Safe Passages
Law and Social Justice Life Skills Coaching

Community Defined Evidence Practice

California Reducing Disparities Project

African Americans Cohort

May 15, 2018 – June 30, 2021

SAFE passages | *bringing together what works for kids*

California Reducing Disparities Project

"The Safe Passages model embedded Life Coaching and other program elements in the context of Know Your Rights and African American/Ethnic Studies education, providing a protective cloak of cultural and historical context for African American participants that is rarely provided in traditional, western approaches to prevention and early intervention services."

-Safe Passages Law and Social Justice Life Skills coaching – California Reducing Disparities Project, Local Program Evaluation

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African American adjudicated and systems involved youth in the target communities experience extreme levels of poverty, crime, violence, discrimination, and disenfranchisement and chronic stress produced by these oppressive conditions. Chronic stress becomes toxic for the target population, greatly increasing the risk of experiencing symptoms associated with trauma and mental illness.

Safe Passages (SP) LSJ Life Coaching Project is a Prevention and Early Intervention (PEI) program that aimed to prevent and/or reduce the effects of exposure to chronic stress, including trauma associated with poverty, exposure to racism, disenfranchisement from the education system, and juvenile justice system involvement among youth of color ages 16-21, who were adjudicated, systems involved, or at risk of becoming systems involved. The project components aimed to decrease mental illness, or the severity of symptoms associated with trauma or mental illness, school failure and drop out, and incarceration/ recidivism. Conversely, the project strived to increase/improve coping skills, self-regulation, relationships with caring adults, access to services, employment, and family engagement. The LSJ Life Coaching Project was an existing Community Defined Evidence Practice (CDEP). However, the particular focus of the California Reducing Disparities Project (CRDP) implementation and local evaluation was on African American youth who resided in Oakland, California. The LSJ Life Coaching Project was designed to be delivered over a 12-month program year.

Incorporation of indigenous knowledge (local and cultural) in the CDEP undergirded the program model and was indispensable to the CDEP. Specific core elements of indigenous knowledge were aligned with each component of the CDEP model, including 1) Outreach and Coordination; 2) Enrollment; 3) Life Coaching and Case Management; 4) Life Skills “Know Your Rights” and African American/Ethnic Studies education; and 5) Family Engagement and Coaching.

Three major historic events produced unanticipated and inescapable impact on the participants, community, CDEP, SP, and the evaluation process. The first event was the murder of George Floyd, an African American son and father, at the hands of the Minneapolis police, an event that ignited many communities in the U.S., including Oakland. The impact of the murder of Mr. Floyd and other African American men and women at the hands of largely white law enforcement officials laid bare the historical trauma of white supremacy and police violence against African Americans. The African American participants and the staff at the heart of the CDEP were profoundly impacted and carried the images of the murders of George Floyd, Breonna Taylor, Ahmaud Arbery, and others burned into their psyches. Program staff brought historical and cultural perspective, and resources to anchor participants in the potential of their futures. The second event was the rise of the Black Lives Matter movement, a movement that reminded American society of the critical power of Black organizing and unexpected wider mainstream appeal of the message. The final unprecedented event was the COVID-19 Pandemic, a watershed event that changed every aspect of the context of the implementation and evaluation of the CDEP. For k-12 students in Oakland the modality of instruction, one of the most fundamental aspect of school, shifted

within days as physical facilities were abandoned and learning migrated to virtual classrooms and remote learning became the norm for the next 18 months. At the time of this writing, the depth of long-term impacts of these events are yet to be determined.

Evaluation Questions

(1.) To what extent were outreach and coordination efforts effective in enrolling participants in life coaching and life skills components? (Process); (2.) What are the characteristics of participants enrolled in SP? (Process); (3.) To what extent was there a decrease in mental illness, or the severity of mental illness symptoms, among SP participants? (Outcome); (4.) To what extent was there grade advancement/ high school graduation/GED attainment among participants? To what extent was there dual/concurrent enrollment in the Peralta College System among participants? (5.) To what extent were there no incidences of system involvement 6, 9, and 12-months post program completion among participants? (6.) To what extent was there an increase in prosocial/resiliency/hope/protective factors/life skills, as well as an increase in coping skills, self-regulation, and relationships with caring adults among participants? (Outcome); and (7.) To what extent was there an increase in employment and family engagement among participants? (Outcome).

Evaluation Design and Sample Size

This evaluation employed a mixed-methods, quantitative, and qualitative design, as well as community based participatory research and intersectional approaches. Its quantitative component entailed a quasi-experimental, pre- and post-design, while its qualitative component entailed a phenomenological, ethnographic, and case study design. 69 African American youth ages 16-21 who were adjudicated, systems involved, or at risk of becoming systems involved participated in this study. As per the Statewide Evaluation Team's Guidance, the Evaluation Team utilized recommended resources to calculate an initial sample size for a quasi-experimental design and arrived at the minimum total sample size of 63 participants over the three years, amounting to 21 per year, yielding a power of 80%. This yielded a 5% or less error rate.

Findings

Positive growth was noted on all quantitative and qualitative evaluation questions; however, statistical significance was not noted on quantitative findings. Specifically, statistical significance was not noted on the statewide evaluation, referred to as the SP CDEP survey. We hypothesize that several significant extenuating circumstances impacted these findings, including survey flaws, COVID-19 and the resulting modified implementation, and small sample size.

The findings demonstrated that subsets of SP CDEP participants experienced the following outcomes.

- 39% of participants experienced improvements with respect to mental well-being, or the severity of mental illness symptoms (39% improved anxiety symptoms and 48% improved depression symptoms).
- 89%-94% of participants improved coping skills/strategies, self-regulation, and relationships with caring adults).
- 89%-94% of participants increased prosocial/resiliency/hope/protective factors.

- 100% of participants experienced grade advancement/high school graduation/ GED/CHSPE attainment.
- 100% of participants experienced no incidences of systems involvement or further systems involvement.
- 67% of participants experienced dual/concurrent enrollment in Peralta College System for high school and college credit.
- 100% of participants experienced employment and family engagement.

Finally, 77% experienced improvement onthe Any Improvement Composite Variable related to culture, anxiety, and depression.

On the larger systems level, the creation of the CRDP Cross Population Sustainability Committee (CPSSC) represented systems changes resulting in the successful policy and budget proposal to invest $63.1 million in California General Funds in CDEPs designed for California's African American, Latinx, Asian Pacific Islander, Native American, and the LGBTQ+ communities. The investment represented the availability of $1.2 million for each CRDP Phase II- Implementation Pilot Project to extend their culturally defined strategies for four additional years.

Discussion and Conclusion

Across all three years, a subset of program participants showed improvements between pre and postmeasurement points on the composite variable for Anxiety. During the first two years, nearly half of all participants showed improvements between pre and post measurement points on the composite variable for Depression. In the third year, the proportion of treatment group participants who saw improvement on this composite dipped marginally. For comparison, between April 2020 and October 2021, the CDC and the National Center for Health Statistics conducted a national survey on anxiety and depression symptoms during the previous 7 days. 59% of 18–29-year-olds and 48% of African Americans experienced anxiety or depression, compared to 43% of African Americans, 18-21-years-olds, participating in the SP CDEP.[1]

For African Americans living in Alameda County, the age-adjusted all- cause mortality rate more than halves for those who have not completed high school compared to those who have completed a bachelor's degree or more (1670.2 per 1000,000 compared to 796.6 per 100,000).[2] 100% of African Americans participating in the SP CDEP either experienced grade advanced or graduated from high school.[3] The education attainment is particularly notable given that the grade advancement and high school graduation continued through the 18 months of remote learning resulting from the COVID-19 shelter in place. One could argue that the impact of the radical and rapid migration to remote learning was mitigated by the protective factors imparted by the CDEP as every participant advanced to the next grade or went on to graduate from high school. The long-term implication of this educational success is most likely to place CDEP participants on a road to

[1]Center for Disease Control and Prevention, "Anxiety and Depression: Household Pulse Survey," Center for Disease Control and Prevention, last modified October 20, 2021, https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm.
[2] Alameda County Public Health Department, "An Intro to Measures of Mortality: Assessing Overall Health, Cause of Death Rankings, Health-Adjusted Life Expectancy, and Socioeconomic Conditions in Alameda County."
[3] California Department of Education, "2019-2020 Four-Year Adjusted Cohort Graduation Rate: Oakland Unified District Report (01-61259)," Data Quest, Accessed October 25, 2021, https://dq.cde.ca.gov/dataquest/dqcensus/CohRate.aspx?agglevel=district&year=2019-20&cds=0161259.

improved economic and health outcomes.

Further, arrest and probation rates among the target population, residing in the target communities, are the highest in Alameda County. As uplifted in the introduction/literature review, approximately 20% of Alameda County's youth arrested resided in the target communities, 45% on probation were from Oakland, and an average youth incarceration rate of 17 per 1,000. These adverse experiences have grave implications for African American youth who are already dealing with the health, economic mobility, and life expectancy implications of poverty. 100% of African Americans participating in SP CDEP did not experience systems or further systems involvement. This was maintained throughout all COVID-19 shelter in place orders. In addition to the SP CDEP, this success was also attributable to significantly less contact with law enforcement in schools and during travel between schools and homes.

Survey results from the Oakland Fund for Children and Youth' YDLS implemented in the 2018-19 and 2020-21 program years showed that 89% - 94% of participants demonstrated increased prosocial/resiliency/hope/protective factors, significant youth development outcomes. These data correlated with results from the staff focus groups that indicated increases in protective factors, resiliency, and self-agency among participants. Staff attributed these gains to the alignment of staff demographics and experience to those of participants facilitating relationship building and connections to caring adults.

Growth in protective factors and resiliency among participants were attributed by participants and staff to the focus of building knowledge of African American culture and history. Culture is a protective factor that anchors youth and provides context and identify in a society that minimizes black culture and identity. The CDEP embedded Life Coaching and other program elements in the context of Know Your Rights and African American/Ethnic Studies education, providing a protective cloak of cultural and historical context for African American participants that is rarely provided in traditional, western approaches to prevention and early intervention services. CDEP participants migrated towards the African American dual enrollment courses and the KYR education with a strong desire to learn about their own history and their rights to help them navigate their education and other public systems. This is an area that appears promising and given the CDEP outcomes of no new or additional systems involvement and 100% grade advancement/high school graduation warrants additional research.

Finally, the impact of the CRDP CPSSC must be uplifted as it is instructive for the larger community of BIPOC and LGBTQ+ providers engaged in culturally appropriate strategies in the mental health sector, as well as the larger public sector engaged in the herculean effort of reducing disparities historically experienced by BIPOC communities. The creation and work of the CPSSC represented a modification of the planned CDEP, yet the legacy of the CPSSC may represent the most widespread impact of the project in terms of public investment and the number of participants served across the initiative. The procurement of $63.1 million dollars from California's General Fund may represent the largest investment of general funds in culturally defined mental health programs for BIPOC and LGBTQ+ communities in the history of California. These outcomes were realized as a direct result of the intentional and thoughtful collaboration between IPP representing the African American, Latinx, Asian Pacific Islanders, Native American, and LGBTQ+ communities created in the hopes of systematically reducing mental health disparities.

Section 3. Introduction/Literature Review

SP is a multiservice organization led by women of color with over 26 years of demonstrated effective service to communities of color in Oakland and other high need areas of Alameda County. The organization strives to achieve its mission "***to disrupt the cycle of poverty by engaging youth and families to build and drive a continuum of services that support student success and community development,"*** by delivering a comprehensive range of culturally relevant services to over 4500 children, youth, and families each year.

Core principles of the organization include social justice, service to the community, systems change, cultural humility, youth development, family and community engagement, and continuous improvement. The core principles are evidenced throughout the program portfolio. SP categorizes its programs and strategies within the following core functions: 1) direct services; 2) policy and advocacy; 3) innovative program development, incubation, and replication; and 4) investment in human capital. The SP Law and SocialJustice Life Coaching Project (LSJ Life Coaching Project) is a Community Defined Evidence Practice (CDEP) and was developed in accordance with the organization's core principles and is representative of its core functions. The LSJ Life Coaching Project) serves adjudicated youth ages 16 to 21 residing in the most crime impacted and economically disenfranchised areas of the City of Oakland in Alameda County. The presenting mental health need is a result of the target populations exposure to trauma and their experiences growing up in poverty, exposure to racism, being disenfranchised from the education system, and being subjected to the juvenile justice system, including incarceration.

With more than 30% of our local California Reducing Disparities Program (CRDP) program and local evaluation to be implemented, the COVID-19 global pandemic disrupted every aspect of our global society. The pandemic's impact on the youth and families at the center of our program, larger community, SP staff, and organization as a whole, was immediate and acute. The majority of youth serviced through our CDEP lived and attended school in the Oakland zip codes with the highest rate of COVID-19 infections in Alameda County.[4] Moreover, the populations SP serves experienced the highest disparities in our local jurisdiction, with African American residents dying from COVID-19 at 4x the rate of white residents and with Latinx residentsbecoming infected with COVID-19 at 6x the rate of white residents.[5] The impact of the pandemic on the youth, families, and communities served by SP cannot be overstated. The direct and indirect impacts on the SP LSJ Life Coaching project and its CRDP local evaluation are unquantifiable and were inconceivable when the project evaluation was designed.

Based on the available American Community Survey data, the average poverty rate of the target communities located in East and West Oakland is 30.7%. In Alameda County, neighborhoods with 30% or more residents living in poverty are defined as very-high poverty neighborhoods.[6] Of residents in very-high poverty neighborhoods in Alameda County, 64.1% are African American,

[4] https://covid-19.acgov.org/data.page?#geography

[5] https://covid-19.acgov.org/covid19-assets/docs/response/update-actions-to-support-equity-2020.07.30.pdf

[6] Alameda County Public Health Department, "An Intro to Measures of Mortality: Assessing Overall Health, Cause of Death Rankings, Health-Adjusted Life Expectancy, and Socioeconomic Conditions in Alameda County, "Alameda County Public Health Department, November 2017, https://acphd-web-media.s3-us-west-2.amazonaws.com/media/data-reports/city-county-regional/docs/mofm.pdf.

compared to very low poverty neighborhoods (<5% of residents in poverty), where 79.0% of residents are White and Asian.[7] In addition to being located in very-high poverty neighborhoods, the target communities reside in areas of persistent poverty, which are defined as areas that have had high rates of poverty (20.0%+) for at least five decades.[8] Health data clearly illustrates the impact of health disparities associated with living in neighborhoods with historically very-high poverty rates, with a general decline in life expectancy with each increasing level of neighborhood poverty.[9] There is nearly a 7-year difference in life expectancy between an Oakland resident living in an affluent neighborhood and a resident living in a very-high poverty neighborhood.[10] Further, school age children and teens living in very high poverty neighborhoods are dying at nearly three times the rate of their peersliving in affluent neighborhood.[11]

Residents of very-high poverty neighborhoods have less access to educational resources and experience less educational attainment. Schools in high poverty neighborhoods are often underperforming, failing to provide students with the same educational opportunities afforded to students attending schools in more affluent neighborhoods. African American youth in Oakland and Alameda County begin school with many more health and education disadvantages than their white counterparts. By third grade, only 11% of all Black boys are reading proficiently in comparison to their white counterparts, where 65% are reading at proficiency in Oakland Unified School District (OUSD). Additionally, 83% of all Black students TK-3rd grade qualified for Free & Reduced-Price Lunch as compared to 18% of White students in OUSD.[12]

Further, residents of very-high poverty neighborhoods are almost four times as likely to have less than a high school diploma than residents of affluent neighborhoods.[13] High school graduation rates among the target population are some of the lowest in Alameda County. 32.0% - 49.3% of all target population residents ages 25 and older do not have a high school diploma or equivalent, compared to county wide averages of 12.7%.[14] This disparity greatly

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[7] Alameda County Public Health Department, "An Intro to Measures of Mortality: Assessing Overall Health, Cause of Death Rankings, Health-Adjusted Life Expectancy, and Socioeconomic Conditions in Alameda County."

[8] Alameda County Public Health Department, "Persistent Poverty Story Map," Alameda County Public Health Department, 2015, https://ac-hcsa.maps.arcgis.com/apps/MapSeries/index.html?appid=c7eac040d44e47939d94bbad80ab630e.

[9] Alameda County Public Health Department Community Assessment, Planning, and Evaluation (CAPE) Unit, "Map Set 2018," Alameda County Public Health Department, April 2018, https://acphd-web-media.s3-us-west-2.amazonaws.com/media/data-reports/city-county-regional/docs/mapset2018.pdf.

[10] Alameda County Public Health Department Community Assessment, Planning, and Education (CAPE) Unit and Division of Communicable Disease Control and Prevention, "Alameda County Health Data Profile, 2014: Community Health Status Assessment for Public Health Accreditation," Alameda County Public Health Department, May 2014, https://acphd-web-media.s3-us-west-2.amazonaws.com/media/data-reports/city-county-regional/docs/acphd-cha.pdf.

[11] Alameda County Public Health Department Community Assessment, Planning, and Education (CAPE) Unit and Division of Communicable Disease Control and Prevention, "Alameda County Health Data Profile, 2014: Community Health Status Assessment for Public Health Accreditation."

[12] Urban Strategies Council, "Starting from Behind, Black Boys in Oakland Infographic," Urban Strategies Council, September 2017, https://urbanstrategies.org/wp-content/uploads/2019/07/Black-Boys-Infographic-FINAL-2017.png.

[13] Alameda County Public Health Department Community Assessment, Planning, and Education (CAPE) Unit and Division of Communicable Disease Control and Prevention, "Alameda County Health Data Profile, 2014: Community Health Status Assessment for Public Health Accreditation."

[14] Alameda County Public Health Department Community Assessment, Planning, and Evaluation (CAPE) Unit, "Map

impacts prospects of employability and economic mobility. Levels of education have been shown to impact health outcomes, and for African Americans living in Alameda County, the age-adjusted all-cause mortality rate more than halves for those who haven't completed high school compared to those who have completed a bachelor's degree or more (1670.2 per 1000,000 compared to 796.6 per 100,000).[15]

COVID-19 and the ensuing economic fallout have only exacerbated health and economic disparities among communities of color. Communities of color face persistent health disparities, including higher rates of asthma, diabetes, and obesity due to structural and racist inequities. Underlying and preexisting health conditions have worsened COVID-19 outcomes for communities of color and African American people have nearly twice as many cases of COVID-19 infections than white counterparts. In addition to the health impacts of COVID-19, communities of color have disproportionately experienced the economic consequences because of the pandemic. Communities of color have the highest percentage of essential workers, with 48% of African American individuals working in this category.[16]

Poverty is layered with the added risk factors of crime and violence in low-income African American communities. The average crime rate in the target communities is higher than the crime rate of the surrounding communities. The LSJ Life Coaching Project target communities are located within the 15 highest stressor beats in Oakland. In 2014, these 15 beats accounted for 58% of all youth arrests and 57% off all shootings and homicides in Oakland.[17] In Oakland, Black men, youth, and young adults have represented the highest number of homicides of any ethnic or demographic group. While African Americans account for 24% of all Alameda County residents, they represent 72% of all homicide victims.[18] In OUSD, half of Black boys in 5th grade have had at least one friend or family member die violently, with a third having experienced two or more such deaths.[19]

African Americans are also disproportionately affected by these risk factors. "Nearly three quarters of juvenile arrests in Oakland are African American boys, who are often picked up for relatively minor offenses," according to a study released by the local nonprofit Black Organizing Project, Public Counsel, and the American Civil Liberties Union of Northern California.[20] Titled "The Impact of Policing Oakland Youth,"the report looked at arrest data between 2006 and 2012 and found that African American boys made up almost 75 percent of all juvenile arrests in Oakland despite being less than 30 percent of the city's under 18

Set 2018."

[15] Alameda County Public Health Department, "An Intro to Measures of Mortality: Assessing Overall Health, Cause of Death Rankings, Health-Adjusted Life Expectancy, and Socioeconomic Conditions in Alameda County."

[16] California Pan-Ethnic Health Network, "Landscape of Opportunity," California Pan-Ethnic Health Network, February 11, 2021, https://cpehn.org/reports/landscape-of-opportunity/.

[17] Urban Strategies Council, "Oakland Stressor Model," Oakland Unite, 2011, http://oaklandunite.org/wp-content/uploads/2012/11/Stressor-Table-2011-1-11-12.pdf.

[18] Urban Strategies Council, "Rethinking Violence Prevention in Oakland, CA: 'From the Voices of the People Most Impacted,'" Urban Strategies Council, September 2019, https://urbanstrategies.org/wp-content/uploads/2020/05/Rethinking-Violence-Prevention-in-Oakland-CA.pdf.

[19] Urban Strategies Council, "Starting from Behind, Black Boys in Oakland Infographic."

[20] Black Organizing Project, Public Counsel, and the ACLU of Northern California, "From Report Card to Criminal Record: The Impact of Policing on Oakland Youth," Public Counsel, August 2013, http://www.publiccounsel.org/tools/assets/files/0436.pdf

population."[21]

Furthermore, according to the Alameda County Probation Department data, 874 (or 45%) of the 1,943 juveniles on probation as of mid 2012 resided in Oakland. 342 youths were arrested in the Project's target communities in 2014. The 15 beats included in the target communities have the highest youth incarceration and probation rates in Oakland, with an average incarceration rate of 17 per 1,000. One target beat in particular (07X) has a youth incarceration rate of 33 per 1,000 and a youth probation rate of 22 per 1,000. The target communities, therefore, have on average 524 youths incarcerated per year. As of July 2019, youth booked into Juvenile Hall are overwhelmingly African American or Hispanic, with an average age of 16.[22] Criminalization of Black youth begins in early school and in OUSD schools,1 in 11 Black boys face/ have faced suspension by 3rd grade.[23] Further, while Black youth represent 26% of all students enrolled in OUSD schools, they account for 73% of all students arrested. Black students in OUSD are 11 times more likely to be suspended than their white peers.[24]

People of color living in poor neighborhoods experience the cumulative effect of multiple stressors, like poverty, crime, and violence. Stress levels rise in the absence of basic human needs, such as safety, employment, health care and affordable housing. Social isolation resulting from racial stigmatization, the breakdown of the family unit, and lack of social support reduces an individual's ability to manage stress. "Constant pressures and lack of control trigger a chronic stress response (or allostatic load), which over time, wears down body systems and increases risk of ill conditions like hypertension or diabetes."[25]

The historical and persistent racism experienced by African Americans compounds the stress like compounding loan interest, exacerbating negative health outcomes for the population. Notable, all five of the population reports developed by the Strategic Planning Workgroups found "the history of racism, bigotry, heterosexism, and other discrimination in the United States is a constant source of stress which can lead to feelings of invalidation, negation, dehumanization, disregard, and disenfranchisement."[26] Further, specific data illustrates the profound impact of racism on the health of African Americans demonstrating that "experiences of racism at multiple levels-including institutional, interpersonal, and internalized racism-can serve as a chronic stressor that contributes to increased risk of hypertension among African

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[21] Black Organizing Project, Public Counsel, and the ACLU of Northern California, "From Report Card to Criminal Record: The Impact of Policing on Oakland Youth."
[22] Alameda County Probation Department, "Reductions in Juvenile Detention in Alameda County," Alameda County Probation Department, July 2019, https://probation.acgov.org/probation-assets/files/resources-info/Reductions%20in%20Juvenile%20Detention%20in%20Alameda%20County_7.25.19.pdf.
[23] Urban Strategies Council, "Starting from Behind, Black Boys in Oakland Infographic."
[24]Black Organizing Project, "OUSD's $6.5 Million Dollar Problem: Examining Bay Area Black School Pushout," Black Organizing Project, 2018, https://drive.google.com/file/d/1WRYrN07c1ZR_HBEgVSXYm0fushNgraTk/view?ts=5b3be9e0.
[25] Pamela J. Feldman and Andrew Steptoe, "Neighborhood Problems as Sources of Chronic Stress: Development of a Measure of Neighborhood Problems, and Associations with Socioeconomic Status and Health," *Annals of Behavioral Medicine,* 23, no. 3 (2001): 177 – 185, doi: 10.1207/S15324796ABM2303_5.
[26] California Pan-Ethnic Health Network, "California Reducing Disparities Project Strategic Plan to Reduce Mental Health Disparities," California Pan-Ethnic Health Network, May 2014, https://cpehn.org/assets/uploads/archive/crdpstrategicplan2014final2.pdf.

Americans in particular."[27]

Chronic stress also leaves an enduring impact on mental health, increasing the risk of depression, anxiety, and other mental health disorders. If not prevented or treated effectively, severe mental illnesses can substantially impair the individual's ability to function. Severe mental illness (SMI) can include conditions like major depression, anxiety, or schizophrenia and can lead to suicide. The disparity in mental health treatment is evidenced in local Alameda County data, where the rate of visits to the emergency department for severe mental disorders in very-high poverty neighborhoods is nearly three times that of affluent neighborhoods.[28] In California, 4% of all adults have been diagnosed with severe mental illnesses. African Americans have rates of SMI above the state average, with 5.8% of residents having received a SMI diagnosis. Gaps in coverage, workforce inadequacy, affordability, and systemic discrimination have led to significant barriers for access to mental health services by the target communities.

Incarceration and juvenile justice system involvement are amplifying social determinates of health for African American adjudicated youth. Incarcerated individuals experience higher incidences and prevalence of disease, and are indirectly affected through stigmatization, unemployment, strained social networks, and long-term effects on economic mobility.[29] One study found that approximately 50-70% of juvenile justice involved youth have a diagnosable behavioral health disorder compared to a rate of about 9-13% of the general population of youth.[30] The same study also concluded that up to 2/3 of youth with a mental health diagnosis have co-occurring substance use disorders. Another study found, "62% of juvenile justice involved youth met the criteria for one mental health diagnosis (excluding conduct disorder), and 39% met criteria for more than one diagnosis."[31] The most common diagnosis was conduct disorder, followed by substance abuse, anxiety, ADHD, PTSD, depression, and mania. Although disproportionately represented in the juvenile justice system, African American adjudicated youth are not overrepresented in treatment. Youth of color tend to be underserved in the mental health system compared to White youth, and African American youth with mental health issues are more likely to be referred to the juvenile justice system rather than treatment.[32]

[27] Alameda County Public Health Department Community Assessment, Planning, and Education (CAPE) Unit and Division of Communicable Disease Control and Prevention, "Alameda County Health Data Profile, 2014: Community Health Status Assessment for Public Health Accreditation."
[28] Alameda County Public Health Department Community Assessment, Planning, and Education (CAPE) Unit and Division of Communicable Disease Control and Prevention, "Alameda County Health Data Profile, 2014: Community Health Status Assessment for Public Health Accreditation."
[29] Andrea John and Jason Schnittker, "Enduring Stigma: The Long-Term Effects of Incarceration on Health," *Journal of Health and Social Behavior* 48, no. 2 (2007): 115-130, doi: 10.1177/002214650704800202.
[30] John and Schnittker, "Enduring Stigma: The Long-Term Effects of Incarceration on Health."
[31] John and Schnittker, "Enduring Stigma: The Long-Term Effects of Incarceration on Health."
[32] John and Schnittker, "Enduring Stigma: The Long-Term Effects of Incarceration on Health."

Section 4. CDEP Purpose, Description, and Implementation

a. CDEP Purpose

SP LSJ Life Coaching Project is a Prevention and Early Intervention (PEI) program that aimed to prevent and/or reduce the effects of exposure to chronic stress, including trauma associated with poverty, exposure to racism, disenfranchisement from the education system, and Juvenile Justice system involvement among African American youth, ages 16-21, who were adjudicated, systems involved, or at risk of becoming systems involved. The project components aimed to decrease mental illness, or the severity of symptoms associated with trauma or mental illness, school failure and drop out, and incarceration/ recidivism. Conversely, the project strived to increase/improve: coping skills, self-regulation, relationships with caring adults, access to services, employment, and family engagement.

b. CDEP Description and Implementation Process

The SP LSJ Life Coaching Project was an existing Community Defined Evidence Practice (CDEP) that served youth of color, ages 16-21 who were adjudicated, systems involved, or at risk of systems involvement. However, the particular focus of the CRDP implementation and local evaluation was on African American youth who resided in the most crime impacted and economically disenfranchised areas of the City of Oakland in Alameda County.

The data clearly illustrates the extreme level of poverty, crime, violence, discrimination, and disenfranchisement experienced by African American adjudicated youth in the CDEP target communities and the chronic stress produced by these oppressive conditions. Chronic stress becomes toxic for the target population, greatly increasing the risk of experiencing symptoms associated with trauma and mental illness. The LSJ Life Coaching Project provided effective trauma-informed, culturally competent life coaching as PEI services to reduce toxic stress levels andincrease support to mitigate participants' risk of symptoms associated with trauma and mental illness.

Moreover, African American residents living in neighborhoods with high concentrations of poverty have less access to educational resources, and experience less educational attainment. Schools in high poverty neighborhoods are often underperforming, failing to provide their students went the educational opportunities afforded schools in more affluent neighborhoods. Residents of high poverty neighborhoods are almost four times more likely to haveless than a high school diploma than affluent neighborhoods– reducing prospects for employability and economic mobility.[33]

Simply stated, the project components were designed to eliminate the stress and trauma associated with being in foster, juvenile justice, and education systems. The theory of change was driven by strategies to prevent African American youth, ages 16-21, from entering or re-entering the juvenile

[33] Muntu Davis, "Investing in People and Place: Poverty and Children's Health in Alameda County," Alameda County Public Health Department, April 23, 2014, http://www.acgov.org/icpc/documents/presentation-ChildrenInPovertyForum2014-04.pdf.

justice system and to effectively navigate bureaucratic inequitable systems (foster care, juvenile justice, public benefits, health care and education) to ensure that youth successfully exit these systems. Significant emphasis was placed on supporting youth to graduate from high school and concurrently enroll in community college courses. African American culture and history were taught to African American youth to strengthen protective factors and resiliency as a strategy to fortify them for their current and future navigation of oppressive systems undergirding by institutional racism. Over the last decade, much has been written regarding the intersection between the African American high school dropout rate and the incarceration of African American men.

A 2010 Pew report "Collateral Costs: Incarceration's Effect on Economic Mobility," found that 37 black maledropouts between the ages of 20 and 34 were incarcerated, which is 3x the rate of their white counterparts. The authors state, *"Young black men without a high school diploma are more likely to be found in a cell than in the workplace."*[34] Therefore, the LSJ Life Coaching Project was designed to disrupt the School to Prison Pipeline and its long-lasting mental health implications for African Americans by prioritizing resources within the model to support high school graduation and the potential for economic mobility. For example, successfully graduating from high school prevents future trauma associated with dropping out of high school. Further, the average annual salary for jobs requiring a high school diploma in Oakland, as of August 8, 2021, was $48,828,[35] providing high school graduates with entry level economic opportunity and the possibility of continuing to higher education, with California providing free tuition for community college.

Incorporation of Indigenous Knowledge in CDEP

Incorporation of indigenous knowledge (local, cultural, or LGBTQ) in the CDEP implementation undergirded the program model and wasindispensable to the CDEP. Specific core elements of indigenous knowledge were aligned with each component of the CDEP model.

LSJ Life Coaching Project includes the following components.

1. Outreach and Coordination. Two levels of activities including: 1) Public Systems Level- met one on one with program managers and agency heads to ensure buy-in at the highest systems levels, and on-going referrals across systems; help inform policies and collaborate on delivery of services. 2) School Community Level - meet with principals and teachers at target sites to help identify and refer participants, inform them regarding program deliverables and integrate and coordinate services; as well as disseminate outreach materials and meet with families of referred youth to ensure they are informed and encouraged to participate.
   Duration: Outreach and Coordination occurred on a continuous basis throughout each year. It entailed working with public systems partners, as well as target school communities and other community-basedorganizations to support referrals, recruitment coordination, and integration of services at target schools.
2. Enrollment – Life Coaches (LCs) consistently reviewed and followed up with referrals

[34]The Pew Charitable Trust, "Collateral Costs: Incarceration's Effect on Economic Mobility."
[35] Zip Recruiter, "High School Diploma Salary," Zip Recruiter, Accessed October 25, 2021, https://www.ziprecruiter.com/Salaries/High-School-Diploma-Salary.

from schools, community-based and systems partners (social services, education probation), and families. Activities included inputting participant information into data base; analyzing profiles; collecting school data, available Juvenile Justice data, health data, social services, and family information; conducting one on one interviews/meetings with participants (including identifying intersectional identities and issues); and assigning participants to Life Coaches after enrollment activities were completed via consultation within theteam to determine the best fit.
Duration: At least 1.5 hours per participant. This activity may have taken place over multiple sessions. Attention was paid to screening for trauma and related symptoms. Duration was ongoing: occurring at the beginning of participant program enrollment and continuing on a rolling basis continuously throughout the project year, followed sequentially with the outreach and coordination component.'

3. Life Coaching Case Management - Activities were designed to provide youth with the skills required to navigate the multiple systems in which they encountered (e.g. schools, Juvenile Justice, Law Enforcement, Public Benefits, Health care), in a way that empowered them. Activities included coaching, modeling for, andmentoring youth; accompaniment to public system appointments; direct assistance with securing gateway documents (e.g., driver licenses birth certificates, work permits) that gave or prevented the young person's agency when they were interacting with public systems; and assistance to reconnect with family, treating them like "family," and conducting one on one sessions with them. More traditional case management activities included brokering services and increasing the likelihood that services would be accessed by providing advocacy with providers and supporting participants in utilizing services.
Duration: Life Coaching sequentially followed the Enrollment component and usually occurred up to a12-month period. A few high need students remained in the program longer than 12 months due to COVID-19 exacerbation of need.

4. Life Skills "Know Your Rights" and Ethnic Studies. Included education about African American/EthnicStudies to increase protective factors to counter the toxic stress produced by the inherent inequities in the education and juvenile justice systems and to decrease recidivism and the likelihood of future incarceration. Participants learned about their history, culture, and rights in terms of juvenile justice, education, public benefits/social services and law enforcement. Activities included: Life Coaches implement classes, group workshops, and individual coaching to program participants.
Duration: This component was implemented concurrently with Life Coaching and the Family Engagement/coaching components. Know Your Rights/Ethnic Studies was a significant component thathelped participants think critically about the social, historical and political context of their lives, and provided participants with an understanding of their individual rights while teaching them strategies tonavigate public systems, particularly the juvenile justice system, to minimize obstruction of rights on participants. It was intrinsically connected to Life Coaching, which sought to increase individual coping strategies, pro social skills, and family and community cohesiveness.

5. Family Engagement/Coaching. Activities included 1) Providing families with resources to meet basic needs,such as food and clothing through the allocation of provisions available

at the Family Resource Centers, and/or referring them to available free or low-cost academic, legal and mental health services. 2) Conducting Parent/Family seminars that educated parents and foster parents on how to navigate the school system, juvenile justice system, and social services/child welfare. 3) Providing individual follow up to families and family coaching to encourage and help stabilize the family unit.

***Duration*:** The component was integrated into the Life Coaching component and was provided as needed and tailoredto the needs of the family.

Staffing for the SP LSJ Life Coaching Project was designed to be representative of the youth population served. The Project Director was a woman of color who grew up in one of the Oakland zip codes served by the project. The Project Manager and Life Coaches were African American and Latinx and were from Oakland or communities with similar demographics. The team was designed to be multidisciplinary, with three members of the team possessing degrees in Law, Ethnic Studies, and Social Welfare. Two members of the team were Bachelor level staff, with one graduate from a Historically Black College. The newest member of the team was a former program participant who was attending community college. The team expanded to seven members for the 2020-21 program year with two women of color and five males. During the CDEP implementation period, the project staff was augmented with additional Life Coaches with 100% staff retention. The local evaluation was initiated by two Principal Investigators, one African American Women, Dr. Quinta Seward, and one Latina, Dr. Nina Moreno. Dr. Steward retired towards the end of the first year of the CRDP, so the evaluation was continued by Dr. Moreno.

CDEP Delivery and Expected Dosage

The LSJ Life Coaching Project was designed to be delivered over a 12-month program year, inclusive of the 10-month standard school year and through the summer. Three cycles of the CDEP were implemented during the local evaluation period. The program was delivered in the target communities within Oakland, California, as intended. Program delivery was intended to consist of primarily in-person direct services. Delivery of services proceeded in this manner until March 2020, when our jurisdiction was placed under Alameda County and State of California mandated shelter in place public health orders. Effective March 2020, the LSJ Life Coaching Project migrated to a hybrid model of majority virtual services, with limited in-person direct services to the young adults and families served. Beginning in June 2021, SP increased in-person direct services during the summer portion of programming. This was the first-time youth participants were brought together with staff since March 2020 due to the pandemic. June 30, 2021, marked the end of data collection for the project.

Expected dosage for participants is 6-12 months depending on the specific elements of the program accessed by participants. Dosage was extended to 18 months given the challenges created by COVID-19 and the tremendous need for support given the socio-economic impacts resulting from the pandemic.

CDEP Demographics

The CDEP intended population was high risk African American youth, ages 16-21. The population served included 69 African American youth, ages 16-21, who were systems involved, adjudicated, or at risk of becoming systems involved. For the purposes of the CDEP, systems referred to the juvenile justice system, child welfare system, and the education system. Participants identify as African American but include mix race individuals that include Afro-Latinos and African American-

Asian youth. Historically, most participants were born, and their educational experience has been centered in the United States. All African American participants spoke English. Youth participants identified as male, female, and a variety of other gender identities as discussed in subsequent sections of the report. Sexual orientation of participants included heterosexual and LGBTQ+ orientations. Youth participants came from low-income families and resided in the desired target communities that historically experience higher rates of poverty, unemployment, homelessness, violence, incarceration, school dropouts, health disparities, including morbidity, and low levels of educational attainment, sustainable wage job opportunities, and home ownership.

CDEP Attrition

CDEP participant attrition was 0%.

Outreach and Coordination

1. Working across public systems to solicit buy-in, referrals, coordination of services across systems, and tohelp remove systemic barriers experienced by target youth. SP has a 26-year track record of working with Alameda County public systems, including Social Services, Health Care Services, Probation, the Oakland Police Department, and Oakland Unified School District. This also included brokering relationships at the school community level, in which SP has more than 10 years of established relationships.

2. Implementing African American culturally responsive strategies to directly engage the target population inkeeping with African American values and principles as outlined in the OnTrack's CRDP Evaluation Guidelines for African American pilot projects (updated March 2017), including the value of collective/individual identity and the collective/inclusive nature of family structure; the value of interpersonal relationships, and several of the seven principles attributed to the Black Leadership Initiativeincluded in Ontrack's guideline and listed here: "We are Family; It Takes a Village, Come As you are, and We shall overcome."

3. Life Coaches looked like and shared similar experiences as the target community and approached community members and target youth and their families in respectful, familial, and nonthreatening ways. Life Coaches met familieswhere they were, in their homes and in their communities, as an alternative to sterile meeting locations, to establish interpersonal rapport and promote collective problem solving ("It takes a Village").

4. Community Outreach included engaging the community in identifying gallery space to exhibit youth artwork and public/private wall space for mural production that represented the African American experience, culture, andhistory. Artwork also communicated social justice and intersectionality.

Enrollment

1. Building trust between the Life Coaches and participants and treating each other as family align with African American values for interpersonal relationships and are culturally responsive strategies thatmust be employed to encourage participants to open up, "Come

as you are," and to not feel judged.

2. It helped that SP was well known to the target school communities as providing effective and culturally responsive programs and services and by having longstanding relationships with the schools, youth, and families. Life Coaches had been working with youth in Oakland for the past 8 to 10 years in multiple capacities as after school staff, instructors, and/or former AmeriCorps Members. Participants trusted them and often referred to them as fictive kin (Sis, Bro, "Unc" Auntie).

3. The LSJ Life Coaching Project sought to enroll and retain at risk African American youth into the program. The Project recognized that these youth are not lone entities but come out of community and family contexts including Foster Care and/or group homes. Therefore, the project engaged public partners, as wellas individual families, to connect the whole family to resources to help reduce toxic stress on families resulting from the inability to meet their basic needs (food, housing, employment, and health care access).

Life Coaching Case Management

The core element of this component was rooted in an understanding of the historical and contextual realities of the African American experience and the impact of long-term systemic bias across multiple domains, inclusive of, but not limited to, Education, Employment, Housing, Health, Social Services, Adult and Juvenile Justice, and Law Enforcement. Life Coaching was grounded in cultural socialization to increase participants' consciousness about the historical legacies of hegemonic forces and its impact on their lives, as well as expose them to the rich heritage of African American resistance. Life Coaches shared strategies of survival and modeled and demonstrated effective strategies to engage and navigate the multiple public systems that continued to shape the life choices of participants in a way that promoted individual and community agency.

Four key assumptions guided this work:

1) The target population is at risk or experiencing associated symptoms associated with trauma and mental health illness resulting from their experiences growing up in poverty, exposure to racism, disenfranchisement in the public education system, and/or being subjected to the Juvenile Justice system.

2) The target population will be more responsive to a Life Coaching model, which is asset-driven and empowerment-focused, rather than deficit or pathology-focused.

3) A strategy that provides effective trauma-informed coaching, helps to create safety around accessing mental health services, and empowers young people to have greater academic, career, personal, and relationship successwill substantially reduce stress levels.

4) Reduced stress levels and increased support will mitigate participants' risk of symptoms associated with traumaand mental illness.
The Life Coaching component utilized a trauma informed practice that was aligned with the Mental Health Services Act (MHSA) Direct programing categories; 1) Early Intervention toward

achieving short term and long term outcomes for mental health recovery and reduction of symptoms (anxiety, trauma, crisis; depression, emotional dysregulation difficulties, disruptive behaviors disorders, severe behaviors/conduct disorder, parenting and family difficulties, as well as reduced suicide, prolonged suffering, incarceration, homelessness, school drop-out, and home removal, and unemployment). 2) Prevention Program aimed towards reducing individual/family or community risk factors or stressors and building protective factors and skills and increasing support; promoting positive cognitive, social and emotional development and encouraging a state of well-being.

Life Skills "Know Your Rights" and Ethnic Studies

This component was closely related to Life Coaching, as described above, and was implemented through approaches that honored the legacy of resistance prevalent in the African American experience and aligned with cultural values. For example, after the murder of George Floyd, guest speakers were invited to the classes to discuss how African American history relates to current state-sanctioned violence against African Americans.

This component encompassed direct MHSA programming with a focus on Prevention – reducing individual/family risk factors or stressors and building protective factors and skills to reduce the onset, or experience of mental illness and underscored the intent behind the title of "We Ain't crazy, Just Dealing with a Crazy System," Pathway into the Black Population Eliminating Mental Health Disparities Report.[36]

Family Engagement and Coaching

This component was closely related to Life Coaching, as described above, and encompassed African American cultural principles and values, such as collective/individual identity and the collective/inclusive nature of family structure, as well as It Takes a Village, Health, Wholeness and Healing, Go Tell it on the Mountain, and We ShallOvercome (for more discussion of these principles, see the California Reducing Disparities Project, Evaluation Guidelines for African American Pilot Projects, prepared by ONTrack (updated March 2017)).

Our core belief was that families cannot engage in services unless basic needs were met. For example, families cannot engage in school events if housing and food are not secured. Food is central to family stability.

This component also encompassed Direct MHSA Direct programming, including Early Intervention and Prevention strategies to reduce MHSA negative outcomes among people with greater than average risk of mentalillness, by linking families to basic provisions (such as food, clothing) and by educating them about the school system and the availability of free or low-cost academic and mental health services.

[36] Diane V. Woods, et al. "'We Ain't Crazy! Just Coping with a Crazy System:' Pathways into the Black Population for Eliminating Mental Health Disparities," Little Hoover Commission, May 2012, https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/225/ReportsSubmitted/CRDPAfricanAmericanPopulationReport.pdf.

Relevant or Significant Changes to CDEP Components

As previously mentioned, the impact of COVID-19 on the CDEP, the community served, and SP as an organization cannot be overstated. The pandemic exponentially amplified the health, education, and economic disparities experienced by the target population and communities. SP stretched its infrastructure to provide critical basic services to meet the urgent needs of the larger community. For example, between March 2020 and March 2021, SP directly distributed over 750,000 pounds of food to families. In addition, the organization migrated all services, which were historically delivered in person, to virtual or hybrid models.

The LSJ Coaching Project transitioned from 100% in person programming to a virtual hybrid model. The Program Manger and Life Coaches migrated services to a broad range of virtual platforms, including, but not limited to, phone, text, Google Classroom, Zoom, Canvas, and DocuSign. While the project components continued, the modality of the service delivery was radically different and required Life Coaches to ensure that participants had access to sufficient technology at home to support the numerous platforms used by public systems and the LSJ Life Coaching Project.

CRDP Cross Population Sustainability Steering Committee (CPSSC)

At the beginning of CRDP Phase II, SP identified the need to sustain CRDP beyond April 2022, which is when Phase II was slated to end. Based on previous experience, the SP CDEP was developed with a diverse blended funding model. As a result, SP was asked by it's the CRDP African American Grants Manager to present its unique CDEP funding model to the larger CRDP community at the CRDP annual convening held in October 2018.

During that presentation given by Josefina

Alvarado Mena, SP CEO, she offered the suggestion of creating a collaboration among the five CRDP Phase II population groups focused on future sustainability. IPPs attending the presentation expressed interest and the idea of the CRDP CPSSC was born. In March of 2019, SP launched the CRDP CPSSC, with representation from every IPP hub and all Technical Assistance Providers (TAPs). During the Second Annual CRDP convening held in October 2019, SP presented on and received 100% IPP affirmation on the following CRDP sustainability strategies:

1. Request for additional CRDP investment from the state set aside of the Mental Health Services Act or other funding sources to extend the CRDP to support an additional 3-5 years of adequate funding for 35 IPPs serving the existing 5 underserved populations to provide the following categories of services: Direct Services, Outreach and Education, Data Collection and Local Evaluation, Dissemination of lessons learned through multimedia strategies at the state and national level to impact the national discourse on ending mental health disparities.

2. Request state funding to engage the local counties in a planning phase for CRDP Phase III that will expand the CRDP to support taking the CDEPs to scale by leveraging MHSA funds at all levels.

These initial strategies drove the work of the CRDP CPSSC from October 2019 and July 2021. The results of this modification to the CDEP workplan are discussed in the Results Section of this Report.

Section 5. Local Evaluation Questions

This evaluation aimed to measure decreases in participant mental illness, or the severity of symptoms associated with trauma or mental illness, school failure and drop out, and incarceration/ recidivism via increases/improvements in: coping skills, self-regulation, relationships with caring adults, access to services, employment, and family engagement. Its questions and accompanying indicators and instruments/data sources included:

Evaluation Question #1: To what extent were outreach and coordination efforts effective in enrolling participantsin life coaching and life skills components? (Process)
Indicators: number of public system contacts, number of participants enrolled, number of referrals by public system.
Instruments/Data Sources: staff records, completed enrollment documents.

Evaluation Question #2: What are the characteristics of participants enrolled in SP? (Process)
Indicators: demographic characteristics, including ethnicity, cultural identity, class, gender, national origin, LGBTQQ+ affiliation, and neighborhood affiliation, among others.
Instruments/Data Sources: staff records, completed enrollment forms

Evaluation Question #3: To what extent was there a decrease in mental illness, or the severity of mental illnesssymptoms, among SP participants? (Outcome)
Indicators: number of mental illness symptoms.
Instruments/Data Sources: SP CDEP pre/post matched survey; staff records; and interviews, focus groups, and observations, as needed.

Evaluation Question #4: To what extent was there a decrease in school failure and drop out among SPparticipants? (Outcome)
Indicators: number of classes failed, number of grade repetitions, number of participants who discontinued attending school.
Instruments/Data Sources: school records (high school transcripts), staff records.

Evaluation Question #5: To what extent was there a decrease in incarceration/recidivism among SP participants? (Outcome)
Indicators: number of contacts with the juvenile/criminal justice systems.
Instruments/Data Sources: court documents/records, staff records.

Evaluation Question #6: To what extent was there an increase in coping skills, self-regulation skills, and relationshipswith caring adults among SP participants? (Outcome)
Indicators: number of coping skills, number of self-regulation skills, and number of relationships with caring adults.
Instruments/Data Sources: The Youth Development and Leadership Survey- post-test only; staff records; interviews, focus groups, and observations, as needed.

Evaluation Question #7: To what extent was there an increase in employment and family engagement among SP participants? (Outcome)
Indicators: number of attained jobs, number of family contacts.

Instruments/Data Sources: pay stubs; staff records; interviews, focus groups, and observations, as needed.

As a result of an infusion of additional funding to support the SP' Law and Social Justice Life SkillsCoaching, in March 2020, aforementioned evaluation questions 4 through 6 were expanded as follows:

Evaluation Question #4: To what extent was there grade advancement/ high school graduation/GED/high school equivalency certificate (CHSPES) attainment among SP participants? Towhat extent was there dual/concurrent enrollment in the Peralta College System among SP participants?
Indicators: number of students promoted, number of students graduated, number of students who attained GED/high school equivalency certificate (CHSPES).
Instruments/Data Sources: school records- including report cards, high school transcripts,high school diploma, GED/high school equivalency certificate (CHSPE); high school schedules; staff records.

Evaluation Question #5: To what extent were there no incidences of system involvement 6-, 9-, and 12-months post program completion among SP participants?
Indicators: number of contacts with the juvenile/criminal justice systems.
Instruments/Data Sources: court documents/records, staff records.

Evaluation Question #6: To what extent was there an increase in prosocial/resiliency/hope/ protective factors/life skills as well as an increase in coping skills, self-regulation, and relationships with caring adults among SP participants? (Outcome)
Indicators: number of prosocial/resiliency/hope/protective factors/life skills, number of coping skills, number of self-regulation skills, and number of relationships with caring adults.
Instruments/Data Sources: SP CDEP pre/post matched survey; the Youth Development and Leadership Surv

Section 6. Evaluation Design & Methods

a. Design

This evaluation employed a mixed-methods, quantitative, and qualitative design, as well as community basedparticipatory research and intersectional approaches to this evaluation's design and implementation.

Its quantitative component entailed a quasi-experimental, pre- and post design. Thequantitative design also entailed the use of IBM SPSS Statistics, an interactive, statistical analysis software, used for purposes oflooking at the relationship between a variety of aspects of the survey data.

The qualitative design was primarily steeped in the theoretical traditions of ethnography, phenomenology, and case studies (Patton, 2015) as they aimed to (1.) describe the ways of life of people (ethnography), (2.) describe thelived experiences of people and allow for themes of most salience to them to emerge through discourse (phenomenology), and (3.) study people, groups, neighborhoods, programs, organizations, cultures, regions, nation-states, etc. as a unit of analysis (case study). SP' Evaluation Team conducted a range of qualitative approaches, including direct observation, focus groups, and interviews, to provide a more comprehensive story of quantitative data with respect to the intended outcomes of the five program components and to understand the personal experiences of the participants as they accessed and received services, and as they reflected onthe services they received. Questions were designed to understand the effectiveness of the model, such as identifying ways in which the strategies employed made a difference in their lives, the ways in which the model was culturally responsive to them, and ways in which the model helped give them the tools to navigate the multiple systems in which they encountered. Qualitative data analysis consisted of transcribing, coding, and analyzing all qualitative research responses, with an eye towards understanding the participants' progress and challenges and how to further refine SP' CDEP. Survey administration, interviews, focus groups, and observations occurred at targeted school sites and/or SP offices.

Community Based Participatory Research Approach

The population served by SP' CDEP assisted in the design and implementation of this evaluation plan by servingon the evaluation planning team, acting as external reviewers for the evaluation design and data collection instruments, assisting with collecting data, and interpreting findings. The assigned local evaluator, Dr. Nina Moreno, Ph.D. in Social Welfare, along with the former local evaluator, Quinta Seward, Ph.D. in Social Anthropology, began the population's design of the evaluation plan via interviews conducted in July, 2017, with the following staff and community stakeholders:

- CEO and Program Director, Josefina Alvarado-Mena, who designed the Project and was raised in Oakland's San Antonio neighborhood that borders East Oakland and the Fruitvale area, and is one of the Project's target communities. She has a BA in Ethnic Studies, a JD in Law from UC Berkeley, and is licensed to practice law in California.
- Jonathan Brumfield, the Urban Arts Manager, who also served as a Life Coach for the project and was raised inand around Oakland. He has a BA in Criminal Justice and MA in

Ethnic Studies from San Francisco State University.

- Lauren Chambers, one of the LSJ Life Coaches, who was raised in East Oakland, and has a BA in BusinessAdministration, from Florida A&M.
- Lucias Potter, a former recipient of SP services, who currently works as an After School instructor,attends a local community college and served as a Summer Associate VISTA member in the project during the 2016 and 2017 summers. He was also raised in East Oakland.
- Kasem Green, a Loyola Marymount student, approaching his senior, year, who was raised in Watsonville, California(a largely migrant agricultural area in Northern California). His major is History.

Interview questions and the subsequent synthesis were guided by the California Reducing Disparities Project(CRDP) State-Wide Evaluators guidelines for completing the Cube exercise, as well as principles, values, andguidelines for conducting Community Based Participatory Research in the African American Community, included in the California Reducing Disparities Project for African American Pilot Projects (updated March, 2017), prepared by OnTrack, Technical Assistance Provider for African American Implementation Pilot Projects (IPPs).

Intersectional Approach

During program enrollment, youth had an opportunity to identify the multiple ways they defined themselves, including gender, ethnicity, cultural identity, class, national origin, LGBTQQ+ affiliation, and neighborhood affiliation. As discussed in the enrollment period, Life Coaches recorded this data. The SP Evaluation Team collected and reviewed data retrieved by Life Coaches to capture the ways youth identified and claimed intersectional identities.Using the community based participatory research frame, the evaluation design incorporated surveys, interviews, focus groups, and observations with/of youth, family, community members, and program staff, inclusive of questions to track the ways the program served youth with intersectional identities and how services were perceivedby participants, family and community members. The SP Evaluation Team presented preliminary findings to program staff during program meetings (at least quarterly), to encourage a participatory feedback process that continuously examined and adjusted program strategies to ensure that programming attracted the range of ways African American youth identified, as well as to explore ways to fill gaps in services, if they existed.

b Sampling Methods and Size

SP was interested in evaluating the impact of its CDEP (see components above) on individuals participating in its Law and Social Justice Life Skills Coaching program (purposive sample). While the program had been in existence since 2013, individuals participating in the program between 2018 and 2021 who were willing topartake in the evaluation (convenient sampling) were the focus. This time period encompassed three cycles, each lasting 12 months, with the first cycle beginning in July 2018 and ended June 2019. Lastly, SP was always interested in including individuals from program participants' networks who meet program criteria. These individuals were also invited to participate in the evaluation (snowball sampling).

Inclusion/Exclusion Criteria

This evaluation focused on African American Youth ages 16-21 participating in SP' CDEP between 2018 and 2021. Intersectional populations included:

- African American/Black/African-Latinx; African American/Black/African-Asian/Pacific Islander; African American/Black/African-Native American; and African American/Black/African-White;
- junior high, high school, and college;
- male and female-identified as well as gender-nonconforming/queer;
- LGBTQQ+;
- urban, suburban, rural, and/or outside of Alameda County;
- homeless because of gentrification, unemployment, seasonal work, etc- living out of cars, doubling up,couch surfing, and transitional housing;
- refugees, green card holders, and undocumented individuals;
- Muslim, Christian, Catholic, Jehovah's Witness, Mormon, Buddhist, Agnostic, and Atheist individuals;
- poor, extremely poor, working class, and middle class;
- autism, epilepsy, asthma, diabetes, ADHD/ADD, learning disabilities, and dyslexia;
- uninsured, underinsured, Medical, and insufficient amount of medical providers; and
- systems involved or at risk of systems involvement (i.e., juvenile/criminal justice and/or foster caresystems);
- unable to vote; and/or
- at risk of deportation.

Participant Recruitment Strategies

The SP Evaluation Team worked with program staff to implement a Community Based Participatory Research (CBPR) approach to solicit and include the involvement of youth and their families along each phase of the evaluation (including the overall design, development of survey instruments, and implementation of focus groups, interviews, and observations toensure linguistic and cultural appropriateness). The SP Program Team had a network of youth to recruit from for this study as a result of the LSJ Life Coaching Project's existence for approximately five years prior to the start of this study and as a result of its focuses on providing participants with the skills required to navigate the multiple systems in which they encountered (e.g. schools, Juvenile Justice, Law Enforcement, Public Benefits, Health care). The SP Program Team reached out to former participants and invited them to participate in all phases of the evaluation. Participants were compensated for their expertise. Further, all SP Program Team staff were from the target population; thus their perspectives informed all phases of this evaluation. Program staff helped identify youth to carry out these tasks including the designing tailoring survey instruments, data collection methods, evaluation findings/interpretation, and methods of dissemination of findings, as well as the convening and recording of focus groups, interviews, and observations. SP provided gift cards and other incentives to solicit and maintain youth and community participation in the evaluation tasks. The SP Team trained youth and community members on basic evaluation methods and the CBPR approach.

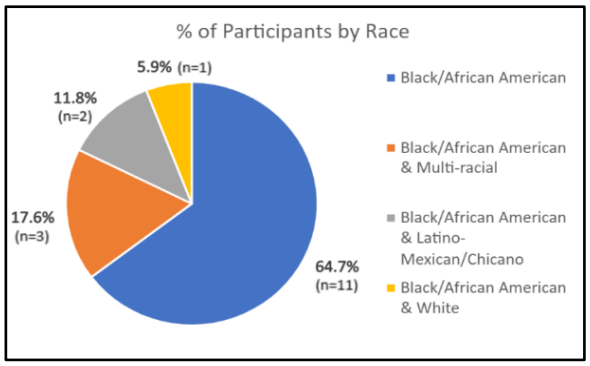
Sampling Size

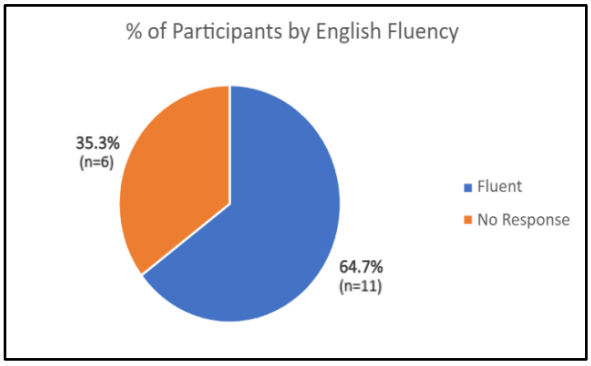
As per the Statewide Evaluation Team's Guidance, the SP Evaluation Team utilized recommended resources to calculate an initial sample size for a quasi-experimental pre-/post-test research design andarrived at the minimum total sample size of 63 participants over the three years, equaling 21 participants per year. This will yield a 5% or less error rate and a power of 80%.

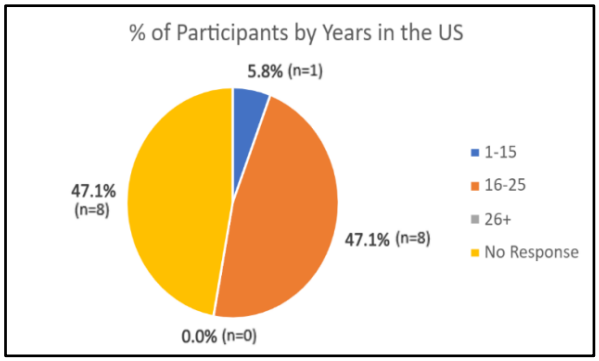
Descriptive Demographic Information of Final Sample

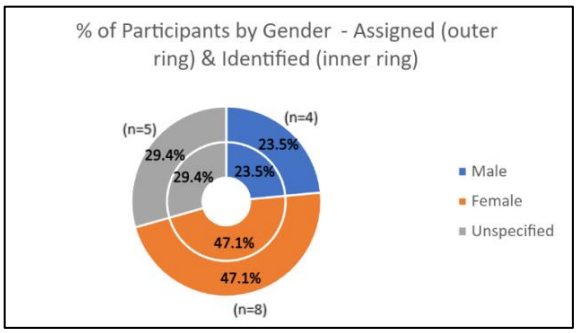
Adult participants (18 years and older) were captured via five demographical composites, including race, language fluency, years lived in the U.S., gender, and sexual orientation. Participants in this study cut across different racial groups. All respondents identified as Black and/or African American. 65% identified as Black/African American, 18% indicated being Black/African American and Multi-racial, 12% identified as Black/African American & Latino-Mexican/Chicano and 6% represents Black/African American and white. Language of communication is broadly English. Whereas 65% indicated fluency in speaking English, 35% abstained from indicating either fluency or partial fluency. About half (47%) of respondents said they have lived in the US for between 16 and 25 years, while an equal proportion (47%) abstained from indicating their time lived time in the US. All male and female respondents showed equal perception about their gender; 24% and 47% as assigned at birth and as preferred gender respectively. In addition, 71% of respondents indicated their sexual orientation as Straight/Heterosexual and 30% as Other/Unidentified. The following table uplifts adult findings.

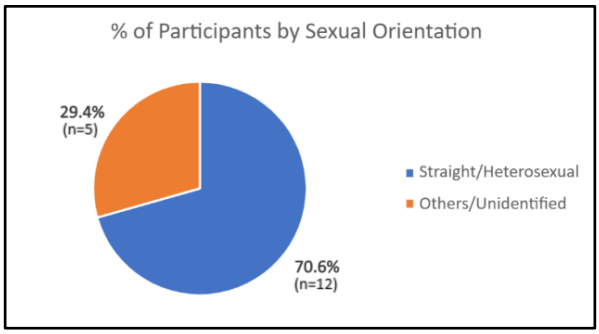
Adult Survey





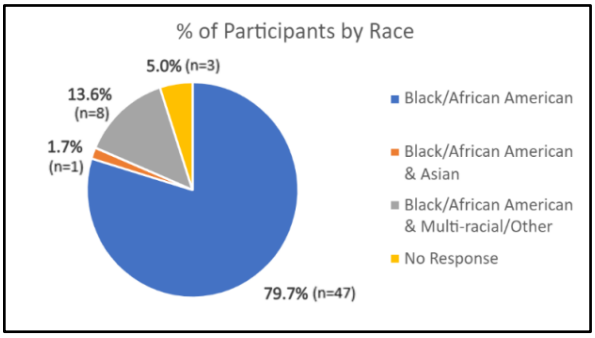


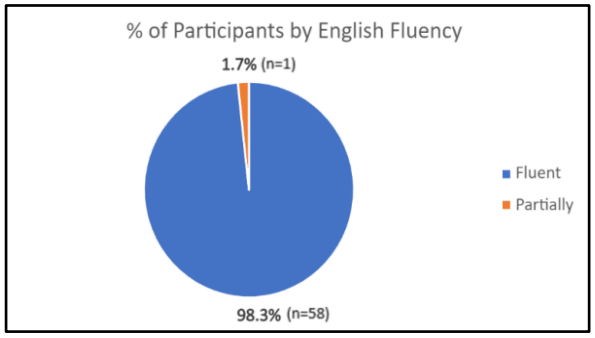


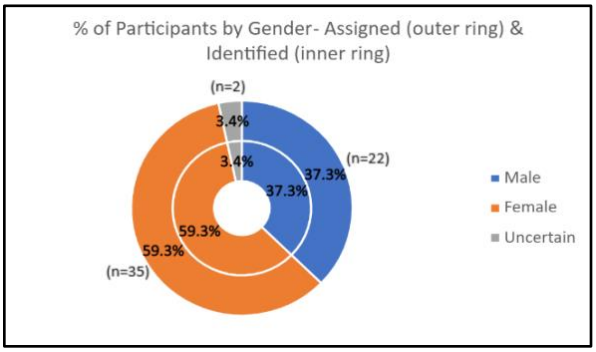


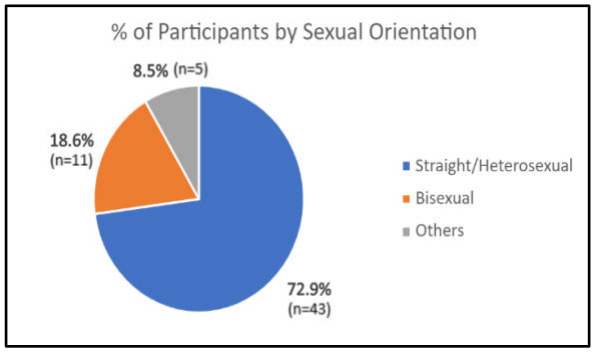
All youth participants identified as Black and/or African American. 80% said they are Black/African American. 2% indicated Black/African American and Asian, 14% identified as Black/African American and Multi-racial/Other, and 5% did not indicate an additional Race/Ethnicity beyond Black/African American. 98% said they speak fluently in the English language; however, 27% did not respond. This could account for respondents who have limited English-speaking fluency. 80% have lived in the US for 15 years and more. 37% and 59% of the respondents are female and male and believe it to be their identities as it was equally assigned at birth. Furthermore, both genders indicated being Straight/Heterosexual are represented by 73%. 19% are bisexual and 8% fall into the "Others" category. The below table punctuates this description.

Youth Survey









Extent to which the evaluation sample is representative of the CDEP participant universe (qualitative orquantitative description)

The evaluation sample mirrored the CDEP participant universe- see above introduction/literature review description of the universe, with rates of average poverty, health disparities, academic proficiency, educational attainment, COVID-19 infection rates, average crime, and arrest, incarceration, and probation rates reflecting that of the CDEP participant universe.

Local Evaluation Attrition

Throughout the duration of this study, 0 participants refused to participate at the onset nor chose to discontinuetheir participation after the study began.

IRB Approval Status

SP received approval; specifically, an exemption from the California Department of Health and HumanServices' (CDHH's) Office of Statewide Health Planning and Development's (OSHPD's) Committee for the Protection of Human Subjects (CPHS) on October 27, 2017. However, SP' local evaluation included the statewide evaluation team's pre and post test surveys; thus, SP had to wait until the statewide evaluation received approval. This occurred on May 15th, 2018. SP' official study began July 1, 2018, and formally ended on June 30, 2021.

As a result of an infusion of funding, SP decided to expand its local evaluation to include the below indicators and instruments/data sources. On March 4, 2020, SP received an approval to add these components.

Indicators:
(1) grade advancement/high school graduation/GED attainment;
(2) no incidences of system involvement 6, 9, and 12 months post program completion;(3.) dual/concurrent enrollment in Peralta College System;
(4) improved coping strategies, increased prosocial/resiliency/hope/protective factors; and(5.) increased life skills.

Instruments/Data Sources:
(1) Report cards, high school transcripts, high school diploma or GED or high school equivalency certificate (CHSPE);
(2) Court documents/reports;
(3) High school schedule; Peralta College System transcript; and
(4) the Youth Development and Leadership Survey- pre and post test.

Lastly, SP' original IRB application (in 2017) covered the electronic obtainment of assents and consents as well as the administration of pre- and post-test surveys. Nonetheless, to formalize this, SP submitted aCOVID modification letter to CDHH's OSHPD's CPHS stating that as a result of the COVID-19 shelter in place orders and subsequent shift to administering our CDEP remotely, we would also obtain assentsand consents as well as the administer of pre and post-test surveys remotely/electronically. On May 28, 2020, they formally approved this modification.

c. Measures and Data Collection Procedures

The following quantitative and qualitative measures were utilized to assess the following outcomes:

Quantitative/Qualitative Measures	
Indicators & Measures	*Outcomes*
Indicators: number of public system contacts, number of participants enrolled, number of referrals by public systems Measures: email, phone, video communication logs, enrollment tracker	Increase in enrollment of participants in life coaching and life skills components as a result of outreach and coordination efforts
Indicators: demographic characteristics, including ethnicity, cultural identity, class, gender, national origin, LGBTQQ+, and neighborhood affiliation, among others Measures: self-identification categories selected by participants on survey and program forms	Participant characteristics
Indicators: number of mental illness symptoms; number of prosocial/resiliency/hope/protective factors/life skills; number of coping skills; number of self-regulation skills; and number of relationships with caring adults Measures: SP CDEP Pre/Post-Test Matched Survey- adolescent (under 18 years of age) and adult (18 and above yearsold) versions; the Youth Development and Leadership Survey- post test only; interviews; focus groups, and observations, as needed; and/or staff records	A decrease in mental illness or the severity of mental illness symptoms among SP participants; an increase in coping skills/strategies, self-regulation,and relationships with caring adults; increased prosocial/resiliency/hope/protective factors; and increased life skills
Indicators: number of participants promoted, number of students graduated, number of students who attained GED/high school equivalency certificate (CHSPES) Measures: school records, staff records- including report cards, high school schedules, high school transcripts, and high school diplomas, GED and high school equivalency certificates (CHSPEs), interviews, focusgroups, and observations, as needed	Grade advancement/high school graduation/GED/CHSPE attainment- i.e., a decrease in school failure and drop
Indicators: number of contacts with the juvenile/criminal justice systems Measures: Court documents/reports	No incidences of systems involvement or further systems involvement at 6-, 9-, and 12-months post program completion- i.e., a decrease in incarceration/ recidivism among SP participants

Quantitative/Qualitative Measures	
Indicators & Measures	*Outcomes*
Indicators: number of participants dually/concurrently enrolled in Peralta College System Measures: High school schedule; Peralta College System transcript	dual/concurrent enrollment in Peralta College System
Indicators: number of attained jobs, number of family contacts Measures: Staff records, pay stubs, interviews, focus groups, andobservations, as needed	an increase in employment and family engagement

The SP Pre/Post-Test Matched Survey (both the adult and adolescent versions) captured psychological distress levels among participants by including the Kessler 6 (K6) measure. This is a 6-item screening instrument that asked respondents how frequently during the past 30 days they had experienced the following symptoms[37]:

- *Feeling nervous* (PREADULT34 and PREYOUTH34);
- *Feeling hopeless* (PREADULT35 and PREYOUTH35);
- *Feeling restless or fidgety* (PREADULT36 and PREYOUTH36);
- *Feeling so depressed that nothing could cheer you up* (PREADULT37 and PREYOUTH37);
- *Feeling that everything was an effort (*PREADULT38 and PREYOUTH38) and
- *Feeling worthless (*PREADULT39 and PREYOUTH39).

The frequency for these symptoms ranged from "none of the time" to "all of the time". The K6 is also included in the California Health Interview Survey (CHIS) and the National Survey on Drug Use and Health (NSDUH). CHIS and NSDUH used similar wording and included the same response options.

To assess the impact of impaired functioning among adult participants, the SP Pre/Post-Test Matched Survey included a set of items that made up the Sheehan Disability Scale (SDS). The SDS is also included in the CHIS and the NSDUH. Adult participants were asked to think about one month within the past 12 months when they were at their worst emotionally, and how often their emotions interfered in the following four domains: (a) performance at work or school (PREADULT41), (b) household chores (PREADULT42), (c) social life (PREADULT43), and (d) relationship with friends and family (PREADULT44). CHIS only asked these questions to respondents that were in severe psychological distress. Adolescent participants were asked about how much their fears and worries messed things up with: (a) school and homework (PREYOUTH41), (b) friends (PREYOUTH42), and (c) at home (PREYOUTH43).

Culturally based protective factors can maintain and improve health among individuals with

[37] California Health Interview Survey 2017 utilizes a 12-month reference period in addition to the 30-day reference period.

mental health disorders.[38] To capture the role of culture in maintaining and improving mental health wellbeing, the SP Pre/Post-Test Matched Survey included the following four items anchored in "present" time:

- *Your culture gives you strength* (PREADULT1 and PREYOUTH1);
- *Your culture is important to you* (PREADULT2 and PREYOUTH2);
- *Your culture helps you to feel good about who you are* (PREADULT3 and PREYOUTH3); and
- *You feel connected to the spiritual/religious traditions of the culture you were raised in* (PREADULT4 and PREYOUTH4).

The SP Pre/Post-Test Matched Survey included another set of four cultural measures, anchored in frequency experienced over the "past 30 days".

Two items are indicative of protective factors:

a) Personal culture acceptance: *Feeling connected to your culture* (PREADULT5 and PREYOUTH5); and
b) Holistic wellness: *Feeling balanced in mind, body, spirit and soul* (PREADULT6 and PREYOUTH6).

Two items are indicative of risk factors: (societal culture acceptance)

a) *Feeling marginalized or excluded from society* (PREADULT7 and PREYOUTH7); and
b) *Feeling isolated and excluded from society* (PREADULT8 and PREYOUTH8).

All pre and post-test surveys (both for adolescents and adults) as well as participant responses per year are included in the Attachments.

Three composites were constructed: Culture, anxiety, and depression. The culture composite consisted of the following measures: At present, your culture gives you strength, your culture is important to you, your culture helps you feel good about who you are, and you feel connected to spiritual/religious traditions of the culture you were raised in. The anxiety composite consisted of two of the K6/psychological distress measures: (1.) During the past 30 days/3-4 months, how often did you feel nervous? and (2.) During the past 30 days/3-4 months, how often did you feel restless or fidgety? The depression composite consisted of 4 of the K6 measures and two additional, marginalization and isolation measures: (1.) About how often during the past 30 days/3-4 months did you feel marginalized or excluded from society? (2.) About how often during the past 30 days/3-4 months did you feel isolated or alienated from society? (3.) During the past 30 days/3-4 months, how often did you feel hopeless? (4.) During the past 30 days/3-4 months, how often did you feel so depressed that nothing could cheer you up? and (5.) During the past 30 days/3-4 months, how often did you feel that everything was an effort? (6.) During the past 30 days/3-4 months, how often did you feel worthless? The inclusion of K6/psychological distress measures in the anxiety and depression composites, as well as the naming of these composites, was driven by what made the most sense for what our program addressed with participants- see above CDEP components descriptions and evaluation questions above. Further, the marginalization and

[38] Onowa McIvor, Art Napoleon, and Kerissa M. Dickie, "Language and Culture as Protective Factors for At-Risk Communities," *International Journal of Indigenous Health,* 5, no 1 (2013): 6-25, doi:10.18357/IJIH51200912327.

isolation measures were included in the depression composite as the literature shows that African American feelings of marginalization and isolation lead to depression.[39]

Participants responded to each of these measures by selecting an item on a 5-point Lickert scale, ranging from Strongly Agree to Strongly Disagree. Each response was coded and scored. An increase in score represented an improvement. Total sums are represented in Tables 1-7. Further, means/averages for pre and post data collection points related to life aspects "messed up" by mental health/emotional struggles as well as a comparison of these means were calculated and are reflected in Table 1.

Data Collection

Consent and assent forms were drafted and presented to the SP CDEP staff and a core group of participants for feedback, including understandability of the language in each form by their intended audiences. Next, forms werefinalized and then presented to an IRB for approval- please see above for the IRB approval timeline.

Consent was obtained from parents or legal guardians of evaluation participants in the treatment group, followed by assent obtainment from evaluation participants.

Parents/legal guardians of evaluation participants who agreed to discuss participation in the evaluation were ontacted to discuss the consent process, purpose of the study, types of questions asked, the option of tape recording the interviews/focus groups/observations, etc., and how the results of the study would be used.

Parent/legal guardian questions were answered. All parents/legal guardians agreed to proceed, and the SP Evaluation Team obtained assent from evaluation participants. The SP Evaluation Team and evaluation participants decided on a mutually convenient time and place to meet for survey administration/interviews/focusgroups/observations. The SP Evaluation Team confirmed at least one day before the survey administration/interviews/focus groups/observations/etc. to make certain the time and place was still convenient and reminded all evaluation participants that they could withdraw from the study at any point if they wished. As previously discussed, no evaluation participant refused to participate at the onset nor chose to discontinue their participation after the study began.

Measures and data collection procedures used, including modifications to existing measures and/or procedures, are centered on indigenous knowledge (local, cultural or LGBTQ-specific knowledge)

African American knowledge, principals, values, beliefs, history, language, and practices/traditions related to ethnic culture, social justice, intersectionality, collectivism, relations, age, CBPR, and LGBTQQ+ inclusion, were incorporated throughout all evaluation activities,

[39] Dorothy Chin, et al. "Racial/ ethnic discrimination: Dimensions and relation to mental health symptoms in a marginalized urban American population," *American Journal of Orthopsychiatry* 90, no.5 (2020): 614-622, doi: 10.1037/ort0000481.

including data collection. Emphasis was placed on African American indigenous knowledge of wholeness, community, harmony, and collective responsibility/ethic were infused at every step of the evaluation process. For example, during the evaluation design and planning phase, the SP Evaluation Team discussed the importance of introducing and framing the SP CDEP survey to community members in an African American intersectional, equity lens- i.e., uplifting the importance of reporting on their health and well-being and what it means for them and their community's legacies. Further, community members assisted in the administration of surveys and in the troubleshooting process when barriers arose. They also assisted in the translation of survey questions into understandable language for participants and used the cultural practice/tradition of cultural response, as needed. Translation and call and response were also utilized when acquiring parent agreement/consensus.

As previously mentioned, modifications were made to measures and/or procedures- please see IRB approvalnarrative above for more details.

Lastly, pretest surveys were administered at the start of SP's CDEP intervention and post tests were administered at the conclusion of SP's CDEP. Surveys were self-administered by the treatment group, with support from program staff, as needed. After surveys were completed, focus groups, interviews, and observations were conducted to complement surveys, as needed, and were convened by the SP Evaluation Team and/or program staff. SP followed all Contractor Data Security Standards outlined in Attachment G1 of the Solicitation entitled 15-10647, California Reducing Disparities Project (CRDP) Phase 2 African American Implementation Pilot Projects.

All completed surveys and focus group/interview/observation notes were stored in a locked cabinet to which only Dr. Moreno had access. Once all survey and focus group/interview/observation were inputted into electronic documents, notes were shredded. All electronic documents were stored on the web-based, encrypted Microsoft One Drive, and all documents were shared via password-protected links that had expiration dates.

Sensitive documents were not shared as attachments to electronic mail messages nor any other shared drives outside of Microsoft One Drive (such as dropbox.com) and were never placed on removable, flash drives. All laptops with sensitive information were confined to SP's Central office and always stored in a locked cabinet.

Each participant was assigned a number that was recorded on paper surveys and interview/focus group/observation notes. A legend of participant name/number was stored on One Drive. All paper files werestored in a locked cabinet.

Ongoing training was conducted with the SP Evaluation and Program Teams. Scripts of protocols related to all aspects of the evaluation were formulated to ensure that the same procedures were followed, from start to finish, with each participant in the treatment group. During training, role plays that addressed the mostcommon errors related to accuracy and reliability were executed and discussed in an effort to avoid errors.

Administrative data used to assess or contextualize outcomes

Internal SP records, as well as CDPH OHE Quarterly Progress Reports and Statewide Evaluation Semi-Annual Reports, were used to assess and contextualize the above discussed outcomes, as reflected in the findings sectionbelow.

d. Fidelity and Flexibility

A formal assessment of the following domains of CDEP implementation fidelity was conducted:

- Adherence;
- Quality of Delivery; and
- Participant Responsiveness.

Criteria, measurement tools, and protocols for each domain was as follows:

Domain	Criteria	Measurement Tool	Protocol
Adherence	(1) All participants willreceive 90% of the components. (2.) Staff will deliver 100% of the components to all participants.	(1) Sign in sheets and (2) staff records.	The SP evaluation teamand/or staff will assess adherence via the measurement tools.
Quality of Delivery	(1) 80% of participantswill report overall satisfaction of the SP CDEP and (2.) will provide a description ofthe SP CDEP that is in alignment with SP's description of it.	(1) Survey assessing (a.) overall satisfaction in program participation and (2) participant description of the SP CDEP.	The SP evaluation teamand/or staff will assess adherence via the measurement tools.
Participant Responsiveness	85% of Know Your Rights (KYR) participantswill report that they gained new knowledge and skills related to knowing their rights.	(1) Participant observation of 2 workshops of KYR.	The SP evaluation teamand/or staff will assess adherence via the measurement tools.

Changes made to the CDEP (or recommended for future implementation) based on fidelity assessment information

All criteria were met for the aforementioned fidelity domains. Successful implementation of all aforementioned CDEP components with all participants, high program satisfaction, and KYR knowledge and skills attainment contributed the successful outcomes outlined below- see Findings. Nonetheless, it is worth noting that as a result ofthe COVID-19 shelter in place orders, CDEP implementation migrated to a virtual context.

Balancing of fidelity & flexibility (e.g., formative evaluation methods, including CBPR, to explore/understand if the CDEP was working and whether changes were needed to strengthenit to meet theneeds of the participants, IPP, community, local/state circumstances, etc.)

During the 2019-2020 year, participants provided feedback and indicated their need for CDEP implementation tomigrate to virtual delivery; SP accommodated this request accordingly.

Further, early focus groups of participants indicated the need to scale up SP's CDEP given the need for it in the largerAfrican American population. Consequently, SP exponentially augmented its sustainability efforts, which led to a significant increase in investment of its CDEP by the Governor's California Community Reinvestment grant, Edna McConnell Clark Foundation's Propel Next grant, and Alameda County's Probation Department's Youth Employment grant. Further, SP led a statewide sustainability effort which led to a four-year, $63.1 million investment in the continuation and Phase III planning via California's FY 2021-205 budget.

e. Data Analysis Plan Implemented

Quantitative statistical analyses (e.g., inferential tests, effect-sizes, comparisons tested)

Quantitative data was analyzed using SPSS. Specifically, composite variables were constructed and a comparison of means between the pre and post data collection points on disruption of life aspects, as well asstatistical analysis (Chi square and ANOVA), were conducted.

Qualitative analytic strategies (e.g., how data was coded, analyzed, use of inter-rater reliability methods)

As previously discussed, the SP' Evaluation Team conducted a range of qualitative approaches, including direct observations, focus groups, and interviews to provide a more comprehensive story of quantitativedata with respect to the intended outcomes of the five program components and to understand the personal experiences of the participants as they accessed, received services, and reflected on the services they received.

Questions were designed to understand the effectiveness of the model, such as identifying ways in which the strategies employed made a difference in their lives, the ways in which the model was culturally responsive to them, and ways in which the model helped give them the tools to navigate the multiple systems in which they encountered. Qualitative data analysis consisted of transcribing, coding, and analyzing all qualitative research responses, with an eye towards understanding participants' progress and challenges and how to further refine SP'sCDEP. More specifically, aggregated, qualitative analysis was conducted and included: Review and theme identification within each interview/focus group/observation; theme distillation; word frequency analysis; at least two rounds of coding; and reconciliation and final review.

The following Table summarizes evaluation questions as well as analytical techniques used for each:

Evaluation Question	Indicators & Meetings	Type of Analytical Strategy	Types of Test/Analytical Technique
To what extent were outreach and coordination efforts effective in enrolling participants in life coaching and life skills components?	Indicators: number of public system contacts, number of participants enrolled, number of referrals by public systems Measures: email, phone, video communication logs, enrollment tracker	Qualitative	Coding of themes; higher order themes analysis
What are the characteristics of participants enrolled in SP?	Indicators: demographic characteristics, including ethnicity, cultural identity, class, gender, national origin, LGBTQQ+, and neighborhood affiliation, among others Measures: self-identification categories selected by participants on survey and program forms	Quantitative	Total summing of participants' self-identification
To what extent was there a decrease in mental illness or the severity of mental illness symptoms among SP participants? To what extent was there an increase in prosocial/resiliency/hope/protective factors/life skills as well as an increase in coping skills, self-regulation, and relationships with caring adults among SP participants?	Indicators: number of mental illness symptoms; number of prosocial/resiliency/hope/ protective factors/life skills; number of coping skills; number of self-regulation skills; and number of relationships with caring adults Measures: SP CDEP Pre/Post-Test Matched Survey- adolescent (under 18 years of age) and adult (18 and above years old) versions; the	Quantitative	Total summing, means, means comparison, Chi square, and ANOVA

Evaluation Question	Indicators & Meetings	Type of Analytical Strategy	Types of Test/Analytical Technique
	Youth Development and Leadership Survey- post test only; interviews; focus groups, and observations, as needed; and/or staff records		
To what extent was there grade advancement/ high school graduation/GED/high school equivalency certificate (CHSPES) attainment among SP participants? To what extent was there dual/concurrent enrollment in the Peralta College System among SP participants?	Indicators: number of participants promoted, number of students graduated, number of students who attained GED/high school equivalency certificate (CHSPES) Measures: school records, staff records- including report cards, high school schedules, high school transcripts, and high school diplomas, GED and high school equivalency certificates (CHSPEs), interviews, focus groups, and observations, as needed Indicators: number of participants dually/concurrently enrolled in Peralta College System Measures: High school schedule; Peralta College System transcript	Quantitative	Total summing at the start and at the end of CDEP intervention
To what extent were there no incidences of system involvement 6-, 9-, and 12-months post program	Indicators: number of contacts with the juvenile/criminal justice systems	Quantitative	Total summing at the start and at the end of CDEP intervention

Evaluation Question	Indicators & Meetings	Type of Analytical Strategy	Types of Test/Analytical Technique
completion among SP participants?	Measures: Court documents/reports		
To what extent was there an increase in employment and family engagement among SP participants?	Indicators: number of attained jobs, number of family contacts Measures: Staff records, pay stubs, interviews, focus groups, and observations, as needed	Quantitative	Total summing at the start and at the end of CDEP intervention

Data triangulation (various data sources) to increase confidence in conclusions/findings

In an effort to overcome potential bias resulting from the use of a single method/source of data (i.e., SP CDEP Pre/Post-Test Matched Survey), data triangulation was employed in this study. Specifically, the following data sources were also included in this study: staff records, school records- including report cards, high school schedules, high school transcripts, high school diplomas, GED and high school equivalency certificates (CHSPEs), high school schedules, Peralta College System transcripts, court reports/documents, and interview,focus group, and observation notes.

Section 7. Results

To what extent were outreach and coordination efforts effective in enrolling participants in life coaching and life skills components?

SP' outreach and coordination efforts with school and funding (namely, California Department of Pubic Health- CRDP, City of Oakland, Oakland Fund for Children and Youth, City of Oakland, Oakland Unite Initiative, Alameda County Social Services Agency, and California Community Reinvestment Grant Program) partners were highly effective with respect to a multitude of areas, including initial engagement of potential participants, participant enrollment, and the coordination between multiple public systems.

Between May 2017 and April 2021, 69 participants were enrolled and 71 families were reached. Beginning in March 2020, the global pandemic reached Oakland, California resulting in federal, state, and local states of emergency requiring extensive shelter in place public health orders. As of the date of this submission, remnants of public health restrictions remain in place and life has not returned to pre pandemic norms.

During the pandemic a wide variety of COVID relief services were provided to participants and families, including assistance with applying for unemployment benefits, pandemic CalFresh, direct cash assistance, food, personal hygiene, Personal Protective Equipment (PPE), and technology equipment. Educational and support services were provided to participants via remote platforms, including Life Coaching, Know Your Rights/Ethnic Studies, Urban Arts, and family support services. SP also supported in person learning hubs for the most at-risk students. In collaboration with Oakland Unified School District/Peralta Community College System, SP executed 20 dual enrollment, Ethnic Studies classes at several school sites between May 2018 and April 2021. Further, during the Spring 2019 teacher strike, SP successfully navigated this partnership so that students were not dropped from their courses and earned their credits.

Another area in which SP efforts were highly effective included the sustainability of the California Reducing Disparities Project (CRDP).

Between March 2019 and July 2021, SP led the CRDP Cross Population Sustainability Steering Committee to accomplish:

1. Inclusion of $63.1 m in California FY 2021 budget, to support CRDP Phase II extension and Phase III planning. Resulting in the availability of $1.2 million in additional state funding for each of the 35 IPPs and additional contracts for technical assistance, cultural brokerage, and statewide evaluation.
2. Support of this investment by both the California Senate and Assembly as well as 20 statewide, behavioral health associations.
3. Execution of a successful 2-day, legislative briefing as part of the Third Annual CRDP convening.
4. Execution of over 20 IPP leaders providing testimony at all budget hearings of both the California Senate and Assembly.
5. Execution of a 2-day, CRDP Sustainability Summit in October 2020 with attendance of

over 100 participants on both days of the convening.
6. Creation of IPP introduction video representing all 35 IPPs across the 5 population groups for debut at the Sustainability Summit.
7. Collection of 20 IPP Success Stories as well as 2 videos which were used during sustainability advocacy efforts.
8. Creation CRDP communications collateral materials.
9. Became the advisory body to California Pan Ethnic Health Network (CPEHN) in the implementation of the Education, Outreach, and Awareness contract.
10. Development and activation of a rapid response network to respond to items, including, but not limited to, improving MHSA regulations, providing input into Request for Proposals (RFPs) and future legislation, and pushing for sustainability.
11. Organization of two webinars for the larger IPP community on the following topics, held on 08/16 and 09/04: the history and current context of the CRDP, the Mental Health Services Oversight and Accountability Committee (MHSOAC) and the CA budget process, and possible sustainability strategies.

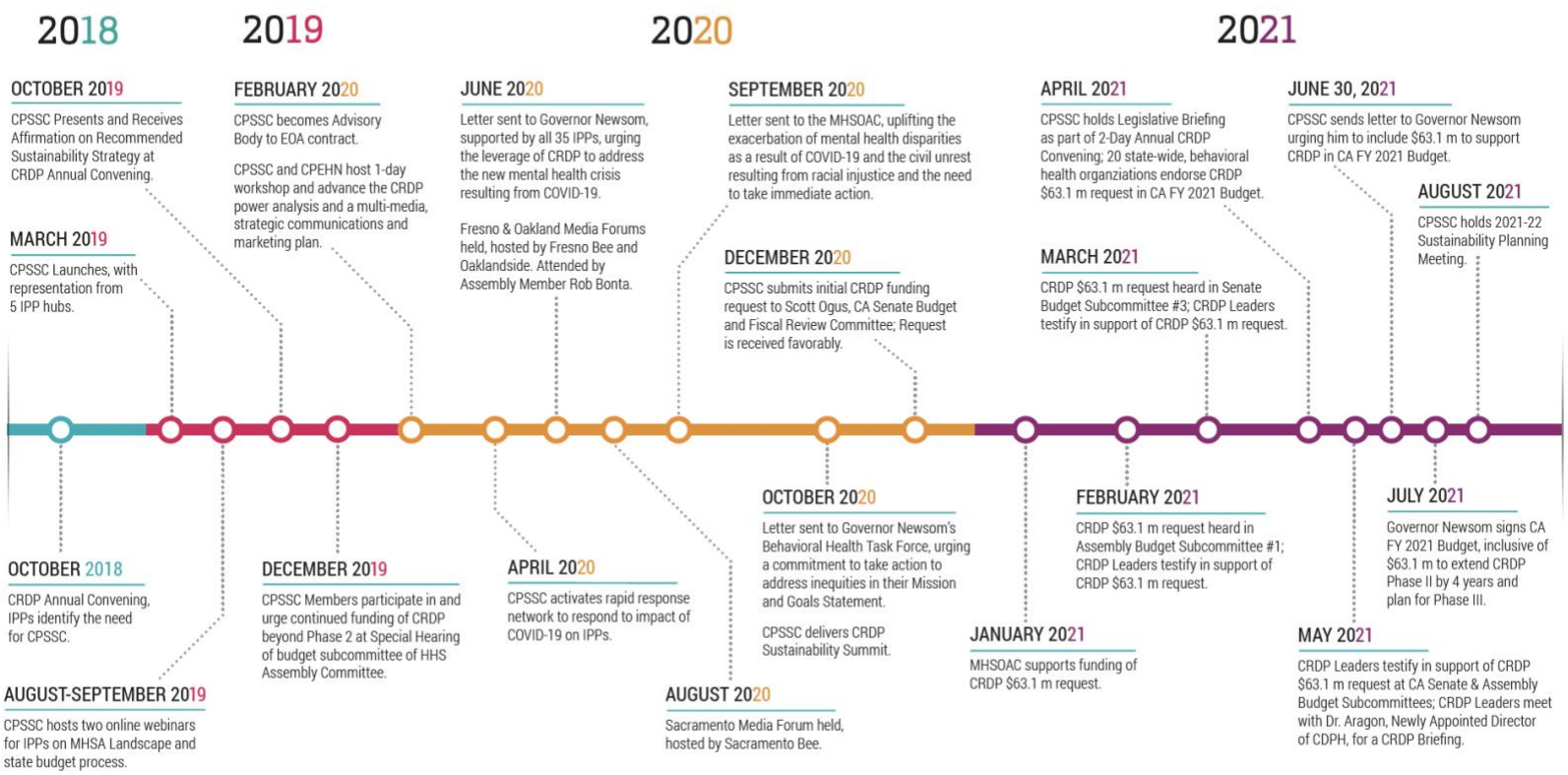
The CPSSC timeline graphically illustrates the activities and impact.

In addition to participant enrollment, family engagement, and CRDP sustainability, SP' partnerships with the City of Oakland, Oakland Unite Initiative, yielded the following additional results: (a.) Successfully completed several years of grant funding. (b.) As a result of participation in a series of town hall meetings to advise the City of Oakland's Department of Violence Prevention's spending plan and continued advocacy, the contracts will move forward for a new 12-month term. (c.) Provided internships and summer jobs to several youth.

For a comprehensive list of SP's outreach and coordination efforts for years 2018-2021, please refer to Attachment 13.

California Reducing Disparities Project
a culturally responsive mental health initiative

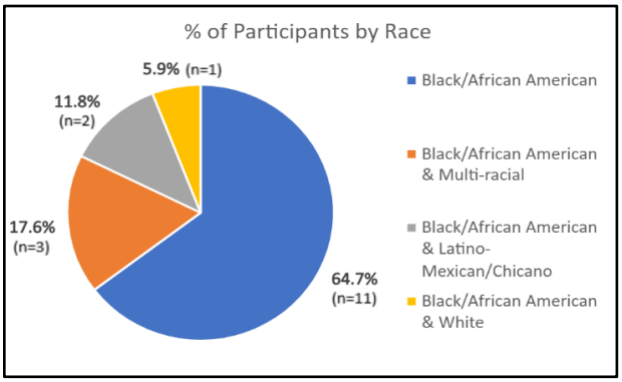
California Reducing Disparities Project, Cross-Population Sustainability Steering Committee Timeline

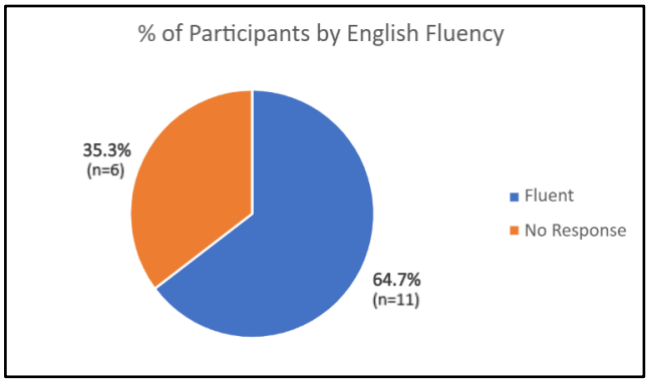


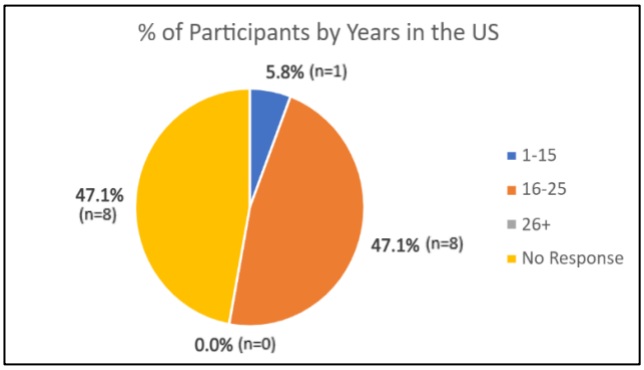
What are the characteristics of participants enrolled in SP? (Process)

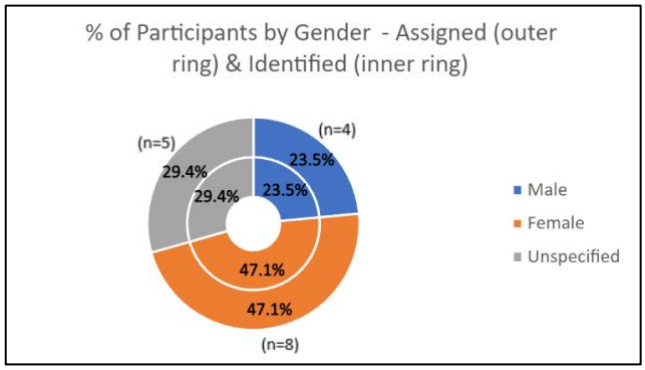
Adult participants (18 years and older) were captured via five demographical composites, including race, language fluency, years lived in the U.S., gender, and sexual orientation. Participants in this study cut across different racial groups. All respondents identified as Black and/or African American. 65% identified as Black/African American, 18% indicated being Black/African American and Multi-racial, 12% identified as Black/African American & Latino-Mexican/Chicano and 6% represents Black/African American and white. Language of communication is broadly English. Whereas 65% indicated fluency in speaking English, 35% abstained from indicating either fluency or partial fluency. About half (47%) of respondents said they have lived in the US for between 16 and 25 years, while an equal proportion (47%) abstained from indicating their time lived time in the US. All male and female respondents showed equal perception about their gender; 24% and 47% as assigned at birth and as preferred gender respectively. In addition, 71% of respondents indicated their sexual orientation as Straight/Heterosexual and 30% as Other/Unidentified.

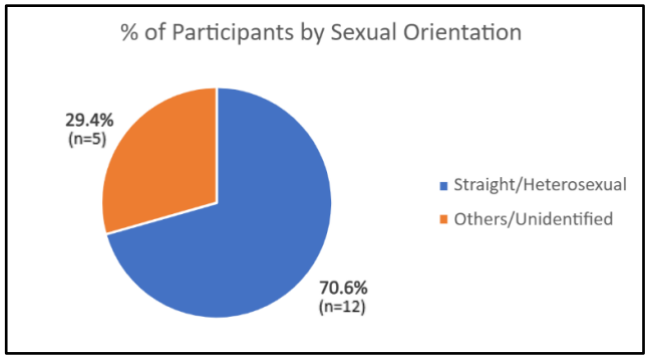
Adults Surveyed





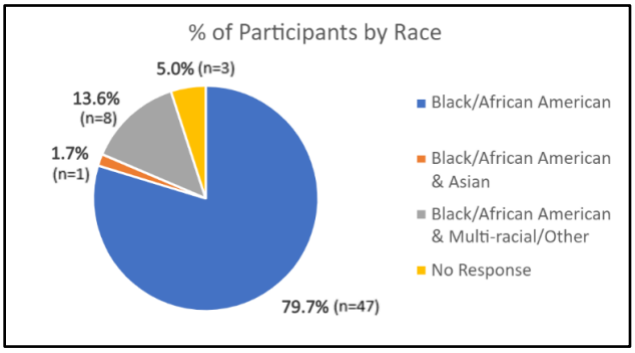


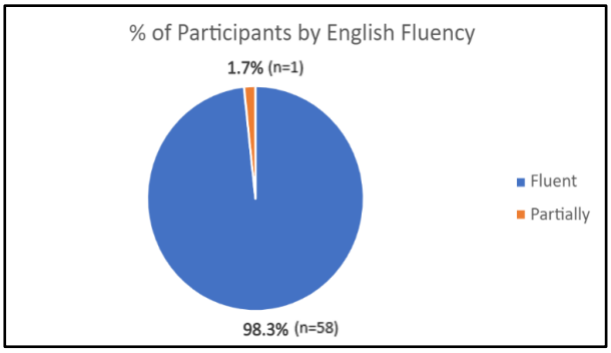


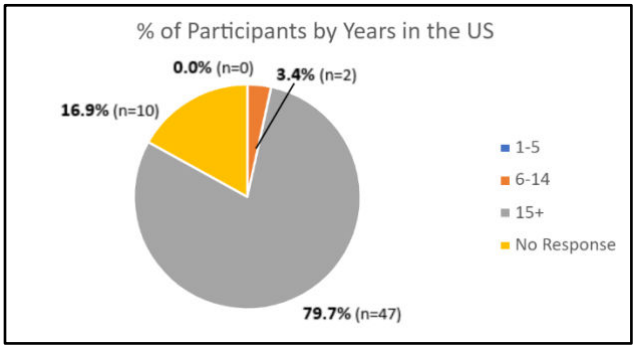


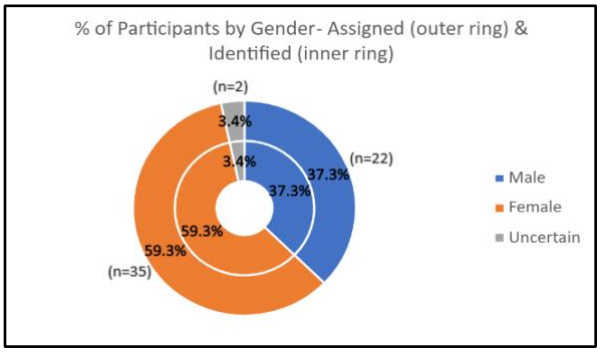
Youth Surveys

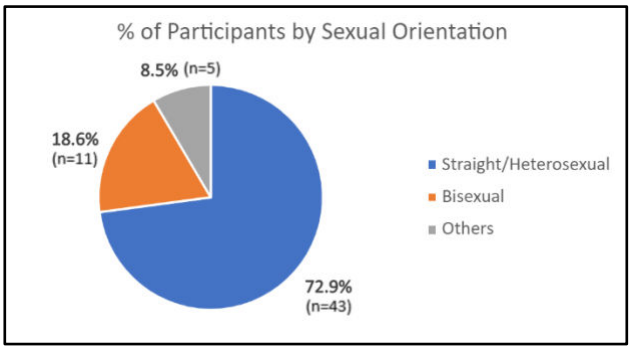
All youth participants identified as Black and/or African American. 80% said they are Black/African American. 2% indicated Black/African American and Asian, 14% identified as Black/African American and Multi-racial/Other, and 5% did not indicate an additional Race/Ethnicity beyond Black/African American. 98% said they speak fluently in the English language; however, 27% did not respond. This could account for respondents who have limited English-speaking fluency. 80% have lived in the US for 15 years and more. 37% and 59% of the respondents are female and male and believe it to be their identities as it was equally assigned at birth. Furthermore, both genders indicated being Straight/Heterosexual are represented by 73%. 19% are bisexual and 8% fall into the "Others" category. The below table punctuates this description.











To what extent was there a decrease in mental illness or the severity of mental illness symptoms among SP participants? To what extent was there an increase in prosocial/resiliency/hope/protective factors/life skills as well as an increase in coping skills, self-regulation, and relationships with caring adults among SP participants? (Outcome)

During the first two years, nearly half of all participants showed improvements between SP CDEP pre and post measurementpoints on the composite variable for Culture, a protective factor that offsets mental illness. In the third year, however, when services were forced to move to virtual spaces by the COVID-19 pandemic, improvements were noted; however, there was a decrease in the percentage of participants who saw improvement on the Culture and Depression composite measures compared to first- and second-year participants. Figure 1 outlines these results.

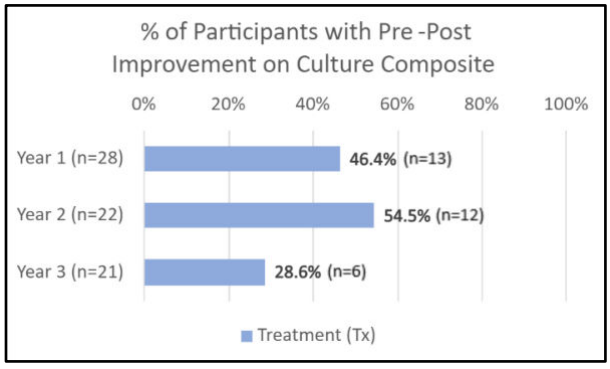


Figure 1. Percentage of Participants Who Experienced Improvement on Culture Composite Variable.

Across all three years, a substantial minority of program participants showed improvements between SP CDEP pre and postmeasurement points on the composite variable for Anxiety. In the third year, 42.9% of treatment group participants demonstrate improvements on this composite. Figure 2 outlines these results.

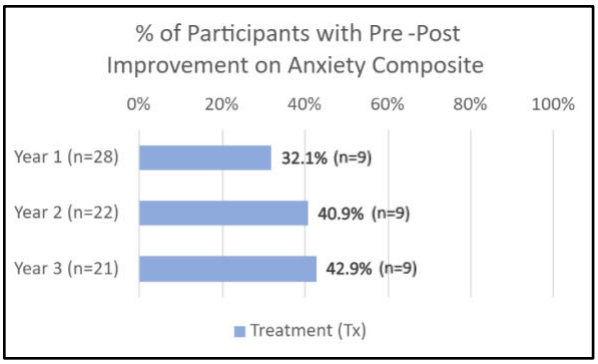


Figure 2. Percentage of Participants Who Experienced Improvement on Anxiety Composite Variable.

During the first two years, nearly half of all participants showed improvements between SP CDEP pre and post measurement points on the composite variable for Depression. In the third year the proportion of treatment group participants who saw improvement on this composite dipped marginally. Figure 3 outlines these results.

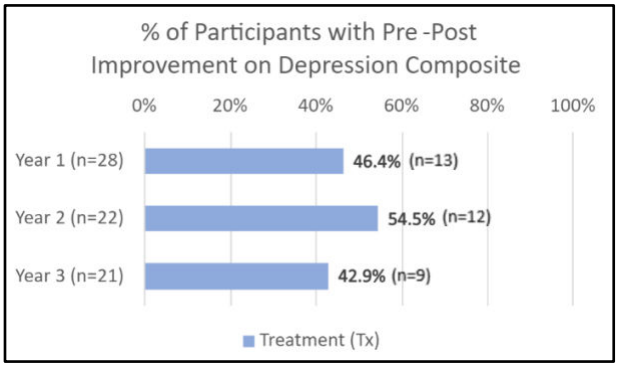


Figure 3. Percentage of Participants Who Experienced Improvement on Depression Composite Variable.

We built a single variable that combined all three of the Culture, Anxiety, and Depression composite variables and considered whether a client experienced improvement on any of the composites between pre and post measurement points - see Figure 4 for results.During the first two years, 85.7% and 81.8% of participants showed improvements on the Any Improvement Composite Variable. In the third year, however, when participants were required to live under the multi-jurisdictional shelter in place orders, attend school virtually, and services were forced to move to virtual spaces by the COVID-19 pandemic, we saw a drop in the percentage of participants who saw improvement to 61.9% on this composite measure. Locally and nationally, youth experienced increases in feelings of depression as a result of the social isolation resulting from COVID-19 public health guidance.

Chi-square analyses were conducted on these differences. Due to the small n values across years, none of these differences produced a p-value signifying statistical significance.

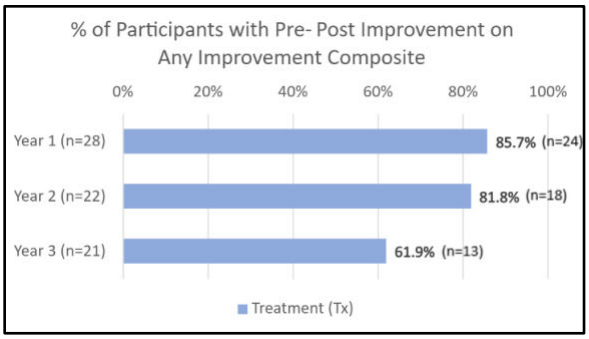
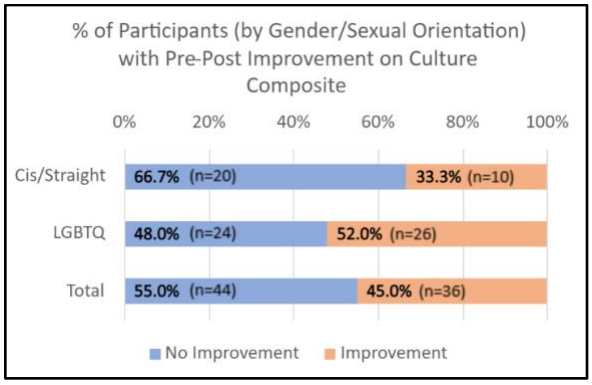


Figure 4. Percentage of Participants Who Experienced Improvement on Any Improvement Composite Variable.

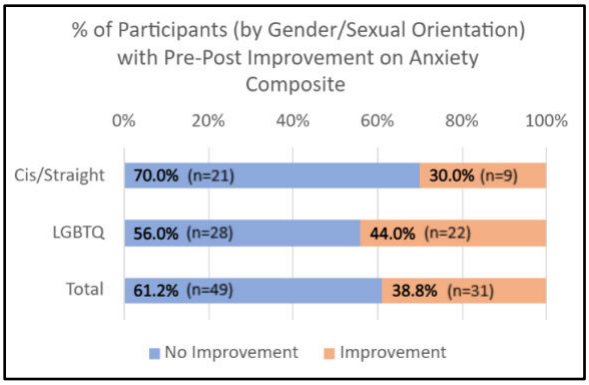
Next, we conducted a comparison of results between Cis/Straight-identified and LGBTQ+ participants on the Culture, Anxiety, and Depression composite variables - see Figures 5, 6, and 7. LGBTQ+ participants were generally more likely to show pre-post improvement than Cis/Straight participants onthe three composite variables.



Chi-square test shows *p-value* to be .081 (approaching significance).

Figure 5. Percentage of Participants Who Experienced Improvement on Culture Composite Variable for Cis/Straight and LGBTQ.

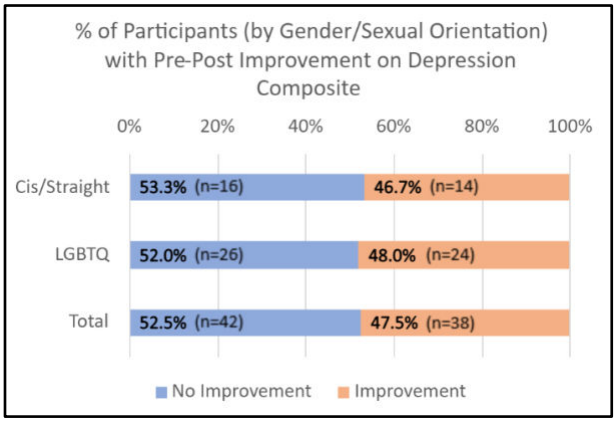
In Figure 5, the results were approaching statistical significance, with a p-value of 0.081 and degrees of freedom at 1. The chi-square value was 2.64.



Chi-square test shows *p-value* to be .157 (not significant).

Figure 6. Percentage of Participants Who Experienced Improvement on Anxiety Composite Variable for Cis/Straight and LGBTQ.

In Figure 6, the results were not statistically significant, with a p-value is 0.157 and degrees of freedom at 1. The chi-square value was 1.548.



Chi-square test shows *p-value* to be .546 (not significant).

Figure 7. Percentage of Participants Who Experienced Improvement on Depression Composite Variable for Cis/Straight and LGBTQ.

In Figure 7, the results were not statistically significant, with a p-value is 0.546 and degrees of freedom at 1. The chi-square value was 0.013.

We also built a composite variable combining the scales that were designed to measure the extent to which respondents' life aspects were disrupted by their fears and worries. These scales included: How much have your fears and worries messed things up with school and homework? How much have your fears and worries messed things up with friends? How much have your fears and worries messed things up at home? On this variable, the higher the score, the more disrupted the respondent's life aspects.

We conducted a comparison of means between the pre and post data collection points. Across all three years, this analysis showed a slight increase in disruption of life aspects between pre and post. In Year 3, however, we saw dramatically lower levels of life disruption, both pre and post. The lower levels of disruption may have been related to the reduced complexity of life, such as the challenges of navigating school systems that came with COVID-19-related changes to work, school, and life in general. Table 1 outlines these results.

Table 1. Percentage of Participants Who Experienced Improvement on Life Aspects "Messed Up" by Mental Health/Emotional Struggles.

	Treatment (Tx)	
	Pre	Post
Year 1 (n=28)	2.39 (SD=2.06)	2.86 (SD=2.26)
Year 2 (n=22)	3.59 (SD=2.22)	3.68 (SD=2.42)
Year 3 (n=21)	1.24 (SD=1.81)	1.57 (SD=2.50)

Analysis of Variance (ANOVA) was conducted on differences in Tables 1-4 and 8. Due to the small n values across years, noneof these differences produced a p-value signifying statistical significance.

The evaluation was designed to include additional data collection from local youth development surveys administered by SP in partnership with the Oakland Fund for Children and Youth. The City of Oakland's Fund for Children and Youth's (OFCY) evaluation process included the administration of the Youth Development and Leadership Survey (YDLS), most of which consisted of questions drawn from validated surveys used in the youth development field. However, the YDLS tool itself was not validated. OFCY administered this survey during the 2018-19 and 2020-21 school year; however, they suspended survey administration for the 2019-20 school year. During the 2019-20 year, OFCY suspended the survey because of the overlapping of the timing of the COVID shelter in place orders and when the survey was scheduled to launch. Simply put, OFCY did not have the capacity to pivot the survey administration to the remote setting in time for its launch. Consequently, there were no findings for this year. 66 youth completed the YDLS during the 2018-19 year and 82 youth completed it in 2020-21. The following Table 2 reflects results:

Table 2. Percentage of Youth who Improved/Increased Protective Factors

Protective Factor	2018-19 Outcomes	2020-21 Outcomes
Greater connections to caring adults	90%	79%
Increased confidence and self-esteem	92%	74%
Improved decision-making and goal setting	94%	82%
Development and mastery of skills	89%	82%
Greater empowerment and agency	93%	Not measured
Increased knowledge of and engagement in community	91%	82%
Increased leadership capacity	91%	73%
Increased risk avoidance/conflict resolution	90%	Not measured
Increased sense of belonging and emotional wellness	Not measured	82%
Increased persistence and resiliency	Not measured	73%

To what extent was there grade advancement/ high school graduation/GED/high school equivalency certificate (CHSPES) attainment? To what extent was there dual/concurrent

enrollment in the Peralta College System? (Outcome)

The following table outlines grade advancement/graduation for 69 enrolled participants. Approximately 100% of all participants either advanced a grade or graduated. This data was gathered via school records-including report cards, high school transcripts, high school diploma, GED/high school equivalency certificate (CHSPE); high school schedules; staff records. All participants were determined to be at risk of the school failure/drop out and related risk factors (see introduction/literature review section), as identified by participants and/or referring sources, most of whom represented school and justice systems.

Table 3. Percentage of Participants Who Experienced Grade Advancement/Graduation.

Time Period	# of participants enrolledin SP's CDEP	# of participants at risk of school failure/drop out at time of enrollment (n/%)	# of students who advanced a grade orgraduated by July 2020/2021 (n/%)
03/04/20-07/31/20	69	69/100%	69/100%
08/01/20-07/31/21	69	69/100%	68/99%

On average, 67% of participants were dually/concurrently enrolled in the Peralta College System and successfully completed their community college courses.

Evaluation Question 5:

To what extent were there no incidences of system involvement 6, 9, and 12 months post program completion? (Outcome)

Table 4 outlines systems involvement for participants during the following two time periods: 03/04/20-07/31/20 and 08/01/20-07/31/21. 100% of participants did not become systems involved, or if systems involved at the time of enrollment, did not go into a higher level of involvement. This data was gathered via court documents/records, staff records. All participants were determined to be at risk of the systems and related risk factors (see introduction/literature review section), as identified by referring sources.

Table 4. Percentage of Participants Who Did Not Experience Systems Involvement.

Time Period	# of participants enrolled in SP's CDEP	# of participants at risk ofor involved with systems (including, child welfare, juvenile/criminal justice, etc.) at time of enrollment (n/%)	# of students with no systems involvement or ifsystems involved, did notgo in to a higher level of involvement by July 2020/2021 (n/%)
03/04/20-07/31/20	30	30/100%	30/100%
08/01/20-07/31/21	69	69/100%	69/100%

To what extent was there an increase in employment and family engagement among SP participants? (Outcome)

Table 5 outlines participant employment. 100% of participants became employed during their

involvement with the SP CDEP. Table 6 outlines family engagement- 100% of families became engaged. This data was gathered via school, staffrecords, and interviews.

Table 5. Percentage of Participants Who Became Employed.

Time Period	# of participants enrolled in SP's CDEP	# of participants unemployed at time of enrollment (n/%)	# of students who became employed by July2020/2021 (n/%)
03/04/20-07/31/20	30	30/100%	30/100%
08/01/20-07/31/21	69	69/100%	69/100%

Table 6. Percentage of Families Who Were Engaged.

Time Period	# of participants enrolledin SP's CDEP	# of families targeted for engagement among SP CDEP participants (n/%)	# of families engaged among SP CDEP participants (n/%)
03/04/20-07/31/20	30	30/100%	30/100%
08/01/20-07/31/21	69	69/100%	69/100%

As previously mentioned, another result during the 2019-2020 year included participants indicating their need for CDEP implementation to migrate to virtual delivery; SP accommodated this request accordingly.

At the conclusion of this 3-year study, two focus groups were conducted with the LSJ Life Coaching Program Team, centered on the following questions:

1. **Do you think the CDEP achieved its's short-term strategic objectives including increased access to trauma informed care, relationships with caring adults, ability to navigate education and juvenile justice systems, family engagement, and access to culturally responsive mental health services?**

2. **What was the impact on Service Navigation Services for CRDP youth?**

    a. What was the impact on service navigation specifically due to the COVID-19 pandemic?

3. **What was the impact of the Life Coaching Services? Provide specific examples related to youth served?**

    a. What about coping skills/strategies?

4. **What was the impact of the "Know Your Rights" (KYR) education provided through the dual enrollment college level Ethnic Studies/African American Studies classes or that you provided 1-1.**

    a. Impact on learning about their own culture?

The Team indicated that they felt successful in meeting all the objectives when engaging and working with participants. They pointed to intentionality of ensuring that life coaches and staff look like the communities that they are served, reducing initial barriers to connection as the participants feel seen, heard, and in turn, have a corrective experience. They described the LSJ Life Coaching model as a dynamic, didactic and facilitative approach depending on the needs of the participant and/or family. The Team implemented this approach by leaning in with their participants to collaboratively problem-solve and discover non-traditional, non-stigmatizing social and emotional learning and mental health practices to counter the adverse events that occurred to them. They reported that participants and their families gained their own agency by building the skills to continue to navigate systems and resources, allowing them to be leaders in their communities, moving from student to teacher in navigating life's future challenges.

Examples:

- *"One foster youth in particular did not feel prepared for high school and felt that life was coming at her at a very fast pace. The Life Coaching Program, linkages to resources (housing, mental health, 1:1 sessions, mentorship, social emotional learning, and the whole wrap-around approach allowed her to focus on her mental health. She was able to re-enroll in counseling and find her own living situation away from foster mom who was not ideal."*

- *"I have never heard them talk about feeling stigmatized through this particular project. Lots of times when you talk to young people, they'll tell you how they've been stigmatized or they've been pathologized within different service models, at school, or in the different systems, and I have never heard a young person say that about SP, our Life Coaches, or our model at all. As the caring relationships are built out, young people come and ask for help and that's a big deal for a young person. And that's an important part of having your own agency. I see the young people that Life Coaches are working with exhibiting a lot of self-agency and going after services on their own even without theirLlife Coaches which is a significant indicator."*

The Team indicated that it is abundantly apparent that SP is an anchor organization for the communities it serves. They described SP as a resource hub that provides and brokers services for Alameda County's most vulnerable youth. By building a secure base with participants, young people knew that they could depend on SP to provide culturally relevant opportunities and solutions to challenges they are faced with. SP provided low barriers to entry- for example, no appointment was needed, youth had direct access to their Life Coaches, there was minimal intake/administrative steps, and participant choice was emphasized regarding the issues they wanted to address. Further, SP provided participants and their families with a positive and person-centered experience and built the capacity of participants in navigating systems and resources on their own. They also uplifted the COVID-19 pandemic's unique set of challenges, exacerbated by the changing landscape due to shutdowns and quarantines and the lack of healthy outlets throughout the day.

Examples:

- *One Life Coach supported a participant who was undocumented in securing a pathway to*

citizenship. This individual was connected to another SP program, which then set up legal assistance.

- *Another Life Coach assisted a participant in the process of getting a photo identification from the CA Department of Motor Vehicles, which allowed them to explore employment opportunities. This Life Coach implemented the "I do, we do, you do" approach in supporting and building capacity with this young person.*
- *"He pushed beyond where most people would have broken." – A life coach working with a high school student indicated that SP' service navigation greatly benefitted him, resulting in an increase from 30% attendance and failing all but one class to 70% attendance and passing all but one class. When COVID hit, his challenges were amplified. His sister reported abuse, and their father was incarcerated. From that point, the participant was taking care of his siblings and had to take on the responsibility of being the breadwinner in the household at the age of 18, all while completing his high school education. The student then transferred to an alternative education center. The Team helped him navigate conversations with counselors and teachers. The student graduated from high school and found full-time employment, and he was able to keep his home and support his elderly grandparents.*

SP had a strong focus on emotional and empathetic support tailored to participants and families. SP' Life Coaches strengthened protective factors and built resiliency in participants, thereby interrupting the cycle of poverty and structural violence. Life Coaches collaboratively identified supports and coping strategies for participants by meeting them where they were at and by instilling confidence in every interaction.

Examples:

- *A participant was in kinship foster care (form of foster care with some governmental oversight to the family unit) when he started with SP. His mother had a history of substance use, which impacted the engagements she had with her son. She was a present mother in a lot of ways, but the young person expressed that the breakdown in communication between his mother and him was a huge barrier to his success. As a result of this, the mother agreed to designate a SP Life Coach to represent her at meetings with the school district on her behalf. The participant took some classes while incarcerated and felt he wanted to give up and was anxious because he was unsure if those credits would transfer to his new school. The newfound stability from the Life Coach and the identified supports and grounding strategies enabled this student to maintain his composure despite being triggered.*
- *One participant was on probation, his father was in the hospital for months, and his mother was struggling financially. This Life Coach supported this participant in identifying healthy coping strategies. The student decided to start working out to channel his energy, so his Life Coach supported him by sending workout plans and is now benefiting greatly from his self-care routine. Another student walked to the lake every morning, and this was extremely helpful because she was able to start the day by clearing her mind.*

The KYR class catered to adjudicated youth. SP offered a space where systems-involved participants could feel empowered and safe. The topics covered laid out strategies for prevention. Students were able to better navigate education systems, get off probation and recidivism rates decreased after involvement with this course.

A current Life Coach was able to relate personally given that he was a former student of another Life Coach ("JB") in the past. With JB's guidance, he became aware of his educational rights; this gave him a sense of faith in the education system and motivated him to continue to pursue his education. He then went on to graduate from high school and was second in his family to attend college. Further, this Life Coach was tremendously shaped by learning about his culture. He reported learning more about his culture in this setting than from his own parents and from school. He said the dual enrollment college class really focused on how a person who looks like him can show up in the world and how to represent in the community. The young Life Coach is now able to pass this down to his bi-racial daughter and change the narrative for his family's future. Furthermore, participants expressed themselves and engaged with their culture through various mediums, such as music, art, poetry, spoken word, etc. During the height of the 2019 racial reckoning, JB's message and counter-narrative was that media's portrayal of Black and African-American boys/men are not the only images that exist. The counter-narrative challenged the media by personally connecting the participants with African American male leaders in Urban Arts and other sectors.

As a whole, the LSJLC Team expressed being able to draw from decades of experiences, both collectively and individually. This ethnically diverse and multi-generational team highlighted their ability to lean on each other to understand best practices while also learning from their participants given the expertise within each individual. Overall, the group fearlessly and ardently described overcoming their own personal trepidations which the young people find inspiring as it gives them a realistic and encouraging road map of how to move confidently in their communities despite the trauma and adverse effects experienced.

Results – Meta Analysis Data

N/A

Section 8. Discussion and Conclusion

Discussion of findings must be prefaced by three major historic events that provided unanticipated and inescapable impact on participants, community, CDEP, SP, and the evaluation process. The first event was the murder of George Floyd, an African American son and father, at the hands of the Minneapolis police, an event that ignited many communities in the U.S. and the larger global community. The impact of the murder of Mr. Floyd and other African American men and women at the hands of largely white law enforcement officials laid bare the historical trauma of white supremacy and police violence against African Americans. The African American youth and young adults and the staff at the heart of the CDEP were profoundly impacted and carried the images of the murders of George Floyd, Breonna Taylor, Ahmaud Arbery, and others burned into their psyches as the program staff brought historical and cultural perspective, and resources to anchor participants in the potential of their futures. The second event was the rise of the Black Lives Matter movement, a movement that reminded American society of the critical power of Black organizing and unexpected wider mainstream appeal of the message. The final unprecedented event was the COVID-19 Pandemic, a watershed event that changed every aspect of the context of the implementation and evaluation of the CDEP. For K-12 students in Oakland the modality of instruction, one of the most fundamental aspect of school, shifted within days as physical facilities were abandoned and learning migrated to virtual classrooms and remote learning became the norm for the next 18 months. At the time of this writing, the depth of long-term impacts of these events are yet to be determined.

The contextual events summarized above along with the data and statistics outlined in the Literature Review section of this report reinforce the social, health, and economic disparities systemically imposed on African Americans youth and their families. The health impact of the toxic stress created by the real time trauma of growing up in urban cities and the compounded impact of historical racism and inequity result in increased levels of depression, anxiety, social isolation, lack of educational attainment, economic progress, and lower life expectancy among low-income African American communities in Oakland. These conditions created increased and urgent need for prevention and intervention services to mitigate the onset of mental health illness in African American youth.

As African American youth develop into young adults, protective factors can build resiliency and buffer this vulnerable population from the compounding trauma associated with navigating multiple public systems undergirded with systemic racism, including education, child welfare, juvenile justice, and public health. Culture is one of the critical protective factors shown to increase resiliency in youth and support greater self-agency. Therefore, the SP CDEP provided this protective cloak over the African American participants served. As discussed in the description of the CDEP, participants received a compliment of services that were designed to increase their coping skills, connections to caring adults, knowledge of culture and history, and capacity to navigate public systems, most significantly education given the importance of high school graduation in determining future socioeconomic indicators.

The findings demonstrate that a majority of SP CDEP participants experienced the following outcomes:

- Growth with respects to mental illness, or the severity of mental illness symptoms (39% improved anxiety symptoms and 48% improved depression symptoms).
- Improved coping skills/strategies, self-regulation, and relationships with caring adults (89%-94%).
- Increased prosocial/resiliency/hope/protective factors (89%-94%).
- Increased life skills (89%-94%).
- Grade advancement/high school graduation/ GED/CHSPE attainment (100%).
- No incidences of systems involvement or further systems involvement (100%).
- Dual/concurrent enrollment in Peralta College System (67%).
- Employment and family engagement (100%).

The depression and anxiety composite, as well as the grade advancement/high school graduation/ GED/CHSPE attainment findings, are particularly meaningful.

Across all three years, a substantial subset of program participants showed improvements between pre and post measurement points on the composite variable for Anxiety. During the first two years, nearly half of all participants showed improvements between pre and post measurement points on the composite variable for Depression. In the third year, the proportion of treatment group participants who saw improvement on this composite dipped marginally. It is possible that this dip was attributable to the uneven administration of surveys in the virtual context. Specifically, multiple methods of virtual administration were utilized based on youth's technology/wifi access.

It is also possible that anxiety worsened during the last year as a result of the pandemic so more intervention would have been required to reach the levels achieved in years 1-2. During this same period Life Coaching services migrated to virtual platforms, creating greater challenges to relationship building. For comparison, between April 2020 and October 2021, the CDC and the National Center for Health Statistics conducted a national survey on anxiety and depression symptoms during the previous 7 days. 59% of 18–29-year-olds and 48% of African Americans experienced anxiety or depression, compared to 43% of African Americans, 18-21 years-olds, participating in the SP CDEP.[40]

During the first two years of the project, a large majority of participants showed improvements on the *Any Improvement Composite Variable*. In the third year, however, when services were forced to move to virtual platforms by the COVID-19 pandemic, we saw a drop in the percentage of participants who saw improvement on this composite measure. LGBTQ+ participants were generally more likely to show pre-post improvement than Cis/Straight participants on the three composite variables (Culture, Anxiety, Depression). Over all three years, this analysis showed an increase in disruption of life aspects between pre and post. In Year 3, however, we saw dramatically lower levels of life disruption, both pre and post. It was possible that the lower levels of disruption may have been related to the reduced complexity of life that came with COVID-19-related changes to work, school, and life in general.

High school graduation rates among the target population are some of the lowest in Alameda

[40]Center for Disease Control and Prevention, "Anxiety and Depression: Household Pulse Survey," Center for Disease Control and Prevention, last modified October 20, 2021, https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm.

County. 32.0% - 49.3% of all target population residents ages 25 and older do not have a high school diploma or equivalent, compared to county wide averages of 12.7%.[41] As illustrated in the Literature Review section of this report, this disparity greatly impacts prospects of employability and economic mobility. For African Americans living in Alameda County, the age-adjusted all- cause mortality rate more than halves for those who have not completed high school compared to those who have completed a bachelor's degree or more (1670.2 per 1000,000 compared to 796.6 per 100,000).[42] 100% of African Americans participating in the SP CDEP either grade advanced or graduated from high school.[43] The education attainment is particularly notable given that the grade advancement and high school graduation continued through the 18 months of remote learning resulting from the COVID-19 shelter in place. One could argue that the impact of the radical and rapid migration to remote learning was mitigated by the protective factors supported imparted by the CDEP as every participant advanced to the next grade or went on to graduate from high school. The long-term implication of this educational success is most likely to place CDEP participants on a road to improved economic and health outcomes. In addition, educational success related to high school graduation will reduce trauma and stress related to dropping out of high school and improve the earning potential of CDEP participants.

Further, arrest and probation rates among the target population, residing in the target communities, are the highest in Alameda County. As uplifted in the introduction/literature review, approximately 20% of Alameda County's youth arrested resided in the target communities, 45% on probation were from Oakland, and an average youth incarceration rate of 17 per 1,000. These adverse experiences have grave implications for African American youth who are already dealing with the health, economic mobility, and life expectancy implications of poverty. 100% of African Americans participating in SP CDEP did not experience systems or further systems involvement. This was maintained throughout all COVID-19 shelter in place orders, thus interrupting the adverse effects of COVID-19 and poverty. In addition to the SP CDEP, this success was also attributable to significantly less contact with law enforcement in schools and during travel between schools and homes.

Survey results from the Oakland Fund for Children and Youth' YDLS implemented in the 2018-19 and 2020-21 program years demonstrated significant youth development outcomes associated with protective factors as evidenced by the following outcomes:

Table 2. Percentage of Youth who Improved/Increased Protective Factors

Protective Factor	2018-19 Outcomes	2020-21 Outcomes
Greater connections to caring adults	90%	79%
Increased confidence and self-esteem	92%	74%

[41] Alameda County Public Health Department Community Assessment, Planning, and Evaluation (CAPE) Unit, "Map Set 2018."
[42] Alameda County Public Health Department, "An Intro to Measures of Mortality: Assessing Overall Health, Cause of Death Rankings, Health-Adjusted Life Expectancy, and Socioeconomic Conditions in Alameda County."
[43] California Department of Education, "2019-2020 Four-Year Adjusted Cohort Graduation Rate: Oakland Unified District Report (01-61259)," Data Quest, Accessed October 25, 2021, https://dq.cde.ca.gov/dataquest/dqcensus/CohRate.aspx?agglevel=district&year=2019-20&cds=0161259.

Improved decision-making and goal setting	94%	82%
Development and mastery of skills	89%	82%
Greater empowerment and agency	93%	Not measured
Increased knowledge of and engagement in community	91%	82%
Increased leadership capacity	91%	73%
Increased risk avoidance/conflict resolution	90%	Not measured
Increased sense of belonging and emotional wellness	Not measured	82%
Increased persistence and resiliency	Not measured	73%

Although the survey was not administered as planned for 2019-20 program year due to the pandemic, previous years surveys demonstrated similar results. These available data demonstrate increase in dramatic increased in protective factors and increased resiliency among participants. These data correlated with results from the staff focus groups that indicated increases in protective factors, resiliency, and self-agency among participants. Staff attributed these gains to the alignment of staff demographics and experience to those of participants facilitating relationship building and connections to caring adults.

Growth in protective factors and resiliency among participants were attributed by participants and staff to the focus of building knowledge of African American culture and history. Culture is a protective factor that anchors youth and provides context and identify in a society that minimizes black culture and identity. African American youth CDEP participants migrated towards the African American dual enrollment courses and the KYR education with a strong desire to learn about their own history and their rights to help them navigate their education and other public systems, including social services, health, and juvenile justice.

COVID-19 and the ensuing economic fallout have only exacerbated health and economic disparities among African American youth, their families, and communities; subsequently, the impact on this study's findings are expected but remain unconfirmed given that the study was not designed to ascertain that impact. For example, on the Depression composite for Year 3, participants dipped marginally as a possible result of COVID-19-related social isolation.

Further, on the Pre-Post Improvement on Life Aspects "Messed Up" by Mental Health/Emotional Struggles for Year 3, participants experienced dramatically lower levels of life disruption, both pre and post. It is also possible that this may have had something to do with the reduced complexity of life that came with COVID-19-related changes to work, school, and life in general- i.e., fewer social interactions to navigate and being in a more contained environment. However, the surveys

were not designed to measure the impact of a global pandemic as the study was two years into implementation when the pandemic occurred.

It is worth noting that because the *CDEP Pre/Post-Test Matched Survey's* lacked consistency on scales and indicators participants were confused and inadvertently indicated disagreement on statements. Note that the previous sets of questions have the affirmative responses (i.e., Strongly Agree/Agree) on the left side of the Likert scale. Their responses were an anomaly compared to other data. Further, on the marginalization and isolation statements (7 and 8 on both the adolescent and adult pre surveys), the questionnaire reversed the direction of affirmation of well-being, potentially confusing respondents.

Significant systems change outcomes are associated with SP' CDEP work. It has yet to be determined if these outcomes will be reported in an addendum to this report or in a subsequent report.

This study uplifted the imperative, as well as the how-to, of incorporating African American practices/traditions related to language and history, as well as African American principals, values, and beliefs related to ethnic culture, social justice, intersectionality, collectivism, relations, age, CBPR, and LGBTQQ+ inclusion throughout all SP CDEP programming and evaluation activities.

Critically important to the implementation of the CDEP was the composition and expertise of the staff. Building authentic relationships with the African American youth and young adults was at the crux of the CDEP program elements and the strengthening of protective factors. Without the staff's ability to leverage their own cultural, lived experience, and education to earn the trust of participants, they would not have been seen as caring adults in the eyes of participants. The longevity of staff was another critical element of the program to consider. The fact that Life Coaches remained consistent, including during the pandemic, created structure and a stable relationship that participants could depend upon. Future expansion of CDEPs for the target population should consider these foundational elements.

Another takeaway from the study is the potential power of the integration of program elements, particularly Life Coaching and KYR and Ethnic Studies education. As discussed in the CDEP Description Section of this report, the Life Coaching element is rooted in an understanding of the historical and contextual realities of the African American experience and the impact of long-term systemic bias across multiple domains. These include, but are not limited to, Education, Employment, Housing, Health, Social Services, Adult and Juvenile Justice and Law Enforcement.

Life Coaching was grounded in cultural socialization to increase participants' consciousness about the historical legacies of hegemonic forces and its impact on their lives, as well as expose them to the rich heritage ofAfrican American resistance. Life Coaches shared strategies of survival and modeled and demonstrated effective strategies to engage and navigate the multiple public systems that continued to shape the life choices of participants in a way that promoted individual and community agency. The CDEP embedded Life Coaching and other program elements in the context of KYR and African American/Ethnic Studies education, providing a protective cloak of cultural and historical context for African American participants that is rarely provided in traditional, western approaches to prevention and early intervention services. This is an area that appears promising and given the CDEP outcomes of no new or additional systems involvement

and 100% grade advancement/high school graduation warrants additional research.

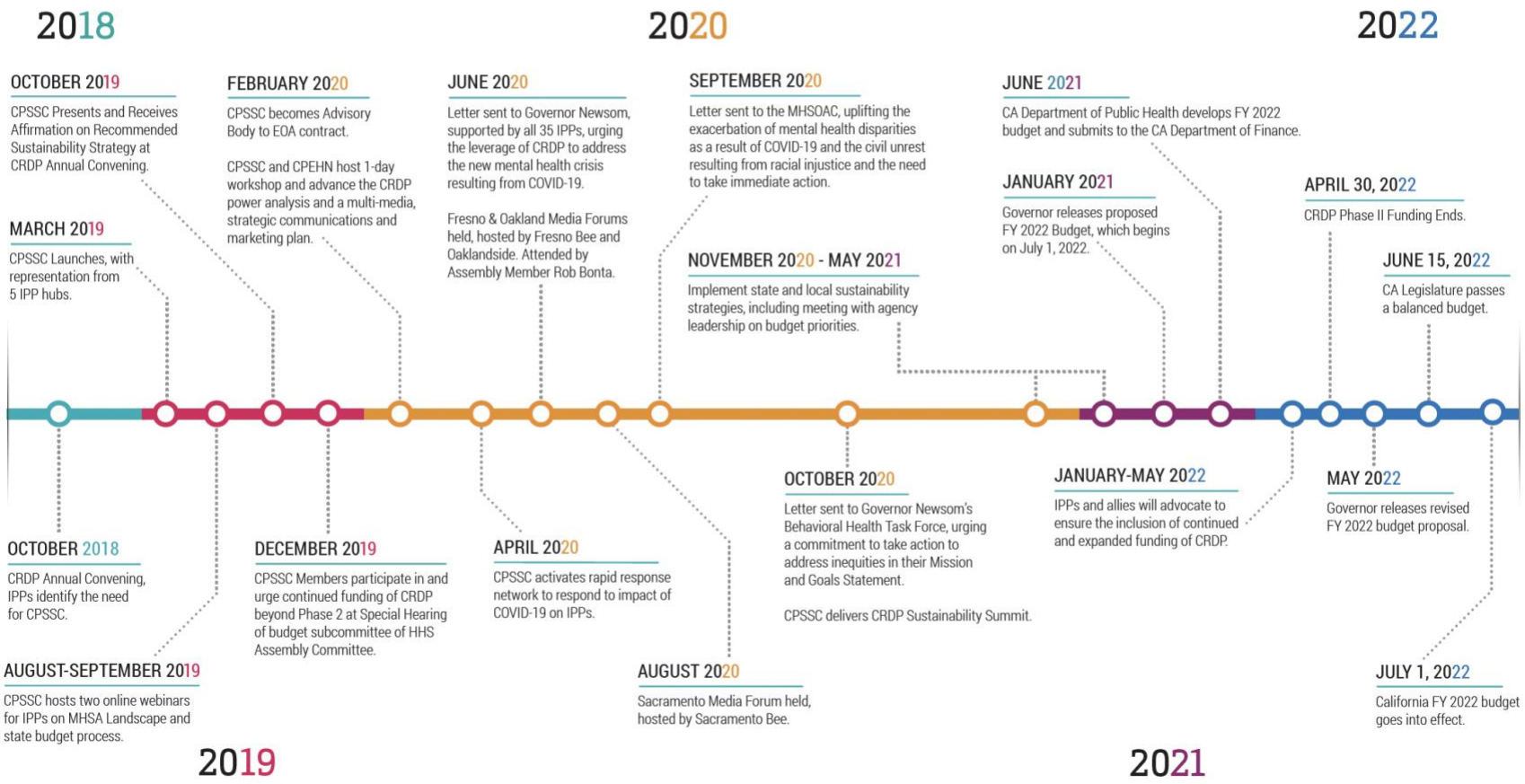
Finally, the impact of the CRDP CPSSC must be uplifted as it is instructive for the larger community of BIPOC and LGBTQ+ providers engaged in culturally appropriate strategies in public health, and mental health specifically, as well as the larger public sector engaged in the herculean effort of reducing mental health disparities historically experienced by BIPOC communities. The creation and work of the CPSSC represented a modification of the planned CDEP, yet the legacy of the CPSSC may represent the most widespread impact of the project in terms of investment of new funding and the number of participants served across the initiative. The procurement of $63.1 million dollars from California's General Fund may represent the largest investment of general funds in culturally defined mental health programs for BIPOC and LGBTQ+ communities in the history of California. Moreover, the policy and budgetary victory represents an unprecedented investment in culturally appropriate prevention and early intervention mental health strategies in our nation's history. As a result of the additional investment, $1.2 million dollars was made available to each of the 35 IPPs to extend their CDEP four additional year expanding the potential impact of the CRDP statewide towards sustainability and scalability. The impact of this investment will not be fully determined for many years to come. These outcomes were realized as a direct result of the intersectionality created by the intentional and thoughtful collaboration between IPP representing the African American, Latinx, Asian Pacific Islanders, Native American, and LGBTQ+ communities created in the hopes of systematically reducing mental health disparities.

Potential areas for future CDEP implementation and evaluation included the potential for scaling of it at the Alameda County and state levels as well as the application of innovative evaluation methods, including but not limited to community narratives, storytelling, photovoice, sharing circle, photo elicitation, reflexive photography, audio/video diaries, draw and write, and written diaries. Future evaluation of the organizational infrastructure and sustainability strategies to support effective CDEP development, implementation, and scalability is urgently needed to address the increasing health disparities experienced by African American youth and their families.

SP CDEP had a positive impact on African American youth, ages 16-21; thus, interrupting the negative impact of poverty, crime, violence, discrimination, and disenfranchisement and the chronic stress produced by these oppressive conditions. Such endeavors worked because of the intentional cultural and historical context of African American practices, history, traditions, principles, values, and beliefs, and public systems should take heed and invest in what works. Further, this study uplifted the urgency, moral imperative, and need to generate the political will for public systems at the federal, state, county, and city levels to invest in culturally appropriate strategies that prove effective with African American youth. Finally, the SP CDEP lead the development of a model that may be replicable to secure additional public investment at the state level to further long-term sustainability for the CDRP and CDEPs more generally.

California Reducing Disparities Project
a culturally responsive mental health initiative

California Reducing Disparities Project, Cross-Population Sustainability Steering Committee Timeline



Section 9. References & Attachments

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Section 3. Introduction/Literature Review

SP is a multiservice organization led by women of color with over 26 years of demonstrated effective service to communities of color in Oakland and other high need areas of Alameda County. The organization strives to achieve its mission "***to disrupt the cycle of poverty by engaging youth and families to build and drive a continuum of services that support student success and community development,"*** by delivering a comprehensive range of culturally relevant services to over 4500 children, youth, and families each year.

Core principles of the organization include social justice, service to the community, systems change, cultural humility, youth development, family and community engagement, and continuous improvement. The core principles are evidenced throughout the program portfolio. SP categorizes its programs and strategies within the following core functions: 1) direct services; 2) policy and advocacy; 3) innovative program development, incubation, and replication; and 4) investment in human capital. The SP Law and SocialJustice Life Coaching Project (LSJ Life Coaching Project) is a Community Defined Evidence Practice (CDEP) and was developed in accordance with the organization's core principles and is representative of its core functions. The LSJ Life Coaching Project) serves adjudicated youth ages 16 to 21 residing in the most crime impacted and economically disenfranchised areas of the City of Oakland in Alameda County. The presenting mental health need is a result of the target populations exposure to trauma and their experiences growing up in poverty, exposure to racism, being disenfranchised from the education system, and being subjected to the juvenile justice system, including incarceration.

With more than 30% of our local California Reducing Disparities Program (CRDP) program and local evaluation to be implemented, the COVID-19 global pandemic disrupted every aspect of our global society. The pandemic's impact on the youth and families at the center of our program, larger community, SP staff, and organization as a whole, was immediate and acute. The majority of youth serviced through our CDEP lived and attended school in the Oakland zip codes with the highest rate of COVID-19 infections in Alameda County.[1] Moreover, the populations SP serves experienced the highest disparities in our local jurisdiction, with African American residents dying from COVID-19 at 4x the rate of white residents and with Latinx residentsbecoming infected with COVID-19 at 6x the rate of white residents.[2] The impact of the pandemic on the youth, families, and communities served by SP cannot be overstated. The direct and indirect impacts on the SP LSJ Life Coaching project and its CRDP local evaluation are unquantifiable and were inconceivable when the project evaluation was designed.

Based on the available American Community Survey data, the average poverty rate of the target communities located in East and West Oakland is 30.7%. In Alameda County, neighborhoods with 30% or more residents living in poverty are defined as very-high poverty neighborhoods.[3] Of residents in very-high poverty neighborhoods in Alameda County, 64.1% are African American,

[1] https://covid-19.acgov.org/data.page?#geography

[2] https://covid-19.acgov.org/covid19-assets/docs/response/update-actions-to-support-equity-2020.07.30.pdf

[3] Alameda County Public Health Department, "An Intro to Measures of Mortality: Assessing Overall Health, Cause of Death Rankings, Health-Adjusted Life Expectancy, and Socioeconomic Conditions in Alameda County, "Alameda County Public Health Department, November 2017, https://acphd-web-media.s3-us-west-2.amazonaws.com/media/data-reports/city-county-regional/docs/mofm.pdf.

compared to very low poverty neighborhoods (<5% of residents in poverty), where 79.0% of residents are White and Asian.[4] In addition to being located in very-high poverty neighborhoods, the target communities reside in areas of persistent poverty, which are defined as areas that have had high rates of poverty (20.0%+) for at least five decades.[5] Health data clearly illustrates the impact of health disparities associated with living in neighborhoods with historically very-high poverty rates, with a general decline in life expectancy with each increasing level of neighborhood poverty.[6] There is nearly a 7-year difference in life expectancy between an Oakland resident living in an affluent neighborhood and a resident living in a very-high poverty neighborhood.[7] Further, school age children and teens living in very high poverty neighborhoods are dying at nearly three times the rate of their peersliving in affluent neighborhood.[8]

Residents of very-high poverty neighborhoods have less access to educational resources and experience less educational attainment. Schools in high poverty neighborhoods are often underperforming, failing to provide students with the same educational opportunities afforded to students attending schools in more affluent neighborhoods. African American youth in Oakland and Alameda County begin school with many more health and education disadvantages than their white counterparts. By third grade, only 11% of all Black boys are reading proficiently in comparison to their white counterparts, where 65% are reading at proficiency in Oakland Unified School District (OUSD). Additionally, 83% of all Black students TK-3rd grade qualified for Free & Reduced-Price Lunch as compared to 18% of White students in OUSD.[9]

Further, residents of very-high poverty neighborhoods are almost four times as likely to have less than a high school diploma than residents of affluent neighborhoods.[10] High school graduation rates among the target population are some of the lowest in Alameda County. 32.0% - 49.3% of all target population residents ages 25 and older do not have a high school diploma or equivalent, compared to county wide averages of 12.7%.[11] This disparity greatly

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[4] Alameda County Public Health Department, "An Intro to Measures of Mortality: Assessing Overall Health, Cause of Death Rankings, Health-Adjusted Life Expectancy, and Socioeconomic Conditions in Alameda County."

[5] Alameda County Public Health Department, "Persistent Poverty Story Map," Alameda County Public Health Department, 2015, https://ac-hcsa.maps.arcgis.com/apps/MapSeries/index.html?appid=c7eac040d44e47939d94bbad80ab630e.

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[9] Urban Strategies Council, "Starting from Behind, Black Boys in Oakland Infographic," Urban Strategies Council, September 2017, https://urbanstrategies.org/wp-content/uploads/2019/07/Black-Boys-Infographic-FINAL-2017.png.

[10] Alameda County Public Health Department Community Assessment, Planning, and Education (CAPE) Unit and Division of Communicable Disease Control and Prevention, "Alameda County Health Data Profile, 2014: Community Health Status Assessment for Public Health Accreditation."

[11] Alameda County Public Health Department Community Assessment, Planning, and Evaluation (CAPE) Unit, "Map

impacts prospects of employability and economic mobility. Levels of education have been shown to impact health outcomes, and for African Americans living in Alameda County, the age-adjusted all-cause mortality rate more than halves for those who haven't completed high school compared to those who have completed a bachelor's degree or more (1670.2 per 1000,000 compared to 796.6 per 100,000).[12]

COVID-19 and the ensuing economic fallout have only exacerbated health and economic disparities among communities of color. Communities of color face persistent health disparities, including higher rates of asthma, diabetes, and obesity due to structural and racist inequities. Underlying and preexisting health conditions have worsened COVID-19 outcomes for communities of color and African American people have nearly twice as many cases of COVID-19 infections than white counterparts. In addition to the health impacts of COVID-19, communities of color have disproportionately experienced the economic consequences because of the pandemic. Communities of color have the highest percentage of essential workers, with 48% of African American individuals working in this category.[13]

Poverty is layered with the added risk factors of crime and violence in low-income African American communities. The average crime rate in the target communities is higher than the crime rate of the surrounding communities. The LSJ Life Coaching Project target communities are located within the 15 highest stressor beats in Oakland. In 2014, these 15 beats accounted for 58% of all youth arrests and 57% off all shootings and homicides in Oakland.[14] In Oakland, Black men, youth, and young adults have represented the highest number of homicides of any ethnic or demographic group. While African Americans account for 24% of all Alameda County residents, they represent 72% of all homicide victims.[15] In OUSD, half of Black boys in 5th grade have had at least one friend or family member die violently, with a third having experienced two or more such deaths.[16]

African Americans are also disproportionately affected by these risk factors. "Nearly three quarters of juvenile arrests in Oakland are African American boys, who are often picked up for relatively minor offenses," according to a study released by the local nonprofit Black Organizing Project, Public Counsel, and the American Civil Liberties Union of Northern California.[17] Titled "The Impact of Policing Oakland Youth,"the report looked at arrest data between 2006 and 2012 and found that African American boys made up almost 75 percent of all juvenile arrests in Oakland despite being less than 30 percent of the city's under 18

Set 2018."

[12] Alameda County Public Health Department, "An Intro to Measures of Mortality: Assessing Overall Health, Cause of Death Rankings, Health-Adjusted Life Expectancy, and Socioeconomic Conditions in Alameda County."

[13] California Pan-Ethnic Health Network, "Landscape of Opportunity," California Pan-Ethnic Health Network, February 11, 2021, https://cpehn.org/reports/landscape-of-opportunity/.

[14] Urban Strategies Council, "Oakland Stressor Model," Oakland Unite, 2011, http://oaklandunite.org/wp-content/uploads/2012/11/Stressor-Table-2011-1-11-12.pdf.

[15] Urban Strategies Council, "Rethinking Violence Prevention in Oakland, CA: 'From the Voices of the People Most Impacted,'" Urban Strategies Council, September 2019, https://urbanstrategies.org/wp-content/uploads/2020/05/Rethinking-Violence-Prevention-in-Oakland-CA.pdf.

[16] Urban Strategies Council, "Starting from Behind, Black Boys in Oakland Infographic."

[17] Black Organizing Project, Public Counsel, and the ACLU of Northern California, "From Report Card to Criminal Record: The Impact of Policing on Oakland Youth," Public Counsel, August 2013, http://www.publiccounsel.org/tools/assets/files/0436.pdf

population."[18]

Furthermore, according to the Alameda County Probation Department data, 874 (or 45%) of the 1,943 juveniles on probation as of mid 2012 resided in Oakland. 342 youths were arrested in the Project's target communities in 2014. The 15 beats included in the target communities have the highest youth incarceration and probation rates in Oakland, with an average incarceration rate of 17 per 1,000. One target beat in particular (07X) has a youth incarceration rate of 33 per 1,000 and a youth probation rate of 22 per 1,000. The target communities, therefore, have on average 524 youths incarcerated per year. As of July 2019, youth booked into Juvenile Hall are overwhelmingly African American or Hispanic, with an average age of 16.[19] Criminalization of Black youth begins in early school and in OUSD schools,1 in 11 Black boys face/ have faced suspension by 3rd grade.[20] Further, while Black youth represent 26% of all students enrolled in OUSD schools, they account for 73% of all students arrested. Black students in OUSD are 11 times more likely to be suspended than their white peers.[21]

People of color living in poor neighborhoods experience the cumulative effect of multiple stressors, like poverty, crime, and violence. Stress levels rise in the absence of basic human needs, such as safety, employment, health care and affordable housing. Social isolation resulting from racial stigmatization, the breakdown of the family unit, and lack of social support reduces an individual's ability to manage stress. "Constant pressures and lack of control trigger a chronic stress response (or allostatic load), which over time, wears down body systems and increases risk of ill conditions like hypertension or diabetes."[22]

The historical and persistent racism experienced by African Americans compounds the stress like compounding loan interest, exacerbating negative health outcomes for the population. Notable, all five of the population reports developed by the Strategic Planning Workgroups found "the history of racism, bigotry, heterosexism, and other discrimination in the United States is a constant source of stress which can lead to feelings of invalidation, negation, dehumanization, disregard, and disenfranchisement."[23] Further, specific data illustrates the profound impact of racism on the health of African Americans demonstrating that "experiences of racism at multiple levels-including institutional, interpersonal, and internalized racism-can serve as a chronic stressor that contributes to increased risk of hypertension among African

[18] Black Organizing Project, Public Counsel, and the ACLU of Northern California, "From Report Card to Criminal Record: The Impact of Policing on Oakland Youth."
[19] Alameda County Probation Department, "Reductions in Juvenile Detention in Alameda County," Alameda County Probation Department, July 2019, https://probation.acgov.org/probation-assets/files/resources-info/Reductions%20in%20Juvenile%20Detention%20in%20Alameda%20County_7.25.19.pdf.
[20] Urban Strategies Council, "Starting from Behind, Black Boys in Oakland Infographic."
[21]Black Organizing Project, "OUSD's $6.5 Million Dollar Problem: Examining Bay Area Black School Pushout," Black Organizing Project, 2018, https://drive.google.com/file/d/1WRYrN07c1ZR_HBEgVSXYm0fushNgraTk/view?ts=5b3be9e0.
[22] Pamela J. Feldman and Andrew Steptoe, "Neighborhood Problems as Sources of Chronic Stress: Development of a Measure of Neighborhood Problems, and Associations with Socioeconomic Status and Health," *Annals of Behavioral Medicine,* 23, no. 3 (2001): 177 – 185, doi: 10.1207/S15324796ABM2303_5.
[23] California Pan-Ethnic Health Network, "California Reducing Disparities Project Strategic Plan to Reduce Mental Health Disparities," California Pan-Ethnic Health Network, May 2014, https://cpehn.org/assets/uploads/archive/crdpstrategicplan2014final2.pdf.

Americans in particular."[24]

Chronic stress also leaves an enduring impact on mental health, increasing the risk of depression, anxiety, and other mental health disorders. If not prevented or treated effectively, severe mental illnesses can substantially impair the individual's ability to function. Severe mental illness (SMI) can include conditions like major depression, anxiety, or schizophrenia and can lead to suicide. The disparity in mental health treatment is evidenced in local Alameda County data, where the rate of visits to the emergency department for severe mental disorders in very-high poverty neighborhoods is nearly three times that of affluent neighborhoods.[25] In California, 4% of all adults have been diagnosed with severe mental illnesses. African Americans have rates of SMI above the state average, with 5.8% of residents having received a SMI diagnosis. Gaps in coverage, workforce inadequacy, affordability, and systemic discrimination have led to significant barriers for access to mental health services by the target communities.

Incarceration and juvenile justice system involvement are amplifying social determinates of health for African American adjudicated youth. Incarcerated individuals experience higher incidences and prevalence of disease, and are indirectly affected through stigmatization, unemployment, strained social networks, and long-term effects on economic mobility.[26] One study found that approximately 50-70% of juvenile justice involved youth have a diagnosable behavioral health disorder compared to a rate of about 9-13% of the general population of youth.[27] The same study also concluded that up to 2/3 of youth with a mental health diagnosis have co-occurring substance use disorders. Another study found, "62% of juvenile justice involved youth met the criteria for one mental health diagnosis (excluding conduct disorder), and 39% met criteria for more than one diagnosis."[28] The most common diagnosis was conduct disorder, followed by substance abuse, anxiety, ADHD, PTSD, depression, and mania. Although disproportionately represented in the juvenile justice system, African American adjudicated youth are not overrepresented in treatment. Youth of color tend to be underserved in the mental health system compared to White youth, and African American youth with mental health issues are more likely to be referred to the juvenile justice system rather than treatment.[29]

[24] Alameda County Public Health Department Community Assessment, Planning, and Education (CAPE) Unit and Division of Communicable Disease Control and Prevention, "Alameda County Health Data Profile, 2014: Community Health Status Assessment for Public Health Accreditation."
[25] Alameda County Public Health Department Community Assessment, Planning, and Education (CAPE) Unit and Division of Communicable Disease Control and Prevention, "Alameda County Health Data Profile, 2014: Community Health Status Assessment for Public Health Accreditation."
[26] Andrea John and Jason Schnittker, "Enduring Stigma: The Long-Term Effects of Incarceration on Health," *Journal of Health and Social Behavior* 48, no. 2 (2007): 115-130, doi: 10.1177/002214650704800202.
[27] John and Schnittker, "Enduring Stigma: The Long-Term Effects of Incarceration on Health."
[28] John and Schnittker, "Enduring Stigma: The Long-Term Effects of Incarceration on Health."
[29] John and Schnittker, "Enduring Stigma: The Long-Term Effects of Incarceration on Health."

Section 4. CDEP Purpose, Description, and Implementation

a. CDEP Purpose

SP LSJ Life Coaching Project is a Prevention and Early Intervention (PEI) program that aimed to prevent and/or reduce the effects of exposure to chronic stress, including trauma associated with poverty, exposure to racism, disenfranchisement from the education system, and Juvenile Justice system involvement among African American youth, ages 16-21, who were adjudicated, systems involved, or at risk of becoming systems involved. The project components aimed to decrease mental illness, or the severity of symptoms associated with trauma or mental illness, school failure and drop out, and incarceration/ recidivism. Conversely, the project strived to increase/improve: coping skills, self-regulation, relationships with caring adults, access to services, employment, and family engagement.

b. CDEP Description and Implementation Process

The SP LSJ Life Coaching Project was an existing Community Defined Evidence Practice (CDEP) that served youth of color, ages 16-21 who were adjudicated, systems involved, or at risk of systems involvement. However, the particular focus of the CRDP implementation and local evaluation was on African American youth who resided in the most crime impacted and economically disenfranchised areas of the City of Oakland in Alameda County.

The data clearly illustrates the extreme level of poverty, crime, violence, discrimination, and disenfranchisement experienced by African American adjudicated youth in the CDEP target communities and the chronic stress produced by these oppressive conditions. Chronic stress becomes toxic for the target population, greatly increasing the risk of experiencing symptoms associated with trauma and mental illness. The LSJ Life Coaching Project provided effective trauma-informed, culturally competent life coaching as PEI services to reduce toxic stress levels andincrease support to mitigate participants' risk of symptoms associated with trauma and mental illness.

Moreover, African American residents living in neighborhoods with high concentrations of poverty have less access to educational resources, and experience less educational attainment. Schools in high poverty neighborhoods are often underperforming, failing to provide their students went the educational opportunities afforded schools in more affluent neighborhoods. Residents of high poverty neighborhoods are almost four times more likely to haveless than a high school diploma than affluent neighborhoods– reducing prospects for employability and economic mobility.[30]

Simply stated, the project components were designed to eliminate the stress and trauma associated with being in foster, juvenile justice, and education systems. The theory of change was driven by strategies to prevent African American youth, ages 16-21, from entering or re-entering the juvenile

[30] Muntu Davis, "Investing in People and Place: Poverty and Children's Health in Alameda County," Alameda County Public Health Department, April 23, 2014, http://www.acgov.org/icpc/documents/presentation-ChildrenInPovertyForum2014-04.pdf.

justice system and to effectively navigate bureaucratic inequitable systems (foster care, juvenile justice, public benefits, health care and education) to ensure that youth successfully exit these systems. Significant emphasis was placed on supporting youth to graduate from high school and concurrently enroll in community college courses. African American culture and history were taught to African American youth to strengthen protective factors and resiliency as a strategy to fortify them for their current and future navigation of oppressive systems undergirding by institutional racism. Over the last decade, much has been written regarding the intersection between the African American high school dropout rate and the incarceration of African American men.

A 2010 Pew report "Collateral Costs: Incarceration's Effect on Economic Mobility," found that 37 black maledropouts between the ages of 20 and 34 were incarcerated, which is 3x the rate of their white counterparts. The authors state, *"Young black men without a high school diploma are more likely to be found in a cell than in the workplace."*[31] Therefore, the LSJ Life Coaching Project was designed to disrupt the School to Prison Pipeline and its long-lasting mental health implications for African Americans by prioritizing resources within the model to support high school graduation and the potential for economic mobility. For example, successfully graduating from high school prevents future trauma associated with dropping out of high school. Further, the average annual salary for jobs requiring a high school diploma in Oakland, as of August 8, 2021, was $48,828,[32] providing high school graduates with entry level economic opportunity and the possibility of continuing to higher education, with California providing free tuition for community college.

Incorporation of Indigenous Knowledge in CDEP

Incorporation of indigenous knowledge (local, cultural, or LGBTQ) in the CDEP implementation undergirded the program model and wasindispensable to the CDEP. Specific core elements of indigenous knowledge were aligned with each component of the CDEP model.

LSJ Life Coaching Project includes the following components.

1. Outreach and Coordination. Two levels of activities including: 1) Public Systems Level- met one on one with program managers and agency heads to ensure buy-in at the highest systems levels, and on-going referrals across systems; help inform policies and collaborate on delivery of services. 2) School Community Level - meet with principals and teachers at target sites to help identify and refer participants, inform them regarding program deliverables and integrate and coordinate services; as well as disseminate outreach materials and meet with families of referred youth to ensure they are informed and encouraged to participate.
   Duration: Outreach and Coordination occurred on a continuous basis throughout each year. It entailed working with public systems partners, as well as target school communities and other community-basedorganizations to support referrals, recruitment coordination, and integration of services at target schools.
2. Enrollment – Life Coaches (LCs) consistently reviewed and followed up with referrals

[31]The Pew Charitable Trust, "Collateral Costs: Incarceration's Effect on Economic Mobility."
[32] Zip Recruiter, "High School Diploma Salary," Zip Recruiter, Accessed October 25, 2021, https://www.ziprecruiter.com/Salaries/High-School-Diploma-Salary.

from schools, community-based and systems partners (social services, education probation), and families. Activities included inputting participant information into data base; analyzing profiles; collecting school data, available Juvenile Justice data, health data, social services, and family information; conducting one on one interviews/meetings with participants (including identifying intersectional identities and issues); and assigning participants to Life Coaches after enrollment activities were completed via consultation within theteam to determine the best fit.
Duration: At least 1.5 hours per participant. This activity may have taken place over multiple sessions. Attention was paid to screening for trauma and related symptoms. Duration was ongoing: occurring at the beginning of participant program enrollment and continuing on a rolling basis continuously throughout the project year, followed sequentially with the outreach and coordination component.'

3. Life Coaching Case Management - Activities were designed to provide youth with the skills required to navigate the multiple systems in which they encountered (e.g. schools, Juvenile Justice, Law Enforcement, Public Benefits, Health care), in a way that empowered them. Activities included coaching, modeling for, andmentoring youth; accompaniment to public system appointments; direct assistance with securing gateway documents (e.g., driver licenses birth certificates, work permits) that gave or prevented the young person's agency when they were interacting with public systems; and assistance to reconnect with family, treating them like "family," and conducting one on one sessions with them. More traditional case management activities included brokering services and increasing the likelihood that services would be accessed by providing advocacy with providers and supporting participants in utilizing services.
Duration: Life Coaching sequentially followed the Enrollment component and usually occurred up to a12-month period. A few high need students remained in the program longer than 12 months due to COVID-19 exacerbation of need.

4. Life Skills "Know Your Rights" and Ethnic Studies. Included education about African American/EthnicStudies to increase protective factors to counter the toxic stress produced by the inherent inequities in the education and juvenile justice systems and to decrease recidivism and the likelihood of future incarceration. Participants learned about their history, culture, and rights in terms of juvenile justice, education, public benefits/social services and law enforcement. Activities included: Life Coaches implement classes, group workshops, and individual coaching to program participants.
Duration: This component was implemented concurrently with Life Coaching and the Family Engagement/coaching components. Know Your Rights/Ethnic Studies was a significant component thathelped participants think critically about the social, historical and political context of their lives, and provided participants with an understanding of their individual rights while teaching them strategies tonavigate public systems, particularly the juvenile justice system, to minimize obstruction of rights on participants. It was intrinsically connected to Life Coaching, which sought to increase individual coping strategies, pro social skills, and family and community cohesiveness.

5. Family Engagement/Coaching. Activities included 1) Providing families with resources to meet basic needs,such as food and clothing through the allocation of provisions available

at the Family Resource Centers, and/or referring them to available free or low-cost academic, legal and mental health services. 2) Conducting Parent/Family seminars that educated parents and foster parents on how to navigate the school system, juvenile justice system, and social services/child welfare. 3) Providing individual follow up to families and family coaching to encourage and help stabilize the family unit.

***Duration*:** The component was integrated into the Life Coaching component and was provided as needed and tailoredto the needs of the family.

Staffing for the SP LSJ Life Coaching Project was designed to be representative of the youth population served. The Project Director was a woman of color who grew up in one of the Oakland zip codes served by the project. The Project Manager and Life Coaches were African American and Latinx and were from Oakland or communities with similar demographics. The team was designed to be multidisciplinary, with three members of the team possessing degrees in Law, Ethnic Studies, and Social Welfare. Two members of the team were Bachelor level staff, with one graduate from a Historically Black College. The newest member of the team was a former program participant who was attending community college. The team expanded to seven members for the 2020-21 program year with two women of color and five males. During the CDEP implementation period, the project staff was augmented with additional Life Coaches with 100% staff retention. The local evaluation was initiated by two Principal Investigators, one African American Women, Dr. Quinta Seward, and one Latina, Dr. Nina Moreno. Dr. Steward retired towards the end of the first year of the CRDP, so the evaluation was continued by Dr. Moreno.

CDEP Delivery and Expected Dosage

The LSJ Life Coaching Project was designed to be delivered over a 12-month program year, inclusive of the 10-month standard school year and through the summer. Three cycles of the CDEP were implemented during the local evaluation period. The program was delivered in the target communities within Oakland, California, as intended. Program delivery was intended to consist of primarily in-person direct services. Delivery of services proceeded in this manner until March 2020, when our jurisdiction was placed under Alameda County and State of California mandated shelter in place public health orders. Effective March 2020, the LSJ Life Coaching Project migrated to a hybrid model of majority virtual services, with limited in-person direct services to the young adults and families served. Beginning in June 2021, SP increased in-person direct services during the summer portion of programming. This was the first-time youth participants were brought together with staff since March 2020 due to the pandemic. June 30, 2021, marked the end of data collection for the project.

Expected dosage for participants is 6-12 months depending on the specific elements of the program accessed by participants. Dosage was extended to 18 months given the challenges created by COVID-19 and the tremendous need for support given the socio-economic impacts resulting from the pandemic.

CDEP Demographics

The CDEP intended population was high risk African American youth, ages 16-21. The population served included 69 African American youth, ages 16-21, who were systems involved, adjudicated, or at risk of becoming systems involved. For the purposes of the CDEP, systems referred to the juvenile justice system, child welfare system, and the education system. Participants identify as African American but include mix race individuals that include Afro-Latinos and African American-

Asian youth. Historically, most participants were born, and their educational experience has been centered in the United States. All African American participants spoke English. Youth participants identified as male, female, and a variety of other gender identities as discussed in subsequent sections of the report. Sexual orientation of participants included heterosexual and LGBTQ+ orientations. Youth participants came from low-income families and resided in the desired target communities that historically experience higher rates of poverty, unemployment, homelessness, violence, incarceration, school dropouts, health disparities, including morbidity, and low levels of educational attainment, sustainable wage job opportunities, and home ownership.

CDEP Attrition

CDEP participant attrition was 0%.

Outreach and Coordination

1. Working across public systems to solicit buy-in, referrals, coordination of services across systems, and tohelp remove systemic barriers experienced by target youth. SP has a 26-year track record of working with Alameda County public systems, including Social Services, Health Care Services, Probation, the Oakland Police Department, and Oakland Unified School District. This also included brokering relationships at the school community level, in which SP has more than 10 years of established relationships.

2. Implementing African American culturally responsive strategies to directly engage the target population inkeeping with African American values and principles as outlined in the OnTrack's CRDP Evaluation Guidelines for African American pilot projects (updated March 2017), including the value of collective/individual identity and the collective/inclusive nature of family structure; the value of interpersonal relationships, and several of the seven principles attributed to the Black Leadership Initiativeincluded in Ontrack's guideline and listed here: "We are Family; It Takes a Village, Come As you are, and We shall overcome."

3. Life Coaches looked like and shared similar experiences as the target community and approached community members and target youth and their families in respectful, familial, and nonthreatening ways. Life Coaches met familieswhere they were, in their homes and in their communities, as an alternative to sterile meeting locations, to establish interpersonal rapport and promote collective problem solving ("It takes a Village").

4. Community Outreach included engaging the community in identifying gallery space to exhibit youth artwork and public/private wall space for mural production that represented the African American experience, culture, andhistory. Artwork also communicated social justice and intersectionality.

Enrollment

1. Building trust between the Life Coaches and participants and treating each other as family align with African American values for interpersonal relationships and are culturally responsive strategies thatmust be employed to encourage participants to open up, "Come

as you are," and to not feel judged.

2. It helped that SP was well known to the target school communities as providing effective and culturally responsive programs and services and by having longstanding relationships with the schools, youth, and families. Life Coaches had been working with youth in Oakland for the past 8 to 10 years in multiple capacities as after school staff, instructors, and/or former AmeriCorps Members. Participants trusted them and often referred to them as fictive kin (Sis, Bro, "Unc" Auntie).

3. The LSJ Life Coaching Project sought to enroll and retain at risk African American youth into the program. The Project recognized that these youth are not lone entities but come out of community and family contexts including Foster Care and/or group homes. Therefore, the project engaged public partners, as wellas individual families, to connect the whole family to resources to help reduce toxic stress on families resulting from the inability to meet their basic needs (food, housing, employment, and health care access).

Life Coaching Case Management

The core element of this component was rooted in an understanding of the historical and contextual realities of the African American experience and the impact of long-term systemic bias across multiple domains, inclusive of, but not limited to, Education, Employment, Housing, Health, Social Services, Adult and Juvenile Justice, and Law Enforcement. Life Coaching was grounded in cultural socialization to increase participants' consciousness about the historical legacies of hegemonic forces and its impact on their lives, as well as expose them to the rich heritage of African American resistance. Life Coaches shared strategies of survival and modeled and demonstrated effective strategies to engage and navigate the multiple public systems that continued to shape the life choices of participants in a way that promoted individual and community agency.

Four key assumptions guided this work:

1) The target population is at risk or experiencing associated symptoms associated with trauma and mental health illness resulting from their experiences growing up in poverty, exposure to racism, disenfranchisement in the public education system, and/or being subjected to the Juvenile Justice system.

2) The target population will be more responsive to a Life Coaching model, which is asset-driven and empowerment-focused, rather than deficit or pathology-focused.

3) A strategy that provides effective trauma-informed coaching, helps to create safety around accessing mental health services, and empowers young people to have greater academic, career, personal, and relationship successwill substantially reduce stress levels.

4) Reduced stress levels and increased support will mitigate participants' risk of symptoms associated with traumaand mental illness.
The Life Coaching component utilized a trauma informed practice that was aligned with the Mental Health Services Act (MHSA) Direct programing categories; 1) Early Intervention toward

achieving short term and long term outcomes for mental health recovery and reduction of symptoms (anxiety, trauma, crisis; depression, emotional dysregulation difficulties, disruptive behaviors disorders, severe behaviors/conduct disorder, parenting and family difficulties, as well as reduced suicide, prolonged suffering, incarceration, homelessness, school drop-out, and home removal, and unemployment). 2) Prevention Program aimed towards reducing individual/family or community risk factors or stressors and building protective factors and skills and increasing support; promoting positive cognitive, social and emotional development and encouraging a state of well-being.

Life Skills "Know Your Rights" and Ethnic Studies

This component was closely related to Life Coaching, as described above, and was implemented through approaches that honored the legacy of resistance prevalent in the African American experience and aligned with cultural values. For example, after the murder of George Floyd, guest speakers were invited to the classes to discuss how African American history relates to current state-sanctioned violence against African Americans.

This component encompassed direct MHSA programming with a focus on Prevention – reducing individual/family risk factors or stressors and building protective factors and skills to reduce the onset, or experience of mental illness and underscored the intent behind the title of "We Ain't crazy, Just Dealing with a Crazy System," Pathway into the Black Population Eliminating Mental Health Disparities Report.[33]

Family Engagement and Coaching

This component was closely related to Life Coaching, as described above, and encompassed African American cultural principles and values, such as collective/individual identity and the collective/inclusive nature of family structure, as well as It Takes a Village, Health, Wholeness and Healing, Go Tell it on the Mountain, and We ShallOvercome (for more discussion of these principles, see the California Reducing Disparities Project, Evaluation Guidelines for African American Pilot Projects, prepared by ONTrack (updated March 2017)).

Our core belief was that families cannot engage in services unless basic needs were met. For example, families cannot engage in school events if housing and food are not secured. Food is central to family stability.

This component also encompassed Direct MHSA Direct programming, including Early Intervention and Prevention strategies to reduce MHSA negative outcomes among people with greater than average risk of mentalillness, by linking families to basic provisions (such as food, clothing) and by educating them about the school system and the availability of free or low-cost academic and mental health services.

[33] Diane V. Woods, et al. "'We Ain't Crazy! Just Coping with a Crazy System:' Pathways into the Black Population for Eliminating Mental Health Disparities," Little Hoover Commission, May 2012, https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/225/ReportsSubmitted/CRDPAfricanAmericanPopulationReport.pdf.

Relevant or Significant Changes to CDEP Components

As previously mentioned, the impact of COVID-19 on the CDEP, the community served, and SP as an organization cannot be overstated. The pandemic exponentially amplified the health, education, and economic disparities experienced by the target population and communities. SP stretched its infrastructure to provide critical basic services to meet the urgent needs of the larger community. For example, between March 2020 and March 2021, SP directly distributed over 750,000 pounds of food to families. In addition, the organization migrated all services, which were historically delivered in person, to virtual or hybrid models.

The LSJ Coaching Project transitioned from 100% in person programming to a virtual hybrid model. The Program Manger and Life Coaches migrated services to a broad range of virtual platforms, including, but not limited to, phone, text, Google Classroom, Zoom, Canvas, and DocuSign. While the project components continued, the modality of the service delivery was radically different and required Life Coaches to ensure that participants had access to sufficient technology at home to support the numerous platforms used by public systems and the LSJ Life Coaching Project.

CRDP Cross Population Sustainability Steering Committee (CPSSC)

At the beginning of CRDP Phase II, SP identified the need to sustain CRDP beyond April 2022, which is when Phase II was slated to end. Based on previous experience, the SP CDEP was developed with a diverse blended funding model. As a result, SP was asked by it's the CRDP African American Grants Manager to present its unique CDEP funding model to the larger CRDP community at the CRDP annual convening held in October 2018.

During that presentation given by Josefina

Alvarado Mena, SP CEO, she offered the suggestion of creating a collaboration among the five CRDP Phase II population groups focused on future sustainability. IPPs attending the presentation expressed interest and the idea of the CRDP CPSSC was born. In March of 2019, SP launched the CRDP CPSSC, with representation from every IPP hub and all Technical Assistance Providers (TAPs). During the Second Annual CRDP convening held in October 2019, SP presented on and received 100% IPP affirmation on the following CRDP sustainability strategies:

1. Request for additional CRDP investment from the state set aside of the Mental Health Services Act or other funding sources to extend the CRDP to support an additional 3-5 years of adequate funding for 35 IPPs serving the existing 5 underserved populations to provide the following categories of services: Direct Services, Outreach and Education, Data Collection and Local Evaluation, Dissemination of lessons learned through multimedia strategies at the state and national level to impact the national discourse on ending mental health disparities.

2. Request state funding to engage the local counties in a planning phase for CRDP Phase III that will expand the CRDP to support taking the CDEPs to scale by leveraging MHSA funds at all levels.

These initial strategies drove the work of the CRDP CPSSC from October 2019 and July 2021. The results of this modification to the CDEP workplan are discussed in the Results Section of this Report.

Section 5. Local Evaluation Questions

This evaluation aimed to measure decreases in participant mental illness, or the severity of symptoms associated with trauma or mental illness, school failure and drop out, and incarceration/ recidivism via increases/improvements in: coping skills, self-regulation, relationships with caring adults, access to services, employment, and family engagement. Its questions and accompanying indicators and instruments/data sources included:

Evaluation Question #1: To what extent were outreach and coordination efforts effective in enrolling participantsin life coaching and life skills components? (Process)
Indicators: number of public system contacts, number of participants enrolled, number of referrals by public system.
Instruments/Data Sources: staff records, completed enrollment documents.

Evaluation Question #2: What are the characteristics of participants enrolled in SP? (Process)
Indicators: demographic characteristics, including ethnicity, cultural identity, class, gender, national origin, LGBTQQ+ affiliation, and neighborhood affiliation, among others.
Instruments/Data Sources: staff records, completed enrollment forms

Evaluation Question #3: To what extent was there a decrease in mental illness, or the severity of mental illnesssymptoms, among SP participants? (Outcome)
Indicators: number of mental illness symptoms.
Instruments/Data Sources: SP CDEP pre/post matched survey; staff records; and interviews, focus groups, and observations, as needed.

Evaluation Question #4: To what extent was there a decrease in school failure and drop out among SPparticipants? (Outcome)
Indicators: number of classes failed, number of grade repetitions, number of participants who discontinued attending school.
Instruments/Data Sources: school records (high school transcripts), staff records.

Evaluation Question #5: To what extent was there a decrease in incarceration/recidivism among SP participants? (Outcome)
Indicators: number of contacts with the juvenile/criminal justice systems.
Instruments/Data Sources: court documents/records, staff records.

Evaluation Question #6: To what extent was there an increase in coping skills, self-regulation skills, and relationshipswith caring adults among SP participants? (Outcome)
Indicators: number of coping skills, number of self-regulation skills, and number of relationships with caring adults.
Instruments/Data Sources: The Youth Development and Leadership Survey- post-test only; staff records; interviews, focus groups, and observations, as needed.

Evaluation Question #7: To what extent was there an increase in employment and family engagement among SP participants? (Outcome)
Indicators: number of attained jobs, number of family contacts.

Instruments/Data Sources: pay stubs; staff records; interviews, focus groups, and observations, as needed.

As a result of an infusion of additional funding to support the SP' Law and Social Justice Life SkillsCoaching, in March 2020, aforementioned evaluation questions 4 through 6 were expanded as follows:

Evaluation Question #4: To what extent was there grade advancement/ high school graduation/GED/high school equivalency certificate (CHSPES) attainment among SP participants? Towhat extent was there dual/concurrent enrollment in the Peralta College System among SP participants?
Indicators: number of students promoted, number of students graduated, number of students who attained GED/high school equivalency certificate (CHSPES).
Instruments/Data Sources: school records- including report cards, high school transcripts,high school diploma, GED/high school equivalency certificate (CHSPE); high school schedules; staff records.

Evaluation Question #5: To what extent were there no incidences of system involvement 6-, 9-, and 12-months post program completion among SP participants?
Indicators: number of contacts with the juvenile/criminal justice systems.
Instruments/Data Sources: court documents/records, staff records.

Evaluation Question #6: To what extent was there an increase in prosocial/resiliency/hope/ protective factors/life skills as well as an increase in coping skills, self-regulation, and relationships with caring adults among SP participants? (Outcome)
Indicators: number of prosocial/resiliency/hope/protective factors/life skills, number of coping skills, number of self-regulation skills, and number of relationships with caring adults.
Instruments/Data Sources: SP CDEP pre/post matched survey; the Youth Development and Leadership Survey.

Section 6. Evaluation Design & Methods

a. Design

This evaluation employed a mixed-methods, quantitative, and qualitative design, as well as community basedparticipatory research and intersectional approaches to this evaluation's design and implementation.

Its quantitative component entailed a quasi-experimental, pre- and post design. Thequantitative design also entailed the use of IBM SPSS Statistics, an interactive, statistical analysis software, used for purposes oflooking at the relationship between a variety of aspects of the survey data.

The qualitative design was primarily steeped in the theoretical traditions of ethnography, phenomenology, and case studies (Patton, 2015) as they aimed to (1.) describe the ways of life of people (ethnography), (2.) describe thelived experiences of people and allow for themes of most salience to them to emerge through discourse (phenomenology), and (3.) study people, groups, neighborhoods, programs, organizations, cultures, regions, nation-states, etc. as a unit of analysis (case study). SP' Evaluation Team conducted a range of qualitative approaches, including direct observation, focus groups, and interviews, to provide a more comprehensive story of quantitative data with respect to the intended outcomes of the five program components and to understand the personal experiences of the participants as they accessed and received services, and as they reflected onthe services they received. Questions were designed to understand the effectiveness of the model, such as identifying ways in which the strategies employed made a difference in their lives, the ways in which the model was culturally responsive to them, and ways in which the model helped give them the tools to navigate the multiple systems in which they encountered. Qualitative data analysis consisted of transcribing, coding, and analyzing all qualitative research responses, with an eye towards understanding the participants' progress and challenges and how to further refine SP' CDEP. Survey administration, interviews, focus groups, and observations occurred at targeted school sites and/or SP offices.

Community Based Participatory Research Approach

The population served by SP' CDEP assisted in the design and implementation of this evaluation plan by servingon the evaluation planning team, acting as external reviewers for the evaluation design and data collection instruments, assisting with collecting data, and interpreting findings. The assigned local evaluator, Dr. Nina Moreno, Ph.D. in Social Welfare, along with the former local evaluator, Quinta Seward, Ph.D. in Social Anthropology, began the population's design of the evaluation plan via interviews conducted in July, 2017, with the following staff and community stakeholders:

- CEO and Program Director, Josefina Alvarado-Mena, who designed the Project and was raised in Oakland's San Antonio neighborhood that borders East Oakland and the Fruitvale area, and is one of the Project's target communities. She has a BA in Ethnic Studies, a JD in Law from UC Berkeley, and is licensed to practice law in California.
- Jonathan Brumfield, the Urban Arts Manager, who also served as a Life Coach for the project and was raised inand around Oakland. He has a BA in Criminal Justice and MA in

Ethnic Studies from San Francisco State University.

- Lauren Chambers, one of the LSJ Life Coaches, who was raised in East Oakland, and has a BA in BusinessAdministration, from Florida A&M.
- Lucias Potter, a former recipient of SP services, who currently works as an After School instructor,attends a local community college and served as a Summer Associate VISTA member in the project during the 2016 and 2017 summers. He was also raised in East Oakland.
- Kasem Green, a Loyola Marymount student, approaching his senior, year, who was raised in Watsonville, California(a largely migrant agricultural area in Northern California). His major is History.

Interview questions and the subsequent synthesis were guided by the California Reducing Disparities Project(CRDP) State-Wide Evaluators guidelines for completing the Cube exercise, as well as principles, values, andguidelines for conducting Community Based Participatory Research in the African American Community, included in the California Reducing Disparities Project for African American Pilot Projects (updated March, 2017), prepared by OnTrack, Technical Assistance Provider for African American Implementation Pilot Projects (IPPs).

Intersectional Approach

During program enrollment, youth had an opportunity to identify the multiple ways they defined themselves, including gender, ethnicity, cultural identity, class, national origin, LGBTQQ+ affiliation, and neighborhood affiliation. As discussed in the enrollment period, Life Coaches recorded this data. The SP Evaluation Team collected and reviewed data retrieved by Life Coaches to capture the ways youth identified and claimed intersectional identities.Using the community based participatory research frame, the evaluation design incorporated surveys, interviews, focus groups, and observations with/of youth, family, community members, and program staff, inclusive of questions to track the ways the program served youth with intersectional identities and how services were perceivedby participants, family and community members. The SP Evaluation Team presented preliminary findings to program staff during program meetings (at least quarterly), to encourage a participatory feedback process that continuously examined and adjusted program strategies to ensure that programming attracted the range of ways African American youth identified, as well as to explore ways to fill gaps in services, if they existed.

b Sampling Methods and Size

SP was interested in evaluating the impact of its CDEP (see components above) on individuals participating in its Law and Social Justice Life Skills Coaching program (purposive sample). While the program had been in existence since 2013, individuals participating in the program between 2018 and 2021 who were willing topartake in the evaluation (convenient sampling) were the focus. This time period encompassed three cycles, each lasting 12 months, with the first cycle beginning in July 2018 and ended June 2019. Lastly, SP was always interested in including individuals from program participants' networks who meet program criteria. These individuals were also invited to participate in the evaluation (snowball sampling).

Inclusion/Exclusion Criteria

This evaluation focused on African American Youth ages 16-21 participating in SP' CDEP between 2018 and 2021. Intersectional populations included:

- African American/Black/African-Latinx; African American/Black/African-Asian/Pacific Islander; African American/Black/African-Native American; and African American/Black/African-White;
- junior high, high school, and college;
- male and female-identified as well as gender-nonconforming/queer;
- LGBTQQ+;
- urban, suburban, rural, and/or outside of Alameda County;
- homeless because of gentrification, unemployment, seasonal work, etc- living out of cars, doubling up,couch surfing, and transitional housing;
- refugees, green card holders, and undocumented individuals;
- Muslim, Christian, Catholic, Jehovah's Witness, Mormon, Buddhist, Agnostic, and Atheist individuals;
- poor, extremely poor, working class, and middle class;
- autism, epilepsy, asthma, diabetes, ADHD/ADD, learning disabilities, and dyslexia;
- uninsured, underinsured, Medical, and insufficient amount of medical providers; and
- systems involved or at risk of systems involvement (i.e., juvenile/criminal justice and/or foster caresystems);
- unable to vote; and/or
- at risk of deportation.

Participant Recruitment Strategies

The SP Evaluation Team worked with program staff to implement a Community Based Participatory Research (CBPR) approach to solicit and include the involvement of youth and their families along each phase of the evaluation (including the overall design, development of survey instruments, and implementation of focus groups, interviews, and observations toensure linguistic and cultural appropriateness). The SP Program Team had a network of youth to recruit from for this study as a result of the LSJ Life Coaching Project's existence for approximately five years prior to the start of this study and as a result of its focuses on providing participants with the skills required to navigate the multiple systems in which they encountered (e.g. schools, Juvenile Justice, Law Enforcement, Public Benefits, Health care). The SP Program Team reached out to former participants and invited them to participate in all phases of the evaluation. Participants were compensated for their expertise. Further, all SP Program Team staff were from the target population; thus their perspectives informed all phases of this evaluation. Program staff helped identify youth to carry out these tasks including the designing tailoring survey instruments, data collection methods, evaluation findings/interpretation, and methods of dissemination of findings, as well as the convening and recording of focus groups, interviews, and observations. SP provided gift cards and other incentives to solicit and maintain youth and community participation in the evaluation tasks. The SP Team trained youth and community members on basic evaluation methods and the CBPR approach.

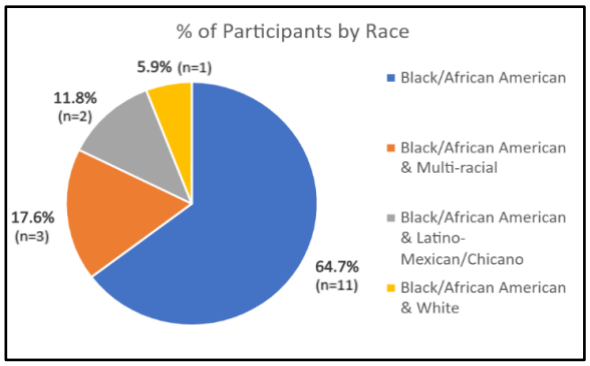
Sampling Size

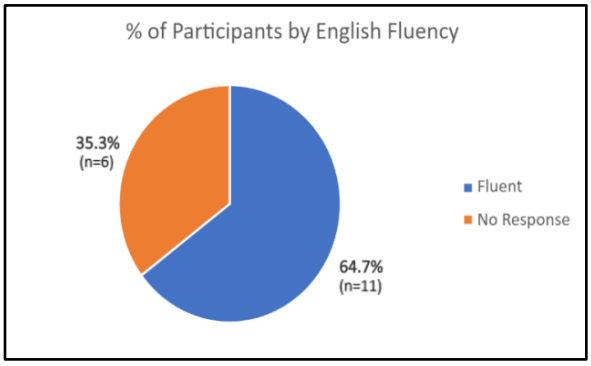
As per the Statewide Evaluation Team's Guidance, the SP Evaluation Team utilized recommended resources to calculate an initial sample size for a quasi-experimental pre-/post-test research design andarrived at the minimum total sample size of 63 participants over the three years, equaling 21 participants per year. This will yield a 5% or less error rate and a power of 80%.

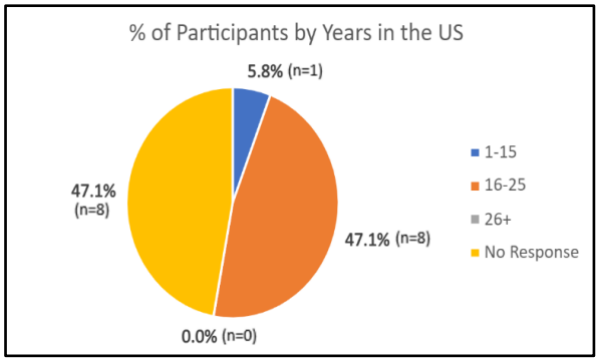
Descriptive Demographic Information of Final Sample

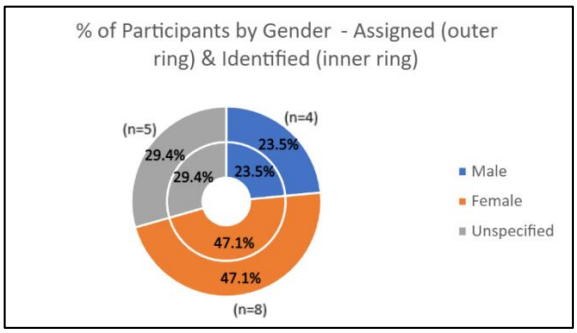
Adult participants (18 years and older) were captured via five demographical composites, including race, language fluency, years lived in the U.S., gender, and sexual orientation. Participants in this study cut across different racial groups. All respondents identified as Black and/or African American. 65% identified as Black/African American, 18% indicated being Black/African American and Multi-racial, 12% identified as Black/African American & Latino-Mexican/Chicano and 6% represents Black/African American and white. Language of communication is broadly English. Whereas 65% indicated fluency in speaking English, 35% abstained from indicating either fluency or partial fluency. About half (47%) of respondents said they have lived in the US for between 16 and 25 years, while an equal proportion (47%) abstained from indicating their time lived time in the US. All male and female respondents showed equal perception about their gender; 24% and 47% as assigned at birth and as preferred gender respectively. In addition, 71% of respondents indicated their sexual orientation as Straight/Heterosexual and 30% as Other/Unidentified. The following table uplifts adult findings.

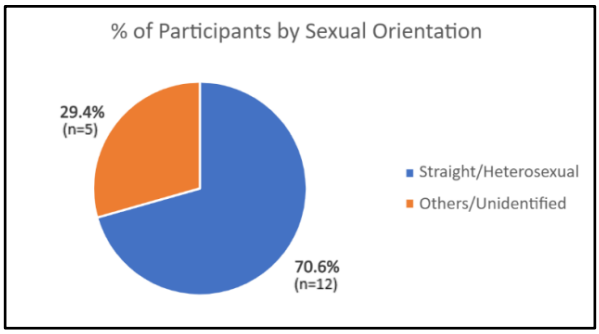
Adult Surveyed





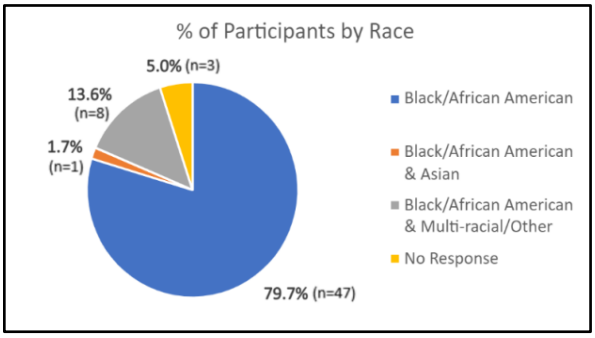


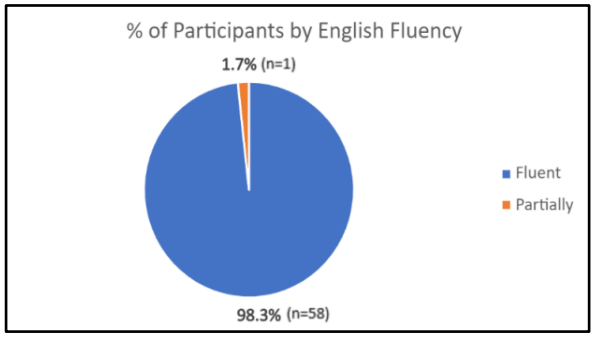


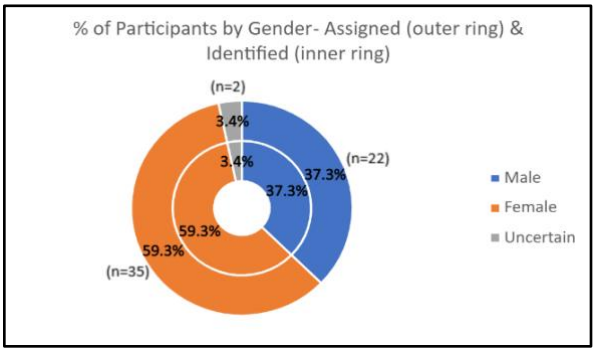


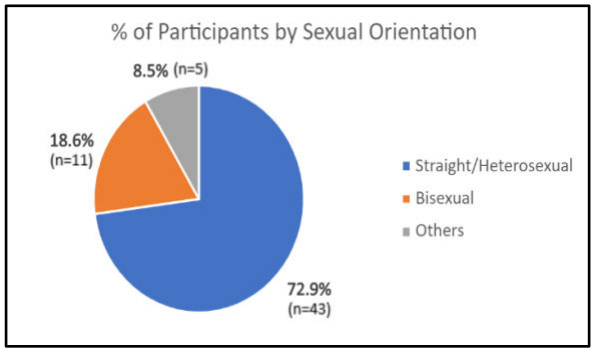
All youth participants identified as Black and/or African American. 80% said they are Black/African American. 2% indicated Black/African American and Asian, 14% identified as Black/African American and Multi-racial/Other, and 5% did not indicate an additional Race/Ethnicity beyond Black/African American. 98% said they speak fluently in the English language; however, 27% did not respond. This could account for respondents who have limited English-speaking fluency. 80% have lived in the US for 15 years and more. 37% and 59% of the respondents are female and male and believe it to be their identities as it was equally assigned at birth. Furthermore, both genders indicated being Straight/Heterosexual are represented by 73%. 19% are bisexual and 8% fall into the "Others" category. The below table punctuates this description.

Youth Surveyed









Extent to which the evaluation sample is representative of the CDEP participant universe (qualitative orquantitative description)

The evaluation sample mirrored the CDEP participant universe- see above introduction/literature review description of the universe, with rates of average poverty, health disparities, academic proficiency, educational attainment, COVID-19 infection rates, average crime, and arrest, incarceration, and probation rates reflecting that of the CDEP participant universe.

Local Evaluation Attrition

Throughout the duration of this study, 0 participants refused to participate at the onset nor chose to discontinuetheir participation after the study began.

IRB Approval Status

SP received approval; specifically, an exemption from the California Department of Health and HumanServices' (CDHH's) Office of Statewide Health Planning and Development's (OSHPD's) Committee for the Protection of Human Subjects (CPHS) on October 27, 2017. However, SP' local evaluation included the statewide evaluation team's pre and post test surveys; thus, SP had to wait until the statewide evaluation received approval. This occurred on May 15th, 2018. SP' official study began July 1, 2018, and formally ended on June 30, 2021.

As a result of an infusion of funding, SP decided to expand its local evaluation to include the below indicators and instruments/data sources. On March 4, 2020, SP received an approval to add these components.

Indicators:
(1) grade advancement/high school graduation/GED attainment;
(2) no incidences of system involvement 6, 9, and 12 months post program completion; (3.) dual/concurrent enrollment in Peralta College System;
(4) improved coping strategies, increased prosocial/resiliency/hope/protective factors; and (5.) increased life skills.

Instruments/Data Sources:
(1) Report cards, high school transcripts, high school diploma or GED or high school equivalency certificate (CHSPE);
(2) Court documents/reports;
(3) High school schedule; Peralta College System transcript; and
(4) the Youth Development and Leadership Survey- pre and post test.

Lastly, SP' original IRB application (in 2017) covered the electronic obtainment of assents and consents as well as the administration of pre- and post-test surveys. Nonetheless, to formalize this, SP submitted aCOVID modification letter to CDHH's OSHPD's CPHS stating that as a result of the COVID-19 shelter in place orders and subsequent shift to administering our CDEP remotely, we would also obtain assentsand consents as well as the administer of pre and post-test surveys remotely/electronically. On May 28, 2020, they formally approved this modification.

c. Measures and Data Collection Procedures

The following quantitative and qualitative measures were utilized to assess the following outcomes:

Quantitative/Qualitative Measures	
Indicators & Measures	*Outcomes*
Indicators: number of public system contacts, number of participants enrolled, number of referrals by public systems Measures: email, phone, video communication logs, enrollment tracker	Increase in enrollment of participants in life coaching and life skills components as a result of outreach and coordination efforts
Indicators: demographic characteristics, including ethnicity, cultural identity, class, gender, national origin, LGBTQQ+, and neighborhood affiliation, among others Measures: self-identification categories selected by participants on survey and program forms	Participant characteristics
Indicators: number of mental illness symptoms; number of prosocial/resiliency/hope/protective factors/life skills; number of coping skills; number of self-regulation skills; and number of relationships with caring adults Measures: SP CDEP Pre/Post-Test Matched Survey- adolescent (under 18 years of age) and adult (18 and above yearsold) versions; the Youth Development and Leadership Survey- post test only; interviews; focus groups, and observations, as needed; and/or staff records	A decrease in mental illness or the severity of mental illness symptoms among SP participants; an increase in coping skills/strategies, self-regulation,and relationships with caring adults; increased prosocial/resiliency/hope/protective factors; and increased life skills
Indicators: number of participants promoted, number of students graduated, number of students who attained GED/high school equivalency certificate (CHSPES) Measures: school records, staff records- including report cards, high school schedules, high school transcripts, and high school diplomas, GED and high school equivalency certificates (CHSPEs), interviews, focusgroups, and observations, as needed	Grade advancement/high school graduation/GED/CHSPE attainment- i.e., a decrease in school failure and drop
Indicators: number of contacts with the juvenile/criminal justice systems Measures: Court documents/reports	No incidences of systems involvement or further systems involvement at 6-, 9-, and 12-months post program completion- i.e., a decrease in incarceration/ recidivism among SP participants

Quantitative/Qualitative Measures	
Indicators & Measures	*Outcomes*
Indicators: number of participants dually/concurrently enrolled in Peralta College System Measures: High school schedule; Peralta College System transcript	dual/concurrent enrollment in Peralta College System
Indicators: number of attained jobs, number of family contacts Measures: Staff records, pay stubs, interviews, focus groups, andobservations, as needed	an increase in employment and family engagement

The SP Pre/Post-Test Matched Survey (both the adult and adolescent versions) captured psychological distress levels among participants by including the Kessler 6 (K6) measure. This is a 6-item screening instrument that asked respondents how frequently during the past 30 days they had experienced the following symptoms[34]:

- *Feeling nervous* (PREADULT34 and PREYOUTH34);
- *Feeling hopeless* (PREADULT35 and PREYOUTH35);
- *Feeling restless or fidgety* (PREADULT36 and PREYOUTH36);
- *Feeling so depressed that nothing could cheer you up* (PREADULT37 and PREYOUTH37);
- *Feeling that everything was an effort (*PREADULT38 and PREYOUTH38) and
- *Feeling worthless (*PREADULT39 and PREYOUTH39).

The frequency for these symptoms ranged from "none of the time" to "all of the time". The K6 is also included in the California Health Interview Survey (CHIS) and the National Survey on Drug Use and Health (NSDUH). CHIS and NSDUH used similar wording and included the same response options.

To assess the impact of impaired functioning among adult participants, the SP Pre/Post-Test Matched Survey included a set of items that made up the Sheehan Disability Scale (SDS). The SDS is also included in the CHIS and the NSDUH. Adult participants were asked to think about one month within the past 12 months when they were at their worst emotionally, and how often their emotions interfered in the following four domains: (a) performance at work or school (PREADULT41), (b) household chores (PREADULT42), (c) social life (PREADULT43), and (d) relationship with friends and family (PREADULT44). CHIS only asked these questions to respondents that were in severe psychological distress. Adolescent participants were asked about how much their fears and worries messed things up with: (a) school and homework (PREYOUTH41), (b) friends (PREYOUTH42), and (c) at home (PREYOUTH43).

Culturally based protective factors can maintain and improve health among individuals with

[34] California Health Interview Survey 2017 utilizes a 12-month reference period in addition to the 30-day reference period.

mental health disorders.[35] To capture the role of culture in maintaining and improving mental health wellbeing, the SP Pre/Post-Test Matched Survey included the following four items anchored in "present" time:

- *Your culture gives you strength* (PREADULT1 and PREYOUTH1);
- *Your culture is important to you* (PREADULT2 and PREYOUTH2);
- *Your culture helps you to feel good about who you are* (PREADULT3 and PREYOUTH3); and
- *You feel connected to the spiritual/religious traditions of the culture you were raised in* (PREADULT4 and PREYOUTH4).

The SP Pre/Post-Test Matched Survey included another set of four cultural measures, anchored in frequency experienced over the "past 30 days".

Two items are indicative of protective factors:

a) Personal culture acceptance: *Feeling connected to your culture* (PREADULT5 and PREYOUTH5); and
b) Holistic wellness: *Feeling balanced in mind, body, spirit and soul* (PREADULT6 and PREYOUTH6).

Two items are indicative of risk factors: (societal culture acceptance)

a) *Feeling marginalized or excluded from society* (PREADULT7 and PREYOUTH7); and
b) *Feeling isolated and excluded from society* (PREADULT8 and PREYOUTH8).

All pre and post-test surveys (both for adolescents and adults) as well as participant responses per year are included in the Attachments.

Three composites were constructed: Culture, anxiety, and depression. The culture composite consisted of the following measures: At present, your culture gives you strength, your culture is important to you, your culture helps you feel good about who you are, and you feel connected to spiritual/religious traditions of the culture you were raised in. The anxiety composite consisted of two of the K6/psychological distress measures: (1.) During the past 30 days/3-4 months, how often did you feel nervous? and (2.) During the past 30 days/3-4 months, how often did you feel restless or fidgety? The depression composite consisted of 4 of the K6 measures and two additional, marginalization and isolation measures: (1.) About how often during the past 30 days/3-4 months did you feel marginalized or excluded from society? (2.) About how often during the past 30 days/3-4 months did you feel isolated or alienated from society? (3.) During the past 30 days/3-4 months, how often did you feel hopeless? (4.) During the past 30 days/3-4 months, how often did you feel so depressed that nothing could cheer you up? and (5.) During the past 30 days/3-4 months, how often did you feel that everything was an effort? (6.) During the past 30 days/3-4 months, how often did you feel worthless? The inclusion of K6/psychological distress measures in the anxiety and depression composites, as well as the naming of these composites, was driven by what made the most sense for what our program addressed with participants- see above CDEP components descriptions and evaluation questions above. Further, the marginalization and

[35] Onowa McIvor, Art Napoleon, and Kerissa M. Dickie, "Language and Culture as Protective Factors for At-Risk Communities," *International Journal of Indigenous Health,* 5, no 1 (2013): 6-25, doi:10.18357/IJIH51200912327.

isolation measures were included in the depression composite as the literature shows that African American feelings of marginalization and isolation lead to depression.[36]

Participants responded to each of these measures by selecting an item on a 5-point Lickert scale, ranging from Strongly Agree to Strongly Disagree. Each response was coded and scored. An increase in score represented an improvement. Total sums are represented in Tables 1-7. Further, means/averages for pre and post data collection points related to life aspects "messed up" by mental health/emotional struggles as well as a comparison of these means were calculated and are reflected in Table 1.

Data Collection

Consent and assent forms were drafted and presented to the SP CDEP staff and a core group of participants for feedback, including understandability of the language in each form by their intended audiences. Next, forms werefinalized and then presented to an IRB for approval- please see above for the IRB approval timeline.

Consent was obtained from parents or legal guardians of evaluation participants in the treatment group, followed by assent obtainment from evaluation participants.

Parents/legal guardians of evaluation participants who agreed to discuss participation in the evaluation were ontacted to discuss the consent process, purpose of the study, types of questions asked, the option of tape recording the interviews/focus groups/observations, etc., and how the results of the study would be used.

Parent/legal guardian questions were answered. All parents/legal guardians agreed to proceed, and the SP Evaluation Team obtained assent from evaluation participants. The SP Evaluation Team and evaluation participants decided on a mutually convenient time and place to meet for survey administration/interviews/focusgroups/observations. The SP Evaluation Team confirmed at least one day before the survey administration/interviews/focus groups/observations/etc. to make certain the time and place was still convenient and reminded all evaluation participants that they could withdraw from the study at any point if they wished. As previously discussed, no evaluation participant refused to participate at the onset nor chose to discontinue their participation after the study began.

Measures and data collection procedures used, including modifications to existing measures and/or procedures, are centered on indigenous knowledge (local, cultural or LGBTQ-specific knowledge)

African American knowledge, principals, values, beliefs, history, language, and practices/traditions related to ethnic culture, social justice, intersectionality, collectivism, relations, age, CBPR, and LGBTQQ+ inclusion, were incorporated throughout all evaluation activities,

[36] Dorothy Chin, et al. "Racial/ ethnic discrimination: Dimensions and relation to mental health symptoms in a marginalized urban American population," *American Journal of Orthopsychiatry* 90, no.5 (2020): 614-622, doi: 10.1037/ort0000481.

including data collection. Emphasis was placed on African American indigenous knowledge of wholeness, community, harmony, and collective responsibility/ethic were infused at every step of the evaluation process. For example, during the evaluation design and planning phase, the SP Evaluation Team discussed the importance of introducing and framing the SP CDEP survey to community members in an African American intersectional, equity lens- i.e., uplifting the importance of reporting on their health and well-being and what it means for them and their community's legacies. Further, community members assisted in the administration of surveys and in the troubleshooting process when barriers arose. They also assisted in the translation of survey questions into understandable language for participants and used the cultural practice/tradition of cultural response, as needed. Translation and call and response were also utilized when acquiring parent agreement/consensus.

As previously mentioned, modifications were made to measures and/or procedures- please see IRB approvalnarrative above for more details.

Lastly, pretest surveys were administered at the start of SP's CDEP intervention and post tests were administered at the conclusion of SP's CDEP. Surveys were self-administered by the treatment group, with support from program staff, as needed. After surveys were completed, focus groups, interviews, and observations were conducted to complement surveys, as needed, and were convened by the SP Evaluation Team and/or program staff. SP followed all Contractor Data Security Standards outlined in Attachment G1 of the Solicitation entitled 15-10647, California Reducing Disparities Project (CRDP) Phase 2 African American Implementation Pilot Projects.

All completed surveys and focus group/interview/observation notes were stored in a locked cabinet to which only Dr. Moreno had access. Once all survey and focus group/interview/observation were inputted into electronic documents, notes were shredded. All electronic documents were stored on the web-based, encrypted Microsoft One Drive, and all documents were shared via password-protected links that had expiration dates.

Sensitive documents were not shared as attachments to electronic mail messages nor any other shared drives outside of Microsoft One Drive (such as dropbox.com) and were never placed on removable, flash drives. All laptops with sensitive information were confined to SP's Central office and always stored in a locked cabinet.

Each participant was assigned a number that was recorded on paper surveys and interview/focus group/observation notes. A legend of participant name/number was stored on One Drive. All paper files werestored in a locked cabinet.

Ongoing training was conducted with the SP Evaluation and Program Teams. Scripts of protocols related to all aspects of the evaluation were formulated to ensure that the same procedures were followed, from start to finish, with each participant in the treatment group. During training, role plays that addressed the mostcommon errors related to accuracy and reliability were executed and discussed in an effort to avoid errors.

Administrative data used to assess or contextualize outcomes

Internal SP records, as well as CDPH OHE Quarterly Progress Reports and Statewide Evaluation Semi-Annual Reports, were used to assess and contextualize the above discussed outcomes, as reflected in the findings sectionbelow.

d. Fidelity and Flexibility

A formal assessment of the following domains of CDEP implementation fidelity was conducted:

- Adherence;
- Quality of Delivery; and
- Participant Responsiveness.

Criteria, measurement tools, and protocols for each domain was as follows:

Domain	Criteria	Measurement Tool	Protocol
Adherence	(1) All participants willreceive 90% of the components. (2.) Staff will deliver 100% of the components to all participants.	(1) Sign in sheets and (2) staff records.	The SP evaluation teamand/or staff will assess adherence via the measurement tools.
Quality of Delivery	(1) 80% of participantswill report overall satisfaction of the SP CDEP and (2.) will provide a description ofthe SP CDEP that is in alignment with SP's description of it.	(1) Survey assessing (a.) overall satisfaction in program participation and (2) participant description of the SP CDEP.	The SP evaluation teamand/or staff will assess adherence via the measurement tools.
Participant Responsiveness	85% of Know Your Rights (KYR) participantswill report that they gained new knowledge and skills related to knowing their rights.	(1) Participant observation of 2 workshops of KYR.	The SP evaluation teamand/or staff will assess adherence via the measurement tools.

Changes made to the CDEP (or recommended for future implementation) based on fidelity assessment information

All criteria were met for the aforementioned fidelity domains. Successful implementation of all aforementioned CDEP components with all participants, high program satisfaction, and KYR knowledge and skills attainment contributed the successful outcomes outlined below- see Findings. Nonetheless, it is worth noting that as a result ofthe COVID-19 shelter in place orders, CDEP implementation migrated to a virtual context.

Balancing of fidelity & flexibility (e.g., formative evaluation methods, including CBPR, to explore/understand if the CDEP was working and whether changes were needed to strengthenit to meet theneeds of the participants, IPP, community, local/state circumstances, etc.)

During the 2019-2020 year, participants provided feedback and indicated their need for CDEP implementation tomigrate to virtual delivery; SP accommodated this request accordingly.

Further, early focus groups of participants indicated the need to scale up SP's CDEP given the need for it in the largerAfrican American population. Consequently, SP exponentially augmented its sustainability efforts, which led to a significant increase in investment of its CDEP by the Governor's California Community Reinvestment grant, Edna McConnell Clark Foundation's Propel Next grant, and Alameda County's Probation Department's Youth Employment grant. Further, SP led a statewide sustainability effort which led to a four-year, $63.1 million investment in the continuation and Phase III planning via California's FY 2021-205 budget.

e. Data Analysis Plan Implemented

Quantitative statistical analyses (e.g., inferential tests, effect-sizes, comparisons tested)

Quantitative data was analyzed using SPSS. Specifically, composite variables were constructed and a comparison of means between the pre and post data collection points on disruption of life aspects, as well asstatistical analysis (Chi square and ANOVA), were conducted.

Qualitative analytic strategies (e.g., how data was coded, analyzed, use of inter-rater reliability methods)

As previously discussed, the SP' Evaluation Team conducted a range of qualitative approaches, including direct observations, focus groups, and interviews to provide a more comprehensive story of quantitativedata with respect to the intended outcomes of the five program components and to understand the personal experiences of the participants as they accessed, received services, and reflected on the services they received.

Questions were designed to understand the effectiveness of the model, such as identifying ways in which the strategies employed made a difference in their lives, the ways in which the model was culturally responsive to them, and ways in which the model helped give them the tools to navigate the multiple systems in which they encountered. Qualitative data analysis consisted of transcribing, coding, and analyzing all qualitative research responses, with an eye towards understanding participants' progress and challenges and how to further refine SP'sCDEP. More specifically, aggregated, qualitative analysis was conducted and included: Review and theme identification within each interview/focus group/observation; theme distillation; word frequency analysis; at least two rounds of coding; and reconciliation and final review.

The following Table summarizes evaluation questions as well as analytical techniques used for each:

Evaluation Question	Indicators & Meetings	Type of Analytical Strategy	Types of Test/Analytical Technique
To what extent were outreach and coordination efforts effective in enrolling participants in life coaching and life skills components?	Indicators: number of public system contacts, number of participants enrolled, number of referrals by public systems Measures: email, phone, video communication logs, enrollment tracker	Qualitative	Coding of themes; higher order themes analysis
What are the characteristics of participants enrolled in SP?	Indicators: demographic characteristics, including ethnicity, cultural identity, class, gender, national origin, LGBTQQ+, and neighborhood affiliation, among others Measures: self-identification categories selected by participants on survey and program forms	Quantitative	Total summing of participants' self-identification
To what extent was there a decrease in mental illness or the severity of mental illness symptoms among SP participants? To what extent was there an increase in prosocial/resiliency/hope/protective factors/life skills as well as an increase in coping skills, self-regulation, and relationships with caring adults among SP participants?	Indicators: number of mental illness symptoms; number of prosocial/resiliency/hope/ protective factors/life skills; number of coping skills; number of self-regulation skills; and number of relationships with caring adults Measures: SP CDEP Pre/Post-Test Matched Survey- adolescent (under 18 years of age) and adult (18 and above years old) versions; the	Quantitative	Total summing, means, means comparison, Chi square, and ANOVA

Evaluation Question	Indicators & Meetings	Type of Analytical Strategy	Types of Test/Analytical Technique
	Youth Development and Leadership Survey- post test only; interviews; focus groups, and observations, as needed; and/or staff records		
To what extent was there grade advancement/ high school graduation/GED/high school equivalency certificate (CHSPES) attainment among SP participants? To what extent was there dual/concurrent enrollment in the Peralta College System among SP participants?	Indicators: number of participants promoted, number of students graduated, number of students who attained GED/high school equivalency certificate (CHSPES) Measures: school records, staff records- including report cards, high school schedules, high school transcripts, and high school diplomas, GED and high school equivalency certificates (CHSPEs), interviews, focus groups, and observations, as needed Indicators: number of participants dually/concurrently enrolled in Peralta College System Measures: High school schedule; Peralta College System transcript	Quantitative	Total summing at the start and at the end of CDEP intervention
To what extent were there no incidences of system involvement 6-, 9-, and 12-months post program	Indicators: number of contacts with the juvenile/criminal justice systems	Quantitative	Total summing at the start and at the end of CDEP intervention

Evaluation Question	Indicators & Meetings	Type of Analytical Strategy	Types of Test/Analytical Technique
completion among SP participants?	Measures: Court documents/reports		
To what extent was there an increase in employment and family engagement among SP participants?	Indicators: number of attained jobs, number of family contacts Measures: Staff records, pay stubs, interviews, focus groups, and observations, as needed	Quantitative	Total summing at the start and at the end of CDEP intervention

Data triangulation (various data sources) to increase confidence in conclusions/findings

In an effort to overcome potential bias resulting from the use of a single method/source of data (i.e., SP CDEP Pre/Post-Test Matched Survey), data triangulation was employed in this study. Specifically, the following data sources were also included in this study: staff records, school records- including report cards, high school schedules, high school transcripts, high school diplomas, GED and high school equivalency certificates (CHSPEs), high school schedules, Peralta College System transcripts, court reports/documents, and interview,focus group, and observation notes.

Section 7. Results

To what extent were outreach and coordination efforts effective in enrolling participants in life coaching and life skills components?

SP' outreach and coordination efforts with school and funding (namely, California Department of Pubic Health- CRDP, City of Oakland, Oakland Fund for Children and Youth, City of Oakland, Oakland Unite Initiative, Alameda County Social Services Agency, and California Community Reinvestment Grant Program) partners were highly effective with respect to a multitude of areas, including initial engagement of potential participants, participant enrollment, and the coordination between multiple public systems.

Between May 2017 and April 2021, 69 participants were enrolled and 71 families were reached. Beginning in March 2020, the global pandemic reached Oakland, California resulting in federal, state, and local states of emergency requiring extensive shelter in place public health orders. As of the date of this submission, remnants of public health restrictions remain in place and life has not returned to pre pandemic norms.

During the pandemic a wide variety of COVID relief services were provided to participants and families, including assistance with applying for unemployment benefits, pandemic CalFresh, direct cash assistance, food, personal hygiene, Personal Protective Equipment (PPE), and technology equipment. Educational and support services were provided to participants via remote platforms, including Life Coaching, Know Your Rights/Ethnic Studies, Urban Arts, and family support services. SP also supported in person learning hubs for the most at-risk students. In collaboration with Oakland Unified School District/Peralta Community College System, SP executed 20 dual enrollment, Ethnic Studies classes at several school sites between May 2018 and April 2021. Further, during the Spring 2019 teacher strike, SP successfully navigated this partnership so that students were not dropped from their courses and earned their credits.

Another area in which SP efforts were highly effective included the sustainability of the California Reducing Disparities Project (CRDP).

Between March 2019 and July 2021, SP led the CRDP Cross Population Sustainability Steering Committee to accomplish:

1. Inclusion of $63.1 m in California FY 2021 budget, to support CRDP Phase II extension and Phase III planning. Resulting in the availability of $1.2 million in additional state funding for each of the 35 IPPs and additional contracts for technical assistance, cultural brokerage, and statewide evaluation.
2. Support of this investment by both the California Senate and Assembly as well as 20 statewide, behavioral health associations.
3. Execution of a successful 2-day, legislative briefing as part of the Third Annual CRDP convening.
4. Execution of over 20 IPP leaders providing testimony at all budget hearings of both the California Senate and Assembly.
5. Execution of a 2-day, CRDP Sustainability Summit in October 2020 with attendance of

over 100 participants on both days of the convening.
6. Creation of IPP introduction video representing all 35 IPPs across the 5 population groups for debut at the Sustainability Summit.
7. Collection of 20 IPP Success Stories as well as 2 videos which were used during sustainability advocacy efforts.
8. Creation CRDP communications collateral materials.
9. Became the advisory body to California Pan Ethnic Health Network (CPEHN) in the implementation of the Education, Outreach, and Awareness contract.
10. Development and activation of a rapid response network to respond to items, including, but not limited to, improving MHSA regulations, providing input into Request for Proposals (RFPs) and future legislation, and pushing for sustainability.
11. Organization of two webinars for the larger IPP community on the following topics, held on 08/16 and 09/04: the history and current context of the CRDP, the Mental Health Services Oversight and Accountability Committee (MHSOAC) and the CA budget process, and possible sustainability strategies.

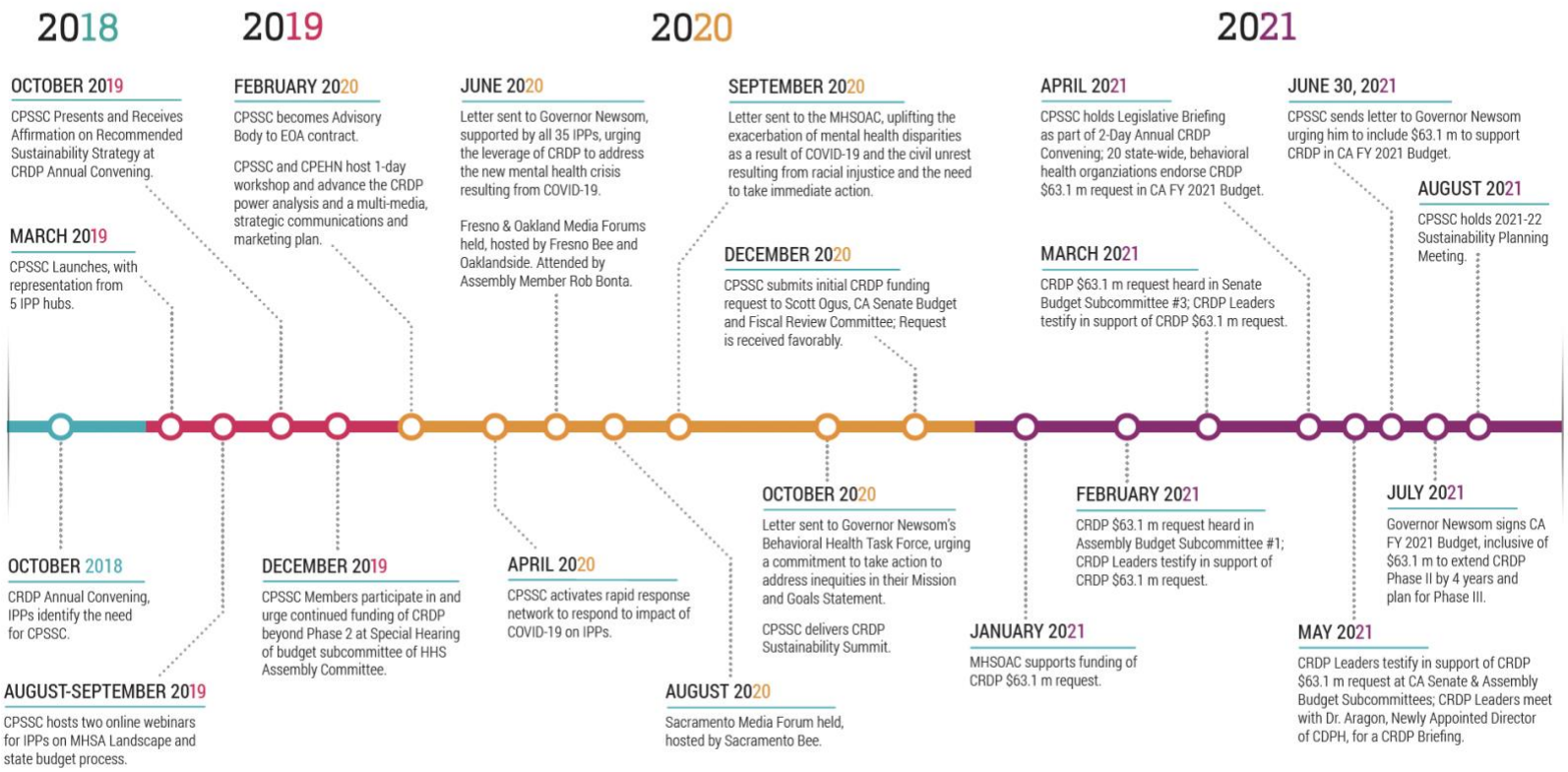
The CPSSC timeline graphically illustrates the activities and impact.

In addition to participant enrollment, family engagement, and CRDP sustainability, SP' partnerships with the City of Oakland, Oakland Unite Initiative, yielded the following additional results: (a.) Successfully completed several years of grant funding. (b.) As a result of participation in a series of town hall meetings to advise the City of Oakland's Department of Violence Prevention's spending plan and continued advocacy, the contracts will move forward for a new 12-month term. (c.) Provided internships and summer jobs to several youth.

For a comprehensive list of SP's outreach and coordination efforts for years 2018-2021, please refer to Attachment 13.

California Reducing Disparities Project
a culturally responsive mental health initiative

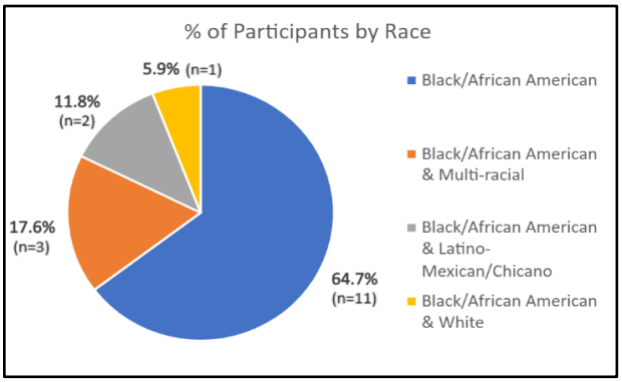
California Reducing Disparities Project, Cross-Population Sustainability Steering Committee Timeline

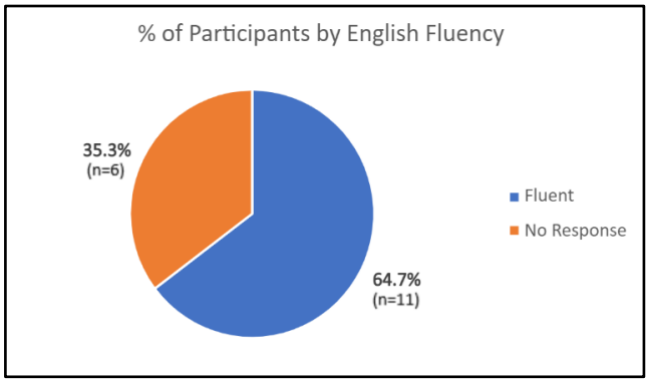


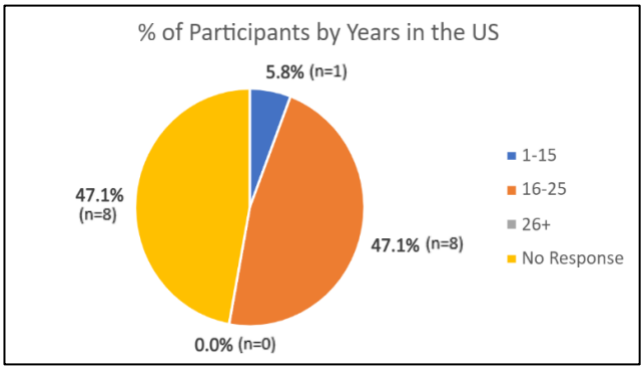
What are the characteristics of participants enrolled in SP? (Process)

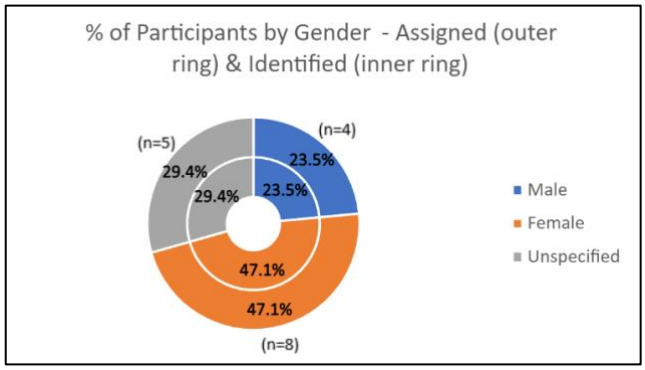
Adult participants (18 years and older) were captured via five demographical composites, including race, language fluency, years lived in the U.S., gender, and sexual orientation. Participants in this study cut across different racial groups. All respondents identified as Black and/or African American. 65% identified as Black/African American, 18% indicated being Black/African American and Multi-racial, 12% identified as Black/African American & Latino-Mexican/Chicano and 6% represents Black/African American and white. Language of communication is broadly English. Whereas 65% indicated fluency in speaking English, 35% abstained from indicating either fluency or partial fluency. About half (47%) of respondents said they have lived in the US for between 16 and 25 years, while an equal proportion (47%) abstained from indicating their time lived time in the US. All male and female respondents showed equal perception about their gender; 24% and 47% as assigned at birth and as preferred gender respectively. In addition, 71% of respondents indicated their sexual orientation as Straight/Heterosexual and 30% as Other/Unidentified.

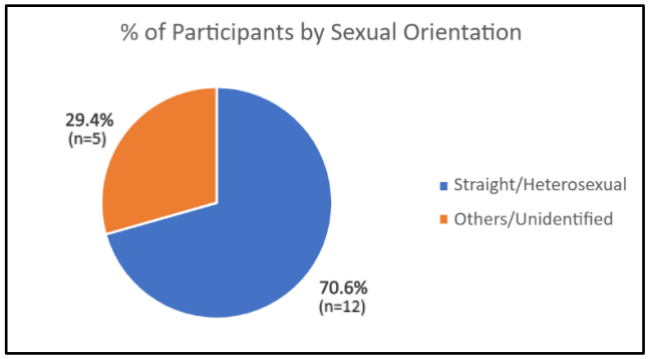
Adults Surveyed





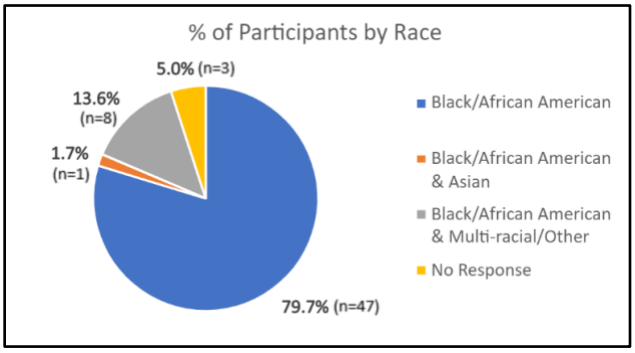


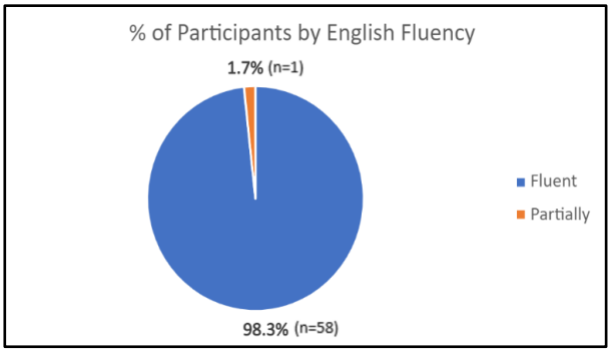


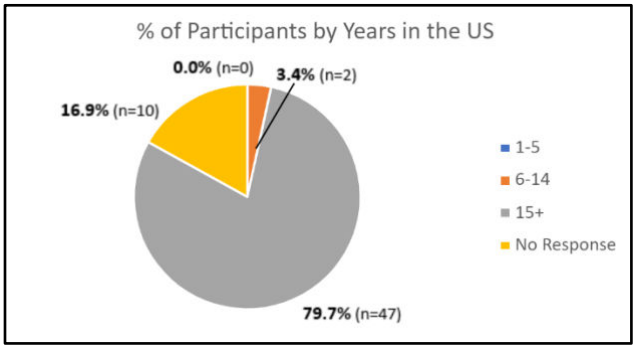


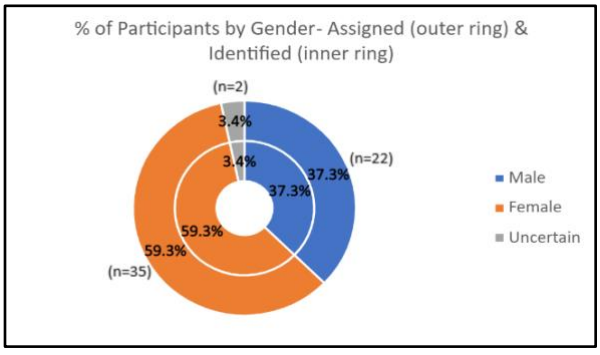
Youth Surveys

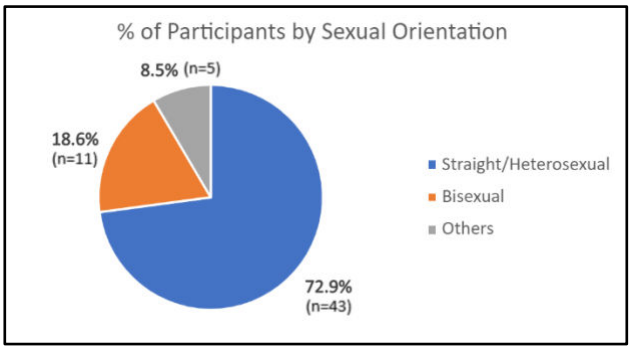
All youth participants identified as Black and/or African American. 80% said they are Black/African American. 2% indicated Black/African American and Asian, 14% identified as Black/African American and Multi-racial/Other, and 5% did not indicate an additional Race/Ethnicity beyond Black/African American. 98% said they speak fluently in the English language; however, 27% did not respond. This could account for respondents who have limited English-speaking fluency. 80% have lived in the US for 15 years and more. 37% and 59% of the respondents are female and male and believe it to be their identities as it was equally assigned at birth. Furthermore, both genders indicated being Straight/Heterosexual are represented by 73%. 19% are bisexual and 8% fall into the "Others" category. The below table punctuates this description.











To what extent was there a decrease in mental illness or the severity of mental illness symptoms among SP participants? To what extent was there an increase in prosocial/resiliency/hope/protective factors/life skills as well as an increase in coping skills, self-regulation, and relationships with caring adults among SP participants? (Outcome)

During the first two years, nearly half of all participants showed improvements between SP CDEP pre and post measurementpoints on the composite variable for Culture, a protective factor that offsets mental illness. In the third year, however, when services were forced to move to virtual spaces by the COVID-19 pandemic, improvements were noted; however, there was a decrease in the percentage of participants who saw improvement on the Culture and Depression composite measures compared to first- and second-year participants. Figure 1 outlines these results.

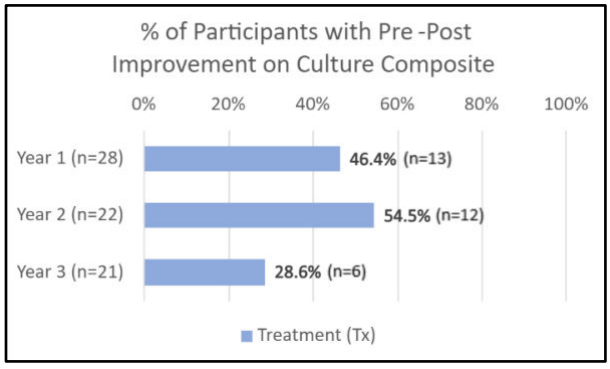


Figure 1. Percentage of Participants Who Experienced Improvement on Culture Composite Variable.

Across all three years, a substantial minority of program participants showed improvements between SP CDEP pre and postmeasurement points on the composite variable for Anxiety. In the third year, 42.9% of treatment group participants demonstrate improvements on this composite. Figure 2 outlines these results.

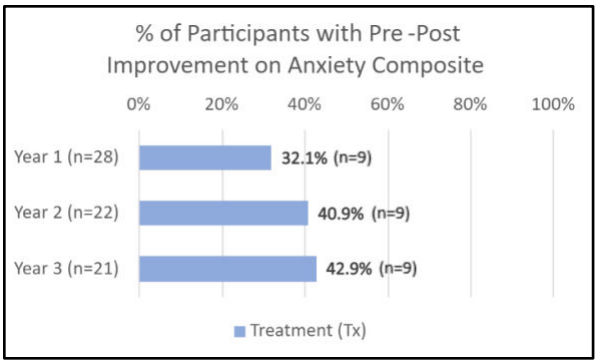


Figure 2. Percentage of Participants Who Experienced Improvement on Anxiety Composite Variable.

During the first two years, nearly half of all participants showed improvements between SP CDEP pre and post measurement points on the composite variable for Depression. In the third year the proportion of treatment group participants who saw improvement on this composite dipped marginally. Figure 3 outlines these results.

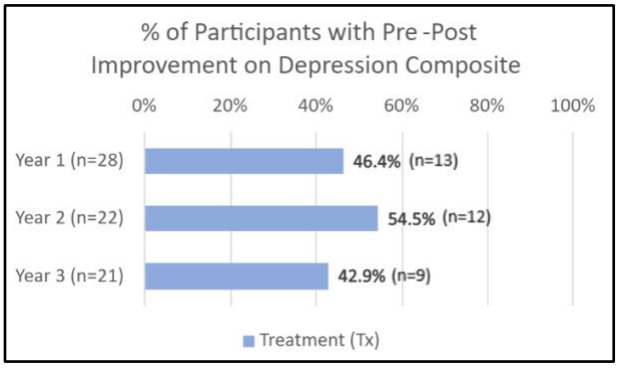


Figure 3. Percentage of Participants Who Experienced Improvement on Depression Composite Variable.

We built a single variable that combined all three of the Culture, Anxiety, and Depression composite variables and considered whether a client experienced improvement on any of the composites between pre and post measurement points - see Figure 4 for results.During the first two years, 85.7% and 81.8% of participants showed improvements on the Any Improvement Composite Variable. In the third year, however, when participants were required to live under the multi-jurisdictional shelter in place orders, attend school virtually, and services were forced to move to virtual spaces by the COVID-19 pandemic, we saw a drop in the percentage of participants who saw improvement to 61.9% on this composite measure. Locally and nationally, youth experienced increases in feelings of depression as a result of the social isolation resulting from COVID-19 public health guidance.

Chi-square analyses were conducted on these differences. Due to the small n values across years, none of these differences produced a p-value signifying statistical significance.

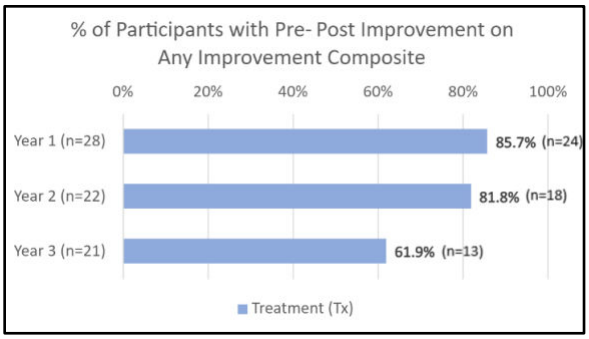
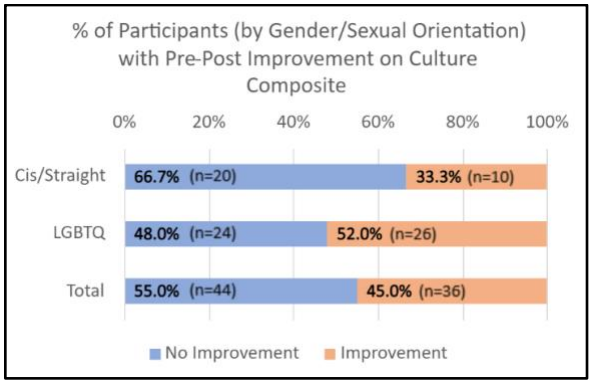


Figure 4. Percentage of Participants Who Experienced Improvement on Any Improvement Composite Variable.

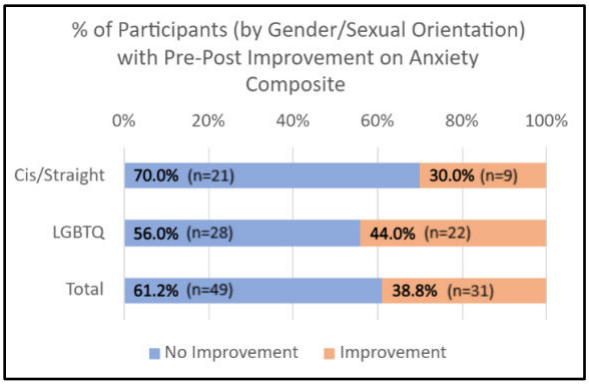
Next, we conducted a comparison of results between Cis/Straight-identified and LGBTQ+ participants on the Culture, Anxiety, and Depression composite variables - see Figures 5, 6, and 7. LGBTQ+ participants were generally more likely to show pre-post improvement than Cis/Straight participants onthe three composite variables.



Chi-square test shows *p-value* to be .081 (approaching significance).

Figure 5. Percentage of Participants Who Experienced Improvement on Culture Composite Variable for Cis/Straight and LGBTQ.

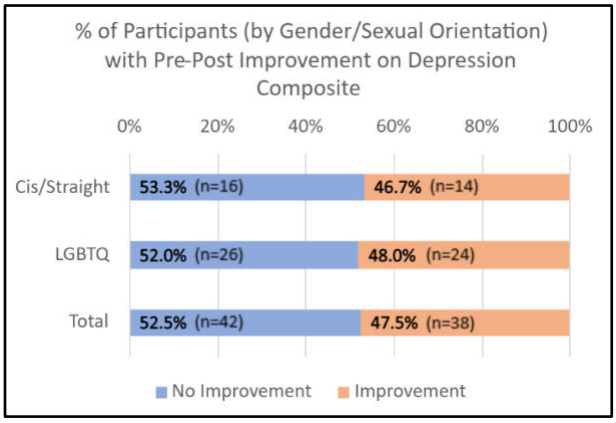
In Figure 5, the results were approaching statistical significance, with a p-value of 0.081 and degrees of freedom at 1. The chi-square value was 2.64.



Chi-square test shows *p-value* to be .157 (not significant).

Figure 6. Percentage of Participants Who Experienced Improvement on Anxiety Composite Variable for Cis/Straight and LGBTQ.

In Figure 6, the results were not statistically significant, with a p-value is 0.157 and degrees of freedom at 1. The chi-square value was 1.548.



Chi-square test shows *p-value* to be .546 (not significant).

Figure 7. Percentage of Participants Who Experienced Improvement on Depression Composite Variable for Cis/Straight and LGBTQ.

In Figure 7, the results were not statistically significant, with a p-value is 0.546 and degrees of freedom at 1. The chi-square value was 0.013.

We also built a composite variable combining the scales that were designed to measure the extent to which respondents' life aspects were disrupted by their fears and worries. These scales included: How much have your fears and worries messed things up with school and homework? How much have your fears and worries messed things up with friends? How much have your fears and worries messed things up at home? On this variable, the higher the score, the more disrupted the respondent's life aspects.

We conducted a comparison of means between the pre and post data collection points. Across all three years, this analysis showed a slight increase in disruption of life aspects between pre and post. In Year 3, however, we saw dramatically lower levels of life disruption, both pre and post. The lower levels of disruption may have been related to the reduced complexity of life, such as the challenges of navigating school systems that came with COVID-19-related changes to work, school, and life in general. Table 1 outlines these results.

Table 1. Percentage of Participants Who Experienced Improvement on Life Aspects "Messed Up" by Mental Health/Emotional Struggles.

	Treatment (Tx)	
	Pre	Post
Year 1 (n=28)	2.39 (SD=2.06)	2.86 (SD=2.26)
Year 2 (n=22)	3.59 (SD=2.22)	3.68 (SD=2.42)
Year 3 (n=21)	1.24 (SD=1.81)	1.57 (SD=2.50)

Analysis of Variance (ANOVA) was conducted on differences in Tables 1-4 and 8. Due to the small n values across years, noneof these differences produced a p-value signifying statistical significance.

The evaluation was designed to include additional data collection from local youth development surveys administered by SP in partnership with the Oakland Fund for Children and Youth. The City of Oakland's Fund for Children and Youth's (OFCY) evaluation process included the administration of the Youth Development and Leadership Survey (YDLS), most of which consisted of questions drawn from validated surveys used in the youth development field. However, the YDLS tool itself was not validated. OFCY administered this survey during the 2018-19 and 2020-21 school year; however, they suspended survey administration for the 2019-20 school year. During the 2019-20 year, OFCY suspended the survey because of the overlapping of the timing of the COVID shelter in place orders and when the survey was scheduled to launch. Simply put, OFCY did not have the capacity to pivot the survey administration to the remote setting in time for its launch. Consequently, there were no findings for this year. 66 youth completed the YDLS during the 2018-19 year and 82 youth completed it in 2020-21. The following Table 2 reflects results:

Table 2. Percentage of Youth who Improved/Increased Protective Factors

Protective Factor	2018-19 Outcomes	2020-21 Outcomes
Greater connections to caring adults	90%	79%
Increased confidence and self-esteem	92%	74%
Improved decision-making and goal setting	94%	82%
Development and mastery of skills	89%	82%
Greater empowerment and agency	93%	Not measured
Increased knowledge of and engagement in community	91%	82%
Increased leadership capacity	91%	73%
Increased risk avoidance/conflict resolution	90%	Not measured
Increased sense of belonging and emotional wellness	Not measured	82%
Increased persistence and resiliency	Not measured	73%

To what extent was there grade advancement/ high school graduation/GED/high school equivalency certificate (CHSPES) attainment? To what extent was there dual/concurrent

enrollment in the Peralta College System? (Outcome)

The following table outlines grade advancement/graduation for 69 enrolled participants. Approximately 100% of all participants either advanced a grade or graduated. This data was gathered via school records-including report cards, high school transcripts, high school diploma, GED/high school equivalency certificate (CHSPE); high school schedules; staff records. All participants were determined to be at risk of the school failure/drop out and related risk factors (see introduction/literature review section), as identified by participants and/or referring sources, most of whom represented school and justice systems.

Table 3. Percentage of Participants Who Experienced Grade Advancement/Graduation.

Time Period	# of participants enrolledin SP's CDEP	# of participants at risk of school failure/drop out at time of enrollment (n/%)	# of students who advanced a grade orgraduated by July 2020/2021 (n/%)
03/04/20-07/31/20	69	69/100%	69/100%
08/01/20-07/31/21	69	69/100%	68/99%

On average, 67% of participants were dually/concurrently enrolled in the Peralta College System and successfully completed their community college courses.

Evaluation Question 5:

To what extent were there no incidences of system involvement 6, 9, and 12 months post program completion? (Outcome)

Table 4 outlines systems involvement for participants during the following two time periods: 03/04/20-07/31/20 and 08/01/20-07/31/21. 100% of participants did not become systems involved, or if systems involved at the time of enrollment, did not go into a higher level of involvement. This data was gathered via court documents/records, staff records. All participants were determined to be at risk of the systems and related risk factors (see introduction/literature review section), as identified by referring sources.

Table 4. Percentage of Participants Who Did Not Experience Systems Involvement.

Time Period	# of participants enrolled in SP's CDEP	# of participants at risk ofor involved with systems (including, child welfare, juvenile/criminal justice, etc.) at time of enrollment (n/%)	# of students with no systems involvement or ifsystems involved, did notgo in to a higher level of involvement by July 2020/2021 (n/%)
03/04/20-07/31/20	30	30/100%	30/100%
08/01/20-07/31/21	69	69/100%	69/100%

To what extent was there an increase in employment and family engagement among SP participants? (Outcome)

Table 5 outlines participant employment. 100% of participants became employed during their

involvement with the SP CDEP. Table 6 outlines family engagement- 100% of families became engaged. This data was gathered via school, staffrecords, and interviews.

Table 5. Percentage of Participants Who Became Employed.

Time Period	# of participants enrolled in SP's CDEP	# of participants unemployed at time of enrollment (n/%)	# of students who became employed by July2020/2021 (n/%)
03/04/20-07/31/20	30	30/100%	30/100%
08/01/20-07/31/21	69	69/100%	69/100%

Table 6. Percentage of Families Who Were Engaged.

Time Period	# of participants enrolledin SP's CDEP	# of families targeted for engagement among SP CDEP participants (n/%)	# of families engaged among SP CDEP participants (n/%)
03/04/20-07/31/20	30	30/100%	30/100%
08/01/20-07/31/21	69	69/100%	69/100%

As previously mentioned, another result during the 2019-2020 year included participants indicating their need for CDEP implementation to migrate to virtual delivery; SP accommodated this request accordingly.

At the conclusion of this 3-year study, two focus groups were conducted with the LSJ Life Coaching Program Team, centered on the following questions:

1. **Do you think the CDEP achieved its's short-term strategic objectives including increased access to trauma informed care, relationships with caring adults, ability to navigate education and juvenile justice systems, family engagement, and access to culturally responsive mental health services?**

2. **What was the impact on Service Navigation Services for CRDP youth?**

    a. What was the impact on service navigation specifically due to the COVID-19 pandemic?

3. **What was the impact of the Life Coaching Services? Provide specific examples related to youth served?**

    a. What about coping skills/strategies?

4. **What was the impact of the "Know Your Rights" (KYR) education provided through the dual enrollment college level Ethnic Studies/African American Studies classes or that you provided 1-1.**

    a. Impact on learning about their own culture?

The Team indicated that they felt successful in meeting all the objectives when engaging and working with participants. They pointed to intentionality of ensuring that life coaches and staff look like the communities that they are served, reducing initial barriers to connection as the participants feel seen, heard, and in turn, have a corrective experience. They described the LSJ Life Coaching model as a dynamic, didactic and facilitative approach depending on the needs of the participant and/or family. The Team implemented this approach by leaning in with their participants to collaboratively problem-solve and discover non-traditional, non-stigmatizing social and emotional learning and mental health practices to counter the adverse events that occurred to them. They reported that participants and their families gained their own agency by building the skills to continue to navigate systems and resources, allowing them to be leaders in their communities, moving from student to teacher in navigating life's future challenges.

Examples:

- *"One foster youth in particular did not feel prepared for high school and felt that life was coming at her at a very fast pace. The Life Coaching Program, linkages to resources (housing, mental health, 1:1 sessions, mentorship, social emotional learning, and the whole wrap-around approach allowed her to focus on her mental health. She was able to re-enroll in counseling and find her own living situation away from foster mom who was not ideal."*

- *"I have never heard them talk about feeling stigmatized through this particular project. Lots of times when you talk to young people, they'll tell you how they've been stigmatized or they've been pathologized within different service models, at school, or in the different systems, and I have never heard a young person say that about SP, our Life Coaches, or our model at all. As the caring relationships are built out, young people come and ask for help and that's a big deal for a young person. And that's an important part of having your own agency. I see the young people that Life Coaches are working with exhibiting a lot of self-agency and going after services on their own even without theirLlife Coaches which is a significant indicator."*

The Team indicated that it is abundantly apparent that SP is an anchor organization for the communities it serves. They described SP as a resource hub that provides and brokers services for Alameda County's most vulnerable youth. By building a secure base with participants, young people knew that they could depend on SP to provide culturally relevant opportunities and solutions to challenges they are faced with. SP provided low barriers to entry- for example, no appointment was needed, youth had direct access to their Life Coaches, there was minimal intake/administrative steps, and participant choice was emphasized regarding the issues they wanted to address. Further, SP provided participants and their families with a positive and person-centered experience and built the capacity of participants in navigating systems and resources on their own. They also uplifted the COVID-19 pandemic's unique set of challenges, exacerbated by the changing landscape due to shutdowns and quarantines and the lack of healthy outlets throughout the day.

Examples:

- *One Life Coach supported a participant who was undocumented in securing a pathway to*

citizenship. This individual was connected to another SP program, which then set up legal assistance.

- *Another Life Coach assisted a participant in the process of getting a photo identification from the CA Department of Motor Vehicles, which allowed them to explore employment opportunities. This Life Coach implemented the "I do, we do, you do" approach in supporting and building capacity with this young person.*
- *"He pushed beyond where most people would have broken." – A life coach working with a high school student indicated that SP' service navigation greatly benefitted him, resulting in an increase from 30% attendance and failing all but one class to 70% attendance and passing all but one class. When COVID hit, his challenges were amplified. His sister reported abuse, and their father was incarcerated. From that point, the participant was taking care of his siblings and had to take on the responsibility of being the breadwinner in the household at the age of 18, all while completing his high school education. The student then transferred to an alternative education center. The Team helped him navigate conversations with counselors and teachers. The student graduated from high school and found full-time employment, and he was able to keep his home and support his elderly grandparents.*

SP had a strong focus on emotional and empathetic support tailored to participants and families. SP' Life Coaches strengthened protective factors and built resiliency in participants, thereby interrupting the cycle of poverty and structural violence. Life Coaches collaboratively identified supports and coping strategies for participants by meeting them where they were at and by instilling confidence in every interaction.

Examples:

- *A participant was in kinship foster care (form of foster care with some governmental oversight to the family unit) when he started with SP. His mother had a history of substance use, which impacted the engagements she had with her son. She was a present mother in a lot of ways, but the young person expressed that the breakdown in communication between his mother and him was a huge barrier to his success. As a result of this, the mother agreed to designate a SP Life Coach to represent her at meetings with the school district on her behalf. The participant took some classes while incarcerated and felt he wanted to give up and was anxious because he was unsure if those credits would transfer to his new school. The newfound stability from the Life Coach and the identified supports and grounding strategies enabled this student to maintain his composure despite being triggered.*
- *One participant was on probation, his father was in the hospital for months, and his mother was struggling financially. This Life Coach supported this participant in identifying healthy coping strategies. The student decided to start working out to channel his energy, so his Life Coach supported him by sending workout plans and is now benefiting greatly from his self-care routine. Another student walked to the lake every morning, and this was extremely helpful because she was able to start the day by clearing her mind.*

The KYR class catered to adjudicated youth. SP offered a space where systems-involved participants could feel empowered and safe. The topics covered laid out strategies for prevention. Students were able to better navigate education systems, get off probation and recidivism rates decreased after involvement with this course.

A current Life Coach was able to relate personally given that he was a former student of another Life Coach ("JB") in the past. With JB's guidance, he became aware of his educational rights; this gave him a sense of faith in the education system and motivated him to continue to pursue his education. He then went on to graduate from high school and was second in his family to attend college. Further, this Life Coach was tremendously shaped by learning about his culture. He reported learning more about his culture in this setting than from his own parents and from school. He said the dual enrollment college class really focused on how a person who looks like him can show up in the world and how to represent in the community. The young Life Coach is now able to pass this down to his bi-racial daughter and change the narrative for his family's future. Furthermore, participants expressed themselves and engaged with their culture through various mediums, such as music, art, poetry, spoken word, etc. During the height of the 2019 racial reckoning, JB's message and counter-narrative was that media's portrayal of Black and African-American boys/men are not the only images that exist. The counter-narrative challenged the media by personally connecting the participants with African American male leaders in Urban Arts and other sectors.

As a whole, the LSJLC Team expressed being able to draw from decades of experiences, both collectively and individually. This ethnically diverse and multi-generational team highlighted their ability to lean on each other to understand best practices while also learning from their participants given the expertise within each individual. Overall, the group fearlessly and ardently described overcoming their own personal trepidations which the young people find inspiring as it gives them a realistic and encouraging road map of how to move confidently in their communities despite the trauma and adverse effects experienced.

Results – Meta Analysis Data

N/A

Section 8. Discussion and Conclusion

Discussion of findings must be prefaced by three major historic events that provided unanticipated and inescapable impact on participants, community, CDEP, SP, and the evaluation process. The first event was the murder of George Floyd, an African American son and father, at the hands of the Minneapolis police, an event that ignited many communities in the U.S. and the larger global community. The impact of the murder of Mr. Floyd and other African American men and women at the hands of largely white law enforcement officials laid bare the historical trauma of white supremacy and police violence against African Americans. The African American youth and young adults and the staff at the heart of the CDEP were profoundly impacted and carried the images of the murders of George Floyd, Breonna Taylor, Ahmaud Arbery, and others burned into their psyches as the program staff brought historical and cultural perspective, and resources to anchor participants in the potential of their futures. The second event was the rise of the Black Lives Matter movement, a movement that reminded American society of the critical power of Black organizing and unexpected wider mainstream appeal of the message. The final unprecedented event was the COVID-19 Pandemic, a watershed event that changed every aspect of the context of the implementation and evaluation of the CDEP. For K-12 students in Oakland the modality of instruction, one of the most fundamental aspect of school, shifted within days as physical facilities were abandoned and learning migrated to virtual classrooms and remote learning became the norm for the next 18 months. At the time of this writing, the depth of long-term impacts of these events are yet to be determined.

The contextual events summarized above along with the data and statistics outlined in the Literature Review section of this report reinforce the social, health, and economic disparities systemically imposed on African Americans youth and their families. The health impact of the toxic stress created by the real time trauma of growing up in urban cities and the compounded impact of historical racism and inequity result in increased levels of depression, anxiety, social isolation, lack of educational attainment, economic progress, and lower life expectancy among low-income African American communities in Oakland. These conditions created increased and urgent need for prevention and intervention services to mitigate the onset of mental health illness in African American youth.

As African American youth develop into young adults, protective factors can build resiliency and buffer this vulnerable population from the compounding trauma associated with navigating multiple public systems undergirded with systemic racism, including education, child welfare, juvenile justice, and public health. Culture is one of the critical protective factors shown to increase resiliency in youth and support greater self-agency. Therefore, the SP CDEP provided this protective cloak over the African American participants served. As discussed in the description of the CDEP, participants received a compliment of services that were designed to increase their coping skills, connections to caring adults, knowledge of culture and history, and capacity to navigate public systems, most significantly education given the importance of high school graduation in determining future socioeconomic indicators.

The findings demonstrate that a majority of SP CDEP participants experienced the following outcomes:

- Growth with respects to mental illness, or the severity of mental illness symptoms (39% improved anxiety symptoms and 48% improved depression symptoms).
- Improved coping skills/strategies, self-regulation, and relationships with caring adults (89%-94%).
- Increased prosocial/resiliency/hope/protective factors (89%-94%).
- Increased life skills (89%-94%).
- Grade advancement/high school graduation/ GED/CHSPE attainment (100%).
- No incidences of systems involvement or further systems involvement (100%).
- Dual/concurrent enrollment in Peralta College System (67%).
- Employment and family engagement (100%).

The depression and anxiety composite, as well as the grade advancement/high school graduation/ GED/CHSPE attainment findings, are particularly meaningful.

Across all three years, a substantial subset of program participants showed improvements between pre and post measurement points on the composite variable for Anxiety. During the first two years, nearly half of all participants showed improvements between pre and post measurement points on the composite variable for Depression. In the third year, the proportion of treatment group participants who saw improvement on this composite dipped marginally. It is possible that this dip was attributable to the uneven administration of surveys in the virtual context. Specifically, multiple methods of virtual administration were utilized based on youth's technology/wifi access.

It is also possible that anxiety worsened during the last year as a result of the pandemic so more intervention would have been required to reach the levels achieved in years 1-2. During this same period Life Coaching services migrated to virtual platforms, creating greater challenges to relationship building. For comparison, between April 2020 and October 2021, the CDC and the National Center for Health Statistics conducted a national survey on anxiety and depression symptoms during the previous 7 days. 59% of 18–29-year-olds and 48% of African Americans experienced anxiety or depression, compared to 43% of African Americans, 18-21 years-olds, participating in the SP CDEP.[37]

During the first two years of the project, a large majority of participants showed improvements on the *Any Improvement Composite Variable*. In the third year, however, when services were forced to move to virtual platforms by the COVID-19 pandemic, we saw a drop in the percentage of participants who saw improvement on this composite measure. LGBTQ+ participants were generally more likely to show pre-post improvement than Cis/Straight participants on the three composite variables (Culture, Anxiety, Depression). Over all three years, this analysis showed an increase in disruption of life aspects between pre and post. In Year 3, however, we saw dramatically lower levels of life disruption, both pre and post. It was possible that the lower levels of disruption may have been related to the reduced complexity of life that came with COVID-19-related changes to work, school, and life in general.

High school graduation rates among the target population are some of the lowest in Alameda

[37]Center for Disease Control and Prevention, "Anxiety and Depression: Household Pulse Survey," Center for Disease Control and Prevention, last modified October 20, 2021, https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm.

County. 32.0% - 49.3% of all target population residents ages 25 and older do not have a high school diploma or equivalent, compared to county wide averages of 12.7%.[38] As illustrated in the Literature Review section of this report, this disparity greatly impacts prospects of employability and economic mobility. For African Americans living in Alameda County, the age-adjusted all- cause mortality rate more than halves for those who have not completed high school compared to those who have completed a bachelor's degree or more (1670.2 per 1000,000 compared to 796.6 per 100,000).[39] 100% of African Americans participating in the SP CDEP either grade advanced or graduated from high school.[40] The education attainment is particularly notable given that the grade advancement and high school graduation continued through the 18 months of remote learning resulting from the COVID-19 shelter in place. One could argue that the impact of the radical and rapid migration to remote learning was mitigated by the protective factors supported imparted by the CDEP as every participant advanced to the next grade or went on to graduate from high school. The long-term implication of this educational success is most likely to place CDEP participants on a road to improved economic and health outcomes. In addition, educational success related to high school graduation will reduce trauma and stress related to dropping out of high school and improve the earning potential of CDEP participants.

Further, arrest and probation rates among the target population, residing in the target communities, are the highest in Alameda County. As uplifted in the introduction/literature review, approximately 20% of Alameda County's youth arrested resided in the target communities, 45% on probation were from Oakland, and an average youth incarceration rate of 17 per 1,000. These adverse experiences have grave implications for African American youth who are already dealing with the health, economic mobility, and life expectancy implications of poverty. 100% of African Americans participating in SP CDEP did not experience systems or further systems involvement. This was maintained throughout all COVID-19 shelter in place orders, thus interrupting the adverse effects of COVID-19 and poverty. In addition to the SP CDEP, this success was also attributable to significantly less contact with law enforcement in schools and during travel between schools and homes.

Survey results from the Oakland Fund for Children and Youth' YDLS implemented in the 2018-19 and 2020-21 program years demonstrated significant youth development outcomes associated with protective factors as evidenced by the following outcomes:

Percentage of Youth who Improved/Increased Protective Factors

Protective Factor	2018-19 Outcomes	2020-21 Outcomes
Greater connections to caring adults	90%	79%
Increased confidence and self-esteem	92%	74%

[38] Alameda County Public Health Department Community Assessment, Planning, and Evaluation (CAPE) Unit, "Map Set 2018."
[39] Alameda County Public Health Department, "An Intro to Measures of Mortality: Assessing Overall Health, Cause of Death Rankings, Health-Adjusted Life Expectancy, and Socioeconomic Conditions in Alameda County."
[40] California Department of Education, "2019-2020 Four-Year Adjusted Cohort Graduation Rate: Oakland Unified District Report (01-61259)," Data Quest, Accessed October 25, 2021, https://dq.cde.ca.gov/dataquest/dqcensus/CohRate.aspx?agglevel=district&year=2019-20&cds=0161259.

Protective Factor	2018-19 Outcomes	2020-21 Outcomes
Improved decision-making and goal setting	94%	82%
Development and mastery of skills	89%	82%
Greater empowerment and agency	93%	Not measured
Increased knowledge of and engagement in community	91%	82%
Increased leadership capacity	91%	73%
Increased risk avoidance/conflict resolution	90%	Not measured
Increased sense of belonging and emotional wellness	Not measured	82%
Increased persistence and resiliency	Not measured	73%

Although the survey was not administered as planned for 2019-20 program year due to the pandemic, previous years surveys demonstrated similar results. These available data demonstrate increase in dramatic increased in protective factors and increased resiliency among participants. These data correlated with results from the staff focus groups that indicated increases in protective factors, resiliency, and self-agency among participants. Staff attributed these gains to the alignment of staff demographics and experience to those of participants facilitating relationship building and connections to caring adults.

Growth in protective factors and resiliency among participants were attributed by participants and staff to the focus of building knowledge of African American culture and history. Culture is a protective factor that anchors youth and provides context and identify in a society that minimizes black culture and identity. African American youth CDEP participants migrated towards the African American dual enrollment courses and the KYR education with a strong desire to learn about their own history and their rights to help them navigate their education and other public systems, including social services, health, and juvenile justice.

COVID-19 and the ensuing economic fallout have only exacerbated health and economic disparities among African American youth, their families, and communities; subsequently, the impact on this study's findings are expected but remain unconfirmed given that the study was not designed to ascertain that impact. For example, on the Depression composite for Year 3, participants dipped marginally as a possible result of COVID-19-related social isolation.

Further, on the Pre-Post Improvement on Life Aspects "Messed Up" by Mental Health/Emotional Struggles for Year 3, participants experienced dramatically lower levels of life disruption, both pre and post. It is also possible that this may have had something to do with the reduced complexity

of life that came with COVID-19-related changes to work, school, and life in general- i.e., fewer social interactions to navigate and being in a more contained environment. However, the surveys were not designed to measure the impact of a global pandemic as the study was two years into implementation when the pandemic occurred.

It is worth noting that because the *CDEP Pre/Post-Test Matched Survey's* lacked consistency on scales and indicators participants were confused and inadvertently indicated disagreement on statements. Note that the previous sets of questions have the affirmative responses (i.e., Strongly Agree/Agree) on the left side of the Likert scale. Their responses were an anomaly compared to other data. Further, on the marginalization and isolation statements (7 and 8 on both the adolescent and adult pre surveys), the questionnaire reversed the direction of affirmation of well-being, potentially confusing respondents.

Significant systems change outcomes are associated with SP' CDEP work. It has yet to be determined if these outcomes will be reported in an addendum to this report or in a subsequent report.

This study uplifted the imperative, as well as the how-to, of incorporating African American practices/traditions related to language and history, as well as African American principals, values, and beliefs related to ethnic culture, social justice, intersectionality, collectivism, relations, age, CBPR, and LGBTQQ+ inclusion throughout all SP CDEP programming and evaluation activities.

Critically important to the implementation of the CDEP was the composition and expertise of the staff. Building authentic relationships with the African American youth and young adults was at the crux of the CDEP program elements and the strengthening of protective factors. Without the staff's ability to leverage their own cultural, lived experience, and education to earn the trust of participants, they would not have been seen as caring adults in the eyes of participants. The longevity of staff was another critical element of the program to consider. The fact that Life Coaches remained consistent, including during the pandemic, created structure and a stable relationship that participants could depend upon. Future expansion of CDEPs for the target population should consider these foundational elements.

Another takeaway from the study is the potential power of the integration of program elements, particularly Life Coaching and KYR and Ethnic Studies education. As discussed in the CDEP Description Section of this report, the Life Coaching element is rooted in an understanding of the historical and contextual realities of the African American experience and the impact of long-term systemic bias across multiple domains. These include, but are not limited to, Education, Employment, Housing, Health, Social Services, Adult and Juvenile Justice and Law Enforcement.

Life Coaching was grounded in cultural socialization to increase participants' consciousness about the historical legacies of hegemonic forces and its impact on their lives, as well as expose them to the rich heritage ofAfrican American resistance. Life Coaches shared strategies of survival and modeled and demonstrated effective strategies to engage and navigate the multiple public systems that continued to shape the life choices of participants in a way that promoted individual and community agency. The CDEP embedded Life Coaching and other program elements in the context of KYR and African American/Ethnic Studies education, providing a protective cloak of cultural and historical context for African American participants that is rarely provided in

traditional, western approaches to prevention and early intervention services. This is an area that appears promising and given the CDEP outcomes of no new or additional systems involvement and 100% grade advancement/high school graduation warrants additional research.

Finally, the impact of the CRDP CPSSC must be uplifted as it is instructive for the larger community of BIPOC and LGBTQ+ providers engaged in culturally appropriate strategies in public health, and mental health specifically, as well as the larger public sector engaged in the herculean effort of reducing mental health disparities historically experienced by BIPOC communities. The creation and work of the CPSSC represented a modification of the planned CDEP, yet the legacy of the CPSSC may represent the most widespread impact of the project in terms of investment of new funding and the number of participants served across the initiative. The procurement of $63.1 million dollars from California's General Fund may represent the largest investment of general funds in culturally defined mental health programs for BIPOC and LGBTQ+ communities in the history of California. Moreover, the policy and budgetary victory represents an unprecedented investment in culturally appropriate prevention and early intervention mental health strategies in our nation's history. As a result of the additional investment, $1.2 million dollars was made available to each of the 35 IPPs to extend their CDEP four additional year expanding the potential impact of the CRDP statewide towards sustainability and scalability. The impact of this investment will not be fully determined for many years to come. These outcomes were realized as a direct result of the intersectionality created by the intentional and thoughtful collaboration between IPP representing the African American, Latinx, Asian Pacific Islanders, Native American, and LGBTQ+ communities created in the hopes of systematically reducing mental health disparities.

Potential areas for future CDEP implementation and evaluation included the potential for scaling of it at the Alameda County and state levels as well as the application of innovative evaluation methods, including but not limited to community narratives, storytelling, photovoice, sharing circle, photo elicitation, reflexive photography, audio/video diaries, draw and write, and written diaries. Future evaluation of the organizational infrastructure and sustainability strategies to support effective CDEP development, implementation, and scalability is urgently needed to address the increasing health disparities experienced by African American youth and their families.

SP CDEP had a positive impact on African American youth, ages 16-21; thus, interrupting the negative impact of poverty, crime, violence, discrimination, and disenfranchisement and the chronic stress produced by these oppressive conditions. Such endeavors worked because of the intentional cultural and historical context of African American practices, history, traditions, principles, values, and beliefs, and public systems should take heed and invest in what works. Further, this study uplifted the urgency, moral imperative, and need to generate the political will for public systems at the federal, state, county, and city levels to invest in culturally appropriate strategies that prove effective with African American youth. Finally, the SP CDEP lead the development of a model that may be replicable to secure additional public investment at the state level to further long-term sustainability for the CDRP and CDEPs more generally.

Section 9. References & Attachments

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Attachment 1 - Year 1 (2018-2019), Pre-Survey, Adults

AA Adult CDEP participants

SECTION 1: PRE QUESTIONNAIRE

Mental health need and met need (in past year)					SWE Questionnaire Q#
MH need	100%	1			Q12a-Q12d - "YES" to any
No MH need	0%	0			
unmet need / unserved	0%	0			"YES" to any Q12a – Q12d & "NO" to all Q13a – Q13d
met need / served	100%	1			"YES" to any Q12a – Q12d & "YES" to any Q13a – Q13d
Mental Health need met (in past year) by type of professional					
traditional helping professional	0%	0			
community helping professional	100%	1			
primary care physician	100%	1			
mental health professional	0%	0			
Insurance, medication, utilization and visits					
	has health insurance		no health insurance		
has health insurance	100%	1	0%	0	
crosstab (by health insurance coverage)					
	has health insurance		no health insurance		
uses MH services	0%	0		0	Has health insurance (Q.9)
insurance covers mental health treatment	100%	1			Health insurance covers treatment for mental health (Q.10)
takes prescription meds	0%	0			Takes prescription medication (Q.11)
avg. # of visits	0%	0			Average number of visits (Q.15)

SECTION 2: PRE QUESTIONNAIRE

Protective Factors	%			N		
At present	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree
culture gives you strength	0%	0%	100%	0	0	1
culture is important to you	0%	0%	100%	0	0	1
culture helps you to feel good about who you ar	0%	0%	100%	0	0	1
you feel connected to spiritual/religious traditior	0%	0%	100%	0	0	1
During the past 30 days	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time
connected to your culture	0%	0%	100%	0	0	1
balanced in mind, body, spirit and soul	0%	0%	100%	0	0	1
	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time
marginalized or excluded from society	0%	100%	0%	0	1	0
isolated and alienated from society	0%	0%	100%	0	0	1

SECTION 3: PRE QUESTIONNAIRE

BARRIERS			
Prejudice and discrimination*	**% YES**	**N**	
limited English		0	
gender identity		nil	
sexual orientation		nil	
age		nil	
religious/spiritual practice		nil	
race/ethnicity		nil	
Structural barriers*			
no transportation		nil	
cost of treatment		nil	
lack of time		**nil**	
Attitudinal barriers*			
psychiatric hospitalization		nil	
negative opinion from community		nil	
negative effect on job		nil	
lack of confidentiality		nil	
might have to take prescription meds		nil	
treatment won't help		nil	
uncomfortable talking about problems		nil	
do not need treatment		nil	
can handle problem on my own		nil	

Instructions: Here are some reasons people have for NOT seeking help from a mental health professional

such as a counselor, therapist, psychologist, psychiatrist or social worker, even when they think they might need it.

Even if you are receiving help now, do you agree or disagree with the following reasons why you might not seek help from a mental health professional?

***Some items could belong to more than one construct cited literature. These is our suggested split**

TOP BARRIERS (by MH need) crosstab			
	MH need	**No MH need**	**diff**
lack of time	**nil**	**nil**	
uncomfortable talking	nil	nil	
cost of treatment	nil	nil	
race/ethnicity	nil	nil	

SECTION 4: PRE QUESTIONNAIRE

Psychological Distress*	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time
nervous	100%	0%	**0%**	1	0	0
hopeless	100%	0%	**0%**	1	0	0
restless or fidgety	100%	0%	**0%**	1	0	0
so depressed that nothing could cheer you up	100%	0%	**0%**	1	0	0
feel that everything was an effort	100%	0%	**0%**	1	0	0
worthless	100%	0%	**0%**	1	0	0
Psychological Functioning (SDS) - within the past 12 months						
Moderate Mental Distress (5 ≤K6≤12)						
	%			N		
	Not at all	**Some**	**A lot**	**Not at all**	**Some**	**A lot**
work/school performance				nil	nil	nil

work/school performance				nil	nil	nil
household chores				nil	nil	nil
social life				nil	nil	nil
relationship with friends & family				nil	nil	nil
	Severe Mental Distress (K6≥13)					
	%			N		
	Not at all	Some	A lot	Not at all	Some	A lot
work/school performance				nil	nil	nil
household chores				nil	nil	nil
social life				nil	nil	nil
relationship with friends & family				nil	nil	nil

SECTION 5: PRE QUESTIONNAIRE

Age		
18-29	100%	1
30-39	0%	0
40-44	0%	0
45-49	0%	0
50-64	0%	0
65+	0%	0
English Fluency		
Fluent	100%	1
Not very well	0%	0
Immigration & Refugee status		
outside of U.S.	0%	0
refugee	0%	0
Years in the U.S.		
1 to 15	0%	0
16 to 25	100%	1
26 or more	0%	0
Race/Ethnicity		
African American	100%	1
Latinx	0%	0
Native American	0%	0
White	0%	0
Multi Racial or "other"	0%	0
African American	100%	1
Black	0.0%	0
Cape Verdean	0.0%	0
Liberian	0.0%	0
Pan African	0.0%	0
Senegambian	0.0%	0
Did not indicate	0%	0
SOGI		
Sex at birth		
male/boy	100%	1
female/girl	0%	0
intersex	0%	0
Gender Identity		
male	100%	1
female	0%	0
trans	0%	0
queer/ non conforming	0%	0
non-binary	0%	0
two-spirits	0%	0
unsure/intersex/no GI	0%	0
Sexual Orientation		
straight	100%	1
gay	0%	0
lesbian	0%	0
bisexual	0%	0
queer	0%	0
pansexual	0%	0
asexual/other	0%	0

Attachment 2 - Year 1 (2018-2019), Pre-Survey, Adolescents

AA Adolescents CDEP participants

SECTION 1: PRE QUESTIONNAIRE

Mental health need, met need (in past year)			SWE Questionnaire Q#
MH need	**22%**	**6**	Q9 - YES
No MH need	52%	14	Q9 - NO
unmet need / unserved	**33%**	**2**	Q9 "YES" & Q11 & Q14 "NO"
met need / served	50%	3	Q9 "YES" & Q11 or Q14 "YES"
Mental Health need met (in past year) by type of professional			
traditional helping professional	**7%**	**2**	
community helping professional	15%	4	
primary care physician	15%	4	
mental health professional	15%	4	

SECTION 2: PRE QUESTIONNAIRE

Protective Factors

	%			N		
At present	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**
culture gives you strength	4%	15%	81%	1	4	22
culture is important to you	4%	11%	85%	1	3	23
culture helps you to feel good about who you are	4%	11%	85%	1	3	23
you feel connected to spiritual/religious traditions	11%	22%	67%	3	6	18
During the past 30 days	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**
connected to your culture	15%	33%	52%	4	9	14
balanced in mind, body, spirit and soul	15%	33%	52%	4	9	14
	A little or none of the time	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**
marginalized or excluded from society	60%	33%	7%	16	9	2
isolated and alienated from society	59%	26%	15%	16	7	4

SECTION 3: PRE QUESTIONNAIRE

BARRIERS

Prejudice and discrimination*	% YES	N
limited English	4%	1
religious/spiritual practice	0%	0
sexual orientation	0%	0
gender identity	0%	0
age	0%	0
race/ethnicity	11%	3
Structural barriers*		
cost of treatment	0%	0
no transportation	0%	0
lack of time	11%	3
Attitudinal barriers*		
negative opinion from peers in school	7%	2
didn't know where to go from help	11%	3
thought friends would find out	4%	1
felt embarrassed about what you were going through	11%	3
negative opinion from family & community	19%	5
issue wasn't serious enough	30%	8
uncomfortable talking about problems	26%	7
didn't want to talk to a stranger about issue	26%	7
can handle problem	41%	11

*Some items could belong to more than one construct cited literature. These is our suggested split

TOP BARRIERS (by MH need)

crosstab

	MH need	No MH need	diff
felt embarrassed about what you were going through	50%	0%	50%
negative opinion from family & community	83%	0%	83%
negative opinion from peers in school	33%	0%	33%
uncomfortable talking about problems	100%	0%	100%
didn't know where to go for help	50%	0%	50%

SECTION 4: PRE QUESTIONNAIRE

Psychological Distresss*	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time
nervous	44%	41%	**11%**	12	11	3
hopeless	67%	22%	**7%**	18	6	2
restless or fidgety	56%	26%	15%	15	7	4
so depressed that nothing could cheer you up	78%	7%	11%	21	2	3
feel that everything was an effort	48%	19%	30%	13	5	8
worthless	**78%**	15%	4%	**21**	4	1

Psychological Functioning (SDS) - within the past 12 months						
Moderate Mental Distress (5 ≤K6≤12)						
	%			N		
	Not at all	Some	A lot	Not at all	Some	A lot
school and homework	7%	26%	0%	2	7	0
friends	15%	19%	0%	4	5	0
at home	19%	15%	0%	5	4	0
Severe Mental Distress (K6≥13)						
	%			N		
	Not at all	Some	A lot	Not at all	Some	A lot
school and homework	4%	0%	4%	1	0	1
friends	4%	4%	0%	1	1	0
at home	4%	4%	0%	1	1	0

SECTION 5: PRE QUESTIONNAIRE		
Age		
12	0%	0
13	0%	0
14	4%	1
15	30%	8
16	44%	12
17	22%	6
English Fluency		
Fluent	96%	26
Somewhat fluent	4%	1
Not very well	0%	0
Knows some or not at all	0%	0
Immigration & Refugee status		
outside of U.S.	85%	23
refugee	4%	1
Years in the U.S.		
1 to 5	0%	0
6 to 14	4%	1
15 +	74%	20
Race		
African American	74%	20
API	0%	0
Latinx	0%	0
Native American	0%	0
White	0%	0
Multi Racial or "other"	26%	7
African American	48%	13
Black	4.0%	1
Creole	0.0%	0
Eritrean	4.0%	1
Ethiopian	4.0%	1
French	0.0%	0
Papua New Guinea	4.0%	1
Did not indicate	37%	10
SOGI		
Sex at birth		
male/boy	33%	9
female/girl	63%	17
intersex	0%	0
Gender Identity		
male	33%	9
female	63%	17
trans	0%	0
queer/ non conforming	0%	0
non-binary	0%	0
two-spirits	0%	0
unsure/intersex/no GI	0%	0
Sexual Orientation		
straight	81%	22
gay	0%	0
lesbian	0%	0
bisexual	11%	3
queer	0%	0
pansexual	4%	1
asexual/other	0%	0

Attachment 3 - Year 1 (2018-19), Post-Survey, Adults

AA Adult CDEP participants

SECTION 1: POST QUESTIONNAIRE

Mental health need and met need (in past 3-4 months)			SWE Questionnaire Q#
MH need	100%	1	Q15 - "A lot or Somewhat"
No MH need	0%	0	
unmet need / unserved	0%	0	"YES" to any Q15 & "NO" to all Q16 – Q19
met need / served	100%	1	"YES" to any Q9 – Q14 & "YES" to any Q16 – Q19

SECTION 2: POST QUESTIONNAIRE

Protective Factors	%			N		
At Present	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree
culture gives you strength	0%	0%	100%	0	0	1
culture is important to you	0%	0%	100%	0	0	1
culture helps you to feel good about who you are	0%	0%	100%	0	0	1
you feel connected to spiritual/religious traditions	0%	0%	100%	0	0	1
In the past 3-4 months	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time
connected to your culture	0%	0%	100%	0	0	1
balanced in mind, body, spirit and soul	0%	0%	100%	0	0	1
	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time
marginalized or excluded from society	0%	100%	0%	0	1	0
isolated and alienated from society	0%	0%	100%	0	0	1

SECTION 3: POST QUESTIONNAIRE

Psychological Distresss*	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time
nervous	100%	0%	0%	1	0	0
hopeless	100%	0%	0%	1	0	0
restless or fidgety	100%	0	0	1	0	0
so depressed that nothing could cheer you up	100%	0	0	1	0	0
feel that everything was an effort	100%	0	0	1	0	0
worthless	100%	0	0	1	0	0

SECTION 4: PRE QUESTIONNAIRE

Psychological Functioning (SDS) - within the past 3-4 months Moderate Mental Distress (5 ≤K6≤12)	%			N		
	Not at all	Some	A lot	Not at all	Some	A lot
work/school performance	0%	100%	0%	0	1	0
household chores	0%	100%	0%	0	1	0
social life	0%	0%	100%	0	0	1
relationship with friends & family	0%	0%	100%	0	0	1

SECTION 5: POST QUESTIONNAIRE

CDEP Quality						
	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree
I like the services that I received here	0%	0%	100%	0	0	1
I would still get services from this agency	0%	0%	100%	0	0	1
I would recommend this agency	0%	0%	100%	0	0	1
convenient location	0%	0%	100%	0	0	1
follow up from staff	0%	0%	100%	0	0	1
convenient time provided	0%	0%	100%	0	0	1
friendly and receptive staff	0%	0%	100%	0	0	1
respectful treatment	0%	0%	100%	0	0	1
i didn't feel embarrassed due to my accent/language	0%	0%	100%	0	0	1
respects my race and/or ethnicity	0%	0%	100%	0	0	1
respects my religion	0%	0%	100%	0	0	1
respects my gender identity and/or sexual orientation	0%	0%	100%	0	0	1
flexible with offering alternative services	0%	0%	100%	0	0	1
respects my cultural beliefs and healing practices	0%	0%	100%	0	0	1
understands that people of my racial/ethnic group are not all alike	0%	0%	100%	0	0	1
understands that people of my gender identity and/or sexual orientatic	0%	0%	100%	0	0	1
understands that people of my religious background are not all alike	0%	0%	100%	0	0	1
Intervention Outcomes						
i deal more effectively with my dialy problems	0%	100%	0%	0	1	0
i do better in school and/or work	0%	0%	100%	0	0	1
my symptoms/problems are not bothering me as much	0%	0%	100%	0	0	1
Communication Style						
services rendered in my preferred language	0%	0%	100%	0	0	1
information resources available in my preferred language	0%	0%	100%	0	0	1

Attachment 4 - Year 1 (2018-2019), Post-Survey, Adolescents

AA Adolescents CDEP participants

SECTION 1: POST QUESTIONNAIRE

Mental health need, met need (in past year)			SWE Questionnaire Q#
MH need	22%	17	Q15 - A lot or Somewhat
No MH need	52%	7	Q15 - Not at all
unmet need / unserved	33%	2	Q9 "YES" & Q11 & Q14 "NO"
met need / served	50%	3	Q9 "YES" & Q11 or Q14 "YES"

SECTION 2: POST QUESTIONNAIRE

Protective Factors	%			N		
At present	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree
culture gives you strength	4%	18%	78%	1	5	21
culture is important to you	0%	4%	96%	0	1	26
culture helps you to feel good about who you are	4%	4%	89%	1	1	24
you feel connected to spiritual/religious traditions	11%	22%	67%	3	6	18
During the past 3-4 months	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time
connected to your culture	11%	33%	56%	3	9	15
balanced in mind, body, spirit and soul	7%	60%	33%	2	16	9
	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time
marginalized or excluded from society	56%	33%	11%	15	9	3
isolated and alienated from society	56%	37%	7%	15	10	2

SECTION 3: POST QUESTIONNAIRE

BARRIERS						
Psychological Distress*	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time
nervous	37%	37%	**26%**	10	10	7
hopeless	78%	18%	**4%**	21	5	1
restless or fidgety	56%	33%	11%	15	9	3
so depressed that nothing could cheer you up	74%	22%	4%	20	6	1
feel that everything was an effort	48%	37%	15%	13	10	4
worthless	85%	11%	4%	**23**	3	1

SECTION 4: POST QUESTIONNAIRE

Psychological Functioning (SDS) - within the past 3-4 months Moderate Mental Distress (5 ≤K6≤12)	%			N		
	Not at all	Some	A lot	Not at all	Some	A lot
work/school performance	37%	48%	15%	10	13	4
with friends	56%	26%	18%	15	7	5
at home	48%	41%	11%	13	11	3

SECTION 5: POST QUESTIONNAIRE

CDEP Quality						
Client Satisfaction	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	Disagree/Strongly disagree	Undecided	Strongly agree/ Agree
satisfactory service	67%	22%	11%	18	6	3
people helping me stuck with me	59%	30%	7%	16	8	2
had someone to talk to when i was troubled	59%	26%	11%	16	7	3
right service received	70%	11%	15%	19	3	4
service location convenient	59%	19%	15%	16	5	4
convenient time of service provided	48%	33%	4%	13	9	1
i got help i wanted	67%	22%	7%	18	6	2
staff treated me with respect	67%	30%	0%	18	8	0
staff respected my religious/spiritual beliefs	59%	19%	7%	16	5	2
staff spoke in a way I understood	59%	22%	7%	16	6	2
staff sensitive to my cultural/ethnic background	**56%**	**30%**	**4%**	**15**	**8**	**1**
Intervention Outcome						
i am better at handling life	**56%**	**22%**	11%	**15**	**6**	**3**
i get along better with family members	**48%**	**44%**	0%	13	12	0
i get along better with friends and other people	**48%**	**44%**	4%	13	12	1
i am doing better at school and work	**59%**	**30%**	7%	16	8	2
i am better able to cope when things go wrong	**56%**	**22%**	11%	15	6	3
i am satisfied with my family life right now	**59%**	**22%**	7%	**16**	**6**	**2**
i am able to do things I want to do	**70%**	**26%**	0%	**19**	**7**	**0**
i know people who will listen and understand me	**63%**	**19%**	7%	**17**	**5**	**2**
i have people I am comfortable talking with about my prol	**67%**	**15%**	7%	**18**	**4**	**2**
i havefamily or friends that would provide support	**63%**	**19%**	11%	17	5	3
i have people I can do enjoyable things with	**78%**	**15%**	0%	21	4	0
Communication Style						
service received was in my preffered language	**0%**	**0%**	100%	0	0	27
written information was in my preffered language	**0%**	**0%**	100%	0	0	27

*values not adding up indicates information either missing or not applicable

Attachment 5 - Year 2 (2019-2020), Pre-Survey, Adults

AA Adult CDEP participants

SECTION 1: PRE QUESTIONNAIRE

Mental health need and met need (in past year)					SWE Questionnaire Q#
MH need	**67%**	**2**			Q12a-Q12d - "YES" to any
No MH need	33%	1			
unmet need / unserved	**33%**	**1**			"YES" to any Q12a – Q12d & "NO" to all Q13a – Q13d
met need / served	33%	1			"YES" to any Q12a – Q12d & "YES" to any Q13a – Q13d
Mental Health need met (in past year) by type of professional					
traditional helping professional	**33%**	**1**			
community helping professional	33%	1			
primary care physician	33%	1			
mental health professional	33%	1			
Insurance, medication, utilization and visits					
	has health insurance		**no health insurance**		
has health insurance	**nil**	**nil**	**nil**	**nil**	
crosstab (by health insurance coverage)					
	has health insurance		**no health insurance**		
uses MH services	nil	nil		nil	Has health insurance (Q.9)
insurance covers mental health treatment	nil	nil			Health insurance covers treatment for mental health (Q.10)
takes prescription meds	nil	nil			Takes prescription medication (Q.11)
avg. # of visits	nil	nil			Average number of visits (Q.15)

SECTION 2: PRE QUESTIONNAIRE

Protective Factors						
	%			**N**		
At present	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**
culture gives you strength	0%	0%	**100%**	0	0	3
culture is important to you	0%	0%	**100%**	0	0	3
culture helps you to feel good about who you are	0%	0%	**100%**	0	0	3
you feel connected to spiritual/religious traditions	0%	0%	**100%**	0	0	3
During the past 30 days	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**
connected to your culture	0%	0%	**100%**	0	0	3
balanced in mind, body, spirit and soul	0%	33%	**67%**	0	1	2
	A little or none of the time	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**
marginalized or excluded from society	33%	33%	**33%**	1	1	1
isolated and alienated from society	33%	0%	**33%**	1	0	1

SECTION 3: PRE QUESTIONNAIRE

BARRIERS			
Prejudice and discrimination*	**% YES**	**N**	
limited English		nil	
gender identity		nil	
sexual orientation		nil	
age		nil	
religious/spiritual practice		nil	
race/ethnicity		nil	
Structural barriers*			
no transportation		nil	
cost of treatment	33%	1	
lack of time	**0%**	**0**	
Attitudinal barriers*			
psychiatric hospitalization		0	
negative opinion from community		0	
negative effect on job		0	
lack of confidentiality		0	
might have to take prescription meds		0	
treatment won't help	33%	1	
uncomfortable talking about problems		nil	
do not need treatment		0	
can handle problem on my own	**33%**	1	

Instructions: Here are some reasons people have for NOT seeking help from a mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker, even when they think they might need it. Even if you are receiving help now, do you agree or disagree with the following reasons why you might not seek help from a mental health professional?

*Some items could belong to more than one construct cited literature. These is our suggested split

TOP BARRIERS (by MH need)			
crosstab			
	MH need	**No MH need**	**diff**
lack of time	**0**	**1**	
uncomfortable talking	nil	nil	
cost of treatment	1	0	
race/ethnicity	nil	nil	

SECTION 4: PRE QUESTIONNAIRE

Psychological Distress (k6) - past 30 days						
Psychological Distress*	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**
nervous	33%	67%	**0%**	1	2	0
hopeless	67%	33%	**0%**	2	1	0
restless or fidgety	67%	0%	**33%**	2	0	1
so depressed that nothing could cheer you up	100%	0%	**0%**	3	0	0
feel that everything was an effort	67%	0%	**33%**	2	0	1
worthless	100%	0%	**0%**	3	0	0

Psychological Functioning (SDS) - within the past 12 months						
Moderate Mental Distress (5 ≤K6≤12)						
	%			**N**		
	Not at all	**Some**	**A lot**	**Not at all**	**Some**	**A lot**
work/school performance	33%	33%	33%	1	1	1
household chores	0%	67%	33%	0	2	1
social life	0%	100%	0%	0	3	0
relationship with friends & family	0%	100%	0%	0	3	0
Severe Mental Distress (K6≥13)						
	%			**N**		
	Not at all	**Some**	**A lot**	**Not at all**	**Some**	**A lot**
work/school performance				nil	nil	nil
household chores				nil	nil	nil
social life				nil	nil	nil
relationship with friends & family				nil	nil	nil

SECTION 5: PRE QUESTIONNAIRE

Age		
18-29	100%	3
30-39	0%	0
40-44	0%	0
15-49	0%	0
50-64	0%	0
65+	0%	0
English Fluency		
Fluent	100%	3
Not very well	0%	**0**
Immigration & Refugee status		
outside of U.S.	0%	**0**
refugee	0%	**0**
Years in the U.S.		
1 to 15	33%	**1**
16 to 25	0%	**0**
26 or more	0%	**0**
Race/Ethnicity		
African American	67%	2
Latinx	0%	**0**
Native American	0%	**0**
White	0%	**0**
Multi Racial or "other"	33%	**1**
African American	100%	3
Black	0.0%	**0**
Cape Verdean	0.0%	**0**
Liberian	0.0%	**0**
Pan African	0.0%	**0**
Senegambian	0.0%	**0**
Did not indicate	0%	**0**
SOGI		
Sex at birth		
male/boy	0%	**0**
female/girl	100%	3
intersex	0%	**0**
Gender Identity		
male	0%	**0**
female	0%	**3**
trans	0%	**0**
queer/ non conforming	0%	**0**
non-binary	0%	**0**
two-spirits	0%	0
unsure/intersex/no GI	0%	0
Sexual Orientation		
straight	100%	3
gay	0%	0
lesbian	0%	0
bisexual	0%	0
queer	0%	0
pansexual	0%	0
asexual/other	0%	0

Attachment 6 - Year 2 (2019-2020), Pre-Survey, Adolescents

AA Adolescents CDEP participants									
SECTION 1: PRE QUESTIONNAIRE									
Mental health need, met need (in past year)			**SWE Questionnaire Q#**						
MH need	**37%**	**7**	Q9 - YES						
No MH need	53%	10	Q9 - NO						
unmet need / unserved	**43%**	**3**	Q9 "YES" & Q11 & Q14 "NO"						
met need / served	57%	4	Q9 "YES" & Q11 or Q14 "YES"						
Mental Health need met (in past year) by type of professional									
traditional helping professional	**21%**	**4**							
community helping professional	26%	5							
primary care physician	21%	4							
mental health professional	16%	3							
SECTION 2: PRE QUESTIONNAIRE									
			Protective Factors						
	%			**N**					
At present	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**			
culture gives you strength	5%	5%	90%	1	1	17			
culture is important to you	5%	0%	95%	1	0	18			
culture helps you to feel good about who you are	5%	0%	95%	1	0	18			
you feel connected to spiritual/religious traditions	21%	32%	47%	4	6	9			
During the past 30 days	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**			
connected to your culture	16%	16%	68%	3	3	13			
balanced in mind, body, spirit and soul	21%	53%	26%	4	10	5			
	A little or none of the time	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**			
marginalized or excluded from society	42%	37%	16%	8	7	3		nil*	
isolated and alienated from society	58%	16%	21%	11	3	4		nil*	
SECTION 3: PRE QUESTIONNAIRE									
BARRIERS									
Prejudice and discrimination*	**% YES**	**N**							
limited English	0%	0							
religious/spiritual practice	11%	2							
sexual orientation	16%	3							
gender identity	5%	1							
age	11%	2							
race/ethnicity	11%	2		*Some items could belong to more than one construct cited literature. These is our suggested split					
Structural barriers*									
cost of treatment	0%	0							
no transportation	0%	0							
lack of time	26%	5							
Attitudinal barriers*									
negative opinion from peers in school	0%	0							
didn't know where to go from help	16%	3							
thought friends would find out	11%	2							
felt embarrassed about what you were going through	11%	2							
negative opinion from family & community	5%	1							
issue wasn't serious enough	16%	3							
uncomfortable talking about problems	26%	5							
didn't want to talk to a stranger about issue	32%	6							
can handle problem	37%	7							
TOP BARRIERS (by MH need)									
crosstab									
	MH need	**No MH need**	**diff**						
felt embarrassed about what you were going through	29%	40%	11%						
negative opinion from family & community	14%	50%	36%						
negative opinion from peers in school	0%	50%	50%						
uncomfortable talking about problems	57%	30%	27%						
didn't know where to go for help	43%	60%	17%						
SECTION 4: PRE QUESTIONNAIRE									
Psychological Distress (K6) - past 30 days									
Psychological Distress*	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**			
nervous	36%	32%	**32%**	7	6	6			
hopeless	79%	16%	**5%**	15	3	1			
restless or fidgety	48%	26%	**26%**	9	5	5			
so depressed that nothing could cheer you up	84%	16%	**0%**	16	3	0			
feel that everything was an effort	47%	37%	**16%**	9	7	3			
worthless	95%	0%	**5%**	18	0	1			

Psychological Functioning (SDS) - within the past 12 months						
Moderate Mental Distress (5 ≤K6≤12)						
	%			N		
	Not at all	Some	A lot	Not at all	Some	A lot
school and homework	0%	75%	13%	0	6	1
friends	12%	88%	0%	1	7	0
at home	25%	75%	0%	2	6	0
Severe Mental Distress (K6≥13)						
	%			N		
	Not at all	Some	A lot	Not at all	Some	A lot
school and homework	100%	0%	0%	1	0	0
friends	100%	0%	0%	1	0	0
at home	100%	0%	0%	1	0	0

SECTION 5: PRE QUESTIONNAIRE		
Age		
12	0%	0
13	0%	0
14	0%	0
15	5%	1
16	58%	11
17	37%	7
English Fluency		
Fluent	100%	19
Somewhat fluent	0%	0
Not very well	0%	0
Knows some or not at all	0%	0
Immigration & Refugee status		
outside of U.S.	5%	1
refugee	0%	0
Years in the U.S.		
1 to 5	0%	0
6 to 14	0%	0
15 +	100%	19
Race		
African American	74%	14
API	5%	1
Latinx	0%	0
Native American	0%	0
White	0%	0
Multi Racial or "other"	5%	1
African American	79%	15
Black	0.0%	0
Creole	0.0%	0
Eritrean	0.0%	0
Ethiopian	0.0%	0
French	0.0%	0
Papua New Guinea	0.0%	0
Did not indicate	21%	4
SOGI		
Sex at birth		
male/boy	26%	5
female/girl	68%	13
intersex	0%	0
Gender Identity		
male	26%	5
female	68%	13
trans	0%	0
queer/ non conforming	0%	0
non-binary	0%	0
two-spirits	0%	0
unsure/intersex/no GI	0%	0
Sexual Orientation		
straight	53%	10
gay	5%	1
lesbian	0%	0
bisexual	37%	7
queer	0%	0
pansexual	0%	0
asexual/other	0%	0

Attachment 7 - Year 2 (2019-2020), Post-Survey, Adults

AA Adult CDEP participants								
SECTION 1: POST QUESTIONNAIRE								
Mental health need and met need (in past 3-4 months)					**SWE Questionnaire Q#**			
MH need	**100%**	**3**			Q15- "A lot or Somewhat"			
No MH need	0%	0						
unmet need / unserved	**0%**	**0**			"YES" to any Q15 & "NO" to all Q16 – Q19			
met need / served	100%	1			"YES" to any Q9 – Q14 & "YES" to any Q16 – Q19			
SECTION 2: POST QUESTIONNAIRE								
Protective Factors								
	%			**N**				
At Present	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**		
culture gives you strength	0%	0%	**100%**	0	0	3		
culture is important to you	0%	0%	**100%**	0	0	3		
culture helps you to feel good about who you are	0%	0%	**100%**	0	0	3		
you feel connected to spiritual/religious traditions	0%	0%	**100%**	0	0	3		
In the past 3-4 months	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**		
connected to your culture	0%	0%	**100%**	0	0	3		
balanced in mind, body, spirit and soul	0%	0%	**100%**	0	0	3		
	A little or none of the time	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**		
marginalized or excluded from society	67%	0%	**33%**	2	0	1		
isolated and alienated from society	67%	0%	**33%**	2	0	1		
SECTION 3: POST QUESTIONNAIRE								
Psychological Distress*	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**		
nervous	0%	67%	**33%**	0	2	1		
hopeless	67%	0%	**33%**	2	0	1		
restless or fidgety	33%	67%	**0%**	1	2	0		
so depressed that nothing could cheer you up	67%	33%	**0%**	2	1	0		
feel that everything was an effort	67%	33%	**0%**	2	1	0		
worthless	**100%**	0%	**0%**	3	0	0		
SECTION 4: PRE QUESTIONNAIRE								
Psychological Functioning (SDS) - within the past 3-4 months								
Moderate Mental Distress (5 ≤K6≤12)								
	%			**N**				
	Not at all	**Some**	**A lot**	**Not at all**	**Some**	**A lot**		
work/school performance	0%	100%	0%	0	3	0		
household chores	0%	100%	0%	1	1	1		
social life	0%	0%	100%	1	1	1		
relationship with friends & family	0%	0%	100%	0	3	0		
SECTION 5: POST QUESTIONNAIRE								
CDEP Quality								
	Disagree/Strongly disagree	**Neutral**	**Strongly agree/ Agree**	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**		
I like the services that I received here	0%	33%	67%	0	1	2		
I would still get services from this agency	0%	33%	67%	0	1	2		
I would recommend this agency	0%	33%	67%	0	1	2		
convenient location	0%	33%	67%	0	1	2		
follow up from staff	0%	33%	67%	0	1	2		
convenient time provided	0%	33%	67%	0	1	2		
friendly and receptive staff	0%	33%	67%	0	1	2		
respectful treatment	0%	33%	67%	0	1	2		
i didn't feel embarrassed due to my accent/language	0%	33%	67%	0	1	2		
respects my race and/or ethnicity	0%	33%	67%	0	1	2		
respects my religion	0%	33%	67%	0	1	2		
respects my gender identity and/or sexual orientation	0%	33%	67%	0	1	2		
flexible with offering alternative services	0%	67%	33%	0	2	1		
respects my cultural beliefs and healing practices	0%	33%	67%	0	1	2		
understands that people of my racial/ethnic group are not all alike	0%	33%	67%	0	1	2		
understands that people of my gender identity and/or sexual orientation are not all alike	0%	33%	67%	0	1	2		
understands that people of my religious background are not all alike	0%	33%	67%	0	1	2		
Intervention Outcomes								
i deal more effectively with my dialy problems	0%	33%	67%	0	1	2		
i do better in school and/or work	0%	0%	100%	0	0	3		
my symptoms/problems are not bothering me as much	0%	0%	100%	0	0	3		
Communication Style								
services rendered in my preferred language	0%	0%	67%	nil	nil	2		
information resources available in my preferred language	0%	0%	67%	nil	nil	2		

Attachment 8 - Year 2 (2019-2020), Post-Survey, Adolescents

AA Adolescents CDEP participants

SECTION 1: POST QUESTIONNAIRE

Mental health need, met need (in past year)			SWE Questionnaire Q#
MH need	63%	12	Q15 - A lot or Somewhat
No MH need	16%	3	Q15 - Not at all

SECTION 2: POST QUESTIONNAIRE

Protective Factors	%			N		
At present	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**
culture gives you strength	0%	0%	100%	0	0	19
culture is important to you	0%	0%	100%	0	0	19
culture helps you to feel good about who you are	0%	5%	95%	0	1	18
you feel connected to spiritual/religious traditions	0%	26%	74%	0	5	14
During the past 3-4 months	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**
connected to your culture	0%	21%	79%	0	4	15
balanced in mind, body, spirit and soul	21%	42%	37%	4	8	7
	A little or none of the time	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**
marginalized or excluded from society	32%	42%	16%	6	8	3
isolated and alienated from society	47%	32%	21%	9	6	4

SECTION 3: POST QUESTIONNAIRE

BARRIERS						
Psychological Distress*	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**
nervous	42%	47%	**11%**	8	9	2
hopeless	89%	11%	**0%**	17	2	0
restless or fidgety	58%	31%	11%	11	6	2
so depressed that nothing could cheer you up	68%	32%	0%	13	6	0
feel that everything was an effort	58%	31%	11%	11	6	2
worthless	84%	11%	5%	**16**	2	1

SECTION 4: POST QUESTIONNAIRE

Psychological Functioning (SDS) - within the past 3-4 months Moderate Mental Distress (5 ≤K6≤12)	%			N		
	Not at all	**Some**	**A lot**	**Not at all**	**Some**	**A lot**
work/school performance	26%	53%	16%	5	**10**	3
with friends	37%	42%	16%	7	8	3
at home	37%	53%	5%	7	**10**	1

SECTION 5: POST QUESTIONNAIRE

CDEP Quality						
Client Satisfaction	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**	**Disagree/Strongly disagree**	**Undecided**	**Strongly agree/ Agree**
satisfactory service	79%	16%	0%	15	3	0
people helping me stuck with me	95%	5%	0%	18	1	0
had someone to talk to when i was troubled	89%	11%	0%	17	2	0
right service received	84%	11%	0%	16	2	0
service location convenient	84%	16%	0%	16	3	0
convenient time of service provided	90%	5%	5%	17	1	1
I got help I wanted	79%	11%	5%	15	2	1
staff treated me with respect	95%	30%	0%	18	0	0
staff respected my religious/spiritual beliefs	100%	0%	0%	19	0	0
staff spoke in a way I understood	84%	5%	5%	16	1	1
staff sensitive to my cultural/ethnic background	**74%**	**5%**	**11%**	**14**	**1**	**2**
Intervention Outcome						
i am better at handling life	**63%**	**32%**	5%	**12**	**6**	**1**
I get along better with family members	**42%**	**37%**	16%	8	**7**	3
i get along better with friends and other people	**74%**	**11%**	16%	14	2	3
I am doing better at school and work	**74%**	**16%**	5%	14	3	1
i am better able to cope when things go wrong	**74%**	**16%**	5%	14	3	1
i am satisfied with my family life right now	**68%**	**21%**	0%	**13**	**4**	**0**
I am able to do things I want to do	**53%**	**26%**	11%	**10**	**5**	**2**
i know people who will listen and understand me	**79%**	**11%**	5%	**15**	**2**	**1**
I have people I am comfortable talking with about my problems	**84%**	**5%**	11%	**16**	**1**	**2**
i havefamily or friends that would provide support	**95%**	**5%**	0%	18	1	0
I have people I can do enjoyable things with	**89%**	**11%**	0%	17	2	0
Communication Style						
service received was in my preffered language	**0%**	**0%**	100%	0	0	19
written information was in my preffered language	**0%**	**0%**	100%	0	0	19

*values not adding up indicates information either missing or not applicable

Attachment 9 - Year 3 (2020-2021), Pre-Survey, Adults

AA Adult CDEP participants

SECTION 1: PRE QUESTIONNAIRE

Mental health need and met need (in past year)					SWE Questionnaire Q#
MH need	0%	0			Q12a-Q12d - "YES" to any
No MH need	100%	8			
unmet need / unserved	0%	0			"YES" to any Q12a – Q12d & "NO" to all Q13a – Q13d
met need / served	0%	0			"YES" to any Q12a – Q12d & "YES" to any Q13a – Q13d
Mental Health need met (in past year) by type of professional					
traditional helping professional	0%	0	U		
community helping professional	38%	3	V		
primary care physician	0%	0	W		
mental health professional	0%	0	X		
Insurance, medication, utilization and visits					
	has health insurance		no health insurance		
has health insurance	75%	6	25%	2	M
crosstab (by health insurance coverage)					
	has health insurance		no health insurance		
uses MH services	75%	6		0	Has health insurance (Q.9)
insurance covers mental health treatment	0%	0			Health insurance covers treatment for mental health (Q.10)
takes prescription meds	0%	0			Takes prescription medication (Q.11)
avg. # of visits	0%	0			Average number of visits (Q.15)

SECTION 2: PRE QUESTIONNAIRE

Protective Factors							
	%			N			
At present	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	
culture gives you strength	0%	0%	100%	0	0	8	E
culture is important to you	0%	0%	100%	0	0	8	F
culture helps you to feel good about who you ar	0%	0%	100%	0	0	8	G
you feel connected to spiritual/religious traditio	13%	0%	87%	1	0	7	H
During the past 30 days	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time	
connected to your culture	0%	25%	75%	0	2	6	I
balanced in mind, body, spirit and soul	25%	25%	50%	2	2	4	J
	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time	
marginalized or excluded from society	0%	100%	0%	5	1	2	K
isolated and alienated from society	0%	0%	100%	7	0	1	L

SECTION 3: PRE QUESTIONNAIRE

BARRIERS				
Prejudice and discrimination*	**% YES**	**N**		*Instructions: Here are some reasons people have for NOT seeking help from a mental health professional*
limited English	13%	1	AI	*such as a counselor, therapist, psychologist, psychiatrist or social worker, even when they think they might need it.*
gender identity	13%	1	AM	*Even if you are receiving help now, do you agree or disagree with the following reasons why you might not seek help from a mental health professional?*
sexual orientation	13%	1	AN	
age	13%	1	AK	
religious/spiritual practice	13%	1	AL	
race/ethnicity	13%	1	AJ	*Some items could belong to more than one construct cited literature. These is our suggested split
Structural barriers*				
no transportation	0%	0	AQ	
cost of treatment	13%	1	AO	
lack of time	0%	0	AP	
Attitudinal barriers*				
psychiatric hospitalization	0%	0	AX	
negative opinion from community	13%	1	AU	
negative effect on job	25%	2	AV	
lack of confidentiality	25%	2	AW	
might have to take prescription meds	13%	1	AY	
treatment won't help	0%	0	AT	
uncomfortable talking about problems	25%	2	AH	
do not need treatment	0%	0	AR	
can handle problem on my own	25%	2	AS	

TOP BARRIERS (by MH need)				
crosstab				
	MH need	No MH need	diff	
lack of time	0%	0%	0%	AP
uncomfortable talking	29%	0%	29%	AH
cost of treatment	0%	100%	100%	AO
race/ethnicity	14%	0%	14%	AJ

SECTION 4: PRE QUESTIONNAIRE

Psychological Distress*	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time	
nervous	37%	63%	0%	3	5	0	AZ
hopeless	75%	25%	0%	6	2	0	BA
restless or fidgety	75%	25%	0%	6	2	0	BB
so depressed that nothing could cheer you up	100%	25%	0%	6	2	0	BC
feel that everything was an effort	37%	25%	37%	3	2	3	BD
worthless	0%	13%	87%	0	1	7	BF
Psychological Functioning (SDS) - within the past 12 months							
Moderate Mental Distress (5 ≤K6≤12)							
	%			N			

	Not at all	Some	A lot	Not at all	Some	A lot	
work/school performance	38%	25%	25%	3	2	2	BG
household chores	63%	0%	25%	5	0	2	BH
social life	63%	25%	0%	5	2	0	BI
relationship with friends & family	63%	25%	0%	5	2	0	BJ
	Severe Mental Distress (K6≥13)						
	%			N			
	Not at all	Some	A lot	Not at all	Some	A lot	
work/school performance				nil	nil	nil	
household chores				nil	nil	nil	
social life				nil	nil	nil	
relationship with friends & family				nil	nil	nil	

SECTION 5: PRE QUESTIONNAIRE

Age		
18-29	100%	8
30-39	0%	0
40-44	0%	0
15-49	0%	0
50-64	0%	0
65+	0%	0
English Fluency		
Fluent	88%	7
Not very well	0%	0
Immigration & Refugee status		
outside of U.S.	0%	0
refugee	0%	0
Years in the U.S.		
1 to 15	0%	0
16 to 25	88%	7
26 or more	0%	0
Race/Ethnicity		
African American	88%	7
Latinx	0%	0
Native American	0%	0
White	0%	0
Multi Racial or "other"	0%	1
African American	88%	1
Black	0.0%	0
Cape Verdean	0.0%	0
Liberian	0.0%	0
Pan African	0.0%	0
Senegambian	0.0%	0
Did not indicate	0%	7
SOGI		
Sex at birth		
male/boy	38%	3
female/girl	62%	5
intersex	0%	0
Gender Identity		
male	38%	3
female	62%	5
trans	0%	0
queer/ non conforming	0%	0
non-binary	0%	0
two-spirits	0%	0
unsure/intersex/no GI	0%	0
Sexual Orientation		
straight	100%	8
gay	0%	0
lesbian	0%	0
bisexual	0%	0
queer	0%	0
pansexual	0%	0
asexual/other	0%	0

1 person did not respond

Attachment 10 - Year 3 (2020-2021), Pre-Survey, Adolescents

AA Adolescents CDEP participants							
SECTION 1: PRE QUESTIONNAIRE							
Mental health need, met need (in past year)			**SWE Questionnaire Q#**				
MH need	**38%**	**5**	Q9 - YES				
No MH need	54%	7	Q9 - NO				
unmet need / unserved	**100%**	**5**	Q9 "YES" & Q11 & Q14 "NO"				
met need / served	0%	0	Q9 "YES" & Q11 or Q14 "YES"				
Mental Health need met (in past year) by type of professional							
traditional helping professional	**0%**	**0**	N				
community helping professional	23%	3	O				
primary care physician	0%	0	T				
mental health professional	15%	2	P				
SECTION 2: PRE QUESTIONNAIRE							
	Protective Factors						
	%			**N**			
At present	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**	**Disagree/Strongly disagree**	**Neutral**	**Strongly agree/ Agree**	
culture gives you strength	0%	0%	100%	0	0	13	E
culture is important to you	0%	0%	100%	0	0	13	F
culture helps you to feel good about who you are	0%	0%	100%	0	0	13	G
you feel connected to spiritual/religious traditions	23%	15%	62%	3	2	8	H
During the past 30 days	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**	
connected to your culture	15%	38%	46%	2	5	6	I
balanced in mind, body, spirit and soul	15%	23%	62%	2	3	8	J
	A little or none of the time	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**	
marginalized or excluded from society	62%	31%	8%	8	4	1	K
isolated and alienated from society	62%	0%	8%	12	0	1	L
SECTION 3: PRE QUESTIONNAIRE							
BARRIERS							
Prejudice and discrimination*	**% YES**	**N**					
limited English	8%	1	AD				
religious/spiritual practice	8%	1	AG				
sexual orientation	8%	1	AI				
gender identity	8%	1	AH				
age	8%	1	AF				

race/ethnicity	8%	1	AE	*Some items could belong to more than one construct cited literature. These is our suggested split
Structural barriers*				
cost of treatment	8%	1	AS	
no transportation	15%	2	AT	
lack of time	23%	3	AR	
Attitudinal barriers*				
negative opinion from peers in school	8%	1	AQ	
didn't know where to go from help	15%	2	AO	
thought friends would find out	8%	1	AI	
felt embarrassed about what you were going through	8%	1	AP	
negative opinion from family & community	8%	1	AN	
issue wasn't serious enough	46%	6	AK	
uncomfortable talking about problems	0%	0	AC	
didn't want to talk to a stranger about issue	38%	5	AM	
can handle problem	69%	9	AJ	

TOP BARRIERS (by MH need)				
crosstab				
	MH need	**No MH need**	**diff**	
felt embarrassed about what you were going through	0%	0%	0%	AP
negative opinion from family & community	0%	0%	0%	AN
negative opinion from peers in school	0%	0%	0%	AQ
uncomfortable talking about problems	0%	0%	0%	AC
didn't know where to go for help	20%	0%	20%	AO

SECTION 4: PRE QUESTIONNAIRE

Psychological Distresss*	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**	
nervous	69%	15%	**15%**	9	2	2	AU
hopeless	92%	8%	**0%**	12	1	0	AV
restless or fidgety	77%	15%	8%	10	2	1	AW
so depressed that nothing could cheer you up	92%	8%	0%	12	1	0	AX
feel that everything was an effort	54%	31%	15%	7	4	2	AY
worthless	**100%**	0%	0%	13	0	0	AZ

Psychological Functioning (SDS) - within the past 12 months							
Moderate Mental Distress (5 ≤K6≤12)							
	%			**N**			
	Not at all	**Some**	**A lot**	**Not at all**	**Some**	**A lot**	
school and homework	25%	50%	25%	1	2	1	BB
friends	75%	25%	0%	3	1	0	BC
at home	75%	0%	25%	3	0	1	BD
Severe Mental Distress (K6≥13)							
	%			**N**			
	Not at all	**Some**	**A lot**	**Not at all**	**Some**	**A lot**	
school and homework	0%	0%	0%	0	0	0	
friends	0%	0%	0%	0	0	0	
at home	0%	0%	0%	0	0	0	

SECTION 5: PRE QUESTIONNAIRE

Age				
12	0%	0		
13	0%	0		
14	3%	1		
15	20%	3		
16	39%	3		
17	36%	6		
English Fluency				
Fluent	100%	13	DT	
Somewhat fluent	0%	0		
Not very well	0%	0		
Knows some or not at all	0%	0		
Immigration & Refugee status				
outside of U.S.	0%	0		4 did not respond
refugee	0%	0		
Years in the U.S.				
1 to 5	0%	0		
6 to 14	8%	1		
15 +	62%	8		
Race				

African American	100%	13	BH							
API	0%	0								
Latinx	0%	0								
Native American	0%	0								
White	0%	0								
Multi Racial or "other"	0%	0								
African American	0%	3	BI							
Black	0.0%	0								
Creole	0.0%	0								
Eritrean	0.0%	0								
Ethiopian	0.0%	0	BP							
French	0.0%	0								
Papua New Guinea	0.0%	0								
Did not indicate	100%	10	BQ							
SOGI										
Sex at birth										
male/boy	62%	8	EB							
female/girl	38%	5	EC							
intersex	0%	0	EJ							
Gender Identity										
male	62%	8	EB	1 answered twice						
female	38%	5	EC							
trans	0%	0	ED							
queer/ non conforming	0%	0	EG							
non-binary	2%	1	EH							
two-spirits	0%	0	EI							
unsure/intersex/no GI	0%	0	EK							
Sexual Orientation										
straight	84%	11	EO							
gay	0%	0	EP							
lesbian	0%	0	EQ							
bisexual	8%	1	ER							
queer	0%	0	ES							
pansexual	8%	1	ET							
asexual/other	0%	0	EU							

Attachment 11 - Year 3 (2020-2021), Post-Survey, Adults

AA Adult CDEP participants

SECTION 1: POST QUESTIONNAIRE

Mental health need and met need (in past 3-4 months)				SWE Questionnaire Q#	
MH need	100%	8		Q15- "A lot or Somewhat"	
No MH need	0%	0			

SECTION 2: POST QUESTIONNAIRE

Protective Factors							
	%			N			
At Present	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	
culture gives you strength	0%	0%	**100%**	0	0	8	E
culture is important to you	0%	0%	**100%**	0	0	8	F
culture helps you to feel good about who you are	0%	0%	**100%**	0	0	8	G
you feel connected to spiritual/religious traditions	13%	13%	**75%**	1	1	6	H
In the past 3-4 months	**A little or none of the time**	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**	
connected to your culture	0%	13%	**87%**	0	1	7	J
balanced in mind, body, spirit and soul	13%	13%	**75%**	1	1	6	K
	A little or none of the time	**Some of the time**	**All or most of the time**	**A little or none of the time**	**Some of the time**	**All or most of the time**	
marginalized or excluded from society	38%	100%	**63%**	3	0	5	L
isolated and alienated from society	50%	0%	**50%**	4	0	4	M

SECTION 3: POST QUESTIONNAIRE

Psychological Distresss*	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time	
nervous	38%	50%	**13%**	3	4	1	O
hopeless	63%	25%	**13%**	5	2	1	P
restless or fidgety	75%	13	**13%**	6	1	1	Q
so depressed that nothing could cheer you up	75%	13	**13%**	6	1	1	R
feel that everything was an effort	75%	13	**13%**	6	1	1	S
worthless	75%	13	**13%**	6	1	1	T

SECTION 4: PRE QUESTIONNAIRE

Psychological Functioning (SDS) - within the past 3-4 months Moderate Mental Distress (5 ≤K6≤12)							
	%			N			
	Not at all	Some	A lot	Not at all	Some	A lot	
work/school performance	60%	20%	20%	3	1	1	X
household chores	60%	20%	0%	3	1	0	Y
social life	60%	40%	0%	3	2	0	Z
relationship with friends & family	60%	40%	0%	3	2	0	AA

SECTION 5: POST QUESTIONNAIRE

CDEP Quality							
	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	
I like the services that I received here	0%	0%	100%	0	0	8	AC
I would still get services from this agency	0%	13%	87%	0	1	7	AD
I would recommend this agency	0%	0%	100%	0	0	8	AE
convenient location	0%	0%	87%	0	0	7	AF
follow up from staff	0%	0%	100%	0	0	8	AG
convenient time provided	0%	0%	100%	0	0	8	AF
friendly and receptive staff	0%	0%	100%	0	0	8	AI
respectful treatment	0%	0%	100%	0	0	8	AJ
i didn't feel embarrassed due to my accent/language	0%	0%	100%	0	0	8	AK
respects my race and/or ethnicity	0%	0%	100%	0	0	8	AL
respects my religion	0%	13%	75%	0	1	6	AM
respects my gender identity and/or sexual orientation	0%	0%	100%	0	0	8	AN
flexible with offering alternative services	0%	0%	100%	0	0	8	AO
respects my cultural beliefs and healing practices	0%	0%	87%	0	0	7	AP
understands that people of my racial/ethnic group are not all alike	0%	0%	100%	0	0	8	AQ
understands that people of my gender identity and/or sexual orientatic	0%	0%	100%	0	0	8	AR
understands that people of my religious background are not all alike	0%	0%	87%	0	0	7	AS
Intervention Outcomes							
i deal more effectively with my dialy problems	0%	13%	87%	0	1	7	AT
i do better in school and/or work	0%	25%	75%	0	2	6	AU
my symptoms/problems are not bothering me as much	0%	25%	75%	0	2	6	AV

Communication Style							
services rendered in my preferred language	0%	0%	100%	0	0	8	AW
information resources available in my preferred language	0%	0%	100%	0	0	8	AX

ID:
__ 1__ - __7 __ - __ __ __
Priority Pop *IPP Code* *CDEP Participant Code*

ADOLESCENT VERSION

(12-17)
Code

POST

Attachment 12 - Year 3 (2020-2021), Post-Survey, Adolescents

AA Adolescents CDEP participants

SECTION 1: POST QUESTIONNAIRE

Mental health need, met need (in past year)			SWE Questionnaire Q#
MH need	77%	10	Q15 - A lot or Somewhat
No MH need	23%	3	Q15 - Not at all

SECTION 2: POST QUESTIONNAIRE

Protective Factors	%			N			
At present	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	Disagree/Strongly disagree	Neutral	Strongly agree/ Agree	
culture gives you strength	0%	8%	92%	0	1	12	E
culture is important to you	0%	8%	92%	0	1	12	F
culture helps you to feel good about who you are	0%	15%	85%	0	2	11	G
you feel connected to spiritual/religious traditions	38%	15%	46%	5	2	6	H
During the past 3-4 months	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time	
connected to your culture	0%	23%	77%	0	3	10	J
balanced in mind, body, spirit and soul	15%	8%	77%	2	1	10	K
	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time	
marginalized or excluded from society	54%	15%	31%	7	2	4	L
isolated and alienated from society	69%	8%	23%	9	1	3	M

SECTION 3: POST QUESTIONNAIRE

BARRIERS

Psychological Distress*	A little or none of the time	Some of the time	All or most of the time	A little or none of the time	Some of the time	All or most of the time	
nervous	46%	46%	8%	6	6	1	O
hopeless	92%	0%	8%	12	0	1	P
restless or fidgety	69%	23%	8%	9	3	1	Q
so depressed that nothing could cheer you up	92%	0%	8%	12	0	1	R
feel that everything was an effort	77%	15%	8%	10	2	1	S
worthless	92%	8%	0%	12	1	0	T

SECTION 4: POST QUESTIONNAIRE

Psychological Functioning (SDS) - within the past 3-4 months Moderate Mental Distress (5 ≤K6≤12)	%			N			
	Not at all	Some	A lot	Not at all	Some	A lot	
work/school performance	33%	50%	17%	2	3	1	W
with friends	67%	33%	0%	4	2	0	X
at home	50%	33%	17%	3	2	1	Y

SECTION 5: POST QUESTIONNAIRE

CDEP Quality Client Satisfaction	Strongly Agree/Agree	Undecided	Strongly Disagree/ Disagree	Strongly Agree/Agree	Undecided	Strongly Disagree/ Disagree	
satisfactory service	85%	0%	8%	11	0	1	AA
people helping me stuck with me	85%	0%	8%	11	0	1	AB
had someone to talk to when i was troubled	77%	0%	15%	10	0	2	AC
right service received	77%	15%	8%	10	2	1	AD
service location convenient	77%	8%	8%	10	1	1	AE
convenient time of service provided	85%	0%	8%	11	0	1	AF
i got help i wanted	77%	8%	15%	10	1	2	AG
staff treated me with respect	92%	0%	8%	12	0	1	AH
staff respected my religious/spiritual beliefs	69%	15%	8%	9	2	1	AI
staff spoke in a way I understood	92%	0%	8%	12	0	1	AJ
staff sensitive to my cultural/ethnic background	**85%**	**0%**	**15%**	**11**	**0**	**2**	**AK**
Intervention Outcome							
i am better at handling life	**69%**	**8%**	15%	**9**	**1**	**2**	**AL**
i get along better with family members	**69%**	**15%**	15%	9	2	2	AM
i get along better with friends and other people	**69%**	**8%**	15%	9	1	2	AN
i am doing better at school and work	**62%**	**8%**	31%	8	1	4	AO
i am better able to cope when things go wrong	**69%**	**8%**	15%	9	1	2	AP
i am satisfied with my family life right now	**69%**	**15%**	15%	**9**	**2**	**2**	AQ
i am able to do things I want to do	**69%**	**15%**	15%	**9**	**2**	**2**	AR
i know people who will listen and understand me	**69%**	**15%**	15%	**9**	**2**	**2**	AS
i have people I am comfortable talking with about my prol	**92%**	**0%**	8%	**12**	**0**	**1**	AT
i havefamily or friends that would provide support	**92%**	**0%**	8%	12	0	1	AU
i have people I can do enjoyable things with	**85%**	**0%**	15%	11	0	2	AV
Communication Style							
service received was in my preffered language	**0%**	**0%**	100%	0	0	13	AW
written information was in my preffered language	**0%**	**0%**	100%	0	0	13	AX

*values not adding up indicates information either missing or not applicable

Attachment 13: Plank Pre-Survey, Adolescents

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group. The next questions are about your culture.

At present…	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
1. Your culture gives you strength.	☐	☐	☐	☐	☐
2. Your culture is important to you.	☐	☐	☐	☐	☐
3. Your culture helps you to feel good about who you are.	☐	☐	☐	☐	☐
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.	☐	☐	☐	☐	☐

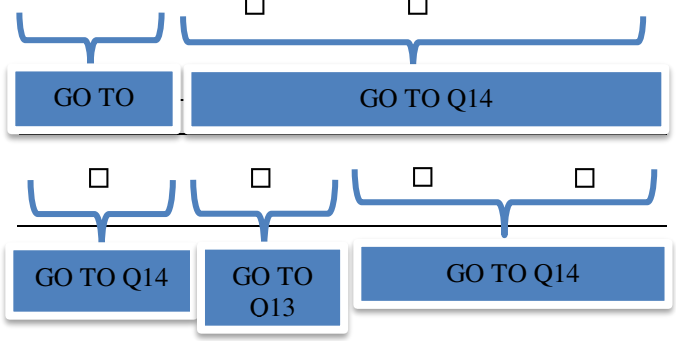
The next questions are about how you have been feeling during the past 30 days.

About how often during the past 30 days did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
5. …connected to your culture?	☐	☐	☐	☐	☐
6. …balanced in mind, body, spirit and soul?	☐	☐	☐	☐	☐
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter*.)	☐	☐	☐	☐	☐
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond your family, school, and friends.)*	☐	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
9. In the past 12 months did you <u>THINK YOU NEEDED HELP</u> for emotional or mental health problems, such as feeling sad, anxious, or nervous?	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
10. In the past 12 months, have <u>YOU RECEIVED</u> any psychological or emotional counseling from any of the following…				
a. <u>Traditional helping professional</u> such as a culturally-based healer, religious/spiritual leader or advisor?	☐	☐	☐	☐
b. <u>Community helping professional</u> such as a health worker, *promotor*, or peer counselor?	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
11. In the past 12 months, have <u>YOU RECEIVED</u> any psychological or emotional counseling from someone <u>AT SCHOOL</u>, such as a school counselor, school psychologist, school therapist, school social worker?	☐	☐	☐	☐
12. Are you still receiving psychological or emotional counseling from someone <u>AT SCHOOL</u>?	☐	☐	☐	☐



13. If not, what was the **MAIN REASON** you stopped psychological or emotional counseling AT SCHOOL? (Please select **ONE** main reason.)

☐The counselor, therapist, psychologist, psychiatrist or social worker said I finished and/or met my goals
☐ I ended it because I got better/I no longer needed services
☐School ended
☐Hours not convenient
☐I changed schools
☐ Had bad experiences with counselor, therapist, psychologist, psychiatrist or social worker
☐Couldn't get appointment
☐Not getting better
☐Didn't have time
☐Other (Specify) _____
☐The counselor, therapist, psychologist, psychiatrist or social worker did not understand my problem
☐I felt discriminated against
☐I did not want to go anymore
☐Wanted to handle the problem on my own

	Yes	No	Refused	Don't Know
14. In the past 12 months, have YOU RECEIVED any psychological or emotional counseling from someone OUTSIDE OF SCHOOL, like a counselor, therapist, psychologist, psychiatrist or social worker?	☐ GO TO	☐ GO TO Q17	☐ GO TO Q17	☐ GO TO Q17

	Yes	No	Refused	Don't Know
15. Are you still receiving psychological or emotional counseling from someone OUTSIDE OF SCHOOL?	☐ GO TO Q17	☐ GO TO O16	☐ GO TO Q17	☐ GO TO Q17

16. What was the **MAIN REASON** you stopped psychological or emotional counseling OUTSIDE OF SCHOOL? (Please select **ONE** main reason.)

☐The counselor, therapist, psychologist, psychiatrist or social worker said I finished and/or met my goals
☐ I ended it because I got better/I no longer needed services
☐Insurance did not cover
☐Too expensive
☐School ended
☐Hours not convenient
☐Had bad experiences with counselor, therapist, psychologist, psychiatrist or social worker
☐Couldn't get appointment
☐Not getting better
☐Didn't have time
☐I moved
☐Other (Specify) _____
☐The counselor, therapist, psychologist, psychiatrist or social worker did not understand my problem
☐Didn't have transportation
☐I felt discriminated against
☐I did not want to go anymore
☐Wanted to handle the problem on my own

	Yes	No	Refused	Don't Know
17. In the past 12 months, did you receive any professional help for your use of alcohol or drugs?	☐	☐	☐	☐
18. During the past 12 months, have you take any medication because of difficulties with your emotions, concentration, or behavior?	☐	☐	☐	☐

Instructions: Here are some reasons youth/teens have for NOT seeking help from a mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker, even when they think they might need it. Even if you are receiving help now, do you agree or disagree with the following reasons why you might not seek help from a mental health professional?

	Agree	Disagree	Refused	Don't Know
19. You were planning to or are already getting help from…				
a. Traditional helping professional such as a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐

b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐
20. You didn't know these types of mental health professionals existed.	☐	☐	☐	☐

	Agree	Disagree	Refused	Don't Know
21. You didn't feel comfortable talking with them about your personal problems.	☐	☐	☐	☐
22. You didn't think you would feel safe and welcome because of your…				
a. limited English	☐	☐	☐	☐
b. race/ethnicity	☐	☐	☐	☐
c. age	☐	☐	☐	☐
d. religious or spiritual practice	☐	☐	☐	☐
e. gender identity	☐	☐	☐	☐
f. sexual orientation	☐	☐	☐	☐
23. You thought you could solve your issue on your own.	☐	☐	☐	☐
24. You thought your issue wasn't serious enough.	☐	☐	☐	☐
25. You thought your friends would find out.	☐	☐	☐	☐
26. You didn't want to talk to a stranger about your issue.	☐	☐	☐	☐
27. You were worried that your family and others in the community may think differently about you.	☐	☐	☐	☐
28. You didn't know where to go for help.	☐	☐	☐	☐
29. You felt embarrassed about what you were going through.	☐	☐	☐	☐
30. You were worried that your peers and others in school may think differently about you.	☐	☐	☐	☐
31. You didn't have time because of after-school activities and other commitments.	☐	☐	☐	☐
32. It was too expensive.	☐	☐	☐	☐
33. You didn't have transportation to get there.	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 30 days.

During the past 30 days, how often did you feel…	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
34. … nervous?	☐	☐	☐	☐	☐
35. … hopeless?	☐	☐	☐	☐	☐
36. … restless or fidgety?	☐	☐	☐	☐	☐
37. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
38. … feel that everything was an effort?	☐	☐	☐	☐	☐
39. … worthless?	☐	☐	☐	☐	☐

40. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q34-Q39) match how you would describe those experiences? (Check one)

☐ **A Lot**	☐ **Somewhat**	☐ **Not At All**

Okay, you just told me about how you have been feeling the past 30 days. Now I want to know how much your fears and worries have messed things up for you. In other words, how much have they stopped you from doing things you want to do?

How much have your fears and worries messed things up …	A Lot	Some	Not At All
41. …with school and homework?	☐	☐	☐
42. …with friends?	☐	☐	☐
43. …at home?	☐	☐	☐

44. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q41-Q43) match how you would describe the negative effect of emotions on your life? (Check one)

☐ **A Lot** ☐ **Somewhat** ☐ **Not At All**

	Yes	No	Refused	Don't Know
45. In the past 6 months, have you done any volunteer work or community service that you have not been paid for?	☐	☐	☐	☐

46. *How old are you? Write in age:* _____

47.

What is your race and ethnic origin(s)? ***Select only one race category; select your ethnic origin(s)***

☐ American Indian or Alaska Native

☐ Black or African American

Check your ethnic origin(s):

☐ African American ☐ South African ☐ Refused
☐ Caribbean ☐ Ghanaian ☐ Don't Know
☐ Egyptian ☐ Nigerian ☐ Other Black or African American
☐ Kenyan ☐ Ethiopian (Please specify):_____

☐ Latino, Hispanic, or Spanish

Check your ethnic origin(s):

☐ Mexican/Chicano ☐ Puerto Rican ☐ Nicaraguan
☐ Salvadoran ☐ Cuban ☐ Refused
☐ Guatemalan ☐ Peruvian ☐ Don't Know
☐ Dominican ☐ Chilean ☐ Other Latino
☐ Honduran ☐ Colombian (Please specify):_____

☐ Asian

Check your ethnic origin(s):

☐ Afghan ☐ Indonesian ☐ Thai
☐ Bangladeshi ☐ Japanese ☐ Vietnamese
☐ Burmese ☐ Korean ☐ Refused
☐ Cambodian ☐ Laotian ☐ Don't Know
☐ Chinese ☐ Malaysian ☐ Other Asian
☐ Filipino ☐ Pakistani (Please specify):_____
☐ Hmong ☐ Sri Lankan
☐ Indian (India) ☐ Taiwanese

☐ Native Hawaiian or Other Pacific Islander

Check your ethnic origin(s):

☐ Samoan ☐ Refused
☐ Guamanian ☐ Don't Know
☐ Tongan ☐ Other Hawaiian or Pacific Islander
☐ Fijian (Please specify):_____

☐ Multi-Racial: Check all that apply and specify your ethnic origin(s).

☐ White: (Please specify):_____
☐ Black/African American (Please specify):_____
☐ Latino, Hispanic, or Spanish
☐ Asian (Please specify):_____
☐ Native Hawaiian or Other Pacific Islander (Please specify):_____
☐ Refused

(Please specify):_____

☐ American Indian or Alaska Native ☐ Don't Know

(Please specify):_____

☐ White: Please specify your ethnic origin(s):_____

☐ Other Race: Please specify your race and ethnic origin(s):_____

☐ Refused

☐ Don't Know

48. How well can you speak the English language?

☐ Fluently

☐ Somewhat fluently; can make myself understood but have some problems with it

☐ Not very well; know a lot of words and phrases but have difficulties communicating

☐ Know some vocabulary, but can't speak in sentences

☐ Not at all

49. What is your preferred language? _____

50. Were you born:

☐ Inside the U.S.

☐ Outside the U.S.

☐ Refused

☐ Don't Know

51. What are the first 3 digits of your ZIP Code? _ _ _ ☐Unstable housing/ no ZIP code ☐ Refused ☐ Don't Know

52. Have you ever spent time in a temporary settlement area for refugees or displaced persons or been held at ICE facilities?

☐ Not Applicable

☐ Yes

☐ No

☐ Refused

☐ Don't Know

53. About how many years have you lived in the United States? [*For less than a year, enter 1 year*]
Number of years_____ ☐ Not Applicable

Gender Identity Instructions: We use terms like "male" or "female" or "trans" as a short-hand way to capture the gender of individuals. We fully understand, however, that people use a wide range of labels – some prefer other terms such as Genderfluid, Agender, Enby, Androgynous, etc. To help us understand you personally, please tell us the term that you personally prefer to describe your gender. There are no right or wrong answers to these questions. Please be honest and answer as you really think and feel.

54. When I was born, the person who delivered me (e.g., doctor, nurse/midwife, family members), thought I was a:
Choose the one best answer.

☐ Male/Boy

☐ Female/Girl

☐ Intersex (they were unsure about my sex at birth)

☐ I am not sure about my sex assigned at birth

☐ My assigned sex at birth (please specify):_____

☐ I do not wish to answer this question

55. When it comes to my gender identity, I think of myself as: Choose all that apply.

☐ Man/Male

☐ Woman/Female

☐ Transgender/Trans

☐ Trans man/Trans male

☐ Non-binary (not exclusively male or female)

☐ Two Spirit

☐ Intersex (between male and female)

☐ I am not sure about my gender identity

☐ Trans woman/Trans female
☐ Genderqueer/Gender non-conforming
☐ I do not wish to answer this question
☐ I do not have a gender/ gender identity
☐ My gender identity is (please specify):_____

Sexual Orientation Instructions: Everyone has a sexual orientation. Some people are straight and are attracted to people of another gender. For example, a straight woman is attracted to men and prefers to date or have sex with men. Other people are gay or lesbian and are attracted to people of the same gender. For example, a gay man is attracted to other men and prefers to date or have sex with other men. Still other people are bisexual and are attracted to both men and women. Some people are attracted to people of all genders including those who do not define their gender within the binary "male or female" framework. Others are unsure about their attractions or are just not attracted to anyone. Just to be clear, who you are attracted to and prefer to date or have sex with is called sexual orientation.

56. What is your sexual orientation? Choose all that apply.

☐ Straight/heterosexual
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Queer
☐ Pansexual/Non-monosexual (I am attracted to all genders)
☐ Asexual (I am not attracted to anyone sexually)
☐ I am not attracted to anyone romantically
☐ I am not sure who I am attracted to sexually
☐ I am not sure who I am attracted to romantically
☐ Something else: _____
☐ I do not wish to answer this question

Thank you for taking time to complete this questionnaire. Did any of the questions above upset you? Please check one.

☐ Yes
☐ No

If any of the above questions upset you and you want to talk to someone about it, here is a list of referrals for support services.

Attachment 14: Plank Pre-Survey, Adults

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group. The next questions are about your culture.

At present…	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
1. Your culture gives you strength.	☐	☐	☐	☐	☐
2. Your culture is important to you.	☐	☐	☐	☐	☐
3. Your culture helps you to feel good about who you are.	☐	☐	☐	☐	☐
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.	☐	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 30 days

About how often during the past 30 days did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
5. …connected to your culture?	☐	☐	☐	☐	☐
6. …balanced in mind, body, spirit and soul?	☐	☐	☐	☐	☐
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)	☐	☐	☐	☐	☐
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond your family, school, and friends.*)	☐	☐	☐	☐	☐

9. Do you currently have health insurance coverage? (check one)

☐ **Yes (GO TO Q10)** ☐ **No** ☐ **Refused (GO TO Q11)** ☐ **Don't Know (GO TO Q11)**

Did you have health insurance coverage in the past 12 months?
☐ Yes ☐ No ☐ Refused ☐ Don't Know **(GO TO Q11)**

	Yes	No	Refused	Don't Know
10. Does your insurance cover treatment for mental health problems, such as visits to a psychologist or psychiatrist?	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
11. During the past 12 months, did you take any prescription medications, such as an antidepressant or an antianxiety medication, almost daily for two weeks or more, for an emotional or personal problem?	☐	☐	☐	☐

	Yes	No	Refused	Don't Know	NA

12. Because of problems with your mental health, emotions, nerves or your use of alcohol or drugs, was there ever a time during the past 12 months when you FELT LIKE YOU MIGHT NEED to see a…

	Yes	No	Refused	Don't Know	NA
a. Traditional helping professional like a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐	☐
b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐	☐
c. Primary care physician or general practitioner	☐	☐	☐	☐	☐
d. Mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker	☐	☐	☐	☐	☐

13. In the past 12 months, because of problems with your mental health, emotions or your use of alcohol or drugs

	Yes	No	Refused	Don't Know	NA
a. HAVE YOU SEEN a traditional helping professional like a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐	☐
b. HAVE YOU SEEN a Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐	☐
c. HAVE YOU SEEN a Primary care physician or general practitioner	☐	☐	☐	☐	☐
d. HAVE YOU SEEN a Mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker	☐	☐	☐	☐	☐

If YES to Q13c OR 13d GO TO Q14. Otherwise, GO TO Q19

GO TO Q19

14. Did you seek help for your mental or emotional health or for an alcohol or drug problem? (*Circle one*)

Yes Mental/Emotional Health Problem	*Yes Alcohol-Drug Problem*	*Yes Both Mental & Alcohol-Drug Problems*	*Refused*	*Don't Know*

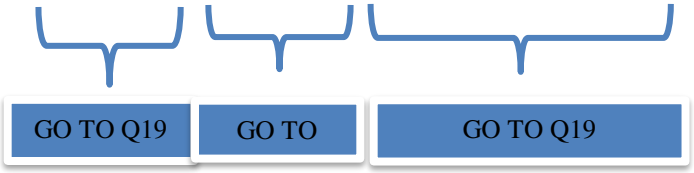
15. In the past 12 months, how many visits did you make to a mental health professional (counselor, therapist, psychologist, psychiatrist or social worker) for problems with your mental or emotional health, alcohol-drug problem, or both? Do not count overnight hospital stays.

_____ # of visits

Yes	No	Refused	Don't Know

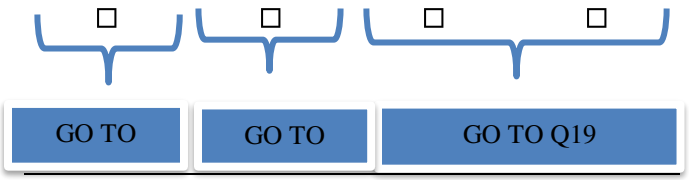
16. Are you still receiving treatment for these problems from one or more of these providers?

☐ ☐ ☐ ☐



17. Did you complete the full course of treatment? In other words, you ended treatment when your counselor, therapist, psychologist, psychiatrist or social worker told you it was ok to end?

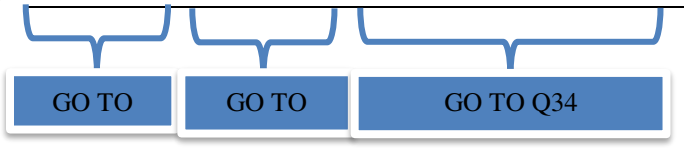
☐ ☐ ☐ ☐



18. What is the **MAIN REASON** you are no longer receiving treatment? (Circle ONE only)
    - ☐ Got better/No longer needed
    - ☐ Not getting better
    - ☐ Wanted to handle the problem on own
    - ☐ Had bad experiences with treatment
    - ☐ Lack of time/transportation
    - ☐ Too expensive
    - ☐ Insurance does not cover
    - ☐ Other (Specify) _____
    - ☐ Refused
    - ☐ Don't Know

Instructions: Here are some reasons people have for NOT seeking help from a mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker, even when they think they might need it. Even if you are receiving help now, do you agree or disagree with the following reasons why you might not seek help from a mental health professional?

	Agree	Disagree	Refused	Don't Know
19. You were planning to or already getting help from a…				
a. Traditional helping professional such as a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐
b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐
20. You did not know of or have never heard of these types of mental health professionals (e.g. counselor, therapist, psychologist, etc.)	☐	☐	☐	☐



	Agree	Disagree	Refused	Don't Know
21. You didn't feel comfortable talking with them about your personal problems.	☐	☐	☐	☐
22. You didn't think you would feel safe and welcome because of your…				
g. limited English	☐	☐	☐	☐
h. race/ethnicity	☐	☐	☐	☐
i. age	☐	☐	☐	☐
j. religious or spiritual practice	☐	☐	☐	☐
k. gender identity	☐	☐	☐	☐
l. sexual orientation	☐	☐	☐	☐
	Agree	**Disagree**	**Refused**	**Don't Know**
23. You were concerned about the cost of treatment.	☐	☐	☐	☐

24. You didn't have time (because of job, childcare, or other commitments).	☐	☐	☐	☐
25. You had no transportation, or the program was too far away, or the hours were not convenient.	☐	☐	☐	☐
26. You didn't think you needed mental health counseling or treatment at the time.	☐	☐	☐	☐
27. You thought you could handle the problem on your own.	☐	☐	☐	☐
28. You didn't think mental health counseling or treatment would help.	☐	☐	☐	☐
29. You were concerned that getting mental health treatment or counseling might cause your neighbors or community to have a negative opinion of you.	☐	☐	☐	☐
30. You were concerned that getting mental health treatment or counseling might have a negative effect on your job.	☐	☐	☐	☐
31. You were concerned that the information you gave the counselor might not be kept confidential.	☐	☐	☐	☐
32. You were concerned that you might be admitted to a psychiatric hospital.	☐	☐	☐	☐
33. You were concerned that you might have to take medicine.	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 30 days.

About how often during the past 30 days did you feel…	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
34. … nervous?	☐	☐	☐	☐	☐
35. … hopeless?	☐	☐	☐	☐	☐
36. … restless or fidgety?	☐	☐	☐	☐	☐
37. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
38. … feel that everything was an effort?	☐	☐	☐	☐	☐
39. … worthless?	☐	☐	☐	☐	☐

40. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q34-Q39) match how you would describe those experiences? (Check one)

☐ **A Lot** ☐ **Somewhat** ☐ **Not At All**

NOW, think about the one month, within the past 12 months, when you were at your worst emotionally.

Did your emotions interfere a lot, some, or not at all with your…	**A Lot**	**Some**	**Not At All**	**Refused**	**Don't Know**
41. …performance at work or school?	☐	☐	☐	☐	☐
➡ *Check here if not working and not in school during the past 12 months* ☐					
42. …household chores?	☐	☐	☐	☐	☐
43. …social life?	☐	☐	☐	☐	☐
44. …relationship with friends and family?	☐	☐	☐	☐	☐

45. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q41-Q44) match how you would describe the negative effect of emotions on your life? (Check one)

☐ **A Lot** ☐ **Somewhat** ☐ **Not At All**

46. How old are you?

☐ between 18 and 29 years of age
☐ between 30 and 39 years of age
☐ between 40 and 44 years of age
☐ between 45 and 49 years of age
☐ between 50 and 64 years of age
☐ 65 or older years of age

47.

What is your race and ethnic origin(s)? ***Select only one race category; select your ethnic origin(s)***

☐ American Indian or Alaska Native

☐ Black or African American:
Check your ethnic origin(s):

☐ African American	☐ South African	☐ Refused
☐ Caribbean	☐ Ghanaian	☐ Don't Know
☐ Egyptian	☐ Nigerian	☐ Other Black or African American
☐ Kenyan	☐ Ethiopian	(Please specify):_____

☐ Latino, Hispanic, or Spanish:
Check your ethnic origin(s):

☐ Mexican/Chicano	☐ Puerto Rican	☐ Nicaraguan
☐ Salvadoran	☐ Cuban	☐ Refused
☐ Guatemalan	☐ Peruvian	☐ Don't Know
☐ Dominican	☐ Chilean	☐ Other Latino
☐ Honduran	☐ Colombian	(Please specify):_____

☐ Asian:
Check your ethnic origin(s):

☐ Afghan	☐ Indonesian	☐ Thai
☐ Bangladeshi	☐ Japanese	☐ Vietnamese
☐ Burmese	☐ Korean	☐ Refused
☐ Cambodian	☐ Laotian	☐ Don't Know
☐ Chinese	☐ Malaysian	☐ Other Asian
☐ Filipino	☐ Pakistani	(Please specify):_____
☐ Hmong	☐ Sri Lankan	
☐ Indian (India)	☐ Taiwanese	

☐ Native Hawaiian or Other Pacific Islander:
Check your ethnic origin(s):

☐ Samoan	☐ Refused
☐ Guamanian	☐ Don't Know
☐ Tongan	☐ Other Hawaiian or Pacific Islander
☐ Fijian	(Please specify):_____

☐ Multi-Racial: Check all that apply and specify your ethnic origin(s).

☐ White:	☐ Asian
(Please specify):_____	(Please specify):_____
☐ Black/African American	☐ Native Hawaiian or Other Pacific Islander
(Please specify):_____	(Please specify):_____
☐ Latino, Hispanic, or Spanish	☐ Refused
(Please specify):_____	
☐ American Indian or Alaska Native	☐ Don't Know
(Please specify):_____	

☐ White: Please specify your ethnic origin(s):_____
☐ Other Race: Please specify your race and ethnic origin(s):_____
☐ Refused
☐ Don't Know

48. How well can you speak the English language?
    - ☐ Fluently
    - ☐ Somewhat fluently; can make myself understood but have some problems with it
    - ☐ Not very well; know a lot of words and phrases but have difficulties communicating
    - ☐ Know some vocabulary, but can't speak in sentences
    - ☐ Not at all

49. What is your preferred language? _____

50. Were you born:
- ☐ Inside the U.S.
- ☐ Outside the U.S.
- ☐ Refused
- ☐ Don't Know

51. What are the first 3 digits of your ZIP Code? _ _ _ ☐Unstable housing/ no ZIP code ☐ Refused ☐ Don't Know

52. Have you ever spent time in a temporary settlement area for refugees or displaced persons or been held at ICE facilities?
- ☐ Not Applicable
- ☐ Yes
- ☐ No
- ☐ Refused
- ☐ Don't Know

53. About how many years have you lived in the United States? [*For less than a year, enter 1 year*]
Number of years_____ ☐ Not Applicable

Gender Identity Instructions: We use terms like "male" or "female" or "trans" as a short-hand way to capture the gender of individuals. We fully understand, however, that people use a wide range of labels – some prefer other terms such as Genderfluid, Agender, Enby, Androgynous, etc. To help us understand you personally, please tell us the term that you personally prefer to describe your gender. There are no right or wrong answers to these questions. Please be honest and answer as you really think and feel.

54. When I was born, the person who delivered me (e.g., doctor, nurse/midwife, family members), thought I was a:
Choose the one best answer.
- ☐ Male/Boy
- ☐ Female/Girl
- ☐ Intersex (they were unsure about my sex at birth)
- ☐ I am not sure about my sex assigned at birth
- ☐ My assigned sex at birth (please specify):_____
- ☐ I do not wish to answer this question

55. When it comes to my gender identity, I think of myself as: Choose all that apply.
- ☐ Man/Male
- ☐ Woman/Female
- ☐ Transgender/Trans
- ☐ Trans man/Trans male
- ☐ Trans woman/Trans female
- ☐ Genderqueer/Gender non-conforming
- ☐ I do not wish to answer this question
- ☐ Non-binary (not exclusively male or female)
- ☐ Two Spirit
- ☐ Intersex (between male and female)
- ☐ I am not sure about my gender identity
- ☐ I do not have a gender/ gender identity
- ☐ My gender identity is (please specify):_____

Sexual Orientation Instructions: Everyone has a sexual orientation. Some people are straight and are attracted to people of another gender. For example, a straight woman is attracted to men and prefers to date or have sex with men. Other people are gay or lesbian and are attracted to people of the same gender. For example, a gay man is attracted to other men and prefers to date or have sex with other men. Still other people are bisexual and are attracted to both men and women. Some people are attracted to people of all genders including those who do not define their gender within the binary "male or female" framework. Others are unsure about their attractions or are just not attracted to anyone. Just to be clear, who you are attracted to and prefer to date or have sex with is called sexual orientation.

56. What is your sexual orientation? Choose all that apply.
- ☐ Straight/heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Queer
- ☐ Pansexual/Non-monosexual (I am attracted to all genders)
- ☐ Asexual (I am not attracted to anyone sexually)
- ☐ I am not attracted to anyone romantically
- ☐ I am not sure who I am attracted to sexually
- ☐ I am not sure who I am attracted to romantically
- ☐ Something else: _____
- ☐ I do not wish to answer this question

Attachment 15: Plank Post-Survey, Adolescents

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group. The next questions are about your culture.

At present…	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
1. Your culture gives you strength.	☐	☐	☐	☐	☐
2. Your culture is important to you.	☐	☐	☐	☐	☐
3. Your culture helps you to feel good about who you are.	☐	☐	☐	☐	☐
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.	☐	☐	☐	☐	☐

During the past 3-4 months (since you started our program) how often did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
5. …connected to your culture?	☐	☐	☐	☐	☐
6. …balanced in mind, body, spirit and soul?	☐	☐	☐	☐	☐
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)	☐	☐	☐	☐	☐
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond of your family, school, and friends.*)	☐	☐	☐	☐	☐

During the past 3-4 months (since you started our program) how often did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9. … nervous?	☐	☐	☐	☐	☐
10. … hopeless?	☐	☐	☐	☐	☐
11. … restless or fidgety?	☐	☐	☐	☐	☐
12. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
13. … feel that everything was an effort?	☐	☐	☐	☐	☐
14. … worthless?	☐	☐	☐	☐	☐

15. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q9-Q14) match how you would describe those experiences? (Check one)

☐ **A Lot**	☐ **Somewhat**	☐ **Not At All**

Okay, you just told me about how you have been feeling during the past 3-4 months (since you started our program). Now I want to know how much your fears and worries have messed things up for you. In other words, how much have they stopped you from doing things you want to do?

How much have your fears and worries messed things up …	A Lot	Some	Not At All
16. …with school and homework?	☐	☐	☐
17. …with friends?	☐	☐	☐
18. …at home?	☐	☐	☐

The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q16-Q18) match how you would describe the negative effect of emotions on your life? (Check one)

Instructions: Please help our make our program better by answering some questions. Please answer the questions based on the services, program or activities connected to [name of CDEP]. Indicate if you Strongly Disagree, Disagree, are Undecided, Agree, or Strongly Agree with each of the statements below. If the statement is about something you have not experienced, check the box

for Not Applicable to indicate that this item does not apply to you. <u>Please note: the word "service" stands for any program activities or events connected to</u> [name of CDEP]

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
1. Overall, I am satisfied with the services I received.	☐	☐	☐	☐	☐	☐
2. The people helping me stuck with me no matter what	☐	☐	☐	☐	☐	☐
3. I felt I had someone to talk to when I was troubled	☐	☐	☐	☐	☐	☐
4. I received services that were right for me.	☐	☐	☐	☐	☐	☐
5. The location of services was convenient for me.	☐	☐	☐	☐	☐	☐
6. Services were available at times that were convenient for me.	☐	☐	☐	☐	☐	☐
7. I got the help I wanted.	☐	☐	☐	☐	☐	☐
8. Staff treated me with respect.	☐	☐	☐	☐	☐	☐
9. Staff respected my religious / spiritual beliefs.	☐	☐	☐	☐	☐	☐
10. Staff spoke with me in a way that I understood.	☐	☐	☐	☐	☐	☐
11. Staff were sensitive to my cultural / ethnic background.	☐	☐	☐	☐	☐	☐
12. I am better at handling daily life.	☐	☐	☐	☐	☐	☐
13. I get along better with family members.	☐	☐	☐	☐	☐	☐
14. I get along better with friends and other people.	☐	☐	☐	☐	☐	☐
15. I am doing better in school and/or work.	☐	☐	☐	☐	☐	☐
16. I am better able to cope when things go wrong.	☐	☐	☐	☐	☐	☐
17. I am satisfied with my family life right now.	☐	☐	☐	☐	☐	☐
18. I am better able to do things I want to do.	☐	☐	☐	☐	☐	☐
19. I know people who will listen and understand me when I need to talk.	☐	☐	☐	☐	☐	☐
20. I have people that I am comfortable talking with about my problem(s).	☐	☐	☐	☐	☐	☐
21. In a crisis, I would have the support I need from family or friends.	☐	☐	☐	☐	☐	☐
22. I have people with whom I can do enjoyable things.	☐	☐	☐	☐	☐	☐

	Yes	No
23. Were the services you received here provided in the language you prefer?	☐	☐
24. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available in the language you prefer?	☐	☐

ID:

__ 1__ - __7 __ - __ __ __

Priority Pop *IPP Code* *CDEP Participant Code* **ADOLESCENT VERSION**

(12-17)

Code **POST**

Thank you for taking time to complete this questionnaire. Did any of the questions above upset you? Please check one.

Yes	**No**
☐	☐

Attachment 16: Plank Post-Survey, Adults

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group. The next questions are about your culture.

At present…	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
1. Your culture gives you strength.	☐	☐	☐	☐	☐
2. Your culture is important to you.	☐	☐	☐	☐	☐
3. Your culture helps you to feel good about who you are.	☐	☐	☐	☐	☐
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.	☐	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 3-4 months (since you started our program).

About how often during the past 3-4 months (since you started our program) did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
5. …connected to your culture?	☐	☐	☐	☐	☐
6. …balanced in mind, body, spirit and soul?	☐	☐	☐	☐	☐
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)	☐	☐	☐	☐	☐
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond of your family, school, and friends.*)	☐	☐	☐	☐	☐

Instructions: During the past 3-4 months (since you started our program) how often did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9. … nervous?	☐	☐	☐	☐	☐
10. … hopeless?	☐	☐	☐	☐	☐
11. … restless or fidgety?	☐	☐	☐	☐	☐
12. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
13. … feel that everything was an effort?	☐	☐	☐	☐	☐
14. … worthless?	☐	☐	☐	☐	☐

15. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q9-Q14) match how you would describe those experiences? (Check one)

☐ **A Lot** ☐ **Somewhat** ☐ **Not At All**

Think about one month in the past 3-4 months (since you started our program) when you were at your worst emotionally.

Did your emotions interfere a lot, some, or not at all with your…	A Lot	Some	Not At All	Refused	Don't Know
16. …performance at work or school?	☐	☐	☐	☐	☐
Check here if not working or in school during the past 12 months ☐					
17. …household chores?	☐	☐	☐	☐	☐
18. …social life?	☐	☐	☐	☐	☐
19. …relationship with friends and family?	☐	☐	☐	☐	☐

20. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q16-Q19) match how you would describe the negative effect of emotions on your life? (Check one)

☐ **A Lot** ☐ **Somewhat** ☐ **Not At All**

Instructions: Please answer the following questions based on the services you have received so far. Indicate if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each of the statements below. If the question is about something you have not experienced, check the box for Not Applicable to indicate that this item does not apply to you. Please note: the word "service" stands for any program activities or events connected to the program.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
21. I like the services that I received here.	☐	☐	☐	☐	☐	☐
22. If I had other choices, I would still get services from this agency.	☐	☐	☐	☐	☐	☐
23. I would recommend this agency to a friend or family member.	☐	☐	☐	☐	☐	☐
24. The location of services was convenient (parking, public transportation, distance, etc.).	☐	☐	☐	☐	☐	☐
25. Staff were willing to see me as often as I felt it was necessary.	☐	☐	☐	☐	☐	☐
26. Services were available at times that were good for me.	☐	☐	☐	☐	☐	☐
27. When I first called or came here, it was easy to talk to the staff.	☐	☐	☐	☐	☐	☐
28. The staff here treat me with respect.	☐	☐	☐	☐	☐	☐
29. The staff here don't think less of me because of the way I talk.	☐	☐	☐	☐	☐	☐
30. The staff here respect my race and/or ethnicity.	☐	☐	☐	☐	☐	☐
31. The staff here respect my religious and/or spiritual beliefs.	☐	☐	☐	☐	☐	☐
32. The staff here respect my gender identity and/or sexual orientation.	☐	☐	☐	☐	☐	☐
33. Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	☐	☐	☐	☐	☐	☐
34. The people who work here respect my cultural beliefs, remedies and healing practices.	☐	☐	☐	☐	☐	☐
35. Staff here understand that people of my racial and/or ethnic group are not all alike.	☐	☐	☐	☐	☐	☐
36. Staff here understand that people of my gender and/or sexual orientation group are not all alike.	☐	☐	☐	☐	☐	☐
37. Staff here understand that people of my religious and spiritual background are not all alike.	☐	☐	☐	☐	☐	☐

As a direct result of my involvement in the program:

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
38. I deal more effectively with my daily problems.	☐	☐	☐	☐	☐	☐
39. I do better in school and/or work.	☐	☐	☐	☐	☐	☐
40. My symptoms/problems are not bothering me as much.	☐	☐	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
41. Were the services you received here in the language you prefer?	☐	☐	☐	☐
42. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available in the language you prefer?	☐	☐	☐	☐