La Familia
COUNSELING CENTER

Centro de Apoyo Latino

Implementation Pilot Project

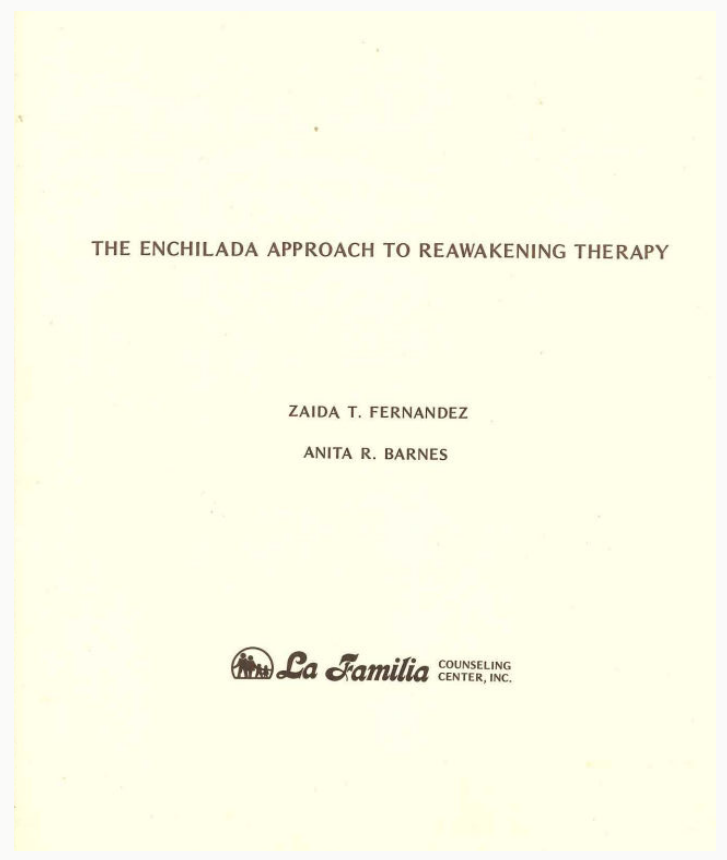
California Reducing Disparities Project
Phase 2

November 2021

La Familia Counseling Center
5523 34th Street, Sacramento, CA 95820
Rachel Rios, Executive Director
Phone: (916) 452-3601
Email: rachelr@lafcc.org
Website: www.lafcc.org

Evaluation prepared by Jesus Hernandez, PhD,
Research Consultant , JCH Research

We acknowledge the visionary work of the founders of La Familia Counseling Center who developed the "The Enchilada Approach to Reawakening Therapy" – Zaida Tormes Fernandez, Anita Ramos Barnes, and Oralia Bermudez for which the Centro de Apoyo Latino was based upon.
Their implementation of this model has continued to inspire hope.



La Familia Counseling Center - Centro de Apoyo Latino

Rachel Rios, Executive Director

Mark Dandeneau, Programs and Behavioral Health Manager

Jessie Armenta, Clinical Director

Emilio Ramirez, Clinician

Veronica Briody, Clinician

Rocio Daujan, Community Mental Health Worker

Rosa Rosas, Community Mental Health Worker

Alejandra Cruz, Data Entry Specialist

Acknowledgements

The Board of Directors, Executive Director, administration and staff of La Familia Counseling Center, wish to acknowledge the California Department of Public Health, Office of Health Equity for selecting La Familia Counseling Center's - Implementation Pilot Project, "Centro Apoyo Latino" as part of the California Reducing Disparities Project. This important funding provided to review and assess the culturally responsive services delivered through the Centro de Apoyo Latino (CAL) program was critical in validating this Community Defined Evidence Practice.

La Familia acknowledges the key work of Principal Investigator, Dr. Jesus Hernandez PhD, Research Consultant JCH Research, for the design and conduct of the evaluation, and for preparing much of this report. His commitment to research integrity and his tremendous expertise were essential to the success of this project and are greatly appreciated.

Special thanks to others who supported Dr. Hernandez's work such as Dr. David Nylund, Clinical Director of the Gender Health Center, who initiated the Feedback Informed treatment (FIT) for CAL clients. We thank Ms. Susana Morales, Special Development Consultant, Leap Solutions, for providing leadership, facilitation and training for service providers and for conducting the client interviews. Thanks to Dr. Maria Trejo and La Familia's Behavioral Health Director, Mark Dandeneau for their review of the report and their technical support.

We thank the staff of the Statewide Evaluators and all of the staff at the Office of Health Equity who were a valuable and supportive part of this process. Many thanks to the UC Davis Center for Reducing Health Disparities Technical Assistance Providers (TAP) and all their staff including Dr. Sergio Aguilar-Gaxiola, Cassie Chandler, Dr. Health Diaz, Gustavo Loera and Rachel Guerrero for all of their support and encouragement.

Thank you to the entire staff and administrative leadership of the various programs and offices at La Familia Counseling Center for their tireless work and dedication. A personal thanks to Lynn Keune, La Familia's retired Clinical Director who was devoted to this work and project, and to the invaluable current and previous staff at CAL: Marianela Applegren, Veronica Briody, Cesar Castaneda, Alejandra Cruz, Rocio Daujan Adriana Martinez, Rosie Ramos, Emilio Ramirez, Mao Vang, and others who have been dedicated to provide the CAL services to improve wellness in the Hispanic community served by La Familia.

We give special acknowledgements to the Community Advisory Board (CAB) composed of CAL clients and community members for their valuable and ongoing feedback on the pilot, service quality and client satisfaction. Most importantly, thank you to the Hispanic community for the trust you continue to place in all of us.

Table of Contents

Executive Summary

This evaluation report reviews La *Familia* Counseling Center's service delivery model – *Cultura de Salud* within their *Centro de Apoyo Latino* (CAL) program. CAL is a community based mental health program using a Community Defined Evidence Practice (CDEP). It is a delivery model based on *La Familia*'s "*Enchilada Approach to Reawakening Therapy*."

In 2016, the California Reducing Disparities Project (CDRP) a statewide mental health intervention program administered by the California Department of Public Health, Office of Health Equity, selected the *Centro de Apoyo Latino* (CAL) as part of a demonstration project to evaluate Community Defined Evidence Practices (CDEP). The CAL program was selected as an innovative strategy for delivering health and wellness services.

One main goal of the CAL CDEP pilot was to demonstrate the value of culturally and linguistically appropriate treatment and intervention strategies at the community level. The premise is that such services can advance the wellness and resiliency of Latino families and reduce risk factors that lead to increased anxiety, trauma, stress, reduced retention rates and costly higher-level services. The CAL CDEP proposed to determine: "**To what extent do culturally defined service delivery practices improve access and utilization of mental health services for the Latino population**?" This evaluation was further refined as follows:

- To what extent did program participation strengthen individual wellness and resilience?
- To what extent did program participation reduce risk factors to mental illness?
- To what extent did the program approaches improve retention in CAL services?

The evaluation of the CAL CDEP reports a positive link between client stabilization and wellness and a culturally focused approach to service design and delivery for adult Latinos. It presents a rare opportunity to understand the value of integrating cultural principles for wellness in a community mental health program design and provides an opportunity to empirically demonstrate culture as an important ingredient for wellness.

The CAL service approach to community mental health program design is a service delivery model that integrates cultural principles that guide Latino family and community life into the practice and program *La Familia's* approach to making mental health services accessible to the Latino community has been in place for over 45 years. Agency founders recognized the importance of having community mental health services that were culturally and linguistically appropriate. They developed these cultural principles and outlined them in their book, *"The Enchilada Approach to Reawakening Therapy"* (Fernandez and Barnes, 1978). *The Enchilada Approach to Awakening Therapy* identifies eight key culturally based principles deemed essential for delivering effective community-based mental health. The principles include:

- Culture is collective not individualistic. The individual and community are interdependent and equally important;
- Services are embedded in the community and delivered by an authentic community-based agency;
- Responsibility for change is shared between client and staff;
- Mutual respect and value are always present for each other;

- Freedom to move forward is personal, but limitations and impairments must be explored and considered;
- Sincere engagement with healthy boundaries is practiced between client and staff;
- Emphasis is placed on the whole family; and
- Respect and understanding of cultural values are essential.

These eight principles are what makes up the *Cultura de Salud* (Culture of Health). They guide the daily practice of community service and mental health at CAL, and also the service delivery for all programs at *La Familia*.

The CAL CDEP applies this culturally informed program design through three modes of service delivery: outreach and educational workshops to engage community, reduce stigma, and provide information and access to other services; short-term individual and group therapy with a licensed therapist to provide for immediate intervention and stabilization; navigation services, from *Promotoras* (Community Mental Health Workers) who provide support services and a "warm hand-off" for longer-term services to other community agencies.

The results of the evaluation of CAL CDEP indicate that culturally and linguistically appropriate services are effective in improving wellness and resiliency of Latino families, reduce risk factors, and consequently, have the potential of reducing costly and higher-level interventions.

The evaluation and conclusions are based on data and information gathered from a variety of sources, over a five-year period. The pilot and key findings include results from 374 pre intake interviews and 338 post interviews. Staff studied client satisfaction from formal assessments conducted after therapeutic sessions. Feedback was collected from clients via questionnaires distributed during webinars and community events. Observations were gathered from multiple observers, staff and service providers. Demographic data and general health information were collected. The work was informed by a thorough review of related research and current practices. Additionally, a Community Advisory Board (CAB), consisting of community members, many of whom participated in the CAL program, was created to ensure fidelity to the pilot. It helped to identify client needs , quality of care and to ensure that authentic community engagement remained a priority of the program.

Given concerns with analyzing the effects of culturally driven community health programs, this evaluation combined multiple observers, theories, methods, and empirical materials. This strategy was used to overcome, to the extent possible, many of the weaknesses, biases, and problems that come from single method, single-observer, and single-theory research designs. One important undertaking for this evaluation was to avoid the problem of reducing the value of cultural designs for wellness to presumed rituals that lack merit or knowledge of healing. Acknowledging that cultural practices can also function as healing practices that come with generations of knowledge, it is vital to not only the design of community mental health programming, but also to the way that programs are evaluated. This recognition allows evaluators to infuse scientific methods into the evaluation process in a manner that highlights, rather than ignores, important cultural indicators of and for wellness.

This evaluation incorporated both scientific and cultural approaches to understanding conditions that impact community mental health care delivery. The high rate of positive changes in client wellness and the results captured for the evaluation, required multidimensional methods of evaluation in order to capture the "whole client condition." Multidimensional cultural designs of the eight principles required a

variety of instruments and data gathering inputs for the evaluation. This approach helped avoid reducing the value of cultural designs to presumed rituals that lack merit or knowledge of healing**.** Instead, they were validated as ways of healing that come with generations of knowledge - as holistic approaches to humanizing the intervention and healing process, approaches that leverage basic principles for living inherent to the practice of culture, community building, and promoting community health.

A key objective of the CAL CDEP study was to demonstrate the impact of cultural rituals and practices on wellness and mental health interventions and prove that this could be scientifically evaluated. The findings would indicate that, with the use of multiple data collection points and triangulated research practices, it is possible to scientifically evaluate the complexities and effectiveness of culturally embedded wellness and health services in minority communities. Two schools of thought were merged: The use of scientific methods to understand the value of integrating cultural principles for wellness, and community mental health program design. To overcome weaknesses, biases and problems that come from single method, single-observer and single-theory research designs, four data sources were used to evaluate the effectiveness of the CAL CDEP: 1) Statewide Evaluation (SWE) data generated during intake interviews; 2) Feedback Informed Treatment (FIT) data generated from clients evaluating the quality of their therapeutic session following each visit; 3) data on navigation services performed by community mental health workers; and 4) interviews with CAL staff and clients.

These four data sources showed that prior to receiving CAL services, clients experienced high levels of emotional distress. Clients showed indicators of suicidal tendencies, severe depression, domestic violence, Post Traumatic Stress Disorder (PTSD) from physical abuse experienced in earlier years, and the effects of Adverse Childhood Experiences (ACES) (which were now emerging in their adult years). Many clients were having problems in managing simple day-to-day social activities.

Following treatment in CAL, the data showed that clients self-reported significant improvements in their ability to manage their emotions in daily social relations. The following are key findings:

- Ordinal Logistic Regression showed that post treatment clients were nine times more likely to report improved ability to manage work/school activities than pretreatment clients. The results also showed that post treatment clients were eight times more likely to report improvements in the ability to manage household chores, improvements in social life (nine times more), and improvements in relationships with family and friends (six times more). The regression analysis provided compelling evidence that clients experienced significant improvements in their ability to manage their emotions in daily social relations after completing treatment in CAL.

- Structural Equation Modeling used for a latent variable analysis of key wellness indicators from the Kessler Psychological Distress Scale captured in the SWE dataset found a 1.244 difference (standard deviations) in the standardized pre and post treatment mean values suggesting a very high indication of positive change for CAL clients. Generally, a change of 0.5 standard deviations is considered a very high indication of change.

- Using the Jacobson Plot method to interpret FIT therapy session data, the average CAL client experienced a positive significant change that is beyond a trivial amount of day-to-day fluctuation. Approximately 78% of CAL clients reached or exceeded target scores indicating improvements in wellbeing. The results of the FIT data strongly suggest that alliances of trust, so important for effective therapy and stabilization to occur, were highly effective. These alliances contributed to

the client's willingness to engage in therapy, thereby encouraging utilization and retention, which are critical for reaching some degree of stabilization.

- Navigation services were assessed and are important to mitigating the problems and conditions clients experience when seeking other services/assistance that can lead to additional severe emotional distress. During the pilot, CAL received 855 requests for navigation services. The average number of requests for navigation services per client was 2.6 with a range from one to 16 requests for assistance. Approximately 68% of all requests were related to health services, social welfare, and legal and law enforcement related issues; giving us an idea of the problems clients face as they seek assistance for emotional distress.

- The CAL team approach, with both therapist and community mental health workers creating effective therapy and resource plans to reduce immediate danger and risk factors for each client, contributed to the high retention rates of clients with no dropouts from therapy. Interview data captured the extraordinary efforts and number of hours *Promotoras* spent in connecting clients with resources and services such as health providers, nutritional and short-term financial assistance, legal and immigration services, police intervention, domestic violence and protective services, and services through the family courts. City and County COVID-19 protocols made their efforts even more time consuming.

- Content analysis of transcribed client interviews and staff focus group data revealed a strong relationship between evaluation indicators such as Changes in Wellness and Service Satisfaction and the program's eight culture-based principles. Emphasis on the Whole Family, Mutual Respect, Respect and Understanding of Culture, and Sincere Engagement were emphasized by clients as important factors that connected clients to the program. The content analysis leads to two key findings. First, CAL clients view cultural competence, cultural sensitivity, and language as important to the wellness process. Second, respect for the client and acknowledging the importance of the family may be equally important to the wellness process. The connections between the eight principles and evaluation indicators suggest that successful community mental health intervention may very well be a cultural process.

The statistical analysis of the SWE data suggests that clients experienced significant and positive changes in wellbeing during their participation in CAL. The review of FIT data on client/therapist alliances suggests strong and positive alliances needed for successful therapy occurred without any dropouts. The review of requests for CAL Navigation Services were overwhelming and reflected the significant amount of external conditions CAL patients faced in navigating to access resources critical for stabilization. The high demand for navigation services validated the multidimensional approach CAL staff used to provide a process of care. An extensive analysis of client interviews also revealed the multidimensional and interdependent characteristics of service satisfaction as well as the eight principles used to guide CAL services. Data collected from individual and group therapy sessions strongly suggests that when trusting relationships between therapists and service providers are established, persistence to seeking help and therapy then stabilization occurs.

One point is clear from this evaluation – Latino clients are ready to seek mental health assistance. They are no longer waiting for public agency referrals. Culturally sensitive community education over time is leading to reduced stigma, increased awareness, and trust. Clients are willfully seeking help. Moreover, navigation services remain an important part of the trust clients need to engage in therapy. Accessing public services safely and respectfully is essential to keeping the trust gained by clients. The results are

increased utilization, significant changes in wellbeing, and increased engagement with family and community. Moreover, the impact is even more compelling - there were no psychiatric hospitalizations, no increase in costs for higher-level services, and no suicides reported for CAL program participants.

An important observation from reviewing the interview data was how, time after time, clients repeatedly expressed their gratitude to the CAL staff for their assistance and selfless commitment. Every interview described the efforts that CAL therapists and *Promotoras* would go through to ensure clients' success in therapy. Clients continually pointed to the CAL environment as a positive space for wellness. Perhaps a client's words provide a better perspective on why this program is so successful…

> "*Porque soy respetado. Soy bien recibido. Me dan mi tiempo para explicar mis cosas. Me escuchan. Y más que todo como familia. Lo siento la verdad." ["Because I am respected. I am welcomed here. They give me my time to explain my things. They listen to me. And, most of all, it's like family. It's the truth."]*

Understanding community mental "wellness" as a cultural process with multidimensional characteristics allows one to consider holistic approaches to humanizing the intervention and healing process. Approaches to service delivery that leverage the basic principles for living, that are inherent to the practice of culture, community building, and promoting community mental wellness, are essential for promoting community mental health. The knowledge gained from this evaluation suggests that: it is possible to develop evaluation strategies that are also "multidimensional."

The fact that program design was centered on cultural principles and practices for healing and wellness that considered the client's social, historical, and economic surroundings, suggests that culturally based programming is important in community mental health service delivery. Accordingly, one important conclusion of this evaluation is that context matters and needs to be considered in developing mental health service delivery programs to those most at risk.

When we fully embrace those holistic approaches to mental health that are rooted in cultural designs, we can understand the dynamics of healing, at the community level, and we can leverage culture, as well as expertise in the people in our communities as essential assets required for urgent public health interventions. Efforts must be made to ensure that these approaches to wellness are properly and impartially considered in the planning of community mental health programs.

Introduction

In 2004, California voters passed the Mental Health Services Act (MHSA or Proposition 63). The Act was designed to transform mental health delivery systems in the state to better serve individuals with, and at risk, of serious mental health issues. Though the failure to provide timely treatment can impact individuals and families, an important focus of the MHSA is to improve prevention and early intervention services to effectively support the public behavioral health system. The MHSA directs the state to expand the kinds of successful, innovative service programs for children, adults, and seniors to include culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.[1]

To further the MHSAs mission of reducing mental health disparities, the California Department of Mental Health initiated the California Reducing Disparities Project (CRDP) in 2009 to promote community-defined evidence and population-specific strategies for reducing disparities in behavioral health. The CRDP consists of several community-grounded Implementation and Pilot Projects (IPP), also known as Community Defined Evidence Projects (CDEP). These IPPs incorporate innovative community-defined, culturally situated mental health practices specifically targeted at reducing mental health disparities, improve access and quality of care, and increase positive behavioral outcomes for racial, ethnic, Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ), and cultural communities in California. The CRDP also requires the evaluation of these pilot projects, which provides a unique opportunity to offer evidence of the impact and value of community mental health services that prioritize the use of culture as a key component of program design. At issue with services provided in the past has been the lack of rigorous evaluation and research to support their long-standing impact and effectiveness of various delivery models. Thus, the CDEPs were tasked with implementing 5-year pilot projects, delivering strategic services, and evaluating these by independent state and individual researchers.

In 2016, *La Familia Counseling Center* was one of seven CDEPs selected by the California Department of Public Health to demonstrate how the use of culturally and linguistically appropriate treatment and intervention strategies at the community level was an important component of mental health services. The CAL program addresses culturally and linguistically appropriate treatment. The premise is that culturally and linguistically appropriate treatment is needed to improve the wellness and resiliency of Latino families and reduce risk factors that, if left unmet, will lead to reduced participation and retention rates and result in higher-level services and costs. The program proposed a multi-level approach to engage Latino community members, build trust and understanding about mental health, wellness and illness. In a culturally and linguistically appropriate fashion, staff would: 1) conduct a variety of targeted outreach strategies which included informative workshops and trainings; 2) provide short-term individual or group counseling sessions with a clinician, and 3) throughout the program, staff (*Promotoras*/ Community Mental Health Workers) would provide navigation and a warm handoff to other needed services.

This evaluation report reviews *La Familia's Cultura de Salud* service delivery model used with the *Centro de Apoyo Latino* (CAL) program as a community-defined mental health project. The projects overall design is to integrate mental health services as a natural public resource that is more accessible to the Latino population who are facing crisis conditions in Sacramento, California.

[1] See the California Mental Health Services Act, Section 3(c). Purpose and Intent.

La Familia's approach to community mental health service delivery was formulated and put into practice over 45 years ago by agency founders Zaida Thormes Fernandez and Anita Ramos Barnes. As early as 1973, Fernandez and Barnes recognized the importance of having community mental health services that were culturally specific. They developed what is known as the *Enchilada Approach to Reawakening Therapy*, which posits that the mental health experience must be understood in relation to both the family and community. This theoretical perspective for community mental health, according to Fernandez and Barnes, "…is distinguished from the contemporary practice of the traditional psychologies by its process: its theoretical views are inferred from daily practice rather than accepted as a theoretical given to be applied in daily practice" (Fernandez and Barnes, 1978). The model developed and outlined eight key principles necessary to gain high levels of client response and engagement based on trust. The premise being that a culturally responsive delivery model improves wellness and resiliency of Latino families. With appropriate and timely services, risk factors such as increased anxiety, trauma and stress would be addressed before becoming critical. The model would also increase retention rates and reduce costly higher-level services for Latino communities.

These eight key concepts (or principles) are essential for the effective practice of Reawakening Therapy in community mental health and provide the foundation for services provided at *La Familia*. These principles provide the context for the CAL program and are the tenets tested for the CDRP Project. They are briefly summarized below.

- Culture is collective not individualistic. The individual and community are interdependent and equally important;
- Services are embedded in the community and delivered by an authentic community-based agency;
- Responsibility for change is shared between client and staff;
- Mutual respect and value are always present for each other;
- Freedom to move forward is personal, but limitations and impairments must be explored and considered;
- Sincere engagement with healthy boundaries is practiced between client and staff;
- Emphasis is placed on the whole family; and
- Respect and understanding of cultural values are essential.

These eight principles that guide the daily practice of community service and mental health at *La Familia* make up what is now referred to as the *Cultura de Salud*, or Culture of Health. Through this approach, *La Familia* has long ago established themselves as a trusted partner for community mental health services in the Latino community. *La Familia* staff are often asked by other local or state agencies to provide support or coordinate services for this often hard to reach community because of the long-standing history of building and maintaining trust, relationships and respect.

The creation of CAL as a CDEP can be seen as a complementary extension of the work *La Familia* has been involved with over the years. When Sacramento County was awarded MHSA funding to implement Prevention and Early Intervention programs, *La Familia* was selected to provide awareness and intervention services for the Latinx community through the Supporting Community Connections (SCC) program. The services included suicide prevention, support services, referral and linkage to other community resources, and community building through outreach and engagement activities. Through this effort, *La Familia* was seen by both community and public agencies as a trusted partner with the capacity

for delivering community mental health services to children and adults. However, SCC is focused on prevention and does not provide funding for therapeutic services to adults resulting in an urgent need for adult mental health services in the Latino community. When the opening of CAL was announced as an effort to help fill the gap in community mental health services for Latinos, referrals from agencies and other providers as well as walk-ins were immediate.

Research dating back to 1978 details how Latinos have faced difficulties in accessing quality mental health treatment, and how providers have failed to appreciate how mental health needs are directly related to cultural and racial diversity.[2] For quite some time, Latinos experiencing a mental disorder have been less likely than non-Hispanic whites to use mental health services (Hough et al., 1987; Vega et al., 1999). Other studies have documented the persistent underutilization and the lack of quality mental health services available to Latinos; one basic issue being how to get quality mental health services to Latino consumers and their families (Lopez, 2002). Corroborating these trends, more recent research from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2018) reported that 6.7 million Latinos in the U.S. experienced some form of mental illness. However, 67% of them did not receive any form of treatment. Of the 6.7 million, 1.5 million Latinos reported suffering from severe mental illness and 44% of this group did not receive any treatment either.[3] Although stigma is usually singled out as a primary deterrent to seeking services, financial barriers also impose huge and persistent impediments to Latinos in accessing mental health services (Aguilar-Gaxiola et al., 2012).

It is important to understanding the setting or context for CAL services is the inner-city location of the program. South Sacramento has been shaped by a number of historical conditions that concentrate poverty, immigration, and racial residency in a pattern that has led to social, economic, and racial isolation.[4] Providing services to mental health clients in the inner-city requires consideration of multiple demographics as well as social characteristics that go beyond just identification as a Latino to acknowledge the overlapping identities and crises now experienced by the Latino population. Racial and gender orientations by themselves can be sufficient triggers for mental illness. However, when combined with, for example, poverty, uncertain housing conditions, deportation fears, and traditional cultural norms in a rapidly changing urban society, symptoms of mental illness will undoubtedly increase, especially with a paucity of options available for care. Added to the crisis-level conditions is the COVID-19 public health pandemic, which ultimately led to a shutdown of the publicly administered social determinants needed for families and neighborhoods to remain economically and socially productive. Those experiencing higher degrees of poverty were the most vulnerable to its effects.

Also, important to contextualizing the broader conditions of the CAL service area, is the fact that many Latinos in the surrounding rural areas see *La Familia* as a primary and safe connection to services and resources not found in their immediate area. The Sacramento region is an important agricultural hub that depends on a Latino workforce. This predominantly rural population, isolated from services, depends on

[2] See Mental Health in America: Report to the President from the President's Commission on Mental Health, vol I: Number 040-000-00390-8. Washington, DC, US Government Printing Office, 1978

[3] See Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S. 2020. Office of Behavioral Health Equity - Substance Abuse and Mental Health Services Administration. https://www.opioidlibrary.org/document/double-jeopardy-covid-19-and-behavioral-health-disparities-for-black-and-latino-communities-in-the-u-s/

[4] For more detailed information on the historical, geographical, and social processes that provide the specific context for where the CAL CDEP is located, see Racism in Fine Print: How Old Housing Impact Non-White Communities. NBC Nightly News, August 4, 2020. Racism in fine print: How old housing policies impact non-white communities (nbcnews.com)

La Familia as a trusted provider of resources and information. Many clients travel considerable distances to safely access these services.

This combination of urban and rural clientele presents a wide scope of social and emotional factors and conditions that can lead to changes in wellness. *La Familia* staff are trained to understand the multiple ways that a client can be suffering and how they intersect to trigger distress and mental illness. Moreover, because staff are a part of the community they serve, they witness firsthand the intersectionality of these social conditions and how they lead to mental illness.

CDEP Purpose and Description

CALs *Cultura de Salud* (CdS) service delivery model operationalizes the eight culturally responsive principles found in *The Enchilada Approach to Reawakening Therapy* in three ways: 1) outreach, education and awareness programming; 2) individual and group therapy; and 3) navigation services. The CAL project is a program operated by *La Familia* that oversees a multitude of community services and programs within Sacramento, CA. *La Familia* utilizes a "no wrong door" approach to services; therefore, clients may enter into services from a variety of entry points. Clients being considered for the CAL program are initially triaged through *La Familia's* suicide prevention and early intervention program by intake staff and then are referred to CAL for crisis intervention and stabilization activities. While the CAL program operates out of one office at *La Familia's* Maple site, the "no wrong door" approach means that clients may receive navigation services in the community at outreach events or at the main site.

Outreach, Education, and Awareness: *La Familia* provides an array of educational and awareness opportunities to the community that create a nurturing pathway to the CAL program. Through this educational programming, *La Familia* helps to circumvent misinformation and reduce cultural barriers known to impede access to mental health services. Emphasis is placed on making information available that leads to changes in the knowledge, attitudes, beliefs, practices, and behaviors of individuals including *La Familia's* external partners and service providers. Building upon their outreach work with SCC, *La Familia's* community engagement program enhances the connectivity between services and Latino patients in need of critical mental health services. These community-building efforts serve to increase access to and improve utilization of culturally and linguistically appropriate mental health services that can strengthen family stability, resiliency, community cohesion and individual wellbeing.

La Familia staff help build strong local and regional ties to connect to the community through cultural events such as Hispanic Heritage Month, Latino Behavioral Health Week, *Dia del Nino*, *La Familia's* Health and Safety Fair, and various holiday events. Staff also work with many school districts and participate at both in person and virtual outreach events. Presenting parenting and mental health awareness information to school parent groups and student career days serve as examples of the ongoing working relationships with educators. The gatherings are mostly conducted entirely in Spanish and feature social activities, health and exercise classes, educational seminars and other informational presentations. A *Techno Sabios* group for *Manitos* members provides opportunities to learn about basic computer use, how to use Facebook and other social media platforms to reach out to their loved ones in other countries.

A strong commitment to community service places *La Familia* on the front line of important social and public health crises facing the Latino community in Sacramento, including immigration reform and the COVID-19 pandemic. *Platicas*, or informational workshops, such as "Know Your Rights" and "Signs of Suicide" help to correct misinformation on immigration and mental health issues. COVID-19 testing and vaccinations provided a safe and trusted location for Latino residents to access both information and

vaccinations without fear of immigration issues. A committed working relationship with the Mexican Consulate helps to coordinate regional efforts for public crisis intervention, often resulting in partnerships with local governments to fill the gaps in services where government planning and capacity leave off.

Individual Therapy: Clients who need immediate and urgent interventions, as determined by an assessment, are provided individual therapeutic sessions. The sessions focus on crisis intervention and stabilization. Clients attend an average of three to six individual therapy sessions lasting one hour each; generally conducted weekly or bi-weekly. All sessions are led by a licensed therapist whose primary language is Spanish. The sessions, conducted in a private room at the CAL office, provide a safe location for clients to discuss the core issues leading to their emotional distress. Clients learn coping strategies that they can utilize to improve functional impairment and the ability to manage day-to-day social interactions with family and in work settings. The sessions also help inform the development of an individual care plan, developed using a team approach by the mental health therapist and a *Promotora*/Community Mental Health Workers to understand both clinical and resource needs required to promote stabilization. Therapy sessions were initially conducted in person for the first two years of the program, but in response to local government COVID-19 protocols, sessions were conducted through telehealth conferencing with appropriate security and informed consent.

Group Therapy Sessions: For clients with less urgent but critical symptoms of mental illness and family stress care needs, CAL offers 90-minute group therapy sessions guided by a licensed therapist and a *Promotora*/Community Mental Health Worker. This team approach to managing therapy sessions allows staff to observe the types of resources and services clients need to promote long-term stabilization, which in turn can be facilitated through navigation services. Group therapy frequency is once a week for approximately four to six weeks. Group therapy provides the opportunity for clients to begin their integration back to healthy social relations in a safe environment. In these support groups, clients share their experiences and discuss strategies to manage their emotional wellbeing. Clients can address problems such as stigma and actual situations of discrimination and domestic violence in a supportive, constructive environment that allows them to regain a sense of community and connectivity, especially for isolated seniors. Clients provide each other with mutual support through shared experiences and together form new and healthy connections with others as well as to resources in their community. Sessions were initially conducted in person during the first two years of the program but moved to telehealth when COVID-19 protocols limited public meetings.

Navigation Services: CALs navigation services are designed to facilitate the connection to services and resources needed to stabilize crisis conditions. CAL staff understand how delivery systems fail to reach the at-risk Latino population and design programs that can improve access to mental health care. They realize that for their clients, there is much more to mental health intervention than just traditional therapeutic approaches. *The Enchilada Approach to Reawakening Therapy* recognizes that healing and wellness must consider the client's whole environment. Therefore, paths to wellness also require mitigating client conditions that may inhibit the ability to engage in therapy and benefit from treatment. However, access to resources and assistance needed to support stabilization are often out of the reach of CAL clients.

For CAL staff, navigation activities are a team approach with both therapist and a *Promotora*/Community Mental Health Worker collaborating to create effective therapy and resource plans to reduce immediate danger and risk factors for each client. Because discrimination, language barriers, and legal issues (such as deportation) represent very real fears that prevent individuals from receiving the help they need, navigation assistance provides a safety net for clients to access essential services and resources and help

begin the stabilization process. This "warm handoff" to long-term service providers and other support systems works to intervene in conditions of distress that traditional mental health delivery systems are not designed to address. As clients work with CAL staff to safely access resources, they also learn skills on how to safely navigate the mental health system on their own, thereby building client responsibility, awareness, and increasing the chances of long-term utilization.

CAL Community Mental Health Workers, more formally known as *Promotoras*, are linguistically and culturally connected to the Latino community, which allows them to provide a high level of client advocacy. These trusted members of the CAL program provide a variety of supports, resources, and assistance to community members to link them to longer-term services as needed. They help clients with critical referrals and support such as enrollment in Medi-Cal, access to housing, food, and shelter, domestic violence support, transportation, and accompanying them to appointments for warm handoffs to longer term clinical providers. *Promotoras* often accompany clients to appointments, sit with them if requested and follow up to see if the resource was helpful, culturally sensitive, and appropriate to meeting their needs. CAL also works with the new service agency to provide support in encouraging continued engagement and follow through to ensure that the linkages and connectivity needed for mental health intervention are successful.

A bilingual staff is required to properly support the CAL program, from intake to program completion, as language is a key factor in adhering to the culture-based design presented in *The Enchilada Approach to Reawakening Therapy*. All CAL services are administered only by staff proficient in the Spanish language. Therapists, Community Mental Health Workers, program manager, clinical director, and front desk staff are all Spanish speakers. All meetings and services are conducted in Spanish as staff prefer speaking in the language used by their clients. All documentation and forms provided to clients are in Spanish. Even the data entry staff are Spanish proficient - all the data for CAL are collected in Spanish.

CAL is a program immersed in the language of the population it serves. CAL staff understand the cultural importance of language when communicating with clients. They understand how a simple greeting in the right language is a starting point for establishing the trust needed for clients to share their deeply personal and private experiences regarding their emotional wellbeing. Language is the starting point for clients to know and believe that they are in a safe, supportive environment to share and address problems such as stigma, immigration fears, and harmful situations of discrimination and domestic violence. Clients know that CAL staff are from the same community with similar cultural experiences and similar family histories that brought them to this country. The CAL CDEP design is clear - having this shared linguistic and cultural history is the essential starting point for *The Enchilada Approach to Reawakening Therapy*.

Evaluation Questions

La Familia contends that an environment of culturally sensitive support and encouragement is necessary for wellness and resiliency to occur. *La Familia's* services have embraced this service delivery model for decades. Staff understood that by providing such an environment, the *Cultura de Salud* delivery model encourages Latinos to overcome social stigmas, conditions of core trust, social status, and cultural barriers and allows them to seek out mental health services in crisis situations. Moreover, the emphasis on strengthening family as well as community mental health means important principles of the Latino culture are at the core of community mental health programming. The CRDP now provides the opportunity to demonstrate the effectiveness of such practices.

This evaluation focuses on measuring the effects of the *Cultura de Salud* approach to delivering community mental health services. The overarching research question of this evaluation is, "To what extent do culturally defined service delivery practices improve access and utilization of mental health services for the Latino population?" This research question is further refined into three basic evaluation questions:

- To what extent does program participation strengthen individual wellness and resilience?
- To what extent does program participation reduce risk factors to mental illness?
- To what extent does the program approach improve retention in CAL services?

Seven indicators are used to respond to these questions: Client Responsibility, Awareness, Connectivity, Stabilization, Service Utilization, Service Satisfaction, and Changes in Wellbeing. Four data sources were used for analyzing these indicators. These include: 1) The CDRP Statewide Evaluation Dataset (SWE) contains data collected from pre and post questionnaires for each CAL client. The evaluation focused on variables from the Kessler Psychological Distress Scale, the Sheehan Disability Scale, general satisfaction, and cultural sensitivity captured in the SWE dataset. Client demographic data was also obtained using the SWE dataset. 2) The Feedback Informed Treatment Outcomes (FIT) dataset contains client feedback on their progress in therapy and the connections they established with their therapist. Bilingual forms CRS and SRS were used. 3) The CAL Cultural Services Satisfaction Questionnaire (CSSQ) captured data from each navigation service provided to CAL clients. 4) Semi-structured interviews with CAL clients and staff provided rich detailed descriptions of the client, their emotional and social conditions, their experiences in the program, and their assessment of the effectiveness and quality of care received. The following matrix shows how each data source and indicator were used in responding to the evaluation questions.

Table 1

Evaluation Questions, Indicators and Data Sources

	Evaluation Questions		
	To what extent does program participation strengthen individual wellness and resilience?	To what extent does program participation reduce risk factors to mental illness?	To what extent does the program approach improve retention in CAL services?	
Measurement Indicators				**Data Source**
Client Responsibility		X	X	2,4
Awareness	X	X	X	1,2,4
Connectivity	X	X	X	2,3,4
Stabilization	X	X	X	1,2,4
Service Utilization	X	X	X	1,2,3,4
Service Satisfaction			X	1,2,3,4
Changes in Wellbeing	X	X	X	1,2,4
Data Sources				
1. Statewide Evaluation Dataset				
2. FIT Outcomes				
3. CAL Navigation Data				
4. Semi-Structured Interviews				

Methods

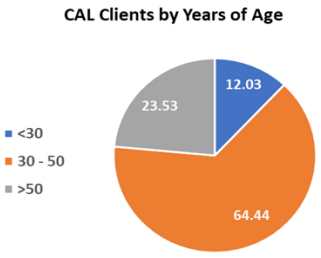
CDEP Implementation

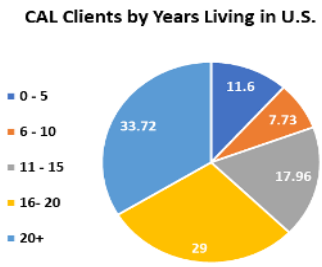
Program Activities: *La Familia* receives referrals for assistance from a variety of sources, including walk-ins. When clients first arrive at *La Familia*, staff conducts intake interviews to determine each client's particular needs and assesses the urgency for mental health services. It is at this critical point where *La Familia* staff identifies the need for navigation services. If appropriate, adult clients are then referred to CAL for services and support. CAL staff then assess further the needs of participants and then inform the client about the CRDP research project. All clients were informed that participation in the study was not a requirement for receiving services. However, for those wishing to participate in the study, signing appropriate consent forms would be required

Two instruments were used which consisted of a series of questions as part of a pretest that was used to establish each participant's baseline conditions. The Cultural and Social Impact Scale (CSIS), a form developed and administered by CAL staff to document baseline conditions, is used as the basis for a "wellness" index that provides an indicator of a client's stability at the time of entering the program. Clients were also given the SWE pretreatment questionnaire to document health and demographic information.

CAL staff then determine the appropriate level of services for the clients based on information gathered. Therapists provided short-term counseling services, including therapeutic support groups, and/or individual counseling sessions. *Promotoras*/Community Mental Health Workers provided navigation services such as hands-on linkages to external services and referrals. At the end of each session, participants were asked to complete short questionnaires that documented how the client felt about the CAL service(s) received, the appropriateness of the service(s) and any cultural and linguistic barrier(s) that they experienced. Following the completion of CAL services, participants were given the SWE Post Treatment Questionnaire. The results of both the pre and post questionnaire data were transmitted to the Psychology Applied Research Center (PARC).

Demographics: CAL staff conducted 374 pretreatment intake interviews and 338 post treatment exit interviews where SWE questionnaire data was collected. Thirty-six interviews were completed as a pilot to test the SWE pretreatment questions with clients. Although counted as part of the SWE pretreatment data, these clients were not required to complete post treatment questionnaires.





Demographic information from the SWE dataset indicates that 100% of CAL clients reported their ethnicity as Latino, Hispanic or Spanish descent. Just over 64% of clients at intake were between 30 and 50 years of age. Slightly over 94% of clients reported their place of birth was outside of the U.S. However, they were not recent arrivals. Approximately 80% reported living in the U.S. more than ten years with 34% of clients residing in the U.S. 20 years or more. Just over 94% of clients reported their primary language as Spanish. Regarding gender identity and sexual orientation, 80% identified as female at birth, 19.5% as male, and 0.05% were unsure; 99.5% identified as heterosexual.

Evaluation Participants and Recruitment

During the initial evaluation planning stage, the program anticipated a relatively small population of program participants. Concerned that a small population would compromise the strength of any random sample selected, a convenience sample was recommended where 100% of the client population would be used for the evaluation. The target population for the program was primarily Latino, Spanish speaking, adults. However, at *La Familia*, no one is denied services regardless of their background. All of the clients in CAL agreed to participate in the CDEP evaluation.

The CAL recruitment process was a natural extension of the Supporting Community Connections (SCC) work that was initiated years ago. *La Familia's* long-standing partnership with Sacramento County, the SCC program, and the Sacramento County Children's Behavioral Health program, were important recruitment tools for the CAL CDEP. Through SCC, *La Familia* had been providing suicide prevention, awareness and support services, referral and linkage to other community resources, and community building through outreach and engagement activities. However, SCC funding is focused on prevention and unfortunately did not include funding for therapeutic services. There was clearly a gap in services for Latino adults.

As part of their CDEP, *La Familia* staff had planned outreach events to recruit clients. However, when the opening of CAL was announced as an effort to help fill the gap in community mental health services for adults, the requests for services were immediate. It is important to note that, during a portion of this study, there was a wave of anti-immigrant sentiment during the Trump Administration that sent fears and mistrust throughout the Latino community. "Know Your Rights" immigration training also uncovered more residents that became CAL clients, with many experiencing suicidal ideations and in need of urgent care. *La Familia* quickly became the trusted site for accessing resources and information, increasing its visibility as a dependable community partner. A subsequent spike in requested services occurred during the COVID-19 pandemic.

Swift responses to provide assistance during unanticipated community crisis have been a hallmark of *La Familia*, making it is easy to see how CAL was quickly accepted as a valued and much-needed resource within the community. In reviewing the interview data, clients consistently reported that *word-of-mouth* was perhaps the most effective recruitment tool; further indicating the trust that the community has placed in *La Familia* staff and its programs.

CAL program services became integrated into *La Familia* outreach efforts in a variety of ways. The COVID-19 pandemic amplified the intense need and demand for mental health services. As part of the community relief effort for the COVID-19 public health crisis, *La Familia* was a site for dispensing emergency meals, food and Personal Protective Equipment (PPE) supplies to thousands of community members. *La Familia* became a COVID-19 testing site, serving as many as 800 individuals on any given day; they became a vaccination site, hosting pop-up clinics on site and in farmworker communities. Thousands of lunches were provided to youth and families and hundreds of community members sought services of their career center, their Family Resource Center, youth programs, health programs and mental health services. When families arrived to pick up food, grab PPE items, arrived for testing or vaccinations, they would also receive an informational flyer announcing CAL program activities. When *La Familia* administered the Housing for the Harvest program for agricultural workers who had COVID-19, they were provided with mental health wellness checks and referrals to the CAL program, if needed. All of these activities increased the demand for services and resulted in a number of CAL clients. These indirect recruitment activities resulted in a waiting list of people for CAL services. The large demand across all of *La Familia's* programs indicated that

there was a Latino population ready to participate in mental health services despite the stigma and assorted cultural norms associated with mental illness. The pandemic served to uncover as well as amplify the inequities that exist and the demand for culturally and linguistically responsive mental health services.

Demographic information from the SWE data indicated 64% of CAL patients were between 30 and 50 years of age and 67% were without any form of health insurance. All clients interviewed for this evaluation were volunteers. Services were mostly carried out at the CAL office in quiet rooms secluded from other activities, providing clients with a safe environment to engage in therapy. Navigation services were also carried out at the CAL office or at the site of an external service or resource provider. For the most part, services were delivered as planned with in-person therapy and navigation assistance. When COVID-19 statewide lockdowns occurred, therapy services transitioned to a virtual format (generally using Zoom as a means for telehealth services). Often, navigation services by *Promotoras*/Community Mental Health Workers were paired with emergency food services. This made it possible to help access clients in person, albeit through screen doors or windows. Informed consent procedures were followed for all evaluation participants in accordance with procedures submitted to Institutional Review Board (IRB). COVID-19 safeguards required the use of DocuSign to ensure appropriate evidence of signed consent for services delivered through telehealth. Through this intense outreach effort with clients, no dropouts from the program were reported.

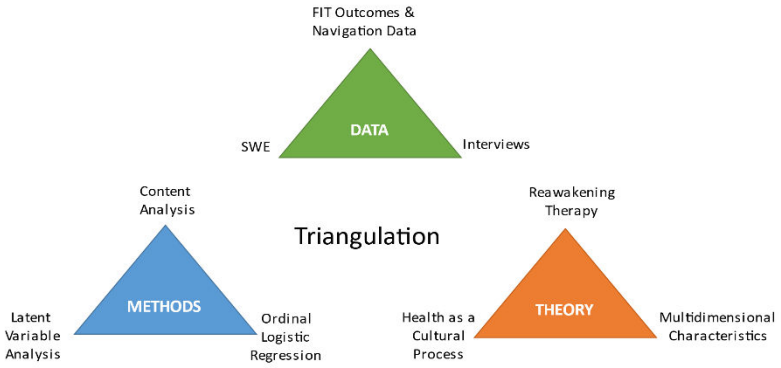
Evaluation Measures and Data Collection Procedures

La Familia staff interviewed and collected client's personal information by administering specific forms such as the CSIS questionnaire. This information was then entered into a Filemaker Pro database following a standardized set of data administration procedures. Clients referred for CAL services were administered the SWE pretreatment questionnaire, which was forwarded to PARC for data entry.

To record the overall progress on client/therapist alliances and client progress, the Feedback Informed Treatment (FIT) data was collected manually using the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) forms. The ORS and SRS data were then entered into the FIT Outcomes data system (a proprietary data management system managed by an independent contractor). The Summary data was ultimately prepared by the contractor for use in the final report.

Navigation services are recorded on the program's Cultural Service Satisfaction Questionnaire (CSSQ) documenting the services and resource connection provided to each client. Designated program staff then entered the data into the Filemaker Pro database. Contact with many external service providers changed as communications and events, such as legal hearings, moved to virtual formats. Although the number of services providers decreased due to COVID-19, the volume of requests for navigation services increased. CAL services continued with extra attention paid to SWE data collection to ensure pre and post questionnaire data were collected. An independent contractor reviewed all of the data and provided a detailed analysis to complete this evaluation report.

Figure 1
CAL Evaluation Methods of Triangulation



Three different approaches to triangulation were used in this evaluation. Data triangulation included four different sources of quantitative and qualitative data to analyze the effects of CAL services on clients: 1) the SWE pre and Post Questionnaire dataset with data initially collected by CAL and submitted in batches to PARC for processing; 2) the FIT Outcomes summary data on client reported feedback following every therapeutic treatment session; 3) CAL navigation data documenting client reported feedback with navigation services; and 4) 24 client and staff volunteer interviews regarding their experiences in CAL.

Methodological triangulation incorporated multiple ways of measuring both qualitative and quantitative analysis. Ordinal logistic regression and a latent variable analysis using structural equation modeling were used to analyze the SWE data as non-matched and matched pairs. Qualitative interview data was used for content analysis on staff and client reported information regarding their program experience.

Theory triangulation incorporated three theoretical perspectives not normally used in evaluating community mental health programs: 1) Reawakening Therapy, which requires attention to client backgrounds, history, and culture to determine appropriate and responsive treatment plan; 2) treating evaluation indicators as multidimensional as well as interdependent; and 3) culturally informed design of services as an indicator showing how wellness is part of a cultural process. Together the three approaches to triangulation should increase confidence in the findings presented in this report.

Evaluation Fidelity and Flexibility

Three dimensions for fidelity are reviewed: 1) adherence between services delivered and those proposed in the evaluation plan; 2) quality of service delivery; and 3) participant responsiveness.

The first dimension of fidelity was attention to the adherence between services delivered and those proposed. The CAL team spent considerable time clarifying program components, program activities, evaluation design, and the data analysis plan. From the beginning of the program, administrative procedures, including data collection procedures, were in place to ensure that information collected would be robust enough to determine that the CAL program delivered quality services in a manner consistent with the program purpose: using community and cultural assets and community-defined strategies to improve access, quality of care, and achieve positive mental health outcomes.

Administrative practices were implemented to facilitate appropriate and efficient data collection methods that allowed for timely program decisions to ensure fidelity. One common theme that was continually emphasized and prioritized by management was the Statewide Evaluation (SWE) data collection process. Regularly scheduled quality control team meetings focused on daily observations and practices to ensure sensitivity to clients during service delivery. A data dictionary was developed and updated following periodic review of collected data to ensure its consistent and accurate recording of navigation data. Data collection procedures for staff were continually updated so that the flow of data to the Psychology Applied Research Center (PARC) remained in place and any changes in personnel would minimize any problems with data integrity. A Community Advisory Board (CAB) composed of community members and CAL clients was also initiated to obtain ongoing feedback on service quality and client satisfaction.

All CAL staff and managers were provided training through the Building Research Integrity and Capacity Program (BRIC) which were designed to increase research literacy and capacity among community members, such as *Promotoras*/Community Mental Health Workers, who assisted with the design and/or implementation of health-related research. BRIC was designed for individuals who are engaged in providing direct services but are called upon to assist with the design, implementation and reporting of community health research. This training helped CAL staff to understand how research is designed and implemented. It helped staff understand and appreciate the issues needed to properly support the research study.

An organizational development consultant (Susana Morales) with Leap Solutions assisted with the monitoring of the implementation process. She conducted the focus group interviews with staff in addition to the client post treatment interviews. Training was provided to staff on coaching teams, effective strategic planning, change management, culture management, community engagement, facilitation skills and evaluation. Her deep understanding of communities of color and historically disadvantaged populations and her ability to interact with the clients and staff in their native language was an important part of the data collection process for this evaluation as evidenced by the detailed personal responses reported in all of the interviews.

Despite the program's intensive planning, considerable adjustments and procedure reviews were required due to the COVID-19 pandemic. In person contacts were severely curtailed and many services shifted to virtual sessions. Therefore, program implementation did require adjustments to continue program operations. Internet meetings were used to reach many clients. Drive-bys, phone calls, and other safe contact methods mandated by COVID-19, were also used, when possible, for difficult to reach clients. Social distancing, mask wearing, communication via phone/Telehealth, and working from home, were all implemented during heightened COVID-19 protocols. Informed consent procedures were modified to ensure client protections remained while internet-based services were delivered. Data regarding community engagement was deemed invalid as educational and awareness events were halted.

One important adjustment to obtaining SWE data is important to note here. Many clients were conscious of the number of therapy sessions allowed by CAL. Post treatment SWE data collection was problematic because the SWE data collection interview was the signal to clients that their time at CAL was ending. Clients simply did not want their time to end. Many CAL clients would not come to the interview so that they could keep one final session as a reserve, making sure they would still be connected to the program in case they were in need of extra care. To avoid the additional staff time required to locate the "missing" clients, staff began conducting exit interviews prior to the last visit. This ensured that the SWE data collection would not be compromised. Even with these program changes, client post treatment reporting,

presented in the Results section of this report, indicates a high degree of satisfaction with CAL services along with the acknowledgement of sincere and respectful engagement by staff to assist clients.

The second dimension of fidelity reviewed here is quality of delivery, which reflects the manner in which a program is delivered. Interview data show that clients were able to effectively engage in treatment and navigation programming. Client interviews indicate that the quality of service delivery was maintained despite the switch to remote services at some point during their participation. No dropouts from therapy were reported and over 800 requests for navigation services were received, suggesting that services were operational and delivered to clients. Clients reported in interviews that services were delivered with respect and sensitivity to culture. Clients reported that navigation services showed an extreme level of care provided to them and that staff engagement was sincere. Clients consistently reported that the level of care they experienced gave them the feeling like they were part of a family.

The third fidelity dimension**,** participant responsiveness, refers to the level of engagement of those involved in the study. Both staff and clients were provided with the informed consent protocol prior to their participation in the study and again prior to focus group and individual interviews. No dropouts from participation were reported even after consent procedures were administered. High rates of participation, utilization, and retention, discussed in the Results section of this report, suggest participant responsiveness may have played a role in client outcomes. Interview data show how clients willingly participated in program activities and reported positive perceptions about the relevance and usefulness of the program.

Another important part of the program design impacting all three dimensions of fidelity incorporated feedback from clients as a part of the service delivery protocol. For therapeutic services, continuous client feedback during the course of therapy was collected using the FIT outcome management system, discussed in greater detail in the Results section. Through this process, client progress as well as the alliance between client and therapist was monitored at each treatment session. FIT scores also reflected the client's continuous assessment of the quality of services they received with the FIT data reflecting clinical progress, high utilization, and positive client/therapist alliances. The FIT data served as an important marker of both adherence to the implementation protocol as well as participant responsiveness.

Qualitative and Statistical Data Analysis

For qualitative data, a Content Analysis method is used as part of this evaluation to analyze client interview data. For qualitative data, Ordinal Logistic Regression and a Latent Variable Analysis using Structural Equation Modeling are used to analyze the SWE data. Each of these measurement methods are discussed in greater detail in the Results section of this report.

Results

The purpose of the pilot CAL CDEP was to determine, "To what extent do culturally defined service delivery practices improve access and utilization of mental health services for Latino populations"? Specifically, results were analyzed to assess: 1) the effect of culturally centered mental health service programming on clients in distress, and 2) the extent to which mental health programs designed with a focus on a client's culture can strengthen individual wellness and resilience, reduce risk factors associated with mental illness, and improve client retention in program treatment and related activities. Four data sources are used to evaluate the effectiveness of CAL programming: Statewide Evaluation Data (SWE) Analysis, FIT Outcomes, CAL Navigation Services, and interviews with clients and staff.

Statewide Evaluation Data Analysis (SWE)

Data from personal interviews with CAL clients show that prior to treatment, clients often reported experiencing serious concerns with their ability to function in daily situations such as social interaction. For example, one client shares how she felt prior to participating in CAL. *"Estaba muy deteriorada. Primero angustiada porque no tenía con quién hablar ni nada. Segundo porque no conocía a nadie. Y conocía el entorno donde vivo nada más." ["I was really rundown. First, I was distressed because I had no one to talk to or anything. Second, because I didn't know anyone. And I only knew the environment where I live and nothing else."]*

Pretreatment conditions expressed by clients often included signs of sadness and depression, a lack of connectivity, stress, anxiety, and isolation; all which can lead to problems in navigating everyday social interactions. Another CAL client describes how increasingly difficult it became to manage the onset of conditions known to affect the ability to participate in family and social relationships.

> *"Antes, estaba yo en un grado de estrés ya muy fuerte de que por cualquier cosa lloraba o estaba preocupada. Empezaba lo que nunca en mi vida había sentido. Empezaba a sentir mucha ansiedad. Yo no sabía lo que era la ansiedad, el estrés, el no dormir, el preocuparme de no saber por qué, el sentirme muy triste."*
>
> *["Before, I was in a degree of stress so strong that I cried or was worried about everything. I began to feel something I had never felt in my life. I began to feel a lot of anxiety. I did not know what anxiety was, stress, not sleeping, worrying about not knowing why I was feeling very sad."]*

The personal interviews revealed an alarming level of despair experienced by CAL clients. The interviews help place into context the serious degree of distress clients experience within today's broader social and financial conditions such as COVID-19 and the loss of personal contacts, employment and income, fears of being targeted for immigration enforcement and deportation of family members. One interviewee described how her condition deteriorated to the point of giving up all hope of wellness. *"Antes de participar, o sea, yo me sentía… pues bien, este… yo no sé si ida, o sea, bien, sin ganas de hacer nada, de tirar todo, aventar todo a la borda." ["Before I participated, I mean, I felt... well... I don't know if I'm going, I mean, well, I had no desire to do anything, I felt like throwing everything, just throwing everything overboard."]*

The interviews revealed a number of recurring themes or preconditions regarding client wellness prior to CAL participation. Most of the clients were experiencing two or more of the preconditions. The table

below provides a good idea of the concerns clients were facing at the time of their intake interview. All 22 clients participating in personal interviews expressed having one or more of the pretreatment conditions identified through the interviews. A review of the SWE data confirms these indicators of emotional distress expressed by clients. For example, in SWE pretreatment questionnaires, clients were asked how often their emotions interfered with their social life. A total of 372 CAL clients responded to the question. Almost 65% responded with "A Lot" indicating that a majority of CAL clients were experiencing a high degree of difficulty in managing personal interactions (Figure 2).

Table 2: Coding Categories for CAL Client Pretreatment Conditions N=22 interviews

Code Category	**Respondents**	**%**
No Connectivity	15	68%
Sadness and depression	13	59%
Stress and anxiety	10	46%
In need of resources	12	55%
Urgency for help	15	68%
Victimization	7	32%

However, SWE post treatment data from 338 respondents show that many CAL clients reported significant changes in their emotional wellbeing and progress towards stabilization during their participation in CAL services. The SWE post treatment responses show only 20% of clients reporting that emotions interfered "A Lot" with their social life, a 44% difference that represents a considerable change in wellbeing. Similarly, when asked if emotions affected relationships with friends and family, 61% of CAL clients at their intake interview reported "A Lot" indicating some difficulty in managing day-to-day personal relationships (Figure 3). However, following treatment, only 21% reported the same response. Again, the data show a 40+ point difference in pre/post responses suggesting that CAL clients experienced a very positive change in how emotions affected their relationships. Even more suggestive of positive change is the number of clients reporting after treatment that their emotions no longer affected their social life (from 4% to 25%) and their relationships (from 8% to 31%). Thus, the possibility exists that a significant and positive change occurred in the mental health status of clients during their time with CAL.

Figure 2

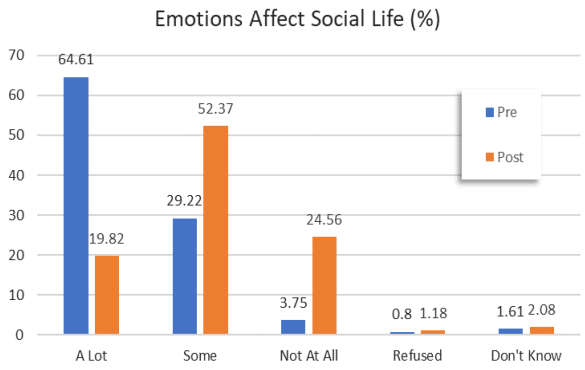
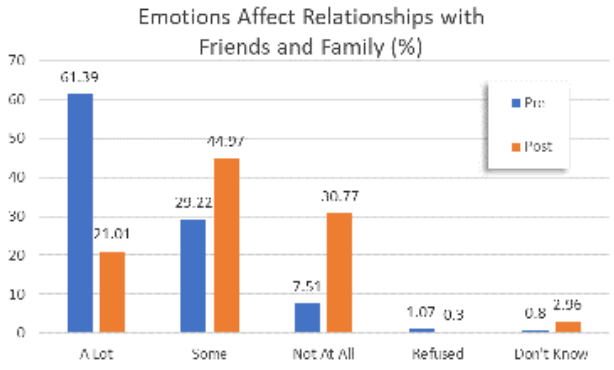


Figure 3



The SWE data also show consistent 15 to 30 point improvements across a number of variables such as isolation, depression, hopelessness, and feeling worthless, indicators commonly used to measure wellness

and the ability to manage social interaction. These client-reported changes indicate rather substantial improvements in wellbeing that require further investigation.

Client responses to ten questions based upon the Sheehan Disability Scale (SDS) and the Kessler Psychological Distress Scale (K6) are included as part of the SWE data. The data are used here to test for statistically meaningful changes in functional impairment that may have occurred during the time clients were participating in CAL programming.

Sheehan Disability Scale

The SDS provides information regarding functional impairment in three interrelated domains: work/school, social life, and family life. Because of its generic design, the SDS is widely used in the treatment of many chronic medical illnesses (Sheehan, 1983; Sheehan et al., 1996). For CAL clients, the SDS was integrated into the SWE pre and post questionnaires and recorded as part of the SWE data set. The SDS questions are also included as part of the California Health Interview Survey (CHIS) making them reasonably appropriate indicators of wellness to use for this portion of the evaluation. There is no recommended cutoff score for the SDS. Instead, our interests lie in its utility for monitoring a response to treatment, making the SDS a useful tool to measure client reported changes in wellbeing that may occur from pretreatment to post treatment.

The SWE data captures responses to four widely used questions in the SDS: "Did your emotions interfere A Lot, Somewhat, or Not at All with your… performance at work or school, household chores, social life, and relationships with family and friends." Responses to the SDS questions in the SWE data are coded in the form of a Likert Scale where a response is captured in the form of a scale or ranking. SDS questions allow the client the following response categories: 1- A Lot, 2- Some, 3- Not at All, 4- Don't Know, 5- Refused. Those responses with "Don't Know" or "Refused" were recoded as missing data. Also worth noting is that many of the post treatment interviews were conducted during the height of the COVID-19 pandemic shutdown with the real potential for mental health challenges to worsen. Therefore, we should expect some indication of clients being increasingly impacted or impaired by their emotions as they manage daily situations and social interactions during acutely adverse conditions.

The most commonly used test for pre/post hypothesis testing is the Paired T-Test, which determines if there is a significant difference between the means of two events for a particular group. One key assumption for using the T-Test is that the data, when plotted, results in a normal bell-shaped distribution. However, the use of Likert Scale responses violates the recommended normal distribution assumption for traditional T-Tests. Likert Scale data are ordinal and do not produce a normal distribution of response data. For that reason, an Ordinal Logistic Regression is used here to estimate the probability of an event, in this case a client reporting an indication of improved wellness, will happen.

Ordinal Logistic Regression is used because of the ordered nature of Likert Scale responses to the SDS questions, which have more than two response categories. This method allows us to consider the values of each response category as they have a meaningful sequential order where one value is higher than the previous one. In addition, Ordinal Logistic Regression does not require a matched pair of respondents to analyze the pre/post effects of treatment. One of the assumptions for using a regression model is independence of observations. One observation cannot be related to another observation. As a result of having two observations from almost all participants, this assumption is violated. A mixed model is the proper model to analyze repeated measurements from each participant. A mixed ordinal logistic regression is the correct model to use when the outcome is measured on an ordinal scale with more than one observation per participant.

To understand how the emotions of CAL clients affect their ability to manage daily social interactions, the SDS responses in the form of a Likert Scale allow us to use the client's reported emotions as a response variable that captures the level of emotion experienced in four different social settings, which helps identify signs of functional impairment. Ordinal Logistic Regression allows us to use CAL treatment as a predictor variable to estimate the probability of clients reporting improvements in their ability to manage daily interactions after treatment. The regression allows us a way to explain the effectiveness of CAL treatment. Table 3 displays the results of the ordinal logistic regression. The results for each SDS response variable are discussed in detail following the table.

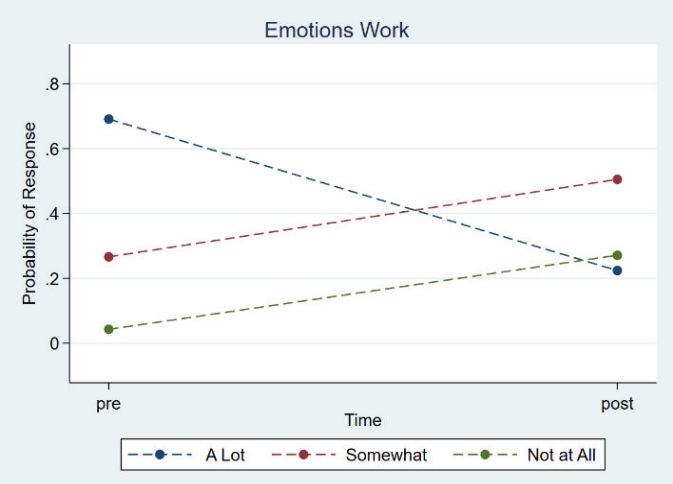
Table 3: Odds Ratio of Higher Post Score as Compared to Higher Pre-Score

	Odds Ratio	Std. Err.	z	p-value	95% Conf. Interval		N
Work/School	9.026109	1.988355	9.99	0.000	5.861246	13.89988	339
Household	8.273967	1.631478	10.72	0.000	5.621757	12.17743	374
Social Life	9.277019	1.865671	11.08	0.000	6.254982	13.75913	372
Family/Friends	6.852973	1.278672	10.32	0.000	4.753968	9.878743	372

Emotions affect performance at work or school

The SWE data recorded 339 respondents to the question, "Did your emotions affect your performance at work or school?" Approximately 20% of CAL clients responded with "Don't Know" or "refused." These categories were recoded to missing data. One possible reason for the reduced number of responses to this question is that many clients were not working or going to school for an extended period due to COVID-19 protocols put in place by the County of Sacramento over the last year. Following the recode of missing data, the one to three ordinal rankings for the responses indicate that higher scores reflect reduced periods of time where emotions interfered with work or school. Therefore, if clients report improved ability in work and school performance, the probability of post treatment responses of "A Lot" when questioned about the effect of emotions on work/school performance will be greatly reduced.

Figure 4 displays the probability of responses in client-reported changes on how emotions affect work/school performance. The graph shows that 69% of pretreatment clients are likely to report that emotions affect work/school performance "A Lot." However, following treatment, that probability decreased to just 22% indicating the probability of reporting that emotions have a negative effect on work/school performance is significantly lower after treatment. Also, if treatment is indeed effective, we would expect the probability of responses indicating emotions affect work/school performance in response categories other than "A Lot" to increase following treatment. Figure 4 shows that following



treatment, an increase in the probability of clients responding “Somewhat” (from 26% to 50%) and “Not at All” (from 4% to 27%) occurred suggesting that treatment has a positive effect on a client’s ability to manage emotions.

The odds ratio that results from Ordinal Logistic Regression can be interpreted as the effect size, or in this case, the impact upon how a client responds to SDS questions before and after treatment. The odds ratio of 9.026 shown in Table 3 indicates that a Cal client is approximately nine times more likely to report a positive response regarding emotions and work/school performance following treatment than a client responding to the same question prior to treatment. This is a very strong indication that a positive change in a client’s ability to manage emotions has occurred during the treatment period. The z-score of 9.99 and the p-value of 0.000 suggest that the findings are reliable.

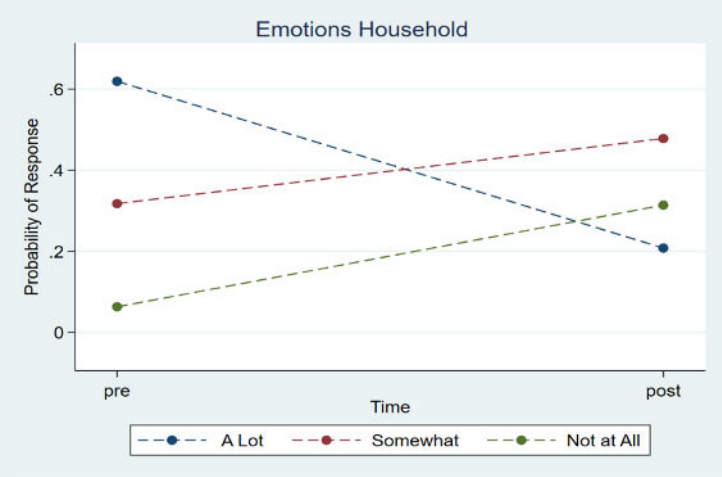
Emotions affect the ability to perform household chores

The SWE data recorded 374 pretreatment and 338 post treatment respondents to the question, “Did your emotions affect your ability to perform household chores?” Responses with, “Don’t Know” or, “Refused” were recoded to missing data. Following the recode of missing data, the one to three ordinal rankings for the responses indicate that higher scores reflect reduced periods of time where emotions interfered with performing household chores. Therefore, if clients report improved ability in performing household chores, the probability of post treatment responses of “A Lot” will be greatly reduced.

Figure 5 displays the probability of responses in client-reported changes on how emotions affect the ability to perform household chores. The graph shows that 62% of pretreatment clients are likely to report that emotions affect performing household chores “A Lot.” However, following treatment, that probability has declined to just 21% indicating the probability of reporting that emotions affect household chores is significantly lower after treatment. Also, if treatment is indeed effective, we would expect the probability of responses indicating emotions affect household chores in response categories other than “A Lot” to increase following treatment. Figure 5 shows an increase in the probability of clients responding “Somewhat” (from 30% to 54%) and “Not at All” (from 4% to 25%) following treatment. These 20+ point increases in the probability of responses for these categories suggest that treatment has a positive effect on client’s ability to manage emotions.

The odds ratio of 8.273 shown in Table 3 suggests that a CAL client is approximately eight times more likely to report a positive response regarding household chores following treatment than a client responding to the same question prior to treatment. This is a very strong indication that a positive change in managing emotions has occurred during the treatment period. The z-score of 10.72 and the p-value of 0.000 suggest that the findings are reliable.

Figure 5



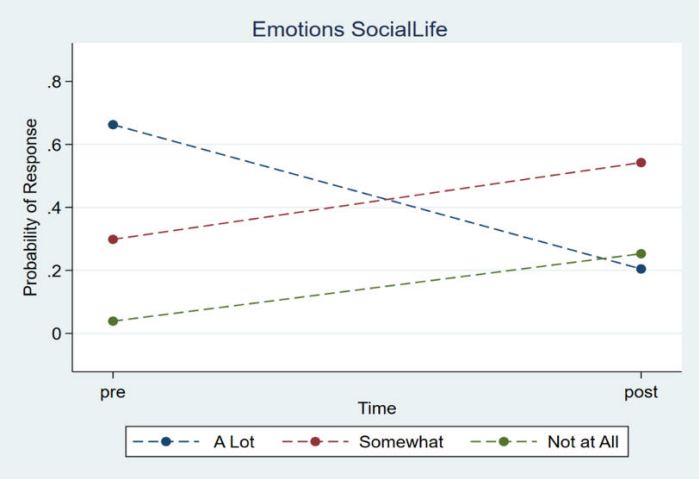
Emotions affect a client's social life

The SWE data recorded 372 pretreatment and 338 post treatment respondents to the question, "Did your emotions affect your social life?" Responses with "Don't Know" or "Refused" were recoded to missing data. Following the recode of missing data, the 1 to 3 ordinal rankings for the responses indicate that higher scores reflect reduced periods of time where emotions interfered with a client's social life. Therefore, if clients report an improved social life, the probability of post treatment responses of "A Lot" when questioned about the effect of emotions on social life will be greatly reduced.

Figure 6 displays the probability of responses in client reported changes on how emotions affect a client's social life. The graph shows that 66% of pretreatment clients are likely to report that emotions affect their social life "A Lot." However, following treatment, that probability decreased to just 20% indicating that the probability of reporting emotions affecting social life is significantly lower after treatment. Also, if treatment is indeed effective, we would expect the probability of responses indicating emotions affect social life in categories other than "A Lot" to increase following treatment. Figure 6 shows an increase in the probability of clients responding "Somewhat" (from 30% to 54%) and "Not at All" (from 4% to 25%) following treatment suggesting that treatment has a positive effect on managing emotions.

The odds ratio of 9.277 shown in Table 3 indicates that a Cal client is approximately nine times more likely to report a positive response regarding emotions affecting social life following treatment than a client responding to the same question prior to treatment. This is a very strong indication that a positive change in managing emotions has occurred during the treatment period. The z-score of 11.08 and the p-value of 0.000 suggest that the findings are reliable.

Figure 6



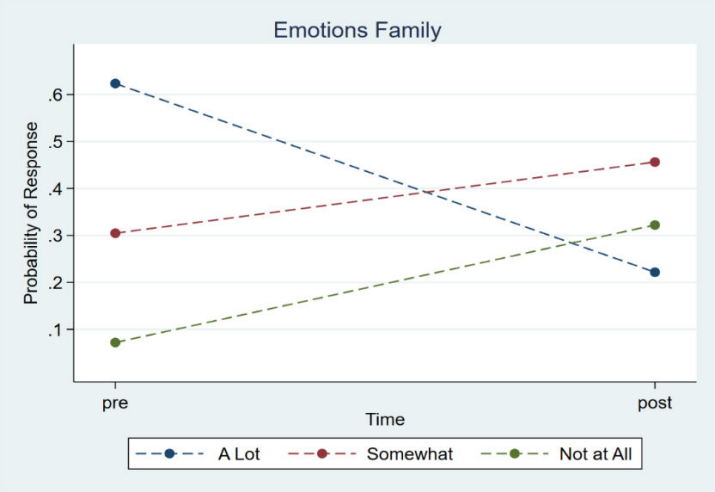
Emotions affect a client's relationships with family and friends

The SWE data recorded 372 pretreatment and 338 post treatment respondents to the question, "Did your emotions affect your relationships with family and friends?" Responses with "Don't Know" or "Refused" were recoded to missing data. Following the recode of missing data, the 1 to 3 ordinal rankings for the responses indicate that higher scores reflect reduced periods of time where emotions interfered with personal relationships. Therefore, if clients report improved personal and family relations, the probability of post treatment responses of "A Lot" when questioned about the effect of emotions on these relationships will be greatly reduced.

Figure 7 displays the probability of responses in client reported changes on how emotions affect personal and family relationships. The graph shows that 62% of pretreatment clients are likely to report that emotions affect these relationships "A Lot." However, following treatment, that probability has decreased to 22% indicating that the probability of reporting emotions affecting personal and family relationships is significantly lower after treatment. Also, if treatment is indeed effective, we would expect the probability of responses indicating emotions affecting personal and family relationships in categories other than "A Lot" to increase following treatment. Figure 7 shows an increase in the probability of clients responding "Somewhat" (from 30% to 46%) and "Not at All" (from 7% to 32%) following treatment suggesting that treatment has a positive effect on managing emotions.

The odds ratio of 6.8529 shown in Table 3 indicates that a Cal client is approximately six to seven times more likely to report a positive response regarding personal and family relationships following treatment than a client responding to the same question prior to treatment. This is a very strong indication that a positive change in managing emotions has occurred during the treatment period. The z-score of 10.32 and the p-value of 0.000 suggest that the findings are reliable.

Figure 7



The results of the Ordinal Logistic Regressions suggest that significant and positive changes in the wellness and stabilization of CAL clients may have occurred during their treatment period. Prior to treatment, the probability of emotions affecting personal relationships was high for each of the SDS questions. However, clients answering questions following treatment show a higher probability for responses in categories that indicate a reduced impact from emotions on functioning. Because the Sheehan Disability Scale provides important clues in determining levels of psychological distress and functioning, the consistent patterns of responses described in the probability of responses graphs confirm important and persistent signs of improved client ability to manage emotions when engaged in work, school, social, and family interactions.

Latent Variable Analysis

Interviews with staff indicate that CAL services are not intended or designed to be standalone concepts or services. CAL staff note that services are often interdependent, and that stabilization often cannot be achieved without a combination of interventions that connect clients to social services as well as therapy. The CAL therapist explains:

> "In my case, when a client is with me, I don't just focus on the therapeutic part by itself. I have to consider that that person is in the middle of a community with other concerns – connected to other problems that may affect my work as a therapist. I have to be aware that my client might be going through other conflict that may impair my work as a therapist. So, I have to meet the client where the client is, not just therapeutically but also considering she's in the middle of a community which brings other problems or concerns."[5]

Through this therapeutic approach, the therapist not only investigates indicators of mental distress but also attempts to identify external social, economic and everyday domestic problems that may inhibit the client's ability to actively participate and respond to care. Again, the therapist elaborates:

[5] The focus group interview with CAL staff was conducted in Spanish as that is the preferred language of staff. The interview was transcribed and translated to English. Only the English translation was available for this review.

> "For example, I have a client with housing problems. She was in my session and was really concerned about the pandemic and was having financial problems. For her, it was really difficult to focus just on therapy - I tried to help her relax but even though she was relaxed, the problem was still there – housing, food, and work. So, I brought in my team and said, she needs more than just therapy. So, we worked together in meeting her needs. You don't need only housing – it sounds like there is some trauma, etc. We're looking at all the spots in her community that she's disconnected from – financial means, then housing – all of those parts of the community is where she's lost the connection."

Staff point out that a team approach is needed to address the multiple problems facing clients in distress. Going beyond traditional, "therapy only" programming, the actions of staff make it clear that connectivity to resources is critical to first stabilizing a client's personal situation before therapy can even begin. A CAL Community Mental Health Worker discusses a client's need for urgent care:

> "One man was in diabetic arrest and had lost his Medi-Cal, he's disoriented – they get him to the emergency room, and Rosie stays on the phone until she can get him Medi-Cal. We called the clinic so he got it right away. We also gave him lunch that day to address the blood sugar. He came back the next day with his medication, smiling, thanking her for saving his life. He got his medication, then we helped him to find a job this year. Housing also. So that's what we did. He started getting therapy too. Then his son came for therapy. And we got Medi-Cal for his son too."

Although connecting clients to community resources is an important step towards stabilization, staff are quick to note that helping clients make those connections also helps build trust. Staff are clear that building trust is a process required for making the personal connections that lead to effective treatment for a client base that has a troubling history of public neglect. A CAL *Promotora*/Community Mental Health Worker stresses this point:

> "When they come here, they've been knocking on so may doors and no one helps. When they come here, we start working, looking for resources for them – they trust us, and clinicians make them feel comfortable and also, they can understand, we can understand their needs more."

Clearly, CAL staff view service delivery as something fundamentally different from traditional mental health intervention. A *Promotora*/Community Mental Health Worker conveniently summarizes the purpose and intent of CAL: "The *enchilada* is all about reconnecting the person to those resources in a community a healthier individual = healthy community." CAL staff point out that programming is designed as a cultural process rather than a service. From this view, CAL services are designed as a bundle of interdependent tools used simultaneously depending on the condition of the client; strategies for their application are guided by the agency's culturally driven principles. Therefore, concepts such as improved wellness or decreased levels of distress can be attributed to a number of coordinated interventions and actions. As a result, they may not be easily measured by a single indicator or variable. Although these concepts are not measured directly in the research design, they are indeed the ultimate goal of the project. The challenge here is to demonstrate how the obvious impact of a bundle of culturally driven practices can be measured, evaluated, and validated using scientific methods.

The SWE data set is used here to analyze the hypothesis that CAL services have a positive impact on the level of distress experienced by CAL clients. The concept of distress can best be described as a "latent variable," a variable or, "construct" which is not directly observed but instead inferred from multiple variables or indicators, which allows us to consider the design of CAL as a process rather than a dosage-oriented treatment protocol. These indicators are in the form of responses to a series of questions that can help measure the impact of the latent variable. The idea is that the value, or impact, of the latent variable, labeled as "Depression" for this portion of the evaluation, caused clients to respond as they did to the questions on the pretreatment intake and post treatment exit questionnaires.

Eight questions were identified as part of the SWE Pre-Post Core Outcome Measures as directly addressing a client's psychological distress. Six of these questions constitute what is known as the Kessler Psychological Distress Scale (K6). The K6 involves six basic questions about a person's emotional state. The K6 protocol asks the questions…How often did you feel… nervous, hopeless, restless, distressed, worthless, and feeling like everything was an effort? In the SWE data set, the client response to each question is scored from 1 (All of the time) to 5 (None of the time).

Two additional questions in the SWE data set, "How often did you feel marginalized or excluded from society" and, "how often did you feel isolated from society," were also included as part of the "Depression" latent variable as they also represent important indicators of psychological distress, especially during the COVID-19 public health crisis. These two questions are intended to capture the clients' own assessment of their condition and therefore have the potential to identify important signs of distress. Like the K6 variables, these questions in the SWE data set are scored from 1 (All of the time) to 5 (None of the time). Together, these eight questions are used to measure the latent construct variable labeled for this experiment as "Depression."

Traditionally, scores of the K6 questions are summed, yielding a minimum score of one and a maximum score of 30. Low scores, as coded in the SWE data, indicate high levels of psychological distress, and high scores indicate low levels of psychological distress. A mean score would then be calculated for pretreatment and post treatment scores and compared to indicate whether a statistically significant change to the client's mental health has occurred. This method of adding up the K6 scores implies that every indicator influences the strength of the latent construct equally. However, this method does present some problems as it does not account for the differences in impact each of the variables will have on the concept of wellness. We simply cannot assume each variable has the same impact or "weight" on the concept of wellness that we are looking to test. Also, we need to avoid questions that may be measuring the same thing (multicollinearity). We are looking for questions that have a good relationship or interaction (correlation) with each other but do not say the same thing. This will help improve the quality of hypothesis testing.

To help address these concerns, an alternative approach is needed to test whether the variables used to construct the "Depression" latent variable are appropriate to assess a statistically significant change in behavior from pretreatment to post treatment. A Structural Equation Modeling approach (SEM) is used to measure the difference in pre and post responses to the latent variable indicators. First, we determine if the variables selected from the SWE data set are appropriate for testing the impact of our latent variable "Depression." SEM utilizes a series of tests that allow for correcting measurement error and help avoid problems of multicollinearity with indicators that are essentially measuring the same thing.

A goodness of fit test was applied to the eight "Depression" indicators to determine if any of the indicators inhibit a well-fitting model. This test incorporates a process known as confirmatory factor analysis. A series of Chi-Squared tests allows us to evaluate the "fit" or appropriateness of each indicator in the model using a null hypothesis significance test approach.

Modification indices for the model identified four indicators with high Chi-Squared statistics. The test results for these four indicators: nervous, hopeless, restless, and marginalized; suggested a degree of ambiguity or uncertainty in client responses. For example, were clients able to distinguish the difference between restlessness and nervousness when responding to questions during the pretreatment intake interview? And was their interpretation of the terms applied similarly during the post treatment interview? The exploratory process of SEM allows the data to reveal these ambiguities and as a result, the indicators were subsequently dropped from the model. After correcting for these ambiguities, the final model for testing the "Depression" latent variable was reduced to four indicators: isolated, depressed, feeling worthless, and effort. Figure 8 shows the SEM diagram with weights. Coefficients for the model are shown in Table 4.

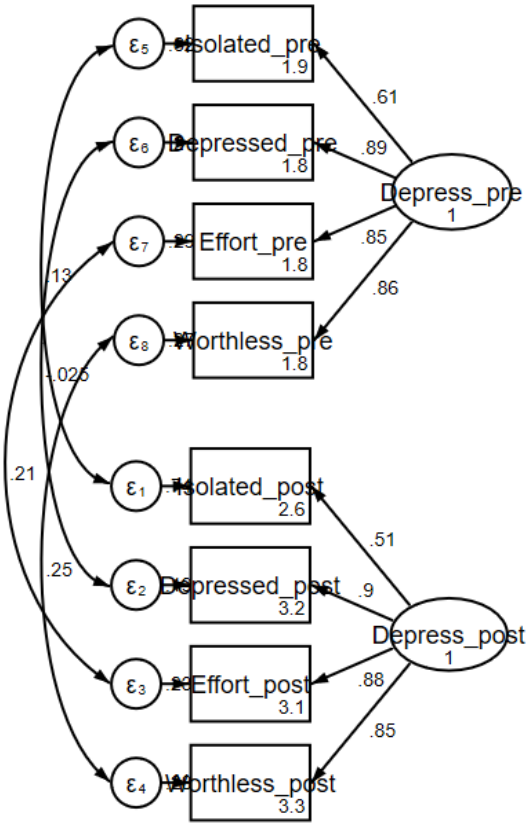


Figure 8: Pre/Post Measurement Model

Table 4. Pretreatment Measurement Model

Standardized	Coef.	OIM Std. Err.	z	P>|z|	[95% Conf.	Interval]
Measurement						
Isolated_pre						
Depress	0.640	0.034	18.99	0.000	0.574	0.706
_cons	1.911	0.087	21.90	0.000	1.740	2.082
Depressed_pre						
Depress	0.887	0.017	52.94	0.000	0.854	0.919
_cons	1.831	0.085	21.56	0.000	1.665	1.997
Effort_pre						
Depress	0.829	0.020	41.32	0.000	0.790	0.869
_cons	1.798	0.084	21.41	0.000	1.634	1.963
Worthless_pre						
Depress	0.869	0.018	48.36	0.000	0.834	0.904
_cons	1.778	0.083	21.32	0.000	1.615	1.942
var(e.Isolated_pre)	0.591	0.043			0.512	0.682
var(e.Depressed_pre)	0.214	0.030			0.163	0.281
var(e.Effort_pre)	0.312	0.033			0.253	0.385
var(e.Worthless_pre)	0.245	0.031			0.191	0.315
var(Depress)	1.000	.			.	.

The goodness of fit statistics showed a well-fitting model of the “Depression” construct variable. The Root Mean Squared Error of Application (RMSEA) is 0.084. The Comparative Fit Index (CFI) is 0.994 and the Standardized Root Mean Residual (SRMR) is 0.17.

In a Structural Equation Modeling framework, Measurement Invariance is commonly used to test the hypothesis of whether a theoretical model fits well to the data across groups, in this case the pre and post treatment data on the “Depression” construct. For simplicity, Measurement Invariance can be summarized as assessing the psychometric equivalence of a construct across groups or across time (Putnick and Bornstein, 2016). In this evaluation, Measurement Invariance examines whether questions regarding isolation, depression, effort, and worthless are interpreted in the same way across time as in “before and after” type questions. Therefore, prior to testing mean differences across groups, we must first assess the invariance of the “Depression” construct. In other words, we want to make sure we are comparing “apples to apples and not apples to oranges” (Clark and Donnellan, 2021).

Three tests of Measurement Invariance were used to ensure that the loadings and intercepts were consistent across models. Configural Invariance (structural equivalence) determined that the basic organization (loadings on each latent factor) of the “Depression” construct holds for both pre and post groups. Metric Invariance (measurement unit equivalence) indicated that the factor loadings (slopes) are the same across pre and post groups. Scalar Invariance (full score equivalence), where the intercepts are

the same across pre and post groups, indicated that the latent means can be compared across pre and post groups meaningfully.[6]

Having proved Measurement Invariance, Table 5 presents the means for the pre and post indicators in the "Depression" latent variable and shows a change in the group mean score of 1.244 standard deviations from pre to Post. To account for any non-normally distributed data, an asymptotic distribution free (ADF) method was use for the estimated parameters. The z-score of 13.60, a p-value of 0.000, and confidence intervals of 1.064 to 1.423 at the 95% confidence level indicate that a statistically reliable and positive change occurred. This is considered a very strong indicator that a positive change in client wellness has occurred during the time of treatment at CAL.

Table 5: Latent Variable Analysis:
Comparison of Mean Differences between Pre and Post Treatment

	Standardized	Coef.	Std. Err.	z	P>|z|	[95% Conf.	Interval]
Measurement							
Isolated_pre							
	Depress_base	0.631	0.032	19.62	0.000	0.568	0.695
	_cons	1.913	0.057	33.62	0.000	1.802	2.025
Depressed_pre							
	Depress_base	0.906	0.019	47.96	0.000	0.869	0.943
	_cons	1.850	0.054	34.01	0.000	1.744	1.957
Effort_pre							
	Depress_base	0.897	0.019	48.30	0.000	0.861	0.934
	_cons	1.815	0.050	36.19	0.000	1.717	1.913
Worthless_pre							
	Depress_base	0.848	0.020	43.11	0.000	0.809	0.886
	_cons	1.749	0.052	33.32	0.000	1.646	1.852
Isolated_post							
	Depress_post	0.545	0.032	17.18	0.000	0.483	0.608
	_cons	1.931	0.073	26.34	0.000	1.787	2.074
Depressed_post							
	Depress_post	0.893	0.017	52.61	0.000	0.860	0.926
	_cons	2.131	0.095	22.55	0.000	1.946	2.317
Effort_post							
	Depress_post	0.900	0.026	35.17	0.000	0.850	0.950
	_cons	2.126	0.099	21.40	0.000	1.931	2.321
Worthless_post							
	Depress_post	0.894	0.018	50.63	0.000	0.860	0.929
	_cons	2.155	0.100	21.45	0.000	1.958	2.352
	mean(Depress_post)	1.244	0.091	13.60	0.000	1.064	1.423

The difference between the standardized pre and post mean values can also be interpreted as the effect size. The effect size can help us understand the magnitude as well as the importance of the difference. The effect size between pre and post mean values is one more way to evaluate the client reported difference between before and after treatment. Generally, a change of 0.5 standard deviations is

[6] See Putnick and Bornstein 2016 for detailed methodological steps used in conducting Measurement Invariance tests for this evaluation.

considered to be a very high indication of change. The 1.244 difference in the standardized pre and post mean values captured in this latent variable analysis suggests a very high indication of change for CAL clients.

From a review of the SWE data, it is clear something meaningful did take place with CAL clients. Important to note is the fact that the post treatment questionnaire process for many CAL clients was mostly completed in a countywide COVID-19 restricted social environment, an environment that has highly affected the everyday social and economic relations of residents. We would expect to see higher rates of distress and high rates of client dropouts during this time. The SWE data highly suggests the opposite has occurred for CAL clients.

It is important to note here that these findings are specifically for CAL clients. It is reasonable to suggest that the results may not be the same for a different population in a different location with different circumstances. Therefore, generalization of these findings to a wider population is not recommended. However, the data suggest the potential for this program design to be effective for a similar demographic population experiencing similar social and economic conditions. And these similarities do exist in a number of cities and neighborhoods, both rural and urban, across California. Given the important implications of these findings, it may help to explain how such positive changes take hold with a population that historically has been difficult for therapists to connect with; a problem that has consistently resulted in high dropout rates from mental health intervention programs.

Feedback Informed Treatment

There is clearly evidence supporting positive connections between CAL clients in distress and the culturally focused care they receive through their participation in the program. The evidence also highly suggests that client wellness significantly improves as a result of their participation. However, one obvious question is how does this actually happen? Why does the treatment work?

An important component of *La Familia's* Community-Defined Evidence Practice is the use of the FIT for CAL clients. FIT is an outcome management system that provides immediate, valid, and reliable client feedback during therapy sessions using simple but effective data collections methods that are user-friendly for both therapists and consumers.[7] The use of FIT at *La Familia* was initiated by Dr. David Nylund, Clinical Director of the Gender Health Center. Dr. Nylund is a certified trainer in FIT through the International Center for Clinical Excellence. He has also assisted with Clinical Supervision and training at *La Familia* since 1998. His work with marginalized people and their experience with public mental health systems led to his suggesting the use of FIT for clients seeking services at *La Familia*. Nylund states that, "because FIT centers the experience of the client, it lends itself to culturally responsive principles of partnering with clients. Latino/a/x communities have been underserved in mental health. FIT privileges their experience which includes the clients' cultural context." FIT forms are also available in Spanish, facilitating their use with the Hispanic community. From this view, FIT complements the *Cultura de Salud* principles used to design CAL services and delivery practices making it a valuable tool to demonstrate the effectiveness of community-defined mental health programming with culture serving as the foundation for program design.

Like *The Enchilada Approach to Reawakening Therapy*, the reasoning behind FIT is that mental health practitioners are shaped by their own social and economic class, race, ethnicity, sexuality, gender, ability,

[7] Feedback Informed Treatment (FIT) is also referred to as the Partners for Change Outcome Management System (PCOMS).

age, and spiritual/religious traditions. Tilsen and colleagues (2012) stress that to provide service that is responsive to the, "patient characteristics, culture, and preferences," therapists must become aware of the impact their own culture and worldview has on what is seen or heard (or not seen or heard), deemed important (or not), and either given attention or ignored. In a sense, FIT is a process that provides therapists with the feedback necessary for becoming culturally responsive through ongoing learning, reflection, and consideration of how each client feels about their treatment as well as the relationship with their therapist. FIT Outcomes provides therapists with an immediate and continuous opportunity for self-reflection after every therapy session with client feedback helping them to be aware and culturally responsive to the client's social and emotional condition.

The CAL team clearly see a value in integrating culture as a priority in community mental health program design. Using FIT as a clinical tool to help overcome language, educational, and cultural barriers while building effective and responsible client/therapist alliances is one way CAL works to operationalize the principles of *The Enchilada Approach to Reawakening Therapy* in daily practice. The decision to use FIT to monitor and to collect therapeutic session data is one component of program design that helps define CAL as a community defined evidence practice. The CAL program further supports the program design by using staff that fluently speak the same language, come from the same community, and share similar family migration and life histories with their clients.

In addition to cultural sensitivities, FIT also helps address the high dropout rates from therapy. Swift and Greenberg (2012) found that about one in every five clients drop out of therapy. Populations, historically marginalized by traditional mental health systems, experience even higher rates of treatment failure and dropping out of treatment (Spoont et al., 2017). Clients who drop out of therapy prematurely often have poorer outcomes than patients who continue in therapy until treatment goals are achieved (Archer et al., 2000; Klein et al., 2003; Moras, 1986). The long-term negative impacts to clients, therapists, health care agencies, and society (Barrett et al., 2008; Swift and Greenberg, 2012) signal an urgency to understanding treatment failure and the dropout problem facing marginalized populations such as CAL clients.

Roseborough et al. (2015) suggest that client dropout and the resulting treatment failure can be anticipated, identified, and reduced. Howard et al. (1996) posits that patient-focused research using continuous feedback from clients can directly address retention problems. Their research shows how providing therapists feedback about client progress during treatment can help therapists understand the need for further treatment for patients not progressing at expected rates. Extensive research also shows that using continuous assessment information was helpful to all clients with those who were predicted to not succeed in treatment especially benefitting more than other clients (Harmon et al., 2007; Hawkins et al., 2004; Slade et al., 2008). Taking the continuous assessment model a step further, Whipple et al. (2003), Harmon et al. (2007), and Slade et al. (2008) found that adding feedback measures regarding the client/therapist alliance, motivation to change, and perceived social support for clients identified as not on track resulted in incremental effectiveness when compared to a simple continuous feedback model.

The research on continuous client feedback also documents how an integrated and systematic evaluation of client response to treatment during the course of therapy benefits both client and therapist; the continued and immediate flow of information can be used to determine the appropriateness of the current treatment. Winkeljohn et al. (2017) state that the use of client feedback, via self-report measures of psychological functioning and working alliance, is an effective way to improve therapy outcomes. They examine the effectiveness of FIT by analyzing therapy outcomes, alliance processes, and verbatim dialogue of in-session exchanges. Their research found that feedback assisted with alliance formation,

specifically decision-making about therapeutic tasks and managing negative counter transference resulting in positive therapy outcomes in clients.

Duncan and Miller (2000) found that understanding the client's view of the client/therapist alliance is a much more accurate predictor of success than the therapist's perspective. Using brief and frequently scheduled measurements of client feedback promotes consistency in treatment administration, which in turn leads to increased validity of the data the clinician accumulates (Seidel and Miller, 2012).

Research also indicates that access to such data improves retention and outcome for clients most at risk for treatment failure (Miller et al., 2005). Using FIT in clinical practice has been shown to result in a three and a half times more likelihood of achieving reliable change and half the likelihood of deterioration during treatment services (Lambert et al., 2011).

The FIT Model

The FIT model uses two simple forms (available in Spanish) to obtain continuous client information regarding the therapeutic alliance with their therapist as well as the outcome of care: the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). The ORS helps monitor therapeutic outcomes by using four basic questions to assess the degree of severity of clients' experience in a number of key areas of life functioning: individual (personal wellbeing), interpersonal (family, close relationships), social (work, school, friendships), and overall (general sense of wellbeing). The responses are captured as scores from one to ten for a maximum score of 40. Low scores represent lower levels of functioning and represent an early warning system for clients at risk of a negative outcome. The ORS also helps identify any external conditions that may be impairing forward progress.

The ORS is completed at the beginning of therapy. It is designed to help a therapist assess what has occurred since the last session and allows a therapist to determine if the present course of action should be maintained or modified. The "clinical cutoff" for the ORS score is 25 for adults. The clinical cutoff refers to a statistical equation that provides a baseline which best differentiates a sample clinical population (those seeking help from a therapist) to those who are not (a sample non-clinical population). The clinical cutoff as used with FIT is the score that represents the level of distress (what the ORS actually measures) that typifies the level of distress of clients entering or not entering therapeutic services (Seidel and Miller, 2012).

The SRS is the tool used at the end of each session and results in an assessment of the day's work. The information collected is then used to inform service delivery. The SRS is designed to routinely and formally solicit feedback from clients to measure the important therapeutic alliance between client and therapist required for reaching positive treatment outcomes. The SRS is a visual instrument with scales for scoring the results of four questions that have proven to be extremely effective for facilitating therapy (Duncan et al., 2003). The SRS provides the opportunity for clients to provide immediate feedback on if they felt heard and respected during the session, did the session address the issues they wanted to work on, if the therapist's approach is a good fit for the client, and overall comments on if anything was missing in the session. The SRS gives the therapist immediate feedback on how the session has gone for the client and allows for timely adjustments to treatment plans and approach.

Analysis of FIT Data for CAL Clients

Client feedback from CAL therapy sessions is recorded using FIT Outcome, a web-based outcome management system designed to support the use of the ORS and the SRS during therapy sessions. A total of 293 clients completed ORS and SRS forms following 1,197 therapy sessions for an average of just over

four sessions per client. The program was unable to complete Post ORS and SRS forms for 45 clients due to COVID-19 restrictions. The switch to online communications was problematic as the lack of computer resources impacted the ability for CAL staff to administer the ORS and SRS to those clients. However, given the fact that there were 338 post treatment evaluations captured on the SWE data, it is apparent that there were no dropouts from the CAL program.

ORS Scores: The Average ORS Intake score for CAL clients is 18.81, approximately seven points below the ORS clinical "cut off" of 25. The data indicate that the average CAL client was in a great deal of distress, experiencing some degree of instability, and in need of intervention at the time of their first meeting with a CAL therapist. The Average Raw Change, which indicates the average change in ORS score from the client's first therapy session to the last session is 11.32. The increased average change indicates a clinically significant change – in the case of CAL clients, a significant and positive change from the initial therapy session. A clinically significant change is defined as a score that changed from below the clinical cutoff to a score that is equal to or greater than the cutoff, and also changed by at least 5 points (Seidel and Miller, 2012). The Average Final Score, arrived at by adding the intake score to the Average Raw Change, is 30.13 for CAL clients. Using the Jacobson Plot method to interpret the score, (see Figure 9) the data show that the average CAL client experienced a positive significant change that is beyond a trivial amount of day-to-day fluctuation (Jacobson and Truax, 1991).

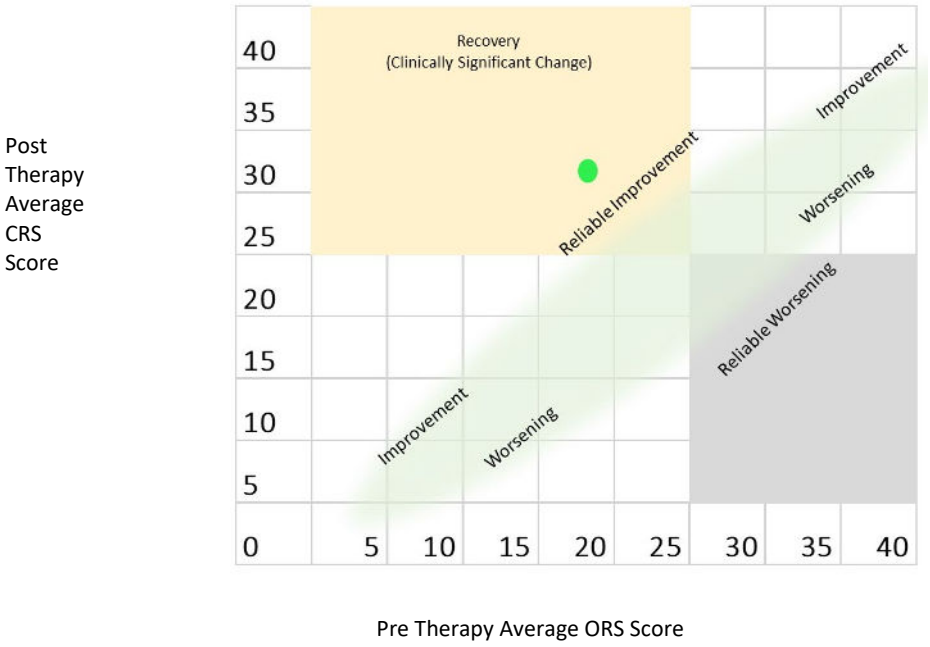


Figure 9: Jacobson Scatterplot for CAL Average ORS Score.
Average CAL Final ORS score indicated by green dot.

Effect Size:
For FIT and the ORS, the Effect Size is a statistic that is used to measure the amount of change (the size of change overall, rather than how many people changed). The Effect Size takes into account the severity of a client's distress at the start of therapy then measures the size of the change relative to the client's functioning at the outset. The Effect Size for CAL clients is .77 indicating a significant and positive change towards stabilization.

Percent Reaching Target: The metric refers to the number of clients whose scores improve by the end of treatment at least to a score that is expected given their wellbeing score in the first session. The "expected" score is an approximation based on changes documented before and after therapy for a very large reference pool of clients who start therapy at varying levels of distress. The baseline score is then used to track the trend of change for the reference pool, which is used to estimate an expected or "target" amount of change for new clients at the start of their treatment. Half of all clients are expected to score below the target and half are expected score above the target score (Seidel and Miller, 2012). The CAL score of .78 means that approximately 80% of CAL clients reached or exceeded the expected target score.

SRS Scores: The SRS average score for CAL clients at their first therapy session is 35.83, slightly below (.17) the cutoff. Final SRS averages indicated 90% of final scores were above the cutoff indicating that CAL therapists created a very strong therapeutic alliance where clients felt safe to give feedback. This means that the therapists had outstanding relationships with their clients, created a culture of feedback during the course of therapy, and supported clients to give honest feedback to the therapist (which honors the clients' local knowledge and culture). The fact that there were no dropouts from treatment helps support both the SRS findings of positive client/therapist alliances and that culturally sensitive programming may help address the retention problem.

We know that making connections with the Latino client base is difficult due to their experiences with a lack of information, stigmas, and limitations in traditional medical models that place less of a priority on patient backgrounds and surroundings. The use of FIT in CAL provides an effective method of monitoring and measuring progress, from the client's perspective, in building strong client/therapist relationships. The results of the FIT data suggest that alliances of trust, so important for effective therapy and stabilization to occur, were effective and may have contributed to the client's willingness to engage in therapy thereby encouraging utilization and retention, which are critical for reaching some degree of stabilization. The forging of these successful client/therapist alliances can be attained when cultural practices are prioritized and nurtured as part of the treatment model. Interview data helps verify the strong client/therapist alliances. Clients eagerly described the connections and trust they experienced with CAL staff:

> *"Me siento valorada en el respecto de que me escuchan... Y me siento pues como cualquier persona apoyada, valorada, que no discriminan nada, al contrario, como de la familia."*
>
> *["I feel valued in the respect that they listen to me… And I feel like any other person who is supported, and valued, where they don't discriminate on anything, on the contrary, I feel like part of the family."]*

Simply feeling like they are being heard can bring a sense of being valued in the client/therapist relationship. As the client points out, this changes the relationship between the client and therapist. Language is also a key part of building trust as it is important for clients to feel like they can communicate freely without worrying about using the right words and know with confidence that they are being heard.

> *"Aquí hay muchas personas que hablan español, y es nuestro idioma, y se nos hace más fácil comunicarnos y todo. Y yo nunca tuve la oportunidad de comunicarme bien con la terapista en español y todo."*

["Here they have many people who speak Spanish, and it is our language, and it makes it easier for us to communicate and everything. And I never had the opportunity to communicate well with the therapist and everything in Spanish and everything."]

Interview data also suggest that the supportive environment and genuine engagement with staff brought a sense of security that proved effective for receiving therapy, retention and utilization.

"Él me dio terapias, me escuchó, me ayudó a cómo comprender y entender las cosas. Yo me sentí muy apoyada de él, muchísimo. No sé cómo explicarlo, pero me ayudó mucho. Me sentía muy bien cuando iba con él a las citas que tuve. Todo me sentí bien tranquila, bien serena. Como que todo lo que yo sentía lo eché para afuera. Era como yo lo siento. Y me siento bien."

["He gave me therapy, listened to me, helped me how to understand things. I felt very supported by him, a lot. I don't know how to explain it, but it helped me a lot. I felt great when I would meet with him. Everything felt very calm, very serene. Like everything I felt, I threw out. That's how I feel. And I feel good."]

Clients point out that despite their intense life situations that find them at a point of crisis and vulnerability, there is still the need to feel like their lives deserve a level of respect and sincerity, and that this encourages them to be comfortable expressing their experiences and their opinions as well. A client explains… *"La ayuda que he necesitado me la han dado, y sobre todo con respeto, y me han dejado a mí opinar, desenvolverme todo lo que yo quería expresar. ["The help I have needed they have given to me, and given to me with respect, and they have let me express my opinion, to unwrap everything I wanted to express."]*

Similarly, another client describes how the supportive environment helps her connect with the therapeutic process*. "Hubo como un tipo de conexión que en realidad se siente muy bien y entra uno en un estado de confort para poderse expresar mejor." ["There was like a kind of connection that actually feels great and you go into a state of comfort to be able to express yourself better."]*

The *Cultura de Salud* principles used in designing CAL service delivery emphasize responsibilities of awareness to therapists as well as clients. Incorporating the ORS/SRS tools as part of the program design provides the tools for both CAL therapists and clients to meet those responsibilities through consistent monitoring of the client/therapist alliance and demonstrates how these eight principles move from theory to practice. Or, in the words of the CAL therapist – "from practice to theory." In other words, it is the daily cultural practices that shape the theories used to describe how culture remains a key component of effective mental health intervention. From an evaluator's vantage point, FIT appears to be a useful method for measuring as well as monitoring the effectiveness of an evidenced-based service delivery model designed with attention to culturally based principles that guide service and care.

Navigation Services

"… what's going on right now is getting trusted messengers, not government officials like myself, but trusted messengers in the community to outreach to people." Dr. Anthony Fauci[8]

[8] Dr. Anthony Fauci on Face the Nation, CBS News. July 11, 2021. https://www.msn.com/en-us/news/us/full-transcript-of-face-the-nation-on-july-11-2021/ar-AAM1Sqm

Social, legal, and economic acculturation presents daily challenges for Latino and immigrant families in accessing opportunities for employment, education, health care, and in obtaining safe and suitable shelter. All too often, stressors trigger conditions of distress requiring immediate attention that family members and friends are ill equipped to provide. Navigating the urban environment inevitably requires trust in public support agencies where language and culture are constant barriers.

Staff are clear that stabilization goes beyond therapy. Staff consistently point out that for therapy to be effective, a bundle of support services are necessary. Therefore, in the CAL treatment model, navigation services play an important role in neutralizing the effects of external factors that may impact a client's ability to attend and complete therapy. This view of support services reinforces the CAL concept of program design as a process where connecting clients to resources provides a window of opportunity for therapy and engagement to be successful. In the CAL model, navigation has a significant role in client retention, service utilization, changes in wellbeing, and stabilization. CAL staff also note that navigation services are not just about connecting clients to resources but serve as a path for clients to assume responsibility for seeking and accessing services. A CAL *Promotora/* Community Mental Health Worker explains:

> *The navigation is very important because when we go with them to different agencies for the first time, they are looking at how we talk, how we ask for help, what you have to do. So, when we take them and hold their hands, we are teaching them this, the first few times. Then they begin to feel comfortable to go by themselves to ask for these services. I think that the navigation is very important for them because it empowers the client.*

It is easy to see from the above explanation how navigation services go beyond simply connecting a client to resources. These services clear a path for therapy to be successful – not just by mitigating adverse conditions, but also by placing clients in a position where they can practice concepts learned in therapy for managing their daily lives. The navigator not only provides a safe passage to resources, but also a safe environment for learning and practicing independence of action. A significant amount of trust is required for navigation services to be effective. Like the therapist, community health workers must also build strong alliances between themselves and clients to become the "trusted messenger."

The concept of a community health worker has its roots in the "*Promotoras de Salud*" model, where people serve as a cultural bridge between community-based organizations, health care agencies, and the communities in which they live. "A *Promotora* is someone that is working in the community and comes from within the community" (Capitman et al., 2009). Relied upon widely in Latin American countries, *Promotoras* are used to bridge prevention, management, and control of public health problems (Balcázar et al., 2016). *Promotoras* act through community models that incorporate their work as a part of health care systems and other systems such as schools, recreation facilities, churches and cultural hubs in neighborhoods (Balcázar and de Heer, 2015). In a resource-limited environment, *Promotoras* become an essential part of the public health model making it possible to integrate an asset model of prevention in our most medically underserved places (Balcázar and de Heer, 2015).

The *Promotoras de Salud* model is widely used to promote nutrition assessments, establishment of cooperatives to produce basic and healthy nutrition products, and health awareness (Balcázar et al., 2016). They have also been effective in public health campaigns for tuberculosis, sexual and reproductive health, blindness prevention, health insurance programs, diabetes detection, environmental health, dental health, and even consumer financial education (Capitman et al., 2009; Hoeft et al., 2015; Ogland,

2010). Promotoras provide front-line public health care with an understanding of and connection to the communities served. *Promotoras* can play an important role in helping public health agencies to learn more about the communities they serve, improve service strategies, and reach hundreds, if not thousands, of people where traditional outreach has been largely ineffective (Gonzalez-Hernandez and Coleman, 2019).

In CAL, *Promotoras* function by design as members of an interdisciplinary team that supports clients as well as therapists by establishing alliances with local resource providers and creating pathways for wellness through information sharing and awareness, advocacy, and access to services. By breaking down language and cultural barriers between clients and resource providers, they build social capital to channel resources to clients who remain outside of the public health mainstream. This form of assistance works to build strong alliances and trust with clients increasing the potential for retention and utilization, which are necessary for stabilization to occur.

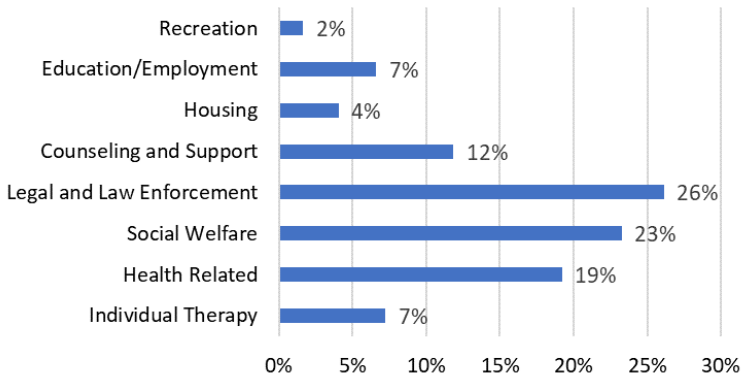
Because CAL is a short-term intervention program, many clients will need to continue some form of therapy and supportive services to sustain the progress they made in CAL. Many clients also require an array of services and assistance that are also important to stabilizing conditions associated with mental health crisis. The Cultural Service Satisfaction Questionnaire was designed by CAL to capture client feedback regarding navigation services. CAL coordinated client connections to 88 external service providers and public agencies for a variety of social and mental health services. Navigation services are grouped and summarized as follows:

- Mental health services: individual therapy and crisis intervention;
- Health related services: health care clinics and primary care providers;
- Social welfare services: nutritional resources, short-term financial and utility assistance. assistance with public welfare agencies;
- Legal and law enforcement: legal and immigration services, police intervention, domestic violence and protective services, family court;
- Counseling and support services: support groups, counseling, and behavioral oriented supportive services;
- Housing: assisting with unmet housing needs, emergency housing needs;
- Education and employment: referrals for ESL and GED courses, workforce development training, job search and placement; and
- Recreation: referrals to organized recreation activities such as Zumba.

CAL staff received 855 requests from 333 clients for navigation services. A total of 664 requests from 251 clients, or 78% of all requests, were successfully navigated where the client actually connected and received services from an external service provider. The average number of requests for navigation services per client is 2.6 with a range from 1 to 16 requests per client for assistance. Figure 9 shows the frequency of CAL navigation services by category.

Figure 10

CAL Navigation Services by Category



Almost 70% of all navigation services were concentrated in three categories: legal and law enforcement, social welfare, and health related services. Just over one out of every four clients (26%) were facing some form of legal or law enforcement issue such as incidents of domestic violence or immigration issues and navigating the related legal processes (e.g., restraining orders, family court). These types of problems tend to spill over to other areas of family life where families are separated and require additional emergency resources to stabilize a family's domestic situation. Approximately 200 requests or 23% of all requests for support received from CAL clients were for social welfare related services such as food, emergency financial support, and help with public welfare agencies.

A total of 191 requests for navigation services from 137 clients, or 22% of all requests were unsuccessful. However, in those instances when a client did not or could not follow through with navigation assistance, many of those clients were already on the receiving end of other successfully navigated connections with external service providers.

Approximately 92% of clients reported receiving the appropriate language services during the navigation process indicating that language remains an important asset when seeking assistance and connecting to services. Also, 96% of navigation clients reported that external agencies serving them were respectful of their culture. The presence of navigation services in the referral and follow up process indicates the impact of the culturally focused design. This focus emphasizes the use of the eight principles in working with CALs network of service providers as well as the efforts of CAL staff to ensure that the connections are successful as well as respectful to the client.

The categories for navigation services help in part to describe the situation of CAL clients at intake. What is not collected on any form is how CAL staff managed the crisis conditions of clients at intake and guiding them to stabilization. Interview data demonstrate the multiple "hats" the CAL *Promotora*/Community Mental Health Worker must wear to help with the varied, as well as urgent conditions of each client.

One important point to make here is that no data were collected on the number of outreach attempts by staff to find culturally competent services. It took CAL navigators hours upon hours of searching for help suitable for clients. When navigators were unable to locate the appropriate services, they took it upon themselves to provide interpreter services and attend client appointments at medical and other service providers to ensure access to care. This also helped create and build trust and a sense of safety between the CAL client and the external service provider.

Navigation as support function: From a review of the multiple forms of data available for this evaluation, it is reasonably safe to assume clients arrive at CAL with some degree of distress that adversely impacts their mental wellbeing. Language barriers, lack of connectivity to resources, lack of information, cultural norms, and stigmas, when coupled with mental distress all compound the challenges of seeking help from a not always welcoming social environment. CAL recognizes that the lack of support in navigating social and health services is one key reason Latinos routinely shy away from reaching out to traditional public support systems. Here, a client describes the importance of having someone who can provide emotional support.

> *"… yo no tengo familia. Toda mi familia está en Costa Rica… me sentí muy bien, me sentí apoyado, me sentí que no estaba solo. Fueron un apoyo muy grande, porque también tenía un poco de miedo ir al hospital y recibir noticias que no fueran muy alentadoras, muy positivas para uno. Y en ese momento sentir una persona que uno no la conoce, pero está ahí para apoyarlo a uno y darle las buenas vibras y hacerlo animarse uno y que se sienta bien, es muy bonito eso, eso es muy bonito y uno siempre se va a acordar de esos momentos."*
>
> *["…I don't have family here. My entire family is back in Costa Rica… I felt very good. I felt supported, and I felt that I wasn't alone. They were incredibly supportive, because I was a bit afraid of going to the hospital and getting bad news or not-so-great news. Having a person that maybe you don't know very well but is there to support you and give you positive vibes, cheer you up, and make you feel well, it's quite nice. It's quite nice, and you will always remember moments like these."]*

The client makes an observation that many CAL clients have expressed; having the physical presence of a navigator is also important to feeling supported in situations where clients may feel uncomfortable requesting or receiving assistance. When asked if he felt supported by CAL staff, the same client explains…

> *"Claro. Súper apoyado. De hecho, no sé si en todos los centros hacen lo mismo, pero me ayudaron como dándome información para yo poder sacar Medi-Cal, porque no tenía seguro. Entonces, ellos me ayudaron en eso. Y después, una vez que me dieron la primer cita en el doctor del Medi-Cal, me acompañaron a la cita. Me acompañaron a la cita, estuvieron ahí conmigo en todo momento, desde que llegamos a la clínica hasta que salimos. O sea, yo creo que no todos los centros tienen una atención así tan agradable para uno como la atención que me dieron ellos."*
>
> *["Of course, very supported. In fact, I don't know if they do the same thing at every center, but they helped me by giving me information so I could get Medi-Cal because I didn't have insurance. And once they gave me my first doctor's appointment with Medi-Cal, they accompanied me to the appointment. They were there with me the entire time since we got to the clinic up until the moment we left. I don't think that all centers offer the kind of support they do or are as caring as they were with me."]*

This level of support clients receive from CAL navigation services is frequently compared to that expected from a family member. Clients feel an unconditional support without judgement, something that may be missing from their current family relationships for a number of reasons such as physical distance or conflict. One client explains…

"… Porque es el apoyo que nunca tuve de mi familia. Me siento más en familia cuando llego ahí. Porque me preguntan cómo estoy, me hablan para ver cómo estoy, si necesito alguna ayuda. Usted sabe que cualquier palabra que a uno le digan, uno se siente bien. Y yo me siento apoyada porque, también, si en algo ocupo ayuda, ella luego, luego, halla la forma en que uno se sienta bien."

["It's the support I never had from my family. I feel more like family when I get there. Because they ask me how I am, they talk to me to see how I am, if I need any help. You know that any word you're told, you feel good. And I feel supported because, also, if I need help with something, she then, then, finds a way to make a person feel better."]

Clients have a sense that they can rely on CAL staff to support them in crisis conditions when they are most vulnerable to distress from crisis conditions.

"… El apoyo que nunca tuve en mi familia, lo tengo con ellos. Y ella, …si algo está mal, siempre tiene las palabras para decirme, 'No se preocupe, vamos a salir adelante. Voy a ver en qué la puedo ayudar y la voy a ayudar en lo más que se pueda.'"

["The support I never had from my family, I have it with them. And she, … if something is wrong, she always has the words to tell me, 'Don't worry, we're going to pull through. I'm going to see where I can help you as I'll help you as much as I can.'"]

Finally, an important support theme that was expressed in all of the interviews was the importance of language. A CAL client explains how important language is in navigating access to services. *"… Muy importante porque no hablo muy bien inglés, entonces muy importante. Y expresarse en el idioma que es de uno originalmente es muy importante, es muy bueno porque se puede expresar correctamente uno y que lo entiendan y uno entender a esa persona." ["… Very important because I don't speak English very well. So, it was very important. And being able to express yourself in your original language is very important. It's good because you're able to express yourself correctly, and you understand each other."]* Not only do the support activities of CAL navigators help intervene and stabilize crisis conditions, but their actions also create strong, dependable alliances built upon trust.

Navigators as protectors: CAL clients are aware of the importance of the navigation services they are provided. More important, they are aware that with the services also comes a sense of protection. CAL clients are acutely aware that connecting with public services outside of their community comes with emotional, social, and legal risks and vulnerabilities and that they may not always receive the level of care they need. Another client explains… *"Sí, porque yo ya he estado en otras agencias donde ofrecían consejería, pero pues solamente era consejería, no era – no había nada, así como que alguien estuviera pendiente ni nada." ["Because I have visited other agencies where they provided counseling but that was all they provided; there was no one looking out for you closely or anything like that."]*

Here a client describes being mistreated at a health clinic in the presence of a CAL navigator.

"Rocío me llevó también a lo del doctor porque soy una persona diabética. Y me gustó porque me sentí apoyada. Y ella me ayudó muchísimo porque la persona que nos atendió allí en la clínica, allí en el doctor, fue una persona bien déspota que me trató. Y Rocío dijo, 'Eh, eh, párale.' Y la señora a lo último nos pidió disculpas, quería llorar, cuando

Rocío le paró el alto. Porque yo no haya hecho eso, yo no. Yo no me sentía capaz porque a veces las personas humillan a uno. Creen que porque están ahí nos pueden tratar mal. Y Rocío le dijo, 'Eh, Ya. No te está diciendo nada para que la trates así… tú la estás tratando mal. Si tú has tenido un mal día, no tienes por qué desquitarte con ella.' Sí, me sentí muy apoyada, dije, 'Oh my God!' Ella me llevó, ella me regresó de vuelta; ahí, al lugar donde La Familia. Muy apoyada y siempre que ocupo algo, yo sé que le hablo a ella y ella me ayuda."

["Rocío also took me to the doctor's because I am a diabetic. And I liked it because I felt supported. And she helped me a lot because the person who treated us at the clinic, at the doctor's, was a very bad person who treated me. And Rocio said, 'Hey, hey, stop that.' And the lady apologized to us in the end, she wanted to cry, when Rocío stopped her. Because I wouldn't have done that, not me. I didn't feel capable because sometimes people humiliate you. They think that because we are there, they can treat you badly. And Rocío said, 'Hey, now. She's not telling you anything for you to treat her like that… you're treating her badly… If you've had a bad day, you don't have to take it out on her.' Yes, I felt very supported. I said, 'Oh my God!' She took me; she brought me back there, to the place where La Familia is. Very supportive and whenever I need something, I know that if I talk to her, she will help me."]

Navigators as sources of encouragement: Often CAL navigators must play the role of a coach giving steady encouragement to clients. During their time in the program, clients are learning new ways and approaches to healing – ways that also include personal responsibility. Navigators motivate clients to stay on track with appointments and check on them to make sure appointments and follow ups are kept, including the rescheduling of appointments when they are missed. Clients feel that this connectivity with staff helps them remain a part of the program. One client explains…

"… yo creo que quizás el hecho de que se tomen la molestia a veces de hablarle por teléfono a uno es lo que los… Me gusta mucho eso, que yo a veces le digo llamo por ciertas cosas, por ejemplo 'No voy a poder ir.' O pero después me están diciendo, 'Mira, ¿vas a venir? ¿vas a hacer tú cita?' O 'Es un recordatorio. No voy a poder estar, pero ¿puedes venir a tal hora?.' Es sentirse ese contacto que uno tiene con ellos de que están al pendiente que tú tienes una cita, pero okay ellos no van a estar aquí o yo la voy a mover, cómo hacemos para hacer un nuevo schedule. Me gusta mucho que hay mucha comunicación con ellos, no que los miras solo así solo porque vas a venir a recibir tus servicios y te vas, no."

["I think maybe the fact that they take the trouble sometimes to talk on the phone to you is what the... I really like that, which I sometimes say I call for certain things, for example 'I'm not going to be able to go.' And then they're telling me, 'Look, are you going to come? are you going to make your appointment?' Or 'It's a reminder. I'm not going to be able to be there, but can you come at such a time?' Just to feel that contact that one has with them that they are aware that you have an appointment, but okay they are not going to be here, or I am going to move it, how do we make a new schedule. I really like that there's a lot of communication with them, not that you look at them just like that just because you're going to come and get your services and you're out of here, no."]

Clients clearly feel a sense of caring and sincere engagement that keeps them engaged in the program. Furthermore, the unconditional offer to assist creates a safe haven for those unsure of their safety when seeking resources and assistance. For Latinos, the cultural directive is to provide assistance rather than seek assistance. For recent arrivals to this country and city and language isolated families, venturing into new surroundings to seek assistance is an enormous first step full of vulnerabilities, urgencies, and risks. A client recounts how CAL staff interacted with one such family.

> *"Por ejemplo, bueno me ha tocado ver aparte, me ha tocado ver aparte gente muy humilde, que se cohíbe en entrar o preguntar porque están así como tímidos pero, y luego… Me tocó ver que, por ejemplo alguien de La Familia los vio, los vio y le pregunta, en qué necesitan en qué los podemos ayudar, y todos cohibidos y 'Oh no, pásele venga, aquí lo orientamos...' O sea, es algo bien bonito a ver esa calidez, esa calidad de personas para otras personas que son, como muy tímidas e inseguras, y el temor principal de que se puedan sentir, que puedan dar ellos alguna información en cuanto a – Como hay muchas personas que no tienen documentos legales en este país, es muy triste."*
>
> *["For example, well I have seen, I've seen very humble people, who hold back from entering or asking because they are shy but, and then... I saw that, for example someone from La Familia saw them and asks them, what do they need, how can they help them, because they are feeling self-conscious and 'Oh no, come on in, come in, we're here to help you ...' I mean, it's a very nice thing to see that warmth, that quality from people for other people who are, timid and insecure, and the main fear that they may have, that they may give them some information about – because there are many people who do not have legal documents in this country, it is very sad."]*

She continues her story…

> *"… en unos centros comunitarios, aun siendo latinos, a veces hay rechazo, pero aquí no aquí, aquí La Familia es algo muy especial porque los hacen sentir como, los acogen con esa, esa calidez, esa seguridad que les brindan de manera que ellos se sienten con la confianza de expresar necesito esto, no tengo esto, qué hago, cómo me puede ayudar o cómo me puede rescatar de esto. Eso es una cosa que me ha tocado ver."*
>
> *["… in some communities, even Latino communities, sometimes there is rejection, but here not here, here La Familia is something very special because they make you feel like, they welcome them with that, that warmth, that security that they give you so that you feel confident to express I need this, I do not have this, what do I do, how can you help me or how you can rescue me from this. That's one thing I've seen."]*

Through multiple sources of qualitative and quantitative data, both clients and staff revealed that navigation services are essential to setting the positive conditions necessary for therapy to be successful. By design, CAL navigation services create pathways to stabilization and wellness by building strong alliances and trust that contribute to retention and utilization, and initiate awareness through multiple ways of information sharing. All of the different ways of intervening and connecting clients to resources, from social services to legal support, remain invaluable assets in the wellness process. These ways are often overlooked and devalued in traditional models for delivering mental health care.

Content Analysis

"… se acuerdan que yo existo en los momentos en que necesito que alguien me escuche."
["… they remember that I exist in the very moments when I need someone to listen to me."]

Understanding client satisfaction is important for the success of community mental health programs. When clients are not satisfied with their experience in treatment, it has an adverse effect on client retention as well as their participation in therapy and in dropout rates. Levels of engagement that are critical for interventions and treatment to be successful will decline and ultimately minimize the potential for stabilization and wellness. There are no universally agreed upon methods for measuring satisfaction. Since no specific measurement instruments were created to analyze client satisfaction for programs participating in CRDP, the SWE data set is used as a starting point to identify suitable variables that may help in understanding how clients feel about their level of satisfaction with CAL.

The SWE data reveals 338 CAL clients responded to post treatment questions regarding their experience in the program. The data show that just over 99% of clients (99.7%) agree or strongly agree that they liked the services they received and state that if they had other choices, they would still get services from this agency (99.11%). Nearly all clients (99.7%) would recommend CAL to friends or family. Clients overwhelmingly agreed or strongly agreed that the location of services was convenient (97.63%), that services were available at convenient times (98.82%), and that staff were willing to see them as often as they felt necessary (99.7%). Regarding access, almost all clients agreed or strongly agreed that staff were easy to talk to upon arrival to the center (97.34%), and that services were provided in the client's preferred language (99.7%).

The data suggest that clients are satisfied to some degree with their experience at CAL. However, Williams and Wilkinson (1995) stress that this type of measurement tends to treat clients as consumers and may provide false indicators of how clients feel about the care they received. They argue that the concept of satisfaction is too general to provide a meaningful guide to the way in which patients think about healthcare. Fisher (1983) similarly argued that such measurements provide only a crude understanding of the reaction of clients regarding their satisfaction of services received. CAL staff continually note that services and healing should be considered as a process rather than a dosage-oriented program design; that client wellness is the result of a coordinated bundle of interventions and resource connectivity tied together by cultural practices that guide service delivery. Given that perspective, measuring satisfaction requires a more comprehensive review. Although the above descriptive statistics may indicate some degree of satisfaction, they fail to consider key indicators outlined in this evaluation study such as changes in wellness, stabilization, awareness, and levels of engagement.

How do we assess client satisfaction? Noll and Dubinsky (1984) suggest that satisfaction should be considered as multidimensional – there is not one specific factor that leads to satisfaction. Instead, client-reported satisfaction is conditioned upon exposure to a number of factors. Lebow's (1983) extensive review of client satisfaction in community mental health programs also suggests that satisfaction appears to be a multidimensional concept. It is this multidimensional approach to measurement that appears to best complement the CAL program design.
The academic literature on community mental health offers some factors to consider. Studies examining consumer satisfaction with mental health treatment point to a strong relationship between satisfaction and patient-reported global outcomes (Lebow 1983). Clients reporting positive experiences with access, program quality, and participation in treatment planning also were more likely to report that they were generally satisfied with services (Sohn et al., 2014). Stamboglis and Jacobs (2020) found that seeing a

health professional closer to the community improves satisfaction, with patients seeing a community-psychiatric nurse, a social worker or a mental-health support worker being more satisfied. Flynn et al. (1981) offered that confidence with the therapeutic relationship is positively correlated with improvement. Similarly, a review of common factors in community mental health intervention by Kidd et al. (2017) supports the likely importance of the therapeutic alliance in positive client-reported outcomes of community mental health interventions.

Also important to this discussion is the question of cultural competence. Greene (1996) in her study of African American women experiencing societal barriers to psychotherapy states that a culturally literate and antiracist therapist must begin by understanding the roles of multiple identities and oppressions play in client's lives. She argues that therapists must be willing to acquire a familiarity with the client's cultural and ethnic heritage in addition to understanding the role of institutional barriers in a client's life. According to Greene, the therapist must be willing to acknowledge each client's personal barriers and resources by exploring significant figures, relationships, and their patterns, and events in their personal lives.

CAL, through the eight principles that make up the *Cultura de Salud*, incorporates the concepts articulated by Green and others into their daily practice as they serve not only as guides for service delivery but for building alliances while providing important client protections as well. Here, it is important to note that these concepts are not new to La Familia. It bears repeating that for over 45 years, they have intentionally connected these culturally based principles to their daily practice of community mental health (Fernandez and Barnes, 1978). Therefore, any assessment or measurement of client satisfaction in CAL must somehow attempt to incorporate the eight culturally based principles into the analysis.

For this segment of the evaluation, a Content Analysis is used on qualitative data extracted from 22 volunteer interviews of CAL clients following their participation in the program are used to analyze client satisfaction. Two focus groups, one with the CAL Community Advisory Board (CAB) and another with CAL staff are also included as part of the data for a total of 24 interviews. The interviews were transcribed and produced 154 pages of data. Each interview was reviewed a minimum of three times to identify recurring and common themes and to ensure that translations were reasonably accurate. These themes, which consisted of text phrases and sentences, described important characteristics or conditions experienced by CAL clients. The themes were then assigned codes which allows responses to be categorized and transformed into metrics that can be analyzed, compared, and interpreted.

Both deductive and inductive methods of coding were used to assign codes to the identified themes. Deductive coding, where predetermined codes were identified before reviewing the data, was used to identify the client responses that best described how the eight principles were integrated into the client experience. Deductive coding was also used to incorporate the seven evaluation indicators into the analysis. Inductive coding was used to include themes important to understanding client conditions that were not included in the predetermined codes used in the deductive coding process. This allowed for the inclusion of themes such as barriers to help, client pretreatment conditions, and client post treatment conditions; each of which were further refined into subcategories. Using Dedoose, a qualitative software application designed for this type of research, a total of 52 codes (16 primary or "parent" codes and 36 secondary or "child" codes) were created and applied during the comprehensive review of each interview transcription. A total of 2065 code applications resulted from the review. Table 6 shows the frequencies of code applications applied during the review of the interview transcriptions. Only codes with applications higher than 50 occurrences are shown.

Table 6. CAL Qualitative Code Applications by Frequency

Code Applications	Total
Awareness	103
Changes in Wellbeing	69
Client Responsibility	76
Accessing Services	51
Positive connections with community	62
Positive connections with therapist	104
Staff connecting with client	93
Stabilization	69
Service Utilization	154
Service Satisfaction	139

The frequency of the code applications shows how often the interviewees described an experience or expressed some feeling related to each of the codes. Service utilization is the code with the highest frequency. Clients recounted the ways in which service utilization was made possible by staff and how using CAL services benefitted them in some way. No negative recollections of service utilization were recorded. The high frequency of this code indicates some level of importance was placed on it by the group of interviewees as a whole. We also see high frequencies of code applications for service satisfaction, positive connections with therapist, client awareness, and staff connecting with clients. This method of applying and quantifying the code categories provides insight on the program characteristics that clients experience and could be most concerned with. The method provides a baseline of information that can be used to identify some level of client satisfaction.

Code co-occurrence is used here to identify and isolate indications of client satisfaction. In qualitative research, code co-occurrence is understood as the overlap or common occurrence of two or more codes for a particular segment of a coded text – in this case, the coded interview transcription. With the assistance of qualitative software, we can identify coded quotations that are touching each other in some way. Through this method, it is possible to see the exact quotations in which two codes are "co-occurring." Two codes that are co-occurring in the coded transcriptions are indications that the two codes in some ways are associated with each other, thus giving a coded passage or phrase multiple meanings. By exploring these quotations, we can come to an understanding of the actual meanings behind these associations.

Table 7: CAL Interview Qualitative Code Co-Occurrence with Service Satisfaction

Service Satisfaction Code Co-Occurrence	Total	Percent*
Awareness	44	43%
Changes in Wellbeing	39	57%
Client Responsibility	31	41%
Accessing Services	27	53%
Positive connections with community	37	60%
Positive connections with therapist	72	69%
Staff connecting with client	63	68%
Stabilization	42	61%
Service Utilization	90	58%

*Percent of all code applications in category

Table 7 isolates the frequency of code co-occurrence between Service Satisfaction and each of the codes listed in Table 6. Using the code co-occurrence between Service Satisfaction and Positive Connections with the therapist as an example, we can see that in the 104 instances where the Positive Connections code was applied, 72 instances were also related to Service Satisfaction. In other words, in the total number of applications for the "Positive connections with therapist" code, 69% of such applications also represent some form of positive client feedback on Service Satisfaction. Through this method of analysis, it is possible to deduce, for example, that a client's positive connection with their therapist may be somewhat or highly associated with Service Satisfaction and that this association may contribute to increased responses of satisfaction. Table 7 suggests that, to some degree, all of the code applications with the highest frequencies have an important and positive connection to Service Satisfaction. The fact that a good number of code applications may have an impact on Service Satisfaction supports the notion expressed by Noll and Dubinsky (1984) and Lebow (1983) that Service Satisfaction may very well be multidimensional.

Table 8: CAL Qualitative Code Applications by Frequency for the Eight Principles

Code Applications - Eight Principles	**Total**
Community embedded services	85
Cultural and community connection	71
Emphasis on the whole family	55
Facing limitations	70
Mutual respect	61
Respect and understanding of culture	65
Shared responsibility for change	92
Sincere engagement	79

Table 9: Service Satisfaction Code Co-Occurrence with the Eight Principles

Service Satisfaction Code Co-Occurrence - Eight Principles	**Total**	**Percent***
Community embedded services	36	42%
Cultural and community connection	36	51%
Emphasis on the whole family	34	62%
Facing limitations	26	37%
Mutual respect	40	66%
Respect and understanding of culture	41	63%
Shared responsibility for change	36	39%
Sincere engagement	49	62%

*Percent of all code applications in category

A similar approach was used to analyze the relationship between the program's use of the *Cultura de Salud's* eight principles and Service Satisfaction. Table 8 shows the frequency of the eight principles when applied as codes to the 24 transcribed interviews. The code for each principle was applied over 50 times showing that interviewees quite often expressed some feeling related to each of the principles. This frequency should give us some indication that the eight principles may have some significance when attempting to understand the overall treatment experience as reported by CAL clients.

Table 9 isolates the frequency of code co-occurrence between Service Satisfaction and each of the eight principles displayed in Table 8. Using the code co-occurrence between Service Satisfaction and the principle Facing Limitations, the principle with the lowest frequency in this comparison, we can see that for all of the instances where the Facing Limitations code was applied, just over one out of every three instances (37%) were also indicators of positive Service Satisfaction. The process of clients dealing with facing their limitations is not always a simple task. The fact that almost 40% of instances where this code was applied was also related to some form of positive client feedback on Service Satisfaction suggests something important may be taking place.

Table 9 also provides additional clues on what may be important for CAL clients when they consider their responses to Service Satisfaction. Even higher rates of code co-occurrence are seen with the codes Emphasis on the whole family (63%), Mutual respect (66%), Respect and understanding of the client's culture (66%) and Sincere engagement (62%). Two important points can be gleaned here. First, clients may view cultural competence and sensitivity as important to the wellness process. Second, respect for the client and acknowledging the importance of the family may be equally important to the wellness process. Using this Content Analysis approach for understanding the connections between the eight principles and Service Satisfaction again suggests that Service Satisfaction as well as successful intervention may very well be multidimensional. Perhaps the most effective way to gain insight on client satisfaction is simply to hear the words of clients and staff.

Service Satisfaction and Client Responses

The CAL client interviews provided an extensive amount of data regarding the feelings and opinions of their experience in the program – far more than what can be presented in this short evaluation report. In the review of 154 pages of client feedback, this evaluator was unable to identify any negative comments from clients regarding their experiences in the program. The quotes from clients that follow should give some idea of how the multidimensional characteristics of CALs program design may lead to Service Satisfaction.

The abundance of positive responses reported by CAL clients speaks to the wide scope of tasks and efforts undertaken by CAL staff to facilitate intervention and stabilization and the high level of care and concern delivered to CAL clients. The fact that these passages represent only a fraction of the positive responses from clients may help us understand the level of service satisfaction they reported. Service satisfaction is related to so many success indicators and demonstrates the presence of the eight principles in the course of service delivery. Therefore, the number of passages here an important and warranted part of the program evaluation.

Positive experience with therapy: We know from the above data that a positive experience in therapy may be an indicator of client satisfaction. Here is the response of one client during his post treatment interview. When asked how he feels now, the client responded…

> *"Me siento muy bien. Como le comentaba yo a Emilio, es otro nivel porque ya tengo más deseos de seguir luchando todavía más. Y pues aceptar más mi realidad, porque hablo del pasado, mucho del pasado años atrás, porque no podía aceptar mi realidad por mi situación. Entonces agradecido con Dios, agradecido con la familia, con los que me apoyaron para seguir adelante. Me hicieron saber y entender que la vida tiene que continuar. Pero no vamos a recibir o a estar en paz completamente por la situación que yo viví, el cien porciento no voy a estar. Pero me dieron más ánimos de seguir adelante y luchar por lo que estoy viviendo todos los días."*

["I feel great. As I told Emilio, it is another level because I already have more desire to continue fighting even more. And I can accept my reality more, because I talk about the past, a lot of the past years ago, because I could not accept my reality because of my situation. Then also grateful to God, grateful to La Familia, to those who supported me to move forward. They let me know and understand that life has to go on. But we are not going to receive or be completely at peace because of the situation I experienced, one hundred percent I will not be. But they gave me more encouragement to move forward and fight for what I'm going through every day."]

Another client responds to the same question…

"Ahora yo pienso que estoy mejor que antes. Gracias al Sr. Emilio que él es mi terapista. Con él he platicado todo. Él nos evaluó nuestra vida, todas nuestras etapas de nuestra vida, qué es lo que nos ha afectado, qué es lo que nos ha afectado desde nuestra niñez hasta ahora adultos, y por qué hemos tenido esos problemas, y por qué nunca paramos por ese problema. No. Sí me ha ayudado muchísimo."

["Now I think I'm better than before. Thanks to Mr. Emilio he is my therapist. I've talked about everything with him. He assessed our life, all our stages of our lives, what has affected us, what has affected us from our childhood to now adults, and why we have had those problems, and why we never stopped because of that problem. No. Yes it has helped me a lot."]

Here, a client explains what he would say to people in need of mental health care but are apprehensive about seeking care…

"Que vengan al programa. Que se unan a las sesiones… Que existe la ayuda. Y que sí nos dan la ayuda. Y que vale la pena agarrar esta ayuda. Y que es bien importante esta ayuda. Y que no nos lo deberían de quitar este programa porque realmente nos ayuda mucho. Emilio y Rosy realmente créame que a mí en lo personal, y creo que si le pregunta a las demás compañeras le van a también decir cosas positivas de ellos, porque ellos nos han ayudado demasiado. El programa ayuda mucho. No deberían de quitarlo. Es muy buen programa."

["Let them come to this program. Let them join the sessions… To see that there is help. And they do give us the help. And it's worth the effort to get this help. And that this aid is very important. And that we should not take this program away because it really helps us a lot. Emilio and Rosy really believe in me personally, and I think if you ask the other clients, they will also say positive things about them because they have helped us so much. The program helps a lot. They should keep the program. It's a very good program."]

We can begin to see the convergence, or co-occurrence, of multiple indicators related to satisfaction such as changes in wellness, awareness, client responsibility.

Changes in wellness/awareness: Changes in clients' wellness and levels of awareness are of course primary goals of the program as well as key indicators of satisfaction. When asked what is the most important thing that you learned during your time at CAL, one client explains…

> *"Pues yo en mi aprendí pues en mi persona cómo desarrollarme emocionalmente para platicar, para tratar más a las personas, más que nada a mis hijos." ["Well, myself, I learned, me personally, how to develop emotionally to talk, how to treat people more… more than anything my children."]*

The client then adds…

> *"Lo más importante que he aprendido es expresarme yo sola, expresar mis emociones es lo más importante, sentirme segura. Porque antes no. Como le digo, no me sentía segura, me estresaba y empezaba a llorar y todo, y ahora no."*
>
> *["The most important thing I have learned is to express myself, expressing my emotions is the most important thing, feeling safe. Because I could not do that before. As I say, I didn't feel safe, I was stressed and started crying and everything, and not now."]*

Similarly, another client explains their change in awareness that led to changes in wellness…

> *"A entender por el momento que estaba pasando. Más que todo, a ver lo bueno y lo malo del momento, el por qué me había pasado eso a mí, ¿me entiende? Más que todo como para entender la situación de lo que estaba pasando y de lo que yo estaba viviendo. Entonces, era que si lo acepto, y si no lo acepto pues no voy a seguir adelante."*
>
> *["They helped me understand what I was going through, to see the good and bad aspects of the situation, and why this had happened to me. Do you understand me? They mostly helped me understand the situation and what I was going through or experiencing. So, I had to accept it. Otherwise, I would not be able to move on."]*

Clients were also asked if they have what they need to move forward and have they learned what they need to do to manage their health and to take care of themselves.

> *"Sí, sí porque inclusive uno lo proyecta y, por ejemplo personas me ven y me dicen, '¡Qué bien te ves! ¿Qué estas haciendo,' y digo sabes qué yo creo que después de mi terapia hice muchos cambios, hice muchas cambios, y eso me ayudó a crecer emocionalmente, espiritualmente hablando también, pero a sentirme valorada, amarme, a respetarme y sí ha mejorado mi salud pues se proyecta ¿verdad? En la energía entonces independientemente de todas las situaciones difíciles que he tenido este año, porque han sido situaciones muy fuertes y muy estresantes, pero he sabido manejar ahora el estrés de alguna manera, no tomarlo personal."*
>
> *["Yes, yes because now each of us project it and, for example, people see me and say, 'You're looking good! What are you doing?' and I say you know what I think after my therapy I made many changes, I made many changes, and that helped me to grow emotionally, spiritually speaking also, but to feel valued, to love me, to respect me and yes, it has improved my health because we project it, right? With this energy, then*

regardless of all the difficult situations I've had this year, because they have been very difficult and very stressful situations, but I now know how to handle stress now in some way, not take it personally."]

The client continues…

> *"Entonces fue algo muy bonita mi terapia, que me ayudó bastante, que también me desbalanceó un poquito ¿verdad? Porque luego había información que yo no sabía, que desconocía, pero gracias a eso tomé más conciencia."*
>
> *["It was something very beautiful my therapy, which helped me a lot, and also unbalanced me a little bit, right? There was information that I didn't know, that I didn't know, but thanks to that I became more aware."]*

Finally, one client describes changes in her wellbeing by simply putting a number to her progress.

> *"Antes, estaba yo en un punto del 1 al 10, como en un 5. Ahorita ya estoy en el 9.5 o 9. He avanzado bastante."*
>
> *["Before, I was at a point from 1 to 10, as in a 5. Right now, I'm at 9.5 or 9. I have come a long way."]*

Feeling like family: Many clients express a deep appreciation for the level of respect and kindness they received throughout their participation in the program; often likening the treatment to that received from a family member. Again, we see how evaluation indicators and eight principles continue to intersect: a sense of family, mutual respect, sincere engagement, connectivity. One client explains what made him feel like he became part of a family during his time in the program…

> *"Porque soy respetado. Soy bien recibido. Me dan mi tiempo para explicar mis cosas. Me escuchan. Y más que todo como familia. Lo siento la verdad."*
>
> *["Because I am respected. I am welcomed here. They give me my time to explain my stuff. They listen to me. And most of all, it's like family. It's the truth."]*

Another client commented on the appropriateness of the organization's name, *La Familia*.

> *"Cuando veo personas aquí, dicen 'ay, yo no sabía que tengo familia' … Y le digo, 'con razón le pusieron de nombre La Familia,' le dije yo, muy linda."*
>
> *["When I see people here, they say 'oh, I didn't know I have family' ... And I say, 'no wonder they named it La Familia,' I said, how nice."]*

CALs emphasis on family shows the interdependency of cultural understanding and mutual respect and how it can lead to client satisfaction and acceptance of intervention programming…

> *"Pues bien, a mí lo que me gustado a mí, si me dicen de La Familia, como me han tratado a mí. Para mí, han sido más que mi familia, que me han tratado, no como cualquier*

clienta o como cualquier paciente, sino me han tratado como si fuera de la casa. Y me hacen sentir como si anduviera yo en mi propio país, México."

["Well, what I've liked… if we're talking about La Familia, it's how they've treated me. In my opinion, they've been more than my family. They don't treat me like I'm just another client or patient, but they've treated me as if I were at home. And they make me feel as if I were in my own country, Mexico."]

"Mi experiencia ahí fue muy bonita, porque a mí me trataron muy bien, como una persona normal. A mí me encantó las pláticas que tuvimos. A mí me sirvió bastante y me gustó mucho, porque ahí te explican cómo debes de analizar las cosas y te tratan como si fueran de tu familia."

["My experience there was very nice, because I was treated very well, like a normal person, I loved the conversations we had. It helped me a lot and I liked it a lot, because there they explain how you should analyze things and they treat you as if they were your family."]

One client discusses how the CAL focus on family differs from traditional mental health interventions that separate family members…

"Para mí hace único, porque hace en vez de desunir a la familia, la une más."

["In my opinion, what's unique about it is that instead of separating the family, they work to unite it more."]

Again, we see how clients appreciate family values and an understanding of their culture – factors that lead to utilization, sincere engagement, and changes in wellness, which are interdependent with client satisfaction.

Utilization: An important point to make here is the different ways CAL staff make utilization possible. CAL staff explain how they facilitate utilization by eliminating as many administrative formalities as reasonably possible. One staff person noted… *"You make it easy to receive services and people feel welcome."* He continues…

"This is not a government agency. Community services means they don't have to go through any type of paperwork related to government. We get information based on the documents developed by our own agency… it's not technical. It's easier for people to understand the forms and no fear that they will be uncovered – they feel connected, like they can trust us, and they can share." "When they come here, they've been knocking on so may doors and no one helps. When they come here, we start working, looking for resources for them – they trust us, and clinicians make them feel comfortable and, they can understand, we can understand their needs more."

Clients describe how utilization sometimes can mean physically bringing the services to the client…

"Por eso le digo aquí me ayudaron bastante, como le digo, emocionalmente y todo. Por eso le digo que yo estoy contenta. Yo estoy contenta porque las veces que los he

necesitado – y créame que me he sentido en ratitos que no puedo, desesperada o algo. Y les llamo y, 'No. Tranquila. Espérate. Ahorita vamos a mandar a alguien que te ayuden con tu hijo o con tu hija o algo.' Y sí, sí van. Sí van. Y por eso yo estoy contenta."

["That's why I tell you, here, they helped me a lot, as I say, emotionally and everything. That is why I say to you that I am happy. I'm happy because the times I've needed them – and believe me I've felt in those little moments that I can't, I'm desperate or something… And I call them and, 'No. Quiet. Wait. Right now, we're going to send someone to help you with your son or your daughter or something.' And yes, they do go. Yes, they go. And that's why I'm happy."]

Another client describes her satisfaction with staff actually coming to her home to make sure she received the attention needed to mitigate her urgent situation…

"Pues no. Estoy satisfecha, como le digo, en todo. En todo porque especialmente han ido a mi casa. Han ido a mi casa, y muy amables. Y a la hora que pase, si es una emergencia o algo, el consejero de mi hijo, 'Ahorita voy. ¿Qué está pasando?' Y va. Hasta eso que me siento bien apoyada."

["I am satisfied, as I say, in everything. In all because they have especially come to my house. They came to my house and are very friendly. And when the time happens, if it's an emergency or something, my son's counselor, 'I go immediately. What's going on?' And that's how it goes. Even with that I feel well supported."]

Sincere Engagement: One indicator expressed by clients as important for client satisfaction was knowing there is sincere engagement by staff in the treatment process. Clients often noted that one important difference between CAL and traditional programs is the way staff engage with clients in meaningful ways that promote trust and build alliances needed for effective treatment to occur.

"Yo como le digo, conviví con Rosy y con Emilio. Ellos, es una pasión para ellos luchar. Y ella me decía, 'No. El fin de semana después de mis horas, no me importa, yo quiero que me hables y me digas cómo te sientes y qué necesitas.' O sea, Emilio igual."

["As I say, I spent time with Rosy and Emilio. For them, this work is a passion. And she said to me, 'No. The weekend or after my work hours, I don't care, I want you to call me and tell me how you feel and what you need.' That is, Emilio is the same."]

Staff explain how they approach engagment with a client…

"It's really important for the person to feel that there's a compromise on our part. To feel this realistic interdependence so they feel supported and wiling to move forward. They are at the same time becoming at some point – we have very vulnerable clients, they really need - they need to know we are holding them while they are becoming independent enough to support themselves. At the beginning, they need to know we will hold them, but not forever. Until the person is able to be on his or her own feet."

Again, we can how see how the evaluation indicators intersect as sincere engagement by staff also serves to introduce clients to their responsibility to sincerely engage in their wellness. Sincere engagement also

reveals the connectivity between staff and clients, yet another indicator for client satisfaction. Here, one client expresses just how important it is to hear CAL staff reach out and encourage her to attend workshops and get engaged in program activities…

> *"Okay. Por ejemplo, me toman en cuenta para hacer los cursos, para las charlas. Me llaman a ver cómo me siento, cómo estoy, cómo – si necesito algo, si me hace falta algo. Eso es muy bueno porque pues se acuerdan que yo existo en los momentos en que necesito que alguien me escuche."*
>
> *["Okay. For example, they reach out to me to take the courses, the lectures. They call me to see how I feel, they ask me how I'm doing – if I need something. That's very good because they remember that I exist in the very moments when I need someone to listen to me."]*

The ability for CAL staff to connect with clients was noted often in interviews. Clients frequently describe a genuine effort by staff to be respectful and to meet clients on their terms and in their current situations.

> *"Ya cuando llegué ahí con Rocío, fue cuando me pude desenvolver bien todo el problema que yo tenía. Ella me escuchó sin criticarme, sin sentir lástima, compasión, como dicen. Es como si ella ya me conociera. Me hizo sentirme bien. Y fue como yo me pude desenvolver todo lo que yo sentía y lo que había vivido."*
>
> *["When I got there with Rocío, that was when I could talk about all the problems that I had. She listened to me without criticizing me, without feeling pity, compassion, as they say. It's as if she already knew me. It made me feel good. And it was like I was able to unwrap everything I felt and what I had lived through."]*

For CAL staff, sincere engagement is also reflected not just through their sensitivity to client conditions but also in the willingness to be available beyond the normal workday schedule. One client describes how staff welcome clients to check in at any time they feel the need for support.

> *"Entonces es bueno tener a alguien para abrir su pensamiento, su mente para – es bueno que lo escuchen a uno y que sientan que están ahí para apoyar. Entonces sí los veo a ellos muy apasionados con su trabajo, y quisieran tener más tiempo. O sea, no tienen suficiente tiempo. Créame que – dice, 'No importa. Llámame. Y como quiera hago un lugar.' Y esto y lo otro. Y como están muy ocupadísimos, yo lo entiendo, yo lo comprendo, hay mucha gente que están compartiendo con situaciones diferentes. Entonces yo me mantengo yo – cuando necesito algo solamente porque de verdad necesito algo, no nada más por llamar. Entonces sí les doy su espacio. Pero sí es demasiado lo que hacen por nosotros, demasiado."*
>
> *["So, it's good to have someone to open up to, your mind to – it's good to be heard and feel like you're being supported. I do see them being very passionate about their work, and they would like to have more time. Even if they don't have enough time. Believe me – they say, 'It doesn't matter call me and I'll figure out how to make time.' And this and that. And because they are very busy, I understand it, I understand it, there are many people they are helping with different situations. Then I take care of myself– I call when*

I really need something, not just to call. So, I do give them their space. But they do so much for us, so much."]

Many clients also see the sincere engagement from CAL staff through their efforts to provide access to multiple forms of assistance and resources. CAL staff understand the importance of addressing immediate needs so that treatment can be most effective. One client describes this form of engagement…

> *"Porque se preocupan por ayudar y si ven que hay alguna necesidad y ellos pueden ayudar, lo hacen. Siempre están buscando no sólo el grupo, si requiero otro tipo, asistencia legal, asistencia, no sé con ropa, con comida, con trabajo. Aportan… Empatía. Empatía, sentía comprensión, no me sentía como juzgada tampoco me sentía como ignorada, eso fue lo que yo sentí en el grupo."*
>
> *["Because they care about helping and if they see that there is any need and they can help, they do. They're always looking, not just in group, to see if I need other kinds, legal assistance, assistance, I don't know with clothes, with food, with work. They contribute… Empathy. Empathy, I felt understood, I didn't feel like I was judged didn't feel like I was ignored either, that's what I felt in the group."]*

Satisfaction encourages utilization through recruitment: One indication of service satisfaction is how clients feel the need to reciprocate to others experiencing distress by encouraging them to take advantage of CAL services. In a sense they become promoters of CAL as they see others also in need of care and support. A client describes how she encourages others in need of care to go to the center…

> *"Yo sí he hablado con personas que yo las he visto así mal, digo 'mire, vayan a La Familia,' de hecho les di los números de ahí, para que se comunicaran, para que se sientan a gusto así como me siento yo, porque, qué me gano con yo sentir mi felicidad, si los demás yo sé también que la necesitan. Yo sé que la necesitan. Saben qué? Mira, aquí en la familia ayudan mucho, este, dan buenos consejos, le sirve a uno… mentales y psicológicamente."*
>
> *["I have talked to people that I have seen that were not doing good, I say 'look, go to La Familia,' in fact I gave them the phone number, so that they could communicate, so that they feel comfortable just as I feel, because what do I gain feeling happy if the others I know that others also need help? I know what they need. You know what? Look, here at La Familia they help a lot, they give good advice, they serve people... mentally and psychologically."]*

Here, a client recounts how a friend revealed her own experience with therapy at *La Familia*, which encouraged her to seek help at CAL…

> *"… le ayudan a uno, lo escuchan, lo dejan hablar, y después lo hacen a uno ver por lo que uno está pasando, darse cuenta del momento, del ahora y tratar de entender. Entonces, sí, sí lo recomendaría y les diría de que les podría ayudar mucho si están pasando por una situación fuerte… En realidad, me ayudaron mucho, me ayudaron mucho y yo creo que por la ayuda de mi amigo haberme hablado de este centro, yo creo que estamos hablando de que si yo no hubiera ido a este centro y no me hubieran ayudado como me ayudaron, probablemente hubiera pasado algo muy feo, ¿me entiende?*

["… they help you, listen to you, let you talk, and then make you see what you are going through, realize the moment, the now and try to understand you. So, yes, I would recommend it and tell them that it could help them a lot if they're going through a difficult situation… Actually, they helped me a lot, they helped me a lot and I think that for the help of my friend who told me about this center, I think we are talking about that if I had not gone to this center and they had not helped me as they helped me, probably something very ugly would have happened, do you understand me?"]

Again, another client refers a friend in need of care…

"Entonces por medio de una amistad me dice, 'Vaya a La Familia. Allá le pueden ayudar.' Y yo vine. Y ahora estoy agradecida. He tenido la terapia. Me ha ayudado demasiado gracias a todas estas personas que nos están ayudando, porque no nada más a mí, yo pienso que a más personas. Y yo me siento contenta de tener amistades, porque pues prácticamente uno cuando viene de México no sabemos a dónde acudir, se nos cierra el mundo, estamos desesperados porque no sabemos en la situación que estamos, y más con violencia doméstica. Por eso."

["Then a friend tells me, 'Go to La Familia. There they can help you.' And I came. And now I'm grateful. I've had therapy. It has helped me so much thanks to all these people who are helping us, because not just me, I think they are helping more people. And now I feel happy to have friends, because practically for someone comes from Mexico, we do not know where to go, the world is closed to us, we are desperate because we do not know in the situation we are in, and more with domestic violence. That's why."]

Finally, a client discusses how he encourages his friends to seek care because it is something that can help…

"Bueno, pues no he yo conocido otro programa, como le digo, no había yo conocido una organización así. Y pues para mí es algo especial. Yo lo recomiendo a las personas que yo conozco, cuando necesiten algo, 'Mira, ve. Ahí te pueden guiar. Es importante.'"

["Well, I haven't known another program, as I say, I hadn't known an organization like that. And for me it is something special. I recommend it to people I know, when they need something, 'Look, go. There they can guide you. It's important.'"]

Client satisfaction is one important indicator of a successful program. The above passages from client interviews demonstrate how the concept of satisfaction in a community mental health program is multidimensional. This multidimensional characteristic, not just of the client satisfaction indicator, but also the multidimensional characteristics of culturally focused programs require multiple ways to understand client satisfaction and its interdependency with wellness.

Summary

In this section, four different data sources were reviewed to assess whether mental health programs designed with a focus on a client's culture can strengthen individual wellness and resilience, reduce risk factors associated with mental illness, and improve client retention in program treatment.

The statistical analysis of the SWE data in this section suggests that clients experienced significant and positive changes in wellbeing during their participation in CAL. The review of FIT data on client/therapist alliances suggests strong and positive alliances needed for successful therapy occurred without any dropouts. The review of CAL Navigation Services shows over 800 requests for assistance and reflects the significant amount of external conditions CAL patients face in navigating to access resource critical for stabilization. The high demand for navigation services validates the multidimensional approach CAL staff use to provide a process of care. An extensive analysis of client interviews also reveals the multidimensional and interdependent characteristics of service satisfaction as well as the eight principles used to guide CAL services.

Three different approaches to triangulation were used to increase the confidence in the findings presented here providing a more comprehensive picture of the results than just one research method can convey. Data triangulation incorporated four different data sources, both quantitative and qualitative into the analysis. Methodological triangulation incorporated multiple ways of both qualitative and quantitative analysis. And theory triangulation incorporated three theoretical perspectives not normally used in evaluating community mental health programs: Reawakening Therapy; evaluation indicators may be multidimensional as well as interdependent; and the culturally informed design of services indicates how wellness is part of a cultural process requiring attention to client backgrounds, history, and culture to determine appropriate and responsive treatment plans. These approaches provide a clearer picture of the problems encountered in considering the value of cultural assets in the evaluation process as well as increasing confidence in the findings presented in this report.

Discussion

"Sino que como que, como que entabla uno una relación, ajá. De que están cuidándote cuando recibes el servicio."

["But it's like, like you're in a relationship. They are taking care of you when you receive the services."]

Improving access to quality community mental health services for our most underserved and most vulnerable groups is a primary goal for CRDP. To demonstrate the power as well as the value of cultural practices as important assets in early intervention and stabilization strategies, *La Familia* designed a program specifically for adult Latinos, a population historically denied access to traditional mental health services. *La Familia's* program design has its roots in over 45 years of practicing the concepts of Reawakening Therapy, which considers the client's external realities in which they live as a key part of the therapeutic treatment plan. Interventions are directed at the whole person in relation to their familial, cultural, ethnic, political, social, and economic context (Fernandez and Barnes, 1978). The concept of Reawakening Therapy, originated from *La Familia* founders Zaida Fernandez and Anita Barnes, is the foundation for the eight principles that are used to guide *La Familia's* daily practice of community mental health.

Considering the success of clients indicated by the results presented in this report, is it safe to say that the positive outcomes reported by CAL clients came about through intention rather than coincidence? Paying close attention to *La Familia's* approach to community mental health service delivery, the primary research question of this evaluation is, "To what extent do culturally defined service delivery practices improve access and utilization of mental health services for the Latino population?" This research question is further refined into three basic evaluation questions:

- To what extent does program participation strengthen individual wellness and resilience?
- To what extent does program participation reduce risk factors to mental illness?
- To what extent does the program approach improve retention in CAL services?

To respond to these questions, seven key indicators were used as an analytical guide to identify and collect the data required to assess the impact of culturally responsive programming: Changes in Wellbeing, Client Responsibility, Awareness, Connectivity, Stabilization, Service Utilization, and Service Satisfaction. In the previous section of this report, we are alerted to the importance of how these indicators appeared to be conditioned by, as well as function interdependently with, the eight principles – continually interacting and informing us of how service delivery behaves as a cultural process for healing. In other words, CAL, by intention, is a holistic approach to healing with its foundations in the cultural and historical past and present realities of clients that guide the daily practice of health for Latinos. In hindsight, it is clear from the data presented that the interdependent characteristics of these indicators and the eight principles lend support to the notion of community based mental health as multidimensional with program design framing the concepts of healing and wellness as distinct cultural processes.

An important point to make here is how measurement approaches need to correspond to the program design. All too often, the value of cultural assets in community mental health programming is overlooked as researchers and administrators continue to rely on traditional methodological approaches to evaluate mental health outcomes. Indicators for wellness are typically developed externally from the program design. Because the characteristics of cultural assets do not easily translate into data for traditional forms

of research, this evaluation is highly concerned with the problem of failing to recognize the value of culturally based data. Efforts to mitigate this concern are reflected through the use of multiple data sources and multiple methods of both measurement and triangulation.

Accordingly, the multidimensional approach to community mental health also makes a response to the three evaluation questions difficult. Much like the components of the CAL program design, these questions presented as a part of the evaluation plan also appear to be interdependent with the indicators for one question equally responding to the other two questions. Therefore, this discussion will focus on the seven indicators and how they help our understanding of wellness and resilience, reducing risk factors, and improving client retention.

Here, the indicator "Changes in Wellbeing" is used to demonstrate the interdependency of indicators and how positive results in one indicator may be contingent upon the positive results in one or more additional indicators. Interview data as well as frequency tables using SWE data revealed significant and positive changes in client wellbeing. Ordinal Logistic Regression was used as a method to measure the changes. Focusing on indicators from the Sheehan Disability Scale, CAL clients reported via the SWE pre/post treatment questionnaires that their emotions, prior to treatment, had a significant impact on their ability to manage emotions when engaged in work, school, social, and family interactions. In contrast, the regression analysis shows that clients answering the SDS questions following treatment reported a six to nine times higher probability for their ability to navigate daily social interactions.

Keeping the focus on the multidimensional characteristic of CAL program design, we know that wellness and distress are not simple concepts that can be directly observed, much less measured by one variable. Instead, they are constructs that are impacted and influenced by a number of factors. A Latent Variable Analysis was performed using Structural Equation Modeling that allowed for measuring client improvement using an array of variables contained in the Kessler Psychological Distress Scale (K6). The K6 questions provide information on a client's emotional state and represent important indicators of psychological distress. The Latent Variable Analysis showed a significant improvement in the bundle of wellness indicators of over one standard deviation (+1.244) suggesting a very high indication of positive change for CAL clients.

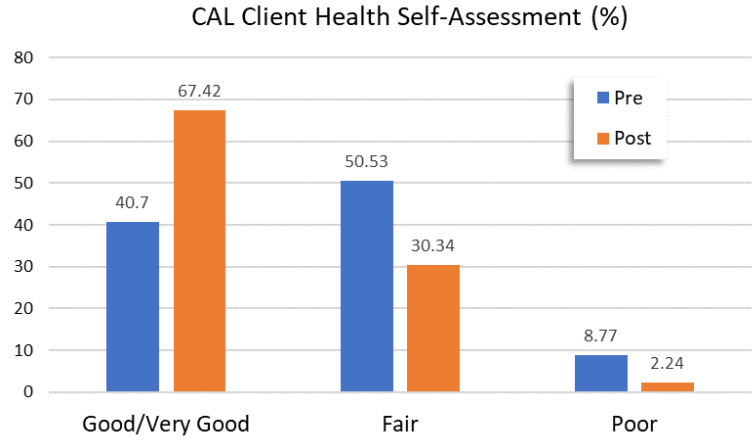
It is here where the interdependency of the indicators takes on its importance, as the statistical findings of positive change are contingent upon a number of factors. We know that positive changes in wellbeing do not occur without high rates of service utilization. The FIT Outcomes data show no dropouts from CAL therapy as well as strong alliances between therapist and client, both indicating high rates of utilization and retention. The strong alliances also suggest a high degree of client connectivity with the therapist, which improves the opportunity for stabilization and reducing risk factors. Connectivity is also another important indicator that impacts both utilization and client satisfaction as clients feel safe to engage in therapy, which allows them to absorb and process the benefits of the interventions. As a result, the FIT Outcomes data show a significant and positive change toward stabilization and wellness. These outcomes also reflect the positive changes in client awareness found in SDS responses indicating clients are learning to manage the triggers for emotional distress while building resiliency against future situations that can lead to distress. The improved ability to manage emotional distress also reflects a reduction in risk factors and clients assuming more responsibility for their wellbeing.

The CAL navigation data shows over 800 requests for assistance from clients and clearly demonstrates high program utilization. More importantly, it also shows how program efforts to mitigate external client social/economic problems while building trust and alliances help pave the way for retention and successful therapy making positive changes in wellbeing possible. The utilization rate for navigation services also reflects a high degree of connectivity between the client, staff, and resources in the community, another indicator required for positive changes in wellbeing. The assisted connection with resources also builds awareness as clients are shown how to navigate the paths towards services. This guided learning experience leads to clients assuming greater responsibility for their own wellbeing, increases program retention, reduces risk factors to mental illness, and increases utilization with other *La Familia* programs. The result is a long-term path towards resilience. Substantial interview data was presented to demonstrate and support the notion of interdependency between evaluation indicators.

We can begin to see how the positive outcome in one indicator may be supported and sustained by the interdependence with other key indicators. We can also see how a positive outcome in one indicator such as wellness may result in improved outcomes for other indicators. This interrelated bundle of indicators directly responds in multiple ways to the evaluation concerns of improved wellness and resilience, reducing risk factors, and improving client retention.

We also know from interview data that these indicators are moderated by cultural principles and practices such as the high levels of mutual respect needed to build alliances and the presence of community-based services. These alliances build multiple forms of connectivity and increase access to resources in the places where clients live. A deep cultural awareness and sensitivity results in sincere levels of engagement. When seen as an interactive whole, these indicators and principles lead to clients reporting a high degree of satisfaction, which is one more indicator that improves retention, moderates client wellness and resilience, and as a result, reduces risk factors to mental health.

Figure 11



Finally, Figure 11 shows the results of CAL clients reporting their self-assessment of overall health. Post treatment reporting indicates a 27-point increase in the number of clients feeling good or very good about their health. It represents one more example of the positive effects of incorporating culturally based program designs into community mental health.

This evaluation does recognize limitations. Data regarding the time devoted to navigation functions was not collected. It would be useful to do so at a later date to help external agencies in understanding and appreciating the critical role navigation has in planning and supporting overall client care. The COVID-19

pandemic also halted the numerous in-person activities *La Familia* conducts daily. These activities would have resulted in increased connectivity not just with clients but between clients and allowing for the community-building process called for in the program design to happen. Finally, the need for a more robust data system would facilitate data collection over a longer period and allow for more research that could support the expansion of programs like CAL.

Conclusion

This evaluation of the *Centro de Apoyo Latino* analyzed client-reported data regarding their experience in a culturally focused community based mental health model of early intervention and stabilization. **This evaluation found that program participants reported significant improvement in their ability to manage emotions when engaged in work, school, social, and family interactions.** Multiple forms of data and measurement strongly suggest that client improvement was not coincidental or happenstance but instead through intention and design. The fact that program design was centered on cultural principles and practices for healing and wellness that consider the client's social, historical, and economic surroundings suggest that culturally based programming may be important in community mental health service delivery. Accordingly, one important conclusion of this evaluation is that context matters and needs to be considered in developing mental health service delivery programs to those most at risk.

One challenge with evaluating mental health programs is understanding the value of culture as an important conduit to convey effective practices for successful intervention and treatment for at risk populations. Culture is not given the importance it is due in mental health studies. On one hand, cultural practitioners posit that traditional scientific methods fail to capture the emotional and spiritual foundations needed to understand the conditions leading to wellness. Consequently, a full understanding of mental health and mental illness cannot be fully realized. This error, in turn, can lead to policies that fail to leverage the important cultural assets found in people, organizations, and neighborhoods into solutions for prevention, intervention, and stabilization for those in our poorest of neighborhoods. On the other hand, social and behavioral scientists warn that without scientific tools for analysis, mental health interventions may be based upon generalizations rather than evidence.

This evaluation of the *Centro de Apoyo Latino* attempts to incorporate both scientific and cultural approaches to understanding conditions that impact community mental health care delivery. The high rate of positive changes in client wellness following a treatment design based upon cultural principles means a bundle of methodological approaches must be used to understand treatment based on the "whole client condition." Multidimensional cultural designs for mental health programming require multidimensional methods for evaluation. This approach helped to avoid reducing the value of cultural designs to presumed rituals that lack merit or knowledge of healing. Instead, they must be validated as ways of healing that come with generations of knowledge - as holistic approaches to humanizing the intervention and healing process, approaches that leverage basic principles for living inherent to the practice of culture, community building, and promoting community health.

The importance of a data system to monitor this type of programming cannot be overstated. A barrier to acceptance of culturally driven mental health interventions in community mental health is the lack of data to scientifically validate success. Without such validation, the success of culturally influenced programming will be often seen as a spurious placebo-type result. The urgency for this type of community mental health programming merits an effective data management system to support the level of public policy needed for at risk groups. Local non-profits are not equipped financially for the type of data management needed over extended periods of time. A state-supported centralized cloud-based data management information system would allow for more rigorous research for programs and should be considered as a policy priority.

An important take away from this evaluation is understanding the significant role that the *Promotoras*/Community Mental Health Workers play in client stabilization and retention. The different

ways in which navigators applied cultural assets in building the trust needed for interventions and therapy to be successful must be viewed as an essential component of any community-based public health planning effort. The important role of the navigator in public health and mental health systems must be recognized and formalized into services deemed reimbursable by health care systems.

Finally, it is absolutely imperative to recognize that the best-designed program is only as effective as the staff that makes it work. This is the immeasurable factor that truly makes culturally based community mental health work at *La Familia's* center. *La Familia* staff have been stretched beyond normal conditions at a time when clients are facing the effects of overlapping crises such as immigration issues, job and income loss, school closures, racial tensions in the city and COVID-19. This was made overwhelmingly clear from the abundance of gratitude and respect reported by clients. The embodiment of the *Cultura de Salud's* eight Principles and the sincere unconditional dedication of CAL staff to their community is what make this program a success.

How much more successful would a permanently and properly funded CAL program be in a post COVID-19 environment. When in-person awareness programming and improved linkage with other *La Familia* activities can again be integrated into the daily workflow, the convergence of community events with CALs program design can show that wellness is just not an intervention strategy but also part of a collective approach to healing and prevention. When we fully embrace those holistic approaches to mental health are rooted in cultural designs, we can understand the dynamics of healing at the community level and we can leverage culture as well as the people in our communities as essential assets required for urgent public health interventions.

References

Aguilar-Gaxiola, S., Loera, G., Méndez, L., Sala, M., Latino Mental Health Concilio, and Nakamoto, J. 2012. Community-Defined Solutions for Latino Mental Health Care Disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup Population Report. Sacramento, CA: UC Davis.

Archer, R., Forbes, Y., Metcalfe, C., & Winter, D. 2000. An investigation of the effectiveness of a voluntary sector psychodynamic counselling service. British Journal of Medical Psychology, 73(3), 401-412.

Baekeland, F. and Lundwall, L. 1975. Dropping out of treatment: A critical review. Psychological Bulletin, 82(5), 738-783.

Balcázar, H. and de Heer, H. 2015. Community health workers as partners in the management of non-communicable diseases. The Lancet Global Health. http://dx.doi.org/10.1016/S2214-109X(15)00142-4

Balcázar, H., Perez-Lizaur, A., Izeta, E., and Villanueva, M. 2016. Community Health Workers-Promotores de Salud in Mexico History and Potential for Building Effective Community Actions. Journal of Ambulatory Care Management, 39(1), 12–22.

Barrett, M., Chua, W., Crits-Christoph, P., Gibbons, M., and Thompson, D. 2008. Early Withdrawal from Mental Health Treatment: Implications for Psychotherapy Practice. Psychotherapy: Theory, Research, Practice, and Training, 45, 247–267.

Capitman, J., Pacheco, T., Ramírez, M., and Gonzalez, A. 2009. Promotoras: Lessons Learned on Improving Healthcare Access to Latinos Fresno, CA: Central Valley Health Policy Institute.

Chesworth, B., Filippelli, A., Nylund, D., Tilsen, J., Minami, T., and Barranti, C. 2017. Feedback-Informed treatment with LGBTQ Clients: Social Justice and Evidenced-Based Practice. In Feedback-Informed Treatment in Clinical Practice: Reaching for Excellence. (eds.) Prescott, D., Maeschalck, C., and Miller, S. American Psychological Association: Washington, D.C.

Clark, D. and Donnellan, M. 2021. What if apples become oranges: A primer on measurement invariance in repeated measures research, in The Handbook of Personality Dynamics and Processes. Academic Press.

Duncan, B. and Miller, S. 2000. The client's theory of change: Consulting the client in the integrative process. Journal of Psychotherapy Integration. 10,169-187.

Duncan, B., Miller, S., Sparks, J., Claud, D., Reynolds, L., Brown, J., and Johnson, L. 2003. The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. Journal of Brief Therapy 3 (1), 3-12.

Fernandez, Z. and Barnes, A. 1978. The Enchilada Approach to Reawakening Therapy. La Familia Counseling Center. Sacramento, CA.

Fisher, M. 1983. Speaking of Clients. Sheffield: University of Sheffield Press.

Flynn, T., Balch, P., Lewis, S., and Katz, B. 1981. Predicting client improvement from and satisfaction with community mental health center services. American Journal of Community Psychology. 9(3):339-46.

Gonzalez-Hernandez, L. and Coleman., K. 2019. Integrating the Promotores Model to Strengthen Community Partnerships. Center for the Study of Social Policy.

Greene, B. 1996. African-American women: considering diverse identities and societal barriers in psychotherapy. Annals of the New York Academy of Sciences. 789:191-209.

Harmon, S., Lambert, M., Smart, D., Hawkins, E., Nielsen, S., Slade, K., and Lutz, W. 2007. Enhancing outcome for potential treatment failures: Therapist/client feedback and clinical support tools. Psychotherapy Research, 17, 379 –392.

Hawkins, E., Lambert, M., Vermeersch, D., Slade, K., and Tuttle, K. 2004. The effects of providing patient progress information to therapists and patients. Psychotherapy Research, 14, 308 –327.

Hoeft, K., Rios, S., Guzman, E., and Barker, J. 2015. Using community participation to assess acceptability of "Contra Caries," a theory based, promotora-led oral health education program for rural Latino parents: a mixed methods study. BioMed Central Oral Health 15:103 DOI 10.1186/s12903-015-0089-4.

Hough, R., Landsverk, J., Karno, M., Burnam, A., Timbers, D., Escobar, J., and Regier, D. 1987. Utilization of health and mental health services by Los Angeles Mexican Americans and non-Hispanic whites. Archives of General Psychiatry; 44(8):702-9.

Howard, K., Moras, K., Brill, P., Martinovich, Z., and Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. American Psychologist, 51, 1059 –1064.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. Journal of Consulting and Clinical Psychology, 59(1), 12-19.

Kidd, S., Davidson, L., and McKenzie, K. 2017. Common Factors in Community Mental Health Intervention: A Scoping Review. Community Mental Health Journal, 53(6):627-637.

Klein, E., Stone, W., Hicks, M., and Pritchard, I. 2003. Understanding dropouts. Journal of Mental Health Counseling, 25(2), 89-100.

Lambert, M. and Shimokawa, K. 2011. Collecting client feedback. In Norcross, J.C. (ed.), Psychotherapy relationships that work: evidence-based responsiveness (2nd ed, pp. 203-223). New York, NY: Oxford.

Lebow, J. 1983. Research assessing consumer satisfaction with mental health treatment: a review of findings. Evaluation and Program Planning, 6(3-4):211-36.

López, S. 2002. A Research Agenda to Improve the Accessibility and Quality of Mental Health Care for Latinos. Psychiatric Services, 53(12):1569-73.

Miller, S., Duncan, B., Sorrell, R. and Brown, G. 2005, The partners for change outcome management system. Journal of Clinical Psychology, 61: 199-208.

Moras, K. (1986). Early termination and the outcome of psychotherapy: Patients' perspectives. ProQuest Information & Learning. 46 (8-B).

Noll, G, and Dubinsky, M. 1984. Dimensions of satisfaction with mental health treatment. Evaluation and the Health Professions. 7(1):65-75.

Ogland, C. 2010. Using Promotoras to Deliver Financial Education in Low-Income Communities. Journal of Consumer Education, Vol. 27.

Putnick, D. and Bornstein, M. 2016. Measurement Invariance Conventions and Reporting: The State of the Art and Future Directions for Psychological Research. Developmental Review. 41:71-90. https://doi.org/10.1016/j.dr.2016.06.004

Roseborough, David J., "Attrition in Psychotherapy: A Survival Analysis" 2015. Social Work Faculty Publications. 39. http://ir.stthomas.edu/ssw_pub/39

Seidel, J. and Miller, S. 2012. Documenting Change: A Primer on Measurement, Analysis, and Reporting. Manual 4: The ICCE Manuals on Feedback-Informed Treatment (FIT). International Center for Clinical Excellence.

Sheehan, D. 1983. The Anxiety Disease. Charles Scribner & Sons, New York.

Sheehan, D., Harnett-Sheehan, K., and Raj, B. The measurement of disability. International Clinical Psychopharmacology. 1996; 11(suppl 3):89-95.

Slade, M., Amering, M., and Oades, L. 2008. Recovery: an international perspective. Epidemiologia e Psichiatria Sociale, 17(2), 128-37.

Sohn, M., Barrett, H., and Talbert, J. 2014. Predictors of consumer satisfaction in community mental health center services. Community Mental Health Journal. 50(8):922-5.

Spoont, M., Nelson, D., van Ryn, M., and Alegria M. 2017 Racial and Ethnic Variation in Perceptions of VA Mental Health Providers are Associated With Treatment Retention Among Veterans With PTSD. Med Care. 55 Suppl 9 Suppl 2:S33-S42.

Stamboglis, N. and Jacobs, R. 2020. Factors Associated with Patient Satisfaction of Community Mental Health Services: A Multilevel Approach. Community Mental Health Journal. 56(1): 50–64. Published online 2019 Sep 14. doi: 10.1007/s10597-019-00449-x.

Swift, J. and Greenberg, R. 2012. Premature Discontinuation in Adult Psychotherapy. Journal of Consulting and Clinical Psychology. Vol. 80, No. 4, 547–559.

Tilsen, J., Maeschalck, C., Seidel, J., Robinson, B., and Miller, S. 2012. Feedback-Informed Clinical Work: Specific Populations and Service Settings. Manual 5: The ICCE Manuals on Feedback-Informed Treatment (FIT). International Center for Clinical Excellence.

Vega, W., Kolody, B., Aguilar-Gaxiola, S., and Catalano, R. 1999. Gaps in Service Utilization by Mexican Americans With Mental Health Problems. American Journal of Psychiatry, 1999, 156:928–934.

Whipple, J., Lambert, M., Vermeersch, D., Smart, D., Nielsen, S., and Hawkins, E. 2003. Improving the effects of psychotherapy: The use of early identification of treatment failure and problem solving strategies in routine practice. Journal of Counseling Psychology, 58, 59 – 68.

Williams, B. and Wilkinson, G. 1995. Patient Satisfaction in Mental Health Care: Evaluating an Evaluative Method. British Journal of Psychiatry. 166, 559-562.

Winkeljohn, B., Owen, S., Chapman, J., Lavin, K, Drinane, J., and Kuo, P. 2017. Feedback informed treatment: An empirically supported case study of psychodynamic treatment. Journal of Clinical Psychology. 73: 1499– 1509.

Appendices : Centro de Apoyo Latino Forms

La Familia -

- Cultural and Social Impact Scale Pre/Post - CSIS
- Cultural Services Satisfaction Questionnaire - CSSQ A
- Cultural Services Satisfaction Questionnaire - CSSQ B
- Event Feedback Form - EFF

Feedback Informed Treatment- FIT

- FIT Session Rating Scale - SRS
- FIT Outcome Rating Scale - ORS

State Forms - SWE

- Statewide Evaluation Pre
- Statewide Evaluation Post

La Familia COUNSELING CENTER

La Familia COUNSELING CENTER, INC.

CULTURAL AND SOCIAL IMPACT SCALE (CSIS)

Unique ID#:

	Date	Staff Initital
Pre-Contact		
Post-Contact		
Referred To:	☐ SCC ☐ CAL ☐ CMH	

PRE

1. Do you have health insurance? ☐ Yes ☐ No
If yes, please identify: ☐ Medi-Cal ☐ MediCare ☐ Medi-Cal and MediCare ☐ Covered CA ☐ Private ☐ Healthy Partners ☐ Unknown

2. What service have you or your family received at La Familia? (check only one)
☐ Supporting Community Connections workshops/ training
☐ Youth Programs – Youth Voice, Gang Violence Prevention
☐ Children's Mental Health Services
☐ La Familia Community Event
☐ Education and Employment Services
☐ Adult English classes/ citizen prep
☐ Birth and Beyond – Family Resource Center
☐ Health Access - Navigation, Medi-Cal
☐ Services through WEAVE
☐ None

POST

1. Do you have health insurance? ☐ Yes ☐ No
If yes, please identify: ☐ Medi-Cal ☐ MediCare ☐ Medi-Cal and MediCare ☐ Covered CA ☐ Private ☐ Healthy Partners ☐ Unknown

2. What service have you or your family received at La Familia? (check only one)
☐ Supporting Community Connections workshops/ training
☐ Youth Programs – Youth Voice, Gang Violence Prevention
☐ Children's Mental Health Services
☐ La Familia Community Event
☐ Education and Employment Services
☐ Adult English classes/ citizen prep
☐ Birth and Beyond – Family Resource Center
☐ Health Access - Navigation, Medi-Cal
☐ Services through WEAVE
☐ None

Guide: Give a score to each section between 0-4. CRISIS=4, VULNERABLE=3, STABLE=2, SAFE/SELF-SUFFICIENT=1, THRIVING=0

3. PHYSICAL WELLNESS	pre	post
Medical challenges		
Chronic disease		
Dental/eye problem		
Medication management		
Substance abuse/dependence		
Hospice/bereavement		
Total		

4. TRAUMA	pre	post
Traumatic stress from country of origin		
Immigration experience		
Domestic abuse		
Victim of bullying		
Victim of exploitation		
Victim of a crime		
Victim of social media		
Law enforcement involvement		
Victim due to sexuality		
Victim of natural disaster		
Family safety		
CPS involvement		
Child abuse/neglect/sexual abuse		
Total		

5. MENTAL HEALTH (CURRENT)	pre	post
Depression		
Anxiety		
Traumatic stress		
Other diagnosis if known _____		
Total		

6. CULTURAL COMMUNITY CONNECTIONS	pre	post
Isolated from friends/family		
Spiritual connections		
Communication limitations (email, phone, other)		
Community events/challenges attending		
Total		

7. CULTURAL STRESS	pre	post
Navigating systems of care/trust		
Acculturation/family values & traditions		
Total		

8. IMMIGRATION STATUS	pre	post
Current deportation process		
At risk for ICE contact		
Self-deporting		
Total		

9. LIFE DOMAIN FUNCTIONING	pre	post
Legal challenges		
Family problems		
Employment		
Housing/food/basic needs		
Utilities/bills		
Total		

10. TOTALS	pre	post
PHYSICAL WELLNESS		
TRAUMA		
MENTAL HEALTH		
CULTURAL COMMUNITY CONNECTIONS		
CULTURAL STRESS		
IMMIGRATION STATUS		
LIFE DOMAIN FUNCTIONING		
11. TOTAL SCORE FOR NEEDS		
12. TOTAL SCORE FOR STRENGTHS		

13. How did you hear about us? _____

14. NOTES:

Updated on 11/14/19

Cultural Service Satisfaction Questionnaire (CSSQ – A)

La Familia COUNSELING CENTER, INC.

Centro de Apoyo Latino (CAL)

Staff Initial: _____

Unique ID/Name: _____ Cycle #: _____

Date: _____

1. I attended the following service at La Familia today: (check only one)

- ☐ (Youth) Mental Health First Aide
- ☐ Applied Suicide Intervention Skills Training
- ☐ Reconozca las Señales
- ☐ Substance Abuse Information/education
- ☐ Workshop/event about mental health
- ☐ Support group
- ☐ Community Mental Health Worker services/ navigation: _____

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
2. As a result of today's service, I am more informed about mental illnesses and resources.	☐	☐	☐	☐	☐	☐
3. Staff was respectful of my cultural values, ethnicity, race, gender preferences, age and social status.	☐	☐	☐	☐	☐	☐
4. Services were provided in the language of my choice.	☐	☐	☐	☐	☐	☐
5. LFCC staff showed me how to navigate services and how to contact someone for help.	☐	☐	☐	☐	☐	☐
6. I am more aware of the services available to me.	☐	☐	☐	☐	☐	☐
7. I feel confident about how to connect to services in the future.	☐	☐	☐	☐	☐	☐

8. What other services at La Familia have you and/or your family participated in?

- ☐ Supporting Community Connections
- ☐ Children's Mental Health Services
- ☐ Education and Employment Services
- ☐ Birth and Beyond – Family Resource Center
- ☐ Services through WEAVE
- ☐ Youth Programs – Youth Voice, Gang Violence Prevention, STEM
- ☐ La Familia's Community Event
- ☐ Adult English classes/Citizen prep
- ☐ Health Access
- ☐ None

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
9. LFCC staff understand that my whole family is important in helping me build wellness.	☐	☐	☐	☐	☐	☐
10. It is important that services are provided in the community.	☐	☐	☐	☐	☐	☐

11. Your feedback is very important to us; how can we help improve services for Latinos:

_____

_____

_____

Updated 03/11//2020

Cultural Service Satisfaction Questionnaire (CSSQ)
Part B

La Familia COUNSELING CENTER, INC.

Centro de Apoyo Latino (CAL)

Staff Initial: _____

Unique ID/Name: _____ Cycle #: _____

Date: _____

The follow up was:

☐ In person/ face to face
☐ By phone
☐ Other: _____

If you were referred to another agency, please answer the following questions:

1. I contacted the source of referral and utilized the service.

   Yes ☐ No ☐
   Name of Agency: _____ If no, why? _____
   Go to #2 *Go to # 5.*

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
2. _____ was respectful of my culture.	☐	☐	☐	☐	☐
3. _____ provided language accommodations.	☐	☐	☐	☐	☐

4. I attended the following service at the agency I was referred to:

   ☐ Individual therapy ☐ Medical
   ☐ Support group ☐ Other: _____
   ☐ AA/Alanon/Alateen

5. Your feedback is very important to us; how can we help improve services for Latinos:

_____

_____

_____

Event Feedback Form (EFF)

La Familia COUNSELING CENTER, INC.
Centro de Apoyo Latino (CAL)

	Not At All	Somewhat	Agree	Strongly Agree
1. The event was beneficial.	☐	☐	☐	☐
2. I learned something I did not know.	☐	☐	☐	☐
3. Staff understand that my whole family is important in helping me in building wellness.	☐	☐	☐	☐
4. Staff was respectful of of my race, cultural values, gender preference, age and social status.	☐	☐	☐	☐
5.The event was provided in a location that was convenient for me.	☐	☐	☐	☐
6.The event had my language accommodations.	☐	☐	☐	☐
7. I am aware of La Familia's mental health services.	☐	☐	☐	☐

8. I am interested in learning about other mental health services:
Check all that apply:

- ☐ Workshops on Health
- ☐ Cultural wellness celebrations
- ☐ Counseling for adults
- ☐ Support groups
- ☐ Assistance in finding help in the community
- ☐ Would you like us to contact you? Name:_____ Phone Number: _____

9. How can we help improve? We want to hear from you.

Session Rating Scale (SRS V.3.0)

Patient Unique ID Number: _____
Name _____ Age (Yrs): _____ Sex: M / F
Session # ____ Date:_____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard by the therapist, understood, and respected. I----------I I felt heard by the therapist, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. I----------I We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me. I----------I The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. I----------I Overall, today's session was right for me.

Institute for the Study of Therapeutic Change

www.talkingcure.com

Outcome Rating Scale (ORS)

Patient Unique ID Number: _____
Name _____ Age (Yrs): _____ Sex: M / F
Session # ____ Date:_____
Who is filling out this form? Please check one: Self:_____ Other: _____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help me understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person*, *please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

Institute for the Study of Therapeutic Change

www.talkingcure.com

03 - _ _ - _ _ _ _	
Priority Pop Code / *IPP Code* / *CDEP Participant Code*	**ADULT VERSION (18+)** **PRE**

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

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

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

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

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

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

→ *Did you have health insurance coverage in the past 12 months?*

☐ Yes ☐ No ☐ Refused ☐ Don't Know

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

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

	Yes	**No**	**Refused**	**Don't Know**	**NA**
12. Because of problems with your mental health, emotions, nerves or your use of alcohol or drugs, was there ever a time during the past 12 months when you FELT LIKE YOU MIGHT NEED to see a…					
a. Traditional helping professional like a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐	☐

b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐	☐
c. Primary care physician or general practitioner	☐	☐	☐	☐	☐
d. Mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker	☐	☐	☐	☐	☐

	Yes	**No**	**Refused**	**Don't Know**	**NA**
13. Because of problems with your mental health, emotions or your use of alcohol or drugs, HAVE YOU SEEN (or met with) any of the following helping professionals in the past 12 months?					
a. Traditional helping professional like a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐	☐
b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐	☐
c. Primary care physician or general practitioner	☐	☐	☐	☐	☐
d. Mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker	☐	☐	☐	☐	☐

If YES to Q13c OR 13d, **GO TO Q14**
(otherwise **GO TO Q19**)

	No **GO TO Q19**	*Yes Mental/Emotional Health Problem* **GO TO Q15**	*Yes Alcohol-Drug Problem* **GO TO Q15**	*Yes Both Mental AND Alcohol-Drug Problems* **GO TO Q15**	*Refused* **GO TO Q19**	*Don't Know* **GO TO Q19**
14. Did you seek help for your mental or emotional health or for an alcohol or drug problem? (*Circle one*)						

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

	Yes	**No**	**Refused**	**Don't Know**
16. Are you still receiving treatment for these problems from one or more of these providers?	☐ **GO TO Q19**	☐ **GO TO Q17**	☐ **GO TO Q19**	☐ **GO TO Q19**
17. Did you complete the full course of treatment? In other words, you ended treatment when your counselor, therapist, psychologist, psychiatrist or social worker told you it was ok to end?	☐ **GO TO Q19**	☐ **GO TO Q18**	☐ **GO TO Q19**	☐ **GO TO Q19**

18. What is the **MAIN REASON** you are no longer receiving treatment? (Circle ONE only)

-Got better/No longer needed
-Not getting better
-Wanted to handle the problem on own
-Had bad experiences with treatment
-Lack of time/transportation
-Too expensive
-Insurance does not cover
-Other (Specify) _____
-Refused
-Don't Know

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

	Agree	Disagree	Refused	Don't Know
19. You were planning to or already getting help from a…				
a. Traditional helping professional such as a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐
b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐
20. You didn't know these types of professionals existed.	☐	☐	☐	☐
	GO TO Q34	**GO TO Q21**	**GO TO Q34**	**GO TO Q34**

	Agree	Disagree	Refused	Don't Know
21. You didn't feel comfortable talking with them about your personal problems.	☐	☐	☐	☐
22. You didn't think you would feel safe and welcome because of your…				
a. limited English	☐	☐	☐	☐
b. race/ethnicity	☐	☐	☐	☐
c. age	☐	☐	☐	☐
d. religious or spiritual practice	☐	☐	☐	☐
e. gender identity	☐	☐	☐	☐
f. sexual orientation	☐	☐	☐	☐
23. You were concerned about the cost of treatment.	☐	☐	☐	☐
24. You didn't have time (because of job, childcare, or other commitments).	☐	☐	☐	☐
25. You had no transportation, or the program was too far away, or the hours were not convenient.	☐	☐	☐	☐
26. You didn't think you needed mental health counseling or treatment at the time.	☐	☐	☐	☐
27. You thought you could handle the problem on your own.	☐	☐	☐	☐
28. You didn't think mental health counseling or treatment would help.	☐	☐	☐	☐
29. You were concerned that getting mental health treatment or counseling might cause your neighbors or community to have a negative opinion of you.	☐	☐	☐	☐
30. You were concerned that getting mental health treatment or counseling might have a negative effect on your job.	☐	☐	☐	☐
31. You were concerned that the information you gave the counselor might not be kept confidential.	☐	☐	☐	☐
32. You were concerned that you might be admitted to a psychiatric hospital.	☐	☐	☐	☐
33. You were concerned that you might have to take medicine.	☐	☐	☐	☐

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

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

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

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

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

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

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

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

46. How old are you?

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

47. **VERSION 2**

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

☐ American Indian or Alaska Native

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

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

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

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

☐ Asian:
Check your ethnic origin(s):

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

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

☐ Samoan ☐ Refused
☐ Guamanian ☐ Don't Know
☐ Tongan ☐ Other Hawaiian or Pacific Islander

☐ Fijian (Please specify):_____

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

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

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

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

☐ Refused

☐ Don't Know

48. How well can you speak the English language?

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

49. What is your preferred language? _____

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

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

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

☐ Not Applicable
☐ Yes
☐ No
☐ Refused
☐ Don't Know

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

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

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

☐ Male/Boy
☐ Female/Girl
☐ Intersex (they were unsure about my sex at birth)
☐ I am not sure about my sex assigned at birth
☐ My assigned sex at birth (please specify):_____
☐ I do not wish to answer this question

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

- ☐ Man/Male
- ☐ Woman/Female
- ☐ Transgender/Trans
- ☐ Trans man/Trans male
- ☐ Trans woman/Trans female
- ☐ Genderqueer/Gender non-conforming
- ☐ I do not wish to answer this question
- ☐ Non-binary (not exclusively male or female)
- ☐ Two Spirit
- ☐ Intersex (between male and female)
- ☐ I am not sure about my gender identity
- ☐ I do not have a gender/ gender identity
- ☐ My gender identity is (please specify):_____

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

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

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

Health Status

At present…

	Very Good	Good	Fair	Poor
Would you say your health is Very Good, Good, Fair, or Poor?	☐	☐	☐	☐

Racism/Discrimination

a. In your day-to-day life how often have any of the following things happened to you? (Would you say almost every day, at least once a week, a few times a month, a few times a year, less than once a year, never?)

	Almost everyday	At least once a week	A few times a month	A few times a year	Less than once a year	Never
You are treated with less courtesy than other people.	☐	☐	☐	☐	☐	☐
You are treated with less respect than other people.	☐	☐	☐	☐	☐	☐
You receive poorer service than other people at restaurants or stores.	☐	☐	☐	☐	☐	☐
People act as if they think you are not smart.	☐	☐	☐	☐	☐	☐
People act as if they are afraid of you.	☐	☐	☐	☐	☐	☐
People act as if they think you are dishonest.	☐	☐	☐	☐	☐	☐
People act as if you are not as good as they are.	☐	☐	☐	☐	☐	☐
You are called names or insulted.	☐	☐	☐	☐	☐	☐
You are threatened or harassed.	☐	☐	☐	☐	☐	☐

b. What do you think was the main reason for this/these experience(s)? Would you say…?

- ☐ Your race or ethnicity
- ☐ Your gender
- ☐ Your skin color/tone
- ☐ Your sexual orientation
- ☐ Your language or accent
- ☐ Your religion
- ☐ Your immigration status
- ☐ Other (Please specify)_____
- ☐ Don't know
- ☐ Refused

03 - ___ ___ - ___ ___ ___	ADULT VERSION (18+)
Priority Pop Code *IPP Code* *CDEP Participant Code*	**POST**

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

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

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

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

Instructions: During the past month how often did you feel…

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

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

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

Think about the one week in the past month when you were at your worst emotionally.

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

20. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q16-Q19) match how you would describe the negative effect of emotions on your life? (Check one)

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

Instructions: Please answer the following questions based on the services you have received so far. Indicate if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each of the statements below. If the question is about something you have not experienced, check the box for Not Applicable to indicate that this item does not apply to you. Please note: the word "service" stands for any program activities or events connected to the program.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
21. I like the services that I received here.	☐	☐	☐	☐	☐	☐
22. If I had other choices, I would still get services from this agency.	☐	☐	☐	☐	☐	☐
23. I would recommend this agency to a friend or family member.	☐	☐	☐	☐	☐	☐
24. The location of services was convenient (parking, public transportation, distance, etc.).	☐	☐	☐	☐	☐	☐
25. Staff were willing to see me as often as I felt it was necessary.	☐	☐	☐	☐	☐	☐
26. Services were available at times that were good for me.	☐	☐	☐	☐	☐	☐
27. When I first called or came here, it was easy to talk to the staff.	☐	☐	☐	☐	☐	☐
28. The staff here treat me with respect.	☐	☐	☐	☐	☐	☐
29. The staff here don't think less of me because of the way I talk.	☐	☐	☐	☐	☐	☐
30. The staff here respect my race and/or ethnicity.	☐	☐	☐	☐	☐	☐
31. The staff here respect my religious and/or spiritual beliefs.	☐	☐	☐	☐	☐	☐
32. The staff here respect my gender identity and/or sexual orientation.	☐	☐	☐	☐	☐	☐
33. Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	☐	☐	☐	☐	☐	☐
34. The people who work here respect my cultural beliefs, remedies and healing practices.	☐	☐	☐	☐	☐	☐
35. Staff here understand that people of my racial and/or ethnic group are not all alike.	☐	☐	☐	☐	☐	☐
36. Staff here understand that people of my gender and/or sexual orientation group are not all alike.	☐	☐	☐	☐	☐	☐
37. Staff here understand that people of my religious and spiritual background are not all alike.	☐	☐	☐	☐	☐	☐

As a direct result of my involvement in the program:

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
38. I deal more effectively with my daily problems.	☐	☐	☐	☐	☐	☐
39. I do better in school and/or work.	☐	☐	☐	☐	☐	☐
40. My symptoms/problems are not bothering me as much.	☐	☐	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
41. Were the services you received here in the language you prefer?	☐	☐	☐	☐
42. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available in the language you prefer?	☐	☐	☐	☐

Health

At present…	Very Good	Good	Fair	Poor
Would you say your health is Very Good, Good, Fair, or Poor?	☐	☐	☐	☐

Racism/Discrimination

a. In your day-to-day life how often have any of the following things happened to you? (Would you say almost everyday, at least once a week, a few times a month, a few times a year, less than once a year, never?)

	Almost everyday	At least once a week	A few times a month	A few times a year	Less than once a year	Never
You are treated with less courtesy than other people.	☐	☐	☐	☐	☐	☐
You are treated with less respect than other people.	☐	☐	☐	☐	☐	☐
You receive poorer service than other people at restaurants or stores.	☐	☐	☐	☐	☐	☐
People act as if they think you are not smart.	☐	☐	☐	☐	☐	☐
People act as if they are afraid of you.	☐	☐	☐	☐	☐	☐
People act as if they think you are dishonest.	☐	☐	☐	☐	☐	☐
People act as if you are not as good as they are.	☐	☐	☐	☐	☐	☐
You are called names or insulted.	☐	☐	☐	☐	☐	☐
You are threatened or harassed.	☐	☐	☐	☐	☐	☐

b. What do you think was the main reason for this/these experience(s)? Would you say…?

- ☐ Your race or ethnicity
- ☐ Your gender
- ☐ Your skin color/tone
- ☐ Your sexual orientation
- ☐ Your language or accent
- ☐ Your religion
- ☐ Your immigration status
- ☐ Other (Please specify)_____
- ☐ Don't know
- ☐ Refused