**CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)**

# PHASE 2 STATEWIDE EVALUATION GUIDELINES
# 2017

Psychology Applied Research Center @ Loyola Marymount University

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# ACRONYMS

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

# ABOUT THE STATEWIDE EVALUATION GUIDELINES

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

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

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

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

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

But as we can see from the car metaphor above, it's a partnership. Each of us has a vital and essential role to play. The SWE Guidelines serve as a resource for IPPs, their community members, local evaluators, the TAPs, CDPH, and other key stakeholders to establish culturally

and linguistically credible evidence for CRDP Phase 2 and the CDEPs.  The Guidelines also serve to establish a shared understanding of our respective roles in this initiative.
The CRDP Phase 2 SWE Evaluation Guidelines provide an overview of:

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

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

- [Centers for Disease Control and Prevention (CDC) Framework for Program Evaluation in Public Health](#)
- [A Framework for Program Evaluation: A Gateway to Tools](#)
- [American Evaluation Association](#)
- [RAND Corp: Program Evaluation](#)
- [Penn State Extension Program Evaluation Resources](#)

*Individually, we are one drop. Together, we are an ocean.*
-Ryunosuke Satoro

# INTRODUCTION

**Overview**

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

**Interrelated Elements**

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

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

**Interrelated Evaluation Levels**

CDPH requires that an evaluation be conducted by PARC@LMU and by evaluators at each IPP. This requirement constitutes three interrelated levels of evaluation activity:

1. Individual IPPs supported by a priority population TAP and PARC@LMU will evaluate their CDEPs to determine the effectiveness of interventions in preventing mental illnesses from becoming severe and disabling in the communities they are serving.

2. The TAPs will prepare guidelines to ensure consistency across the IPPs for each population group. This includes data definitions and collection methods, common outcome measures as is practical and evaluation methods/approaches.
3. Every Phase 2 component (IPPs, TAPs, EOA, SWE, CDPH) will be assessed by the SWE to determine if each individual component, and Phase 2 as a whole, are effective in achieving the goals of CRDP, including developing a business case and evaluating the potential to reduce mental health disparities by expanding effective strategies to a statewide scale.

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

**CDPH Defined Contractor Responsibilities**

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

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

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

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

collecting or providing SWE data required by PARC@LMU.  CDPH has the sole discretion to accept or reject the Updated Evaluation Plan.

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

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**CDPH DEFINED Evaluation Responsibilities Checklist**

☐ IPPs will work with their TAP to finalize their local evaluation plan and submit to CDPH by May 26th, 2017.

☐ IPPs are responsible for collecting the SWE core measures as part of their local CDEP evaluation.

☐ PARC@LMU will review all CDEP Evaluation Plans and provide recommendations to CDPH and the IPPs on how to improve them, if warranted.

☐ IPPs will revise the CDEP evaluations as appropriate.  TAPs and PARC@LMU will support IPPs in these revisions.

☐ IPPs will submit Annual Updates to CDPH within 60 days after the end of each grant year; IPPs, TAPs, and EOA will complete and submit a SWE semi-annual report until the end of the data collection period.

☐ PARC@LMU will provide ongoing technical assistance and support to TAPs, IPPs, and the local evaluators and throughout the implementation stage related to the CDEP evaluation or SWE core measures.

☐ TAPs and PARC@LMU will provide ongoing support throughout the implementation stage of their CDEP evaluation to help refine and troubleshoot issues that may arise.

☐ IPPs will consult with TAPs regarding any TA needs.

☐ IPPs will provide a CDEP Final Evaluation Report that details the results/outcomes of their CDEP at the end of the data collection period.

☐ PARC@LMU will review the CDEP evaluation reports and provide recommendations and solutions to CDPH on how to improve them, if warranted.

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# SECTION 1:  THE CRDP PHASE 2 PARTNERS

*When you have people together who believe in something very strongly - whether it's religion or politics or unions - things happen.*
-Cesar Chavez

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

## The Implementation Pilot Projects (IPPs)



## African American

- **California Black Women's Health Project** (Los Angeles, Alameda, Sacramento and San Bernardino County)
  - CDEP:  *Sister Circle*
- **Healthy Heritage Movement** (Riverside and San Bernardino County)
  - CDEP: *Broken Crayons…Still Color*
- **Whole Systems Learning** (Los Angeles and Riverside County)
  - CDEP: *Turning Resilience into Brilliance for Eternity*
- **Catholic Charities of the East Bay** (Richmond and Oakland)
  - CDEP: *Restorative Trauma-Informed Practices for Teens*
- **Safe Passages** (Oakland)
  - CDEP: *Law and Social Justice Pipeline*
- **The Village Project** (Monterey County)

- CDEP: *Emanyatta ("Warrior's Camp")*
- **West Fresno Health Care** Coalition (Fresno County)
  - CDEP: *The Sweet Potato Project*

## Asian and Pacific Islander

- **Hmong Cultural Center of Butte County** (Butte County)
  - CDEP: *Zoosiab Program*
- **Muslim American Society: Social Services Foundation** (Sacramento County)
  - CDEP: *Shifa*
- **Cambodian Association of America** (Long Beach and Santa Ana)
  - CDEP: *API Strength-Based Community Wellness Program*
- **East Bay Asian Youth Center** (Oakland and Sacramento)
  - CDEP: *GroundWork Program*
- **Fresno Center for New Americans** (Fresno, Merced and San Joaquin Counties)
  - CDEP: *Southeast Asian Cross Cultural Counseling Model*
- **HealthRIGHT 360** (North San Mateo County)
  - CDEP: *Asian American Recovery Services*
- **Korean Community Services** (Orange County)
  - CDEP: *Promotora ("Community Health Workers")*

## Latino

- **Humanidad Therapy and Education Services** (Sonoma County)
  - CDEP: *Humanidad Therapy and Education Services*
- **Integral Community Solutions Institute** (Fresno County)
  - CDEP: *Platicas and el Circulo*
- **Latino Service Providers** (Sonoma County)
  - CDEP: *TESTIMONIOS*
- **Health Education Council** (24 Counties)
  - CDEP: *Ventanilla de Salud*
- **La Clinica de La Raza** (Alameda County)
  - CDEP: *Cultura y Bienestar*
- **La Familia Community Counseling** (Sacramento County)
  - CDEP: *Cultura de Salud*
- **Mixteco-Indigena Community Organizing Project** (Ventura County)
  - CDEP: *Living with Love*

## LGBTQ

- **Gay & Lesbian Center of Bakersfield** (Kern County)
  - CDEP: *Reducing Isolation through Support and Empowerment*
- **Gender Health Center** (Sacramento County)
  - CDEP: *Mental Health, Health Advocacy, Community-Building Social and Recreational Programming*
- **San Joaquin County Pride Center, Inc.** (San Joaquin County)

- CDEP: *Mental Health Access and Youth Empowerment Program*
- **Asian & Pacific Islander Wellness Center** (San Francisco Bay Area)
  - CDEP: *Touchpoints*
- **Gender Spectrum** (San Francisco Bay Area)
  - CDEP: *Gender Spectrum*
- **On The Move** (Napa, Sonoma, and Solano County)
  - CDEP: *OASIS Model*
- **Openhouse** (San Francisco Bay Area)
  - CDEP: *Community Engagement Program*

**American Indian/Alaska Native**

- **Friendship House Association of American Indians** (San Francisco and Alameda County)
  - CDEP: *Friendship House Youth Program*
- **Indian Health Center of Santa Clara Valley** (Santa Clara County)
  - CDEP: *Classes and the Gathering*
- **Indian Health Council, Inc.** (San Diego County)
  - CDEP: *REZolution*
- **Native American Health Center** (Alameda, Contra Costa and San Francisco County)
  - CDEP: *Gathering of Native Americans*
- **United American Indian Involvement, Inc.** (Los Angeles County)
  - CDEP: *The Native Drum, Dance and Regalia Program*
- **Sonoma County Indian Health Project, Inc.** (Sonoma County)
  - **CDEP:** *Aunties and Uncles Program*

# The Technical Assistance Providers (TAPs)

## TAPS At-A-Glance

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

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

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

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

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

**African American TAP:**

*ONTRACK Program Resources*

Email: mcrucker@ontrackconsulting.org

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

**Latino TAP:**

*University of California, Davis*

Email: aguilargaxiola@ucdavis.edu

UC Davis is a member of the University of California system. The team primarily operates out of Sacramento. The project will be led by Dr. Sergio Aguilar-Gaxiola of the Center for Reducing Health Disparities. Dr. Aguilar-Gaxiola is the Founding Director of the Center for Reducing Health Disparities, a World Health Organization scientist and was the Latino population lead for CRDP, Phase I. He has over 25 years of experience directing federal, state and foundation funded research programs that focused on community engaged approaches to reducing health disparities. The team will include Dr. Linda Ziegahn, Dr. Heather Diaz and Dr. Gustavo Loera, who will each be responsible for working closely with two to three pilot projects. In addition, Rachel Guerrero will advise on cultural and linguistic competence and support the development of materials and curricula.

**API TAP:** *Special Services for Groups*

Email: eshehane@ssg.org

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

**LGBTQ TAP:**

*Center for Applied Research Solutions*

Email: knakai@cars-rp.org

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

**American Indian/Alaska Native TAP:**

*Pacific Institute for Research and Evaluation*

Email: roland@prev.org

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

COMING SOON

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



**PARC At-A-Glance**

PARC@LMU General Information: http://bellarmine.lmu.edu/psychology/parc/

My SWE contact
    General information or requests for evaluation technical assistance & support:
    Diane Terry           diane.terry@lmu.edu, 310.338.7095

PARC priority population SWE team assignments:
    → African American           Deanna Cooke
    → Asian and Pacific Islander    Jennifer Abe
    → Latino                   Sandra Villanueva
    → LGBTQ               Negin Ghavami
    → American Indian/Alaska Native   Cheryl Grills

    Additional information:
    → Business Case    Sean D'Evelyn
    → Data Analysis    Ben Fitzpatrick
    → The Alliance      Cheryl Grills

**About PARC@LMU**

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

**PARC's Core Values**

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

The core values guiding the PARC SWE are:
- *Shared Vision* – creating a common identity, purpose, and commitment with IPPs, local evaluators, TAPs, EOA, and CDPH about the CRDP Phase 1 and Phase 2 goals and objectives;

- *Inclusiveness* – engaging diverse stakeholders and those most affected by mental health disparities to create intended change at the local and state levels;
- *Collaboration* - working cooperatively to get the SWE and CDEP evaluations successfully implemented;
- *Flexibility* - adapting and making changes to the SWE and CDEP evaluations to meet local circumstances;
- *Empowerment* - helping IPPs to develop lasting skills in evaluation that strengthen organizational capacity; and
- *Cultural Responsiveness* - viewing the strengths and needs of the specific populations served by the IPPs within the context of their cultural, linguistic, organizational, community, historical, and intersectional perspectives.

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

**PARC Subject Matter Specialists**

PARC@LMU will be working collaboratively with a team of specialists known as The Alliance, on cultural issues connected to the priority populations. As specialists in matters of culture and identity, they will provide TA and support to PARC to inform specific SWE deliverables. They are members and representatives of three ethnic psychology organizations, one research center, and members of a division of the APA.

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

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

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

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

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

# Say Hey to SWE!

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

Cheryl.Grills@lmu.edu

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

Sandra.Villanueva@lmu.edu

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

Diane.Terry@lmu.edu

Christopher.Hill@lmu.edu

Jennifer.Garcia@lmu.edu

Zachary.Stamper@lmu.edu

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

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

Brian.Clark@lmu.edu

**Zach Stamper** is a Research Assistant who has worked on federal and state level efforts focused on sexual assault, food programs, and monitoring of online tobacco sales.

**Aisha Walker** is a Research/Administrative Coordinator who has examined racial microagressions and discrimination for African American women in the workforce.

Aisha.Walker@lmu.edu

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

**Deanna Cooke, Ph.D.**
deanna.cooke@lmu.edu

Her specialty areas are community-based collaborative research, education evaluation, youth social development programs, novel teaching pedagogies, public policy change efforts, and public health issues

**Jennifer Abe, Ph.D.**
jennifer.abe@lmu.edu

Her specialty/areas are Asian American mental health; cultural competence; culture, spirituality, place, and identity; and liberation psychologies.
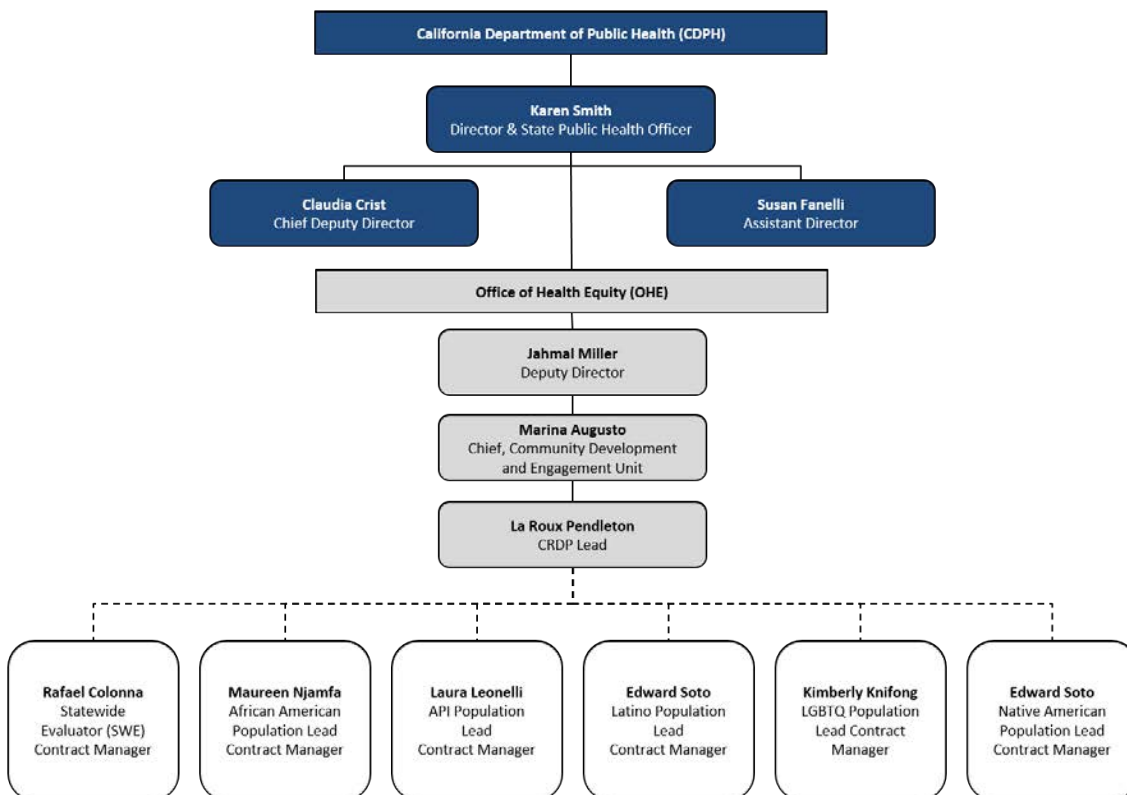
**Ben Fitzpatrick, Ph.D.**
bfitzpatrick@lmu.edu

His specialty areas include applied mathematics and statistics, and quantitative analyses in collaboration with diverse stakeholders such as engineers, researchers, and policy makers.

The Association of Black Psychologists

Asian American Psychological Association

**Garland Kirkpatrick, M.F.A.**
garland.kirkpatrick@lmu.edu

His areas of specialty areas include communications/publications design, & social graphics in collaboration with artists, education and community groups related to social justice campaigns, visual identities, and other publishing projects.

**Senior Research Associates and Partners**

**Nora Murphy, Ph.D.**
nora.murphy@lmu.edu

Her areas of specialty are meta analysis, large datasets involving intensive analytic plans, sophisticated statistical modeling techniques, nonverbal communication, perception, emotion psychology & aging.

APA Division 44

National Latino Psychological Association

Indigenous Wellness Research Institute

**Sean D'Evelyn, Ph.D.**
sdevelyn@lmu.edu

His areas of specialty are public economics, environmental economics, experimental economics, labor economics, and statistics, and environmental cost benefit analysis.

**Negin Ghavami, Ph.D.**
negin@ucla.edu

Her areas of specialty are social processes that produce social inequity or promote social justice, sexual orientation combined with ethnicity and gender and how they shape stereotypes, prejudice, discrimination and inequity.

**The California Department of Public Health**

**CRDP At-A-Glance**

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

# CRDP within the context of CDPH [1]



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# SECTION 2: THE PUBLIC HEALTH APPROACH TO MENTAL HEALTH

*"Behavioral health is essential…prevention works, treatment is effective, and people recover from mental and/or substance use disorders."*
-Substance Abuse and Mental Health Services Administration

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

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

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

## Level of Prevention

Within public health, prevention occurs at three levels:

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

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

## Type of Program

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

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

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

**"Visual to Come"**

## Prevention Strategy

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

- *Universal* prevention strategies are designed to reach the entire population
- *Selective* prevention strategies address "at-risk" subgroups within the general population. Individuals who are part of an at-risk group, may or may not exhibit problem behavior themselves (e.g., youth in the foster care system)

- *Indicated* prevention strategies focus on individuals who exhibit high-risk behaviors. This type of prevention strategy includes tailored interventions for individuals who may not have a clinical diagnosis, but are exhibiting serious problematic behavior.

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

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**Prevention Strategies: A Substance Abuse Prevention Example**

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

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

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

Source: Texas DSHS

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## Health Promotion

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

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

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

3) **Use an asset-model rather than deficit-model to identify and build upon pre-existing strengths and resources in communities.** Deficit-model thinking tends to focus on the "problems that need fixing" within a community, which often obscures or ignores different forms of cultural wealth, experience and wisdom of community members, and

non-Western healing practices (e.g., talking circles and drumming led by traditional Indian healers) (Native American Population Report, 2012).

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

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

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

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

# SECTION 3: THE MENTAL HEALTH SERVICES ACT & PREVENTION AND EARLY INTERVENTION

*Health equity' means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.*
–California Health and Safety Code Section 131019.5

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

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

**About PEI**

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

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

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

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

**PEI and CRDP**

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

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

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

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

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

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

**MHSA Prevention & Early Intervention: Program Evaluation Standards and Regulations**

| | Name | Definition | Types of Indicators | Levels of Outcomes | Short-Term and Intermediate Outcomes | Long Term Outcomes (Public Health) |
|---|---|---|---|---|---|---|
| | **Direct Programs**: intend to reduce MHSA-specified "negative outcomes" that "may result from untreated mental illness" for individuals with risk (Prevention) or early onset (Early Intervention) of a mental illness. | | | | | |
| **Direct Prevention** | Early Intervention Program | Directed toward individuals and families for whom a short (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve mental health problems or concerns very early on in its manifestation, and avoid the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse | Unduplicated number of individuals served annually | Individual and Family | **-Mental health recovery** (e.g., healthy relationships, physical health, stable living situation)<br><br>**-Reduction of symptoms/negative outcomes** (anxiety, trauma, crisis, first break/TAY; depression, emotional dysregulation difficulties, disruptive behavior disorders, severe behaviors/conduct disorder, parenting and family difficulties) | **Reduced Suicide**<br><br>**Mental Health Related**: prolonged suffering, incarceration, homelessness, school drop-out, out of home removal, unemployment, differences across groups |
| | Prevention Program | Reducing individual/family or community risk factors or stressors, building protective factors and skills, and increasing support; promotes positive cognitive, social and emotional development and encourages a state of well-being | Unduplicated number of individuals served annually<br><br>Community activities | Individual and Family<br><br>Community | **-Reduced risk or sub clinical manifestation of mental illness & other indicators related to negative outcomes**<br><br>**-Increased protective factors** (risks/protective factors: social, environmental, economic determinants, individual, family) | |
| | **Indirect Programs**: goals include early and prompt access to treatment and other mental health services and supports, and/or changes in someone's attitude, knowledge, and/or behavior that are likely to facilitate access to mental health services | | | | | |
| **Indirect Prevention** | Timely Access to Services for Underserved Populations | To increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program | Unduplicated number of individuals referred | Individual and Family<br><br>Program and Service | **-Number of individuals referred who followed through with referral** (participated at least once)<br><br>**-Average interval between referral and participation in service** | |

| | Name | Definition | Types of Indicators | Levels of Outcomes | Short-Term and Intermediate Outcomes | Long Term Outcomes (Public Health) |
|---|---|---|---|---|---|---|
| | | features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services | | | **-Duration of onset of risks for referred individuals (interval between onset and entry into treatment)**<br><br>**-Dosage of Treatment** | |
| | Access and Linkage to Treatment for People with Serious Mental Illness | Connecting children, adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs | Unduplicated number of individuals referred<br><br>Kinds of treatment referred | Individual and Family | **-Number of individuals referred who followed through with referral** (participated at least once)<br><br>**-Duration of untreated mental illness for referred individuals (interval between onset and entry into treatment)**<br><br>**-Dosage of treatment** | |
| | Outreach for Increasing Recognition of Early Signs of Mental Illness | A process of engaging, encouraging, educating, and/or training and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. | Number, type, and setting of potential responders engaged (e.g., school, orgs, clinic; principals, teachers) | Program and Service | | |
| | Stigma and Discrimination Reduction | Direct <u>activities</u> to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families | | Individual and Family<br><br>Community | **Changes in knowledge, attitudes, and/or behaviors** related to mental illness or seeking mental health services (within priority community) | |

| | Name | Definition | Types of Indicators | Levels of Outcomes | Short-Term and Intermediate Outcomes | Long Term Outcomes (Public Health) |
|---|---|---|---|---|---|---|
| | Non-Stigmatizing and Non-Discriminatory Service Delivery Implementation Strategy | Promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and make services accessible, welcoming, and positive | Types of strategies used, | Program and Service | **Changes in attitudes** towards mental illness and increased accessibility of services | |
| | Suicide Prevention | Organized activities to prevent suicide as a consequence of mental illness; does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness | | Community | **Changes in knowledge, and/or behaviors** related to preventing suicide associated with risk or presence of mental illness | |

# SECTION 4: THE STATEWIDE EVALUATION PLAN AT-A-GLANCE

*Simple Rule #1: Evaluations of complex, major initiatives are not experiments, but part of the community change process.*
-Thomas Kelly, Jr., The Annie E. Casey Foundation

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

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

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

**The SWE At-A-Glance**

> ❖ The SWE is a cross-site evaluation with data collected about the IPP, TAP, SWE, EOA, and CDPH contributions and efforts to promote change.
>
> ❖ Comparison data for the SWE will be obtained from county PEI data and other state and federal data.
>
> ❖ IPPs design and implement individual CDEP evaluations plus collect SWE core measures data.
>
> ❖ For a summary reference guide of SWE core outcome measures— see Appendix 2.
>
> ❖ For a summary table of SWE core process measures— see Appendix 3.
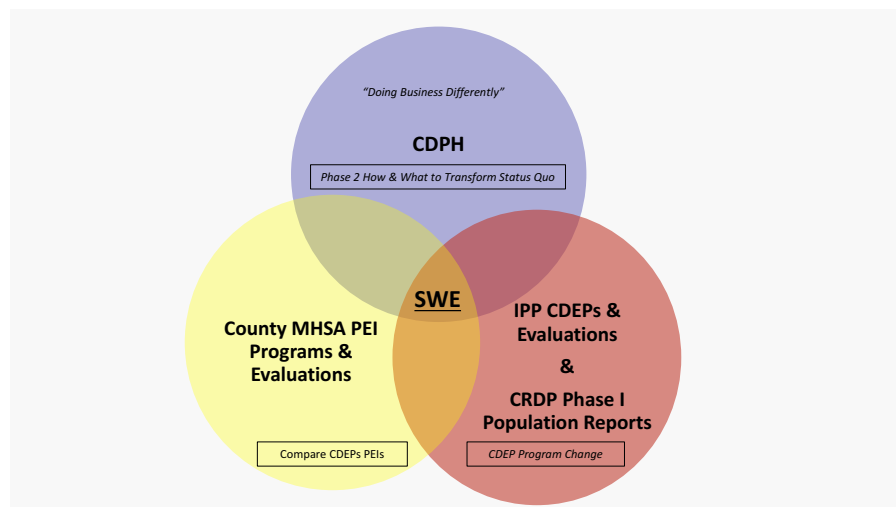
*Simple Rule #2: Evaluations of Complex Community Initiatives need a strong focus on the processes of community change.*
-Thomas Kelly, Jr., The Annie E. Casey Foundation


**Doing Business Differently**

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

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



*Simple Rule #3: Evaluations of CCIs need to measure ongoing progress towards achieving outcomes and results in order to help a community guide its change process and hold itself accountable.*
-Thomas Kelly, Jr., The Annie E. Casey Foundation

**SWE Objectives and Questions**

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

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

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

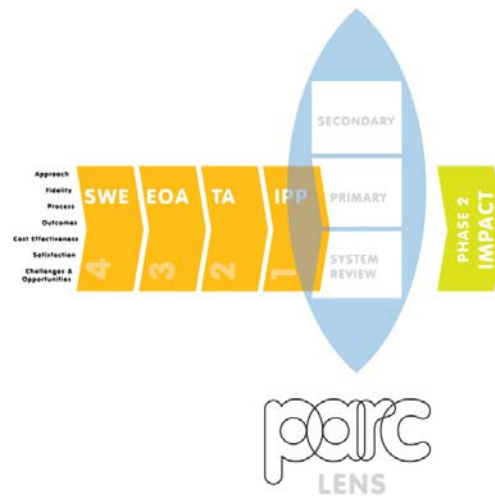Objective 2—Determine Effectiveness of Community-Defined Evidence Programs

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

*Simple Rule #4: Evaluations of CCIs need to understand, document, and explain the multiple theories of change at work over time.*
-Thomas Kelly, Jr., The Annie E. Casey Foundation

**SWE Data Sources**

Multiple data sources will be used to determine both overall effectiveness and the business case component (return on investment) of CRDP Phase 2.

This "triangulation" of data using methodologically diverse data sources can collectively explain the mechanisms and outcomes of CRDP 2 and begin to validate different culturally tailored methods of evaluation. This will strengthen the internal and external validity of the findings, potentially increase the generalizability of the findings to similar populations within the state and throughout the nation, and expand the range of evaluation research strategies that can be employed with our priority populations. These diverse data sources include:

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


*Simple Rule #5: Evaluations of Complex Community Initiatives need to prioritize real time learning and the community's capacity to understand and use data from evaluations.*
-Thomas Kelly, Jr., The Annie E. Casey Foundation

**SWE Core Measures**.

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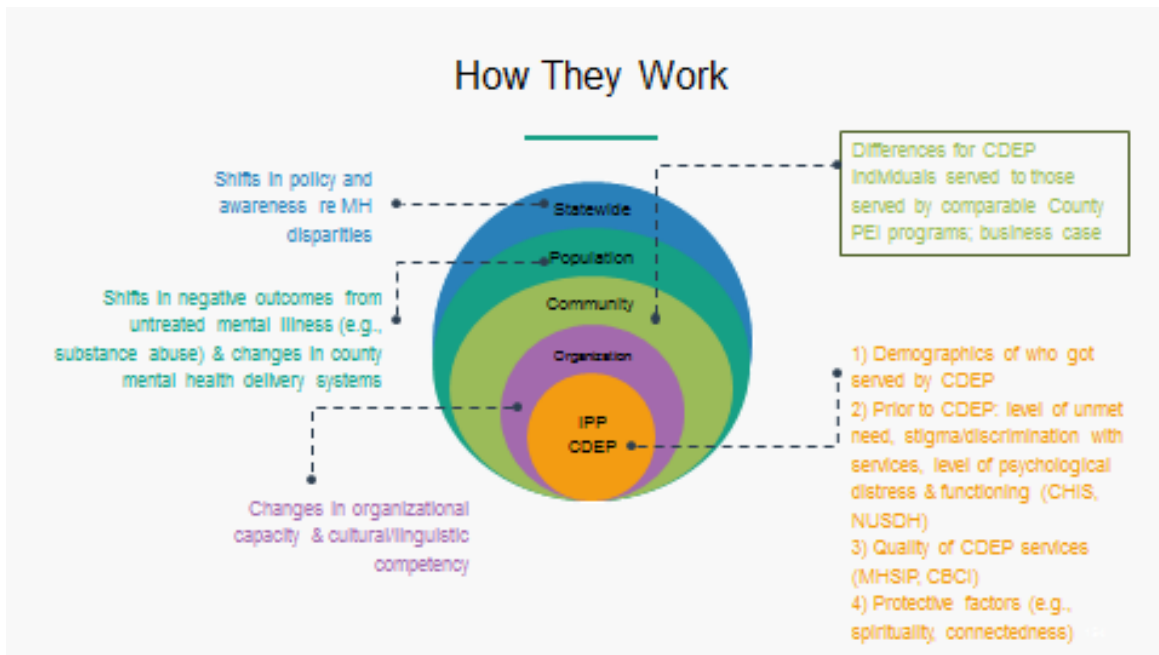
develop meaningful measures of progress that were capable of informing, providing critical feedback, and reinforcing positive change on an ongoing basis over several years.  Even though each IPP will approach their local evaluation quite differently (because of the unique cultural, linguistic, historical,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

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

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

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

The following table provided a detailed overview the SWE Core Outcome Measures and their associated levels.

**Core Outcome Measure Levels and Information Yielded**

| | |
|---|---|
| **CDEP** | • Number People Served (by key demographics)<br>• 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 psychological distressed at program entry)<br>• Help-Seeking Behavior (changes over time)<br>• Psychological Distress (e.g., general improvement)<br>• Social Isolation/Marginalization (changes over time)<br>• Functioning (e.g., changes in impairment in performance at work, personal relationships, etc.)<br>• Protective Factors (e.g., changes in spirituality/religiosity, wellness, social/community connectedness, cultural connectedness, etc.)<br>• Quality (e.g., general satisfaction, accessibility, quality & cultural appropriateness, perceived outcomes, cultural competence, etc.) |
| **Organization (IPP)** | • Changes in organizational capacity and cultural/linguistic competency |
| **Community** | • Differences between CDEP individuals served and those served by comparable County PEI programs; business cases. |
| **Population** | • Shifts in negative outcomes from untreated mental illness (e.g., substance abuse) and changes in county mental health delivery systems. |
| **Statewide** | • Shifts in policy and awareness regarding mental health disparities. |

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

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

# SECTION 5:  COLLECTING AND REPORTING SWE CORE MEASURES

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

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

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

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

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

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

**Understanding the SWE Core Measures**

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

> **The SWE Core Measures include the following**
>
> 1. Core Outcome Questionnaire Items (including demographics)
> 2. Organization/Program Core Data
> 3. Organizational and Cultural Competency Core Data
> 4. Phase 2 Surveys and/or Interview Core Data

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

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

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

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

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

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

**Questionnaire Items:  When, Why, What If?**

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

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

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

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

[SWE Core Measures Adult Version (PRE)](#)

[SWE Core Measure Child Version (PRE)](#)

[SWE Core Measures Adolescent Version (PRE)](#)

[SWE Core Measures Adult Version (POST)](#)

[SWE Core Measure Child Version (POST)](#)

[SWE Core Measures Adolescent Version (POST)](#)

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

| | Participant Codes Example (Pre/Post) | |
|---|---|---|
| 1.1_001_PRE | 1.1_001_POST | |
| 1.1_002_PRE | 1.1_002_POST | |
| … | … | |
| 1.1_021_PRE | 1.1_021_POST | |

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

**IPP Priority Population Evaluation Codes**

| Population Group | IPP Name | IPP Code |
|---|---|---|
| **1= African American** | California Black Women's Health Project | 1.1 |
| | Healthy Heritage Movement | 1.2 |
| | Whole Systems Learning | 1.3 |
| | The Village Project | 1.4 |
| | Catholic Charities | 1.5 |
| | West Fresno Health Care Coalition | 1.6 |
| | Safe Passages | 1.7 |
| **2= Asian Pacific Islander** | MAS SSF | 2.1 |
| | Hmong Cultural Center of Butte County | 2.2 |
| | East Bay Asian Youth Center | 2.3 |
| | Korean Community Services | 2.4 |
| | Cambodian Association of America | 2.5 |
| | HealthRight 360 | 2.6 |
| | Fresno Center for New Americans | 2.7 |
| **3= Latino** | Humanidad Therapy & Education Services | 3.1 |
| | Integral Community Solutions Institute | 3.2 |
| | Latino Service Providers | 3.3 |
| | Health Education Council | 3.4 |
| | La Familia Counseling Center Inc. | 3.5 |
| | La Clinica de la Raza | 3.6 |
| | Mixteco/Indigena Community Organizing Project | 3.7 |
| **4= LGBTQ** | Gay & Lesbian Center Bakersfield | 4.1 |
| | San Joaquin Pride Center | 4.2 |
| | Gender Health Center | 4.3 |
| | Open House | 4.4 |
| | Gender Spectrum | 4.5 |
| | API Wellness Center | 4.6 |
| | On the Move | 4.7 |

| 5= American Indian/Alaska Native | United American Indian Involvement | 5.1 |
| | Friendship House | 5.2 |
| | Indian Health Council | 5.3 |
| | Indian Health Center of Santa Clara | 5.4 |
| | Native American Health Center | 5.5 |
| | Sonoma County Indian Health Center Inc. | 5.6 |

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

Click on the following link for more information on the importance of process evaluation to an outcome evaluation. ([Using Process Evaluation to Monitor Program Implementation](#)).

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

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

**Process and Outcome Data: When, Why, What If?**

| Data | When is it collected? | Why is this important? | What happens if these data are not systematically collected? |
|---|---|---|---|
| **Process and Outcome Data** | Process and outcome data should be systematically collected from the time your CDEP begins to the end of CDEP data collection tentatively on 9/14/2020. | Process and outcome data should be tracked on a consistent basis to paint a clear and compelling picture of the inner workings of your CDEP. It helps diverse stakeholders see how your program outcomes were achieved. Although some data will be reported numerically in this report, there are other data that cannot easily be measured by numbers. It requires more descriptive or qualitative data. These data capture the real-life impact of your work. | If IPPs don't keep up with process and outcome data collection, they run the risk of not being able to accurately remember what they did, how they did it, and what impact it had on participants, the organization, or community. Imagine having to recall from memory the number of individuals you outreached to for your CDEP over the last 6 months, or the important lessons learned during the first quarter of your evaluation. Not consistently tracking this information would result in |

| | | | | inaccurate reporting for your local evaluation and the SWE. You would miss a valuable opportunity to tell your CDEP's story including the type of outcomes achieved and the specific steps taken to achieve success. |

*The SWE Semi-Annual Evaluation Report*

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

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

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

**SWE Semi-Annual Reporting Schedule**

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

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

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


**Helpful Hints for Collecting and Submitting CDEP Participant SWE Core Outcome Items**

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

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

   > The following questions can help you determine which administration method works best for your organization and the communities you serve.
   >
   > ☐ Do you have reliable and consistent internet access?
   > ☐ Does your CDEP program staff have access to computers or tablet devices?
   > ☐ How comfortable are your CDEP participants with technology?

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

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

> The following questions can help you determine which administration method works best for your IPP and the communities you serve.
>
> ☐ What is the literacy level of your CDEP participants?
> ☐ What age considerations do you need to attend to?
> ☐ Given staffing and time constraints or amount of access to CDEP participants, how feasible is one-on-one versus group administration?
> ☐ If group administration is ideal, do you have the physical space to ensure confidentiality?
> ☐ Do you need opportunities to build rapport or reflect on the participant's experience of the CDEP, making one-on-one administration preferable?

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

> The following questions can help you determine which physical space works best for your IPP and the communities you serve.
>
> ☐ What type of space does your IPP have to facilitate data collection?
> ☐ Is the space you designated for data collection comfortable for participants?
> ☐ Do you have staffing for childcare and space to accommodate participants accompanied by small children?

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

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

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

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

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

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

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

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

8. *What if my participants don't want to respond to sensitive core items?* IPPs are encouraged to collect data on sexual orientation, gender identity, preferred language, immigration and

refugee status, and ethnic/racial background. Because certain social group memberships are stigmatized in the current U.S. social, political, and cultural climate broadly, and more specifically within an individual's community, explicitly identifying with such groups may place the respondents at risk for a wide range of negative consequences with respect to workplace, family, and social outcomes. As such, respondents might be reluctant or fearful of reporting sensitive information, including disclosing their undocumented status, transgender status, and/or sexual minority status for fear that this information could be accessible to third parties. Here are some general strategies for collecting sensitive information.

- It is always good to reassure participants that their responses are confidential and their participation will help with the ongoing development of programs like your CDEP.
- Collect data once at intake, and again a month or so later (depending on the frequency and quality of program involvement) once trust in confidentiality has been established.
- Refer to Appendix 2 which recommends a minimum and maximum number of items IPPs may ask participants related to sexual orientation and gender identity. The minimum number can be utilized by IPPs who serve communities with high LGBTQ stigma, while the maximum number can be asked in IPPs with a larger LGBTQ community or where stigma would not be as much of an issue.
- Work with your TAP and local evaluator to determine which questions are best suited for your community.

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

**Data Collection and Reporting FAQs**

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

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

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

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

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

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

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

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

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

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

4. *What if I have missing process data?*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# SECTION 6:  PROGRAM EVALUATION AND RESEARCH 101

*From the vantage point of the colonized….the word "research"…is probably one of the dirtiest words in the indigenous world's vocabulary.*
--Smith, 1999

## The SWE + IPP Partnership = Synergy

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

## The SWE IPP Synergy

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

## Overview

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

1. Grounding Your Evaluation in Theory, Logic, and Cultural Principles
2. Evaluation Questions and Indicators
3. Evaluation Designs
4. Sampling Procedures
5. Data Collection Strategies
6. Data Analysis Strategies
7. Fidelity, Quality Assurance and Improvement

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

## Grounding Your Evaluation in Theory, Logic, and Cultural Principles

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

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

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

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

CDPH is providing an unprecedented opportunity to develop evidence for intervention strategies that are culturally and contextually grounded.  There may not be theories readily available upon which to situate your particular CDEP.  If the theory doesn't fit *don't force it*.  Instead, offer a clearly articulated rationale of the cultural principles, beliefs, and practices that undergird the intervention strategy and the selected outcomes.  Following the steps in the cube (See Section 7) is a useful tool to you in this regard.  Consulting with the TAPs and PARC are also important resources available to you.

**Evaluation Questions and Indicators**

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

1. **Be clear about what you want the evaluation to answer.**  Knowing what you want answered will help you select an appropriate evaluation design and methods.  Your CDEP evaluation questions should be developed and prioritized with CDEP staff, evaluator, other stakeholders (e.g., youth and adult community members), and your TAP.
2. **Different stakeholders are likely to be interested in different evaluation questions related to your CDEP**.  For example, county-level decision makers and future funders may be most concerned about your CDEP's impact on the community.  Program staff may be more interested in improving their CDEP's delivery or performance. No evaluation will succeed in being "all things to all people."
3. **Prioritize and narrow your list of evaluation questions by considering the resources (e.g., time, funding, personnel etc.) your IPP has available.**  It is often the case in evaluations that too many evaluation questions are posed than is feasible.  The following questions can assist you with prioritizing and narrowing your list of questions:
   - Which questions will yield the most practical information related to cost?
   - Which questions will yield the most practical information related to important outcomes for your priority population?
   - What are the most important questions that will require all of your current evaluation resources?
   - Will the results be credible and useful to diverse stakeholders, including your priority population?
   - Will the results lead to program improvements?
   - How likely is it that the findings from a question will influence decision-making?
   - How likely is it that the findings from a question will demonstrate that your CDEP is a viable strategy?
4. **Develop your outcome questions—the extent to which your CDEP accomplished its intended results—at one or more levels based on your goals and purpose:**
   - Individual Level (CDEP participants): changes in knowledge, attitudes, beliefs, practices, resilience indicators, and behaviors
   - Community Level (population): changes in norms, attitudes, awareness, practices, and behaviors
   - Systems/Policy Level: changes in organizations, policies, laws, and power structures with a focus on the systems that impact mental health

- Three other interrelated issues that can be the focus of evaluation questions include: merit (i.e., quality of CDEP), worth (i.e., cost-effectiveness of CDEP), and significance (i.e., importance of CDEP).

5. **Make sure to include process evaluation questions; namely address the WHO, WHAT, WHEN, WHERE, and HOW MANY of your CDEP activities and outputs.** For example, process evaluation questions yield the following types of information:
   - Extent of CDEP implementation with the priority population
   - Differential priority population constituents' engagement with the CDEP
   - Satisfaction with CDEP program
   - Fidelity to CDEP
   - External barriers/challenges impacting your CDEP implementation

6. **Avoid framing your questions using yes or no answers.**
   - Weak Question: Was the CDEP implemented as planned in the priority population?
   - Strong Question: To what extent was your CDEP implemented in the priority population?

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**Sample Process Evaluation Questions**

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


**Sample Outcome Evaluation Questions**

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

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

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

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**Sample Indicators**

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

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8. **Developing research questions is not a linear process!** For example, identifying indicators may lead you back to refining your evaluation questions and vice versa.

## Evaluation Designs

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

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

> Yes → You may be able to use randomized controlled trial (RCT). Go to Question #2
>
> No → You may be able to use a quasi-experimental design. Go to Question #2

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

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

Yes → This is a randomized controlled trial (RCT).
- B. You will use a pre- and post-test with CDEP participants.
    - Yes → You may be able to use a quasi-experimental design. Go to Question #3
- C. You have a community or population level intervention and will be examining at minimum 3 to 6 data points before and after the introduction of the CDEP intervention (see example below)
    - Yes → You may be able to use a quasi-experimental design such as Interrupted Time Series Design.
    - (See the example below.)  Go to Question #3

**Interrupted Time Series Design**

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

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

3. Are you able to have a COMPARISON GROUP or COMPARISON COMMUNITY – a group of people similar to your participants (or community) who may receive other types of services or no services at all but for whom you can get or collect evaluation assessment data (or archival data)? For example, can you get data for students at a similar school, parents who are too far away from your location to participate in your CDEP, foster youth in group homes located in a nearby section of your county, or people on a waiting list who signed up too late to participate in your intervention?

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

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

    For more information on Experimental and Quasi-experimental Designs:
    Types of Evaluation Designs
    Focus the Evaluation Design
    Quasi-Experimental Evaluations
    Quasi-Experimental Design and Methods

Remember, program evaluations use basic research designs to investigate a social intervention and its effectiveness with data and research methods. Taking the time to carefully think through the design of your study is critical to its success for the following reasons[1]:

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

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

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

| Type of Design | Key Features | Example |
|---|---|---|
| **Experimental** | | |
| Experimental | Participants randomly assigned to intervention and control groups | Every youth who comes to Building Homes has an equal chance of being assigned to traditional Building Homes services or to the Pathways CDEP. The use of random assignment strengthens Pathways' findings because it minimizes the possibility that positive client outcomes happened by chance. |
| **Quasi-Experimental** | | |
| Post-Test only w/ comparison group<br><br>**(USE NOT RECOMMENDED)** | No randomization of participants with a comparison; positive client outcomes collected only after program has ended. | After Pathways CDEP program ends, the program leaders will survey all youth participants and a comparison group of youth in the traditional Building Homes services program. |
| Pre- and post w/ comparison group | No randomization of youth with comparison; positive client outcomes collected before the program begins and after the program has ended. | Civic engagement will be measured before and after the Pathways CDEP program in a group of LGBTQ youth from the surrounding metro-area. The Pathways CDEP program will be compared to the traditional Building Homes services program. |
| Interrupted time series with a single group | Randomization of participants; multiple observations before (as a baseline measurement) and after the program has ended; participants will serve as their own control group. | Civic engagement is examined multiple times prior to and multiple times after youth's participation in Pathways CDEP. Youth in the current sample serve as their own control. |

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[1] Community ToolBox "Selecting an Appropriate Design for the Evaluation" http://ctb.ku.edu/en/table-of-contents/evaluate/evaluate-community-interventions/experimental-design/main

| Interrupted time series with multiple groups | Randomization of participants; multiple observations before (as a baseline measurement) and after the program has ended; control group | The Pathways CDEP will examine civic engagement three times in a sample of LGBTQ youth before the program begins and three times after the program ends. In contrast, the traditional Building Home services will serve as the comparison group, where civic engagement will be examined three times before the program begins and three times after the program ends. |
|---|---|---|
| **Non-Experimental/Non Quasi-Experimental** | | |
| Post-Test only no comparison group<br><br>**(USE NOT RECOMMENDED)** | No comparison group; positive client outcomes collected only after program has ended. | After Pathways CDEP program ends, the program leaders will survey all youth participants. |
| Pre- and post with no comparison group | No randomization of participants with no comparison; positive client outcomes collected before the program begins and after the program has ended. | Civic engagement will be measured before and after the Pathways CDEP program in a group of LGBTQ youth from the surrounding metro-area. |

## Sampling Procedures

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

| Sampling Procedure | What is it? | Best when | Pro's & Con's | What does it look like? |
|---|---|---|---|---|
| **Probability Sampling** | | | | |
| Random selection (also random sampling) | Everyone in the entire priority population has an equal chance of being selected. | Whole population is available | Pro: 1) generally representative of the population being studied; 2) high external validity<br>Con: 1) generally, requires a list of the total population being studied in order to sample | A researcher wants to measure cultural competency of school personnel around LGBTQ issues. Each personnel's name is put into a randomizer, and the first 10 chosen are given a survey to measure cultural competency around LGBTQ students. |
| Stratified sampling | The population is divided into characteristics of importance for the project. | There are specific sub-groups to investigate (e.g., demographic groupings) | Pro: 1) can capture key populations characteristics; 2) generally representative of the population being studied; 3) best when there are specific sub-groups to investigate<br><br>Con: 1) can only be carried out if a complete list of the population is available; 2) each participant can only belong to one stratum group | A researcher wants to measure the number of uninsured clients at an ER by their race. Assume 28% are white, 12% API, 24% African American, 24% Latino and 15% American Indian. Thus, 5 strata are created from the random sampling process. |
| Systemic random sampling | Divide the population into separate groups called strata. A probably sample (a random sample) is drawn from each group. | When a stream of representative people are available | Pro: 1) tends to be more efficient and quick; 2) generally representative of the population being studied; 3) best when a stream of representative people is available<br><br>Con: 1) sample can fall into a fixed pattern that is not generalizable | An API legal organization wants to measure client satisfaction of the organization's legal staff. A survey is given to every 4th client that comes into the organization for an appointment. |
| **Non-Probability Sampling** | | | | |
| **Sampling Procedure** | **What is it?** | **Best when** | **Pro's & Con's** | **What does it look like?** |
| Purposive sampling | Starts with a purpose in mind and the sample is thus selected to include people of interest and exclude those who do not suit the purpose | You are studying particular groups | Pro: 1) Generally useful when needing to reach a priority sample quickly; 2) useful when there is a limited number of desired potential participants in the population; 3) one of the most cost-effective and time-effective sampling methods available.<br>Con: 1) high chance of potential bias of researchers affecting the study; 2) difficult to generalize results to greater populations. | A researcher wants to measure levels of discrimination among LGBTQ youth of color. During events hosted by the local LGBTQ center, the researcher only surveys participants of color. |
| Convenient sampling | Uses people from priority population available at the time and willing to take part. It is literally based | You cannot proactively seek out subjects | Pro: 1) the relative cost and time required to carry out a convenience sample are small in comparison to other sampling strategies; 2) generally easier to | A mental health organization wants to measure counseling center use by African American college students during finals |

| | | | implement with few rule governing how the sample needs to be collected; 3) best when you cannot proactively seek out participants | week. They use a Facebook Poll to assess these levels. |
|---|---|---|---|---|
| | | | Con: 1) Findings may not apply to other samples or individual in that population | |
| Snowball sampling | A researcher may ask participants to refer you other people who fit your program requirements, then follow up with these new people. Repeat this method of requesting referrals until you have gotten enough people. | You seek similar subjects (e.g., young alcohol consumers) | Pro: 1) It allows for studies to take place where otherwise it might be impossible to conduct because of a lack of participants; 2) may help you discover characteristics about a population that you weren't aware existed<br><br>Con: 1) impossible to determine the sampling error or make inferences about populations based on the obtained sample. | |
| Quota Sampling | The proportions of particular sub-groups within a population and you want to ensure each group is proportionately represented. | You have access to a wide population, including sub-groups. | Pro: 1) Insures some degree of representativeness of all the strata in the population<br><br>Con: 1) Degree of generalizability is questionable | The student council at Cedar Valley Public School wants to gauge student satisfaction on a new pilot wellness program. They decide to survey 100 of 1,000 students using the grade levels (7 to 12) as the sub-population. |
| Multistage Random Sampling | Constructed by taking a series of simple random samples. Larger clusters are further subdivided into smaller, more specific groupings for the purposes of surveying. | When sample is geographically dispersed and face-to-face is required and there's a high level of flexibility. | Pro:1) can help reduce time and cost of large-scale survey research<br>Con: 1) can be arbitrary. Researcher may employ whichever method they see fit at each level risking potential bias. 2) not highly representative | In Iyoke et al. (2006) researchers used a multi-stage sampling design to survey teachers in Enugu, Nigeria, in order to examine whether socio-demographic characteristics determine teachers' attitudes towards adolescent sexuality education. First-stage sampling included a simple random sample to select 20 secondary schools in the region. The second stage of sampling selected 13 teachers from each of these schools, who were then administered questionnaires. |

## Data Collection Strategies

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

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

## Data Analysis Strategies

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

### Common Statistics Symbols Used When Reporting Data

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

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

It typically includes the following information.

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

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

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

> For example, if you find that the mean score for spirituality is 100 you may think, "Wow! That's great. Our participants are really spiritually grounded." But if the standard deviation shows high variation in spirituality scores, that's a lot of different responses, so the assumption that everyone is spiritually grounded is not quite accurate.   On the other hand, if the standard deviation is really small, you would have a much better idea that most of your sample really does have high levels of spirituality.

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

Inferential statistics that are useful for making group comparisons include:

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

Other Inferential Statistic Examples:

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

The link below is a useful resource as you think through what statistics to use.
[The Decision Tree for Statistics](#)

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**Case Example: Experimental Design – Gold Standard Typical of an EBP**

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

</div>

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

- ATLAS.ti is a statistical package for the qualitative analysis of large bodies of textual, graphical, audio and video data. This program provides tools that will allow the user to locate, code, and annotate findings in primary data material, to weigh and evaluate their importance with visuals to highlight the complexities of those relationships. You may access more information about ATLAS.ti through this link: http://atlasti.com/
- Dedoose is a web-based application for qualitative and mixed-methods research data in the form of text, photos, audio, video, spreadsheet data and more. Dedoose projects can be analyzed by an entire team of researchers. You may access more information about Dedoose through this link: http://www.dedoose.com/
- NVivo software supports qualitative and mixed methods research. It is designed to help you organize, analyze and find insights in unstructured, or qualitative data like: interviews, open-ended survey responses, articles, social media and web content. You may access more information about NVivo through this link: http://www.qsrinternational.com/nvivo-product/nvivo11-for-windows

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

- For information and examples about eight coding strategies, click on the following link: Analyzing qualitative data: systematic approaches (Bernard, Wutich, and Ryan, 2016).

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

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

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

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

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

O'Connor and Gibson provide an easy to use reference. Click here: Step-by-step Guide to Qualitative Data Analysis

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

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

## Quality Assurance, Improvement, and Fidelity

Conducting program evaluations are a complicated affair. Behavior is difficult to measure and participants are not always easy to recruit. **The reality is that evaluations, often, never run perfectly.** Nonetheless, CDEPs and the SWE can still employ methods and strategies to ensure that their project is carried out in a credible and valid fashion. You can provide the strongest evidence simply by being transparent, accurate, and forthright, even if the project did not run perfectly.

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

- Transparency: Openly report evaluation results with the appropriate amount of detail, even if mistakes were made or findings were not significant. Provide clarity in defining variables and constructs.
- Precision: Be accurate and precise through each step of the evaluation process, from developing clear evaluation questions, administering measures and instructions in a consistent fashion, to entering and analyzing data in a careful fashion.
- Consistency: Maintain consistency throughout the data collection process. *All* participants should receive the same instructions and measurement protocols. Keep an ongoing log and record details during all phases of the project. Just as the evaluation plan helps structure the project timeline, keeping detailed notes throughout the process will assist in recalling and reporting evaluation results. For example, if two participants were dropped because they failed to complete all the questionnaires, the dropped participants would be recorded in the research log (or whatever record-keeping mechanism is being used). The CDEP could consult the evaluation log when writing up results and would be transparent about dropping those participants in the final evaluation report.

- Quality:  Maintain quality assurance through periodic data checks and reliability procedures. If a project entails multiple evaluators or staff collecting data from participants, periodic checks of each person's protocols and procedures would ensure that all members of the team are collecting data consistently. Quality assurance can also occur during data entry and data analysis. If one person entered the data into a computer database, another evaluation team member could recheck the data entry (or a subset of data) for possible data entry errors.

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

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

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## Implementation Fidelity

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

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

Fidelity studies usually encompass the following 5 components:
- Adherence—the extent to which program components are delivered as prescribed by the model
- Dosage—amount of services received by participant
- Quality of delivery—manner in which services were provided
- Participant responsiveness—client engagement and involvement
- Program differentiation—analysis of program components to ascertain their unique contributions to the outcomes, and the ways they differ from other programs.

Here are two useful links for more discussion and examples of how to evaluate fidelity at [Measuring Implementation Fidelity](#) and [Assessing Program Fidelity and Adaptations](#).

# SECTION 7: RE-DEFINING "CREDIBLE" EVIDENCE

*Indigenous communities and researchers have voiced a variety of concerns with "research as usual" and emphasized the value of true partnerships, including decolonizing research to instill a balance between Indigenous and Western frameworks and methods.*
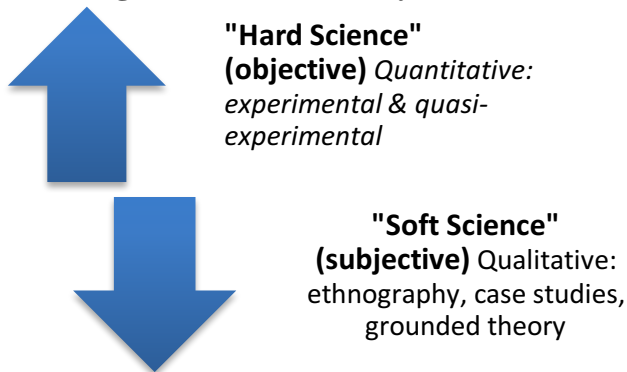-Simonds and Christopher, 2013

**The Challenge**

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

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

**Prevailing Research Hierarchy**



**"Hard Science" (objective)** *Quantitative: experimental & quasi-experimental*

**"Soft Science" (subjective)** Qualitative: ethnography, case studies, grounded theory

Some may ask, "What is the danger or problem with *only* using the "hard" methodological approaches in the Phase 2 CDEP evaluation?"

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

IPPs are being asked to validate their CDEPs via their local evaluations using credible evidence. This is both a challenge and an opportunity.  First, it is a challenge because a very narrow research framework has encumbered what is conventionally considered credible evidence (Schorr & Farrow, 2011).  These methodologies do not necessarily reflect or align with the

worldviews of our priority populations informed by the CRDP Phase 1 Priority Population Reports.  These narrow research frameworks do not capture the collectivistic/holistic perspectives on health articulated by the 5 priority communities as exemplified below.

| Priority Population | Collectivistic/Holistic Emphasis on Health |
|---|---|
| African American | Cited from the CRDP Phase 1 African American Population Report:<br>• "Black family kinship (Stack, 1974), healthy psychological functioning (Martin and Martin, 1978), and collective personhood (Penningroth, 2009; Rowe & Webb- Msemaji, 2004). The intricate relationship between culture and mental health remains an important topic of discussion.  There cannot be mental health without culture and, therefore it has been argued for the need to see culture and mental health as mutually embedded." (p.73)<br>• "In focus groups, when asked: '*What practices do Blacks say help them to have "good" mental health?*' Some themes included: Natural support system (God, Family, Friends); positive role models; Family Settings; Prevention; Freedom from Micro-Aggressions; Positive Systems Interaction for Participation; Cultural Compassion." (p.163)<br>• "Leveraging the positive traditions of strong faith based values and community participation may help to lead us to clues about how to design and implement successful programs and interventions for African Americans throughout Los Angeles County." (p. 51)<br>• "Our belief in the collective, group resiliency of the African people group should also be carefully considered when applied to young Black children." (p. 62)<br>• "The lack of understanding Blacks in America has created a deficit of unmet needs, especially in mental health. Ignoring African American culture is relative to how individuals are socialized and the exchange of knowledge about the population." (p. 73) |
| Asian and Pacific Islander | Cited from the CRDP Phase 1 Asian & Pacific Islander Population Report:<br>• "…given the cultural preference for a holistic view of 'health', the API-SPW deliberately chose the term 'wellness' for the focus group discussions." (p.43)<br>• "Wellness is physical, mental, and spiritual.  Physical means having good food and living well with basic needs met.  Emotional means having self-control and not getting angry easily.  For example, if something is bothering us, we have to deal with it and find ways to solve problems.  Spiritually means we are Buddhist, we have to be good." (p.43)<br>• "We consult with our spiritual healer.  We talk among our family to try to release our tension by sharing our problems with our spiritual counselor or try to go to community service." (p. 57) |
| Latino | Cited from the CRDP Phase 1 Latino Population Report:<br>• "*Familismo* (family) is the cultural value that focuses on the contribution of the extended family.  Improvements in individuals' outlook on life and health have resulted from intervention models that account for *familismo* by focusing on family cohesion." (p. 8)<br>• "In this instance, simply feeling a sense of connectedness and tapping into the strengths of his community resulted in the increase of protective factors and persistence in the face of challenges." (p.31)<br>• "[Being connected to one's spirituality] helps an LGBTQ person accept himself and in defining how do they deal with shortcomings, how do they deal with mental health issues, how do they deal with substance abuse, and all things that put them at higher risk." (p. 32) |
| LGBTQ | Cited from the CRDP Phase 1 LGBTQ Population Report:<br>• "Having community spaces for LGBTQ folks of color helps queer folks of color create a better sense of identity." (p. 84)<br>• "LGBTQ of color folks have support groups within the larger organizations.  There are several different events for African American women that branch up and down the state.  These allow me choices and it makes me feel good." (p. 88)<br>• "Sometimes people don't need an actual service, they need to feel welcome.  We want to feel comfortable in our own communities, in our own skins, and not have to feel judged all |

| | |
|---|---|
| | the time." (p.107) |
| | • "Being a part of it [GSA- gay straight alliance clubs] helped me maintain my sanity and kept me away from drugs." (p. 117) |
| American Indian/ Alaska Native | Cited from the CRDP Phase 1 American Indian/Alaska Native Population Report |
| | • "The role of culture is central to healing and is of great significance as a protective factor for many indigenous people.  Ceremonies and cultural activities often have the ability to connect to a native person and help them on their wellness journey in a way that cannot be described in terms of evidence based practice or even by words." (p. 14) |
| | • "Knowledge of the use of *traditional foods, traditional medicines and traditional ceremonial healers* is the process through which tribal communities reclaim the rights to their knowledge and empower their communities to believe in their own teachings." (p. 24) |
| | • "Traditional healing is holistic wellness; it is a way of life that does not separate the importance of the land, environment, prayer, community, language and all things that are a part of life." (p. 24) |
| | • "The healing power of weaving baskets comes from connecting with something in the past, recognizing and honoring the beauty of the skill, and feelings of pride and a sense of mastery." (p. 27) |

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

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

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

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

**The Opportunity**

*When conducting studies with Latino immigrants in a culturally competent manner, researchers must not only be well versed in qualitative research methods but also know how to work with*

*communities that have been historically exploited by mainstream society. Some of the skills involved in working with vulnerable communities, such as Latino immigrants, involve relying on gatekeepers, having knowledge of the Spanish language, and understanding cultural nuances.*
-Ojeda, Flores, Meza, & Morales, 2011

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

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

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

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

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

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

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

**The Cube – A Conceptual Tool**

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

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

All research is culturally-based, and therefore the "hard" approaches are biased towards the Western- dominant culture. For example, the prevailing view within the "hard" sciences is that health is individualistic (emphasis on individual well-being) and mechanistic (disease leads to imbalance, dysfunction and more disease). It is also focused on risk factors. In contrast, the cultural perspectives and worldviews of many of our priority populations view health as collectivistic (emphasis on the well-being of the group over, or at least as much, as individual well-being) and holistic (integration of mind, body and for many spirit). As a result, there is greater focus on protective factors. Consequently, these worldview differences often lead researchers/evaluators/decision-makers/stakeholders to draw conclusions about findings that may not be valid or justified. While improving measurement techniques and statistical manipulation, increasing sample sizes, including more measurement of risk factors, etc. are typical remedies, they will not solve the problem and we risk continuing to blame the victim. It will require the use of different, innovative, and culturally responsive research methods that are appropriate to task, evaluation question, community context, culture, and language.
PARC@LMU encourages IPPs to employ **The Cube**, a conceptual tool developed for the IPPs, to help you reflect, deliberate, and ultimately "unpack" your CDEP and inform your approach to the local evaluation. This tool will assist with articulating both the visible and invisible dimensions of your CDEP and **it encourages IPPs to go beyond business as usual in the evaluation of their pilot projects.**

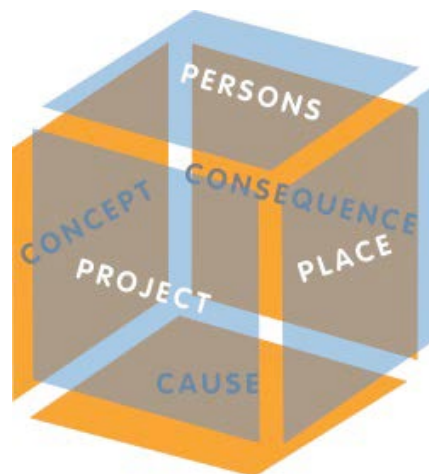The Cube is a two-dimensional conceptualization that:

- guides descriptions of culture, as manifested and expressed in the CDEP
- accounts for historical factors that influence organizational, community, and systems contexts of the CDEP and

- encourages "thick" (ethnographic) description (Nastasi & Hitchcock, 2016) of an IPP's worldview, cultural values and beliefs, practices, and cultural/community indices of health and wellness.

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

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

**The Cube**



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

**Step 1:** Each IPP will revisit the evaluation plan in their grant proposal to begin the process of refining and elaborating of what was proposed. Sometimes what is written in a grant proposal does not fully capture the heart and soul or reasoning behind what a group actually plans to do. Living one's culture is one thing, trying to explain it to someone else is another. This is an opportunity to further define the visible cultural elements in your CDEP. Shared meaning through collaborative dialogue can be particularly useful at this juncture. Therefore, we

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

recommend that IPPs in a participatory session with key community stakeholders collectively answer the following questions:

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

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

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

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

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

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

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

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

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

- identify relevant process and outcome measures and methods that flow out of your Cube
- problem solve ways to capture relevant cultural variables in the evaluation
- examine assumptions about the change process required to achieve CDEP goals

- develop a clear description of your CDEP that can be included in your final evaluation report and
- in collaboration with your assigned TAP, discern cultural variables, outcomes, and measures that might be used across IPPs within a priority population.

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

| Cube Elements | Sweet Potato West Fresno Family Center |
|---|---|
| | **The Observable** |
| **Project**<br><br>*What is the activity or the community defined practice(s)/ intervention(s)?* | Direct prevention program for youth that includes 4 primary components:<br>1) Small business training (harvesting and selling sweet potatoes)<br>2) Motivational counseling<br>3) Life and coping skills development<br>4) Systems level change (economic development throughout the county)<br><br>*(More detail would be provided here)* |
| **Persons**<br><br>*Who will be involved in delivering and participating in our CDEP and what are they doing?* | Program delivery by 5 program staff with strong trusted relationships with West Fresno families. Small business training and professional development led by various professionals from Cal State University, Fresno, Fresno State, and Fresno Unified School District.<br><br>Project participants include African American middle school youth ages 12-15 residing in Fresno. |
| **Place**<br><br>*Where does our CDEP take place in terms of the organizational and/or community setting and geographic location and why is this important?* | The CDEP takes place in Southwest Fresno. This area has historically been a low-income community with high levels of unemployment and poverty, with more than 40% of the households reliant on Cal-Fresh food subsidies. Improving economic development, job opportunities, and educational outcomes is therefore critical.<br><br>*(More detail would be provided here, e.g., an abandoned community lot, community center and its importance)* |
| | **The Invisible** |
| **Conceptualization**<br><br>*How does our CDEP project reflect the cultural values, practices, and beliefs of our community?* | Cultural values are present in the following areas:<br>1) Selection of the sweet potato as the crop, as it is traditionally an African American "soul food," which is associated with social interaction, African American history, and African cultural retentions.<br>2) Use of the African centered perspective to recreate traditional supportive relationships around productive activities with competent adult community members; reinforcing youth and adult relationships as the village raises the child.<br>3) Emphasis on strengthening the sense of spiritual connection between the land and the people and the spiritual connection of people with each other – all within the context of the village. These ties promote resilience and well-being: "I am because we are." |
| **Causes**<br><br>*What are the problems the project is trying to address? How did it start and why? How are causes understood in a) a historical context, b) through the lens of the community's values and c) things that concern or bother the community.* | • 54% of children in south Western Fresno live in poverty, compared to the California rate of 20.9%.<br>• African American youth 12-15 in the low-income community of Southwest Fresno experience disproportionately higher rates of poor health and mental health, poverty, violent crimes, and lower rates of high school graduation.<br>• Youth need job training through dignified work and stipends.<br>• Southwest Fresno neighborhood needs to become safer and more economically self-reliant and self-sustainable.<br>• On a yet deeper level, the tattered community safetynet compromised for African Americans from 400 years of oppression and ongoing racial stress has weakened sense of connection and self-sustaining, vibrant communities.<br><br>*(Additionally, information to further enrich and nuance this description of causes might include: Why is connection to the land important (culturally, historically, spiritually to people of African ancestry and how do the elders relative to the youth* |

| | |
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| | *understand this? What values are important in the community and if one looked at this intervention in that context how/why is the strategy relevant to get at a deeper understanding of causes from a community perspective? What are peoples' concerns about the community that are connected to this strategy that again, further reveal the community's perspective on the causes of the focal problems of this project?)* |
| **Consequences**<br><br>*From our cultural perspective, what are the desired outcomes of the CDEP for our community? We will see more of …. and less of …..* | Expected outcomes for the community include:<br>1) Increased opportunities for youth ages 12-15 to develop skills related to job responsibility and follow-through, effective communication and business planning,<br>2) Strengthened community ties through resilience from increased cultural programs and practices for African Americans,<br>3) Increased outreach opportunities and locations available for residents to receive support and education about mental health issues,<br>4) Decreased stigmatization surrounding mental health issues,<br>5) Reduced residential segregation challenges including neighborhood violence and lack of resources<br><br>*(These outcomes could be strengthened by linking them more directly to the cultural values and the perceived causes of problems identified. For example, articulating the relationship between connection to the land, connection to each other, community building, and resilience for youth and adults). Further, how are these all related to reducing stigma and increase spaces for mental health support. There are proximal and distal outcomes that are discernable in the project that could be clearly articulated and measured.)* |
| **Cube Elements** | **Native American Drum Dance and Regalia (UAIM)** |
| | **The Observable** |
| **Project**<br><br>*What is the activity or the community defined practice(s)/ intervention(s)?* | Direct prevention program that promotes health and wellness through the following culturally-based workshops:<br>1) Drumming (historical customs)<br>2) Dancing (instructional classes on how various dance styles are performed)<br>3) Arena tradition (pow wow arena etiquette)<br>4) Regalia design (design and creation of regalia worn at events)<br><br>*(More detail would be provided here)* |
| **Persons**<br><br>*Who will be involved in delivering and participating in our CDEP and what are they doing?* | Project staff includes 2 executive staff members who are experienced in culturally based mental health and substance abuse research and treatment; a Culture Coordinator responsible for program planning; and community subcontractors including 5 dance instructors, 4 drum/song instructors, and regalia making instructors. All instructors are recognized and respected within the community. Program participants include children ages 3-17 and adults ages 18-59 in Los Angeles County. |
| **Place**<br><br>*Where does our CDEP take place in terms of the organizational and/or community setting and geographic location and why is this important?* | The program is located in Los Angeles County, one of the largest urban AI/AN populations in the country. Despite these high numbers, AI/AN community members only make up .6% of the population, which makes it difficult for the AIAN population to find one another to create bonds and be involved in a community.<br><br>*(More detail would be provided here regarding exact location and setting, e.g., x neighborhood in highly recognized AI/AN community center and its importance)* |

| The Invisible | |
|---|---|
| **Conceptualization**<br><br>*How does our CDEP project reflect the cultural values, practices, and beliefs of our community?* | Cultural traditions and values are reflected in the following areas:<br><br>1) Drumming, dancing, and regalia making provide opportunities to learn cultural traditions and engage in healing activities that have been utilized for centuries among indigenous communities.<br>2) Use of the Medicine Wheel highlights the four dimensions of wellness recognized historically by AI/ANs *(How is the Medicine Wheel central to healing? How does it inform the culture's understanding of the essential elements of human beings – for example, the spiritual element)*<br>3) Program staff represent several different tribes which helps maintain cultural relevance and legitimacy.<br>4) Workshops teach musical techniques, and traditional values, protocols, and expectations. *(What are the traditional values, protocols and expectations; how are these related to mental health and wellness?)* |
| **Causes**<br><br>*What are the problems the project is trying to address? How did it start and why? How are causes understood in a) a historical context, b) through the lens of the community's values and c) things that concern or bother the community.* | Social isolation among AI/AN communities and shortage of treatments and supports that can address the unique needs of the AI/AN population, including historical trauma, oppression, and racial and cultural identity. This leads to needs not being met and the perpetuation of mental health issues, such as loneliness and a disconnect with native identity. *(What others needs aren't being met?)* AI/AN community members are likely to experience increased rates of depression and addiction, including exposure to trauma such as child abuse, domestic violence, and crime victimization further contributes to mental health disorders among this population. |
| **Consequences**<br><br>*From our cultural perspective, what are the desired outcomes of the CDEP for our community? We will see more of …. and less of …..* | Cultural activities promote mental health PEI and will result in the following outcomes:<br>1) Strengthened connection to AI/AN traditions<br>2) Increased connection to cultural identity<br>3) Increased spirituality<br>4) Reduced rates of mental disorders<br>5) Reduced substance abuse rates<br>6) Improved coping skills<br>7) Improved health and wellness<br><br>*(How can this be further nuanced or explained from AI/AN cultural lens?)* |

## Flexible and Collaborative Investigative Methods/Approaches

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

In evaluations that involve groups of vulnerable people who are marginalized (e.g., refugees, LGBTQ, noncitizens), more flexible and/or collaborative methods may be needed.  The table below provides an overview of methods that can assist with:
- obtaining in-depth understandings of how communities in different cultures and subcultures make sense of their lived reality
- understanding complex socio-political problems where cultural diversity is great
- collaboratively working with communities who have historical and current experiences of oppression and exploitation
- providing opportunities for community members to actively pinpoint issues impacting individual lives, families and their communities
- describing and explaining individual experiences, relationships and other social phenomena, such as community/cultural norms and
- evoking responses that are meaningful and culturally salient to the community.

| Method/Approach | Rationale & Advantages | Additional Resources |
|---|---|---|
| **Community-Based Participatory Research (CBPR)** *Community-based participatory research (CBPR) is a "collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community, has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities."* -WK Kellogg Foundation Community Health Scholars Program | CBPR advances the development of culturally centered research designs and public health interventions.  CBPR has several advantages to conventional research paradigms. <br>• Community members are not passive "research subjects," but equal partners and active participants in the development of research questions, program design and implementation, and dissemination of findings. <br>• Researchers are better able to see and understand the complex factors that influence health.  By engaging in true partnerships with community, they learn about strengths and values, different ways of knowing, and policy and systems barriers that are often obscured within conventional research frameworks | University of Washington: Developing and Sustaining Community-based Participatory Research Partnerships: A Skill-building Curriculum  Community-Campus Partnerships for Health (CCPH): Community-Based Participatory Research  Detroit Urban Research Center: What is CBPR? |
| **Ethnography** *"Critical ethnography is an* | Ethnography helps us understand culture through representation of the "insider perspective." | Community Tool Box: |

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| *approach to ethnography that attempts to link the detailed analysis of ethnography to wider social structures and systems of power relationships."* <br> -Madison, D.S., 2004, Critical Ethnography: Method, ethics, and performance | Ethnographic research explores social phenomena in the setting it takes place in. Through the use of participant observation, in-depth interviews, focus groups, etc., ethnographers gain rich insights about culture and community (i.e., the social and physical location of communities, individual viewpoints and values, etc.) that would be hard to ascertain using other methods. | Gathering and Interpreting Ethnographic Information |
| **Mixed Methods** <br> *"Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the purpose of breadth and depth of understanding and corroboration."* <br><br> -Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research*, 1(2), 112-133. | Using multiple methods can improve the quality of your data. Both quantitative and qualitative research have weaknesses. Quantitative research (e.g., surveys) is weak in understanding the context or setting in which data is collected. Qualitative research (e.g., interviews) may include biases and does not lend itself to certain statistical analysis and generalization. A mixed method approach can offset these weaknesses by integrating both quantitative and qualitative methods to provide a better understanding of the research question than either approach alone. <br><br> Researchers using a mixed methods approach will be able to use all the tools available to them and collect more comprehensive data which can generate results that have a broader perspective of the overall problem, and ultimately tell a more complete and accurate story. | Association for Psychological Science: Mixed Methods Research |
| **Triangulation** <br> *"Triangulation involves using multiple data sources in an investigation to produce understanding.* <br><br> *Some see triangulation as a method for corroborating findings and as a test for validity. This, however, is controversial. This assumes that a weakness in one method will be compensated for by another method, and that it is always possible to make sense between different accounts. This is unlikely.* <br><br> *Rather than seeing triangulation as a method for validation or verification, qualitative researchers generally use this technique to ensure that an account is rich, robust, comprehensive and well-developed."* <br><br> -Robert Wood Johnson Foundation | Triangulation combines multiple methods (or data sources) to study one phenomenon. Because a single method can never fully shed light on a social problem or issue, triangulation attempts to understand it from more than one standpoint. <br><br> There can be triangulation between methods and triangulation within methods, each providing different types of insight about your potential findings and the utility of various methods for your priority population. In fact, within qualitative research several types of triangulation methods are possible (e.g., Data Triangulation, Method Triangulation, Investigator Triangulation, Theory Triangulation, and Multiple Triangulation which uses two or more triangulation techniques in one study). (Akomolafe, 2016) | Robert Wood Johnson Foundation Qualitative Research Guidelines Project: Triangulation <br><br> Better Evaluation: Triangulation |

| Qualitative | Qualitative methods (e.g., case study, personal | Community Tool |
|---|---|---|
| *"Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter.  This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them."*<br><br>-Denzin and Lincoln, 2005, p. 3 | experience, interview, observational, visual texts, etc.) tend to be more flexible than quantitative methods because they allow greater spontaneity and adaptation of the interaction between the researcher and the participant.  For example, qualitative methods ask mostly "open-ended" questions that are not necessarily worded in exactly the same way with each participant.  With open-ended questions, participants are free to respond in their own words, and these responses tend to be more complex than simply "yes" or "no."<br><br>An advantage of qualitative methodology is that it provides nuanced, rich, and complex descriptions of how people experience a given phenomenon.  It is effective in identifying intangible factors such as social norms. | Box:<br>Qualitative Methods to Assess Community Issues<br><br>Robert Wood Johnson Foundation Qualitative Research Guidelines Project: What is Qualitative Research? |

## Alternative and Innovative Approaches

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

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

| Method | Description |
|---|---|
| Community Narratives | This method elicits personal or community stories by asking story-based questions, for example, asking about high and low points or transitions in people's lives (e.g., Tell me about a high point episode in your childhood, a time you remember vividly where you felt extremely positive emotions; Tell us a low point in your community?).  More value- or belief-based questions often follow once a participant has warmed up to story-based questions.  Themes that emerge across participants become part of the community narrative.  Collective themes serve as a barometer of transformative and positive changes occurring for individuals and communities. |
| Storytelling (Re-storying) | Storytelling is an oral tradition that involves skilled vocal and body expression including: intonation, the use of verbal imagery, facial animation, context, plot and character development, natural pacing of the telling, and careful authentic recall of the story (First Nations Pedagogy, 2009).  Storytelling is often accompanied with song, music, spoken word, and dance as a way to heighten the senses and enhance feelings of interconnectedness with the surrounding environment.  Storytelling frequently involves the use of *testimonios*—urgent spoken and/or written narratives that are situated in the context and lived experiences of the storyteller.  Storytelling not only serves to preserve tribal history and culture (i.e., elders share stories with younger generations), but also honors and prioritizes Indigenous experiences, value systems and ways of knowing.  The use of stories is grounded in the understanding that narratives about Indigenous, marginalized communities are typically told from the dominant western/colonial perspective—these |

| | perspectives have ultimately perpetuated false, harmful images of community members. Storytelling allows Indigenous people to reconcile these false narratives by providing space for them to reframe and re-tell their stories.  Because of its emphasis on truth-telling and self-determination of marginalized people, the act of storytelling is viewed as political, and ultimately, a tool for resistance and survival against western patriarchy, capitalism, and colonialism. |
|---|---|
| Photovoice (Photoethnography) | This method involves participants taking pictures based on an easy-to-understand prompt or key issue(s) to be explored (e.g., What makes up your neighborhood? What do you like about it? What would you like to change?).  Respondents spend several weeks exploring the question by taking photos that express their behavior, attitudes, and emotions without the bias of an outside observer.  The photographs are "field notes" in which the participants translate their meaning.  Photographs allow participants to: 1) talk about the meanings of their lived experiences through visual symbols; 2) tell their own stories; and 3) talk about and share their sensitive and private issues.  Using a structured format, photographs are discussed within a group.  After several iterations of this process, participants categorize their photographs and accompanying narratives according to themes.  The photos and narratives serve as data points. |
| Sharing Circle | For some indigenous groups, one method of data inquiry is the sharing circle. Similar to focus groups in conventional qualitative methods, it is used to gather information on a particular topic through group discussion.  However, sharing circles differ depending on the indigenous groups' culture and are used as a healing method often times as a part of a ritualistic practice.  Through ceremonial recognition of the presence and guidance of the ancestors, circle participants share all aspects of themselves – heart, mind, and spirit – with permission given to the facilitator to report on discussions.  Other aspects of the sharing circle may vary based on culture such as speaking in a counter clockwise direction, only speaking when holding an object like a speaking stick, or beginning the circle with a smudging ceremony ridding the circle of negativity. |
| Photoelicitation | This method is used to understand the world as seen by the community.  Photographs are a means through which people are able to express their own definitions and meanings.  For example, participants may be provided a series of pictures visually depicting emotional pain and asked the following questions: What is happening to the people in the picture? Is anyone in the pictures in pain? Who is in the most pain out of all the images? With whom do you identify most? |
| Reflexive Photography | In this method, participants take photographs of themselves or localities.  This method has been used successfully with Americans Indian/Alaska Native and African Americans.  The self-generated images symbolize and make visible their identities in social and/or physical environments, as well as highlight what's important for their cultural group.  Participants are asked to describe what the photo represents and why it was taken, and also used in discussions that often lead to spontaneous storytelling. |
| Audio/Video Diaries | This method draws on the tradition of personal narratives and storytelling but is audio or video recorded.  For example, children suffering from asthma were asked to record their daily lives and world.  The diary-like approach revealed situations unknown to the researcher, for example, their social isolation and relationship problems with their parents. |
| Draw and Write | This method combines drawings and writing.  It has mostly been used with children and youth as it 1) gives them a voice, 2) provides insight of how they make sense of the world, and 3) reveal the wealth of knowledge they hold.  It is recommended that this method be integrated with other social science methods.  For example, a 'visual life-line' was used with LGBTQ homeless youth.  A large sheet of flip-chart paper with a line down the middle with a smiling baby on the left-hand side, a mark in the middle, and a smiling person on the right-hand side was placed in the room.  Young people were invited to draw or write text about important moments and events in their life and they could begin wherever they wanted along the line. |
| Written Diaries | In this method, participants record their feelings, experiences, observations and thoughts about a particular aspect of their lives. It provides an in-depth understanding of sensitive issues for hidden and hard-to-reach populations. |

## Examples of Culturally Based Quantitative Measures

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

| AFRICAN AMERICAN | | | |
|---|---|---|---|
| **Citation** | **Scale** | **Population** | **Psychometric Score** |
| Utsey, S.O., Bolden, M.A., Williams, O., Lee, A., Lanier, Y., & Newsome, C. (2007). Spiritual well-being as a mediator of the relationship between culture-specific coping and quality of life in a community sample of African Americans. *Journal of Cross-Cultural Psychology, 38*(2), 123-136. doi: 10.1177/0022022106297296 | Spiritual Well-Being Scale | African American adults | Cronbach's alphas were calculated for each of the subscales and were as follows: connection with God, .82; satisfaction with God and day-to-day living, .73; future/life contentment, .72; personal relationship with God, .54; and meaningfulness, .49. |
| **ASIAN AND PACIFIC ISLANDER** | | | |
| **Citation** | **Scale** | **Population** | **Psychometric Score** |
| Yoon, E., Jung, K. R., Lee, R. M., & Felix-Mora, M. (2012). Validation of Social Connectedness in Mainstream Society and the Ethnic Community Scales. *Cultural Diversity and Ethnic Minority Psychology*, *18*(1), 64. | Social Connectedness in Mainstream Scale & Social Connectedness in the Ethnic Community Scales | Mexican American students from California & Asian international students from the Midwest | the alphas for Mexican American students were .92 for the SCMN and .95 for the SCETH; alphas for Asian students were .90 for the SCMN and .95 for the SCETH. |

| LATINO | | | |
|---|---|---|---|
| **Citation** | **Scale** | **Population** | **Psychometric Score** |
| Steidel, A. G. L., & Contreras, J. M. (2003). A new familism scale for use with Latino populations. *Hispanic Journal of Behavioral Sciences*, *25*(3), 312-330. | Attitudinal Familism scale | Latino adults in the Midwest (Cleveland) | Cronbach's alphas for the factors were .83 for the overall scale, .72 for Familial Support, .69 for Familial Interconnectedness, .68 for Familial Honor, and .56 for Subjugation of Self for Family |
| **Lesbian, Gay, Bisexual, Transgender, Queer/Questioning** | | | |
| **Citation** | **Scale** | **Population** | **Psychometric Score** |
| Frost, D. M., & Meyer, I. H. (2012). Measuring community connectedness among diverse sexual minority populations. *Journal of sex research*, *49*(1), 36-49. | Connectedness to the LGBT Community Scale | Sexual minorities (i.e., lesbian, gay, and bisexual) | Scores on the total connectedness scale were internally consistent for the total sample (Cronbach's .81) |
| **AMERICAN INDIAN/ALASKA NATIVE** | | | |
| **Citation** | **Scale** | **Population** | **Psychometric Score** |
| Snowshoe, A., Crooks, C. V., Tremblay, P. F., Craig, W. M., & Hinson, R. E. (2015). Development of a Cultural Connectedness Scale for First Nations youth. *Psychological assessment*, *27*(1), 249. | Cultural Connectedness Scale | First Nation, Metis, and Inuit youth | 3 Subscales: Identity: .872 Traditions: .791 Spirituality: .808 |

*The debate about criteria for credible evidence is neither academic nor trivial.  How we as a nation deal with issues of evidence will shape the nature of social innovation, programs, and policies—what is and what is not allowed, promoted, and incentivized—for years to come.*
-Schorr & Farrow, 2011

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

# SECTION 8:  DESIGNING AN EVIDENCE-BASED PRACTICE STUDY

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

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

## Evidence-Based Practice and Mental Health PEI Programming

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

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

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

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

## Applying to an Evidence-based Registry

IPPs can apply to a number of EBP registries.  A frequently used registry for mental health and substance abuse programs is the [National Registry of Evidence-based Programs and Practices](#)

(NREPP).  Developed by Substance Abuse and Mental Health Services Administration (SAMHSA), NREPP is designed to increase public awareness of available EBPs.  All interventions in the registry have met NREPP's minimum requirements for review and have been independently assessed and rated for "Quality of Research and Readiness for Dissemination".
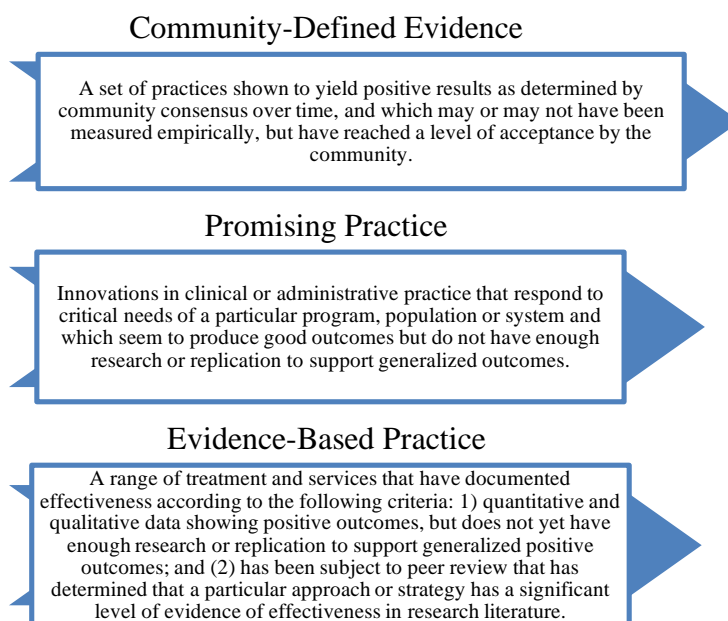
For more details, please visit the following links to learn about requirements for and benefits of having your CDEP included in this registry.

- [NREPP Review Process](#)
- [NREPP Submission Requirements](#)

**Establishing Your CDEP as an EBP**

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

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

### Community-Defined Evidence

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

### Promising Practice

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

### Evidence-Based Practice

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

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

- Where does your CDEP currently fall on this continuum of evidence?
- What type of evidence has been used to demonstrate effectiveness for your CDEP?
- Are there ways your CDEP could benefit from using a randomized control study?
- Do you have the capacity to conduct a randomized control study?

- Are there benefits to establishing your CDEP as an EBP?
- How could you use CRDP Phase 2 resources to help establish your CDEP as an EBP?

**Designing an EBP**

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

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

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

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

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

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

☐ Do you have clearly defined outcomes that should result from participation in your CDEP?
☐ Have you selected valid measures that are related to your anticipated outcomes?

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

(referred to as *d*) which describes *how much* two groups differed on a measured outcome. See the box below for an example that illustrates the difference between these two statistical concepts.

---

**Statistical Significance versus Effect Size**

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

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

---

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

- [How to Select, Calculate, and Interpret Effect Sizes](#)
- [Effect Size Calculator](#)
- [Vacha-Haase and Thompson (2005)](#)

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

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

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

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

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

## EBP Examples

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

- Ecological-Based Family Therapy (EBFT): A family systems therapy designed to support positive family connections as well as communication and problem-solving skills
- HIV Outreach for Parents and Early Adolescents (HOPE) Family Program: A shelter-based preventive intervention designed to decrease youth risk-taking related to HIV infection and mental health
- Promoting Alternative Thinking Strategies (PATHS): A classroom intervention program for children with behavioral and emotional deficits
- Strengthening Families Program (SFP): A family skills training program designed to improve parenting skills and family relationships, and reduce problem behaviors, delinquency and alcohol and drug abuse in children
- Mindful Parenting Groups (MFG): A development-driven, relationship-focused approach to the cultivation of resilient, healthy and secure parent-child bonds among parents, infants, toddlers or preschoolers

## Other Helpful Resources

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

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

# SECTION 9:  HUMAN SUBJECTS PROTECTION

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

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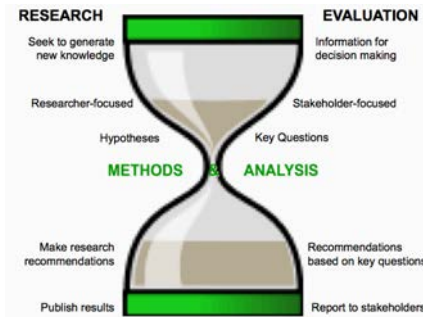
## Research

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

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

## Evaluation

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

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

## Defining "Human Subject"

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

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

## Human Subjects Protection

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

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

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

> *Tearoom Trade*: In the 1960s, a sociologist conducted his dissertation research on the bathroom behaviors of gay men in an effort to combat negative stereotypes held by the public and law enforcement. His methods included stationing himself in public restrooms where sex acts took place and notifying participants if the police were nearby, and showing up to men's homes and obtaining personal information by pretending to be a

health service interviewer.  Despite his intentions to help the gay community, his research raised concerns about invasion of privacy and participant confidentiality.

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

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

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

## IRB Approval

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

## How to Obtain IRB Approval

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

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

IRB boards are usually located within community-based organizations or university settings.  The type of IRB you apply to will depend on the type of research or evaluation you are proposing and the populations participating in the research.  Be sure to ask your IRB how

frequently they review applications, how long the approval is valid, and what type of research they review. This can have a direct impact on the timing of your evaluation and therefore the timetable of your CDEP roll out.

<u>Community-Based IRBs</u>

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

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

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

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

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

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

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

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

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

## FAQs

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

2. *If I want to do research at a local school, what is the procedure for obtaining consent?*
   Generally, you must obtain the consent from the following individuals

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

3. *If my intervention is working with vulnerable populations or sensitive topics, will it take longer for approval?*
   Generally yes. It is customary to allow an IRB at least 30 days to consider an application. When vulnerable populations and/or research with sensitive topics are involved, it often takes longer than the standard time frame for an application to move

through the approval process.  Sometimes these projects are deemed as "full board review," and can take up to 8 weeks or longer to be considered, so plan accordingly!

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

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

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

# SECTION 10: DEVELOPING A BUSINESS CASE

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

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

**Introduction to the Business Case**

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

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

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

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

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

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

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

**Doing *a Business Case* Differently**

**In creating the CRDP business case, we want to make sure that the community gets to have their say in answering this question ("What was the return on investment?").** So, in order to do this, we need to find out from each IPP, out of all the outcomes you measure, which

represent the most important and valued benefits for your community?  Some benefits are so positive and valuable to a community that even if they cost a lot, your community might be very clear that the costs are worth it.  This is critical for CDPH (as well as other potential funders) to know.  Your IPP business case not only provides the cost and benefit information for your CDEP-related activities, it will also provide information about what benefits are viewed as most valuable for your community which may have implication for future funding and programs.

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

### Why the Business Case is Important

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

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

### Making the Case

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

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

1.  Psychological Distress (K6)
2.  Sheehan Disability Scale (SDS)
3.  Social Isolation and Marginalization
4.  Subjective Spirituality & Religiosity
5.  Spiritual Wellness
6.  Community/Social Connectedness
7.  Cultural Connectedness
8.  Health (optional)

As part of your CDEP evaluation, you will also select additional mental health and other outcome measures.  You already are planning on how you want to evaluate progress in these measures.  Such site-specific outcomes could include some of the issues that you identified as

important issues in your initial grant applications, for instance: stigma, poor health, suicide, social exclusion/isolation, in school behavioral problems (youth), substance abuse, community violence, discrimination, homelessness, family problems, adult criminal justice involvement, prolonged suffering, youth criminal justice involvement, domestic violence, unemployment, child welfare system, education inequality, non-help-seeking, and poverty.

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

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

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

**Business Case Example**

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

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

**Tips for Reading & Using the Spreadsheet**

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

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

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

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

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

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

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

# SECTION 11: IPP EVALUATION PLAN INSTRUCTIONS

*Write what should not be forgotten.*
– Isabel Allende

## INTRODUCTION

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

> IPPs can submit their Evaluation Plan Templates using the link provided here (insert link).  IPPs will submit their evaluation plan no later than **April 30th**, **2017** and will receive written feedback from PARC@LMU within about **4-6** weeks of submission.

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

This section will cover:

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

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

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

## TECHNICAL INSTRUCTIONS

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

**Opening the Template**
To complete the template, simply click on the link above.

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

**Saving and Closing Your Work**

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

*Closing and Re-Opening a Partially Completed Template*

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

**Submitting the Evaluation Plan**

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

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

**Printing Your Evaluation Plan**

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

**GUIDANCE FOR COMPLETING THE TEMPLATE**

**Template Overview**

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

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Did you:

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

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

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

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

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

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

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

**CDEP Purpose**
Your CDEP purpose statement (no more than 3-4 sentences) should reflect: a) CDPH defined CDEP goals to prevent and/or reduce the severity of selected mental health conditions, b) desired

outcomes that are of importance to your community from a cultural perspective, and c) CDEP relationship to Phase 1 priority population strategies. Be specific, precise, clear, and goal oriented with desired outcomes that logically connect to the purpose of your CDEP.

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

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

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

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

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

*Helpful Questions*:

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

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

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

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

CDEP Components: Provide detailed information on the individual CDEP components that make up your project/program. If you have different programs/strategies within your CDEP, outline their components separately (e.g., if your CDEP has both direct and indirect program components, provide detailed information for each separately). Be sure to describe how your CDEP reflects the cultural values, practices, and beliefs of your community. When possible, provide relevant citations. *Remember the Cube. It should help ensure that you capture the cultural/linguistic/contextual depth and rich features of your CDEP and priority population.*

- For each CDEP program/strategy, include the following information for each individual component: type/name; length; duration; number of participants; participant demographic features; setting (geographic/physical location); who is implementing the CDEP and how; the timing of each component, and if applicable, their relationship to each other (e.g., if they are in sequential order and/or build on previous components).

**CDEP Components Example #1**

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

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

Component #3: Individual Family Sessions
Three sessions (1 hour each) will be held with each family (parent and child) after the *Platicas* and *Cuentitos* sessions are over. This phase is meant to gain and build family trust, cooperation, rapport, and cohesion between the parent and child. The insights gained from the psychoeducational sessions with parents will be used by the counselor to help the family build on and encourage the use of existing cultural resources/supports during times of stress. Although family discussions will be held about parental depression (i.e., with help from the counselor, parents talk about their depression, possible culturally inferred origins—spiritual elements—and answer questions from their children), the focus will be on recognizing the parent's/family's cultural strengths (protective factors). This will assist with replacing the imagery of parent mental illness/deficits with one of strength and resilience. All sessions will be held in the participating family's home at a day and hour that is most convenient.

**CDEP Components Example #2**

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

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

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

CDEP "Core" and "Optional" Elements: "Core" elements are *indispensable* to your CDEP components—they embody the theory, internal logic, and core values of your intervention and most likely produce the intervention's main effects (Kelly et al., 2000; McKleroy et al., 2006). The core elements are what make your program "work." (In other words, if you don't add cream to your macaroni and cheese, you don't have southern style mac and cheese.) Component #2 as an example, the warm hand-off is a core element while meeting on a Saturday morning is an optional element.

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

☐ In Qualtrics, remember to drag and drop the text entry from your CDEP Component box into either the Core Elements box or Optional Elements box.

Number of Program Cycles: Here you will list how many cycles of your CDEP you anticipate will be held within the grant period. If applicable, include your anticipated start/end date for each cycle, and number of participants per program cycle. Also, indicate whether each cycle will be an entirely new cohort of participants or whether previous participants can also be in subsequent cycles.

## Evaluation Questions and Measures

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

*Helpful hints:*

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

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

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

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

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

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

| EVALUATION QUESTIONS, INDICATORS AND MEASURES EXAMPLE | | | |
|---|---|---|---|
| **Evaluation Questions (please indicate whether it is process or outcome)** | **Process/Outcome Indicators** | **What instruments/data sources will be used to measure your key outcome indicators? Provide a brief description.** | **Development of New Instruments or Modifications Made To Existing Instruments to Make them Culturally and Linguistically Competent** |
| To what extent did youth's personal resilience and self-concept change? (**Outcome**) | #1: Peer problems<br>#2: Overall resilience<br>#3: Adherence to cultural practices, values & beliefs<br>#4: Involvement in meaningful social justice experiences | #1: Peer Problems Subscale from the Strengths and Difficulties Questionnaire (SDQ); Solantaus et al. (2010); youth and parent self-report<br>#2: Child and Youth Resilience Measure (CYRM-28); youth version; youth self-report<br>#3: Modified Phinney MEIM Scale; Phinney and Rotherman (2016)<br>#3 and 4: Focus group with youth; data used for instrument development by IPP evaluator and youth members | #2: Child and Youth Resilience Measure (CYRM-28): A focus group with LGBTQ youth in the community was held to create the 10 site-specific items that make up Section B of the tool. The final items represent specific challenges and coping strategies relevant to LGBTQ youth<br>#3: 6 culture specific items added to Phinney |

| | | | MEIM to reflect local cultural traditions related to family, spirituality, and community responsibility of the primary ethnocultural groups reflected in our CDEP #3-#4: Focus group protocol developed by IPP evaluator and IPP LGBTQ youth members |
|---|---|---|---|
| To what extent was the CDEP implemented as designed in the priority community? (**Process**) | #1: Number, type, and frequency of youth participation #2: Number and type of outreach/recruitment conducted | #1: Sign in sheets with demographics and activity codes #2: Outreach/recruitment sheets | All sign-in sheets will be translated into the languages spoken by our CDEP participants including Spanish and Thai |

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

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

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

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

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

Evaluation Sub-populations: Describe the sub-populations (i.e., subset of your population that shares one or more additional characteristics such as 9th and 11th grade LGBTQ youth; out of school LGBTQ youth etc.) that will be represented in your evaluation sample.

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

Sampling Method: Select the type of sampling method (probability or non-probability) and its associated technique.

Power Analysis: Indicate if a power analysis was conducted and indicate if your sample size is sufficiently powered.

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

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

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

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

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

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

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

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

| DATA COLLECTION PLAN EXAMPLE | | | | |
|---|---|---|---|---|
| **Name of Instrument/ Data Source** | **Timing of Data Collection** | **Data Collection Protocol** | **Data Storage/ Security** | **Training** |
| 1. Columbia-Suicide Severity Rating Scale (C-SSRS) <br> 2. Patient Health Questionnaire (PHQ-9) <br> 3. Alcohol Use Disorders Identification Test (AUDIT) | Pre and Post | Pre- and post-assessments will be completed (self-administered, paper/pencil, 20 minutes in total) by CDEP participants in a group setting at the Community Center, within 1 week of program intake. Frontline staff will welcome participants and provide information about the assessment purpose and content, and instructions for completing the tool. Participants will have an opportunity to ask questions and provide their verbal or written consent to participate in the evaluation. Staff will be available during the assessment to answer any questions that arise. Participants will return to the Community Center within 1 week of program completion to do the post-assessment (self-administered, paper/pencil, 20 minutes in total). Frontline staff will remind participants of the purpose of the assessment and provide instructions for | Assessment data will be input to Microsoft Excel. Assessments will be tracked with a unique client identifier rather than by respondent name (e.g. initials + last 4 digits of phone number). All hard-copy surveys will be stored in a locked cabinet in the data analyst's office to which only select IPP personnel will have access. | All CDEP staff regardless of their role in data collection will participate in a comprehensive training detailing 1) the purpose of the evaluation; 2) data collection protocols; 3) frequently asked participant questions that can arise during survey administration; and 4) the proper procedures for the handling and storage of the surveys once they've been collected. During the training, staff will have an opportunity to practice administering and taking the survey so they can troubleshoot any potential administration challenges. |

| | | | | |
|---|---|---|---|---|
| | | completion. | | |
| 4. Focus Group | Within two weeks of the program start | The CDEP evaluator will facilitate two separate focus groups with newly enrolled CDEP participants in a private room at the IPP facility. Hand held tape recorders will be used to audio record the focus group discussion. An additional staff member will be present to take hand written notes. Before the group starts, the evaluator will explain the purpose of the focus group and shared agreements for participation. Focus groups should take about 1 hour each. | All audio recordings will be transcribed and merged with the handwritten notes. Afterwards, the recordings and notes will be stored in a locked cabinet in the evaluator's office. Pseudonyms will be used in any written reports generated from the focus group findings. | The evaluator has over 15 years of qualitative data collection experience, including the facilitation of focus groups. The evaluator will train the staff member on how to take notes during the focus group discussion. |
| 5. Program Records (attendance rosters) | Monthly | Frontline staff who facilitate the monthly group sessions will ask attendees to sign-in at each session. The sign-in sheet will include participants' names, phone number, and date and time of the event. Monthly CDEP meetings last about 1.5 hours each. | The attendance sheets will be stored in a locked cabinet in the IPP office to which only key staff will have access. | All frontline staff that facilitate monthly CDEP meetings will be trained on the importance of consistent and complete gathering and filing of attendance data. The evaluator will periodically review the sign-in sheets to ensure they are being filled out properly. |
| 6. Death Statistical Data Tables | Annually | Data tables will be retrieved from the CDPH website. | All data files will be stored on the evaluator's password protected computer. | The evaluator has 6 years of quantitative data training, with specific subject-matter specialists in secondary data analysis. |

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

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

IRB Approval: Indicate whether your evaluation plan requires IRB approval, where you will be submitting, and your status in the submission/approval process.

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

**Fidelity Assessment**

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

Fidelity Dimension and Criteria: Fidelity is often examined across at least five dimensions: adherence, exposure, quality of delivery, participant responsiveness, and program differentiation. Indicate which dimensions you will be examining and your criteria for each dimension.

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

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

**Dissemination Plan**

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

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

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

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

Dissemination Methods: Apart from the Phase 2 Final Convening, how will findings be disseminated (e.g., detailed reports, news releases, press conferences, seminars, or email-based list serves, website, community meetings/town halls, etc.)?
- How will you ensure dissemination is culturally/linguistically/contextually accessible and relevant to your priority population and other key stakeholders?

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

# SECTION 12: IPP EVALUATION REPORT

*Until the lion can tell his own stories, tales of the hunt will be told by the hunter.*
--Old African Proverb

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

*The final report should describe the "What," the "How," and the "Why It Matters" questions about your program.*
-CDC, 2013

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

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

Other standards detailed by professional organizations include:

- CDC Developing An Effective Evaluation Report(2013)
- Transparent Reporting of Evaluations With Non-experimental Designs (includes a 22-item checklist; (TREND; Des Jarlais, Lyles, Crepaz, & the TREND Group, 2004),
- Reporting Standards for Research in Psychology (American Psychological Association Publications and Communications Board Working Group on Journal Article Reporting Standards, 2008), and
- Standards for Reporting on Empirical Social Science Research in American Educational Research Association Publications (American Educational Research Association, 2006)

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

The report sections include:

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

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

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

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

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

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

**4. CDEP Purpose and Description**

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

**5. Evaluation Questions**

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

**6. Methods**

CDEP Implementation

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

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

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

Evaluation Study Participants and Recruitment

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

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

> *Helpful hint*: Refer to the following links for examples of how this information has been presented in other evaluation reports.
>
> Final Evaluation Report Example #1
>
> Final Evaluation Report Example #2

Measures and Data Collection Procedures

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

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

Fidelity and Flexibility

Fidelity is often examined across at least five dimensions: adherence, exposure, quality of delivery, participant responsiveness, and program differentiation. It will be important to

consider issues of flexibility—how did your measurement tools and protocols capture changes to your program or evaluation to meet local circumstances?  In this section please describe:

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

Statistical Analyses

- For quantitative data briefly describe the statistical procedures that were used and identify the specific inferential tests, effect-size metrics, and comparisons tested.
- For qualitative data, describe how the data was coded and analyzed, including any inter-rater reliability methods used.

Qualitative Data Analysis

- For qualitative data briefly describe the procedures that were used to review, organize, code, and interpret your data.

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

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

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

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

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

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

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

## 8.  Discussion

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

In this section you will indicate:

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

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

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

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

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

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

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