LOCAL EVALUATION REPORT

FOR COMMUNITY DEFINED EVIDENCE PRACTICES

Title:

Latino-Based Therapies in California's San Joaquin Valley:

The Relation of *Pláticas* and *Atención Plena* to Academic Success

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Table of Contents

List of Tables

Executive Summary

This Local Evaluation Report (LER) focuses on the effect of ICSI's two (2) cornerstone Community Defined Evidence Practices (CDEPs), *pláticas* and *atención plena*, on the health and educational outcomes of youth. *Pláticas* is a traditional Latino therapeutic practice that is grounded in the Latino indigenous wisdom tradition and goes back thousands of years. As a therapeutic practice it has been in the Latino community since at least the 1970s. *Pláticas* translates to cultural conversations and is a form of transmitting knowledge regarding well-being, mental wellness, psychological, and healing *trastornos* (emotional imbalances). *Pláticas* also considers the cultural and linguistic needs of the Latino community and provides a format that facilitates the psycho-emotional healing possible. *Atención plena* translates to *mindfulness*. It is the practice of cultural meditation for the purpose of concentration. ICSI therapists use *atención plena* as a progressive relaxation technique and guided meditation in periods of 5 to 15 minutes to prepare participants to academic readiness. The practice of *atención plena* has been in the Latino community for about 10 to 15 years, but has not become mainstream to addressing psychological trauma and/or academic success. *Pláticas* and *atención plena* are practices in our CDEP with youth, particularly Latinx youth, who have a long history of mental health challenges that affect their success in school and life. Our CDEP attempts to provide youth with an approach and framework to mental health that is culturally relevant and client centered, and to disrupt the school to prison pipeline that our youth are destined to travel when they lack proper and appropriate mental health support.

The research question that guided our work was: *How are Latina/o youth in schools having positive responses (i.e., improved academics, attendance, and behavior) to Latino-based prevention/intervention (i.e., pláticas and atención plena) mental health approaches?* Over the last five (5) years, we have collected data on the effectiveness of our CDEPs, and this LER will show the results of this data. We collected the following quantitative and qualitative data: (a) 6 parents surveys, (b) 1,147 pre and 1,042 post pieces of data, from surveys or existing data, and (c) 309 youth (mostly unduplicated) that were participants in the focus groups, participant observations, and/or qualitative survey. All our data was collected to answer our research question, measure our CDEP's effectiveness, and learn how we can improve our CDEP. Ultimately, our goal is to increase access to our CDEPs, offer them in more schools, train others how to deploy them, stabilize the lives of youth, and increase school success for youth. The overarching goal is to transform a school-to-prison pipeline into a school-to-college pipeline.

An overview of our results:

- Parent surveys (n = 6) show that not only do parents understand our CDEPs, they like music therapy and *pláticas* therapy, but not necessarily hip hop or *atención plena*. It is important to note that when our therapists/counselors are experts in either *pláticas* or *atención plena*, these methodologies take center stage at their school sites, and are what

youth connect with. Parents also attribute our CDEPs with school success, and support our CDEPs because they understand it as facilitating school success for their youth.

- Pre (year before CDEP treatment) and post (at conclusion of CDEP treatment year) school data over 3 years from youth (n = 181) showed that while attendance did not change drastically, there were other confounding reasons that interfered with the potential our CDEP had to give youth an extra reason to attend class and turn around poor attendance records. However, our CDEP did have some effect in improving behavior, lowering behavior incidents by approximately 24%, 48%, and 21% respectively over three (3) years. It also had some effect in improving academics, raising Grade Point Averages (GPAs) by 50%, 20%, and 15% respectively over the three (3) years.

- Our Rosenberg Self Esteem Scale Survey (pre n = 160, post n = 137) showed that youth improved in their self-esteem (mostly during the COVID-19 pandemic) in 9 out of 10 questions from 0.01 to 0.24 points (on a 4 point scale). This was at a time that they were not physically in the school setting, but taking classes online.

- Our PHQ-9 Health Survey (pre n = 173, post n = 126) showed that youth improved in areas such as energy, motivation, and depression (mostly during the COVID-19 pandemic) in 9 out of 10 questions from 0.02 to 0.20 points (on a 4-point scale). This was at a time that they were not physically in the school setting, but taking classes online.

- Our General Self Efficacy Scale Survey (pre n = 159, post n = 130) showed that youth improved in their self-efficacy (mostly during the COVID-19 pandemic) in 10 out of 10 questions from 0.01 to 0.33 points (on a 4 point scale). This was at a time that they were not physically in the school setting, but taking classes online.

- Our State-Wide Evaluation (SWE) Survey (pre n = 112, post n = 106) showed that youth improved in their views on the protective factors that help them cope with school and life, psychological distress, and psychological functioning. In terms of protective factors (e.g., culture, spirituality), youth showed growth in 2 of 4 items (growth from 0.02 to 0.05 on a 5-point scale). When asked about protective factors in the last 30 days, youth also showed improvement in 2 of 4 items (growth from 0.05 to 0.15 in a 5-point scale). In terms of psychological distress, youth showed improvement in 5 of 6 items (growth from 0.03 to 0.31 on a 5-point scale). In terms of psychological functioning, youth showed improvement in 3 of 4 items (growth from 0.01 to 0.23 on a 5-point scale).

- Focus groups (n = 21 youth) show that a connection with their school therapist/counselor positively affects their school success, as youth utilize these counseling sessions to find

answers and a safe space to address their problems with their parents and in their barrio communities.

- Participant observations (n = 157) of youth working with their counselors/therapists revealed that our counselors/therapists were extremely successful, particularly with *pláticas*, in using these sessions to get youth to address the root causes of their mental health issues. These sessions were extremely successful in getting youth who typically do not trust adults, to open up, share their emotions, process their emotions, and find healthy ways to process these emotions, typically their artistic expression such as song writing, poetry, or hip hop musical expression.

- Survey (pre n = 131; post n = 131) to understand the effect of mindfulness on academic success showed that when youth practiced *atención plena* feelings of positivity (e.g., happiness, focus, etc.) increased by approximately 50%, and feelings of negativity (depressed, stress, tiredness) decreased by approximately 44%. Additionally, approximately 87% associated *atención plena* with helping them with their academics by keeping them focused, calm, and relaxed during academic learning.

Our data clearly shows the effectiveness of our CDEP directly, and our disruption of the school-to-prison pipelines indirectly. Undoubtedly, the effectiveness of our CDEP was due to its grounding in Latino culture and historical cultural practices that facilitated students connecting with our counselors and our CDEP. Our CDEP was also effective because it is asset-based and rather than focusing on what students cannot do, it focuses on what they can do. Our CDEP is youth-centered and grounded in affirming youth, their families, and their communities to uplift their confidence, self-efficacy, and improve their condition. Our CDEP was effectively in destigmatizing perceptions of mental health in the Latino community. Despite our success, we believe there are things we can do to improve the delivery of our CDEP through better engagement with parents, teachers, and school staff and administrators, and training more therapists on our CDEP; and we will continue improving on our successes and strengthening our weaknesses.

Introduction/Literature Review

Latinas/os, from recent immigrants to established Americans, have been known to experience issues of mental illness for decades.[1] Along with these mental health issues, Latina/o communities also lack access to mental health services.[2] The prevalence of mental health issues and lack of services to address them, is as prevalent in Fresno and Madera County's Latina/o communities as it is nationally.[3] For these reasons, our study focuses on Latina/o communities in urban Fresno and rural Madera Counties.

Additionally, Vega et al. (2001) found that it is native-born Mexican Americans that have higher rates of mental and psychiatric disorders than their foreign-born counterparts: (a) Mexican immigrants had about ½ the prevalence rates of major psychiatric disorders of either native-born Mexican American and White American counterparts, and (b) native-born Mexican Americans have approximately the same rates (49%) of mental disorders as the U.S. population. These results clearly show that the longer Mexican Americans live in the U.S., the more likely they are to develop mental disorders, largely due to the deeper understandings of dissonance that Latinas/os experience psychologically, socially, culturally, and economically. In a region like Fresno County with large populations of both established urban and new rural Latinas/os, it is important to provide services to both: (a) urban services where Latinas/os clearly have higher rates of mental disorders, and (b) rural services where Latinas/os clearly have less mental disorders than their urban counterparts, but significantly less access to services.[4]

With this data in mind, our Community Defined Evidence Practices (CDEPs)[5] sought to address mental health for youth in schools, from elementary to high school, much of our work is in continuation/alternative schools. All the issues that Latinx youth confront in society, youth confront in schools -lack of belonging, poverty, lack of health care, and school absenteeism and failure. And it is these issues that facilitate the school-to-prison pipeline which our CDEP aims to disrupt.

Disrupting the school-to-prison pipeline, in many ways, is the essence of out CDEP, and our

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[1] Source: Escobar, J. I., Nervi, C. H., & Gara, M. A. (2000). Immigration and mental health: Mexican Americans in the United States. *Harvard Review of Psychiatry, 8*(2), 64-72.

[2] Sources: Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(3), 316-330; Vega, W. A., Kolody, B., & Aguilar-Gaxiola, S. (2001). Help seeking for mental health problems among Mexican Americans. *Journal of immigrant health*, *3*(3), 133-140.

[3] Source: Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., & Caraveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry*, *55*(9), 771-778.

[4] See Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., & Catalano, R. (1999). Gaps in service utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry, 156*(6), 928-934.

[5] See Aguilar-Gaxiola, S., Loera, G., Mendez, L., & Sala, M. (2012). *Community-defined solutions for Latino mental health care disparities: California reducing disparities project*. Sacramento CA: Latino Strategic Planning Workbook Population Report, UC Davis.

ability to document this was through implementation of our two (2) cornerstone CDEPs, *pláticas* and *atención plena*, on the health and educational outcomes of Latinx youth primarily, but other students of color as well. Our data, collected on our sites in Fresno and Madera counties, shows that our approaches do work to improving mental health and educational outcomes. From 2017 to 2021, we collected both qualitative and quantitative data as we deployed our programs and therapies, and this LER will provide evidence over this time period. Additionally, at the state level, the State-Wide Evaluators (SWE), also collected data, which also showed positive outcomes, and which we will display.

Our two CDEPs, *pláticas* and *atención plena*, are the treatment approaches that are key to our analysis and measurements. *Pláticas*, as a practice, is grounded in the Latino indigenous wisdom tradition that goes back thousands of years. It is a form to transmit knowledge regarding well-being, mental wellness, psychological, and healing *trastornos* (emotional imbalances), and related themes addressed through familiar cultural formats such as *canciones* (songs), *dichos* (sayings), *cuentos* (stories), and *poesía* (poetry). A popular method of using *plática* in counseling/therapy is through the use of a group process format, *círculo*.[6] *Círculo* is a broad-based counseling approach where participants commune in a structured dialogue in a circle, to explore identity, unload "cargas," and to learn, share, grow, heal, and cure.[7] This method engages participants in deep reflection about their lives and issues in their lives, to identify and address the whole person-body, mind and spirit. *Pláticas* also considers the cultural and linguistic needs of the Latino community and provides a format that facilitates the psycho-emotional healing possible. The leader who is guiding the *plática* also engages in evidenced-based group therapy methods and techniques such as: active-listening, reflecting, clarifying, summarizing, facilitating, empathizing, interpreting, questioning, linking, confronting, supporting, blocking, assessing, modeling, suggesting, initiating, evaluating, and terminating.[8]

Our *pláticas* approach has been in practice in the Latino community since at least the 1970s. Aguilar (1970) and Aguilar and Wood (1976) were among the first research practitioners to use *pláticas*, without specifically calling them *pláticas* but technically using a multicultural therapeutic approach.[9] Aguilar was an innovator and used his knowledge as a Mexican immigrant to gain key insights into the Latino psychology and need, and devised multiple therapeutic strategies to address their needs.[10] But little research has been done on *pláticas* -it is a

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[6] See Tello, J., Cervantes, R. C., Cordova, D., Santos, S. M. (2010). Joven noble: Evaluation of a culturally focused youth development program. *Journal of Community Psychology, 38*(6), 799-811.
[7] LivingJusticePress.org. (2016). The indigenous origins of circles and how non-natives learned about them. Retrieved from: livingjusticepress.org.
[8] Source: Corey, G., Corey, M.S., Corey, C., Muratori, M. (2014). *Groups: Process and practice* (9th ed.). Monterey, CA: Brooks/Cole Cengage Learning.
[9] See Aguilar, I. (1972). Initial contacts with Mexican-American families. *Social Work*, *17*(3), 66-70; Aguilar. I., & Wood, V. N. (1976). Therapy through a death ritual. *Social Work, 21*(1), 49-54.
[10] See Garcia, J. (1985). *Madness, therapy, and politics: A Psychosocial study of Hispanic adaptation in a state mental hospital*. PhD Dissertation, Stanford University. UMI Dissertation Information Service.

traditional Latino therapeutic practice not a research topic. According to researchers Ortiz and Torres (2007)[11] and Mohr-Almeida (2009),[12] *pláticas* originated from Mesoamerican *curanderismo*, which is native to Aztec, Mayan, and Spanish cultures in Mexico, and has existed for centuries there as a form of healing. Its main contours are described Roman (2012),[13] in which she describes the conceptual bases for dis-ease, *los aires*. It has only been in the last 10 years where researchers have begun using *pláticas* as a topic of research in mental health.[14] Oftentimes, *pláticas* is also used in qualitative research on fields outside of counseling.[15]

Atención plena is loosely the Spanish translation of the English term, "mindfulness." Which Kabat-Zinn[16] defined as, "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment." ICSI uses *atención plena*, progressive relaxation technique and guided meditation in periods of 5, 10, or 15 minutes to prepare participants to learn and practice centering meditation (*meditación centrante*), which consists of a period of 20 minutes. It does not all happen at once, but may be considered as steps toward acquiring the practice of *meditación centrante*[17] as part of an attitude towards life, work, and meaning. *Atención plena* has not been evaluated and assessed in the Latino community with recent immigrants, people with farmworker backgrounds as well as urban and rural Latinos.[18] The practice of *atención plena* has been introduced into the Latino community in the last 10 years, but has not become mainstream. Mindfulness has been incorporated into the treatment of psychological trauma and evaluated for treating victims of trauma, but *atención plena* has not been evaluated. *Atención plena* has been used by therapists in a culturally, linguistically, and contextually appropriate manner by ICSI when serving adolescent and family victims of trauma, but has not been empirically evaluated as to its effectiveness. ICSI blends the best of the old traditional psychotherapy, "mindfulness" (*atención plena*) and the new

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[11] See Ortiz, I. E., & Torres, E. C. (2007). Curanderismo and the treatment of alcoholism: Findings from a focus group of Mexican curanderos. *Alcoholism Treatment Quarterly*, *25*(4), 79-90.

[12] See Mohr-Almeida, K. (2009). *An Integration of American Nontraditional and Mesoamerican Traditional Approaches as a Treatment Model for Traumatic Stress and Post-Traumatic Stress Disorder (PTSD)*. Unpublished doctoral dissertation, Union Institute and University, Cincinnati, OH.

[13] Source: Román, E. (2012). *Nuestra medicina: De los remedios para el aire y los remedios para el alma.* Bloomington, IN: Palibrio.

[14] See Piazza, J., & DelValle, C. M. (1992). Community-based family therapy training: An example of work with poor and minority families. *Journal of Strategic and Systemic Therapies*, *11*(2), 53-69; Hendrickson, B. (2014). 5. Mexican American Healing and the American Spiritual Marketplace. In *Border Medicine* (pp. 113-139). New York University Press; and Comas-Díaz, L. (2016). Mujerista psychospirituality. In T. Bryant-Davis & L. Comas-Díaz (Eds.), *Womanist and mujerista psychologies: Voices of fire, acts of courage* (pp. 149–169). American Psychological Association. https://doi.org/10.1037/14937-007.

[15] See Guajardo, M., & Guajando, F. (2007). Two brothers in higher education: Weaving the social fabric for service in academia. In K. P. Gonzalez & R. V. Padilla (Eds.), *Doing the public good: Latina/o scholars engage civic participation* (pp. 61-81). Sterling, VA: Stylus Publishing.

[16] Source: Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: past, present, and future. Clinical Psychology: Science and Practice, 10(2), 144-156.

[17] *Meditación centrante* is the Spanish translation of Centering meditation.

[18] See Himelstein, S. (2013). *A mindfulness-based approach to working with high-risk adolescents.* New York: Routledge.

(ACT and DBT) together in terms of combining the culturally-defined evidence practices with the latest research in integral psychotherapy[19] which honors these practices and holds them within a context of mainstream psychotherapy. *Atención plena*, and closely related integral cultural approaches, are needed in the Latino community to address Latinos' exposure to traumatic events that are impacting their personal, school and community life. Latino students suffering from depression and having suicidal thoughts, are worried about their present situation, concerned about their parents, experiencing poverty, discrimination, and lack of resources. They are angry and concerned that they have no outlets other than alcohol and drug use, abuse and violence within their families and neighborhoods, and are unable to imagine solutions to oppressive schooling tactics which too often lead directly to the school-to-prison pipeline. *Platicás* and *atención plena* will meet Latino youths' needs, their families, and eventually the overall Latino community.

According to ICSI founder, Dr. Juan C. Garcia, *atención plena* is a practice in the field of contemplative religion, but not necessarily commonly embraced by all Christian denominations, especially the Catholic, yet it is deeply embedded in ancient Christian practices. He states that it is "defined as a sense of mental fullness; however, as we understand it, practice it, and disseminate it, it is [a] sense of emptying, not as pessimistic empty glass, but as a fullness…." *Atención plena,* or "mindfulness" in English, has become mainstream with many of the approaches to psychological trauma in recent psychological and counseling applications to treating victims of trauma. A popular method of using *atención plena* in counseling/therapy is using *Oración Centrante*, which essentially means centering prayer in English. Centering prayer is also popular in meditation and some Christian religious circles. According to Contemplative Outreach (2016),[20] a spiritual network of over 40,000 people, centering prayer is a method of prayer that prepares individuals to receive God's presence, and emphasizes prayer as a method to having a personal and deep relationship with God. Everardo Pedraza, an ICSI educator/therapist, and founder of the Mindfulness Club at Sunnyside High School in Fresno, has ingeniously secularized Centering Prayer and introduced it as Centering Meditation or *Meditación Centrante*. In Pedraza and Rodríguez (2018),[21] the authors describe youth experiencing *atención plena* as finding their voice to transform a school narrative from a "we are not dirt" narrative to a "we are human" and personal agency narrative, "remaining poised and calm through daily mindfulness practice and small-group processing of their thoughts and feelings… they cultivated a healthy relationship to power and began their project..[with] their personal and collective vision and sense of purpose." Within this practice there is a healing component described in Thomas Keating's book, *Intimacy with God*, which incorporates a process of *unloading* and *evacuation* of

[19] See Forman, M. D. (2010). *A guide to integral psychotherapy: Complexity, integration, and spirituality in practice*. Albany: State University of New York.

[20] Source: Contemplative outreach. (2016). *Centering prayer*. Available: http://www.contemplativeoutreach.org/category/category/centering-prayer

[21] Source: Pedraza, E., & Rodriguez, R. J. (2018). "We are not dirt": Freirean counternarratives and rhetorical literacies for student voice in schooling. *English Journal*, *107*(6), 75-81.

painful memories and intrusive traumatic symptoms interfering with daily life functioning. *Oración centrante* is used in ICSI during *atención plena* session because its western Christian origin resonates best with the Latino population, and of its incorporation of elements of indigenous knowledge, ceremony, and ritual, and other cultural elements or components facilitative in providing culturally consonant therapeutic services.

CDEP Purpose, Description, and Implementation

CDEP Purpose

The purpose of this Local Evaluation Report (LER) is to highlight our evidence on the effectiveness of our signature therapeutic approaches, *pláticas* and *atención plena*. In the deployment of our approaches, we aim to disrupt the school-to-prison pipeline directly. Youth in prison often share various characteristics -they are school dropouts and lack mental health wellness. Our CDEP's focus on deploying therapeutic approaches that increase school connectedness, and in turn positively affect school attendance and academic performance, aims to address aspects of youths' lives that can be transformative, such as the reduction of adverse behaviors such as fighting, self-destructive activities, and gang affiliations. Our evidence shows that our purpose was met over the last five (5) years in which we have deployed our CDEP with at-risk youth.

CDEP Description and Implementation Process

Our description and implementation are slightly different for *pláticas* and *atención plena*, and there are also variations across our secondary schools (middle vs. traditional vs. alternative high schools). First, *pláticas* at our middle and alternative schools are similar. Students are identified by a teacher and/or administrator, and then they are assessed by a mental health clinician. This two-step process is to assure that only students needing mental health services are rendered services. Once they are deemed to need mental health services, their parents are contacted to inform them of their child's need, obtain parental consent, and obtain student background and information about the issues. Parents are also given strategies and feedback to help support students. At the middle school, parents are also given the opportunities to participate in parent *plática* support groups and/or *atención plena* sessions. In all contact with parents, our therapists respect and value their language and cultural backgrounds, and often communicate with parents in Spanish.

At the traditional high school where *atención plena* is our main mode of CDEP delivery, parental involvement is not as developed, and it is youth that practice *atención plena*. At the traditional high school, there is not a formal evaluation method for youth, rather, their participation is voluntary; and since their parents are not involved, there is also an *atención plena* support group for school staff so that as they practice *atención plena*, the practice can further permeate the

school culture, and staff and better able to support students and the practice of *atención plena*. Also, at every *atención plena* session, students are invited to complete the pre and post survey before and after the session.

At both the middle and alternative schools, *pláticas* are a means of providing bilingual support to youth and parents that feel lost in the educational system, and to support the social-emotional aspect of youth's lives. *Pláticas* are in many ways a culturally relevant way to teach youth and parents about social emotional skills. *Pláticas* continue to serve as a method to keep youth and parents connected to the school and supported in their school journeys. In our fidelity assessment of our CDEP we go into greater details as to the CDEP dosage/intervention, but in a typical semester students are likely to get 64 hours of CDEP exposure at the alternative schools, and this is appropriate given the high needs of these schools. The dosage amounts at the middle and traditional high schools drops to 40 semester hours. This 64/40/40 is CDEP dosage in ideal conditions. The 64 dosage hours at the continuation schools are mainly for delivery of *pláticas* and *atención plena* activities. At the middle and public high schools, the 40 hours are for CDEP delivery, but also for one-on-one youth mentoring and support.

It is also important to note that in the delivery of our CDEP we rely on indigenous knowledge and traditions of oral storytelling. The *cuentos* we use originally derived from Ignacio Aguilar's innovative Latino mental health interventions. The *cuentos* he used were from the classic anthropological work by Walter Miller, *Cuentos Mixes.*[22] Other sources included the work of Clarissa Pinkola Estes (1992), author of *Woman Who Runs with the Wolves*.[23] Other sources of stories were the students themselves, some of which were from their own parents, grandparents, and traditions, such as *la llorona*.

In the Latino community we call this storytelling tradition *dichos.*[24] These *dichos* are always packed with mental health knowledge, social emotional support, and cultural lessons from our ancestors that promote mental health healing. Even as the COVID-19 pandemic affected the last 18 months of our CDEP delivery under this grant, we were also to have success in shifting services to online. However, we do have to acknowledge that the pandemic caused setbacks in a lot of the communities where we serve youth because many lacked basic technology to be able to continue to stay connected to their schools and our CDEP. And it is important to acknowledge that during this time, Covid-19 caused a lot of grief and harm in the Latino community, in addition to existing economic and social underclass struggles that are common in our communities.

Local Evaluation Question

[22] Miller, W. (1956). *Cuentos mixes.* Mexico: Instituto Nacional Indigena: Biblioteca de Folklore Indigena.
[23] Estes, C. P. (1992). *Women who run with the wolves: Myths and stories of the wild woman archetype.* New York: Ballentine Books.
[24] *Dichos* is the Spanish translation of *sayings* or *proverbs*.

Our work was guided by the following local evaluation question: *How are Latina/o youth in schools having positive responses (i.e., improved academics, attendance, and behavior) to Latino-based prevention/intervention (i.e., pláticas and atención plena) mental health approaches?*

Our mental health approaches work in the Latinx community because they are culturally relevant and culturally appropriate. They are also delivered by Latinx therapists/counselors who know the culture, have the same background as many of the students we serve, and often deliver our approaches in English and/or Spanish. For our *pláticas*, we relied mostly on quantitative data to measure their effectiveness, although we also collected qualitative data. Our *pláticas* occurred mostly at alternative schools, and it was at these schools where we had access to the GPA, behavior, and attendance data to help understand a larger picture of *pláticas'* effectiveness. For our *atención plena,* we relied on survey data. Our *atención plena* occurred mostly at a traditional high school with a majority minority student population, and also at a charter elementary that was predominantly Latino. All SWE data was collected from all four of our sites -2 alternative schools, 1 traditional high school, and 1 elementary charter school.

Evaluation Design and Methods

Design

Our evaluation used mixed-methods, employing both quantitative and qualitative methods to answer the research question.[25] Mixed methods is used when researchers have both time and resources,[26] which were present for this project that required outcomes that were evidence-based over a 5-year period. We began with the collection of quantitative data to establish initial benchmark measurements, continued with qualitative data collection, and ended with quantitative data collection. All the tools and protocols we implemented in this evaluation were shared with ICSI staff and board members beforehand, at board and staff meetings. All their feedback was incorporated when appropriate and feasible.

In terms of the quantitative data, we collected: (a) surveys with parents, (b) three (3) pre/post measures for youth school behavior, GPA, and attendance, (c) three (3) pre/post surveys to measure mental health (Rosenburg, PHQ-9, and General Self-Efficacy Survey), and (d) a pre/post survey for the State-Wide Evaluators.[27] These measures helped us to document student

[25] Our design was approved by two (2) Institutional Review Boards (IRBs). It was first approved by the IRB board at California State University, Fresno, and then again by the IRB board at the California State Department of Public Health, Office of Health Equity.

[26] Sources: Airasian, P., Gay, L. R., & Mills, G. (2009). *Educational research: Competencies for analysis and applications.* Columbus, Ohio: Merrill Pearson; and Marshall, C., & Rossman, G. B. (1999). *Designing qualitative research*. (3rd ed.). Thousand Oaks, CA: Sage Publications.

[27] The State-Wide Evaluators (SWE) data collection was administered and required by our statewide evaluators, based out of Loyola Marymount University. All 25 sites in the State of California doing this mental health work in communities of color were required to collect SWE data.

academic and mental health improvement over time, as well as parents' views on the program. The four (4) school sites on which we collected data (two continuation schools, a traditional high school, and a charter middle school) agreed to share all the relevant school data that we needed, as well as give us access to the youth receiving the treatment for conducting surveys. Pre data was often collected at the beginning of the semester, and post data at the end of the semester.

In terms of the qualitative data, we conducted: (a) focus groups, (b) participant observations, and (c) a qualitative pre/post survey on the effects of *atención plena*. First, the focus groups involved discussions with participants in a group setting, so as to create a comfortable environment where participants have peer support and do not feel that they must engage every topic or question.[28] Our focus groups were conducted by a native Spanish speaker so as to allow students to code-switch in Spanish and English in their responses, and for the researcher to ask probing questions related to the code-switched dialogue when necessary. In our case, because of the close relationship participants had to their therapists, the therapists were invited to sit in on these focus groups to maximize the level of comfort and confidence by the participants. These focus groups were digitally audio recorded to facilitate the way they were archived and password protected. The purpose for the semi-structured focus group was to give the researcher the best chance to connect responses back to our theoretical framework through probing questions that occurred within the realm of the established questions.[29] Semi-structured interviews also gave the researchers the opportunity to best capture complex ideas, and probe into topics that may not have been fully examined in previous focus groups. The semi-structured interview protocol was developed to facilitate deep probing with the inclusion of at least three levels of questions: (a) questions the researcher had to ask, (b) questions the researcher could ask if time permits, and (c) questions the researcher should ask if time permits and if the questions are in an area that requires further examination.

Second, the participant observations that we collected were of the therapists in action, deploying the CDEPs and one of the key factors in our observations was to note any and all ways in which the therapists deploy culturally relevant methods. We conducted observations,[30] and took field notes that had the purpose of capturing: (a) highlights, (b) therapeutic effectiveness, (c) the therapeutic application of *pláticas* and/or *atención plena* were being infused by the therapists, (d) answers to questions for the therapists after their sessions, and (e) reflection notes after the session. These observations were audio recorded, and extensive field notes transcribed, then

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[28] Sources: Grudens-Schuck, N., Allen, B. L., & Larson, K. (2004). *Focus group fundamentals*. Ames, IA: Iowa State University Extension. Retrieved December 13, 2008, from http:// www.extenison.iastate.edu/publications/ PM1969B.pdf; Krueger, R., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage; and Morgan, D. L. (1997). (2nd Ed.). *Focus groups as qualitative research*. Thousand Oaks, CA: Sage.

[29] Source: Airasian, P., Gay, L. R., & Mills, G. (2009). *Educational research: Competencies for analysis and applications.* Columbus, Ohio: Merrill Pearson.

[30] Source: Airasian, P., Gay, L. R., & Mills, G. (2009). *Educational research: Competencies for analysis and applications.* Columbus, Ohio: Merrill Pearson.

analyzed with NVIVO qualitative data analysis software. We used the thematic analysis for phenomenological analysis, which consists of looking for and categorizing themes that emerge from the data.

Lastly, the pre/post mindfulness surveys with students were collected before and after mindfulness sessions. These were deployed through Google Forms, and students were able to use their computers or phones to complete the surveys.

Sampling Methods and Size

To collect our evidence, we used various sampling methods. The following table will provide an overview of our methods and total data collection over five (5) years.

Table 1. Overview of Sampling Methods

Data Type	Method	Sampling Size	Sample	Purpose
Quantitative (Quan)	Survey[31]	6[32]	Parents	To capture beliefs about effects of CDEP
	Existing Data	181	Alternative School Youth	To capture CDEP effects on school success
	Survey (Rosenburg)[33]	160 Pre 137 Post	Traditional High School Youth	To capture self-esteem of youth
	Survey (PHQ-9)[34]	173 Pre 126 Post	Traditional High School Youth	To capture overall health and wellness
	Survey (GSE)[35]	159 Pre 130 Post	Traditional High School Youth	To capture self-efficacy
	Survey (SWE)	121 Pre 106 Post	Youth (from Alternative, Traditional High, Charter Middle)	To capture mental health and wellness

[31] See Appendix A, *ICSI Encuestas de Padres/Parent Survey.*
[32] We were hesitant to include parent surveys because we were only able to collect six (6), but decided to include them because of the importance of including the parent voice, and also because the parent surveys were only one (1) of nine (9) key pieces of data that showed the effectiveness of our CDEP.
[33] See Appendix B, *The Rosenberg Self-Esteem Scale Survey (Pre/Post).*
[34] See Appendix C, *PHQ-9 Patient Health Questionnaire (Pre/Post).*
[35] See Appendix D, *General Self-Efficacy Scale (GSE)Survey (Pre/Post).*

Qualitative (Qual)	Focus Groups (FGs)[36]	3 FGs (21 youth)	Alternative School Youth	To capture views on effects of CDEP
	Participant Observations (POs)[37]	18 POs (157 youth)	Counselors, Youth (from Alternative, Traditional High, Charter Middle)	To capture pros and cons of CDEP implementation
	Qualitative Survey	131 Pre 131 Post	Traditional High School Youth	To capture effects of *atención plena*

For all the data collected above, youth participation was voluntary, and no one that wanted to participate was excluded. At the alternative high schools, youth were recruited by the therapist who was invited to classrooms to present the benefits of the CDEP to students, and from these recruitment talks youth were self-selected to participate. Alternative high school youth were also released from classrooms to participate in the CDEP. At the traditional high school, participants were mostly recruited from other students, and largely grounded on youth that participated in the Mindfulness Club. The Mindfulness Club was the way in which youth were introduced to our CDEP, and no youth that wanted to participate was excluded. At the charter middle school, youth were introduced to our CDEP through a voluntary lunchtime mindfulness group, but also assigned to the mindfulness group by administration if they felt it could help with behavior improvement.

Measures and Data Collection Procedures

To collect our evidence, we used various measures and data collection procedures. The following table will provide an overview of our measures over five (5) years. The explanation that follows documents our data collection procedures.

Table 2. Overview of Measures

Data Type	Method	Measures
Quan	Survey	To assess parents' perspectives and ratings as they relate to CDEP components, counselors, and effects of CDEP of their youth and family
	Existing Data	To assess the effects of CDEP on school success and connected through measurement of pre/post GPAs,[38] school attendance, and behavioral incidents

[36] See Appendix E, *Semi-Structured Focus Group Protocol.*
[37] See Appendix F, *Participant Observation Protocol.*
[38] = Grade Point Averages.

	Survey (Rosenburg)	To assess youth self-worth, positive outlook, life satisfaction, self-respect, and depression
	Survey (PHQ-9)	To assess depression, self-control, concentration ability, suicide ideation
	Survey (GSE)	To assess self-efficacy (goal accompaniment, resiliency, coping abilities, problem-solving)
	Survey (SWE)	To assess mental health (protective factors, access/utilization, psychological distress/functioning, and CDEP quality)
Qual	FGs	To assess mental health and wellness as it relates to self, CDEP counselors, family, community, religion/spirituality, school and future aspirations
	POs	To assess quality of delivery of CDEP, and highlights and challenges in CDEP delivery
	Qualitative Survey	To assess the before (pre) and after (post) qualitative effects of CDEP (namely *atención plena*) on youth, and CDEP effects of academic success

Since we had different types of data collected with different methods, it is important to explain the data collection procedures for each method. First, the parent surveys were conducted at the alternative school, during an after-school parent conference event. The surveys were in Spanish and deployed by the lead counselor at the alternative schools. All six parents at the parent conference completed the voluntary survey. The paper surveys were collected by the counselor and given to the evaluator to digitize and input into a Qualtrics survey. All the parents surveyed were Latino with Spanish as their first language. Of the six (6) parents that completed the survey, five (5) were females and 1 was male. The parent surveys were completed in the Spring of 2020. Surveys were translated from Spanish to English before the survey analysis.

Second, we used existing school data to document progress and success of our CDEP - GPAs, behavioral incidents (e.g., suspensions, detentions), and attendance. Two points (pre and post) were collected for these three types of data. To document the pre, we had access to the school records system, and for each student that participated in the CDEP, we collected data from them from the semester prior to the present semester, to get a sense of how much they would grow after a semester in the CDEP. At the end of the semester, again, for all youth in the CDEP, we collected these three types of data. If youth were in another school in the district the previous semester, we still had access to their GPA, behavior records, and attendance. We only collected this data at the alternative schools and did not have access to this data at the traditional high school or alternative middle school. In total, we collected this pre/post data from 181 youth (19 for year 1, 64 for year 2, and 98 for year 3), during the first three years of the CDEP, and did not

collect it the last two (2) years due to Covid-19 and it would be like comparing apples to oranges collecting this data because youth began taking classes solely online in the district.

Third, during the two years of the Covid-19 pandemic, since we were not collecting existing data (i.e., GPAs, behavior records, attendance), we began collecting survey data on document mental health wellness in the home environment. We collected this data from all students in the CDEP at the alternative schools and the traditional high school on a voluntary basis. We deployed three (3) surveys, and digitized them on Qualtrics so that students can take them from their home computers or phones: (a) the Rosenberg Survey, (b) the General Self-Efficacy Survey, and the (c) PHQ-9 Survey. These were all short surveys, and counselors that were delivering the CDEPs online were told to ask their students if they would volunteer to take the surveys. Nearly all students took the surveys as they were given extra credit points for doing so. We collected this pre/post data for two (2) semesters in which students were taking classes solely online to get a snapshot of the mental health state of our youth, plus how our CDEP was helping them cope and attain academic success.

The first survey, the Rosenberg Self-Esteem (RSES) Scale Survey, has been one of the primary measurements of self-esteem for the last 50 years. It is a 10-item Likert scale survey. At the beginning of Fall 2020 (Pre) we collected 160 surveys at our two (2) alternative schools, as well as our traditional high school. For the post survey at the end of Fall 2020, we collected 137 surveys. Second, the Patient Health Questionnaire (PHQ)-9 is a self-administered 9-item instrument to assess depression. The instrument helps our therapists identify treatment goals, and determine severity of youths' symptoms. At the beginning of Fall 2020 (Pre) we collected 173 surveys at our two (2) alternative schools, as well as our traditional high school. For the post survey at the end of Fall 2020, we collected 126 surveys. Lastly, we administered the General Self-Efficacy (GSE) Scale Survey. The GSE is a 10-item psychometric scale survey that assesses optimistic self-beliefs to cope with difficult life demands. This survey has been used to measure optimistic self-beliefs for the last 40 years. At the beginning of Fall 2020 (Pre) we collected 159 surveys at our two (2) alternative schools, as well as our traditional high school. For the post survey at the end of Fall 2020, we collected 130 surveys.

Fourth, we collected State-Wide Evaluation (SWE) survey data, both pre (at the beginning of the semester) and post (at the end of the semester). This was a paper/pencil survey, and we collected this data for the first three (3) years of the CDEP. The first year, data was collected from the two (2) alternative schools, the second year from the traditional high school, and the third year from the charter middle school. This data was collected by the lead counselors we had at each one of these sites, and students were rewarded with pizza and drinks for completing the pre and post SWE surveys. We also had ICSI staff assist with this data collection. For example, if there were errors or missing data, ICSI staff would work with the counselors and the youth to correct the errors prior to sending the data to the SWE evaluators. We deployed the pre and post adolescent

versions of the survey, meant for youth 12 to 17 years of age. The pre survey consisted of 56 items, with an additional 50 items, for a total of 106 items. The post consisted of 90 items. In total, we collected 112 pre and 106 post surveys.

Fifth, the focus groups (FGs) were conducted by the evaluator, at the alternative school sites. Youth from the CDEP were all invited to participate, but not all were able to be released from their classrooms at the time of the focus group. The focus groups were conducted during lunchtime, and youth were rewarded with pizza and drinks for their voluntary participation. The evaluator digitally audio recorded the focus groups. In total, we conducted 3 focus groups with a total of 21 youth at our two (2) alternative schools. All 21 were Latina/o, 18 were males, and 3 were females. The total combined time of the focus groups was 2 hours and 12 minutes (44-minute average per focus group). The focus groups were conducted in the Spring of 2018.

Sixth, the participant observations were done by the evaluator and the evaluator assistant, who was a graduate student majoring in counseling education and specifically trained to conduct our observations. We were able to conduct 18 observations of *pláticas* and *atención plena* being deployed to youth from May 2018 to September 2019. The average time of each observation was approximately 55 minutes. In total, we observed a total of 157 youth working with our therapists using our methods, 132 (84%) were Latino. These observations were conducted in our two (2) rural alternative schools in Madera County, and our traditional high school in Fresno County. While there were non-Latino students in the classrooms that we observed whom were also part of the CDEP, our observations were focused on the level and quality of interactions between the counselors and the Latino students.

Lastly, a pre-post qualitative survey was deployed at the public high school to qualitatively measure how youth felt before and after the *atención plena* session, and how they believed the *atención plena* session would affect their academic success. The survey was deployed through Google Forms, and the link given to students to complete on their phones or computers. In two (2) months (June and July of 2019) of data collection, 131 youth completed the voluntary online qualitative survey. These were summer school classes ranging in size from 25 to 32 students, and all were part of voluntary *atención plena* sessions lasting approximately 10 minutes -5 minutes to explain the purpose and benefits of *atención plena* , and 5 minutes to conduct *atención plena*. The pre was completed before the beginning of the explication of *atención plena*, and the post at the end of the session.

Fidelity and Flexibility

The fidelity of our CDEP was not traditional in the sense that it was delivered in a controlled setting where participants and dosages are measured and manipulated at will. Rather, our CDEP was delivered in real-life situations at school settings, where participation is optional, and the

intervention (i.e., dosage) is delivered organically and based on specific cultural, language, and contextual needs of youth participants and their families. Additionally, because our CDEP is delivered in a noncontrolled school setting, the student population may consist of Latinos and non-Latinos. It is important to note that among the non-Latino students, from the school sites where our CDEP was administered, many were members of underserved populations and benefited from our CDEP. What makes this unique to our CDEP or *pláticas* and *atención plena* is that when adapted to serve youth from other ethnic backgrounds, it remained effective. However, this may have complicated our fidelity assessment. The following is our attempt to explain the fidelity and flexibility aspects of a CDEP delivered in an uncontrolled setting, with ever-evolving dosages, with mostly Latino students, and interchangeability between *pláticas* and *atención plena*.

Adherence

For the first three (3) years, we delivered our CDEP as designed to serve a specific Latino youth population (a convenience sample). One major upgrade from our original design was that the non-controlled setting in which our CDEP was delivered moved to online from in-person due to the pandemic. Also, ICSI's skilled therapists often tailored the delivery of *pláticas* to *atención plena*, based on how students were feeling and what their needs were on each given day. By tailoring our CDEP to the needs of the youth we increased the effectiveness of the intervention in terms of its content, frequency, duration, and efficacy related to school and academic engagement without significant adaptations that would affect the integrity of its design and intent. This is consistent with a key tenant of ICSI and CRDP of being flexible and focused on what mattered most to students at that time. However, one major adjustment was the 2020 shelter-in-place due to the COVID-19 pandemic. One evident modification to the delivery of *atención plena* to *pláticas* was changing from an in-person school/classroom setting to a virtual one. Our therapists had to quickly transition to delivering our CDEP online through Zoom video conferencing. For example, from April to August 2020, *atención plena* was delivered every Wednesday from 12-1pm followed by a lesson and reflection. Observations by trained ICSI staff were done to assess the intervention and reactions from the youth participants. It is important to note that the ICSI therapists/educators devoted time and effort to establishing a safe virtual space for students to engage and experience the CDEP intervention as it was intended to be delivered. Moreover, the check-in where students make their presence known by saying their names and sharing a feeling describing their current state (e.g., "my name is Miguel and I am checking in feeling overwhelmed due to schoolwork and with that I'm in"). The checking in process is essential to being present and ready to engage.

Exposure

Three student populations from three very different schools (i.e., one middle school; 1 traditional high school; and 1 alternative high school) were exposed to our CDEP. For our Latino-only

sample, we were successful in delivering a student-centered culturally/linguistically-grounded *pláticas* and *atención plena*. For example, at the middle school, the dosage was daily for 30 minutes, totaling 2 1/2 hours per week for approximately a total of 40 hours of dosage or intervention from pre-testing to post-testing. At the traditional high school, dosage was very similar to the middle school, approximately 40 hours per semester. Finally, at our continuation school, students were exposed to our CDEP twice a week for a total of 2-hour doses administered around their academic class schedules. In total, students were exposed to approximately 64 hours of dosage or intervention from pre-testing to post-testing. The total dosage/intervention across the three (3) school sites was 144 hours of exposure to the intervention. ICSI considers this amount adequate in ideal conditions where students were not absent or missing for whatever reason. To ensure that the delivery of the intervention is as uniform as possible regardless of the differences in student population and school settings, student attendance and reflection on the intervention was monitored. However, attendance and reflection do not necessarily mean the intervention was effective, but more support strategies are needed to achieve strong fidelity.

Quality of Delivery

ICSI's therapists are master's level professionals with Marriage and Family Therapy (MFT) degrees. These therapists continually participate in professional development at ICSI under the guidance of ICSI's Executive Director in delivering services that are culturally and linguistically appropriate to Latinos in Fresno County. In the same way, quality assurance or improvement strategies, such as ongoing monitoring and feedback to those delivering the CDEP to the intended population, ensures that *pláticas* to *atención plena* are administered as designed and intended. At a training level, ICSI is recognized by Fresno State as a placement site for pre-masters counseling university students and keeping the quality of delivery current and relevant to the youth being served.

The quality of our CDEP delivery is largely based on our youth participant participation and responsiveness and willingness to receive the intervention. It should be noted that our youth participants have responded positively to *pláticas* to *atención plena*. Our CDEP is grounded in the Cultural Wealth Model (CWM) increasing the relevance of our work to our youth participants. For example, when aligning storytelling and hip-hop therapy sessions with CWM, youth participants relate and comply with their treatment plan including modifying behaviors and fulfilling requirements to return to a traditional school. It has been reported that students who have made significant improvements in their schoolwork and are eligible to return to their traditional home school, many chose not to in order to continue seeing the therapist and participating in our CDEP activities. A principle that ICSI and CWM have in common is to look at youth from a strength lens and value and validate their personal and cultural strengths and assets as potential protective factors. This approach reinforces each youth participant's contributions, core values, and their respect and love for the Latino culture. This we found to be

unique in all our school settings. The connection between students and our therapists has empowered our youth and put them on a well-being path toward rediscovering, rebuilding, and reconnecting with their lived experiences. So, sharing their stories and their reflections, and ultimately their actions linked to academic achievement is youth responsiveness.

Finally, our program was different across each of three sites.[39] At the continuation schools, *pláticas*, and particularly hip-hop therapy predominated. These sites also focused on storytelling, writing, poetry, rap, short stories, memes, recording, and music performance as sources of therapy. The public high school, on the other hand, focused on *atención plena*, and volunteer and recruiters of other participants came through the Mindfulness Club. At the middle school, parent *pláticas*, nature walks that incorporated mindfulness, and art of a form of mindfulness were the program components. And as we expand, we will continue to deliver *pláticas to atención plena,* not as written, but as components of our CDEP that can and should be transformed to meet local school and youth needs, and highlight youth and therapist strengths.

Data Analyses Plan Implemented

For the data analysis, we had various strategies for the quantitative (5 surveys[40] and existing data[41]) and the qualitative (focus groups, participant observations, and a qualitative survey). Regarding the Parent Surveys, this was a 19-item 5-point Likert scale Survey. In this analysis, we calculated the mean scores, and then rank ordered the results based on the means. For the existing school data, this was one of the most complex analyses. We pulled all existing data on the school district system for each student in our CDEP from the previous semester (pre), and then again at the end of the semester in which they participated in the CDEP (post). The system gave us attendance as a percent of attendance, and from this we had to calculate the number of school days to get the number of attendance days. For behavior, we focus on suspensions and expulsions. Our analysis of this existing school data consisted of calculating the means, then calculating numbers and percentages of growth and/or decline in the means. For the Rosenburg, PHQ-9, and GSE surveys, these were all 4-point Likert scale surveys in which we conducted a pre and a post. Our analysis of the data for these three (3) surveys was first calculating the pre and post means, then calculating mean growth and/or decline, and then rank ordering the items based on growth in the means. Lastly, for the SWE Survey, we first calculated means for all items, pre and post, and then rank ordered items from highest growth to lower growth within a particular topic.

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[39] To clarify, we have four (4) sites -two continuation schools, one middle school, and one public high school. But for purposes of our CDEP and data collection, we have always treated the two (2) continuation schools as one site because it was served by one therapist, they were relatively close to each other, and they had very similar student populations.

[40] The five (5) surveys: Parent Survey, Rosenberg Survey, PHQ-9 Survey, General Self-Efficacy (GSE) Scale Survey, and State-Wide Evaluation Survey.

[41] Existing data: GPA Data, Behavior Data, Attendance Data.

For the quantitative data analysis, we used NVIVO Qualitative Data Analysis Software to conduct thematic analysis[42] and find, organize, and report on themes for the focus groups, participant observations, and qualitative survey data. This analysis is exactly what the name states, we look for themes, code them as such, and continue combing through the data until all the data is coded. At the point in the analysis where you start seeing replication in the themes you have reached a data saturation[43] point where you are confident that you have found all the key themes that were presented in the data for that topic. An additional process we deployed for the participant observations prior to data analysis was member checking[44] with our therapists, as the observations were of their practice, and we wanted to make sure what we were observing was indeed what was happening from the point-of-view of the therapists. If the therapists made a correction to the observations record, we made this correction prior to inputting the data in NVIVO for data analysis. Because the focus groups consisted of youth voices, our reporting was of representative quotes, but since the participant observations were of research notes, we conducted a thematic analysis of the themes. The same thematic analysis that was utilized for the participant observations was utilized for the qualitative survey.

Our data triangulation depended on nine (9) sources of data. With all the quantitative data that utilized a pre and post, we used a + and - system to show if there was growth (+) or decline (-) in each of the items we compared. While there is no literature or studies that use a similar system, our rationale for interpreting and describing our results this way is due to ensuring that our Latino community at large, often report having less than a 3rd-grade education, can better make sense of our results. It is also our intent to share these findings with our youth population. To assess the readability of our key findings using the +/- system, we conducted several pilot sessions, where we described our findings to our student population. After the presentation, we gave students one table using the +/- system and asked them to each interpret what they were seeing and all students were able to successfully verbally articulate they key findings and describe implications of the findings in impact that our CDEP can have on: (1) student motivation and academic achievement; (2) recognizing the many risk factors associated with mental health issues; and (3) building on their individual strengths and strengthening their college and career readiness. When there was no pre/post, such as the parent survey, we rank ordered means to show our strongest areas first. In our quantitative data, we utilized the Community Cultural Wealth model to focus on themes of growth, but also not discount areas where we need improvement either in what youth were telling us about our CDEP (focus groups) or through what we were observing (participant observations). For the qualitative survey, we also used the + and - system to document growth. The +/- system helped us to easily get an

[42] Source: Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage Publications.
[43] Source: Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report*, *20*(9), 1408-1416.
[44] Source: Candela, A. G. (2019). Exploring the function of member checking. *The Qualitative Report*, *24*(3), 619-628.

assessment of the success of our CDEP through our data and helped in our data triangulation. Once this +/- system was used to write up a draft of the results, a meeting with key staff and therapists was organized, and the data shared with them, and they were given the opportunity to comment on each of the nine (9) pieces of data, from their point-of-view and from the point-of-views of their schools. This meeting to discuss the results with key ICSI staff and therapists helped in our data triangulation because it gave everyone involved in our CDEP an opportunity to comment and contribute their thoughts on the results.

Results

Quantitative Data Findings

Parent Surveys

The parent surveys asked about youth's: (a) comfort with their therapist, (b) the appropriateness of the various therapies used, and (c) the effect of *atención plena, pláticas*, and hip hop therapy on school and mental health. The responses were measured on a 5-point Likert scale (5: Definitely Agree, 4: Agree, 3: Do not Agree or Disagree, 2: Disagree, 1: Definitely Disagree). The following responses are presented in descending order, from those with the highest rating (5.0), to those with the lower ratings (1.0).

First, there was only one (1) question related to youths' comfort with their therapist/counselor. When they were asked if the therapist makes the kid(s) feel comfortable during therapy, this scored a 4.0 out of 5.0. Clearly, parents agreed that the therapist made kids feel comfortable, but not definitively.

Second, there was a series of five (5) questions related to the appropriateness of various types of strategies for mental health therapy/counseling. The following table (Table 3) rank orders how parents felt about the appropriateness of these therapies.

Table 3. Parent Rating on the Appropriateness of Various Mental Health Therapies

The following are appropriate mental health therapies:	Rating
Music therapy	4.5
Dichos/memes	4.3
Pláticas and/or storytelling	4.2
Hip hop therapy/music production/poetry	4.2
Atención plena	4.0

Clearly, it was the music therapy that ranked the highest, likely because this is what youth share with their parents as approaches that are helping them. Interestingly, when music therapy and hip hop therapy were asked about separately, hip hop therapy only received a 4.2 ranking, likely because while the parents may know that music is helping their kid(s), they might be unaware as to the type of music or the name of the music genre. Given that the parents took the survey in Spanish, and are Spanish-only speakers, it is not surprising that they might not know that the music their kids are producing in therapy is hip hop. Like the results from the focus groups, *atención plena* was not a therapy that parents thought was helping, as it received the lowest rating of 4.0. This is likely because their kids do not talk about this much, or think it helps them in any way. Again, these parent surveys are from parents at the alternative schools, as parents at the public high school think differently and have publicly spoken of the positive benefits of *atención plena* and the mindfulness club in their youth. It is very clear from this data that those therapeutic approaches that the therapists know best and have expertise in are those that they are best able to deliver, and also those that youth get excited about.

Lastly, parents were asked about how all our therapies (Table 4; *atención plena*, *pláticas*, and hip hop) impacted the social and academic lives of youth. These therapies were not asked about separately, but as a whole, so it is very likely that the ratings are high or low based on how parents feel about one therapy type versus another type. Most importantly, parents highly rated that therapy was having a positive effect on kid(s) grades (4.5 rating out of 5). This is also due in part that while they may have been failing out of their public school, their alternative school was not giving them extra attention and help, and many youth were catching up on their credits.

Table 4. Parent Rating on the Effect of Various Therapies on Youths' Mental Health and Academic Success

Atención plena/*pláticas*/hip hop therapy...	Rating
...improves kid(s)' grades	4.5
...makes kid(s) comfortable participating in therapy	4.3
...improves kid(s)' self-esteem	4.2
...reflects aspects of your culture	4.0
...makes kid(s) excited about attending school	4.0
...improves kid(s) behavior	3.8
...helps kid(s) confront some of their problems	3.8

...has changed kid(s)' goals/aspirations	3.8
...has created interest in mental health careers	3.2

The effects of therapy on self-esteem (4.2 out of 5), being a reflection on their culture (4.0), and making kids excited about attending school (4.0) were also highly rated. Parents may not have knowledge of how therapy was positively affecting youth behavior (3.8 rating) if kids were not improving their home behavior, because our data shows clearly that our CDEP therapeutic approaches improve youths' behavior in the school. Parents also rated how therapy was helping their kid(s) confront their problems (3.8), improve their goals and aspirations (3.8), and create interest in mental health careers (3.2 out of 5.0). While youth really connect with their therapist, it is very likely that youth are not seeing counseling as a career path, likely because they are not being talked about the process and education needed to enter the profession. Since youth are not hearing about these career possibilities, it is very likely that they are not talking to their parents about this.

Pre/Post School Data on GPA, Behavior, and Attendance

School data (GPA, behavior incidents, and attendance) were key variables that showed us quantitatively how youth were benefiting from our therapeutic methods over time. We surmised that if youth received our therapeutic approaches, they would be more connected to school, thus have a greater interest in getting up in the morning and attending. Once they were in school, they would not only benefit from our therapy, but also do better in school as often being present in school is key to success. Also, if they were participating in *pláticas* and *atención plena*, they would learn better ways to cope with and address conflict, then behavior incidents would go down. The following data shows our results over a 3-year period. Also, the reason we did not collect year 4 and year 5 data was because Covid-19 hit the school in the Spring of year 4, and students had to continue their education online, thus disrupting the key condition from which our data was dependent, which was being in school. It was years 4 and 5 where we turned to other measures to assess the mental health progress of youth, such as the PHQ-9, GSES, and Rosenburg survey data.

First, Table 5 (below) shows a demographic overview of 3 years of school data, which captures the progress of 3 cohorts of students, each progressively increasing in size. It is also important to point out that each year, as the cohort grew in size, we added interns to assist in deploying our therapies. The interns were all master's level students. Additionally, as the cohort grew, it also got younger, as our alternative schools serve youth as young as the 7th grade. In the first three (3) years we served 181 youth, just at our two (2) alternative schools, which do not account for the youth we were serving at our charter middle school or our public high school. Of the 181 youth we served at these two (2) schools, 75.1% were male.

Table 5. Interns, Grade Level, and Gender Over 3-Year Period

	Interns	Grade	Males	Females	Total
Year 1 (2015-16 to 2016-17)	0	11.4	12 (63.1%)	7 (36.8%)	19 (100%)
Year 2 (2016-17 to 2017-18)	1	10.5	46 (71.9%)	18 (28.1%)	64 (100%)
Year 3 (2017-18 to 2018-19)	3 to 5	9.9	78 (79.6%)	20 (20.4%)	98 (100%)
Average/Total:		10.2	136 (75.1%)	45 (24.9%)	181 (100%)

Table 6 (below) shows attendance of the three (3) cohorts of students from which we collected data. School systems record student attendance in many ways, one being the percent of time that youth are present in school, which is the best measure for us to assess progress. Again, youth attendance was tracked for the entire year beginning the year before they began receiving therapy/counseling, and again at the end of the year in which they received therapy/counseling. For years 1 and 2, we had slightly improved attendance, but this attendance dropped for year 3. Neither the increase or decrease showed significant progress in attendance, which hovered around 84.1% pre and 84.3% post.

Table 6. Pre, Post, and Change of Total Attendance Over 3-Year Period, By Percent

	Attendance Year Before Treatment (Pre)	Attendance at End of Treatment Year (Post)	% Change
Year 1 (2015-16 to 2016-17)	84.2%	85.0%	+ 0.8%
Year 2 (2016-17 to 2017-18)	81.1%	85.0%	+ 3.9%
Year 3 (2017-18 to 2018-19)	87.1%	83.1%	- 4.0%

Note: A +/- system of showing change in growth or decline was used for readability purposes.

Table 7 (below) shows pre and post behavior incidents. Over 3 years, this data does show progress in incident reduction. It is also important to note that this data includes suspensions and expulsions. Over the three (3) years there was a 23.5% (year 1), 47.5% (year 2), and 21.1% (year 3) reduction in behavioral incidents. Part of the reduction is in part because the alternative schools deal with behavior in a different way that did the public high school (where they were

prior to the alternative school), but also because we believe our therapeutic/counselling is having a positive effect on youth in terms of how they deal with conflict.

Table 7. Pre, Post, and Change of Behavior Incidents Over 3-Year Period, By Total Incidents

	Total Behavior Incidents...			
	Year Before Treatment (Pre)	At End of Treatment Year (Post)	Incidents Change	% Reduction
Year 1 (2015-16 to 2016-17)	9.8	7.5	- 2.3	23.5%
Year 2 (2016-17 to 2017-18)	5.9	3.1	- 2.8	47.5%
Year 3 (2017-18 to 2018-19)	5.7	4.5	- 1.2	21.1%

Note: A +/- system of showing change in growth or decline was used for readability purposes.

Table 8 (below) shows the pre and post of their Grade Point Averages (GPAs). While the increase from year 1 to year 3 was progressively less, every year that youth were receiving out therapy/counseling they increased their GPA at least by ⅓ of a grade overall.

Table 8. Pre, Post, and Change of Grade Point Average (GPA) Over 3-Year Period, By GPA

	GPA Year Before Treatment (Pre)	GPA At End of Treatment Year (Post)	Point Change	% Increase
Year 1 (2015-16 to 2016-17)	1.6	2.4	+ 0.8	50%
Year 2 (2016-17 to 2017-18)	2.0	2.4	+ 0.4	20%
Year 3 (2017-18 to 2018-19)	2.0	2.3	+ 0.3	15%

Note: A +/- system of showing change in growth or decline was used for readability purposes.

RSES, PHQ-9, and GSE Surveys

For the COVID-19 years (2019-2020 and 2020-2021), we switched data collection from the school data (GPA, behavior, attendance) to three (3) surveys (RSES, PHQ-9, and GSE) that would better capture students' mental health state and progress. The following (below) captures this progress primarily over 2 semesters (Spring 2020 and Fall 2020), both COVID-19 semesters.

For each semester, we captured data at the beginning of the semester and again at the end of the semester. For Spring 2020, the year Covid-19 began, students began in the classroom and then transitioned to online. These surveys were also easy to deploy because students were at home, and they could complete them online in Qualtrics. These surveys were also distributed to youth at our two (2) alternative schools and at our public high school.

First, the Rosenberg Self-Esteem Survey (RSES) is a 4-point Likert scale survey. The RSES has positively worded questions where the higher the rating, the better self-esteem is being rated, but it also has negatively worded questions where the lower the rating the better they are doing. To differentiate between positively and negatively worded questions, a + (positive) and - (negative) was added to the beginning of the questions in Table 10. For example, if the question is + and the self-esteem change is +, this means that students showed growth from the pre to the post; and if the question is - and the change is -, this also means that students showed growth from pre to post. The Rosenburg consists of 10 questions, which is rank ordered in Table 10 from those where the rating (growth) was the highest to those where the rating was the lowest.

The question in Table 9 where youth showed the most improvement was in their confidence to be *able to do things well as most other people* with a rating of +0.27, which means students increase their agreement to this statement from a 2.87 rating to a 3.14 rating. While students' improvement in self-esteem happened for 9 out of the 10 questions, in one (1) question students declined in their self-esteem. In the question *I wish I could have more respect for myself* student agreement decreased by 0.26 of a point, largely due to misinterpretation of the question. Upon discussion with the therapists who helped with survey deployment, it was explained that students did not think it was good to have more respect for themselves because this would mean they already did not have respect for self. While the concept of respect is extremely important for Latino youth culture, if this question would not have been misinterpreted it could have been the area where student had the largest gains, but it is also not clear how many youth misinterpreted the question, and therefore it cannot be qualified as a question in which students improved in their self-esteem.

Table 9. Pre, Post, and Change of Rosenberg Self-Esteem Survey (RSES), By Rating Average

	Pre Mean (N=160)	SD	Post Mean (N=137)	SD	Mean Change
+ I am able to do things as well as most other people……..	2.87	.79	3.14	.60	+ .27
+ I feel I am a person of worth, at least on an equal basis with others……	2.89	.83	3.12	.66	+ .23

+ I take a positive attitude toward myself……..	2.85	.84	3.07	.68	+ .22
- I feel I do not have much to be proud of……..	2.38	.94	2.19	.85	- .18
+ I feel that I have a number of good qualities..	2.93	.73	3.06	.66	+ .13
+ On the whole, I am satisfied with myself……	2.81	.82	2.94	.70	+ .13
- At times I think I am no good at all…….	2.29	.94	2.21	.90	- .09
- I certainly feel useless at times…….	2.41	.93	2.34	.88	- .07
- All in all, I am inclined to feel that I am a failure……...	2.18	.86	2.14	.70	- .04
+ I wish I could have more respect for myself…	2.71	.88	2.46	.86	- .26

Note: Likert Scale: 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, 4 = Strongly Agree.
Note: A +/- system of showing change in growth or decline was used for readability purposes.

Table 10 (below) shows the results from the Patient Health Questionnaire (PHQ-9). This is also a 4-point Likert scale survey. The results are organized in a rank-order format to first show the largest gains and move towards the least gains. There was improvement in nine (9) out of the 10 questions. All the questions were negatively worded, meaning that the larger the negative the larger the growth. The largest growth was 0.22 (on a 4.0 scale) for the question *feeling tired or having little energy*, meaning that from pre to post students felt less tired and less with little energy. The only question in which students did not grow from pre to post was: *If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?*, but they also did not regress.

Table 10. Pre, Post, and Change of Patient Health Questionnaire-9 (PHQ-9), By Rating Average

	Pre Mean (N=173)	SD	Post Mean (N=126)	SD	Mean Change
- Feeling tired or having little energy…….	2.25	1.03	2.03	1.10	- .22
- Feeling bad about yourself or that you are a failure or have let yourself or your family down…….	1.79	1.10	1.61	.91	- .18

- Moving or speaking so slowly that other people could have noticed. Or the opposite - being fidgety or restless that you have been moving around a lot more than usual…….	1.56	.99	1.38	.72	- .18
- Little interest or pleasure in doing things….	2.18	.98	2.01	.87	- .17
- Trouble falling or staying asleep, or sleeping too much…….	2.31	1.17	2.14	1.17	- .17
- Trouble concentrating on things, such as reading the newspaper or watching television.	1.76	.99	1.67	.93	- .09
- Feeling down, depressed, or hopeless……..	1.70	.93	1.65	.88	- .05
- Thoughts that you would be better off dead, or of hurting yourself……...	1.26	.63	1.23	.62	- .03
- Poor appetite or overeating……	1.72	.95	1.71	.92	- .01
- If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?.....	1.74	.84	1.74	.83	0.0

Note: Likert Scale: 1 = Not at All, 2 = Several Days, 3 = More Than 1/2 the Days, 4 = Nearly Every Day.
Note: A +/- system of showing change in growth or decline was used for readability purposes.

Table 11 (below) shows the results for the General Self-Efficacy (GSE) Survey, also a 4-point Likert scale survey. All the questions were positively worded, meaning increasing change meant progress and growth. The largest growth was on the question *If someone opposes me, I can find the means and ways to get what I want*, with a 0.32 growth (on a 4.0 scale). While this was the question that showed the greatest amount of growth from pre to post, it was the question, *I can solve most problems if I invest the necessary effort* that was rated the highest at both pre (2.99) and post (3.20).

Table 11. Pre, Post, and Change of General Self-Efficacy (GSE) Survey, By Rating Average

	Pre Mean (N=159)	SD	Post Mean (N=130)	SD	Mean Change
+ If someone opposes me, I can find the means and ways to get what I want…….	2.34	.85	2.66	.79	+ .32

+ I am confident that I could deal efficiently with unexpected events……..	2.56	.89	2.83	.76	+ .27
+ I can usually handle whatever comes my way……..	2.82	.87	3.06	.77	+ .24
+ I can solve most problems if I invest the necessary effort……	2.99	.85	3.20	.78	+ .21
+ When I am confronted with a problem, I can usually find several solutions……	2.63	.81	2.81	.79	+ .18
+ Thanks to my resourcefulness, I know how to handle unforeseen situations……..	2.66	.80	2.83	.79	+ .17
+ I can always manage to solve difficult problems if I try hard enough……..	2.90	.79	3.04	.75	+ .14
+ I can remain calm when facing difficulties because I can rely on my coping abilities……	2.64	.95	2.77	.87	+ .13
+ It is easy for me to stick to my aims and accomplish my goals……..	2.62	.90	2.69	.79	+ .07
+ If I am in trouble, I can usually think of a solution……	2.89	.77	2.93	.83	+ .04

Note: Likert Scale: 1: Not at All True, 2: Hardly True, 3: Moderately True, 4: Exactly True.
Note: A +/- system of showing change in growth or decline was used for readability purposes.

SWE Survey

Our State-Wide Evaluation (SWE) data was collected over a three (3) year period, from 2017 to 2020. Our SWE data collection efforts were completed before Covid-19, and therefore data collection was not affected by the pandemic. The following tables show the effects of our CDEP on youth mental health.

First, Table 12 shows the n for pre and post, as at times there was a slight difference from pre to post. This scale showed high reliability ($\alpha = .92$). The table also shows a comparison between pre (collected in the Fall) and post (collected in the Spring), and the change between both. The questions are ranked from factors that were most effective to least. The highest improvement was in the question: *At present, your culture helps you to feel good about who you are*, with an increase of + 0.05 in the direction of *Strongly Agree.* Surprisingly, in the post, the biggest regression was in the question. At *present, your culture is important to you*, moving in the direction of *Strongly Disagree* by 0.09 points.

Table 12. Pre, Post, and Change of Protective Factors for Youth, By Mean and Numbers

At present…	Pre/ Post (n)	Fall (Pre) Mean	SD	Spring (Post) Mean	SD	Mean Change
… your culture helps you to feel good about who you are……	97/98	1.97	.89	1.92	.86	+ 0.05
… your culture gives you strength…….	99/99	2.11	.92	2.09	.94	+ 0.02
… you feel connected to the spiritual/ religious traditions of the culture you were raised in……..	98/98	2.15	1.11	2.17	1.04	- 0.02
… your culture is important to you……	99/99	1.74	.82	1.83	.83	- 0.09

Note: Likert Scale: 1=Strongly Agree; 2=Agree; 3=I am Neutral; 4=Disagree; 5=Strongly Disagree.
Note: A +/- system of showing change in growth or decline was used for readability purposes.

In Table 13 (below), the highest level of growth was to the question *About how often during the past 30 days did you feel connected to your culture,* showing a growth of +0.15. In consideration of Table 13 results, which students may not think that their culture is important to them, they do feel connected to their culture. The Cronbach's alpha for this scale was below the .70 cut off (α = .59). This is likely due to some of the cultural protective factors that students experience by living in predominantly Latino communities and going to predominantly Latino schools. Students did however report that they felt *isolated and alienated from society* in the past 30 days, regressing by a rate of 0.18. It is important to note that where isolation and alienation showed the most regression, it was also a question where students began (in the pre) reporting not having these feelings, even though by the post they did experience some of these feelings.

Table 13. Pre, Post, and Change of Protective Factors for Youth During the Past 30 Days, By Means and Numbers

About how often during the past 30 days did you feel…	Pre/ Post (n)	Fall (Pre) Mean	SD	Spring (Post) Mean	SD	Mean Change
… connected to your culture?	99/98	2.61	1.21	2.46	1.19	+ 0.15
… balanced in mind, body, spirit and soul?	97/97	2.74	1.16	2.65	1.23	+ 0.09

… marginalized or excluded from society?	97/97	3.61	1.28	3.59	1.31	- 0.02
… isolated and alienated from society?	98/98	3.81	1.22	3.63	1.32	- 0.18

Note: Likert Scale: 1=All the time; 2=Most of the time; 3=Some of the time; 4=A little of the time; 5=None of the time.
Note: A +/- system of showing change in growth or decline was used for readability purposes.

What asked about access and utilization to mental health, youth were asked if they felt safe with and welcomed by mental health providers in general, and services they sought or received in the last 12 months. First, Table 14 (below) shows agreement with feeling safe and welcomed. Youth were asked the degree they felt safe and welcomed based on different parts of their identity. Overwhelmingly, youth did not feel safe and welcomed. They disagreed with feeling safe and welcomed, or did not know or refused to answer. Their agreements with feelings safe and welcome were all low, ranging from 2.1% to 5.1% of the sample. This is an area that we underexplored with youth, but also the reason for why our CDEPs were so vital and important for youth, because it is the place where they were in contact with counselors/therapists and they did feel safe and welcomed. Table 14 also shows the work that needs to be done to provide safety and welcomeness to our youth in the field of mental health.

Table 14. Pre-Test of *Atención Plena/Pláticas* Youths' Perceptions of *General* Access and Utilization, By Percent

Access and Utilization	Agree	Disagree	Don't Know/Refused
Did not think you would feel safe and welcome because of your...			
...limited English	4.1%	54.6%	41.3%
...race/ ethnicity	5.1%	49.0%	45.9%
...age	4.2%	51.6%	44.2%
...religious or spiritual practice	4.1%	55.1%	40.8%
...gender identity	3.1%	55.7%	41.2%
...sexual orientation	2.1%	51.5%	46.4%

Table 15 shows *access and utilization in the past 12 months* for youth. A majority, 56.3% stated needing help in the last 12 months, with the majority also receiving the help, the majority from outside of school. Surprisingly, 86% stated receiving help with alcohol/drug use, and 80.6% stated taking medication for difficulties. However, the majority refused to state whether they were still receiving counseling.

Table 15. Pre-Test of *Atención Plena/Pláticas* Youths' Perceptions of Access and Utilization in the Past 12 Months, By Number and Percent

In the past 12 months…	Yes	No	Don't Know/ Refused
…*needed help* for emotional/mental health problems (e.g., feeling sad, anxious, nervous)	23 (22.3%)	58 (56.3%)	22 (21.4%)
…*received* psychological/emotional counseling from *traditional helping professionals* (e.g., culturally-based healer, religious/spiritual leader)	10 (9.7%)	79 (76.7%)	14 (13.6%)
...*received* psychological/emotional counseling from *Community helping professionals* (e.g., health worker, promotor, peer counselor)	18 (18.0%)	68 (68.0%)	14 (14.0%)
...*received* psychological/emotional counseling from someone *at school* (e.g., school therapist)	23 (22.5%)	62 (60.8%)	17 (16.7%)
...*received* psychological/emotional counseling from someone *outside of school* (e.g., social worker)	7 (7.0%)	83 (83.0%)	10 (10.0%)
...*received* professional help for alcohol/drugs use	4 (4.0%)	86 (86.0%)	10 (10.0%)
…*taken* medication because of difficulties with your emotions, concentration, or behavior	6 (6.1%)	79 (80.6%)	13 (13.3%)
Still receiving psychological or emotional counseling from someone *at school*	10 (10.3%)	13 (13.4%)	74 (76.3%)
Still receiving psychological or emotional counseling from someone *outside of school*	3 (3.2%)	6 (6.3%)	86 (90.5%)

Lastly, youth also shared general perceptions on access and utilization. Table 16 (below) provides an overview of issues, ranked ordered based on highest level of agreement. The highest level of agreement is that youth *did not know these types of mental health professionals existed* (30.9%).

Table 16. Pre-Test of *Atención Plena/Pláticas* Youths' Perceptions of *General* Access and Utilization, By Percent

Access and Utilization	Agree	Disagree	Don't Know/ Refused
Did not know these types of mental health professionals existed	30.9%	42.3%	26.8%
Thought you could solve your issue on your own	26.3%	28.3%	45.4%
Thought issue wasn't serious enough	20.2%	29.3%	50.5%
Did not want to talk to a stranger about issue	17.2%	32.3%	50.5%
Did not feel comfortable talking with them about personal problems	17.2%	29.3%	53.5%
Planning to/already getting help from community helping professional (e.g., health worker)	14.6%	56.3%	29.1%
Planning to/already getting help from traditional helping professional (e.g., culturally- based healer)	14.1%	59.6%	26.3%
Worried family and others in the community may think differently about you	14.1%	40.4%	45.5%
Worried peers and others in school may think differently about you	14.1%	37.4%	48.5%
Thought friends would find out	13.1%	37.4%	49.5%
Did not know where to go for help	12.0%	44.0%	44.0%
Felt embarrassed about what you were going through	9.2%	41.8%	49.0%
Did not have time because of after-school activities and other commitments	8.1%	44.4%	47.5%
Did not have transportation to get there	7.1%	46.9%	46.0%
It was too expensive	5.2%	46.4%	48.4%

In relation to psychological distress, Table 17 shows how youth felt in the past 30 days. This scale showed strong consistency ($\alpha = .91$). Table 18 not only provides the pre results, but the post, and the change between both. Table 18 is rank ordered beginning with the item with the largest amount of growth, youth feeling *worthless*, beginning at 3.91 (pre) and ending at 4.22

(post). Since these are negative statements, and the Likert scale from *all of the time* (1) to *none of the time* (5), as the numbers increase, youth have less of these feelings. Therefore, while youth began with a high level of feeling worthless (3.91), by the posttest they had less of this feeling (4.22). The only item where students regressed in their feeling was the last item, feelings *of nervousness*, beginning at 3.27 and ending at 3.21, which means students moved slightly in the direction of *all of the time*.

Table 17. Pre, Post, and Change of Psychological Distress for Youth During Past 30 Days, By Means and Numbers

During the past 30 days, how often did you feel…	Pre/ Post (n)	Fall (Pre) Mean	SD	Spring (Post) Mean	SD	Mean Change
…worthless.	99/99	3.91	1.48	4.22	1.18	+ 0.31
… hopeless.	98/97	3.78	1.47	3.94	1.18	+ 0.16
… so depressed that nothing could cheer you up.	98/98	4.06	1.33	4.17	1.22	+ 0.11
… feel that everything was an effort.	96/99	3.57	1.46	3.68	1.39	+ 0.11
… restless or fidgety.	97/98	3.79	1.39	3.82	1.29	+ 0.03
… nervous.	97/99	3.27	1.37	3.21	1.21	- 0.06

Note: Likert Scale: 1=All of the time; 2=Most of the time; 3=Some of the time; 4=A little of the time; 5=None of the time.
Note: A +/- system of showing change in growth or decline was used for readability purposes.

In relation to *psychological functioning*, Table 18 (below) helps to capture how youth *fears* and *worries* messed things up. The reliability for this scale was good ($\alpha = .77$). These items in Table 19 are also rank ordered beginning from the item with the greatest amount of growth for youth. Again, only the last item shows regression by youth. When asked how their fears and worries messed things up, the greatest growth was in the item *with friends*, where students began (in the pre) with a 2.34 mean, and concluded (in the post) with a 2.57 means. This + 0.23 growth shows that youth moved in the direction of *not at all*, meaning that by the post survey they felt that fears and worries messed things up with friends a little less than at the pre survey. When it came to fears and worries messing things up at home, students also showed a lot of growth in their feelings, beginning at 2.39 (pre) and ending at 2.61 (post), for a growth of + 0.22. The only regression was with the item where *fears and worries messed things up leading to negative emotions in your life*, where students regressed by 0.05 points (from 2.34 pre to 2.29 post).

Table 18. Pre, Post, and Change of Psychological Functioning for Youth in Schools, By Means and Numbers

How much of your fears and worries messed things up…	Pre/ Post (n)	Fall (Pre) Mean	SD	Spring (Post) Mean	SD	Mean Change
… with friends	99/99	2.34	.80	2.57	.64	+ 0.23
… at home	99/99	2.39	.79	2.61	.64	+ 0.22
… with school and homework	99/98	2.17	.80	2.28	.69	+ 0.11
… leading to negative emotions on your life	92/92	2.34	.73	2.29	.67	- 0.05

Note: Likert Scale: 1=A lot; 2=Somewhat; 3=Not at All
Note: A +/- system of showing change in growth or decline was used for readability purposes.

The last table (Table 19) only shows post-test data, as these questions were meant to capture youth's feelings about the quality of our CDEP, and the quality of their lives because of our CDEP. The scores on Table 19 show first the number of respondents, and then the mean for each answer. The items in Table 19 are also rank-ordered, beginning with the item that had the highest rating. This scale had very high reliability ($\alpha = .96$). The items range from a low of 3.41 to a high of 4.02. The item with the highest rating was *I have people with whom I can do enjoyable things* (4.02). As our CDEP *pláticas* did help youth with improving relationships and threatening others with respect, this rating is in line with some of the things taught by our counselors/therapists. Additionally, our *atención plena* groups at the public high school, also spend a lot of time not only learning *atención plena*, but learning leadership and advancing the Mindfulness Club, which also helps to explain this rating of 4.02. All in all, students felt good about the CDEP services, the staff, and the values learned. Two of the items that received low ratings were: (a) *services were available at times that were convenient for me* (3.41 rating), and (b) *the location of the services were convenient for me* (3.53 rating). As our CDEP was only offered for youth at the school, during school hours, this could largely explain these low ratings. We did offer our CDEP at rural schools, and in this way we were providing access to youth that would not otherwise have access to services; but at the same time, school location and hours were our limitations for providing youth with counseling/therapy services.

Table 19. Post-Test of CDEP Quality, By Means

	N	Mean	SD

I have people with whom I can do enjoyable things	92	4.02	.91
I know people who will listen and understand me when I need to talk	92	3.86	.97
I am better able to do things I want to do	92	3.82	.86
I have people that I am comfortable talking with about my problem(s)	90	3.82	.98
In a crisis, I would have the support I need from family or friends	90	3.81	.97
Staff respected my religious/spiritual beliefs	91	3.80	.99
Staff spoke with me in a way that I understood	87	3.80	.95
I am better at handling daily life	90	3.79	.94
Staff treated me with respect	92	3.78	.96
The people helping me stuck with me no matter what	94	3.77	.89
I get along better with friends and other people	94	3.73	1.06
I get along better with family members, and am satisfied with my family life right now[45]	92	3.68	1.15
I got the help I wanted	95	3.67	1.02
Overall, I am satisfied with the services I received	94	3.67	.92
I felt I had someone to talk to when I was troubled	92	3.64	1.07
I am better able to cope when things go wrong	90	3.64	.93
I am doing better in school and/or work	92	3.57	1.10
The location of services was convenient for me	92	3.53	.98
I received services that were right for me	92	3.50	.99
Staff were sensitive to my cultural/ethnic background	85	3.49	1.02

[45] Both of these items had the same n and mean.

Services were available at times that were convenient for me	91	3.41	.99

Note: Likert Scale: 1=Strongly disagree; 2=Disagree; 3=Undecided; 4=Agree; 5=Strongly agree.

Qualitative Data Findings

Focus Groups with Youth

Youth Worry About Family Conflicts in Daily Life

When youth were asked what they look forward to every morning, their responses were mostly in one or two words. “Good day” and “waking up” were typical answers, and only about half of the 21 youth gave a response. But when asked what they do not look forward to, about 66% of youth answered, also mostly short two to three-word answers, but a couple gave more elaborate responses. Conflicts with parents in the morning was a general theme expressed by approximately 20% of the youth, saying they did not look forward to their parents yelling at them in the morning. Some also worried about dying, failing, getting in trouble, messing up, and fighting with their siblings.

Youth Love Their Relational Latino Counselor/Therapist

As opposed to the conflict youth have with their parents on a daily basis, going to school was a haven because they got to work with their counselor/therapist. Their counselor/therapist taught them ways to approach their parents respectfully, which they appreciated. “He gives up advice” was a common assessment. Several also said that their parents thought they were failures because they did not get good grades like their cousins or siblings, and this negatively affected their self-esteem. But when working with their counselor/therapist, this was a person that did not judge them, was able to find and draw upon their strengths, and serve as a role model. For several youths, it was their counselor/therapist, and the “respect” that he showed them that made them love school and want to do well in school. When some left the continuation school to return to the local public high school after catching up on their credits, they wanted to return to their continuation school where they thought they had more support and were respected and helped. Being Latino, speaking Spanish, being a hip hop artist, were all things that were important to the youth who described their therapist/counselor as a “chill dude.”

Conflicting Parental Relationship Negatively Affect School Success and Mental Health

As stated earlier, from the minute many youth awaken, they are in conflict with their parents. A common theme was that there exists cultural dissonance between youth and parents. It is not enough that parents are practicing and grounding youth in the richness of Latino culture, youth

are in constant conflict with their Latino culture and their lives as Mexican American youth.[46] Many youth do not see themselves as having anything in common with their parents; they want to be rappers and make a lot of money, and their parents work in the fields. "They are not educated" so they do not believe their parents could do anything to help them when they struggle in school. The parents just expect them to "get straight As" without even understanding how difficult it is to be a high school student, socially and academically. The only way some parents know to motivate and help their kids is by putting them down, and telling them they are failures because they are not doing as well as others, and this usually creates more conflict than it solves.

Dangerous Neighborhood Life Exacerbates Problem for Youth

When youth conflict with their parents, they just go to their room. Many stated that they spent a lot of time in their room to keep from conflicting with their parents. Additionally, many (approximately 50%) do not want to leave their homes because of the danger in the neighborhoods where they live. "There's gunshots around 1 or 2 in the morning" and "my house got shot up" were commonplace experiences for several youth, such that many felt hearing gunshots was part of life. It was clear that having a difficult home life and living in difficult neighborhoods were contributing factors to youths mental health and educational success.

Youth Completely Disconnected from Religiosity

About 70% of the youth that talked about religion mentioned that it is not something they believe in. If they were to church it is because they were forced to do so, but it was not something they believe in. "My mom and my dad baptized me and did first communion but I don't believe…" was a common sentiment. Several considered themselves Catholic, but only because it was their background, not because it was anything they believed in. "I don't think this generation even cares [about religion]" was a common assessment. Only one youth talked about having a bible. This lack of religious identity also affected the therapist/counselor's ability to work with youth and engage them in mindfulness meditation because some associated this with religion and/or prayer, and were not interested.

Pláticas Work, Mindfulness Does Not

Youth (approximately 30%) spoke positively about *pláticas.* Some did not even see it as a type of therapy, rather as conversations that were really helping them, conversations where they did not feel they were being judged, and where they were able to freely communicate. The *pláticas* were helping them to deal with anger management, and also to better communicate with their

[46] Source: Szapocznik, J., Santisteban, D., Kurtines, W., Perez-Vidal, A., & Hervis, O. (1984). Bicultural effectiveness training: A treatment intervention for enhancing intercultural adjustment in Cuban American families. *Hispanic Journal of Behavioral Sciences*, *6*(4), 317-344.

parents and peers. At the same time, mindfulness meditation did not work in this alternative school setting. Youth spoke about doing meditation only if they were forced or wanting to fall asleep. Some associated meditation with prayer, and therefore only did it if they wanted to go to sleep or find escape from their home life. This result is very different from the results of the positivity of mindfulness at the traditional high school, where many of the youth doing mindfulness were also part of the acclaimed club, and at the middle school where mindfulness was a healthy alternative to harsher disciplinary actions by school officials. For the students that did not find mindfulness to work for them, the lesson learned was that mindfulness was not given proper time for students to develop appreciation for this practice and the therapist reported that he was more a *pláticas* expert, so naturally he gravitated more toward *pláticas*.

Connection With Therapist = Connection With School

All in all, when youth connected with their therapist/counselor, and felt that counseling with him was successful, they connected with school, and they specifically spoke about this relationship. They spoke about wanting to go to school, be in school, drop the ditching, and do well in school, because they liked the *pláticas* therapy. One youth spoke elaborately about always finding ways to not go to school when he was at the public high school, but once we got to the alternative school and started attending *pláticas*, his outlook and attitude changed. One youth put it best, stating:

> My mom hesitated to move me here because she said it was a continuous high school, that it is a small school. I was pretty convinced to move here. I told her, I don't care, I'm still going to move. So, then I moved and then she was pretty surprised that I wasn't doing anything dumb anymore. I was actually coming to school every day. I was getting my credits. I was catching up. I am going to graduate. I am going to college now.

Another student that was typical of so many of the students who liked their alternative school, and wanted to do well, connected this success to the *pláticas* and the hip hop therapy. He stated:

> Honestly, when I came, I didn't like it. I just wanted to go back to my home school but then I started talking. I met [my therapist], other teachers that see me as a bright student, they even told me. Ever since I, honestly from this, from the first day I came to this day now, I have no suspension here. No suspensions, no referrals, or anything.

Therapist/Counselor Is as Close to Role Model as You Get

When asked about role models, youth found it extremely difficult to point to a role model. If they did not mention famous rappers and basketball players, they mentioned their siblings. One mentioned how a famous basketball player was his role model because he uses his anger to be a

better basketball player. In general, youth did not speak about wanting to maybe be therapists/counselors themselves, but some were very impressed and respectful of their counselor, and thought this would be a good profession, to be in a place to help others. Many truly admired and respected their therapist/counselor, but felt short of pointing to this person as their role model, but in many ways, it is those people we respect and admire that we want to model ourselves after.

Participant Observations

Oftentimes, our therapists infused both *pláticas* and *atención plena* into their sessions, so it was not always easy to observe these as separate and distinct therapeutic approaches, but our observations of these approaches was the focus. In total, we observed 23 distinct and unique sessions where our therapist had success in infusing *pláticas* into therapy. By success, we mean that the students were engaged, interested, participating, and experiencing meaningful learning and growing experiences. We observed 22 distinct and unique sessions where the same type of success occurred with the use of *atención plena*. The balance largely reflects that 10 of the observations were done at the two (2) alternative schools with our lead therapist being an expert in *pláticas* and hip hop therapy. Similarly, eight (8) of our observations were done at our public high schools where our lead therapist is an expert in *atención plena*. We will also talk about and provide examples where our therapists struggled infusing our CDEP into therapy, we observed three (3) of these instances for *pláticas* infusion, and two (2) for *atención plena* infusion.

In addition to the general analysis of *pláticas* and *atención plena* infusion, and instances where this posed a challenge, we conducted a thematic analysis of what we observed about how the therapy sessions benefitted students. The following table (Table 20) lists (in rank order) our themes, along with their definitions, and the instances (positive [+] or negative [-]) in which we observed their occurrence.

Table 20. Overview of Themes/Definitions Related to *Pláticas* and *Atención Plena* Success and Challenges

Themes/Definition	Instances +/-
Expressing Emotion: Ability to verbally express their feelings and emotions.	+46, -5
Expressing/sharing events: Ability to express events associated with emotions.	+34, -1
Processing Emotion: Discussing and processing the emotion/feeling.	+17, -1
Therapist exploring emotion: Therapist further probes the student and further assists the exploration of the students' emotions.	+17

Using Spanish: Ability to express emotions and experiences using Spanish.	+11
Relating to experience: Students express their own feelings and experiences, other students relate to their experience and are encouraged to share.	+11, -2
Calming: Students and/or therapists express founding therapy to be calming.	+8
Feeling Validated: Students express that they feel heard and acknowledged.	+6
Focused on work: Students express that they are able to focus on their work.	+5
Gaining trust: Therapist is able to build trust with the student. This trust further allows the sharing of experiences and emotions.	+5
Destigmatize emotions/mental health: Student and/or therapist express how the student is able to express and talk about emotion free of stigma.	+4
Using Spanish to understand: By using Spanish students better understand the emotions and experiences shared.	+3
Sharing of ideas: Students are able to share ideas.	+3, -1
Peaceful space: Students find the space to be welcoming and peaceful.	+3
Normalizing experiences: Students' experiences/emotions/feelings are normalized.	+2
Wants to engage: Students express that they want to engage in the classroom, and therapeutic activities.	+2, -5
Relieves Stress: Students express that the activity (*pláticas* and/or *atención plena*) helps relieve some of their stress.	+2
Engaging/leading activities: Students take lead in engaging/leading activities.	+2
Accepting Emotion: Students express that they have accepted their emotions.	+1
Attention to work: Students express they are able to pay attention to their work.	+1
Wanting to change: Students express that they want to change and improve.	+1
Total:	+184, -15

Note: A +/- system of showing change in growth or decline was used for readability purposes.

To provide some examples of success, the most observed instance was of students *expressing emotion*, mainly during *pláticas* therapy, where we observed 46 instances of this strategy. In one group session, one youth mentioned having to deal with his grandmother having cancer. The therapist had a very genuine one-on-one back-and-forth session with this youth in the middle of

the group session, listening intently and asking questions, and the youth truly felt care and support from the therapist during this session. After this detailed share, the therapist transitioned back to the group, asking if anyone could relate to these experiences. Sometimes this type of caring interchanged happened right at the beginning of sessions when the therapist asked everyone to check in with their feelings. The therapist rarely passes on an opportunity to transition the group session to an individual session, and then have to a group session.

Another common theme where therapists found a lot of success was in *expressing and sharing events*. This oftentimes was observed during specific activities, like hip hop therapy. Youth would listen to a song or artist, talk about what was happening in the life of the artist, and talk about how this related to their lives and their experiences. The songs played and analysis in therapy was specific depending on the theme for the day, and youth would listen to the music and also be given the lyrics to analyze. This was a great method to get youth to share because oftentimes they were similar with the hip hop artist, and already had respect and admiration for them. This type of session usually ended with the therapist providing specific culturally-appropriate methods to address issues. And it was not just hip hop music, the therapist would also use this strategy with *dichos* and memes.

In terms of where therapists had struggles, the most observed was also where youth were *expressing emotion* during therapy, where we observed five (5) instances. In one example, per our notes, we wrote:

> It is sometimes a struggle to have kids focus on the here and now due to them constantly being affected and triggered by their past traumas...and uncertainty about their issues and situations. The therapist was making an effort to have clients process the present moment…. An example in this session is dealing with peer influence and identity development…. The therapist remains being present and practicing empathy and immediacy even when clients become disengaged. The therapist validates clients in becoming frustrated but nonetheless encourages them to participate.

In sessions such as the one noted above, the therapist struggled to get youth to focus and engage, not for lack of effort, but because sometimes it only takes one youth to disrupt the session. There were also other times where during check in, youth would sarcastically say things like “I’m here to talk about my feelings,” implying that this is the last thing they are going to do. But these situations, and these experiences with youth, were the exception not the rule, especially since therapy was a choice for students, not a requirement.

Another example where therapists struggled was with youth *wanting to engage*, where we saw five (5) instances where therapists struggled. Four of these five instances were in the same session where four (4) youth individually decided that they were not going to be part of any type

of group or individual therapy. One student was so disruptive that he tore off his pants, but he was wearing shorts underneath. A couple of other students broke away from the group, they did not leave the classroom, just decided to sit in their own corners of the room, by choice, and worked on other stuff they were interested that had nothing to do with therapy, as if they were doing therapy only to get out of their regular academic classrooms. Another student clearly stated that the goal was to not be part of the group, verbalized active resistance to any type of therapy. On this day, with this group, there was nothing or no strategy, it seemed, that the therapist could infuse to help garner interest in therapy.

Overall, our therapist showed amazing expertise, knowledge, and ability to apply culturally competent therapeutic approaches with largely at-risk youth. In 18 observations, we noted 184 (or 92.4%) incidents where our therapists were able to reach and help youth. It was only in 15 (or 7.6%) instances where therapists struggled to reach youth. The 7.6% is not necessarily a reflection on our therapist, it is also based on so many other conditions, such as how youth were feeling that day, and youths' motivation to even seek therapy in the first place.

Pre/Post Effects of Mindfulness on Outlook and Academics Survey

In total, 131 youth completed our online google forms prompt after the mindfulness session to reflect on how they felt before the session and after the session. However, since our analysis captured feelings, if youth expressed more than one feeling these were double coded. We organized the effects of mindfulness on youth into having positive, neutral, or negative feelings. Table 21 (below) provides an overview of their feelings.

Table 21. Feelings Before and After *Atención Plena* Session (N=131)

Before Mindfulness	# of Total Responses	% of Total Responses	After Mindfulness	# of Total Responses	% of Total Responses	% Change
Positive	27	13.5	Positive	121	63.7	+ 50.2
Neutral	23	11.5	Neutral	10	5.3	- 6.2
Negative	150	75.0	Negative	59	31.1	- 43.9
Total	200	100%		190	100%	

Note: A +/- system of showing change in growth or decline was used for readability purposes.

Before the *atención plena* (i.e., mindfulness) session, students wrote an average of 6 words in their open-ended entry, and the most common positive responses (N=27) about how they felt were *good* (12 times) and *happy* (4 times). Of those that we coded as neutral (N=23), the most common responses were *normal* (7 times) and *cold* (5 times). Of the negative responses (N=150), the most common were *tired* (66 times), *stressed* (13 times), and *sleepy* (11 times).

After *atención plena*, students' outlook about their feelings drastically changed from a generally negative mood to a generally positive mood. Of the positive responses (N=121), the most common were *relaxed* (56 times), *calm* (30 times), and *good* (14 times). Of the neutral responses (N=10), the most common was *nothing* (2 times). Of the negative responses (N=59), the most common were *tired* (26 times) and *sleepy* (16 times).

Clearly there was a shift from negative to positive feelings after the *atención plena* session (see Table 22). As the purpose of *atención plena* was to help youth focus and concentrate on learning, we asked how *atención plena* has affected their learning mood. The following table shows a generally positive belief that *atención plena* had on their learning.

Table 22. Feelings That *Atención Plena* Affected Learning

	# of Total Responses	% of Total Responses	Most Common Responses	# of Most Common Responses
Positive	135	87.1	Kept my focused	52
			Kept me calm	18
			Kept me relaxed	18
Neutral	20	12.9	It doesn't affect learning	5
			Not sure	3
			Don't know	3
Negative	0	0	N/A	N/A
Total	155	100%		

There was not one (1) single student that had something negative to say about *atención plena* and how it was being used to help students with their focus, and ultimately their approach to academics. We also found similar results in our observations of how *atención plena* was affecting academics at the middle school level, even though we did not deploy this survey at that school. While middle school youth were assigned *atención plena* as punishment, ultimately, they saw it as benefiting them and returned to the *atención plena* session held during lunch even after they were not required to.

Synthesis of Findings

Our quantitative and qualitative findings show the effectiveness of our CDEP over the last five (5) years. The following provides a synthesis of findings from data collected from: (a) 6 parents surveys, (b) 1,147 pre and 1,042 post pieces of data, from surveys or existing data, and (c) 309 youth (mostly unduplicated) that were participants in the focus groups, participant observations, and/or qualitative survey.

First, quantitatively, we collected: (a) 6 parent surveys, (b) GPA data from 181 youth, (c) behavior data from 181 youth, (d) attendance data from 181 youth, (e) 160 pre and 137 post Rosenburg surveys, (f) 173 pre and 126 post PHQ-9 surveys, (g) 159 pre and 130 post GSE surveys, (h) and 112 pre and 106 post SWE surveys. In all this data, our findings showed that our CDEP was effective in supporting youth as they improved navigating the school system, their families, and their communities. The parent surveys helped us understand which aspect of our CDEP they either knew most about or found most effective. The GPA, behavior, and attendance data showed when exposed to our CDEP, youth improved their grades, behavior, and attendance. The Rosenburg, PHQ-9, and GSE surveys showed us that students improved in their self-esteem, general mental health wellness, and self-efficacy. Finally, the SWE survey showed that our CDEP helped youth to improve in accessing the protective factors that help them cope with school and life, and psychological distress and functioning. None of these eight (8) pieces of data showed significant growth, but almost all of them showed improvement in most, if not all, of the measures. While the 6 parents survey's purpose was not to measure growth, but a snapshot in time about their views, all of our pre/post data was intended to measure growth over a school semester. Together, we collected 1,147 pre and 1,042 post data points or surveys to measure our growth and improvement, and in most instances when we tracked individual youth we observed growth and improvement.

When it came to the quantitative data, again, we saw growth, excitement about our CDEP, a CDEP that was delivered effectively, and a CDEP that was positively affecting the lives of youth. The 21 youth that we talked with in focus groups shared some of the same sentiments that were documented in the SWE survey, but with more detail and nuance. These youth first and foremost developed a relationship with the therapists based on common racial/ethnic backgrounds, and from there, counselors were important to helping youth with improving school success, but also navigate their home and community lives. In the SWE data, this was known as helping youth connect with the protective factors that help them cope with school and life. These focus groups findings also correlated with most of the other quantitative data points -youth improved academically and socially due to CDEP dosage. In regard to the 157 youth we observed in the participant observations, again, the more CDEP dosage, the more youth opened up to counselors, shared their emotions, and found better and healthier ways to process their emotions. This *opening up* after CDEP dosage helped therapist effectiveness in helping students find academic success, improved overall mental wellness, and better connectedness to family and community life. Lastly, if there was any piece of data where we saw dramatic changes from per to post, it would be in the qualitative *atención plena* survey, where 131 pre/post surveys were collected, and where youth increase positivity feelings by 50% and decreased negativity feelings by 44%. In all, 309 youth (most unduplicated) participated in our qualitative data portion, and almost always youth told us that our CDEP was making a positive difference in the school, family, and community lives.

Meta Analysis Data: Overall Presentation of Findings

The following table shows an overview of our overall findings. We first present the type of data collected, followed by the sample size, and then by the type of findings (positive, negative, or neutral). The totality of our data includes: (a) 6 parent surveys, (b) existing data (GPA, behavior, and attendance data from 181 youth), (c) Rosenburg surveys (160 pre/137 post), (d) PHQ-9 surveys (173 pre/126 post), (e) GSE surveys (159 pre/130 post), (f) SWE surveys (and 112 pre/106 post), (g) focus groups (with 21 youth), (h) participant observations (of 157 youth), and (i) qualitative surveys (131 pre/131 post).

Table 23. Overview of Overall Findings

Type	Sampling Size	Positive (+) Findings	Negative (-)/Neutral Findings
Parent Survey	6	* 5 CDEP components rated >4 on a 5-pt. Scale * 5 ways CDEP components affect youth rated >4 on a 5-pt. scale	* - 4 ways CDEP components affect youth rated <4 on a 5 pt. scale
Existing Data (GPA, Behavior, Attendance)	181 Pre and 181 Post for each data piece (GPA, behavior, attendance)	* 3 years of GPA improvement * 3 years of behavior improvement * 2 years of attendance improvement	* 1 year of attendance decrease
Rosenberg Survey	160 Pre; 137 Post	9 self-esteem items (improvement ratings)	1 self-esteem item (decline in ratings)
PHQ-9 Survey	173 Pre; 126 Post	9 health/wellness items (improvement ratings)	1 health/wellness item (no growth/decline in ratings)
GSE Survey	159 Pre; 130 Post	10 self-efficacy items (improvement ratings)	N/A
SWE Survey	121 Pre; 106 Post	* 12 protective factors and psychological distress/functioning items (improvement ratings) * 19 CDEP quality components rated >3.5 on a 5-pt. Scale	* 4 protective factors and psychological distress/functioning items (decline in ratings) * 2 CDEP quality components rated <3.5 on a 5-pt. Scale
Focus Groups	3 FGs (21 youth)	4 themes showed how the CDEP improved youth lives	4 themes showed how youth face challenges despite CDEP

Part. Observations	18 POs (157 youth)	184 instances where CDEP was + affecting youth	15 instances where CDEP did not + affect youth
Qual Survey	131 Pre; 131 Post	94 students were + affected by *atención plena*	59 students were not + affected by *atención plena*
Total:	6 parent survey; 1,147 pre surveys/data; 1,042 post surveys/data; 309 youth in FGs/POs/qual surveys		

As shown in Table 23, most of our data shows the positive effects that our CDEP has on the lives of youth. In the areas where there was decline in students, the declines were almost always very minimal. And in our effort to document the effect of our CDEP on youth, when our CDEP did not have a positive effect, we documented this as negative because we were expecting growth of all students regardless of what measurement or survey was used. What our meta data indicates, and we recognize that change can take many years, is that based on our current quantitative and qualitative data, we can advance the notion that the youth that experienced *pláticas* and *atención plena* also discovered purpose, personal strengths, and view themselves as assets. Through our many observations during and after the CDEP, in the classroom, and in their interactions with peers and adults, we have seen them build resilience and confidence. What our CDEP has meant for our youth is safe spaces that allow them to engage in meaningful conversations that for many of them only happens within these spaces. That is, for many of our youth, being heavily involved and engaged in our *pláticas* and *atención plena* could be an essential protective factor. While the phrase "meta-analysis data" has more of an academic tone, we recognize the importance of conveying a more simple, concise, yet strong and reader-friendly summary of our data, and that is the following. Since the inception of our CDEP, we have stopped asking youth, "what's the matter with you?" and started asking "what matters most to you?" This is consistent with Pedraza and Rodríguez's (2018)[47] overarching finding that led to the Mindfulness Club. Youth taught us that school-based programs need to stop seeing them as a deficit and start seeing them from a strength-based approach. This is also in line with the CBPR approach that the CRDP is grounded in.

Discussion and Conclusion

Without doubt, after a thorough discussion of the results with all our staff members that are responsible for deploying our CDEP, the results show the importance and effect of our CDEP. Our CDEP changes lives, uplifts youth, and disrupts the school-to-prison pipeline. Particularly when it came to our CDEP connecting culturally with students, this was a highlight because of how our CDEP is grounded in Latino culture. In all aspects of our CDEP, it was either students

[47] Source: Pedraza, E., & Rodriguez, R. J. (2018). "We are not dirt": Freirean counternarratives and rhetorical literacies for student voice in schooling. *English Journal*, *107*(6), 75-81.

or parents that felt a connection, in large part due how our Latina/o therapists embedded culture in their delivery.

Theoretically, from the beginning, we grounded our CDEP in the cultural wealth model, which focuses on student assets rather than deficits. Even in 2021, most Latino students go to school, are taught by White teachers, do not see themselves in the culture, and generally struggle to have cultural continuity from home to school, especially in our Latino, rural, immigrant dominant schools. Our CDEP goes against this current, and places student culture at the center; it reaffirms them, empowers them, and gives them the confidence and self-efficacy to improve their condition.

Five (5) years ago we sought to deploy a Latino-centered CDEP with the purpose of positively transforming lives. Five (5) years later, we were successful. We also reduced the stigma associated with mental health in the Latino community by exposing so many youth and their families to our CDEP. We provided youth with an avenue, and training, and skills to improve their mental health, but also to feel pride in their culture and cultural backgrounds. We also learned how to deliver our CDEP online during the pandemic, and understand that many youth continued to be engaged with our CDEP online even when they were disengaging with the rest of their academic work. Due to our therapists also being Latino, we created cultural safe spaces for youth and became trusted advisors in which they can rely to process issues and problems with.

Despite our success, we believe there are things we can do to improve the delivery of our CDEP. First, we need to engage more parents. We only had 6 parent surveys because of the difficulty in getting parents to our rural schools. Latino immigrant parents, which are most of our parents, rarely come to school to see student success. They are used to only coming or only getting called when their youth is in trouble, and even then, not always. We do need better parent engagement strategies. Second, we also need better communication of our CDEP to school staff and teachers. Over time, we found that the more staff and teachers knew about the purpose and essence of our CDEP, the more they were willing to work with us, such as letting youth out of class if they needed to attend a CDEP session.

If we were to reflect on limitations of our CDEP, the first is that we need more parental involvement. We know the literature has always pointed to the lack of parental involvement in immigrant and Latino communities, and we thought we would change this because we were a Latino-oriented CDEP, but this proved very difficult to do. There is no reason to speculate on the reasons for lack of parental involvement, and we will continue to believe that it is our responsibility to find more and better ways to involve parents. Perhaps instead of asking them to come to the school, we can make home calls on the weekends, in Spanish, and offer them gift certificates to answer our survey questions about the effect of the CDEP on their youth and families. Second, we need more counselors that know how to deliver our CDEP to youth. Right now we have five (5) BBS registered therapists in three (3) schools, and they do oversee 9-12

pre-degree interns that are in the process of obtaining their master's degree, but rarely are they trained in our staple methodologies - *pláticas* and *atención plena*. We lay the groundwork in their training and supervision, but continue to train them in the use of the CDEPs if they are interested and make the time by staying with us after their internships are completed. We need training manuals, trainers, and interest and willingness to join ICSI upon completion of their degrees if we are going to increase the number of therapists that can deploy our CDEP. Third and last, we need more school administrative support. Yes, the schools where we practice our CDEP support us, but we need more and better support, both administrative and financial. We need spaces, like rooms for group therapy, we need equipment, and we need schools to see the impact and benefit of our CDEP and begin to see this as an indispensable aspect of their school culture.

If we had to explicate two (2) critical take-aways from the entirety of our results, they would be that: (a) we were more successful that we expected, and look forward to expanding on our success, and (b) we now know more clearly our challenges and areas for needed growth, and welcome the opportunity to continue to serve youth and their families. First, our data clearly showed growth for always all students, in all areas, in all schools, in all years. Yes, we would have little to see greater growth, and in some areas we did, like in the *atención plena* pre/post qualitative survey, where happiness post-*atención plena* increased by 50% after 5 minutes of *atención plena* centering meditation. But in other areas, such as the SWE survey, the gains were so minimal that we wondered why this tool did not accurately measure all the success we were seeing in-person. Second, we have our work cut out for us in terms of measuring our successes. We feel sometimes the tools for data collection could be better. As we continue to standardize our CDEP in terms of dosage and time amounts, we also look forward to developing tools that specifically measure the unique aspects that make up both of our CDEP key components - *pláticas* and *atención plena*.

Appendices

Appendix A: ICSI Encuestas de Padres/Parent Survey

Q1 Siente usted que la práctica de evidencia definida por la comunidad *Atención Plena*, *Pláticas* y Terapia Hip-Hop refleja aspectos de su cultura?

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q2 Usando cancionero, Hip-Hop o otras formas de música ayuda a que su hijo se sienta más cómodo/a para acceder a los servicios de salud mental.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q3 Usar dichos y memes es apropiado en los servicios de salud mental.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q4 Usar *pláticas* y/o contar historias es apropiado en los servicios de salud mental.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q5 Usar *Atención Plena* es apropiado en los servicios de salud mental.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

El uso de aspectos de la cultura Hip-Hop, como la producción de música, ritmos, letras, poemas, grabación e interpretación, es apropiado en los servicios de salud mental.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q7 Ha visto una mejoría en el comportamiento de su hijo como resultado de participar en *Atención Plena*, *Pláticas* y Terapia Hip-Hop.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q8 Ha estado su hijo/a más dispuesto y/o entusiasmado a asistir a la escuela desde que ha participado en la práctica de evidencia definida por la comunidad, *Atención Plena*, *Pláticas* y Terapia Hip-Hop? ¿Ha habido una mejora en la asistencia de su hijo/a en la escuela?

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q9 Ha completado su hijo/a más trabajo escolar y/o mejorado sus calificaciones mientras participaba en la Terapia *Atención Plena*, *Pláticas* e Hip-Hop.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q10 Cree que participar en los grupos de *Atención Plena*, *Pláticas* y Terapia Hip-Hop ayuda a su hijo/a a afrontar algunos de los problemas que enfrentan.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q11 Participado en los grupos de Terapia *Atención Plena*, *Pláticas* y Hip-Hop ha cambiado las metas o aspiraciones profesionales de su hijo.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q12 Cree que su hijo se siente más cómodo/a asistiendo a la terapia cuando el terapeuta usa *Atención Plena*, *Pláticas* y Terapia Hip-Hop en grupos.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q13 Cree que el terapeuta hace que su hijo/a se sienta cómodo/a en la sesión de terapia.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q14 Ha mejorado la autoestima de su hijo/a desde que participó en la práctica de evidencia definida por la comunidad, *Atención Plena*, *Pláticas* y la terapia de hip-hop

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q15 La participación en los grupos de *Terapia Atención Plena*, *Pláticas* y Hip-Hop ha creado un interés para que su hijo considere una carrera en salud mental.

Muy en Desacuerdo (1) En Desacuerdo (2) Ni de Acuerdo Ni en Desacuerdo (3) De Acuerdo (4) Totalmente de Acuerdo (5)

Q16 ¿ Hay algo que cambiaría o le gustaría ver en la práctica de evidencia definida por la comunidad para el Instituto Integral de Soluciones Comunitarias?

Q17 ¿ Hay algo más que le gustaría decir o que olvidé preguntarle sobre la práctica de evidencia definida por la comunidad?

Q18 Me gustaría participar en un comité comunitario para proporcionar comentarios y opiniones sobre la práctica de evidencia definida por la comunidad.

Me Gustaría Participar (1) Me Niego a Participar (2)

Q19 Nombre e información de contacto (por ejemplo, teléfono o email)

Appendix B: The Rosenberg Self-Esteem Scale Survey (Pre/Post)

1 I feel I am a person of worth, at least on an equal basis with others.

Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)

2 I feel that I have a number of good qualities.

Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)

3 All in all, I am inclined to feel that I am a failure

Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)

4 I am able to do things as well as most other people

Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)

5 I feel I do not have much to be proud of

Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)

6 I take a positive attitude toward myself

Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)

7 On the whole, I am satisfied with myself

Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)

8 I wish I could have more respect for myself

Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)

9 I certainly feel useless at times

Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)

10 At times I think I am no good at all

Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)

Appendix C: PHQ-9 Patient Health Questionnaire (Pre/Post)

Q1 Name_____ Q2 Date_____

Q3 Little interest or pleasure in doing things

Not at all (1) Several days (2) More than 1/2 the days (3) Nearly every day (4)

Q4 Feeling down, depressed, or hopeless

Not at all (1) Several days (2) More than 1/2 the days (3) Nearly every day (4)

Q5 Trouble falling or staying asleep, or sleeping too much

Not at all (1) Several days (2) More than 1/2 the days (3) Nearly every day (4)

Q6 Feeling tired or having little energy

Not at all (1) Several days (2) More than 1/2 the days (3) Nearly every day (4)

Q7 Poor appetite or overeating

Not at all (1) Several days (2) More than 1/2 the days (3) Nearly every day (4)

Q8 Feeling bad about yourself or that you are a failure or have let yourself or your family down

Not at all (1) Several days (2) More than 1/2 the days (3) Nearly every day (4)

Q9 Trouble concentrating on things, such as reading the newspaper or watching television

Not at all (1) Several days (2) More than 1/2 the days (3) Nearly every day (4)

Q10 Moving or speaking so slowly that other people could have noticed. Or the opposite - being fidgety or restless that you have been moving around a lot more than usual

Not at all (1) Several days (2) More than 1/2 the days (3) Nearly every day (4)

Q11 Thoughts that you would be better off dead, or of hurting yourself

Not at all (1) Several days (2) More than 1/2 the days (3) Nearly every day (4)

Q12 If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all (1) Several days (2) More than 1/2 the days (3) Nearly every day (4)

Appendix D: General Self-Efficacy Scale (GSE)Survey (Pre/Post)

1 I can always manage to solve difficult problems if I try hard enough

Not at all true (1) Hardly true (2) Moderately true (3) Exactly true (4)

2 If someone opposes me, I can find the means and ways to get what I want

Not at all true (1) Hardly true (2) Moderately true (3) Exactly true (4)

3 It is easy for me to stick to my aims and accomplish my goals

Not at all true (1) Hardly true (2) Moderately true (3) Exactly true (4)

4 I am confident that I could deal efficiently with unexpected events

Not at all true (1) Hardly true (2) Moderately true (3) Exactly true (4)

5 Thanks to my resourcefulness, I know how to handle unforeseen situations

Not at all true (1) Hardly true (2) Moderately true (3) Exactly true (4)

6 I can solve most problems if I invest the necessary effort

Not at all true (1) Hardly true (2) Moderately true (3) Exactly true (4)

7 I can remain calm when facing difficulties because I can rely on my coping abilities

Not at all true (1) Hardly true (2) Moderately true (3) Exactly true (4)

8 When I am confronted with a problem, I can usually find several solutions

Not at all true (1) Hardly true (2) Moderately true (3) Exactly true (4)

9 If I am in trouble, I can usually think of a solution

Not at all true (1) Hardly true (2) Moderately true (3) Exactly true (4)

10 I can usually handle whatever comes my way

Not at all true (1) Hardly true (2) Moderately true (3) Exactly true (4)

Appendix E: Semi-Structured Focus Group Protocol

Self:

(1) What do you look forward to when you get up every morning? (record answers)

(2) If I was your counselor/therapist, and you had but one session with me, and it was mandatory, and I had to write an evaluation that could improve your lives, what would you want me to write about you?

(3) And if I wrote this evaluation, and happened to share it with your family, friends, and teachers, would they see you the same way that you see yourself? Why or why not?

Counselor:

(4) Tell us about your relationship with your counselor? If this is a person you're happy to see everyday, why or why not?

(5) (Self-esteem) Is your counselor/therapist the same or different in terms of how he makes you feel about yourself?

(6) And how are these feelings about yourself the same or different when you leave the session with your counselor/therapist, and go to your other classes, or interact with other students, teachers, or people in your community?

Family:

(7) Tell us about your relationship with your parents? And how do your parents influence how you feel about yourself?

(8) How does seeing, interacting, and spending time with your parents' influence how you feel about yourself?

(9) When you talk about how your parents make you feel about yourself, is there a difference between your mothers and fathers? (Probe: Regarding father relationships about self-esteem)

Community:

(10) Tell us about the community where you live?

(11) How are you able to use the communication skills that you learn from your counselor/therapist to interact with people in your community? (Probe: Ask for examples)

Religion/Spirituality:

(12) Are you religious/spiritual, and what does your religion/spirituality have to do with how you interact with your counselor/therapist, teachers, and other students?

(13) If you are religious/spiritual, how does religion/spirituality help you to have positive interactions with family, teachers, people in your community, and other students?

(14) How does meditation/prayer help to cope with issues you may be facing? (Probe: Ask for examples)

School:

(15) In general, would you say school has been a welcoming place? Why or why not? (record answers)

(16) What are some of the struggles that you face in school, and how has your counselor/therapist helped to address some of these struggles? (Probe: Ask for examples)

(17) Do you experience discrimination in school, perhaps because of your economic condition, race/ethnicity, gender, or accent/language? And if so, how does your counselor help you address this discrimination?

Aspirations:

(18) Tell us about your career aspirations. What do you desire to do for work when you're done with school? And how does what you're learning with your counselor/therapist help you achieve these aspirations?

(19) Do you have role models that you aspire to be like? If so, who are they, and what about them do you want to be like someday? (record answers)

Reflection:

(20) How do you know when you've been successful? Describe success given the situation/condition you find yourself in today?

(21) What do you see as possibly getting in your way of obtaining this success that you're talking about?

(22) At the beginning of the interview I asked what you looked forward to every morning. Now, what do you not look forward to when you get up every morning? (record answers)

(23) As we continue to learn about *pláticas* and/or *atención plena,* is there anything about these approaches that you would recommend we change?

(24) Is there anything you think I should ask other young men we'll be interviewing?

Appendix F: Participant Observation Protocol

Please complete prior to beginning observation

1. Date:
2. Time/length of observation:
3. School name:
4. Researcher name:
5. Therapist name:
6. Number or % of Students in class/session:
7. Number or % of Latina/o students in class/session:
8. Special lessons/activities planned for the day:
9. Any unique equipment/materials being used in class/session:
10. Anything special about the day (e.g., weather, event, etc.):

Observation Focus

1. In what ways does the therapist infuse *plática* into their therapeutic approach?

2. In what ways does the therapist infuse *atención plena* into their therapeutic approach?

3. In what ways is the multicultural/bilingual approach to therapy having a positive effect on Latina/o youth?

4. In what ways are culturally-appropriate therapies NOT having a positive effect on Latina/o youth?

Post-Observations

List questions to ask therapist after observation:

Appendix G: Statewide Evaluators Pre and Post Questionnaire

Adolescent Version of Pre/Post Questions to Ask for Statewide Evaluation