CDEP Credible Research Evidence Domain Scores

CRED Dimension	Ratings	Use of CRED scores for mapping: % CDEPs reporting data
CDEP Services/ Programming	<ul style="list-style-type: none"> Capacity to deliver services/programming (including training). Culture, language/literacy, and LGBTQ+ affirming. 	<ul style="list-style-type: none"> CRED “fully met” scores for 100% of CDEPs.
CDEP Processes	<ul style="list-style-type: none"> Participation rate (reflecting priority community was reached). Participant satisfaction. 	<ul style="list-style-type: none"> CRED “fully met” scores for 83% of CDEPs. CRED “partially met” scores for an additional 17% of CDEPs.
CDEP Outcomes	<ul style="list-style-type: none"> Mental health-related outcomes: Changes in mental health status; mental health knowledge, attitudes; service access, utilization. Cultural, Community, Social Outcomes: <ul style="list-style-type: none"> Quality of life/social determinants; improved culturally responsive workforce capacity; cultural and community protective factors; community-level norms/perceptions. 	<ul style="list-style-type: none"> CRED “fully met” scores for 94% of CDEPs. CRED “partially met” scores for an additional 6% of CDEPs.
Research Design and Implementation	<ul style="list-style-type: none"> Clear and appropriate design (quantitative, qualitative, mixed methods). Clear and appropriate evaluation implementation and reporting. 	<ul style="list-style-type: none"> CRED “fully met” scores for 83% of CDEPs. CRED “partially met” scores for an additional 14% of CDEPs. CRED “not met” scores for 3% of CDEPs.
Community Engagement	<ul style="list-style-type: none"> CDEP development design. Evaluation design/implementation and data gathering interpretation and dissemination. 	<ul style="list-style-type: none"> CRED “fully met” scores for 86% of CDEPs. CRED “partially met” scores for an additional 5% of CDEPs. CRED “not met” scores for 6% of CDEPs.

9.7.C.I IDENTIFYING OUTCOME CATEGORIES FOR THE CRED

Iterative review of the IPP local evaluation final reports resulted in the identification of seven outcome categories²⁶. All CDEPs reported outcomes supporting CDEP effectiveness in at least one area, although two areas of outcome reporting were required for the CRED mapping tool to report a “fully met” score (94% of CDEPs reported 2 to 4 outcomes). Outcome categories are described in Table 9.17 below²⁷.

Table 9.17: CRED and CDEP Outcomes, Descriptions, and Examples

Outcomes	Description	# CDEPs Reporting Outcome		Examples
Mental Health-Related Outcomes				
Participant Mental Health Status (N=28 CDEPs)	Includes increases in positive mental health and/or reductions in negative mental health symptoms.	Increases in positive mental health	n=6	Positive mental health: increases in self-esteem, self-efficacy, coping, resilience; mind/body/spirit relationships; happiness, sense of belonging, spirituality, social support; hope.
		Reductions in negative mental health	n=6	Negative mental health symptoms: reductions in anxiety, depression, distress, trauma symptoms/PTSD; substance use.
Participant Mental Health Knowledge and Attitudes (N=12 CDEPs)	Increases in knowledge about mental health issues and/or reductions in negative attitudes/stigma.	Increases in knowledge	n=6	Increased comfort in discussing “taboo” topics; increased capacity to recognize substance abuse; suicide prevention; parenting skills; knowledge of mental health issues; lower stigma; greater awareness of mental health services.
		Reduction in negative attitudes/stigma	n=6	
Participant Access, Utilization, and/or Availability of Mental Health Services (N=6 CDEPs)	Includes all aspects of how well participants accessed and used mental health services.		n=6	Faster service delivery time compared with county; more successful utilization of services through referrals, navigation; increased help-seeking behavior.
Cultural, Community, Workforce, and Social Outcomes				
Mental Health Care Provider’s Knowledge of Culturally and LGBTQ Affirming Care (Workforce Capacity) (N=6 CDEPs)	Increases in workforce knowledge and capacity to provide culturally and LGBTQ affirming care.		n=6	Knowledge and sensitivity around LGBTQ+ issues; use of gender inclusive language, written materials, curriculum; support for transgender individuals; cultural knowledge.
Participant Quality of Life or Social Determinants of Health (N=12 CDEPs)	Increases in quality of life or positive changes in social determinants.		n=12	Positive changes in quality-of-life scales; higher grades (for students); lower suspension rates; increased health, life skills; lower involvement in justice system; employment; housing stability; college intentions; racial profiling; reading level.
Cultural and Community Protective Factors among Participants (N=20 CDEPs)	Increases in positive cultural and community connection, attitudes, and experiences.		n=20	Cultural awareness; culture connection; valuing of spiritual traditions; sense of strength from culture; community or peer connectedness; (reduced) marginalization, isolation, loneliness.
Community-Level Norms or Perceptions of Mental Health (N=3 CDEPs)	Improvements in perceptions of community climate or norms.		n=3	Improved school climate related to inclusiveness; increased comfort in reporting bullying.

²⁶ Reported CDEP outcomes using the CRED only include positive outcomes reported in local evaluation reports (e.g., reductions in negative mental health symptoms, increased access to mental health services, decreases in stigma, etc.). This section does not report the number of CDEPs evaluated for each of the outcome categories.

²⁷ Because these categories for CDEP outcomes were developed based on CRDP Phase 2 goals, it is possible to adapt this particular domain by reducing or adding categories, as needed, without compromising the overall use of the CRED.

The above outcome categories were drawn from the work of CDEPs, and included several features, including:

- Twenty-one CDEPs had mental health outcome that reported increasing positive mental health states. This included 14 youth-focused CDEPs that solely focused on increasing positive mental health states. CRED findings suggest that CDEPs used a strengths-based, positive psychology focus to enhance positive mental health states along with, or even instead of, a focus on reducing negative mental health states.
- The majority of CDEPs (94%) reported between 2 to 4 outcomes, resulting in a total of 88 reported outcomes supporting CDEP effectiveness. A near majority of the 88 outcomes were related to mental health (53%), while 47% of the reported outcomes were related to cultural, community, social, and workforce changes. CRED findings suggest that almost half of the outcomes reported by CDEPs to reduce mental health disparities related to categories that fell outside western-centric measures of mental health status and service use.
- Increases in cultural and community protective factors emerged as an important outcome category for CDEPs providing direct services (61% CDEPs overall; 71% of youth-focused CDEPs), second only to changes in mental health status. CRED findings indicate that CDEPs valued the extent to which participants feel connected to their broader communities and cultural traditions, not just their negative mental health states.

9.7.C.II USE OF CRED TO DESCRIBE CDEP MENTAL HEALTH-RELATED OUTCOMES

In total, 35 IPPs reported a total of 88 outcomes supporting CDEP effectiveness, with most IPPs reporting 2 to 4 positive outcomes. Note that the vast majority of IPPs (33 of the 35 IPPs) provided direct services to youth and/or adults; 17 IPPs had youth focused CDEPs.²⁸ About half of the 88 reported outcomes (47 outcomes) supporting CDEP effectiveness were related to mental health.

Based on local evaluation findings from 17 CDEPs with youth-focused direct services:

- Fourteen reported overall improvements in mental health (either reducing negative mental health symptoms and/or increasing positive mental health states).
 - › Five reported increased positive mental health only.
 - › One reported reduced negative mental health symptoms only.
 - › Eight reported increased positive mental health and decreased negative mental health.
- Five reported increased mental health knowledge and/or reduced stigma.
- One reported increased access and use of mental health services.

Based on local evaluation findings from 33 CDEPs providing direct services to youth and adults:

- Twenty-eight reported overall improvements in mental health (either reducing negative mental health symptoms and/or increasing positive mental health dimensions).
 - › Eight reported increased positive mental health only.
 - › Seven reported decreased negative mental health only.
 - › Thirteen reported increased positive mental health and decreased negative mental health.
- Thirteen reported increased mental health knowledge and/or attitudes.
- Twelve reported increased mental health knowledge.
- Eight reported decreased stigma or other negative attitudes towards mental health services.
- Six reported increased access and utilization of mental health services.

²⁸ A sample of CDEPs serving youth did not report youth findings in their LERs and were therefore excluded from this count.

9.8 CRED FINDINGS RELATED TO CDEP CULTURAL, COMMUNITY, WORKFORCE, AND SOCIAL OUTCOMES

Of the 88 reported outcomes supporting CDEP effectiveness, 41 non-mental health specific outcomes related to cultural, community, workforce, and social determinant issues were noted. Youth-focused programs accounted for 20 of these 41 outcomes.

- Based on local evaluation findings from 17 CDEPs providing youth-focused direct services:
 - › Twelve reported increased cultural and community protective factors.
 - › Eight reported improved quality of life/social determinant.
 - › Three reported strengthened workforce capacity.
 - › Two reported positively changed community-level norms/perceptions.
- Based on local evaluation findings from 33 CDEPs providing direct services to adults and youth:
 - › Twenty reported increased cultural and community protective factors.
 - › Twelve reported improved quality of life and/or social determinants of health.
 - › Three reported strengthened positive community-level changes in norms and perceptions.

Across all 35 IPPs:

- Six CDEPs reported increased workforce capacity related to the provision of cultural, linguistic, and/or LGBTQ+-affirming inclusive services. Three were youth-focused CDEPs from the LGBTQ+ hub.

Findings from the CRED yielded important insights into CDEP infrastructure and processes needed to gather credible evidence. The outcomes reported by IPPs supporting CDEP effectiveness extended well beyond traditional mental health measures to encompass social determinants, quality of life, cultural and community factors, and community level changes.

The final chapter will revisit the research questions posed for the CRDP Phase 2 statewide evaluation and provide recommendations for future efforts based on extensive feedback from IPPs, TAPs, and lessons learned by OHE and the statewide evaluation team.



Chapter 10

Closing

Observations

10.1 OVERVIEW

The statewide evaluation final report for CRDP Phase 2 addressed two objectives:

- **Objective 1:** Evaluate CRDP Phase 2's overall effectiveness in identifying and implementing strategies to reduce mental health disparities in five priority populations, specifically using Implementation Pilot Projects (IPPs) and Community-Defined Evidence Practices (CDEPs).
- **Objective 2:** Evaluate the effectiveness of the CDEP strategy as a prevention and early intervention approach to reducing mental health disparities.

Three aspects of the CDEP approach merit further consideration.

First, CRDP was intentional in creating a community-driven and culturally, linguistically, and LGBTQ+-affirming ethos aligned with its IPP-centric initiative goals. These were reflected in the initial solicitations for contracts and grants, which required organizations to provide evidence of their capacity in these areas and experience with community engagement. Solicitations required letters of recommendation from community-based organizations to attest to these competencies, which underscored CRDP Phase 2's commitment to community-driven approaches from its inception. During a six-month capacity-building pilot project phase that led up to the formal launch of the initiative, community-based organizations with less infrastructure received technical assistance to strengthen their organizational capacity before CDEP implementation began.

Second, in line with its community-centered commitment, the central questions of the initiative were aligned to examine the effectiveness, rather than efficacy, of the CRDP approach and CDEP strategies. Whereas efficacy focuses on how well an intervention works under highly controlled conditions, studies of effectiveness focus on how interventions operate in real-world contexts (Godwin, Ruhland, Casson et al., 2003). The CRDP statewide evaluation strategy did not adopt a randomized control trial experimental design in assigning CDEPs or their participants to treatment or control groups. Instead, five qualitative and quantitative core measures (e.g., CDEP participant data, organizational data, annual CRDP partner semi-structured interviews, review of records, secondary data) were used to support the IPPs and uplift their CDEPs to tell the story of the initiative. The statewide evaluation prioritized responsiveness to cultural, linguistic, and contextual competency and LGBTQ+-affirming approaches over strict adherence to standard practices in methodology and measurement, resulting in a "culture first, methods follow" evaluation approach.

Third, there was no template or checklist of steps to follow as CRDP developed the CBPP-informed statewide evaluation. For example, the final form of the cross-site participant questionnaire could neither have been anticipated nor described as part of the initial call for proposals. Instead, CRDP placed the highest priority not on standard measures of efficacy but rather success in building community relationships that would engender collaboration and ultimately lead to sustainable, community-driven interventions. The result was both rich and messy: rich in the sense of yielding insight and data, and messy in responding to varied, multi-textural community experiences. Thus, while CBPP-informed evaluation makes visible the experiences of communities that are often rendered invisible, it also requires a significant investment of time and resources focused on *process*, not just *outcomes*. CRDP Phase 2 allocated approximately 7.5% of its total budget to statewide evaluation efforts. IPPs were required to set aside 20% of their funding for their local evaluation efforts. TAPs provided wrap-around services tailored to the needs of each IPP.

In this chapter, we revisit the findings of the statewide evaluation and offer a non-exhaustive set of data-informed recommendations meant to inform behavioral and mental health systems and guide the development of future initiatives involving CDEPs and other community-centered approaches.



10.2 STATEWIDE EVALUATION QUESTIONS REVISITED

This section revisits the two statewide evaluation objectives and the seven related research questions. It provides a summative account of key findings related to the research questions and notes when and why some questions could not be fully addressed.

(It should be noted that, in addition to CBPP principles, the statewide evaluation's approach and change model was informed by complexity theory and a social ecological model approach, emphasizing the dynamic and interconnected nature of relationships between personal and environmental contexts that require a high level of flexibility and creativity in developing responsive intervention approaches. As such, most of the report findings do not have a one-to-one relationship with individual research questions).

Highlights from the statewide evaluation findings will be used to address six of the seven SWE questions, which have been grouped into three broader questions (See Table 10.1). SWE Q2 (What were vulnerabilities or weaknesses in CRDP's overarching strategies and fiscal operations, and how could they have been strengthened?) is addressed later in this chapter (see Statewide Evaluation Limitations).

Table 10.1: Regrouping of Statewide Evaluation Questions

SWE Questions	Regrouping of SWE Questions
<p>SWE Q1. 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? (Objective 1)</p> <p>SWE Q4. 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)? (Objective 2)</p>	<p>SWE RQ1. What was the effectiveness of CRDP and its use of CDEPs for preventing and/or reducing severity of mental health conditions in its priority populations?</p>
<p>SWE Q3. To what extent did CRDP strategies show an effective return on investment? (Objective 1)</p> <p>SWE Q5. How cost effective were implementation pilot projects? What was the business case for increasing them to a larger scale? (Objective 2)</p>	<p>SWE RQ2. How cost-effective was the CDEP strategy and what was the return on investment for the initiative (i.e., what was the business case for CRDP Phase 2?)</p>
<p>SWE Q6. To what extent did CRDP Phase 2 implementation pilot projects validate their CDEPs? (Objective 2)</p> <p>SWE Q7. What evaluation frameworks were developed and used by the pilot projects? (Objective 2)</p>	<p>SWE RQ3. To what extent were CDEPs validated and what were the evaluation frameworks developed and used for CDEPs?</p>



SWE RQ1: What was the effectiveness of CRDP and its use of CDEPs for preventing and/or reducing the severity of mental health conditions in its priority populations?

Findings in this area (refer to chapters 5, 6, 7, and 8 for more detail) indicated the following:

- **CRDP findings show that the initiative has made mental health services more accessible to the five CRDP priority populations.**
 - › Nearly three in four adults (72%) and one in two adolescents (49%) receiving CDEP services had a mental health need in the 12 months prior to receiving services. Among individuals reporting a mental health need, more than one in four adults (28%) and nearly one in three adolescents (30%) had not received mental health services in the 12 months prior to CDEP services.
 - › IPPs provided CDEP services in 38 of California's 58 counties.
 - › Between May 2017 and April 2021, CRDP provided direct CDEP services to 15,322 unduplicated individuals.
 - › Between May 2017 and April 2021, CRDP (24 CDEPs) provided 21,902 referrals to 17,599 individuals. Among those referrals, 32%, or 5,632, included a linkage and 17%, or 2,994, included a linkage and navigation.
 - › Between May 2017 and April 2021, CDEPs provided approximately 1,243 sessions and 22,922 hours of formal workforce development training and technical assistance.
- **CRDP-wide baseline CDEP demographic data suggest that the IPPs served communities in the five priority populations they intended to serve during CRDP Phase 2.**
 - › Thirty-three percent of adults identified as Latinx, 32% Asian, 16% African American/Black, 13% American Indian/Alaska Native, 10% White, and 2% Native Hawaiian/Pacific Islander.
 - › Thirty-nine percent of adolescents identified as Latinx, 28% African American/Black, 23% American Indian/Alaska Native, 15% Asian, 15% White, and 1% Native Hawaiian/Pacific Islander.
 - › Seventeen percent of adults and 29% of adolescents reported an LGBTQ+ sexual orientation.
 - › Nine percent of adults and 12% of adolescents identified as transgender and gender non-binary, while 2% of both age groups identified as questioning/unsure.
- **In addition to the five CRDP priority populations, a cross section of sub-populations served by CDEPs included immigrants, refugees, and people with limited English fluency.**
 - › Fifty-four percent of adults were born outside of the US (88% of Asian American adults; 91% of Latinx adults), compared to 5% of adolescents.
 - › Eleven percent of adults were refugees (27% of Asian American adults; 9% of Latinx adults), while 3% of adolescents were refugees.
 - › Fifty-two percent of adults had limited English fluency (85% of Latinx adults; 81% of Asian American adults) in compared to 14% of adolescents.
 - › Collectively, 49% of IPPs provided CDEP direct services in 15 non-English languages. All five priority population hubs provided linguistic access (one AfAm IPP, five AANHPI IPPs, one AI/AN IPP, seven Latinx IPPs, and three LGBTQ+ IPPs).

A strength of CRDP Phase 2 is that TAPs had a rare opportunity to engage in long-term relationships with IPPs. Organizations that needed wrap-around technical assistance received intensive services over time, while other organizations, if they chose, had minimal contact with technical assistance providers. This enabled TAPs to provide tailored services that fit each IPP, rather than a standardized set of services applied to all IPPs. Below are findings related to technical assistance.

- **Culturally grounded technical assistance was provided to support CDEP implementation, evaluation, and organizational capacity building.**
 - › The five CRDP technical assistance providers reported 3,943 technical assistance activities with the IPPs. CDEP implementation (55%), local evaluation (48%), and organizational capacity building (45%) were the top three content areas.
 - › Pre/Post-IPP organizational capacity assessments showed statistically significant improvements in nearly every capacity domain with the top three areas of growth including organizational capacity (implementation of key organizational and programmatic functions), adaptive capacity (monitoring and responding to internal and external changes), and management capacity (effective and efficient use of organizational resources).

Next, we consider the evidence gathered through CRDP Phase 2 regarding the effectiveness of CDEPs as an approach to reducing mental health disparities in their priority populations. Note that the statewide evaluation approach goes beyond a “yes” or “no” response to the question of CDEP effectiveness in asking “to what extent” in order to examine nuances in CDEP effectiveness. The findings below provide some highlights related to psychological distress scores.

- **CRDP participant outcomes support CDEP effectiveness with many participants who either maintained low psychological distress levels or decreased their distress level by the end of services.**
 - › Among CDEP participants who began with no/mild psychological distress, 71% of adults and 67% of adolescents maintained this level post initiative.
 - › Among CDEP participants who began with moderate psychological distress, 40% of adults and 28% of adolescents moved to no/mild psychological distress in post, and 49% of adults and 62% of adolescents stayed in the same category (i.e., did not worsen).
 - › Among CDEP participants who began with severe psychological distress, 80% of adults and 70% of adolescents were at or below pretest levels at post. Sixty-six percent of adults and 49% of adolescents moved to a lower state of distress.
- **Statistical modeling of CRDP participant outcomes show that the positive mental health findings are robust and support the overall efficacy of CDEPs as a mental health prevention and early intervention strategy.**
 - › Adult CDEP participants experienced an overall decrease in psychological distress, improved functioning, increased cultural protective factors, and reduced marginalization and isolation.
 - › Adolescent participants showed modest improvements in psychological distress but overall held steady in other measures including psychological functioning, cultural protective factors, and marginalization and isolation. From a prevention standpoint, these findings are promising.
 - › For CRDP participants overall, those who started with higher levels of psychological distress were more likely to show greater improvement than participants experiencing lower levels of distress.
 - › The statistical modeling of outcomes showed that differences in CDEP sample sizes, missing data, age, race, sexual orientation, and gender identity did not change CDEP effectiveness.
 - › The statistical modeling of outcomes also shows that the occurrence of COVID-19 did not affect CDEP effectiveness, either separately or considered together with all other variables.

Finally, the implementation of CRDP Phase 2 was affected by many external factors, including the COVID-19 pandemic. See Chapter 5 for a description of how IPPs pivoted to online work to make their CDEPs accessible to participants, and how IPPs played a critical role in meeting the pandemic-related needs of their communities. Indeed, the fact that IPPs were positioned to respond flexibly to a wide variety of community issues is a distinctive feature of IPPs and their CDEPs. In some cases, the roles of IPPs in their communities transcended the implementation of their CDEPs. Some examples:

- **During the COVID-19 pandemic, IPPs offered various forms of support to help their CDEP participants and prevent mental and physical distress in their communities. IPPs:**
 - › Distributed personal protective equipment (24 IPPs), food and water (7 IPPs), clothing/household goods (17 IPPs), and technology equipment (15 IPPs).
 - › Provided wellness services and support (27 IPPs), English-language COVID-19 information (18 IPPs), grief/bereavement counseling (17 IPPs), financial assistance (17 IPPs), family needs assessments (12 IPPs), internet access (11 IPPs), and housing advocacy/tenant rights support (10 IPPs).
 - › Supported remote learning needs (16 IPPs), and navigated access to unemployment and other government benefits (10 IPPs), and ways to access public transportation (eight IPPs).

SWE RQ2: How cost-effective was the CDEP strategy and what was the return on investment for the initiative? What was the business case for CRDP Phase 2?

To build a generalized model for understanding how changes in the Kessler-6 for the five priority populations may correlate with averted health care and other costs, the SWE used data from the Medical Expenditure Panel Survey (MEPS). This survey is the most complete source of information on the cost and use of health care and health insurance coverage for the United States. The business case also relied on data from the National Health Interview Survey (NHIS) and the California Communities Mental Health Services Survey (CCMHSS). This approach provided a single business case for CRDP overall but did not provide individual CDEP-level business cases.

On one hand, these data sources provided critical information on mental health outcomes linked to health expenditures and enabled the development of a business case to examine the cost effectiveness of the CDEP approach for reducing mental health disparities. On the other hand, gaps or limitations in these data sources also conservatively limited what could be estimated for the initiative. Finally, developing a business case usually requires the identification of appropriate secondary data to create “counterfactuals” or “what would have been” scenarios, had the initiative not been implemented. In this case, however, due to limitations in the availability of county-level PEI program data which would have served as counterfactuals, we could not establish these scenarios. Notwithstanding these constraints, findings in this area (refer to chapter 6 for more details) indicated the following:

- **The CRDP Phase 2 business case found that, for every taxpayer dollar invested in CRDP, there was an estimated return of between \$4.32 and \$5.67 dollars.**
 - › The business case used a cost-benefit analysis to calculate the dollar value of changes in CDEP participants’ mental health through averted health expenses and productivity gains.
 - › The business case showed that prevention matters. Maintaining good mental health for participants who are doing well is as cost effective as helping those who are struggling with serious psychological distress.
 - › The dollar value is a conservative estimate that, due to data limitations, could not include benefits accrued for all identities of LGBTQ+ hub participants or gains in overall years of quality of life.

SWE RQ3: To what extent were CDEPs validated and what were the evaluation frameworks developed and used for CDEPs?

The initial assumption was that attaining EBP status was the key goal for IPPs using CDEPs, representing a path to funding through county, state, and federal mental health services. EBP status was largely abandoned as an aspiration shortly after the first year of the initiative when the funding for National Registry of Evidence-Based Programs and Practices (NREPP) was indefinitely suspended by the Trump administration. As the initiative progressed, many CRDP partners became convinced that CDEPs should be valued on their own terms, rather than seen as potential EBPs.

Why this change? CDEPs, within the context of IPPs, serve communities as their primary mission, from defining activities and refining approaches, to framing and evaluating outcomes. EBPs, however, are often much narrower in scope, and don't always prioritize the interests and concerns of diverse communities. Assumptions underlying the initial development of EBPs are not always aligned with the cultural values of the communities in which they are implemented. Even when EBPs are adapted into different cultural contexts (e.g., culturally adapted treatments), assumptions remain largely western-centric (Abe et al., 2018).

The statewide evaluation adopted two strategies for privileging culture and community over the usual methodological practices. First, it adapted its cross-site participant questionnaire in response to community feedback to reflect more culturally, linguistically, and LGBTQ+-affirming approaches in its methodology (see Chapter 9 for more details). Second, it reviewed local evaluation final reports to identify how these approaches were reflected in CDEP evaluation strategies. The statewide evaluation found that IPPs utilized five overarching strategies (i.e., CBPR/representation, cultural/community norms, community capacity building, intersectionality, and linguistic responsiveness) throughout the design and implementation of their local evaluation activities. Finally, a Credible Research Evidence Domain (CRED) mapping tool was developed from and applied to CDEP local evaluation reports to provide an evaluation framework to identify the infrastructure and processes needed for CDEPs to demonstrate their effectiveness. These processes are described in Chapter 9, but some key findings are highlighted below.

- **IPP Local Evaluation Report findings highlight a range of outcomes supporting CDEP effectiveness with a range of culturally informed outcomes that extend well beyond standard mental health measures.**
 - › Twenty-eight CDEP evaluations reported improved mental health (either reductions in negative mental health symptoms and/or increases in positive mental health dimensions) among their participants.
 - › Twenty CDEP evaluations reported an increase in cultural and community-protective factors among their participants.
 - › Twelve CDEP evaluations reported improvements in participant quality of life and/or social determinants.
 - › Three CDEP evaluations reported positive improvements in community-level norms and perceptions such as, but not limited to, more inclusive school climates.

In the next two sections, we review limitations related to CRDP Phase 2 and the statewide evaluation to add further context related to the implementation of the initiative and to provide evaluation findings.



10.3 CRDP PHASE 2 LIMITATIONS

10.3.A VULNERABILITIES AND WAYS TO STRENGTHEN THE INITIATIVE

10.3.A.I IPP CAPACITY TO ENGAGE IN TECHNICAL ASSISTANCE SUPPORT

The COVID-19 pandemic conditions put into stark relief the wide range of IPP organizational capacity needs and the IPP-specific responses that were required by all CRDP partners to support them.

(-) Many IPPs reported being too overwhelmed with their programmatic and evaluation grant responsibilities to fully take advantage of the technical assistance available throughout CRDP Phase 2 even if it was needed or would have been helpful.

(+) Building in additional resources and dedicated time to engage in technical assistance may have facilitated IPPs' willingness to take full advantage of the services offered to them.

(-) The CRDP technical assistance structure also did not account for IPP-to-IPP technical assistance that emerged during the initiative. Although IPPs could account for the provision of technical assistance to other IPPs through their annually updated grant workplans, this did not equate to additional funding and came at the expense of resources available for other grant activities.

(+) Some IPPs and TAPs highlighted that a more equitable approach would involve dedicated funding to compensate IPPs for technical assistance provided to other IPPs in the initiative.

10.3.A.II EVALUATION-RELATED TECHNICAL ASSISTANCE

(-) The provision of evaluation-related technical assistance was often fraught during CRDP Phase 2. IPPs had a range of evaluation-related experience prior to CRDP, including some with limited to no prior experience. The presence of multiple partners involved in statewide evaluation and the absence of clear, consistent language in the original solicitations for IPPs, TAPs, and SWE regarding each partner's roles and responsibilities in relation to the evaluation posed challenges in providing evaluation-related technical assistance.

(+) More clarity in contract language, an initial planning process, and regular debriefs between partners and within hubs to clarify roles, develop relationships, and to establish trust would have been helpful.

10.3.A.III DATA OWNERSHIP, COMMUNITY REVIEW PROCESSES, DATA SHARING, AND DATA USE

(-) The development of Data Use and Sharing Agreements (DUSA) prior to the implementation of the initiative would have helped established trust and common understanding around these critical and sensitive issues. For one grantee, the absence of a DUSA prevented the inclusion of its CDEP participant questionnaire data in the statewide evaluation.

(+) Greater time was needed to account for community review processes, especially in relation to tribal review protocols and timeframes, which are important for recognizing, respecting, and honoring tribal sovereignty.

10.3.A.IV HUB DESIGN AND INTERSECTIONALITY

(-) While the priority population hubs helped facilitate a sense of community and shared purpose for many IPPs, they also masked differences within groups so that hub affiliation also became a potential barrier to completing intersectional analyses of outcomes. Given these issues, disaggregation of data emerged as a major concern for some of the hubs, especially AANHPI and LGBTQ+ hubs.

(+) Any hub design for a priority population should assume that there is no singular or universal experience within that population. Individuals within and across hubs may hold separate and distinct identities based on important differences in ethnic backgrounds, gender identity and expression, sexual orientation, economic circumstances, immigration experiences, etc.

(-) While CRDP Phase 2 was designed to address intersectionality through cross-population technical assistance, the full potential was not fully realized in the initiative due to implementation challenges (e.g., lack of IPP capacity to participate in additional technical assistance activities; lack of clarity and consensus between OHE and the TAPs related to cross-population technical assistance objectives).

(+) An initiative of this type should include more opportunities for peer-to-peer learning, including a formal, facilitator-led peer-learning community.

10.3.A.IV SUSTAINABILITY CONCERNS

(-) Sustainability emerged as a key concern during CRDP Phase 2 and was primarily addressed through the emergence of entities critical to the success of the overall initiative, but that were not part of its original design. IPPs created a Cross-Population Sustainability Steering Committee (CPSSC) and worked in partnership with the cultural broker contractor, supported by TAPs, to advocate for sustaining their work. This was done in response to the OHE and CDPH vacuum in key, high level leadership roles.

(-) While aspects of sustainability were also supported by the presence of an Education, Outreach, and Awareness (EOA) contractor, the EOA contract was restricted to two years in the middle of the initiative, which did not allow time for the EOA to develop relationships with other CRDP contractors.

(+) IPPs were highly successful in addressing sustainability issues and receiving capacity development related to advocacy. However, more intentional focus on contractor deliverables, timeline, and partner participation from the beginning of the initiative may have helped build greater support for sustainability at the county and state levels.

10.4 STATEWIDE EVALUATION LIMITATIONS

The statewide evaluation also experienced limitations from both a methodological and implementation standpoint. These included:

- SWE contract-defined constraints for CBPP:** All community-based participatory research processes take place in contexts that shape the extent to which principles of community engagement can be realized (see Grills et al., 2018). As part of a publicly funded, state-led initiative, its contract for the statewide evaluation shaped several aspects of its design that ran contrary to the expressed desires of several CRDP partners and IPPs. For example, the CDPH-defined SWE contract formulated the seven statewide evaluation research questions and required the use of a common set of CDEP participant questions. The contractual nature of these elements of the statewide evaluation limited the ability of CRDP partners to define the evaluation questions and measures together.
- Unanticipated state-level IRB barriers:** The unanticipated requirement that the statewide evaluation and all 35 local evaluations go through CalHHS's IRB to individually receive either approval or exemption for their work caused substantial implementation delays. The additional review process ran contrary to the recommendations of the IPPs, TAPs, and SWE to use local/community-based IRBs that are better situated to understand community participatory practice and local knowledge and practices. In many cases, IPPs had their local evaluations reviewed by CalHHS's IRB, local IRBs, and community advisory boards. This placed additional constraints on the statewide evaluation's ability to quickly adapt methods and measures to be culturally, linguistically, and LGBTQ+ affirming. All changes to the statewide evaluation required submitting formal amendments to the CalHHS IRB

and awaiting approval, a process that took substantial labor and often delayed implementation of needed modifications by several weeks.

- **Challenging workload due to CRDP evaluation research agenda and data expectations:**

The CRDP is an ambitious, first of its kind demonstration project. The number and scope of evaluation questions included in the Statewide Evaluator Solicitation reflected this ambition. The initiative's aspirational research agenda also required a high level of data collection, not just by the SWE, but by all CRDP partners. This created a collective burden on the CRDP to collect data to demonstrate CDEP effectiveness while also implementing (and tailoring) the CDEPs to meet the needs of the communities they served. The large amount of data collected at the community level by partners with varying degrees of evaluation experience also created considerable additional labor for all partners collecting and reviewing data. For the SWE, this shortened the time available during the data collection phase to run preliminary analyses and limited how in depth some of the final analyses could be.

- **Limited availability of secondary data needed to develop a more comprehensive business case:**

In developing a business case, it was critical to have secondary data that included linkages between major datasets to enable analyses for priority populations. For example, information linking mental health outcomes and health expenditures through MEPS is only available for adult samples (18 years and older), so estimates supporting a business case for youth-focused CDEPs were not available. Because participant-level data for health care expenses were not available, a business case for each CDEP could not be developed. In addition, data related to sexual orientation and gender identity were not available in the MEPS and sexual orientation data in the NHIS were limited (e.g., inability to disaggregate LGBTQ+ categories, lack of transgender category, etc.). Consequently, the CRDP business case could not fully account for CDEP benefits for all LGBTQ+ identities and youth populations.

- **Small hub-level sample sizes:** Although IPPs and TAPs requested more SWE support for disaggregated data and hub-level analyses, small sample sizes for certain hubs or sub-populations made this unfeasible and might have potentially made IPPs identifiable in the report.

- **Limited capacity to assess CRDP-related environmental, systems-level, and policy change:**

Assessing the scope of environmental, systems, and policy-level change related to CRDP Phase 2 was beyond the capacity of the statewide evaluation and would have entailed gathering and reporting additional local evaluation data. Still, signs of systems changes (e.g., adoption of gender-inclusive practices and training by schools and social service providers; recognition of community-defined practices in county contracting; county-wide adoption of a language access policy, etc.) make this an area ripe for future investigation.



Chapter 11

Recommendations



In this final section, five key recommendations from CRDP Phase 2 are offered for consideration by legislative leaders and policy makers, county mental health systems, mental health practitioners and researchers, and others involved in the development of related initiatives and/or committed to the development and implementation of community-driven approaches to mental health. In making these recommendations, we honor and recognize the efforts of all the CRDP Phase 2 partners, especially IPPs, to demonstrate the effectiveness of CDEPs. For each recommendation, we also highlight further questions and avenues to pursue in future work.

1 Recognize CDEPs as innovative, effective, community-driven PEI approaches to reduce 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 for unserved, underserved, and inappropriately served communities, and should be recognized as such by federal, state, and county mental health service agencies (e.g. NIMH). They were developed *with* communities using culturally, linguistically, and LGBTQ+-affirming evaluation approaches and therefore represent effective, inclusive, and responsive approaches to reducing mental health disparities.

Due to the high level of partnership and trust needed to implement CDEPs, community-based organizations providing CDEPs are well-positioned within communities to respond to public health emergencies (e.g., COVID-19, wildfires) and contextual conditions (e.g., systemic racism) and able to coordinate with state, county, and local officials, especially with high levels of language access.

QUESTIONS TO CONSIDER:

- How can the use of CDEPs be supported within mental health systems?
- Given estimates of CDEP cost-effectiveness and positive return on investment, what sources of funding can be identified, sustained, and/or expanded for CDEPs in California?
- Would the creation of a statewide CDEP registry help uplift community-based prevention and early intervention practices and visibility?
- How could such a system be designed to support consistent long-term documentation and reporting of effective CDEP practices?
- How can further data collection and research efforts increase recognition and understanding of CDEPs?
- How might community members use data to advocate for services in their communities?
- How might technical assistance be reimagined to include consideration of CRDP IPPs as technical assistance providers to make use of their community expertise, support the fidelity of the CDEP approach, and continue expanding their organizational capacity?

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 and there was no single model (e.g., workforce development, direct service, school-based programs, youth development, etc.) that was adopted by all communities. Thus, it is important to remain flexible in defining what

CDEPs look like and how they provide programs and services. Determinations of what CDEPs should look like, and how they should function, are best left to communities to decide.

At the same time, community-based organizations in these unserved, underserved, and inappropriately served communities may have creative, robust ideas, but would benefit from organizational capacity building to further develop their CDEPs and to meet eligibility requirements for different grants or contracts. Specifically, support for organizational capacity development around such issues as fiscal management, leadership development, community engagement, and evaluation, could make a big difference for potential CDEPs. Other resources to support these organizations could also be developed (e.g., toolkits to strengthen community engagement for CDEP planning, decision making, implementation, adaptation, and evaluation).

QUESTIONS TO CONSIDER:

- How might opportunities for supporting the organizational development and capacity building of community-based organizations with less experience and little infrastructure be built into major initiatives and grant opportunities?
- How can promising programs and organizations be nurtured and strengthened as a part of ongoing grant and contract practices?
- What would it look like to be IPP-centric rather than funding-centric in supporting organizational development? (Is it possible, for example, to have grants that help IPPs develop an evaluation portfolio that documents their development and strengthens their capacity to use program data across different funded projects to assist with their long-term sustainability?)
- What would it mean to support researchers and communities to establish CDEP standards of practice?
- What further research might be useful to examine the utility of the Credible Research Evidence Domains (CRED) mapping tool for establishing CDEPs' credible evidence?

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.

Implementing these recommendations will permit better examination of intersectionality issues and assist stakeholders and policy makers to better understand and address mental health disparities. For example, the barriers experienced by the statewide evaluation team to obtaining secondary data for sexual orientation and gender identity issues related to information about mental health outcomes and health expenditures were considerable. A request for restricted access data was made to link MEPS health expenditure data to NHIS sexual orientation data as a work-around strategy to address the lack of SOGI data in MEPS. Even so, the NHIS data was limited, and the resulting small sample sizes did not enable a disaggregation of LGBTQ+ categories. Further, MEPS data was only available for adults 18 years and older.

The lack of access to disaggregated data with robust sample sizes related to LGBTQ+ populations means that it is not yet possible to establish a business case with credible evidence for a full range of identities within 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 a lack of secondary data available to analyze the cost effectiveness of these approaches. One major area of concern is that the absence of a business case that includes LGBTQ+ might be used as a (false) rationale for asserting that there is not enough data to support LGBTQ+ CDEPs.

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 in which populations. Without comprehensive LGBTQ+ data points and the capacity to link datasets, existing datasets cannot

contribute to the examination of intersectionality issues or the needs of priority populations with more fine-grained analyses. The datasets perpetuate a status quo with category-based assumptions about priority populations based on race/ethnicity *or* (rather than *and*) sexual orientation *and* gender identity.

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

Additional efforts can also be made at the state level to link health care administrative data with data collected from other state departments relevant to assessing the impact of mental health PEI programs and CDEPs. For example, in 2018, the California Department of Corrections and Rehabilitation (CDCR) and the Department of Healthcare Services (DHCS) released a report linking data from individuals released from CDCR from 2012 to 2016 with Medi-Cal eligibility and administrative claims data to show the impact of Medicaid expansion in improving access and utilization of mental health services. Similarly, in 2020, the Mental Health Services Oversight and Accountability Commission (MHSOAC) released an [**electronic dashboard**](#) assessing the potential impact of mental health services on criminal justice involvement by linking mental health Full-Service Plan data collected by the Department of Health Care Services with arrest data from the Department of Justice. The CDPH also began in 2020 a Comprehensive Suicide Prevention Program utilizing multiple statewide data sources, including suicide rates, self-harm emergency department rates, and California Violent Death Reporting System data, to identify counties accounting for a significant portion of the State's suicide burden and provide those counties in-depth training and technical assistance to adopt and implement suicide prevention strategies. Continued and expanded efforts such as these are needed to fully inform the costs and benefits of mental health PEI programs and CDEPs.

QUESTIONS TO CONSIDER:

- What are the consequences of multiple and overlapping forms of oppression based on identity for mental health need, as well as mental health services?
- What system-based assumptions are made about who is served by whom, when services (including CDEPs) are solely defined by race/ethnicity or LGBTQ+, but not both?
- How can SOGI items be included in surveys on health expenditures?
- How can youth mental health outcomes be reported at the state and national levels, and then linked to health expenditure data?
- Data collection gaps on certain subpopulations can be addressed through funding dedicated to sponsoring additional items on existing surveys, such as the MEPS or the CHIS. So, how, and by whom, can this funding be initiated?
- How can the researchers and the public access county and state PEI data in a manner that is transparent and user friendly?
- Where can the linkages be made to maximize the utility of existing datasets for unserved, underserved, and inappropriately served populations?

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 communities.

Mission fidelity centers on IPP relationships with their communities, rather than solely on how IPPs implement their programs. From this perspective, the community and its ecology are not simply a background context for program implementation, but a guide for ensuring that programs are responsive to a 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 deviations from a program template or a manualized intervention.

CDEPs delivered PEI services to adults, youth, and older adults representing varied communities, identities, languages, and cultural experiences. What characterized them was their diversity. So then, what does it mean to value and honor CDEP diversity in PEI approaches when EBPs, manualized and standardized, tend to be held as an unquestioned standard for unserved, underserved, and inappropriately communities? 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.

The findings of CRDP Phase 2 and the sheer diversity of effective CDEP approaches also argue against the application of any single CDEP, much less an EBP, even if adapted across different communities. What do communities want and what do they see as credible? Communities must have a voice in determining whether the evidence available for a PEI strategy or mental health intervention is credible and relevant to their needs and worldviews.

QUESTIONS TO CONSIDER:

- What can be done to encourage a wider diversity of PEI approaches that are developed and tailored according to a community's needs?
- How can the development of PEI approaches for different age ranges and in different communities be encouraged and funded?
- How can flexibility and openness to a diversity of effective CDEP PEI approaches be encouraged and reinforced for mental health systems? (How will effectiveness be assessed? How will credible evidence be defined and vetted?)
- How can communities work with mental health systems to advocate for the adoption of CDEP PEI approaches that work for them?

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. While the results demonstrate extraordinary success in expanding access to mental health care, 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 IPPs' self-mobilization around continued sustainability and advocacy through the work of the IPP-led Cross-Population Sustainability Steering Committee.

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 formal data-use and sharing agreements (DUSA). This would help address community concerns about data ownership, data use, and data sharing, and allocate generous time 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.

QUESTIONS TO CONSIDER:

- How do funding efforts that focus on communities build in the necessary infrastructure, time, and resources needed for authentic, meaningful, and sustained community engagement?
- How does support for community engagement get built into initiatives and programs?
- Clarity in goals and roles, and time built in for relationship development (e.g., planning phase) and community review processes to encourage authentic community engagement and build trust between initiative partners is critical to the success of community-centered initiative efforts. So, how are these discussions included as part of the design of initiatives?
- How are DUSA agreements developed?
- What roles or contracts are needed to address fidelity to mission and goal orientation most effectively?
- What state-level staffing roles and programmatic designs are needed to support CDEP efforts (e.g., support for invoicing, contract management, workload, advocacy, etc.) and what are the expectations for each state-level role?
- How are program deliverables aligned, and what time frame and resources are allocated for authentic community engagement, leadership development, and capacity building?



The statewide evaluation team developed a strategy intended to include and honor the experiences of all partners and participants in CRDP Phase 2. We acknowledge its shortcoming and limitations, but the present report represents the collective work of the statewide evaluation team, as part of the Psychology Applied Research Center (PARC) at Loyola Marymount University, under the leadership of Dr. Cheryl Grills. The statewide evaluation work took place over a seven-year period (2016–2022) in collaboration with many valued CRDP partners, including IPPs, TAPs, EOA, CPSSC, Cultural Brokers, and CDPH-OHE, with the support of the LMU Office of Research and Sponsored Projects, and with the many community members who shared wisdom and feedback used to strengthen statewide evaluation procedures. The statewide evaluation team acknowledges all of its colleagues and partners in CRDP Phase 2, especially the exceptional support and guidance provided by Ms. Marina Castillo-Augusto and Dr. Rafael Colonna in the Office of Health Equity, Community Development and Engagement section. Thank you.

For questions regarding the report, please visit the [CRDP website](https://www.cdph.ca/crdp) or contact CDPH-OHE at ohc@cdph.ca.gov.

References

REFERENCES

- Aaron, S. P., Gazaway, S. B., Harrell, E. R., & Elk, R. (2021). Disparities and racism experienced among older African Americans nearing end of life. *Current Geriatrics Reports*, 10(4), 157-166. <https://doi.org/10.1007/s13670-021-00366-6>
- 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*, 62(1-2), 121-134. <https://doi.org/10.1002/ajcp.12266>
- Administration on Aging. (2021, May). *2020 profile of older Americans*. U.S. Department of Health and Human Services. <https://acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans>
- Aisenberg, E. (2008). Evidence-based practice in mental health care to ethnic minority communities: Has its practice fallen short of its evidence? *Social Work*, 53(4), 297-306. <https://doi.org/10.1093/sw/53.4.297>
- Alegría, M., Pérez, D. J., & Williams, S. (2003). The role of public policies in reducing mental health status disparities for people of color. *Health Affairs (Project Hope)*, 22(5), 51-64. <https://doi.org/10.1377/hlthaff.22.5.51>
- Altiraifi, A., & Rapfogel, N. (2020, September 10). *Mental health care was severely inequitable, then came the coronavirus crisis*. The Center for American Progress. <https://www.americanprogress.org/article/mental-health-care-severely-inequitable-came-coronavirus-crisis/>
- Alzheimer's Association. (2021). 2021 Alzheimer's disease facts and figures. *Alzheimer's & Dementia: The Journal of the Alzheimer's Association*, 17(3), 327-406. <https://doi.org/10.1002/alz.12328>
- American Psychiatric Association. (2017). *Mental health disparities: American Indians and Alaska Natives*. <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-American-Indian-Alaska-Natives.pdf>
- American Psychological Association. (2017). *Disparities in mental health status and mental health care*. Retrieved July 2022, from: <https://www.apa.org/advocacy/health-disparities/health-care-reform>
- Applewhite, S. L. (2021). Culturally competent practice with elderly Latinos. In M. Delgado (Ed.), *Latino elders and the twenty-first century: Issues and challenges for culturally competent research and practice* (pp. 1-15). Routledge. <https://doi.org/10.4324/9781315821382>
- Aronowitz, R., Deener, A., Keene, D., Schnittker, J., & Tach, L. (2015). Cultural reflexivity in health research

and practice. *American Journal of Public Health*, 105 Suppl 3, S403–S408.

<https://doi.org/10.2105/AJPH.2015.302551>

Austin, Texas Legislative Budget Board. (2009). *Criminal justice uniform cost report: Fiscal years 2006–2008*. <https://www.ojp.gov/ncjrs/virtual-library/abstracts/criminal-justice-uniform-cost-report-fiscal-years-2006-2008>

Bauldry, S., & Szaflarski, M. (2017). Immigrant-based disparities in mental health care utilization. *Socius: Sociological Research for a Dynamic World*, 3. <https://doi.org/10.1177/2378023116685718>

Beals, J., Manson, S. M., Mitchell, C. M., Spicer, P., & AI-SUPERPPF Team (2003). Cultural specificity and comparison in psychiatric epidemiology: walking the tightrope in American Indian research. *Culture, Medicine and Psychiatry*, 27(3), 259–289. <https://doi.org/10.1023/a:1025347130953>

Bennett, D. A. (2001). How can I deal with missing data in my study? *Australian and New Zealand Journal of Public Health*, 25(5), 464–469.

Billow, R. H. (2011). *A qualitative investigation of the strategies used by a sample of Native American older adults to cope with race-related stressors* [Doctoral dissertation, Montana University]. Graduate Student Theses, Dissertations, & Professional Papers. <https://scholarworks.umt.edu/etd/32>

Boardman, A., Greenberg, D., Vining, A., & Weimer, D. (2018). *Cost-benefit analysis: Concepts and practice* (5th ed.). Cambridge: Cambridge University Press. doi: 10.1017/9781108235594

Brewer, L. P. C., & Williams, D. R. (2019). We've come this far by faith: The role of the Black church in public health. *American Journal of Public Health*, 109(3), 385–386. <https://doi.org/10.2105/ajph.2018.304939>

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

Bubonya, M., Cobb-Clark, D. A., Wooden, M. (2017). Mental health and productivity at work: Does what you do matter? *Labour Economics*, 46, 150–165. <https://doi.org/10.1016/j.labeco.2017.05.001>

Budhwani, H., Hearld, K. R., & Chavez-Yenter, D. (2015). Depression in racial and ethnic minorities: The impact of nativity and discrimination. *Journal of Racial and Ethnic Health Disparities*, 2(1), 34–42. <https://doi.org/10.1007/s40615-014-0045-z>

Bürkner, P.C. (2017). brms: An R package for Bayesian multilevel models using Stan. *Journal of Statistical Software*, 80(1):1–28. <https://doi.org/10.18637/jss.v080.i01>

Burch, K. (2015, August 24). Office of Health Equity Releases Plan to Promote Health & Mental Health Equity.

Health Access. <https://health-access.org/2015/08/office-of-health-equity-releases-plan-to-promote-health-mental-health-equity/>

Byers, A. L., Yaffe, K., Covinsky, K. E., Friedman, M. B., & Bruce, M. L. (2010). High occurrence of mood and anxiety disorders among older adults: The National Comorbidity Survey Replication. *Archives of General Psychiatry*, 67(5), 489–496. <https://doi.org/10.1001/archgenpsychiatry.2010.35>

Byrne, D., & Callaghan, G. (2013). *Complexity theory and the social sciences: The state of the art (1st ed.)*. Routledge. <https://doi.org/10.4324/9780203519585>

California Department of Health Care Services. (2021a). *Performance outcomes and quality improvement (poqi): History & legislation- Introduction*. https://www.dhcs.ca.gov/services/MH/Pages/POQI_History-Legislation.aspx

California Department of Health Care Services. (2021b). *MHSA Components*. <https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Components.aspx>

California Health Care Foundation. (2018). *Mental health in California: For too many, care not there*. <http://resource.nlm.nih.gov/101744391>

California Pan-Ethnic Health Network. (2018). *California reducing disparities project strategic plan to reduce mental health disparities*. <https://cpehn.org/publications/california-reducing-disparities-project-strategic-plan-reduce-mental-health-disparities/>

Canadian Institute of Health Information. (2018). *National health expenditure trends*. <https://www.cihi.ca/en/national-health-expenditure-trends>

Carpenter-Song, E. A., Schwallie, M. N., & Longhofer, J. (2007). Cultural competence reexamined: Critique and directions for the future. *Psychiatric Services*, 58(10), 1362–1365. <https://doi.org/10.1176/appi.ps.58.10.1362>

Carroll, C., Patterson, M., Wood, S., Booth, A., Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity. *Implementation Science: IS*, 2, 40. <https://doi.org/10.1186/1748-5908-2-40>

Center for Community Health and Development. (n.d.). Chapter 2, Section 5: Collective Impact. University of Kansas. Retrieved April 25, 2022, from <https://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/collective-impact/main>

Chandler, D., Spicer, G., Wagner, M., & Hargreaves, W. (1999). Cost-effectiveness of a capitated assertive community treatment program. *Psychiatric Rehabilitation Journal*, 22(4), 327. <https://doi.org/10.1037/h0095219>

- Chen, L. Y., Crum, R. M., Martins, S. S., Kaufmann, C. N., Strain, E. C., & Mojtabai, R. (2013). Service use and barriers to mental health care among adults with major depression and comorbid substance dependence. *Psychiatric Services, 64*(9), 863–870. <https://doi.org/10.1176/appi.ps.201200289>
- Chung, R. C. Y., & Bemak, F. (2002). Revisiting the California Southeast Asian mental health needs assessment data: An examination of refugee ethnic and gender differences. *Journal of Counseling & Development, 80*(1), 111–119. <https://doi.org/10.1002/j.1556-6678.2002.tb00173.x>
- Clark, R. E., Ricketts, S. K., & McHugo, G. J. (1999). Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. *Psychiatric Services, 50*(5), 641–647. <https://doi.org/10.1176/ps.50.5.641>
- Coffman, J., Bates, T., Geyn, I., & Spetz, J. (2018). *California's Current and Future Behavioral Health Workforce*. San Francisco: Heathforce center at UCSF.
- Cohen, D. J., Crabtree, B. F., Etz, R. S., Balasubramanian, B. A., Donahue, K. E., Leviton, L. C., Clark, E. C., Isaacson, N. F., Stange, K. C., & Green, L. W. (2008). Fidelity versus flexibility: Translating evidence-based research into practice. *American Journal of Preventive Medicine, 35*(5, Suppl 1), S381–S389. <https://doi.org/10.1016/j.amepre.2008.08.005>
- Coman, E. N., Wu, H. Z., & Assari, S. (2018). Exploring causes of depression and anxiety health disparities (hd) by examining differences between 1:1 matched individuals. *Brain Sciences, 8*(12), 207. <https://doi.org/10.3390/brainsci8120207>
- Cook, B., Liu, Z., Lessios, A. S., Loder, S., & McGuire, T. (2015). The costs and benefits of reducing racial-ethnic disparities in mental health care. *Psychiatric Services, 66*(4), 389–396. <https://doi.org/10.1176/appi.ps.201400070>
- Cornelius, L. J., Booker, N. C., Arthur, T. E., Reeves, I., & Morgan, O. (2004). The validity and reliability testing of a consumer-based cultural competency inventory. *Research on Social Work Practice, 14*(3), 201–209. <https://doi.org/10.1177/1049731503257886>
- Crenshaw, K., Gotanda, N., Peller, G., & Thomas, K. (1995). Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women. In *Critical Race Theory: The Key Writings That Formed the Movement* (pp. 357–384). New York: The New Press.
- Cusack, K. J., Morrissey, J. P., Cuddeback, G. S., Prins, A., & Williams, D. M. (2010). Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: A randomized trial. *Community Mental Health Journal, 46*(4), 356–363. <https://doi.org/10.1007/s10597-010-9299-z>

Dahlby, B. (2008). *The marginal cost of public funds: Theory and application*. Cambridge, MA: The MIT Press.

- Davie, L., & Rataj, A. (2018). *Developing A Foundation For Integrated Care Coordination*. University Of New Hampshire, Center On Aging And Community Living & NH Alliance For Healthy Aging. University Of New Hampshire.
- Dismuke, C. E., & Egede, L. E. (2011). Association of serious psychological distress with health services expenditures and utilization in a national sample of US adults. *General Hospital Psychiatry*, 33(4), 311-317.
- Drwecki, B. B., Moore, C. F., Ward, S. E., & Prkachin, K. M. (2010). Reducing racial disparities in pain treatment: The role of empathy and perspective-taking. *International Association for the Study of Pain*, 152, 1001-1006. <https://doi.org/10.1016/j.pain.2010.12.005>
- Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, 41(3-4), 327-350. <https://doi.org/10.1007/s10464-008-9165-0>
- Eberhart, N.K., Cerully, J.L., Shearer, A.L., Berry, S.H., Burnam, M.A., & Ebener, P.A.. (2017), *Evaluation Approaches for Mental Health Prevention and Early Intervention Programs*, Santa Monica, Calif.: RAND Corporation, RR-1882-CMHSA. <https://doi.org/10.7249/RR1882>
- Einhaus, K., Stewart-Cassel, V., Espiritu, R., & Toleran, D. (2018, August 6). *LGBTQ population evaluation guidelines*. LGBTQ TA Center. <http://lgbtq-ta-center.org/docs/TA%20Center/LGBTQ%20Population%20Evaluation%20Guidelines%2008-06-18.pdf>
- Essock, S. M., Frisman, L. K., & Kontos, N. J. (1998). Cost-effectiveness of assertive community treatment teams. *American Journal of Orthopsychiatry*, 68(2), 179-190. <https://doi.org/10.1037/h0080328>
- Fernandez, Z. & Barnes, A. (1978). *The Enchilada Approach to Reawakening Therapy*. La Familia Counseling Center, Sacramento, Calif.
- Fowers, A., & Wan, W. (2020, June 12). Depression and anxiety spiked among black Americans after George Floyd's death. *The Washington Post*. Retrieved July 2022, from: <https://www.washingtonpost.com/health/2020/06/12/mental-health-george-floyd-census/?arc404=true>
- Ford-Paz, R. E., Santiago, C. D., Coyne, C. A., Rivera, C., Guo, S., Rusch, D., St. Jean, N., Hilado, A., & Cicchetti, C. (2020). You're not alone: A public health response to immigrant/refugee distress in the current sociopolitical context. *Psychological Services*, 17(S1), 128-138. <https://doi.org/10.1037/ser0000381>
- Fox, K., & Post, M. (2021). Evaluating power building: Concepts and considerations for advocacy evaluators. *New Directions for Evaluation*, 2021, 59-70. <https://doi.org/10.1002/ev.20473>

Fredriksen-Goldsen, K. I. (2011). Resilience and disparities among lesbian, gay, bisexual, and transgender older adults. *The Public Policy and Aging Report*, 21(3), 3–7. <https://doi.org/10.1093/ppar/21.3.3>

Fry, H. (2021, March 22). What data can't do. *The New Yorker*, March 29, 2021 Issue. <https://www.newyorker.com/magazine/2021/03/29/what-data-cant-do>

Garfinkel, I., Sariscsany, L., Ananat, E., Collyer, S. M., Hartley, R. P., Wang, B., & Wimer, C. (2022, March). *The benefits and costs of a U.S. child allowance*. (No. w29854). National Bureau of Economic Research. <https://www.nber.org/papers/w29854>

Garneau, A. B., & Pepin, J. (2015). Cultural competence: A constructivist definition. *Journal of Transcultural Nursing*, 26(1), 9–15. <https://doi.org/10.1177/1043659614541294>

Gelman, A., Carlin, J. B., Stern, H. S., Dunson, D.B., Vehtari, A., & Rubin, D. B. (2014). *Bayesian data analysis* (3rd Edition), CRC Press, Boca Raton.

Godoy Garraza, L. G., Boyce, S. P., Walrath, C., Goldston, D. B., & McKeon, R. (2018). An economic evaluation of the Garrett Lee Smith memorial suicide prevention program. *Suicide and Life-Threatening Behavior*, 48(1), 3–11. <https://doi.org/10.1111/sltb.12321>

Godwin, M., Ruhland, L., Casson, I., MacDonald, S., Delva, D., Birtwhistle, R., Lam, M., & Seguin, R. (2003). Pragmatic controlled clinical trials in primary care: the struggle between external and internal validity. *BMC medical research methodology*, 3, 28–7. <https://doi.org/10.1186/1471-2288-3-28>

Goetzel, R. Z., Ozminkowski, R. J., Sederer, L. I., & Mark, T. L. (2002). The business case for quality mental health services: Why employers should care about the mental health and well-being of their employees. *Journal of Occupational and Environmental Medicine*, 44(4), 320–330. <https://www.jstor.org/stable/44995919>

Grantmakers for Effective Organizations. (2014). *Evaluation community change: A framework for grantmakers*. United Philanthropy Forum. https://www.unitedphilforum.org/system/files/resources/geo2014_indicators_framework.pdf

Gray, A. P., & Cote, W. (2019). Cultural connectedness protects mental health against the effect of historical trauma among Anishinabe young adults. *Public Health*, 176, 77–81. <https://doi.org/10.1016/j.puhe.2018.12.003>

Greenberg, P. E., Stiglin, L. E., Finkelstein, S. N., & Berndt, E. R. (1993). Depression: A neglected major illness. *The Journal of Clinical Psychiatry*, 54(11), 419–424.

Greenberg, P. E., Leong, S. A., Birnbaum, H. G., & Robinson, R. L. (2003). The economic burden of depression with painful symptoms. *Journal of Clinical Psychiatry*, 64, 17–23.

- Gregory, A., Skiba, R. J., & Noguera, P. A. (2010). The achievement gap and the discipline gap: Two sides of the same coin? *Educational Researcher*, 39(1), 59–68. <https://doi.org/10.3102/0013189X09357621>
- Grills, C., Villanueva, S., Subica, A. M., & Douglas, J. A. (2014). Communities creating healthy environments: Improving access to healthy foods and safe places to play in communities of color. *Preventive Medicine: An International Journal Devoted to Practice and Theory*, 69(Suppl), S117–S119. <https://doi.org/10.1016/j.ypmed.2014.10.026>
- Grills, C., Hill, C. D., Cooke, D., & Walker, A. (2018). *California reducing disparities project (crdp) phase 2 statewide evaluation: Best practices in community based participatory practice*. Prepared under California Department of Public Health contract #15-10603. Psychology Applied Research Center. Los Angeles, CA: Loyola Marymount University.
- Grills, C., Carlos Chavez, F. L., Crowder, C., De la Cruz Toledo He, E., Terry, D., & Villanueva, S. (2021, August). *Covid-19 communities of color needs assessment: Executive summary*. National Urban League. https://nul.org/sites/default/files/2022-03/21.35.NUL_.Covid_.Layout.D9_v9.pdf
- Grogger, J. (1998). Market wages and youth crime. *Journal of Labor Economics*, 16(4), 756–791.
- Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology*, 69(3), 502–510. <https://doi.org/10.1037/0022-006X.69.3.502>
- Harrell, F.E. (2015). *Regression Modeling Strategies* (2nd ed.). Springer, Cham.
- Harrell, S. P. (2015). Culture, wellness, and world “peace”: An introduction to person-environment-and-culture-emergence theory. *Community Psychology in Global Perspective*, 1(1), 16–49. doi: 10.1285/i24212113v1i1p16
- Hsieh, N. (2019). Mental health disparities by sexual orientation in the U.S.: Current patterns and recent trends. *EurAmerica*, 49(2), 201–241.
- Human Rights Campaign Foundation. (n.d.). *Glossary of terms*. <https://www.hrc.org/resources/glossary-of-terms>
- Human Rights Campaign Foundation. (2021). *The State of Mental Health in LGBTQ Communities of Color*. <https://hrc-prod-requests.s3-us-west-2.amazonaws.com/assets/BIPOC-Mental-Health-LGBTQ-2021.pdf>
- Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/13128>. <https://mhsoac.ca.gov/transparency-suite/criminal-justice/>

Intersex Society of North America. (n.d.). *DSD Guidelines*. <https://isna.org>

Jacobs, B. (2018). The marginal cost of public funds is one at the optimal tax system. *International Tax and Public Finance*, 25(4): 883–912. <https://doi.org/10.1007/s10797-017-9481-0>

Kessler R. C., Andrews G., Colpe L. J., Hiripi, E., Mroczek D. K., Normand S. L., Walters E. E., & Zaslavsky A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, 32, 959–976. doi: 10.1017/S0033291702006074

Kessler, R.C., Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J., Normand, S.L.T., Manderscheid, R.W., Walters, E.E., & Zaslavsky, A.M. (2003). Screening for serious mental illness in the general population, *Arch. Gen. Psychiatry*, 60(2):184–189. doi: 10.1001/archpsyc.60.2.184.

Kim, S. S., Lee, H.Ok, Kiang, P., Kalman, D., & Ziedonis, D. M. (2014). Factors associated with alcohol problems among Asian American college students: Gender, ethnicity, smoking and depressed mood. *Journal of Substance Use*, 19(1–2), 12–17. <https://doi.org/10.3109/14659891.2012.709912>

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, 49(2), 149–164. <https://doi.org/10.1177/1363461512444673>

Kum, S. (2017). Gay, gray, black, and blue: An examination of some of the challenges faced by older LGBTQ people of color. *Journal of Gay & Lesbian Mental Health*, 21(3), 228–239. <https://doi.org/10.1080/19359705.2017.1320742>

Lara, M., Gamboa, C., Kahramanian, M. I., Morales, L. S., & Bautista, D. E. (2005). Acculturation and Latino health in the United States: A review of the literature and its sociopolitical context. *Annual review of public health*, 26, 367–397. <https://doi.org/10.1146/annurev.publhealth.26.021304.144615>

Le, L. K. D., Esturas, A. C., Mihalopoulos, C., Chiotelis, O., Bucholc, J., Chatterton, M. L., & Engel, L. (2021). Cost-effectiveness evidence of mental health prevention and promotion interventions: A systematic review of economic evaluations. *PLoS Medicine*, 18(5), e1003606. <https://doi.org/10.1371/journal.pmed.1003606>

Lebenbaum, M., Cheng, J., de Oliveira, C., Kurdyak, P., Zaheer, J., Hancock-Howard, R., & Coyte, P. C. (2020). Evaluating the cost effectiveness of a suicide prevention campaign implemented in Ontario, Canada. *Applied Health Economics and Health Policy*, 18(2), 189–201. <https://doi.org/10.1007/s40258-019-00511-5>

Lehman, A. F., Dixon, L., Hoch, J. S., DeForge, B., Kernan, E., & Frank, R. (1999). Cost-effectiveness of assertive community treatment for homeless persons with severe mental illness. *British Journal of Psychiatry*, 174, 346–352. <https://doi.org/10.1192/bjp.174.4.346>

- Lindberg, A. J. (2009). *Examining the program costs and outcomes of San Francisco's behavioral health court: Predicting success*. San Francisco, Superior Court of California, Office of Collaborative Justice Programs.
- Liu, C. M., & Suyemoto, K. L. (2016). The effects of racism-related stress on Asian Americans: Anxiety and depression among different generational statuses. *Asian American Journal of Psychology, 7*(2), 137–146. <https://doi.org/10.1037/aap0000046>
- Loeppke, R., Taitel, M., Haufler, V., Parry, T., Kessler, R. C., & Jinnett, K. (2009). Health and productivity as a business strategy: A multiemployer study. *Journal of Occupational and Environmental Medicine, 41*(1), 411–428.
- Lyon, A. R., Pullmann, M. D., Walker, S. C., & D'Angelo, G. (2017). Community-sourced intervention programs: Review of submissions in response to a statewide call for "promising practices." *Administration and Policy in Mental Health and Mental Health Services Research, 44*(1), 16–28. <https://doi.org/10.1007/s10488-015-0650-0>
- Marrast, L., Himmelstein, D. U., & Woolhandler, S. (2016). Racial and ethnic disparities in mental health care for children and young adults: A national study. *International Journal of Health Services: Planning, Administration, Evaluation, 46*(4), 810–824. <https://doi.org/10.1177/0020731416662736>
- Martinez, K. (2008). *Community defined evidence: What is it? And what can it do for Latinas/os?* El Boletín The Newsletter of the National Latina/o Psychological Association. <https://www.nlpa.ws/assets/docs/newsletters/el%20boletin%20fall-winter%202008.pdf>
- Martinez, K., Callejas, M. A., & Hernandez, M. (2010). Community-defined evidence: A bottom-up behavioral health approach to measure what works in communities of color. *Emotional and Behavioral Disorders in Youth, 10*(1), 11–16. <https://nirn.fpg.unc.edu/sites/nirn.fpg.unc.edu/files/imce/documents/Community%20Defined%20Evidence.pdf>
- Masotti, P., Dennem, J., Hadani, S., Banuelos, K., King, J., Linton, J., Lockhart, B., & Patel, C. (2020). The culture is prevention project: Measuring culture as a social determinant of mental health for Native/Indigenous peoples. *American Indian and Alaska Native Mental Health Research, 27*(1), 86–111. <https://doi.org/10.5820/aian.2701.2020.86>
- McBain, R. K., Ashwood, J. S., Eberhart, N. K., Montemayor, C. K., & Azhar, G. S. (2018). *Evaluating cost savings associated with Los Angeles county's mental health full service partnerships*. RAND Corporation. https://www.rand.org/pubs/research_reports/RR2783.html
- McCann, E., & Sharek, D. (2014). Challenges to and opportunities for improving mental health services for lesbian, gay, bisexual, and transgender people in Ireland: A narrative account. *International Journal of Mental Health Nursing, 23*(6), 525–533. <https://doi.org/10.1111/inm.12081>

- McCollister, K. E., French, M. T., Prendergast, M., Wexler, H., Sacks, S., & Hall, E. (2003). Is in-prison treatment enough? A cost-effectiveness analysis of prison-based treatment and aftercare services for substance-abusing offenders. *Law & Policy*, 25(1), 63–82.
<https://doi.org/10.1111/1467-9930.00140>
- McElreath, R. (2020). *Statistical rethinking*. CRC Press, Boca Raton.
- Mclvor, O., Napoleon, A. & Dickie, K.M. (2009). Language and culture as protective factors for at-risk communities. *International Journal of Indigenous Health*, 5(1).
<https://doi.org/10.18357/ijih51200912327>
- Mihken, G.A. & Johnson, D.E. (1984). *Analysis of messy data. Volume 1: designed experiments*. Van Nostrand Reinhold. New York, New York. USA. P. 127.
- Minkler, M., & Wallerstein, N. (2003). Part one: Introduction to community-based participatory research. *Community-based Participatory Research for Health*. San Francisco, CA: Jossey-Bass, 5–24.
- Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *The Journal of Nervous and Mental Disease*, 180(2), 111–116.
- Mrazek, P., & Haggerty, R. (1994). Risk and protective factors for the onset of mental disorders. *Reducing Risks for Mental Disorders: Frontiers for preventive intervention research*. Washington D.C.: National Academies Press.
- National Academies of Sciences, Engineering, and Medicine. (2022). *Measuring sex, gender identity, and sexual orientation*. The National Academies Press. <https://doi.org/10.17226/26424>
- National Institute of Health. (2022, January). *Mental Illness*. Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness#part_2538
- Nebelkopf, E., King, J., Wright, S., Schweigman, K., Lucero, E., Habte-Michael, T., & Cervantes, T. (2011). Editor's introduction: Native American evidence-based practices. *Journal of Psychoactive Drugs*, 43(4), 263–268. <https://doi.org/10.1080/02791072.2011.628909>
- NORC at the University of Chicago. (2021, September). *The 2020–2021 California Communities Mental Health Services Survey (OCMHSS)*. Final Report.
- Office of Minority Health. (n.d.). *National culturally and linguistically appropriate services standards*. United States Department of Health and Human Services.
<https://thinkculturalhealth.hhs.gov/clas/standards>

Olfson, M., Broadhead, W.E., Weissman, M.M., Leon, A.C., Farber, L., Hoven, C., & Kathol, R. (1996). Subthreshold psychiatric symptoms in a primary care group practice. *Archives of General Psychiatry* 53, 880–886.

Padilla-Frausto, D.I., Grant, D., & Aguilar-Gaxiola, S. (2007). *Assessing adult mental health needs in California using the California Health Interview Survey (CHIS)*. Report prepared for the Mental Health Services Oversight and Accountability Commission. Retrieved July 2022, from http://archive.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC_072811_Tab4_UCD_CHIS.pdf

Palmquist, R. B., Phaneuf, D. J., & Smith, V., K. (2007). *Measuring the values for time*. National Bureau of Economic Research Working Paper Series, No. 13594. doi:10.3386/w13594. <https://www.nber.org/papers/w13594>

Perkins, D. V. (1987). Bayesian inference from qualitative and quantitative data in program evaluation, *J. Community Psych* 15(2): 187–204

Perkins, C. A., Stephan, J. J., & Beck, A. J. (1995). *Jails and jail inmates 1993–94*. U.S. Department of Justice, Bureau of Justice Statistics. <https://bjs.ojp.gov/content/pub/pdf/jaj93.pdf>

Pil, L., Pauwels, K., Muijzers, E., Portzky, G., & Annemans, L. (2013). Cost-effectiveness of a helpline for suicide prevention. *Journal of Telemedicine and Telecare*, 19(5), 273–281. <https://doi.org/10.1177/1357633X13495487>

Pirraglia, P. A., Hampton, J. M., Rosen, A. B., & Witt, W. P. (2011). Psychological distress and trends in healthcare expenditures and outpatient healthcare. *The American Journal of Managed Care*, 17(5), 319–328.

Pollard, W.E. (1986). *Bayesian statistics for evaluation research: An introduction*. Sage, Beverly Hills.

Pomerantz, A., Cole, B. H., Watts, B. V., & Weeks, W. B. (2008). Improving efficiency and access to mental health care: Combining integrated care and advanced access. *General Hospital Psychiatry*, 30(6), 546–551. <https://doi.org/10.1016/j.genhosppsych.2008.09.004>

Price-Feeney, M., Green, A. E., & Dorison, S. (2020). Understanding the mental health of transgender and nonbinary youth. *Journal of Adolescent Health*, 66(6), 684–690. <https://doi.org/10.1016/j.jadohealth.2019.11.314>

Prochaska, J.J., Sung, H.Y., Max, W., Shi, Y., & Ong, M. (2012). Validity study of the K6 scale as a measure of moderate mental distress based on mental health treatment need and utilization. *International Journal of Methods in Psychiatric Research*, 21(2), 88–97. doi: 10.1002/mpr.1349

Psychology Applied Research Center, Los Angeles, CA: Loyola Marymount University (2017). *California*

Reducing Disparities Project Phase 2 Statewide Evaluation Guidelines.

Psychology Applied Research Center, Los Angeles, CA: Loyola Marymount University (2017). *California Reducing Disparities Project Phase 2 Statewide Evaluation Plan v4.0.*

R Core Team (2021). *R: A language and environment for statistical computing*. R Foundation for Statistical Computing, Vienna, Austria. <https://www.R-project.org/>

Rhodes, S. D., Mann, L., Simán, F. M., Song, E., Alonzo, J., Downs, M., Lawlor, E., Martinez, O., Sun, C. J., O'Brien, M. C., Reboussin, B. A., & Hall, M. A. (2015). The impact of local immigration enforcement policies on the health of immigrant Hispanics/Latinos in the United States. *American Journal of Public Health, 105*(2), 329–337. <https://doi.org/10.2105/ajph.2014.302218>

Robertson, L., Akre, E. R., & Gonzales, G. (2021). Mental health disparities at the intersections of gender identity, race, and ethnicity. *LGBT Health, 8*(8), 526–535. <https://doi.org/10.1089/lgbt.2020.0429>

Roche, K. M., Vaquera, E., White, R. M. B., & Rivera, M. I. (2018). Impacts of immigration actions and news and the psychological distress of U.S. Latino parents raising adolescents. *Journal of Adolescent Health, 62*(5), 525–531. <https://doi.org/10.1016/j.jadohealth.2018.01.004>

Rubin, D. B. (1987). *Multiple imputation for nonresponse in surveys*. John Wiley & Sons, New York.

Rubin, D. B. (1996). Multiple imputation after 18+ years. *Journal of the American Statistical Association, 91*(434), 473–489.

Safran, M. A., Mays, R. A., Jr, Huang, L. N., McCuan, R., Pham, P. K., Fisher, S. K., McDuffie, K. Y., & Trachtenberg, A. (2009). Mental health disparities. *American Journal of Public Health, 99*(11), 1962–1966. <https://doi.org/10.2105/AJPH.2009.167346>

Schafer, J. L. (1999). Multiple imputation: a primer. *Statistical methods in medical research, 8*(1), 3–15. <https://doi.org/10.1177/096228029900800102>

Shea, H., Mosley-Howard, G. S., Baldwin, D., Ironstrack, G., Rousmaniere, K., & Schroer, J. E. (2019). Cultural revitalization as a restorative process to combat racial and cultural trauma and promote living well. *Cultural Diversity and Ethnic Minority Psychology, 25*(4), 553–565. <https://doi.org/10.1037/cdp0000250>

Sheehan, D. V. (2000). Sheehan disability scale. *Handbook of psychiatric measures, 113–115.*

Skeem, J. L., Montoya, L., & Manchak, S. M. (2018). Comparing costs of traditional and specialty probation for people with serious mental illness. *Psychiatric Services, 69*(8), 896–902. <https://doi.org/10.1176/appi.ps.201700498>

- Snowshoe, A., Crooks, C. V., Tremblay, P. F., & Hinson, R. E. (2017). Cultural connectedness and its relation to mental wellness for First Nations youth. *The Journal of Primary Prevention, 38*(1–2), 67–86. <https://doi.org/10.1007/s10935-016-0454-3>
- Spiegelhalter, D. J., Abrams, K. R., & Myles, J. P. (2004). *Bayesian approaches to clinical trials and health-care evaluation*. Wiley, New York.
- State of California. (2022). *Regions*. <https://census.ca.gov/regions/>
- Steele, L. S., Daley, A., Curling, D., Gibson, M. F., Green, D. C., Williams, C. C., & Ross, L. E. (2017). LGBT identity, untreated depression, and unmet need for mental health services by sexual minority women and trans-identified people. *Journal of Women's Health, 26*(2), 116–127. <https://doi.org/10.1089/jwh.2015.5677>
- Stolk, Y., Kaplan, I., & Szwarc, J. (2014). Clinical use of the Kessler psychological distress scales with culturally diverse groups, *Int. J. Methods Psychiatr. Res. 23*(2): 161–183. doi: 10.1002/mpr.1426
- Substance Abuse and Mental Health Services Administration. (2021). *Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health* (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>
- Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525–548. <https://doi.org/10.1146/annurev.psych.60.110707.163651>
- Tukey, J. W. (1977). *Exploratory Data Analysis*. Reading, Massachusetts: Addison-Wesley.
- Turner, E. A., Malone, C. M., & Douglas, C. (2019). Barriers to mental health treatment for African Americans: Applying a model of treatment initiation to reduce disparities. In M. T. Williams, D. C. Rosen, & J. W. Kanter (Eds.), *Eliminating race-based mental health disparities: Promoting equity and culturally responsive care across settings* (pp. 27–42). Context Press/New Harbinger Publications.
- Underwood, L. A., & Washington, A. (2016). Mental illness and juvenile offenders. *International Journal of Environmental Research and Public Health, 13*(2), 228. <https://doi.org/10.3390/ijerph13020228>
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. <https://www.ncbi.nlm.nih.gov/books/NBK44243/>
- Van Buuren, S., & Groothuis-Oudshoorn, K. (2011). Mice: Multivariate imputation by chained equations in R.

Journal of Statistical Software, 45(3), 1–67. <https://doi.org/10.18637/jss.v045.i03>

Vandekerckhove, J., Rouder, J. N., & Kruschke, J. K. (2018). Editorial: Bayesian methods for advancing psychological science. *Psychonomic Bulletin & Review*, 25(1), 1–4. <https://doi.org/10.3758/s13423-018-1443-8>

Varaiya, P. (2005). What we've learned about highway congestion. *ACCESS Magazine*, 1(27), 2–9. <https://escholarship.org/uc/item/31j7k3b4>

Viswanathan, M., Ammerman, A., Eng, E., Garlehner, G., Lohr, K. N., Griffith, D., Rhodes, S., Samuel-Hodge, C., Maty, S., Lux, L., Webb, L., Sutton, S. F., Swinson, T., Jackman, A., & Whitener, L. (2004). Community-based participatory research: Assessing the evidence. *Evidence Report/Technology Assessment (Summary)*, 99, 1–8.

Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., Neria, Y., Bradford, J. E., Oquendo, M. A., & Arbuckle, M. R. (2017). Challenges and opportunities in global mental health: a research-to-practice perspective. *Current psychiatry reports*, 19(5), 1–10.

Wakida, E. K., Talib, Z. M., Akena, D., Okello, E. S., Kinengyere, A., Mindra, A., & Obua, C. (2018). Barriers and facilitators to the integration of mental health services into primary health care: A systematic review. *Systematic Reviews*, 7(1), 211. <https://doi-org.electra.lmu.edu/10.1186/s13643-018-0882-7>

Warner, L. R., & Shields, S. A. (2013). The intersections of sexuality, gender, and race: Identity research at the crossroads. *Sex Roles: A Journal of Research*, 68(11–12), 803–810. <https://doi.org/10.1007/s11199-013-0281-4>

Weissman, J. S., Pratt, L. A., Miller, E. A., & Parker, J. D. (2015). *Serious psychological distress among adults, United States, 2009–2013 (Vol. 203)*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Wickham, H., François R., Henry, L., & Müller, K. (2021). *dplyr: A grammar of data manipulation*. R package version 1.0.7. <https://CRAN.R-project.org/package=dplyr>

Wickham, H., & Miller, E. (2021). *Haven: Import and export 'SPSS', 'Stata' and 'SAS' Files*. R package version 2.4.3. <https://CRAN.R-project.org/package=haven>

World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options*. <https://apps.who.int/iris/handle/10665/43027>

Yang, W. (2018). Ethnic identity, second generation Chinese Americans, and mental well-being [ProQuest Information & Learning]. In *Dissertation Abstracts International: Section B: The Sciences and Engineering* (Vol. 79, Issue 9–B(E)).

- Yeganeh, H., Su, Z., & Chrysostome, E. V. M. (2004). A critical review of epistemological and methodological issues in cross-cultural research. *Journal of Comparative International Management*, 7(2). Retrieved from <https://journals.lib.unb.ca/index.php/JCIM/article/view/459>
- Young, C., & Holsteen, K. (2017). Model uncertainty and robustness: A computational framework for multimodel analysis. *Sociological Methods & Research*, 46(1), 3-40.
- Zamudio, G., Wang, C. D. C., & Jin, L. (2020). Adult attachment, social self-efficacy, Familismo, and psychological wellbeing: A cross-cultural comparison. *The Counseling Psychologist*, 48(7), 922-952. <https://doi.org/10.1177/0011000020930637>

Appendices

EXECUTIVE
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APPENDIX 1: CRDP OVERALL REFERRALS

Table 1: CRDP overall Number of Unique Individuals who Received Referrals, Linkages & Navigation (n=24 IPPs)

Age Group	# Referrals*	# Linkages to Care	# Service Navigation
Adults	15,701 (n=21 IPPs)	5,210 (n=19 IPPs)	2,329 (n=21 IPPs)
Adolescents	1,723 (n=14 IPPs)	401 (n=11 IPPs)	606 (n=15 IPPs)
Children	175 (n=7 IPPs)	21 (n=5 IPPs)	59 (n=6 IPPs)
TOTAL	17,599 referrals by 24 IPPs	5,632 of 17,599 (32% received linkage)	2,994 of 17,599 (17% received service navigation)

*Note: Some IPPs provided referrals to multiple age groups and counts may be duplicative across age categories.

Table 1.1: CRDP overall Number of Referrals* by Type and Subtype

Service Referral Type	Total	IPPs
Mental Health	6,439	24
Counseling, therapy, wellness	5,247	24
Substance Abuse (e.g., AOD treatment)	416	20
Sexual Assault	282	15
Psychiatric Care	229	9
Domestic Violence	220	13
Other Mental Health	43	7
Anger Management	2	1
Basic Needs	4,775	20
Food Assistance (e.g., food bank)	2,070	17
Financial Assistance	922	14
Housing, Rent, & Utilities	869	17
Transportation	367	13
Clothing and Furniture Assistance	339	8
Other Basic Needs	190	4
Internet Assistance	18	1
Health Care	4,392	18
Primary Health Care (e.g., well-check, vaccines, etc.)	2,691	17
Nutrition	482	4
COVID-Related Health Supports	379	4
Dental/Optomety/Prescription	356	8
Other Health	195	5
Medical Benefits and Insurance	140	5
Illness specific (HIV/AIDS, dialysis)	77	4
Transgender Health Care	49	1
Health Education	19	1
Female Reproductive Health	2	2
Medical Supplies and Equipment	2	1
Personal Growth & Development	2,188	15
Social/Cultural Enrichment Programs	1,365	11
Support/Mentoring	326	3
Faith-Based or Spiritual Services	230	7
Other (e.g., entrepreneurial training, police athletic league)	141	5
Volunteer Services	120	9
Gang Violence Services	6	1

Service Referral Type	Total	IPPs
Legal/Advocacy	1,707	19
Immigration Services	1,164	13
Other (e.g., free legal services, tenant rights, etc.)	498	16
Legal Mediation (e.g., divorce, custody)	35	3
Child Welfare	8	3
Juvenile Justice	2	1
Education	537	14
Academic Support (e.g., college applications, school placement)	291	12
Tutoring	151	8
Other Education	77	3
Adult Education	18	2
Employment/Career	507	13
Parenting classes, early childcare support	141	7
Specialty Care	73	9
"Multi-Category" (e.g., housing, education, job training, etc.)	1,143	16
TOTAL	21,902	24

*Note: Any 1 individual may have received more than 1 referral; Total Ns across categories are duplicative.

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2A: AFRICAN AMERICAN HUB-LEVEL TABLES

Table 2a.1.1: African American Hub Number of Unique Individuals who Received Referrals, Linkages & Navigation (n=5 IPPs)

Age Group	# Referrals*	# Linkages to Care	# Service Navigation
Adults	133 (n=4 IPPs)	19 (n=2 IPPs)	99 (n=2 IPPs)
Adolescents	232 (n=2 IPPs)	84 (n=2 IPPs)	90 (n=3 IPPs)
Children	56 (n=2 IPPs)	11 (n=2 IPPs)	24 (n=3 IPPs)
TOTAL	421 referrals by 5 IPPs	114 of 421 (27% received a linkage)	213 of 421 (51% received service navigation)

*Note: Some IPPs provided referrals to multiple age groups and counts may be duplicative across age categories.

Table 2a.1.2: African American Hub Number of Referrals* by Type and Subtype

Referral Type and Subtype	# Referrals Provided	#IPP's
Basic Needs	174	3
Transportation	70	3
Food Assistance (e.g., food bank)	34	3
Housing, Rent, & Utilities	34	3
Financial Assistance	30	3
Clothing and Furniture Assistance	6	1
Education	160	4
Academic Support (e.g., college applications, school placement)	91	4
Tutoring	66	2
Other Education	3	1
Mental Health	141	5
Counseling, therapy, wellness	92	5
Substance Abuse (e.g., AOD treatment)	30	4
Sexual Assault	5	3
Psychiatric Care	7	2
Other Mental Health	4	1
Domestic Violence	3	1
Personal Growth & Development	141	2
Social/Cultural Enrichment Programs	107	2
Volunteer Services	16	1
Other (e.g., entrepreneurial training, police athletic league)	12	1
Faith-Based or Spiritual Services	6	1
Employment/Career	116	3
Health	63	4
Primary Health Care (e.g., well-check, vaccines, etc.)	52	4
Dental/Optometry/Prescription	8	2
Nutrition	2	1
Other Health	1	1
Legal/Advocacy	13	3
Other (free legal services, tenant rights, etc.)	7	2
Immigration Services	2	1
Child Welfare	2	1
Juvenile Justice	2	1
Specialty Care	7	2
Parenting classes, early childcare support	1	1
"Multi-Category" (e.g., housing, education, job training, etc.)	61	3
TOTAL	877	5

Table 2a.2.1: African American Adult Hub Demographic Populations Served

African American Adult (N=441)		
Variable	%	
Racial Groups (n=429)	% Total	% Multi-Race
African American/Black	95%*	7%
Latinx	5%	3%
White	3%	3%
American Indian/Alaska Native	2%	-
Asian	1%	1%
Native Hawaiian/Pacific Islander	-	< 0.01%
Age (n=433)		
18-29 years	46%	
30-39 years	16%	
40-44 years	7%	
45-49 years	7%	
50-64 years	16%	
65+ years	9%	
Gender Identity (n=425)		
Cisgender Woman/Female	55%	
Cisgender Man/Male	39%	
Genderqueer/Non-Binary	1.4%	
Transgender Man/Male	0.9%	
Transgender Woman/Female	0.7%	
Sexual Orientation (n=427)		
Straight/Heterosexual	95%	
LGBQ+	5%	
LGBQ+ Identities		
Bisexual	2%	
Queer	1%	
Pansexual	1%	
Asexual/Aromantic	1%	
Gay/Lesbian	0.5%	
Questioning	0.5%	
Something Else	0.5%	
English Fluency (n=430)		
Fluent	86%	
Somewhat fluent	0.7%	
Not very well	0.5%	
Knows some vocabulary	13%	
Not at all	0.7%	
Foreign Born (n=427)	3%	
Refuaeae Status (n=359)	0.6%	

*Note: Any 1 individual may have received more than 1 referral; Total N's across categories are duplicative.

Table 2a.2.2: African American Adolescent Hub Demographic Populations Served

African American Adolescent (N=164)		
Variable	%	
Racial Groups (n=161)	% Total	% Multi-Race
African American/Black	91%	-
American Indian/Alaska Native	7%	5%
Latinx	7%	5%
Asian	4%	3%
White	7%	7%
Native Hawaiian/Pacific Islander	1%	1%
Age (n=159)		
12 years	18%	
13 years	28%	
14 years	7%	
15 years	12%	
16 years	18%	
17 years	17%	
Gender Identity (n=152)		
Cisgender Woman/Female	57%	
Cisgender Man/Male	36%	
Transgender Man/Male	2%	
Genderqueer/Non-Binary	1%	
Sexual Orientation (n=147)		
Straight/Heterosexual	79%	
LGBQ+	21%	
LGBQ+ Identities		
Bisexual	12%	
Gay/Lesbian	5%	
Pansexual	1%	
Asexual/Aromantic	1%	
Questioning	0.7%	
English Fluency (n=158)		
Fluent	94%	
Somewhat fluent	5%	
Not at all	0.6%	
Foreign Born (n=154)	1%	
Refugee Status (n=134)	3%	

Table 2a.3.1: African American Adult Hub Numbers Served by Mental Health Need

African American Adult (N=441)	
Variable	%
Mental Health Need (n=356)	
No Need	41%
Need	59%
PARC Approach (n=210)	
Unmet	31%
Met	64%
Mental Health Helping Professional Seen ¹	
Traditional	37%
Community	20%
Primary Care Physician	30%
Mental Health	42%
CHIS Approach (n=210)	
Unmet	43%
Met	53%
Mainstream ²	19%
Health Insurance Coverage (n=374)	
Coverage	87%
No Coverage	13%
Coverage: Uses MH Services	37%
No Coverage: Uses MH Services	3%
Coverage: Takes Prescription Meds	21%
No Coverage: Takes Prescription Meds	0.3%
Coverage: Median # Visits ³	3
No Coverage: Median # Visits ³	2

¹ This is a multiple response item; participants selected all the categories that were true for them; percentages do not add up to 100

² Primary care physician or general practitioner; MH professional (counselor, therapist, psychologist, psychiatrist or social worker)

³ Different sample size due to skip logic

Table 2a.3.2: African American Adolescent Hub Numbers Served by Mental Health Need

African American Adolescent (N=164)	
Variable	%
Mental Health Need (n=134)	
No Need	60%
Need	40%
PARC Approach (n=53)	
Unmet	28%
Met	64%
Mental Health Helping Professional Seen ¹	
Traditional	34%
Community	36%
Primary Care Physician	30%
Mental Health	42%
CHIS Approach (n=53)	
Unmet	36%
Met	57%
Mainstream ²	17%

¹ This is a multiple response item; participants selected all the categories that were true for them; percentages do not add up to 100

² Primary care physician or general practitioner; MH professional (counselor, therapist, psychologist, psychiatrist or social worker)

Table 2a.4.1: African American Adult Hub Numbers Served by Psychological Distress and Functioning

African American Adult (N=441)	
Variable	%
Psychological Distress (K6)¹ (n=390)	
Low (K6<5)	46%
Moderate (5<=K6<=12)	42%
Serious (K6>=13)	12%
Moderate K6 (5<=K6<=12) by Functional Impairment (SDS)²	
Work/School (n=136)	
Not at all	29%
Some	42%
A lot	29%
Household Chores (n=152)	
Not at all	37%
Some	35%
A lot	28%
Social Life (n=155)	
Not at all	26%
Some	45%
A lot	29%
Relationships with Friends/Family (n=157)	
Not at all	25%
Some	47%
A lot	28%
Serious K6 (K6>=13) by Functional Impairment (SDS)²	
Work/School (n=37)	
Not at all	8%
Some	38%
A lot	54%
Household Chores (n=44)	
Not at all	9%
Some	36%
A lot	55%
Social Life (n=43)	
Not at all	9%
Some	30%
A lot	61%
Relationships with Friends/Family (n=44)	
Not at all	7%
Some	34%
A lot	59%
Moderate K6 (5<=K6<=12) by Number of Functional Impairments (n=164)	
None	17%
1 Impairment	8%
2 Impairment	15%
3 Impairment	19%
4 Impairment	41%
Serious K6 (K6>=13) by Number of Psychological Functional Impairments (n=46)	
None	4%
1 Impairment	2%
2 Impairment	7%
3 Impairment	28%
4 Impairment	59%
Moderate K6 (5<=K6<=12) by Mental Health Need (n=139)	
Mental Health Need	65%
No Mental Health Need	35%
Serious K6 (K6>=13) by Mental Health Need (n=43)	
Mental Health Need	91%
No Mental Health Need	9%

¹ Kessler-6: In the past 30 days, how often have you felt: nervous, hopeless, restless/fidgety, depressed, that everything was an effort, worthless (Scale: 4=All of the time to 0=None of the time; range of responses was 0-24)

² Sheehan Disability Scale: Worst month past year, did your emotions interfere with: work/school performance, household chores, social life, relationship with friends and family (Scale: 2=A lot to 0=Not at all; range of responses was 0-8)

Table 2a.4.2: African American Adolescent Hub Numbers Served by Psychological Distress and Functioning

African American Adult (N=164)	
Variable	%
Psychological Distress (K6)¹ (n=146)	
Low (K6<5)	49%
Moderate (5<=K6<=12)	40%
Serious (K6>=13)	11%
Moderate K6 (5<=K6<=12) by Functional Impairment (SDS)²	
School/Homework (n=52)	
Not at all	37%
Some	48%
A lot	15%
With friends (n=54)	
Not at all	45%
Some	48%
A lot	7%
At Home (n=54)	
Not at all	48%
Some	48%
A lot	4%
Serious K6 (K6>=13) by Functional Impairment (SDS)²	
School/Homework (n=16)	
Some	19%
A lot	81%
With friends (n=16)	
Not at all	12%
Some	19%
A lot	69%
At Home (n=16)	
Some	38%
A lot	62%
Moderate K6 (5<=K6<=12) by Number of Functional Impairments (n=58)	
None	25%
1 Impairment	19%
2 Impairment	28%
3 Impairment	28%
Serious K6 (K6>=13) by Number of Psychological Functional Impairments (n=16)	
None	0%
1 Impairment	0%
2 Impairment	12%
3 Impairment	88%
Moderate K6 (5<=K6<=12) by Mental Health Need (n=44)	
Mental Health Need	48%
No Mental Health Need	52%
Serious K6 (K6>=13) by Mental Health Need (n=11)	
Mental Health Need	100%

Table 2a.5.1: African American Adult Hub Numbers Served by Protective Factors

African American Adult (N=441)	
Variable	%
Your culture gives you strength¹ (n=435)	
Strongly Agree/Agree	87%
Neutral	11%
Strongly Disagree/Disagree	2%
Your culture is important to you¹ (n=437)	
Strongly Agree/Agree	94%
Neutral	5%
Strongly Disagree/Disagree	1%
Your culture helps you to feel good about who you are¹ (n=435)	
Strongly Agree/Agree	88%
Neutral	10%
Strongly Disagree/Disagree	2%
You feel connected to spiritual/religious traditions of the culture you were raised in¹ (n=433)	
Strongly Agree/Agree	73%
Neutral	18%
Strongly Disagree/Disagree	8%
Felt connected to your culture² (n=415)	
All/Most of the time	71%
Some of the time	21%
A Little/None of the time	8%
Felt balanced in mind, body, spirit and soul² (n=410)	
All/Most of the time	57%
Some of the time	33%
A Little/None of the time	10%
Felt marginalized or excluded from society² (n=410)	
All/Most of the time	21%
Some of the time	32%
A Little/None of the time	47%
Felt isolated and alienated from society² (n=410)	
All/Most of the time	18%
Some of the time	23%
A Little/None of the time	59%

¹ Items anchored "at present"² Items anchored in "past 30 days"**Table 2a.5.2: African American Adolescent Hub Numbers Served by Protective Factors**

African American Adolescent (N=164)	
Variable	%
Your culture gives you strength¹ (n=163)	
Strongly Agree/Agree	79%
Neutral	18%
Strongly Disagree/Disagree	3%
Your culture is important to you¹ (n=164)	
Strongly Agree/Agree	88%
Neutral	9%
Strongly Disagree/Disagree	3%
Your culture helps you to feel good about who you are¹ (n=164)	
Strongly Agree/Agree	84%
Neutral	13%
Strongly Disagree/Disagree	3%
You feel connected to spiritual/religious traditions of the culture you were raised in¹ (n=162)	
Strongly Agree/Agree	63%
Neutral	27%
Strongly Disagree/Disagree	10%
Felt connected to your culture² (n=163)	
All/Most of the time	55%
Some of the time	30%
A Little/None of the time	15%
Felt balanced in mind, body, spirit and soul² (n=163)	
All/Most of the time	44%
Some of the time	39%
A Little/None of the time	17%
Felt marginalized or excluded from society² (n=161)	
All/Most of the time	21%
Some of the time	23%
A Little/None of the time	56%
Felt isolated and alienated from society² (n=163)	
All/Most of the time	19%
Some of the time	18%
A Little/None of the time	63%

¹ Items anchored "at present"² Items anchored in "past 30 days"

Table 2a.6.1: African American Adult Hub Numbers Served by Stigma/Barriers

African American Adult (N=441)	
Variable	% Agree
You were planning or already getting help from a...	
Traditional helping professional (n=329)	42%
Community helping professional (n=318)	40%
You did not know of or have never heard of these types of mental health professionals (n=343)	21%
Structural Barriers	
No transportation (n=295)	21%
Lack of time (n=291)	37%
Cost of treatment (n=288)	33%
Prejudice Barriers	
Limited English (n=279)	8%
Race/ethnicity (n=277)	23%
Age (n=276)	12%
Religious or spiritual practice (n=272)	13%
Gender identity (n=276)	9%
Sexual orientation (n=272)	8%
Attitudinal Barriers	
Psychiatric hospitalization (n=286)	14%
Might have to take prescription medication (n=286)	22%
Treatment won't help (n=280)	31%
Uncomfortable talking about problems (n=280)	28%
Can handle problem on my own (n=288)	53%
Do not need treatment (n=287)	33%
Stigma Barriers	
Negative effect on job (n=288)	17%
Lack of confidentiality (n=288)	18%
Negative opinion from community (n=288)	18%

Table 2a.6.2: African American Adolescent Hub Numbers Served by Stigma/Barriers

African American Adult (N=164)	
Variable	% Agree
You were planning or already getting help from a...	
Traditional helping professional (n=116)	19%
Community helping professional (n=116)	31%
You did not know of or have never heard of these types of mental health professionals (n=122)	25%
Structural Barriers	
No transportation (n=104)	6%
Lack of time (n=104)	22%
Cost of treatment (n=98)	1%
Did not know where to get help (n=103)	17%
Prejudice Barriers	
Limited English (n=100)	4%
Race/ethnicity (n=97)	11%
Age (n=98)	10%
Religious or spiritual practice (n=97)	5%
Gender identity (n=95)	6%
Sexual orientation (n=99)	7%
Attitudinal Barriers	
Did not want to talk to stranger (n=99)	47%
Thought issue wasn't serious enough (n=93)	39%
Can solve issue on my own (n=95)	64%
Uncomfortable talking with them (n=89)	36%
Stigma Barriers	
Embarrassed about what you were going through (n=101)	19%
Worried friends would find out (n=95)	19%
Negative opinion from family/community (n=103)	17%
Negative opinion from peers in school (n=103)	16%

Table 2a.7.1: African American Percentage of CDEP Respondents Scoring 3.51 or above on MHSIP**Subscale Items**

Highest and lowest percent's across subscale items are in bold

Subscale Domains	MHSIP Adult Items (N=254)	% strongly agree/agree	MHSIP Adolescent items (N=111)	% strongly agree/agree
General Satisfaction Subscale (Please answer based on the CDEP services, program, or activities)	I like the services that I received here.	96%	Overall, I am satisfied with the services I received.	79%
	If I had other choices, I would still get services from this agency.	94%	The people helping me stuck with me no matter what.	79%
	I would recommend this agency to a friend or family member.	94%	I felt I had someone to talk to when I was troubled.	79%
			I received services that were right for me.	81%
Access Subscale (Please answer based on the CDEP services, program, or activities)			I got the help I wanted.	80%
	The location of services was convenient.	90%	The location of services was convenient for me.	76%
	Services were available at times that were good for me.	91%	Services were available at times that were convenient for me.	76%
	Staff were willing to see me as often as I felt it was necessary.	94%		
Outcomes Subscale (As a direct result of my involvement in the program...)	I deal more effectively with my daily problems.	89%	I am better at handling daily life.	75%
	I do better in school and/or work.	79%	I am doing better in school and/or work.	74%
	My symptoms/problems are not bothering me as much.	77%	I get along better with friends and other people.	69%
			I get along better with family members.	68%
Social Connectedness Subscale (As a direct result of my involvement in the program...)			I am better able to cope when things go wrong.	72%
			I am satisfied with my family life right now.	73%
			I am better able to do things I want to do.	68%
			I know people who will listen and understand me when I need to talk.	77%
			I have people that I am comfortable talking with about my problem(s).	83%
			In a crisis, I would have the support I need from family or friends.	85%
			I have people with whom I can do enjoyable things.	87%

Table 2a.7.2: African American MHSIP Language Assistance Items (written, oral)

MHSIP Linguistic Competence Items	Adult (N=254)	Adolescent (N=111)
Were the services you received [CDEP program] in the language you prefer?	98%	92%
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?	98%	90%

Table 2a.7.3: African American Percentage of CDEP Respondents Scoring 3.51 or above on (1) CBCI Subscale Items by Age Group

Highest and lowest percent's across subscale items are in bold

Subscale Domains	CBCI Adult Items (N=254)	% strongly agree/ agree	CBCI Adolescent Items (N=111)	% strongly agree/ agree
Respectful Behavior (Please answer based on the CDEP services, program, or activities)	The staff here treat me with respect.	99%	Staff treated me with respect.	88%
	The staff here don't think less of me because of the way I talk.	96%	Staff spoke with me in a way that I understood.	83%
	The staff here respect my race and/or ethnicity.	98%	Staff were sensitive to my cultural/ ethnic background.	71%
	The staff here respect my religious and/or spiritual beliefs.	95%	Staff respected my religious/ spiritual beliefs.	82%
	The staff here respect my gender identity and/or sexual orientation.	98%		

Table 2a.7.4: African American Percentage of Adult CDEP Respondents Scoring 3.51 or above on (3) CBCI Subscales

Highest and lowest percent's across subscale items are in bold

Subscale	CBCI Adult items (N=254)	% strongly agree/ agree
Patient-Provider-Organization Interactions (Please answer based on the CDEP services, program, or activities)	When I first called or came here, it was easy to talk to the staff.	93%
Understanding of Indigenous Practices (Please answer based on the CDEP services, program, or activities)	Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	94%
Acceptance of Cultural Differences (Please answer based on the CDEP services, program, or activities)	The people who work here respect my cultural beliefs, remedies and healing practices.	97%
	Staff here understand that people of my racial and/or ethnic group are not all alike.	97%
	Staff here understand that people of my gender and/or sexual orientation group are not all alike.	95%
	Staff here understand that people of my religious and spiritual background are not all alike.	96%

Table 2a.8: African American Hub Workforce Development Summary - Formal Only

	Formal	Combined Formal/Informal
Number of IPPs	2 IPPs	NO INFORMAL
Number of Workforce Activities	16	NO INFORMAL
Foci	44% External (non-CDEP) 25% Internal ("in-house" CDEP) 31% Both	
Type of Workers Engaged	31% Community Members 75% Mental Health Workers 50% First Responders <u>Type of First Responders:</u> 44% school personnel; 25% service providers	
Number of Program Touchpoints	285	
Number of Sessions	105	
Cumulative Hours	270.2	
Racial Workforce Populations Engaged	88% African American 31% AANHPI 50% Latinx 44% LGBTQ+	
Multilingual Capacity of Workers	Spanish, Cantonese, Tagalog, Mandarin, Arabic, Hebrew, Farsi	

Table 2a.9: African American IPP Changes in Organizational Capacity

Casey Domain	Pre	Post	Delta
Operational Capacity	2.16	2.73	+0.57
Skills, abilities, & volunteer commitment	2.00	3.00	+1
Fundraising	2.00	2.57	+0.57
Board involvement & participation in fundraising	1.57	1.86	+0.29
Communications strategy	2.43	2.57	+0.14
Computers, applications, network, & email	2.14	3.14	+1
Website	2.43	3.00	+0.57
Databases/management reporting system	2.14	2.86	+0.72
Buildings & office space	2.43	2.86	+0.43
Management of legal & liability matters	2.29	2.71	+0.42
Adaptive Capacity	2.67	3.08	+0.41
Strategic planning	2.43	2.57	+0.14
Evaluation/performance measurement	2.29	3.00	+0.71
Evaluation & organizational learning	2.00	2.71	+0.71
Use of research to support program planning & advocacy	2.43	2.57	+0.14
Program relevance & integration	3.14	3.29	+0.15
Program growth & replication	2.71	3.43	+0.72
Monitoring of program landscape	3.00	3.43	+0.43
Assessment of external environment & community needs	3.00	3.14	+0.14
Influencing of policy-making	2.43	2.86	+0.43
Partnerships & alliances	3.29	3.43	+0.14
Community presence & standing	3.00	3.43	+0.43
Constituent involvement	2.57	3.00	+0.43
Organizing	2.43	3.40	+0.97
Management Capacity	2.09	2.77	+0.68
Goals/performance targets	2.29	2.71	+0.42
Funding model	1.71	2.71	+1
Fund development planning	2.00	2.86	+0.86
Financial planning/budgeting	2.00	3.00	+1
Operational planning	2.14	2.71	+0.57
Decision making processes	2.29	2.86	+0.57
Knowledge management	2.29	2.71	+0.42
Recruiting, development & retention of management	1.71	2.57	+0.86
Recruiting, development & retention of general staff	2.14	2.71	+0.57
Volunteer management	2.29	2.86	+0.57
Cultural Competence	2.66	3.19	+0.53
Expressed commitment to cultural competence	3.00	3.57	+0.57
Cultural competence policies, procedures, governance	2.29	2.86	+0.57
Planning, monitoring, evaluation	2.14	2.71	+0.57
Communication	2.57	3.57	+1
Human resources	2.29	2.57	+0.28
Cultural factors in engagement with community	3.29	3.43	+0.14
Service array and responsiveness to community context	3.29	3.57	+0.28
Linguistic competency	2.43	3.17	+0.74
Leadership Capacity	2.52	2.74	+0.22
Shared beliefs/values	3.00	3.43	+0.43
Board composition/Commitment	2.14	2.29	+0.15
Board governance	2.29	2.29	0
Board involvement and support	2.29	2.43	+0.14
Board and CEO/ED appreciation of power	2.29	2.86	+0.57
Ability to motivate and mobilize constituents	3.14	3.14	0

Table 2a.10: African American Hub Group Involvement

69 groups formed in total. 10 groups formed per IPP on average (range of 5 to 20)		
Overview	Total	
Total	69	Top Reasons for Forming a Group <ul style="list-style-type: none"> • Increase Mental Health Access thru Service Provision (46%) • Sustain Programming (15%) • Address Health Overall (14%) Top Accomplishments <ul style="list-style-type: none"> • Increased/or strengthened programming (38%) • Increased awareness of mental health issues and services (26%) • Built relationships to advance mental health work (19%) Top Challenges Encountered: <ul style="list-style-type: none"> • Partner Engagement (33%) • COVID-19 (27%) • Limited Resources (19%)
Networks	13	
Collaboratives	18	
Formal Partnerships	38	
Time Period Formed		
Number Formed Before Phase 2	1 network 3 collabs 15 partnerships	
Number Formed During Phase 2	12 networks 15 collabs 23 partnerships	
CRDP Stakeholder Involvement		
With other AA IPPs	1 network 1 collab 2 partnerships	
With other non-AA IPPs	1 network 1 collab 1 partnership	
Types of Groups IPPs were involved with		
% Community-based groups	57%	
% Faith-based groups	28%	
% Gov't-based groups	44%	
% Institution-based groups	35%	
% Tribal-based groups	9%	

Table 2a.11: African American Hub Environmental, Systems, and Policy Change Impact

Hub overall: 13 changes + 3 benchmarks	
Environmental – Physical or social spaces or places where people live, learn, work, and play (i.e., environmental changes). Changes: <ul style="list-style-type: none"> • Started farmers market as a fun, safe space as part of a neighborhood revitalization effort. • Worked with school district and was able to offer dual enrollment ethnic studies classes in high schools. • IPP worked with school district, created murals, and eventually obtained a 12-year additional contract with the City. 	
Systems – Existing processes of organizations, institutions, and formal systems. Benchmarks: <ul style="list-style-type: none"> • IPP was able to increase Census outreach to Black communities. • IPP began providing technical assistance to birth workers to facilitate culturally specific and responsive spaces for emotional support during birth. • IPP participated in a town hall meeting to increase funding for Mental health, and they were also represented on the Governor's Behavioral Health Taskforce. IPP is working to get the county to integrate CDEP into their models and saw some movement in 2020 with some new opportunities at state and county levels. Changes: <ul style="list-style-type: none"> • After several years of sharing Community-defined Practices with the county, the county included Community-defined practices as a component of all county contracts. • IPP supported a parent advisory group and one school recognized, for the first time, an official Parent's Association to allow for parental voice. • The IPP and families of incarcerated individuals worked for several years to develop a political report card for elected officials, focused on their sentencing for African Americans and documenting the cost of prevention versus prison. The IPP met weekly and researched criminal judges and data to create the report card. Ultimately, they established partnerships with police chiefs and created a legal defense fund, which has resulted in changes in how some judges rule regarding certain crimes. • IPP attended parole hearings and wrote letters to probation and parole officers. By 2020, they started seeing policy changes in these systems. • IPP had a federal violence prevention grant and advocated for more trauma responsive services; then for several years they advocated for culturally responsive trauma informed culture and climate in six schools. • IPP provided data to support a change in the paradigm in educating youth of color; they advocated for a middle school to implement a Black Girl Magic group focused on restorative and trauma informed support. The school district administration consulted with IPP to create a restorative practice that works with their community. • IPP advocated for the governor to increase funding for prevention; and then focused on shifting funding from law enforcement and saw some advancement when the city opened a mobile crisis response unit. 	
Policy – Laws, regulations, ordinances, rules (i.e., policy changes). Changes: <ul style="list-style-type: none"> • IPP advocated for and monitored SB10 Mental Health Services Peer Support Certification program. The bill passed the legislature but the Governor vetoed it in January 2020. • CDEP included in the Mental Health Services Act 3-Year Plan. • Reauthorized funding from the Oakland Fund for Children and Youth. 	

Table 2a.12: African American IPP Advocacy Activities and Examples

Major Themes Advocacy Activities	Examples
<p>Participated in community actions (e.g., visible participation in townhall meetings, community forums, school board or city council meetings, <u>including provided public testimony and commentary</u>).</p> <p><i>23 activities reported by 6 IPPs</i></p>	<p>Participated in violence intervention and prevention rally; provided public comment at the Sacramento Behavioral Health Cultural Competence committee to advocate for more dedicated services for the African-American community and to highlight challenges with accessing both private and community mental health services; supported youth participants with speaking at an Oakland School Board Meeting regarding the abrupt closure of a community middle school; held meetings with Fresno County Department of Behavioral Health MHSA Director to advocate for support to continue the work. As a result, the ED expressed he would add our program to the next 3 year MHSA plan.</p>
<p>Conducted mental health education and awareness (with the general public, community members, and/or decision makers)</p> <p><i>12 activities reported by 6 IPPs</i></p>	<p>Educational and awareness activities focused on mental health and spirituality; funding for children and youth serving programs; equitable educational resources.</p>
<p>Conducted formal individual-level advocacy (spoke out and advocated on behalf of a community member to resolve an issue, obtain a needed support/service, or promote a change in the practices, policies and/or behaviors of third parties)</p> <p><i>10 activities reported by 6 IPPs</i></p>	<p>Deescalated a situation involving an African American man whose involvement in a family dispute led to the police being called. The IPP successfully advocated for mental health service provision rather than arrest; attended court with participants and write letters of support to probation officers and parole agents; advocacy on behalf of participants to access educational, health, and employment services from public and private providers.</p>
<p>Used a collective impact approach for change (strategic collaborations, advocated for changes in practices, regulations, policies, programming, or funding streams).</p> <p><i>10 activities reported by 4 IPPs</i></p>	<p>A Parents Advisory Council for one IPP, which is co-chaired by two of IPP parents, has been a consistent source of advocacy for children in the agency within the school district and mental health and social service arenas. As a result of its effectiveness and example, this past school year, the local school district, working with a number of African American parents, organized a first ever African American Parents Association to give African American parents a formal voice for input and advocacy in the school district; partnered with local organizations to advocate that the Oakland city council reauthorize funding for children and youth programs.</p>
<p>Launched media campaigns (used the media, including the arts, for strategic messaging and framing of social justice issues; involved messaging related to root causes and potential solutions)</p> <p><i>10 activities reported by 3 IPPs</i></p>	<p>Participated in art and mural production to promote social justice; IPP wrote an op ed in the widely read newspaper to encourage AA to become vaccinated; Conducted one media panel of African American and Latinx parents on the impact of COVID on their children's educational and health.</p>
<p>Engaged in grassroots community organizing (building of community power to address social inequities and achieve social and political change)</p> <p><i>9 activities reported by 4 IPPs</i></p>	<p>Hosted an annual gathering of Black women leaders which served as an organizing platform for culturally responsive and women-centered renewal where leaders engaged in narrating their own stories and exploring plans for sustainable leadership; As a result of violent conflict between African American and Latino students on one local high school campus, IPP was called on to intervene and find a solution to this problem. In response, IPP helped create a group called "One Circle" which is made up of over 30 African American and Latino former rivals; Work with clients involved in the criminal justice system spurred a grassroots movement where families organized to develop a political report card for elected officials in the county, beginning with the district attorney's office, judges, etc., to show their sentencing rates for African Americans and other marginalized groups.</p>
<p>Conducted research campaigns (community-driven, participatory, action research and evaluation activities used for advocacy)</p> <p><i>7 activities reported by 4 IPPs</i></p>	<p>Participated in interviews and meetings to shed light on how various violence prevention efforts within OUSD are inadequately critical of the school structures that perpetuate racial inequity.</p>
<p>Participated in civic/voter engagement activities (activities that promoted community awareness of and involvement in civic, community, & political life, such as ballot organizing, voter turnout activities, to name a few)</p> <p><i>6 activities reported by 4 IPPs</i></p> <p>WFFRC, CBWHP, SP, TVP</p>	<p>Engaged participants in neighborhood revitalization efforts; developed a census outreach team and conducted door to door outreach in hard-to-reach Sacramento Black communities; led voter registration efforts.</p>
<p>Participated in mass mobilization activities (e.g., rally, protest, marches)</p> <p><i>6 activities reported by 2 IPPs</i></p> <p>TVP, CBWHP</p>	<p>CDEP participants took part in the 2019 Inland Empire NAMI walk; IPP and community members attended and spoke at Black Lives Matter rallies and town hall meetings.</p>

Table 2a.13: CDEP Fidelity and Flexibility in the African American Hub

Total # of Program Components at the start of CRDP Phase 2	25; 4 components per CDEP, on average (range of 2-5)
Total # of Program Components at the end of CRDP Phase 2	25
Components Added	3 (12%) (n=3 IPPs)
Components Dropped	3 (12%) (n=2 IPPs)
Unplanned Delays in Component Implementation	4 IPPs (57%)
Top 3 Types of Component Changes Made	Program Delivery (n=7 IPPs) Personnel (n=4 IPPs) Programmatic (n=3 IPPs); Research (n=3 IPPs)

2B: AMERICAN INDIAN/ALASKA NATIVE (AI/AN) HUB-LEVEL TABLES

Table 2b.1.1: AI/AN Hub Number of Unique Individuals who Received Referrals, Linkages & Navigation

Age Group	# Referrals*	# Linkages to Care	# Service Navigation
Adults	1,158 (n=3 IPPs)	48 (n=3 IPPs)	295 (n=3 IPPs)
Adolescents	451 (n=3 IPPs)	60 (n=3 IPPs)	256 (n=3 IPPs)
Children	88 (n=2 IPPs)	5 (n=1 IPPs)	25 (n= 2 IPPs)
TOTAL	1,697 referrals by 3 IPPs	113 of 1,697 (7% received linkage)	576 of 1,697 (34% received service navigation)

*Note: Some IPPs provided referrals to multiple age groups and counts may be duplicative across age categories.

Table 2b.1.2: AI/AN Hub Number of Referrals* by Type and Subtype

Referral Type and Subtype	# Referrals Provided	#IPP
Mental Health	1,272	3
Counseling, therapy, wellness	1,145	3
Sexual Assault	57	2
Substance Abuse (e.g., AOD treatment)	43	1
Domestic Violence	23	1
Psychiatric Care	4	1
Personal Growth & Development	222	2
Social/Cultural Enrichment Programs	216	2
Faith-Based or Spiritual Services	6	1
Basic Needs	166	2
Food Assistance (e.g., food bank)	75	2
Clothing and Furniture Assistance	39	1
Housing, Rent, & Utilities	20	1
Internet Assistance	18	1
Transportation	14	1
Education	47	2
Academic Support (e.g., college applications, school placement)	32	1
Tutoring	15	1
Employment/Career	28	1
TOTAL	1,735	3

*Note: Any 1 individual may have received more than 1 referral; Total N's across categories are duplicative.

Table 2b.2.1: AI/AN Hub Adult Demographic Populations Served

AI/AN Adult (N=396)		
Variable	%	
Racial Groups (n=376)	% Total	% Multi-Race
American Indian/Alaska Native	88%	13%
Latinx	11%	8%
White	11%	8%
African American/Black	3%	1%
Asian	2%	1%
Native Hawaiian/Pacific Islander	-	1%
Age (n=382)		
18-29 years	31%	
30-39 years	32%	
40-44 years	14%	
45-49 years	8%	
50-64 years	13%	
65+ years	2%	
Gender Identity (n=376)		
Cisgender Woman/Female	53%	
Cisgender Man/Male	40%	
Genderqueer/Non-Binary	3%	
Questioning/Unsure	1%	
Transgender Woman/Female	0.3%	
Transgender Man/Male	0.3%	
Sexual Orientation (n=371)		
Straight/Heterosexual	89%	
LGBQ+	12%	
LGBQ+ Identities		
Bisexual	6%	
Gay/Lesbian	5%	
Asexual/Aromantic	2%	
Questioning	2%	
Queer	1%	
Pansexual	1%	
Something Else	0.5%	
English Fluency (n=381)		
Fluent	97%	
Somewhat fluent	1%	
Not very well	1%	
Knows some vocabulary	0.3%	
Not at all	0.5%	
Foreign Born (n=379)	2%	
Refugee Status (n=311)	2%	

Table 2b.2.2: AI/AN Adolescent Demographic Populations Served

AI/AN Adolescent (N=166)		
Variable	%	
Racial Groups (n=147)	% Total	% Multi-Race
American Indian/Alaska Native	87%	34%
Latinx	37%	27%
African American/Black	7%	6%
Asian	3%	3%
White	-	13%
Native Hawaiian/Pacific Islander	-	2%
Age (n=136)		
11 years	0.7%	
12 years	7%	
13 years	13%	
14 years	29%	
15 years	24%	
16 years	13%	
17 years	10%	
18 years	3%	
19 years	0.7%	
Gender Identity (n=135)		
Cisgender Man/Male	47%	
Cisgender Woman/Female	43%	
Genderqueer/Non-Binary	4%	
Questioning/Unsure	2%	
Transgender Man/Male	0.7%	
Sexual Orientation (n=137)		
Straight/Heterosexual	90%	
LGBQ+	13%	
LGBQ+ Identities		
Bisexual	8%	
Questioning	5%	
Pansexual	3%	
Queer	2%	
Gay/Lesbian	0.7%	
Asexual/Aromantic	0.7%	
English Fluency (n=121)		
Fluent	88%	
Somewhat fluent	3%	
Not very well	3%	
Knows some vocabulary	2%	
Not at all	2%	
Foreign Born (n=142)	2%	
Refugee Status (n=101)	5%	

Table 2b.3.1: AI/AN Adult Hub Numbers Served by Mental Health Need

AI/AN Adult (N=396)	
Variable	%
Mental Health Need (n=359)	
No Need	27%
Need	73%
PARC Approach (n=262)	
Unmet	17%
Met	82%
Mental Health Helping Professional Seen¹	
Traditional	35%
Community	51%
Primary Care Physician	61%
Mental Health	61%
CHIS Approach (n=262)	
Unmet	23%
Met	76%
Mainstream ²	19%
Health Insurance Coverage (n=336)	
Coverage	82%
No Coverage	18%
Coverage: Uses MH Services	51%
No Coverage: Uses MH Services	11%
Coverage: Takes Prescription Meds	32%
No Coverage: Takes Prescription Meds	7%
Coverage: Median # Visits ³	4
No Coverage: Median # Visits ³	3

¹ This is a multiple response item; participants selected all the categories that were true for them; percentages do not add up to 100

² Primary care physician or general practitioner; MH professional (counselor, therapist, psychologist, psychiatrist or social worker)

³ Different sample size due to skip logic

Table 2b.3.2: AI/AN Adolescent Hub Numbers Served by Mental Health Need

AI/AN Adolescent (N=166)	
Variable	%
Mental Health Need (n=106)	
No Need	63%
Need	37%
PARC Approach (n=39)	
Unmet	36%
Met	59%
Mental Health Helping Professional Seen¹	
Traditional	28%
Community	41%
Mental Health	31%
School Mental Health	44%
CHIS Approach (n=39)	
Unmet	41%
Met	54%
Mainstream ²	3%

¹ This is a multiple response item; participants selected all the categories that were true for them; percentages do not add up to 100

² Primary care physician or general practitioner; MH professional (counselor, therapist, psychologist, psychiatrist or social worker)

Table 2b.4.1: AI/AN Adult Hub Numbers Served by Psychological Distress and Functioning

AI/AN Adult (N=396)	
Variable	%
Psychological Distress (K6)¹ (n=379)	
Low (K6<5)	33%
Moderate (5<=K6<=12)	37%
Serious (K6>=13)	30%
Moderate K6 (5<=K6<=12) by Functional Impairment (SDS)²	
Work/School (n=108)	
Not at all	32%
Some	35%
A lot	32%
Household Chores (n=134)	
Not at all	28%
Some	52%
A lot	20%
Social Life (n=136)	
Not at all	22%
Some	49%
A lot	29%
Relationships with Friends/Family (n=136)	
Not at all	17%
Some	46%
A lot	37%
Serious K6 (K6>=13) by Functional Impairment (SDS)²	
Work/School (n=81)	
Not at all	8%
Some	25%
A lot	67%
Household Chores (n=99)	
Not at all	15%
Some	29%
A lot	56%
Social Life (n=104)	
Not at all	6%
Some	33%
A lot	61%
Relationships with Friends/Family (n=104)	
Not at all	6%
Some	22%
A lot	72%
Moderate K6 (5<=K6<=12) by Number of Functional Impairments (n=141)	
None	14%
1 Impairment	6%
2 Impairment	11%
3 Impairment	28%
4 Impairment	41%
Serious K6 (K6>=13) by Number of Psychological Functional Impairments (n=112)	
None	8%
1 Impairment	5%
2 Impairment	8%
3 Impairment	22%
4 Impairment	57%
Moderate K6 (5<=K6<=12) by Mental Health Need (n=130)	
Mental Health Need	81%
No Mental Health Need	19%
Serious K6 (K6>=13) by Mental Health Need (n=110)	
Mental Health Need	91%
No Mental Health Need	9%

¹ Kessler-6: In the past 30 days, how often have you felt: nervous, hopeless, restless/fidgety, depressed, that everything was an effort, worthless (Scale: 4=All of the time to 0=None of the time; range of responses was 0-24)

² Sheehan Disability Scale: Worst month past year, did your emotions interfere with: work/school performance, household chores, social life, relationship with friends and family (Scale: 2=A lot to 0=Not at all; range of responses was 0-8)

Table 2b.4.2: AI/AN Adolescent Hub Numbers Served by Psychological Distress and Functioning

AI/AN Adolescent (N=166)	
Variable	%
Psychological Distress (K6)¹ (n=120)	
Low (K6<5)	47%
Moderate (5<=K6<=12)	34%
Serious (K6>=13)	19%
Moderate K6 (5<=K6<=12) by Functional Impairment (SDS)²	
School/Homework (n=41)	
Not at all	27%
Some	54%
A lot	19%
With friends (n=41)	
Not at all	37%
Some	51%
A lot	12%
At Home (n=39)	
Not at all	39%
Some	51%
A lot	10%
Serious K6 (K6>=13) by Functional Impairment (SDS)²	
School/Homework (n=21)	
Not at all	14%
Some	24%
A lot	62%
With friends (n=20)	
Not at all	10%
Some	15%
A lot	75%
At Home (n=20)	
Not at all	15%
Some	35%
A lot	50%
Moderate K6 (5<=K6<=12) by Number of Functional Impairments (n=41)	
None	12%
1 Impairment	15%
2 Impairment	39%
3 Impairment	34%
Serious K6 (K6>=13) by Number of Psychological Functional Impairments (n=23)	
None	9%
1 Impairment	9%
2 Impairment	26%
3 Impairment	57%
Moderate K6 (5<=K6<=12) by Mental Health Need (n=34)	
Mental Health Need	44%
No Mental Health Need	56%
Serious K6 (K6>=13) by Mental Health Need (n=19)	
Mental Health Need	89%
No Mental Health Need	11%

¹ Kessler-6: In the past 30 days, how often have you felt: nervous, hopeless, restless/fidgety, depressed, that everything was an effort, worthless (Scale: 4=All of the time to 0=None of the time; range of responses was 0-24)

² Sheehan Disability Scale: Worst month past year, did your emotions interfere with: work/school performance, household chores, social life, relationship with friends and family (Scale: 2=A lot to 0=Not at all; range of responses was 0-8)

Table 2b.5.1: AI/AN Adult Hub Numbers Served by Protective Factors

AI/AN Adult (N=396)	
Variable	%
Your culture gives you strength¹ (n=358)	
Strongly Agree/Agree	91%
Neutral	7%
Strongly Disagree/Disagree	2%
Your culture is important to you¹ (n=369)	
Strongly Agree/Agree	94%
Neutral	5%
Strongly Disagree/Disagree	1%
Your culture helps you to feel good about who you are¹ (n=352)	
Strongly Agree/Agree	89%
Neutral	9%
Strongly Disagree/Disagree	2%
You feel connected to spiritual/religious traditions of the culture you were raised in¹ (n=314)	
Strongly Agree/Agree	80%
Neutral	14%
Strongly Disagree/Disagree	6%
Felt connected to your culture² (n=212)	
All/Most of the time	54%
Some of the time	26%
A Little/None of the time	20%
Felt balanced in mind, body, spirit and soul² (n=185)	
All/Most of the time	47%
Some of the time	28%
A Little/None of the time	24%
Felt marginalized or excluded from society² (n=86)	
All/Most of the time	22%
Some of the time	32%
A Little/None of the time	46%
Felt isolated and alienated from society² (n=88)	
All/Most of the time	22%
Some of the time	27%
A Little/None of the time	51%

¹ Items anchored "at present"

² Items anchored in "past 30 days"

Table 2b.5.2: AI/AN Adolescent Hub Numbers Served by Protective Factors

AI/AN Adolescent (N=166)	
Variable	%
Your culture gives you strength¹ (n=146)	
Strongly Agree/Agree	78%
Neutral	20%
Strongly Disagree/Disagree	2%
Your culture is important to you¹ (n=145)	
Strongly Agree/Agree	93%
Neutral	6%
Strongly Disagree/Disagree	1%
Your culture helps you to feel good about who you are¹ (n=146)	
Strongly Agree/Agree	82%
Neutral	17%
Strongly Disagree/Disagree	1%
You feel connected to spiritual/religious traditions of the culture you were raised in¹ (n=143)	
Strongly Agree/Agree	69%
Neutral	27%
Strongly Disagree/Disagree	4%
Felt connected to your culture² (n=142)	
All/Most of the time	55%
Some of the time	32%
A Little/None of the time	13%
Felt balanced in mind, body, spirit and soul² (n=139)	
All/Most of the time	47%
Some of the time	33%
A Little/None of the time	20%
Felt marginalized or excluded from society² (n=139)	
All/Most of the time	19%
Some of the time	26%
A Little/None of the time	55%
Felt isolated and alienated from society² (n=141)	
All/Most of the time	15%
Some of the time	21%
A Little/None of the time	64%

¹ Items anchored "at present"² Items anchored in "past 30 days"**Table 2b.6.1: AI/AN Adult Hub Numbers Served by Stigma/Barriers**

AI/AN Adult (N=396)	
Variable	% Agree
You were planning or already getting help from a...	
Traditional helping professional (n=304)	60%
Community helping professional (n=305)	59%
You did not know of or have never heard of these types of mental health professionals (n=290)	24%
Structural Barriers	
No transportation (n=239)	26%
Lack of time (n=238)	29%
Cost of treatment (n=233)	28%
Prejudice Barriers	
Limited English (n=231)	5%
Race/ethnicity (n=229)	12%
Age (n=228)	11%
Religious or spiritual practice (n=229)	11%
Gender identity (n=230)	7%
Sexual orientation (n=230)	7%
Attitudinal Barriers	
Psychiatric hospitalization (n=237)	8%
Might have to take prescription medication (n=244)	18%
Treatment won't help (n=239)	28%
Uncomfortable talking about problems (n=223)	28%
Can handle problem on my own (n=243)	52%
Do not need treatment (n=238)	34%
Stigma Barriers	
Negative opinion from community (n=241)	23%
Lack of confidentiality (n=243)	19%
Negative effect on job (n=238)	14%

Table 2b.6.2: AI/AN Adolescent Hub Numbers Served by Stigma/Barriers

AI/AN Adolescent (N=166)	
Variable	% Agree
You were planning or already getting help from a...	
Traditional helping professional (n=80)	26%
Community helping professional (n=78)	33%
You did not know of or have never heard of these types of mental health professionals (n=91)	30%
Structural Barriers	
No transportation (n=79)	18%
Lack of time (n=80)	23%
Cost of treatment (n=79)	20%
Did not know where to get help (n=81)	28%
Prejudice Barriers	
Limited English (n=78)	4%
Race/ethnicity (n=80)	13%
Age (n=78)	18%
Religious or spiritual practice (n=76)	9%
Gender identity (n=79)	6%
Sexual orientation (n=78)	5%
Attitudinal Barriers	
Did not want to talk to stranger (n=71)	45%
Thought issue wasn't serious enough (n=79)	53%
Can solve issue on my own (n=81)	62%
Uncomfortable talking with them (n=77)	40%
Stigma Barriers	
Embarrassed about what you were going through (n=79)	30%
Worried friends would find out (n=79)	30%
Negative opinion from family/community (n=80)	28%
Negative opinion from peers in school (n=78)	23%

Table 2b.7.1: AI/AN Percentage of CDEP Respondents Scoring 3.51 or above on MHSIP Subscale Items

Highest and lowest percent's across subscale items are in bold

Subscale Domains	MHSIP Adult Items (N=168)	% strongly agree/agree	MHSIP Adolescent items (N=109)	% strongly agree/agree
General Satisfaction Subscale (Please answer based on the CDEP services, program, or activities)	I like the services that I received here.	94%	Overall, I am satisfied with the services I received.	73%
	If I had other choices, I would still get services from this agency.	90%	The people helping me stuck with me no matter what.	69%
	I would recommend this agency to a friend or family member.	93%	I felt I had someone to talk to when I was troubled.	62%
			I received services that were right for me.	73%
			I got the help I wanted.	72%
Access Subscale (Please answer based on the CDEP services, program, or activities)	The location of services was convenient.	83%	The location of services was convenient for me.	69%
	Services were available at times that were good for me.	83%	Services were available at times that were convenient for me.	70%
	Staff were willing to see me as often as I felt it was necessary.	83%		
Outcomes Subscale (As a direct result of my involvement in the program...)	I deal more effectively with my daily problems.	82%	I am better at handling daily life.*	67%
	I do better in school and/or work.	79%	I am doing better in school and/or work.	61%
	My symptoms/ problems are not bothering me as much.	79%	I get along better with friends and other people.	76%
			I get along better with family members.	70%
			I am better able to cope when things go wrong.	68%
			I am satisfied with my family life right now.	45%
			I am better able to do things I want to do.	73%
Social Connectedness Subscale (As a direct result of my involvement in the program...)			I know people who will listen and understand me when I need to talk.	70%
			I have people that I am comfortable talking with about my problem(s).	69%
			In a crisis, I would have the support I need from family or friends.	81%
			I have people with whom I can do enjoyable things.	87%

*Note: One NA youth-serving IPP (n=39 out of 109, 36%) did not include these items. Total for these items are calculated from a sample size of 70.

Table 2b.7.2: AI/AN MHSIP Language Assistance Items (written, oral)

MHSIP Linguistic Competence Items	Adult (N=168)	Adolescent (N=64*)
Were the services you received [CDEP program] in the language you prefer?	97%	98%
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?	99%	95%

*2 of 5 NA youth serving IPPs have modified instruments and do not include these two questions. These two IPPs have a combined sample size of 45 and represent 41% of the NA sample. The total for these items are calculated from a sample size of 64.

Table 2b.7.3: AI/AN Percentage of CDEP Respondents Scoring 3.51 or above on (1) CBCI Subscale Items by Age Group

Highest and lowest percent's across subscale items are in bold

Subscale Domains	CBCI Adult Items (N=168)	% strongly agree/agree	CBCI Adolescent Items (N=67*)	% strongly agree/agree
Respectful Behavior (Please answer based on the CDEP services, program, or activities)	The staff here treat me with respect.	87%	Staff treated me with respect.	82%
	The staff here don't think less of me because of the way I talk.	88%	Staff spoke with me in a way that I understood.	81%
	The staff here respect my race and/or ethnicity.	93%	Staff were sensitive to my cultural/ethnic background.	67%
	The staff here respect my religious and/or spiritual beliefs.	93%	Staff respected my religious/spiritual beliefs.	78%
	The staff here respect my gender identity and/or sexual orientation.	93%		

*Although 5 IPPs submitted CBCI adolescent data, 1 IPP (n=42) did not include these items. The total for these items are calculated from a sample size of 67.

Table 2b.7.4: AI/AN Percentage of Adult CDEP Respondents Scoring 3.51 or above on (3) CBCI Subscales

Highest and lowest percent's across subscale items are in bold

Subscale	CBCI Adult items (N=168)	% strongly agree/agree
Patient-Provider-Organization Interactions (Please answer based on the CDEP services, program, or activities)	When I first called or came here, it was easy to talk to the staff.	90%
Understanding of Indigenous Practices (Please answer based on the CDEP services, program, or activities)	Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	86%
Acceptance of Cultural Differences (Please answer based on the CDEP services, program, or activities)	The people who work here respect my cultural beliefs, remedies and healing practices.	92%
	Staff here understand that people of my racial and/or ethnic group are not all alike.	91%
	Staff here understand that people of my gender and/or sexual orientation group are not all alike.	90%
	Staff here understand that people of my religious and spiritual background are not all alike.	90%

Table 2b.8: AI/AN IPP Changes in Organizational Capacity

Casey Domain	Pre	Post	Delta
Operational Capacity	2.73	2.77	+0.04
Skills, abilities, & volunteer commitment	2.33	2.25	-0.08
Fundraising	2.14	2.71	+0.57
Board involvement & participation in fundraising	1.83	2.14	+0.31
Communications strategy	2.86	2.57	-0.29
Computers, applications, network, & email	3.00	3.14	+0.14
Website	2.86	3.00	+0.14
Databases/management reporting system	2.86	3.14	+0.28
Buildings & office space	3.14	2.86	-0.28
Management of legal & liability matters	3.29	2.86	-0.43
Adaptive Capacity	2.76	3.09	+0.33
Strategic planning	3.00	3.14	+0.14
Evaluation/performance measurement	2.57	3.29	+0.72
Evaluation & organizational learning	2.71	3.00	+0.29
Use of research to support program planning & advocacy	2.71	3.00	+0.29
Program relevance & integration	2.86	3.43	+0.57
Program growth & replication	2.57	3.14	+0.57
Monitoring of program landscape	2.71	3.00	+0.29
Assessment of external environment & community needs	2.71	3.00	+0.29
Influencing of policy-making	2.71	3.00	+0.29
Partnerships & alliances	3.14	3.43	+0.29
Community presence & standing	3.14	3.29	+0.15
Constituent involvement	2.29	2.33	+0.04
Organizing	2.71	3.00	+0.29
Management Capacity	2.64	2.94	+0.3
Goals/performance targets	2.57	3.14	+0.57
Funding model	3.14	3.43	+0.29
Fund development planning	2.71	3.00	+0.29
Financial planning/budgeting	3.43	3.00	-0.43
Operational planning	2.57	3.00	+0.43
Decision making processes	2.71	3.00	+0.29
Knowledge management	2.57	2.86	+0.29
Recruiting, development & retention of management	2.57	2.71	+0.14
Recruiting, development & retention of general staff	2.57	2.86	+0.29
Volunteer management	1.57	2.00	+0.43
Cultural Competence	3.18	3.27	+0.09
Expressed commitment to cultural competence	3.57	3.57	0
Cultural competence policies, procedures, governance	3.29	3.29	0
Planning, monitoring, evaluation	3.14	2.86	-0.28
Communication	3.00	3.29	+0.29
Human resources	2.71	3.29	+0.58
Cultural factors in engagement with community	3.43	3.43	0
Service array and responsiveness to community context	3.43	3.57	+0.14
Linguistic competency	3.00	2.86	-0.14
Leadership Capacity	3.07	3.26	+0.19
Shared beliefs/values	3.00	3.29	+0.29
Board composition/Commitment	3.14	3.29	+0.15
Board governance	3.57	3.29	-0.28
Board involvement and support	3.29	3.14	-0.15
Board and CEO/ED appreciation of power	3.00	3.43	+0.43
Ability to motivate and mobilize constituents	2.43	3.14	+0.71

Table 2b.9: AI/AN Hub Group Involvement

43 groups formed in total. 6.1 groups formed per IPP on average (range of 3 to 17)		
Overview		Total
Total		43
Networks		5
Collaboratives		27
Formal Partnerships		9
Time Period Formed		
Number Formed Before Phase 2	2 network 6 collabs 6 partnerships	
Number Formed During Phase 2	3 networks 20 collabs 3 partnerships	
CRDP Stakeholder Involvement		
With other AA IPPs	3 network 2 collab	
With other non-AA IPPs	1 network	
Types of Groups IPPs were involved with		
% Community-based groups	47%	
% Faith-based groups	2%	
% Gov't-based groups	21%	
% Institution-based groups	21%	
% Tribal-based groups	53%	
Top Reasons for Forming a Group		
<ul style="list-style-type: none">• Increase Mental Health Access thru Service Provision (58%)• Training, TA or Information Sharing (17%)• Evaluations (15%)		
Top Accomplishments		
<ul style="list-style-type: none">• Increased/or strengthened programming (43%)• Increased awareness of mental health issues and services (32%)• Built relationships to advance mental health work (12%)		
Top Challenges Encountered:		
<ul style="list-style-type: none">• Partner Engagement (40%)• COVID-19 (30%)• Limited Resources (23%)		

Table 2b.10: AI/AN Hub Environmental, Systems, and Policy Change Impact

Hub overall: 4 changes + 3 benchmarks
Environmental – Physical or social spaces or places where people live, learn, work, and play (i.e., environmental changes). Changes: <ul style="list-style-type: none"> • IPP worked with churches to vaccinate all members of the community that met eligibility. • IPP gained access to use the Ya-Ka-Ama land for education and development.
Systems – Existing processes of organizations, institutions, and formal systems. Benchmarks: <ul style="list-style-type: none"> • IPP worked on voter registration and census, and the data showed this election had a large voter turnout. • IPP worked with other Black, Indigenous, and People of Color organizations and to increase the visibility of Native Americans through workshops, trainings, and conversations. Youth began rising as leaders and were starting to influence policy in schools, healthcare, and funding. • One participant from an IPP secured space on the Board for California Rural Indian Health Board. IPP began collaborating with Sonoma IPPs to release final reports to decision making bodies (e.g., MHSA, Board of Supervisors) to expand and stabilize mental health prevention for tribal communities. Changes: <ul style="list-style-type: none"> • IPP adopted a cultural connectivity scale to understand the connection between wellness and culture, and started working with other groups on appropriate adaptations. • IPP worked over many years to provide the tribal voice and choice to reforms in the county. This included developing relationships with decision makers and bringing them to the community to hear from community adult and youth leaders. IPP organized a partnership with tribal social service directors. This work ultimately resulted in several changes. They have provided comments on the county Mental Health Services Act, and these were included in the 3-year plan. • IPP became a billable medical provider. • Humboldt Child Welfare included the tribal voice in reforms with Attorney General Investigation and created a ICWA program because of IPP advocacy.
Policy – Laws, regulations, ordinances, rules (i.e., policy changes). Changes: <ul style="list-style-type: none"> • IPP successfully advocated for the passage of the missing and murdered Indigenous women awareness month. • Community members spoke to legislators about AB2112 (Suicide prevention) and it was passed.

Table 2b.11: AI/AN IPP Advocacy Activities and Examples

Major Themes Advocacy Activities	Examples
Conducted mental health education and awareness (with the general public, community members, and/or decision makers) <i>9 activities reported by 3 IPPs</i>	Facilitated education and awareness activities related to: missing and murdered indigenous women; cultural revitalization of native land; mental health and child welfare; COVID-19 public health guidelines, COVID-19 testing and COVID-19 vaccines.
Used a collective impact approach for change (strategic collaborations, advocated for changes in practices, regulations, policies, programming, or funding streams). <i>6 activities reported by 2 IPPs</i>	The Foursquare Church partnered with our agency and offered their building and parking lot as a center for our COVID-19 vaccination events to the community AND IHC staff are part of the Santa Clara County and Indian Health Service's task forces on the COVID 19 vaccine; partnered with other local tribal agencies to advocate on a county-wide level for systems change in child welfare and mental health.
Participated in community actions (e.g., visible participation in townhall meetings, community forums, school board or city council meetings, <u>including provided public testimony and commentary</u>). <i>14 activities reported by 4 IPPs</i>	Engaged directly with local representatives, and successfully advocated for the passing of a legislative resolution; led a Youth Town Hall focus on CDEP activities; participated in a virtual "Social Mapping" meeting on July 27th and August 26th that had a couple of civic Leaders and representatives from our diverse community were in attendance.
Launched media campaigns (used the media, including the arts, for strategic messaging and framing of social justice issues; involved messaging related to root causes and potential solutions) <i>8 activities reported by 3 IPPs</i>	Relied heavily on social media engagement to advocate and encourage community engagement and advocacy for social justice and equity for Native peoples. This included vlogs related to Food Sovereignty, Mental Health in the Digital Era, and our Tay-led advocacy; hosted a Sonoma Media Forum to bring awareness on how our programs have responded to health disparities, local disasters, and COVID-19; used Facebook as a platform to encourage the community to register to vote and complete the 2020 Census. There were at least daily posts regarding these two issues that involved community.
Conducted formal individual-level advocacy (spoke out and advocated on behalf of a community member to resolve an issue, obtain a needed support/service, or promote a change in the practices, policies and/or behaviors of third parties) <i>5 activities reported by 4 IPPs</i>	Clinicians, support coordinators, and advocates work regularly with their assigned youth and families to address systemic barriers to wellness; regularly advocates for individual youth in educational, child welfare, mental health and juvenile justice systems, as this is part of our holistic approach to mental health and wellness; provided resources, services and support to local tribal community members during COVID and wildfires.
Engaged in grassroots community organizing (building of community power to address social inequities and achieve social and political change) <i>4 activities reported by 2 IPPs</i>	Formed the Red Earth Women's Society, which is an independent community group of Native women. This group originated out of systems and policy meetings and a women's group that formerly met at Native TANF. The women came together to make red dresses (a cultural symbol to highlight the problem of MMIW), discussed how to do outreach, and how to bring awareness to this problem. These women were involved in the legislation and march efforts; engaged in the Slater Fire response and leads a regionally focused Community Intervention meeting for the Hoopa Valley.
Participated in civic/voter engagement activities (activities that promoted community awareness of and involvement in civic, community, & political life, such as ballot organizing, voter turnout activities, to name a few) <i>4 activities reported by 1 IPP</i>	Encouraged the community to complete the Census 2020 and to register to vote for the elections; our agency used Facebook as a platform to encourage the community to register to vote and complete the 2020 Census; Legislative Advocacy Advocated successfully for the passing of a resolution in the California State Assembly to make May 2019 Missing and Murdered Indigenous Women Awareness Month and to begin tracking the number of those missing and murdered.
Participated in mass mobilization activities (e.g., rally, protest, marches) <i>5 activities reported by 3 IPP</i>	Held the May Day March that focused on indigenous women and the four women nominated to lead the march – all of which were Native women of leadership in the community, and included a CDEP staff member. The March focused on Missing and Murdered Indigenous Women and coincided with the Red Dress display at City Hall and at other Native American agencies; Elders were/are part of the Red Earth Women's Society and leading the May Day March; in June, our agency held a kneel-in in solidarity with Black Lives Matter and the George Floyd Protests.
Conducted research campaigns (community-driven, participatory, action research and evaluation activities used for advocacy) <i>2 activities reported by 1 IPP</i>	Implemented focus groups, surveys, and listening sessions in order to incorporate community driven evaluation in all activities.

Table 2b.12: CDEP Fidelity and Flexibility in the AI/AN Hub

Total # of Program Components at the start of CRDP Phase 2	27; 4 components per CDEP, on average (range of 2-6)
Total # of Program Components at the end of CRDP Phase 2	28
Components Added	1 (7%) (n=1 IPP)
Components Dropped	0 (0%) (n=0 IPP)
Unplanned Delays in Component Implementation	4 IPPs (57%)
Top 3 Types of Component Changes Made	Program Delivery (n=4 IPPs) Personnel (n=4 IPPs) Programmatic (n=3 IPPs);

2C: ASIAN AMERICAN, NATIVE HAWAIIAN, PACIFIC ISLANDER (AANHPI) HUB-LEVEL TABLES

Table 2c.1.1: AANHPI Hub Number of Unique Individuals who Received Referrals, Linkages & Navigation (n=7 IPPs)

Age Group	# Referrals*	# Linkages to Care	# Service Navigation
Adults	9,505 (n=6 IPPs)	3,712 (n=6 IPPs)	1,043 (n=6 IPPs)
Adolescents	164 (n=4 IPPs)	10 (n=3 IPPs)	73 (n=4 IPPs)
Children	20 (n=1 IPP)	3 (n=1 IPP)	7 (n=1 IPP)
TOTAL	9,689 referrals by 7 IPPs	3,725 of 9,689 (38% received linkage)	1,123 of 9,689 (12% received service navigation)

*Note: Some IPPs provided referrals to multiple age groups and counts may be duplicative across age categories.

Table 2c.1.2: AANHPI Hub Number of Referrals* by Type and Subtype

Referral Type and Subtype	# Referrals Provided	#IPP
Health	3,261	5
Primary Health Care (e.g., well-check, vaccines, etc.)	2,089	5
Nutrition	395	2
Dental/Optometry/Prescription	339	3
Other Health	194	4
Medical Benefits and Insurance	112	2
COVID-Related Health Supports	61	1
Illness specific (HIV/AIDS, dialysis)	51	2
Health Education	19	1
Female Reproductive Health	1	1
Mental Health	2,531	7
Counseling, therapy, wellness	2,293	7
Psychiatric Care	123	2
Other Mental Health	33	4
Substance Abuse (e.g., AOD treatment)	31	7
Domestic Violence	23	4
Sexual Assault	26	3
Anger Management	2	1
Legal/Advocacy	1,342	7
Immigration Services	1,044	3
Other (free legal services, tenant rights, etc.)	293	7
Child Welfare	5	1
Personal Growth & Development	1,222	4
Social/Cultural Enrichment Programs	862	3
Support/Mentoring	219	1
Other (e.g., entrepreneurial training, police athletic league)	110	2
Faith-Based or Spiritual Services	18	2
Volunteer Services	7	3
Gang Violence Services	6	1
Basic Needs	1,196	7
Food Assistance (e.g., food bank)	1,222	6
Financial Assistance	266	5

Referral Type and Subtype	# Referrals Provided	IPPs
Transportation	171	5
Other Basic Needs	171	2
Housing, Rent, & Utilities	86	6
Clothing and Furniture Assistance	80	3
Education	129	3
Other Education	74	2
Academic Support (e.g., college applications, school placement)	36	3
Adult Education	17	1
Tutoring	2	1
Employment/Career	47	3
Parenting classes, early childcare support	33	2
Specialty Care	16	3
"Multi-Category" (e.g., housing, education, job training, etc.)	935	7
TOTAL	11,512	7

*Note: Any 1 individual may have received more than 1 referral; Total N's across categories are duplicative.

Table 2c.2.1: AANHPI Adult Hub Demographic Populations Served

AANHPI Adult (N=930)		
Variable	%	
Racial Groups (n=922)	% Total	% Multi-Race
Asian	93%	1%
<i>Cambodian</i>	41%	
<i>Hmong</i>	18%	
<i>Korean</i>	17%	
<i>Vietnamese</i>	12%	
Native Hawaiian/Pacific Islander	4%	1%
<i>Samoan</i>	2%	
<i>Tongan</i>	1%	
Latinx	3%	2%
White	2%	1%
African American/Black	< 1%	< 1%
American Indian/Alaska Native	< 1%	< 1%
Age (n=919)		
18-29 years	7%	
30-39 years	13%	
40-44 years	6%	
45-49 years	7%	
50-64 years	43%	
65+ years	26%	
Gender Identity (n=870)		
Cisgender Woman/Female	71%	
Cisgender Man/Male	27%	
Genderqueer/Non-Binary	0.6%	
Transgender Man/Male	0.3%	
Questioning/Unsure	0.1%	
Sexual Orientation (n=757)		
Straight/Heterosexual	97%	
LGBQ+	4%	
LGBQ+ Identities		
<i>Gay/Lesbian</i>	2%	
<i>Bisexual</i>	1%	
<i>Queer</i>	0.4%	
<i>Asexual/Aromantic</i>	0.4%	
<i>Pansexual</i>	0.3%	
<i>Questioning</i>	0.3%	
<i>Something Else</i>	0.1%	
English Fluency (n=381)		
Fluent	19%	
Somewhat fluent	13%	
Not very well	23%	
Knows some vocabulary	25%	
Not at all	21%	
Foreign Born (n=379)	89%	
Refugee Status (n=311)	27%	

Table 2c.3.1: AANHPI Adult Hub Numbers Served by Mental Health Need

AANHPI Adult (N=930)	
Variable	%
Mental Health Need (n=786)	
No Need	29%
Need	71%
PARC Approach (n=555)	
Unmet	20%
Met	77%
Mental Health Helping Professional Seen ¹	
Traditional	34%
Community	42%
Primary Care Physician	53%
Mental Health	53%
CHIS Approach (n=555)	
Unmet	28%
Met	69%
Mainstream ²	22%
Health Insurance Coverage (n=852)	
Coverage	87%
No Coverage	13%
Coverage: Uses MH Services	46%
No Coverage: Uses MH Services	7%
Coverage: Takes Prescription Meds	28%
No Coverage: Takes Prescription Meds	3%
Coverage: Median # Visits ³	5
No Coverage: Median # Visits ³	3

¹ This is a multiple response item; participants selected all the categories that were true for them; percentages do not add up to 100

² Primary care physician or general practitioner; MH professional (counselor, therapist, psychologist, psychiatrist or social worker)

³ Different sample size due to skip logic

Table 2c.4.1: AANHPI Adult Hub Numbers Served by Psychological Distress and Functioning

AANHPI Adult (N=930)	
Variable	%
Psychological Distress (K6)¹ (n=896)	
Low (K6<5)	28%
Moderate (5<=K6<=12)	40%
Serious (K6>=13)	32%
Moderate K6 (5<=K6<=12) by Functional Impairment (SDS)²	
Work/School (n=210)	
Not at all	32%
Some	54%
A lot	14%
Household Chores (n=330)	
Not at all	31%
Some	54%
A lot	15%
Social Life (n=326)	
Not at all	33%
Some	55%
A lot	12%
Relationships with Friends/Family (n=327)	
Not at all	24%
Some	57%
A lot	19%
Serious K6 (K6>=13) by Functional Impairment (SDS)²	
Work/School (n=128)	
Not at all	15%
Some	43%
A lot	42%
Household Chores (n=274)	
Not at all	16%
Some	42%
A lot	42%
Social Life (n=270)	
Not at all	22%
Some	40%
A lot	37%
Relationships with Friends/Family (n=274)	
Not at all	16%
Some	43%
A lot	41%
Moderate K6 (5<=K6<=12) by Number of Functional Impairments (n=360)	
None	18%
1 Impairment	13%
2 Impairment	14%
3 Impairment	29%
4 Impairment	26%
Serious K6 (K6>=13) by Number of Psychological Functional Impairments (n=288)	
None	8%
1 Impairment	9%
2 Impairment	17%
3 Impairment	37%
4 Impairment	29%
Moderate K6 (5<=K6<=12) by Mental Health Need (n=302)	
Mental Health Need	71%
No Mental Health Need	29%
Serious K6 (K6>=13) by Mental Health Need (n=259)	
Mental Health Need	94%
No Mental Health Need	6%

¹ Kessler-6: In the past 30 days, how often have you felt: nervous, hopeless, restless/fidgety, depressed, that everything was an effort, worthless (Scale: 4=All of the time to 0=None of the time; range of responses was 0-24)

² Sheehan Disability Scale: Worst month past year, did your emotions interfere with: work/school performance, household chores, social life, relationship with friends and family (Scale: 2=A lot to 0=Not at all; range of responses was 0-8)

Table 2c.5.1: AANHPI Adult Hub Numbers Served by Protective Factors

AANHPI Adult (N=930)	
Variable	%
Your culture gives you strength¹ (n=923)	
Strongly Agree/Agree	77%
Neutral	20%
Strongly Disagree/Disagree	3%
Your culture is important to you¹ (n=921)	
Strongly Agree/Agree	83%
Neutral	15%
Strongly Disagree/Disagree	2%
Your culture helps you to feel good about who you are¹ (n=922)	
Strongly Agree/Agree	79%
Neutral	18%
Strongly Disagree/Disagree	3%
You feel connected to spiritual/religious traditions of the culture you were raised in¹ (n=921)	
Strongly Agree/Agree	73%
Neutral	20%
Strongly Disagree/Disagree	7%
Felt connected to your culture² (n=915)	
All/Most of the time	56%
Some of the time	32%
A Little/None of the time	12%
Felt balanced in mind, body, spirit and soul² (n=917)	
All/Most of the time	45%
Some of the time	36%
A Little/None of the time	19%
Felt marginalized or excluded from society² (n=914)	
All/Most of the time	15%
Some of the time	33%
A Little/None of the time	52%
Felt isolated and alienated from society² (n=918)	
All/Most of the time	11%
Some of the time	26%
A Little/None of the time	63%

¹ Items anchored "at present"

² Items anchored in "past 30 days"

Table 2c.6.1: AANHPI Adult Hub Numbers Served by Stigma/Barriers

AANHPI Adult (N=930)	
Variable	% Agree
You were planning or already getting help from a...	
Traditional helping professional (n=695)	55%
Community helping professional (n=713)	59%
You did not know of or have never heard of these types of mental health professionals (n=671)	30%
Structural Barriers	
No transportation (n=474)	27%
Lack of time (n=480)	35%
Cost of treatment (n=468)	38%
Prejudice Barriers	
Limited English (n=472)	29%
Race/ethnicity (n=465)	19%
Age (n=466)	15%
Religious or spiritual practice (n=464)	12%
Gender identity (n=466)	8%
Sexual orientation (n=469)	6%
Attitudinal Barriers	
Psychiatric hospitalization (n=469)	16%
Might have to take prescription medication (n=473)	23%
Treatment won't help (n=460)	25%
Uncomfortable talking about problems (n=459)	26%
Can handle problem on my own (n=461)	33%
Do not need treatment (n=465)	30%
Stigma Barriers	
Negative effect on job (n=463)	21%
Lack of confidentiality (n=464)	20%
Negative opinion from community (n=465)	16%

Table 2c.7.1: AANHPI Percentage of CDEP Respondents Scoring 3.51 or above on MHSIP Subscale Items

Highest and lowest percent's across subscale items are in bold

Subscale Domains	MHSIP Adult Items (N=754)	% strongly agree/ agree
General Satisfaction Subscale (Please answer based on the CDEP services, program, or activities)	I like the services that I received here.	97%
	If I had other choices, I would still get services from this agency.	96%
	I would recommend this agency to a friend or family member.	97%
Access Subscale (Please answer based on the CDEP services, program, or activities)	The location of services was convenient.	90%
	Services were available at times that were good for me.	97%
	Staff were willing to see me as often as I felt it was necessary.	96%
Outcomes Subscale (As a direct result of my involvement in the program...)	I deal more effectively with my daily problems.	82%
	I do better in school and/or work.*	79%
	My symptoms/ problems are not bothering me as much.	74%

*31% (n=236) of adult responses reported N/A

Table 2c.7.2: AANHPI MHSIP Language Assistance Items (written, oral)

MHSIP Linguistic Competence Items	Adult (N=754)
Were the services you received [CDEP program] in the language you prefer?	99%
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?	99%

Table 2c.7.3: AANHPI Percentage of CDEP Respondents Scoring 3.51 or above on (1) CBCI Subscale Items by Age Group

Highest and lowest percent's across subscale items are in bold

Subscale Domains	CBCI Adult Items (N=754)	% strongly agree/ agree
Respectful Behavior (Please answer based on the CDEP services, program, or activities)	The staff here treat me with respect.	98%
	The staff here don't think less of me because of the way I talk.	97%
	The staff here respect my race and/or ethnicity.	99%
	The staff here respect my religious and/or spiritual beliefs.	96%
	The staff here respect my gender identity and/or sexual orientation.	96%

Table 2c.7.4: AANHPI Percentage of Adult CDEP Respondents Scoring 3.51 or above on (3) CBCI Subscales

Highest and lowest percent's across subscale items are in bold

Subscale	CBCI Adult items (N=754)	% strongly agree/ agree
Patient-Provider-Organization Interactions (Please answer based on the CDEP services, program, or activities)	When I first called or came here, it was easy to talk to the staff.	95%
Understanding of Indigenous Practices (Please answer based on the CDEP services, program, or activities)	Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	98%
Acceptance of Cultural Differences (Please answer based on the CDEP services, program, or activities)	The people who work here respect my cultural beliefs, remedies and healing practices.	97%
	Staff here understand that people of my racial and/or ethnic group are not all alike.	96%
	Staff here understand that people of my gender and/or sexual orientation group are not all alike.	94%
	Staff here understand that people of my religious and spiritual background are not all alike.	95%

Table 2c.8: AANHPI Hub Workforce Development Summary – Formal Only and Formal/Informal Combined

	Formal	Combined Formal/ Informal
Number of IPPs	2 IPPs	5 IPPs (Formal=2 IPPs + Informal=3 IPPs)
Number of Workforce Activities	23	54
Foci	100% Internal ("in-house" CDEP)	2% External (non-CDEP) 87% Internal ("in-house" CDEP) 11% Both
Type of Workers Engaged	70% Community Members 87% Mental Health Workers 65% First Responders	37% Community Members 91% Mental Health Workers 70% First Responders <u>Type of First Responders:</u> 2% service providers; 17% health worker
Number of Program Touchpoints	316	784
Number of Sessions	198	275
Cumulative Hours	512.5	748.5
Racial Workforce Populations Engaged	43% African American 91% AANHPI 22% Latinx	22% African American 96% AANHPI 17% Latinx
Multilingual Capacity of Workers	Arabic, Dari/Farsi, Pashto, Urdu, Hindi, Punjabi, Hmong, Afghan, Pakistani	

Table 2c.9: AANHPI IPP Changes in Organizational Capacity

Casey Domain	Pre	Post	Delta
Operational Capacity	2.30	2.60	+0.3
Skills, abilities, & volunteer commitment	2.29	2.71	+0.42
Fundraising	1.83	2.29	+0.46
Board involvement & participation in fundraising	2.00	2.29	+0.29
Communications strategy	2.57	2.71	+0.14
Computers, applications, network, & email	2.43	3.00	+0.57
Website	2.43	2.43	0
Databases/management reporting system	2.43	2.86	+0.43
Buildings & office space	2.43	2.71	+0.28
Management of legal & liability matters	2.29	2.43	+0.14
Adaptive Capacity	2.43	2.89	+0.46
Strategic planning	2.43	3.00	+0.57
Evaluation/performance measurement	2.00	2.86	+0.86
Evaluation & organizational learning	2.43	2.86	+0.43
Use of research to support program planning & advocacy	2.00	2.71	+0.71
Program relevance & integration	2.71	2.86	+0.15
Program growth & replication	2.43	3.00	+0.57
Monitoring of program landscape	2.43	2.83	+0.4
Assessment of external environment & community needs	2.43	2.57	+0.14
Influencing of policy-making	2.43	2.86	+0.43
Partnerships & alliances	3.00	3.29	+0.29
Community presence & standing	2.57	3.14	+0.57
Constituent involvement	2.43	2.71	+0.28
Organizing	2.33	2.86	+0.53
Management Capacity	2.37	2.73	+0.36
Goals/performance targets	2.71	3.14	+0.43
Funding model	2.00	2.71	+0.71
Fund development planning	2.33	2.71	+0.38
Financial planning/budgeting	2.71	3.00	+0.29
Operational planning	2.43	2.86	+0.43
Decision making processes	2.43	2.86	+0.43
Knowledge management	2.29	2.86	+0.57
Recruiting, development & retention of management	2.14	2.29	+0.15
Recruiting, development & retention of general staff	2.57	2.71	+0.14
Volunteer management	2.14	2.14	0
Cultural Competence	2.75	3.05	+0.3
Expressed commitment to cultural competence	3.14	3.29	+0.15
Cultural competence policies, procedures, governance	2.57	3.00	+0.43
Planning, monitoring, evaluation	2.29	2.57	+0.28
Communication	2.86	3.14	+0.28
Human resources	2.14	2.86	+0.72
Cultural factors in engagement with community	3.29	3.43	+0.14
Service array and responsiveness to community context	3.14	3.29	+0.15
Linguistic competency	2.57	2.86	+0.29
Leadership Capacity	2.72	2.91	+0.19
Shared beliefs/values	3.00	3.29	+0.29
Board composition/Commitment	2.71	2.71	0
Board governance	2.50	3.17	+0.67
Board involvement and support	2.43	2.71	+0.28
Board and CEO/ED appreciation of power	2.86	2.57	-0.29
Ability to motivate and mobilize constituents	2.86	3.14	+0.28

Table 2c.10: AANHPI Hub Group Involvement

68 groups formed in total. 10 groups formed per IPP on average (range of 5 to 25)		
Overview	Total	
Total	69	<p>Top Reasons for Forming a Group</p> <ul style="list-style-type: none"> • Increase Mental Health Access thru Service Provision (34%) • Address Health Overall (16%) • Address Culture and Diversity in Service Provision (16%) <p>Top Accomplishments</p> <ul style="list-style-type: none"> • Increased/or strengthened programming (32%) • Increased awareness of mental health issues and services (64%) • Built relationships to advance mental health work (15%) <p>Top Challenges Encountered:</p> <ul style="list-style-type: none"> • Partner Engagement (34%) • COVID-19 (33%) • Limited Resources (18%)
Networks	10	
Collaboratives	35	
Formal Partnerships	23	
Time Period Formed		
Number Formed Before Phase 2	2 network 8 collabs 7 partnerships	
Number Formed During Phase 2	8 networks 27 collabs 16 partnerships	
CRDP Stakeholder Involvement		
With other AA IPPs	3 networks 5 collabs 1 partnership	
With other non-AA IPPs	2 network	
Types of Groups IPPs were involved with		
% Community-based groups	81%	
% Faith-based groups	24%	
% Gov't-based groups	22%	
% Institution-based groups	29%	
% Tribal-based groups	4%	

Table 2c.11: AANHPI Hub Environmental, Systems, and Policy Change Impact

Hub overall: 10 changes + 4 benchmarks
<p>Systems - Existing processes of organizations, institutions, and formal systems.</p> <p>Benchmarks:</p> <ul style="list-style-type: none"> • IPP initiated plans for a county health insurance system to provide Cambodian language translation. • Worked with the city to recognize the rise in API hate crimes, and engaged in discussions with the city to build racial reconciliation in Cambodia Town and grow API and Black solidarity. <p>Changes:</p> <ul style="list-style-type: none"> • IPP worked to form a racial equity framework with the city of Long Beach. • Worked with LA County DMH over several years and were able to pilot several CRDP Phase I activities. The county eventually adopted a resolution to fund API organizations. • Orange county health agency has translated health and mental health related resources for Cambodian community. • The City of Long Beach changed Office of Equity from the Health Department to City Manager's Office.
<p>Policy - Laws, regulations, ordinances, rules (i.e., policy changes).</p> <p>Benchmarks:</p> <ul style="list-style-type: none"> • IPP worked with the county to work on cultural competence after the state bill requiring counties to have cultural competence plans was vetoed by the Governor. • Worked with the City of Long Beach to develop a language plan for emergency responses. <p>Changes:</p> <ul style="list-style-type: none"> • After direct engagement with the city, Long Beach formally passed a language access policy. • After direct engagement with the city, Long Beach included multilingual signage in City Hall. • Long Beach passed housing ordinances that included relocation assistance and a moratorium on evictions in Long Beach during COVID-19. • IPP involvement in the Coalition for a Smoke Free Long Beach helped push a policy on a permanent flavored tobacco ban in February 2021. • IPP participated in a Coalition engaged in direct negotiations with the Mayor of Sacramento regarding the 2020-2021 City of Sacramento budget. Eventually the city adopted and directed close to \$9 million in federal CARES Act money to time-limited youth services, including employment/internships and peer-to-peer mental health training. • The City of Sacramento also launched its implementation of the Sacramento Youth Development Plan, which was used to guide new funding investments in four key areas –Mental Wellness, Employment, Expanding Learning, and Violence Prevention. IPP was awarded a two-year Mental Wellness grant from the City of Sacramento.

Table 2c.12: AANHPI Advocacy Activities and Examples

Major Themes Advocacy Activities	Examples
<p>Participated in community actions (e.g., visible participation in townhall meetings, community forums, school board or city council meetings, <u>including provided public testimony and commentary</u>).</p> <p><i>16 activities reported by 3 IPPs</i></p>	<p>CDEP staff presented about the effectiveness of the CDEP on behalf of the Assembly Bill 512 at the Sacramento State Capital; educated community members and decision makers on deportation, census outreach, and language access services via community forums and legislative visits; organized community members to contact their MediCal providers in Orange County (CalOptima) to express challenges they were experiencing in requesting a medical interpreter from their primary care providers; CDEP staff presented at the "Senate Subcommittee on Health and Human Services" to speak out the need of care coordinators in mental health and to ask for the extension of CRDP funding.</p>
<p>Conducted mental health education and awareness (with the general public, community members, and/or decision makers)</p> <p><i>15 activities reported by 5 IPPs</i></p>	<p>Conducted education and awareness focused on: Census participation; protecting the health and safety of underserved communities during COVID-19; COVID-19 testing and vaccinations; sexual assault prevention; tobacco prevention; mental health; self-care; nurturing parenting; Anti-Asian American violence.</p>
<p>Used a collective impact approach for change (strategic collaborations, advocated for changes in practices, regulations, policies, programming, or funding streams).</p> <p><i>10 activities reported by 5 IPPs</i></p>	<p>Extended collaborations with more community clinic programs; participated in the following partnerships for advocacy – Budget Advocacy Workgroup, Cambodian Complete Count Committee, Long Beach Complete Count Committee, and LanguageCAA; actively participated in groups advocating for the LA County DMH to consider adopting a variety of strategies from CRDP Phase I as allowable activities to reduce mental health disparities in Asian Pacific Islander communities; partnered with other IPPs to educate the County about CRDP work and advocated to sustain this work at the local level; initiated a local community collaborative where different Mental Health stakeholder groups in Santa Ana (and Stanton) come together to improve mental health access in their local communities.</p>
<p>Launched media campaigns (used the media, including the arts, for strategic messaging and framing of social justice issues; involved messaging related to root causes and potential solutions)</p> <p><i>6 activities reported by 2 IPPs</i></p>	<p>Used various forms of social media such as organizational website, Facebook, Instagram, and YouTube to share CDEP resources and telehealth services including primary care, mental health, dental health, and Medi-Cal enrollment; IPP's Executive Director was invited to do a Public Service Announcement (PSA) explaining in Khmer the importance of the census and encouraging people to take the census online. These PSAs were made available through the California Census office and given to cities for airing on their public channels. In addition, produced three PSAs in English, Khmer, and Spanish explaining the importance of 2020 Census and encouraging the community to complete the census; worked closely with NBC reporter Agnes Constante on Asian American issues, involving, but not limited to, Khmer voters, COVID-19 vaccinations in under-served communities, Anti-Asian hate/violence, and an Asian American mental health.</p>
<p>Conducted research campaigns (community-driven, participatory, action research and evaluation activities used for advocacy)</p> <p><i>5 activities reported by 3 IPPs</i></p>	<p>CDEP collected mental health data from community members to show barriers in mental health; hosted a focus group for language access services in the city of Long Beach to evaluate barriers and services; partnered with UCLA Semel Institute to host a focus group in Khmer to understand more about how mental well-being impacts people's lives in California. Focus groups were conducted in multiple California counties as part of a project focusing on the MHSA's list of 7 negative outcomes that can result from untreated or improperly treated mental illness.</p>
<p>Participated in civic/voter engagement activities (activities that promoted community awareness of and involvement in civic, community, & political life, such as ballot organizing, voter turnout activities, to name a few)</p> <p><i>4 activities reported by 3 IPPs</i></p>	<p>Participated in a grassroots coalition of youth, youth advocates, and service-providers that successfully collected 39,000 signatures to qualify the Sacramento Children's Fund Act of 2020 onto the March 2020 election ballot. Made over 1,000 phone calls to community members to remind them to fill out their census form; organized and assisted resident leaders in participating in Census meetings and educated community members about the importance of Census and Civic participation.</p>
<p>Participated in mass mobilization activities (e.g., rally, protest, marches)</p> <p><i>4 activities reported by 2 IPPs</i></p>	<p>Partnered with Councilmember Saro to host Anti Hate vigil in Cambodia Town in response to the Atlanta, Georgia tragedy; coordinated rallies around tenant rights.</p>
<p>Engaged in grassroots community organizing (building of community power to address social inequities and achieve social and political change)</p> <p><i>2 activities reported by 2 IPPs</i></p>	<p>Developed resident leaders by educating them on policy changes that could affect their daily lives and helped them build communication and organizing skills; canvassed neighborhoods and promoted the initiative at community events in the runup to the March 2020 election.</p>
<p>Conducted formal individual-level advocacy (spoke out and advocated on behalf of a community member to resolve an issue, obtain a needed support/service, or promote a change in the practices, policies and/or behaviors of third parties)</p> <p><i>1 activity reported by 1 IPP</i></p>	<p>Advocated for language access services for community members to access government services and institutions.</p>

Table 2c.13: CDEP Fidelity and Flexibility in the AANHPI Hub

Total # of Program Components at the start of CRDP Phase 2	29; 4 components per CDEP, on average (range of 3-5)
Total # of Program Components at the end of CRDP Phase 2	29
Components Added	0 (0%) (n=0 IPPs)
Components Dropped	0 (0%) (n=0 IPPs)
Unplanned Delays in Component Implementation	2 IPPs (29%)
Top 3 Types of Component Changes Made	Program Delivery (n=5 IPPs) Personnel (n=3 IPPs) Programmatic (n=2 IPPs); Research (n=2 IPPs)

2D: LATINX HUB-LEVEL TABLES

Table 2d.1.1: Latinx Hub Number of Unique Individuals who Received Referrals, Linkages & Navigation (n=6 IPPs)

Age Group	# Referrals*	# Linkages to Care	# Service Navigation
Adults	2,740 (n= 6 IPPs)	1,053 (n=6 IPPs)	700 (n=6 IPPs)
Adolescents	619 (n=4 IPPs)	173 (n=2 IPPs)	172 (n=3 IPPs)
Children	9 (n=1 IPP)	2 (n=1 IPP)	3 (n=1 IPP)
TOTAL	3,368 referrals by 6 IPPs	1,228 of 3,368 (33% received linkage)	875 of 3,368 (26% received service navigation)

*Note: Some IPPs provided referrals to multiple age groups and counts may be duplicative across age categories.

Table 2d.1.2: Latinx Hub Number of Referrals* by Type and Subtype

Referral Type and Subtype	# Referrals Provided	#IPPs
Mental Health	1,781	6
Counseling, therapy, wellness	1,041	6
Substance Abuse (e.g., AOD treatment)	287	5
Sexual Assault	191	5
Domestic Violence	168	6
Psychiatric Care	90	2
Other Mental Health	4	1
Basic Needs	1,667	5
Financial Assistance	530	4
Food Assistance (e.g., food bank)	489	4
Housing, Rent, & Utilities	359	5
Clothing and Furniture Assistance	172	1
Transportation	100	3
Other Basic Needs	17	1
Health	772	6
Primary Health Care (e.g., well-check, vaccines, etc.)	508	5
COVID-Related Health Supports	149	2
Nutrition	85	1
Medical Benefits and Insurance	22	2
Dental/Optomety/Prescription	7	2
Female Reproductive Health	1	1
Personal Growth & Development	441	4
Social/Cultural Enrichment Programs	146	2
Support/Mentoring	103	1
Volunteer Services	87	3
Faith-Based or Spiritual Services	86	2
Other (e.g., entrepreneurial training, police athletic league)	19	2
Employment/Career	269	3

Referral Type and Subtype	# Referrals Provided	#IPPs
Legal/Advocacy	273	6
Other (free legal services, tenant rights, etc.)	125	4
Immigration Services	112	6
Legal Mediation (e.g., divorce, custody)	35	3
Child Welfare	1	1
Education	155	3
Academic Support (e.g., college applications, school placement)	90	3
Tutoring	64	2
Adult Education	1	1
Parenting classes, early childcare support	100	3
Specialty Care	30	2
"Multi-Category" (e.g., housing, education, job training, etc.)	122	4
TOTAL	5,637	6

*Note: Any 1 individual may have received more than 1 referral; Total N's across categories are duplicative.

Table 2d.2.1: Latinx Adult Hub Demographic Populations Served

Latinx Adult (N=750)		
Variable	%	
Racial Groups (n=742)	% Total	% Multi-Race
Latinx	99%	-
Mexican/Chicano	82%	
Salvadoran	2%	
Guatemalan	2%	
Honduran	2%	
African American/Black	< 1%	-
American Indian/Alaska Native	< 1%	-
White	< 1%	-
Age (n=746)		
18-29 years	18%	
30-39 years	28%	
40-44 years	18%	
45-49 years	14%	
50-64 years	18%	
65+ years	3%	
Gender Identity (n=725)		
Cisgender Woman/Female	81%	
Cisgender Man/Male	15%	
Genderqueer/Non-Binary	0.8%	
Transgender Woman/Female	0.3%	
Transgender Man/Male	0.3%	
Questioning/Unsure	0.3%	
Sexual Orientation (n=701)		
Straight/Heterosexual	97%	
LGBQ+	3%	
LGBQ+ Identities		
Gay/Lesbian	1%	
Asexual/Aromantic	1%	
Questioning	1%	
Bisexual	0.6%	
Queer	0.3%	
English Fluency (n=739)		
Fluent	15%	
Somewhat fluent	16%	
Not very well	21%	
Knows some vocabulary	21%	
Not at all	27%	
Foreign Born (n=728)	91%	
Refugee Status (n=672)	9%	

Table 2d.2.2: Latinx Adolescent Hub Demographic Populations Served

Latinx Adolescent (N=145)		
Variable	%	
Racial Groups (n=137)	% Total	% Multi-Race
Latinx	84%	5%
Mexican/Chicano	41%	
Salvadoran	1%	
Guatemalan	0.07%	
Honduran	0.07%	
Asian	9%	1%
African American/Black	7%	2%
American Indian/Alaska Native	5%	3%
White	3%	2%
Age (n=140)		
12 years	11%	
13 years	4%	
14 years	1%	
15 years	37%	
16 years	37%	
17 years	10%	
Gender Identity (n=120)		
Cisgender Man/Male	53%	
Cisgender Woman/Female	40%	
Transgender Woman/Female	0.8%	
Genderqueer/Non-Binary	0.8%	
Questioning/Unsure	0.8%	
Sexual Orientation (n=114)		
Straight/Heterosexual	88%	
LGBQ+	12%	
LGBQ+ Identities		
Bisexual	11%	
Questioning	2%	
Gay/Lesbian	1%	
Asexual/Aromantic	1%	
English Fluency (n=141)		
Fluent	82%	
Somewhat fluent	14%	
Not very well	3%	
Not at all	0.7%	
Foreign Born (n=137)	4%	
Refugee Status (n=119)	3%	

Table 2d.3.1: Latinx Adult Hub Numbers Served by Mental Health Need

Latinx Adult (N=750)	
Variable	%
Mental Health Need (n=728)	
No Need	29%
Need	71%
PARC Approach (n=515)	
Unmet	46%
Met	51%
Mental Health Helping Professional Seen¹	
Traditional	16%
Community	19%
Primary Care Physician	33%
Mental Health	28%
CHIS Approach (n=515)	
Unmet	53%
Met	45%
Mainstream ²	22%
Health Insurance Coverage (n=705)	
Coverage	44%
No Coverage	56%
Coverage: Uses MH Services	20%
No Coverage: Uses MH Services	18%
Coverage: Takes Prescription Meds	8%
No Coverage: Takes Prescription Meds	5%
Coverage: Median # Visits ³	1
No Coverage: Median # Visits ³	2

¹ This is a multiple response item; participants selected all the categories that were true for them; percentages do not add up to 100

² Primary care physician or general practitioner; MH professional (counselor, therapist, psychologist, psychiatrist or social worker)

³ Different sample size due to skip logic

Table 2d.3.2: Latinx Adolescent Hub Numbers Served by Mental Health Need

Latinx Adolescent (N=145)	
Variable	%
Mental Health Need (n=116)	
No Need	63%
Need	37%
PARC Approach (n=43)	
Unmet	40%
Met	65%
Mental Health Helping Professional Seen¹	
Traditional	26%
Community	42%
Mental Health	21%
School Mental Health	47%
CHIS Approach (n=43)	
Unmet	51%
Met	53%
Mainstream ²	16%

¹ This is a multiple response item; participants selected all the categories that were true for them; percentages do not add up to 100

² Primary care physician or general practitioner; MH professional (counselor, therapist, psychologist, psychiatrist or social worker)

Table 2d.4.1: Latinx Adult Hub Numbers Served by Psychological Distress and Functioning

Latinx Adult (N=750)	
Variable	%
Psychological Distress (K6)¹ (n=725)	
Low (K6<5)	15%
Moderate (5<=K6<=12)	37%
Serious (K6>=13)	48%
Moderate K6 (5<=K6<=12) by Functional Impairment (SDS)²	
Work/School (n=204)	
Not at all	19%
Some	49%
A lot	32%
Household Chores (n=256)	
Not at all	17%
Some	53%
A lot	30%
Social Life (n=249)	
Not at all	20%
Some	54%
A lot	26%
Relationships with Friends/Family (n=253)	
Not at all	25%
Some	49%
A lot	26%
Serious K6 (K6>=13) by Functional Impairment (SDS)²	
Work/School (n=299)	
Not at all	4%
Some	22%
A lot	74%
Household Chores (n=342)	
Not at all	5%
Some	25%
A lot	70%
Social Life (n=342)	
Not at all	2%
Some	23%
A lot	75%
Relationships with Friends/Family (n=340)	
Not at all	3%
Some	25%
A lot	72%
Moderate K6 (5<=K6<=12) by Number of Functional Impairments (n=267)	
None	9%
1 Impairment	6%
2 Impairment	15%
3 Impairment	29%
4 Impairment	41%
Serious K6 (K6>=13) by Number of Psychological Functional Impairments (n=346)	
None	0.3%
1 Impairment	1%
2 Impairment	5%
3 Impairment	18%
4 Impairment	76%
Moderate K6 (5<=K6<=12) by Mental Health Need (n=260)	
Mental Health Need	72%
No Mental Health Need	28%
Serious K6 (K6>=13) by Mental Health Need (n=340)	
Mental Health Need	80%
No Mental Health Need	20%

¹ Kessler-6: In the past 30 days, how often have you felt: nervous, hopeless, restless/fidgety, depressed, that everything was an effort, worthless (Scale: 4=All of the time to 0=None of the time; range of responses was 0-24)

² Sheehan Disability Scale: Worst month past year, did your emotions interfere with: work/school performance, household chores, social life, relationship with friends and family (Scale: 2=A lot to 0=Not at all; range of responses was 0-8)

Table 2d.4.2: Latinx Adolescent Hub Numbers Served by Psychological Distress and Functioning

Latinx Adolescent (N=145)	
Variable	%
Psychological Distress (K6)¹ (n=135)	
Low (K6<5)	38%
Moderate (5<=K6<=12)	38%
Serious (K6>=13)	24%
Moderate K6 (5<=K6<=12) by Functional Impairment (SDS)²	
School/Homework (n=51)	
Not at all	30%
Some	39%
A lot	31%
With friends (n=51)	
Not at all	43%
Some	35%
A lot	22%
At Home (n=51)	
Not at all	49%
Some	39%
A lot	12%
Serious K6 (K6>=13) by Functional Impairment (SDS)²	
School/Homework (n=33)	
Not at all	6%
Some	36%
A lot	58%
With friends (n=33)	
Not at all	15%
Some	55%
A lot	30%
At Home (n=33)	
Not at all	12%
Some	27%
A lot	61%
Moderate K6 (5<=K6<=12) by Number of Functional Impairments (n=51)	
None	16%
1 Impairment	22%
2 Impairment	31%
3 Impairment	31%
Serious K6 (K6>=13) by Number of Psychological Functional Impairments (n=33)	
None	0%
1 Impairment	6%
2 Impairment	21%
3 Impairment	73%
Moderate K6 (5<=K6<=12) by Mental Health Need (n=37)	
Mental Health Need	46%
No Mental Health Need	54%
Serious K6 (K6>=13) by Mental Health Need (n=26)	
Mental Health Need	88%
No Mental Health Need	12%

¹ Kessler-6: In the past 30 days, how often have you felt: nervous, hopeless, restless/fidgety, depressed, that everything was an effort, worthless (Scale: 4=All of the time to 0=None of the time; range of responses was 0-24)

² Sheehan Disability Scale: Worst month past year, did your emotions interfere with: work/school performance, household chores, social life, relationship with friends and family (Scale: 2=A lot to 0=Not at all; range of responses was 0-8)

Table 2d.5.1: Latinx Adult Hub Numbers Served by Protective Factors

Latinx Adult (N=750)	
Variable	%
Your culture gives you strength¹ (n=748)	
Strongly Agree/Agree	87%
Neutral	10%
Strongly Disagree/Disagree	3%
Your culture is important to you¹ (n=744)	
Strongly Agree/Agree	91%
Neutral	7%
Strongly Disagree/Disagree	2%
Your culture helps you to feel good about who you are¹ (n=740)	
Strongly Agree/Agree	88%
Neutral	9%
Strongly Disagree/Disagree	3%
You feel connected to spiritual/religious traditions of the culture you were raised in¹ (n=747)	
Strongly Agree/Agree	82%
Neutral	12%
Strongly Disagree/Disagree	6%
Felt connected to your culture² (n=748)	
All/Most of the time	67%
Some of the time	23%
A Little/None of the time	10%
Felt balanced in mind, body, spirit and soul² (n=740)	
All/Most of the time	53%
Some of the time	29%
A Little/None of the time	18%
Felt marginalized or excluded from society² (n=744)	
All/Most of the time	32%
Some of the time	31%
A Little/None of the time	37%
Felt isolated and alienated from society² (n=749)	
All/Most of the time	34%
Some of the time	27%
A Little/None of the time	39%

¹ Items anchored "at present"

² Items anchored in "past 30 days"

Table 2d.5.2: Latinx Adolescent Hub Numbers Served by Protective Factors

Latinx Adolescent (N=145)	
Variable	%
Your culture gives you strength ¹ (n=144)	
Strongly Agree/Agree	69%
Neutral	28%
Strongly Disagree/Disagree	3%
Your culture is important to you ¹ (n=144)	
Strongly Agree/Agree	87%
Neutral	12%
Strongly Disagree/Disagree	1%
Your culture helps you to feel good about who you are ¹ (n=142)	
Strongly Agree/Agree	78%
Neutral	20%
Strongly Disagree/Disagree	2%
You feel connected to spiritual/religious traditions of the culture you were raised in ¹ (n=143)	
Strongly Agree/Agree	64%
Neutral	27%
Strongly Disagree/Disagree	9%
Felt connected to your culture ² (n=144)	
All/Most of the time	55%
Some of the time	28%
A Little/None of the time	17%
Felt balanced in mind, body, spirit and soul ² (n=140)	
All/Most of the time	40%
Some of the time	34%
A Little/None of the time	26%
Felt marginalized or excluded from society ² (n=142)	
All/Most of the time	21%
Some of the time	21%
A Little/None of the time	58%
Felt isolated and alienated from society ² (n=143)	
All/Most of the time	18%
Some of the time	20%
A Little/None of the time	62%

¹ Items anchored "at present"
² Items anchored in "past 30 days"

Table 2d.6.1: Latinx Adult Hub Numbers Served by Stigma/Barriers

Latinx Adult (N=750)	
Variable	% Agree
You were planning or already getting help from a...	
Traditional helping professional (n=654)	25%
Community helping professional (n=659)	40%
You did not know of or have never heard of these types of mental health professionals (n=675)	60%
Structural Barriers	
No transportation (n=282)	28%
Lack of time (n=282)	49%
Cost of treatment (n=278)	55%
Prejudice Barriers	
Limited English (n=280)	39%
Race/ethnicity (n=276)	22%
Age (n=273)	14%
Religious or spiritual practice (n=275)	15%
Gender identity (n=272)	10%
Sexual orientation (n=276)	11%
Attitudinal Barriers	
Psychiatric hospitalization (n=277)	23%
Might have to take prescription medication (n=282)	34%
Treatment won't help (n=269)	36%
Uncomfortable talking about problems (n=258)	43%
Can handle problem on my own (n=281)	52%
Do not need treatment (n=277)	43%
Stigma Barriers	
Lack of confidentiality (n=279)	28%
Negative opinion from community (n=283)	25%
Negative effect on job (n=279)	16%

Table 2d.6.2: Latinx Adolescent Hub Numbers Served by Stigma/Barriers

Latinx Adolescent (N=145)	
Variable	% Agree
You were planning or already getting help from a...	
Traditional helping professional (n=109)	19%
Community helping professional (n=109)	26%
You did not know of or have never heard of these types of mental health professionals (n=113)	39%
Structural Barriers	
No transportation (n=84)	15%
Lack of time (n=84)	26%
Cost of treatment (n=78)	14%
Did not know where to get help (n=88)	26%
Prejudice Barriers	
Limited English (n=89)	5%
Race/ethnicity (n=86)	9%
Age (n=83)	12%
Religious or spiritual practice (n=88)	5%
Gender identity (n=87)	3%
Sexual orientation (n=85)	6%
Attitudinal Barriers	
Did not want to talk to stranger (n=78)	44%
Thought issue wasn't serious enough (n=81)	54%
Can solve issue on my own (n=85)	64%
Uncomfortable talking with them (n=78)	53%
Stigma Barriers	
Negative opinion from family/community (n=82)	29%
Embarrassed about what you were going through (n=78)	32%
Negative opinion from family/community (n=83)	35%
Worried friends would find out (n=82)	24%

Table 2d.7.1: Latinx Percentage of CDEP Respondents Scoring 3.51 or above on MHSIP Subscale Items

Highest and lowest percent's across subscale items are in bold

Subscale Domains	MHSIP Adult Items (N=597)	% strongly agree/ agree	MHSIP Adolescent Items (N=131)	% strongly agree/ agree
General Satisfaction Subscale (Please answer based on the CDEP services, program, or activities)	I like the services that I received here.	99%	Overall, I am satisfied with the services I received.	70%
	If I had other choices, I would still get services from this agency.	98%	The people helping me stuck with me no matter what.	73%
	I would recommend this agency to a friend or family member.	99%	I felt I had someone to talk to when I was troubled.	70%
			I received services that were right for me.	66%
			I got the help I wanted.	72%
Access Subscale (Please answer based on the CDEP services, program, or activities)	The location of services was convenient.	96%	The location of services was convenient for me.	63%
	Services were available at times that were good for me.	98%	Services were available at times that were convenient for me.	59%
	Staff were willing to see me as often as I felt it was necessary.	98%		
Outcomes Subscale (As a direct result of my involvement in the program...)	I deal more effectively with my daily problems.	89%	I am better at handling daily life.	70%
	I do better in school and/or work.	84%	I am doing better in school and/or work.	63%
	My symptoms/ problems are not bothering me as much.	81%	I get along better with friends and other people.	70%
			I get along better with family members.	66%
			I am better able to cope when things go wrong.	64%
			I am satisfied with my family life right now.	70%
			I am better able to do things I want to do.	76%
Social Connectedness Subscale (As a direct result of my involvement in the program...)			I know people who will listen and understand me when I need to talk.	77%
			I have people that I am comfortable talking with about my problem(s).	77%
			In a crisis, I would have the support I need from family or friends.	77%
			I have people with whom I can do enjoyable things.	84%

Table 2d.7.2: Latinx MHSIP Language Assistance Items (written, oral)

MHSIP Linguistic Competence Items	Adult (N=597)	Adolescent (N=131)
Were the services you received [CDEP program] in the language you prefer?	99.8%	85%
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?	94%	88%

Table 2d.7.3: Latinx Percentage of CDEP Respondents Scoring 3.51 or above on (1) CBCI Subscale Items by Age Group

Highest and lowest percent's across subscale items are in bold

Subscale Domains	CBCI Adult Items (N=597)	% strongly agree/agree	CBCI Adolescent Items (N=131)	% strongly agree/agree
Respectful Behavior (Please answer based on the CDEP services, program, or activities)	The staff here treat me with respect.	99.8%	Staff treated me with respect.	79%
	The staff here don't think less of me because of the way I talk.	99%	Staff spoke with me in a way that I understood.	79%
	The staff here respect my race and/or ethnicity.	99.7%	Staff were sensitive to my cultural/ethnic background.	64%
	The staff here respect my religious and/or spiritual beliefs.	99%	Staff respected my religious/spiritual beliefs.	79%
	The staff here respect my gender identity and/or sexual orientation.	99%		

Table 2d.7.4: Latinx Percentage of Adult CDEP Respondents Scoring 3.51 or above on (3) CBCI Subscales

Highest and lowest percent's across subscale items are in bold

Subscale	CBCI Adult items (N=597)	% strongly agree/agree
Patient-Provider-Organization Interactions (Please answer based on the CDEP services, program, or activities)	When I first called or came here, it was easy to talk to the staff.	97%
Understanding of Indigenous Practices (Please answer based on the CDEP services, program, or activities)	Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	99%
Acceptance of Cultural Differences (Please answer based on the CDEP services, program, or activities)	The people who work here respect my cultural beliefs, remedies and healing practices.	99.8%
	Staff here understand that people of my racial and/or ethnic group are not all alike.	99%
	Staff here understand that people of my gender and/or sexual orientation group are not all alike.	99%
	Staff here understand that people of my religious and spiritual background are not all alike.	98%

Table 2d.8: Latinx Hub Workforce Development Summary – Formal Only and Formal/Informal Combined

	Formal	Combined Formal/Informal
Number of IPPs	5 IPPs	7 IPPs (Formal=5 IPPs + Informal=2 IPPs)
Number of Workforce Activities	84	94
Foci	37% External (non-CDEP) 55% Internal ("in-house" CDEP) 8% Both	36% External (non-CDEP) 56% Internal ("in-house" CDEP) 7% Both
Type of Workers Engaged	56% Community Members 33% Mental Health Workers 33% First Responders <u>Type of First Responders:</u> 18% school personnel; 20% service providers; 11% health worker	50% Community Members 40% Mental Health Workers 31% First Responders <u>Type of First Responders:</u> 17% school personnel; 18% service provider; 11% health worker
Number of Program Touchpoints	1,190	1,324
Number of Sessions	307	391
Cumulative Hours	1,599	1,928
Racial Workforce Populations Engaged	2% African American 1% AI/AN 5% AANHPI 100% Latinx 13% LGBTQ+	4% African American 1% AI/AN 7% AANHPI 100% Latinx 15% LGBTQ+
Multilingual Capacity of Workers	Spanish, Mixteco, Zapoteco, Bengali, Purepecha	

Table 2d.9: Latinx IPP Changes in Organizational Capacity

Casey Domain	Pre	Post	Delta
Operational Capacity	2.65	2.61	-0.04
Skills, abilities, & volunteer commitment	2.71	2.40	-0.31
Fundraising	2.57	2.50	-0.7
Board involvement & participation in fundraising	2.29	2.29	0
Communications strategy	2.71	3.00	+0.29
Computers, applications, network, & email	2.86	2.71	-0.15
Website	2.43	2.86	+0.43
Databases/management reporting system	2.29	2.50	+0.21
Buildings & office space	3.29	2.50	-0.79
Management of legal & liability matters	2.71	2.71	0
Adaptive Capacity	2.87	2.93	+0.06
Strategic planning	3.00	2.86	-0.14
Evaluation/performance measurement	2.14	2.71	+0.57
Evaluation & organizational learning	2.29	2.60	+0.31
Use of research to support program planning & advocacy	2.57	3.00	+0.43
Program relevance & integration	3.43	3.17	-0.26
Program growth & replication	3.14	3.33	+0.19
Monitoring of program landscape	3.29	3.43	+0.14
Assessment of external environment & community needs	3.14	3.29	+0.15
Influencing of policy-making	2.71	3.00	+0.29
Partnerships & alliances	3.29	3.83	+0.54
Community presence & standing	3.14	3.17	+0.03
Constituent involvement	2.71	2.33	-0.38
Organizing	2.43	2.43	0
Management Capacity	2.70	2.61	-0.09
Goals/performance targets	2.71	3.00	+0.29
Funding model	2.43	2.50	+0.07
Fund development planning	2.71	2.67	-0.04
Financial planning/budgeting	3.00	2.71	-0.29
Operational planning	2.71	2.50	-0.21
Decision making processes	3.00	2.60	-0.4
Knowledge management	2.43	2.60	+0.17
Recruiting, development & retention of management	2.71	2.80	+0.09
Recruiting, development & retention of general staff	3.00	3.00	0
Volunteer management	2.29	2.00	-0.29
Cultural Competence	3.34	3.35	+0.01
Expressed commitment to cultural competence	3.86	3.43	-0.43
Cultural competence policies, procedures, governance	3.00	2.86	-0.14
Planning, monitoring, evaluation	2.43	2.86	+0.43
Communication	3.14	3.50	+0.36
Human resources	3.14	3.00	-0.14
Cultural factors in engagement with community	3.71	3.83	+0.12
Service array and responsiveness to community context	3.71	3.50	-0.21
Linguistic competency	3.71	3.83	+0.12
Leadership Capacity	2.95	2.83	-0.12
Shared beliefs/values	3.29	3.33	+0.04
Board composition/Commitment	2.71	2.83	+0.12
Board governance	2.57	3.00	+0.43
Board involvement and support	3.00	2.57	-0.43
Board and CEO/ED appreciation of power	3.00	2.57	-0.43
Ability to motivate and mobilize constituents	3.14	3.00	-0.14

Table 2d.10: Latinx Hub Group Involvement

93 groups formed in total. 13.4 groups formed per IPP on average (range of 3 to 32)		
Overview	Total	
Total	93	<p>Top Reasons for Forming a Group</p> <ul style="list-style-type: none"> • Increase Mental Health Access thru Service Provision (47%) • Training, TA or Information Sharing (21%) • Address Health Overall (10%) <p>Top Accomplishments</p> <ul style="list-style-type: none"> • Increased/or strengthened programming (42%) • Built relationships to advance mental health work (32%) • Increased awareness of mental health issues and services (17%) <p>Top Challenges Encountered:</p> <ul style="list-style-type: none"> • Challenges with Service Provision (28%) • Partner Engagement (27%) • COVID-19 (18%)
Networks	13	
Collaboratives	56	
Formal Partnerships	23	
Time Period Formed		
Number Formed Before Phase 2	3 networks 7 collabs 5 partnerships	
Number Formed During Phase 2	10 networks 49 collabs 18 partnerships	
CRDP Stakeholder Involvement		
With other AA IPPs	1 network 9 collabs 1 partnership	
With other non-AA IPPs	1 network 5 collabs 2 partnerships	
Types of Groups IPPs were involved with		
% Community-based groups	59%	
% Faith-based groups	12%	
% Gov't-based groups	23%	
% Institution-based groups	32%	
% Tribal-based groups	10%	

Table 2d.11: Latinx Hub Environmental, Systems, and Policy Change Impact

Hub overall: 9 changes
<p>Environmental – Physical or social spaces or places where people live, learn, work, and play (i.e., environmental changes).</p> <p>Changes:</p> <ul style="list-style-type: none"> • IPP Co-located programs at relevant sites and added new sites over time. • IPP was awarded project funding through MHSA PEI to sustain direct services to uninsured Latinx individuals for at least two years. • IPP received a short-term grant to assist farm workers testing positive for COVID to receive temporary shelter, food, and housing assistance. • IPP partnered with Council Member, YMCA and Univision to distribute food, school lunches, and financial housing assistance, respectively. • IPP received additional funding and resources to reach migrant indigenous communities to provide information in multiple indigenous languages. The resources allowed the IPP to engage in grassroots strategies to connect with the community and inform them about the benefits of COVID-19 vaccines and distribute 5,666 facemasks and 248 hand sanitizers to migrant indigenous communities.
<p>Systems – Existing processes of organizations, institutions, and formal systems.</p> <p>Changes:</p> <ul style="list-style-type: none"> • IPP worked with a number of schools to change their approaches to discipline. They now provide the mental health services in one school, incorporated programmatic approach in another school and in one school, and saw that the disciplinary measures have changed to be supportive rather than punitive. • IPP worked with various mental health organizations and local government agencies to provide training on working with their population. By 2019, they began seeing organizations refer clients to them. Law enforcement called them for support when engaging with people from their population. By 2020, Child Protective Services was calling IPP when they obtained custody of minors from their community. • IPP, along with other community-based organizations, has achieved positive systems-level change for farmworker communities, such as increasing the access to COVID-19 vaccines in the agricultural fields, mobile clinics in identified areas, COVID-testing, COVID-19 Supplemental Paid Sick Leave, and increased information on safety health measures, etc.
<p>Policy – Laws, regulations, ordinances, rules (i.e., policy changes).</p> <p>Changes:</p> <ul style="list-style-type: none"> • IPP worked on and saw the passage of Peer Support Certification bill SB803 to establish statewide requirements for counties or their representatives to use in developing certification programs for peer support specialists.

Table 2d.12: Latinx IPP Advocacy Activities and Examples

Major Themes Advocacy Activities	Examples
<p>Participated in community actions (e.g., visible participation in townhall meetings, community forums, school board or city council meetings, including provided public testimony and commentary).</p> <p><i>21 activities reported by 6 IPPs</i></p>	<p>Met with Board of Supervisors to share information about the need for mental health services in the County; CDEP participant provided commentary for a Kaiser Permanente Roseville Service Area Community Health Needs Assessment about mental health services needs for the community; engaged in various conversations with the Director of the Ventura County Behavioral Health department about the Mexican indigenous communities' needs in terms of mental health services; provided testimony in Sonoma County COAD (Community Organizations Active in Disaster) meetings to ensure needs specific to the Latinx community were accounted for in the County's disaster response.</p>
<p>Conducted mental health education and awareness (with the general public, community members, and/or decision makers)</p> <p><i>19 activities reported by 6 IPPs</i></p>	<p>Conducted education and awareness activities focused on: impact of Covid 19 in the Latinx community; inclusive health access system for Mexican indigenous communities; social justice, healing and liberation.</p>
<p>Used a collective impact approach for change (strategic collaborations, advocated for changes in practices, regulations, policies, programming, or funding streams).</p> <p><i>18 activities reported by 6 IPPs</i></p>	<p>Partnered with Roseville City School District to work with parents and teachers to reduce mental health stigma among families. This has included a parent workshop on mental health, connecting school staff to mental health trainings, and mental health awareness activity with Elementary's after school program students; participated in the Suicide Prevention Task Force to create awareness, increase access, change procedures for detection and treatment and change policy; in collaboration with Barrios Unidos, IPP engaged in providing support services to youth engaged in advocating for the reduction of police violence against their community; participated in multiple committees providing recommendations and strategies to reach farmworker, migrant indigenous populations and create access and education on COVID-19 vaccines.</p>
<p>Participated in civic/voter engagement activities (activities that promoted community awareness of and involvement in civic, community, & political life, such as ballot organizing, voter turnout activities, to name a few)</p> <p><i>8 activities reported by 4 IPPs</i></p>	<p>Provided a voting site, census site, and marketed both to encourage Latinx to come and vote and complete the census; promoted the census by handing out bags that had masks and hand-sanitizer in them, as well as information about when and how to take the census; used IPP office as a voting site in November 2020.</p>
<p>Conducted research campaigns (community-driven, participatory, action research and evaluation activities used for advocacy)</p> <p><i>8 activities reported by 3 IPPs</i></p>	<p>Worked one-on-one with CDEP participants, who required additional support from mental health providers, to ensure accessibility; assisted with navigation for client to meet with workman's compensation dept., and empowered client to follow through with services which ultimately resulted in client receiving award and compensation; advocated for efficient transfer of educational transitional services for CDEP participants (e.g., transfer from one school site to the next); assisted families with food and shelter resources, connecting with funding sources.</p>
<p>Launched media campaigns (used the media, including the arts, for strategic messaging and framing of social justice issues; involved messaging related to root causes and potential solutions)</p> <p><i>8 activities reported by 3 IPPs</i></p>	<p>Started a podcast and radio program to address mental health issues and health equity; created a Spanish language video called "La Importancia del Censo 2020" to engage the community in filling out their census; aired Univision speaking about available services to the Latino community for support during Covid-19; promotional materials were made bilingual and were culturally appropriate with images and sayings that the Latinx community would recognize and resonate with.</p>
<p>Engaged in grassroots community organizing (building of community power to address social inequities and achieve social and political change)</p> <p><i>5 activities reported by 5 IPPs</i></p>	<p>Organized community members to help renovate a classroom in a park to make the classroom available for public use; in an effort to organize youth, IPP received funding through the Fresno Arts Council to give youth a voice in their response to the pandemic.</p>
<p>Conducted formal individual-level advocacy (spoke out and advocated on behalf of a community member to resolve an issue, obtain a needed support/service, or promote a change in the practices, policies and/or behaviors of third parties)</p> <p><i>3 activities reported by 3 IPPs</i></p>	<p>Participated in community wide evaluation efforts to gauge the community's perspective on policing in the schools, with the end result to change that policy; engaged in a Youth participatory qualitative research project examining the lived experiences of Latinx youth and young adults in the Sonoma County area having lived through multiple crises (Covid, political unrest, and/or fires).</p>
<p>Participated in mass mobilization activities (e.g., rally, protest, marches)</p> <p><i>3 activities reported by 3 IPPs</i></p>	<p>Helped coordinate an educational event in response to local youth action being taken for racial and social justice; participated in efforts supporting Tenant's and Domestic Worker rights.</p>

Table 2d.13: CDEP Fidelity and Flexibility in the Latinx Hub

Total # of Program Components at the start of CRDP Phase 2	24; 3 components per CDEP, on average (range of 1–6)
Total # of Program Components at the end of CRDP Phase 2	29
Components Added	5 (21%) (n=3 IPPs)
Components Dropped	0 (0%) (n=0 IPP)
Unplanned Delays in Component Implementation	3 IPPs (43%)
Top 3 Types of Component Changes Made	Program Delivery (n=3 IPPs) Programmatic (n=3 IPPs) Research (n=3 IPPs)

2E: LGBTQ+ HUB-LEVEL TABLES

Table 2e.1.1: LGBTQ+ Hub Number of Unique Individuals who Received Referrals, Linkages & Navigation (n=3 IPPs)

Age Group	# Referrals*	# Linkages to Care	# Service Navigation
Adults	2,165 (n=2 IPPs)	378 (n=2 IPPs)	192 (n=3 IPPs)
Adolescents	257 (n=1 IPPs)	74 (n=1 IPPs)	15 (n=2 IPPs)
Children	2 (n=1 IPPs)	0	0
TOTAL	2,424 referrals by 3 IPPs	452 of 2,424 (19% received linkage)	207 of 2,424 (9% received service navigation)

*Note: Some IPPs provided referrals to multiple age groups and counts may be duplicative across age categories.

Table 2e.1.2: LGBTQ+ Hub Number of Referrals* by Type and Subtype

Referral Type and Subtype	# Referrals Provided	#IPP
Basic Needs	772	3
Housing, Rent, & Utilities	370	2
Food Assistance (e.g., food bank)	250	2
Financial Assistance	96	2
Clothing and Furniture Assistance	42	2
Transportation	12	1
Other Basic Needs	2	1
Mental Health	714	3
Counseling, therapy, wellness	676	3
Substance Abuse (e.g., AOD treatment)	25	3
Psychiatric Care	5	2
Domestic Violence	3	1
Sexual Assault	3	2
Other Mental Health	2	1
Health	296	3
COVID-Related Health Supports	169	1
Transgender Health Care	49	1
Primary Health Care (e.g., well-check, vaccines, etc.)	42	3
Illness specific (HIV/AIDS, dialysis)	26	2
Medical Benefits and Insurance	6	1
Dental/Optometry/Prescription	2	1
Medical Supplies and Equipment	2	1
Personal Growth & Development	162	3
Faith-Based or Spiritual Services	114	1
Social/Cultural Enrichment Programs	34	2
Volunteer Services	10	2
Support/Mentoring	4	1

Referral Type and Subtype	# Referrals Provided	IPPs
Legal/Advocacy	79	3
Other (free legal services, tenant rights, etc.)	73	3
Immigration Services	6	3
Education	46	2
Academic Support (e.g., college applications, school placement)	42	1
Tutoring	4	2
Specialty Care	20	2
Employment/Career	20	3
Parenting classes, early childcare support	7	1
"Multi-Category" (e.g., housing, education, job training, etc.)	25	2
TOTAL	2,141	3

*Note: Any 1 individual may have received more than 1 referral; Total N's across categories are duplicative.

Table 2e.2.1: LGBTQ+ Adult Hub Demographic Populations Served

LGBTQ+ Adult (N=378)		
Variable	%	
Racial Groups (n=352)	% Total	% Multi-Race
White	62%	16%
Latinx	24%	12%
Asian	13%	4%
African American/Black	11%	6%
American Indian/Alaska Native	7%	6%
Native Hawaiian/Pacific Islander	-	1%
Age (n=364)		
18-29 years	43%	
30-39 years	16%	
40-44 years	4%	
45-49 years	6%	
50-64 years	15%	
65+ years	16%	
Gender Identity (n=368)		
Genderqueer/Non-Binary	37%	
Cisgender Man/Male	22%	
Cisgender Woman/Female	17%	
Transgender Man/Male	11%	
Transgender Woman/Female	10%	
Questioning/Unsure	9%	
Sexual Orientation (n=365)		
Straight/Heterosexual	90%	
LGBTQ+	10%	
LGBTQ+ Identities		
Gay/Lesbian	43%	
Queer	30%	
Pansexual	28%	
Bisexual	24%	
Asexual/Aromantic	10%	
Questioning	7%	
Something Else	7%	
English Fluency (n=366)		
Fluent	96%	
Somewhat fluent	3%	
Not very well	0.2%	
Not at all	0.2%	
Foreign Born (n=363)	12%	
Refugee Status (n=313)	1%	

Table 2e.2.2: LGBTQ+ Adolescent Hub Demographic Populations Served

LGBTQ+ Adolescent (N=126)		
Variable	%	
Racial Groups (n=126)	% Total	% Multi-Race
Latinx	50%	8%
White	48%	10%
American Indian/Alaska Native	6%	4%
Asian	6%	3%
African American/Black	2%	1%
Age (n=120)		
12 years	1%	
13 years	6%	
14 years	12%	
15 years	12%	
16 years	20%	
17 years	18%	
18 years	6%	
19 years	5%	
20 years	5%	
21 years	5%	
22 years	7%	
23 years	3%	
24 years	3%	
Gender Identity (n=122)		
Cisgender Woman/Female	40%	
Genderqueer/Non-Binary	24%	
Transgender Man/Male	18%	
Questioning/Unsure	8%	
Cisgender Man/Male	6%	
Transgender Woman/Female	4%	
Sexual Orientation (n=119)		
Straight/Heterosexual	83%	
LGBQ+	16%	
LGBQ+ Identities		
Bisexual	26%	
Pansexual	24%	
Gay/Lesbian	22%	
Queer	18%	
Asexual/Aromantic	8%	
Questioning	8%	
Something Else	5%	
English Fluency (n=121)		
Fluent	98%	
Not very well	2%	
Foreign Born (n=123)	8%	
Refugee Status (n=92)	2%	

Table 2e.3.1: LGBTQ+ Adult Hub Numbers Served by Mental Health Need

LGBTQ+ Adult (N=378)	
Variable	%
Mental Health Need (n=352)	
No Need	10%
Need	90%
PARC Approach (n=318)	
Unmet	17%
Met	81%
Mental Health Helping Professional Seen¹	
Traditional	20%
Community	32%
Primary Care Physician	51%
Mental Health	70%
CHIS Approach (n=318)	
Unmet	20%
Met	78%
Mainstream ²	35%
Health Insurance Coverage (n=350)	
Coverage	91%
No Coverage	9%
Coverage: Uses MH Services	67%
No Coverage: Uses MH Services	5%
Coverage: Takes Prescription Meds	43%
No Coverage: Takes Prescription Meds	2%
Coverage: Median # Visits ³	12
No Coverage: Median # Visits ³	10

¹ This is a multiple response item; participants selected all the categories that were true for them; percentages do not add up to 100

² Primary care physician or general practitioner; MH professional (counselor, therapist, psychologist, psychiatrist or social worker)

³ Different sample size due to skip logic

Table 2e.3.2: LGBTQ+ Adolescent Hub Numbers Served by Mental Health Need

LGBTQ+ Adolescent (N=126)	
Variable	%
Mental Health Need (n=112)	
No Need	10%
Need	90%
PARC Approach (n=101)	
Unmet	28%
Met	74%
Mental Health Helping Professional Seen¹	
Traditional	20%
Community	42%
Mental Health	55%
School Mental Health	41%
CHIS Approach (n=101)	
Unmet	32%
Met	70%
Mainstream ²	22%

¹ This is a multiple response item; participants selected all the categories that were true for them; percentages do not add up to 100

² Primary care physician or general practitioner; MH professional (counselor, therapist, psychologist, psychiatrist or social worker)

Table 2e.4.1: LGBTQ+ Adult Hub Numbers Served by Psychological Distress and Functioning

LGBTQ+ Adult (N=378)	
Variable	%
Psychological Distress (K6)¹ (n=355)	
Low (K6<5)	14%
Moderate (5<=K6<=12)	38%
Serious (K6>=13)	48%
Moderate K6 (5<=K6<=12) by Functional Impairment (SDS)²	
Work/School (n=103)	
Not at all	15%
Some	43%
A lot	42%
Household Chores (n=131)	
Not at all	13%
Some	53%
A lot	34%
Social Life (n=128)	
Not at all	5%
Some	48%
A lot	47%
Relationships with Friends/Family (n=96)	
Not at all	18%
Some	48%
A lot	34%
Serious K6 (K6>=13) by Functional Impairment (SDS)²	
Work/School (n=140)	
Not at all	4%
Some	27%
A lot	69%
Household Chores (n=160)	
Not at all	6%
Some	23%
A lot	71%
Social Life (n=163)	
Not at all	1%
Some	28%
A lot	71%
Relationships with Friends/Family (n=104)	
Not at all	4%
Some	28%
A lot	68%
Moderate K6 (5<=K6<=12) by Number of Functional Impairments (n=136)	
None	4%
1 Impairment	6%
2 Impairment	14%
3 Impairment	42%
4 Impairment	34%
Serious K6 (K6>=13) by Number of Psychological Functional Impairments (n=169)	
None	3%
1 Impairment	2%
2 Impairment	12%
3 Impairment	34%
4 Impairment	49%
Moderate K6 (5<=K6<=12) by Mental Health Need (n=133)	
Mental Health Need	91%
No Mental Health Need	9%
Serious K6 (K6>=13) by Mental Health Need (n=162)	
Mental Health Need	98%
No Mental Health Need	2%

¹ Kessler-6: In the past 30 days, how often have you felt: nervous, hopeless, restless/fidgety, depressed, that everything was an effort, worthless (Scale: 4=All of the time to 0=None of the time; range of responses was 0-24)

² Sheehan Disability Scale: Worst month past year, did your emotions interfere with: work/school performance, household chores, social life, relationship with friends and family (Scale: 2=A lot to 0=Not at all; range of responses was 0-8)

Table 2e.4.2: LGBTQ+ Adolescent Hub Numbers Served by Psychological Distress and Functioning

LGBTQ+ Adolescent (N=126)	
Variable	%
Psychological Distress (K6)¹ (n=120)	
Low (K6<5)	10%
Moderate (5<=K6<=12)	39%
Serious (K6>=13)	51%
Moderate K6 (5<=K6<=12) by Functional Impairment (SDS)²	
School/Homework (n=46)	
Not at all	24%
Some	37%
A lot	39%
With friends (n=46)	
Not at all	26%
Some	54%
A lot	20%
At Home (n=45)	
Not at all	31%
Some	51%
A lot	18%
Serious K6 (K6>=13) by Functional Impairment (SDS)²	
School/Homework (n=60)	
Not at all	10%
Some	30%
A lot	60%
With friends (n=60)	
Not at all	20%
Some	43%
A lot	37%
At Home (n=60)	
Not at all	5%
Some	37%
A lot	58%
Moderate K6 (5<=K6<=12) by Number of Functional Impairments (n=47)	
None	13%
1 Impairment	13%
2 Impairment	23%
3 Impairment	51%
Serious K6 (K6>=13) by Number of Psychological Functional Impairments (n=61)	
1 Impairment	5%
2 Impairment	29%
3 Impairment	66%
Moderate K6 (5<=K6<=12) by Mental Health Need (n=61)	
Mental Health Need	88%
No Mental Health Need	12%
Serious K6 (K6>=13) by Mental Health Need (n=55)	
Mental Health Need	100%

¹ Kessler-6: In the past 30 days, how often have you felt: nervous, hopeless, restless/fidgety, depressed, that everything was an effort, worthless (Scale: 4=All of the time to 0=None of the time; range of responses was 0-24)

² Sheehan Disability Scale: Worst month past year, did your emotions interfere with: work/school performance, household chores, social life, relationship with friends and family (Scale: 2=A lot to 0=Not at all; range of responses was 0-8)

Table 2e.5.1: LGBTQ+ Adult Hub Numbers Served by Protective Factors

LGBTQ+ Adult (N=378)	
Variable	%
Your culture gives you strength¹ (n=361)	
Strongly Agree/Agree	58%
Neutral	28%
Strongly Disagree/Disagree	14%
Your culture is important to you¹ (n=361)	
Strongly Agree/Agree	68%
Neutral	23%
Strongly Disagree/Disagree	9%
Your culture helps you to feel good about who you are¹ (n=360)	
Strongly Agree/Agree	60%
Neutral	25%
Strongly Disagree/Disagree	15%
You feel connected to spiritual/religious traditions of the culture you were raised in¹ (n=357)	
Strongly Agree/Agree	25%
Neutral	27%
Strongly Disagree/Disagree	48%
Felt connected to your culture² (n=366)	
All/Most of the time	33%
Some of the time	32%
A Little/None of the time	35%
Felt balanced in mind, body, spirit and soul² (n=366)	
All/Most of the time	22%
Some of the time	33%
A Little/None of the time	45%
Felt marginalized or excluded from society² (n=365)	
All/Most of the time	31%
Some of the time	31%
A Little/None of the time	38%
Felt isolated and alienated from society² (n=369)	
All/Most of the time	44%
Some of the time	27%
A Little/None of the time	29%

¹ Items anchored "at present"

² Items anchored in "past 30 days"

Table 2e.5.2: LGBTQ+ Adolescent Hub Numbers Served by Protective Factors

LGBTQ+ Adolescent (N=126)	
Variable	%
Your culture gives you strength¹ (n=125)	
Strongly Agree/Agree	59%
Neutral	34%
Strongly Disagree/Disagree	7%
Your culture is important to you¹ (n=126)	
Strongly Agree/Agree	72%
Neutral	21%
Strongly Disagree/Disagree	7%
Your culture helps you to feel good about who you are¹ (n=125)	
Strongly Agree/Agree	58%
Neutral	28%
Strongly Disagree/Disagree	14%
You feel connected to spiritual/religious traditions of the culture you were raised in¹ (n=126)	
Strongly Agree/Agree	20%
Neutral	30%
Strongly Disagree/Disagree	50%
Felt connected to your culture² (n=126)	
All/Most of the time	38%
Some of the time	27%
A Little/None of the time	35%
Felt balanced in mind, body, spirit and soul² (n=122)	
All/Most of the time	19%
Some of the time	34%
A Little/None of the time	47%
Felt marginalized or excluded from society² (n=124)	
All/Most of the time	19%
Some of the time	28%
A Little/None of the time	53%
Felt isolated and alienated from society² (n=124)	
All/Most of the time	24%
Some of the time	33%
A Little/None of the time	43%

¹ Items anchored "at present"² Items anchored in "past 30 days"**Table 2e.6.1: LGBTQ+ Adult Hub Numbers Served by Stigma/Barriers**

LGBTQ+ Adult (N=378)	
Variable	% Agree
You were planning or already getting help from a...	
Traditional helping professional (n=293)	29%
Community helping professional (n=293)	43%
You did not know of or have never heard of these types of mental health professionals (n=300)	20%
Structural Barriers	
No transportation (n=280)	35%
Lack of time (n=272)	44%
Cost of treatment (n=289)	62%
Prejudice Barriers	
Limited English (n=273)	3%
Race/ethnicity (n=264)	13%
Age (n=268)	12%
Religious or spiritual practice (n=267)	12%
Gender identity (n=266)	33%
Sexual orientation (n=261)	37%
Attitudinal Barriers	
Psychiatric hospitalization (n=281)	28%
Might have to take prescription medication (n=282)	27%
Treatment won't help (n=262)	32%
Uncomfortable talking about problems (n=273)	40%
Can handle problem on my own (n=274)	54%
Do not need treatment (n=277)	33%
Stigma Barriers	
Lack of confidentiality (n=283)	20%
Negative opinion from community (n=266)	15%
Negative effect on job (n=265)	15%

Table 2e.6.2: LGBTQ+ Adolescent Hub Numbers Served by Stigma/Barriers

LGBTQ+ Adolescent (N=126)	
Variable	% Agree
You were planning or already getting help from a...	
Traditional helping professional (n=99)	19%
Community helping professional (n=99)	47%
You did not know of or have never heard of these types of mental health professionals (n=104)	21%
Structural Barriers	
No transportation (n=94)	24%
Lack of time (n=96)	31%
Cost of treatment (n=87)	48%
Did not know where to get help (n=92)	33%
Prejudice Barriers	
Limited English (n=88)	5%
Race/ethnicity (n=87)	6%
Age (n=85)	21%
Religious or spiritual practice (n=81)	6%
Gender identity (n=86)	37%
Sexual orientation (n=89)	39%
Attitudinal Barriers	
Did not want to talk to stranger (n=95)	48%
Thought issue wasn't serious enough (n=91)	68%
Can solve issue on my own (n=90)	69%
Uncomfortable talking with them (n=83)	42%
Stigma Barriers	
Negative opinion from family/community (n=94)	29%
Embarrassed about what you were going through (n=93)	48%
Negative opinion from family/community (n=91)	47%
Worried friends would find out (n=96)	17%

Table 2e.7.1: LGBTQ+ Percentage of CDEP Respondents Scoring 3.51 or above on MHSIP Subscale Items
Highest and lowest percent's across subscale items are in bold

Subscale Domains	MHSIP Adult Items (N=179)	% strongly agree/ agree	MHSIP Adolescent Items (N=79)	% strongly agree/ agree
General Satisfaction Subscale (Please answer based on the CDEP services, program, or activities)	I like the services that I received here.	90%	Overall, I am satisfied with the services I received.	91%
	If I had other choices, I would still get services from this agency.	85%	The people helping me stuck with me no matter what.	95%
	I would recommend this agency to a friend or family member.	91%	I felt I had someone to talk to when I was troubled.	85%
			I received services that were right for me.	82%
			I got the help I wanted.	86%
Access Subscale (Please answer based on the CDEP services, program, or activities)	The location of services was convenient.	80%	The location of services was convenient for me.	82%
	Services were available at times that were good for me.	91%	Services were available at times that were convenient for me.	76%
	Staff were willing to see me as often as I felt it was necessary	88%		
Outcomes Subscale (As a direct result of my involvement in the program...)	I deal more effectively with my daily problems.	74%	I am better at handling daily life.	40%
	I do better in school and/or work.	72%	I am doing better in school and/or work.	42%
	My symptoms/ problems are not bothering me as much.	65%	I get along better with friends and other people.	59%
			I get along better with family members.	31%
			I am better able to cope when things go wrong.	47%
			I am satisfied with my family life right now.	35%
			I am better able to do things I want to do.	62%
Social Connectedness Subscale (As a direct result of my involvement in the program...)			I know people who will listen and understand me when I need to talk.	87%
			I have people that I am comfortable talking with about my problem(s).	85%
			In a crisis, I would have the support I need from family or friends.	79%
			I have people with whom I can do enjoyable things.	84%

Table 2e.7.2: LGBTQ+ MHSIP Language Assistance Items (written, oral)

MHSIP Linguistic Competence Items	Adult (N=179)	Adolescent (N=79)
Were the services you received [CDEP program] in the language you prefer?	99%	100%
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?	99%	99%

Table 2e.7.3: LGBTQ+ Percentage of CDEP Respondents Scoring 3.51 or above on (1) CBCI Subscale Items by Age Group

Highest and lowest percent's across subscale items are in bold

Subscale Domains	CBCI Adult Items (N=179)	% strongly agree/agree	CBCI Adolescent Items (N=79)	% strongly agree/agree
Respectful Behavior (Please answer based on the CDEP services, program, or activities)	The staff here treat me with respect.	95%	Staff treated me with respect.	94%
	The staff here don't think less of me because of the way I talk.	97%	Staff spoke with me in a way that I understood.	87%
	The staff here respect my race and/or ethnicity.	94%	Staff were sensitive to my cultural/ethnic background.	85%
	The staff here respect my religious and/or spiritual beliefs.	91%	Staff respected my religious/spiritual beliefs.	88%
	The staff here respect my gender identity and/or sexual orientation.	97%		

Table 2e.7.4: LGBTQ+ Percentage of Adult CDEP Respondents Scoring 3.51 or above on (3) CBCI Subscales

Highest and lowest percent's across subscale items are in bold

Subscale	CBCI Adult Items (N=179)	% strongly agree/agree
Patient-Provider-Organization Interactions (Please answer based on the CDEP services, program, or activities)	When I first called or came here, it was easy to talk to the staff.	92%
Understanding of Indigenous Practices (Please answer based on the CDEP services, program, or activities)	Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	87%
Acceptance of Cultural Differences (Please answer based on the CDEP services, program, or activities)	The people who work here respect my cultural beliefs, remedies and healing practices.	89%
	Staff here understand that people of my racial and/or ethnic group are not all alike.	93%
	Staff here understand that people of my gender and/or sexual orientation group are not all alike.	94%
	Staff here understand that people of my religious and spiritual background are not all alike.	91%

Table 2e.8: LGBTQ+ Hub Workforce Development Summary – Formal Only and Formal/Informal Combined

	Formal	Combined Formal/Informal
Number of IPPs	5 IPPs	6 IPPs (Formal=5 IPPs + Informal=1 IPP)
Number of Workforce Activities	188	194
Foci	87% External (non-CDEP) 13% Internal ("in-house" CDEP)	84% External (non-CDEP) 16% Internal ("in-house" CDEP)
Type of Workers Engaged	13% Community Members 54% Mental Health Workers 70% First Responders <u>Type of First Responders:</u> 37% school personnel; 32% service providers; 7% health worker; 4% law enforcement	14% Community Members 55% Mental Health Workers 68% First Responders <u>Type of First Responders:</u> 36% school personnel; 31% service providers; 7% health worker; 4% law enforcement
Number of Program Touchpoints	10,352	10,460
Number of Sessions	630	648
Cumulative Hours	20,540.5	20,609
Racial Workforce Populations Engaged	55% African American 15% AI/AN 55% AANHPI 66% Latinx 72% LGBTQ+	56% African American 15% AI/AN 55% AANHPI 67% Latinx 73% LGBTQ+
Multilingual Capacity of Workers	American Sign Language, Spanish, Japanese	

Table 2e.9: LGBTQ+ IPP Changes in Organizational Capacity

Casey Domain	Pre	Post	Delta
Operational Capacity	2.65	2.84	+0.19
Skills, abilities, & volunteer commitment	2.57	2.57	0
Fundraising	2.57	2.71	+0.14
Board involvement & participation in fundraising	2.00	2.71	+0.71
Communications strategy	2.57	2.71	+0.14
Computers, applications, network, & email	2.67	3.29	+0.62
Website	3.00	3.29	+0.29
Databases/management reporting system	2.43	2.57	+0.14
Buildings & office space	2.57	3.00	+0.43
Management of legal & liability matters	3.43	2.71	-0.72
Adaptive Capacity	2.72	3.03	+0.31
Strategic planning	2.29	2.71	+0.42
Evaluation/performance measurement	2.14	2.71	+0.57
Evaluation & organizational learning	2.14	2.86	+0.72
Use of research to support program planning & advocacy	2.29	2.86	+0.57
Program relevance & integration	2.86	3.29	+0.43
Program growth & replication	2.86	3.00	+0.14
Monitoring of program landscape	3.00	3.14	+0.14
Assessment of external environment & community needs	3.00	3.00	0
Influencing of policy-making	3.14	3.14	0
Partnerships & alliances	3.29	3.57	+0.28
Community presence & standing	3.14	3.29	+0.15
Constituent involvement	2.86	3.00	+0.14
Organizing	2.43	2.86	+0.43
Management Capacity	2.31	2.60	+0.29
Goals/performance targets	2.57	2.43	-0.14
Funding model	2.43	2.29	-0.14
Fund development planning	2.43	2.71	+0.28
Financial planning/budgeting	2.57	3.00	+0.43
Operational planning	2.14	2.57	+0.43
Decision making processes	2.71	2.86	+0.15
Knowledge management	2.00	2.86	+0.86
Recruiting, development & retention of management	2.14	2.43	+0.29
Recruiting, development & retention of general staff	2.14	2.57	+0.43
Volunteer management	2.00	2.29	+0.29
Cultural Competence	2.86	2.91	+0.05
Expressed commitment to cultural competence	2.86	3.57	+0.71
Cultural competence policies, procedures, governance	2.71	3.00	+0.29
Planning, monitoring, evaluation	2.29	2.71	+0.42
Communication	2.86	2.71	-0.15
Human resources	2.57	2.71	+0.14
Cultural factors in engagement with community	3.57	3.00	-0.57
Service array and responsiveness to community context	3.43	3.00	-0.43
Linguistic competency	2.57	2.57	0
Leadership Capacity	2.9	2.91	+0.01
Shared beliefs/values	3.14	3.29	+0.15
Board composition/Commitment	2.43	2.86	+0.43
Board governance	3.00	2.40	-0.6
Board involvement and support	2.71	2.71	0
Board and CEO/ED appreciation of power	2.71	2.86	+0.15
Ability to motivate and mobilize constituents	3.43	3.14	-0.29

Table 2e.10: LGBTQ+ Hub Group Involvement

64 groups formed in total. 8.9 groups formed per IPP on average (range of 1 to 22)		
Overview	Total	
Total	64	<p>Top Reasons for Forming a Group</p> <ul style="list-style-type: none"> • Address Culture and Diversity in Service Provision (28%) • Address Health Overall (23%) • Training, TA or Information Sharing (18%) <p>Top Accomplishments</p> <ul style="list-style-type: none"> • Increased awareness of mental health issues and services (33%) • Built relationships to advance mental health work (27%) • Increased/or strengthened programming (16%) <p>Top Challenges Encountered:</p> <ul style="list-style-type: none"> • Partner Engagement (31%) • COVID-19 (27%) • Limited Resources (17%)
Networks	12	
Collaboratives	34	
Formal Partnerships	18	
Time Period Formed		
Number Formed Before Phase 2	7 networks 10 collabs 5 partnerships	
Number Formed During Phase 2	5 networks 23 collabs 13 partnerships	
CRDP Stakeholder Involvement		
With other LGBTQ+ IPPs	3 networks 2 collabs	
With other non-LGBTQ+ IPPs	4 collabs	
Types of Groups IPPs were involved with		
% Community-based groups	89%	
% Faith-based groups	22%	
% Gov't-based groups	47%	
% Institution-based groups	52%	
% Tribal-based groups	5%	

Table 2e.11: LGBTQ+ Hub Environmental, Systems, and Policy Change Impact

Hub overall: 14 changes + 2 benchmarks
<p>Systems - Existing processes of organizations, institutions, and formal systems.</p> <p>Benchmarks:</p> <ul style="list-style-type: none"> • IPP built partnerships with physical and mental health stakeholders to support organizations being trans-affirmative and to increase resources for and visibility of the transgender community. IPP wrote an equity policy centering Black and Brown transgender community members. They started seeing a shift in the conversations that were more inclusive of the transgender community. • Advocacy efforts resulted in the City of Napa moving towards developing a language access plan for emergencies/disasters. <p>Changes:</p> <ul style="list-style-type: none"> • The County CEO office accepted IPP feedback for the Board of Supervisors, and they created a 3 year strategic plan that included "equity language for the first time." • Resolutions were adopted to proclaim racism and discrimination a public health crisis. • The school district adopted inclusion/non-harassment policies. • The City council mandated LGBTQ+ best practices training for employees to be conducted by the IPP. • IPP worked with the county mental health provider to update its intake process and working procedures that was inclusive of gender diversity. The IPP provided and then were requested to provide cultural competency trainings. By 2019, there was increased access to both physical and mental health care to LGBTQ+ families and by 2020, the IPP was listed in the County mental health provider's 3-year funding plan. • IPP developed a formal partnership with the county mental health provider and created new policies to help interns better work with LGBTQ+ community and with the IPP. • The IPP trained school district employees (e.g., district office staff and teachers) on gender inclusivity. These trainings resulted in consultation with the superintendent, adjusting the student information system to be gender inclusive, and creating an expanded library collection meant to be more inclusive. • IPP trained numerous entities and they committed to implementing changes to local practice. The IPP conducted a follow-up survey with organizations to check the implementation status of these changes. Systematic changes reported by providers included: updated intake forms to be more gender inclusive; mandatory LGBTQ+ training; commitment to instituting best practices. • Between 2018-2020, numerous municipalities and schools became willing, based on the advocacy of the IPPs, to fly the Rainbow flag/Gay Pride Flag. • Advocacy efforts resulted in Gay-Straight Alliances being restarted at 4 schools. • The disaster and suicide and prevention office named LGBTQ+ as a priority population for communications and inclusive resources. • Several organizations changed their referral process and email tags to be more inclusive. • A medical center prioritized health equity in 3-year needs assessment for the first time. • The LGBTQ+ spirit day was supported by the city.

Table 2d.12: Latinx IPP Advocacy Activities and Examples

Major Themes Advocacy Activities	Examples
<p>Participated in community actions (e.g., visible participation in townhall meetings, community forums, school board or city council meetings, <u>including provided public testimony and commentary</u>).</p> <p><i>17 activities reported by 6 IPPs</i></p>	<p>Lodi Unified School Board meeting regarding the concerns community members had about Lodi School Board's attitudes and intentions towards teaching LGBT+ History in Lodi schools; helped organize the No Cops at Pride city council meeting in June 2019 to advocate for systems and environmental accountability for police brutality that impacts our participants and community members; Public testimony at Board of Supervisors meeting about SOGI data collection in City departments. Testimony included advocacy on needs of LGBTQ+ homeless seniors in San Francisco and the ineffectiveness of the current system to support these communities through direct referrals because SOGI data was not being collected.</p>
<p>Conducted mental health education and awareness (with the general public, community members, and/or decision makers)</p> <p><i>16 activities reported by 5 IPPs</i></p>	<p>Facilitated educational and awareness activities focused on: mental health disparities in LGBTQ+ communities; protections needed for transgender and nonbinary students; violence and harassment being targeted at Asian & Pacific Islander communities; mental health awareness and stigma reduction.</p>
<p>Used a collective impact approach for change (strategic collaborations, advocated for changes in practices, regulations, policies, programming, or funding streams).</p> <p><i>13 activities reported by 5 IPPs</i></p>	<p>Co-organized a Trans Job Fair with another local organization (Sol Collective) to tackle the lack of access, job discrimination, and unsafe work environments; partnership with Kern Behavioral Health and Recovery Services (KBHRS) in an effort to increase culturally competent mental health services for LGBTQ+ community, families, and allies; working with 15 organizations dedicated to transgender health and wellness equities with funds from the Transgender Wellness Bill (AB2218); worked with several individuals in the community who were seeking to legally change their name and/or gender markers.</p>
<p>Conducted formal individual-level advocacy (spoke out and advocated on behalf of a community member to resolve an issue, obtain a needed support/service, or promote a change in the practices, policies and/or behaviors of third parties)</p> <p><i>15 activities reported by 6 IPPs</i></p>	<p>One IPP's Resources and Referrals Navigation Team, Friendly Visitor staff, and Community Wellness Services staff advocated for individual community members within housing, aging services, and other social services; advocating with and for youth participants to access a wide range of affirming services within mental health systems, medical systems, school systems, employment, family acceptance, faith communities, etc.; supported a transgender female adult to advocate with their insurance provider (Partnership HP) to ease finding a Spanish speaking, trans experienced clinician and to cover gender affirming medical treatment.</p>
<p>Engaged in grassroots community organizing (building of community power to address social inequities and achieve social and political change)</p> <p><i>8 activities reported by 3 IPPs</i></p>	<p>Established a youth advisory committee to help inform our outreach to the LGBTQ+ youth; youth leaders hosted a teen mental health summit to grow allies in the community and advocate for what teens need and want to be healthy.</p>
<p>Participated in civic/voter engagement activities (activities that promoted community awareness of and involvement in civic, community, & political life, such as ballot organizing, voter turnout activities, to name a few)</p> <p><i>5 activities reported by 3 IPPs</i></p>	<p>Staff and youth leaders were also involved in Napa County's implementation of Voter's Choice. This not only expanded the days and ways that locals could vote but worked directly with the county's registrar to expand voting locations, ballot boxes, and outreach to make voting more accessible to disenfranchised voters, including LGBTQ+ people; LGBTQ+ youth representation on Napa County Voter's Choice committee to expand implementation by elaborating new policies and practice and environmental changes (i.e., placement of ballot drop boxes); IPP posted several "get out to vote" posts on social media platforms, and did the same with posts that support "filling out the Census."</p>
<p>Participated in mass mobilization activities (e.g., rally, protest, marches)</p> <p><i>10 activities reported by 4 IPPs</i></p>	<p>Community members, participants, and staff from GHC organized a rally at the Capitol to protest the injustices imposed on Roxsana Hernandez, a trans community member who died in ICE detention; LGBTQ+ Connection staff, youth leaders and volunteers recruited hundreds of allies, community leaders and community organizations to wear purple in October for Spirit Day. Thursday, Oct 17 is #SpiritDay, a special international tradition that was started in Oct 2011 after a number of LGBTQ+ young people were lost to bullying & suicide; staff attended a multitude of rallies, protests, and marches following the death of George Floyd.</p>
<p>Conducted research campaigns (community-driven, participatory, action research and evaluation activities used for advocacy)</p> <p><i>4 activities reported by 2 IPPs</i></p>	<p>Participated in research groups for with our county mental health Kern BH&RS to help make changes in health care management and services to the LGBTQ+ community; CDEP Program & Evaluation Manager Hankins conducted community-based participatory research to gain understanding about current unmet needs and the potential for a comprehensive LGBTQ+ Community Center in Sonoma County. Based on community response, staff aimed to information gained through the research project to push for more county funding to meet unmet needs in Sonoma County.</p>
<p>Launched media campaigns (used the media, including the arts, for strategic messaging and framing of social justice issues; involved messaging related to root causes and potential solutions)</p> <p><i>2 activities reported by 1 IPP</i></p>	<p>Posted several "get out to vote" and "filling out the Census" posts on our social media platforms; participants made the pledge [against bullying], shared their photo on their own social media, and sent their photo to the IPP to be featured on a social media collage.</p>

Table 2e.13: CDEP Fidelity and Flexibility in the LGBTQ+ Hub

Total # of Program Components at the start of CRDP Phase 2	28; 4 components per CDEP, on average (range of 2-7)
Total # of Program Components at the end of CRDP Phase 2	29
Components Added	2 (7%) (n=1 IPPs)
Components Dropped	1 (4%) (n=1 IPP)
Unplanned Delays in Component Implementation	4 IPPs (57%)
Top 3 Types of Component Changes Made	Programmatic (n=5 IPPs) Program Delivery (n=5 IPPs) Personnel (n=5 IPPs)

APPENDIX 3: IMPROVEMENTS IN MENTAL HEALTH

The overarching goals of Statewide Evaluation's data analysis are two-fold: 1) to understand to what extent is CRDP preventing/reducing the severity of mental illness in unserved, underserved, and/or inappropriately served communities, and 2) to understand how other characteristics might enhance or moderate the overall CRDP effect. The regression models applied give some insight into these questions. The findings of Section 6.2 of the Final Report provide a very brief synopsis of the entire statistical modeling process. This appendix details the technical issues associated with the quantitative data analysis. We present preliminary exploratory analysis, modeling choices and their comparisons, workflow, and software implementation information.

Regression modeling strategies for complex evaluation studies like the Statewide Evaluation could take any number of paths (Harrell, 2015; Gelman et al, 2014). To select modeling strategies appropriate for CRDP goals, the Statewide Evaluation used a four-step process illustrated in Figure 6.26 of the Final Report:

- **Step One:** Descriptive analysis of mental health outcome measures;
- **Step Two:** Descriptive analysis of pre-post repeated outcome measures;
- **Step Three:** Examination of relationships among the independent and outcome measures; and
- **Step Four:** Execution of the Bayesian regression models and interpretation of their results.

This appendix contains those specifics of the four steps that were not discussed in detail in the Final Report, organized as follows.

- **3a: Exploratory analysis**
 - › 3a.1. The outcome measures and their inter-relationships
 - ◆ Pre- and post-intervention outcomes
 - ◆ Changes in outcomes pre-post
 - ◆ Correlations between pre and change
 - ◆ Correlations among different outcome measures
 - › 3a.2. The K-6 outcome measure its relationships with independent variables
 - ◆ Hub
 - ◆ Age
 - ◆ Race
 - ◆ Gender identity
 - ◆ Sexual orientation
 - › 3a.3. Independent variable inter-relationships
 - ◆ Hub/race

- ◆ Hub/gender identity
- ◆ Hub/sexual orientation

- **3b. Bayesian regression modeling**

- › 3b.1. Multilevel regression
 - ◆ Basic structure
 - ◆ Baseline regression equation
- › 3b.2. Bayesian aspects
 - ◆ Bayes' theorem
 - ◆ Posterior probabilities
- › 3b.3. Missing data imputation

- **3c. Model results**

- › 3c.1. Regressions for five univariate outcome measures in the baseline model
- › 3c.2. Comparison of baseline to other models
 - ◆ Multivariate outcome measures
 - ◆ Interaction terms among selected independents
 - ◆ Distinct missing data treatments
- › 3c.3. Logistic regression as a model of prevention

- **3d. Software implementation**

- › 3d.1. Programming environment
- › 3d.2. Additional packages

- **3e. Workflow**

- **3f. Discussion**

The reader who is primarily interested in results for different outcome measures and modeling choices may wish to skip to Section 3c. Section 3f contains discussion of the interpretation of the “many models” examinations of Section 3c, as well as some of the challenges and limitations of the Statewide Evaluation. For the reader who seeks understanding of the entire model development process, Section 3a begins that four-step journey.

3A. EXPLORATORY DATA ANALYSIS FOR SYSTEM UNDERSTANDING

Any first approach to the statistical analysis of a large dataset requires initial exploratory data examination (Chatfield, 1985; Tukey, 1977). We begin with boxplots (or box and whiskers plots), graphical descriptive statistics that highlight the center and spread of the data, symmetry or skew of the data distribution, and potential outlier data points. Next we examine relationships among the five outcome measures, among the independent variables, and between independent and outcome measures. These steps allow us to gain a “feel” for the data and to check the assumptions we rely on in our regression models (Chatfield, 1985). Tables 6.25 and 6.26 list the variables considered in the Statewide Evaluation Bayesian multilevel models.

Boxplots (Tukey, 1977) rely on the process of sorting the data from smallest to largest. The box is formed by finding the 25th percentile and 75th percentile points. The median (or 50th percentile) is the line inside the box. The whiskers typically reach from each end of the box to the smallest or largest data point. In the case of outlier data points, points that stray beyond the central group of data, we highlight those as circles and halt the whiskers at the furthest “non outlier” points. Outliers are identified as being at least 1.5 times the box width either above the 75th percentile point or below the 25th percentile point.

To examine relationships among continuous variables, we employ Pearson's correlation coefficient (Chatfield, 1985). When examining continuous and discrete relationships, we again employ boxplots, making a separate plot for each discrete value. When considering two discrete variables, we use frequency tables that count the number of participants whose data records meet the value pairs of the two variables. Each of these initial analyses provides insight into the data that may support initial modeling decisions or suggest modifications.

3A.1. OUTCOME VARIABLES AND THEIR INTER-RELATIONSHIPS

We begin with an examination of our five outcome measures: Kessler 6 (K6), 3-item Sheehan Disability Scale (SDSr), Cultural Protective Factor 1 (CPF1), Cultural Protective Factor 2 (CPF2), and Social Isolation Risk Factor (SIRF). The following box plots summarize the data in terms of range and quartiles.

The measures found in the following figures are on a scale for which large numbers indicate higher levels of distress or lower levels of protection, so the decreases we see pre- to post-intervention indicate that the participants experienced an improvement over the course of the CRDP. The first five figures show changes in outcome measures for adult participants. The following five show changes for youth participants.

Figure 3a.1.1: K6 Adult data, pre- and post-intervention box plot

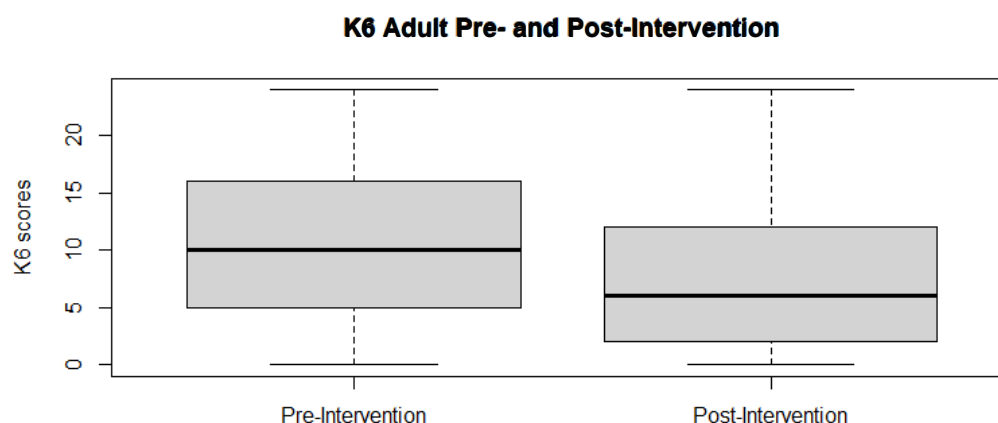


Figure 3a.1.2: SDSr Adult data, pre- and post-intervention box plot

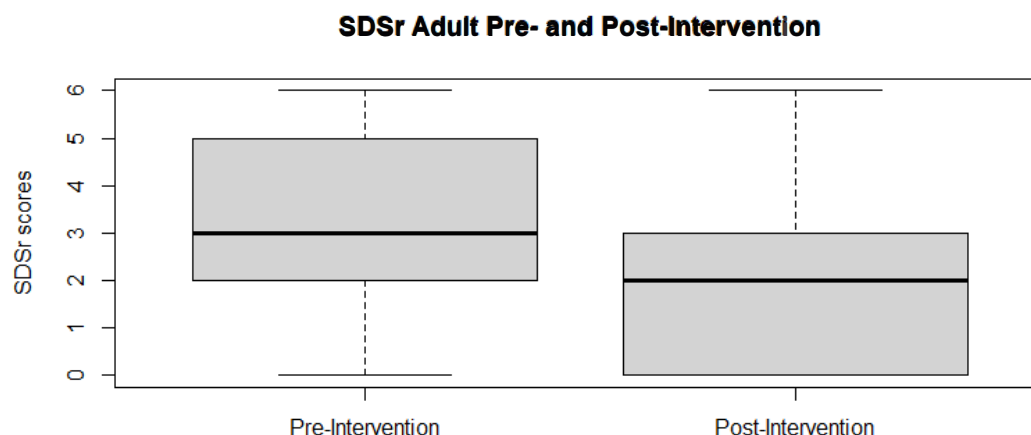


Figure 3a.1.3: CPF 1 Adult data, pre- and post-intervention box plot

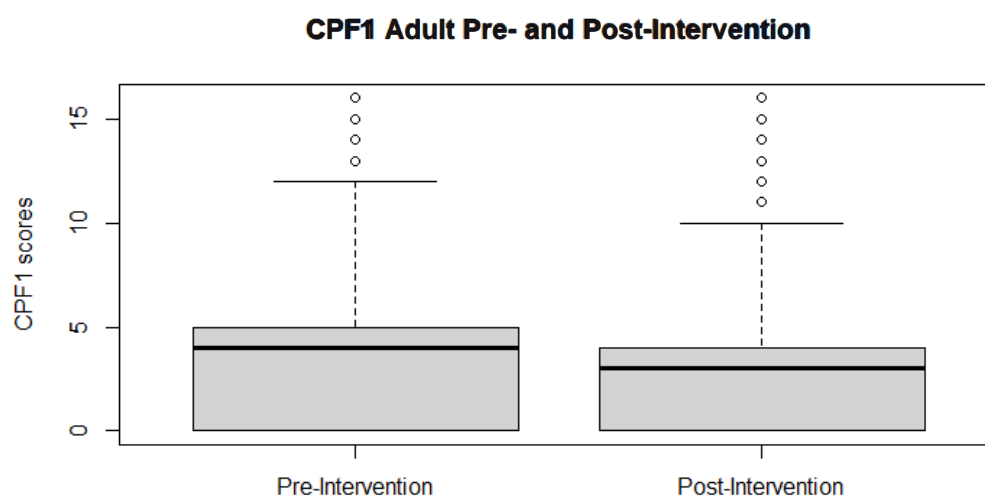


Figure 3a.1.4: CPF 2 Adult data, pre- and post-intervention box plot

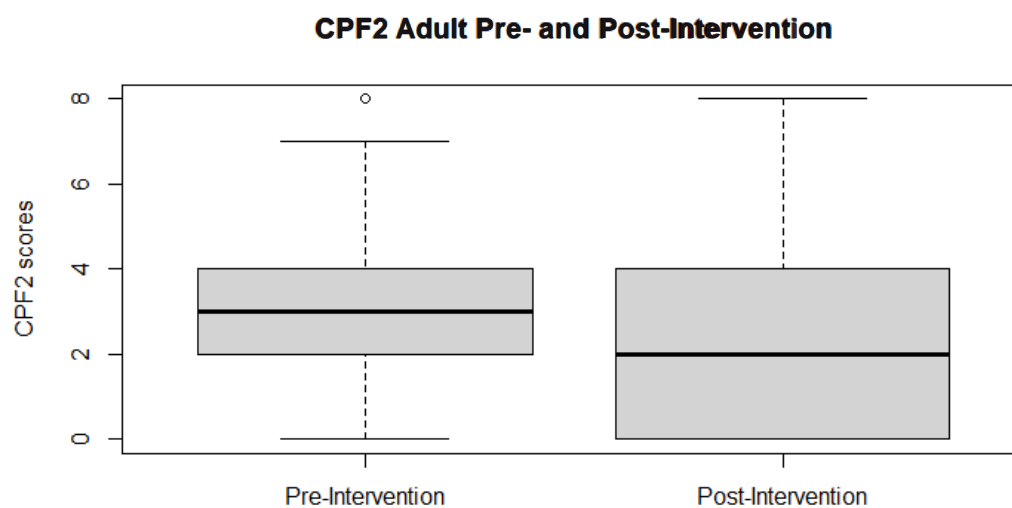
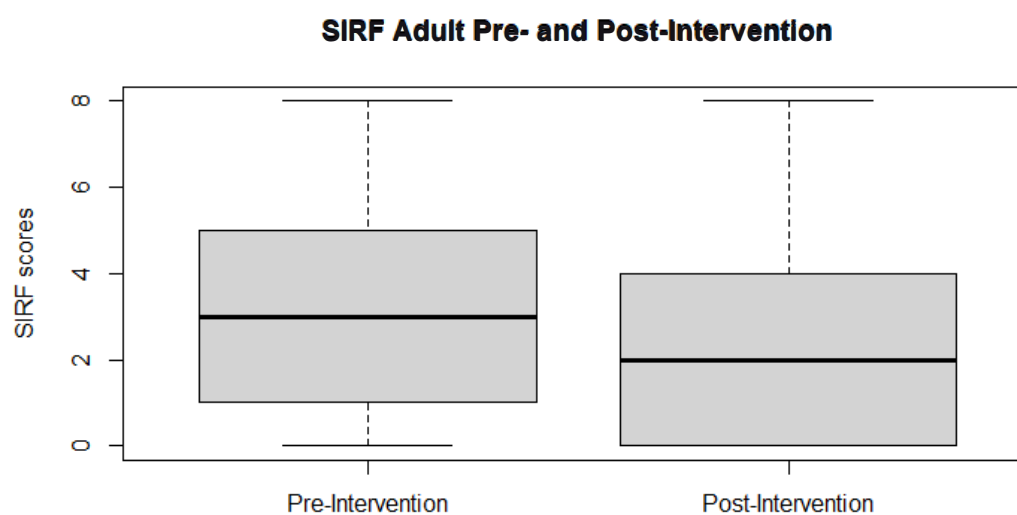


Figure 3a.1.5: SIRQ Adult data, pre- and post-intervention box plot



It is important to note (as highlighted in Figures 6.29–6.33 of the Final Report) that participants’ improvement with respect to each of these five outcomes depended quite strongly on their corresponding pre-intervention score.

Table 3a.1.1: Correlations for Adult pre-intervention score and pre-to-post score change

K6	SDSr	CPF 1	CPF 2	SIRF
0.65	0.60	0.55	0.59	0.58

We now turn to the Youth data, which does not show the same level of improvement as does the Adult data. Youth pre-intervention scores across the different outcomes tend to be lower than the Adult scores, so the room for improvement is reduced.

Figure 3a.1.6: K6 Youth data, pre- and post-intervention box plot

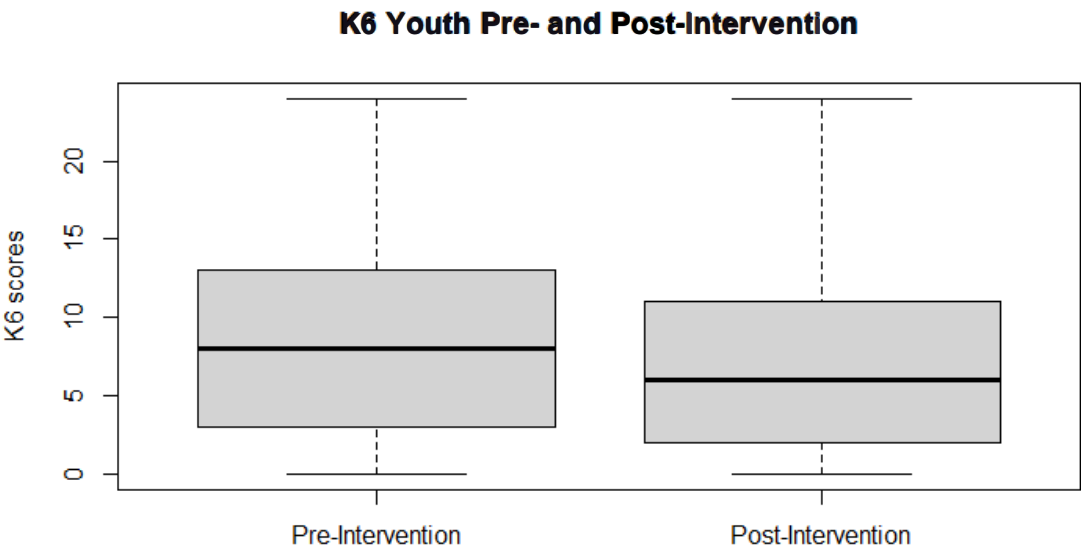


Figure 3a.1.7: SDSr Youth data, pre- and post-intervention box plot

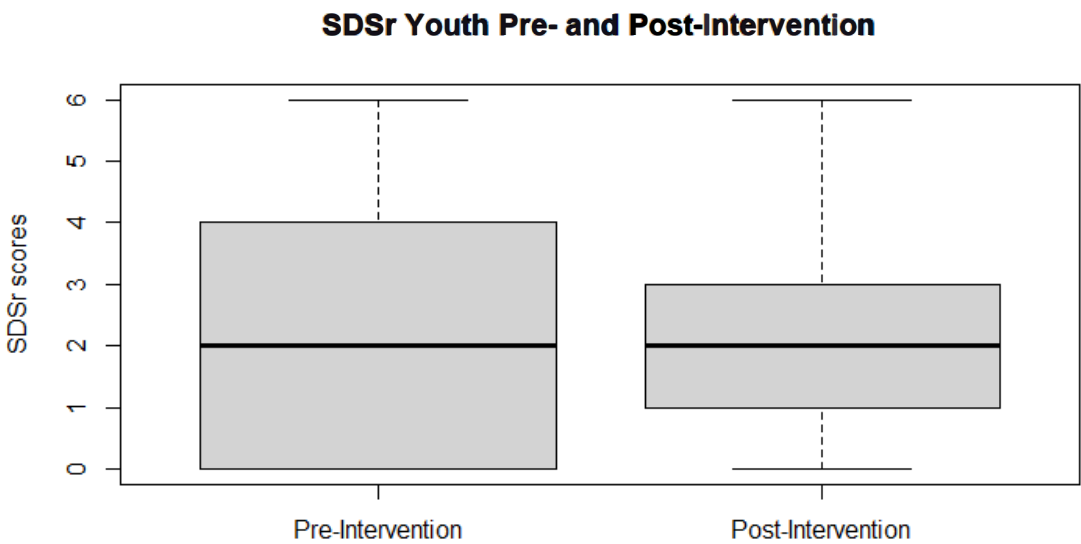


Figure 3a.1.8: CPF 1 Youth data, pre- and post-intervention box plot

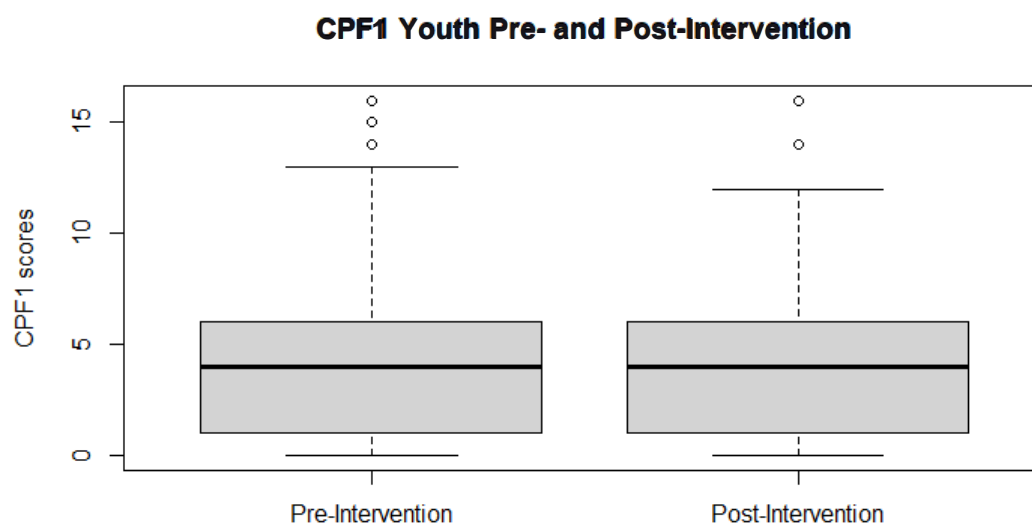


Figure 3a.1.9: CPF 2 Youth data, pre- and post-intervention box plot

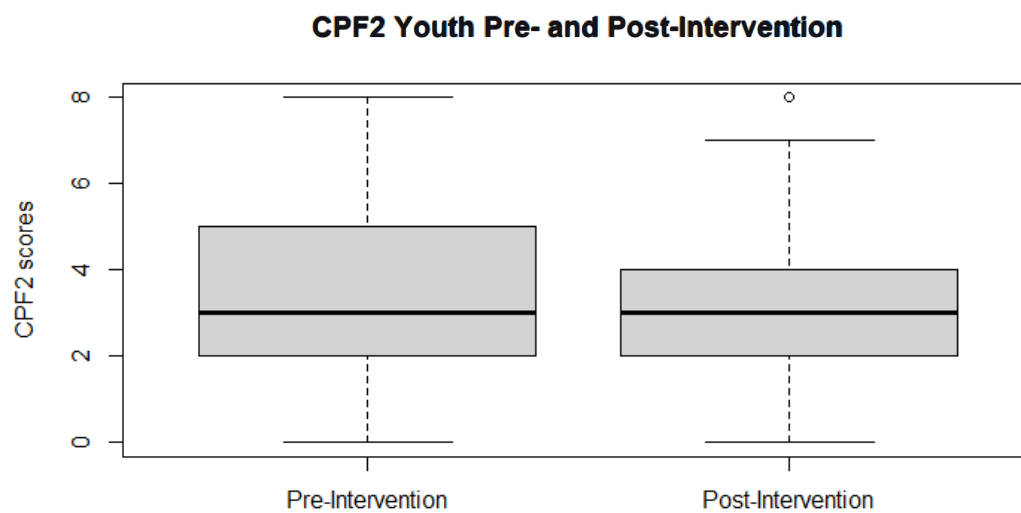
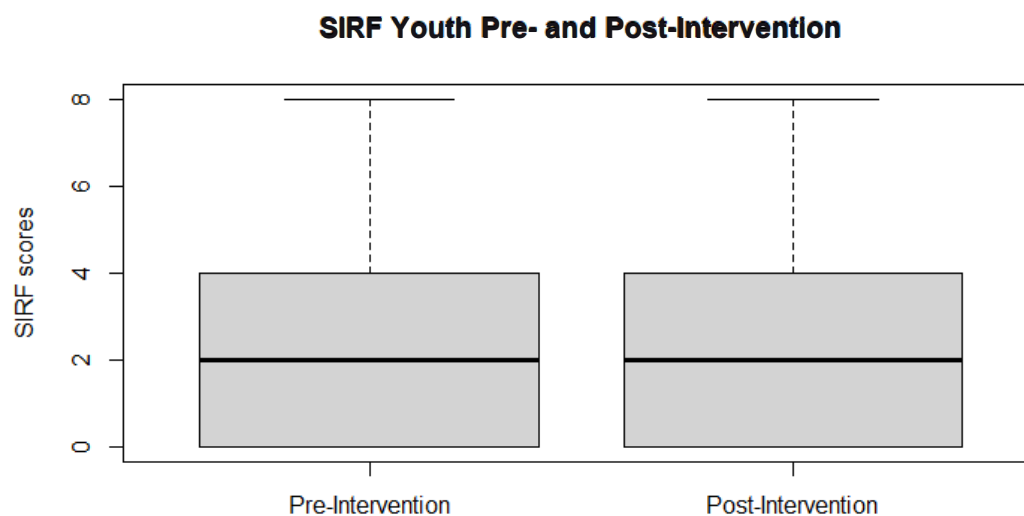


Figure 3a.1.10: SIRF Adult data, pre- and post-intervention box plot



As with the Adult data, the pre-intervention and change scores closely associate.

Table 3a.1.2: Correlations for Youth pre-intervention scores and pre-to-post score change score.

K6	SDSr	CPF 1	CPF 2	SIRF
0.55	0.58	0.44	0.49	0.57

This first exploratory step illuminates a number of issues. First, when the median is closer to the top end of the box, when the upper whisker is longer than the lower one, or when outliers appear towards the top, the boxplot is showing positive skew. The Adult pre-intervention measures show little skew, except for CPF1, which is somewhat positively skewed. In contrast, the Adult post-intervention scores appear to be positively skewed, with the post-K6 being the least skewed. The Youth data show slightly more skew than do the Adult data, with the K6 data again showing the least. The presence of skew suggests that the data may not be normally distributed (an important assumption in linear regression modeling).

Our next exploratory analysis looks at the correlations among the different outcome measures.

A multivariate model that uses all five outcomes together may provide more rigorous results over five separate models that treat single outcome measures independently when the outcomes exhibit strong correlations. Unnecessary table values are left blank. Roughly speaking, values above 0.05 will be statistically significant at the 5% level, but without accounting for multiple comparisons, one should be cautious about inferential conclusions.

Table 3a.1.3: Adult outcome measures' correlations at pre-intervention.

Outcome	SDSr	CPF 1	CPF 2	SIRF
K6	0.60	0.03	0.15	0.55
SDSr		0.05	0.18	0.40
CPF 1			0.51	0.00
CPF 2				0.06

Table 3a.1.4: Adult outcome measures' correlations at post-intervention.

Outcome	SDSr	CPF 1	CPF 2	SIRF
K6	0.54	0.23	0.30	0.51
SDSr		0.13	0.26	0.34
CPF 1			0.53	0.07
CPF 2				0.17

Table 3a.1.5 Adult outcome measures' correlations for change pre-to-post.

Outcome	SDSr	CPF 1	CPF 2	SIRF
K6	0.43	0.00	0.15	0.37
SDSr		0.07	0.10	0.20
CPF 1			0.35	-0.01
CPF 2				0.04

The correlations for the Youth data are similar to the Adult correlations. Due to the reduced sample size for the Youth data, correlations below about 0.1 will not be statistically significant at the 5% level of confidence. Again, we caution against inferential conclusions: the goal of this analysis is exploratory insight into conducting regression modeling.

Table 3a.1.6: Youth outcome measures' correlations at pre-intervention.

Outcome	SDSr	CPF 1	CPF 2	SIRF
K6	0.68	0.16	0.16	0.41
SDSr		0.08	0.11	0.43
CPF 1			0.60	0.05
CPF 2				-0.03

Table 3a.1.7: Youth outcome measures' correlations at post-intervention.

Outcome	SDSr	CPF 1	CPF 2	SIRF
K6	0.54	0.17	0.23	0.36
SDSr		-0.01	0.03	0.31
CPF 1			0.67	-0.06
CPF 2				-0.08

Table 3a.1.8: Youth outcome measures' correlations for change pre-to-post.

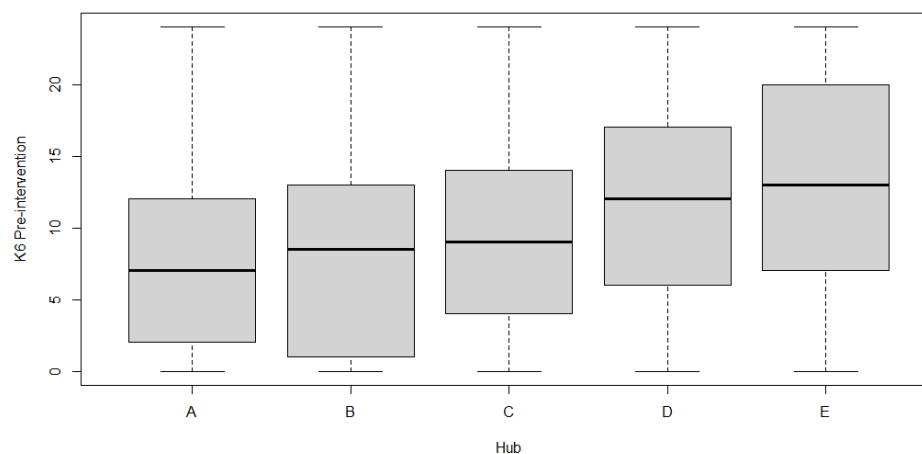
Outcome	SDSr	CPF 1	CPF 2	SIRF
K6	0.42	0.16	0.10	0.23
SDSr		0.09	0.02	0.16
CPF 1			0.36	-0.02
CPF 2				-0.10

3A.2. OUTCOME MEASURES AND INDEPENDENT VARIABLES.

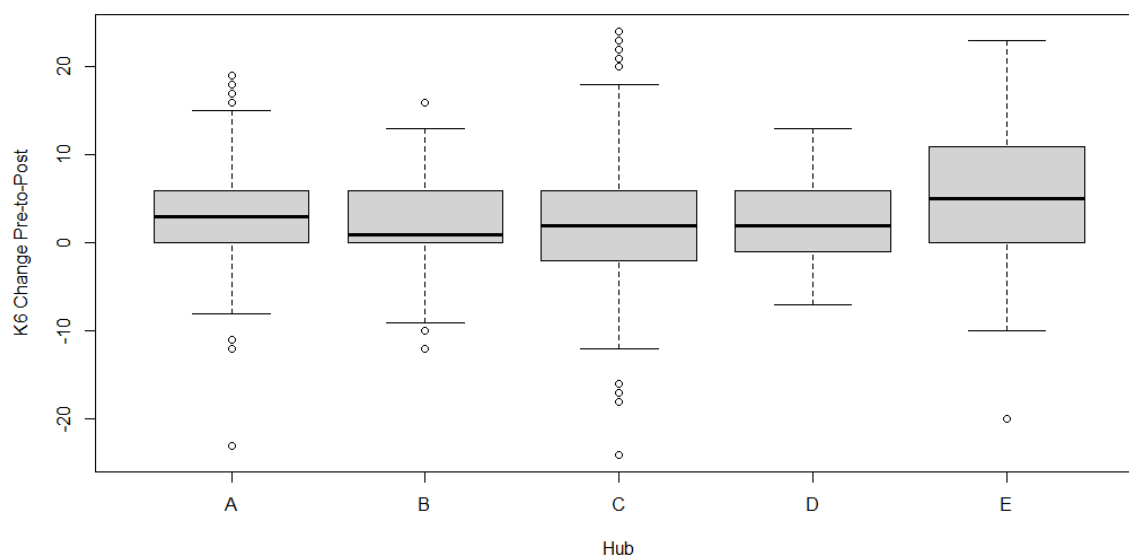
With some basic high-level views of the outcome measures in hand, we turn to the variables to be considered as regressors or independent variables that might have some impact on these outcomes: priority population hub (hereafter abbreviated to "hub"), race, gender identity, sexual orientation, age, covid timing, and IPP service model.

The next series of boxplots examines differences in outcomes across hubs. To avoid comparison making across hubs, we sorted the hubs in terms of their medians, and we have re-labeled them.

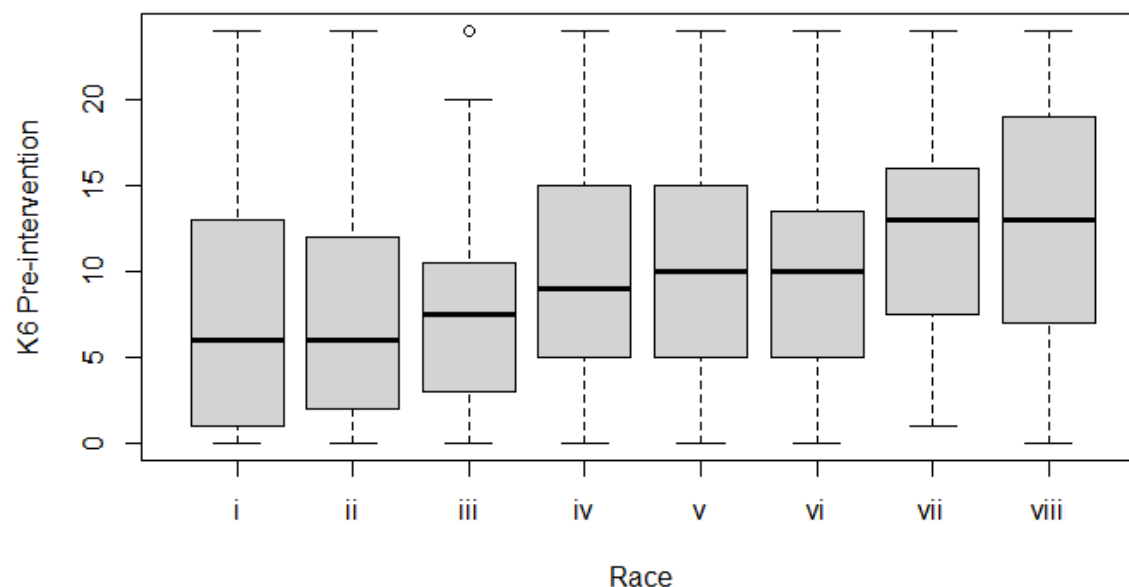
Figure 3a.2.1: Pre-intervention Adult K-6 levels across the five hubs.



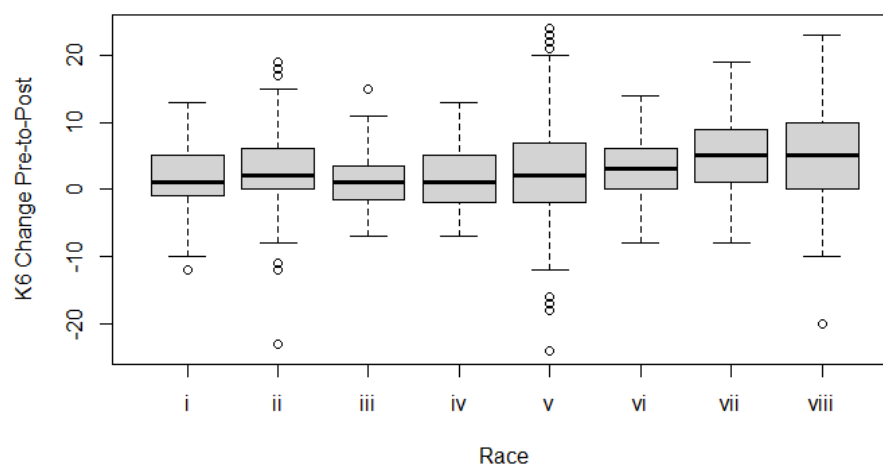
The reduction in psychological distress (in the same order) is given in Figure 3a.2.2.

Figure 3a.2.2: Change in Adult K-6 levels across the five hubs.

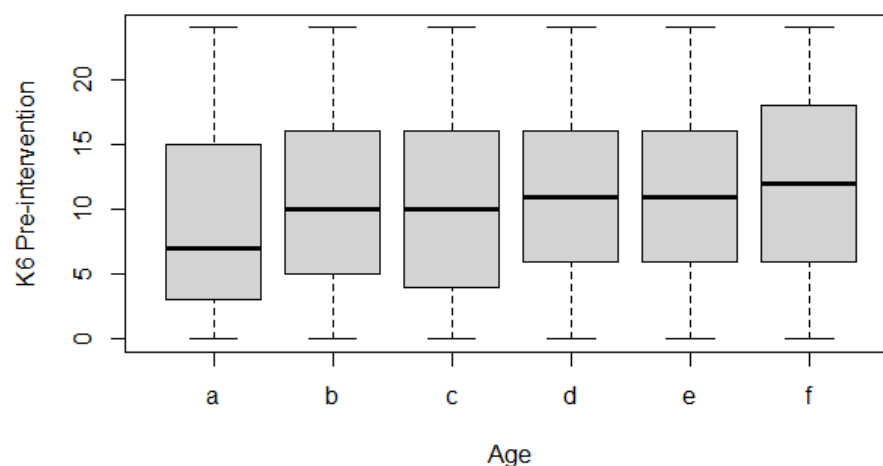
As with the hubs, pre-intervention K6 does appear to vary with race. Once again we have re-labeled boxplots to avoid comparisons and sorted by medians. For reference, the eight categories used are "no race given," "American Indian/Alaska Native," "Black/African American," "Latinx," "Asian," "Hawaiian/Pacific Islander", "White," and "Multi-racial."

Figure 3a.2.3: Pre-intervention Adult K-6 levels across the eight race/ethnicity categories.

In terms of race, we see that the amount of K6 improvement corresponds closely to the pre-intervention levels, at least at the higher levels of pre-intervention distress.

Figure 3a.2.4: Change in Adult K-6 levels across the eight race/ethnicity categories.

Other factors considered in the modeling include age, gender identity (no identity given, cisgender male, cisgender female, transgender, and non-binary), sexual orientation (heterosexual, LGBTQ+), covid timing (pre, trans, and post), and service models (Holistic, Communication, Co-Located/Collaborative, Integrated). For the Adult data, we present boxplots for pre-intervention and change in K6 for these variables.

Figure 3a.2.5: Pre-intervention Adult K-6 levels across the age categories.

The CRDP Participant SWE questionnaire included six age categories: 18 to 29, 30 to 39, 40 to 44, 45 to 49, 50 to 64 and 65 years of age. Once again, we have re-labeled boxplots to avoid comparisons and sorted by medians.

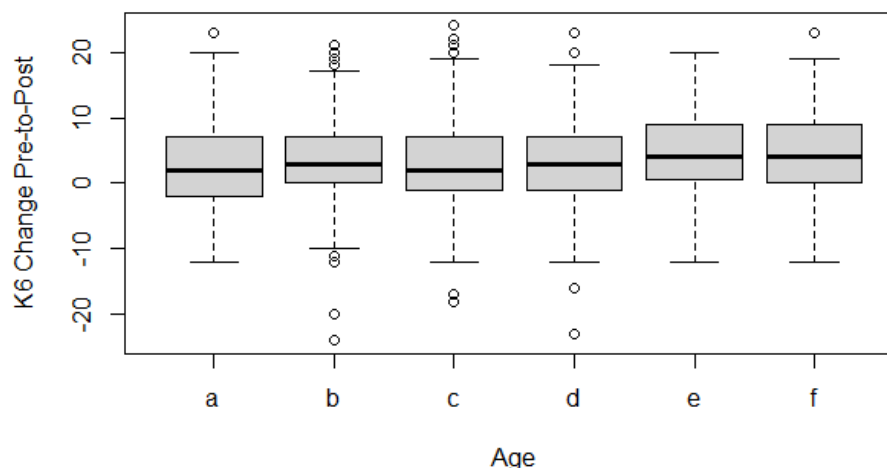
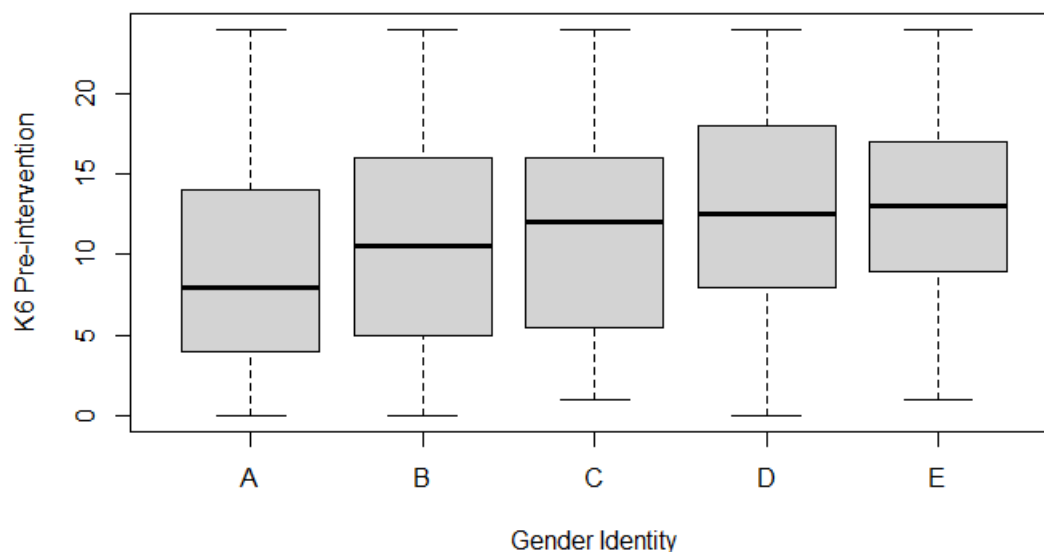
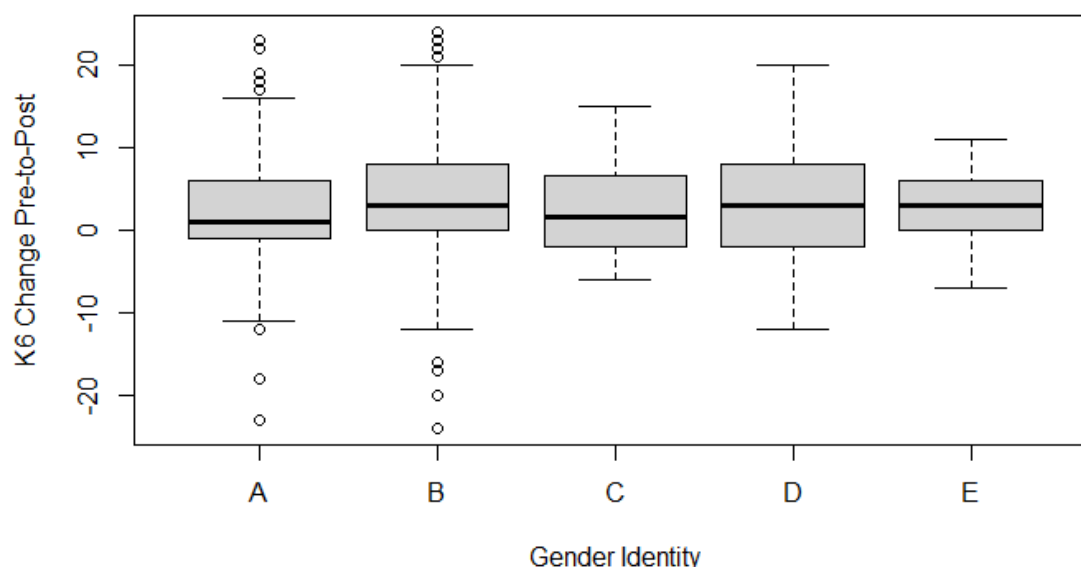
Figure 3a.2.6: Change in Adult K-6 levels across the age categories.

Figure 3a.2.7: Pre-intervention Adult K-6 levels across the gender identity categories.**Figure 3a.2.8: Change in Adult K-6 levels across the gender identity categories.**

From these plots, we see diversity in the Adult pre-intervention K-6 levels of distress in terms of each independent variable. For example, the hubs' median pre-intervention K-6 values range from a low of 7 to a high of 13. Race and gender identity show similar differences. The change in K-6 shows lessened differences, perhaps due to the relationship between pre-intervention K-6 and change in K-6. Also, the change in K-6 boxplots all show very little skew, suggesting that the normality assumptions in the planned regression studies may be reasonable.

3A.3. INTER-RELATIONSHIPS AMONG INDEPENDENT VARIABLES.

Considerable difficulty in regression modeling arises when two independent variables have high correlation. In a statistical sense, one may view the two variables as measuring the same characteristic of the participants. There are some obvious issues of this nature within CRDP: four of the five hubs are organized in terms of participant race and ethnicity, and the fifth hub is organized around LGBTQ+ participants. We now examine the relationships between race and hub, between gender identity and hub, and between sexual orientation and hub.

Table 3a.3.1: Counts of Adult participants by race and hub. Blue highlights race/hub alignment.

	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
No race given	10	6	3	4	9
Native American/ American Indian	1	99	0	0	2
Black/African American	212	1	3	0	8
Latinx	3	4	9	581	17
Asian	0	1	694	0	22
Hawaiian/Pacific Islander	0	2	21	0	1
White	1	5	7	2	71
Multi-racial	16	26	15	3	43

To make a clearer connection, we determine, for each race/ethnicity, the percent of those participants in each hub.

Table 3a.3.2: Percentages of Adult participants of each race across the hubs.

	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
No race given	31.3	18.8	9.4	12.5	28.1
Native American/ American Indian	1.0	97.1	0.0	0.0	2.0
Black/African American	94.6	0.4	1.3	0.0	3.6
Latinx	0.5	0.7	1.5	94.6	2.8
Asian	0.0	0.1	96.8	0.0	3.1
Hawaiian/Pacific Islander	0.0	8.3	87.5	0.0	4.2
White	1.2	5.8	8.1	2.3	82.6
Multi-racial	15.5	25.2	14.6	2.9	41.7

Note: Blue highlights race/hub alignment, while pink highlights percents above 25. Each row sums to 100%.

We note that over 80% of the White participants and over 40% of multi-racial participants are served by the LGBTQ+ hub. Also, more than 25% of multi-racial participants are served by the AI/NA hub. Participants who did not provide race/ethnicity information are mostly served by the AfAm and LGBTQ+ hubs.

An alternative percentage view, one that shows the race/ethnicity breakdown of each hub, is shown in Table 3a.3.3.

Table 3a.3.3: Percentages of Adult participants of each race across the hubs.

	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
No race given	4.1	4.2	0.4	0.7	5.2
Native American/ American Indian	0.4	68.8	0.0	0.0	1.2
Black/African American	87.2	0.7	0.4	0.0	4.6
Latinx	1.2	2.8	1.2	98.5	9.8
Asian	0.0	0.7	92.3	0.0	12.7
Hawaiian/Pacific Islander	0.0	1.4	2.8	0.0	0.6
White	0.4	3.5	0.9	0.3	41.0
Multi-racial	6.6	18.1	2.0	0.5	24.9

Note: Blue highlights race/hub alignment, while pink highlights percents above 25. Columns in this table sum to 100%.

We note that over the LGBTQ hub is 41% White and 25% multi-racial, while the AI/AN hub is 18% multi-racial.

We repeat these analyses for the Youth participants. Results are shown in the following tables. One important point is that the matched pre-post Youth data contained no participants who indicated Hawaiian/Pacific Islander race.

Table 3a.3.4: Counts of Youth participants by race and hub. Blue highlights race/hub alignment.

	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
No race given	4	10	0	6	5
Native American/ American Indian	0	41	0	3	1
Black/African American	86	2	0	6	1
Latinx	3	7	0	93	34
Asian	1	0	44	10	3
White	0	0	0	1	20
Multi-racial	16	25	1	5	9

Table 3a.3.5: Percentages of Youth participants of each race across the hubs.

	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
No race given	16.0	40.0	0.0	24.0	20.0
Native American/ American Indian	0.0	91.1	0.0	6.7	2.2
Black/African American	90.5	2.1	0.0	6.3	1.1
Latinx	2.2	5.1	0.0	67.9	24.8
Asian	1.7	0.0	75.9	17.2	5.2
White	0.0	0.0	0.0	4.8	95.2
Multi-racial	28.6	44.6	1.8	8.9	16.1

Note: Blue highlights race/hub alignment, while pink highlights percents above 25. Rows in this table sum to 100%.

We note that over 95% of the White participants and nearly 25% of Latinx participants are in the LGBTQ+ hub. Also, almost 45% of multi-racial participants are in the AI/AN hub, and nearly 30% are in the AfAm hub. Participants who did not provide race/ethnicity information are mostly in the AfAm and LGBTQ+ hubs.

An alternative percentage view, one that shows the race/ethnicity break-down of each hub, is shown in Table 3a.3.6. In this table, the columns sum to 100%.

Table 3a.3.6: Percentages of Youth participants of each race across the hubs.

	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
No race given	3.6	11.8	0.0	4.8	6.8
Native American/ American Indian	0.0	48.2	0.0	2.4	1.4
Black/African American	78.2	2.4	0.0	4.8	1.4
Latinx	2.7	8.2	0.0	75.0	46.6
Asian	0.9	0.0	97.8	8.1	4.1
White	0.0	0.0	0.0	0.8	27.4
Multi-racial	14.5	29.4	2.2	4.0	12.3

Note: Blue highlights race/hub alignment, while pink highlights percents above 20%.

We note that over the LGBTQ+ hub is 46% Latinx and 27% White, while the AI/AN hub is 29% multi-racial.

Overall, the race/hub alignment of the Adult population is quite close, with almost 95% of Black, Latinx, Asian, and Native American participants within their respective hubs, and over 87% of Hawaiian/Pacific Islanders in the AANHPI hub. This alignment is not quite as close for the youth, with less than 80% Asian and Latinx youth in their respective hubs.

The results shown in these tables led PARC to create a “race-hub misalignment” indicator variable that is “1” if a participant’s race does not match that of the hub and “0” if it does. As noted in Table 6.24 of the Final Report, the baseline model replaces race as a variable with this race-hub alignment variable.

Alignment of LGBTQ+ sexual orientation and transgender and non-binary gender identity with the LGBTQ+ hub may also carry collinearity issues for regression modeling. We consider similar “cross tabs” for these variables below.

Table 3a.3.7: Counts of Adult participants by gender identity and hub.

	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
No gender identity given	14	12	58	28	14
Cisgender Male	46	48	196	83	44
Cisgender Female	174	81	492	470	35
Transgender	4	0	3	4	25
Non-binary	5	3	3	5	55

To make a clearer connection, we determine, for each gender identity, the percent of those participants in each hub. In Table 3a.3.8 below, each row sums to 100%.

Table 3a.3.8: Percentages of Adult participants of each gender identity across the hubs.

	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
No gender identity given	11.1	9.5	46.0	22.2	11.1
Cisgender Male	11.0	11.5	47.0	19.9	10.6
Cisgender Female	13.9	6.5	39.3	37.5	2.8
Transgender	11.1	0.0	8.3	11.1	69.4
Non-binary	7.0	4.2	4.2	7.0	77.5

The LGBTQ+ hub has about 70% of the transgender participants and over 77% of the non-binary participants, a hub alignment that is not as close as the race/hub alignments shown above.

An alternative percentage view, one that shows the gender identity break-down of each hub, is shown in Table 3a.3.9. In this table, the columns sum to 100%.

Table 3a.3.9: Percentages of Adult participants of each gender identity across the hubs.

	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
No gender identity given	5.8	8.3	7.7	4.7	8.1
Cisgender Male	18.9	33.3	26.1	14.1	25.4
Cisgender Female	71.6	56.3	65.4	79.7	20.2
Transgender	1.6	0.0	0.4	0.7	14.5
Non-binary	2.1	2.1	0.4	0.8	31.8

The Youth data tell a similar story.

Table 3a.3.10: Counts of Youth participants by gender identity and hub.

	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
No gender identity given	10	30	1	25	8
Cisgender Male	38	30	24	53	6
Cisgender Female	58	23	20	43	35
Transgender	2	0	0	1	8
Non-binary	2	2	0	2	16

To make a clearer connection, we determine, for each gender identity, the percent of those participants in each hub. In Table 3a.3.11 below, each row sums to 100%.

Table 3a.3.11: Percentages of Youth participants of each gender identity across the hubs.

	AfAm	AI/AN	AANHPI	Latinx	LGBTQ+
No gender identity given	13.5	40.5	1.4	33.8	10.8
Cisgender Male	25.2	19.9	15.9	35.1	4.0
Cisgender Female	32.4	12.8	11.2	24.0	19.6
Transgender	18.2	0.0	0.0	9.1	72.7
Non-binary	9.1	9.1	0.0	9.1	72.7

The LGBTQ+ hub has over 70% of the trans and non-binary participants.

An alternative percentage view, one that shows the gender identity break-down of each hub, is shown in Table 3a.3.12. In this table, the columns sum to 100%.

Table 3a.3.12: Percentages of Youth participants of each gender identity across the hubs.

	AfAm	AANHPI	Latinx	LGBTQ+	AI/AN
No gender identity given	9.1	2.2	20.2	11.0	35.3
Cisgender Male	24.5	53.3	42.7	8.2	35.3
Cisgender Female	52.7	44.4	34.7	47.9	27.1
Transgender	1.8	0.0	0.8	11.0	0.0
Non-binary	1.8	0.0	1.6	21.9	2.4

Hubs developed to focus on race/ethnicity contain very small fractions of non-binary and trans participants.

Our last look at inter-relationships among independent variables for Adult and Youth participants involves hubs and sexual orientation.

Table 3a.3.13: Adult participant counts by hub and sexual orientation.

	AfAm	AANHPI	Latinx	LGBTQ+	AI/AN
Heterosexual/Straight	227	733	572	13	130
LGBQ+	16	19	18	160	14

Table 3a.3.14: CRDP Overall – Adult participant hub membership percent for each sexual orientation.

	AfAm	AANHPI	Latinx	LGBTQ+	AI/AN	CRDP Overall
Heterosexual/ Straight	13.6	43.8	34.1	0.8	7.8	100%
LGBQ+	7.0	8.4	7.9	70.5	6.2	100%

Table 3a.3.15: Adult participant sexual orientation percent in each hub.

	AfAm	AANHPI	Latinx	LGBTQ+	AI/AN
Heterosexual/Straight	93.4	97.5	96.9	7.5	90.3
LGBQ+	6.6	2.5	3.1	92.5	9.7
TOTAL	100%	100%	100%	100%	100%

Table 3a.3.16: Youth participant counts by hub and sexual orientation.

	AfAm	AANHPI	Latinx	LGBTQ+	AI/AN
Heterosexual/Straight	89	43	112	15	73
LGBQ+	21	2	12	58	12

Table 3a.3.17: CRDP Overall – Youth participant hub membership percent across CRDP overall for each sexual orientation.

	AfAm	AANHPI	Latinx	LGBTQ+	AI/AN	CRDP Overall
Heterosexual/ Straight	26.8	13.0	33.7	4.5	22.0	100%
LGBQ+	20.0	1.9	11.4	55.2	11.4	100%

Table 3a.3.18: Youth participant sexual orientation percent in each hub.

	AfAm	AANHPI	Latinx	LGBTQ+	AI/AN
Heterosexual/Straight	80.9	95.6	90.3	20.5	85.9
LGBQ+	19.1	4.4	9.7	79.5	14.1
TOTAL	100%	100%	100%	100%	100%

One important modeling decision made from this initial data examination is the creation of the race/hub alignment variable. With four of the five hubs having really strong racial alignment of participants, the race variable is largely being measured by the hub variable and vice versa. Thus, we have two model parameters quantifying the same effect. In essence, the model would be trying to answer the question “I am thinking of two numbers that add up to 12. What are the two numbers?” There is no unique pair, of course, and the modeling effort that attempts to estimate the pair is not going to produce a reliable answer.

Another important modeling decision is the inclusion of both gender identity and sexual orientation as variables. Even though the numbers are small for non-binary and transgender participants not in the LGBTQ+ hub, the percentages across CRDP suggest a need for inclusion of these variables.

Lastly, we note that examining the intersectionality of race/ethnicity, gender identity, and sexual orientation would be a very interesting and important study. However, the small numbers of participants at the intersections lead to effect size estimates that have large uncertainties.

3A.4 USE OF SECONDARY DATA: CALIFORNIA HEALTH INTERVIEW SURVEY (CHIS)

During exploratory analysis of CHIS data, the SWE used the “AskCHIS” web application to compare CDEP participant pre- and post-intervention severe distress frequencies (K6 outcomes) with those of the CHIS 2020 sample. The intent of this exploratory analysis was to determine the viability of the comparison group approach and to help inform the SWE in developing the syntax/code to request sensitive mental health data and/or geo-coded data from the CHIS Data Access Center ultimately needed to fully model the comparisons with the CRDP participants. Table 3a.4.1 shows the results of this exploratory analysis for K6 frequencies by CRDP Participants (pre- and post- intervention) and the CHIS sample.

For all groups, the percentages of CRDP participants enduring severe distress were much greater at both time points than the general population surveyed in CHIS. As previously noted in part 1 of this chapter, the higher percentage of severe psychological distress among CRDP participants may reflect the CDEPs filling a critical gap in access to mental health services for previously unserved individuals. However, given the small fraction of people reporting severe psychological distress in the CHIS, approximately 10-15% in the past year (or 5-10% in the past 30 days), and at the overall sample size of the CHIS, the potential comparison group built from the CHIS would not be large enough to use as a point of comparison in more advanced statistical modeling and analysis. This limitation is compounded by the CHIS’s small sample for several CRDP population groups including AI/AN, AANHPI (including NHPI populations and specific Asian American ethnic groups served by CDEPs, including Cambodian and Hmong), and LGBTQ+ populations, which also further limit the utility of the potential comparison group even when pooled years of CHIS samples might be considered.

For these reasons, the SWE determined that further comparisons between CRDP participants and CHIS respondents would be inappropriate and misleading.

Table 3a.4.1: Percentage of K6 Severe Distress for CRDP Overall (Adult and Youth Combined) CDEP Pre-Intervention, Post-Intervention, & CHIS Population

Population	CDEP Pre % K-6 Severe Distress (2018–2021)	CDEP Post % K6 Severe Distress (2018–2021)	CHIS % K6 Severe Distress (2020)
No race given	42.1	21.1	no data
American Indian or Alaska Native	26.9	8.6	10.9
Black or African American	14.8	5.3	5.0
Latino, Hispanic, or Spanish	50.3	19.2	6.4
Asian	33.4	19.5	4.6
Native Hawaiian or Other Pacific Islander	13.0	13.0	no data
White	34.1	23.5	5.1
Multi	34.0	18.6	6.5
LGBTQ+	41.7	25.0	no data

*Note that the AskCHIS web application provided data “for the past year” rather than the “for the past 30 days. The SWE estimated the “for the past 30 days” percentages using CHIS Youth data that contained severe distress percentages for both time periods.

3B. REGRESSION MODELING

The Statewide Evaluation regression models are based on the structure of the general multilevel linear model imbedded in the Bayesian framework of posterior distributions that quantify the uncertainty in our population parameters after conditioning on the observed data (Gelman et al., 2014; McElreath, 2020; Pollard, 1986). In this section, we discuss the regression models we used, the Bayesian framework, and the treatment of missing data. The material in this section is necessarily somewhat technical. The reader interested primarily in the output of these models may want to skip to Section A.6.2.2.3.

3B.1. MULTILEVEL REGRESSION MODELING

Regression modeling seeks to treat an outcome data value as “model plus variation.” The model combines each of the factors thought to impact the outcome. The strength of the impact, which is called the effect size of the factor, is an unknown quantity that must be estimated from the data. Variation includes the natural variation of living beings, as well as the IPPs (which were sampled/selected by CDPH-OHE to participate in CRDP). This estimation process involves complex numerical simulations that determine effect size values that are consistent with the data.

Model factors take one of two basic forms: 1) continuously varying within a range of possible numbers and 2) discretely selected from a (short) list of levels. In the CRDP context, we treat the pre-score (K6, SDS, CPF1, CPF2, SIRF) as continuously varying. All the other factors listed in Table 6.24 (Chapter 6) are treated as discrete. In a regression model, the continuous variable will have a single term, multiplying the variable’s value by a coefficient that must be estimated from the data. The discrete variables will have a distinct coefficient for each level.

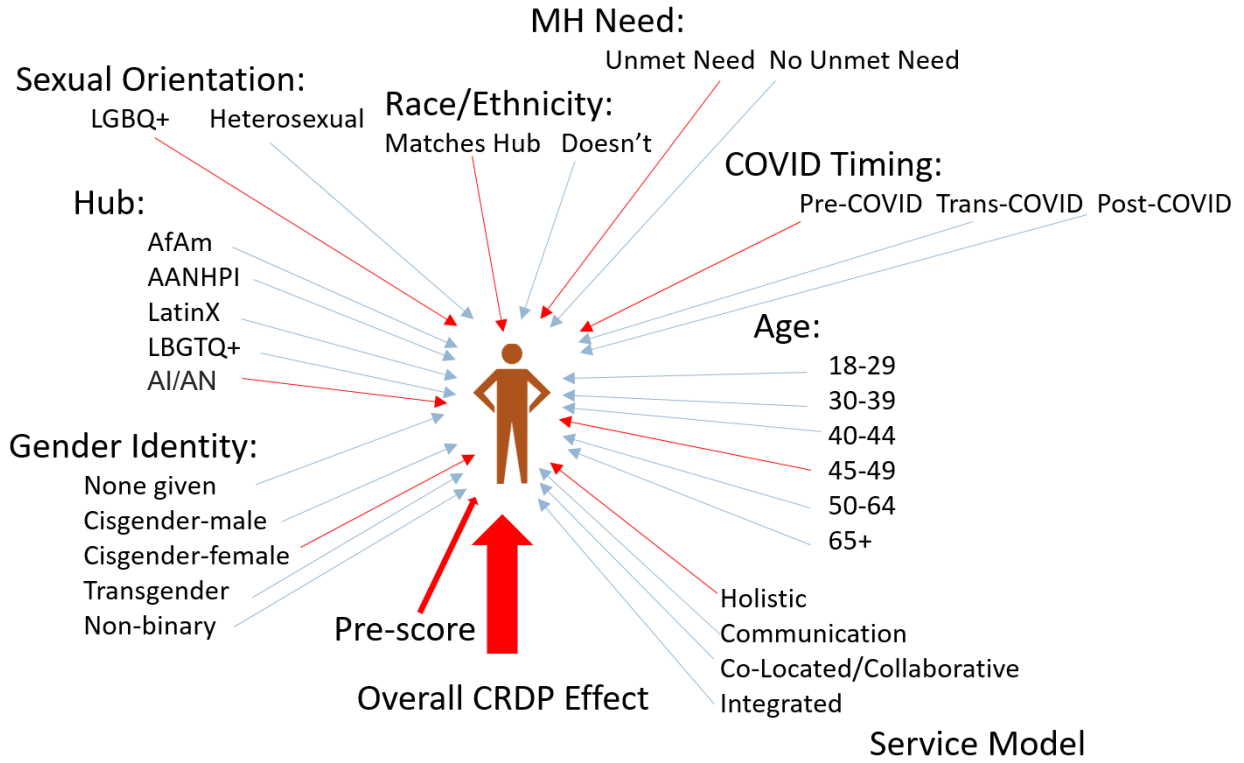
The Statewide Evaluation baseline regression model starts with an overall CRDP effect coefficient. To this term, we add the dependence on the pre-score as a continuous term and the dependence on hub, age, race, gender identity, sexual orientation, unmet mental health need, COVID-19 timing, CDEP service model, as discrete terms, and dependence on IPP as a random effect. In Figure 3b.1.1 below, each arrow has a strength or weight that are estimated from the CRDP data using Bayes’ theorem (see 3b.2 below).

Once those weights (effect sizes model coefficients) have been estimated from the CRDP data, one might wish to examine the CRDP effect on a hypothetical participant type. To do so, one would need to know all of the modeled characteristics of that hypothetical participant:

- The pre-score for the outcome measure of interest,
- The hub,
- The age group,
- The race,
- The gender identity,
- The sexual orientation,
- Whether or not there was an existing unmet need for mental health services,
- COVID-19 timing, and
- The CDEP service model.

Knowledge of those, with the estimated model, would allow prediction of a “typical” hypothetical CDEP client; that is, the model forecasts a “mean outcome” that is relative to the characteristics used by the model. It is important to remember that statistical models such as those presented here are making inferences about population mean or on-average characteristics. They are not meant to be interpreted as predicting the behavior of a specific individual – such predictions could only be made with confidence bounds so wide as to be meaningless. Figure 3b.1.1 illustrates this modeling approach.

Figure 3b.1.1: Illustration of the baseline regression model. For each variable, exactly one arrow will activate for an individual participant.



Note: Red arrows demonstrate the activation of factor levels for a hypothetical 45–49-year-old American Indian/Alaska Native cisgender female participant with LGBTQ+ orientation whose race matches her hub, and her IPP used a holistic service model. She has an unmet MH service need at pre, and her participation occurred pre-COVID lockdown.

To turn this conceptual modeling structure into a quantitative analysis tool, PARC built equations using the general linear (multivariate) model (Harrell, 2015; Gelman et al., 2014). The rest of this section provides specific statistical details, including equations, that are used to work with the CRDP pre-post matched data files.

To put the cartoon model of Figure 3b.1.1 into the quantitative statistical form of a regression model, we use the following equation

$$\begin{aligned}
 Y_i^k = & \beta_{overall}^k \\
 & + \beta_{pre}^k (pre_i^k - \overline{pre}^k) \\
 & + \beta_{pre-h1}^k (pre_i^k - \overline{pre}^k) I_i(h_1) + \beta_{pre-h2}^k (pre_i^k - \overline{pre}^k) I_i(h_2) + \beta_{pre-h3}^k (pre_i^k - \overline{pre}^k) I_i(h_3) \\
 & + \beta_{pre-h4}^k (pre_i^k - \overline{pre}^k) I_i(h_4) + \beta_{pre-h5}^k (pre_i^k - \overline{pre}^k) I_i(h_5) \\
 & + \beta_{h_1}^k I_i(h_1) + \beta_{h_2}^k I_i(h_2) + \beta_{h_3}^k I_i(h_3) + \beta_{h_4}^k I_i(h_4) + \beta_{h_5}^k I_i(h_5) \\
 & + \beta_{a_1}^k I_i(a_1) + \beta_{a_2}^k I_i(a_2) + \beta_{a_3}^k I_i(a_3) + \beta_{a_4}^k I_i(a_4) + \beta_{a_5}^k I_i(a_5) + \beta_{a_6}^k I_i(a_6) \\
 & + \beta_{ra}^k I_i(ra) + \beta_{rm}^k I_i(rm) \\
 & + \beta_{gi_1}^k I_i(gi_1) + \beta_{gi_2}^k I_i(gi_2) + \beta_{gi_3}^k I_i(gi_3) + \beta_{gi_4}^k I_i(gi_4) + \beta_{gi_5}^k I_i(gi_5) \\
 & + \beta_{het}^k I_i(het) + \beta_{lgbq+}^k I_i(lgbq+) \\
 & + \beta_{noUnmet}^k I_i(noUnmet) + \beta_{unmet}^k I_i(unmet) \\
 & + \beta_{c_1}^k I_i(c_1) + \beta_{c_2}^k I_i(c_2) + \beta_{c_3}^k I_i(c_3) \\
 & + \beta_{sm_1}^k I_i(sm_1) + \beta_{sm_2}^k I_i(sm_2) + \beta_{sm_3}^k I_i(sm_3) + \beta_{sm_4}^k I_i(sm_4) \\
 & + u_1^k I_i(IPP_1) + u_2^k I_i(IPP_2) + \dots + u_N^k I_i(IPP_N) + \varepsilon_i
 \end{aligned}$$

in which $I_i(x) = 1$ or 0 depending on whether or not participant i has property x . This I function is the function that picks which arrow (in Figure 3b.1.1) applies to a given participant. Each row of terms corresponds to a particular independent variable, and except for the pre rows and the last row, these work like a multi-way ANOVA model. Table 3b.1.1 defines the notations associated with this baseline model.

Table 3b.1.1: Notation for the baseline model

pre_i	=	pre-score of participant i
h_j	=	hub $j, j = 1, 2, 3, 4, 5$
a_j	=	age category $j, j = 1, 2, 3, 4, 5, 6$
ra, rm	=	race aligned, not aligned with hub
gi_j	=	gender identity $j, j = 1, 2, 3, 4, 5$
het	=	heterosexual orientation
$lgbq+$	=	LGBQ+ orientation
$noUnmet, unmet$	=	mental health need that was not unmet, or was unmet
c_j	=	covid timing $j, j = 1, 2, 3$
sm_j	=	service model $j, j = 1, 2, 3, 4$
u_j	=	random effect of IPP $j, j = 1, 2, \dots, N$

Those familiar with ANOVA models will know that this specification actually has too many unknown parameters. Table 6.24 makes note this issue in that each parameter type has one fewer parameters than the factor has levels.

One common ANOVA approach is to choose a category from each independent variable to be the “baseline” or “comparator” case. In experiments that use a control group, this approach makes sense. For CRDP, there is no meaningful way to choose a baseline value for each independent variable. The Statewide Evaluation’s approach is to use “sum contrasts,” in which all the β ’s in each row of the model formula sum to 0. In practice, this means that the final β in each row is the negative of the sum of the previous ones. It also means that the overall effect is not a baseline value but a sort-of overall average. In a balanced design without a continuous covariate (the pre-score in this model), the overall effect would just be the grand mean, but the diversity of sample sizes and target audiences of the IPPs leads to an unbalanced design.

With multiple models under consideration, we lump them all into the form of the general linear multivariate model, which takes the mathematical form

$$Y = X\beta + Zu + \varepsilon$$

in which:

- Y is a matrix of n rows and q columns containing the outcome variables,
- X is a matrix of n rows and p columns containing the regressors or independent variables,
- β is a matrix of p rows and q columns containing the effects of the independent variables,
- Z is a matrix of n rows and r columns, containing the independent variables associated with random effects,
- u is a matrix of r rows and q columns containing the random effects, and
- ε is a matrix of n rows and q columns containing the participant-level random variation.

The dimensions of all these quantities relate to data and to model complexity:

- The row dimension n of $Y, X, Z,$ and β denotes the total number of participant data records,
- The column dimension q of $Y, \beta, u,$ and ε denotes the number of outcome variables in the multivariate model,
- The dimension p denotes the number of regressors (or independent variables or “fixed” effects) in the model, and
- The dimension r denotes the number of random effects in the model.

The first entries of randomness/uncertainty/variation into the model come with the quantities ν and ε . The most common statistical model is that ν is a 0-mean multivariate normal random matrix whose elements are correlated and that ε is a 0-mean multivariate normal random matrix whose rows are independent with a common covariance matrix. In the case of a single outcome measure, $q=1$, and the complexity of the mathematics is greatly reduced.

Within this model, the data matrix Y and the regressor matrices X and Z are known from observed data. The coefficient matrix β and the covariances of ε and ν must be estimated from these observed data.

We also note the use of both fixed and random effects, a modeling approach that falls under the general framework of multilevel modeling. All of the independent variables (or regressors or factors) in the model – except IPP – are essentially characteristics of the participants, intervention (service models), or environment (covid timing). The IPPs were selected through a state proposal review process, a purposive sampling device not unlike the participant selection of many IPPs. To address the CRDP Objective 1.1,

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?

The Statewide Evaluation seeks to generalize, not only from the actual participants to other participants in the CRDP priority population communities, but also from the actual CRDP IPPs to other CDEPs that might be eligible for an expanded program. Toward that end, PARC chose to model the IPPs as random effects rather than fixed effects, so the covariance of the ν 's is to be estimated in the regression process.

The Statewide Evaluation further examined some perturbations of this model: five univariate models computed independently for each outcome measure versus a single multivariate model that uses all five outcome measures simultaneously; inclusion of an eight-parameter race model versus the race/hub alignment model; and a model that includes hub/gender identity and hub/sexual orientation interaction terms versus the baseline.

3B.2. BAYESIAN MULTILEVEL REGRESSION

As described in some detail in Chapter 6 of the Final Report, PARC chose to use a Bayesian approach over the traditional frequentist approach to multilevel regression. Bayesian statistical methods emphasize effect sizes: what values from all possible effect sizes are most likely to be consistent with the observed data?

Bayesian analysis begins with a prior distribution, which models our beliefs about the likely values of all the parameters in the model. In most cases, one has very little information. Perhaps pilot studies or related efforts in the research literature may apply, but often we must start by acknowledging our lack of information. Toward that end, it has become common to use “weakly informative” prior distributions (Gelman et al., 2014). This somewhat qualitative term refers to a prior distribution whose initial uncertainty about parameter values is large. For the purposes of CRDP analysis, we have used a flat prior on the overall effect, normal priors centered at 0 and with a variety of standard deviations for the additional effects, and half-t distributions for the variance parameters. We are primarily relying on the default specifications in the R package brms (see Burkner, 2017).

The next step in Bayesian analysis is the likelihood model for the data, given the parameter values. The general linear multivariate model specified in Section 3b.1 goes part of the way in this direction. Remaining is the specification of the distributions of the random quantities ν and ε . We assume here that those distributions are multivariate normal centered at 0. Their covariances are unknown parameters for which prior distributions are specified.

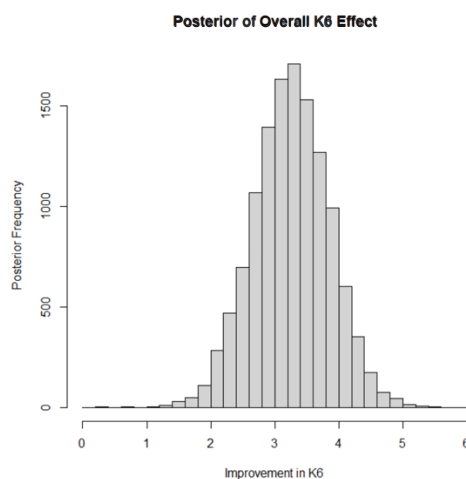
With the prior and likelihoods specified, the main task of Bayesian analysis is to compute the posterior distribution, the probability distribution of the model parameters conditioned on the observed data. This conditional distribution is characterized by Bayes' theorem (Gelman, 2014), which, roughly speaking, says:

$$\Pr[\text{effect sizes}|\text{data}] = \frac{\Pr[\text{data}|\text{effect sizes}]\Pr[\text{effect sizes}]}{\Pr[\text{data}]}$$

The factor **Pr[effect sizes]** denotes the prior, while the factor **Pr[data|effect sizes]** denotes the likelihood. The left-hand side is the (desired) posterior, and the denominator must be computed using the prior and the likelihood. Classical statistical analyses are based solely on the likelihood factor in this equation. The idea of Bayesian analysis is to determine how likely various effect sizes might be given the observed data in the model.

In all but the very simplest problems, this computation is performed through a complex simulation process called Markov Chain Monte Carlo. The result of this computation is a large number of simulated values for all of the model effects. A histogram of each effect provides a graphical display of the posterior distribution, but generally an analyst will compute the median of the simulation sample along with the 2.5% and 97.5% points for a 95% credible interval. An example of the posterior distribution for the overall CRDP effect of K6 improvement is shown in Figure 3b.2.1.

Figure 3b.2.1: Posterior frequency for the overall effect in the K6 Baseline model.



Note: This posterior computation used 12,500 simulated values, most of which occurred between 2 and 5, with a median of 3.26.

The graphics in Figures 6.29–6.33 of the Final Report also show posterior distributions, specifically for the mean improvement in the five outcome measures conditioned on the pre-score value. The simpler graphics of Section 3c show specific summaries of the posterior distribution, namely the median, the 1st and 3rd quartiles as a thick line segment, and the 2.5% and 97.5% points as a thin line segment.

3B.3. MISSING DATA TREATMENTS

As in many complex survey designs, the SWE core measure participant questionnaires presented some missing data entries. For many of the independent variables, these were coded as “no data given” (e.g., no race given, no gender identity given). For the outcome measures, however, these missing data may have an impact on the overall inference. We applied two of the most common approaches to missing data treatment: complete-case-only and multiple imputation by chained equations (Harrell, 2015; Rubin, 1996; van Buuren & Groothuis-Oudshoorn, 2011).

The basic idea of imputation is to build a regression that predicts the missing values conditioned on all the known values. As with the Bayesian posterior distribution, this process requires iteration and simulation to approximate the missing values. As the name contains “multiple,” one might expect that the output of such a procedure includes multiple predictions. Those multiple predictions respect the uncertainty inherent in the data and the population they are meant to represent.

The Bayesian approach allows us to integrate both types of missing data treatments into a single posterior. The default for the R package mice (van Buuren & Groothuis-Oudshoorn, 2011) is five replicate imputations. For each imputation, we compute a posterior (in the form of a large sample of effect values), and then we compute a posterior for the complete-case data set. These six posteriors are combined with equal weighting in the results presented in Section 3c.

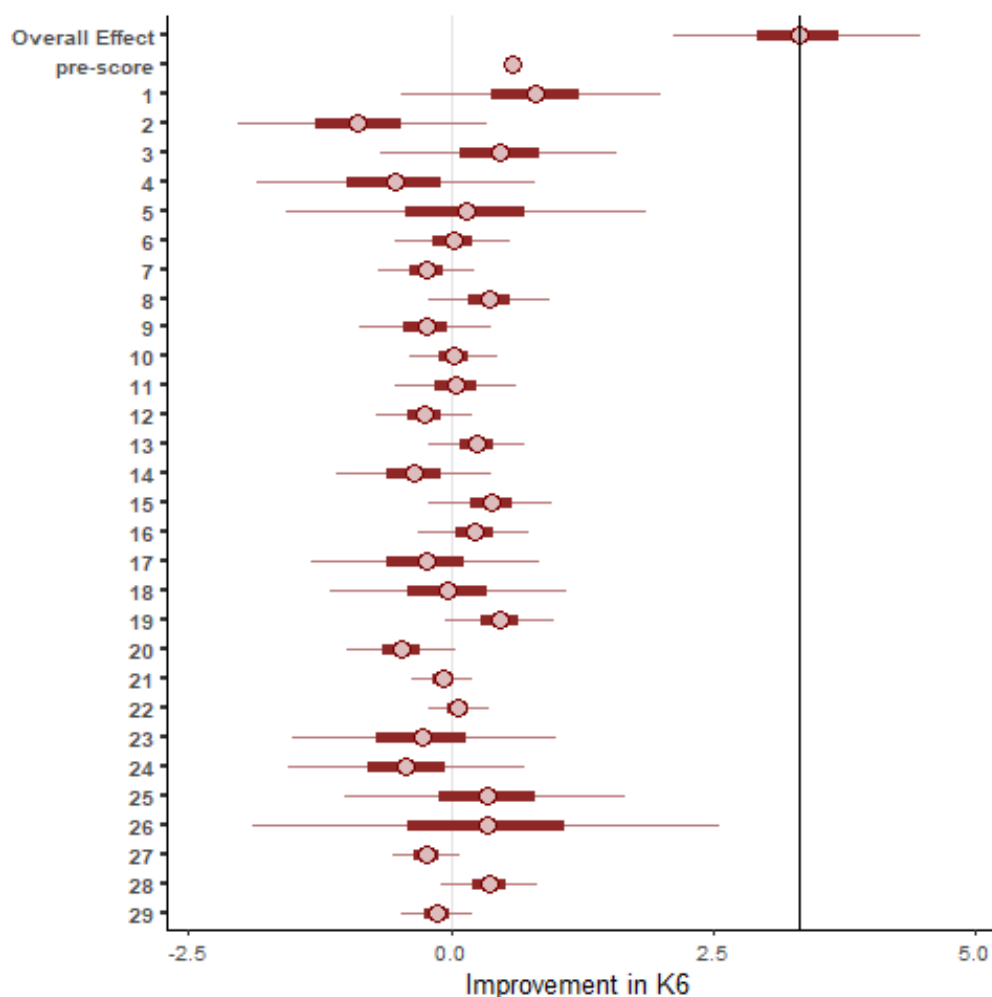
3C. MODEL RESULTS

The models described in Section 3b were applied to the CRDP datasets, and the results are given in a series of figures and tables. The figures show the Bayesian estimators of the effect sizes along with uncertainties from the posterior distributions. These uncertainties are illustrated in the form of nested credible intervals at the 50% (the thick ones) and 95% (thin ones) levels. Roughly speaking, one could view an effect whose 95% credible interval does not touch the 0 vertical line as statistically significant.

3C.1. BASELINE RESULTS

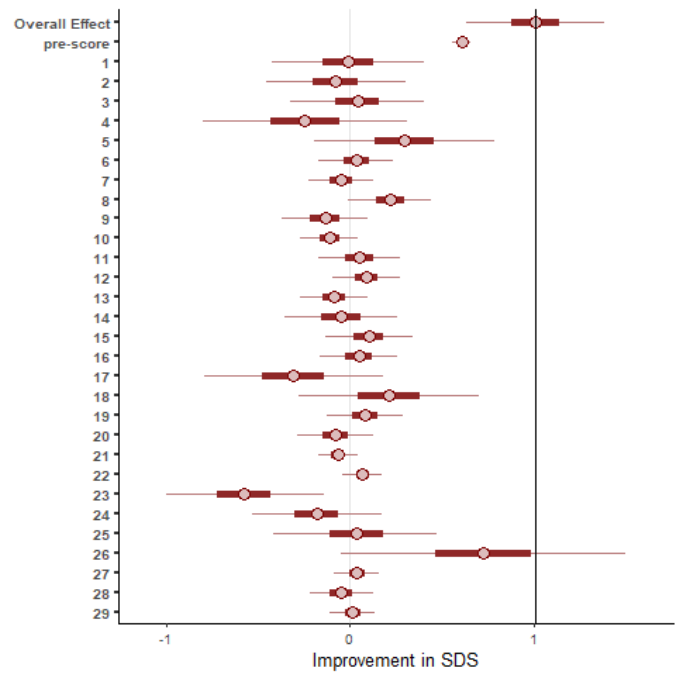
We begin the results section with 10 views of posterior distributions for the baseline model. For Adult and for Youth populations, we examine the likely values for each of the five outcome measures' effect sizes, overall, pre-score, and for each model characteristic. Labels for each of the regressors have been suppressed to discourage direct comparisons of priority populations.

Figure 3c.1.1: Adult baseline K6 model credible intervals



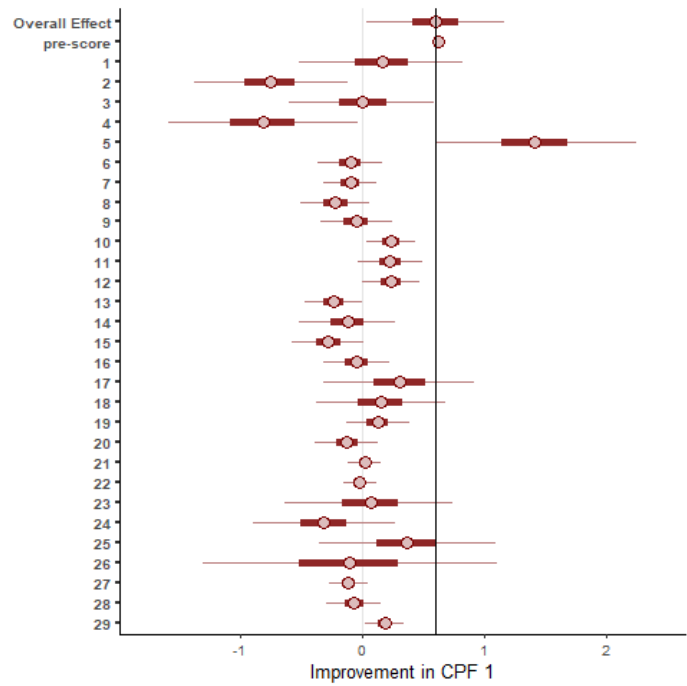
Other than the (main) overall effect and the effect of the pre-K6 score, there are no effects that exhibit major impact on expected participant K6 improvement among adult participants.

Figure 3c.1.2: Adult baseline SDSr model credible intervals



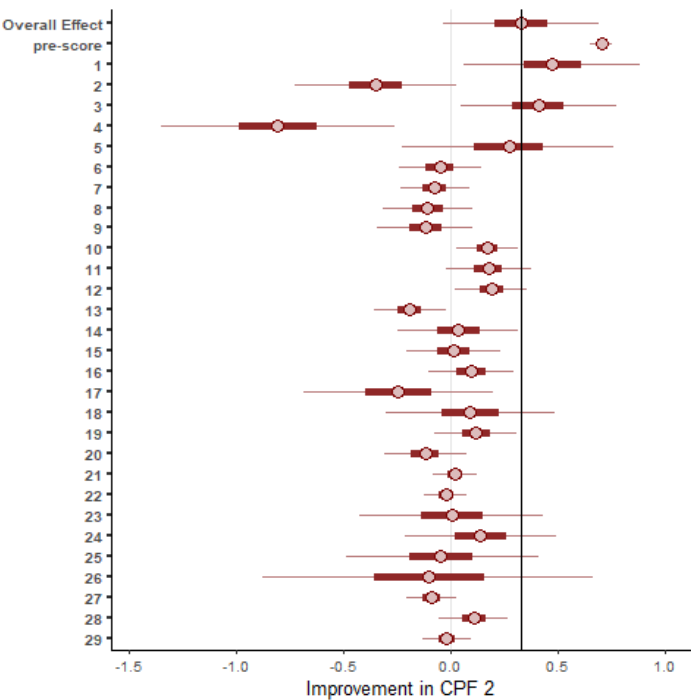
Other than the (main) overall effect and the effect of the pre-SDSr score, there are few effects that exhibit major impact on expected participant SDSr improvement. The holistic service model underperforms for participants, and the integrated service model overperforms (but has wide-ranging uncertainty).

Figure 3c.1.3: Adult baseline CPF 1 model credible intervals



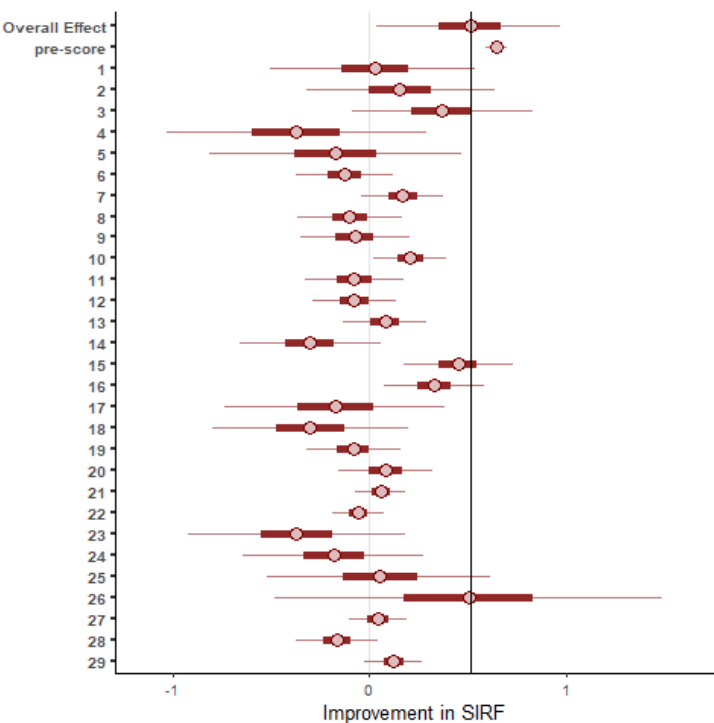
Other than the (main) overall effect and the effect of the pre-CPF1 score, some of the hub effects seem to impact participant CPF 1 improvement (or lack thereof). The AI/AN hub had a strong positive effect, with an effect size over 1 point on this scale. However, the pre-score mean for that hub was 1.38 points below the CRDP-wide CPF1 pre-score mean, cancelling out most of that gain. Likewise, the hubs with below-CRDP-wide-average CPF1 pre-score means have large negative effects that are cancelled out. We again caution the reader that interpreting statistically significant secondary effects requires full consideration of model terms.

Figure 3c.1.4: Adult baseline CPF 2 model credible intervals



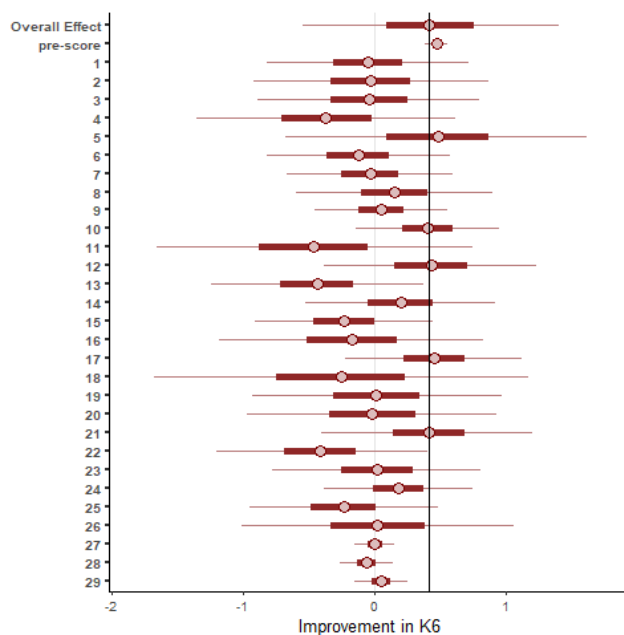
Other than the (main) overall effect and the effect of the pre-CPF 2 score, some of the hub effects seem to impact participant CPF 2 improvement (or lack thereof). Again, the pre-score effect is a moderator, offsetting what might appear to be hub-specific gains and losses.

Figure 3c.1.5: Adult baseline SIRF model credible intervals



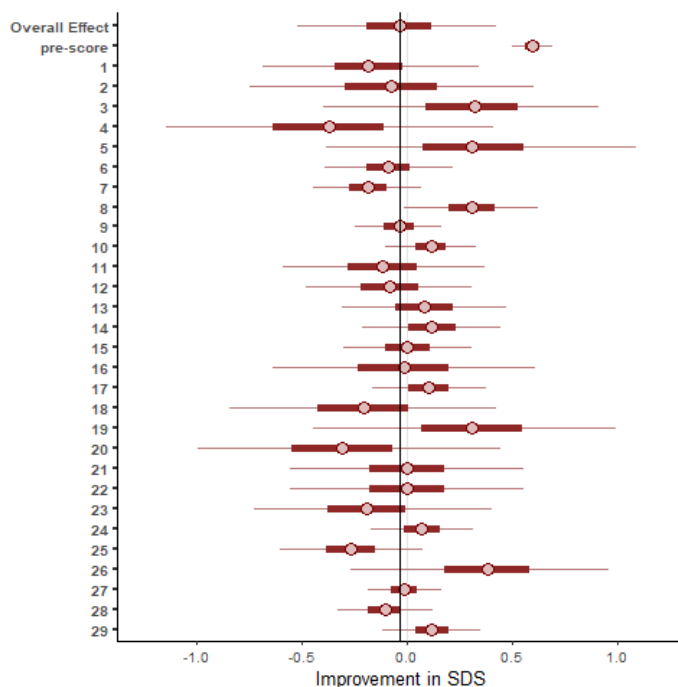
Once again, some of the hub effects seem to impact participant SIRF improvement (or lack thereof). Again, the pre-SIRF score effect is a moderator, offsetting what might appear to be hub-specific gains and losses. Moreover, there are two gender identity effects that appear to show significant gains beyond the overall effect, and these are also partially offset by the hub and pre-score effects.

Figure 3c.1.6: Youth baseline K6 model credible intervals



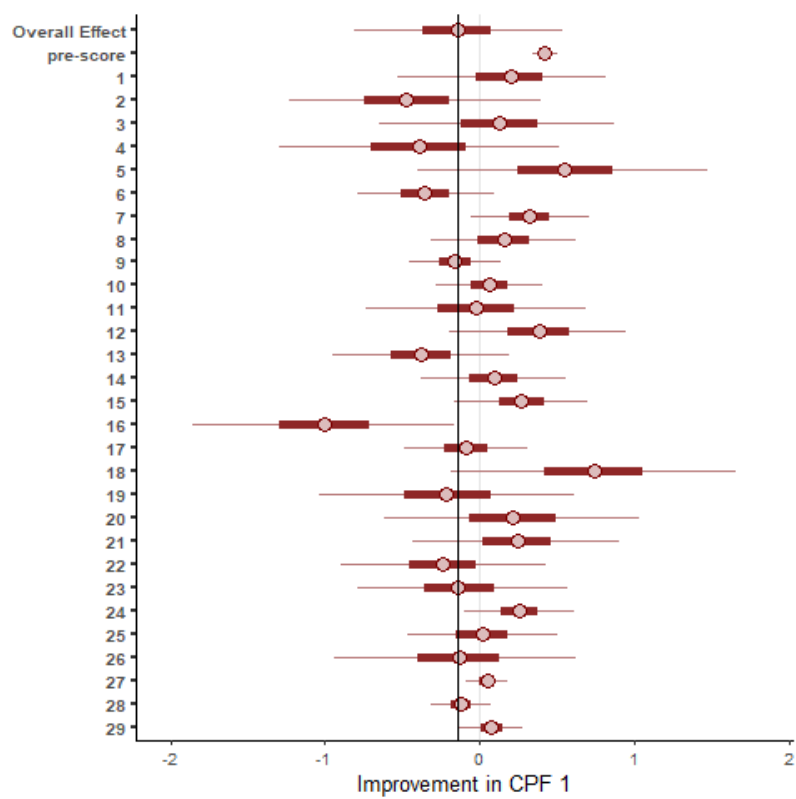
The only effect whose credible interval stands clear of zero is the pre-score effects. The main effect is positive, roughly 0.4, but the wide credible interval suggests large uncertainty in this value. At this point the advantages of a posterior probability model are worth noting. Were the analysis to use a p-value focus, the null hypothesis test of an overall CRDP effect would fail to be rejected. A common (but incorrect) conclusion might be that there is no effect. What we see in Figure 3c.1.6 above is that the 50% credible interval is above 0, meaning there is some moderate evidence for an effect. The 95% credible interval contains 0, so that the evidence of a positive effect is not all that strong. Viewed differently, the 95% credible interval being mostly positive can be interpreted as evidence for prevention.

Figure 3c.1.7: Youth baseline SDSr model credible intervals



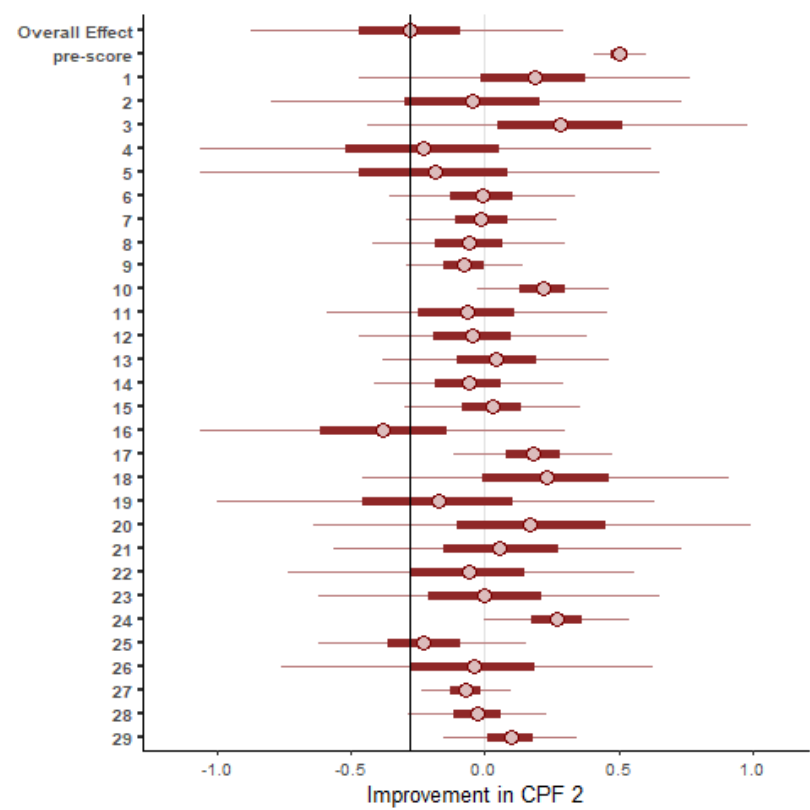
The only effects whose credible interval stands clear of zero are the pre-score effect and the 17-18 age effect (whose credible interval just barely exceeds 0).

Figure 3c.1.8: Youth baseline CPF 1 model credible intervals



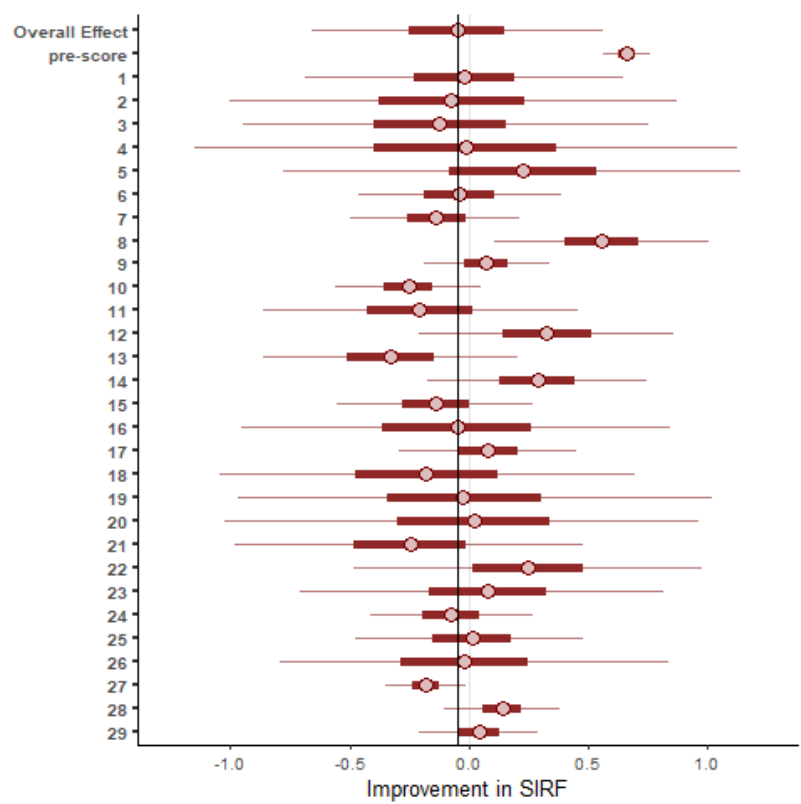
Once again, the primary story here is uncertainty.

Figure 3c.1.9: Youth baseline CPF 2 model credible intervals



Again, only the pre-score effect appears to be precisely estimated.

Figure 3c.1.10 Youth baseline SIRF model credible intervals



The only effects whose credible interval stands clear of zero are the pre-score effect and the 17-18 age effect (whose credible interval just barely exceeds 0).

Again, we note that the 95% credible intervals for the overall CRDP effect, for each of the five outcome measures, contain 0. Null hypothesis statistical testing would fail to find an effect, but for prevention, small or even 0 change is perhaps a positive outcome. In Section 3c.3 below we take a different look at prevention.

3C.2. RESULTS FOR MODELS BEYOND THE BASELINE

The multilevel statistical analysis tools employed in social science are often coarse quantitative descriptions of the complex systems they model. Choosing appropriate regressor variables from the tens (or hundreds) generated by survey instruments is a huge challenge. The so-called “garden of forking paths” (Gelman and Loken, 2014) offers many routes to potentially statistically significant results. To mitigate the risk of choosing a misleading path, the Statewide Evaluation employed techniques in robustness analysis with many “competing” models including different combinations of factors (Young and Holsteen, 2017). These techniques compare multiple models using the factors they have in common. For example, if we include interaction terms to model intersectionality (ethnicity, gender identity) at the priority population, do main effect terms change dramatically with the presence/absence of those model components? If we use a multivariate model versus five univariate models, do the effect sizes remain consistent or diverge? These Type M (magnitude) and Type S (sign) errors (Gelman and Carlin, 2014) are perhaps more important than the classical Type I and II errors of null hypothesis statistical testing – are the magnitudes and directions of estimated effects stable with respect to model specification? Modeling choices are an often overlooked (and difficult to quantify) source of uncertainty in results.

To explore the extent to which inferences may be dependent on the forks of the paths taken or not taken, we compare the effect size results of the five Adult baseline models to the results obtained from the multivariate Adult baseline model. This multivariate model uses all five outcome measures together, estimating their covariances along with the population effect sizes. Table 3c.2.2 contains ten columns of effect sizes, with the first five determined by the five baseline univariate models and the last five all determined together from the multivariate baseline.

It is important to remember that the multivariate model includes several more terms than the five univariates. First, each outcome in the multivariate may depend on all five of the pre-outcome scores. Second, the outcome correlations must be estimated. Thus, while all of the effects in the univariate models appear in the multivariate model, there are terms in the multivariate model that do not show up in the univariate model. We show those parameters common to both.

In terms of Type M (magnitude) and Type S (sign) differences between these two approaches, we see 14 out of 155 parameter estimates showing sign differences, or about 9%. The magnitude differences for each outcome measure should be considered relative to that outcome measure's units and range of values: the K6 ranges from 0 to 24, while the SDSr ranges from 0 to 6. In Table 3c.2.1, we show the Type M error averages and standard deviations (over the 31 modeled effects) for each outcome. Each number is in terms of the points of the outcome.

Table 3c.2.1: Type M error assessment for univariate baselines versus multivariate.

	K6	SDSr	CPF 1	CPF 2	SIRF
Average Type M	0.18	0.09	0.07	0.09	0.10
Type M standard deviation	0.13	0.10	0.08	0.08	0.10

Table 3c.2.2: Comparison of Two Modeling Approaches: five univariate baseline models versus one multivariate model.

Univariate Baseline Models					Multivariate Model				
K6	SDSr	CPF 1	CPF 2	SIRF	K6	SDSr	CPF 1	CPF 2	SIRF
3.31	1.01	0.60	0.33	0.51	3.24	1.02	0.33	0.01	0.59
0.58	0.60	0.63	0.70	0.65	0.70	0.74	0.68	0.80	0.73
0.81	-0.01	0.16	0.48	0.03	0.37	-0.10	0.18	0.39	-0.29
-0.89	-0.08	-0.76	-0.35	0.15	-0.96	-0.13	-0.56	-0.16	0.36
0.47	0.04	0.00	0.41	0.36	0.49	0.08	0.20	0.50	0.34
-0.54	-0.24	-0.82	-0.80	-0.37	-0.29	-0.26	-1.01	-1.01	-0.36
0.14	0.29	1.41	0.27	-0.18	0.39	0.41	1.19	0.28	-0.05
0.02	0.03	-0.10	-0.05	-0.13	0.00	0.07	-0.03	-0.11	-0.09
-0.23	-0.05	-0.10	-0.07	0.17	-0.09	-0.08	-0.11	0.06	0.26
0.37	0.22	-0.22	-0.11	-0.10	0.33	0.18	-0.30	-0.10	-0.16
-0.24	-0.14	-0.05	-0.12	-0.07	-0.47	-0.22	-0.04	-0.19	-0.10
0.03	-0.11	0.24	0.17	0.21	0.09	-0.11	0.24	0.19	0.15
0.05	0.05	0.23	0.18	-0.08	0.14	0.16	0.24	0.15	-0.06
-0.24	0.09	0.23	0.19	-0.08	-0.06	0.12	0.19	0.10	-0.05
0.24	-0.09	-0.23	-0.19	0.08	0.06	-0.12	-0.19	-0.10	0.05
-0.35	-0.05	-0.12	0.04	-0.30	-0.61	0.29	-0.08	0.27	-0.23
0.38	0.10	-0.28	0.01	0.45	0.55	0.06	-0.31	0.04	0.20
0.23	0.05	-0.05	0.10	0.33	0.17	0.00	-0.08	0.19	0.19
-0.24	-0.31	0.30	-0.24	-0.17	0.23	-0.17	0.36	-0.47	0.22
-0.03	0.21	0.15	0.09	-0.30	-0.34	-0.18	0.11	-0.03	-0.38
0.46	0.08	0.13	0.12	-0.08	0.20	0.05	0.16	0.13	-0.13
-0.46	-0.08	-0.13	-0.12	0.08	-0.20	-0.05	-0.16	-0.13	0.13
-0.08	-0.07	0.02	0.02	0.06	0.03	-0.10	0.05	0.04	0.00
0.08	0.07	-0.02	-0.02	0.06	-0.03	0.10	-0.05	-0.04	0.00
-0.27	-0.58	0.06	0.01	-0.37	-0.33	-0.59	0.23	-0.01	-0.36
-0.42	-0.18	-0.32	0.14	-0.18	-0.15	-0.04	-0.31	0.28	0.00
0.36	0.03	0.36	-0.05	0.05	0.59	0.20	0.43	0.03	0.16
0.34	0.72	-0.11	-0.10	0.50	-0.11	0.43	-0.35	-0.30	0.20
-0.23	0.04	-0.11	-0.09	0.04	-0.34	0.07	-0.09	-0.11	-0.03
0.36	-0.05	-0.07	0.11	-0.17	0.34	-0.12	-0.10	0.09	-0.15
-0.13	0.01	0.18	-0.02	0.12	0.00	0.05	0.19	0.02	0.18

Generally, the differences in magnitudes are small, especially relative to the overall effect size, and there are very few sign differences.

These two interaction terms come with relatively wide credible intervals and mostly very small effect sizes.

An important internal validity check is to compare the common effects in the baseline model to those of this interaction model, realizing that the interaction effects will potentially moderate the main effects of hub, race-alignment, and gender identity. Table 3c.2.3 contains a numerical comparison of these effect size estimates. Average Type M error is 0.11 with a standard deviation of 0.12 K6 points. Four Type errors occurred in the 29 common effects.

Table 3c.2.3: Comparison of Two Modeling Approaches: Common terms of the baseline and interaction models.

K6 Baseline	K6 with Interactions
3.46	3.31
0.58	0.58
0.67	0.81
-0.70	-0.89
0.17	0.47
-0.63	-0.54
0.49	0.15
0.06	0.02
-0.27	-0.23
0.31	0.37
-0.28	-0.24
0.04	0.03
0.14	0.06
0.02	-0.24
-0.02	0.24
-0.34	-0.35
0.13	0.38
-0.02	0.23
-0.13	-0.24
0.36	-0.03
-0.06	-0.08
0.06	0.08
-0.23	-0.27
-0.38	-0.42
0.29	0.36
0.32	0.34
-0.24	-0.23
0.36	0.36
-0.12	-0.13

Note: As in all other presentations, labels have been avoided to discourage direct comparisons among priority populations.

Table 3c.2.4: Comparison of imputation vs complete-case-only analysis.

Missing Data Imputed	Complete Cases Only
3.26	3.26
0.58	0.54
0.80	0.38
-0.88	0.03
0.47	0.23
-0.52	-0.73
0.13	0.09
-0.09	0.20
-0.20	0.08
0.40	0.19
-0.28	-0.28
0.09	-0.13
0.08	-0.06
-0.29	0.00
0.29	0.00
-0.38	-0.19
0.37	0.64
0.27	0.21
-0.38	-0.01
0.12	-0.65
0.54	0.22
-0.54	-0.22
-0.09	0.16
0.09	-0.16
-0.31	-0.73
-0.40	-0.04
0.37	0.43
0.34	0.34
-0.24	0.18
0.39	-0.25
-0.15	0.07

Note: As in all other presentations, labels have been avoided to discourage direct comparisons among priority populations.

Generally, the differences in magnitudes are small, especially relative to the overall effect size, and there are very few sign differences.

It is also worth comparing regression results from “complete cases only” versus “missing data imputation.” In Table 3c.2.4, we show the parameter estimates for a single missing data imputation result (on the left) and the complete-cases result (on the right). The overall effect and pre-score effect remain quite consistent, but there are 11 (out of 31) Type S differences. The Type M average difference is 0.27 with a standard deviation of 0.21, suggesting that the parameter estimates are more sensitive to missing data than they are to details of the modeling (e.g., multivariate vs univariate, interaction terms). Even so, the average Type M error of 0.27 K6 score points is a relatively small effect in comparison to the overall effect size of more than 3 points.

3C.3. A DISTINCT LOOK AT PREVENTION: LOGISTIC REGRESSION

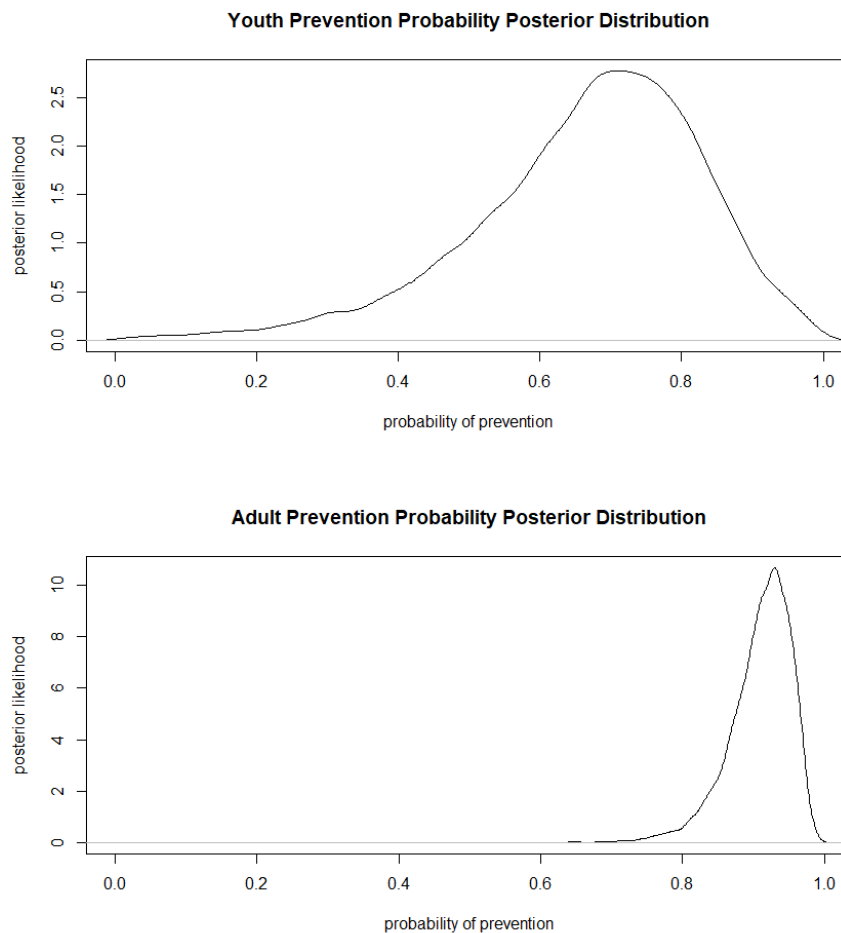
The problem of demonstrating the effectiveness of prevention has long challenged mental health researchers (Wainberg et al., 2017), especially in a classical statistical context. Null hypothesis statistical testing aims to detect a difference, while prevention is often successful when differences are avoided. By providing credible intervals rather than p-values, the Statewide Evaluation's analysis of the Youth data yield some evidence that mental health deterioration has been prevented. To seek further (and perhaps stronger) evidence of prevention, PARC implemented a logistic regression version of its baseline K6 model with baseline missing data treatment. Here we view prevention as one of two possible outcomes: post-intervention K6 below 5 (i.e., low level of psychological distress), or post-intervention K6 below pre-intervention K6. The outcome for this model is binary: 1 if prevention, 0 if not. The logistic regression model looks at the probability of prevention: the log-odds-ratio for prevention, rather than the change in K6, obeys the regression equation:

$$\log\left(\frac{p}{1-p}\right) = Y = X\beta + Zu + \varepsilon$$

$$p = \frac{\exp(X\beta + Zu + \varepsilon)}{1 + \exp(X\beta + Zu + \varepsilon)}$$

in which p represents the probability of a prevention outcome. The output for this logistic regression yields an overall effect size of 2.43 for Adults and 0.79 for Youth. In practical terms, these log-odds effects mean a 69% probability of prevention (with 95% CI of 28-93) for Youth and 92% probability (95% CI of 80-97) for Adults. The posterior distributions for these are shown in the two panels of Figure 3c.3.1.

Figure 3c.3.1: Posterior distributions for Youth (top) and Adult (bottom) prevention probabilities.



The Youth result is derived from a dataset with a much smaller sample size, so it has a broader and hence more uncertain probability of prevention. Nonetheless, the results show great promise. The Adult result, given the strong intervention effect already shown in the baseline linear regressions, is not so surprising.

Effect size estimates (with labels suppressed) are given in the following table.

Table 3c.3.1: Logistic regression effect sizes (in log-odds-ratio units) for Youth and Adult K6.

Youth Prevention Model			1284. Adult Prevention Model		
Effect size	Lower CI	Upper CI	Effect size	Lower CI	Upper CI
0.79	-0.94	2.54	2.43	1.41	3.54
0.03	-0.02	0.09	0.12	0.08	0.17
-0.05	-2.31	2.37	0.34	-0.76	1.39
0.27	-3.72	4.47	-0.29	-1.32	0.80
0.37	-3.14	3.49	-0.33	-1.24	0.56
-1.33	-5.60	2.64	-0.09	-1.44	1.28
-0.67	-1.32	-0.03	-0.24	-0.71	0.26
0.27	-0.23	0.78	0.06	-0.36	0.49
0.52	-0.09	1.14	0.00	-0.51	0.55
			-0.04	-0.63	0.61
			0.15	-0.27	0.58
-0.12	-0.55	0.29	0.09	-0.34	0.51
0.30	-0.10	0.70	0.05	-0.47	0.54
-0.23	-1.16	0.68	0.12	-0.68	0.95
-0.39	-1.06	0.27	0.40	-0.20	0.98
0.10	-0.52	0.72	0.18	-0.37	0.72
-0.03	-1.33	1.40	-0.32	-1.65	1.14
0.42	-0.09	0.93	-0.31	-0.64	-0.01
0.80	-4.21	5.54	-0.98	-2.17	0.12
-0.65	-3.88	2.18	-0.42	-1.52	0.52
-0.65	-3.49	2.38	-0.46	-1.72	0.67
-0.22	-0.75	0.31	0.00	-0.33	0.33
0.22	-0.59	1.03	-0.19	-0.64	0.29
-0.06	-0.18	0.05	-0.03	-0.12	0.07
-0.12	-0.26	0.00	-0.01	-0.08	0.06
0.09	0.00	0.18	0.04	-0.02	0.11
0.15	0.04	0.27	0.01	-0.09	0.11

Note: The Youth data lacks two rows due to fewer age groupings.

3D. SOFTWARE AND PACKAGES

The R statistical programming environment (R Core Team, 2021) was used for all statistical computations discussed in Section 6.2.2. The function “read_sav” provided in the R package “haven” (Wickham and Miller, 2021) was used to import the basic SPSS databases into R. The function “full_join” in the R package “dplyr” (Wickham, François, Henry and Müller, 2021) was used to merge the individual IPP pre- and post-data frames into a single CRDP-wide data frame for analysis. The bulk of the data analysis was performed using the Bayesian multilevel modeling package “brms” (Bürkner, 2017). Missing data were imputed using the multiple imputation models provided in the package “mice” (van Buuren and Groothuis-Oudshoorn, 2011). The R programming environment is available free of charge at <https://www.R-project.org>, and all packages may be installed from within R using the “install.packages” function.

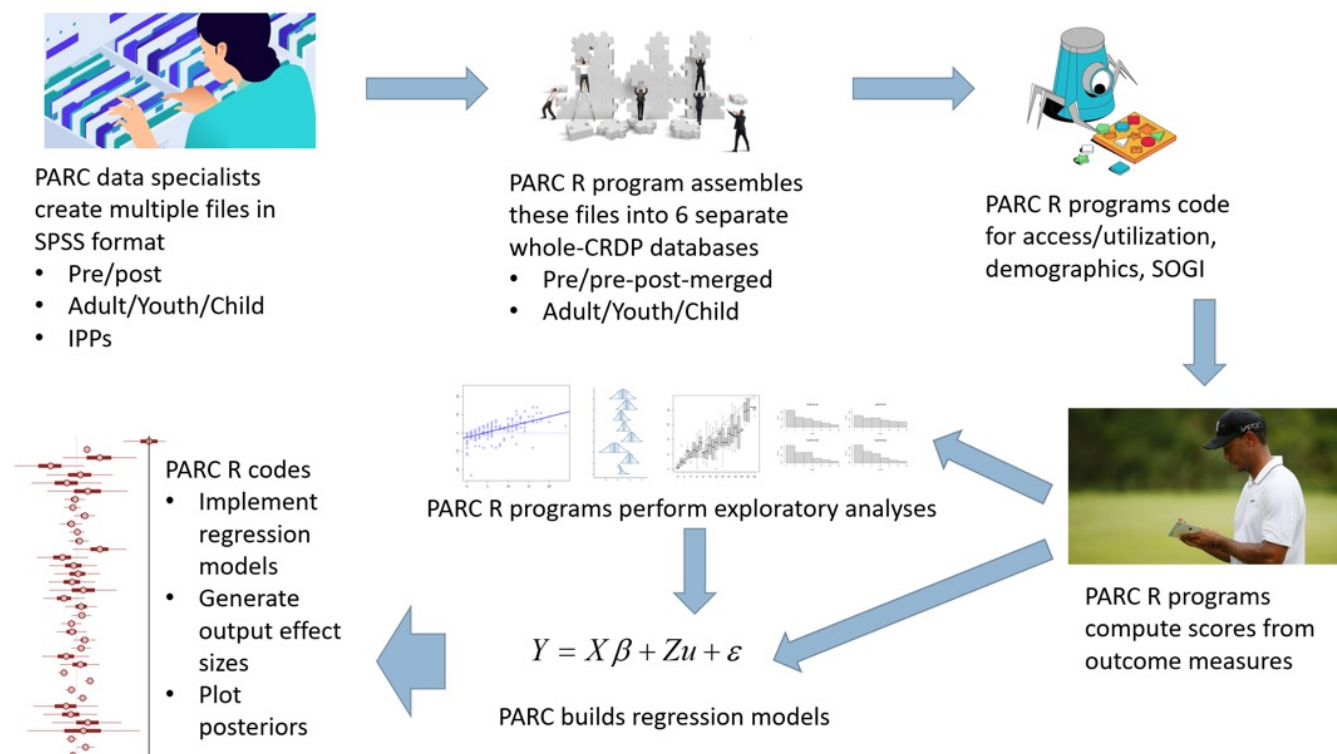
3E. WORKFLOW FOR QUANTITATIVE DATA ANALYSIS

The data entry and quality review process is described in Chapter 4 Statewide Evaluation Methods Section of the Final Report. That effort resulted in a collection of SPSS files that form the SWE core measures database. For each IPP, there may be as many as 6 total files, organized in terms of the two time points (pre-intervention, post-intervention) and 3 age groups (Adult, Adolescent, Child). Our software performs the following tasks:

1. Read each SPSS file into a data frame;
2. Organize these data frames by IPP, time point, and age group;
3. Merge data frames into 6 CRDP-wide data frames, organized by time point and age group;
4. For each IPP and age group that has both pre- and post- data frames, merge pre- and post- data frames in 3 CRDP-wide data frames (one for each age group);
5. For a given age group, process the CRDP-wide pre- database to extract demographic information;
6. For a given age group, process the pre-post merged database to extract pre- and post- K6 and SDS scores;
7. Perform multiple imputation (if desired) to treat missing data;
8. Estimate posterior distributions for multilevel models; and
9. Process posterior distributions to produce output.

Figure 3e.1 illustrates the workflow.

Figure 3e.1: PARC quantitative data analysis workflow.



3F. DISCUSSION

The primary results of the Statewide Evaluation quantitative data analysis have been presented in the Final Report. The main objective was to provide evidence to CDPH-OHE concerning the effectiveness of CRDP overall. Using five distinct outcome measures, the Statewide Evaluation presented strong evidence of mental health improvements for Adults, CRDP-wide. For Youth, with lower on-average levels of mental health problems, the Statewide Evaluation results show evidence of prevention.

In this Appendix, we sought to fill in more information for quantitative evaluators and others with interests in the technical details. While we have endeavored to conduct an exhaustive and complete set of analyses, there are undoubtedly other ways to examine the data. We have also endeavored to provide enough detail that the interested analyst (with permission to access the data) could replicate these analyses.

From PARC's perspective, the different modeling approaches tell a consistent story. Missing data issues do not detract from the overall effect sizes but may potentially impact some of the smaller-magnitude effects of other relevant factors.

On the technical side, the assumptions of linearity and normality in the regression models may be an issue for inference. Residual plots do suggest non-uniform variance in the errors. A regression model built on beta distributions for the pre- and post- outcome measures could possibly provide more accurate modeling of the participant-to-participant variation, an opinion deriving from the skewed shapes of the data distributions. Development of software to fit and analyze such a model is a task well beyond the scope and budget of the CRDP Phase 2 Statewide Evaluation.

The larger scale issues impacting the interpretation of the Statewide Evaluation quantitative data analysis involve the problem of sampling and representativeness. With most IPPs recruiting participants through convenience and purposive sampling, there is a question of what larger population of people is being represented. A look at the CHIS, data which attempts to represent the whole of California, the sample recruited in CRDP is, on average, in much greater need of mental health support (see Table 6.21 of the Final Report) than the average CA resident of the same race/ethnicity. This result suggests the CDEPs are reaching people who need their help, but it also means that CHIS offers little insight into what larger population might share that need. Sampling issues also extend to attempts to generalize these results beyond the 22 IPPs that provided adult matched pre-post participant data and 14 IPPs that provided youth matched pre-post participant data. The state of CA undertook a purposive sampling approach, selecting IPPs through a rigorous proposal review. Other CDEPs in CA might show comparable impacts, but that could only be inferred through a similar vetting process.

Finally, we note that the Statewide Evaluation was not a designed multi-site randomized controlled trial. No control group exists to which the Statewide Evaluation could compare the intervention effects. Moreover, the sites (IPP) in this evaluation conducted their unique, culturally-attuned interventions, with durations, cohorts, and sample sizes governed by their capacities and approaches. Many, if not most, of the CRDP CDEPs had already demonstrated their potential through basic research studies. The purpose of the CRDP was not a basic science effort into individual CDEP effectiveness; rather, CRDP sought to demonstrate what mental health results could be obtained in a relatively large-scale rollout of a variety of thoughtfully designed, scientifically based, culturally competent interventions. The Statewide Evaluation quantitative data analyses were conducted with that goal at the forefront.

APPENDIX 4: COST-BENEFIT ANALYSIS METHODOLOGY

4.1: STEPS TO CALCULATE BENEFITS FROM REDUCED PSYCHOLOGICAL DISTRESS

Step 1: Estimating Health Expenditures Model

We used an ordinary least square (OLS) regression model that included covariates such as age, sex at birth, English language fluency, whether a person was born in the U.S., household income, and education. The SWE participant questionnaire did not include all these variables, especially health expenditures. All the variables were available in the MEPS, and we relied on these data to model health expenditure changes for the different hubs.

To obtain the potential dollar value associated with the change in psychological distress, measured through changes in the MEPS-K6 scores, we estimated the following regression:

$$\text{Health Expenditures}_i = \beta_0 + \beta_1 \text{K6 score}_i + \beta_2 \text{African American}_i + \beta_3 \text{AI/AN}_i + \beta_4 \text{AANHPI}_i + \beta_5 \text{Latinx}_i + \beta_6 \text{African American}_i * \text{K6}_i + \beta_7 \text{AI/AN}_i * \text{K6}_i + \beta_8 \text{AANHPI}_i * \text{K6}_i + \beta_9 \text{Latinx}_i * \text{K6}_i + \beta_{10} \text{Sex at birth}_i + \beta_{11} \text{English Language Fluency}_i + \beta_{12} \text{U.S. born}_i + \beta_{13} \text{Health Insurance}_i + \beta_{14} \text{Household income}_i + \beta_{15} \text{Education dummies}_i + \beta_{16} \text{Age dummies}_i + \varepsilon_i \quad (1)$$

where the interactions between race-ethnicity and K6 scores (β_6 to β_9) were the main coefficients of interest and ε was the independent and identically distributed error term.

To calculate health expenditures for the LGBTQ+ hub, we used an analogous health expenditure model for LGBTQ+ individuals, which included the following NHIS response categories of gay, lesbian, bisexual, or something else. As previously mentioned, this categorization does not fully encompass the diversity of the hub and its participants, but even after accessing restricted data there are no better indicators available to match our needs.

$$\text{Health Expenditures}_i = \alpha_0 + \alpha_1 \text{K6 score}_i + \alpha_2 \text{LGBQ}^+ + \alpha_3 \text{LGBQ}^+ * \text{K6}_i + \alpha_4 \text{English Language Fluency}_i + \alpha_5 \text{U.S. born}_i + \alpha_6 \text{Health Insurance}_i + \alpha_7 \text{Household income}_i + \alpha_8 \text{Education dummies}_i + \alpha_9 \text{Age dummies}_i + \varepsilon \quad (1a)$$

where the interactions between the LGBQ+ dummy and K6 scores (α_3) was the main coefficient of interest and ε was the independent and identically distributed error term.

The MEPS data included information on different types of health expenditures. For this CBA, we adopted a societal perspective and our health expenditure models focused on three types of expenditures: 1) out-of-pocket (oop) health expenditures (relevant for CRDP participants/program beneficiaries), 2) Medicaid/Medicare expenditures and 3) health insurance expenditures (that represent public and private insurance costs to taxpayers/non-participants who are part of the society).

Step 2: Calculating Health Expenditures Associated with Point Changes in K6

We used the estimated values from a regression model (1) to calculate health expenditures (\widehat{HE}) associated with changes in psychological distress. To calculate projected health expenditures by hub, we used predictive marginal probabilities by race-ethnicity. These predictive margins were the weighted average of the expected difference in health expenditures associated with a 1-unit change in the MEPS-K6 score of a representative sample of individuals, adjusted to the sample distributions of all variables in the model. Marginal probabilities were estimated separately for each of the race-ethnicities of interest and for LGBQ+.

$$\text{Marginal Changes in Health Expenditures } \Delta = \frac{d(\text{Health Expenditures}|\bar{X}, \text{Race/Ethnicity})}{dK6_{k=0, \dots, 24}}$$

$$\text{Marginal Changes in Health Expenditures } \Delta = \frac{d(\text{Health Expenditures}|\bar{X}, \text{LGBQ}^+)}{dK6_{k=0, \dots, 24}}$$

This empirical methodology provided the potential dollar value associated with 1-point changes in psychological distress (from 0 to 24) for the five CRDP hubs.

Step 3: Matching K6 Scores from MEPS and CRDP Data

In our CRDP participant database we estimated average K6 pre scores (column 1 from table 4a) and average K6 post scores (column 2) for the five hubs. We obtained the K6 scores from the matched CRDP participant data with complete K6 cases. This meant that only participants that answered the six K6 items in the pre- and post-questionnaire were considered as part of the analytic sample. Participants with missing values were dropped from the sample to avoid biased estimates. The total matched adult sample size was 1,784.

We matched pre- and post- CRDP K6 scores from our data to MEPS K6 scores to determine the dollar value from a change in K6 scores. We then subtracted the MEPS dollar value at the K6 pre score from the MEPS dollar value at the K6 post score (column 3).

Step 4: Aggregating Benefits

We multiplied the dollar values from column 3 by the number of CDEP participants. To determine the potential number of CDEP participants we used the numbers reported in the SAR as direct service counts by hub (column 5). Table 4.a shows the four steps described.

Table 4a: Health Expenditure Values from Point Changes in MEPS K6

	1	2	3	4	5
Hub	Average CRDP K6 pretest score	Average CRDP K6 posttest score	Dollar value from changes in MEPS K6	Number of CRDP participants	Benefit from reduction in psychological distress
AfAm	A1	B1	Z1= MEPS \$ of K6 @A1 – MEPS \$ of K6 @B1	X1	Z1*X1
AI/AN	A2	B2	Z2= MEPS \$ of K6 @A2 – MEPS \$ of K6 @B2	X2	Z2*X2
AANHPI	A3	B3	Z3= MEPS \$ of K6 @A3 – MEPS \$ of K6 @B3	X3	Z3*X3
Latinx	A4	B4	Z4= MEPS \$ of K6 @A4 – MEPS \$ of K6 @B4	X4	Z4*X4
LGBTQ+	A5	B5	Z5= MEPS \$ of K6 @A5 – MEPS \$ of K6 @B5	X5	Z5*X5
CRDP wide estimate					$\sum_{i=1}^5 Z_i * X_i$

The CRDP wide estimate added up benefits from each hub. This estimate was considered the aggregate benefit from a reduction in psychological distress monetized through oop health expenditures. The process described for oop health expenditures was replicated for Medicare/Medicaid health expenditures, health insurance expenditures, and public assistance dollars.¹

4.2: STEPS TO CALCULATE BENEFITS FROM REDUCED PSYCHOLOGICAL FUNCTIONING

Step 1: Estimating the Probability of Scoring K6≥13

We estimated the probability of experiencing symptoms associated with SPD (i.e., scoring a composite value of K6≥13) using K6 scores from the matched CRDP adult participant dataset with complete K6 cases and the following model:

$$P_i = Pr(\text{SPD} = 1 \text{ or } K6 \geq 13, \forall k = 13, \dots, 24) = \gamma_0 + \gamma_1 \text{African American}_i + \gamma_2 \text{AI/AN}_i + \gamma_3 \text{AANHPI}_i + \gamma_4 \text{Latinx}_i + \gamma_5 \text{Sex at birth}_i + \gamma_6 \text{English Language Fluency}_i + \gamma_7 \text{U.S. born}_i + \beta_8 \text{Health Insurance}_i + \beta_9 \text{Household income}_i + \beta_{10} \text{Education dummies}_i + \beta_{11} \text{Age dummies}_i + \varepsilon_i \quad (2)$$

¹ In the case of public assistance, the model would differ in that the dependent variable was self-reported public assistance dollars available in MEPS, with all independent variables being analogous to those observed in the health expenditure models.

To calculate the probability of experiencing symptoms associated with SPD for the LGBTQ+ hub, we used an analogous model for LGBTQ+ individuals

$$P_i = Pr(SPD = 1 \text{ or } K6 \geq 13, \forall k = 13, \dots, 24) = \theta_0 + \theta_1 LGBQ^+_i + \theta_2 \text{Sex at birth}_i + \theta_3 \text{English Language Fluency}_i + \theta_4 \text{U.S. born}_i + \theta_5 \text{Health Insurance}_i + \theta_6 \text{Household income}_i + \theta_7 \text{Education dummies}_i + \theta_8 \text{Age dummies}_i + \varepsilon_i \quad (2a)$$

where the variable *SPD* was a dummy that took on the value of 1 if $K6 \geq 13, \forall k = 13, \dots, 24$ and took on the value of 0 if $K6 < 13$.

Using the CRDP data and model (2), we calculated the probability of experiencing SPD at pre (column 1 in table 4b) and post (column 2) interventions per hub.

Step 2: Estimating Health Expenditures Model

We estimated health expenditures associated with experiencing symptoms of SPD using MEPS data and the following models:

For different races/ethnicities:

$$\text{Health Expenditures}_i = \gamma_0 + \gamma_1 \text{Serious Psychological Distress}_i + \gamma_2 \text{African American}_i + \gamma_3 \text{AI/AN}_i + \gamma_4 \text{AANHPI}_i + \gamma_5 \text{Latinx}_i + \gamma_6 \text{African American}_i * SPD_i + \gamma_7 \text{AI/AN}_i * SPD_i + \gamma_8 \text{AANHPI}_i * SPD_i + \gamma_9 \text{Latinx}_i * SPD_i + \gamma_{10} \text{Sex at birth}_i + \gamma_{11} \text{English Language Fluency}_i + \gamma_{12} \text{U.S. born}_i + \gamma_{13} \text{Health Insurance}_i + \gamma_{14} \text{Household income}_i + \gamma_{15} \text{Education dummies}_i + \gamma_{16} \text{Age dummies}_i + \varepsilon_i \quad (3)$$

For LGBTQ+:

$$\text{Health Expenditures}_i = \theta_0 + \theta_1 \text{Serious Psychological Distress}_i + \theta_2 LGBQ^+_i + \theta_3 LGBQ^+_i * SPD_i + \theta_4 \text{Sex at birth}_i + \theta_5 \text{English Language Fluency}_i + \theta_6 \text{U.S. born}_i + \theta_7 \text{Health Insurance}_i + \theta_8 \text{Household income}_i + \theta_9 \text{Education dummies}_i + \theta_{10} \text{Age dummies}_i + \varepsilon_i \quad (3a)$$

where the variable *SPD* was a dummy that took on the value of 1 if $K6 \geq 13, \forall k = 13, \dots, 24$ and took on the value of 0 if $K6 < 13$.

Step 3: Calculating Transitions in Psychological Distress Status

To calculate how projected health expenditures changed by SPD status and race-ethnicity, we used predictive marginal probabilities. These can be expressed as the derivative of health expenditures with respect to SPD status given all the other covariates (X_i).

$$\frac{d(\text{Health Expenditures}|X, \text{Race/Ethnicity or } LGBQ +)}{dK6 \geq 13_{k=13, \dots, 24}}$$

This derivative provided the estimates for the transition out of the status of SPD. In the equations below, we presented the calculations of the discrete difference around the K6 cutoff for the different hubs:

$$\text{AfAm transition } \{(K6 \geq 13 = 1) - (K6 \geq 13 = 0)\} = \gamma_1 + \gamma_6 * \text{African American}_i$$

$$\text{AI/AN SPD transition} = \gamma_1 + \gamma_7 * \text{AI/AN}_i$$

$$\text{AANHPI SPD transition} = \gamma_1 + \gamma_8 * \text{AANHPI}_i$$

$$\text{Latinx SPD transition} = \gamma_1 + \gamma_9 * \text{Latinx}_i$$

$$\text{LGBTQ}^+ \text{SPD transition} = \theta_1 + \theta_3 * LGBQ^+_i$$

Step 4: Obtaining Health Expenditure Dollar Values and Adjusting Estimates

The subtracted dollar value of the probability of $K6 \geq 13$ from the dollar value of the probability of $K6 < 13$ (column 4) was adjusted by multiplying it by differences in column 3 as shown in the table below. Lastly, we multiplied the adjusted dollar value by the number of CRDP participants in each hub.

Step 5: Aggregating Benefits

We multiplied the dollar values from column 5 by the number of CRDP participants. In the SWE participant questionnaire, 35% of CDEP participants reported experiencing symptoms associated with SPD. We adjusted the number of participants benefiting from reductions in SPD by that percentage (column 6). The table below shows the steps described.

Table 4b: Health Expenditure Changes from Transitions Out of SPD (Proxy for Psychological Functioning)

	1	2	3	4	5	6	7
Hub	Probability of K6≥13 in CRDP pretest	Probability of K6≥13 in CRDP posttest	Change in probability of K6≥13 pre – post	Dollar value from a 0% to 100% in the probability of K6≥13 from MEPS	Adjusted dollar value using change in probability of K6≥13 from CRDP	Number of participants	Benefit from reduction in serious psychological distress
AfAm	C1	D1	C1-D1	Y1= MEPS \$ of K6≥13–MEPS \$ of K6<13	Y1*(C1-D1)	X1	Y1*X1
AI/AN	C2	D2	C2-D2	Y2= MEPS \$ of K6≥13–MEPS \$ of K6<13	Y2*(C2-D2)	X2	Y2*X2
AANHPI	C3	D3	C3-D3	Y3= MEPS \$ of K6≥13–MEPS \$ of K6<13	Y3*(C3-D3)	X3	Y3*X3
Latinx	C4	D4	C4-D4	Y4= MEPS \$ of K6≥13–MEPS \$ of K6<13	Y4*(C4-D4)	X4	Y4*X4
LGBTQ+	C5	D5	C5-D5	Y5= MEPS \$ of K6≥13–MEPS \$ of K6<13	Y5*(C5-D5)	X5	Y5*X5
CRDP wide estimate							$\sum_{i=1}^5 Y_i * X_i$

The CRDP wide estimate summed benefits from each hub (column 7). This estimate is considered the aggregate benefit from a reduction in psychological functioning monetized through oop health expenditures. An analogous process was followed for Medicaid/Medicare health expenditures, for health insurance expenditures and for public assistance dollars.²

4.3: STEPS TO CALCULATE BENEFITS FROM IMPROVED PRODUCTIVITY AND INCOME GAINS

Step 1: Estimating an Income Model

To estimate associated changes in gross income from changes in K6 scores, a linear model was used that included a selection correction. It is possible that people who work and whose income is observed systematically differs from those who do not work. It is hypothesized that some individuals who are offered low wages are unlikely to choose to work, and thus the sample of observed wages is biased upward. Running a regression using this incomplete “self-selected” sample would result in biased estimates. Typically, sex at birth and number of children are two common factors that determine selection into employment, in our case we additionally include race-ethnicity to account for vulnerabilities across racial-ethnic lines.

We used an income model with Heckman selection correction to account for selection in labor market participation. The Heckman selection models included two equations, one focused on selection into the sample (participation) and the main equation linking the covariates to income. These equations were the following:

$$\text{Income}_i = X_i' \theta + \mu_i \quad (4)$$

$$\text{Participation}_i = Z_i' \gamma + \eta_i \quad (4a)$$

² In the case of public assistance, the model would differ in that the dependent variable was self-reported public assistance dollars available in MEPS, with all independent variables being analogous to those observed in the health expenditure models.

Where X_i' included the K6 score, race-ethnicity categories, an interaction of race-ethnicity and K6 scores, health insurance status, sex at birth (female as the default category), age dummies, occupation dummies and education dummies. And Z_i' included marital status (married as the default category), family size, race-ethnicity, and age. In general, x tends to be a subset of z , which means that all factors predicting income also predict selection into employment (participation). The primary parameter vector of interest is θ which includes the race-ethnicity and K6 interactions. Error terms μ and v are normally distributed.

Step 2: Calculating Income Gains from Point Changes in K6

We used the estimated values from the two-step regression models (4 and 4a) to calculate projected income gains (\hat{I}) by hub using predictive marginal probabilities by race/ethnicity and for LGBTQ+ individuals.

$$\Delta \text{Income} = \frac{d(\text{Income}|X, \text{Race/Ethnicity or LGBTQ} +)}{dK6_{k=0,...,24}}$$

This methodology provided the potential income value associated with 1-point changes in psychological distress for the five hubs.

Step 3: Matching K6 Scores from MEPS and CRDP Data

Average K6 pre scores (column 1 from table 4c) and average K6 post scores (column 2) from the adult data were matched to MEPS K6 scores to determine the income value from a change in K6 scores. We subtracted the MEPS dollar value at the K6 pre score from the MEPS dollar value at the K6 post score (column 3).

Step 4: Aggregating Benefits

We multiplied the income values from column 3 by the number of CRDP participants. In the SWE participant questionnaire, we observed that 19.5% of adult respondents did not work at the time of their involvement with the CDEPs. We used this percentage to adjust the number of participants receiving the gain in gross earnings (i.e., only 80.5% of adults). The summation of values in column 5 represented the aggregate value of benefits from an increase in productivity (operationalized through gross earnings) derived from lower psychological distress.

Table 4c: Gross Income Gains from Point Changes in MEPS K6

	1	2	3	4	5
Hub	Average CRDP K6 pretest score	Average CRDP K6 posttest score	Dollar value from changes in MEPS K6	Number of CRDP participants	Benefits from an increase in income from higher productivity
AfAm	A1	B1	W1= MEPS \$ of K6 @A1 – MEPS \$ of K6 @B1	X1	W1*X1
AI/AN	A2	B2	W2= MEPS \$ of K6 @A2 – MEPS \$ of K6 @B2	X2	W2*X2
AANHPI	A3	B3	W3= MEPS \$ of K6 @A3 – MEPS \$ of K6 @B3	X3	W3*X3
Latinx	A4	B4	W4= MEPS \$ of K6 @A4 – MEPS \$ of K6 @B4	X4	W4*X4
LGBTQ+	A5	B5	W5= MEPS \$ of K6 @A5 – MEPS \$ of K6 @B5	X5	W5*X5
CRDP wide estimate					$\sum_{i=1}^5 W_i * X_i$

4.4: CALCULATION OF COSTS

Costs

Program Operating Costs

OHE provided information on the operating costs of the CRDP initiative. These included IPP's program costs and CRDP operating costs. CRDP Phase 2 planning started in fiscal year 2014–2015. By fiscal year 2016–2017 the IPPs and the stakeholders started operating and costs accrued until 2021–2022.

The total grant amount for 24 IPPs was \$26,776,089. In addition, 11 IPPs initially designated as Capacity Building Pilot Projects (CBPPs) received an additional \$40,000 each for a six-month capacity building phase prior to the CRDP kick-off. The total grant amount for those IPP/CBPP was \$12,702,984. The total cost for IPP's operating costs (inclusive of program and evaluation) was \$39,479,073.

CRDP operating costs (accounting for inflation) included contractors' costs and OHE staffing costs. Contractors included the SWE (\$4,583,928), the TAPs (\$12,160,788), the EOA (\$1,836,874), and ancillary contractors such as meeting, planning and logistics, marketing, and RFP development (\$1,267,491). The OHE staffing costs were \$6,527,471. The total operating costs from IPPs grants, OHE staffing and contractors totaled \$65,855,624.

CDEP Participants' Travel Costs

To take part or become involved in CDEP activities or events, participants incurred in travel costs. We did not directly collect information from CDEP participants or IPPs, but we used several pieces of information to calculate potential travel costs for the different hubs.

First, we accessed data from the California Communities Mental Health Services Survey (CCMHSS) which was designed to understand the perspectives of mental health among historically underserved populations in California. The survey oversampled priority populations including communities of color, Asian American and Pacific Islander American subgroups, LGBTQ+ individuals, and non-native English speakers. The survey was conducted in May 2021 with a sample size of 4,283 adults (NORC at the University of Chicago, 2021).

In this survey, respondents were asked whether there was a time during the past 12 months when they saw a mental health care worker due to challenges with mental health or emotions. Those who responded "yes" were asked a follow up question regarding how long it took them to travel to see a professional in relation to mental health, emotions, or nerves. Response options were given in minute brackets, with additional options for overnight, and telehealth. We had access to descriptive results with frequencies by hub (referred to as priority populations in the CCMHSS) and we used the median response to calculate an approximation to a one-way travel time for individuals with characteristics like those of the CDEP participants (column 1 from Table 4d). These numbers represented conservative estimates because there were CDEPs with a vast geographic territory serving multiple zip codes where participants might have to travel considerable distances. However, we did not have precise information on the travel costs for these cases.

To convert average travel time into distance, we multiplied average travel time by the average speed in California freeways. Based on a study on highway congestion in California, we found that the average speed in California freeways with a medium level of congestion (midpoint between free-flow and chaotic states) was 46.9 miles/hour (Varaiya, 2005). We used this speed estimate to convert travel time into distance (column 2). To calculate the cost of one-way travel time we multiplied the average distance by the standard vehicle mileage reimbursement rate. The California Department of Human Resources uses a 56 cents per mile rate for general vehicle use, but the IRS uses a more specific reimbursement rate for medical purposes of an 18 cents per mile rate driven. We used the latter rate (column 3). The potential travel cost per CDEP visit is multiplied by 2 to reflect round trip travel (column 4).

To calculate the average number of CDEP visits per person, we used information from IPP local evaluation reports. These documents described the total duration of CDEP activities and the frequency of CDEP involvement and participation activities or events. For IPPs with multiple CDEP components we used the midpoint duration of the program (column 5).

CDEP travel costs (column 6) resulted from multiplying the average cost per trip to the CDEP location for a given person by the average number of visits for a given CDEP cycle. We multiplied these numbers by the number of adult participants and obtained an aggregate travel cost for all adult participants of \$12,459,688.

Two caveats arose in these calculations. First, for reasons that are discussed in the following subsections we are not able to accurately estimate CRDP benefits for children and youth. From an accounting point of view, it would be inaccurate to include costs for these age groups while excluding the benefits. Therefore, in these calculations we only included IPPs that serve adults. Second, these estimates were not adjusted for the proportion of time that CDEP participants may have participated in CDEP activities remotely due to the pandemic. Even though we did receive information from IPPs about adjustments to the CDEPs and the use of telehealth, we did not have precise numbers per participant. The uncertainty from potentially longer travel distances not captured by our estimates could be offset by the decrease in CDEP trips due to the use of telehealth.

Table 4d. Travel Costs for CDEP Participants

	1	2	3	4	5	6	7	8
Hub	One-way travel time (minutes)	Distance (miles)	Cost of one-way travel time	Average cost per person per visit (to/from)	Average number of CDEP visits per person	CDEP travel costs	Number of CDEP participants	Total travel costs
AfAm	67	52	\$9.4	\$18.9	33	\$622	653	\$406,260
AI/AN	44.5	35	\$19.5	\$38.9	33	\$1,286	4,959	\$6,374,935
AANHPI	44.5	35	\$19.5	\$38.9	26	\$1,013	1,584	\$1,604,492
Latinx	67	52	\$29.3	\$58.7	11	\$666	3,849	\$2,564,079
LGBTQ+	67	52	\$29.3	\$58.7	19	\$1,114	1,355	\$1,509,921
CRDP WIDE								\$12,459,688

CDEP Participants' Reduction in Leisure Time

Interventions often generate intangible effects such as foregone leisure while participating in programs. Intangible effects are difficult to measure, but not accounting important intangible costs and benefits is a recurring issue in conducting CBAs of social programs (Boardman et al., 2018).

In economics, leisure refers to all activities that take place outside the labor market. Measuring the value of lost leisure can be challenging since it requires calculating a reservation wage, which are the lowest salaries at which a person would be willing to work. Boardman and colleagues (2017) suggested using 25% of the gross wage in the region. Others use the value of the minimum wage. We used Palmquist et al. (2007) estimates of time valuation which are based on a calculation of shadow wages and data from stated preferences on household time allocation.³ The advantage of using this approach was that we could rely on stated preferences for leisure activities by income quantile. We used the value for the 50th quintile of income (representing the average income), of the stated preferences for a 2-hour block of leisure time, which was \$20.14. We multiplied this value by the average of total CDEP duration in hours (column 2). Once we had those values, we multiplied them by the number of CDEP participants and we obtained an aggregate value of lost leisure of \$11,649,127.

³This analysis distinguishes short-run from long-run shadow value of time that differs depending on the size of the time block. The authors provided the quantiles of the distribution of the predicted marginal value of time for blocks of leisure time for 2, 4, 6, and 8 hours.

Table 4e: Valuation of Leisure for Participation in CDEP Activities

1	2	3	4	5
Hub	Average CDEP duration for a full cycle (hours)	Average valuation of leisure	Number of CDEP participants	Total leisure valuation for all participants
AfAm	63	\$1,274	653	\$831,785
AI/AN	64	\$1,289	4,959	\$6,391,483
AANHPI	35	\$698	1,584	\$1,105,952
Latinx	31	\$624	3,849	\$2,403,085
LGBTQ+	34	\$677	1,355	\$916,822
CRDP WIDE				\$ 11,649,127

4.5: NON-MONETARY BENEFITS

Reduction in Suicide Risk

Le et al., (2021) reviewed 65 studies that provided economic evaluations across countries and age groups. Studies focused on prevention of depression and/or anxiety disorders, promotion of mental health and well-being and suicide prevention. From this review, the articles with the highest quality scores that provided reliable economic valuations are discussed. The purpose of this exercise is to provide examples of economic values that this CBA did not monetize (i.e., PEI hypothesized outcomes positively affected by mental health interventions).

Godoy Garraza et al. (2018) focused on suicide reduction outcomes for U.S. youth aged 16–23 from 36 states and 8 tribes. They evaluated a large suicide prevention program that included education, mental health awareness, linkages to services, crisis hotlines, among other activities. Estimates showed a return of \$4.50 in medical savings from avoided hospitalizations and emergency department visits for every dollar invested in implementing community-based suicide prevention programs. Estimates showed that over a 3-year period (2007–2010), a decrease in suicide rates due to community-based suicide prevention programs resulted in \$222.1 million in returns compared to \$49.4 million in program investments.⁴

Lebenbaum et al.'s (2020) cost-utilization analysis of a multi-component suicide prevention program aimed at Ontario's population showed an incremental cost-effectiveness ratio (ICER) of 18,853 Canadian dollars per quality-adjusted life year (QALY) gained over a 50-year time horizon. Given a willingness-to-pay (WTP) threshold of 50,000 Canadian dollars per QALY, the suicide prevention program was considered cost-effective.⁵

Pil et al.'s (2013) cost-utilization analysis showed similar benefits in Flanders, Belgium; over the course of 10 years, suicide helpline users (ages ranging from 10–80 years of age and even older) were estimated to gain 0.083 quality-adjusted life years (QALYs) through the telephone service and 0.039 QALYs through the chat service, with healthcare and productivity costs associated with suicide attempts/suicides decreasing by 4,537 Euros when compared to the absence of a suicide helpline. While the health benefits of the suicide helpline were relatively small, Pil's (2013) analysis suggests that even minimal preventative efforts can be cost-effective and socially beneficial.

These three examples show that targeted efforts in suicide prevention programs can be cost-effective as shown by positive ROI and gains in QALYs. Most of the time estimates represented conservative calculations due to the savings not considered. For instance, the suicide prevention program discussed in Godoy Garraza et al., (2018) did not consider possible averted costs from enrollment in mental health treatment programs post suicide attempt.

⁴ The estimated medical savings were derived from secondary sources (i.e., administrative data).

⁵ The program consisted of an annual mental health awareness and stigma reduction campaign, suicide risk identification training for community workers and volunteers, depression detection and treatment training for primary care physicians, and a psychosocial intervention for high-risk individuals who attempted suicide and were subsequently hospitalized.

Incarceration/ Recidivism

Research has also shown that increases in employment and earnings might decrease criminal activities among participants of interventions. For example, one study found that a 1 percent increase in income reduces the propensity to commit crime by 0.6 percent among male youth who have permanently left school (Grogger, 1998).

We conducted a search of studies providing economic valuations of reductions in recidivism rates through mental health programs. Skeem et al. (2018) analyzed a 2-year longitudinal matched study consisting of 359 probationers aged 18–65 who were either enrolled in traditional probation or specialty mental health probation. Specialty mental health probation reduced recidivism more effectively than traditional probation, and the costs of specialty mental health probation were \$11,826 lower per participant than traditional probation, which indicated an overall 51% in savings.⁶ Although the specialty mental health program invested more money in supervision to allow for smaller caseloads of probationers per supervisor, this was offset by the reduced costs associated with recidivism, likely due to the better relationships established.

Lindberg (2009) found that in San Francisco a behavioral health court (BHC) focused on helping mentally ill defendants access community treatment led to reduced recidivism as well as net savings after program entry. Using administrative data from city and community-based agencies to compare criminal justice and mental health treatment costs pre and post BHC entry showed that by the third-year post entry, the cost to operate a BHC were offset by reduced criminal justice and mental health treatment costs. This offset resulted in a net benefit of \$277,000, a benefit that could potentially increase if the economic burden on the criminal justice system continues to decrease due to reduced recidivism.

Cusack et al. (2010) analyzed a forensic assertive community treatment (FACT), which provided mental health services as well as substance abuse, housing and employment assistance to county jail detainees diagnosed with a major mental disorder. The analysis compared FACT to treatment-as-usual (TAU), which entailed providing routine county-operated public behavioral health services. FACT participants had fewer jail bookings within 2 years post enrollment compared to TAU participants. In addition, the projected long-term inpatient and jail costs for FACT participants would be lower than those of TAU participants. Mean inpatient and jail costs were \$4,296 and \$2,050 for FACT participants, respectively, and \$7,141 and \$3,046 for TAU participants, respectively. Although outpatient costs were higher for FACT participants (\$7,836 vs. \$4,249), studies have consistently shown that increased investment in mental health, substance abuse, housing, and employment services are offset by reduced hospital and other criminal justice costs (Chandler et al., 1999; Essock et al., 1998; Lehman et al., 1999).

These studies suggest that mental health treatments provided to jail detainees, defendants, and probationers can be cost-effective in terms of the use of public money and can have a positive incidence in reducing recidivism. Although the CDEPs did not engage with detainees or probationers, the evidence shows the reach of programs that focus on treating mental illness under the adverse circumstances.

Cultural Connectedness

The historical trauma that continues to overtly and covertly affect marginalized individuals and communities represented by CRDP's hubs is deeply intertwined with a sense of cultural dissonance. The acculturation many marginalized groups face because of colonization and oppression of racial, ethnic, and/or sexual/gender identity inherently creates a mental health crisis in which culture must become the center, or at least an embedded part, of effective healing. Mainstream mental health treatment oftentimes invalidates or disregards cultural factors, which subsequently creates access barriers and mental health disparities for these marginalized cultures (Turner et al., 2019). Lack of culturally appropriate mental health treatment may produce a host of negative individual consequences that can, in turn, "burden" the collective society through productivity loss or increased inpatient medical costs due to untreated mental disorders that

⁶ Estimated healthcare costs (e.g., outpatient care, emergency room care, hospitalization, residential treatment) were calculated from county and state-level administrative data as well as from the MEPS. Estimated criminal justice contact costs (e.g., probation supervision days, arrests, prison nights) were similarly calculated from county and state-level databases, as well as from the Federal Bureau of Investigation (FBI) rap sheets and several previous studies that informed unit costs, including Perkins et al. (1995), Clark et al. (1999), McCollister (2003), the Pew Charitable Trusts, and Austin, Texas Legislative Budget Board (2009).

disrupt people's ability to function. Accessible and culturally appropriate treatment for the diverse U.S. population is vital.

Shea et al. (2019), found that Myaamia tribal college students at Miami University who took heritage culture courses had higher predicted graduation rates compared to those who did not. They also had higher scores on the cultural connectedness scale, a stronger sense of belonging, and increased language use (Shea et al., 2019). This suggests that "cultural revitalization," which serves to combat the historical trauma that many indigenous and oppressed populations experience, may contribute to increased bicultural competence that can reduce cultural dissonance on the individual level and increase rates of mainstream academic attainment on the societal level. Although the heritage culture courses were not explicitly mental health treatments, the positive emotional and academic outcomes of an affirming culture infused course provides evidence for investing in even more culturally appropriate programs like mental health treatments. Other studies on indigenous populations, such as Snowshoe et al. (2017), Gray and Cote (2019), and Masotti et al. (2020), similarly highlighted the link between cultural connectedness and positive mental health outcomes.

Yang's (2018) research on the conflicting ethnic identity of second-generation Chinese Americans also suggests a link between cultural connectedness and mental well-being. The cultural conflict they face between their internalized Chinese values and the overarching Western culture of the society they live in negatively affects individual development. As preschool children, they are at first unaware of this conflict until their increased encounters with the dominant Western society begin to breed resentment. Not until high school or college do they begin to accept and merge their bicultural identities, but the time between preschool and high school/college leaves a large window of time for low self-esteem and depressive symptoms to develop because of a lack of understanding about how to deal with racism and discrimination from the dominant culture. Yang (2018) found that having a strong connection to the Chinese community and knowledge of Chinese culture served as protective factors for positive ethnic identity development and mental well-being.

4.6: CALCULATION OF MONETARY BENEFITS

Increase in Gross Earnings

In-Program Benefits

Through the methodology described in the previous section, we calculated the increase in gross earnings for adult CDEP participants resulting from higher productivity linked to better mental health (lower psychological distress). Our preferred model included a correction for selection into employment which inferred an earning's value for some individuals that we did not initially observe in the data. If we had not included that correction, wages and benefits would have been biased upward and we confirmed that by running the model with (\$11,796,675) and without (\$25,116,522) the selection correction.

Out-of-Program Benefits

Gains in productivity from program participation were permanent and participants kept accruing the gains once they were no longer involved in programs. To calculate the long-term income benefits from better mental health, we calculated the present value by adding the present values of the income gained from the period participants were involved in CDEP activities through the end of their potential productive life in the labor market, using the following formula:

$$PV = \sum_{t=0}^n \frac{I_t}{(1+r)^t}$$

Where I_t was the income gain in constant dollars that corresponded to the first period of the program, r was the interest rate and t was the time horizon that varied by hub. The choice of discount rate determines the size of the benefits, the higher the discount rate the lower the value of future benefits. It is common to use discount rates between 5% and 10%. To provide conservative estimates, we used a discount rate of 10%.

The horizon of potential employment and accrual of gains in employment was calculated separately by hub based on two factors, the average age of adult participants in a hub and the average duration of a CDEP. The average age for AA, AI/AN, and LGBTQ+ participants was 29, while for Latinx and AANHPI participants the average age was 37 and 55, respectively. The average duration of the CDEP was found in the LERs.

Using the gains in employment calculated with the selection corrected model (ranging from \$321 to \$1,840) we calculated the net present value (NPV) of the income gains by hub. Accrual started at the average age of participation in the CDEP programs and ended at age 65, which is the last period of potential employment. These are hypothesized average trajectories and do not imply that all participants will follow a linear trajectory of employment. Thus, this estimate might be an upper bound and could overestimate productivity gains for those with unstable job trajectories.

The last step was to multiply the NPVs by the number of adult CDEP participants by hub. The total value of out-of-program gains in income from better mental health was \$524,593,073.

Health Expenditure Benefits from a Decrease in Psychological Distress

Using health expenditure models and the methodology described above, we estimated reductions in health expenditures associated with decreased in psychological distress. This CBA focused on a societal perspective and that meant that costs and benefits from non-participants were also considered. An associated reduction in oop health expenditures benefited participants by \$776,799, a reduction in Medicare/Medicaid health expenditures benefited non-participants in their role of taxpayers by \$13,620,176, and a reduction in health insurance expenditures benefited non-participants in the role of insurance companies by \$2,134,265.

There are important nuances worth mentioning. First, national longitudinal MEPS data showed that the average drop in K6 scores for adults in a year was about 1 point. CRDP data showed that participants on average reported a 3-point drop in K6 scores from pre- to post-interventions, with a range of 1.5-to-5.6-point drops in K6. Second, dollar value changes associated with changes in the composite K6 score were not linear and varied by hub. Third, the largest drops in K6 scores did not yield the largest benefits in oop health expenditures. For instance, a hub with an average 6-point drop in K6 scores was translated into a per capita benefit of \$96, and a score change from a serious to a moderate distress. But a 2.2-point drop in K6 scores for another hub translated into a \$126 per capita benefit while remaining in a moderate score. This implies that maintaining participants' good mental health (or preventing mental health deterioration) is as important as attaining large changes among individuals experiencing serious psychological distress.

Health Expenditure Benefits from a Proxied Decrease in Psychological Functioning

We used health expenditure models to estimate the reduction in health expenditures that resulted from a proxy decrease in psychological functioning, operationalized as the probability of transitioning out of the SPD threshold. An associated reduction in oop health expenditures benefited participants by \$258,422, a reduction in Medicare/Medicaid health expenditures benefited non-participants in their role of taxpayers by \$6,092,030, and a reduction in health insurance expenditures benefited non-participants in the role of insurance companies by \$99,861.

CRDP data showed that the probability of reporting symptoms associated with SPD dropped across all hubs from pre- to post-interventions. For instance, while it was estimated that participants in one hub had a 50% probability of scoring $K6 \geq 13$ pre-intervention, that probability dropped to 19% post-intervention, that equaled a -32% in the probability of experiencing symptoms associated with SPD. For other hubs the drop was not as large but equally important and even small gains translated into positive dollar gains.

Lower Dependence on Public Assistance

We hypothesized that an increase in productivity and a consequent increase in income from better mental health outcomes would lower dependence in public assistance. Using a model analogous to that of health expenditures and the process described in the corresponding section, we obtained estimates of a drop in public assistance related to lower psychological distress (\$146,554) and lower proxied psychological functioning (\$53,571). The lower dependence in public assistance represented a loss of wealth for adult participants and a gain of resources for non-participants as taxpayers, this mechanism had a net effect of zero in the society.