ESSENCE OF MANA

Final Local Evaluation Report

July 2017 - June 2021

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Contents

Executive Summary

Synopsis

MANA is a Pacific Islander (PI) concept representing a connection to, and spirit of a higher power (e.g., gods, ancestors, the universe). This concept was used to promote a holistic view of wellness among the Pacific Islander (PI) populations and served as the foundation for the Essence of MANA (EOM) Program. EOM aimed to increase awareness of mental health, reduce stigma, and create access to care and services among the PI population with a particular focus on Samoans and Tongans in San Mateo County, CA. Specifically, EOM strived to address PI mental health issues including but not limited to depression, anxiety or post-traumatic stress disorder related to issues of domestic violence and rape/molestation, and substance use disorders. Through the delivery of a 12-week Parent-Caregiver class held each quarter, where participants met once a week in the evenings, the overarching goal for EOM programming was to:

> 1) Improve communication skills among family members; 2) Increase leadership skills & community involvement; 3) Increase knowledge on aspects of mental health conditions (including offering and receiving support); 4) Find voice and understanding of spiritual beliefs; 5) Reduce stigma around mental health conditions and other taboo topics (i.e. domestic violence, rape/molestation, substance use disorders, etc.); and 6) Increase access to culturally supportive care and services.

The overarching approach of EOM was a whole-person approach, wherein the community, culture, and family members were engaged and involved in all elements of the program. The Culturally Defined Evidence Practice (CDEP) was an educational curriculum in the form of Parent-Caregiver classes for Samoan and Tongan caregivers, where the curriculum and other program elements were enhanced by staff to better reflect the interests and needs of community members. Over the tenure of the program, EOM conducted 7 cohorts that included 79 participants using this curriculum; with 66 participants completing both the pre- and post- in-house surveys. On average, the attrition rate was 15%.

EOM used community-based, family-centered, and culturally-responsive approaches for the development, implementation, and evaluation of the program. While EOM was performing well pre-COVID, this culturally-responsive approach was especially crucial and beneficial during COVID, where EOM was able to quickly adapt its programming to continue conducting classes online, as well as serve as a means for communal mental health and social service support by engaging the broader PI community through social media (i.e., Facebook Live and Zoom). EOM succeeded in establishing and maintaining a program that increased awareness of mental illness, directed community members to preventive services members, and enabled a community organization to implement culturally-relevant programing. As a result of these efforts, EOM felt that they

Evaluation Questions

Four evaluation goals guided EOM's evaluation, which included: 1) Documenting change over time in participants' reported behavior related to addressing mental health including improved communication skills, increased leadership skills, and increase in knowledge; 2) Assisting MANA in capturing participants' "voice" and understanding of spiritual beliefs as related to mental health programming; 3) Determining if participants' reported a reduction in stigma around mental health conditions and other taboo; and 4) Documenting participants experiences with access to culturally supportive care and services.

The following evaluation questions were used to address the aforementioned goals through process and program outcome evaluation approaches:

- What are participants' perceptions about the EOM program? (***Process***)
- How do the core stakeholders (MANA Staff, CAB and culturally-competent mental health service providers) perceive MANA and its components with regards to providing bicultural, bilingual services that accommodate the program's cultural competency goal? (***Process***)
- To what extent have participants' reported behavior changed over time in relation to addressing mental health, including improved communication skills, increased leadership skills and community engagement, and increased knowledge? (***Outcome***)
- To what extent has stigma been reduced regarding mental health conditions and other taboo topics (i.e., domestic violence, rape/molestation, substance use disorders, etc.)? (***Outcome***)
- Are participants more knowledgeable about how/where to access culturally-competent mental health services and support (e.g., AARS Managed Care program, Daly City Youth Health Center, Pyramid Alternative, Daly City Partnership)? (***Outcome***)
- To what extent have participants found a voice as it relates to mental health? (***Outcome***)

Executive Summary

addressed the target populations' needs that so often lead to the perpetual stigmatization of mental illness, lack of access to care, and disproportionately negative health outcomes.

Evaluation Research Design

The evaluation research design used for the EOM evaluation was a non-experimental pre/post intervention, single group design. In addition to using the evaluation questions mentioned above, the EOM evaluation used mixed methods to document and collect data related to the process and program outcome evaluation components.

There was no comparison group, since it would have required recruiting Samoan and Tongan individuals living in Northern San Mateo County who were not enrolled or affiliated with EOM to participate. Instead, EOM staff and it's Community Advisory Board (CAB) members preferred to practice inclusion and outreach to the entire targeted population to further implement overall program goals of the CDEP.

Quantitative methods included:

- EOM application that was completed by all Parent-Caregiver Class participants.
- EOM In-House Baseline Survey administered to all participants at the first session of each cohort and an EOM Post In-House Survey administered at the final session.
- Program records including attendance, outreach, enrollment, and referrals were tracked using monthly reporting tools in the form of MS Excel spreadsheets and SurveyMonkey created by the local evaluator.

Qualitative methods included:

- Participatory observation with one cohort using the Storytelling or Narrative Approach.
- Focus group with CAB members conducted during one of their quarterly meetings.
- Participant End-of-Program Interviews using the Storytelling or Narrative Approach conducted with 4-5 participants.
- Collection of website analytics during COVID for social media activities.

Key Findings

Overall, EOM has been successful with the six objectives it sought to address. Specifically:

- Survey results showed self-reported improvements in communication skills among family members.
- There was a statistically-significant increase in knowledge of aspects of mental health conditions.
- Throughout its programming and work with its CAB, EOM staff successfully collaborated with various PI community groups to gain access to schools and faith-based communities to recruit participants. They also utilized their community connections to outreach to law enforcement offices and social media.
- EOM garnered trust and support among the targeted community to the extent that they could engage and involve community members in the program's sustainability process for advocating for additional State funds to continue CRDP programming along with other IPPs.
- There was a reduction in beliefs related to stigma around mental health conditions and other taboo topics.
- EOM saw not only an increase to access to culturally-supportive care and services, but also an increase in requests for such services.

Conclusion

Throughout the tenure of the program, EOM staff were very cognizant of the community's hesitancy to engage with anyone from mental health or social services based community members' past negative experiences, such as the discontinuation of helpful programs, or individuals being treated dismissively. As a result, EOM has been able gain the trust among its targeted community of those of PI descent. The program has engaged 79 individuals in its CDEP curriculum, and guided several community members in the right
direction towards finding supportive and culturally- relevant mental health services. In addition, they have built up the community "voice" or communication skills and knowledge of services so that the community can be "heard" regarding their mental health needs.

Introduction / Literature Review

HealthRIGHT 360- Asian American Recovery Services (AARS) developed and implemented Essence of MANA (EOM) to address Asian and Pacific Islander (API) mental health issues including but not limited to depression, anxiety or post-traumatic stress disorder related to issues of domestic violence, rape/molestation, and substance use disorders. MANA specifically targeted Samoan and Tongan populations living in Northern San Mateo County (SMC) to: 1) Improve communication skills among family members; 2) Increase leadership skills & community involvement; 3) Increase knowledge on aspects of mental health conditions (including offering and receiving support); 4) Find voice and understanding of spiritual beliefs; 5) Reduce stigma around mental health conditions and other taboo topics (i.e. domestic violence, rape/molestation, substance use disorders, etc.); and 6) Increase access to culturally supportive care and services. Specifically, the EOM team through their programming sought to address the following recommendation made in CRDP's Phase 1 Asian and Pacific Islander (API) Population Report: *Increase access by supporting culturally competent outreach, engagement, and education to reduce stigma against mental illness and raise awareness of mental health issues.*[1]

Within the Pacific Islander community, the "MANA" tradition emphasizes the relationship and spirit of higher power. The term "Essence" acknowledges how deeply-rooted the traditional and cultural aspects of MANA are within the Samoan and Tongan communities. EOM staff delivered the Essence of MANA to the target population through a community-defined evidence program that addresses the physical, mental, and spiritual health of Samoan and Tongan families. By practicing these culturally conscious programming methods, EOM staff sought to reduce the stigma surrounding mental illness and increase mental health access and awareness, amongst other desired outcomes.

Community Needs. Within the Bay Area, North San Mateo County (SMC) is a hub for Native Hawaiian and Pacific Islander (NHPI) families with an NHPI population over 15,000. Of California's fifty-eight counties, SMC has the highest proportion of Native Hawaiian and Pacific Islander (NHPI) individuals (1.9% of the total population),[2] and a majority of the NHPI population is Samoan or Tongan (61%).[3] These groups are also growing at a much faster rate than the general population; between 2000 and 2010 the Bay Area's Samoan population grew 19% and its Tongan population grew 48%, compared to a 5% total population growth.[4]

Samoan and Tongan populations in the Bay Area experience social and economic disparities that increase vulnerability to mental health risks.[5] Compared to all other NHPI subpopulations in the Bay Area, Tongans and Samoans have the lowest per capita incomes ($15,669 and $16,291, respectively) and the lowest educational attainment (only 10% attain a bachelor's degree, compared to 41% in the total population).[6] Anecdotal reports from the EOM team during COVID pandemic since March 2020 noted that this disparity grew even larger, with many being challenged to keep housing and or provide food for their families.

These same populations reported lower than average mental health status. In a 2012 study, 35% of Samoans and 25% of Tongans reported mental health status that was less than good, compared to only 14% among the general population in SMC. Pacific Islanders have a higher prevalence rate of serious mental illness (7%) than both API in general (5.6%) and the total California population (6.25%).[7] The prevalence rate of severe mental illness in API populations is likely higher than estimated, due to cultural barriers to diagnosis and care including stigma and a lack of culturally appropriate providers. In confirmation, APIs receive behavioral health services in the lowest proportion (6%) compared to all other ethnic groups (17% for whites, 31% for African Americans).[8] In California, the rate of uninsured Tongans (30%) and Samoans (15%) is higher than among whites (11%).[9] These numbers are even higher in the EOM service area.

Existing Disparities. In a study of API residents of SMC, 21% of Samoans and 26% of Tongans reported having no form of health insurance, compared to 10% of the general county population.[10] The target population experiences barriers to care that contribute to mental health risks and underutilization of services. The cultural barriers to care include the stigmatization of mental illness in API cultures, a lack of culturally appropriate services, and language barriers. Studies have shown that stigma is among the chief barriers to mental health services for API populations.[11] Mental illness is perceived as morally shameful, rather than a treatable health condition. Community members agree that for APIs in the Bay Area, mental health problems are frequently unaddressed because they are linked to taboo subjects, such as partner violence or substance abuse.[12] These taboo subjects lead to a silence as APIs are unable to communicate openly about mental health and unable to address mental health problems and related problems within the family and community.

The association of mental illness with shame, dysfunction, and moral failing prevents awareness about mental health conditions and resources. Furthermore, the lack of culturally appropriate services exacerbates problems. Despite low self-reported mental wellness, Samoans and Tongans are more likely than all residents of the counties in which they reside to delay seeking medical care.[13] Samoan and Tongan individuals are more likely to seek out help within their community, through trusted and respected spiritual leaders or family members. Without culturally competent providers, an already underutilized and stigmatized service becomes even more untrusted and inaccessible, leading to disproportionate levels of severe mental illnesses and related negative health outcomes.

Failing to meet the target populations' needs leads to the perpetual stigmatization of mental illness, lack of access to care, and disproportionate negative health outcomes among the target population. Poor mental health status is related to other negative health outcomes and high mortality rates. According to the Mental Health Services Act (MHSA), negative outcomes related to mental illness include: suicide, incarcerations, unemployment, prolonged suffering, removal of children from their homes, homelessness, and school

failure or dropout.[14]

The data below demonstrate the target population is currently experiencing disproportionate and increasing negative outcomes listed above. NOTE: A majority (61%) of the NHPI population in SMC is Tongan or Samoan.

- Suicide: In California, the number of NHPI suicide deaths increased 100% from 2005 to 2010, compared to a 17% increase in whites over the same time period.[15]
- Incarcerations: In California, while the number of NHPI grew 29% between 2000 and 2010, the number of NHPI in prison grew 192%; compared to a 10% statewide population growth and 1% statewide prison population growth.[16]
- Unemployment: In SMC, the unemployment rate for NHPIs is 16.8%, which is higher than Asians (7%) and all other ethnic groups except African Americans (18.2%).[17]
- Homelessness: In SMC, NHPI are overrepresented among the homeless population, accounting for 5% of the homeless population and only 1.4% of the total population.[18]
- School Failure or Dropout: In SMC, NHPI youth have lower-than average high school graduation rates and above-average dropout rates; Tongans and Samoans are less likely to be college graduates (only 10%) than all other ethnic groups.
- Alcohol and substance use: In California, NHPI adolescents reported higher use of cigarettes (3.8%), e-cigarettes (12%), heavy drinking (7.4%), and cannabis use (13%) compared to Asians, Blacks, and Latinos.[19]
- Mortality Rates: In 2012, the age adjusted death rate for NHPI in SMC was higher than any other racial group (826 per 100,000 people, compared to 536 per 100,000 for the total population).[20]
- In California, Native Hawaiians and Pacific Islanders have the highest COVID-19 rate at 11,830/100,000 as of July 14, 2021. This is almost twice as high as the rate of Blacks/African Americans (6,045/100,00) and almost three times as high as whites (4,267/100,00).[21]

The myriad of societal challenges and health disparities faced by the targeted community appear to create a “perfect storm” in terms of health equity. As a program, EOM strived to work within the community’s comfort level in addressing these challenges and disparities, particularly when it came to seeking services. Throughout the tenure of the program, EOM staff have been very cognizant of the community’s hesitancy to engage with anyone from mental health or social services based on individuals’ past negative experiences (e.g., seeking help from services, only to receive the threat of removal of children), being dismissed, and having helpful programs “sunset.” EOM staff hoped they could guide community members to supportive and culturally relevant services. Additionally, they hoped to help build up community members’ “voice” or communication skills and knowledge of services so that they could be “heard” regarding their mental health needs.

CDEP Purpose, Description & Implementation (A-B)

A. CDEP Purpose

As an indirect Prevention and Early Intervention (PEI) program, EOM aimed to prevent and/or reduce mental illness among Samoan and Tongan families living in Northern SMC. The program emphasized the MANA tradition of spiritual connection to a higher power and physical, mental, and spiritual wellness. Additionally, all aspects of the programming were made culturally appropriate and led by trained facilitators and program staff who were bicultural and/or bilingual (including Tongan or Samoan speaking). This culturally designed approach addressed the following Phase I priority population recommendation: Increase access to mental health services by supporting culturally competent outreach, engagement, and education to reduce stigma against mental illness and raise awareness of mental health issues. The expected outcomes of EOM were to: 1) Improve communication skills among family members; 2) Increase leadership skills & community involvement; 3) Increase knowledge on aspects of mental health conditions (including offering and receiving support); 4) Find voice and understanding of spiritual beliefs; 5) Reduce stigma around mental health conditions and other taboo topics (i.e. domestic violence, rape/molestation, substance use disorders, etc.); and 6) Increase access to culturally supportive care and services.

B. CDEP Description & Implementation Process

Level of Intervention. EOM aimed to reduce mental health issues with an individual level intervention using cultural and spiritual approaches with the inclusion of Tongan/Samoan communities by: 1) Improving communication skills among family members; 2) Increasing leadership skills & community involvement; 3) Increasing knowledge on aspects of mental health conditions (including offering and receiving support); 4) Finding voice and understanding of spiritual beliefs; 5) Reducing stigma around mental health conditions and other taboo topics (i.e. domestic violence, rape/molestation, substance use disorders, etc.); and 6) Increasing access to culturally supportive care and services.

EOM Cycles or Cohorts. EOM intended to offer 10 cycles or cohorts over the course of the grant (to end in June 2022). For the purposes of this Final Local Evaluation Report, 7 of the 10 cohorts fell within the reporting period of July 2017 and June 2021. From these cohorts, 104 enrolled into the program, 79 completed the pre in-house survey, and 51 completed both the pre and post in-house survey.

EOM strived to enroll 20 individuals per cohort, however, with the first three cohorts, fewer than 20 enrolled (average enrolled participants was 11), and fewer from those enrolled remained in the program (average number of participants was 7). Recruiting efforts were a challenge given the targeted communities were not familiar with EOM and leery of mental health-based services in general. By Cohort 4, after consistent outreach via EOM's social media accounts and rapport building with the community by means of the CAB and participation in community events, the number of participants began to increase, with enrollment averaging 18-15 individuals and 10-11 individuals staying on to complete the program. By the 6th and 7th cohort, even with COVID, EOM maintained these enrollment and participation numbers.

As with many community programs, EOM saw more individuals enrolled than would complete programming (attrition), with the attrition rate averaging 15%. The most common reason reported for not completing the program was scheduling challenges, such as change in work schedule or unforeseen family challenges. Other reasons given were discomfort with the program topic, and opting to complete the program with a similar Spanish-language program.

CDEP Components – Building of a Culturally Relevant Program. The expected outcomes of the cultural and spiritual approach and utilization of storytelling methods were to: 1) Improve communication skills among family members, 2) Increase leadership skills & community involvement, 3) Increase knowledge on aspects of mental health conditions (including offering and receiving support), 4) Find voice and understanding of spiritual beliefs, 5) Reduce stigma around mental health conditions and other taboo topics (i.e. domestic violence, rape/molestation, substance use disorders, etc.), and 6) Increase access to culturally supportive care and services.

Throughout all of the CDEP components, the EOM staff were culturally responsive by providing a culturally safe and family centered environment for participants, using culturally conscious language, implementing culturally relevant topics, and providing culturally appropriate referrals and access to resources. To establish culturally effective connections with the community, EOM staffed individuals who were bicultural and/or bilingual (including Tongan or Samoan speaking). Of a staff of 4 working directly with the community, 3 were of PI descent, and all three were partially or fully fluent in either Tongan or Samoan. Additionally, these staff members had life experiences and ethnic backgrounds (e.g. full or multi-ethnic Pacific Islander) that were in common with the populations served, and they were trained in integrating an individual's spiritual beliefs and cultural practices into the development and provision of services wherever possible. All EOM staff attended an API Cultural Competency that was provided annually by AARS/HR360 leadership staff. Additionally, all EOM staff were trained by Nani Wilson (Project Supervisor) in the implementation of the related program elements listed later in this section.

In terms of the "essence of MANA", staff acknowledged that participants may not all share the same religion or faith, and emphasized the spiritual tradition of MANA of recognition of participants' individual spiritual beliefs when implementing the Parent-Caregiver Curriculum. Using this spiritually-responsive approach aided participants in building upon their cultural and spiritual foundations and beliefs when dealing with mental health issues.

Another form of cultural relevancy was EOM staff being culturally responsive or adhering to the traditional hierarchy within the Samoan and Tongan community in who gets to speak and use their voice. To do this, EOM staff ensured a safe space that allowed all participants to be respected and have the opportunity to speak/communicate. In creating this safe space, EOM staff exhibited their understanding of the deeply-rooted layers of trauma or mental health problems that parents/caregivers may have experienced. The "understanding" was woven throughout all program elements (whether community outreach or session facilitation) by focusing upon one layer at a time and addressing the most immediate concerns. For example, offering childcare or food at the family workshops addressed an immediate family care concern that enabled parents/caregivers to participate in the family workshops. In another example of "understanding," EOM staff acknowledged the need and, most importantly, utilized their abilities and knowledge to tailor the curriculum to a topic of interest expressed by a participant such as past trauma of physical or sexual abuse, or substance misuse.

The tradition of storytelling in the Samoan and Tongan community to share history, culture, and family legacies is long-standing. To address this, EOM ensured and allowed storytelling to occur informally and formally across all CDEP components. These stories provided an introductory platform for reducing stigma around mental health topics and gaining trust between EOM staff and the targeted population and local communities. Storytelling also created space for peer support and opportunities to voice out concerns, challenges, and share their own journey. For example, informally, participants or staff shared their experiences and stories in the parent workshops, community outreach events, such as "Talonoa Tuesday." Formally, EOM staff collected stories from participants, staff, and CAB members to get feedback and ensure program components were culturally appropriate.

CDEP Adaptations – Pre and Post-COVID. Given EOM was an adaption of a previous program implemented by the same individuals who had implemented the previous program, no adaptations were needed for EOM's Cohorts 1 through 5 (pre-COVID). For these

cohorts, the facilitation duo was familiar with the curriculum, as it was based on both existing and adapted program concepts generated by the facilitators. These concepts were based on the facilitation duo's familiarity with the program and their understanding of what should be taught based on years of experience and the testing of different program topic ideas to address cultural relevancy and approaches to teaching. The facilitation duo checked in once a week to discuss the past session taught as well as the upcoming session. They also reviewed session feedback provided by participants through a weekly session evaluation.

During COVID, adaptation of the program came after much discussion on how to capture "essence" of the program that greatly depended upon frequent, direct contact with participants. Consultation with the EOM CAB as well as continued discussion within the internal EOM team, led to adapting the program so that procedures were in place to consistently be engaged with participants through Zoom, Facebook Like, phone calls, and mobile phone direct-messaging apps. Specific post-COVID strategies for each CDEP component can be at the end of each component section below.

CDEP Components – Specifics. Components included:

1. MANA Family Workshops: Parent-Caregiver Classes, Youth Classes, Family Nights, Community Wellness Celebration

Parent-Caregiver Classes (Including COVID Adaptions)

- "Caregivers" were defined as individuals who were legal guardians of children under the age of 18.
- The 12-week Parent-Caregiver Classes met once per week in the evening. The class began with a family-style meal, a cultural norm for Samoan and Tongan gatherings. The menus were pre-planned and culturally thoughtful, with the food being donated or purchased as coordinated by MANA staff. This allowed participants to experience a safe place, with other parents and caregivers with a cultural vibe, and ultimately a place where they could start conversations about taboo topics.
- The MANA curriculum was based on a previous Parent-Caregiver course offered by AARS using the San Mateo County Health Department's Parent Project Curriculum that offered through the department's Behavioral Health & Recovery Services and Office of Diversity and Equity. Through implementation of the county's Parent Project Curriculum, AARS recognized a need for more culturally tailored topics for PI populations, thus adapted the curriculum to include culturally specific activities, strategies, and methods to address issues in mental health relevant to the PI population.
- The Parent-Caregiver Curriculum included:
  - 1 orientation session, where participants were welcomed and surveyed on topics of interest;
  - 5 classes, with activities and topics pulled from the Parent-Project Curriculum; and
  - 6 sessions developed by EOM that were based on topics-of interest surveys (completed by participants during orientation), feedback from the Community Advisory Board (CAB), AARS experience, and participant outcomes. While some of the workshops involved didactic presentations and education on key topic areas, EOM staff also ensured space was available to encourage open dialogue and discussion, avenues for supporting one another, and opportunities to share experiences, ask questions, and offer advice or resources amongst the participants.
- *COVID ADAPTATIONS.* Once the COVID shutdown was in place, EOM immediately shifted to continuing classes through Zoom. Prior to the first Zoom class, EOM staff spent time working with individuals to ensure that participants were able to work with Zoom and their electronic devices (i.e., computer or mobile phone). The shutdown took place during class 8 of Cohort 6, leaving 4 more classes to complete. Given EOM staff and their local evaluator's concern over the new delivery style impacting post-survey results, the Cohort 6's data was compared to earlier cohorts and found not to be different (see 6. *Evaluation Design & Methods – Section E Data Analysis* and *Results – Quantitative Findings*).

  Since March 2020 all classes have been conducted via Zoom, including the last four sessions of Cohort 6, and all 12 sessions of Cohort 7.

Youth Classes

In order to support parents and caregivers and improve adult engagement and retention, MANA offered Youth Classes (for ages 10-17 years old) concurrently with the Parent-Caregiver Classes. Parent-Caregivers may be reluctant to attend evening classes when they have young children or teenagers who need supervision.

- Youth Classes were facilitated by the Program Assistants, with younger children originally engaging in age-appropriate play or art activities, while older youth participated in a Pacific Islander cultural education component. By Cohort 3, all youth, regardless of age were engaged in the cultural education. Since 2011, members of EOM staff have provided youth classes to Pacific Islander groups through The Parent Project, and were able to easily adapt youth topics from the previous classes in the same process as

the Parent-Caregiver Curriculum (in consultation with the CAB and Community Informed Approach). Previously adapted topics for the youth-focused component have included: alcohol and other drug abuse, family dynamics (e.g. acculturation and identity), API culture and history (e.g. mapping of islands, quizzes), and arts and crafts. In addition to EOM staff's experience with the API-focused youth curriculum described above, AARS/HR360 has extensive experience developing and delivering youth prevention program activities to API populations in various settings.

- *COVID ADAPTATIONS.* EOM staff worked with participants and their household to establish space for the caregiver and the youth to engage on ZOOM privately. Often time this involved the parent going into one part of the home and youth often in a bedroom where they could shut the door.

  Zoom youth engagement occurred during the final four sessions of Cohort 6. The time and resources (i.e., energy) to do both caregivers and youth was a lot, and the EOM staff decided to minimize the time with youth and met with youth twice a month for Cohort 7.

Family Nights

- Family nights served as an outreach event where family members could come together in a comfortable environment and learned about EOM and additional resources. Most often this was in the form of an event titled *Journey to Empowerment*.
- Those invited to family nights included any community stakeholders, such as: Community Advisory Board (CAB) members; potential or previous participants; family members; program graduates; HR360/AARS staff; and local providers or community based organizations.
- *COVID ADAPTATIONS.* To continue this event, EOM staff expanded this concept by hosting "Talanoa Tuesdays," a Facebook Live event podcast-ish event where guests were brought in to discuss different mental health issues and other community-based concerns (i.e. COVID). This event, as with the classes still occurs.

Community Wellness Celebration

- This was a celebratory event to congratulate program graduates. A total of 7 "celebrations" were held.
- Youth also presented a final project at the events that they worked on during the Youth Classes. Final projects ranged from cultural dances or songs to spoken-word pieces.
- Family members, volunteers, and other relevant community members were always invited to attend this event as a family style dinner with certificates of completion given out during dinner.
- *COVID ADAPTATIONS.* This event still took place during COVID, with EOM staff and volunteers helping to deliver meals on the given day to participants so that all could celebrate together online.

The expected outcomes of the MANA Family Workshops (Parent-Caregiver Classes, Youth Classes, Family Night, Community Wellness Celebration) were to: 1) Improve communication skills among family members, 2) Increase leadership skills & community involvement, 3) Increase knowledge on aspects of mental health conditions (including offering and receiving support), 4) Find voice and understanding of spiritual beliefs, 5) reduce stigma around mental health conditions and other taboo topics (i.e. domestic violence, rape/molestation, substance use disorders, etc.), and 6) increase access to culturally supportive care and services.

2. Community Outreach

- EOM provided outreach services almost on a daily basis as they posted frequently (even pre-COVID) on their Facebook page.
- Pre-COVID, outreach efforts included going out into the community to set up booths and engage with individuals and families, distributing bilingual materials at community centers and schools, and conducting follow-up with current and prior participants.
- Outreach was an essential practice to recruit and **continually engage** participants. In this case, "engage" generally meant to speak with participants and stay in touch with them to be available to discuss their participation in EOM. One of the Program Assistants providing outreach was bilingual in Tongan, which helped to encourage community members' involvement in the program.
- *COVID ADAPTATIONS.* As with the aforementioned "Family Night" event, EOM staff use "Talanoa Tuesdays" to outreach to the community. This has been the main source for recruitment as they have "reached"(web-analytic measure that counts number of Facebook users who came into contact with EOM site on Facebook) and "engaged" (web-analytic measure that measures the number of times someone took action on EOM's posts) 77,223 individuals (61,030 individuals reached, 16,193 engaged).

Because of this strategy, they now have waiting lists for their classes.

The expected outcomes of the community outreach were to: 1) Increase knowledge on aspects of mental health conditions (including offering and receiving support), 2) Reduce stigma around mental health conditions and other taboo topics (i.e. domestic violence, rape/molestation, substance use disorders, etc.); and 3) Increase access to culturally supportive care and services.

3. Culturally Competent Referrals

- EOM staff initially wanted to provide referrals to individuals who **exhibited a need for mental health treatment** and/or further resources. Over the course of the program, however, individuals actually reached out to EOM staff for assistance, particularly after hearing different representatives from community programs speak at the classes.
- Pre-Covid, the most common referral request was for linkages to guest speakers who worked with the local school districts and PI communities, and the guest speaker doing gang intervention work.
- Referrals were culturally appropriate, meaning staff connected individuals with providers that have the ability address cultural and linguistic needs and utilize the individual's/family's strengths (e.g. languages spoken, values). Referrals were provided by knowledgeable staff who have similar backgrounds and experiences to the target population.
- Additionally, on some occasions, staff needed to provide cross county referrals to AARS' programs, which was useful for family members who may attended outreach events but were residents in the neighboring counties of San Francisco and Santa Clara or who have family in those counties. An example of this is when a family experienced a crisis requiring EOM intervention when one of their children ran away. EOM staff were instrumental in reaching out to various community organizations, community elders, and community gatekeepers to mobilize the community to locate, negotiate, and reunify the child with their family. Such efforts show how well connected EOM is within and around the community as this issue was quickly resolved.
- *COVID ADAPTATIONS.* Within the first months of COVID, the most common request were related to finding food pantries and housing.
  - As COVID entered into the later months, the economic impact in EOM's targeted community grew deeper with more families being short on food; the EOM staff worked diligently to do all that they could to connect these families to needed social and food services.
  - Through "Talanoa Tuesdays," more services were introduced to the community, which led to more individuals reaching out to EOM Staff through social media and direct messaging to get linkages to specific guests and their services.
  - With all Facebook postings, different staff were assigned different times to watch or go through the Facebook page and Group to reply to any inquiries and or address any postings that required a reply. Doing so made the staff highly visible to the community and helped build a strong following once the newly developed "Talanoa Tuesday" launched, which in turn resulted in more referrals.

The expected outcomes of the culturally competent referrals were to: 1) Reduce stigma around mental health conditions and other taboo topics (i.e. domestic violence, rape/molestation, substance use disorders, etc.), and 2) Increase access to culturally supportive care and services.

4. Community Engagement: (CAB, Community Informed Approach, Community Member Involvement)

Community Advisory Board (CAB)

- The CAB was composed of community stakeholders, which included participants, family members, community leaders and advocates, and other providers. EOM monthly CAB meetings to gather information on community needs and interests, as well as initial input and feedback on the proposed activities and evaluation tools during the first year.
- After Year 1, EOM met with its CAB bi-monthly (every other month) or quarterly depending upon people's schedules.
- During the post-Year 1 meetings, stakeholders were provide verbal and written presentations on EOM was performing and asked to provide feedback on how service delivery could be improved. Stakeholders were also asked to link EOM with any services they felt were a good fit for the targeted community.
- *COVID ADAPTATIONS*. Adaptations to this component were minimal as EOM continued to meet with the CAB, and went from meeting in person to on Zoom. During the first few months of COVID, the CAB met with EOM staff monthly to provide support during the initial shock and impact to the community for both social service issues and the infection rate.

Community-Informed Approach

- Community involvement in all phases of the program were vital for engaging the target population. This begins with effectively listening to the expressed needs and feedback of community members.
- Methods to achieve community stakeholder involvement will included: provision of services in community-based settings, such as faith-based organizations and community centers; and fostering relationships.
- *COVID ADAPATATIONS.* EOM staff implemented "Talanoa Tuesdays" to address this approach, particularly when the staff were collaborating with other PI organizations to alert community members to the impact of COVID infection and how to address it.

Community Member Involvement

- To engage individuals and families in Parent-Caregiver sessions, EOM incorporated community leaders into activities. For example CAB members, community members and past participants were often invited back to the first session to assist with data collection, signing people and simply welcoming individuals to the cohort. Such a practice was engaging because it will enhanced feelings of trust for participants.
- Additionally EOM involved 1-2 volunteers per cohort, who talked about specific topics such as alcohol and other drugs, gangs, and LGBTQ+ issues. The volunteers often were previous program graduates or community leaders/advocates.
- *COVID ADAPATATIONS.* As with the *Community-Informed Approach* above, EOM staff implemented "Talanoa Tuesdays" to address this approach, particularly when the staff collaborated with other organizations to identify speakers on different topics related to "Talanoa Tuesdays."

The expected outcomes of emphasizing Community Member Involvement were to: 1) Increase leadership skills & community involvement; 2) Increase knowledge on aspects of mental health conditions (including offering and receiving support); 3) Find voice and understanding of spiritual beliefs; 4) Reduce stigma around mental health conditions and other taboo topics (i.e. domestic violence, rape/molestation, substance use disorders, etc.); and 5) Increase access to culturally supportive care and services.

Local Evaluation Questions

Four evaluation goals guided this program evaluation, and included: 1) Documenting change over time in participants' reported behavior related to addressing mental health including improved communication skills, increased leadership skills, and increased in knowledge; 2) Assisting EOM in capturing participants "voice" and understanding of spiritual beliefs as it relates to mental health programming; 3) Determining if participants' report a reduction in stigma around mental health conditions and other taboo; and 4) Documenting participants experiences with access to culturally supportive care and services.

Six (6) evaluation questions were developed to address the process and outcome evaluation components and included**:**

Process Evaluation Related	1. What are participants' perceptions about the MANA program?
	2. How do the core stakeholders (MANA Staff, CAB and culturally competent mental health service providers) perceive MANA and its components as it relates to providing bicultural, bilingual services that accommodate the programs cultural competency goal?
Outcome Evaluation Related	3. To what extent have participants' reported behavior changed over time in relation to addressing mental health including improved communication skills, increased leadership skills and community engagement, and increased in knowledge?
	4. To what extent did a reduction occur in stigma around mental health conditions and other taboo topics (i.e. domestic violence, rape/molestation, substance use disorders, etc.)?
	5. Do participants feel more knowledgeable of where to access culturally competent mental health services and supports (e.g. AARS Managed Care program, Daly City Youth Health Center, Pyramid Alternative, Daly City Partnership)?
	6. To what extent have participants found a voice as it relates to mental health?

Using the evaluation goals and questions, the EOM staff along with their evaluators designed an evaluation plan and collected data to answer the questions. During COVID slight adjustments were made, where observations and multiple check-ins with staff were made to assess community responses; however, for the most part the evaluation goal and questions remained the same.

Evaluation Design & Methods (A-E)

A. Design

Using the above-mentioned evaluation goals and questions, the EOM evaluation design utilized mixed methods to guide the process and program outcome evaluation components for a non-experimental pre/post intervention single group design. Additionally, the qualitative research design was of an ethnographic nature, in that the evaluator immersed themselves into the EOM's environment to understand the goals, culture, challenges, motivations, and themes.

Quantitative methods include:

- EOM In-House Baseline Survey administered to all participants at the first session and an EOM Post In-House Survey administered at the final session;
- OHE - SWE Pre and Post Survey administered to all Parent-Caregiver Class participants at the first (pre) and final (post) session; and
- Program records including attendance, outreach, enrollment, referrals and web analytics tracked monthly through internal reporting tools.

No comparison group was involved as it was deemed necessary to recruit any Samoan and Tongan individuals living in Northern San Mateo County who were not enrolled or affiliated with EOM. Rather than recruiting such individuals for comparison group participants, EOM staff and CAB members preferred to practice outreach and inclusion towards the targeted population in further implementing overall goals of the CDEP.

Qualitative methods included:

- Monthly check-ins with EOM staff to gain insight about programming and conduct any strategic planning necessary;
- Participatory observation with one cohort using the Storytelling or Narrative Approach;
- Focus group with CAB members conducted during one of their quarterly meetings;
- Participant End-of-Program focus group using the Storytelling or Narrative Approach conducted with 4 participants; and
- Collection of website analytics during COVID for social media activities.

Inclusion of Local knowledge

The CAB was composed of community stakeholders that included past participants, family members, community leaders and advocates, and other providers. EOM initially held monthly CAB meetings to gather information on community needs and interests, as well as initial input and feedback on the proposed activities and evaluation tools. Once the program was implemented, the meetings with the CAB were held either bi-monthly (every other month) or quarterly depending on CAB members' availability. Stakeholders generally provided verbal feedback on how services might be delivered (e.g. locations, course topics, and engagement strategies), and served as links to culturally relevant services such as the Samoan Community Development Center, Taulama for Tongans, and Samoan Solutions.

The main feedback from the CAB regrading local knowledge was that community involvement at all phases of the program was vital for engaging the target population. To do this, Stakeholders stressed the need for effectively listening to the expressed needs and feedback of community members. Seeing the CAB representing the "community," EOM incorporated community stakeholder feedback at all times by ensuring that every event may it be outreach or the classes had some form of "listening" component. Such tactics included the EOM team providing direct contact information to be contacted in the future with any additional questions and or concerns, a quick check-in to see what participants thought about a discussion or event, or weekly class evaluation forms. Additionally, they listened to participants during the cohort, as well as when they participated in community events (e.g., health fairs, cultural events).

To engage individuals and families in Parent-Caregiver classes, EOM incorporated community leaders into activities, particularly "Talanoa Tuesdays." This practice was engaging because it enhanced feelings of trust for participants by having "people who look like them" share stories about mental health. Prior to COVID, EOM involved 1-2 volunteers per cohort, who would talk about specific topics such as alcohol and other drugs, gangs, and LGBTQ. In some cases the volunteers were previous program graduates, and at other times community leaders/advocates.

Addressing Intersectionality

To respectfully adhere to the diverse social complexities of the PI participants, the local evaluator considered the cultural appropriateness of all evaluation methods and protocols, by discussing and involving the EOM staff in developing and implementing the evaluation plan. All data collection instruments created, including focus group protocols and/or surveys were carefully crafted with culturally appropriate language that was mindful of gender, age, generation (parent versus grandparent as a caretaker), religious/spirituality, mixed ethnic identity, and sexual identity.

The local evaluator and EOM staff were also culturally responsive in acknowledging the traditional family hierarchy within the Samoan and Tongan communities, which elects who gets to speak and use their voice. EOM staff always ensured a safe space that allowed all participants to be respected and have the opportunity to speak and communicate. In creating this safe space, EOM staff exhibited to the community their understanding of the deeply-rooted layers of trauma or mental health issues that parents/caregivers/youth may have experienced. Such efforts showed they were mindful of the intergenerational differences and hierarchical tradition during class sessions and when engaging with the community.

B. Sampling Methods and Size

Non-Probability Sampling, either convenience or purposive, was used throughout the program as none of the participants or CAB stakeholders were randomly selected. Criteria used for all sampling included being of PI descent (i.e., identification could include full or partial PI) or having child(ren) of PI descent (i.e., biological, adopted or fostered). Specifically:

- For quantitative data collection -
  - A convenience sample of all participants were included in the sample for the administration of the in-house pre/post survey, and each group served as its own comparison group by the use of a post-survey asking the exact same questions found in the pre-survey and comparing change in responses. It was hypothesized (evaluation hypothesis) that post-intervention responses would be different than pre-intervention responses.
  - The sample was recruited through various methods including direct community outreach through community agencies, community cultural events, EOM's own "family night" events, and social media.
  - While 104 initially enrolled into the program, 79 individuals completed the pre in-house survey, while 66 completed both pre and post in-house survey. All enrolled participants were invited to complete the surveys.
- For qualitative data collection -
  - Purposive sampling was used as certain individuals were identified based on the information they could provide in focus groups to provide perceptions or feedback about EOM.

Intended and Final Sample

- Although there will be 10 program cycles by the end of the program in 2022, 7 cohorts were held during the reporting period covered by this report. Estimating a minimum of 20 individuals per cohort at 7 cohorts, EOM intended to enroll 140 individuals. The final sample of enrolled individuals was 104 or 74% of the intended sample.

  For the Quantitative data collection, the intended evaluation sample size for each cycle was 80% of the total participant population, which is a minimum of 112 individuals. With 104 enrolled, EOM was 6-percentage points short of meeting the intended 80%.
- A convenience sample was used for the quantitative piece of the evaluation when looking at participants in the program. With adjustments made to the sample size to accommodate the shortened time period covered in this report, the size needed for power analysis was recalculated. The new appropriate sample size needed was 112, which was based on the program population of 140 over the tenure of the grant using a confidence level of 95% and a confidence interval of 4. This sample size represents 80% of the population and was believed to be an appropriate enough size for power analysis. Alas, enrollment in the earlier cohorts was a challenge as EOM built rapport and trust with the targeted community, thus the program fell slightly short of this number. It is hoped that they will reach this number by the end of 2022.
- All program records tracking (attendance, outreach, enrollment, and cultural competency data) were inclusive of all (applicable) Parent-Caregiver participants, EOM staff, and CAB stakeholders.
- For the Qualitative data collection, 4 participants from 1 Parent-Caregiver cohort participated in a focus group, with all 4 EOM staff being semi-interviewed monthly, and all 6 CAB stakeholders participating in 3 different focus groups.

Demographics

- Table 1 includes the demographics of the 79 participants completing the pre-survey.
- The majority of the participants were women and average age 42.
- Most of the participants of were of full Samoan descent followed by those who identified as multi-ethnic PI and other racial group.

Table 1
Demographics (N=79)

Demographic	%
Gender (Female)	69%
Average Age (SD)	38.2 (14.7)
Ethnicity	
• Samoan	53%
• Tongan	11%
• Multi-Ethnic PI	11%
• Multi-Ethnic PI & Other Racial Group	23%
• Other PI	2%

Evaluation Recruitment

- Most evaluation participants were already enrolled in the EOM program and informed of evaluation procedures by EOM staff at Parent-Caregiver sessions. Also, CAB stakeholders continued to be involved in the evaluation process by attending regular CAB meetings. Finally, to create a sense of community and accountability, EOM staff sought to increase leadership skills and community involvement amongst EOM participants and CAB members. This was done through the development of relationships as a process of gaining trust between EOM participants, staff, and CAB members. Additionally, part of this process involved encouraging EOM participants and CAB members to take on leadership initiatives and get involved in community mental health efforts.
- *COVID ADAPTATION.* During COVID, recruitment for evaluation participation was done directly through phone calls and Zoom sessions. EOM staff collected survey data through a semi-structured interview approach (which was approved by the HR360 IRB).

IRB

- At the statewide level, EOM received exemption from the California Department of Public Health as they did not include/combine SWE items with their local evaluation survey. At the local level, EOM received IRB approval from HR360's IRB Commission for all of its surveys and interview/focus group protocols, and data management procedures.
- HR360's IRB was not comfortable with some of the proposed data collection features for the children participating in the project, particularly any videos as part of the storytelling process, thus children were excluded from most of the evaluation.

C. Measures & Data Collection Procedures

Table 2 includes the indicators and data collection instruments used over the course EOM programming.

- The main local evaluation data collection instrument was the EOM In-House survey (see Appendix A), a pre/post survey administered to cohort participants. The instrument consisted of 54 closed-ended questions, of which 5 questions had sub-questions or categories requiring responses. Survey questions addressed communication with family members including children, the ability to recognize mental health symptoms, the comfort level with the discussion of topic deemed taboo in the PI community, knowledge and use of mental health services, and spiritual beliefs as they pertain to one's mental health.
- Appendices A-E include other more widely used data collection items including interview/focus group protocols and the web analytic data collection form. In some cases, though an interview was intended, it was often difficult to get people to do the interviews, but from the communal sense, they would do a focus group. For the EOM, focus groups were often easier to set up and less and stress on staff.

Table 2.
Measures and data collection procedures

Evaluation Activity	Indicators	Instruments/Data sources used to measure key indicators?	New instruments or modifications to existing instruments due to cultural/linguistic considerations
Evaluation Approach			
Process	1.1 General Satisfaction Questions (*EOM*) 1.2 Access Questions (*EOM*) 1.3 Quality and Cultural Sensitivity Questions (*EOM*) 1.4 Describe your satisfaction with the MANA program. (*Interview*) 1.5 How effective were EOM staff in delivering the EOM program? What are some of the things they did that made the program successful? (*Interview*)	1a. EOM In-House Post Survey 1b. End of Program Interviews using Storytelling Approach	New instruments include an interview protocol incorporating the Story Telling approach.
Process	2.1 Since EOM has launched what do you feel are the strengths of the program? (*Meeting minutes & Interview*) 2.2 Since EOM has launched, what do you feel are areas of improvement? (*Meeting minutes & Interview*) 2.3 As a (CORE MEMBER TYPE), are you satisfied with what you see in: (*Interview*) a. Participant involvement or buy-in? b. Participant outcome? 2.4 How have you been impacted by working with EOM? (*Interview*) 2.5 How have you contributed to the efforts of EOM? (*Interview*) 2.6 EOM staff attendance of API cultural competency trainings. 2.7 EOM staff providing culturally sensitive services.	2a. Meeting minutes from monthly EOM team meetings with local evaluator. 2b. Annual Core Stakeholder Interviews using the Storytelling Approach 2c. Cultural Competency Training Reporting Tool recording trainings given and received.	New instruments include: • MS Excel documents to record training data. • Interview protocols incorporating the Storying Telling approach.

Evaluation Activity	Indicators	Instruments/Data sources used to measure key indicators?	New instruments or modifications to existing instruments due to cultural/linguistic considerations
Evaluation Approach			
	1.1. How difficult is it for you and your child to communicate with each other? (*EOM*) 1.2. When you and your child are having a problem, how often do you raise your voice or yell? (*EOM*) 1.3. I consider myself a leader in my community (*EOM*) 1.4. I want to become more involved with my community (*EOM*) 1.5. How else are you involved in your community? (*EOM*) 1.6. I am able to recognize signs, symptoms and/or risk factors of the following… (*EOM*) 1.7. How has your communication with family (or communication on mental health topics) changed since being in the EOM program? (*Interview*) 1.8. What are three things you learned from being in the MANA program? (Ex. Communication, leadership, community involvement, identifying symptoms and risk factors of mental health, finding voice and understanding of spiritual beliefs, reduced stigma around mental health)? (*Interview*)	1a. EOM In-House Baseline & Post Surveys 1b. End of Program Interviews using Storytelling Approach	New instrument includes an interview protocol incorporating the Story Telling approach.
Outcome	2.1 My level of comfort talking about the following community taboo topics… (*EOM*) 2.2 What are three things you learned from being in the EOM program? (Ex. Communication, leadership, community involvement, identifying symptoms and risk factors of mental health, finding voice and understanding of spiritual beliefs, reduced stigma around mental health)? (Interview)	2a. EOM In-House Baseline & Post Survey 2b. End of Program Interviews using Storytelling Approach	New instrument includes an interview protocol incorporating the Story Telling approach.

Evaluation Activity	Indicators	Instruments/Data sources used to measure key indicators?	New instruments or modifications to existing instruments due to cultural/linguistic considerations
Evaluation Approach			
Outcome	3.1 Do you know where to go to get help for mental health, emotions, nerves, or your use of alcohol or drugs that also addresses your culture? 3.2 Do you know where to go to get help for mental health, emotions, nerves, or your use of alcohol or drugs that that can address your issues in Tongan or Samoan? 3.3 My level of comfort guiding someone to services addressing the following…(*EOM*) 3.4 Staff identify culturally appropriate mental health services of which to refer participants. 3.5 Staff follow-up with identified culturally appropriate agencies to see if received clients accepted referred services.	3a. EOM In-House Baseline& Post Surveys 3b. EOM web analytics to measure reach and response by audience to individuals addressing specific mental health issues during Talanoa Tuesdays 3c. On-going list of agencies with culturally appropriate services and a signed MOU with EOM to take in participants	Indicators 3.1-3.2 will be added as modifications to the EOM Baseline & Post Surveys. New instruments include: • MS Excel form documenting social media
Outcome	4.1 What does it mean to have a voice in your community as it relates to mental health? 4.2. Do you feel your voice is different after being part of Essence of Mana? 4.3 How has your understanding of spiritual beliefs changed since being in the EOM program? 4.4 How has your experience with the MANA program impacted your life 4.5 In what ways have you found your voice?	4a. Participant End of Program Interviews using Storytelling Approach	New instrument includes interview protocol incorporating the Storying Telling approach.

D. Fidelity and Flexibility

The EOM evaluation plan involved five fidelity dimensions. The following describes how fidelity was maintained with the evaluation and the data collection.

Fidelity Dimension	Criteria for each dimension	Measurement tools for each dimension	Protocol for each dimension
Adherence	EOM staff delivered program components as described and intended.	The local evaluator was in continuous contact with the EOM team by phone, email, and at the monthly meetings. During the monthly meetings, administrative, program, and evaluation updates were discussed to adhere to the	Monthly meetings with local evaluator that had a standard agenda protocol- Administrative, program, and evaluation updates.

Fidelity Dimension	Criteria for each dimension	Measurement tools for each dimension	Protocol for each dimension
		project and evaluation goals.	
Exposure	EOM participants received the adapted Parent-Project Curriculum and culturally appropriate mental health support referrals.	Measured through EOM participant and staff feedback from EOM pre/post in-house survey, and testimonial data. Also, # of sessions implemented, and # attended.	Completed EOM pre/post in-house survey data was input into SurveyMonkey as part of the data collection and management procedures. All collected data was uploaded into SurveyMonkey online or a shared MS Excel document. Client stories were securely by an online transcription service and later cleaned by the local evaluator.
Quality of Delivery	EOM participants were receiving satisfactory quality of services.	Measured through EOM participant and staff feedback from in-house post survey and testimonial data.	Completed EOM in-house post survey. All collected data was uploaded into SurveyMonkey online. Client stories were securely by an online transcription service and later cleaned by the local evaluator.
Participant Responsiveness	MANA participants were engaged in the Parent-Caregiver Classes.	Measured through EOM participant feedback from MANA In-House Pre/Post and testimonial data. Also, the quantitative analysis of the participant attendance, outreach, enrollment data, and web analytic data.	Completed EOM in-house post survey. All collected data was uploaded into SurveyMonkey online. Client stories were securely by an online transcription service and later cleaned by the local evaluator. Program records data were documented on a quarterly basis by EOM staff and submitted to local evaluator for analysis.
Program Differentiation	Program components are properly functioning and producing desired outcomes.	Analysis of EOM In-House Pre/Post surveys of cohort participants. Also, analysis of testimonial data.	Completion of EOM in-house pre/post survey data, later inputted into SurveyMonkey. Client stories were securely by an online transcription service and later cleaned by the local evaluator.

E. Data Analysis Plan Implemented

Quantitative Analysis

Quantitative analysis was conducted on pre- and post-survey results and program records by the local evaluator.

- Completed pre- and post-surveys were analyzed as follows: Descriptive information and general associations between variables and primary outcomes were analyzed using univariate and bivariate analyses (i.e. frequencies, means, and chi-square). More advanced statistical analysis, such as ANOVA, were used to measure change over time for knowledge, attitudes about, and behaviors associated with, mental health awareness, stigma reduction, and access to culturally appropriate mental health services,

and differences between the cohorts.

- Descriptive information and general associations between variables for process evaluation were analyzed using univariate and bivariate analyses (i.e. frequencies, means, and chi-square). This data included attendance for Parent-Caregiver and Youth Classes, Wellness Conferences, Family Nights, and CAB meetings, outreach efforts, the number of individuals enrolled per 12-week cycle, client referrals information, any updated EOM staff cultural competency information, and web analytics from "Talanoa Tuesdays."
- Given EOM staff were present to assist with the completion of both the pre- and post-in-house surveys, all surveys were completed thus there was no missing data for the 66 matched surveys.
- *COVID ADAPTATIONS.* With an EOM cohort (Cohort 5) going on brief hiatus during Week 8 as a result of the COVID shutdown, the local evaluator and EOM staff discussed how the break would or could impact cohort participants' knowledge and experience with the program. A "Z-test" for comparison of column proportions with adjustments for p-values (at p=.05) using the Bonferroni method was to conducted between post-survey results from Cohort 5 and the past four cohorts to see if results differed as a result of not finishing the last four sessions in-person. If there were no differences, then the post-COVID-19 Post-surveys could be included and analyzed with the existing data set. The guiding evaluation hypothesis suggested that given the Cohort 5 was two-thirds completed, no difference in post-survey results would be observed. The hypothesis was based on the notion that a rapport had been built among individuals, and Week 8 of general programming is when the support group activity started. Given these two factors, it was expected that a deep bond already existed with EOM staff maintaining contact with participants, providing Shelter-in-Place support (i.e., setting up food deliveries, referrals to counseling for the overwhelmed, referrals to housing services to prevent evictions, and basic counseling), thus mirroring pre-COVID support.

  Z-test results found no statistically significant differences between the pre/post COVID post-surveys, thus Cohort 5's data was included in the overall data analysis comparing change in knowledge, attitude and behaviors from pre- to post-intervention.

Qualitative Analysis

Qualitative Analysis was conducted on focus group transcript and notes, observational notes, and monthly meeting notes generated by the local evaluator.

- The local evaluator used the web-based tool Dedoose[21] to conduct the qualitative analysis by coding and categorizing data into relevant themes from the EOM participants, staff, and CAB members'. The local evaluator first reviewed the transcript and observation notes to identify potential themes. Secondly, these themes were shared with staff and CAB, in which they discussed what these themes meant and prioritized which to code (i.e., program components, satisfaction, or overall experience). These themes were then described and defined into codes. Generated themes or codes included 1) cultural relevancy throughout the different program components, 2) consistent community engagement, and 3) adaptability. The local evaluator later went through and coded the transcripts or notes, and shared the results with the staff and CAB.

Results

A. Quantitative Data Findings

Local pre/post survey data was analyzed at the end of the cohorts, with the sample including participants from all 7 cohorts who completed both the pre and post in-house evaluation survey. From 104 individuals who initially enrolled in one of EOM's 7 cohorts, 66 individuals (83%) completed both the pre- and post-in-house surveys. Using the Central Limit Theorem that suggest a sample approaches a normal distribution with a minimum of 30, it was felt that 66 individuals provide the needed number to see true variance within the sample during data analysis.

- **Participants' satisfaction with relationship with their child (N=66)**. At pre-survey, 41% of the participants reported being "Very satisfied," while at post-survey 67% reported the same, with the 26-point increase being statistically significant (p=.03). The increase, suggests that after participating in EOM, parents feel better about their communication with their child(ren).
- **Participants' concern about depression and mental health issues with child (N=66).** At pre-survey, 47% of the participants reported being "Very concerned," while at post-survey 41% reported the same. The observed 6-point decrease was not statistically significant. Additionally this trend in the decrease of concern was observed throughout EOM program. Discussion with EOM staff and CAB stakeholders for interpretation of the decrease (at first glance it could be interpreted as if parents do not care about their child), it was explained that staff would expect this shift or decrease as now participants have a better understanding of mental health as it relates to their children. Additionally, through EOM some parents have connected with culturally-relevant services, thus staff felt parents now had the support to address their children's behavior or better understand the behavior, thus were less concerned.
- **Parent's ability to show love and affection (N=66).** At pre-survey 69% of the participants reported "Always" being able to show

love and affection towards their child(ren), and at post-survey 69% reported the same. Although there was no observed change with "always" being able to express love, percentage changes were seen for self-reported "Sometimes," with 16% reporting this a pre-intervention compared to 28% at post-intervention. The increase, though not statistically significant, was encouraging and suggested that after participating in MANA, parents are more open to showing affection to their children.

- **Feeling supported as a parent (N=66).** At pre-survey 48% of the participants reported feeling "Very supported," while at post-survey 67% reported the same, with the 19-point increase for the desired response being statistically significant (p=.00). The increase was encouraging and suggested that there is something about EOM and its' programming that has participants feeling supported as they conclude the program.

Two other items pertaining to knowledge and discussion comfort around different mental health issues were also analyzed.

- **Recognize signs, symptoms and/or risk factors (N=66).** Of six mental health issues (depression, anxiety, substance use disorder, domestic violence, rape/molestation, and child abuse) where participants were asked if they could recognize signs, symptoms and risk factors, increases in reporting "Always" recognize were seen for all (see Table 3). One item's increase over time, substance use disorder, was statistically significant (p=.00).

Table 3.

Percentages for Question 16 (N=66)

16. I am able to recognize signs, symptoms and/or risk factors of the following: (Always)	Pre	Post	Change
Depression	42%	60%	↑
Anxiety	44%	56%	↑
Substance use disorder*	34%	60%	↑
Domestic violence	44%	50%	↑
Rape/Molestation	42%	44%	↑
Child abuse	50%	55%	↑

*p=.00

An interesting trend seen throughout the EOM program for two items (Rape/Molestation and Child abuse) was decrease in the reporting of "always" recognizing the signs, symptoms or risk factors. Interpretation discussions with EOM staff revealed the lack in increase or even a decrease may be due to participants still feeling uncomfortable with the topic. Another rationale provided was that participants may have thought they knew more about these two topics, however, after participation in EOM their ideas about the issues may have changed leaving them feeling "less informed."

- **Discussion of culturally "taboo" topics (N=66).** Participants were asked how comfortable they were discussing nine "taboo" topics (parenting skills, chronic disease, family counseling, alcoholism, substance use disorder, mental health conditions, rape/molestation, child abuse, and religion). Similar to responses about recognizing factors associated with mental health, increases in reporting "Always" was seen for all. Additionally, increase in percentages for three items (see Table 4) were statistically significant, while two other items (child abuse and mental health conditions) saw statistical trends (p=.06). Increase in comfort across all items, suggests that for the most part EOM influenced participants comfort levels.

Table 4

Percentages for Question 17 (N=66)

My level of comfort talking about the following community taboo topics: (Very Comfortable)	Pre	Post	Change
Parenting skills*	68%	82%	↑
Chronic disease	60%	74%	↑
Domestic violence	58%	66%	↑
Rape/Molestation	52%	56%	↑
Child abuse	60%	70%	↑
Family counseling	66%	84%	↑
Alcoholism**	60%	82%	↑
Substance use disorder*	56%	78%	↑
Mental health conditions	61%	80%	↑
Religion	56%	74%	↑

*p=.05 **p=.04

- **Culturally-relevant referrals.** One of the main efforts of EOM was to ensure that PI's engaged with EOM could be referred to culturally-relevant mental health services. Between cohorts 1 and 7, 557 referrals were made across or to 18 different mental health/medical/social services (see Table 5). Social/Cultural Enrichment programs and Personal Growth/Development were the most common referrals, followed by COVID-related referrals, food assistance, primary healthcare and mental health care.

  Of the 557 referrals, 245 (44%) were culturally-relevant, that is, the program specifically addressed PI's and their issues, may it be personal growth, assistance with housing or finding a primary care or mental health provider that was of PI descent or familiar with PI issues.

- **Satisfaction with Services received (N=66).** When asked if participants knew where to go near where they lived or worked to seek out behavioral health services such as substance use disorders or mental health, an increase was observed in those reporting

"Yes," and the increase was statistically significant (p=.00). Other services findings included:

- Of the satisfaction items reported below, all responses reported at post-intervention were either "Strongly agree" or "Agree."
- At pre-intervention, 47% of participants found the services received with EOM helpful, and this increased to 80% at post-intervention, with the increase being statistically significant (p=.00).
- At pre-intervention, 50% of participants reported they would return to get services from EOM/AARS, and this increased to 84% at post-intervention, with the increase being statistically significant (p=.00).
- At pre-intervention, 63% of participants reported services were provided in a language they understood, and this increased to 84% at post-intervention, with the increase being statistically significant (p=.02).

Table 5
Referral category by frequency (N=557)

Referral Category (N=18 categories)	N
Faith Based or Spiritual	3
Mental Health Services:	21
Other Mental Health Services:	12
Primary Care	25
Specialty Care	8
Domestic Violence	1
Social/Cultural Enrichment Programs	255
Other Personal Growth Development	125
Academic Support	7
Special Needs/Disability and Personal Care	3
Substance	1
Parenting	11
Transportation	6
Housing	2
Food Assistance	29
Legal	11
Psychiatric	1
COVID Related	36
TOTAL	**557**

- At pre-intervention, 63% of participants reported EOM staff here were respectful of their religious and/or spiritual beliefs, and this increased to 80% at post-intervention. Though not statistically significant, a statistical trend was observed with p=.06.
- At pre-intervention, 64% of participants reported EOM staff here were respectful of their gender identity and/or sexual orientation, and this increased to 82% at post-intervention. Though not statistically significant, a statistical trend was observed with p=.06.

- **Empowerment.** Three cultural empowerment questions ("I find strength in my culture," "I find identity in my culture," "My culture is important to me") were asked of participants. Positive changes from pre-to post-survey included an increase for all three questions, with:
  - At least 88% or more at both pre- and post-intervention reported they found strength in their culture.
  - At least 89% or more at pre- and post-intervention reported finding identity in their culture.
  - At least 94% or more at pre- and post-intervention reported that their culture was important to them.

  Although no statistical significance was found with the slight increases over time for all three items, it should be noted that participants came into the program feeling culturally proud and EOM participation seems to have enhanced these feelings.

B. Qualitative Data Findings

The local evaluator conducted content analysis on various pieces of data including, observational notes from their participatory observation, observational notes from monthly meetings with EOM staff and bi-annual meetings with the CAB, and a focus group transcript. Generated themes or codes included 1) cultural relevancy throughout the different program components, 2) consistent community engagement, and 3) adaptability.

Cultural Relevancy

Cultural relevancy was theme, essence, topic that was seen throughout EOM work. To the staff it meant to "meet participants and community where they are at," and acknowledge how EXISTING culture is great protector but at times could create challenges in how mental health is viewed and or appreciate.

- **Participatory Observation.** With Cohort 4, EOM's program evaluator conducted a participatory observation exercise with the program. The goal of the activity was to gain a close and intimate familiarity with the MANA team as it delivered a parenting class with cultural adaptation spin. The activity involved in-depth involvement over 12 weeks, where the evaluator was part of the

cohort (e.g. participated in the session activities, did the homework, completed forms rating the program) in its entirety. The other cohort participants were made of aware of me working for EOM, but other than that, I was treated as all the other participants were treated.

There were very visible, cultural aspects of EOM such as the sharing of a meal before every session, music during breaks and meals, and the provision of child care, all cultural "traits" noted in the grant and work plan and were to be expected. All of these different features made the overall atmosphere feel like someone's home, an attribute highly valued within many of the Pacific Islander cultural groups. Within the childcare component, participants' children were offered tutoring with homework and engaged in discussion of Polynesian culture, such as common terms and dances. The child care component also offered the older children (e.g. 14-16 years old) the chance to help with caring for the younger children. Such activities encouraged being responsible for others, another attribute highly valued within the Pacific Islander community.

It was participation with the cohort and curriculum, however, which highlighted how small things like words, phrases or simple questions can adapt or make a standard curriculum culturally relevant. Facilitated discussions with reference to cultural experiences about child-rearing and discipline were introduced simply, yet had a strong impact. I participated in several very deep conversations where there were comparisons on how "they" (referring to white people) dealt with things compared to "us" (Pacific Islander or African American). Or in some cases there were no comparisons, just discussions on what was done because it was how it was done "back home," and the practices continued with the American born with both negative and positive consequences. These discussions derived out of prompts from the facilitators, who were of Pacific Islander descent, and could bring the cultural piece out in the open through discussion of childrearing and dealing with stress. The prompts though simple, were extremely powerful.

Cultural terms were heard being used in discussions about discipline and caring for others, and was the evaluator was pleased to see how even those who were not fluent in any of the Polynesian languages, still knew the terms and their application. Again, gentle prompts with reference to the group's culture, enable the facilitators to bring a cultural aspect to the parenting curriculum, which seemed to make the program more meaningful and relevant to the participants. All of us were able to come back and relate to experiences of trying the newly learned strategies, and knew we could talk within an environment to get ideas to have make the strategies more culturally relevant needed.

The evaluator now feels they have an extended family, as they were made an honorary Samoan on the last day, and by participating was given a space to explore their thoughts about mental health in their own family and community, and how CULTURE plays a major role in how we explore the phenomenon.

- **Focus Group Findings.** Participants and CAB stakeholders were often asked about the cultural significance of EOM, with initial responses often being somewhat general, and some of the respondents stating it was culturally relevant but never being specific. To clarify the question and concept, the evaluator started asking "Could anyone teach this class then?" and saw immediate responses immediately change with one cohort participant stating…

> *"If she wasn't here* [pointing to one of the facilitators]*, I wouldn't have come, because I was not about to go to some parenting class taught by some social worker, usually a white woman, who knows nothing about me and my culture, where I come from."* – EOM Multi-Ethnic PI Parent

Although the mother was born in the US and did not fluently speak a Polynesian language, they still strongly identified with the Pacific Islander community. Others often cited similar responses, with answers noting a "them not knowing or understanding us" stance. This stance was also strongly based in garnering trust, with several citing their negatives experiences with systems, such as education, law enforcement and social services. Some noted these systems were supposed to help them, yet time and time again, these systems failed, where people from these systems discriminated against them, were bias in decisions made about the care of their children, and simply were not helpful. They appreciated EOM because it was coming from people who looked like them, understood their struggles, and this led to them trusting EOM staff. Trust was a big issue as it related to the cultural relevance of EOM, and all the participants felt that without it EOM would not have been successful, especially if it were to target other Pacific Islanders.

> *"The cultural part of Essence of MANA meant many things to me. I remember walking into the first day of class and feeling safe, comfortable and welcomed. Since I felt safe and comfortable during the class, I did not hesitate sharing experiences and stories from my life"* – EOM Tongan Parent

Others reported being pleased to have different discussions about child-rearing, noting people "just raise their kids," thus to discuss other approaches was helpful. Specifically, one participant noted:

> *"This course is a new approach to child rearing, learning how to show love and how to speak without becoming angry. Culturally we do what we know… now I know different."* – EOM Samoan Parent

Due to the parenting emphasis through a cultural lens, on a couple of occasions, participants repeated the Parent-Caregiver cohort, often times bringing a family member (i.e., spouse or significant other, sibling or adult children) to participate as well. One participant noted:

> *"I've taken this class 2 times and its helping me to remember tools I need during the week. I love the results. I want to say a big thank you!"* – EOM Samoan Parent

Such sentiments suggest that an environment had been created where some of the participants felt welcomed back and felt that there was more to learn, may it be through the facilitators or other participants. Most encouraging was the newly included family members suggesting that the initial or earlier participant saw the need to share the information and experience with others as participants built up their newly learned parenting skills.

- **Capacity to Work with the PI community.** EOM staff have submitted and had accepted two abstracts for oral presentations the American Public Health Association (APHA) annual meetings (virtual 2020 and virtual / in-person 2021).
  - The 2020 APHA oral presentation included "The essence of MANA: Promotion of mental health wellness for Pacific Islander communities in the SF west bay area" and included findings from the local pre/post in-house survey data related to change in program participants' behaviors/relationships with their child (ren).
  - Additionally, at the same virtual conference they participated as part of a larger oral presentation with other agencies describing community-focused and culturally-responsive strategies in mental health prevention and early intervention (PEI) for AANHPIs, titled "Culturally-responsive strategies to reduce mental health disparities among Asian and Pacific islanders".
  - For the 2021 APHA, an oral presentation titled "Talanoa Tuesday and the Community Within: Navigating the Virtual Wave" is being developed and made ready for presenting in October 2021. The focus of the presentation is a discussion of "Talanoa Tuesdays" as an adapted program component as a result of COVID.

  All presentations served to build the capacity of conference attendees as it related to administering health education strategies within priority populations that are often underserved.

Community Engagement

One of the reasons for AARS submitting the CDEP/CRDP grant was to start to engage the PI community around mental health. Although AARS has always offered services to those from the PI community, there is a recognition by AARS that this community is not as open or ready to engage as the other targeted Asian groups. As a mental/behavioral health program within HR360, AARS wanted to make sure the PI community was fully included, thus much of EOM efforts and programming involved community engagement to build rapport and become more visible to the community.

- **Community "Friends."** Throughout EOM, staff continued ongoing outreach efforts to schools, law enforcement offices and social media. In some cases, through existing AARS programs, "friends" in some of these agencies were already known to EOM staff. In other cases, and more often than not, it was their connections through family, friends, and PI community stakeholders (i.e., sometimes the person who simply knows EVERYBODY, or the elder with strong standing in the community), that opened up opportunities to be part of community workgroups, have a table a certain community cultural events or be invited to participate in podcast or radio show. For example, one community "friend," PolyByDesign, has been influential in EOM's presence in the social media realm as they have and continue to share MANA flyers on all social media platforms and on their weekly Faika Podcast. Additionally, PolyByDesign has instrumental in helping EOM build its online presences through "Talanoa Tuesdays."

  On a monthly basis, the EOM staff host the Journey to Empowerment event (every 1st Friday) to share information about EOM and build up interest. Even with COVID the event has simply gone virtual. As time has progressed, EOM staff have noted how outreach has become less challenging as community members, other organizations and the schools seem to know who they are now, and are less resistant when the program is being promoted.

- **Building Community Capacity.** Through its community engagement efforts to raise awareness about mental health issues within the community and available mental health services to address these issues, EOM hoped to encourage PI community members to become interested and or active in mental health service delivery. Some of the motivation behind this effort was to increase the visibility of more PIs in such services.

  In the case of EOM, two such individuals came from the community to work in mental health services. The first person, Lu Masina,

was introduced to the PI mental health work four years ago at one of AARS' other PI community advocacy events, and a few months later was hired as a EOM program assistant. She is also a college student, and noted how her experience with EOM has steadily encouraged her to keep pursuing her degree. Ms. Masina also has been instrumental in helping EOM build its own capacity to disseminate program findings as well as assist EOM as it help other organizations build their own capacity to work with PI communities. The individual, Meri Veavea, attended the first cohort of EOM, and was so moved by her experience that they continued to volunteer and work with EOM. Ms. Veavea has gone on to work with AARS with a new API youth program and has become the program's project coordinator. The work of these two women as a result of their link to EOM shows how EOM's visibility in the community is encouraging and changing how the PI community can help and become involved with mental health care.

- **COVID Adaptations – Immediate Response.** Between April and June 2020, EOM had 98 online instances where they either participated in or hosted community or service provider coalition Zoom meetings (9 instances), hosted the new "Talanoa Tuesday" Facebook Live community engagement event or existing Journey to Empowerment community gatherings (10 events), or posted detailed information on their Facebook page (79 instances) including links to videos, podcasts and resources for different events in the community, health resources on the coronavirus and Pacific Islander community response for the disparate occurrences of COVID-19 in the community, resources for foodbanks and mental health services. To keep up the community engagement EOM staff had built over the past 2.5 years, with all Facebook postings different staff were assigned different times to watch or go through the Facebook page and Group to reply to any inquiries and or address any postings that required a reply. Doing allowed the staff to continue to be highly visible to the community and helped build a strong following once the newly developed Talanoa event was launched on May 12, 2020. Additionally, the concerted efforts to engage the community through the Facebook social media avenue helped gain an additional 116 "Likes" over three months, and 507 page views between April and June 2020 alone. Their increased presence in the virtual world also helped EOM expand its reach with its Talanoa LIVE events to 25,524 individuals (either directly or indirectly with tags and shares).

- **COVID Adaptations – Continued Online Presence.** As of June 2021, EOM was to the point of hosting or posting about four different events: Talanoa Tuesday (Facebook Live), Talanoa Tuesdays – Rewind (Facebook Live), PSA's (Facebook Posts) and Heartwork Spotlight (Facebook Posts). Through these events, the total number of individuals reached and engaged was 77,223 (61,030 individuals reached, 16,193 engaged). The top three "reached" events were a "Heartwork Spotlight" with 4,120 reached, followed by two different Talanoa Tuesdays (3,834 and 3,708, respectively). Further investigation found that the individuals highlighted or presenting were those highly valued and respected in the community. Larger numbers associated with these events may reflect community members desire to "hear" from these people as it relates to EOM's messaging around maintaining mental health and self-care. The top three "engaged" events were all Talanoa Tuesdays (1,675, 1,560, and 1,246 engaged, respectively), with speakers ranging from gang and violence prevention program to a pastor. Although not as high as the new Talanoa sessions, Talanoa Tuesday – Rewind sessions saw an average of 318 for total reach and engagement. Two of the Rewind events reached over 440 individuals (441 and 449, respectively), with one of these events engaging 86 of the 441 individuals.

  At this point, EOM appears to have fully established its online presence and are moving towards becoming a possible social media influencer within the PI community. EOM's ability to quickly adapt to and build its online presence highlights the program's ability to read and work with the community as it is apparent that community prefer to social media related events and have been responsive to EOM's online efforts. From May 2020 to May 2021 virtual community engagement saw at least a 20-fold increase in EOM's outreach numbers, excluding "likes" or followings. Engaged individuals originally included the targeted community in the San Francisco Bay area yet through live virtual engagement allowed for the expansion to the rest of California, nationally, and US Samoa.

- **COVID Adaptations – Continued Safe Space.** With the COVID adaptations, EOM through its aforementioned community engagement strategies, was able build and maintain a space identified as an online "safe space" as identified by community members and program participants. As with its programming prior to COVID, EOM's Talanoa Tuesday was able to create a space for community members to be heard through shared experiences as well as learn new information through the various community programs and members that served as guest speakers. This virtual event appeared to be very successful with some participants noting:

  > *"I cannot express enough how appreciative I am for Essence of Mana & the safe space you all have created with your Talanoa Tuesday programming."* – Talanoa Tuesday Viewer
  >
  > *"I wanted to give huge thank you's to organizations like... #EssenceOfMana for creating emotionally & mentally- centering virtual spaces for our NHPI community members during these times."* – Talanoa Tuesday Viewer

The growing number of viewers of the event over the first year of COVID adaptations suggest that the platform and the information

shared was something that viewers were seeking. Having the information available virtually was also helpful, as it allowed viewers to go back and re-watch or view for the first time after it was initially broadcast:

> *"I was on three other meetings last night and am so happy I can go back and watch Essence of MANA's Talanoa! I appreciate these important conversations thank you."* – Talanoa Tuesday Viewer

Adaptability

As with all programs, mid-course corrections or adaptions are sometimes needed to ensure that programming continues to address the needs of the targeted community and or population. While some programs have challenges with change "to the script," EOM was the opposite and seemed to flourish with its mid-course changes. Though at time the adaptations were a stretch on resources, particular time and energy during COVID, EOM has been creative in adapting its programming to address community needs when the time arises.

- **Adapting to Work with New Groups.** EOM had its set group of agencies, cultural events and social media streams from which to recruit, when recruitment was a bit slow, staff were able to shifts in who to approach. While this mention may seem to go under the previous section "Community Engagement," it is included here because it highlights how EOM was able to quickly shift to doing things in different ways when introduced to new ideas by community members or CAB stakeholders. For example, after months of working with schools, EOM staff realized an immense amount of work was required to engage with these entities (i.e., often involved approval from school boards, which is a very time-consuming and long process), yet they needed pool of parents to target their recruitment efforts. When an idea as suggested that EOM collaborate with another group, they were introduced to Camp Unity, a Pacific Islander summer enrichment program for Pacific Islander youth, and collaborated in hosting opportunities for staff to meet youth and their families, share more about the class and encourages families to participate. EOM also have cultivated a deeper partnership with their county Pacific Islander Initiative by hosting a meeting at their office every quarter, attending the monthly meetings at other partner agency offices and utilized the space to outreach to other PI networks.
- **Adapting Program Norms.** EOM initially closes out the cohort after 12 session, including 10 classes guided the Parent-Caregiver curriculum. With the third cohort, however, prior to the close out celebration, several participants inquired to whether EOM could be extended. After review of the program's budget, the MANA staff decided to carry out the workshops to the full 16 weeks of curriculum instead of stopping at the 12th workshop. In addition to information about seeking out services, curriculum content discussed how to start support groups (informally or formally), something in which several respondents expressed interest. At the conclusion of the 16th workshop, a peer-led support group was started and, to MANA's knowledge, still meets weekly.
- **Adapting to the Times.** On March 16 2020, 6 Bay Area counties instituted a Shelter-in-Place (SIP) requiring all non-essential workers to work from home. This occurred in what would have been Week 9 for Cohort 5. After a week and a half of re-planning and revising services delivery, EOM staff reverted to providing services virtually (i.e., phone, private social media messaging or online, such as Zoom) for both adults and their children.

  The EOM staff have been quite successful in the past with using social media, and during the SIP quickly adapted to make great use of social media as a resource for getting information out to the community (both to Cohort 5 and potential participants) about services available during the SIP, and for individual EOM staff offering support to or referrals for participants to other partnering agencies for different services (i.e., health issues, stress issues). Additionally, EOM was very active in organizing and co-facilitating/hosting different online community events to either build the capacity of other organizations to support members of the different local Pacific Islander communities, or to provide support to community members themselves. In particular, the EOM staff were vigilant about keeping the community aware and knowledgeable about the corona virus and its impact on communities of color, particularly the Pacific Islander community, which was and still is disproportionately impacted by COVID-19 in California. EOM staff also mobilized with other Pacific Islander organizations from Southern California to generate an informational campaign to keep community members aware of the disease's impact and strategies for protection and reduction of transmission.

C. Synthesis of Findings

Through mixed methods data collection analysis, triangulated findings included:

- As seen with the qualitative data, the concept of cultural relevancy was important to participants and the CAB stakeholders and appears to have influenced why individuals wanted to participate in EOM programming. Quantitative data showing an increase in the participation numbers over the last four years, and the major increase in EOM's online presence complement the qualitative findings.
- Positive feedback through interviews/focus groups and anecdotal community encounters, coupled with positive change in survey data from pre- to post-intervention suggests the program was influential on individual's behaviors and how they

perceived their own mental health and the health of others around them.

- Although not all of the observed changes in data were statistically significant, it was encouraging to see all data moving in the intended direction as it pertains to improved behavior, raised awareness, and increased knowledge of services.
- Both quantitative and qualitative data documented that cohort participants were satisfied with the services received. This is encouraging as EOM moves into its final year of current funding, and prepares to implement future services.

D. Overall Presentation of Findings

Below are overall findings in relation to the evaluation question and whether the question was fully answered (●), partially answered (◐) or not answered at all (○) with the data collected for the evaluation.

Process Evaluation Related

Evaluation Questions

1. What are participants' perceptions about the EOM program?

Process evaluation findings indicate that perceptions of EOM are extremely positive as exhibited by buy-in from the community (increase in number of participants, increase in number of referrals, growth of Talanoa Tuesdays) and continuous feedback from cohort participants and CAB. Other data revealed that during COVID enough of a rapport was built within the community, that EOM was seen as an "essential service," as they provided services and referrals that several participants noted on the EOM Facebook page and through direct contact with staff.

2. How do the core stakeholders (EOM staff, CAB and culturally competent mental health service providers) perceive EOM and its components as it relates to providing bicultural, bilingual services that accommodate the programs cultural competency goal?

Process evaluation findings indicate that core stakeholders felt EOM and all of its components provided culturally relevant services (including bicultural and bilingual services). This was evident during the first three years of programming as EOM staff were diligent with their community engagement and inclusion efforts through program recruitment, introduction to services during the cohort, and expansion of its referral pool. In Year 4, such efforts had a great impact on the success of "Talanoa Tuesdays," as finding guest speakers locally and nationally became easy due to full engagement of the community. Furthermore staff are on their way to becoming social media influencers, as they are now often recognized out in the community as part of "Talanoa Tuesday" and being the ones to "help" people.

Outcome Evaluation Related

3. To what extent have participants' reported behavior changed over time in relation to addressing mental health including improved communication skills, increased leadership skills and community engagement, and increased in knowledge?

Outcome evaluation findings displayed that EOM cohort participants changed for the positive by the end of their time with EOM. Specifically, participants reported feeling closer to their children, having the skills need to engage with their children, and expressed feeling they now had a support system.

4. To what extent did a reduction occur in stigma around mental health conditions and other taboo topics (i.e. domestic violence, rape/molestation, substance use disorders, etc.)?

Outcome evaluation findings revealed that stigma associated with mental health conditions and other taboo topics was reduced for most topics by the end of participation in EOM. Stigma around the topics of rape and molestation remained about the same, yet EOM staff and the CAB did not see this a bad thing, noting many people have set ideas about rape and sexual assault. Through EOM, these set ideas were challenged, or as some stated "corrected," thus participants may not have felt as confident to say they recognize the symptoms as newly learned information may suggest otherwise.

5. **Do participants feel more knowledgeable of where to access culturally competent mental health services and supports?**

Outcome evaluation findings suggest participants awareness of the culturally relevant services increased after participation in EOM. This was exhibited by self-reports at post-interventions and the continuous referrals made throughout the four years of programming.

6. **To what extent have participants found a voice as it relates to mental health?**

The answer to this evaluation question is probably the most impactful of all of the answers, because a "voice" was most certainly documented through community engagement around the Senate Budget hearing testimonies, and the growth of EOM staff. Throughout the program, EOM staff consistently did all that it could to "empower" the community, may it be small things like answering a Facebook inquiry or phone call to finding a family food or a culturally relevant school counselor to help the family with their child's Individualized Educational Plan (IEP). The goal behind each effort/action was to raise individuals' knowledge and awareness to that they would feel empowered to utilize service to benefit them and their families.

E. Meta-Analysis

At this point in time, EOM has decided that it would not report on its SWE data, with data analysis for this report focusing solely on its local evaluation data.

Discussion and Conclusion

Final review of participatory observational notes revealed that EOM staff have made great inroads within the different San Mateo county Pacific Islander-based community organizations, as it was later learned that some of the participants reached out to community presenters for assistance. Again the cultural piece of having culturally-relevant services available to community members served to raise awareness and understanding about mental health, and how it impacts participants on individual, familial, and community levels. Often times, agencies in mental health, social services or education will hire individuals who on the surface appear "culturally sensitive." EOM's approach addresses the notion of the need for cultural relevancy, as the concept of relevancy goes beyond cultural sensitivity. This finding, to the evaluator, stressed the continued need for identifying individuals within the different Pacific Islander communities to encourage them or make it possible to pursue employment in the areas of social services, mental health and education as their presence is needed, especially when encouraging community members to seek such services.

EOM has been able to take their culturally relevant approach online as well, and their online engagement numbers are to be commended. The large number of those engaged have helped to increase the number of people EOM staff have access to for recruitment and enrollment into programming. The large numbers also indicate that the EOM team has fully established itself in the community, and from an environmental impact stance, it might be said that community awareness of mental health and its challenges and rewards, have been raised.

Through observations of meetings, community events and participation in staff and hub TA discussions, evaluation efforts have discerned that a driving force behind the EOM team's efforts is their passion and COMPASSION to serve their community. This drive has shown itself most recently with the EOM staff inviting and organizing local community advocates to join them alongside other CRDP IPP's to speak at public hearings hosted by the State of California's Assembly Budget Subcommittee.

There is a great concern by staff that community members may see or believe that services will "suddenly disappear," a phenomenon staff argues is something commonly experienced by their targeted communities. Thus, they are determined to make sure that the community does not feel abandoned. All activities online and even pre-COVID, have been done to ensure that community members feel supported and that "they count."

Limitations

Both the EOM and its evaluator had high hopes of collecting rich, qualitative data. Yet, even prior to COVID, the program met challenges in collecting such data, particularly with the interviews and focus groups. Unfortunately, participants were never keen on interviews (i.e., hesitant to volunteer to do them, unresponsive to invites). While the program had planned to do more focus groups to make the process easier on participants, the pandemic came, and the dynamics with rapport were just not quite there yet to reincorporate the focus groups during the virtual cohorts. Buy-in as well as comfort were crucial issues with the EOM team collecting information from people they felt were already vulnerable, with the EOM team not wanting to invade participants' new found safe space. Thus not as much qualitative data was collected, with more emphasis placed on the surveys (i.e., both the in-house pre/post and

SWE) where the EOM team felt that a bit more control to collect data about change among the targeted communities.

Over the tenure of the grant, the EOM team was concerned about evaluation overload, in particular because of the length of the SWE survey taken at pre-and post-program. The EOM team met several times with their local evaluator and TAP team to identify ways to reduce the burden of SWE surveys and to ensure participants understood the question and correct directions for survey completion. As a result, the EOM team submitted their recommended changes to the SWE survey to PARC LMU (including reformatting SWE question and providing clear directions/arrows of skip patterns). In addition, all team members were present to support participants with SWE pre/post-test administration to ensure that participants can understand the survey questions and did not get frustrated or turned off by the experience. Given the "involvement" required from the participants with the two different surveys, combined with participant hesitancy to do interviews and the additional required time by the EOM team to keep participants engaged with both, energy and time slowly became more directed towards the quantitative portion of the evaluation. In the end, the EOM team felt the survey data was more telling in regards to documenting behavioral change and perceptions.

In the future, the evaluator will ask EOM team to build in a reflection session at the end of each cohort to serve as a focus group to gather feedback, outcomes/changes as a result of participation and program satisfaction. Additionally, given interviews are not something participants with EOM are comfortable with (i.e., after 4 years it is still difficult to get people to participate in them), it is believed that a focus group approach may actually be more feasible or appropriate as the interview approach would miss the opportunity to capture the group dynamic and magic that a focus group could capture.

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APPENDICES

Appendix A – In House Pre/Post Survey

AARS Pre/Post Survey
REV: Dec6

Please complete this form for the Essence of MANA Parent Project ®. All of the information is completely CONFIDENTIAL. Some questions may bring feelings of discomfort or uneasiness, however we do ask that you answer each question as best as you can. It is very important for participants to be as transparent as you can in order for us to provide the best possible support. If you have any questions, feel free to ask your facilitators.

Participant ID#: _____

Date: _____ Class Location: _____

Please be sure to answer the questions about "YOUR CHILD" indicated on your application form.

	Very	Somewhat	A little	Not at all
1. Overall, how satisfied are you with your relationship with your child?	◻	◻	◻	◻
2. How difficult is it for you and your child to communicate with each other?	◻	◻	◻	◻
3. How supported do you feel as parent?	◻	◻	◻	◻
4. Thinking about your child, how concerned are you about alcohol use and/or drug use?	◻	◻	◻	◻
5. Thinking about your child, how concerned are you about depression and mental health issues?	◻	◻	◻	◻
	Always	**Sometimes**	**Rarely**	**Never**
6. When you and your child are having a problem, how often do you raise your voice or yell?	◻	◻	◻	◻
7. How often do you spend time with your child?	◻	◻	◻	◻
8. How often do you show love and affection to your child?	◻	◻	◻	◻
9. How often does your child meet your expectations for success?	◻	◻	◻	◻
10. How often does your child follow and keep household rules?	◻	◻	◻	◻
11. How often do you give your child negative consequences for problematic behavior?	◻	◻	◻	◻
12. How often do you give your child positive consequences for compliant behavior?	◻	◻	◻	◻
13. Does your child have good school attendance? (Arrives to school on time at least 3-5 times a week)	◻	◻	◻	◻

	Yes	No	Too Young For School
14. Within the last year, as your child been suspended from school?	◻	◻	◻
15. Within the last year, has your child been expelled from school?	◻	◻	◻

AARS Pre/Post Survey
REV: Dec6

The following questions relate to YOU, **not** to "YOUR CHILD".

16. I am able to recognize signs, symptoms and/or risk factors of the following	Always	Sometimes	Rarely	Never
a) Depression	◻	◻	◻	◻
b) Anxiety	◻	◻	◻	◻
c) Substance Use Disorders	◻	◻	◻	◻
d) Domestic Violence	◻	◻	◻	◻
e) Rape/Molestation	◻	◻	◻	◻
f) Child Abuse	◻	◻	◻	◻
17. My level of comfort talking about the following community taboo topics	**Very**	**Somewhat**	**A little**	**Not at all**
a) Parenting skills	◻	◻	◻	◻
b) Chronic disease	◻	◻	◻	◻
c) Domestic violence	◻	◻	◻	◻
d) Rape/Molestation	◻	◻	◻	◻
e) Child abuse	◻	◻	◻	◻
f) Family Counseling	◻	◻	◻	◻
g) Alcoholism	◻	◻	◻	◻
h) Substance Use Disorders	◻	◻	◻	◻
i) Mental Health Conditions	◻	◻	◻	◻
j) Religion	◻	◻	◻	◻
18, My level of comfort guiding someone to services addressing the following	**Very**	**Somewhat**	**A little**	**Not at all**
a) Parenting Skills	◻	◻	◻	◻
b) Chronic disease	◻	◻	◻	◻
c) Domestic violence	◻	◻	◻	◻
d) Rape/Molestation	◻	◻	◻	◻
e) Child abuse	◻	◻	◻	◻
f) Family Counseling	◻	◻	◻	◻
g) Alcoholism	◻	◻	◻	◻
h) Substance Use Disorders	◻	◻	◻	◻
i) Mental Health Conditions	◻	◻	◻	◻
j) Religion	◻	◻	◻	◻

19. Would you know where to go near where you live or work to seek out behavioral health services such as substance use disorders or mental health?
◻ YES ◻ NO

20. In your day-to-day life, do you ever feel that you are treated with less respect than other people?
◻ YES (continue to 20a.) ◻ NO (skip to 21)

20a. What do you think is the main reason for these experiences? (Check all that apply to you. If none of the answers apply, check "None of the above.")

◻ Your race or ethnicity ◻ Your religion ◻ Your gender ◻ Your age
◻ Your sexual orientation ◻ A disability ◻ Your mental health status
◻ Your immigration status ◻ None of the above

AARS Pre/Post Survey
REV: Dec6

21. When accessing services, do you ever feel that you receive poorer services than other people?
◻ YES (continue to 21a) ◻ NO (skip to 22)

21a. What do you think is the main reason for these experiences? (Check all that apply to you. If none of the answers apply, check "None of the above.")

◻ Your race or ethnicity ◻ Your religion ◻ Your gender ◻ Your age
◻ Your sexual orientation ◻ A disability ◻ Your mental health status
◻ Your immigration status ◻ None of the above

Spirituality and Wellness	Not at all	Somewhat	Quite a bit	Very
22. Do you consider yourself religious?	◻	◻	◻	◻
23. Do you consider yourself spiritual?	◻	◻	◻	◻
24. Is religion important to you?	◻	◻	◻	◻
25. Is spirituality important to you?	◻	◻	◻	◻
26. Do you consider your life in balance physically, emotionally, mentally and spiritually?	◻	◻	◻	◻
27. How often do you seek health advice from your religious leader?	◻	◻	◻	◻
28. How often do you seek health advice from a holistic community healer?	◻	◻	◻	◻
29. How does you spiritual-life impact your mental wellness?	◻	◻	◻	◻

Community Connectedness	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	N/A
30. I am content with the relationships I have	◻	◻	◻	◻	◻	◻
31. I have a network of supportive friends and family in times of crisis	◻	◻	◻	◻	◻	◻
32. I have a network of supportive family and/or friends who I can spend quality time with	◻	◻	◻	◻	◻	◻
33. I find strength in my culture	◻	◻	◻	◻	◻	◻
34. I find identity in my culture	◻	◻	◻	◻	◻	◻
35. My culture is important to me	◻	◻	◻	◻	◻	◻
36. I consider myself a leader in my community	◻	◻	◻	◻	◻	◻
37. I want to become more involved with my community	◻	◻	◻	◻	◻	◻

AARS Pre/Post Survey
REV: Dec6

38. How else are involved in your community?
◻ Church group ◻ Volunteer in schools ◻ Volunteer with community based organizations
◻ Community/City Clean-up ◻ Neighborhood Watch ◻ Mentorship program

Quality of Services	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	N/A
39. The services I received here were helpful	◻	◻	◻	◻	◻	◻
40. I would return to get services from this agency	◻	◻	◻	◻	◻	◻
41. I would recommend services from this agency to a friend or family member	◻	◻	◻	◻	◻	◻
42. The content of the workshops were delivered in a clear and concise manner	◻	◻	◻	◻	◻	◻
43. Services were provided in a language I understood	◻	◻	◻	◻	◻	◻

Access to workshop	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	N/A
44. Location of services is convenient for me	◻	◻	◻	◻	◻	◻
45. Staff were willing to see me as often as I felt it was necessary	◻	◻	◻	◻	◻	◻
46. Services were available at times that were good for me	◻	◻	◻	◻	◻	◻
47. It has been easy to talk to staff	◻	◻	◻	◻	◻	◻

Quality and Cultural Sensitivity	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	N/A
48. Staff here treated me with respect	◻	◻	◻	◻	◻	◻
49. Staff here didn't think less of me or treat me differently because of the way I talk, walk or dress	◻	◻	◻	◻	◻	◻
50. Staff here were respectful of my religious and/or spiritual beliefs	◻	◻	◻	◻	◻	◻
51. Staff here were respectful of my gender identity and/or sexual orientation	◻	◻	◻	◻	◻	◻
52. Staff here are knowledgeable and able to provide a variety of approaches to address my needs	◻	◻	◻	◻	◻	◻
53. Staff here respect my cultural beliefs and practices	◻	◻	◻	◻	◻	◻
54. Staff were respectful of my health beliefs	◻	◻	◻	◻	◻	◻

Appendix B – Participant Interview Protocol

Sharing Your Story MANA Evaluator Protocol - Participant

Step 1: Introduce "Sharing Your Story"

1) Inform the participant that the MANA staff and HealthRIGHT 360/AARS want to talk to them about what it is like to be in the MANA Program. Explain that we would like to interview them in a one-on-one private session, where they can share their story and experience in the MANA program with us. Let participants know that this will help us grow and improve the program.

Step 2: Review Paperwork and Schedule Appointment

2) Review the consent/assent form(s) with the participants and schedule their "Sharing Your Story" appointment, at least one week out. Give them the Sharing Your Story Protocol according to their sub-group (participant, staff, CAB member). Instruct them to review the protocol and review and sign consent/assent forms and bring both to scheduled appointment. **Emphasis that participants may select to opt out of the activity at any time**.

Step 3: "Sharing Your Story"

3) Appointments are 30 to 45 minutes long. When the participant arrives, collect the signed consent forms and review with them. Also review Sharing Your Story Protocol and ask if they have any questions.

4) Begin audio recording the participant being sure to ask each question (including probing questions when needed). Use Sharing Your Story Protocols for specific sub-group questions.

5) After all the questions have been asked, turn off the recording equipment and explain to the participant we will be using their story for our evaluation.

Sharing Your Story MANA Participant Protocol

Sharing Your Story-Appointment Information:

Date: _____ **Time:** _____

Location: _____

Contact for Questions: Nani Wilson, Program Facilitator, wilson@aars.org, 415-337-0140 or Dr. Robynn Battle, Program Evaluator, robynn.battle@camiconsulting.com, 510-919-8858.

Preparation and Recording Procedures:
When you arrive to share your story, please bring this completed worksheet with you. These are the questions listed below that you will be asked by the MANA evaluator when your story is recorded. Please take some time (at least 3 days before your appointment), to reflect on these questions and take notes in the space provided. This will help you to gather and organize your thoughts about your MANA experience. Please feel free to contact Brittany Afu or Sean Kirkpatrick if you have any questions about the storytelling process.

Here are the questions you will be asked when sharing your story:

Background

1) Tell us a few things about yourself (family background, racial/ethnic identity, age, religion/spirituality etc.)

Program Satisfaction

2) What led you to join the MANA program? What helped you to continue attending the sessions?

3) How effective were MANA staff in delivering the MANA program? What are some of the things they did that made the program successful?

Program Outcomes

4) What are three things you learned from being in the MANA program? (*Ex.* Communication, leadership, community involvement, identifying symptoms and risk factors of mental health, finding voice and understanding of spiritual beliefs, reduced stigma around mental health)

5) How has your communication with family (or communication on mental health topics) changed since being in the MANA program?

6) Do you feel MANA staff were sensitive to your cultural needs?

7) In what ways have you found your voice?

8) How has your understanding of spiritual beliefs changed since being in the MANA program?

9) What does it mean to have a voice in your community as it relates to mental health?

10) Is there anything else you want to share about the program and your experience?

Appendix C – CAB Interview/Focus Group Protocol

Sharing Your Story MANA Evaluation Protocol - CAB

Step 1: Introduce "Sharing Your Story"

1) Inform the CAB member that the MANA staff and HealthRIGHT 360/AARS want to talk to them about what it is like to be involved with the MANA Program. Explain that we would like to interview them in a one-on-one private session, where they can share their story and experience in the MANA program with us. Let participants know that this will help us grow and improve the program.

Step 2: Review Paperwork and Schedule Appointment

2) Review the consent/assent form(s) with the participants and schedule their "Sharing Your Story" appointment, at least one week out. Give them the Sharing Your Story Protocol according to their sub-group (participant, staff, CAB member). Instruct them to review the protocol and review and sign consent/assent forms and bring both to scheduled appointment. **Emphasis that participants may select to opt out of the activity at any time.**

Step 3: "Sharing Your Story"

3) Appointments are 30 to 45 minutes long. When the participant arrives, collect the signed consent/assent forms and review with them. Also review Sharing Your Story Protocol and ask if they have any questions.

4) Begin audio recording the participant being sure to ask each question (including probing questions when needed). Use Sharing Your Story Protocols for specific sub group questions.

5) After all the questions have been asked, turn off the recording equipment and explain to the participant we will be using their story for our evaluation and the findings will be made available to them in the future.

Sharing Your Story MANA Community Advisor Board Member Protocol

Sharing Your Story-Appointment Information:

Date: _____ **Time:** _____

Location: _____

Contact for Questions: Nani Wilson, Program Facilitator, wilson@aars.org, 650-201-4498 or Dr. Robynn Battle, Program Evaluator, robynn.battle@icamiconsulting.com, 510-919-8858

Preparation and Recording Procedures:
When you arrive to share your story, please bring this completed worksheet with you. These are the questions listed below that you will be asked by the MANA evaluator when your story is recorded. Please take some time (at least 3 days before your appointment), to reflect on these questions and take notes in the space provided. This will help you to gather and organize your thoughts about your MANA experience. Please feel free to contact Brittany Afu or Sean Kirkpatrick if you have any questions about the storytelling process.

Here are the questions you will be asked when sharing your story:

Background

1) Tell us a few things about yourself (family background, racial/ethnic identity, age, religion/spirituality etc.)

2) What led you to join the Community Advisory Board (CAB)? Why do you continue to work with the CAB?

Program Satisfaction

3) Describe your involvement with the Community Advisory Board. What did you do?

4) Describe your satisfaction with the MANA program (i.e. participant involvement and engagement, impact on the participants and community members).

5) How do certain factors (attitudes, beliefs, events, or policies) affect the program outcomes?

Program Outcomes

6) What are 3 things that you gained/learned from your MANA Community Advisory Board experience? (*Ex.* Communication, leadership, community involvement, identifying symptoms and risk factors of mental health, finding voice and understanding of spiritual beliefs, reduced stigma around mental health)

7) Is there anything else you want to share about the program and your experience?

Appendix D – Staff Interview Protocol

Sharing Your Story MANA Evaluation Protocol - Staff

Step 1: Introduce "Sharing Your Story"

1) Inform the participant that the MANA staff and HealthRIGHT 360/AARS want to talk to them about what it is like to be in the MANA Program. Explain that we would like to interview them in a one-on-one private session, where they can share their story and experience in the MANA program with us. Let participants know that this will help us grow and improve the program.

Step 2: Review Paperwork and Schedule Appointment

2) Review the consent/assent form(s) with the participants and schedule their "Sharing Your Story" appointment, at least one week out. Give them the Sharing Your Story Protocol according to their sub-group (participant, staff, CAB member). Instruct them to review the protocol and review and sign consent/assent forms and bring both to scheduled appointment. **Emphasis that participants may select to opt out of the activity at any time.**

Step 3: "Sharing Your Story"

3) Appointments are 30 to 45 minutes long. When the participant arrives, collect the signed consent/assent forms and review with them. Also review Sharing Your Story Protocol and ask if they have any questions.

4) Begin audio recording the participant being sure to ask each question (including probing questions when needed). Use Sharing Your Story Protocols for specific sub-group questions.

5) After all the questions have been asked, turn off the recording equipment and explain to the participant we will be using their story for our evaluation and the findings will be made available to them in the future.

Sharing Your Story MANA Staff Protocol

Sharing Your Story-Appointment Information:

Date: _____ **Time:** _____

Location: _____

Contact for Questions: Dr. Robynn Battle, Program Evaluator, robynn.battle@camiconsulting.com, 510-919-8858.

Preparation and Recording Procedures:
When you arrive to share your story, please bring this completed worksheet with you. These are the questions listed below that you will be asked by the MANA evaluator when your story is recorded. Please take some time (at least 3 days before your appointment), to reflect on these questions and take notes in the space provided. This will help you to gather and organize your thoughts about your MANA experience. Please feel free to contact Sean Kirkpatrick if you have any questions about the storytelling process.

Here are the questions you will be asked when sharing your story:

Background

1) Tell us a few things about yourself.

2) What led you to work with the MANA program? Why do you continue to work with the MANA program?

Program Satisfaction

3) Describe your satisfaction with the MANA program (i.e. participant involvement and engagement, impact on the participants and community members).

4) How do certain factors (attitudes, beliefs, events, or policies) affect the program outcomes?

Program Outcomes

5) Reflecting on your MANA experience, what are best practices for serving the Samoan and Tongan populations?

6) What were some outreach strategies that worked for recruiting Samoan and Tongan populations into MANA? What did not work?

7) Provide at least three example key outcomes MANA participants gained/learned the most by the end of the cohort? (*Ex.* Communication, leadership, community involvement, identifying symptoms and risk factors of mental health, finding voice and understanding of spiritual beliefs, reduced stigma around mental health)

8) Is there anything else you want to share about the program and your experience?

Appendix E – Web Analytics Form

Date	Event Name	Event Type	Total Reached	Unique Details
	Talanoa Tuesday			
	Talanoa Related			
	Talanoa Tuesday Rewind			

	Other Online FB LIVE			
	EoM MANA PSA Announcement			
	Other FB Postings			
	Heartwork Spotlight			