LA CLINICA DE LA RAZA

CULTURA Y BIENESTAR PROGRAM

Final Local Evaluation Report

California Reducing Disparities Project (CRDP)
Statewide Evaluation (SWE) Community-Defined Evidence Practice (CDEP)

LatinX/Hispanic at high risk for experiencing mental health problems in Alameda County
Local Evaluation Time Period 2017-2021

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Prepared by:
Behavioral Assessment, Inc. in conjunction with Cultura Y Bienestar Staff
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Executive Summary

This final Local Evaluation Report presents a summary of the 4-year evaluation study for La Clinica de La Raza, Cultura Y Bienestar Program (CyB). This report provides detailed information on the background of the mental health issues facing Latinos in Alameda County, California, as well as the methodology used to evaluate this Community-Defined Evidence Practice (CDEP). In addition, data results from both the qualitative and quantitative evaluation study are presented along with data-based suggestions on how to expand and enhance CyB to further increase access to high quality, culturally appropriate services for Latinos.

Hispanic/Latinx populations in Alameda County have historically shown low use of mental health services. Low utilization rates for this population result from several factors, including lower access to cultural and language-specific services, lack of knowledge about mental health services, and cultural stigma associated with receiving mental health care. Strategies for outreach, screening, assessment, early intervention, and treatment programming for this underserved population are much needed. La Clinica de la Raza has been providing a range of publicly funded health and mental health services and programs to serve Spanish-speaking and immigrant populations and has developed a comprehensive community level approach to engage Hispanic/Latinx adults, youth, and families into prevention and early mental health intervention services. Cultura Y Bienestar (CyB) is a "community-defined evidence program" that offers a comprehensive, community-based approach toward mental health access and services for Latinx populations living in the Oakland/Alameda region. Our approach offers multiple, culturally acceptable avenues to access services for a population that may otherwise fear traditional mental health services.

The purpose of the CRDP funded study was to evaluate core components of the Cultura Y Bienestar (CyB) model. As part of the California Reducing Disparities Phase II Pilot project, a mixed-methods approach to the CyB evaluation proved beneficial. The local evaluation team and CyB staff worked together successfully to implement a very rigorous quantitative and qualitative evaluation. A pre-post evaluation design was used for the quantitative outcome study, while focus group data was collected to ascertain information on clients' perceptions about CyB services, the cultural relevance of services, and satisfaction with CyB staff. Outcome data from the SWE Core measure points to several significant project results. For CyB participants who received the 6 individual support (n=61) and PEI services, a number of serious mental health problems was reduced. Based on pre-post measures, participants reported reductions in symptoms of depression, anxiety and reported reduced interference in daily functioning due to mental health problems (all $p<.001$). For example, when asked, "In the past 30 days how often did you feel nervous, hopeless, restless, or fidgety, depressed, that everything was an effort and worthless", the analysis shows that the ***participants improved with decreased mental health symptoms at post****-survey* administration. For example, 46% reported feeling **worthless** (Some, Most or All of the time) at the pre-test, while at the post-test only 26% reported feeling **worthless** (Some, Most or All the time). Another example, 65% reported feeling **hopeless (**Some, Most or All of the time) at pretest, while at posttest only 25%

felt **hopeless** (Some, Most or All the time) at the post. Participants who completed CyB programming reported feeling less marginalized and less isolated from society as well as feeling more connected to their culture.

High client satisfaction ratings also provide evidence about Cultura Y Bienestar (CyB) service acceptability. Our qualitative data findings corroborate positive client outcomes from the SWE measure. The use of focus groups to elucidate the nature and perceived effectiveness of CyB services proved to be successful. Taken together, the findings here support the richness of CyB as a community-based, early intervention and prevention program. The program model and services offered are highly valued, regardless of the service location.

Introduction - Literature Review

Demographics of Population Served by Cultura y Bienestar (CyB)

Cultura y Bienestar serves large areas of central and southeast Alameda County, including East Oakland, Hayward, San Leandro, Fremont, Union City, and Livermore. These are traditionally areas with limited access to health and mental health services among ethnic and linguistic minority groups and low-income and immigrant families. Large segments of the populations that Cultura Y Bienestar (CyB) serves in Alameda County are low-income families who earn less than the 200% of the Federal Poverty Level. These residents include Latino and Indigenous immigrants and other Black, Indigenous and People of Color (BIPOC) communities, uninsured residents, and Medi-Cal beneficiaries. Latinos represent nearly 1 out of 4 residents in Alameda County (22.9%), and their average household income is about one-fourth lower than that of non-Hispanic/Latinoresidents. (Source: www.healthyalamedacounty.org) About 16.15% of all residents in Alameda speak only Spanish at home, which represent about 2 out of 3 Latino residents in the area. (Source: www.healthyalamedacounty.org) Monolingual, Spanish-speaking, and Mam-speaking immigrants represent two of the most vulnerable populations in the area of influence of CyB. The communities we serve confront many cultural and linguistic barriers to access health and other social services. As a result, residents often avoid interacting with large systems of care that are intimidating and complex to navigate. Moreover, during the public health crisis of COVID-19, many Alameda County residents, who are essential workers and live-in high-density areas, have been disproportionately impacted by the illness. Significant numbers of them have lost their jobs and income in the services, retail, and construction industries and many lack workplace protections, and are not eligible to receive unemployment insurance or any other form of government economic relief. These factors make these populations extremely vulnerable to suffer of mental health disorders and less likely to receive adequate and timely treatment.

Behavioral health needs are significant among the population CyB partners serve. In Alameda County, 10% of adults report serious psychological distress. Of those who reported psychological distress, 50.1% reported being unable to work for more than 8 days in the previous year due to their mental health, and 15.8% reported experiencing moderate to severe social impairment in the past 12 months. Meanwhile, 10.3% reported taking prescription medication for mental/emotional health problems in the past year. COVID has significantly increased the need for behavioral health services while at the same time limiting how services can be provided. Despite this high need, evidence demonstrates that Latinos typically underutilize behavioral health services due to cultural beliefs about mental health, inappropriate treatments, lack of Spanish-speaking mental health care providers and the protective effects of family and social networks of support (Vega et al. 1999). The Alameda County Health Data Profile (2014) states that; "hospitalization rates for racial/ethnic minorities may be disproportionately high due to barriers in obtaining a proper diagnosis, treatment, and management of mental illness." A significant reason for this high rate is the lack of training among service and healthcare providers to appropriately identify and intervene when

signs and symptoms of mental health challenges are shown among their clients/consumers. We intend to close these gaps by empowering community members to provide support to others in their community and to their healthcare providers by bridging some of the cultural, linguistic and knowledge barriers that often get on the way of appropriate identification of mental health challenges and timely access to services and treatment.

Alameda County has 1.7 million people, with 22,8% being of Hispanic /Latinx origin. Hispanics in Alameda County, when compared to other ethnic/racial groups, underutilize public mental health services, with only 10% of this population receiving mental health care (Alameda County Behavioral Health, Adult Specialty Mental Health Services Report, August 2017). Penetration rates for this population are even lower at <6% and reflect a profound disparity in access and utilization of mental health care for the Hispanic/Latinx population in Alameda County (the penetration rate is calculated by taking the total number of adults who received a number of SMHS and dividing that by the total number of Medi-Cal eligible adults for that FY). Low utilization rates for this population likely result from a number of factors, including lower access to cultural and language-specific services, lack of knowledge about mental health services, and cultural stigma associated with receiving mental health care.

Specific to Latinx/Hispanics populations, immigration-related stress and acculturation stress is associated with poor behavioral health and is predictive of higher drug use (Cervantes et al. 2018), risky sexual behavior (Levy, Page-Shafer, Evans, Ruiz, Morrow, Reardon et al., 2005) and mental health symptoms (Cervantes, Fisher, Padilla & Napper, 2016). These findings are important in the context of racial and ethnic disparities in health, given that minorities report more exposure to chronic and acute stress than do non-Hispanic Whites (Boardman & Alexander, 2011).

Acculturative stress is a distinct but related construct, referring to culturally-based stressors including discrimination, context of reception, and bicultural stress (Cervantes et al. 2012; Salas-Wright and Schwartz 2019). Discrimination is being excluded, attacked, and/ or viewed suspiciously due to ethnicity (e.g., Greene, Pahl, and Way 2006). Context of reception refers to the opportunity structure that immigrants encounter (e.g., Portes and Rumbaut 2014). Bicultural stress is the conflict between expectations and demands imposed by two cultures (e.g., Romero and Roberts 2003). Acculturative stressors likely co-occur in U.S. Latinx immigrants; the accumulation of multiple stressors is likely more hurtful than any single stressor (Córdova and Cervantes 2010; Ennis, Ríos-Vargas, and Albert 2011; Salas-Wright and Schwartz 2019).

Acculturation and acculturative stress have theoretical links to alcohol or drug use. Acculturation may lead to adopting permissive attitudes or normative beliefs about drinking or drug use; retaining heritage practices and cultural identity may have the opposite effect (e.g., Caetano 1987). In a meta-analysis of 88 samples of 68,282 Latinx adults (Lui and Zamboanga 2018), acculturation was not linked to drinking frequency or volume (rs = .01, .02), but was positively related to drinking intensity (r = .09), heavy episodic drinking (r = .05), and hazardous drinking (r = .06). Acculturative stress may lead to maladaptive coping with alcohol or drug use

to emotionally disengage when stress appears insurmountable (e.g., Carver, 1989; Crockett et al. 2007). Further, acculturative stress may disrupt protective aspects of family functioning. Familism refers to the importance of one's family or placing family needs above individual needs. Familism creates a sense of obligation of family care and consideration when making decisions, and is believed to protect against unhealthy behaviors, including alcohol or drug use (De La Rosa et al. 2005). Acculturative stress in Latinx adults has been linked to substance use disorders (Ehlers et al. 2009), drinking problems (Lee et al. 2013), hazardous drinking (Jankowski et al. 2020), and alcohol use (Sanchez et al. 2015); and to alcohol and polysubstance use in Latinx adolescents (Berger Cardoso et al. 2016; Goldbach et al. 2016), although acculturative stress failed to differentiate drinking patterns of Latinx participants in treatment in one study (Arciniega et al. 1996)

Low access to behavioral health care for all Americans continues to be a public health concern. Over 17 million adults did not receive *needed* treatment at a specialty facility for their substance use. Hispanics had the lowest rates of any mental health services (7.3%) of any racial and ethnic group and much lower than use rates in the general population (17.6%), SAMHSA (2015). Low use of behavioral health among immigrant Hispanics has been associated with deportation fears, low insurance coverage rates, lack of knowledge about existing services and cultural taboos surrounding behavioral health care.

No evidence-based opioid prevention programming for immigrant families exists. Perhaps the intervention with the strongest evidence of potential effectiveness, *Familias Unidas* has not studied opioid prevention outcomes (Pantin, 2003). A study of *Strengthening the Bonds of Chicano Youth* (El Proyecto de Nuestra Juventud) included 450 high-risk youth in an established, non-immigrant community setting but did not test for opioid prevention or reduction (Varela, 2001). Similarly, The Bridges universal prevention program included middle schools that were located in the disadvantaged neighborhoods in Phoenix, Arizona, with the highest enrollment of Mexican origin students (ranging between 69% and 82% has not focused on opioid use or prevention (Arizona Department of Education 2005).

Substance abuse treatment interventions also exist to address intra-familial stress in Hispanic families, such as Brief Strategic Family Therapy (BSFT; Santisteban, et al., 2003) and more recently, Culturally Informed Family Therapy for Adolescents (CIFTA; Santisteban, et al, 2011). Randomized controlled trials of *Familias Unidas* suggest that strengthening the family system, rather than targeting specific health behaviors, is efficacious in preventing and reducing cigarette smoking, illicit drug use, and unsafe sex in Hispanic adolescents (Prado, et al., 2007; Pantin, et al., 2009). Unfortunately, this curriculum is parent-centered and requires prolonged involvement of highly trained (MS/MA or higher) bilingual intervention staff (Prado, et al., 2006), an asset frequently lacking in new Latino settlement communities. *Storytelling for Empowerment* (Nelson & Arthur, 2003) helps adolescents at risk for substance use, HIV, and behavioral health problems, but there is no evidence of effectiveness with opioids in immigrants. *Strengthening the Bonds of Chicano Youth* emphasizes cultural strengths, but it does not incorporate a parent education or family component. *Bridges to High School* has a family component but does not take on the stressors of Mexican immigrant youth or families.

No existing program has been tested to determine its effectiveness in curbing opioid use in the at-risk and growing Latino youth population. Effective opioid interventions must promote healthy coping strategies for acculturation- and immigration-based stressors (Cervantes et al., 2016).

Studies of school-based drug prevention show promise. In one study to test a school- and home-based version of Beginning Alcohol and Addictions Basic Education Studies (BABES), a parent–child interaction component for home use (BABES Plus) was compared to a classroom-only version of BABES (BABES Only) and a no-treatment control group. The quality of the home environment improved, and depressive symptoms decreased over the post-intervention period for the BABES Plus group, but not for the other two groups. The BABES Only group had greater parent involvement in school activities at 6 months post-intervention, compared to the other groups. The effect of the BABES Plus intervention was demonstrated at 6 months for environmental and parental risk factors. In an earlier randomized study of Keep a Clear Mind (KACM) students received four weekly correspondence lessons designed to be completed at home with a parent. KACM students reported significantly less perceived peer use of alcohol, tobacco, and marijuana, as well as significantly less peer pressure susceptibility to experiment with cigarettes. Mothers in the KACM program reported significantly more recent and frequent communication with their children about refusing drugs, and significantly greater discussions with their children regarding how to resist peer pressure to use alcohol, tobacco, and marijuana. Intervention program fathers reported significantly more communication with their children concerning how to resist peer pressure to drink alcohol and use tobacco, and significantly greater motivation to help their children avoid drug use. No significant differences were found between groups on student intentions to use drugs. These data suggest a print medium that emphasizes parent-child activities holds promise for accessing families and enhancing drug prevention communication. Results from a study of the in-house version of Project Northland were conducted among a large cohort of 6th graders in the sixth-grade home-based intervention, the Slick Tracy Home Team. Findings of broad-based participation across sex, race, and risk status were documented (Williams, et. al, 1995).

Each of the programs mentioned above has some core components that are relevant to CyB and have been incorporated into some of the CyB core component strategies. These programs typically focus on familismo and reducing acculturation stress and are available in Spanish. Similarly, CyB has an emphasis on working with families and addressing cultural strengthening and acculturation. All CyB program components are available in Spanish.

CDEP Purpose, Description & Implementation

A. CDEP Purpose

The Cultura y Bienestar (Culture and Wellness) Program is a project of La Clínica de La Raza in collaboration with La Familia Counseling Services and Tiburcio Vázquez Health Center. Together, these three agencies have almost a century of experience providing health and other social services to Latinx communities in Alameda County and serve a large geographical area in the central, south and eastern areas of the county. Our partnership allows the program to serve families from Central and East Oakland, including the Fruitvale district with a large Latinx population all the way to Hayward, Union City and Livermore as well as other smaller jurisdictions such as City of Alameda, San Lorenzo, Castro Valley and San Leandro. All these agencies have a strong presence in their respective communities. La Clinica de La Raza, founded in 1977, serves three counties in the Bay Area with a full range of health services including primary care, prenatal care, adolescent health, school-based health services,dental, vision, health education and other preventive services. Behavioral health is one of La Clinica's main focuses, providing a range of outpatient mental health services including psychotherapy, psychiatry, and psychoeducational services. Cultura y Bienestar is part of this system providing early intervention and prevention services, specifically focusing on the East Oakland geographical area. As the lead agency in this partnership, La Clinica takes on most of the contractual, fiscal, and other financial and fiduciary responsibilities to ensure our program meets its commitments and obligations with funders and other regulatory entities. Tiburcio Vasquez Health Center is also a well-established health care provider in the East Bay with nearly 50 years of experience serving residents of the central and south regions of Alameda County, providing a wide range of health and prevention services to Latinx and other diverse communities. La Familia Counseling Services has more than 40 years of experience providing specifically mental health services for Latinxs in the greater Alameda County region. It started in Hayward in 1975 and over the years has added a number of sites in Oakland, Livermore, Ashland, and other parts of the county with a range a counseling services that include youth development services, family therapy, group education, prevention services, substance abuse treatment, violence prevention, diversion and reentry services for Latinxs and others in Alameda.

In 2006, California voters passed proposition 63, also known as the Mental Health Services Act (MHSA), which provided a steady stream of funding for community mental health services through the establishment of what is now known as the *millionaire's tax*. Part of the mission of this funding and program is to address health inequities among underserved ethnic and linguistic populations. In 2010, the state of California, through the Alameda County Behavioral Health Services Agency, made this funding available for community-based organizations to create programming to address these inequities. This program is known as the UELP Program (Underserved Ethnic and Linguistic Populations) and it has helped create or strengthen about half a dozen programs serving different populations providing prevention and early intervention services that are culturally relevant and linguistically competent and that address the specific needs of each one of these communities. La Clinica de La Raza's Mental Health Department took the lead to seek this funding, and in an effort to amplify the reach and impact

of these resources, it reached out to its current partners to establish an alliance to ensure more people in a larger geographical area were served. Over the years, this partnership has evolved into a solid collaborative with a great deal of communication and coordination that shares models, information, and resources to ensure services of high quality and that respond to the emerging needs of our individual populations. In 2018, the partnership was awarded additional funding through the California Department of Public Health, Office of Health Equity to plan and implement the California Reducing Disparities program, which primarily supports the evaluation of our model of interventions.

This program is a Latino-focused mental health prevention and early intervention program that provides outreach, education, and consultation to the Latino community and those who serve Latinos in Alameda County. The goal of this program is to promote mental health and emotional well-being through education, consultation, and the practice of traditional healing methods. More specifically, the program aims to reach the following goals: 1) successfully engage unserved & underserved Latinxs, 2) improve Latino's knowledge about mental health issues and decrease mental health stigma, 3) decrease acculturation stress & early mental health symptoms, and 4) increase mental health service use. The desired outcomes are to decrease mental health problems & reduce disparities in mental health care among low-income Latinos in Alameda County. The Cultura y Bienestar Program uses five of the six core strategies from the California Reducing Disparities Project (CRDP) Latino Population report, including: 1) peer-to-peer support to individuals; 2) family psychoeducational curricula to increase family and extended family involvement and to promote health & wellness; 3) promote culturally relevant wellness & illness management; 4) increase community capacity by building on community strengths to improve Latino behavioral health outcomes; and 5) reduce stigma through media & education.

B. CDEP Description & Implementation Process

Within these categories, CyB offers a range of individual and group services and interventions that meet the needs of the diverse populations each of our partnering agencies serves. All services are provided in a linguistically and culturally appropriate manner in Spanish, English and more recently in Mam, as well as responding to other community and specific group needs. Some specific groups served by our program include TAY, seniors, parents, and recent immigrants. Our partnership has four sites run semi-independently by each of the three partnering agencies including two sites (one in Hayward and one in Livermore) run by La Familia Counseling Services, one site in Union City managed by Tiburcio Vasquez Health Center and one more in Oakland administered by La Clinica de La Raza. Each one of the sites run by La Familia and Tiburcio Vasquez Health Center employs two peer health educators and a mental health specialist supervisor and a site supervisor. The site in Oakland has three peer health educators on staff as well as a mental health specialist, two administrative assistants and a program manager. Our entire program is composed of 16 staff members, including 9 peer educators, 3 mental health specialists, 2 program assistants and one site supervisor and a program manager. Additionally, La Clinica as the lead agency provides financial, planning, and other higher-level administrative support to the program. Site supervisors and mental health specialists meet

twice a month to review progress, to address administrative and training issues, and to troubleshoot any challenges that educators may be confronting. The entire collaborative staff meets once a month to share expertise and knowledge and to support each other and receive information and resources to improve their work. During these meetings, peers have reinforced their skills and knowledge about traditional healing and community-based practices for wellness and healing. Peer educators act independently when providing outreach and other group and individual services to members of the community. However, our model also requires that they consult regularly with their respective mental health specialist in their team to ensure cases are of adequate level of complexity and to ensure that any safety concerns are addressed by a licensed clinician in the team. If a case is determined by Mental Health specialist to be outside of the scope of the peer health educators practice, the individual case can be either reassigned to the Mental Health specialist of referred out to higher level of service or to other services as appropriate. Mode of services includes both individual and group-based interventions. Among the individual interventions our program offers are 1) short-term prevention and early intervention counseling and psychoeducational services, 2) outreach and promotion services, and 3) Information and referral services. These services are delivered by trained peer educators, who adhere to a strict model of supervision and code of conduct that ensures they are supported and trained appropriately to improve outcomes and reduce risks. They are able to assess and connect participants with appropriate services when more complex treatment is needed. Individual interventions are delivered in an ongoing basis and take significant time and effort by our team. Prevention visits are generally offered to individuals who educators encounter during their outreach activities or to clients referred to our program by other departments or outside agencies. These often-one-time sessions are informational in nature and provide assistance to participants in identifying resources or specific tools to cope with everyday stressors. Educators offer basic tools such as mindfulness or herbal teas, that participants can use to start coping with everyday mental health challenges. During these sessions educators might offer information and referral services as needed. Additionally, educators may offer early intervention services in the form of short-term psychoeducational and peer support services. These sessions are limited to 6 encounters and are intended to provide participants with specific tools to address and cope with mental health challenges utilizing a wide range of approaches, including traditional healing methods and community-based interventions. Similarly, during early intervention sessions, educators might initiate referrals to other services as needed, such as immigration and labor legal services, housing and shelter services as well as higher level mental health services. These referrals are different to the ones provided during prevention sessions in that educators will assist participants in connecting to the services and follow up after a few days to make sure participants are receiving services or to try and initiate a new referral if the initial one did not result in a formal connection to services. During the public health emergency due to the COVID19 pandemic, most individual encounters were moved to virtual or phone call appointments. Initially, much of the time was spent in teaching participants the use of video conferencing platforms and adapting materials to such an environment. We extended sessions up to 10 sessions in many instances to make up for the time lost in technology troubleshooting with clients. Each of the program components is clearly described and linked to our outcomes in the Cultura y Bienestar logic model found in **Appendix 1**.

Group interventions include support groups, psychoeducational workshop series, stand-alone workshops, traditional healing events, traditional celebrations, and ceremonial activities as well as community events. These activities are also ongoing throughout the year in the different agencies that are part of the collaborative. Each partner agency in the CyB collaborative has the flexibility to schedule activities according to their own needs, context, and capabilities. Support groups include a group for Latinx women and one for Latino men in Oakland that provide gender-specific information and education to help these groups cope with some of the mental health challenges they face. During the COVID19 pandemic, grief and loss were common in these groups as well as couples' issues and financial and other similar struggles were often discussed during these groups. Facilitators offered culturally relevant tools to address some of these challenges, including addressing issues of gender roles, toxic masculinity as well as ceremonies and other rituals to help individuals manage some of these issues better. Additionally, partner agency Tiburcio Vasquez offered a support group for recent immigrants to help participants identify and cope with some of the most common adjustment challenges faced by recent immigrants and refugees. These support groups are ongoing, and anyone can join at any time. They occur weekly and, in some cases, monthly. Workshops are scheduled on a regular basis on average including parent education series at ARISE schools in Oakland, youth summer programs at La Familia Hayward and Livermore, and youth educational groups utilizing curricula such as Joven Noble in Hayward and Union City. Additionally, we have created our own curriculum and materials to cover such topics as migration and mental health and gardening and healing, and we are currently developing material to address stigma in the Latinx community around mental health. We also offer ongoing support groups for Latino men, a healing circle for Latinas and 2 support groups for seniors in Oakland and Hayward. A youth leadership development group also is organized once a year by partner agency La Familia in Livermore.

In addition to these groups, CyB organizes monthly workshops on a range of topics, including traditional healing practices and other relevant topics such as racial justice or COVID19 vaccination education. Also, each partnering agency organizes 6 traditional healing events a year. These events are gatherings (virtual these days) in which a traditional healer offers teachings and opportunities for participants to engage in traditional practices to prevent mental health challenges or to cope more effectively with these issues when they arise.

CyB is also a resource for service providers and community leaders around community mental health. Our mental health specialists as needed deliver workshops and provide consultation to schoolteachers, faith-based leaders, and other organizations that request help from our program.

Our multiagency program utilizes a diversity of ways of obtaining and incorporating community and client feedback into our regular programming. Some of these methods are formal processes, and others involve more informal communication with clients and community members by our team's peer educators and mental health specialists. Each one of the partnering agencies has a different approach to obtaining client and community input. The

most common way to obtain this information is through the direct contact that our team of educators has with the community and their clients. Our team of well-trained educators live and are part of the communities they serve, thus giving them a very unique position when it comes to hearing directly from their own communities about what are needs, strengths, opportunities and wisdom that can be used in their planning of activities. This knowledge is also often relayed back to program manager and coordinators to then be incorporated into the larger planning and strategic planning processes for the program. This method has been effective in bringing input from particular communities served by our program, including seniors and youth, and more recently, Indigenous families. Other methods used by our program include applying client evaluation surveys among attendees to some of our events to gather participants' suggestions and needs. We also have established relationships with community-based groups that inform our planning and implementation processes. An example of this is a collaboration our program has developed with Grupo Desarrollo Maya, a group of young Indigenous leaders in our community that continues to advise us around the needs of their community and about ideas for activities to reach out and engage these families in our program. In the next few months, we will launch a formal client advisory council (CAB) which we hope will assist us in gathering some of this information, feedback, ideas, and wisdom in a much more systematic and formal way.

CyB Program Component #1

Outreach, Engagement, and Education-CyB Promotores provide outreach and education at community locations (schools, churches, senior centers, streets, etc.), events (such as Dia de Los Muertos celebrations), and through group platicás. Promotores provide culturally relevant information, mental health promotion education (for example stress coping skills) and resources for mental health and wellness. Outreach activities range from quick 1 hour tabling at an event or platica to an 8-hour long Dia de los Muertos event or Mother's Day celebration. They can occur during the daytime, evenings, and often during weekends when many of our clients and their families are available. Single session platicás or 1.5-2-hour discussions/workshops introduce a wellness topic such as parenting to the group. Through sharing and discussion, they emphasize recognizing existing strengths, developing coping skills, and reducing stressors and other risks. The number of participants varies from 15-300 people depending on the location and time of the event. It is important to note that while we adhere to a series of specific topics that include such areas as depression, anxiety, stigma, parenting, relationships, and others, we also tailor some of these workshops to the specific needs of the group we are serving. For example, during the return to in-person instruction after the almost 18 months of shelter in place order due to the pandemic, our teams were asked to discuss isolation issues on youth and addressing fears and anxieties about COVID19 with parents as well as with students. Returning to in-person instruction was an anxiety-provoking experience for many young students and our educators adapted to this reality and offered specific workshops to discuss this topic. During the initial rollout of the COVID19 vaccines, we organized some workshops to inform and dispel some common myths about the vaccine itself and to help ease some of the anxieties and fears about getting vaccinated among participants. We organized some events to address the issue of racial equity during the summer of 2020 and also

started to have a discussion about anti-immigrant sentiments in the community and about Indigenous people's rights. This is how our program also seeks to address contemporary social issues affecting Latinxs families in Alameda.

During the pandemic, many community events such as health fairs, festivals and other cultural activities were suspended, which impacted the ability of our program to be out in the community conducting outreach and other educational activities. We joined some virtual gatherings and resorted to social media to pass on the information and remind individuals about our other services. Some sites in the collaborative have started to engage in in-person activities more and more as the number of COVID cases goes down and vaccine rates improve in our region.

CyB Program Component #2

Support Groups-CyB Promotores create an opportunity to engage in a more in-depth dialogue with at-risk Latinxs community members around the interconnection of mental health and overall wellness. These multiple session support groups are for men, women, seniors, transitional age youth, and children. These support groups are hosted at locations that are trusted by the Latino community and include community members experiencing a range of mental health risk factors and stressors. Groups are scheduled during the day, evening or weekends depending on the preference of participants and last 2 to 4 hours. Some groups follow an established curriculum (i.e., Cara y Corazon, which is 8 sessions), and others are drop-in groups for different subpopulations such as men, women, or seniors or on topics such as stress and anxiety. There are a variety of different groups and participation may range from 5-30 people. Overall, 62% of participants are female, 92% Latino, and 82% prefer services in Spanish. While participants may hear about support groups at outreach or traditional healing events, they can also learn about support groups from community partners, the CyB website, by dropping by a CyB office or being referred by current participants. Currently, a Latino Men's Group and Women's Healing Circle are being conducted virtually due to the pandemic restrictions and a senior group has been resumed in an outdoor setting and with strict restrictions such as masking required, social distancing and no eating during the session. Seniors have had a much more difficult time connecting using technology, so we decided to go ahead and try to bring the group back in person sooner than the other groups. A youth group using the Cara y Corazon curriculum has resumed in-person in Hayward as well following strict guidelines to prevent the spread of COVID19. The delta variant of COVID has also set us back in resuming some of the other groups in-person in Livermore and in our Oakland site as well.

CyB Program Component #3

Home/Community Visits- During home visits (prevention and early intervention services) Program peer educators provide between one and six visits to offer individual/family support. During these visits, Promotores hear concerns, provide support, and deliver mental health promotion education, information, and skills building to build on protective factors and allow

participants to learn methods to address early signs of mental health problems. Typically, these 30–90-minute visits address issues such as depression (tristeza), trauma, grief (luto), anxiety (nervous/susto), and stress through these brief intervention services. When the participants' severity is high or by participant preference, a visit will be conducted by a mental health specialist who builds on protective factors and focuses on symptom and risk reduction. A key element during these sessions is reaffirming the use of traditional healing and community-based practices to address emotional, spiritual or community health challenges. Educators might resort to a range of practices that they themselves have been trained on and can offer to participants such as herbal teas, limpias (cleansings) ceremony, altar building, drumming, thumb holding, tapping, physical activity, movement, or dance, among others. Educators might offer other options such as gardening and community service activities as means to assist participants to build community, ground themselves in traditional practices for farming and connecting with mother earth as a form of healing.

While participants may hear about our services at outreach events, traditional healing events, or support groups, they can also learn about this component of the program from community partners, the CyB website by dropping by a CyB office or being referred by other participants.

During the COVID19 pandemic, many of these services had been moved to completely virtual or a mix of virtual and outdoor activities. For example, during the height of the pandemic in 2020, educators started a program to meet clients at their front yards or conduct wellness checks by waiving through their windows to participants while calling their number. Most services, however, were completely moved to virtual mode, which implied having to first spend a few sessions teaching participants how to use the platforms and assisting in downloading applications, creating accounts and a number of other technical challenges that participants had. Fortunately, smartphones were already widely used among our client-base and the leap from in-person to virtual, while still difficult, it did not take too long. By the early summer of 2020 we had adapted all of our services to remote or socially distanced modes.

CyB Program Component #4

Training and Consultation for community leaders-Training topics include depression, trauma, anxiety, and suicide. We also offer consultation around traditional healing practices and culturally rooted interventions to help leaders and services providers identify and manage some common mental health challenges among their clients. These 1.5-3 hours long trainings and consultations are provided either one-to-one or in group format for teachers, group or church leaders, coaches, health professionals, and community service agencies to provide education about risk factors, identification of signs/symptoms, supporting individuals/families, and linking community members to treatment when needed. Additionally, MH Specialists provide training for mental health providers at other CBOs. This training includes information on using "dichos" and other culturally responsive approaches and tools to engage Latinos, acculturation, and migration issues, and use cultural approaches to working with children with behavioral health issues and their families. For example, some of these consultations might discuss how teachers can use storytelling or how physicians can identify early signs of depression and what services

are available to support their clients. Participation varies between 15-40 people in each group training session, or individual sessions are also available.

Participants may hear about training and consultation for community leaders from community partners, the CyB website, outreach, or word of mouth. Our team of peers also makes presentations to the public including in schools and in some local media outlets that help in getting the word out about this particular service we offer.

CyB Program Component #5

Traditional Healing and Cultural Events Method: Traditional Healing workshops and Cultural Events are held regularly in the community and last 2-3 hours. These events draw an average of 30-70 participants. They include workshops or demonstrations on such topics as therapeutic drumming circles, natural herbal remedies, building altars, or making "Papel Picado" or sugar skulls. These events are conducted in each geographic region of Alameda County and are facilitated by Traditional Healers with the support of program staff who discuss the history of the approach, demonstrate the traditional methods, and teach individuals and families how they can use these methods to support their own health and wellness. Our program has identified a circle of traditional healers that support our clients with a range of different healing practices that include drumming, traditional music, movement and physical activity, nutrition, medicinal herbs, arts and crafts as well as sweat lodges and ceremonial activities. Participants are reached through advertisements, the CyB website, referrals, outreach, or volunteer promotores. Traditional Healing workshops are considered entry level services, if during these events educators identify clients that need additional support they may refer them for individual visits, support groups or to other community partners as needed. During the pandemic for COVID19, these activities had been moved to all virtual events, which has been challenging as many of these traditions are best presented in person. For example, drumming circles were temporarily canceled as the sound provided through videoconferencing was not adequate to facilitate a circle in real time. Also, some practices such as "limpias" that require close contact between the healer and the participant were canceled to keep everyone safe. However, All of these activities were resumed virtually and have continued until now in this mode.

CyB Program Component #6

Referral and Linkage -Across all strategies, a key component to CyB's PEI services is to link Latinxs with available specialty mental health services beyond the scope of this project or other social services as needed, if those services are appropriate and desired. CyB connects community members to County centralized services for further screening, information, and referral, making every effort to make "warm hand-offs." When needed, CyB staff describe their confidence in a referral organization, offer to help link them to treatment and make sure that they feel comfortable with the services to help participants more readily accept linkages. This builds on all the other elements of the program. Participants in outreach events, traditional healing events, support groups, and home visits may receive referral and linkage.

Local Evaluation Questions

The initial Phase II CyB evaluation questions were submitted with the original evaluation plan are listed below, although due to COVID19, the scope of the evaluation was reduced caused by shelter in place orders and temporary interruption of core CyB program component activities:

1. Were all CyB recruitment and retention target numbers to be served, met and was quality of services adequate and were prevention support groups well attended? (Process)

2. Did CyB increase participants' ability to manage mental health signs and symptoms, particularly symptoms of depression cultural stressors, and trauma related PTSD symptoms (Outcome)

3. Did CyB result in reduction in mental health stigma among program participants? (Outcome)

4. Did CyB result in decreased mental health problems among program participants? Specifically, were symptoms of depression and trauma-related anxiety symptoms reduced? (Outcome)

5. Did CyB reduce disparities in mental health care and increase access among program participants (i.e., low-income Latinos in Alameda County)? (Outcome)

Evaluation Design & Method

A. Design

As part of the California Reducing Disparities phase 2 pilot project, both a statewide and local evaluation were conducted. As part of the local evaluation, both a quantitative and qualitative design was used so that statewide survey evaluation data and focus group information can be combined to determine the effectiveness of Cultura y Bienestar (CyB). Behavioral Assessment Inc. (BAI) served as the independent local evaluator and managed the design and implementation of process and outcome evaluation activities. Dr. Richard Cervantes served as Lead Evaluator. Donna Camacaro, Research Associate, had responsibilities of supervising the data management and providing the data analysis for the reports. Behavioral Assessment Inc. staff met monthly with project staff to discuss evaluation related activities which included: recruitment, retention, and data management updates. BAI provided a monthly participant list of all recruited participants to CyB staff. The participant list included participants by ID number and a section for each administration point (Pre-Baseline and Post Surveys).

B. Sampling Method and Size

CyB's intended target was 150 Latino participants. Annually, the SWE Core Outcome Measure data was to be collected from n=50 youth and adult clients who received 6 or more intensive outpatient visits via home/community visits. This represents a 10% random sample based on 2016 annual utilization data which showed that La Clínica served n=473 clients in CyB intensive outpatient services via home visitation. An aggregated matched sample of n=200 was initially proposed; however, due to delayed statewide IRB approvals, the sample was reduced to 150. This includes youth and adult clients. A total of n=150 completed SWE Core Outcome Measures were to be submitted for the statewide evaluation.

A total of 96 pre-surveys and 63 post-surveys have been collected since the onset of the program. A total of 61 matched pre to post surveys were collected. For the SWE and local outcome evaluation, a randomly selected set of CyB clients who received the 6 session individual support services were included in this analysis. Clients were recruited from each of the four La Clínica service sites including: La Clínica, La Clínica East Bay, La Familia Hayward, and Tiburcio Vasquez. The initial randomization plan called for the selection of every 5th client to be offered participation in the study. Approximately 10% of clients who were offered participation in the CRDP evaluation agreed to participate.

The attrition rate for this component of the evaluation is 34%. About one third of those who responded to the pre-SWE survey did not respond to a post-SWE survey. Most of these cases were clients that dropped out from the program or individuals who after successfully completing the six-session program we were unable to reach to respond to the survey. We do not have an accurate account of the reasons for either one of these scenarios, but we think that many of these cases were individuals ready to move on with their lives and not able/willing to spend the additional 60-90 minutes responding to the post-survey. It is also possible that the triggering nature of some of the questions in the SWE-survey, could have deterred some people from responding to the post-survey after experiencing some discomfort during the administration of the initial survey.

The COVID19 pandemic was also a big factor that impacted the ability of educators to engage participants in responding to the survey by phone and the inability to obtain signed consent during the initial months of the pandemic. This resulted in several weeks of suspension in the collection of surveys and in many clients being lost during this time. The initial communication gap generated as staff and clients sheltered in place and stopped in-person interactions may have contributed to the disengagement of some of these clients who struggled to use the remote communication platforms to stay in contact with their educators. It was also noted that as clients had difficulty finding a private space in their homes, where entire families were sheltering in place, many of these individuals chose to disengage with the program and we were not able to reach them to respond to the post-survey. Some clients reported that there was no place in their homes where they could privately discuss sensitive topics with their providers and that it was easier to just not pick up the phone when the program called them.

Finally, at a critical time during this project, staff turnover impacted the continuity of the data collection process. As the COVID19 pandemic started, key staff members including the program manager, program assistant and a senior health educator left the program in a span of about three weeks, which resulted in a gap in communication between the departing and entering staff that came to replace these positions of about three months. This impacted the ability of new staff to resume data collection immediately while they were being trained and briefed on this project by the evaluation team and other staff members.

Client Demographic Profile

SWE surveys were collected at 4 different sites, La Clinica, La Clinica Hayward, La Familia East Bay, and Tuburcio Vazquez. A total of **96** surveys were collected from all 4 sites. Twenty-there were collected for La Clinica, 15 for La Clinica Hayward, 12 for La Familia East Bay and 45 for Tuvburcio Vazquez.

Appendix 2 shows the demographic analysis for n=96 program participants. Seven percent of the clients were male, 93% were female and 1% were genderqueer/gender non-conforming. Ninety-one percent were heterosexual, 6% were gay and 2% were bisexual. Nineteen percent of the clients are between 18-29 years of age, 30% percent of the clients are between 30-39 years of age, 18% are between 40-44 years of age, 11% are between 45-64 years of age, 18% are between 50-64 years of age and 4% are 64 or older years of age. Ninety-nine percent were Hispanic, and most were of Mexican ethnicity. Thirty-eight percent speak English fluently or somewhat fluently. Ninety percent prefer to speak Spanish. Eighty-three percent of the clients were born outside of the U.S. Eighty percent have not spent time in a settlement for refugees or held by ICE.

Regarding other baseline participant characteristics most of the clients (86%) reported having fair to good health. In terms of current mental health care and utilization, Baseline data analysis shows that 71% of the clients currently have insurance of those 71% that currently have insurance, 28% had insurance in the past 12 months. Twenty-six percent have insurance that covers mental health problems. Twenty-four percent of the clients have taken prescription medication in the last 12 months for an emotional or personal problem. Eighty-five percent sought help for a mental, emotional, alcohol or drug problem. In the past 12 months, 53% of the clients visited a mental health professional for mental, emotional, alcohol or drug problems 1-5 days, 11% for 6-10 days and 4% for 11-15 days**.**

A sampling and procedures *protocol* was developed in conjunction with CHJ staff see **Appendix 3.** Due to a slowdown in client consents to participate in the study, CRPD and La Clinica determined that the randomization protocol change so that every 3rd client would be offered participation in the study.

The sample is highly representative of the CDEP Universe of clients served. For example, data for La Clinica mental health service client recipients for 2020 as reported to Alameda County Dept of Mental Health showed that 38% percent of our clientele marked themselves as being

Hispanic or Latino, more than 81% reported Spanish as their primary language. About 57% of participants did not specify their ethnic background.

C. Measures and Data Collection Procedures

A number of qualitative and quantitative evaluation measures were used as part of the local evaluation. This mixed methods data collection provided multiple sources of data and information to address the evaluation questions.

Quantitative Outcome Measure

The instrument that was used during the CyB project was the **Statewide Evaluation SWE CDEP Participant Questionnaire.**) This questionnaire addresses a) access /utilization items, b) stigma and other barriers to help seeking items, c) psychological distress and functioning, (Kessler et al. 2002) d) satisfaction/appropriateness/quality/outcomes of services items and the consumer-based cultural competency inventory, e) subjective religiosity/spirituality items, f) social connectedness items, g) cultural connectedness items and h) demographics. For the purpose of this outcome analysis, The Kessler measure scores were modified to capture discrete mental health symptom clusters (E.g., Depression, Anxiety, Interference with Daily Activities, Culture Resilience, Culture Connectedness and Marginalized). Conceptual sub scores were calculated, and reliability estimates for the adapted sub scores are presented in Table 1. The questionnaire was collected at two time points: pre and post.

Staff were trained in the SWE data collection administration which was done person to person and later revised to online administration due to the COVID pandemic.

Qualitative

The Focus Group Questionnaire was developed by the local evaluator in collaboration with program staff. The following grand tour questions were asked during each focus group interview: How did you learn about the CyB program (s)?

1. Do you remember how CyB staff or promotoras made you feel when participating in our services? What did they do to make you feel that way?

2. How did the CyB staff and promotoras use things like confianza, respeto, and familismo to make you feel comfortable with our services?

3. What kind of things did you learn about Salud Mental as a result of participating in the CyB program?

4. Do you think CyB services helped you or a family member with stress or health issues, if so, how did they do it?

5. Since you received services through the CyB program, have you been able to use other community resources or services? Which one?

6. What part of the CyB services did you like the most? Why?

7. Do you have any suggestions for how we can improve the CyB services?

In addition to the focus group protocol that was used, several demographic questions were included to determine client characteristics including age, gender, ethnicity, country of origin, family composition, language preference and education. In addition, an informed consent form was created and collected at the time of the focus group interview. Participants were made aware of the audio recording and were offered an opportunity to ask questions for clarification.

Focus Group Procedures

Clients were recruited from each of the four La Clínica service sites including: La Clínica, La Clínica East Bay, La Familia Hayward, and Tiburcio Vasquez. The initial sampling plan required that each of the four CyB site coordinators would recruit up to 10 focus group participants composed of adult Latinos who had participated in one or more of the CyB program activities (e.g., Zumba classes, Traditional Healing groups, parent platica group). Current CyB clients involved in the quantitative study were excluded from recruitment from the focus groups. Due to scheduling conflicts, participant hesitancy and the time frame for data collection, a final sample of n=23 was included. The final sample was representative of the client population served at LCDLR; primarily Spanish speaking Latinx immigrants residing in Alameda County. A convenient focus group schedule was created for recruitment purposes. Focus groups were conducted by each of the four La Clínica service sites. Interview length for each focus group was approximately one to one and a half hours long. After consent was given by each participant, interviews were recorded. All the interview responses are kept confidential. Each participant received a gift card at the end of the interview. The BAI independent NIH IRB committee reviewed all focus group protocols and consent forms for this sub-study.

Focus Group Data Analysis

Using an approach to code focus group data (Cordova, Cervantes & Ciofu, 2014), the data was analyzed using a grounded theory and constant comparative method that included a process of open, axial, and selective coding. First, independent open coding of the transcripts to identify general themes was conducted for bilingual researchers and led by a Ph. D level lead evaluator. The researchers used the axial process of relating categories to subcategories. Thereafter, an integration process took place, which fostered a refining of the theory (Strauss & Corbin, 1998). This analytic process led to the identification of several emerging themes related to consumer perceptions of CyB services. Axial coding, the second analytical phase, reached a higher level of data conceptualization by creating categories within each node or concept (La Rossa, 2005). This allowed for the identification of relationships among categories based on properties and dimensions. The process of selective coding aimed at integrating a theoretical schema of the

phenomenon under study (Strauss & Corbin, 1998). The coders independently coded the data and met to discuss the emerging themes. This also assisted in the selection of text segments from the transcripts that best illustrate the nodes and underlying schema.

D. Fidelity Measurement

No Specific fidelity tools were used as this CyB program has many fluid components and is not a curriculum driven model.

E. Data Analysis Plan Implemented

A qualitative analysis using open, axial and selective coding as suggested in the Strauss and Corbin, (1988) focus group interview method was utilized for our focus group data as described above. For our quantitative analysis, SPSS v 28 was utilized to conduct all data transformation, coding, reliability and means testing analysis using paired t-test for matched samples.

Results

A. Quantitative Data Findings

Anxiety, Depression, Cultural Connectedness, Culture Resilience, Racial and Ethnic Discrimination and Daily Interference

In addition, presenting frequency data, the evaluation team conducted basic comparative analysis to determine other program outcomes. Specifically, paired t-tests were computed for 6 core mental health factors that are conceptually linked to our CyB mental health outcomes including, Psychological Distress “Anxiety”, Psychological Distress “Depression”, Cultural Connectedness, Psychological Functioning “Daily Interference” and Racial and Ethnic Discrimination. The composite mental health factors described above were all analyzed using the original scoring codes designated by PARC in the SPSS database and were NOT re-coded for this Cyb analysis. However, the findings are carefully interpreted despite the counterintuitive scoring.

The following table highlights pre-post survey findings for matching samples in each scale, comparing pre scores with post scores. As shown on Table 1, for the mental health outcomes, there was significant improvement in Psychological Distress-Anxiety, Psychological Distress-Depression, and Psychological Functioning - Daily Interference from Pretest to Posttest administration. Regarding the cultural variables, there was no significant change in Culture Resilience from Pretest to Posttest administration.

Also shown in Table 1, there was significant improvement in the Marginalized scale from Pretest to Posttest administration. Participants who completed CyB programming reported feeling less marginalized and less isolated from society at posttest. In addition, there was significant and positive change in Culture Connectedness from Pretest to Posttest

administration. Participants reported feeling more connected to their culture and balanced in mind, body, spirit and soul.

As shown in Table 1, there was significant change in Racial and Ethnic Discrimination from Pretest to Posttest administration. Interestingly, the scores for the Racial/Ethnic Discrimination Index changed significantly where clients reported a heightened awareness of Discriminatory experiences (e.g., Received poor service, treated with less respect) from pre to post assessment.

All the modified SWE sub scales used for this analysis were found to have acceptable internal consistency reliability estimates as shown in Table 1.

Table 1: Outcome Changes (n=61)	Reliability	PRE-Mean Score	POST-Mean Score	T-Value	Probability
Psychological Distress "Anxiety" (2)	.715	5.46	7.33	-6.14	p<.000 Significant improvement
Psychological Distress "Depression" (4)	.673	13.28	15.69	-4.32	p<.000 Significant improvement
Psychological Functioning "Daily Interference" (4)	.679	6.90	8.11	-3.42	p<.001 Significant improvement
Culture Resilience (4)	.856	7.46	7.01	1.28	p<.203 No Significant Change
Marginalized "Risk Factors" (2)	.664	6.70	8.09	-5.48	p<.000 Significant Improvement
Cultural Connectedness "Protective Factors" (2)	.647	4.75	3.91	3.22	p<.002 Significant Improvement
Racial and Ethnic Discrimination (9)	.908	43.84	30.98	4.83	p<.000 Significant change

CyB Post Program-Staff Satisfaction Questions

Sixty-one participants filled out the post survey, see **Appendix 4**. Within the post survey, participants were asked post satisfaction questions regarding staff and program satisfaction. Overall participants were satisfied with the program and staff and were very positive about the cultural proficiency and relevance of the staff and programming. For example:

- Eighty-four percent liked the services they received and 82% would recommend the agency to a friend or family member.

- Seventy-five percent strongly agree that services were available at times that were good for them.
- Seventy-seven percent strongly agree that it was easy to talk to the staff while 77% felt that staff did not think less of them because of the way they talked.
- Over 80% felt respected by staff.
- Participants felt that staff understood that they were not all alike when it came to their race/ethnicity, gender/sexual orientation and religious/spiritual beliefs.
- As a direct result of the program, participants feel that they can deal more effectively with their daily problems, do better in school/work and that their symptoms/problems are not bothering them as much.
- One hundred percent of the participants received services in the language they preferred.
- Seventy-seven percent of the participants said yes, written information was in the language they preferred while 26% said no.

B. Qualitative Data Findings – Adult Focus Groups

Purpose of the Focus Group Evaluation Sub Study

The purpose of the CyB program's Focus Group Study was to provide data that will help to improve the services of the CyB program clients. The interview questions asked participants about their level of knowledge about mental health symptoms and inquired about the impact of the CyB program on improved knowledge. Special attention was given to assess increased knowledge among participants to identify mood and vegetative symptoms of depression, as well as signs of trauma, including cultural stressors and related PTSD symptoms. In addition to knowledge regarding mental health symptoms, participants were also assessed in terms of their knowledge and use of cultural resiliency resources including 'familismo', extended family supports, ethnic pride (orgullo), and traditional cultural healing practices. CyB Focus Group guide was also developed by the local evaluator. Staff and promotoras received the focus group guide and provided input on ways to improve the open-ended questions for the use with lover acculturated Latino clients. Interview participants provided feedback on their perceptions of reduced stigma at the personal, family and community levels based on CyB participation.

Focus Group Findings

Appendix 5 shows the demographic analysis for (N=23) focus group participants. Ninety percent (90%) of the participants are female and (9%) are male. The majority of all participants (30%) are 36-45 years of age. The majority of all participants live with their children (74%), followed by their spouse (43%). Fifty percent (50%) are married, (18%) are single, (14%) are separated, and a small percentage (4% or less) of participants are divorced, living with someone or widowed. Eighty three percent (83%) have children and (17%) do not have any children. The number of persons living in the participants home ranged from 1-8 persons. Thirteen percent (13%) of the participants were born in the United States and (87%) were not born in the United States. Of those that were not born in the U.S, the average number of years in the U.S is 18 yrs.

Spanish is the primary language spoken at home. Ninety-one percent (91%) of the participants are Hispanic/Latino. Seventy-four percent (74%) are Mexican/Mexican American, (17%) are Central American, (4%) are South American and (4%) are other (Hispanic). The highest level of education ranged from second grade through college senior completion, of those that had an education level of twelfth grade and below, (12%) have a GED. Most of the participants are unemployed not looking for work (27%) or homemakers (23%). Most of the participants (21%) annual income is between $30,000 to over $45,000.

Common Themes and Categories

Following the analytic approach noted above, common themes and categories emerged from the focus groups. The coded analysis resulted in the following data findings for each specific focus group question.

How did you learn about the CyB program(s)?

The focus group participants reported being referred for CyB services in several different ways. Many of the participants were referred by family and friends and others were referred after attending a variety of other community events that were sponsored by CyB such as Zumba exercise classes, faith-based events, and presentations.

Do you remember how CyB staff or health educators make you feel when participating in our services? What did they do to make you feel that way?

Several responses were given related to consumer perceptions of staff interactions. Generally, consumers had very positive perceptions about staff. Three primary themes emerged that highlighted the importance of ***staff professionalism, a caring interpersonal quality. In addition, consumers added comments that they felt welcomed,*** - were made to feel comfortable and were made to feel good. Consumers said that they were made to feel Important and felt that their problems and concerns were taken seriously in a professional manner.

One participant said for example, “I felt very welcomed here -in my very first session I left with a desire to return; the sessions have been for my son … I'm very happy and my son feels that he can trust them, and he has friends to talk to without feeling ashamed or being judged. I have seen the change in him and see how he is much happier now.” Another participant mentioned “We feel they are listening to us and not telling us what we want to hear - they always made me feel like I was (part of the) family.” Other comments included “I trusted them, they made me feel at peace” and “they assisted me with my mobility due to my poor eyesight.” Another stated, “They make you feel comfortable, and they inform us; the change is good for both our children and us,” while another mentioned “The confidence they instill in you builds trust and the games and activities they do with children helps build communication and trust.” Other participants were happy that there were no language barriers as the CyB staff spoke Spanish.

How did the CyB staff and health educators use things like trust, respect, and familism to make you feel comfortable with our services?

Participants were asked about their perceptions regarding CyB staff and specifically regarding the personal qualities of staff members in relationship to the client's comfort level.

A range of responses were given, and several common themes were noted. Like the responses from the previous question, a common theme that emerged was ***professionalism*.** Several respondents highlighted their perceptions that CyB staff were highly professional with a high degree of knowledge in the mental health field.

One participant said for example, "they speak to us with such professionalism that they make us trust them." Another participant mentioned "the (staff) are very professional and very human; they put themselves in your place. They understand you because similar things have happened to them. They show that human side of themselves. And yes, very professional and very respectful. They let you speak and express what you really feel. They make you feel comfortable not that they disagree with you or that they are criticizing you, on the contrary."

A second common theme emerged which was that of staff ***trustworthiness***. Here the respondents mentioned that staff could be trusted when hearing about personal problems and other topics that were highly private. One participant mentioned for example, "they speak to us with such professionalism that they make us trust them**.** We feel they are listening to us and not telling us what we want to hear." Another participant mentioned, "we all have our problems with relationships with our children, as I do with my daughters, but they are professionals, and they make me feel better; they are not giving you advice or their point of view but instead their professional evaluation of your situation. At times, on sensitive issues, we need to take certain paths with our children that we had never related to. They inform us and the change is good for both our children and us."

One participant said, "The confidence they instill in you builds trust" and another participant mentioned "They gained our trust because they were so friendly, they told us it was confidential; they made us feel good."

What kind of things did you learn about mental health as a result of participating in the CyB program?

Participants were asked about knowledge gained from CyB, specifically regarding things they learned about mental health. Participants learned about ***stigma, how to communicate, the connection between mind and body and overall self-awareness***

A range of responses were given, and several common themes were noted. The first theme that emerged was ***learning about stigma***. Several respondents highlighted their perceptions that CyB staff taught them that **"you are not crazy"**. One participant said, "we learned that

psychologists/psychiatrists are not for crazy people" and another said, "I learned that families have stereotypes about mental health – they have stigma."

How to ***communicate*** one's problems, and the problems with family members was a skill learned by many. To have a **'voice'** was another common theme among participants. One participant stated, "I have learned when to seek help. I would expect someone to come forward to help me, but instead I learned to help myself. I learned not to keep quiet, to defend myself. In my sessions I learned not to fight but to say what I was feeling." Another participant mentioned, "We are all fearful of asking for help, maybe it's a cultural thing, but when we take these courses, we learn how to find peace and see that there is light ahead. We must be of sound mind ourselves before we can help our families and others. This is all part of what I have learned here."

A third common theme emerged regarding the concept that ***physical health is part of mental health***. One participant mentioned for example "I learned that mental health and physical health go hand in hand - we are mostly concerned with our physical health and forget about our mental health." Another person commented, "I feel mental health is basic and important for everyone because that way we all help one another."

Self-awareness was another theme. One participant mentioned, "I learned how to value myself, I also feel stronger, I only lived for my kids and work." Another participant mentioned, "I fell into depression and fear; I thought I was stronger than I was, I changed a lot; the therapy has helped me a lot because **I feel good, happy and I continue to learn."** And another said, "I learned that I don't need to understand women, I need to love them -they had told us to count to 10 before we answer people; that has helped us to calm down and it has helped me."

How have the services that you have received from Cultura y Bienestar helped other members of your family? Please explain.

Participants were asked about their perceptions regarding the services received from CyB and how they affected members of their families. A range of responses were given, and several common themes were noted. Some of the participants expressed they experience more feelings of ***happiness***. Other participants said they experienced more ***relaxation*** and noticed a change for the good and ***felt more comfortable***. Some indicated they had an **"everything will be OK" attitude**, and some felt more ***family unity***.

One participant mentioned, "The family can tell how you feel; if you come into the house with a smile on your face, they can tell that you feel better. **What the mother does is contagious**." Another participant commented, "The therapy is like an altar to the dead to help cure us. It's something very comforting that the program does for us, we do not lose our traditions." Another participant mentioned "I had to get to know my mother and understand some of the problems she brings from her past and how they affected her marriage and how they affect her children in the present. **It's easier for me to understand children**; you need patience and at work we have a lot of pressure, and we must be patient to deal with the children." Another

comment from a participant was, “When I am relaxed it helps other family members relax as well…helps with family communication, my son could see positive changes and he got involved (in getting help).” Another participant mentioned, “This had a great impact on my family. When I got here from my country, I stayed with my sister, and I witnessed a lot of domestic violence. After a few sessions, my sister came to therapy to see if she could abandon that life she was living. Now my sister is better, she looks much better and is healthier emotionally.”

Since you received services through the CyB program, have you been able to use other community resources or services? Which one(s)?

Many of the participants engaged in some of the other services and activities offered through the CyB program including Zumba (exercise) classes, Drumming Therapy, (using drum rhythm to promote healing), and school-based programs for children such as Joven Noble (a youth development and leadership program), and Team Together (a language and learning skills program) among others.

One participant commented, “More than anything I am taking advantage of traditional medicines; natural things that help me sleep and relax me.” Another participant mentioned, “I receive services from the Women’s, Infants, and Children’s (WIC) Program, and utilize all the children’s activities provided.”

Other participant commented, “Alfredo was giving some courses called ‘Joven Noble’ at school and I convinced my son to register and attend. I think the course is more appropriate for his age, he can get together with children his age and it’s in an environment that he feels comfortable in. I was surprised he liked it so much.” And another participant commented, “I registered my daughter in a program in school called ‘Team Together’; they help them with their homework, and they also have many other activities. They have their own time and their own space, and it is important for them. I also use drum therapy on my girls when they go wild, it helps a lot with the children when they have anxiety.”

What part of the CyB services did you like the most? Why?

Participants were asked which part of the CyB services they liked the most. There were several responses given. Common themes among participants were noted, including ***fellowship, the positive environment, support, the constant flow of information, resources, and the encouragement to participate in activities/groups.***

One participant said, “It's what it has done for my son; not only in the sessions, but the recommendations they give you about other courses and activities or continuing with the same counselor for more sessions.” Other comments emphasized the caring nature of the CyB services. One participant mentioned, “Environment is positive, more spacious rooms than other services and equipped with games. But it really does not matter where they are held even if it’s in the parking lot, **it’s what people bring to it and the services being delivered**.” Another participant mentioned “With all the problems that we may have, we come here and feel very

well" and another said, "I worked with Monica for several sessions - I felt relaxed, it was very private, I felt comfortable to talk. I wish there were more sessions than what I did, but it was very good."

Do you have any suggestions for how we can improve the CyB services?

Participants were asked to give any suggestions they may have that would improve the CyB services. A range of topics were discussed, yet the most common themes were the need to ***continue and expand CyB services*** and the ***desire for more marketing and community awareness*** about CyB.

Specific suggestions made by participants included the following:

- Find ways for more funding for CyB services.
- More ongoing CyB services without downtimes.
- Better outreach.
- More publicity – let people know it is FREE.
- Offer classes to teach employment skills.
- More outreach and activities for men.
- Offer sessions for couples.
- Take donations.
- Offer more traditional healing and spiritual sessions.
- Create pamphlets describing the programs with the dates and times.
- Increase attendance and offer longer sessions.

One participant mentioned, for example, "They must reach more people to make CYB services more accessible. I am very fortunate because I come in the morning because I work at night but most men work during the day so they can't come to the sessions as I do. Many times, I have been the only man in the sessions. I think it is very important that the father's attend not just the mothers because they need the information too. The balance is not the same."

Another participant commented, "I had no idea that this was here so it's important to get the information out to the community. Perhaps you could promote the program in community events to increase awareness of what services you're offering here." Another commented, "I was in a meeting at my children's school, and they were talking about bullying and they didn't know that there was help here about that and how to address it. I think the school should be aware that we have programs to work with them so they could come here or get the information to the schools."

Regarding the need to sustain and expand CyB services, one participant mentioned "There is too much of a gap between sessions; I feel that I need to be able to get together with the group and talk about issues and listen to them for advice. I would like to see some other activities that will allow us to continue to be involved with the groups here so that there is continuity after the sessions. I would really like to see that."

Discussion and Summary of Evaluation Findings

The CyB program offers a comprehensive, community-based approach toward mental health access and services for Latinx populations living in the Oakland/Alameda region. As noted in the program description and logic model, our approach offers multiple, culturally acceptable avenues to access services for a population that may otherwise fear traditional mental health services.

A mixed methods approach to the CyB evaluation proved beneficial. The local evaluation team and CyB staff successfully worked together to implement a very rigorous evaluation. Staff capacity was built in terms of survey administration, data management, and participant protection/IRB issues.

The quantitative project evaluation findings first demonstrate that the CyB project was successful in recruiting and serving Latinx/Hispanic clients who are in need of prevention and support services. All of the clients are Latinx/Hispanic. Baseline information on mental health symptoms clearly indicates that clients enter Cyb services with high needs for mental health services and typically have less insurance coverage than found in the general population.

Outcome data from the SWE Core measure points to a number of significant project results. For Cyb participants who received the 6 individual support, PEI services, a number of serious mental health problems was reduced. Clients reported reductions in symptoms of depression, anxiety and reported reduced interference in daily functioning due to mental health problems. High client satisfaction ratings also provide evidence about Cyb service acceptability. Participants who completed CyB programming reported feeling less marginalized and less isolated from society as well as feeling more connected to their culture.

Our qualitative data findings corroborate positive client outcomes from the SWE measure. The use of focus groups to elucidate the nature and perceived effectiveness of CyB services proved to be successful. A representative sample of adult consumers from each of the four CyB service sites was accomplished. The findings offer perceptions about this innovative services model from the perspective of Latino clients whose voices are not often heard in traditional research or evaluation settings.

All focus group participants that were interviewed had very positive perceptions about the CyB staff and highlighted the staff showed professionalism and a caring interpersonal quality. A number of core themes emerged in the focus group sessions. Participants felt welcomed, important, and felt that their problems and concerns were taken seriously in a professional way. When asked about knowledge gained from CyB, specifically regarding mental health, participants were very satisfied with the knowledge gained about stigma and repeatedly mentioned how the CyB services helped them identify and communicate about sources of personal and familial stress, conflict, and depressive symptoms. In addition, participants gained knowledge about the importance of communication within the family, the connection between

physical health and mental health. Promoting cultural resilience was noted throughout. Concepts of “familismo” were emphasized, as was the concept of “confianza.”

These are essential aspects of CYB that help engage and retain clients in services. Traditional healing practices were mentioned by numerous participants as a well-accepted, culturally appropriate mental health care that emphasizes ‘carino’, a form of cultural respect and interpersonal interaction seen in traditional settings. When asked if the CyB program helped their families, participants expressed they were happy, relaxed, and noticed a change for the good. Some indicated they had a better attitude, and some felt more family unity. Other CyB services participants received was Drumming Therapy, which helped with anxiety and Zumba exercise classes. School-based programs for youth (Joven Noble) were also noted.

Valued highly among CyB focus group participants included a sense of fellowship, a positive caring environment, ongoing support, and the constant flow of information and resources. Also, the encouragement to participate in activities/groups was appreciated. Some suggestions for improving CyB services emphasized expansion of current services and the need for more community outreach to let others know about CyB.

Taken together, the findings here support the richness of CyB as a community based, early intervention and prevention program. The program model and services offered are highly valued, regardless of the service location. The qualitative findings augment other quantitative CRDP findings about the success of CyB.

Impact of COVID19 on CyB

The COVID19 pandemic has had a significant impact on the work we do at CyB. The initial months of shelter in place in the spring and summer of 2020, sent our teams scrambling to try to adapt to the virtual mode of communication with clients and among staff, while at the same time trying to stay in touch with clients and community at large at a time when stress, fear and anxiety were at its peak. From securing equipment to training ourselves and our clients on the use of video-communication to provide psychoeducational services in a safe yet effective manner and ensuring that the most vulnerable stayed connected to our program, we had to overcome many hurdles to ensure we remained open and accessible to our communities. All of our centers closed down completely for more than a year and no site or home visits were not permitted during this time, making it impossible for us to meet our clients in person. For a program and model that relies heavily on the direct contact with individuals to build trust and create a safe and appropriate environment, this was a major change in our model and culture. Overnight rooms full of families, kids, youth, and seniors went empty and they all had to learn how to connect on videoconferencing to be able to participate in our events. Truth be told, we still don’t know the full impact of this new way of serving our clients in the quality and number of services they received during the worst of the pandemic. The creativity and resiliency of the teams was remarkable as they continued to find ways to stay close to their clients with daily phone check-ins, socially distanced visits, and drive-through events where educators showed up in their cars with groceries at people’s homes and from their cars waved and called to check in

on participants. Some group activities moved outside to the front lawn of people's houses or in the parking lot of senior centers. We quickly moved to ensure that food and other necessities were met for our clients, delivering gift cards, meals, groceries, face masks and other toiletry. Individual sessions over the phone or on video call became the norm and educators had to work from home managing their own family lives while assisting people in crisis. Team meetings also moved to virtual and soon we adopted this mode and made the best of it with meditation and other self-care activities as well as icebreakers and other ways to keep everyone engaged and active. The pandemic has left a devastating mark of loss, grief, struggle, and pain in our communities, this is the work ahead for CyB as we attempt to return to the new normality. The resiliency of the communities we serve was also incredible, as people soon learn how to use their smartphones and tablets to stay in touch with our program and with one another. Networks of support formed quickly to provide everything from food, resources, money, and emotional support in the community. People also resorted to social media and other forms of virtual communication to build connections and many friendships and collaborations were started during this period as people found commonality in their reality and struggles. Advocacy and organizing have become ever more essential and new leaderships have emerged during this time that we hope will carry us through the next phase in the pandemic. CyB is well positioned to continue to assist communities in their plans and processes to confront the challenges ahead from the perspective of wellness and mental health prevention.

What is Next for CyB

Over the next years, CyB will continue its work dismantling stigma and promoting health and wellness in our communities. We are pleased with the findings of this evaluation showing that our individual visits have helped our clients in reducing stress, depression, and anxiety symptoms. We plan to engage in a conversation with staff members about ways to enhance our practices and compile a more formal guide that can be more easily shared among educators and partnering agencies so that we can benefit from each other's knowledge and experience in managing these challenges among our clients. We also recognize that in the areas of cultural resiliency and cultural connectedness, this evaluation showed no significant change among participants in early intervention services. We plan to assess why that is the case by looking at the cultural and traditional knowledge content in the materials that educators use and interviewing educators to gather more information about these areas. While we do that, we theorize that since educators have not received training and support to reinforce their knowledge about traditional healing and cultural practices for wellness in a long time, their level of knowledge, understanding and confidence in sharing this with their clients might have diminished over time. This in turn results in clients receiving much less of this type of information and skills during individual sessions and thus they report little change in how our program helps them in using culture and the resiliency we acquire from it to cope with mental health challenges. Along similar lines, we think that it is still possible that this little change may be due to the fact that many of our clients come into the program with an already existing strong sense of cultural and community connectedness and that may be one of the reasons why they come to our program in the first place. If that is the case it is possible, we are doing something right in the way we present the program to the community and other agencies that

attract this type of clients to our program. If that were to be the case, it might be important for CyB to determine what is that exactly and explore enhancing it and/or replicating it. Even during the ongoing global public health crisis, our program has taken a series of steps aimed at strengthening our collaboration and consolidating, improving, and expanding our services. Internally, CyB has set a series of ambitious goals to ensure that our work continues to be relevant to our community and that our services respond to their needs and aspirations, while at the same time we continue to improve the quality of our work. These initiatives include 1) CyB curriculum development, 2) Ongoing evaluation and quality improvement of CyB programming and services, 3) Addressing existing health disparities within the Latinx community in Alameda County, 4) Increase client and community input and participation in our programming and 5) assess and address the impact of the COVID19 pandemic in our community and in our work. A recently launched curriculum development committee has been tasked with creating curriculum and educational materials that respond to the unique needs of our communities as well as reviewing and adapting existing materials to make them relevant to the culture, language, and context of our client-base. The committee is composed of staff members from all partnering agencies including administrators, mental health specialists and health educators. We hope that in the next few months this group will produce the first series of workshops on stigma that will bring a consistent way of addressing the issue in our community across all the collaborating agencies. While this is happening, our administrative team has developed and put forward a series of goals to measure the quality of our services and the effectiveness of our programs and is in the process of developing tools and methods to collect and analyze data as well as a process to review this data with the intent of creating quality improvement strategies. The goal of this initial work is to eventually convene a CQI committee that can evaluate and provide feedback and support across the collaborative on service improvement efforts. Part of the data collection effort will be geared towards gathering information that will allow our program to track existing health disparities across ethnicity, gender, sexual orientation, and age groups. Our partners at Alameda County Behavioral Health Services have agreed to support our program in this effort with providing us some of the data they collect already for these purposes. We hope this will eventually translate into an increased ability by our program to identify and address the systemic causes of these health disparities. Similarly, in the next few months our administration team will engage coordinators and staff in a conversation about COVID19 healing in our community. This will include a process to engage community members and other stakeholders to gather their input and to assess the magnitude and nature of the impact of the pandemic in the wellbeing of their communities. All these actions along with the evidence gathered of the effectiveness of our model, we hope will help CyB become more established and access additional support and resources.

In terms of expanding services, CyB is preparing to launch a new leadership development program in October of this year, in which we will train a new cohort of Health Promoters to become educators, system navigators and advocates in mental health in our communities. We will make a special effort to recruit and train from the emerging Indigenous communities in Alameda to ensure their voices are heard and their communities are reached with services and engaged in any future planning efforts. Additionally, we will formalize our relationship with an Indigenous-based group called Grupo Desarrollo Maya to have them support our program with

feedback and ideas on programming and services to meet the needs of the growing Maya-Mam population in our area.

Finally, as noted in the results of this evaluation, our program helps participants in reducing feelings of being racially or ethnically discriminated against, which we think is critical in helping them maintain their wellbeing and have a more positive experience when accessing our services. This finding is in line with our program's committed to addressing the issue of racial equity and otherwise systemic racism as we see these two issues as key in addressing mental health and wellness in our communities. We are currently in the process of seeking funding to bring Mental Health First Aid training to service providers, teachers, and others in our community, including first responders, and police officers. The hope is to integrate issues of racial-bias, de-escalation, and adequate management of mental health crises into their daily interactions with communities of color. If all goes well, this program could be launched early next year.

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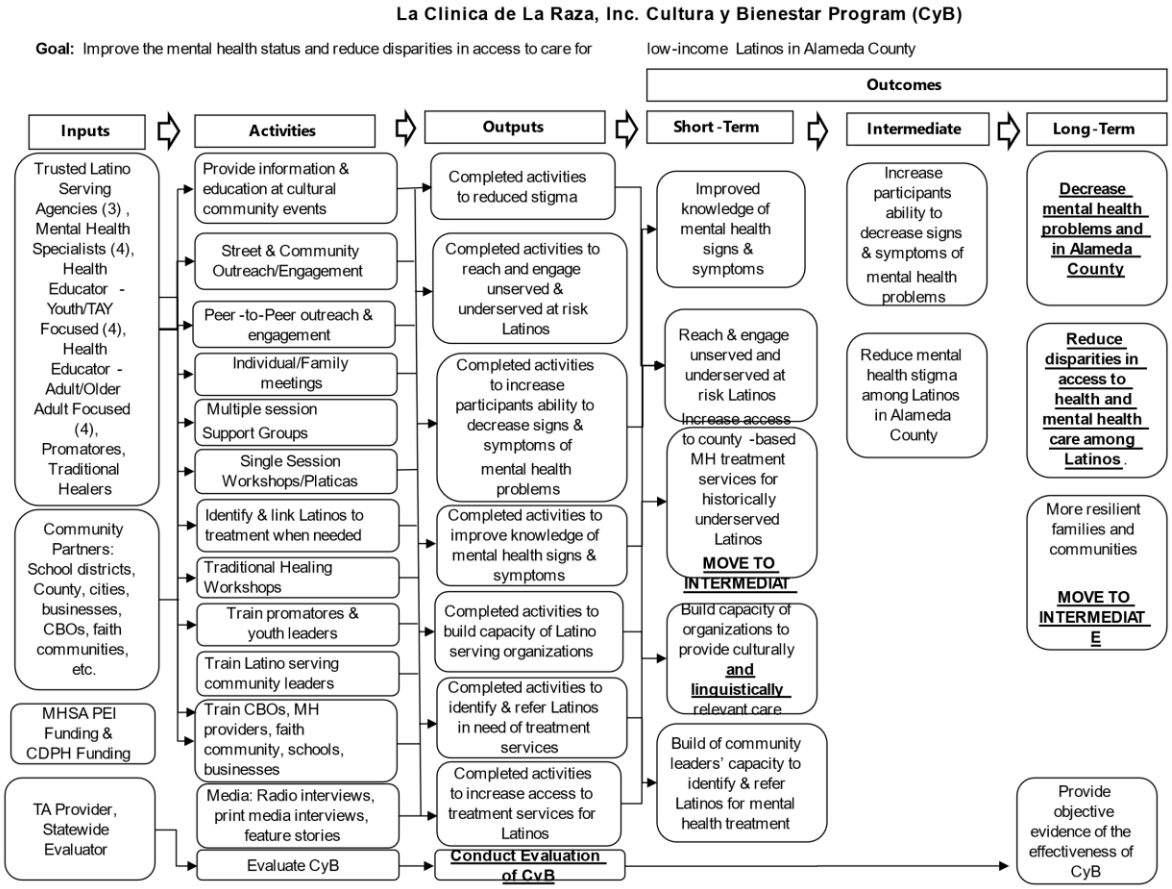
Appendices

Appendix 1



Appendix 2

Table 1: Client Demographic Profile	N=96 Baseline Participants
Gender	
Male	7%
Female	93%
Genderqueer/Gender Non-Conforming	1%
What is your sexual orientation?	
Heterosexual	91%
Bisexual	2%
Gay	6%
Age	
Between 18-29 years of age	19%
Between 30-39 years of age	30%
Between 40-44 years of age	18%
Between 45-49 years of age	11%
Between 50-64 years of age	18%
65 or older years of age	4%
What is your race or ethnic origin?	
Latino, Hispanic, or Spanish	99%
● Mexican	76%
● Salvadoran	8%
● Guatemalan	8%
● Honduran	3%
● Peruvian	1%
● Colombian	1%
● Nicaraguan	1%
● Other (Argentinian, Bolivian, Venezuelan)	3%
Multiracial	1%
How well can you speak the English language?	
Fluently	13%
Somewhat Fluently	25%
Not very well	30%
Know some vocabulary, but can't speak in sentences	15%
Not at all	17%
What is your preferred language?	
English	10%
Spanish	90%
Were you born in the US?	
Inside the US	14%
Outside the US	83%
Refused	3%
Have you ever spent time in a temporary area for refugees or displaced persons or been held at ICE facilities?	
Yes	9%
No	80%
Refused	2%
Don't Know	3%
Not Applicable	6%

Appendix 3

PROTOCOL FOR CyB CALIFORNIA REDUCING DISPARITIES EVALUATION DATA COLLECTION
PRE-POST Statewide Evaluation (SWE) Measure Data Collection

All clients who receive individual outpatient mental health counseling services lasting up to 6 sessions are eligible for participation. Clients are eligible for the CRDP Evaluation if they are adolescent (ages 12-17) or adults (18 and older). The La Clinica "Blue Form" will be completed for all eligible counseling clients

1. Starting June 1, 2018, all eligible counseling clients at any one CRDP Site (Familia, Tubercio, La Clinica, La Clinica – East) will be randomly selected.

2. Random selection will be done by selecting the 3rd eligible counseling client beginning with all new clients as of June 1, 2018, at each site. Site Coordinators will oversee the randomization

3. The randomly selected counseling client will be offered to participate in the CRDP Evaluation and given a verbal summary of the evaluation study, including participant incentive payment. The Site Coordinator (or trained assistant) will provide this summary.

4. If the eligible client declines or refuses to participate in the evaluation study, randomization will proceed by offering the next eligible counseling client (6^{th} client) with an opportunity to participate. Repeat Step Above.

5. The randomly selected counseling client will be provided with the written CyB consent form. The Site Coordinator (or trained assistant) will read the consent form with the client and obtain client signature. A copy of the consent form will be provided to the client.

6. The CyB Project Director will be provided with the name and copy of the signed consent within 24 hours.

7. The CyB Project Director will use the SWE Instructions for assigning a unique ID# to be included on all SWE Data Collection Measure Surveys.

8. The CyB Project Director will maintain a master list of all evaluation study participants and their CRDP

9. The Site Coordinator will schedule a time for the client to complete the on-line (Qualtrics) or paper and pencil version of the SWE Pre Test Survey.

10. The Site Coordinator will administer the SWE Pre Test Survey to the selected client.

11. The Site Coordinator will confirm completion of the SWE Pre Test Survey with the CyB Project Director within 24 hours.

12. If a paper and pencil version of the SWE Pre Test Survey was collected, it will be scanned to the project evaluator (upload to designated Drop Box).

13. All SWE measures will be uploaded to PARC LMU on each Friday by CyB clerical staff – Confirmation from PARC will be distributed to PD and Evaluator

Appendix 4

Program/Staff Satisfaction	N=61 Participants
I like the services that I received here.	
Strongly Agree	84%
Agree	16%
If I had other choices, I would still get services from this agency.	
Strongly Agree	80%
Agree	18%
Disagree	2%
I would recommend this agency to a friend or family member.	
Strongly Agree	82%
Agree	18%
The location of services was convenient (parking, public transportation, distance, etc.).	
Strongly Agree	51%
Agree	23%
I am Neutral	5%
Strongly Disagree	2%
Staff were willing to see me as often as I felt it was necessary.	
Strongly Agree	69%
Agree	26%
I am Neutral	5%
Services were available at times that were good for me.	
Strongly Agree	75%
Agree	20%
I am Neutral	5%
When I first called or came here, it was easy to talk to the staff.	
Strongly Agree	77%
Agree	20%
I am Neutral	2%
Not Applicable	2%
The staff here don't think less of me because of the way I talk.	
Strongly Agree	77%
Agree	23%
The staff here treat me with respect.	
Strongly Agree	83%
Agree	17%
The staff here respect my race and/or ethnicity.	
Strongly Agree	82%
Agree	16%
I am Neutral	2%
The staff here respect my religious and/or spiritual beliefs.	
Strongly Agree	85%
Agree	13%
I am Neutral	2%
The staff here respect my gender identity and/or sexual orientation.	
Strongly Agree	80%
Agree	16%
I am Neutral	2%
Not Applicable	2%
Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	

Strongly Agree	72%
Agree	26%
I am Neutral	2%
The people who work here respect my cultural beliefs, remedies and healing practices.	
Strongly Agree	67%
Agree	28%
Not Applicable	5%
Staff here understand that people of my racial and/or ethnic group are not all alike.	
Strongly Agree	61%
Agree	34%
I am Neutral	3%
Not Applicable	2%
Staff here understand that people of my gender and/or sexual orientation group are not all alike.	
Strongly Agree	59%
Agree	31%
I am Neutral	5%
Not Applicable	5%
Staff here understand that people of my religious and spiritual background are not all alike.	
Strongly Agree	67%
Agree	28%
I am Neutral	3%
Not Applicable	2%
As a direct result of my involvement in the program: I deal more effectively with my daily problems.	
Strongly Agree	58%
Agree	39%
I am Neutral	2%
Not Applicable	1%
As a direct result of my involvement in the program: I do better in school and/or work.	
Strongly Agree	50%
Agree	29%
I am Neutral	5%
Not Applicable	16%
As a direct result of my involvement in the program: My symptoms/problems are not bothering me as much.	
Strongly Agree	48%
Agree	33%
I am Neutral	16%
Disagree	2%
Strongly Disagree	2%
Were the services you received here in the language you prefer?	
Yes	100%
Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available in the language you prefer?	
Yes	77%
No	16%
Don't Know	7%

Appendix 5

CyB Focus Group Participant Demographics 2019	Date: November 4-5, 2019
Locations: La Clinica, La Clinica East Bay, La Familia Hayward, Tiburcio Vasquez.	Total Participants: N=23
Gender- How would you describe yourself?	
Female 19= 90% Male 2=9%	
Age Range	
18-35 (5=22%) 36-45 (7=30%) 46-55 (6=26%) 56 and over (5=22%)	
Where you live now, who lives with you?	
Spouse 10=43% Partner 4=17% Children 17=74% Mother 3=13% Father 2=9% Stepfather 1=4% Brother-Sister 5=22% Grandparents 1=4% Other Adults 2=9% Other Kids 1=4%	
What is your marital status?	
Single 4=18% Married 11=50% Separated 3=14% Divorced 1=4% Living with someone 1=4% Widowed 1=4% Other 1=4% (Single Dad)	
Do you have children?	
No 4=17% Yes 19=83%	
How many persons live in your home?	
The number of persons living in the participants home ranged from 1-8 persons	
Were you born in the United States?	
No 20=87% Yes 3=13%	
If Non-US Born (How long in this County)	
The average number of years participants have been in the U.S is 18 years	
What is the primary language spoken in your home?	
Spanish 22=96% English 1=4%	
Are you Hispanic or Latino?	
Hispanic or Latino 21=91%	
How would you best describe yourself? (Ethnicity)	
African American/Black 0% White 0% Asian/Asian American 0% American Indian/Alaskan Native 0% Mexican/Mexican American 17=74% Central American 4=17% El Salvador/Guatemala South American 1-4% Puerto Rican 0% Other 1=4% (Hispanic)	
What is the highest level of education?	
The highest level -of education ranged from Second grade through College Senior Completion	
If less than 12 years (12th grade) do you have a GED?	
No 15=88% Yes 2=12%	
What is your current employment status?	
Employed full time 4=18% Employed part time 4=18% Unemployed, looking for work 1=4% Unemployed, not looking for work 6=27% Unemployed, disabled 1=4% Unemployed, retired 1=4% Other 5=23% (Homemaker, Own Business)	
About how much income did the whole household have in the past year?	
0-5000 16% 10,001-15,000 10% 20,001-30,000 5% 30,001-35,000 21% 40,001-45,000 21% Over 45,000 21%	