

California Reducing Disparities Project (CRDP)
Asian & Pacific Islander Technical Assistance Provider (API TAP)

Asian and Pacific Islander Population Guidelines 1.0

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Population Guidelines Overview

Section 1: Overview and Purpose

Overview of the California Reducing Disparities Project (CRDP)

In 2009, the former California Department of Mental Health launched the California Reducing Disparities Project (CRDP), a statewide prevention and early intervention effort to reduce mental health disparities in underserved communities. CRDP focuses on five specific populations: African-Americans; Asians and Pacific Islanders (API); Latinos/Latinas; Lesbian, Gay, Bisexual, Transgender, Queer & Questioning (LGBTQ) individuals; and Native Americans. CRDP is currently administered by the California Department of Public Health's (CDPH) Office of Health Equity (OHE). This initiative has been organized into two phases. Phase I provided funding for strategic planning work groups in each of the five priority populations. In alignment with the values of the Mental Health Services Act (MHSA), the strategic planning work groups were composed of a diverse set of stakeholders, including mental health providers, community leaders, client and family members, community mental health advocates and academic researchers.[2] Phase I also involved the California Pan-Ethnic Health Network (CPEHN) to compile the five population reports into one comprehensive draft strategic plan.[1]

Phase II of CRDP launched in September of 2016 and includes six years of funding, totaling \$60 million allocated from MHSA, to implement and evaluate the strategies and recommendations that were brought forth from Phase I strategic planning work groups. The goal of Phase II is to demonstrate the effectiveness of community-defined evidence practices (CDEPs) to reduce mental health disparities in the five priority populations.[2] Organizations have been selected based on their proposed pilot projects and potential success for validating their project as a CDEP. With their local evaluator, these organizations will implement and evaluate their proposed pilot projects from 2017-2022. Pilot projects within each population are provided with strong technical assistance and capacity building support to ensure the success of their CDEPs by securing future funding and sustainability of their organizations. The Asian and Pacific Islander Technical Assistance Provider (API TAP) team for Phase II has been charged with developing these population guidelines to support API pilot projects as they implement and evaluate their CDEPs.

"In response to former U.S. Surgeon General David Satcher's call for national action to reduce mental health disparities, the former Department of Mental Health (DMH), with support from the Mental Health Services Oversight and Accountability Commission (MHSOAC), the California Mental Health Directors Association (CMHDA) and the California Mental Health Planning Council (CMHPC), created a statewide policy initiative to identify solutions for historically unserved, underserved, and inappropriately served communities." [1]

Purpose of Asian & Pacific Islander Population Guidelines

These API Population Guidelines have been drafted at the beginning of Phase II as a guide for the Asian and Pacific Islander Implementation Pilot Projects (API IPPs) and their local evaluators to support the development/refinement of local evaluation approaches and plans. We aim to specify processes that ensure community stakeholders are engaged in the entire evaluation process and that evaluation is culturally and linguistically appropriate as well as considerate of multiple identities of individuals served by IPPs (i.e. cross-population issues). We have outlined broad benchmarks that allow the API TAP team to coordinate technical assistance (TA) and trainings to support the API IPPs throughout the stages of implementation. However, we understand that with any complex multi-year project, flexibility and responsiveness to the needs of IPPs as they evolve over the course of the project will be essential to the success of CRDP.

It is our intention to balance consistency within the API population with a need to be responsive to sub-population specific nuances. We also acknowledge the vast heterogeneity among API communities. For CRDP Phase II alone, we estimate that the API IPPs collectively plan to implement their CDEPs in over 20 languages and dialects, in eight counties in California, including rural, suburban and urban locales. Our challenge is to be able to elevate the efficacy of innovative strategies across the API population as a whole, without detracting from the nuances of the individual pilot projects serving some of the most diverse communities in the State. For example, we understand that an evaluation method that works well for Cambodian transitional age youth in Long Beach may not be appropriate for Hmong elders in Butte County. However, there may be approaches and practices that apply across the API populations being served through CRDP. Given the scarcity of literature about community-driven approaches to address mental health disparities in API communities, we recognize the imperative need to elevate these practices and lessons learned through CRDP.

The API Strategic Planning Workgroup Population report from Phase I of CRDP identified the specific issues and challenges API communities face related to mental health. The Phase I API Population Report also identified some culturally competent strategies that are currently being implemented and show promise to reduce API mental health disparities in California. [3]

Building off the work and expertise from the API strategic planning workgroup in Phase I, we view these API Population Guidelines as the next chapter of the API Population Report. As documented in the API population report, other CRDP population reports, and the CRDP draft strategic plan, at least part of the reason mental health disparities exist is that traditional mental health services have been provided *to* Asian and Pacific Islander communities rather than *with* these communities. Therefore, the API TAP team's approach is designed to allow the wisdom of API communities in California to be leveraged, highlighted, and scaled. The API Population Guidelines are intended to balance the needs for local flexibility and uniform evaluation guidelines for CRDP. They bring forward core values of the CRDP to "do business differently" to promote mental health equity and advance social justice.

The overall purpose of these API Population Guidelines is to present best practices to guide evaluation of CDEPs that are being implemented by the API IPPs as part of CRDP Phase II. We offer shared definitions (e.g., community-defined evidence, cultural and linguistic competency) and priorities (e.g., milestones for program evaluation, technical assistance, and organizational capacity building) for the implementation among the seven API IPPs. Through a participatory approach, we aim to document experiences from multiple perspectives (e.g., clients, service providers, organizational leaders, API TAP team, and local evaluators, Statewide Evaluator and OHE liaisons). **These guidelines are viewed as a *living document* that will be updated as needed to reflect feedback from CRDP stakeholders, especially the API IPPs and their local evaluators.** We also plan to update the guidelines as API IPPs further refine their CDEPs, evaluation aims, and approaches.

These guidelines have been developed as a toolkit and reference tool for the API population in Phase II of CRDP. We aim to provide a resource that API IPPs and their local evaluators can use to structure their thinking as they refine their CDEPs and local evaluation plans. We have also provided information about how API IPPs were conceptualizing their CDEPs per their proposals for Phase II. Finally, we offer details about our TA approach and support we can offer throughout the course of the initiative.

Box 1: What the API Population Guidelines Are

- A resource for API IPPs and their local evaluators
- A toolkit that can help inform how to refine and evaluate the proposed CDEPs
- A reference for shared definitions and priorities
- Documentation of the seven API IPPs at the beginning of CRDP phase II
- A living document that will be revised throughout the project

At the end of Phase II, we will build upon these guidelines to provide lessons learned from the development, implementation, and evaluation of CDEPs within the selected API communities. While the primary audiences for these guidelines are the API IPPs and their local evaluators, all stakeholders involved with CRDP Phase II can benefit from this document (see Table 1).

Table 1: Audiences for API Population Guidelines	
Audience*	Potential Use of API Population Guidelines
API IPP organizations	<ul style="list-style-type: none"> • To have a shared understanding of key definitions, CRDP expectations, and processes for refining and scaling their CDEPs • To provide information about innovative community defined practices that can be a model to other organizations in the future • To document their expertise and experiences in implementing and evaluating community-defined evidence practices
Local evaluators	<ul style="list-style-type: none"> • To have shared practices and understanding related to local evaluations and ensure consistency within the API population

	<ul style="list-style-type: none"> To use sections on community-based participatory research (CBPR) and the spectrum of evidence related to CDEPs and EBPs as guidelines for determining appropriate evaluation approaches that will validate the CDEPs
API TAP	<ul style="list-style-type: none"> To establish a common set of expectations, definitions, and practices that will inform TA and training To present recommended processes that will ensure consistency and shared approaches across the API priority populations in Phase II related to evaluation of the CDEPs
SWE	<ul style="list-style-type: none"> To document population-level approach and processes that establish evaluation standards for measurement over course of CRDP Phase II
CDPH/OHE	<ul style="list-style-type: none"> To better understand the nuances and needs of API community and identify ways the State can better address needs of API communities and organizations To see the strengths and challenges in organizational capacity to plan/implement/evaluate CDEPs

Given that there has never before been an initiative like CRDP, there are a lot of unknowns and so we pursue a participatory process to document the experiences and perspectives of each player. Further, the literature on community-defined approaches to mental health in API communities is scarce. Therefore, these guidelines serve as an approach to document what we aim to learn over the five years of CRDP Phase II. By the end of the initiative, we plan to finalize this document including the lessons learned with the intention of helping community mental health providers and agencies to improve practices and reduce disparities in API communities for the future.

Summary of Phase 1 API Population Report

Asian Americans, Native Hawaiians and Pacific Islanders (AANHPIs) are among the fastest growing racial groups in the United States, according to the United States Census. Over one-third of the Asian population and just under a quarter of the Native Hawaiian and Pacific Islander (NHPI) population in the United States reside in California.[3] AANHPIs represent nearly 16% of California’s population.[3] While it may appear that APIs have low prevalence rates for serious mental illness, evidence shows otherwise. According to a report by the Asian & Pacific Islander Health Forum, based on 2008 data by the Center for Disease Control and Prevention, NHPI adults had the highest rate of depressive disorders and second highest rate of anxiety disorders among all racial groups.[3] API women 65 years and older have the highest suicide rate compared to other racial groups.[3] It may be that APIs as a group are more reluctant to seek care. However, it may also be that available care is not culturally and linguistically appropriate to address the mental health issues and concerns presented by the API community. The heterogeneity among APIs is important to recognize in order to better understand and address these mental health concerns. The California Reducing Disparities Project Asian and Pacific Islander Strategic Planning Workgroup (CRDP API SPW) was formulated in 2009 to help understand the issues and challenges of API communities, and to help document potential competencies and strategies that are needed to address the mental health concerns presented by APIs.

The CRDP API SPW concluded Phase I with a report (published in 2013) that highlighted the overall purpose and process of the API SPW. It also identified issues and challenges, core competencies and strategies to work with API communities, and implications for systems and public policy to help reduce mental health disparities among API populations. The key issues and areas of challenge identified by the API SPW were, broadly, 1) a lack of access to care and support for access to care; 2) lack of availability of culturally appropriate services; 3) lack of quality care, 4) language barriers, 5) lack of disaggregated data and culturally appropriate outcome evaluation; 6) stigma and a lack of awareness and education on mental health issues within communities; and 7) workforce shortage.[3]

Box 2: Challenges and Competencies

Key challenges API communities experience that contribute to mental health disparities

1. Lack of access to care and support for access to care;
2. Lack of availability of culturally appropriate services;
3. Lack of quality care;
4. Language barriers;
5. Lack of disaggregated data and culturally appropriate outcome evaluation;
6. Stigma and a lack of awareness and education on mental health issues within communities; and
7. Workforce shortage.

Core competencies needed to reduce mental health disparities in AANHPI communities

The following skills are necessary at the provider, agency, and systems levels:

1. Professional skills;
2. Linguistic capacity;
3. Culture-specific considerations;
4. Community relations and advocacy;
5. Flexibility in program design and service delivery;
6. Capacity building;
7. Use of media; and
8. Data collection and research

Source: Pacific Clinics (2012). The California Reducing Disparities Asian Pacific Islander Population Report: *In Our Own Words*, California Department of Public Health Office of Health Equity.

The solution to addressing the challenges for API communities is often stated as cultural competency. However, cultural competency is highly nuanced and simply having someone from the same ethnic community who may speak the same language does not eliminate all barriers to care. The API SPW developed a list of core competencies for consideration in working with API communities. They conceptualized the competencies into three levels, 1)

provider, 2) agency, and 3) systems, moving beyond the individual level in terms of the need for cultural competence. The eight competency categories are 1) professional skills; 2) linguistic capacity; 3) culture-specific considerations; 4) community relations and advocacy; 5) flexibility in program design and service delivery; 6) capacity building; 7) use of media; and 8) data collection and research. In addition to developing these competencies, the API SPW reviewed 56 programs from throughout the state, reporting promising programs or strategies that should be considered for replication. After review with specified criteria around program design, program evaluation/outcome and agency capacity, the programs and/or strategies were organized into stages of development (overall submission of an existing program, programs with innovation/suggested strategies with potential, an existing program that has been evaluated, and already recognized programs that have been formally evaluated and deemed effective by credible entities (such as local counties, research groups, professional associations or the Substance Abuse and Mental Health Services Administration) and type of program/service provided/audience served. A table summarizing all of these programs and criteria is provided in the Phase I report (Table 5).[3]

The API SPW also looked at the environment in which mental health services are provided, and addressed systems level and public policy implications to reduce mental health disparities for API communities. They made five key recommendations for policy considerations: 1) increase access by modifying eligibility requirements, by including ancillary services supporting access and thereby providing affordable options; 2) increase the availability and quality of care supporting the development and retention of a culturally competent workforce; 3) increase the availability and quality of care by supporting services that meet the core competencies and program criteria as defined by the API SPW; 4) reduce disparities by collecting disaggregated data to accurately capture the needs of various API communities, by supporting culturally appropriate outcome measurements, and by providing continuous resources to validate culturally appropriate programs; and 5) empower the community by supporting community capacity building through efforts such as leadership development, technical assistance, inclusion of community in participatory decision making processes, and establishing infrastructures that can maximize resource leveraging.[3]

Box 3: Five key policy recommendations to reduce mental health disparities in API Communities

1. Increase access by modifying eligibility requirements, by including ancillary services supporting access and thereby providing affordable options;
2. Increase the availability and quality of care supporting the development and retention of a culturally competent workforce;
3. Increase the availability and quality of care by supporting services that meet the core competencies and program criteria as defined by the API SPW;
4. Reduce disparities by collecting disaggregated data to accurately capture the needs of various API communities, by supporting culturally appropriate outcome measurements, and by providing continuous resources to validate culturally appropriate programs; and
5. Empower the community by supporting community capacity building through efforts such as leadership development, technical assistance, inclusion of community in participatory decision making processes, and establishing infrastructures that can maximize resource leveraging.

Source: Pacific Clinics (2012). The California Reducing Disparities Asian Pacific Islander Population Report: *In Our Own Words*, California Department of Public Health Office of Health Equity.

About the API TAP team

Special Service for Groups Research and Evaluation Team (SSG R&E) is the lead for the API TAP team. We have also subcontracted with some of our long-time partners to provide expanded geographic reach and subject matter expertise. Harder+Company will work closely with the SSG R&E team to provide on-going technical assistance to the API IPPs. Camillia Lui, PhD of Alcohol Research Group, Public Health Institute and Jacqueline Tran, DrPH, will provide subject matter expertise. Please refer to Section 8 for more information about the API TAP team and our approach to technical assistance.

A note about limitations and terms

We acknowledge the diversity of API communities in California. Not only are API communities extremely diverse in ethnic subgroups, language and culture, but there is also considerable diversity within API communities with respect to age, gender and gender identity, sexual orientation, religion, immigration/refugee history, and geography. For the sake of being practical, we have limited the details of these API Population Guidelines to be tailored to the specific communities the API IPPs in Phase II were funded to serve. Additionally, we understand that choice of terminology is meaningful. We acknowledge that the Phase I report from the API Strategic Planning Workgroup often referred to Asian Americans, Native

Hawaiians and Pacific Islanders (AANHPI). To our knowledge, Phase II grantees are not implementing their CDEPs with Native Hawaiian populations. In light of this and to be consistent with CRDP language, we aligned our language to reflect terminology that has been used by the Office of Health Equity and selected to continue the use of “Asian and Pacific Islander (API)” when referring to the population as a whole.

Implementation Pilot Projects

Section 2: Overview of Phase II Asian and Pacific Islander Implementation Pilot Projects

In Phase II of CRDP, OHE funded seven IPPs that serve API communities across California (refer to Appendix 2). Among the seven IPPs in the API population, CDEPs are being implemented in 24 languages with approximately 17 ethnicities in 8 counties.

Seven community based organizations (CBO) lead the API IPPs: Hmong Cultural Center of Butte County (HCCBC), Muslim American Society-Social Services Foundation (MAS-SSF), Cambodian Association of America (CAA), East Bay Asian Youth Center (EBAYC), Fresno Center for New Americans (FCNA), Asian American Recovery Services (AARS), a program of HealthRight 360 (HR360), and Korean Community Services (KCS).

Phase II of CRDP included a specific funding mechanism to support small community-based organizations (i.e., organizations with an annual operating budget of less than \$500,000) through the Capacity Building Pilot Project (CBPP) phase. The CBPPs started Phase II six months ahead of the IPPs with the intention to receive additional capacity building support from the API TAP and ensure their success alongside the other API IPPs. Hmong Cultural Center of Butte County (HCCBC) and Muslim American Society – Social Services Foundation (MAS-SSF) were initially awarded as CBPPs. During the first six months of CRDP Phase II, they worked with the API TAP to build organizational capacity and submit a proposal to advance to the IPP stage. In March 2017, MAS-SSF and HCCBC graduated to become Implementation Pilot Projects, totaling seven IPPs in the API population.

Snapshots of API IPPs

Hmong Cultural Center of Butte County (HCCBC) is an organization based in Oroville, California. The organization has been serving the community since 2000 with the mission to *improve the lives of individuals and families through culturally sensitive education, advocacy, support, and services*. The organization's core values are *cultural diversity, respect, accountability, trust, integrity, collaboration, and networking*. HCCBC was established to support Hmong families by promoting cross-cultural awareness through education and advocacy. The organization is a family strengthening organization working to support Hmong culture and improve the quality of life of Hmong families. Family dynamics are an important consideration for all decisions and actions for this community; as a result, the programs provided by HCCBC include the consideration of the families of all individuals served. HCCBC has a governing board of five community members.

The Zoosiab program intends to address the ongoing concerns of the aging Hmong population. Culturally and linguistically appropriate services will aid in increasing access to mental health services for underserved Hmong elders, who lack transportation and logistical support (language and cultural understanding) to access mental health services. The program aims to work with individuals who have experienced stress, isolation, stigmatization, and depression. The goal of the program is to help participants feel *zoosiab* or happy. HCCBC plans

to conduct outreach, provide client support, and coordinate group gatherings to prevent and reduce the severity of mental illness among Hmong adults 50 years and older.

Muslim American Society – Social Services Foundation (MAS-SSF) is a nonprofit that aims to aid families at large and the Muslim community in particular with their social service needs. The organization is supported by volunteers and donors with one employed staff member, the Executive Director. The proposed project *Shifa for Today* aims to address mental health needs of South Asian Muslims (SAMs). SAMs have suffered historical/intergenerational, cultural and political traumas, putting them at increased risk for severe mental illness. SAMs tend to be underserved due to lack of culturally, linguistically and spiritually/religiously sensitive mental health services; fear of seeking services due to Islamophobia; and the presence of cultural stigma against seeking help.[4] Many SAMs have experienced trauma in their countries of origin and experience continued trauma in the United States – experiences of abuse, displacement and trauma.[5, 6] Studies conducted in the United States, Canada and the United Kingdom show SAMs have an increased risk of developing anxiety, PTSD, depression, emotional distress and suicide.[7] Gender discrimination and shaming/threats of shaming are also sources of trauma for individuals in this community, especially among women.[8, 9]

Shifa for Today focuses on early identification and treatment of people at-risk for or already suffering from symptoms signaling the onset of severe mental health illness. Peer counselors incorporate authentic traditional spiritual and religious Islamic content and practices that are congruent with the consumer's beliefs about health and disease. The Trans theoretical Model will help peer counselors identify the stages of change of a client, to apply the best counseling technique(s). Motivational interviewing will also be used by peer counselors in a cognitive behavioral therapy framework. The program intends to reach SAMs in the Sacramento area, providing services in-language to engage consumers appropriately. The program intends to increase the number of SAMs seeking psychological help and support (before emerging symptoms develop into severe mental illness), increase wellness, resilience and recovery for those receiving services, to reduce the burden of mental illness on suffering individuals, to minimize new trauma to their families as a result of unmet needs for appropriate prevention and early intervention services, and to reduce attempted and completed suicides.

Cambodian Association of America (CAA) is a nonprofit organization based in Long Beach, California with over forty years of experience in providing human and social services to low-income, ethnically diverse residents. CAA and its Cambodian Advocacy Collaborative (CAC) which includes four additional nonprofit agencies as partners proposes to provide culturally and linguistically appropriate mental health services in Long Beach and Santa Ana through the API Strength Based Community Wellness Program (API –SBCWP). The other partner organizations are United Cambodian Community (UCC), Khmer Parents Association (KPA), Families in Good Health (FiGH), and The Cambodian Family (TCF). The CAC partners bring an additional 30 years of experience in providing culturally and linguistically appropriate services in Khmer, Hmong, Lao, Vietnamese, Spanish, and English. The API –SBCWP program focuses on the Cambodian population which has experienced significant physical health, mental health, socioeconomic, and educational disparities. Many of the older adults in this community

lived through the “Killing Fields,” the genocide that took place from 1975-1979. The impacts of torture from this experience, trauma from the refugee experience, and resettlement have contributed to post-traumatic stress disorder (PTSD), emotional distress, depression, memory loss, concentration problems, and learning difficulties. While decades have passed since the war and genocide in Cambodia, a RAND study (from 2005) involving Long Beach Cambodians reflected rates as high as 62% of the population meeting the DSM-IV diagnosis criteria for post-traumatic stress disorder (PTSD) and 51% meeting criteria for major depression.[10] The trauma experienced by these elders has become multigenerational and is compounded by poverty and financial hardships, challenges with acculturation, inadequate parenting skills, low academic achievement and poor academic support, neighborhood crime and violence, and a lack of social support.[10]

The API –SBCWP proposes to demonstrate the effectiveness of culture-specific outreach techniques and culture-specific interventions that aim to shift cultural norms pertaining to mental illness. The project aims to 1) reduce the severity and disabling aspects of mental health, 2) to increase life management skills, 3) to increase the ability to cope and make healthy decisions, and 4) to improve communication between family members. The project design includes planned behavior and social cognitive change theories and integrates cultural elements (such as oral history and spiritual healing practices).

Participants will be enrolled through outreach and engagement efforts, encouraging them to participate in a minimum of five workshops and monthly group activities for six months. The program model includes 1) peer-led PEI community outreach and education, 2) PEI educational workshops with a focus on mental wellness promotion, suicide prevention and healthy living skills practices, 3) case management/navigation and 4) peer-led peer and family support groups focusing on meditation, prayer, and other Buddhist rituals associated with healing. The anticipated outcomes of the project are:

- Older adults are better positioned to address past experiences and acculturation issues, report reduced mental health related stigma and depression related symptoms
- Transitional Age Youth (TAY) have reduced mental health stigma and depression related symptoms, discuss mental health, and are empowered to take ownership of their mental health needs early on, and
- Overall, Cambodians will increase social connectedness – through peer and social support groups, Western and Eastern forms of healing to include dance, yoga, Cambodian specific healing techniques – holy water blessings, prayer, and meditation.

East Bay Asian Youth Center (EBAYC)

The East Bay Asian Youth Center (EBAYC) was founded in 1976 as the “Asian Drop-in Center” for Asian American youth in South Berkeley. The organization grew and expanded to Oakland in 1988 to address the growing race- and gang-related violence among Southeast Asian youth. For over 39 years, EBAYC has created a space for youth where they can share and affirm their experiences, providing culturally-responsive and language-appropriate case management services for Southeast Asian youth and their families. The mental health needs of Asian and Pacific Islander (API) youth are often overlooked and misunderstood, they are often viewed as

the “model minority.” Survey data reflect that API youth report having inadequate bi-cultural and cross-cultural navigation skills, family conflict and poor/inconsistent family management practices, experiencing transgenerational trauma, having a declined commitment to school, and emerging aggressive problem behaviors. EBAYC focuses on critical protective factors and aims to sustain relationships with supporting and caring adults, provide positive cultural identity and knowledge, and access to family support services for local area youth.

EBAYC proposes Groundwork, a community-defined evidence practice targeting high risk Hmong, Lu-Mien and Laotian youth, ages 14 to 18, in Sacramento. The program is designed to address and prevent behavioral problems, such as chronic absenteeism, academic failure, gang association and involvement in the juvenile justice system, while fostering youth’s wellness and family functioning. The program intends to organize two cohorts of 20 male youth and two cohorts of 20 female youth. Each counselor will have an on-going caseload of no more than 20 youth/families. Each cohort will participate in the following core program elements:

- Needs and Strengths assessment – within 72 hours of referral from school or probation, EBAYC meets with the youth and parent/guardian and secure consent
- Individual Mentoring and Counseling
- Service Access and Monitoring
- Group Work

In addition, community outreach and education will be provided to reduce stigma around mental health with local schools. The program intends to reduce risk factors for mental illness (measured by pre/post assessment with Child and Adolescent Needs and Strengths (CANS) tool), to increase educational attainment (measured by earned school credits, high school graduation and enrollment in postsecondary education) and to have youth released from court-ordered probation (as measured by Juvenile Justice records).

Fresno Center for New Americans (FCNA) was established in Fresno in 1991 with the mission to *empower new Americans*. FCNA serves as the lead on the Southeast Asian Mental Health Collaborative (SEA MHC) which partners with Lao Family of Merced and Lao Family Community Empowerment. The collaborative has over 50 years of combined experience providing culturally appropriate services to the underserved Southeast Asian community in Fresno, Merced and San Joaquin counties. The project aims to serve Cambodian, Hmong (white and blue), and Laotian individuals. Clients are refugees from Southeast Asia (SEA) who have had limited exposure to Western culture. Many of the clients do not read or write in their own native language or in English. Common diagnoses reported for SEA clients seen through FCNA are depressive disorder (55%), anxiety (13%), post-traumatic stress disorder (25%) and persistent depressive disorder (7%). The project aims to address reluctance to seek help, suicidal ideation, social disconnection, fear of community engagement, a belief that one’s destiny is predetermined, acculturation issues, relationship problems, and a sense of hopelessness, helplessness, and powerlessness.

The program model includes workshops on SEA culture, beliefs and practices, therapy (Individual/Group rehabilitation therapy), case management, alternative healing practices, peer support groups that include arts and crafts, and engaging in a community garden—all leading to an individual who is stabilized and can be discharged from program services. The program intends to use a Cross Cultural Cognitive Behavioral Approach to address appraisal and experiential and cultural interaction to bring about adaptive cognition, emotion and behaviors. Cognitive behavioral therapy may help to change maladaptive or biased thoughts or behaviors which affect change in emotions. In order to achieve the change in maladaptive and negative emotions, behaviors require rational and adaptive thoughts and beliefs and attitudinal change in cultural values, group consensus and practices. Psycho-education and practicing coping strategies – including positive affirmation techniques—will be used to help engender confidence and to focus on strengths. Community resources (housing, social services), arts and craft celebrations, gardening, and group support groups will support an adapted cognitive behavioral therapy, adapted positive psychology and cultural strengths approach, group psycho-education, teaching of coping strategies, teaching problem solving skills and cultural counseling approach to move individuals on a spectrum from severe to moderate to mild mental illness. The goal is to increase help seeking, reduce suicidal ideation, improve social connection and community engagement, and increase awareness and knowledge around mental health and well-being.

Asian American Recovery Services (AARS), a program of HealthRight 360 (HR360): Asian American Recovery Services (AARS) was founded in 1985 to address the rising substance abuse rates among Asians and Pacific Islanders in the San Francisco Bay Area. The agency has grown and expanded and now serves thousands of people throughout San Francisco, Santa Clara, and San Mateo counties. In 2014, HealthRight 360 (HR360) merged with AARS. HR360 provides integrated health care services to disenfranchised and vulnerable community members, includes those experiencing homelessness, substance use disorder and/or mental illness. AARS has been providing services in San Mateo County for 15 years. The program aims to reach caregivers and youth (ages 3-17) who are Samoan and Tongan in north San Mateo County.

AARS has been providing psychoeducational classes to Pacific Islander populations since 2011. The proposed program will expand current services to develop a Wellness curriculum focused on addressing the growing Samoan and Tongan population. The program aims to reduce the stigma associated with mental illness and to increase awareness of mental health issues among Pacific Islanders, especially Samoans and Tongans in north San Mateo County. The project aims to facilitate early and prompt access to treatment and other mental health services and supports, and to change participant attitudes, knowledge, and behavior to facilitate access to mental health services.

The proposed program model will provide culturally responsive services with language, appropriate staff, culturally relevant topics, and continuing resources. The program includes quarterly 12-week caregiver classes that meet once a week in the evening for three hours. The meeting includes a family style meal followed by education about mental illness risks, mental health resources and related issues. The program also includes a parenting curriculum that

tailors acculturation, intergenerational conflict, and communication modules. Participants take part in one orientation session, five classes with activities and topics from the parenting curriculum and six classes to be developed based on interest of participants. The project aims to increase outreach and education, increase awareness and early access to mental health services, and to reduce stigma.

Korean Community Services (KCS) began in 1977 out of the vision of an immigrant church to provide social services and community outreach to the influx of Koreans coming to Southern California. KCS has become the largest Orange County Korean multi-service agency providing an array of behavioral health, public health and social services to Korean community members and the community at large. KCS's primary services area is Orange County, with offices in Buena Park, Fullerton, Garden Grove, and Irvine. KCS proposes to partner with the Southland Integrated Services, Inc. (SIS), a Vietnamese focused nonprofit that has also evolved over the last 30 years from a refugee resettlement agency. Today the organization continues to provide social services and has also become a federally qualified health center through its Southland Health Center. SIS's areas of focus are Santa Ana, Garden Grove, and Westminster.

The recent CRDP report showed that in a 2005-2006 study, 34% of Korean Americans over the age of 60 were assessed with probable depression and an additional 8.5% reported suicidal ideation.[3] However, of this group only 6.5% had contacted a professional.[3] Vietnamese elders reported 7% mental disability, above the state average of 5%; with Vietnamese study participants reporting a higher frequency of mental stress than other Asian and Pacific Islander subgroups.[3] In addition to these statistics, Koreans and Vietnamese have a very different worldview from most Western European cultures – valuing family cohesion, cooperation, solidarity, and conformity.[11] These values are contrary to Western European characteristics of a highly individualistic society, often times causing conflict. The program aims to support clients in navigating an integrated healthcare system with cultural and linguistic competence.

The proposed program will implement Korean and Vietnamese Integrated Care Coordinators (ICCs) to address the specific needs of Korean and Vietnamese in Orange County. The overall outcomes are to increase wellness or well-being, to be physically healthy and active, to increase emotional well-being, to have good social relationships and support, to have good family relationships, to have financial stability, and helping clients feel at peace and stable. The program aims to reduce negative outcomes such as suicide, incarcerations, school failure, unemployment, prolonged suffering and homelessness; and to increase knowledge and skills to access existing resources, to promote positive attitude towards accessing help, and to increase statewide community-based organization collaboration. For clients, the project aims to increase mental health knowledge, to increase linkages to community resources, to increase utilization of mental health services, and to improve health outcomes. Long-term client outcomes are an increased perception of support, decreased self-stigma and social stigma regarding mental health, increased awareness and knowledge about and willingness to seek help and/or appropriate treatment, and reduced use of emergency services for mental health. The project aims to reduce racial and cultural disparities in unmet need for mental health

services, to improve community mental health, and to reduce the societal costs related to untreated mental health.

Section 3: API IPP Cross-Cutting Themes

Among the numerous ethnicities, cultures and geographies represented by the API IPPs, we expect to see differences between cultures, diversity within cultures, and similarities across the various cultures and sub-populations. It will be important to capture and document how diversity and sameness manifests across the communities served by the seven API IPPs. The API TAP, with the support of the SWE, will be capturing these common features found across API CDEPs. We believe these are essential elements to capture as an advocacy tool for the API population as a whole to inform OHE, CDPH, and other mental health stakeholders.

The inclusion of cross-cutting themes here is also intended to support deeper thinking about evaluation. We encourage IPPs to consider these themes in finalizing their evaluation plans. To the extent that these themes resonate across IPPs and IPPs can gather data to describe these themes more fully, CRDP will contribute significantly both to reducing health disparities and to advancing knowledge about API mental health.

Based on the API IPP grant proposals for CRDP Phase II, this section presents cross-cutting themes in how API IPPs described the characteristics of the priority populations that will be served, cultural and social processes that contribute to risk and protective factors related to mental health, and the primary mental health problems that will be addressed.

We reiterate here that this is a living document given that CDEPs may change, especially between proposal and implementation. As the API IPPs make improvements or address barriers in the CDEP implementation process, we plan to reflect these changes in an updated document.

Cross-Cutting Themes among API IPP Populations

- **Community Context/Ethnicities & Languages:** The priority populations served by the API IPPs are quite diverse with over 17 different ethnic communities. The following API subpopulations are being addressed by the CDEPs implemented among the API IPPs: 1) Cambodian, Hmong, Korean, Laotian, Lu-Mien, Pacific Islander (including Samoan and Tongan), South Asian (including Afghani, Bangla, Bhutanese, Indian, Iranian, Maldivian, Nepalese, Pakistani, Sri Lankan), and Vietnamese. This alone, encompasses 24 languages with multiple dialects.
- **Historical Experiences and Immigration/Settlement Issues:** All populations include refugees and immigrants and have experienced political turmoil and/or war prior to their U.S. arrival. These individuals face adaptation to a new culture and language that impacts their behavioral health and well-being.
- **Intergenerational Relations and Biculturalism:** This impacts not only the refugee and immigrant generation, but those that follow leading to intergenerational tensions and issues with bi-cultural identity and bi-lingual needs.

- **Collectivistic & Family Oriented:** These priority populations come from a collectivistic worldview, where the family unit and family cohesion are important, even conveying a façade of the perfect family unit to keep from airing problems and tensions. This portrayal may limit a family and individual’s ability to seek help to address mental illness, which is stigmatized in all of these communities.
- **Mental Health Stigma:** Priority populations all experience stigma related to experiencing mental health problems, dealing with the problem, and accessing and utilizing mental health services. The concept of *saving face* is one example in which Koreans and Vietnamese will hide their mental health problem so that it does not bring shame to their families. This concept may also resonate in other cultures represented within the API population of CRDP Phase II.
- **Mental Health Illnesses:** The following are commonly identified issues that impact mental health in these priority populations: cultural isolation/social disconnection, PTSD, anxiety disorders, depression, drug addiction, suicidal ideation, self-mutilation, emotional distress, memory loss, concentration problems/learning difficulties, fear of community engagement, belief of a pre-determined destiny, sense of hopelessness and helplessness, and incarceration.

Cross-Cutting Themes among API IPP Individual/Family Practices

The implementation of CDEPs require practices that address mental health with the priority populations at the individual- or family-level. Across the seven IPPs, different techniques and strategies have been proposed, representing CDEPs that have shown or may show effectiveness in addressing mental health and illness among specific API populations. Below we present the cross-cutting themes related to key strategies and practices proposed by the API IPPs.

- **Culturally Relevant Practices:** These include the use of cultural activities and practices that are common in the community, association with spiritual and religious beliefs and practices, association with healing beliefs and practices, recognizing the role of family and not just the individual in health-education and decision-making, recognizing the collective worldview, and utilizing formats that create safe spaces for learning (such as small group meetings with family style meals and counseling sessions in the community at trusted organizational sites/community gathering spaces).
- **View of Mental Health:** Many of the programs also propose to look at mental health with a holistic lens, recognizing overall physical, mental, and spiritual well-being, not just mental health/well-being. IPPs have also identified the need for having and using the appropriate terminology for discussing mental health in-language to increase awareness and to reduce stigma related to mental illness terminology.
- **Intervention Models:** Models proposed include: individual therapy, case management, system navigation, group education, social support, and combinations of the above. Psycho-education and skills building (such as coping skills) are also included on many of the projects. All projects also intend to link clients to other needed services that are identified. The duration of services varies with individual need; some programs are as

short as two educational sessions, while others provide ongoing social support and services.

Perspectives on Cultural Competence

The API IPPs have used the term, “cultural competence” in implementation of their CDEP with their priority populations. Based on their proposed CDEPs, cultural competency will be operationalized through the following strategies:

- Consideration of ethnic culture and traditions, such as:
 - Examining Western, traditional and a combination of Western and traditional cultural practices of a community
 - Identifying these aspects as individual and community assets to support individuals experiencing mental illness
 - Integrating cultural practices to build trust and rapport
 - Gardening
 - Cultural activities
 - Physical exercise (such as tai chi, dance, yoga, etc.)
 - Story telling
- Culturally and linguistically sensitive outreach and education efforts, such as:
 - Concordant language
 - Provision of in-language services aligned with proficiency of priority population
 - Literacy level
 - Understanding the literacy level of the priority population and considering the oral history of communities
 - Culturally appropriate terminology to discuss mental illness
 - Using concordant terminology to address mental illness and wellness
 - Understanding of the perceptions (including stigma) of mental illness not just to the individual but the family and community
 - Use of ethnic media (print, television, radio, internet radio) for outreach and education
- Culturally and linguistically sensitive counseling services, such as:
 - Understanding of the historical background of a community (e.g. war trauma, refugee experience, asylum status, etc.)
 - Understanding/willingness to understand and respect the values, beliefs, traditions, spirituality, worldview of the community
 - Understanding/willingness to understand and respect the collective worldview of a community
 - Recognizing that “I” and “we” can be one and the same and the importance of this in help-seeking and decision-making
 - Understanding and accommodation of the API community practice “to agree to” provider recommendations due to deference to authority

Cross-Cutting Themes among API IPP Organizational Practices

All IPPs propose having bi-cultural and bi-lingual staff on site to work with the populations they serve. In addition to having staff with a similar cultural and linguistic background as the client/consumer, sites will also employ techniques to ensure culturally competent care, as noted by the key areas below. These organizations also do not just employ culturally competent techniques, but demonstrate cultural and linguistic competence in terms of governance, communication and staff development. The leadership of the organization and staff believe in a commitment to cultural competency, non-discrimination, and diversity.

In delivering the CDEP practices, IPPs propose to incorporate cultural competency at the agency level. These include:

- Professional Skills to Provide Support
 - Training on professional skills in counseling: understanding prevention and early intervention strategies and relevant clinical issues
 - Ability to effectively work with other agencies
 - Ability to effectively engage the community
 - Ability to effectively communicate with the family and extended family as appropriate in treatment
 - Knowledge about community resources and ability to provide proper linkage
- Flexibility in Program Design and Service Delivery
 - Flexibility in delivery of service, such as providing interventions in individual vs. group settings
 - Flexibility in delivery of service, such as understanding the need for inclusion of family and extended family,
 - Flexibility in delivery of service related to hours and location
 - Understanding and accommodation about the need to take more time for API communities to build rapport and trust
- Capacity Building
 - Helping to empower client/consumers, family members and community with help-seeking skills

The API IPPs take into consideration the various factors aforementioned to ensure that trust is established and individuals needing services are linked to appropriate resources. This sensitivity to providing support and services is essential to nearly all their CDEPs.

Cross-Cutting Themes Related to Outcomes

The API IPPs aim to demonstrate that techniques and practices which are culturally and community-accepted have the potential to yield meaningful outcome measures and impact. Not only will efforts increase access to and utilization of mental health services, they are also expected to yield improved mental health outcomes.

- **Mental Health:** All API IPPs have defined mental health as state of being that contributes to physical and spiritual health and overall well-being. Mental illness is considered to be all diagnoses as categorized by the DSM 5, as well as the risk factors that may lead to mental disorders. Some of the outcomes include reduced depression related symptoms, reduced attempted and completed suicides, and improved well-being (not just in mental health but overall) including wellness, resilience and recovery.
- **Mental Health Risk and Protective Factors:** API IPPs have described risk and protective factors related to mental health. CDEPs aim to reduce incarcerations, reduce school failure, increase social connectedness (among peers, family members and community), increase educational attainment (academically and to community resources), to increase help-seeking behaviors, and to minimize new trauma (such as domestic violence and removal of children from the home).
- **Access to Mental Health Services:** CDEPs aim to improve awareness of and increase access to appropriate mental health services as identified by mental health needs in the priority populations. This includes increased awareness of mental health, mental illness (including mood disorders), and community resources.
- **Utilization of Mental Health Services:** CDEP projects aim to increase utilization of available mental health services.

API IPPs are also aiming to achieve long-term goals such as reducing stigma around mental health; creating a norm change about mental illness; reducing prolonged suffering; and reducing use of the emergency room for mental health/illness.

Addressing Mental Health

The mental health issues identified by the IPPs affect the youth, adolescent, and adult population in these communities; they also impact family dynamics. In communities where interpersonal relationships and decision making is strongly influenced by the family, it becomes imperative to understand these aspects deeply. The API IPPs have identified that in many communities mental illness can be perceived as being weak and may bring shame to a family, preventing individuals from seeking help. In addition to this, some of these cultures have beliefs and practices around gender roles. These cultural norms may simultaneously influence help seeking behaviors and serve as stressors in some communities. Ironically, to effectively provide mental health services, services must attend to cultural and individual nuance, as sameness treatment to everyone may not apply, given the heterogeneity of API populations and cultures.

Cultural/Linguistic Factors

In addition to looking at mental health through a collective lens, it is also important to look at language and how terminology, or the lack of terminology may hinder access to mental health. In some communities, mental illness is associated with the term *crazy*, which yields a negative connotation and creates barriers for individuals to access care for fears of being labeled *crazy*. In some communities, there is a lack of terminology to describe mental illness, therefore making it difficult to communicate what one is experiencing. In some communities, spirituality,

or the lack of spirituality, may also be associated with mental illness or psychiatric disturbance. Thus, the IPPs have emphasized the importance of understanding the entire person – their physical, mental and spiritual well-being, as well as how this ties into their family and family harmony and well-being.

Evaluation

Section 4: Considerations for Refining CDEPs and Developing Local Evaluations

API IPPs have identified and described mental health issues of APIs in a manner that is culturally, socially, and practically relevant to their communities. Through their initial grant proposals and during the remainder of Phase II implementation and evaluation, API IPPs are moving forward to address these needs and offer practices that reduce mental health problems and increase access/utilization of mental health services. In doing so, they are validating API CDEPs for mental health prevention and early intervention for their communities. By the end of Phase II, the goal of API IPPs is “to evaluate and validate CDEP practices as effective in preventing mental illness from becoming severe and disabling” in the priority population. In the process of validating the practice, each CDEP should be “sufficiently well-developed and described, teachable to other agencies, [so that it can] be delivered in a consistent manner” for future adoption and replicability.[12] Thus CDEPs must:

- Be well articulated with description of the core components and how the components address the mental health issues in the priority API populations;
- Have outcomes that are clearly stated and measurable tailored to priority population’s cultural and linguistic needs; and
- Be able to be replicated by others so it can be taught to others.

Refining the CDEP

This section outlines guidelines for API IPPs to use when refining their CDEPs. These guidelines are meant to provide clarity about core elements of a CDEP while providing sufficient flexibility to allow the IPPs to tailor their CDEPs to the specific needs of their communities. The expectation is that CDEPs being implemented by the API IPPs will be able to address these guidelines with support and technical assistance from the API TAP team.

The following are questions to consider to guide the refinement of the CDEPs. Many of these questions are sourced from the SWE Evaluation Guidelines by PARC@LMU. Refer to Section 7 of the SWE guidelines for more details about *The Cube*.

- I. **Describe the priority population and the reasons for program development:**
Provide a description of the circumstances under which the practice evolved, including the characteristics of the community, the nature of problems or issues addressed, associated resources, the intent or purpose of the practice, and supporting theory. Address the following:
 - a) **Who is the priority population?**
Specify the Asian and/or Pacific Islander community, including the age group(s), gender(s) and any other demographic information that helps define who is included and who is not. This may also include specificity related to:
 - Historical Context (immigration experience (whether as refugee, family reunification, employment, years in U.S., etc.),

- Identity (subgroups),
- Values (cultural beliefs, spirituality, religion, concepts of family, respect),
- Culture,
- Social ties
- Living in America (i.e. the goods and the bads, employment/educational opportunity, discrimination, stigma, poverty)

b) How does the priority population view mental health?

Identify how the priority population conceptualizes and views mental health. This may include alternative terms for well-being or wellness that are inclusive of positive mental health outcomes. Questions to consider include:

- How is mental health expressed? What does it look like?
- What are causes of poor mental health?
- What prevents poor mental health?
- What are appropriate treatments/interventions to improve mental health?

c) What are the problems the CDEP is trying to address?

Identify the causes of the problem experienced by the priority population.

- How did the problems the community is facing start? Why did they start?
- How are causes of the problem understood in a) a historical context, b) through the lens of the community's values, c) through a community's practice?
- What are the things that concern or bother the community?

II. Describe the CDEP goals and key outcomes

Identify the specific changes expected as a result of the CDEP. Describe how the priority population, their families and communities will change. Questions to consider include:

- What are the specific goals the CDEP aims to achieve?
- What are the key outcomes?
- What outcomes are expected as a result of the CDEP? What is desired by the community? What does the community want to see more of? What do they want to see less of?

III. Describe the key strategies/program components

Specify the essential components of the CDEP. Reflect on which elements are essential for making the CDEP successful in the priority population. Include information about client/family level strategies as well as those at the organizational level.

a) Overall

- What is the activity or community-defined evidence practice or intervention?

b) Individual Client Level (or Family Level)

For each item listed for the individual level, specify the culturally-responsible strategy used and how the priority population's traditions, beliefs and customs are incorporated.

- *Engagement*: How is community outreach conducted? How are potential clients recruited and identified?
- *Assessment/Intake*: Who is involved in the CDEP (e.g., client, family, community)? Who determines diagnosis/problem addressed by the CDEP? What is the process to document need?
- *Intervention/Key components of CDEP*: How are interventions delivered (e.g., one-on-one session, group sessions)? What is the intended dosage, frequency, duration, and group size? Where is it conducted? How is it implemented?
- *Resource Coordination*: What support are CDEP clients/families seeking services for? How is clarity about needs and linkage to appropriate resources/services determined?
- *Logistics*: Are there any logistical supports that are needed in order for clients/families to access CDEP services? For example, transportation support, child care, access outside of normal (Monday-Friday, 9am-5pm) business hours, etc. How are those addressed?
- *Aftercare*: When is the program no longer needed or appropriate? Who determines that and how? What are the next steps to ensure continuity of care?

c) Cultural responsiveness

For each item listed below, specify how cultural responsiveness is operationalized through implementation of the CDEP.

- How does the CDEP reflect the cultural values, practices or beliefs of the community?
- What makes the CDEP activities culturally competent?
- In what language do clients/families involved with the CDEP prefer to communicate?
 - Are CDEP activities implemented in-language?
 - Are interpreter services used? If so, how does this impact the implementation of the CDEP?
- Is gender/age concordance important to those participating in the CDEP?
- How are concerns related to modesty, shame, elder deference considered in the CDEP?

d) Organizational Level

For each item listed for the organizational level, specify the culturally-responsive strategy used and how the priority population's traditions, beliefs, and customs are incorporated.

- a. *Staffing*: What is the appropriate staffing structure? What training/qualifications/experiences are required to implement the CDEP effectively?

- b. *Leadership practices from supervisors or organizational directors:* What are the expectations of leadership to support the success of the CDEP? How does supervision of staffing implementing the CDEP reflect the culture and values of the organization and the priority population? What processes allow leadership to receive authentic feedback from staff, clients, and community members?
- c. *Organizational capacity building:* What organizational capacity is needed to successfully implement the CDEP? What organizational attributes impact how the CDEP is implemented?
- d. *Organization's relationship with local mental health departments, other community organizations and other funders:* How do these relationships influence the organization's ability to implement/sustain the CDEP? Are there opportunities for collaboration?
- e. *Evaluator's role:* What evaluation approaches are aligned with the organizational culture and the community priorities? How can evaluation contribute to improved processes and organizational learning?
- f. *Community:* Who determines community consensus for CDEP success? What processes are in place to receive authentic feedback from the community? What processes are in place to share with the community what is being learned through evaluation?

Developing the Local Evaluation Plan

In this section, we outline a process to ensure that key outcomes, lessons learned, and evolutions within the API population of CRDP are consistently captured and documented. Given the diversity of sub-populations, languages, dialects and cultures within the API group for CRDP we have elected to propose **key questions to consider at the beginning of Phase II.**

The following are questions intended to guide the development of the local evaluation plan. Refer to Section 6 on how to use the Statewide Evaluation Guidelines to ensure that local evaluation efforts are aligned with but not duplicative of the core measures being implemented at the statewide level.

I. Evaluation Infrastructure and Resources

1. What tools, databases, or systems are used to capture data?
2. How are data captured and reported?
3. What considerations are needed to capture data appropriately/accurately with diverse populations (language/culture considerations)?
4. Are there appropriate tools to capture/measure mental health and illness for the population(s) of priority? Is there a need to translate and adapt validated tools?

II. Process Evaluation

1. How will IPPs learn from on-going evaluation efforts and make timely adjustments to the CDEP based on evaluation results?

2. How do IPPs know that the CDEP activities are culturally accepted?
 - a. If there are no other resources, do IPPs know that this is the best way to deliver the service?
 - b. Is there a participatory opportunity for client feedback?

III. Outcome Evaluation

1. How is mental health defined and measured?
 - a. How is it communicated with CDEP participants?
 - b. What are indicators of success from the perspective of the CDEP participants?
2. At what levels are data captured?
 - a. Individual – client/family?
 - b. Organizational level?
 - c. Systems level?
 - d. Other levels?

IV. Define the Evidence

Identify the primary aims of evaluation and consider what types of evidence are most appropriate for measuring outcomes with the priority population. Questions to consider include:

- a) *Measures and variables*: How are cultural beliefs and definitions about mental health reflected in these measures? How is this evidence community-defined?
- b) *Assessment Tools*: How are decisions made about whether to use validated scales or assessment tools versus the organization's own tool? To what extent do the tools reflect community values and preferences (both in terms of content and mode of administration)?
- c) *Literacy and translation*: How do tools address literacy/translation needs of the priority population? How is community input incorporated?
- d) *Source of data*: Which sources (e.g., the client, family, staff or community) are the appropriate sources of data? What questions are being asked of each source and why?
- e) *Data collection type*: What data collection methods are the most appropriate in terms of culture, language, literacy, community preferences and evidence?

V. Evaluation of Evidence: Is the program effectiveness based on community consensus or via other means?

Identify how the effectiveness of the CDEP will be determined. If community consensus is a critical part of the evidence, consider which members of the community will be represented and how consensus will be determined. Think about the following:

- a) Description of data points (pre/posttest; follow-ups)
- b) Process in which evidence is collected and interpreted/analyzed
- c) Approaches to validate the results

VI. Methods for replication or dissemination

Identify when and how it would be appropriate to replicate the CDEP in other communities. This information may not be known at the beginning of Phase II, however, it's helpful to keep these questions in mind to ensure that evaluation activities can answer them.

1. What are the key components for practice/model fidelity?
2. What is the applicability of the CDEP to other populations and settings? How it will be introduced and distributed appropriately? What adaptations might need to occur if replicated in other communities?

Reflections at the end of CRDP Phase II

Every six months, through our annual peer learning circles and annual assessment updates, the API TAP team will capture information from the seven IPPs that documents the progress the IPPs have made implementing their CDEP, evaluation processes and outcomes, and any key changes. This information will be summarized at the end of CRDP to demonstrate what was learned within the API population.

We anticipate that local evaluations from CRDP Phase II will produce a significant amount of new knowledge about how to address mental health inequities in API communities. We hope to capture the many lessons learned and wisdom from the API IPPs as they progress over the course of the initiative. Below are some of the questions we intend to answer at the end of CRDP Phase II.

CDEP implementation

1. What was learned about language, translation, interpretation and literacy and the impacts on the effectiveness of the CDEPs? What worked and what didn't?
2. What were challenges/successes related to referrals? (i.e., to what extent are other community resources able to meet language/literacy needs?)
3. In what ways did cultural norms related to gender/age concordance influence the success of the CDEP?
4. To what extent were IPPs able to meet logistical needs of clients/families to participate in the CDEP? What was learned?
5. To what extent did these core elements change over time (and why)?
6. What makes the CDEP work in the particular community/culture/context?

CDEP Evaluation

1. How did IPPs define/conceive of key mental health outcomes and did this evolve over the course of the project?
2. To what extent did evaluation tools/approaches evolve over the project? What was the rationale?
3. What were effective strategies for collecting data that accurately reflect the priority population's experiences?
4. What worked for CDEP quality improvement efforts?
 - How can quality improvement be developed and integrated more effectively?

- Are there recommendations for rapid cycle evaluation opportunities for program improvements?
 - To what extent is a culture for data collection and evaluation cultivated within an organization/collaborative?
5. How did IPPs promote a balance with evaluation and direct services?

Section 5: Community Based Participatory Research

The draft strategic plan for CRDP developed by CPEHN recommends that evaluation in Phase II of the initiative “take a community-based, community-driven approach”.^[13] In response to this, API IPPs, their local evaluators, the API TAP and the Statewide Evaluator will be coordinating efforts to “demonstrate through a rigorous, CBPR process that selected CDEPs are effective in preventing or reducing the severity of mental illness.”^[14] In this section, we offer a brief review of best practices around CBPR and provide some basic guidance for ensuring meaningful stakeholder engagement in evaluation of the API IPPs.

Community based participatory research (CBPR) overlaps conceptually with other approaches such as collaborative research, participatory action research (PAR), community participatory evaluation and empowerment evaluation. A simple definition suggests that a core element of CBPR is the involvement of non-evaluator stakeholders in the “act of inquiry”, or evaluation process.^[15] Non-evaluator stakeholders may include former clients or family of former clients, religious/spiritual leaders, community members, community advocate or others. For the purposes of CRDP, community-participatory evaluation has been defined specifically to include the *active engagement of stakeholders in developing evaluation and all phases of evaluation implementation* (see box 4).

Box 4: Community-Participatory Evaluation

Community-participatory evaluation is a partnership approach to evaluation in which stakeholders actively engage in developing the evaluation and all phases of its implementation. Those who have the most at stake in the program – partners, program beneficiaries, funders and key decision makers – play active roles. Participation occurs throughout the evaluation process, including:

- Identifying the relevant questions;
- Planning the evaluation design;
- Selecting the appropriate measures and data collection methods;
- Gathering and analyzing data;
- Reaching consensus about findings, conclusions and recommendations; and
- Disseminating results and preparing an action plan to improve program performance.

(Zukoski & Luluquisen, 2002)

Source: State of California Health and Human Services Agency California Department of Public Health (August 2015). Solicitation #15-10648, California Reducing Disparities Project Phase 2 Asian Pacific Islander Implementation Pilot Projects.

Core Elements, Opportunities and Challenges

CBPR is an approach that embodies inherent values about the benefit of involving non-evaluators in the evaluation process. Some core assumptions of CBPR include the following [16]:

- Communities have strengths, resources, and relationships that can be mobilized, supported, and fostered through meaningful participation in an evaluation process.
- A co-learning model implies that expertise and knowledge exist at multiple levels on a project team. For example, the community member has as much wisdom to share with the evaluator as the evaluator has to share with the community member.
- Integrated collaborative processes at **all stages** of the evaluation yields results that are actionable and more relevant to the community in which the evaluation was conducted. This means that stakeholders engage in co-creation of all evaluation processes, including: identification of evaluation questions/priorities, evaluation design, development of data collection tools, data collection, data analysis, data interpretation, and dissemination of findings.
- Power dynamics are identified and named, rather than ignored.
- All stakeholders involved in evaluation commit to using the results of the evaluation to take action and contribute to social change.

CBPR is an intensive process that requires a considerable commitment of time and financial resources. The co-learning and co-creation aspects make this an evaluation approach that is highly relationship based, requiring stakeholders to invest significant time in building trust and creating appropriate mechanisms for meaningful engagement. However this commitment of time and resources yields specific advantages that are uncommon in most other evaluation approaches. Some of these advantages include: ability to obtain information that couldn't otherwise be gathered (i.e., from hard to reach communities); capturing why a program worked (or didn't work) from the perspective of those most directly involved; empowerment of stakeholders and long-term capacity for evaluation; and facilitation of ownership for the program and the evaluation.[17]

Because of its empowerment philosophy, CBPR is an ideal approach in communities that have historically been disenfranchised or exploited by external evaluators and researchers. CBPR has also been especially useful when the topic of evaluation is complex, sensitive, and challenging as it is able to elevate the perspectives of multiple stakeholders who are closest to the issues on-the-ground.[18]

However, CBPR also presents some challenges that are not present in more conventional approaches. This approach requires significantly more time than other approaches, which can result in evaluation fatigue for stakeholders. Funders may also not be willing to support a process that requires a much lengthier timeline. It can also be difficult to provide processes and structures that ensure stakeholders are meaningfully involved and aren't simply tokenized. This requires that evaluation leaders also have strong facilitation skills in community settings. Many community members express benefit from their involvement in participatory

evaluations. However, it can be difficult for some community members to participate consistently or for the duration of the project given other priorities related to work, family, and children.

Another challenge of community-participatory evaluation is the perception that the approach lacks rigor. While it may not be an ideal approach for certain communities or evaluation questions, more often than not it can *increase* rigor and quality. As an example, Balazs & Morello-Frosch (2013) describe a study about clean water disparities in Central California where the involvement of community members resulted in stronger demographic data collected and an improved research design.[18]

Table 2: Opportunities and Challenges of Community-Participatory Evaluation	
Opportunities	Challenges
Relationship-focused	Requires trust & buy-in from all stakeholders
Empowerment approach recognizes community strengths	Difficult to ensure that all are involved in meaningful way, not just most vocal
Trains stakeholders to use evaluation to take action for issues they care about	Requires significant time commitment from community members and stakeholders
Provides a mechanism for stakeholders to elevate their voices about community issues	Hard to ensure equitable decision-making about evaluation priorities
Results in findings that are actionable & relevant to the community	Must overcome inaccurate perception that approach lacks rigor

Community-Based Participatory Research: A Necessary Approach for CRDP

CRDP is about doing business differently and elevating evidence that has been defined by the community. Community members and participants of the CDEPs are the true experts about what works to reduce mental health disparities in their communities. They are the ones who will know if the CDEP has community consensus to be effective, if the community is receptive to the approaches and whether the outcomes the CDEP intends to reach are the actual priorities for their community. A CBPR approach allows local evaluations to capture the cultural nuances of the CDEP and to accurately understand why the CDEP is effective in specific communities. CBPR evaluations adequately capture how problems are conceptualized by the priority populations and how the IPPs have developed CDEPs to effectively address these problems. It also provides a process for community stakeholders to have a voice about which outcomes are important to evaluate and which types of methods will most appropriately measure the desired outcomes.

A CBPR approach is absolutely necessary for local evaluations of the API IPPs. It is the only way capture the data that is needed for CRDP Phase II to make the case for the effectiveness of CDEPs to reduce mental health disparities in API communities.

Recommendations for CBPR

Collectively, the API TAP team has decades of experience with communities implementing participatory evaluation and research projects. In this section, we've summarized our best thinking to offer practical suggestions to consider when designing a CBPR process for CRDP. It is our intention that these suggestions provide a common ground upon which the API IPPs and local evaluators may stand when designing evaluation efforts. The API TAP team plans to work with each API IPP related to the details of each local evaluation.

Roles

CBPR by nature is a highly collaborative process. We recommend designating clear roles for the multiple stakeholders involved in evaluation.

Evaluation Coordinator: *We highly recommend that each API IPP designate a staff person from the organization to coordinate the evaluation activities.* This person will work closely with the local evaluation, community stakeholders and the API TAP team to design, plan and implement the evaluation. Depending on the IPP, the evaluation coordinator may oversee administration of evaluation tools or coordinate data collection activities. This person likely will package raw data to provide to the local evaluator and API TAP team. Having staff time designated for evaluation ensures evaluation activities are integrated in organizational programming and also ensures that evaluation knowledge is retained with the agency.

Local Evaluator: All API IPPs proposed to have an external local evaluator. While each evaluator will have a different approach, the local evaluator will likely play a lead role in evaluation design, development of evaluation tools/protocols, guidelines for data collection, data management and data analysis. It is expected that the local evaluator will work closely with the API IPP staff and the API TAP team.

Community Stakeholders: Depending on the design of the local evaluation, community members will likely play different roles. It may make sense for community members to serve on an evaluation advisory committee, to collect data from CDEP participants, and/or to help the API IPPs and the local evaluators interpret and disseminate evaluation findings.

Planning Phase

The following recommendations are especially important during the planning phase. However, it may be useful to revisit these annually, given the complexity and length of CRDP.

Stakeholder involvement: One of the first things to consider is which stakeholders to involve in the CBPR. For each stakeholder that is considered, it is helpful to consider what perspective they can bring to the evaluation and why that perspective is important for the evaluation. As a list of potential stakeholders begins to develop, determine whether certain stakeholder groups are over- or under-represented. It may not be necessary to have equal representation from all groups. The key at this phase is to ensure that stakeholder involvement is intentional and

purposeful. Some broad categories of stakeholders to consider include, but aren't limited to, the following:

- Community members who have knowledge about the CDEP
- Community/faith/spiritual leaders who represent the CDEP's focus population, but may or may not receive services from the CDEP
- Leaders or staff from other community-based organizations working with the CDEP's focus population
- Leaders from the IPP organization/collaborative who are familiar with the CDEP
- Direct service staff who are implementing the CDEP
- Local evaluator
- Other trusted evaluation/academic partners

It may also be helpful to consider engaging certain key individuals at specific moments in the evaluation process. For example, in years 2 or 3, it may be of interest to share what has been learned through evaluation with key funders to leverage their support for the program or organization. If evaluation findings could have an impact on organizational direction, it may be important to include the Executive Director or Board of Directors at key junctures.

Structure for collaboration: Determine a structure that will allow stakeholders to collaborate in meaningful ways to guide the evaluation. This may include development of an evaluation committee or community advisory board that meets at specific intervals. The structure may also be more informal to be responsive to needs of community members or others who prefer this.

Ensure common goals and common vision: Often CBPR processes become difficult because not everyone in the room has a full understanding of the goals or vision for the project. We recommend dedicating sufficient time at the beginning of the project to ensure that all those involved have a shared understanding of CRDP, the CDEP, and the priority population(s) being served by the CDEP. This is an opportunity for stakeholders to engage in dialogue about the intersections of community, culture, history, language, spirituality and how those are relevant to evaluation of the CDEP. It's also a key moment to document some broad aspirations for the evaluation process. Consider the following:

- How does our CDEP reflect our culture and needs of our community?
- What is the goal of the evaluation and how will we know if we reached it?
- What roles do community and culture play in the evaluation process?
- Are there key values the group commits to uphold?

Decision-making processes: Early on it will be important to clarify how decisions are made and who has authority to make which decisions. It is also helpful to be clear who needs to be consulted before certain decisions are made. For example, a change in evaluation budget may need to be approved by the OHE contract manager. Additionally, the lead organization for CRDP may have specific policies or practices to consider that could impact how decisions are made and who can make them. Ultimately, some decisions will need to be made as a group.

Collaboration can be greatly enhanced if the following questions are discussed and agreements are made early in the process:

- Who has the authority to make which decisions?
- What's the process for stakeholders to provide input, even when they may not be in a place to make a formal decision?
- What is the process for group decision-making? (i.e., is it a consensus process, majority vote or some other method)
- What information will the group need to make informed decisions? (i.e., are there specific materials that can be shared ahead of time for review?)
- What is the process for resolving disagreements within the group?

Clarify and agree on parameters: Every evaluation project has certain practical limitations based on budget, timeline and other constraints. The CBPR process is inherently generative as it strives to seek input from a broad range of stakeholders. It can be extremely frustrating to engage a group in a process to gather their ideas about evaluation only to tell them those ideas aren't possible. This can be avoided by being transparent and realistic with stakeholders about what is possible for this project. Some of these constraints may not be known until later phases in the project. However, it's important to share what is known at any given point in time. Some points of clarification include:

- What OHE expects from the evaluation
- What the Executive Director/Board of Directors expect from the evaluation
- Amount of time and money available to conduct the evaluation
- Amount of time staff have to implement the evaluation
- Availability of clients/community members to provide data for evaluation
- Language/literacy considerations
- Priorities for evaluation: What's absolutely necessary? What would we like to do if we have more time/resources?

Assess strengths and interests: CBPR involves building the capacity of stakeholders. Many people engaged in the process will be new to evaluation but will likely have strengths and expertise in other areas. In fact, the reason that these specific stakeholders will be included is because they bring additional value to the evaluation process. Early on it can be helpful to assess the strengths and interests of those involved in the evaluation. This can be as formal or informal as the group would like. A simple exercise could include asking stakeholders what they perceive as their strengths or what they are most knowledgeable about and also what they would like to learn more about through participating. It will likely be necessary to re-assess needs and interests at various points in the project and if new stakeholders join the process.

Identify needs: Similarly, it's helpful to understand what each stakeholder needs to be able to best participate in the evaluation process. Often, some planning to address these needs can ensure more equitable participation. Some needs to consider include:

- Language: Consider holding meetings in-language and having interpretation for English speakers at least periodically. Plan for interpretation/translation of materials in advance.
- Literacy: Consider ways to reduce reliance on written materials by incorporating images or verbal discussions.
- Transportation: Consider rotating locations and/or offering alternative ways for people to participate. If budget allows, consider providing bus passes or paid parking.
- Child care: Consider meeting when children are in school and/or providing child care during meetings, if possible.
- Religion/Spirituality: Consider obtaining a list of prayer times, religious holidays, or other customs to be observed.
- Disabilities: Inquire with stakeholders about whether there are specific needs related to a disability or lived experience as a mental health consumer.

Roles and responsibilities: As much as possible, it's recommended to clarify roles and responsibilities early in the process and continue to revisit these throughout the life of the project. It's suggested that duties be aligned with how much time each person can commit to the project. Typically, it helps to be very explicit and communicate often about roles and responsibilities, especially when a project is new. When defining roles/responsibilities it's helpful to consider the following:

- Paid staff: Some stakeholders may be involved in the project as part of their paid work for an organization. It's helpful to clarify whether their participation in the evaluation process is part of their position and any limitations their employer may have related to schedule or amount of time that can be dedicated to the project.
- Non-paid stakeholders: Often community members and leaders volunteer their time to be involved in a CBPR process. Because this process is extremely time-intensive, it's highly recommend that budgets include some form of stipend or reimbursements to compensate community members for their time.
- Time commitments: It can be useful to ask each stakeholder to commit to a specific amount of time they can agree to be involved in the project (e.g., six months or one year), as well as how much time they can commit per week or month. This can help all parties involve respect one another's time and also allow stakeholders to set health boundaries without fear of judgment.

Implementation Phase

The following recommendations relate to the implementation phase of the evaluation process. Given the need for iteration and on-going learning, it's recommended that these are revisited on an annual basis.

Evaluation questions and aims: The CBPR process can help unearth evaluation questions and aims that might be missed by a more conventional approach. Once stakeholders have a solid understanding of CRDP and the CDEP, engage them to obtain their input about the research questions and primary aims of the evaluation. It will be especially important to draw on their

expertise of the focus population, the community, and culture. Questions that may be helpful to guide this discussion include:

- How does the focus population think about mental health? What does mental health look like in this community?
- How will we know the CDEP has improved mental health in this community? What would that look like for clients, families, and the community at large?
- How can evaluation be reflective of the community and culture in which the CDEP is being implemented?

Evaluation design: Stakeholders likely have a wealth of information about how to design the evaluation in a way that will enhance receptivity and also result in better data. When thinking about the evaluation design, consider what approaches and methods will align with the values of the community in which it's being implemented. Stakeholders may be able to share their own experiences participating in other evaluation or research projects and what worked or didn't work with those projects. The most rigorous design may not actually produce good data if the community isn't open to collaborating with the evaluators. Empower stakeholders to provide input related to approaches that will help create buy-in for the project and also result in data that is actually reflective of the community. Some questions to consider related to evaluation design include:

- What are the best methods to capture the complex nature of culture and mental health in measuring the effects of our CDEP? Does our CDEP capture our cultural and community needs in the best way possible? What consequences do we expect and want to see from its success? How should we measure these outcomes? It might be helpful to focus on what's not being captured by core measures from the statewide evaluation plan.
- Which methods might be most appropriate for the specific community? For example, surveys may not work due to language/literacy, but focus groups may be more responsive to the community's history of story-telling.
- Who are the best people to collect the data? It may be better to train community leaders to collect data due to stigma/subject sensitivity. Also, consider whether gender/age concordance is important in the specific community.
- How can the expertise and commitment of the stakeholders involved in the evaluation guide the evaluation process? Consider specific evaluation milestones when stakeholders must be engaged. Provide structures that promote reflection about the process and openness to refinement or modifications if needed.

Data Processing, Analysis, and Dissemination

It is recommended that data processing, analysis and dissemination be conducted on an on-going basis throughout the CRDP initiative to ensure that IPPs benefit from the opportunity for stakeholders to be involved with these processes.

Data processing: It's likely that the IPP and local evaluator will primarily be the ones responsible for data entry, cleaning and on-going management. For data security and quality purposes, it's recommended that only designated evaluators/analysts work with the raw data.

It's also advised that data is entered, cleaned, and analyzed on an on-going basis. Any errors that are found as a result can be identified in a timely way to ensure that evaluation processes can be modified if needed.

Data analysis: It's recommended that evaluation data is analyzed at least annually. Preliminary results from the annual analysis of data should be shared with the stakeholders to obtain their input related to interpretation of results. This annual review of data may help inform adjustments made to either the CDEP program or evaluation in future years. Discussion questions that may help guide the discussion of annual evaluation findings with stakeholders include:

- What results were you expecting?
- What results are most surprising or interesting?
- What does this say about the CDEP? Does this align with our expectations for where we expected the CDEP to be at this phase of the project?
- What challenges were encountered during the last year of evaluation? How were they overcome? (Or, what challenges remain that need to be problem solved?)
- Based on these results, what should we keep doing? Is there anything we should change related to the program or the evaluation?

Dissemination: Much of the last year will focus on dissemination; however, IPPs may find it beneficial to share preliminary findings sooner. Additionally, because CRDP is a 6 year project, it will likely be necessary to share some findings back with key community members and stakeholders to keep them engaged and invested in the evaluation project. During the annual review of evaluation findings, it's recommended that IPPs also consider ways to share what has been learned to date through CRDP. Engage stakeholders to co-design dissemination methods that would be most appropriate for the information that is to be shared as well as the needs of the audiences.

Section 6: Guidance for Incorporating the SWE Evaluation Guidelines

While API IPPs will have their own evaluation plans (including key outcomes and approaches), they will also have to incorporate SWE evaluation tools and reports into their design. The SWE is tasked with overall cross-site evaluation for CDRP Phase II, and have identified key evaluation outcomes at the individual client level and organizational level. To ensure there are no overlaps or redundancies in evaluation strategies, API IPPs and their local evaluators should review the SWE guidelines Sections 4 and 5 that discuss the overall evaluation plan and the Appendices for the specific tools. Please note that the API TAP team is available to help the API IPPs and their local evaluators align local evaluation plans with the SWE Evaluation Guidelines.

Issues to consider:

1. Are there any measures that overlap with your own evaluation plan? (i.e., duplicates, or captures similar concepts)
2. Do the SWE core outcome measures capture the key outcomes that your CDEP is aimed at changing? For example, do the six items measuring psychological distress capture your priority population’s view of mental health? If not, what is a better way to assess/measure?
3. Language: Does the terminology make sense to your priority population, especially after it’s been translated?
4. Literacy: Are the core measures aligned with the literacy level of your priority population? If not, how could the measures be adapted to meet the needs of your priority population?
5. How culturally appropriate are the SWE core outcome measures?
6. How linguistically appropriate are the SWE core outcome measures?
7. What is the time and cost associated with translating these measures?
8. How will this questionnaire be administered to clients (e.g., paper/pen, orally via interview)?

Level	Key Outcomes	SWE Core Measures	Potential Issues API IPPs should consider
Client- or Family- Level	Access/Utilization to Mental Health Services Stigma/Barriers to Help-seeking	<ul style="list-style-type: none"> • Number People Served (by key demographics) • Access/Utilization (e.g., number served who had prior unmet needs; number served who had experienced stigma/barriers to help-seeking prior to CDEP; number served who were 	<ul style="list-style-type: none"> • Unit of analysis (capturing individuals versus families)

		<p>psychologically distressed at program entry)</p> <ul style="list-style-type: none"> • Help-Seeking Behavior (changes over time) 	
	Psychological Distress and Functioning	<ul style="list-style-type: none"> • Psychological Distress (e.g., general improvement) • Social Isolation/Marginalization (changes over time) • Functioning (e.g., changes in impairment in performance at work, personal relationships, etc.) 	<ul style="list-style-type: none"> • How do these measures match with proposed CDEP outcomes? • Translation?
	Protective Factors	<ul style="list-style-type: none"> • Changes in spirituality/religiosity, wellness, social/community connectedness, cultural connectedness, etc. 	<ul style="list-style-type: none"> • Translation?
	Quality of CDEP	<ul style="list-style-type: none"> • General satisfaction, accessibility, quality & cultural appropriateness, perceived outcomes, cultural competence, etc. 	<ul style="list-style-type: none"> • Translation?
Organization (IPP)	Changes in organizational capacity and cultural/linguistic competency	<ul style="list-style-type: none"> • Leadership capacity • Adaptive capacity • Management capacity • Operational capacity • Cultural Competence capacity 	<ul style="list-style-type: none"> • How do CDEPs with multiple organizations complete this tool?
Community	Differences between CDEP individuals served and those served by comparable County PEI programs; business cases.	To Be Determined	
Population	Shifts in negative outcomes from untreated mental illness (e.g., substance abuse) and changes in county mental health delivery systems.	To Be Determined	
Statewide	Shifts in policy and awareness regarding mental health disparities.	To Be Determined	

Section 7: Doing Business Differently through CDEPs

CRDP Priorities

CRDP is motivated to “*do business differently*” through promotion of **community-defined evidence practices (CDEP)**. Doing business as usual typically entails the use or adoption of **evidence-based practices (EBPs)**. Since 2000, the use and expansion of EBPs (via the requirement by funders to select, adopt and implement EBPs) have been widespread, in particular by mental health departments and funders.[19] However, there are a number of pitfalls when implementing conventional EBPs in API communities that are further exacerbated in API sub-population groups. One key problem is that EBPs tend to focus on a “universalistic” approach to treatment, emphasizing the same approach for all. The evidence for EBPs are often obtained through methods that favor Western psychological approaches and outcomes that lend themselves to crisp measurement (i.e., a validated depression scale). The problem is that EBPs are developed using constructs and evidence that are largely aligned with straight, elite, Caucasian American concepts and values that are then generalized to extremely diverse communities. Further considerations related to age, gender, sexual orientation, immigration experience/generation status, and urban/rural residence must be taken into account. Yet, some attempts to “culturally adapt” EBPs have fallen short as these continue to perpetuate a top-down approach: namely outside “experts” imposing interventions on a community that they have very little understanding of. Mental health providers often struggle with the adoption of EBPs because they fail to meet the cultural, linguistic, and social needs of API (and other racial/ethnic and sexual minority groups) clients, their families, and community.[3] Furthermore, few EBPs have been developed and tested with API populations, and thus the strategies and outcomes may not be culturally or socially relevant.[20]

CRDP is a response to the fact that these EBPs are not effective in diverse communities. Through CRDP, community members are recognized as the experts of their own communities. They have the opportunity to define for themselves how mental health interventions should be implemented and evaluated based on their own values, beliefs and culture. The more the CDEPs implemented by the API IPPs reflect the values and expertise of their communities, the more effective and successful they will be.

In order to do business differently, for CRDP Phase II, the IPPs have been tasked to validate: “service delivery approaches defined by multicultural communities for multicultural communities using community-defined evidence to improve outcomes and reduce mental health disparities.”[14]

Doing Business as Usual: EBPs

DEFINITIONS

“Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.”—American Psychological Association [21]

Evidence-Based Practice (EBP) is the “use of systematic decision-making processes or provision of mental health services which have been shown, through available scientific evidence, to consistently improve measurable client mental health outcomes. Instead of tradition, gut reaction or single observations as the basis for making decisions, EBP relies on data collected through experimental research and accounts for individual client characteristics and clinician expertise.” --University of Washington [22]

The adoption and dissemination of EBPs in the mental health field is based on the idea that individuals with mental health problems should receive the best care that meets their needs and is based on the best scientific knowledge available (IOM 2000). The care should be delivered effectively with clear evidence of improving mental health and ensuring quality and accountability in the mental health care system.

Evidence: Does the program work? The value of EBPs is that there is evidence or proof that after engagement in the program (i.e., key components/services) an individual in the target population will successfully improve her/his outcome. EBPs emphasize internal validity. Can the observed changes be attributed to the program (i.e., the cause) and not to other possible causes (sometimes described as “alternative explanations” for the outcome).[23] While EBPs are successful with determining internal validity, there are often limitations with external validity which establishes the generalizability of the program to other people, places, and even time.[23] Specifically, how well does a specific EBP work for API populations?

IPPs who are interested in establishing their CDEP as an EBP should refer to the SWE Evaluation Guidelines, Section 8.

Doing Business Differently: CDEPs

DEFINITIONS

“A CDEP is defined as a set of bottom-up practices derived from a community’s ideas of illness and healing or positive attributes of cultural or traditional practices. In addition, the practice has been used by the targeted community, which has determined it to yield positive results through community consensus.” -- CRDP API IPP Solicitation (2015) [14]

A CDEP is “a set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community.” -- Martinez, 2008; Martinez, Callejas, & Hernandez, 2010 [24]

“Community-defined evidence validates practices that have a community-defined evidence base for effectiveness in achieving mental health outcomes for underserved communities. It also defines a process underway to nationally develop specific criteria by which practices’ effectiveness may be documented using community-defined evidence that eventually will allow the procedure to have an equal standing with evidence-based practices currently defined in the peer reviewed literature.” –Los Angeles County Department of Mental Health (2011) [12]

Criteria for CDEPs: Demonstrating That the Program Works

Through CRDP, the API IPPs have the opportunity to offer to the field of mental health what really works for API communities. We’ve provided some information from the literature about how others are conceptualizing CDEPs. The CDEP concept is relatively new, thus providing an opening to further define what community defined evidence means in API communities. We’d like to emphasize that the API IPPs are being asked to implement their CDEPs for CRDP without the constraints of attempting to mimic what others have done or what funders have imposed on them. They are tasked with obtaining the evidence that is going to work best for them with their priority populations. Isaacs, Huang, Hernandez, and Echo-Hawk (2005) proposed that **practitioners need to draw upon the cultural strengths and context of the community, respectfully respond to local definitions of wellness and healing, and consistently incorporate this field-driven knowledge into all phases of mental health treatment, including engagement, assessment, diagnosis, intervention, and aftercare.**[20]

The following section is based on recommendations outlined previously by Lieberman and colleagues for the Outcomes Roundtable for Children and Families (2010); Isaacs and colleagues’ Practice-Based Evidence (2005; 2008), and the Recommended Strategies for Building the Evidence and Funding Community-Defined Practice from the 2014 California Institute of Mental Health Center for Multicultural Development Summit. [20, 25, 26]

Community: The API community constitutes as much similarity as diversity. In the context of CDEPs, it is important to define the community: who is a part of the specific community and who is not. These criteria for inclusion may be based on geography (LA County residence versus Orange County), specific Asian/Pacific Islander subgroup identity, age, gender, religious affiliation, or shared history (refugee experience, time spent in probation).

Community-Defined Practices: In the policy report of the Outcomes Roundtable for Children and Families (Lieberman et al., 2010), community-defined evidence practices should be (a) community valued, (b) culturally and socially embedded, (c) heretofore unaddressed

community/population conditions, and (d) emergent issues. More specifically, they are described in the following, with extra emphasis from us on tailoring to APIs.

- a. Practices that have been implemented in API communities, have emerged locally, are accepted with general consensus, and are considered successful by the specific API community. Based upon experience and practice they are believed to be effective but have not yet been subjected to empirical testing. These practices may currently lack a developed theoretical foundation and funding may be unavailable to demonstrate efficacy in a controlled study that would meet EBP standards.
- b. Practices that are embedded in the cultural and social conditions of the API community. These address relevant and important outcomes as defined by the API community, even if they are different from traditional outcomes associated with similar EBPs.
- c. Practices that address populations, circumstances, or conditions for which EBPs have not been developed, and for which there is community consensus. This would include arenas in which science is currently silent or studies were inconclusive, populations with multiple or special needs, or service issues that reflect complexities in service population
- d. Practices that address emergent issues or concerns that have not been addressed by traditional empirical science. These issues or concerns may include disparities in research and services that have yet to be studied.

Community-Defined Evidence

“Community-defined evidence refers to the knowledge gained from a ‘community-placed’ program or practice. Such knowledge is in the form of ‘evidence’ that is obtained and gleaned through the analysis of the experience in community. Such data are often obtained from observations by program staff, participants, and members of the community who are relevant to the experiences of the participants in the program (e.g., teachers, parents in a school-based program focusing on students), the notes kept by the program staff, and records from other parts of the agency implementing the practice. Community-defined evidence should be a correlate of community-defined practice.”[27]

Evaluation or Process of validating the evidence: The process of validating evidence for CDEPs may benefit from triangulation and the use of mixed-methods approaches that is community-based and participatory rather than an empirical approach such as a randomized control trial. For example, the American Psychological Association (APA) endorses multiple types of research designs that can contribute to evidence for best practices.[21] CRDP local evaluations will likely focus on the following design types:

- Process– outcome studies are especially valuable for identifying mechanisms of change.
- Studies of interventions as these are delivered in naturalistic settings (effectiveness research) are well suited for assessing the ecological validity of treatments.

Redefining Evidence

The call to action through CRDP is to redefine what 'evidence' means for our diverse communities in California. CDEPs are a nascent and evolving concept. CRDP presents an opportunity for the IPPs to define for themselves what community defined evidence practices are and the best evidence to support their efficacy *from the ground up*. We understand that IPPs may have questions about how to define concepts such as community consensus. While we've attempted to provide some clarity in this section, we also acknowledge the wisdom of the IPPs about what works in their communities. The API TAP team is available to help IPPs think through their own definitions of these concepts and to document this for the population. Our intention is to further incorporate existing knowledge and anything that is learned through CRDP in future iterations of this document.

Technical Assistance

Section 8: Getting the Most out of API TAP Technical Assistance and Support

Special Service for Groups Research & Evaluation Team is proud to be the Asian & Pacific Islander Technical Assistance Provider (API TAP) for Phase II of the CRDP initiative. From 2016-2022, we will provide technical assistance and capacity building to the API IPPs across California. Our work will support the IPPs to test & demonstrate the effectiveness of their community-defined evidence practices. We are happy to collaborate with Harder+Company, Dr. Camillia Lui of Alcohol Research Group, and Dr. Jacqueline Tran and on this innovative and much needed project.

Special Service for Groups Research and Evaluation Team

Special Service for Groups (SSG) is a community-based 501(c)(3) nonprofit organization with a mission to support grassroots communities to develop solutions to the social, health, educational and economic issues facing those greatest in need. SSG was founded in Los Angeles during the post-World War II era in response to the Zoot Suit uprisings. To address racial tensions and youth social issues of the time, the United Way (then known as the Community Chest) formed a 'special service unit'. In 1952, SSG incorporated as its own nonprofit. SSG now operates over 20 divisions primarily in Los Angeles County, but also Orange County and San Francisco. The API TAP team is led by SSG's Research and Evaluation Team from the downtown Los Angeles office.

SSG's Research and Evaluation Team (SSG R&E) was founded in 2003 in part as a result of a community-based participatory research project with API communities funded by the Centers for Disease Control and Prevention (CDC). SSG was the lead in two Racial and Ethnic Approaches to Community Health (REACH) research projects: HAPAS (Health Access for Asian Pacific Seniors) and PATH for Women (Promoting Access to Health). In the last decade, SSG R&E has become recognized for our expertise in providing technical assistance, empowerment evaluation, and CBPR. We developed the California Community Foundation's Building a Learning Organization TA program that was piloted in 2009 and continues to be implemented to this day. In addition, we have adapted our TA approach to build capacity of advocacy grantees funded by the Liberty Hill Foundation and environmental justice organizations funded by the Los Angeles Department of Water and Power. Since 2014, SSG R&E has been working with a collaborative of over 40 social justice organizations as the local learning and evaluation team for the South Los Angeles site of the California Endowment's ten year Building Healthy Communities (BHC) initiative. We provide capacity building, technical assistance and evaluation support to the funder and the grantees involved in the BHC initiative. SSG R&E is also the National Institute of Mental Health (NIMH) Outreach Partner for Southern California. We are one of 55 organizations across the nation selected through a competitive process to educate the public about mental health research. For the 2015 annual conference at NIMH, our director, Erica Shehane, and one of our community partners were invited to present on culturally competent mental health outreach and engagement strategies in the Korean and Samoan communities.

Harder+Company Community Research

Harder+Company Community Research (H+Co) works with public sector, philanthropic and nonprofit clients throughout California to reveal new insights about the nature and impact of their work. Through high-quality, culturally-based technical assistance, evaluation, and planning, they help organizations across a wide range of areas, including health, mental health, and substance abuse, to translate data into meaningful action. They have significant experience in facilitating community-based research with diverse populations. Through previous planning and evaluation projects across California involving API populations, they bring hands-on experience and a deep understanding of the mental health issues and challenges faced by these communities.

An example of H+Co's mental health expertise is their longstanding work with the San Francisco Community Behavioral Health Services (SFCBHS), where they led the process to develop an Integrated Plan for MHSA services in that city. The process included gathering feedback from a range of API groups, including communities that reflect the greatest disparity in mental health access in San Francisco (i.e. Southeast Asian, Filipino, Samoan). Subsequently, they provided TA on program development and evaluation to MHSA-funded API agencies, including API Youth & Family Community Support Services and the API Health Parity Mental Health Collaborative. As part of this process, H+Co developed TA tools for API agencies to tailor their program objectives and develop the appropriate methods to collect evaluation data.

Subject Matter Experts

Our team includes two subject matter experts with extensive experience conducting CBPR projects with diverse Asian and Pacific Islander populations. Both Dr. Lui and Dr. Tran are long-time colleagues of SSG who are deeply trusted by our staff and community partners.

Dr. Camillia Lui is a subcontractor on the proposed team. She is an Associate Scientist at the Alcohol Research Group and Public Health Institute in Emeryville. She received her Ph.D. in Community Health Sciences at UCLA in 2012. Dr. Lui provided research and evaluation consulting for many API organizations, including Asian American Drug Abuse Program, Asian Pacific Health Care Venture, Chinatown Service Center, South Asian Network, and SSG. She previously worked for the UCLA Gambling Studies Program overseeing IRB protocols and project management of state and NIH grants and the UCLA/RAND Prevention Research Center as community liaison on a CBPR study of Filipino American families and HIV prevention. Applying both qualitative and quantitative research methods, she has worked with organizations to conduct needs assessments, adapt EBPs, and develop program evaluation systems. Her research experience covers some of the most stigmatized issues in the API communities, including alcohol and substance abuse, HIV/AIDS, problem gambling, and mental health for LGBT populations.

Dr. Jacqueline Tran is a subcontractor on the proposed team. She received her doctorate in public health in 2013 from UCLA. She was a staff member at the Orange County Asian and Pacific Islander Community Alliance (OCAPICA) from 2001 to 2012, assuming various positions, including Acting Executive Director in 2008; Community Director of Weaving an Islander Network for Cancer Awareness, Research and Training in 2010 and 2011, where she worked with five Pacific Islander organizations in Southern California on community outreach and engagement, research, and training; Director of Health Programs in 2007 to 2012; and Director of the Center of Excellence to Eliminate Disparities (CEED) in 2007 to 2012, where she provided oversight of a 5-year project funded by the CDC. Through her research and community experience, Dr. Tran developed a strong network of relationships with particularly Southeast Asian and Pacific Islander organizations throughout California, such as Hmong Women's Heritage Association in Sacramento, Lao Family Community in Stockton, and Union of Pacific Asian Communities (UPAC) in San Diego. She is a current member of the IRB for both SSG and the Asian Pacific Community Health Organizations in Oakland.

For more information about our team, please refer to Appendix 3 and visit our website: http://www.ssgresearch.org/api_tap

API TAP Team's Approach and Philosophy

Our approach to providing TA is based on our understanding of Phase II of the CRDP and our significant experience with California's API populations and subpopulations. We regard community members (youth, clients, family members, etc.) as change agents, and not as individuals with deficits who need their problems solved. We intend to provide TA and training in ways that allow API IPPs to utilize *community-participatory evaluation* processes, which recognize service providers, key stakeholders and community members as knowledge producers and experts, ultimately facilitating community ownership and leadership. We will also practice *appreciative inquiry* to arrive at a better understanding of not only the problems, but also the collective ideas about community strengths and possibilities. The API TAP team brings a set of core values and skills to ensure the highest quality TA to promote the success of the CRDP as a whole. These values and skills are described below.

Dynamic and Highly Customized Approach to Technical Assistance: We have learned through our own experiences providing TA and also our own research about what makes TA effective, that the provision of TA is nonlinear and should always be highly customized. There may be many similarities among the API IPPs, yet there may also be significant differences with respect to organizational infrastructure, language, urban/rural culture, community histories, spirituality/religion and ethnic culture. While we will provide TA and training that is based on evidence and best practices in the field, our team will ensure that TA is also tailored to the specific needs of the API IPPs. Culturally relevant TA goes far beyond language and ethnic culture. Our TA and training approach includes:

- A genuine interest in and willingness to learn about a specific community (i.e., humility),

- Ability to adapt methods and content to specific contexts (i.e., relevance to communities/organizations),
- Organic processes that allow for evolution and application of models (i.e., integration into current work), and
- Ability to build upon existing strengths and infrastructures (i.e., leveraging of resources).

Relationships and Trust-Building: We recognize that the IPPs are entering the CRDP with considerable strengths and respect from their local communities. We designed our API TAP team to prioritize relationship-building with the API IPPs, their local evaluators and their community stakeholders. Each staff member on the project team brings expertise in entering diverse communities with respect and care. The majority of the API TAP team members have existing quality relationships with API organizations and collaboratives across California. When establishing new relationships, our approach always involves deep listening and honoring the inherent assets of every individual and organization.

Partnership and Collaboration: The API TAP team has worked on numerous large-scale projects that require coordination among multiple stakeholders representing diverse entities. We understand the importance of highly effective and timely communication in these types of projects to prevent siloed efforts and to help all parties take coordinated actions that support a shared vision. Our approach accounts for close partnership and collaboration with OHE staff, other TA Providers, the SWE, and the IPPs throughout the duration of the project. We expect that we will often act as a liaison among the API IPPs, other populations in CRDP and the SWE.

Overview of TA and Training Process

The TA and training will be highly customized and tailored to address the specific needs of API IPPs as identified in the IPP Assessments and TA and Training Plans that we develop of each API IPP in April and May of 2017. Although the seven API IPPs may be entering this phase of the project with varying capacities and needs, we anticipate that many, if not all, will have significant expertise in certain areas that could benefit their peers. Based on our understanding of the CRDP objectives to do business differently and to build community capacity, we offer a TA approach that cultivates a *community of practice* among the API IPPs. Throughout the duration of the project this community of practice will facilitate rich opportunities for peer learning, relationship building and partnership that we hope extend even beyond CRDP. Specifically, we plan to achieve this through monthly phone calls with each IPP, annual peer learning circles, small group trainings, IRB review (if needed) and capacity building and on-going technical assistance.

We will assign TA leads for each API IPP. This will allow the API TAP team members to develop close relationships with the IPPs and gain a thorough understanding of their CDEP, community culture and historical context. We will ensure that more than one API TAP team member has in-depth understanding of each IPP to allow for team member coverage and knowledge transfer.

Monthly Phone Calls: The assigned API TAP team member(s) will conduct monthly phone calls with each IPP as a scheduled opportunity to monitor progress and assess on-going TA needs. We will collaborate with each IPP to determine who from their organization should participate in the calls and how to structure the calls to ensure the best use of time. We expect these calls to be informal check-ins that allow the IPPs to bring up any issues or questions and provide opportunity for collaborative trouble-shooting and planning. It will also be an opportunity to discuss how the IPPs are applying the information they learned through the small group trainings. Our team will also make available alternative modes for the calls, such as video conference or webinar, should the IPPs prefer.

Annual Peer Learning Circles: We understand the importance of facilitating opportunities for the API IPPs to learn from one another and not just from the API TAP team. We plan to create opportunities for the API IPPs to share information, tools, and best practices through a *community of practice*. We propose to engage the seven API IPPs in Annual Peer Learning Circles in Years 2-6, which will be one-day in-person gatherings that focus on reflection and shared learning. As part of our on-going TA, we will assess each IPP’s ability and interest to participate in the planning and facilitation of the Learning Circles. However, it will be the full responsibility of our API TAP team to ensure the successful completion of the Learning Circles.

Small Group Trainings: The API TAP team will offer up to five small group, in-person trainings per year that will last at least two hours and will be highly interactive in nature. We plan to tailor each training for 2-4 specific IPPs depending on their geography and training needs. As part of our scope, we will cover travel expenses for 1-2 people to attend from the IPPs for whom the training is tailored. Other IPPs will be notified of the training and invited to participate virtually or in-person (but covering their own expenses).

The sequencing of the training series over the five-year period will strategically build organizational capacity to plan, implement, evaluate, refine, and scale programming. We will also consider where the API IPPs are in their project phase and plan to align the timing of training to their implementation phase so that they have the opportunity to apply what has been learned. For example, Year 1 trainings may focus on organization and business development and evaluation basics, so that trainings in subsequent years can expand into scaling programs, non-traditional evaluation methods, and publication/dissemination. The final year will prepare IPPs for the final convening. The API TAP team will work with the IPPs to prioritize topics and determine the appropriate sequencing of trainings.

TA Activity	Timeline
API IPP site visits and assessments <ul style="list-style-type: none"> One per IPP 	March 2017: Initial site visits April 2017: Initial assessment 2018-2021: Updated annually
API IPP TA & Training Plans <ul style="list-style-type: none"> One per IPP 	May 2017: Initial TA/training plan 2018-2021: Updated annually

Monthly phone calls with each IPP	On-going
Annual Peer Learning Circles <ul style="list-style-type: none"> • Convening of all 7 IPPs 	2018- 2021: Once per year
Small group trainings <ul style="list-style-type: none"> • Up to five per year for 2-4 IPPs • Based on need and geography 	On-going
On-going technical assistance <ul style="list-style-type: none"> • Coordinated on individual basis 	On-going

Role of the API TAP team

The structure of the CRDP initiative requires that various contractors and grantees work in close collaboration and partnership. The API TAP team’s primary responsibility is to support the API IPPs with specific capacity building needs that may arise. We understand that at any given point in time the needs of the IPPs might be very broad and varied. Our team is committed to helping IPPs problem solve as needs arise. However, in order to be good stewards of the public funds that are supporting our work, we will prioritize TA needs that are directly related to CRDP. A summary of the specific TA and training support that our team is prepared to provide is shown in Box 5.

Box 5: Technical Assistance and Training Priorities for CRDP

API IPPs are able to receive support from the API TAP team through technical assistance and training related to the following content areas:

- Board development, including selection, recruitment and governance, as appropriate;
- Resource development, including partnership development, marketing, fundraising and grant writing, as appropriate;
- Business development, including financial, human resources, information technology and program management, as appropriate;
- Regulatory compliance, including HIPAA, as appropriate;
- Other core operational requirements, as identified;
- Community outreach and engagement;
- Marketing and promotion, including development of collateral materials;
- Program development;
- Continuous quality improvement strategies;
- Evaluation planning, design and implementation;
- Data collection, including measurement of baseline;
- Engaging community members in the evaluation process;
- Seeking recognition as an evidence-based practice or program;
- Hiring an appropriate evaluator;
- Refining a program evaluation budget; and
- Obtaining IRB approval of research protocols, as necessary

Source: State of California Health and Human Services Agency California Department of Public Health (September 2015). Solicitation #15-10609, California Reducing Disparities Project Phase 2 Asian Pacific Islander Technical Assistance Provider.

Roles Related to Evaluation

CRDP is essentially a complex evaluation project, with evaluation occurring at every level of the initiative. Each of the contractors/grantees play a critical role to ensure that data collected at each level is rigorous, while remaining reflective of diverse communities in which CRDP is being implemented. The SWE, TAPs and IPPs will all be responsible for evaluation throughout the project. A broad summary of the various roles each entity will play is outlined in Table 5.

Table 5: Roles related to evaluation	
Contractor/Grantee	Evaluation Roles
API IPPs and Local Evaluators	<ul style="list-style-type: none"> • Implement evaluation of CDEPs, including all data collection & data analysis • Work directly with community stakeholders to include them throughout evaluation process
API TAP	<ul style="list-style-type: none"> • Provide TA and training to API IPPs/local evaluators related to local evaluation and collection of data for SWE core measures

	<ul style="list-style-type: none"> • Collaborate with SWE & API IPPs to ensure local evaluations are consistent with statewide evaluation • Ensure consistent evaluation priorities, definitions, and processes among API IPPs • Support API IPPs to ensure meaningful community engagement in evaluation process • Coordinate with other TAPs, SWE and OHE to ensure consistency in approach
SWE	<ul style="list-style-type: none"> • Implement evaluation of entire CRDP Phase II initiative • Provide guidance to TAPs to ensure consistency among all 35 IPPs related to core measures for statewide evaluation • Provide subject matter expertise to TAPs as needed • Conduct interviews/focus groups with TAPs and IPPs to collect data about CRDP processes and impact

The API TAP team plans to work closely with the API IPPs and their local evaluators to ensure that IPPs are consistently implementing certain evaluation processes. It is also our responsibility to act as a liaison with other TAPs, the SWE and OHE to ensure that the guidance we provide to API IPPs is aligned with other populations, the statewide evaluation plan and expectations from OHE. We acknowledge that evaluation processes for CRDP are likely to be iterative in nature. The API TAP team plans to work closely with all CRDP partners to ensure that when course corrections are needed, there is good rationale for doing so, that these decisions can be documented and that API IPPs have the support they need to make any necessary modifications.

Getting the Most out of TA

We expect that the API IPPs funded through CRDP are open to the idea of additional help and expertise provided through TA. In our experience, however, many community-based organizations (CBOs) have had little experience working with technical assistance providers in a formal way. In this section, we’re hoping to demystify the TA process by consolidating the collective expertise the API TAP team has gained by providing TA with hundreds of CBOs.

TA is the process of providing targeted support to an organization to address a specific need. Our approach to TA involves tailoring and customization to meet the specific needs of the IPPs; delivery over a period of time to provide support as the IPPs learn and apply the new skills; responsiveness to changing dynamics and conditions; and reflection of our social justice values and commitment to community priorities.

The following are eight key actions IPPs can take to maximize the impact of TA provided through CRDP.

1. **Identify specific goals for TA.** Determine the specific needs of the IPP at a given point in time. It might be helpful to consider goals for each year of the CRDP initiative. What are the expected outcomes for TA in Year 1, Year 2, etc.? How will the organization and/or collaborative be different as a result of TA?
2. **Assess available staff resources.** Working with the API TAP team will require an investment of staff time. Consider how much time the IPP team has to collaborate with the API TAP team. Also, consider if there are key moments during the project when TA will be especially needed.
3. **Obtain buy-in from leadership and staff.** Ensure that leadership and staff understand CRDP and the TA component of the initiative. Seek agreement within the IPP organization/collaborative about expectations of TA and anticipated results.
4. **Dedicate a team to work with the TA Provider.** TA will have the most impact if a specific team from each IPP can dedicate time to work with the TA provider to learn and apply new skills/techniques. Ensure that the IPP team understands that collaborating with the API TAP team is an essential component of their work. Prepare the team to do work between TA training/coaching sessions to maximize time with the API TAP.
5. **Communicate honestly and clearly.** The more transparent IPPs can be about specific needs, concerns and expectations, the more TA can be modified to address these. The API TAP team will work with each IPP to establish clear communication and feedback mechanisms early in the TA process. Be explicit about who has the authority to make key decisions related to TA and organizational changes.
6. **Apply what you learn.** Create a practice of applying what is learned through TA in immediate and concrete ways. Engage the IPP staff/collaborative partners to identify specific action steps after each TA interaction. Work with the API TAP team to troubleshoot and adapt as you apply new skills and techniques acquired through the TA process.
7. **Lean into change.** TA facilitates a change process. Be open to change and have specific conversations with the IPP team/leadership about how planned changes will benefit the organization/collaborative. Seek help from the API TAP team if there is resistance to certain changes to ensure that TA can be responsive to these dynamics.
8. **Plan for retention of knowledge at the organization level.** CBOs often have staff turnover that can be difficult to anticipate. Develop processes and protocols to ensure that skills and knowledge gained from TA are shared across multiple team members. This can include sharing materials from workshops across the organization and conducting peer learning sessions to allow staff who receive TA to share their knowledge with the rest of the organization/collaborative.

As stated throughout this section, the API TAP team is committed to being highly responsive to the needs of the API IPPs. We're prepared to help IPPs address any questions or concerns that arise throughout the course of the project. We may not be able to meet every need. But we are committed to listening to the IPPs and walking with the IPPs to problem solve issues.

Measuring the Impact of TA

Throughout the course of CRDP, the API TAP team will also be practicing evaluation of the TA that we provide. We plan to use the IPP assessments and annual updates as a way to document IPP needs and how responsive TA has been to address those needs. We also will ask IPPs how their organizations have evolved or changed during the course of CRDP. We will use this information to assess what types of TA have been most used and most helpful as well as what formats are most conducive to learning for various topics. As we learn what is most effective for the API IPPs, we will adjust our approach. We commit to providing opportunities for IPPs to provide feedback to the API TAP team about how we are doing. We also intend to reduce barriers to make it easy for IPPs to give input. Our specific strategies for this will be discussed with each IPP during the assessment phase.

Appendix 1: Acronyms

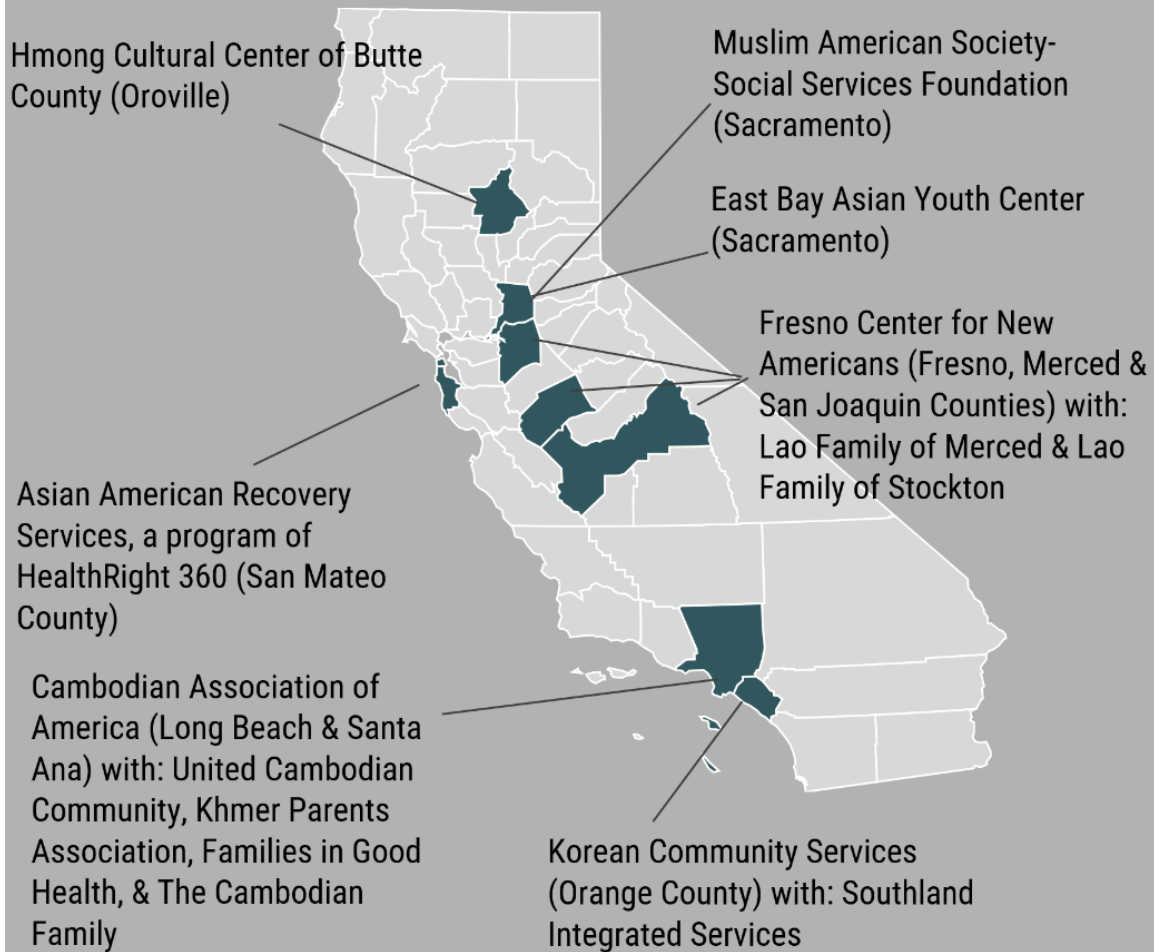
AANHPI	Asian Americans, Native Hawaiians, and Pacific Islanders
AARS	Asian American Recovery Services
API	Asian and Pacific Islander
API-SBCWP	Asian Pacific Islander Strength Based Community Wellness Program
BHC	Building Healthy Communities
CAA	Cambodian Association of America
CAC	Cambodian Advocacy Collaborative
CANS	Child and Adolescent Needs and Strengths
CBO	Community-based organization
CBPR	Community-based Participatory Research
CDC	Centers for Disease Control
CDEP	Community-defined Evidence Practice
CDPH	California Department of Public Health
CEED	Center of Excellence to Eliminate Disparities
CMHDA	California Mental Health Directors Association
CMHPC	California Mental Health Planning Council
CPEHN	California Pan-Ethnic Health Network
CRDP	California Reducing Disparities Project
EBAYC	East Bay Asian Youth Center
EBP	Evidence-based practice
FCNA	Fresno Center for New Americans
FiGH	Families in Good Health
HAPAS	Health Access for Asian Pacific Seniors
HCCBC	Hmong Cultural Center of Butte County
HR360	HealthRIGHT 360
ICC	Integrated Care Coordinators
IPP	Implementation Pilot Project
IRB	Institutional Review Board
KCS	Korean Community Services
KPA	Khmer Parents Association
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer & Questioning
LMU	Loyola Marymount University
MAS-SSF	Muslim American Society-Social Services Foundation
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
NHPI	Native Hawaiians and Pacific Islanders
NIMH	National Institute of Mental Health
OCAPICA	Orange County Asian and Pacific Islander Community Alliance
OHE	Office of Health Equity
PARC	Psychology Applied Research Center

PATH	Promoting Access for Health
PEI	Prevention and Early Intervention
PTSD	Post-traumatic Stress Disorder
R&E	Research and Evaluation
REACH	Racial and Ethnic Approaches to Community Health
SAM	South Asian Muslim
SEA	Southeast Asia
SEA MHC	Southeast Asian Mental Health Collaborative
SFCBHS	San Francisco Community Behavioral Health Services
SIS	Southland Integrated Services, Inc.
SPW	Strategic Planning Workgroup
SSG	Special Service for Groups
SWE	Statewide Evaluator
TA	Technical Assistance
TAP	Technical Assistance Provider
TCF	The Cambodian Family
UCC	United Cambodian Community
UPAC	Union of Pacific Asian Communities

Appendix 2: API IPPs

Asian & Pacific Islander (API) Population

CRDP API Pilot Projects



Appendix 3: API TAP Team

Meet the CRDP API TAP Team

Special Service for Groups Research and Evaluation Team (SSG R&E)



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Subject Matter Experts



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