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Creating Community Solutions
Evaluation Report

September 29, 2015

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Office of Communications
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Executive Summary

On January 16, 2013, President Barack Obama directed Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services and Secretary Arne Duncan of the U.S. Department of Education to launch a national conversation on mental health to reduce the shame and secrecy associated with mental illness, encourage people to seek help if they are struggling with mental health problems, and encourage individuals whose friends or family are struggling to connect them to help. The emphasis of the initiative was on community-based solutions and a national scope.

The National Dialogue on Mental Health (National Dialogue) was launched to give Americans a chance to learn more, from research and from each other, about mental health issues. People across the nation have organized community conversations to assess how mental health problems affect their communities and to discuss topics related to the mental health of young people. In a variety of ways, they have taken action to improve mental health in their families, schools and communities. These actions have encompassed the prevention of mental illness, promotion of mental health, public education and awareness, early identification, treatment, crisis response, and supports for recovery.

An evaluation of CCS was conducted to understand the extent to which a large-scale public conversation can lead to greater public awareness, education, and local action on mental health and what it takes to connect local conversations to issues of national significance. Since the spring of 2013, CCS helped to organize 6 lead city, large-scale dialogues reaching 1,741 participants, and 258 distributed conversations, totaling over 11,000 participants. An innovative, texting-supported, face-to-face process called “Text, Talk, Act” (TTA) engaged an additional 27,500 participants. In total, the project has touched directly over 40,000 individuals.

The conclusion from the evaluation is positive: Mental health conversations, which varied in length across CCS platforms, demonstrate improvements in awareness and education and have led communities to some remarkable outcomes to improve mental health, especially for youth. The evaluation found that the themes and actions across all platforms have been remarkably consistent. The evaluation team’s analysis showed that CCS events have had a positive impact on individuals participating in the conversations, and participants have come away with a commitment to take actions that engage new voices and partnerships to improve mental health. While TTA and many of the distributed conversations were designed to be singular events, the ongoing work in the lead cities and in some of the distributed conversations makes it evident that CCS has tapped a broad interest in doing something significant about mental health.

To make a difference in the prevention, early identification, and treatment of youth, this evaluation concludes with a broad set of findings drawn from all of the CCS work:

- Traditional attempts to convene on-line dialogues do not create broad participation, but provided direction as to how to engage youth more directly;
- Community engagement lends a new and legitimate voice to improve local mental health services and address community needs;
Recommendations for local action are remarkably consistent across platforms;

New partnerships have been created nationally and, in the lead cities, have led to some clear outcomes;

Conversations on mental health are an important starting point in changing social norms about mental health; and

Differences in participation rates may offer the opportunity to target conversations to populations.

The following recommendations are presented to SAMHSA and other communities interested in using community-based dialogues as a method to continue to build comprehensive action on mental health.

1. Sustain local action planning effort in lead cities and other communities;
2. Create replicable mental health awareness campaigns;
3. Establish a national home to coordinate and sustain this model of community engagement;
4. Offer multiple engagement platforms to scale conversations;
5. Use toolkits and materials to create ready community capacity and look to target specific populations;
6. Develop a training system to help community members and institutions organize and conduct community dialogues;
7. Provide support for continuing the planning and implementation process that follows a community dialogue;
8. Build coalitions and partnerships; and
9. Don’t wait for another tragedy to spur action on mental health.
Chapter 1. Creating Community Solutions

On January 16, 2013, President Barack Obama directed Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services and Secretary Arne Duncan of the U.S. Department of Education to launch a national conversation on mental health to reduce the shame and secrecy associated with mental illness, encourage people to seek help if they are struggling with mental health problems, and encourage individuals whose friends or family are struggling to connect them to help. From the beginning, there was a clear emphasis on community-based solutions and a national scope.

One of the key elements of the National Dialogue on Mental Health is Creating Community Solutions (CCS), an unprecedented attempt to engage Americans in deliberation and action on a pressing national issue. Under the CCS banner, non-profit organizations, government agencies, health care providers, and mental health associations organized large-scale deliberative processes, small-group dialogues, and text-supported conversations to involve thousands of people in assessing and strengthening our nation’s mental health.

Since the spring of 2013, CCS has helped organize 6 lead city large-scale dialogues reaching 1,741 participants, and 258 distributed conversations, totaling over 11,000 participants. An innovative, texting-supported, face-to-face process called “Text, Talk, Act” has engaged an additional 27,500 participants. In total, the project has touched directly over 40,000 individuals. These CCS activities have taken place in all 50 states. In addition, to date, social media efforts have generated over 1.64 billion impressions using #MentalHealthMatters and #TextTalkAct.

This evaluation of CCS will help us better understand how a large-scale public conversation can lead to greater public awareness, education, and local action on mental health and what it takes to connect local conversations to issues of national significance.

National Dialogue on Mental Health: A National Initiative

The tragedy at Sandy Hook Elementary School in Newtown, Connecticut, in December 2012 threw a national spotlight on the issue of mental health, especially as it affects our young people. While some people quickly drew a connection between mental illness and violence, others pointed to research showing people with mental illness are no more violent than other people. The incident led many inside and outside government to embrace mental health as a critical public health priority.

The National Dialogue on Mental Health (National Dialogue) was launched to give Americans a chance to learn more, from research and from each other, about mental health issues. People across the nation have organized community conversations to assess how mental health problems affect their communities and to discuss topics related to the mental health of young people. In a variety of ways, they have taken action to improve mental health in their families, schools and communities. These actions have encompassed the prevention of mental illness, promotion of mental health, public education and awareness, early identification, treatment, crisis response, and supports for recovery.
This National Dialogue involved two-way communication to engage citizens in conversations about health, such as the healthy communities movement, public deliberation on health policy decisions, and the practices of patient engagement and patient-centered care. These forms of engagement in health give people two-way opportunities to tell their stories, consider choices and options, and plan for action (Nabatchi and Leighninger 2015).

**CCS Role in the National Dialogue**

Creating Community Solutions was designed to apply the principles and practices of deliberative democracy, as an intensive form of two-way communication, within the framework of a National Dialogue. Government officials from the Substance Abuse and Mental Health Services Administration, an agency within the Department of Health and Human Services, understood the need to foster the field of deliberative democracy to design a process that integrated multiple levels of collaboration. Dr. Carolyn Lukensmeyer of the National Institute for Civil Discourse (NICD) spearheaded planning for this national effort. NICD, AmericaSpeaks, the Deliberative Democracy Consortium, Everyday Democracy, the National Issues Forum, and the National Coalition for Dialogue and Deliberation joined to form the Creating Community Solutions coalition.

Deliberative democracy is an approach to public engagement in which citizens engage meaningfully with each other and with government to produce better decisions and better solutions to public problems. In deliberation, people compare values and experiences, and consider a range of views and policy options. In short, people with different opinions decide together what they think should be done about a public issue.

Thus, CCS served as the coalition that brought together diverse public viewpoints in a national dialogue on mental health. Over the course of one year, this coalition employed several innovative strategies to engage the public across the nation.

**CCS Goals**

Convening a truly nationwide process has been a paramount challenge for public participation practitioners. Previously, leading organizations have demonstrated how to bring diverse citizen voices together to influence policy decisions but these models have rarely been taken to scale. With CCS, the coalition was poised to integrate their efforts to produce nationwide public participation.

From the beginning, CCS used three main goals as stated by President Obama:

1. Get Americans talking about mental health to break down barriers and promote recovery and healthy communities;
2. Find innovative community-based solutions to mental health needs, with a focus on helping young people; and
3. Develop clear steps for communities to move forward in a way that complements existing local initiatives and activities.
CCS Strategies

CCS has organized and/or supported three main forms of participation:

- In the cities of Albuquerque (NM), Birmingham (AL), Columbus (OH), Greater Kansas City (MO/KS), Sacramento (CA), and Washington, DC, one of the CCS organizations helped form a local steering committee, led by the mayor, for a large-scale process leading to a metro-wide action plan for strengthening mental health, with up to $200,000 raised in each city for the implementation of the plan;
- In 258 cities and towns, CCS has helped local organizers host deliberative forums or town meetings;
- On 4 occasions, CCS has held “Text, Talk, and Act,” a nationwide, text-enabled, face-to-face discussion on mental health.

In all three formats, participants used an array of materials produced by CCS to learn more about mental health, survey some of the options for strengthening mental health, and recommend measures to be included in local action plans.

CCS Leadership

SAMHSA

A coalition of public participation organizations formed to organize and support the CCS process. In collaboration with SAMHSA, the CCS coalition created a discussion guide, information brief, and grassroots organizing guide to support communities in creating opportunities for dialogue and change on mental health. SAMHSA also designed and distributed an infographic, displaying mental health statistics in a community setting. These materials were used or modified for the Distributed Community conversations across the country, and adapted for the centralized conversations in the lead cities. “Text, Talk, Act,” an initiative designed to expand participation in learning, discussion and citizen action, also gave participants—particularly young people—a chance to identify themes and ideas that could be reported to SAMHSA and other agencies.

National Organizations

The organizing group for Creating Community Solutions consisted of six different national organizations:

1. AmericaSpeaks—AmericaSpeaks’ mission has been to reinvigorate American democracy by engaging citizens in the public decision-making that most impacts their lives.

2. The Deliberative Democracy Consortium (DDC)—DDC is an alliance of the major organizations and leading scholars in the field of deliberation, public engagement, and democratic governance. The DDC represents more than 50 practitioner organizations, operating foundations, and universities, collaborating to support research activities and advance democratic practice in North America and around the world.

3. Everyday Democracy—Everyday Democracy is the primary project of The Paul J. Aicher Foundation, a nonpartisan operating foundation dedicated to strengthening democracy. Everyday
Democracy helps people organize, have dialogues, and take action on issues they care about, so that they can create communities that work for everyone. It helps community coalitions strengthen their capacity to bring a racial equity lens to every aspect of public engagement and problem solving. Everyday Democracy’s ultimate goal is to contribute to the creation of a strong, equitable democracy that values everyone's voice and participation.

4. **The National Issues Forums Institute (NIFI)**—NIFI is a nonprofit, nonpartisan organization that serves to promote public deliberation and coordinate the activities of the National Issues Forums network. Its activities include publishing the issue guides and other materials used by local forums groups, encouraging collaboration among forum sponsors, and sharing information about current activities of the network.

5. **The National Coalition for Dialogue & Deliberation (NCDD)**—NCDD is a community of practice, a clearinghouse for resources and news, and a gathering place for thousands of innovators in dialogue, deliberation and public engagement.

6. **The National Institute for Civil Discourse (NICD)**—NICD integrates research and practice to support and enable a congress and executive branch working to solve the big issues facing the country, public demand for civil discourse and media that informs and engages citizens.

### Creating Community Solutions Evaluation

SAMHSA provided funding to support the CCS initiative under the evidence-based hypothesis that representative, well-structured community engagement would lead to greater understanding and awareness of mental health and mental illness and that the results of community engagement would lead to specific actions to expand access to mental health services, enhance the quality of mental health services, and improve mental health across the lifespan. Figure 1 is a logic model showing the inputs, activities, outputs, and expected outcomes of the CCS initiative. Activities included community meetings and conversations through text messaging. These activities were considered important contributors to achieving short-term, intermediate, and, ultimately, long-term outcomes. Participation in the CCS initiative was also considered an important output and the number of individuals participating and their diversity was deemed critical for producing the desired outcomes.

SAMHSA requested an evaluation of the CCS initiative to assess its effectiveness in achieving the intended outcomes. The logic model for CCS assumes that education and awareness are short-term outcomes of the initiative; collaborative action, new and expanded mental health services, and new linkages follow later and are intermediate outcomes; and improved mental health services are more distal outcomes that will take longer to appear, because they are affected through changes in attitudes and practices of community members, mental health providers, and the mental health system as a whole. Nevertheless, this evaluation sought to document signs that communities were on a path toward changing awareness of mental health needs and expanding and improving mental health services, especially for young people. Successful efforts to increase education, awareness, and engagement of individuals from diverse demographic and professional backgrounds are a logical precursor to changes in mental health services, as illustrated in the logic model below.
The remainder of this chapter discusses the evaluation questions, data collection methods, and analysis plan.

**Research Objective and Evaluation Questions**

The objective of the CCS evaluation was to analyze the outcomes of the Lead Cities and Distributed Community conversations, as well as conversations that occurred through the Text, Talk, and Act (TTA) mobile platform. The evaluation’s focus was on documenting outcomes related to awareness, education, changes in social norms, and local action supporting improved mental health in communities where CCS events took place.

Six questions guided the evaluation:

- **Question 1:** To what extent did CCS dialogue and action lead to increased education, awareness, and collaborative action for mental health?
- **Question 2:** What are the important issues and themes that emerge across the community conversations?
- **Question 3:** How did social norms change as a result of CCS dialogue/community conversation?
- **Question 4:** What were the themes in action plans in Lead Cities and Distributed Community Conversations?
• **Question 5:** To what extent did CCS dialogue and action produce new linkages and collaboration among local actors for mental health education, awareness and/or collaborative action?

• **Question 6:** In what ways are the impacts different or similar considering and comparing (1) different levels of organizing effort and investment in the CCS event and resulting community processes, and (2) different CCS strategies applied?

The first two questions and Question 6 are relevant for conversations occurring across all three CCS platforms (Lead Cities, Distributed Community, and TTA). Questions 3, 4, and 5, focusing on changes in social norms, action plans, and new linkages, are applicable only for Lead Cities and Distributed Community conversations. Action plans were not developed from conversations that occurred through the TTA mobile platform, which mainly involved young people throughout the U.S. engaging in dialogues on mental health through text messaging. Moreover, changing social norms and new linkages and collaboration were not objectives of the TTA initiative.

**Data Collection Methodology**

The emphasis of the evaluation was on a multi-method, multi-informant design, with the analyses drawing upon four data sources:

• *Surveys* conducted pre and post events in the lead cities;

• *Polling data* collected from more than 1400 individuals participating in lead city conversations;

• *Telephone interviews* with organizers and leaders of and participants in CCS conversations; and

• *Written documents*, including reports on each Lead City event, community action plans, and an earlier evaluation of Text, Talk, and Act.

Table 1.1 provides an overview of the evaluation questions and data sources for the evaluation.
Table 1.1. Evaluation Questions and Data Sources

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>CCS Platform for which Question is Relevant</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To what extent did CCS dialogue and action lead to increased education, awareness, and collaborative action for mental health?</td>
<td>• All</td>
<td>• Surveys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Key informant interviews</td>
</tr>
<tr>
<td>2. What are the important issues and themes that emerge across the community conversations?</td>
<td>• All</td>
<td>• Surveys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Polling data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Key informant interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Documents: Reports, action plans</td>
</tr>
<tr>
<td>3. How did social norms change as a result of CCS dialogue/community conversation?</td>
<td>• Lead Cities</td>
<td>• Key informant interviews</td>
</tr>
<tr>
<td></td>
<td>• Distributed Community Conversations</td>
<td></td>
</tr>
<tr>
<td>4. What were the trends in action plans in Lead Cities and Distributed Community Conversations?</td>
<td>• Lead Cities</td>
<td>• Surveys</td>
</tr>
<tr>
<td></td>
<td>• Distributed Community Conversations</td>
<td>• Documents: Action plans</td>
</tr>
<tr>
<td>5. To what extent did CCS dialogue and action produce new linkages and collaboration among local actors for mental health education, awareness and/or collaborative action?</td>
<td>• Lead Cities</td>
<td>• Key informant interviews</td>
</tr>
<tr>
<td></td>
<td>• Distributed Community Conversations</td>
<td></td>
</tr>
<tr>
<td>6. In what ways are the impacts different or similar considering and comparing (1) different levels of organizing effort and investment in the CCS event and resulting community processes, and (2) different CCS strategies applied?</td>
<td>• All</td>
<td>• Polling data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Key informant interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Documents: Reports, action plans</td>
</tr>
</tbody>
</table>

Quantitative Polling Data

Polling data was collected with participants in each of the six Lead Cities. The evaluation team was able to obtain individual participant responses from five cities; for the sixth city (Birmingham, AL), only aggregate survey data were available. Survey questions asked participants to provide demographic information (age, race, ethnicity, education level), as well as their prior experience with mental illness. A small number of questions were asked before and again immediately after the event. These included questions about how confident the participant was that participants in the day’s discussion can develop an effective plan to address mental health challenges in the community; the phase of life that adult mental illnesses begin; and the likelihood that a person seeking to recover from mental illness can do so. Two questions were only asked on the post-event survey: whether the discussion helped the participant better understand mental health challenges in their local community and whether their views changed about addressing mental health challenges.

Participant Recommendations

During each type of conversation (Lead Cities, Distributed Community Conversations, and TTA), participants shared their perspectives and ideas about mental health issues and how to address them in their communities. This information was obtained through polling, text messaging, and discussions about action steps during the dialogues and events.
Telephone Interviews

Members of the evaluation team interviewed 24 key informants associated with conversations occurring on each platform. Key informants fell into three categories: leaders, organizers, and participants. The purpose of the interviews was to obtain different perspectives on the implementation and effectiveness of the CCS initiative. For Lead Cities, the evaluation team interviewed an informant in each category at each Lead City (total of 18 interviews). The evaluation team also interviewed one key informant within each category for both the Distributed Community Conversations and TTA (three interviews for each of these platforms, a total of six interviews). The evaluation team used a separate interview guide for each platform, tailoring the questions to the process of conducting the community conversations and the desired outcomes of conversations on each platform. Interviewers sent the questions to key informants prior to the interview. Interviews lasted approximately 45 minutes.

Document Review

The evaluation team reviewed documents prepared after CCS events. These included reports prepared by leaders and organizers summarizing what took place and themes that emerged from the conversations, action plans developed by six lead cities, and an evaluation previously conducted for Text, Talk, and Act. These documents provided information about the length and format of events, the topics discussed and questions asked, and the number and diversity of participants.

Analysis Methods

The evaluation used systematic, quantitative and qualitative methods to analyze and synthesize the data that were collected. For the survey data, collected from lead cities, the evaluation team compiled descriptive statistics to show the demographic characteristics of individuals participating in each of the lead cities conversations and the differences across sites. For the questions that were asked before and immediately after the event, the team calculated the change from the initial response to the post-event response to examine both the proportions and directionality of participants’ changes in views. To compare across lead city sites, the evaluation team examined the mean change in responses by site and tested for statistical significance using basic significance tests to determine whether changes differed significantly for various subgroups of participants. For the two questions that were only asked following the events, the evaluation team compared response rates both overall and by lead city site. Variations were tested for statistical significance using appropriate statistical tests, primarily chi square goodness of fit tests for cross-site comparisons.

Qualitative methods were used to analyze three types of data: (1) the polling data and text messages, (2) data collected during telephone interviews, and (3) information abstracted from action plans and other documents. The evaluation team coded these data for overall themes. The coding scheme aligned with the evaluation questions, and sub-codes were then created within the primary codes to further segment the data. The coding scheme was refined, as needed, as the coding process progressed. To ensure accurate coding, two evaluators independently coded data from one interview and then met to check for consistency of coding and to resolve discrepancies. When an acceptable level of inter-coder reliability was reached, (e.g., with Kappas ranging from .80 – 1.00 and percent agreement from 90 – 100 percent for each code), the two evaluators then independently coded the remaining data. Qualitative data analysis software—either ATLAS.ti or NVivo—was used to assist in coding, organizing, and analyzing the polling data, text messages, and the interview data.
The evaluation team had two main goals for analyzing the qualitative data. First, the team analyzed themes to develop a detailed understanding of the implementation and outcomes of community conversations occurring through each platform. Second, the evaluation team conducted an analysis across platforms to identify themes and patterns in the implementation process and outcomes of the overall CCS initiative.

Outcomes of the conversations occurring through each platform are discussed in the next three chapters. Each chapter begins with an overview of the objectives and format of the conversations and then summarizes the outcomes for each of the relevant evaluation questions, above, and lessons learned. The final chapter of this report discusses outcomes for the CCS initiative and recommendations for community-based solutions to mental health issues and future community conversations.
Chapter 2: Lead Cities

Lead Cities Initiative: Overview

The Creating Community Solutions initiative was initiated with six lead cities that conducted dialogues on a common set of topics. Each city committed to a set of objectives and process to enable comparative analysis of results.

The common objectives included:

- Achieve a demographically representative sample of participants with an oversample of youth aged 16-24;
- Conduct dialogues that enabled participants to explore a common set of topics in depth;
- Use a common pre- and post-test for evaluation purposes; and
- Commit to an action planning process to ensure that recommendations from the dialogue are implemented.

The general format for the discussions included presentations and information on mental health using a discussion guide. There were four main discussion sessions and topics during what was generally a six-hour day.

1. The importance of mental health in the community
2. The challenges in addressing mental health
3. Recommendations for improving mental health for youth (two age bands: 12-17; 18-24)
4. Recommendations for the action planning steps

Each lead city used a dialogue process that included roundtable conversations with a variety of participants at each table. Conversations lasted about 40 minutes for each topic. Dialogues were led by trained facilitators. Inputs and recommendations were themed and voted upon.

The process used in each lead city enabled participants to build knowledge and awareness and explore the topics in greater depth. Each conversation built on the previous discussion and presentation. The flow of the day was designed to enable participants to create a working base of knowledge on mental health and proceed to discuss recommendations that would contribute to action planning in their community.

The table in Appendix 1 describes the tools and processes that were used in each of the lead cities. It explains the process and timing used by each lead city in the dialogues that were convened and the action planning that followed.

All cities used a process that involved a diverse, large conversation of participants. Cities convened steering committees and action planning teams to design the process, analyze results, and implement the recommendations through action plans. Some cities, including Birmingham, Columbus, and Albuquerque, used neighborhood planning processes to further augment their findings and deepen the community engagement process.
## Overall Demographic Composition of Lead City Events

Table 2.1 below summarizes participation in the lead city events across demographic categories.

### Table 2.1. Demographic Summary of Lead City Event Participants

<table>
<thead>
<tr>
<th>Demographic Categories</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
</tr>
<tr>
<td><strong>Number of Participants</strong></td>
<td>1741</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>1. Male</td>
<td>529</td>
</tr>
<tr>
<td>2. Female</td>
<td>1120</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1649</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>1. Asian American/Pacific Islander</td>
<td>95</td>
</tr>
<tr>
<td>2. Black/African American</td>
<td>603</td>
</tr>
<tr>
<td>3. Latino/Hispanic</td>
<td>147</td>
</tr>
<tr>
<td>4. Native American/American Indian</td>
<td>18</td>
</tr>
<tr>
<td>5. White/Caucasian</td>
<td>485</td>
</tr>
<tr>
<td>6. More than one race</td>
<td>119</td>
</tr>
<tr>
<td>7. Other</td>
<td>33</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1500</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>1. 14-18</td>
<td>219</td>
</tr>
<tr>
<td>2. 19-24</td>
<td>123</td>
</tr>
<tr>
<td>3. 25-34</td>
<td>201</td>
</tr>
<tr>
<td>4. 35-44</td>
<td>199</td>
</tr>
<tr>
<td>5. 45-54</td>
<td>280</td>
</tr>
<tr>
<td>6. 55-64</td>
<td>304</td>
</tr>
<tr>
<td>7. 65 and better</td>
<td>155</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1481</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>1. Elementary or middle school</td>
<td>12</td>
</tr>
<tr>
<td>2. Some high school</td>
<td>107</td>
</tr>
<tr>
<td>3. High school graduate</td>
<td>61</td>
</tr>
<tr>
<td>4. Some college</td>
<td>148</td>
</tr>
<tr>
<td>5. College graduate</td>
<td>228</td>
</tr>
<tr>
<td>6. Post-college degree</td>
<td>350</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>906</td>
</tr>
</tbody>
</table>
As shown in Table 2.1, a total of 1,741 individuals participated in the lead cities conversations. The lead cities were successful in getting demographically diverse participation. Across all cities, 68 percent (68%) of participants were female and 32 percent (32%) were male. The racial/ethnic makeup of participants was also diverse, although due to the high African American population in two of the lead cities (i.e., Washington, DC and Birmingham), African Americans were overrepresented:

- Forty percent (40%) of participants were African American
- Thirty two percent (32%) were White Caucasian
- Ten percent (10%) identified themselves as Latino
- Six percent (6%) were Asian American
- Eight percent (8%) self-identified as being more than one race
- Two percent (2%) indicated marked “Other” when asked about their race

Because of recruitment strategies and objectives, the lead cities were highly successful in achieving strong youth participation. Youth participation aged 14-24 was 24 percent.

### Analysis of Individual-Level Participant Data

Of the six lead city sites hosting day long events, five cities maintained survey data with individual participant responses. The sixth city, Birmingham, reported participant responses in aggregate following their event. Because individual participant responses were unavailable for the next set of analysis, the aggregate data from Birmingham has been excluded.

Surveys conducted at the beginning of lead cities events, asked participants about their prior experience with mental health. Nearly 89 percent of participants reported some prior experience with mental illness, with 75 percent reporting first-hand experience with a family member or friend’s mental health issues. Among those with prior experience with mental illness, over 50 percent reported having direct personal experience with mental health issues. Only 37 percent of those with prior experience with mental illness identified as mental health service providers. Lastly, more than half of those with prior mental health experience reported two or more types of prior experience amongst the three categories.
Table 2.2 illustrates the composition of lead city events by different demographic categories. As noted above, the lead city events drew an ethnically and racially diverse set of attendees across the five cities. However, the racial and ethnic representation was not spread equally across the five cities. Lead city sites had statistically significant differences \((p < .001)\) in the racial and ethnic composition of participants. Participants at the Washington, DC event identified more frequently as Black/African American as compared to other sites, while larger proportions of attendees identified as Latino/Hispanic in Albuquerque and Sacramento than elsewhere. This can be explained by the overall racial and ethnic composition of the population in these cities.

While the lead city sites overall had a wide representation of different age groups, similar to race, the differences in the composition of participants at the individual sites are statistically significant \((p < .001)\). While those 18 and under comprised nearly 14 percent of total attendees, the 66 participants under 18 in Washington, DC represented 22 percent of that event’s attendees, and over 40 percent of all the under 18 participants in total. Sacramento, on the other hand, had a smaller proportion of attendees (approximately 8 percent) between 35 and 44 than other sites.

Attendees’ prior experience with mental health was also significantly different across sites \((p = .041)\). While the majority of attendees reported prior experience with mental illness, Washington, DC (approximately 15 percent) and Sacramento had larger proportions of attendees (approximately 15 percent and 14 percent respectively) without prior experience with mental illness. Of those attendees with prior mental illness experience, each lead city drew a fairly equal proportion of mental health service providers (between 35 percent and 42 percent per lead city). The vast majority of attendees had prior experience with a family member’s or friend’s mental illness, although these proportions varied across sites. At several sites, except Columbus and Washington, DC, over half of participants had direct personal experience with mental illness. Lastly, in Albuquerque, Kansas City, and Sacramento, more than half of the attendees had prior mental illness experience across two or more of the aforementioned categories.
### Table 2.2. Comparison of Participant Demographics Across Lead Cities

<table>
<thead>
<tr>
<th>Demographic Categories</th>
<th>Albuquerque</th>
<th>Birmingham</th>
<th>Columbus</th>
<th>Washington, DC</th>
<th>Kansas City</th>
<th>Sacramento</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Participants</strong></td>
<td>271</td>
<td>301</td>
<td>101</td>
<td>353</td>
<td>333</td>
<td>370</td>
<td>1741</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Male</td>
<td>81</td>
<td>77</td>
<td>21</td>
<td>98</td>
<td>78</td>
<td>89</td>
<td>528</td>
</tr>
<tr>
<td>2. Female</td>
<td>81</td>
<td>91</td>
<td>70</td>
<td>76</td>
<td>81</td>
<td>92</td>
<td>508</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>272</td>
<td>300</td>
<td>101</td>
<td>353</td>
<td>333</td>
<td>370</td>
<td>1741</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Asian American/Pacific Islander</td>
<td>7</td>
<td>2</td>
<td>6</td>
<td>21</td>
<td>21</td>
<td>7</td>
<td>95</td>
</tr>
<tr>
<td>2. Black/African American</td>
<td>2</td>
<td>21</td>
<td>41</td>
<td>56</td>
<td>164</td>
<td>29</td>
<td>603</td>
</tr>
<tr>
<td>3. Latino/Hispanic</td>
<td>67</td>
<td>27</td>
<td>13</td>
<td>6</td>
<td>43</td>
<td>13</td>
<td>147</td>
</tr>
<tr>
<td>4. Native American/Indian</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>5. White/Caucasian</td>
<td>114</td>
<td>47</td>
<td>52</td>
<td>29</td>
<td>49</td>
<td>16</td>
<td>485</td>
</tr>
<tr>
<td>6. More than one race</td>
<td>18</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>42</td>
<td>7</td>
<td>119</td>
</tr>
<tr>
<td>7. Other</td>
<td>4</td>
<td>1</td>
<td>0.32</td>
<td>1</td>
<td>1.23</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>240</td>
<td>100</td>
<td>175</td>
<td>122</td>
<td>275</td>
<td>91</td>
<td>1500</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. 14-18</td>
<td>26</td>
<td>26</td>
<td>21</td>
<td>4</td>
<td>66</td>
<td>22</td>
<td>219</td>
</tr>
<tr>
<td>2. 19-24</td>
<td>15</td>
<td>6</td>
<td>31</td>
<td>0.00</td>
<td>20</td>
<td>6</td>
<td>123</td>
</tr>
<tr>
<td>3. 25-34</td>
<td>28</td>
<td>11</td>
<td>56</td>
<td>18.12</td>
<td>32</td>
<td>11.07</td>
<td>201</td>
</tr>
<tr>
<td>4. 35-44</td>
<td>44</td>
<td>18</td>
<td>48</td>
<td>15.53</td>
<td>15</td>
<td>12.15</td>
<td>144</td>
</tr>
<tr>
<td>5. 45-54</td>
<td>44</td>
<td>18</td>
<td>49</td>
<td>15.86</td>
<td>22</td>
<td>13.16</td>
<td>280</td>
</tr>
<tr>
<td>6. 55-64</td>
<td>48</td>
<td>19</td>
<td>50</td>
<td>16.18</td>
<td>25</td>
<td>50</td>
<td>304</td>
</tr>
<tr>
<td>7. 65 and better</td>
<td>38</td>
<td>15</td>
<td>17</td>
<td>5.50</td>
<td>12</td>
<td>31</td>
<td>157</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>243</td>
<td>100</td>
<td>175</td>
<td>122</td>
<td>275</td>
<td>91</td>
<td>1500</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Elementary or middle school</td>
<td>2</td>
<td>0.82</td>
<td>—</td>
<td>4</td>
<td>4.94</td>
<td>1.35</td>
<td>12</td>
</tr>
<tr>
<td>2. Some high school</td>
<td>21</td>
<td>8.57</td>
<td>—</td>
<td>0.00</td>
<td>63</td>
<td>21.28</td>
<td>107</td>
</tr>
<tr>
<td>3. High school graduate</td>
<td>12</td>
<td>4.90</td>
<td>—</td>
<td>2</td>
<td>2.47</td>
<td>7.43</td>
<td>61</td>
</tr>
<tr>
<td>4. Some college</td>
<td>38</td>
<td>15.51</td>
<td>—</td>
<td>13</td>
<td>16.05</td>
<td>40</td>
<td>148</td>
</tr>
<tr>
<td>5. College graduate</td>
<td>73</td>
<td>28.90</td>
<td>—</td>
<td>26</td>
<td>32.10</td>
<td>58</td>
<td>228</td>
</tr>
<tr>
<td>6. Post-college degree</td>
<td>99</td>
<td>40.41</td>
<td>—</td>
<td>36</td>
<td>44.44</td>
<td>109</td>
<td>350</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>245</td>
<td>100</td>
<td>175</td>
<td>122</td>
<td>275</td>
<td>91</td>
<td>1500</td>
</tr>
<tr>
<td><strong>Experience with mental illness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Experience</td>
<td>227</td>
<td>91.90</td>
<td>—</td>
<td>71</td>
<td>88.75</td>
<td>245</td>
<td>243</td>
</tr>
<tr>
<td>No Mental Health Experience</td>
<td>20</td>
<td>8.10</td>
<td>—</td>
<td>9</td>
<td>11.25</td>
<td>42</td>
<td>243</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>247</td>
<td>100</td>
<td>175</td>
<td>122</td>
<td>275</td>
<td>91</td>
<td>114</td>
</tr>
<tr>
<td><strong>Mental health service providers</strong></td>
<td>82</td>
<td>36.12</td>
<td>45</td>
<td>14.56</td>
<td>27</td>
<td>36.03</td>
<td>103</td>
</tr>
<tr>
<td>Experience with a family member or friend's mental health issues</td>
<td>175</td>
<td>77.09</td>
<td>151</td>
<td>48.87</td>
<td>46</td>
<td>64.79</td>
<td>178</td>
</tr>
<tr>
<td>Dried personal experience with mental health issues</td>
<td>130</td>
<td>57.27</td>
<td>56</td>
<td>18.12</td>
<td>18</td>
<td>25.35</td>
<td>104</td>
</tr>
<tr>
<td>Multiple types of experience with mental health issues</td>
<td>122</td>
<td>53.74</td>
<td>—</td>
<td>—</td>
<td>16</td>
<td>22.54</td>
<td>112</td>
</tr>
</tbody>
</table>

†Total omits responses from Birmingham, as data to identify the total participants with mental health experience was unavailable.

Outcomes of Lead Cities Events

To evaluate the lead city events and assess their impacts, the evaluation team used multiple types of data: participant polling data, participant recommendations emerging from each of the lead city conversations, action planning recommendations, and telephone interviews conducted with participants, organizers, and leaders.

Table 2.3 details the evaluation questions and lead city data sources used to analyze each of the evaluation questions (see Chapter 1).
Table 2.3. Evaluation Questions and Data Sources for Analysis of Outcomes from Lead City Events

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Lead City Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To what extent did CCS dialogue and action lead to increased education, awareness, and collaborative action for mental health?</td>
<td>• Participant polling data&lt;br&gt;• Key informant interviews</td>
</tr>
<tr>
<td>2. What are the important issues and themes that emerge across the community conversations?</td>
<td>• Participant polling data&lt;br&gt;• Key informant interviews&lt;br&gt;• Documents: Reports, action plans</td>
</tr>
<tr>
<td>3. How did social norms change as a result of CCS dialogue/community conversation?</td>
<td>• Key informant interviews&lt;br&gt;• Participant polling data</td>
</tr>
<tr>
<td>4. What were the trends in action plans in Lead Cities and Distributed Community Conversations? Do these trends change/vary when analyzed by demographic and geographic data?</td>
<td>• Surveys&lt;br&gt;• Documents: Action plans</td>
</tr>
<tr>
<td>5. To what extent did CCS dialogue and action produce new linkages and collaboration among local actors for mental health education, awareness and/or collaborative action?</td>
<td>• Key informant interviews</td>
</tr>
</tbody>
</table>

Increased Education and Awareness of Mental Health

Analysis of Participant Polling Data. To quantitatively assess potential increases in education and awareness of mental health, the evaluation team examined relevant polling data captured during lead city events. At each lead city event, attendees were asked a few questions pertaining to their understanding and awareness, both prior to and immediately following the session. The pre-post measures that were examined consisted of the following questions and possible responses:

How confident are you that the participants in today’s discussion can develop an effective plan to address mental health challenges in our community?

1. Extremely confident
2. Very confident
3. Somewhat confident
4. Not at all confident

During what phase of life do most adult mental illnesses begin?

1. When people are children or young adults
2. After 25 years of age

How likely is it that a person seeking to recover from mental illness can do so with a combination of therapy, medical help, and continued support?

1. Very likely
2. Somewhat likely
3. Not likely
4. Not at all likely

Additionally, at the conclusion of each lead city conversation event, participants were asked a series of questions to measure how the event had affected their knowledge of and outlook of the mental health issues facing their community. The following two questions were asked after the event only:

- Overall, did the discussion help you better understand mental health challenges in your local community?
- As a result of the table discussions you participated in today, have your views changed about addressing the mental health challenges facing our community?

The evaluation team used these self-reported measures to assess how education and awareness of community mental health issues may have increased for lead city event participants. For questions following the events, the evaluation team compared response rates both overall and by lead city site. Variations in responses were tested for statistical significance using appropriate statistical tests, primarily chi-square goodness of fit tests for cross-site comparisons.

For the questions asked both before and after events, the evaluation team calculated the change from the initial response to the after response, to examine both the proportions and directionality of participant changes in views. To compare across lead city sites, the team examined the mean change in responses by site and tested for statistical significance using Wilcoxon signed-rank test or other suitable statistical tests.

**Overview of Polling Responses.** Based on analysis of attendee responses in the five lead city events about understanding, views, confidence in addressing community mental health challenges, and the likelihood of recovery, key findings suggest that:

- Attendance at all lead city sites had a beneficial effect on participants’ understanding and awareness of mental health issues.
- The effect upon attendee understanding and awareness differed between lead cities.

A large majority of participants reported that the events were helpful in understanding the mental health challenges in their community. Over half reported that the events were extremely helpful, while over a third of participants reported that they were somewhat helpful in understanding their community’s mental health challenges. Less than 10 percent of attendees did not find the events helpful.

At the conclusion of lead city events, the vast majority of participants (78 percent) also reported increased optimism regarding their views on addressing mental health challenges facing their community. Just over a third of participants felt a lot more optimistic following the event, while approximately 44 percent reported being a little more optimistic. Just under 4 percent of participants felt more pessimistic following the events, indicating that for the vast majority of attendees, the lead cities events were viewed by participants as a positive experience.

At the beginning of each session, 1,176 attendees across the five lead cities responded to the question about their confidence in being able to develop an effective plan to address the community’s mental health challenges after the discussion. Table 2.4 below illustrates these initial responses across the five
sites and in total. Based on the responses, the majority of attendees expressed confidence in the session’s ability, enabling them to develop an effective community plan. Combined, 45 percent of attendees were either very or extremely confident, while 42 percent expressed limited confidence. As shown in the table, initial estimates of confidence did not vary significantly across sites.

Table 2.4. Initial Participant Confidence in Addressing Mental Health Challenges, by Site

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque</td>
<td>n = 34</td>
<td>13.99%</td>
<td>n = 76</td>
<td>31.28%</td>
<td>n = 28</td>
</tr>
<tr>
<td>Columbus</td>
<td>n = 9</td>
<td>10.84%</td>
<td>n = 17</td>
<td>20.48%</td>
<td>n = 14</td>
</tr>
<tr>
<td>Washington, DC</td>
<td>n = 49</td>
<td>16.78%</td>
<td>n = 79</td>
<td>27.05%</td>
<td>n = 41</td>
</tr>
<tr>
<td>Kansas City</td>
<td>n = 47</td>
<td>17.41%</td>
<td>n = 87</td>
<td>32.22%</td>
<td>n = 110</td>
</tr>
<tr>
<td>Sacramento</td>
<td>n = 48</td>
<td>16.67%</td>
<td>n = 88</td>
<td>30.56%</td>
<td>n = 110</td>
</tr>
<tr>
<td>All Sites</td>
<td>n = 187</td>
<td>15.90%</td>
<td>n = 347</td>
<td>29.51%</td>
<td>n = 491</td>
</tr>
</tbody>
</table>

At the conclusion of the session, attendees were again asked about their confidence in being able to develop an effective plan. Nearly 40 percent of respondents across the five sites reported improved confidence in the ability to develop an effective plan to address the community’s mental health challenges. Conversely, only 17 percent of respondents reported feeling less confident following the event, while the other respondents remain unchanged and predominately confident. These responses suggest that attendees viewed participation in the event as benefitting their understanding, awareness, and capacity for change.

Lead city sites also asked attendees about the likelihood of recovery for sufferers of mental illness. The majority of respondents (nearly 81 percent) felt recovery either extremely or very likely. Sixteen percent (16%) of attendees felt it somewhat likely, while only 3 percent began the sessions believing recovery not at all likely.

At the conclusion of the session, attendees in four sites were again asked about the likelihood of a person’s recovery. Following the session, 30 percent now felt recovery was more likely than they initially believed, while roughly a fifth of respondents felt recovery less likely than before. The other half of respondents felt unchanged in their initial assessment of likelihood, with the bulk of these (over 45 percent of respondents overall) believing recovery very likely. Less than 5 percent of respondents felt that recovery was only somewhat or not at likely and held fast to this view following the session. These responses suggest that through participation in the session, attendees more frequently became increasingly optimistic that recovery was likely, as opposed to feeling increasingly pessimistic about an individual’s chances for recovery.

Comparison of Polling Responses by Site. The combined results indicate that the lead city events were helpful in improving understanding and awareness of community mental health challenges. The evaluation team also examined these results by site to identify any significant variation in responses between lead cities.

Participant Changes in Understanding. When compared by site, as shown in Table 2.5, the evaluation team observe strong statistically significant differences in participants’ understanding ($p < .001$). Nearly 75 percent of Kansas City participants reported the session to be extremely helpful in better understanding mental health challenges in the local community, a far higher proportion than any other site. While only a
low number of participants felt the session was not very helpful in better understanding community mental health challenges, a slightly greater proportion of Albuquerque participants (5.83 percent) responded this way than in other sites.

### Table 2.5. Participant Understanding of Mental Health Challenges, by Site

<table>
<thead>
<tr>
<th>Lead City</th>
<th>Total Sample</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, did the discussion help you better understand mental health challenges in your local community?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. It was extremely helpful</td>
<td>201</td>
<td></td>
<td>74</td>
<td>36.63%</td>
<td>116</td>
<td>57.74%</td>
<td>1</td>
<td>0.44%</td>
<td></td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>2. It was somewhat helpful</td>
<td>125</td>
<td></td>
<td>74</td>
<td>58.91%</td>
<td>46</td>
<td>36.42%</td>
<td>3</td>
<td>2.37%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. It was not very helpful</td>
<td>104</td>
<td></td>
<td>74</td>
<td>51.14%</td>
<td>46</td>
<td>36.42%</td>
<td>3</td>
<td>2.37%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. It was not at all helpful</td>
<td>62</td>
<td></td>
<td>74</td>
<td>41.84%</td>
<td>46</td>
<td>36.42%</td>
<td>3</td>
<td>2.37%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These results suggest that while lead city events were helpful in increasing understanding among participants, programmatic or other differences between sites may have affected the degree of understanding amongst attendees.

### Participant Changes in Views.

By site, as shown in Table 2.6 below, the evaluation team again found statistically significant variation (p<0.001) in attendee responses. Following the session, Kansas City attendees (48 percent) were a lot more optimistic in their views about addressing community mental health challenges than other sites, where the proportion of those a lot more optimistic ranged between 20 to 36 percent. Washington, DC had the highest proportion of attendees whose views on addressing community mental health did not change, at 22 percent. These results further suggest that differences between lead city events had an effect on attendee views. While these differences are significant, a clear majority of attendees in all sites resoundingly reported at least a little more optimism following their participation in the sessions.

### Table 2.6. Participant Views about Addressing Mental Health Challenges, by Site

<table>
<thead>
<tr>
<th>Lead City</th>
<th>Total Sample</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a result of the table discussions you participated in today have your views changed about addressing the mental health challenges facing our community?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Changed - a lot more optimistic</td>
<td>201</td>
<td></td>
<td>74</td>
<td>36.63%</td>
<td>116</td>
<td>57.74%</td>
<td>1</td>
<td>0.44%</td>
<td></td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>2. Changed - a little more optimistic</td>
<td>125</td>
<td></td>
<td>74</td>
<td>58.91%</td>
<td>46</td>
<td>36.42%</td>
<td>3</td>
<td>2.37%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Did not change my views</td>
<td>104</td>
<td></td>
<td>74</td>
<td>51.14%</td>
<td>46</td>
<td>36.42%</td>
<td>3</td>
<td>2.37%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Changed - a little more pessimistic</td>
<td>62</td>
<td></td>
<td>74</td>
<td>41.84%</td>
<td>46</td>
<td>36.42%</td>
<td>3</td>
<td>2.37%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Changed - a lot more pessimistic</td>
<td>62</td>
<td></td>
<td>74</td>
<td>41.84%</td>
<td>46</td>
<td>36.42%</td>
<td>3</td>
<td>2.37%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† Birmingham results were only available in aggregate, and were excluded from significance testing. Birmingham data are presented here only for descriptive purposes.
Participant Changes in Confidence. Table 2.7, below, shows the pre-post changes in attendee confidence by lead city. When compared by lead city event, attendees had significant differences in changes to their confidence \((p=0.022)\). Overall, each site had the majority of attendees either increasing in confidence or unchanged from being very confident initially. Looking closely, however, both Albuquerque and Washington, DC had slightly higher proportions (approximately 20 percent) whose confidence decreased following the session. This finding suggests that differences between the lead city events themselves again had a significant effect upon attendee confidence.

Table 2.7. Change in Pre-Post Responses to Attendee Confidence in Developing an Effective Community Mental Health Plan

<table>
<thead>
<tr>
<th>Site</th>
<th>Improved Confidence</th>
<th>No Change, Very Confident</th>
<th>No Change, Somewhat Confident</th>
<th>Less Confident</th>
<th>No Change, Not at All Confident</th>
<th>Total Sample</th>
<th>Missing</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque</td>
<td>57</td>
<td>31.0%</td>
<td>39</td>
<td>21.2%</td>
<td>44</td>
<td>23.9%</td>
<td>37</td>
<td>20.1%</td>
</tr>
<tr>
<td>Columbus</td>
<td>26</td>
<td>49.1%</td>
<td>9</td>
<td>17.0%</td>
<td>12</td>
<td>22.6%</td>
<td>6</td>
<td>11.3%</td>
</tr>
<tr>
<td>Washington, DC</td>
<td>64</td>
<td>35.0%</td>
<td>47</td>
<td>25.7%</td>
<td>26</td>
<td>14.2%</td>
<td>40</td>
<td>21.9%</td>
</tr>
<tr>
<td>Kansas City</td>
<td>83</td>
<td>43.9%</td>
<td>50</td>
<td>26.5%</td>
<td>30</td>
<td>15.9%</td>
<td>21</td>
<td>11.1%</td>
</tr>
<tr>
<td>Sacramento</td>
<td>79</td>
<td>42.0%</td>
<td>44</td>
<td>23.4%</td>
<td>29</td>
<td>15.4%</td>
<td>34</td>
<td>18.1%</td>
</tr>
</tbody>
</table>

Participant Changes in Views of Recovery. Table 2.8 presents the initial responses by participants when asked about a person’s likelihood of recovery from mental illness. Comparing by lead city site, a majority of participants in all sites believed recovery likely, with those believing recovery extremely likely ranged between 37 and 51 percent in Sacramento and Washington, D.C., respectively. However, as demonstrated, these initial estimates of recovery likelihood varied significantly by lead city \((p=0.008)\).

Table 2.8. By Site Comparison of Attendee’s Initial Estimates of Recovery Likelihood for Person with Mental Illness Receiving Support Services

<table>
<thead>
<tr>
<th>Lead City</th>
<th>How likely is it that a person seeking to recover from mental illness can do so with a combination of therapy, medical help, and continued support?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Extremely likely</td>
</tr>
<tr>
<td></td>
<td>n</td>
</tr>
<tr>
<td>Albuquerque</td>
<td>110</td>
</tr>
<tr>
<td>Columbus</td>
<td>31</td>
</tr>
<tr>
<td>Washington, DC</td>
<td>153</td>
</tr>
<tr>
<td>Kansas City</td>
<td>109</td>
</tr>
<tr>
<td>Sacramento</td>
<td>100</td>
</tr>
<tr>
<td>All Sites</td>
<td>503</td>
</tr>
</tbody>
</table>

Table 2.9 presents the shifts in participant responses about recovery likelihood after the session. Compared for each of the five lead city events, the evaluation team finds statistically significant variation in responses \((p<0.001)\). Most notably, attendees in Kansas City began the conversation with a majority of participants (55 percent) believing mental illness recovery very likely, and remain unchanged in that view. Conversely, attendees at the Washington, DC event had the highest proportion (40 percent) who felt mental illness recovery less likely than they had initially following the event. This variation in Washington, DC responses, it should be noted, does not necessarily indicate a decrease in understanding.
or awareness of community mental health challenges by attendees. An alternate interpretation may be that through the conversation held in that community, attendees became increasingly aware of difficulties those suffering from mental illness have in making a full recovery, even with more robust support services. What the variation does confirm, however, is that, while attendees overall felt recovery likely following the event, sites individually produced significantly different outcomes.

Table 2.9. Change in Attendee Estimates of Recovery Likelihood for Person with Mental Illness Receiving Support Services, by Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Improved Likelihood</th>
<th>No Change, Very Likely</th>
<th>No Change, Somewhat Likely</th>
<th>Less Likely</th>
<th>No Change, Not at All Likely</th>
<th>Total Sample</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>275</td>
</tr>
<tr>
<td>Columbus</td>
<td>24</td>
<td>46.15%</td>
<td>18</td>
<td>34.62%</td>
<td>0.00%</td>
<td>0</td>
<td>275</td>
</tr>
<tr>
<td>Washington, DC</td>
<td>35</td>
<td>19.66%</td>
<td>67</td>
<td>37.64%</td>
<td>3.76%</td>
<td>1</td>
<td>175</td>
</tr>
<tr>
<td>Kansas City</td>
<td>58</td>
<td>30.69%</td>
<td>104</td>
<td>55.03%</td>
<td>10</td>
<td>1</td>
<td>175</td>
</tr>
<tr>
<td>Sacramento</td>
<td>71</td>
<td>38.59%</td>
<td>89</td>
<td>48.37%</td>
<td>6</td>
<td>1</td>
<td>144</td>
</tr>
</tbody>
</table>

Examination of Demographics on Understanding Across Lead City Events. Lastly, to better inform the assessment of programmatic outcomes in lead city sites, the evaluation team examined attendee responses for demographic trends across the lead city events. As discussed previously, the demographic composition of events varied significantly by lead city, which causes difficulty in identifying whether response trends result from programmatic differences or demographic and other differences between sites. For this analysis, the evaluation team attempted to disentangle site and demographic effects, utilizing two exploratory regression modeling approaches for how attendees rated their understanding following the session:

- First, the evaluation team modeled pooled attendee responses in a generalized linear model considering site and demographic categorizations as predicting variables.
- Second, within site, the evaluation team modeled attendee responses in a generalized linear model using demographic categorizations as predictors. The estimated demographic parameters from each site were then compared against each other and tested for differences.

Both approaches yielded models with poor abilities to predict participant responses of understanding. Demographic variables, when either pooled across lead cities or within each lead city’s model, had little to no significant effect predicting participant responses. Most models within site were not statistically significant, and evidenced extremely poor fit. Therefore, the demographic categories have little predictive value regarding whether an attendee found an event extremely helpful.

Based on the limited results of both exploratory modeling approaches, the evaluation team concludes that the degree to which attendees found lead city events helpful is likely influenced by a combination of site-specific programmatic differences and other unidentified factors, more than the demographic characteristics identified through polling. Polling data affirm that lead city events improved attendee understanding and awareness, but to different degrees across sites. Interviews with lead city participants
and organizers were conducted to provide a fuller understanding of how programmatic differences and other potential factors may have influenced attendee understanding.

**Interviews.** Key informant interviews were conducted with participants, organizers, and leaders at each of the lead city sites. The intent of the interviews was to gather qualitative data related to the expected outcomes and evaluation questions. The interviews explored the key outcome and process questions related to the role that the individual played in the CCS initiative. A total of 18 interviews were conducted across the six lead cities. The interviews had separate questions for each of three types of key informants. A crosswalk between the questions asked and the evaluation questions is provided in Appendix 2. For each interview, two members of the evaluation team conducted the interview, with one person asking the questions and the other taking notes during the interview. The two-person team then used a common process for coding each interview (see Chapter 1). The discussion that follows summarizes the themes that materialized from the interviews.

One organizer was interviewed for each of the lead cities events. The following six themes emerged from the interviews across all sites:

- The community engagement process was important for increasing awareness of mental health challenges and deepening the awareness of mental health across all segments of the community.
- Recovery is possible even though it may be difficult to access services in some cases.
- The lead cities events deepened participants’ understanding of the importance of having appropriate language for different cultural communities.
- The events empowered people to speak out, especially youth, by broadening their perspective and providing education about myths and facts of mental health.
- An outcome of the events was that the conversations normalized mental health so it carries less stigma, thereby creating the possibility of ripple effects throughout the community.
- The high levels of diversity among participants enabled a large cross-section of the community to have a chance to participate in a dialogue on mental health.

Key informant interviews were also conducted with a leader of each lead city event. From the perspective of the leaders, the following themes emerged:

- The events positively increased awareness about mental health concerns among youth and especially among those who have not been actively involved in community programs.
- The diversity of participation helped increase the awareness among different ethnicities, genders, and age groups.
- The events brought together a broad-based group that demonstrated the depth and breadth of communities’ challenges related to mental health.

**A Participant’s Viewpoint on the Outcomes of the Lead Cities Event**

“Because of my involvement with this process, the follow-up and the other related discussion activities, it’s given me more of a voice in the community. I know what we’re working towards. I know the process - you have a dialogue and discover what the barriers are.” (Kansas City)
• The events also led to commitments across agencies and communities to improve education and awareness of mental health needs.

• Increased education and awareness also occurred through the follow-up dialogues (dialogues following the lead city events) in the neighborhoods and action planning efforts.

• Youth led action planning and media involvement increased awareness of mental health among youth in the community.

One participant from each lead city event was also interviewed. These participants shared insight into their experiences with respect to outcomes of increased education and awareness of mental health. Three main themes emerged from these interviews:

• Increased awareness about youth mental health was made ever more salient by the participation of communities of youth who came to the event because of their relationships with and support from numerous community-based programs.

• Normalizing mental health is an essential part of ensuring overall health.

• Tools gained from the lead city event have been applied to other ongoing conversations in the community; thus, the lead cities events were effective in increasing participant education about mental health.

Changes in Social Norms

Changes in social norms are difficult to measure, especially in the short-term. However, in the themed responses from participants, there was clear evidence of participants’ understanding the importance of mental health in the community and what norms need to be to address mental health challenges. During the interviews, leaders of the lead cities events reported that it was difficult to tell and generally too early to determine whether changes in social norms have resulted from the lead cities effort. They believe the effort may have led to individual-level changes, but changes in community or systemic norms will occur over a much longer timeframe. Nevertheless, participants agreed that normalizing mental health challenges and reducing stigma are important first steps to changing social norms.

Participants had important points to make about changes in norms, beliefs, and community-level action.

Community-level Change. Participants overwhelmingly reported that “things are changing” in their communities. They recognized that their communities are more likely to now acknowledge that mental health is a community issue; this, in itself, is evidence of changing social norms. In general, participants reported an increase in awareness about mental health at the individual, family, school, and community levels. Further, they described a growing shift toward community problem solving to address the needs of individuals with mental health problems and their families. Organizations are using events like lead city conversations to assess their priorities and processes and make changes based on feedback from consumers and youth.

Activities to Improve Mental Health in Communities. Participant responses revealed an increase in social norms with regard to communities’ willingness to actively take action to address mental health issues. Findings indicate an increase at the community level in advocacy around mental health. Advocacy activities include the creation of a youth-led film to increase mental health awareness in
Albuquerque, the development of a navigation tool for transition age youth to find services in Sacramento, social media campaigns, school-based youth groups to increase awareness around mental health, and many others.

### Three Participants’ Viewpoints on Improving Mental Health in Their Communities

“*When I was younger I tried to avoid dealing with people with mental health issues. And now, I’m one of the ones, I’m the one who helps. People tell them to call me, you’re my relative. Now I’m a lot more calm, more relaxed, and I know how to deal with people.*” (Birmingham)

“*People are always interested in mental health because it affects everyone. Even if you personally aren’t affected with it, you know someone. It hits close to home for lots of people so to have a space where you can engage in conversation about it, education around it, and resources to help for recovery and wellness.*” (District of Columbia)

“*[The event] helped us to focus in and begin to identify some challenges for our youth and the community. It was a tremendous help for us. Matter of fact, it changed the whole emphasis, we have a whole teen institute here, it changed the whole emphasis of our group from general prevention to what it means to be healthy mentally. The discussion helped us actually identify four needs that our youth expressed, and we’re really working on them.*” (Columbus)

Table 2.10, below, provides examples of the conversation themes and responses from participants that relate to the question of changing social norms.

### Table 2.10. Themes from the Conversations about Mental Health in the Community

<table>
<thead>
<tr>
<th>Mental Health in the Community – Themes</th>
<th>Changing Social Norms</th>
</tr>
</thead>
</table>
| 1. Mental health affects nearly everyone in the community  
  • “A community is only as healthy as its individuals.” | • Widespread recognition of the prevalence of mental health needs can foster the sense that people deserve care.  
  • “We have a moral obligation to help people.”  
  • Create a climate to help people feel comfortable to seek help. |
| 2. People with mental health challenges face serious barriers to receiving services.  
  • “We need care from the community and not the streets.” | • Positive attitudes will lead to more public support for services. |
| 3. Left untreated, recovery becomes more difficult, costs escalate, greater family disruption.  
  • “Many people in pain are shouting in the wind.” | • Early diagnosis is essential for effective treatment and reduced societal costs. |
| 4. Diagnosis can lead to isolation and poor coping mechanisms. | • “Mental health is not a curse or a punishment.”  
  • Schools and communities can spark safe conversations; family members can be powerful resources. |
| 5. Youth experience bullying, lost social connections, cycle of alienation. | • Youth empowerment and engagement on mental health can break through stigma and help peers get help.  
  • Promote education which “allows peers to advocate for each other and build a stronger community.” |
| 6. Concern about mistreatment, profiling, social justice, and cultural bias. | • Train first responders in careful, safe responses to people with mental health challenges. |
Hope for Change. An interesting theme that emerged in lead city conversations was that of “hope.” Participants overwhelmingly commented on their hope that mental health would improve in their communities (see text box for two examples).

Two Participants’ Viewpoints on Hope in Their Communities

“We’ve always said Albuquerque, New Mexico is not a good place to have a mental illness because of the lack of services. Feeling like the city was going to make a difference—that was definitely our hope. Nothing ever happens as quickly as we want, but maybe it changed by adding hope that something was going to change.” (Albuquerque)

“[The event] helped me; it enlightened me, made me want to learn more. It helped me understand that when I interact with people and when they say something off the wall, or do something, a lot of times they’re not accountable for their actions. Now I have a better understanding. I can help more. I have more resources and have helped my family to seek more treatment. I really just want to know more and help and understand what they’re going through. If a family member does not get help, they can deteriorate to the point where they can’t help themselves. It allows me to step in and help, and provide alternatives, and help them get treatment. It makes me more hopeful.” (Birmingham)

Issues and Themes Emerging Across Lead Cities Conversations

Reports that were prepared following each of the six events were used to identify common themes and recommendations. Table 2.11 lists the major themes that emerged from the conversations with young people who participated in the events. The themes can be categorized into those obtained from individuals in two age groups (12-17) and (18-24). Conversations about younger age youth focused on a more direct relationship at school and ways to provide support through peers, social media, and professionals. Conversations about young adults focused on their need to transition to independence and find support services and care that match their adult legal status.

Table 2.11. Themes Emerging from Conversations during Lead Cities Events

<table>
<thead>
<tr>
<th>Themes for Youth Age 12-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Need to Provide Direct Connections for Youth</td>
</tr>
<tr>
<td>- Encourage youth to talk about their problems; provide opportunities for them to express themselves; ensure confidentiality and safety.</td>
</tr>
<tr>
<td>- Conduct outreach to youth to connect them with programs, a caring adult, peer mentors, peer groups. Teach kids about their own mental health in a variety of places where youth already are.</td>
</tr>
<tr>
<td>- Encourage culturally specific discussions, including disparities in communities of color.</td>
</tr>
<tr>
<td>2. Need to Strengthen Existing Services and Continuity of Care</td>
</tr>
<tr>
<td>- Provide services &amp; support sooner – “Start early, 12-17 years is too late”</td>
</tr>
<tr>
<td>- Create better services for crisis prevention and intervention.</td>
</tr>
<tr>
<td>- Integrate services with schools, primary care, and hospitals.</td>
</tr>
<tr>
<td>- Provide services in different ways – social media, pop culture, etc.</td>
</tr>
<tr>
<td>- Increase mental health education for community-based professionals.</td>
</tr>
<tr>
<td>3. Need for a More Active Role for Schools</td>
</tr>
<tr>
<td>- Add more therapists and licensed mental health workers in schools; conduct more regular screenings.</td>
</tr>
<tr>
<td>- Educate teachers on early signs and symptoms of mental health challenges with mental health first aid and ongoing professional development.</td>
</tr>
<tr>
<td>- Develop more K-12 curriculum elements on mental health awareness and skills.</td>
</tr>
<tr>
<td>4. Need for Extracurricular Activities that Promote Skills and Mentoring</td>
</tr>
<tr>
<td>- Provide more peer support groups (e.g. buddy systems, school groups focused on mental health).</td>
</tr>
<tr>
<td>- Offer more positive developmental and vocational opportunities to help transition from school to the workforce.</td>
</tr>
</tbody>
</table>
• Need more positive outlets and safe places for youth (art, music, phys. ed.).
• Increase parent involvement, education, and volunteerism.

5. Need for a Broad-Based Social Media Campaign
• Conduct social media campaign to reduce stigma around discussing mental health issues.
• Increase bullying and cyber-bullying prevention programs in schools.

Themes for Young Adults 18-24

1. Need for Responsive Support Networks
• Develop strong support networks with positive peer role models and mentors.
  • “Having a positive relationship with youth is very important.”
• Promote healthy activities and responsible behavior: getting outdoors, arts, sex education, parenting skills.
• Strengthen youth leadership and peer-to-peer support.

2. Need for Access to Transitional Housing
• Identify housing opportunities for members of that community who have mental health challenges.
• Include safe places for youth and transitional services.

3. Need for Skills for Independence and Life Readiness
• Provide life readiness training, including conflict resolution, budgeting/finance, relationships, and parenting skills.
• Encourage economic independence through job training, vocational skills, financial education, and preparation for higher education.
• Provide access to internships to experience a professional work environment and more entry level job opportunities.
• Offer life skills training (e.g. financial management, communication skills, time management).

4. Need for Follow Along Care
• Provide mental health services that follow youth as they transition into young adulthood.
• Make it easier to apply for and access affordable health insurance.
• Offer 24-hour access for age-appropriate crisis support.
• Provide help in navigating the available services—“There’s a lot of pressure, where do I go?”

5. Need for Education, Training, and Outreach
• Offer teacher training and mental health education in schools and colleges.
• Provide sensitivity training and support for law enforcement officers.
• Make and distribute mental health information in formats/media accessible to youth. Build awareness through transit ads, billboards, PSAs and social media.
• “Give accurate and credible information.”
• Provide social interaction opportunities for different ethnic groups starting at a young age.

Overarching themes from participants can be grouped as follows: (1) a need for education; (2) a need for services; (3) a need for reducing stigma; and (4) youth needs. Each is discussed below

Overwhelmingly, participants reported the need for increased education and training around mental health in their communities. The perceived benefits of education and training included early identification of mental health problems, reduced stigma, increased compassion, an increase in those seeking treatment, and more services and resources for people with mental health problems and their families.

It was also noted that people with mental health challenges face serious barriers to receiving services. Participants expressed an urgency for early identification and access to treatment services. Participants emphasized that when left untreated, recovery becomes more difficult, costs escalate, and there are greater consequences at the personal, family, and community levels.

Two Participants’ Viewpoints on Reducing Stigma

“It was kind of daunting to understand the community’s perspective of mental illness, of stigma and inequity that those living with mental illness are violent, and need to be watched, and can’t care for themselves.” (Kansas City)

“Even with that, we ran into an obstacle structurally, because we meet in a local recreation center, of how comfortable the administrator at the recreation center felt about having a mental health counselor there, even though we’d already started. Part of their concern was, ‘well we don’t offer mental health counseling there.’ So this is [among] the barriers as you go in, this is what they are and this is what it looks like.” (Columbus)
Participants also emphasized stigma as a salient barrier to improving mental health and the need to reduce stigma in communities. Participants in the lead cities events reported that they encounter stigma in personal settings, professional settings, and when trying to do work around mental health in their communities.

Youth needs that emerged from lead city conversations included how to improve access to a counselor and other mental health services, increased mental health awareness in schools, youth-specific resources and services, and needs of transition age youth, including job training and life skills.

**Trends Across Action Plans**

Each of the lead cities engaged in an action planning process following the dialogues. Table 2.12 highlights the themes across the action plans.

**Table 2.12. Common Themes across Community Action Plans**

1. **Develop broad-based community awareness and education campaigns**
   - Continue to expand the conversations throughout the community.
   - Utilize public and social media to bring education and awareness to the issues highlighted in the conversations.

2. **Engage the youth directly in promoting awareness of mental health**
   - Build youth-driven campaigns using social media and other channels that highlight the importance of mental health and ways to get help.
   - Utilize curricula in the schools on mental health and positive development models.

3. **Utilize effective programs that help identify early signs and symptoms and connect people with local services**
   - Expand the use of youth mental health first aid for adults and professionals.
   - Consolidate ways to better navigate access to services.
   - Ensure first responders are effectively trained.

4. **Develop specific and targeted systems of care for “transition-age youth” (18-24)**
   - Ensure a more specific set of services for the mental health challenge for transition-age youth.
   - Provide access to housing, jobs, education, and independent living programs.

5. **Ensure that services delivered are culturally specific and appropriate**
   - Work with key cultural groups as to how education, awareness, and services can be made more culturally competent.
   - Make recommendations on how best to improve culturally appropriate mental health services.

6. **Develop systems to integrate mental health into other services, such as health and schools**
   - Develop connections across service providers (primary care, behavioral health, student health) to increase the awareness of mental health needs and services.
   - Find ways to integrate mental health effectively into student health centers or career services programs at the schools.

7. **Build the capacity and leadership to sustain community-based progress on mental health**
   - Build leadership from the teams that produced the CCS events; continue the action planning; and commit to implement action plans.
   - Provide value-added support to the infrastructure in each community while building new assets for broadening support.
   - Develop ongoing funding for projects and the leadership to maintain implementation.

**Youth Involvement.** The evaluation team asked key informants during the interviews about trends across the action plans. They emphasized that youth had a very important role in contributing to the themes and issues at the events and the action planning that followed. In some cases, youth took an ongoing leadership role through social media and action planning. In other lead cities, youth roles were

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**A Participant’s Viewpoint on the Need for Treatment Services**

“As a police officer, I come into contact a lot with people with mental health issues; I pass those resources to my detective. My detective deals with mental health issues more than I do, so they were able to get the word out and get more resources out to people. There are different levels of help and types of help for people with mental health issues.” (Birmingham)
not as visible. Notable examples of strong youth participation include pushing for work on: bullying and reducing stigma, formation of youth leadership teams, social inclusion, and transition age youth.

Youth have continued to be involved after the lead cities events. A participant described organizing groups of youth to further the topic of mental health:

> It’s important to get a teenager’s perspective. We met for eight weeks, not consecutively; they had homework assignments, engaged in Text Talk Act. When you get youth excited about mental health, you know you’re helping on a larger scale than you can see. They’d call me up: ‘Ms. B., when are we meeting? I’m bringing my friend with me. When is my cab coming to get me?’ That gave me life. You can hear it in my voice. (Kansas City)

When asked if organizing the youth groups was what she typically would have done or if it was in some way influenced by the lead cities conversations, this participant stated:

> It was totally influenced by [the event]. I facilitated the group that talked about bringing mental health awareness to schools. It was a direct follow-up to our community conversation. (Kansas City)

Thus, there are clear examples of the lead city events creating opportunities to strengthen mental health conversations while also engaging youth in taking ownership of conversations through their own advocacy. Participants have furthered conversations on the topic of mental health and youth and have engaged youth in these conversations. Many lead city participants had also established relationships with youth prior to the event and through continued outreach assured that youth voices were represented both during and following the event. In Sacramento, Columbus, and Albuquerque, for example, transportation and support (e.g., groups, counseling, jobs) were cited as essential components to successful outreach and engagement of youth:

> People made commitments to drive youth if they needed a ride so that young people could get there. And that’s how we continue to get [them engaged] and how we got 32 percent of the youth involved in our implementation activities. We get them there to make sure they have a voice. The young people have adopted a motto and made t-shirts: ‘Nothing about us, without us.’ They definitely understood their role.” (Sacramento)

**Action Plan Results.** Tangible results from the action plans are already evident. They have been influential in increasing funding for programs such as mental health first aid and have helped shape plans for city and county behavioral health programs—for example, funding for transition age youth housing programs. The action planning work has also increased advocacy for improvements in mental health. For example, training has occurred with teachers, faith leaders, and first responders who have become more sensitized to the need for increased mental health services.

Further, the action planning process has been successful in gaining leadership commitments from elected officials and key partners to continue the work begun during the lead cities events. A number of elected officials now prioritize new mental health programs and are working to unify a fractured system with a goal toward more systematic approaches to services.
**Replicating the Process.** It was common to find participants incorporate or replicate the Creating Community Solutions process demonstrated during the lead city events. For example, a Sacramento participant described such an opportunity:

...Someone just invited us to a coalition on youth alcohol. It’s a totally different thing. But starting an action plan process [with lead cities]… has been very powerful and people want to address other issues too. And there’s still a link between mental health concerns and alcohol. It’s a little different focus. We’re using a similar framework, modeled after the implementation process after the Day of Dialogue. (Sacramento)

A Kansas City participant summarized how the lead cities process facilitated her engagement later in implementation of their action plan.

*Because of my involvement with this [lead cities event] process, the follow-up, and the other related discussion activities… it’s given me more of a voice in the community. I know what we’re working towards. I know the process. You have a dialogue and discover what the barriers are.* (Kansas City)

Actions plans reflect the uniqueness and diversity of each lead city. For example, Albuquerque (and other cities) developed several task forces and groups to take on various aspects of their action plan. Members of the Albuquerque community have promoted discussions and solutions, leading to a youth-driven video and curriculum guide. Albuquerque has also produced, *Live Well Albuquerque*, a report on the results of the task forces and has obtained city and county funding for implementation of an afterschool program for parents and their children. Sacramento has focused on eight action planning strategies, with a focus on transition aged youth. They noted the importance of concentrating on this group: “It was an issue that kept coming up because they’re a population that is underserved and sometimes inappropriately served.”

**New Linkages and Collaboration as a Result of CCS**

Another outcome of CCS has been the unique collaborations and new linkages that have resulted from this process. By initiating a community engagement effort, there was a direct community voice injected into mental health planning efforts. This voice continued to be heard after the lead cities events. In each city, a new, collaboration was initiated with community members and has been sustained to varying degrees within each lead city.

Interviews with leaders, organizers, and participants in lead cities events confirmed this outcome of the formation of important linkages and collaboration at the community level. Leaders provided the following insights:

- Action plans helped to secure new relationships and strengthened existing partnerships across the community.
- Organization of the planning process during and following the lead cities events allowed for inclusion of important political and community voices.
- The lead cities events helped to focus the effort on mental health planning throughout the metropolitan area and to secure the collaboration of funders and to pool and leverage resources.
The lead cities events assisted agencies and organizations within the communities in securing additional grant funds to continue their focus on mental health challenges.

Organizers of the lead cities events provided the following comments (quotes) to substantiate the outcome of improved linkages and collaboration:

- There have been new levels of communication between the city and the mental health agencies since the lead cities events.
- People who previously had not talked or worked together are now on the planning committees.
- Individuals in leadership roles within the lead cities have increased their awareness of how common mental illness is and the multiple pathways for recovery.
- New linkages and collaborations have been made for transition age youth; new housing, drop-in centers, and focused services have been funded.
- The lead cities events have provided new insights; we now think of our work within communities as a pyramid with the engagement of the broad community at the bottom and attention to how we can support them.
- There are now new levels of funding for mental health and we see engagement of a broader set of funding partners.

Participants in the lead cities events also reported that they saw new linkages and collaboration because of the events. Networking among participants started at the event and set the stage for later collaborations when preparing and implementing the action plan. Moreover, the events fostered leadership and action that, in some cities, resulted in new and more formal collaborations. The momentum toward greater collaboration began during the event and continued in the months that followed. As one participant noted:

"...following the lead cities event, we were fortunate in our area to get a group of funders together and sponsor a long-term project in which we implemented part of the action plan. I was part of the leadership of that team. (Sacramento)"

Other examples illustrate the different types of networking that took place. In Albuquerque, following the lead cities event, a community-based youth group, a teacher advocate for suicide prevention, and Everyday Democracy collaborated on developing an educational guide and video for youth by youth, called *Breaking the Silence*. In Birmingham, participants collaborated to bring additional training and resources to others in the community. One participant reported the following:

"...from attending the [event], I got help from the JBS-Jefferson Blunt Mental Health Council to put on a class called Mental Health 911 or Mental Health First Aid. At least 25 officers were trained on recognizing mental health issues and how to get help. It made a big impact. ...And now, in my department, we get a lot more training on mental health. It opened my eyes and it brought more training to the force as well. It changed the ways we do policing. (Birmingham)"
Other examples of new collaborations and linkages in the lead cities are provided in Table 2.13, below.

**Table 2.13. Illustrative Examples of New Collaborations and Linkages in Lead Cities**

<table>
<thead>
<tr>
<th>City</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque</td>
<td>The lead cities event was a significant outreach component for the city in the neighborhoods and has influenced city priorities for mental health funding.</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Birmingham has integrated the priorities identified during the lead cities event into the city goal setting process to ensure that mental health needs are part of a broader plan.</td>
</tr>
<tr>
<td>Columbus</td>
<td>The coalition formed for the lead cities event has continued neighborhood conversations to develop a set of priorities for implementation.</td>
</tr>
<tr>
<td>Kansas City</td>
<td>Five action teams have been formed to continue to refine and implement priorities identified during the CCS effort. The city bridged a large geographic area: two cities, two mayors, six counties, and two states to form an action planning process and enable people with mental health challenges a safe place to have a voice.</td>
</tr>
<tr>
<td>Sacramento</td>
<td>From the lead cities event, Sacramento established a long-term partnership with a local education agency to manage the implementation effort across a set of five major priorities. Funding from foundations continues to support the effort with a special emphasis on cultural competencies. Transition age homeless project initiated.</td>
</tr>
<tr>
<td>Washington DC</td>
<td>Significant funding and grants ($1.6 million) were obtained after the action plan was finished to implement key recommendations for an education awareness campaign and transition age youth services. Management of the implementation was transferred to the DC Trust. Innovative transition age housing project established with blend of private and municipal funds.</td>
</tr>
</tbody>
</table>

The ability to involve a diverse and representative sample of each of the lead city communities was essential to their success. By and large, organizers were very successful in delivering that diversity. Table 2.14 lists the range of outreach efforts that were used by organizers to create a diverse level of participants.

**Table 2.14. Outreach Efforts Used by Lead City Organizers**

<table>
<thead>
<tr>
<th>Mixed Media Outreach</th>
<th>Outreach Efforts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emails, letters, phone calls</td>
<td>High schools counselors, local colleges, clubs, youth organizations</td>
</tr>
<tr>
<td>Face-to-face conversations</td>
<td>Charismatic spokesperson for youth outreach</td>
</tr>
<tr>
<td>Stipends</td>
<td>Working with city, community centers, non-profits</td>
</tr>
<tr>
<td>Provide transportation</td>
<td>Outreach to church with MH program</td>
</tr>
<tr>
<td>Translate promotional pieces</td>
<td>PTA</td>
</tr>
<tr>
<td>Flyers</td>
<td>Neighborhood association</td>
</tr>
<tr>
<td>Youth radio program</td>
<td>canvassing community</td>
</tr>
<tr>
<td>Social media: Facebook, Twitter, Instagram</td>
<td>Hired organizer for communities of color</td>
</tr>
<tr>
<td>African-American teen radio show</td>
<td>Outreach team</td>
</tr>
<tr>
<td>Flyers (Different language)</td>
<td>Latina community organization for Latina outreach</td>
</tr>
<tr>
<td>Unique twitter hashtag</td>
<td>Youth media team</td>
</tr>
<tr>
<td>Youth developed vignettes</td>
<td>Mayoral support and leadership</td>
</tr>
<tr>
<td>Local paper ads (senior outreach)</td>
<td></td>
</tr>
<tr>
<td>Translations into variety of languages</td>
<td></td>
</tr>
<tr>
<td>Survey</td>
<td></td>
</tr>
</tbody>
</table>
Lessons Learned

*Distinctions in the Lead Cities Demographics and Planning Processes*

Although there were differences in how each lead city implemented the dialogue within its community, the recommendations across sites are remarkably similar. Despite site differences in demographics, dialogues yielded similar recommendations and action steps that then became the foundation for action efforts. The recommendations from the broad-based community involvement in lead city discussions focus on themes of youth involvement, early identification of signs and symptoms, more training in mental health first aid, and greater access to mental health services. The focus was less on the severely mentally ill and more on identification, prevention, and access.

*Challenges in Sustaining the Dialogues and Deepening Community Engagement*

A significant amount of effort was expended in developing the dialogues on mental health in each lead city. It is a major challenge to bring a representative sample of participants, especially youth, together on a weekend day. The development of a broad-based coalition to initiate and manage the dialogue process was fundamental to the success of its implementation. In many cases, the coalition that established the effort stayed involved in continuing the action planning process. What was new was the addition of community voices in a planning discussion that has previously been provider-dominated. Providers were also in the room and participated in the process, and comprised up to 30 percent of participants at some sites, but it was hearing from members of the community—i.e., those with lived experience, and especially youth—that provided a fresh look and authentic voice to the recommendations. In many ways, it was the power of a genuine discussion with communities that have a deep desire to bring mental health issues out of the shadows that provided the impetus to push the action planning forward.

The lead cities were also remarkable for bringing a truly diverse community together with a shared purpose; this lent legitimacy to the effort. The results were:

- African American’s feeling more positive about dealing with mental health after a day of dialogue;
- Latinos, Asian Americans, and refugees being able to name a problem that has been hidden by trauma and talk about the lack of a language to cross a cultural divide; and
- Families, vets, and LGBTQ people, challenged with difficult mental health experiences, sharing their stories of a common struggle.

In each lead city, the work of CCS has been sustained by a coalition and partnership that continues to manage the effort. In some cases, such as Sacramento and Washington, DC, communities have found a longer-term home for sustaining the process. In others, it has been the continued diligence of advocates, community members, elected officials, and providers that see the value of keeping the work alive. The effort in the lead cities was never about a one-time event or planning process. It was about action.

There is a common recognition of the challenges about sustaining a mental health action effort:

- **Addressing mental health is a long-term effort**: Achieving improved mental health and changing social norms are long-term efforts that will require a broad community-based engagement if it is to be successful.
• **Getting and keeping the right people involved is difficult**: The breadth of community participation in mental health action planning is a core part of its strength and success. At the same time, keeping diverse communities engaged requires a purpose that will provide benefits to each of the constituencies involved.

• **Problems of bullying, discrimination, and stigma continue to undermine progress**: The lack of tolerance and acceptance of people with mental health challenges is a barrier to getting help and requires an active effort to educate people to such a degree that mental health problems can be normalized.

• **Sustaining infrastructure for action planning is essential**: The core work of the National Dialogue on Mental Health has been community engagement and action planning. Sustaining the work will depend on the value-added benefits that the work can provide to improvements in mental health services. Dollars are scarce in mental health work, but to the extent that the action planning can galvanize new partnerships and a mix of public and private funding, efforts can be sustained in future years.

**The Importance of Being Part of A National Conversation**

The National Conversation on Mental Health was kicked off by President Obama in June 2013. This was a key catalyst for the success of CCS. Through the interviews, leaders stressed that Presidential leadership and the national process provided essential benefits:

1. Being part of a national effort was important to create visibility, connect the importance of the work to national events, and provide an audience for the results.

2. The national conversation helped partners to get funding, create greater publicity, and bring in elected officials.

3. The national scope and steering committee facilitated the work with other lead cities, enabling them to learn from each other, share best practices, and identify national funding opportunities.

4. The national collaboration created momentum for joint activities and opportunities to work on and expand other CCS efforts such as Text, Talk, and Act.

**A Leader’s Viewpoint**

The national call to action helped catalyze our political leadership, heightened the importance, and gave us a sense of pride.

**General Recommendations for Moving Forward:**

**Increase Community Problem-Solving Through Partnerships**: Participants emphasized the power of building community partnerships to promote community problem solving, specifically between state and local governments, schools, service providers, law enforcement, community organizations, and community members.

*There are a lot of people doing different things. We’ve all sat at the table and heard each other, and [learned] how their particular piece fits into the larger piece about mental health and how to better deliver it to our consumer. It just further showed me that we can get together as a group*
and develop ideas to best serve the needs of the District and anywhere with people with mental issues. (District of Columbia)

Engaging and Educating Youth: Almost everyone stressed the importance of engaging youth in the dialogue around mental health, with the purposes of reducing stigma at home and school, empowering youth to identify their needs, and encouraging youth to think critically about how to address their needs.

Together with the young people, work on their expressed needs, what they thought would make a healthier community for them was so important...Youth workers would be trained to identify when there may be some needs...From that, the professionals would offer their services to those youth who had been identified by community people. (Columbus)

Increased Training: Participants believe that mental health training and education can promote compassion and recognition of the prevalence of mental health needs, and subsequently reduce stigma.

I can say we need more tools, more training. It’s brought awareness, but now I understand the need to get more training to help our young people and [the need to] make it culturally sensitive and relevant. How do we hear from our kids? And then, with the information that’s available, how do we present it to them in a way that they can receive it? (Columbus)

Increased Services and Resources: Participants reported the need for additional mental health resources and services to meet the needs of individuals with mental health problems and their family members.

Changes in Policy: Participants recommended that system changes, laws, and resources should reflect the needs of individuals and families.

Implementing Future Community Dialogues

Increasing Outreach: Participants recommended holding more events and suggested that the events would improve over time; one participant suggested that “practice makes perfect.” Participants suggested holding another event and doing more outreach to increase attendance.

Using Technology: CCS strategies included table conversations and keypad voting. Both were very well received, with considerable positive feedback about how the strategies utilizing technology enhanced the conversation, especially for the youth.

Absolutely, the way the whole day was structured definitely supported the community getting to a place where some recommendations could actually be made. People were talking about their own challenges and service provision challenges. It was the voting piece, the table talk, and mixing different groups of people together that really enhanced that...They’re (youth) very social media savvy and so they were able to get engaged that way. The way the event was set up [was also important]. There was a mix of participants: people who [were] interested, people who have no knowledge—adults and youth, and people living with mental illness. So there was a nice mixture of those individual groups. (Kansas City)
Allow for Separate Youth and Adults Groups: A participant suggested separating youth and adults initially to allow them to discuss issues within their peer group, and then have the two groups come together to debrief and continue discussion.

Because I’m partial to youth I would have liked to see all of them together, no adult interaction other than the facilitator. Just getting them in a room together and letting them go at it...So just having a separate opportunity for the youth to get together and talking, separate from adults. Then once their level of comfort is higher, then we go join the adults and tell them what you came up [with]. (Kansas City)
Chapter 3. Distributed Communities

Distributed Conversations Initiative: Overview

More than 200 communities across the country have engaged an estimated 11,000 people in CCS distributed conversations to talk about and take on issues around mental health. The term distributed conversations is used because of the widely distributed and diverse conversations that took place in every state in America. The design was to mirror the effort of the lead cities, but allow many more communities to participate through a simpler and shorter process.

Often led by local mental health agencies, grassroots activists, and public officials, the community conversations sought to increase awareness of and educate people on mental health as well as reduce stigma towards those who suffer from mental illness.

Communities hosting distributed conversations shared similar objectives as the lead cities:

- Draw together a diverse cross-section of participants;
- Conduct conversations that enable participants to explore common mental health issues; and
- Develop recommendations that can be implemented in their communities.

To meet the needs of a diverse constituency of organizers, the distributed conversations were supported in a variety of ways, as discussed below.

CCS Website and Dialogue Map

The CCS website, created in March 2013, featured a community dialogues map that allowed potential organizers, funders, and facilitators to find one another, advertise upcoming events, provide resources, and report on the results of their conversations.

Written Materials and Online Training

SAMHSA collaborated with CCS to create a series of resources for communities to use, including a discussion guide, an information brief, and a planning guide (collectively referred to as a toolkit). CCS also shared community generated materials, and developed additional resources, including a “Quick Start” abbreviated discussion guide and webinars on a range of topics, in response to emerging needs expressed by communities.

Community Liaison

The CCS Community Liaison provided technical assistance by phone and email to local, regional and statewide organizers across the country. The liaison:

- Responded to inquiries from individuals and groups who wished to organize CCS events in their communities;
• Conducted outreach calls and followed up with people who were thinking of conducting conversations;
• Provided encouragement, support, and advice needed to help communities move from intention to implementation;
• Advised and supported groups and individuals who wished to move to action following their CCS dialogues; and
• Told the story of what was happening around the country through periodic updates to the CCS Coalition.

The distributed conversations took many forms, reflecting the unique nature of each community. Event formats included stand-alone two-hour dialogues, day-long forums, and multi-session conversations. Some events focused on a specific mental health topic; some were designed to lead to collective action; and some were targeted toward raising awareness and promoting mental health advocacy. The conversations were guided by discussion materials that helped people:

• Share their personal experiences with mental health;
• Discuss the challenges around issues of mental health, particularly for young people;
• Explore how to support young people suffering from mental illness; and
• Find ways to work as a community toward solutions.

Focus of the Conversations

The distributed conversations have focused on a variety of issues relating to mental health. While most used the toolkits as a starting point for their conversations, they often moved directly into local community issues.

The following examples offer more detail on the focus of the distributed conversations.

• The National Alliance of Mental Illness (NAMI) of Colorado Springs, Colorado, helped lead town-wide dialogues that focused on the mental health care needs facing the Pikes Peak region.
• The Mental Health Association of Palm Beach County, Florida, spearheaded a series of dialogues called #OK2TalkPBC. The conversations focused on the intersection of youth, mental health, and the criminal justice system.
• In Skokie, Illinois, the focus of the distributed conversation was on the intersection between mental health and the business community. This dialogue, hosted by Turning Point Behavioral Health Care Center and the Skokie Public library, began with a former businessman who suffered a serious mental breakdown explaining how his career served as a catalyst for his mental illness.
• In Washington, DC, The Campbell Center and the Howard University Department of Psychiatry co-hosted an event that focused on mental health and substance use.
• In Jacksonville, Florida, the United Way of Northeast Florida partnered with Mental Health America and the Jacksonville System of Care to host three mental health conversations focused on youth.
New Hampshire Listens held regional conversations around the state that explored a wide range of topics related to mental health, including stigma, substance use, barriers to preventing, identifying, and coordinating treatment as well as strategies and approaches for addressing these issues.

Healthy Minds CT in Fairfield County, Connecticut, held a series of dialogues across the county. Conversations centered on awareness, stigma, information about resources, and access to services.

Outcomes

As part of CCS, 258 distributed conversations events were conducted across the country. Of those, 82 uploaded the outcomes from their events to the CCS website, representing the ideas of over 5,596 participants. The CCS evaluation included coding those outcomes and incorporating them into the analysis of the questions below.

In addition, the evaluation team conducted three interviews with a leader, organizer and participant from the distributed conversations that were conducted in Colorado Springs, Colorado. The interviews had separate questions for each of the three types of roles: leader, organizer, and participant.

**Increased Education and Awareness of Mental Health**

The distributed conversations, by use of written materials and dialogue, were generally successful at increasing education and awareness. The toolkit had significant educational materials about the current state of mental health, its challenges, and statistics on youth and mental health. Many of the summary reports from the conversations highlighted the basic educational points:

- The prevalence of mental health challenges in the population;
- The early onset of mental health issues for youth;
- The costs of not treating mental health; and
- The likelihood of recovery through proper treatment.

From the outcomes uploaded to the website, there are many examples of how the conversations have not only increased education and awareness but have led to continuing efforts to address mental health issues.

- Multiple communities are planning to organize mental health awareness day/weeks, spurred to taking action because of the distributed conversations.
- Multiple cities/organizations are continuing to hold dialogue events focus on mental health.

From distributed conversation reports and interviews, it was clear that:

- People have increased comfort in talking about mental illness;
- The number of community-based providers participating in mental health events has increased;

**An Organizer’s Viewpoint**

It was a very constructive process that allowed for real and meaningful dialogue. Providers saw, for the first time, the gaps and the pain for people in the system in a new way.
Demand for mental health first aid training has increased and is an important component of responding to mental health needs;

Barriers to accessing mental health information for underserved groups through local information groups such as NAMI have been reduced;

Participants left the dialogue with a better understanding of mental health issues; and

Consumers became more active—for example, a Living with Bipolar Disorder group reported increased attendance for every session (12 sessions) as a result of their conversation.

Changes in Social Norms

A shift in social norms can be the result of a catalyzing incident, an understanding of the need to address problems such as discrimination of people with mental illness, or a recognition of the widespread nature of mental health challenges, to name a few. For the more than 11,000 participants in these distributed conversations, the recognition of the need to change attitudes and beliefs was a common theme. In addition, the intention to take action was clear. Dealing with mental illness is a complicated, difficult, and challenging proposition in the best of circumstances. Most participants had personal experiences that provided graphic examples of the need to change social norms. As a result of these conversations, it was emphasized that:

- People want to make a difference in mental health;
- It is possible to increase the number of people who care about mental health; and
- Increased public understanding of mental health can lead to increased public advocacy in mental health

An organizer commented:

Because it was diverse, there were genuine learnings for us. I didn’t comprehend the cultural differences on mental health until I went to the dialogue process. We learned about the differences and about the additional challenges that you face if you live with mental illness in one of these communities.

Issues and Themes

The themes from the distributed conversations were reflective of the participants in the community and the particular needs that were identified in the dialogue process. An analysis of the themes demonstrated the widespread concerns about discrimination, access to services, support by peers, effective training for first responders, and important work in schools and colleges.

Important recommendations or actions that have emerged from the distributed conversations include:

- **Expand mental health training and support:**
  - Mental health first aid training community wide;
o Focus on school teachers and first responders—i.e., fire department personnel and law enforcement.

- **Develop peer support:** Legitimize peer roles in the mental health system through training and certification for people recovering from mental illness working in the system.

- **Address problems of funding:** Schools, communities, businesses, prisons, hospitals, and criminal justice systems lack the funding, knowledge, and facilities to properly handle mental health issues.

- **Address discrimination:** Mental health issues need to be destigmatized and thought of in the same way as physical health:
  o Increase public awareness of mental health issues especially in the media;
  o Identify and implement strategies to address discrimination encountered by LGBTQ people, which can have a negative effect on mental health;
  o Develop an advocacy effort for better access to mental health care.

- **Create better coordination and access to effective services:** Participants cited several examples of and recommendations for addressing the lack of coordination and access among current initiatives and services, for example:
  o Navigation through the system is complex, especially among veterans, the poor and non-English speaking populations;
  o Better processes to assess someone’s mental health should be developed (whether by a judge, doctor, or professional);
  o Divert youth and adults with mental health challenges away from the criminal justice system and into a healthy therapeutic environment;
  o Provide more talk-based therapy or religious/ holistic therapy rather than psychiatric prescriptions.

- **Improving the mental health environment in schools and colleges:** K-12 and universities are becoming more high pressure for students, with negative results:
  o Youth/young adults are most susceptible to developing mental health issues;
  o Lack of a safe place to have open dialogue about mental health

**Trends Across Action Plans**

The evaluation team analyzed action ideas gathered during the CCS distributed conversations for trends. Of the 79 communities reporting on their conversations, 64 listed specific action steps they are recommending to their communities. While the evaluation team currently does not have data on whether these action ideas were implemented, they reflect a consistent need to move from discussion to concrete action in communities across America. As a leader of one of the distributed conversations stated:
It was my goal to put the same amount of effort into action as the organizing. It worked well for us. From the beginning, our goals and that of the national initiative were to educate, raise awareness, and reduce stigma. We put that out at every event we held.

Common themes and recommendations emerged from the distributed conversations:

- **Create an ongoing community voice** on what matters to the community in mental health.

- **Educate community leaders and advocates** by continuing conversations (in multiple languages) throughout communities in order to reduce the negative stigma surround mental health:
  - Invite/bring family, friends, and neighbors;
  - Stress the importance of a peer support system.

- **Reprioritize mental health services** in community/state/federal budgets:
  - Write/meet with legislators;
  - Promote voting based on mental health priorities.

- **Develop a K-12 mental health curriculum** including topics such as bullying and provide early intervention screening, services, and dialogue spaces for students/young adults. In addition:
  - Provide training for teachers and parents on how to help or get the help a child needs;
  - Routine and early mental health screenings for all school children.

- **Connect local health agencies with mental health specific organizations** and advertise (in multiple languages) the available mental health services; provide a website for local mental health services

- **Provide (more) training for first responders** on how to deal with mental health crises and screening for law enforcement employees. In particular:
  - Develop a system(s) to differentiate whether a person should enter the criminal justice system or health care system.

- **Provide basic support**: Provide housing, employment help/opportunities, and transportation for persons diagnosed with a mental health illness; develop a support system for inmates and their families.

- **Improve integration of mental health and physical health**: Provide more mental health training for primary care physicians. In addition:
  - Re-evaluate insurance policies to include support for mental health;
  - Shift away from medicating first to more social therapy.

- **Engage youth** around reducing bullying, stigma, and discrimination associated with mental illness
  - Get youth comfortably engaged in learning about their challenges, asking questions and advocating for themselves.
New Linkages and Collaboration

The theme for continuing work following the distributed conversations was **partnerships**. An outcome of the organizing of these community conversations was the injection of new voices and community engagement in mental health planning and services. A wide variety of new levels of collaboration among local actors for mental health resulted from distributed conversations.

The following trends and examples surfaced:

- Engagement of general public in planning and participation in mental health events;
- Convenings that have brought together mental health service providers—for example, the North Central Regional Mental Health Board is partnering with the Hartford public library to continue dialogue on mental health;
- Multiple communities are planning to work with NAMI for future dialogue and awareness events;
- Multiple communities are planning to work with their state 211 phone line (which provides information and referrals to local health, human, and social service agencies) to improve the available mental health information;
- North Iowa Mental Health Coalition plans to work with the Blue Zones group to organize a mental health day, and the North Iowa Youth Center and Rhythm Church plan to reach out to more youth;
- The group in Florence, South Carolina, plans to partner with the mental health center and the school board/administration;
- In Palm Beach County, Florida, partnerships between health care providers, mental health advocates, first responders, and the criminal justice system were formed.
- The group in Albany, Georgia, plans to work with the Georgia Department of Behavioral Health & Developmental Disabilities on the closing of the region’s mental health hospital; and
- Groups in Kansas City are working with leaders in the psychiatric survivors’ movement to spread the word about CCS dialogue opportunities.

An organizer summarized what many others also felt:

> We organized something, stuck with it, took it through action, delivering on actions. There’s a credibility that came with the effort that’s translating to a trust.

Lessons Learned

The lessons learned, briefly summarized below, come from the evaluation team’s review of the distributed conversation reports and analysis of participant input and interview data.

**An Organizer’s Viewpoint**

Because youth are more aware, sophisticated, and have less stigma, we had the confidence to take bolder actions with youth. For the youth, they’re already there. They know mental health’s an issue for them and their peers. They want to get past stigma and start doing something.
**Recommended action steps are extremely consistent across all the conversations despite a wide variance in the scope, quality, and depth of the events.** The distributed conversations took on many forms, from in-depth dialogue and deliberation to short conversations and awareness-raising events. Despite these multiple formats, the conversations generated common themes for action ideas. Some even led to action planning and implementation.

Many communities lack an understanding of and skills for engaging people in dialogue and action, but they are open to learning. While many events initially focused on raising awareness rather than on engaging people in dialogue, some organizers made adjustments for building more deliberation into their efforts.

The CCS website was an important resource and offered an opportunity to impart a deeper level of assistance. While communities often required help uploading their events to the CCS website, it provided an important and convenient organizing space for communities to compare outcomes and identify others doing the work in their state. Interestingly, the technical assistance opened the door to offering them more customized coaching. The CCS Community Liaison talked with people about their dialogue plans and suggested ways to create more inclusive and deliberative events. Not everyone was open to suggestions, but many people were happy to receive the additional advice. As a result, several communities reworked their events to make them more participatory.

Once people experienced the deliberative process and saw its impact, they valued it and wanted to build on what they started. Many new CCS events are intended as a follow-up to earlier events. This is particularly true for coalitions spearheaded by mental health providers and mental health advocates.

Only one-third posted their outcomes to the CCS website. The fact that only 82 communities posted their outcomes to the website was a failure on the part of CCS to follow up and draw upon the breadth of community work being accomplished throughout the country. CCS needed to put more resources into the follow up process to encourage each community to report the outcomes of their work.

Shorter, less deliberative efforts seem less likely to move to action. Many of the shorter, less deliberative events did not move to action. Some strong mental health organizations (municipal or non-profit) were the exception in that they are moving forward effectively with actions generated from their events. It is yet to be seen how much community support these efforts receive.

The most successful efforts are led by coalitions that include both mental health professionals and people who understand how to carry out community engagement. Combining community engagement experience and mental health knowledge is unique for communities carrying out CCS conversations, and the arrangement seems to be yielding results. Coalitions leading such efforts have made it possible for people who have never been involved in mental health conversations to identify and help execute on action ideas.

Strong local leadership is a key ingredient for success. Strong local leaders include those with expertise in deliberation or management experience in municipal or non-profit mental health organizations. These leaders may also be passionate individual advocates.

The CCS distributed conversations are a novel approach to public participation by a government agency. Upon the launch of the national dialogue, SAMHSA intentionally chose to work with the public in a way that required a fundamental shift in its usual approach. The agency knew that the strength of any process would ultimately depend on the willingness of local organizations to assume leadership in addressing mental health problems in their communities. This required collaboration among government,
organizations, and community organizers. SAMHSA’s readiness to collaborate represents a significant and positive shift away from the federal government’s traditional public participation models.

**The process is transferable to other issues.** The CCS website is a central organizing component of the distributed conversations initiative. Event organizers used the website to post pins on the community dialogues map and to share information about the dialogues, outcomes, and action planning in their community. The network of community leaders and organizers coupled with the website and contacts database are helping to develop the capacity of communities to self-organize. The process, network, and platform have far-reaching implications for other government programs wishing to develop future national conversations.
Chapter 4. Text, Talk, and Act

Text, Talk, and Act Initiative: Overview

Text, Talk, Act (TTA) is a discussion platform that uses text messaging to facilitate a face-to-face conversation on mental health. Participants gather in small groups (3-4 people) with one cell phone per group. They text START to the number 89800 to receive a series of text messages that guides their group through a conversation on mental health: why it is important, how to care for it, and how to help a friend in need. The text messages include videos, social media interactions, polling questions and discussion questions.

Text, Talk, Act official events have been held on the following dates: December 5, 2013 (pilot event), April 24, 2014, October 6, 2014, April 14, 2015, and May 7, 2015. Approximately 27,500 people (primarily young people) have participated in these events. Due to the nature of TTA (i.e. groups of people using a single cell phone to facilitate discussion) it is difficult to collect specific demographic information about all participants so the evaluation team has only general information about those who have participated. However, TTA events have been targeted at young people and often carried about by schools, clubs, and student groups who were already interested in mental health issues, so the evaluation team can reasonably assume that a large portion of participants have been young people who were already somewhat knowledgeable about mental health.

From the data the evaluation team was able to collect, it is clear that participants in the Text Talk Act Evaluation Study were diverse. For two of the five TTAs (April 14, 2015 and May 7, 2015), the population was comprised of 355 devices, representing approximately 2,192 individuals. The majority of participants who engaged in one of the TTA events had never participated in a previous TTA event (65%). The average age was 20.5 years. The gender characteristics of TTA participants are shown in Figure 1.

Figure 1. Gender Characteristics of TTA Participants
Engagement based on gender indicated that the majority of participants identified as female (65%).

*Evaluation Methods*

This evaluation of the TTA initiative’s effectiveness had several components. First, the evaluation team reviewed the results of an independent evaluation of the April 14 and May 7, 2015 TTA events, which had been conducted to determine if TTA events were successful in achieving their goals of helping participants learn why mental health is important, how to enhance mental health services, and what to do for a friend in need. The evaluation report was released on June 17, 2015. Second, as part of the current evaluation, the evaluation team analyzed TTA participant responses to the TTA activity. Third, the evaluation team conducted and analyzed interviews with an organizer, leader, and participant involved with TTA. Each component of this evaluation contributed to the evaluation team’s drawing conclusions about the effects of TTA on participants and their communities.

The second component, noted above, consisted of identifying common themes expressed by participants in the TTA events. This involved reviewing participants’ texted replies to TTA prompts between winter 2013 and spring 2015. The evaluation team then entered these responses into an NVivo database and systemically analyzed the data for thematic content using a dual coding technique.

The third component helped us to better understand the on-the-ground experience of those involved in TTA. The evaluation team conducted three interviews with people involved with a TTA event at Pensacola State College in Florida and analyzed the interview responses. One interview was conducted with a TTA leader (i.e., a professor who was a primary contact person and overseer of the TTA activity), one with a TTA organizer (i.e., a person directly involved with gathering participants and carrying out the activity), and one with a TTA participant (i.e., a person who engaged in the TTA activity).

*Outcomes*

*Increased Education and Awareness of Mental Health*

**TTA Independent Evaluation.** To answer the evaluation question about whether or not TTA increased education and awareness regarding mental health issues, the evaluation team looked first to the results of the independent evaluation. The evaluation provides us with some evidence that participating in TTA contributed to an increase in knowledge and awareness.

Participants who reported having “slight” to “no” prior familiarity/knowledge with the topic of mental health, the availability of mental health resources/services, and the ability to recognize mental health issues in others at the beginning of their TTA experience showed the most improvement. Seventy percent (70%) of individuals who reported a slight-to-no prior familiarity on the topic of mental health reported being moderately to extremely familiar with the topic after the event. Fifty-two percent (52%) of participants experienced the same change in reference to the availability of mental health resources/services. Fifty-five percent (55%) expressed similar changes in recognizing mental health issues in others.

Knowledge of and familiarity with mental health issues increased over time. The p values of < .05 indicate that the increase in mean scores from prior to to after experiencing TTA reflect an actual increase in knowledge; the increases did not occur by chance (Table 3).
To understand the extent of this change over time, or the size of the effect that TTA had on knowledge of mental health issues, Cohen’s (1988) d was calculated. Standard, accepted guidelines (Cohen, 1988) indicate that a d value of .20 translates to a small effect, .50 indicates a moderate effect, and .80 indicates a large effect.

As shown in Table 4.1, TTA had a moderately-sized effect on knowledge of the topic of mental health (d = 0.49). In addition, TTA had a small-to-moderate effect on knowledge of the availability of mental health resources/services and on knowledge related to recognizing mental health issues in others (d = 0.37 and 0.30, respectively). These findings indicate a meaningful improvement in knowledge and familiarity of mental health issues as a result of TTA.

Table 4.1. Comparison of Participant Knowledge Prior To and After TTA

<table>
<thead>
<tr>
<th>Question After participating in TTA, how familiar/knowledgeable are you with: (n=285)</th>
<th>Mean Prior to TTA</th>
<th>Mean After TTA</th>
<th>t</th>
<th>p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>The topic of mental health?</td>
<td>3.17</td>
<td>3.67</td>
<td>8.57</td>
<td>&lt;.001</td>
<td>0.49</td>
</tr>
<tr>
<td>The availability of mental health resources/services?</td>
<td>2.95</td>
<td>3.35</td>
<td>6.79</td>
<td>&lt;.001</td>
<td>0.37</td>
</tr>
<tr>
<td>Recognizing mental health issues in others?</td>
<td>3.16</td>
<td>3.47</td>
<td>5.70</td>
<td>&lt;.001</td>
<td>0.30</td>
</tr>
</tbody>
</table>

After participating in TTA, though having a moderate level of knowledge prior to the event, participants reported an increase in all three knowledge/familiarity measures (Table 4.2). The difference in mean scores indicates a change in participants’ familiarity and knowledge. For example, participants familiarity with the topic of mental health increased by 0.39. Participants’ knowledge of the availability of mental health resources/services increased by 0.54. In addition, participants’ familiarity with recognizing mental health issues in others increased by 0.29.

Table 4.2. Familiarity/Knowledge of Mental Health After TTA Event

<table>
<thead>
<tr>
<th>Question After participating in TTA, how familiar/knowledgeable are you with: (n=292)</th>
<th>Not at all (1)</th>
<th>Slightly (2)</th>
<th>Moderately (3)</th>
<th>Very (4)</th>
<th>Extremely (5)</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>The topic of mental health?</td>
<td>3%</td>
<td>7%</td>
<td>28%</td>
<td>44%</td>
<td>17%</td>
<td>3.67</td>
</tr>
<tr>
<td>The availability of mental health resources/services?</td>
<td>5%</td>
<td>17%</td>
<td>30%</td>
<td>32%</td>
<td>15%</td>
<td>3.33</td>
</tr>
<tr>
<td>Recognizing mental health issues in others?</td>
<td>3%</td>
<td>11%</td>
<td>33%</td>
<td>35%</td>
<td>15%</td>
<td>3.47</td>
</tr>
</tbody>
</table>
Results of statistical tests indicate that people who participated in TTA actually perceived an increase in comfort, ability and likeliness to engage in positive mental health activities as a result of participating in TTA (Table 4.3). The p values of < .05 and the Cohen’s d’s reflecting large effects of 0.80 to 1.19 indicate that the mean scores reflecting perceived change in comfort, ability and likeliness to engage in positive mental health activities as a result of participating in TTA are actually greater than a response of “no change” (a response of 3.0). Therefore, these differences are unlikely to have occurred by chance, and actually indicate a perceived increase in comfort, ability and likeliness to engage in positive mental health activities.

Table 4.3. Participant Comfort, Ability, and Likeliness to Engage in Mental Health Activities After TTA

<table>
<thead>
<tr>
<th>Question After participating in TTA: (n=287)</th>
<th>Mean</th>
<th>t</th>
<th>p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to talk about mental health with others</td>
<td>3.71</td>
<td>14.05</td>
<td>&lt;.001</td>
<td>0.82</td>
</tr>
<tr>
<td>Feeling of connectedness with your peers</td>
<td>3.66</td>
<td>13.59</td>
<td>&lt;.001</td>
<td>0.80</td>
</tr>
<tr>
<td>Ability to recognize a peer with a mental health issue</td>
<td>3.73</td>
<td>17.95</td>
<td>&lt;.001</td>
<td>1.06</td>
</tr>
<tr>
<td>Ability to reach out to a peer in need</td>
<td>3.85</td>
<td>20.03</td>
<td>&lt;.001</td>
<td>1.19</td>
</tr>
<tr>
<td>Comfort engaging in mental health advocacy activities (i.e., events, support groups)?</td>
<td>3.72</td>
<td>15.31</td>
<td>&lt;.001</td>
<td>0.90</td>
</tr>
<tr>
<td>Likelihood to seek additional information on the topic of mental health</td>
<td>3.73</td>
<td>15.70</td>
<td>&lt;.001</td>
<td>0.92</td>
</tr>
</tbody>
</table>

**Satisfaction**

Data also were collected on eight satisfaction measures: (1) overall event experience; (2) relevance of TTA content; (3) usefulness of TTA content; (4) quality of prompted materials/questions; (5) technological experience; (6) structure and pace; (7) clarity of TTA purpose; and (8) achievement of purpose (Table 4.4). Every satisfaction measure recorded a mean between 4.02 (quality of prompter materials/questions) and 4.21 (clarity of TTA purpose and technological experience). The strength of these statistics indicates a very positive experience for those who engaged in TTA and the TTA Evaluation Study.
Table 4.4. Participant Satisfaction with TTA Components

<table>
<thead>
<tr>
<th>Component</th>
<th>Very Poor (1)</th>
<th>Poor (2)</th>
<th>Fair (3)</th>
<th>Good (4)</th>
<th>Excellent (5)</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall event experience</td>
<td>2%</td>
<td>1%</td>
<td>20%</td>
<td>43%</td>
<td>33%</td>
<td>4.05</td>
</tr>
<tr>
<td>Relevance of TTA content</td>
<td>2%</td>
<td>2%</td>
<td>19%</td>
<td>41%</td>
<td>36%</td>
<td>4.06</td>
</tr>
<tr>
<td>Usefulness of TTA content</td>
<td>2%</td>
<td>3%</td>
<td>15%</td>
<td>43%</td>
<td>37%</td>
<td>4.11</td>
</tr>
<tr>
<td>Quality of prompted materials/questions</td>
<td>2%</td>
<td>2%</td>
<td>21%</td>
<td>44%</td>
<td>31%</td>
<td>4.02</td>
</tr>
<tr>
<td>Technological experience</td>
<td>0%</td>
<td>2%</td>
<td>17%</td>
<td>37%</td>
<td>43%</td>
<td>4.21</td>
</tr>
<tr>
<td>Structure and pace</td>
<td>1%</td>
<td>3%</td>
<td>16%</td>
<td>47%</td>
<td>33%</td>
<td>4.08</td>
</tr>
<tr>
<td>Clarity of TTA purpose</td>
<td>1%</td>
<td>2%</td>
<td>15%</td>
<td>38%</td>
<td>44%</td>
<td>4.21</td>
</tr>
<tr>
<td>Achievement of purpose</td>
<td>2%</td>
<td>2%</td>
<td>16%</td>
<td>39%</td>
<td>41%</td>
<td>4.17</td>
</tr>
</tbody>
</table>

TTA Participant Responses. Next, the evaluation team turned to the analysis of TTA participant responses across all events. The nature of the prompts to which TTA participants responded was such that responses primarily indicated the kinds of things people thought were good ideas for addressing mental health issues. The prompts were not designed to evaluate changes in participants’ beliefs or knowledge about mental health. However, responses very clearly indicate that increasing education and awareness about mental health should be a top priority (see Emerging Issues and Themes discussion below).

TTA Participant Interviews. Finally, the evaluation team analyzed data collected during interviews with TTA participants. From the perspective of a TTA participant, the TTA events had a positive effect on education and awareness. Among the outcomes noted in the participant interview were the following:

- TTA helped raise awareness that mental health covers a broad spectrum that encompasses various conditions.
- The TTA initiative educated participants in basic skills, listening, talking, and the importance of compassion around mental health; it taught students that they could help people suffering from mental illness even if they are not professionals.

From the perspective of a TTA leader, the TTA event was a good opportunity to evaluate the potential of TTA as an educational tool for students and mental health professionals. Among the outcomes noted in the TTA leader interview were the following:

- TTA should be piloted as part of mental health education for general psychology students and nursing student training in mental health.
- TTA activities and outcomes of the event prompted the leader and organizer to change their approach to professional preparation of college nursing students, specifically by integrating TTA into the first semester coursework of the nursing program. The TTA leader is also planning to encourage the psychology faculty at her college to bring the TTA activities to their classrooms.
• Students completing TTA events can be trained to lead TTA in the upcoming National Day Without Stigma events.

• Nursing faculty should be trained to use TTA as part of the professional training curriculum for the RN program.

Changes in Social Norms

TTA Independent Evaluation. The results of the independent evaluation indicate that participating in TTA contributes to an increase in participants’ ability to recognize a peer in need, reach out to a peer in need, and talk about the topic of mental health. In addition, participation in TTA increases the likeliness of participants to seek additional information about mental health issues and implement information or skills learned from TTA (Table 4.5).

Table 4.5. Changes in Participants As a Result of Participating in TTA

<table>
<thead>
<tr>
<th>Question</th>
<th>Significantly Decreased (1)</th>
<th>Decreased (2)</th>
<th>No Change (3)</th>
<th>Increased (4)</th>
<th>Significantly increased (5)</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to talk about mental health with others?</td>
<td>3%</td>
<td>3%</td>
<td>27%</td>
<td>54%</td>
<td>13%</td>
<td>3.71</td>
</tr>
<tr>
<td>Feeling of connectedness with your peers?</td>
<td>2%</td>
<td>3%</td>
<td>33%</td>
<td>51%</td>
<td>11%</td>
<td>3.66</td>
</tr>
<tr>
<td>Ability to recognize a peer with a mental health issue?</td>
<td>0%</td>
<td>1%</td>
<td>33%</td>
<td>55%</td>
<td>10%</td>
<td>3.73</td>
</tr>
<tr>
<td>Ability to reach out to a peer in need?</td>
<td>0%</td>
<td>2%</td>
<td>25%</td>
<td>58%</td>
<td>15%</td>
<td>3.85</td>
</tr>
<tr>
<td>Comfort engaging in mental health advocacy activities (i.e., events, support groups)?</td>
<td>1%</td>
<td>2%</td>
<td>24%</td>
<td>57%</td>
<td>15%</td>
<td>3.72</td>
</tr>
<tr>
<td>Likelihood to seek additional information on the topic of mental health?</td>
<td>1%</td>
<td>2%</td>
<td>32%</td>
<td>51%</td>
<td>13%</td>
<td>3.73</td>
</tr>
<tr>
<td>Likelihood to implement information or skills from TTA into your life?</td>
<td>2%</td>
<td>1%</td>
<td>28%</td>
<td>53%</td>
<td>15%</td>
<td>3.80</td>
</tr>
<tr>
<td>Likelihood to recommend TTA to others?</td>
<td>1%</td>
<td>1%</td>
<td>24%</td>
<td>49%</td>
<td>25%</td>
<td>3.97</td>
</tr>
</tbody>
</table>

Participants in the TTA Evaluation Study reported increases in their comfort, ability, and likeliness to engage in positive mental health activities. For example, participants’ comfort engaging in mental health advocacy activities (i.e. events, support groups, etc.) showed an increase of 0.72 on a 5-point scale. In addition, each of the following also increased: participants’ ability to talk about mental health (+0.71), ability to recognize a peer with a mental health issue (+0.73) and ability to reach out to a peer in need (+0.085). These increased abilities might be partially attributed to the participants’ increase in connectedness with their peers, which increased 0.66. Participants also reported an increase in the integration of learned materials. For example, their likeliness to implement information or skills from TTA into their life increased by 0.80. Similarly, participants’ likeliness to seek additional information (+0.73) and to recommend TTA to others increased (+0.97).
**TTA Participant Responses.** Analysis of TTA participant responses indicates that participants see a need to change social norms, especially when it comes to the stigma currently attached to mental illness (see Emerging Issues and Themes discussion below).

**TTA Participant Interviews.** The interviews, like the open-ended participants responses, were not designed to evaluate changes in social norms, but key informants who were interviewed made some comments on this topic. According to the TTA leader in Pensacola, the TTA process helped students to talk openly about mental health in their lives.

*I think that it made it less scary—that kind of a structure, the kind of fun interactive approach allows them to talk about a sensitive issue with a level of comfort that they would not have had otherwise.*

The TTA organizer reported that, at Pensacola State College, TTA is becoming part of a broader movement to engage the community in mental health awareness and advocacy and currently, partnerships are being formed across stakeholders, organizations, and institutions to improve mental health in the community. The TTA participant also noted:

*It was great to see that the effort was made to start the conversation and once it was going, you could tell it wasn’t an easy subject for people, and was hard to talk about. That just reaffirmed the need for efforts like this to be able to really make a difference and to get people that don’t normally talk about it to talk about it.*

**Issues and Themes Emerging Across TTA Conversations**

**TTA Participant Responses.** The evaluation team analyzed TTA participant responses for common themes. Generally, the open-ended questions presented to TTA participants sought suggestions for ways to take action in support of mental health issues:

1. Your ideas - Some schools/communities do amazing things to address mental health issues. What do you think works?
2. If your school/community could do one thing to improve mental health what would it be?
3. What do people need that isn't available or accessible?
4. What are your ideas for ways to reach out and support friends and peers who may be dealing with mental health issues?
5. Who would you reach out to in your school/community to help you take action?

A number of recurring themes emerged from an analysis of responses.

- The need to engage people with mental illness through personal and supportive interactions;
- Community advocacy that serves to raise awareness of mental health;
- Counteracting and reducing bias surrounding mental illness in the community;
- Providing schools with trained staff and/or other additional mental health services; and
• Greater exposure to mental health issues in schools, particularly through group or other types of events.

Responses related to each of these themes recurred regularly across the various TTA prompts, although some occurred more frequently in response to specific prompts. For example, the themes involving schools occurred most frequently in response to TTA questions 1 and 2, which focused on schools. More discussion of each of these themes is presented below.

Theme One: Engage people on a personal level. The first theme concerning engaging people with mental illness on a personal level occurred commonly throughout TTA responses. Many responses concerned forging personal connections with those who had mental illness, by making friends, active listening, or supportive conversations. Responses focusing on community actions to raise awareness of mental health issues were also frequent.

Some representative responses include:

• I think what would work is to be friends with the person, get comfortable with him/her, and have a little discussion to help him/her with their problems as best you can.
• Befriend the person. Show them that you are there for them if they need you. Let them know that you won't force them to tell you but instead will be there if they need you and they can tell you in their own time.
• One on one discussions where they can open up and just have someone listen.
• Spreading more positive awareness about mental health.
• Increase public awareness.
• Have an awareness festival where people can come to learn more about mental health.
• Outreach in the streets and public transportation hubs.

Theme Two: Reduce mental-health related bias in the community. Another theme to emerge was the importance of reducing mental health-related bias in the community. Although expressed in different ways, responses included the word “stigma,” and although infrequently, some school-focused responses talked about “bullying.” Generally, responses identified bias against mental illness in public settings as an environmental impediment to treatment. Other responses pointed to addressing personal judgments and bias against mental illness.

Some representative comments include:

• Need: more support and a safe place to go, especially on a college campus where there is an abundance of stigma.
• Need: caring professionals, housing, safe environment free of social stigma.
• Need: The freedom for people with mental health issues to express themselves and discuss their issue openly without feeling ashamed or judged.
• Do not make judgements and watch how your phrase things when talking to them.
Theme Three: Importance of schools in supporting community mental health. Another major category of responses centered on the role of schools in supporting community mental health. In part, responses that focused on schools were understandably driven by TTA prompts and outreach efforts that specifically emphasized schools. Two primary themes surrounding schools emerged: (1) schools can and should be better prepared with training and resources for mental health, and (2) schools can and should be a place where young people are informed about mental health issues and resources.

Responses related to the first school theme centered on providing mental health services in schools with trained staff or other resources. Responses also suggested that the school provide or refer students to mental health services and expand staff and capabilities to provide mental health interventions.

Some representative comments include:

- Easy accessibility of mental health clinicians in work and educational and primary care settings.
- Crisis training.
- School counselors to provide in-school support.
- In-resident counselor and free mental health services in schools.

Responses related to the second school theme viewed schools as an opportunity to introduce young people to the community issues of mental illness and supportive services. Often, these responses suggested student-based support group meetings or special events to increase understanding amongst students and faculty, and their families. The possibility of classroom-specific programs focusing on mental health education was also raised. Some responses suggested incorporating mental health education into curricula.

Representative comments include:

- Start a support group for mental health, with student leaders and a comfortable, secular environment.
- Have a club, support group, or something that meets after school for people in crisis that need help.
- Have local forums in schools and communities on mental health.
- Offer mentor programs at school, which would provide someone I can go to to ask for support; advertise resources to the school community; go to people you feel close to and trust, don’t hold it in, don’t be scared to ask for help.
- Start a mental health club.

TTA Participant Interviews

Across the three interviews conducted, a few common themes emerged as well. Key informants stated that there was some initial resistance to the TTA discussion, but participants gradually became more engaged and open to the discussion facilitated by TTA. Once participants were able to adjust to the unique discussion space, students engaged in an authentic conversation about mental health. Participants in the TTA activity were also diverse, which helped to generate meaningful dialogue around mental
health. For some, it appeared that it was the first time that participants had spoken openly about mental health on a personal or community level.

The use of cell phones helped to facilitate the TTA process and made it engaging for participants. One participant commented:

*I think the interface was great, the use of the cell phones helped facilitate it and make it smoother. We’re all accustomed to using smart phones and it’s very quick and very easy. We’d pass it around and the other person would read it. We used two different phones. It made it smooth and simple.*

Participants also noted that a larger screen, like on an iPad, would be welcome when doing TTA.

Some resistance emerged in the discussion of the general psychology students participating in TTA, especially with regard to the question, “how do you define mental health?” However, participants gradually became more engaged and open to the discussion. As the leader explained:

*In a classroom setting it’s more about education than action. I think that from my students’ point of view, it was an informative exercise and it reduced some stigma and allowed them the opportunity to discuss issues that they don’t typically have an opening for.*

The data analyzed to assess the effectiveness of the TTA initiative indicates statistical significance in the following:

- Increased knowledge of the topic of mental health;
- Increased knowledge of the availability of mental health resources/services;
- Increased knowledge related to recognizing mental health issues in others; and
- Perceived increase in comfort, ability and likeliness to engage in positive mental health activities as a result of participating in TTA.

The data also show that TTA participants liked the activity and the platform and that it got people who might not otherwise have had a reason to talk about mental health to do so.

Furthermore, TTA participants commonly identified the following themes as ways for individuals and the community to encourage mental health:

- Engage people on a personal level.
- Reduce mental-health related bias in the community
- Importance of schools in supporting community mental health.

One TTA participant summed it up particularly well:

*We all really learned from each other. That was part of the glory of it; we were from all different backgrounds and education levels, which made it that much more intriguing and beneficial for each of us.*
Lessons Learned

TTA is a highly valuable approach to education and awareness of mental health challenges because it engages participants directly in an accessible mobile platform. This is true especially for youth, as it enables them both to use a phone and have face-to-face conversations in ways that they are accustomed to using.

Moving out of the comfort zone: As one TTA organizer said, initially the participants were skeptical and the process took them out of their comfort zone. Yet, TTA is a platform that youth are comfortable with and interested in. For mental health issues, it is one of the more accessible mediums to help participants feel safe and willing to learn from each other in authentic ways. While initially participants are uncomfortable, after about 10 minutes they readily engage in the process. It is important to ensure that the invitations and initial exercises provide a welcoming and safe way to explore mental health.

Opportunity to build partnerships: After the TTA events, it was recognized by a leader and an organizer that “this is something that we need.” On a school campus, the question was how the school might use TTA to build some momentum and scale the effort? To move in this direction, it was reported that reaching out to local health departments, grassroots community organizations, law enforcement, and other partners would be useful to expand an effective mental health awareness tool.

Replicating the model: Because TTA is inherently a social media initiative, it is readily available and accessible through multiple media channels. However, a key to its success is the importance of face-to-face conversations which take organizing and leadership to convene them. The combination of national partners and the experience of the many users to date builds a solid base to replicate the model. At the same time, it will take substantial effort by a team to continually coordinate these events, to improve the software, and provide a meaningful participant experience to expand the use of TTA.
Chapter 5. Cross-Site Findings and Recommendations

The Creating Community Solutions initiative has been a two-and-a-half-year effort to respond to President Obama’s call for the National Conversation on Mental Health. The three goals of the CCS initiative are:

- Get Americans talking about mental health to break down barriers and promote recovery and healthy communities;
- Find innovative community-based solutions to mental health needs, with a focus on helping young people; and
- Develop clear steps for communities to move forward in a way that complements existing local initiatives and activities.

From this evaluation of CCS, it is evident that these goals have been addressed seriously by many communities across the country. The conclusion from all of these data sources is very positive: Mental health conversations, which varied in length across CCS platforms, demonstrate improvements in awareness and education and have led communities to some remarkable outcomes to improve mental health, especially for youth.

The recommendations generated by CCS were based on research and evidence-based practices provided by SAMHSA and integrated into the discussion guides, toolkit, and materials used in distributed conversations, lead city conversations and Text, Talk, and Act. While SAMHSA does not promote community engagement as an input to public policy, its critical role in CCS was in providing resources to educate the public about mental health and substance abuse. In this way, SAMHSA acted as a catalyst for the community conversations and local action ideas envisioned in the President's call for a national dialogue.

The final evaluation question is about differences and similarities across all platforms and implementation of CCS efforts. The evaluation team found that the themes and actions across all platforms have been remarkably consistent. The analysis shows that CCS events have had a positive impact on individuals participating in the conversations and come away with a commitment to take actions that engage new voices and partnerships to improve mental health. While TTA and many of the distributed conversations were designed to be singular events, the ongoing work in the lead cities and in some of the distributed conversations makes it evident that CCS has tapped a broad interest in doing something significant about mental health.

A substantial amount of the success of this broad-based community engagement process has been the result of having a national steering committee of key partners, driven by the team at the National Institute of Civil Discourse. Each of the national partners has continued over the almost three years since the CCS events to support the process in the lead cities, in distributed conversations, and for Text, Talk, and Act. In regular calls, the national partners have provided the coordination, oversight, and support necessary to muster a national conversation. With the lead cities, they have held a retreat and monthly discussion meetings. In each lead city, the degree of local ownership has increased and interest in sharing learnings as a community of lead cities has continued.
Yet, the road forward is not entirely clear. Can the lead city efforts be continued over time relying on local support? Can the national effort find a home for this work that will build upon the work across all three platforms – lead city action planning, distributed conversations, and Text, Talk, and Act? Can a national and local infrastructure be created to work on significant issues in mental health and related fields?

Continued success in putting the “community” back into mental health should be based on an engagement strategy that extends this conversation into schools, community groups, ethnic communities, businesses, and faith groups on a consistent basis. From the conversations and interviews, it is evident that there is a need to bring about greater awareness and education, but also to shape social norms around mental health on a long-term basis. Galvanizing events such as shootings by mentally disturbed persons occur on a frighteningly regular basis. But this is just the tip of the iceberg. As the informational materials make clear, a large portion of the population (over 20%) in the U.S. experience mental health challenges and these conditions frequently start with youth.

Summary of Cross-Site Findings and Learnings

To make a difference in the prevention, early identification, and treatment of youth, this evaluation concludes with a broad set of findings drawn from all of the CCS work:

- **Initial attempt to convene on-line dialogues did not create broad participation, but provided direction as to how to engage youth more directly:** The first attempt by CCS to convene on-line dialogues through the use of the Civic Commons and the National Coalition for Dialogue and Democracy was not successful in generating youth involvement. CCS learned that more than a regular on-line platform was needed; there needed to be a much more active outreach effort to engage youth. Subsequent efforts included more targeted outreach using youth organizers, incentives, and youth-serving organizations to draw young people into the process.

- **Community engagement lends a new and legitimate voice to improve local mental health services and address community needs:** Community engagement efforts do make a difference at the individual level and in promoting community action. Diverse representation helps to promote meaningful dialogue at the conversation level and in the engagement of communities whose concerns have not been adequately heard. Government funding priorities have been influenced directly from the recommendations that resulted from CCS efforts. In this way, a new civic infrastructure around public engagement has been established to address community issues – especially those that concern mental health.

- **Recommendations for local action are remarkably consistent across platforms:** They include involving schools, engaging youth, promoting public awareness through education and social media, training first responders, integrating mental health into health care clinics, and promoting cultural awareness in mental health language. As might be expected, community recommendations focused more on early identification, prevention, and community networking then on treatment gaps for seriously mentally ill patients.

- **New partnerships have been created nationally and, in the lead cities, have led to some clear outcomes:** The reach of the partnerships and the ability to galvanize new action in the lead cities has been impressive. Remarkably, CCS has contributed to the establishment of a network of 34 national
organizations interested in working together on issues of youth mental health. In particular, efforts related to transition age youth, public awareness campaigns, and cultural work are underway, and these activities represent a long-term opportunity for these cities. The creation of new services for transition age youth and the homeless are providing benefits now in both Washington, DC and Sacramento. The broad-based publicity for the events also has been transformed into public awareness and social media campaigns inspired by these discussions. And, the long-term problem of cultural awareness and discrimination has led to a focused effort to ensure cultural competencies in mental health.

- **Conversations on mental health are an important starting point in changing social norms about mental health:** While it is difficult to change social norms in the short-term, it is clear that the CCS conversations about mental health were an important starting point to bring difficult issues out of the shadows. Participants found that the dialogues, community conversations, and Text, Talk, and Act provide comfortable and educational platforms to engage thousands of people to discuss the importance of mental health. The more that the problems of mental health are understood and normalized, the less discrimination people with mental health conditions will experience and the better outcomes individuals will have for recovery, school performance, and future employment.

- **A national call to have a conversation about mental health was a powerful catalyst:** President Obama’s call to action made a significant difference in the draw and organizing of CCS. Organizers and leaders found that the connection to a White House event and a national interest to raise awareness about mental health was an important ingredient of the success of engaging participants. National leadership on mental health makes a difference.

- **Differences in participation rates may offer the opportunity to target conversations to populations:** Many more females participated in CCS conversations than males (70% vs. 30%). While studies on differential gender rates of mental health problems may offer some explanation, the fact that more women would like to talk about mental health provides an interesting insight into the need to broaden the conversation to all populations. High percentages of participants had lived experience with mental health challenges (nearly 90%) demonstrating both the high rates of mental health problems in the population and that people participating have personal experiences that shape their perspective and interest.

### Recommendations Going Forward

The following recommendations are presented to SAMHSA and other communities interested in using community-based dialogues as a method to continue to build comprehensive action on mental health.

1. **Sustain action planning effort in lead cities and other communities:** Use the model that has been established by CCS that promotes both dialogue and action to initiate improvements in mental health. Diverse community involvement can be a powerful force for implementing changes in mental health.

2. **Create replicable mental health awareness campaigns:** Involve local organizations especially youth in an outreach effort to link services to those in need. There are many campaigns about mental health awareness and education. Use the best of these campaigns, with additional design and support of local youth and organizations, to efficiently extend the reach of the educational process.
3. **Establish a national home to coordinate and sustain this model of community engagement:** The success of this work could not have been accomplished without a strong national home. There is still interest and momentum for this work. A national coordinating entity could continue to build on this work with a Web site, technical assistance, and support to the wide variety of community groups working on mental health planning.

4. **Offer multiple engagement platforms to scale conversations:** In depth face-to-face conversations, distributed conversations using different lengths of discussions, and, blended social media campaigns using texting and video provide a strong basis to scale discussions to reach large populations.

5. **Use toolkits and materials to create ready community capacity and look to target specific populations:** The information and tools used in CCS can be readily used and adapted for future work in the mental health field. Work to focus on specific ethnic groups should use materials that focus on cultural needs. Additional work to involve males in conversations might yield interesting insights about mental health needs and services.

6. **Develop a training system to help community members and institutions organize and conduct community dialogues:** A wide variety of communities participated in the dialogues. There was substantial interest in developing methods to train leaders to facilitate these sensitive conversations and then link them to local planning and mental health services.

7. **Provide support for continuing the planning and implementation process that follows a community dialogue:** The work of the community dialogues has inspired some creative new ideas and programs. The continued development of a national learning community to share best practices, outcomes, and recommendations would enhance the work of the entire effort.

8. **Build coalitions and partnerships:** There are a wide variety of partners at the local, state, and national level that are involved in this type of work. A broad national network to work on mental health awareness that is guided by local community dialogues could build upon the success of CCS.

9. **Don’t wait for another tragedy to spur action on mental health:** The incidents and tragedies of untreated mental health happen every day and in families and communities across the county. There is a hunger and deep need to continue to extend the awareness, support, and services of communities to all who need it.
### Appendix 1. Documentation of Tools and Processes

<table>
<thead>
<tr>
<th>Lead City</th>
<th>Outreach Methodology</th>
<th>Dialogue Method</th>
<th>Action Plan Process</th>
<th>Implementation Effort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque</td>
<td>Outreach April-July</td>
<td>July 20th 2013 Regional Dialogue</td>
<td>Action Planning Team formed January 2014</td>
<td>Six-month implementation process</td>
</tr>
<tr>
<td></td>
<td>• Mayor had focused on mental health in the past, including a November 2011 summit</td>
<td>• 8-hour, one-day event; 300 people; roundtable discussions (8 people each, trained facilitator and trained recorder)</td>
<td>• 22 actions identified from July 20th event, Neighborhood Dialogues</td>
<td>• Actions categorized as immediate, intermediate, and long-term</td>
</tr>
<tr>
<td></td>
<td>• In April 2013, cross-sector steering committee formed</td>
<td>• Facilitators and recorders identified through UNM, paid a small stipend</td>
<td>• Analysis based on detailed dialogue reports (all records) and summary reports from each event</td>
<td>• Some city staffing and resources deployed</td>
</tr>
<tr>
<td></td>
<td>• Flyers and emails were developed, but personal invitation was the most effective recruitment method</td>
<td>• Child care and translation provided</td>
<td></td>
<td>• Estimated project completion date June 30th, 2015</td>
</tr>
<tr>
<td></td>
<td>• Target audiences: people with lived experience; those with no personal connection to mental illness; youth; first responders; mental health providers; elected officials</td>
<td>• Theme team comprised of EvDem staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach for Neighborhood Dialogues</td>
<td></td>
<td>• Themed using keypad devices and a sticky wall</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Similar target audiences</td>
<td>Six Neighborhood Dialogues in 2014</td>
<td>Action Forum held November 1, 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Organized by lead contact from steering committee and lead contact from neighborhood</td>
<td>• 4 hours spent in 3 sessions meeting over several weeks; 257 participants (some of whom also attended Regional Dialogue); small-group discussions, with facilitators, recorders</td>
<td>• 80 participants, about half participating for the first time</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Took place April-October 2014</td>
<td>• 6 Action Teams formed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Child care and translation provided</td>
<td>• Teams asked to complete assignments within 90 days</td>
<td></td>
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<tr>
<td>Lead City</td>
<td>Outreach Methodology</td>
<td>Dialogue Method</td>
<td>Action Plan Process</td>
<td>Implementation Effort</td>
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<tr>
<td>Sacramento</td>
<td>Outreach April-July</td>
<td>July 20th Event</td>
<td>Adopted October 31, 2013</td>
<td>Two Year Implementation Process</td>
</tr>
<tr>
<td></td>
<td>- Census Data in Sacramento County and West Sacramento City.</td>
<td>- 6 hour Large event; 375 Persons; Roundtable Discussions.</td>
<td>- Action Planning Team meetings prior to and after</td>
<td>- Implementation contract with local education agency.</td>
</tr>
<tr>
<td></td>
<td>- Outreach Organizers</td>
<td>- Theming Software and team using Covision.</td>
<td>- Lead facilitator process</td>
<td>- Work teams based on action plan priorities.</td>
</tr>
<tr>
<td></td>
<td>- Social Media – Youth Team</td>
<td>- Keypad Voting from PPT Slides</td>
<td>- Report draft reviewed by Action Team and participants from dialogue.</td>
<td>- Action team continues implementation.</td>
</tr>
<tr>
<td></td>
<td>- Agreements with non-profits to bring participants</td>
<td>- Preliminary</td>
<td>- Final Plan adopted by Executive Committee.</td>
<td>- Foundations monitor progress.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Washington DC</th>
<th>Outreach</th>
<th>October 12th 2013 Event</th>
<th>Action teams formed in late 2013</th>
<th>Implementation process</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Built on connections established through 2011 Children’s Plan, 2012 SAMHSA System of Care grant</td>
<td>- 400 people, including 100 young people</td>
<td>- 5 cross-sector teams formed</td>
<td>- In early 2015, DC Trust assumed leadership for implementing CCS-DC agenda</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Theming software and team from Covision</td>
<td>- 50 participants</td>
<td>- More than $1.6 million raised from multiple sources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Keypad voting from PPT Slides</td>
<td>- Met for 4.5 months</td>
<td>- 4 initiatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Established 12 priority recommendations (7 focused on youth aged 12-17, five on ages 18-24)</td>
<td>- Teams proposed 7 initiatives and 8 policy recommendations</td>
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<tr>
<td></td>
<td></td>
<td>- Recommendations incorporated into a “Community-based Mental Health Action Plan for the District’s Youth and Young Adults”</td>
<td>- Presented plan in March 2014 to Mayor Gray and other District leaders</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Kansas City</th>
<th>Outreach</th>
<th>September 21st, 2013 Event</th>
<th>Action teams formed in 2014</th>
<th>Bridged large geographic area 2 cities, 2 mayors, 6 counties, 2 states to form action planning process and enable people with mental</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Mayors of Kansas City and Wyandotte County appointed a planning team of 14 mental health</td>
<td>- 8-hour, one-day event; 360 people; 14% young people; roundtable discussions</td>
<td>- 5 action teams formed, one for each outcome</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Theming software and team from Covision</td>
<td>- Used RFP</td>
<td></td>
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<tr>
<td>Lead City</td>
<td>Outreach Methodology</td>
<td>Dialogue Method</td>
<td>Action Plan Process</td>
<td>Implementation Effort</td>
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</tr>
<tr>
<td></td>
<td>stakeholders</td>
<td>Keypad voting from PPT Slides</td>
<td>process to select action team conveners</td>
<td>health challenges a safe place to have a voice.</td>
</tr>
<tr>
<td></td>
<td>Planning team worked with KC Consensus, a local public engagement nonprofit</td>
<td>Identified five priority outcomes, and strategies to achieve each one</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Special meeting for mental health service providers, October 8th, 2013**
- 30 participants

**Follow-up public meeting, March 29, 2014**
- 82 participants, 3 hours
- Reviewed outcomes and strategies, identified objectives and action steps

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<table>
<thead>
<tr>
<th>Columbus</th>
<th>Outreach</th>
<th>Dialogue Method</th>
<th>Action Plan Process</th>
<th>Implementation Effort</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>September 4 event and kickoff helped recruit participants for Community Conversations</td>
<td>Planning event, 32 participants</td>
<td>76 participants</td>
<td>60 participants total</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Engaging Community In Preventing Youth of Color with Behavioral Health Challenges from Entering the Legal Justice System”</td>
<td>Summary information presented to conversation participants</td>
<td>Action teams meeting, reporting on progress</td>
</tr>
<tr>
<td></td>
<td></td>
<td>October 10th, 2013 Franklin County kickoff event</td>
<td></td>
<td>Youth Summit, October 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Growing Healthy Communities”</td>
<td></td>
<td>37 participants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>131 participants</td>
<td></td>
<td>Text, Talk, Act, May 2015</td>
</tr>
<tr>
<td></td>
<td>6 Community Conversations, October 2013</td>
<td>2 sessions each, except for one group</td>
<td>Participants: 66</td>
<td>35 young people, 10 adults</td>
</tr>
<tr>
<td></td>
<td></td>
<td>138 participants</td>
<td>Summary information</td>
<td></td>
</tr>
</tbody>
</table>
### Lead City

#### Outreach Methodology

- Each developed 3-6 action ideas
- 5 Youth conversations, October 2013
- 128 participants

#### Dialogue Method

- NAMI Franklin County awarded a grant by City of Columbus to create a community action plan, July 2014

#### Action Plan Process

- Effort

#### Implementation

---

### Birmingham

#### Outreach

- Built on previous planning efforts, including the Mental Health Goals Group of the Jefferson County “Community Roadmap to Health,” active since 2007
- Sparks Consulting worked with Birmingham Planning Group to recruit participants

#### Community-wide forums

- 7 forums held between October 2013-January 2014
- 325 participants total; small-group discussions

#### Jefferson County Dept. of Health is completing Community Health Improvement Plan (CHIP) – a five-year plan based on a 2014 Community Health Assessment. It was “informed through the participation of over 1,000 individuals and developed by more than 100 community stakeholders.”
## Appendix 2. Crosswalk of Interview Guide Questions to Overall CCS Evaluation Questions

<table>
<thead>
<tr>
<th>CCS Evaluation Questions and Topics</th>
<th>Leader</th>
<th>Organizer</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1a: Increased education and awareness of mental health</td>
<td>2. To what extent (if any) did CCS dialogue and action lead to increased education, awareness, and action for mental health?</td>
<td>8. Has this process changed how you think about mental health? If so, how?</td>
<td>2. Our goal was to engage people who wouldn't normally be involved in issues of mental health. How did this opportunity to hear from others affect your experience and the quality of the discussions?</td>
</tr>
<tr>
<td>Q1b(2): Changes in social norms</td>
<td>5. Did attitudes, beliefs, or social norms change as a result of CCS dialogue? If so, how?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1b(1): Issues and themes emerging from Lead Cities conversations</td>
<td>6. What were some of the most important recommendations and/or actions that have emerged from the Creating Community Solutions process in your community? (also relevant to Q1c and Recommendations on community-based solutions to MH issues—see below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1c: Trends across action plans</td>
<td>3. Did the way in which the effort was organized lead to increased momentum and recommendations for the action planning process? If so, how? (may also be relevant to Recommendations on community-based solutions to MH issues—see below)</td>
<td>6. Did the engagement of youth in the process assist in the outcomes of the meeting and action planning? If yes, how so?</td>
<td>10. Has this process made an impact on public policies, major decisions, or plans relating to mental health? If so, please describe these impacts and why they happened.</td>
</tr>
<tr>
<td></td>
<td>6. What were some of the most important recommendations and/or actions that have</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCS Evaluation Questions and Topics</td>
<td>Leader</td>
<td>Organizer</td>
<td>Participant</td>
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<tr>
<td>emerged from the Creating Community Solutions process in your community?  (also relevant to Q1b(1) above and Recommendations on community-based solutions to MH issues below)</td>
<td>7. Has this process made an impact on public policies, major decisions, or plans relating to mental health? If so, please describe these impacts and why they happened.  (also relevant to Recommendations on community-based solutions to MH issues—see below)</td>
<td>6. Did this process affect the relationship between people who are experts or decision-makers on mental health issues, and people who are not? If so, why did it have this effect?</td>
<td></td>
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<tr>
<td>7. Has this process made an impact on public policies, major decisions, or plans relating to mental health? If so, please describe these impacts and why they happened.  (also relevant to Recommendations on community-based solutions to MH issues—see below)</td>
<td>6. Did this process affect the relationship between people who are experts or decision-makers on mental health issues, and people who are not? If so, why did it have this effect?</td>
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</tr>
<tr>
<td>Q1d: New linkages and collaboration</td>
<td>4. To what extent (if any) did CCS dialogue and action produce new levels of collaboration among local actors for mental health education, awareness?</td>
<td>7. Has this process resulted in new connections or insights into what people want from the mental health system?</td>
<td>6. Did this process affect the relationship between people who are experts or decision-makers on mental health issues, and people who are not? If so, why did it have this effect?</td>
</tr>
<tr>
<td>Not related to specific CCS evaluation question</td>
<td>11. Are there any other points that you would like to make in the evaluation of the Creating Community Solutions effort?</td>
<td>3. How successful were you in reaching the level of diversity you were trying to achieve?</td>
<td>3. Did the questions, presentations and materials affect participants’ ability to have an effective discussion and to develop recommendations for use in the</td>
</tr>
<tr>
<td>Recommendations: Community-based solutions to MH issues</td>
<td>6. What were some of the most important recommendations and/or actions that have emerged from the Creating Community Solutions process in your community?</td>
<td>7. What are the most important challenges that your community faces to ensure that recommendations lead to real action and outcomes?</td>
<td>3. Did the questions, presentations and materials affect participants’ ability to have an effective discussion and to develop recommendations for use in the</td>
</tr>
<tr>
<td>Recommendations: Implementing future community dialogues</td>
<td>7. Did the way in which the effort was organized lead to increased momentum and recommendations for the action</td>
<td>3. How successful were you in reaching the level of diversity you were trying to achieve?</td>
<td>4. What challenges (if any) did you face in bringing in a</td>
</tr>
<tr>
<td>CCS Evaluation Questions and Topics</td>
<td>Leader</td>
<td>Organizer</td>
<td>Participant</td>
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<tr>
<td>planning process? If so, how?</td>
<td></td>
<td>representative sample of participants?</td>
<td>community? If so, how?</td>
</tr>
<tr>
<td>9. Was it important that this process was part of a national effort, and that there were other communities engaging people on these issues? Why or why not?</td>
<td></td>
<td>did achieve affect the process and the outcomes of the local effort?</td>
<td></td>
</tr>
<tr>
<td>10. Please identify activities (if any) that were an important linkage between your community-based effort and the national effort. What additional activities might be helpful to connect your community-based work with a national effort?</td>
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</tbody>
</table>

**OTHER QUESTIONS**

1. What was your role in the creating community solutions event in your community?  
2. Describe the different methods that were used to bring in a diverse and representative sample of participants into the CCS process.
3. What was your experience in being involved in the Creating Community Solutions process in your community?  
4. If someone invited you to be part of a similar process, but on some other issue or decision unrelated to mental health, would you want to take part? Why or why not?  
5. How did the diversity that you did achieve affect the process and the outcomes of the local effort?  
6. Did the process that was used to facilitate the conversations, including table conversations and keypad voting, affect the ability of the participants to have an effective discussion and produce a set of recommendations? If so, how?  
7. Do you think it was important that President Obama called for a national dialogue on mental health? Did this affect your willingness to participate, and do you think it had an impact on others?  
8. If someone invited you to be part of a similar process, but on some other issue or decision unrelated to mental health, would you want to take part? Why or why not?  
9. What were your responsibilities in the organizing and outreach for CCS?  
10. Are there any other points that you would like to make in the evaluation of the Creating Community Solutions effort?