MIXTECO INDIGENA COMMUNITY ORGANIZING PROJECT'S (MICOP) LIVING WITH LOVE (LWL): A COMMUNITY-DEFINED EVIDENCE PROGRAM FOR THE LATINO/MIXTECO INDIGENOUS AND FARMWORKING POPULATIONS

CALIFORNIA REDUCING DISPARITIES PROJECT
PHASE II

2021 LOCAL EVALUATION REPORT FOR COMMUNITY-DEFINED EVIDENCE PRACTICES

MIXTECO INDIGENA COMMUNITY ORGANIZING PROJECT/LIVING WITH LOVE
135 Magnolia Ave, Oxnard, CA 93030
www.https://mixteco.org/

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Program Promotoras: Teresa Santos, Leticia Galicia, Luisa Lopez, Victoria Gomez, Delfina Lopez, Alberta Salazar

Project Manager: Dulce Vargas

Evaluation Coordinator: Irisela Contreras

MICOP's Supervisors: Genevieve Flores-Haro & Arcenio J. Lopez

CAB Members: Carmen Tum, Elizabeth Pazos, Jacinta Vásquez, Clemencia Muñoz, Lidia López, Leonor Hernández, Maria Francisco, Ruth Magana, Martha Ruelas, Jesus Noyola, Victoria Gomez

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Abstract

Living with Love (LwL) is a direct Prevention and Early Intervention mental health program, developed by the Mixteco Indigena Community Organizing Project (MICOP), to address issues of depression, anxiety, domestic violence, and socio-cultural/linguistic isolation for indigenous Mexican immigrants. LwL consists of eight classes, delivered in Spanish and Mixteco languages by trained Promotoras, to small groups of women recruited in community settings, including agricultural fields. The program's effect on mental health and service utilization was evaluated as part of the California Reducing Disparities Project (CRDP). Pre-post program survey (N=168) and 2-month follow-up focus group/interview (N=75) data were collected from women (65% married, 54% born in Oaxaca, Mexico; mean age 39 years; mean time in U.S. 16 years) who completed LwL between 2017-2021. Statistically significant improvements, representing medium-large effects, were observed across targeted program outcomes (mental health and domestic violence knowledge, cultural identity, family relationships, social support, coping tools, mental health resource familiarity and utilization, symptomatology). Multivariate analyses revealed that observed changes were largely unaffected by participants' demographic characteristics or variations in program delivery, including modifications made due to the COVID-19 pandemic, and suggest that changes endure over time. Qualitative data yielded rich and complementary information along six themes: strengthening the family structure; reducing social, cultural and linguistic isolation; living with love during COVID-19; attaining self-love and emotional healing; mental wellness and domestic violence knowledge gaps; strengthening capacity to practice coping skills. All aspects of the evaluation were conducted with guidance from community members. Results provide strong evidence for the effectiveness of LwL among community dwelling Mexican immigrant women.

Executive Summary

Summary of Community Defined Evidence-Based Program (CDEP) Purpose and Description

Living with Love (LwL) is a direct Prevention and Early Intervention mental health program that was developed to address issues of depression, anxiety, domestic violence, and (socio-cultural and linguistic) isolation for Mexican immigrants, specifically indigenous Mexicans, by decreasing mental health stigma, improving knowledge about mental health issues, and increasing knowledge/awareness/access to mental health services (including domestic violence support resources). The Mixteco Indigena Community Organizing Project (MICOP) developed Living with Love (LwL) as a direct response to the depression and domestic violence they witnessed among indigenous Mexican migrant women. MICOP is a non-profit community-based organization that was founded in 2001 with a mission to support, organize and empower the indigenous migrant communities in California's Central Coast. Ventura County, where MICOP is based, is home to over 20,000 indigenous Mexicans, a majority of whom are employed as farmworkers. As a longstanding, trusted member of the local community, MICOP is uniquely positioned to develop and deliver culturally and linguistically appropriate programs aimed to improve living and working conditions, increase mental and physical health, and build toward a more equitable future for the individuals and families that they serve. The LwL program meets a critical need given the significant barriers that indigenous community members face in accessing mental health services, including lack of health insurance, long working hours and low wages, high cost of treatment, unmet needs for childcare, and unavailability of services in indigenous languages or Spanish. Moreover, mental health issues are heavily stigmatized in the broader indigenous community.

LwL is a culturally and linguistically appropriate program that consists of a series of eight small group class sessions, led by trained Promotoras, with the aims to: (1) increase mental health and domestic violence knowledge; (2) increase ability to cope with daily stressors; (3) increase social and cultural connectedness; (4) reduce stigma related to mental health issues; (5) increase familiarity with local mental health services/resources. In 2017, after delivering and refining the program for seven years, MICOP's Living with Love (LwL), a Community Defined Evidence Practice, was selected to participate in the California Reducing Disparities Project (CRDP), a statewide, cross-population initiative, to reduce mental health disparities among underserved populations. This project provided the opportunity to gather robust evidence, over multiple years, to evaluate the effectiveness of the program. The onset of the COVID-19 pandemic in the final year of the program introduced challenges for both program delivery and data collection. In an effort to continue meeting the pressing mental health needs of community members while keeping participants and program staff as safe as possible, the program delivery context and format were modified. As a result, for the final year of the program, sessions were delivered in a virtual, one-on-one (Promotora and participant) format.

Evaluation Questions

A series of questions was developed by the project team to capture the primary targets of the LwL program: (1) Did mental health knowledge increase and stigmatization of mental health care decrease among program participants following LwL? (2) Did knowledge about domestic violence increase among program participants following LwL? (3) To what extent are cultural factors that may enhance mental health strengthened by LwL? (4) Did participants' capacity to manage daily stressors improve following LwL? (5) To what extent did participants' knowledge and awareness of local mental health services increase following LwL? We also sought to understand how valuable participants found the LwL program.

Local Evaluation Research Design

The local evaluation was designed as a collaborative effort between MICOP staff and Promotoras, the local evaluation team at the UCLA Kaiser Permanente Center for Health Equity, and the LwL Community Advisory Board (CAB). Together, we worked to develop an approach that would allow for the collection of detailed data related to each of the evaluation questions, as well as for input related to program delivery and guidance for future program modifications. We agreed upon a mixed-method, quasi-experimental, pre/post design that utilized surveys as well as 2-3 month, post-program focus groups and interviews to collect the data. We prioritized use of a pragmatic approach that interfered minimally with program delivery and placed limited burden on program participants. Throughout the project, flexibility in our approaches was maintained, allowing for refinement as needed.

We sought to collect local evaluation data from all program participants, over the full period of the CRDP. This approach was modified to accommodate other required evaluation components included in the program, such that local evaluation data were collected from every other cohort of program participants. With 6-8 participants expected per group, we intended to collect data from approximately 220 participants at baseline, anticipating some attrition at follow-up. All participants were invited to take part in focus groups delivered two months following the conclusion of the program. The scope of focus groups was expanded over the course of the program, providing an opportunity to gather in-depth data related to program outcomes as a complement to the quantitative data collected via surveys. The onset of the COVID-19 pandemic necessitated modifications to program delivery. This provided a natural opportunity to examine the effectiveness of LwL delivered as intended, in-person to small groups of participants, versus delivered virtually in a one-on-one context with Promotora and participant.

Key Findings

A total of 210 women participated in LwL and took part in the local evaluation between 2017-2021. Pre-post program survey (N=168; 80% retention from baseline) and 2-month follow-up focus group/interview (N=75) data were collected from participants in Spanish and Mixteco. A

majority of these participants (77%, N=129) took part in small group class sessions, delivered across a total of 25 eight-session series. The remaining 39 women (23%) completed the program one-on-one, with one of two program Promotoras in a virtual setting.

Approximately two-thirds (65%) of women who completed pre- and post- program surveys were married or living with a partner and average household size, including children and adults, was 7 persons (M=6.51, SD=2.44). On average, participants were 39 years old (SD=11) and had lived in the U.S. for 16 years (SD=9). Over half of participants were born in Oaxaca (54%), 14% were born in Michoacan and the remaining third (32%) were born in other Mexican states. No significant differences were observed when comparing the baseline demographic characteristics of those who completed the LwL program and post-program evaluation to those who were lost to follow-up. Group and 1:1 participants were largely similar, however group participants were more likely to be married (73% vs. 38%, $p<.001$) and to have lived at the same address for a year or more (81% vs. 69%, $p=.032$). Time between pre- and post- surveys ranged from 1.29 to 7.71 weeks (M=3.375, SD=1.359).

Pre- post comparisons of survey data revealed statistically significant improvements across all targeted program outcomes (mental health and domestic violence knowledge, stigma, cultural identity, family relationships, social support, coping tools, mental health resource familiarity and utilization, symptomatology). Each change was representative of a medium-large effect, with the largest overall effects observed for an increased ability to use coping tools. Within the 1:1 cohort specifically, large effects were observed for mental health knowledge, domestic violence awareness, coping tools, mental health resources and symptomatology.

Using a series of multivariate models, we assessed whether the changes observed in program outcomes varied in relation to participants' demographic characteristics or adaptations to program format. Separate models were fit for each of the nine key outcomes listed above. Results demonstrate that observed improvements in programmatic outcomes were largely consistent across participants and program formats, with few differences observed in relation to participants' demographic characteristics or variations in program delivery, including program duration and which Promotora delivered the program in a one-on-one setting.

Qualitative data yielded rich, complementary information that provided nuanced context to the survey results. These data were examined along six themes: strengthening the family structure; reducing social, cultural and linguistic isolation; living with love during COVID-19; attaining self-love and emotional healing; mental wellness and domestic violence knowledge gaps; strengthening capacity to practice coping skills. For this portion of the local evaluation, we used a phenomenological perspective by closely examining participants' lived experiences as they developed personal meanings that in turn guide their thoughts and behaviors (Flynn et al., 2012). We grounded this qualitative evaluation of Mexican indigenous populations' participation in LwL in phenomenology because of the multidimensionality in their experiences associated with

accessing mental health services and domestic violence as a risk factor. Using focus groups, participants connected their own experiences in the LwL class series.

Discussion

Together, these local evaluation results provide strong evidence for the effectiveness of LwL in improving outcomes related to mental health and domestic violence knowledge, cultural identity, as well as family and social relationships. Moreover, the program provided participants with important skills for managing stressors and increased familiarity with, and willingness to use, community support services. The strength and robustness of effects observed illustrate the power of LwL for improving mental health and well-being among Mexican immigrant women of varied ages, marital statuses, and family sizes, including those who speak indigenous languages alone or in combination with Spanish. Furthermore, these data provide considerable evidence that adapting the program delivery approach to meet the needs of the community does little to impact effectiveness. Although it was planned that one LwL session would be delivered each week over an eight-week time frame for all participants, the time between pre- and post- test administration ultimately varied by nearly eight weeks. Some participants did take part in weekly sessions but many others completed multiple sessions per week. Yet, most LwL outcomes were not influenced by program duration. Additionally, LwL proved to be effective when delivered in a small group setting, as intended, as well as when delivered in a one-on-one format.

The opportunity to deliver and evaluate the program among women who were enrolled in MICOP's case management program, and received the program in a one-on-one format was not anticipated when the evaluation approach was developed. When community-based recruitments and group program delivery were not feasible or safe due to the COVID-19 pandemic, the LwL team came together and decided to offer the program to women with whom they were connecting through MICOP's case management program, through which they received services associated with accessing and navigating issues related to family court and the legal system. Women recruited to LwL from the case management program had greater familiarity with local mental health resources and greater symptomatology as compared with women recruited in community settings. They were also less likely to be married or living with a partner than those recruited in community settings. Not only was LwL effective among this high need group of women, effects associated with post-program improvements in this cohort were greater than those in the group cohort on every measure assessed.

Moving forward, it will be important to explore options for varied program delivery formats capable of meeting the needs of diverse groups of participants. In so doing, the benefits of participation in LwL may be gained by a wider variety of community members. Given the tremendous size of the Mexican immigrant community in California and nationally, as well as the dearth of programs available to meet the needs of this community, LwL presents a promising approach to reducing mental health disparities in the Latino community at large.

INTRODUCTION

Ventura County is home to approximately 20,000 migrant indigenous community members, mostly farm workers laboring in the strawberry and blueberry fields. Nearly all indigenous Mexicans live specifically in the Oxnard Plain of Ventura County, a 10-mile stretch of primarily agricultural land that includes the cities of Oxnard and Hueneme, and the unincorporated Rio area. Latinos constitute 73% of Oxnard's 205,437 residents (2014 U.S. Census estimate), and indigenous Latinos comprise 10% of the city's population. This community faces many obstacles as immigrants learning to navigate new social and cultural systems while experiencing discrimination, isolation, and linguistic barriers, as many only speak their primary indigenous languages and are not fluent in Spanish or English. Widespread lack of legal status and anti-indigenous discrimination from the dominant Mexican culture cause further social exclusion.

Mental health treatments are not an option for many indigenous community members due in part to cost of treatment, lack of health insurance and low farmworker wages; only 26% of Mixtec adults report working enough of the year to support their family. Many mental health providers do not understand the unique indigenous immigrant culture, resulting in ineffective care. Cultural beliefs and stigma regarding mental health further exacerbate the barriers to accessing these services. Domestic violence is a common concern in this community due to strict gender expectations, a culture of silence regarding domestic violence, and shame, affecting the mental well-being of the individual and family.

Existing mental health services in Ventura County severely neglect Latino immigrants and especially indigenous immigrants. According to the Ventura County Behavioral Health (VCBH) Mental Health Services Act (MHSA) 2015 report, only 0.03% of the 17,597 VCBH clients—five people in total—served in the last three years spoke a language other than Spanish or English; and of those, presumably only a fraction spoke Mixteco. On the state level, 85% of Mexican-born Latinos and 91% of migrant farmworkers needing mental health treatment are unserved (Aguilar-Gaxiola et al., 2012).

The 2015 report Community-Defined Solutions for Mixteco Mental Health Care Disparities (Aguilar-Gaxiola, et al. 2015) identifies the following factors restricting indigenous Latino access to quality mental health care: a) insufficient numbers of mental health care professionals who are familiar with the indigenous Latino culture; b) lack of indigenous language interpreters or native speaking providers; c) social and systematic barriers including the high cost of services, inconvenient hours, and long wait times; d) limited understanding of the US mental health system among indigenous Latinos ; and e) negative cultural attitudes and stigma toward the idea of seeking mental health services, exacerbated by significant machismo and exposure to domestic violence due to a "negative male characteristic of a segment of the Mixteco community." These challenges result in greater risk for mental health concerns (Aguilar-Gaxiola et al., 2012)

Lack of mental health support leads to significant problems for indigenous Mexican families. Poor communication in families often creates misunderstandings between Mexico-born parents and their US-born children, causing parental isolation from their children's academic careers. Mixtec students often encounter family pressure to drop out of school to earn money by working in the fields. The problem of domestic violence has resulted in multiple Mixtec and Zapotec children being removed from their homes (NCTSN, 2010) According to the Oxnard Police Department, 77% of all reports of simple and aggravated domestic assaults in 2014 came from Latino households and the Mixteco Indigena Community Organizing Project (MICOP) regularly provides support services to indigenous Mexican wives whose husbands are incarcerated for domestic violence. Finally, prolonged suffering results when those who need mental health treatment do not receive it.

MICOP emerged as a non-profit community-based organization with a mission to advocate and meet the needs of indigenous Mexican migrant populations. MICOP believes in the power of harnessing the cultural strengths and assets of the community to overcome challenges that impact the indigenous communities' well-being. In 2010, MICOP developed Living with Love (LwL) as a direct response to the depression and domestic violence they witnessed among indigenous Mexican migrant women. In 2013, this Prevention and Early Intervention (PEI) class series was updated in partnership with Ventura County Behavioral Health Department (VCBH). In 2017, MICOP's LwL, a culturally and linguistically appropriate Community Defined Evidence Practice, was selected to participate in the California Reducing Disparities Project, a statewide, cross-population initiative, to reduce mental health disparities among underserved populations. This initiative comprises 35 culturally responsive, innovative Implementation Pilot Projects (IPPs) across the state of California working in five population groups: African American; Latino/x; Asian and Pacific Islander; Native American; and LGBTQ+.

Literature Review

Violence against women and girls is a serious human rights abuse and public health issue (Garcia-Moreno et al., 2006). Domestic violence or intimate partner violence is also known to be associated with mental health issues, prolonged trauma, and poor quality of life among women (Coker et al., 2002). Higher levels of gynecological, central nervous system, and stress related problems have been observed in abused women (Campbell et al., 2002). They are at a greater risk of post-traumatic stress disorder, depression, suicide attempts, alcohol and substance use, and aggressive behavior toward their children (McCauley et al., 1998; Lansford, 2014).

According to the Center for Disease Control and Prevention, domestic violence is defined as physical violence, sexual violence, stalking, and psychological aggression by a current or former intimate partner. Domestic violence affects all types of women and families. Yet, recent studies have found associations between women's perceptions of domestic violence, the presence of a

mental health disorder in women, the employment status of a woman's spouse, and presence of medical/psychiatric illness in a woman's spouse and the occurance of physical violence against women (Almis, et al., 2018; Faramarzi et al., 2005; Yu et al., 2019).

Children also suffer long term mental and physical health consequences as well as developmental issues as a result of domestic and family violence (Graham-Bermann & Seng, 2005). Children exposed to domestic and family violence have greater odds for experiencing mental health hospitalizations, respiratory system problems, and endocrinology disorders compared to non-exposed children (Orr et al., 2020). Similarly, children who are victims of physical abuse or repeatedly exposed to domestic and family violence are at a greater risk of experiencing intimate partner violence in adulthood (Jirapramukpitak et al., 2010). They may adopt the belief that violence is the manner in which to resolve conflicts. Young males who have witnessed abuse of their mothers are 10 times more likely to abuse their partners as adults. On the other hand, females exposed to domestic violence as children are more likely to be victims of abuse (Vargas et al., 2005). Children exposed to domestic violence are also susceptible to witness and/or be victims of a domestic homicide (Jaffe et al., 2012). Domestic and family violence is a learned behavior from family, community, and culture. These studies highlight the significant impact of the social environment in children's physical and psychological health.

Many Latino immigrants who migrate to the U.S. endure multiple traumas in their journey for a better future. In a recent study conducted to evaluate the pre-migration trauma exposure on individuals arriving at the U.S. border from Central America, the authors found that death and violence threats, murdered family members, and kidnapping were among the traumatic experiences that led immigrants to flee to the U.S. (Keller et al., 2017). Poverty and war or persecution in their home countries are also among the main reasons for migration that are highly associated with trauma (Perreira & Ornellas, 2013). During the migration journey, separation from family, exposure to violence (theft, physical violence/beatings, kidnappings, and death), and entry without authorization present further traumas (Perreira & Ornellas, 2013). Finally, there are the traumas of arriving in a new country and having to adjust to a new language and culture, and survive in the face of poverty, discrimination, violence, potnetial deportation, and other social adversities (Cook et al., 2009; Perreira & Ornellas, 2013; Leong et al., 2013). For migrant indigenous communities, the traumas of arriving to a new country are further exacerbated by discriminatory practices individuals experience as low-wage workers, as indigenous people, and for many, for their limited ability to speak Spanish (Fox & Rivera-Salgado, 2004). For indigenous women, these traumas are also rooted in the "triple discrimination" that they face from practices and systems of justice in their countries that have historically discriminated against indigenous women for their gender, ethnicity, and socioeconomic marginalization (Sieder & Sierra, 2011). The lack of access to education, illiteracy, and poverty among indigenous women greatly limits their capacity to exercise their rights (Sieder & Sierra, 2011). Unfortunately, those barriers along with traditional gender

expectations place indigenous women in vulnerable positions within their communities, more likely to experience abuse and violence without a system that supports them (Sieder & Sierra). Now, their status as migrants in the U.S. adds a new intersectional element of stigmatization for migrant indigenous women (Robles-Santana, 2011).

Among the many indigenous people who are able to adjust and find work in the U.S. to support themselves and their families left behind in the home country, a majority end up as agricultural workers picking fruits and vegetables. For indigenous women the traumas of abuse, sexual violence and harassment all too often continue to occur in the agricultural fields. A 2015 literature review titled *Working in Fear: Sexual Violence Against Women Farmworkers in the United States* reported a high prevalence of women farmworkers exposed to sexual violence and the challenge of addressing the issue due to their seasonal and migrant nature, and undocumented status (Kominers et al., 2015). The male perpetrators—supervisors, senior workers, and husbands—pray on the most vulnerable and powerless women and girls. Numerous studies have found these traumas and types of violence increase the fear of retaliation and deportation if women farmworkers report any abuse and harm against them (Murphy et al., 2014; Kim et al., 2016; Cohen & Caxaj, 2018; Caxaj & Cohen, 2019). Language and communication are also a significant barrier to reporting. A majority (53%) of California farm workers who come from the Mexican states of Oaxaca and Guerrero speak variants of Mixteco, 26% Zapoteco and 10% Triqui (Mines et al., 2010; Soriano, 2020). Variants of these indigenous languages are determined by their regional home culture and environment. The resulting subtle and significant differences can lead to misunderstandings when translating from these languages, which often have negative implications for the health and well-being of these vulnerable communities.

Theoretical Perspective

Personal agency—feeling in charge of your life, having a say in what happens to you, having the ability to shape your circumstances—influences mental wellness. Having personal agency means being in control and effectively regulating the behaviors that impact our well-being. It means consciously managing one's own actions and changing habits to improve personal wellbeing (Renes & Aarts, 2018). When abused individuals are able to increase their personal agency, they are more likely to act and change their circumstances. On the other hand, prolonged trauma impairs a victim/survivor's inner compass and robs them of their personal agency or the idea that they deserve something better (Webb et al., 2018). Loss of agency for a domestic violence victim can result in feelings of imprisonment. Being out of touch with their needs and not being able to care for themselves increases revictimization, shuts down their sense of purpose and meaning, and reduces opportunities to feel pleasure and happiness. As mentioned earlier, indigenous immigrant women face a number of challenges (e.g., domestic violence, poverty, discrimination, etc.) that reinforce their perceived inability to control their own circumstances. These types of risk factors negatively impact one's personal agency and are linked to poor mental health

outcomes. LwL was designed to build individual women's personal agency and to provide opportunities to develop coping skills to address these social determinants of health.

Early Intervention Curriculum: Living with Love (LwL; *Viviendo Con Amor)*

Living with Love (LwL) is a direct Prevention and Early Intervention mental health program that was developed to address issues of depression, anxiety, domestic violence, and (socio-cultural and linguistic) isolation for Mexican migrants, specifically indigenous Mexicans, by decreasing mental health stigma, improving knowledge about mental health issues, and increasing knowledge/awareness/access to mental health services (including domestic violence support resources). LwL's education and training component ensures that victims/survivors of domestic violence and other traumatic experiences, related to immigration, discrimination, and mental health problems are provided with a safe environment to learn and share lived experiences. The initial design and purpose of LwL was to focus on serving domestic violence victims and survivors, and on the prevention and early intervention of violence cycle in families. However, when exploring and addressing this trend, the frequency of traumatic experiences and stigma associated with mental health issues became very evident, resulting in an expansion of the scope of LwL to address mental health issues more broadly. Through LwL, people recognized domestic and family violence as a risk factor associated with mental health issues. Unfortunately, domestic violence against women is a public social issue that affects society regardless of social and economic status, rooted in gender inequality and abuse of power, placing women and children in the most vulnerable positions. This includes, the devaluation of women that exposes them to physical, emotional, psychological, and sexual abuse affecting their well-being.

The LwL curriculum was designed and tested through a collaborative development process. First, our team of educators analyzed existing county and state curricula to identify essential topics related to the prevention and early intervention of domestic and family violence on indigenous women. Next, our education team developed and piloted an eight-week course with a small cohort of women seeking support to address their past and/or current abusive circumstances. Our team of educators then conducted focus groups and individual interviews with participants who completed the eight-week LwL course. The focus groups and individual interviews provided in-depth information about the effectiveness and usefulness of the skills and strategies that they gained from participating in the classes. These pilot data helped to inform and modify the content and overall design of the LwL curriculum components.

Living with Love Components

Peer Support Group Series

LwL is a gender-specific curriculum that was designed to bring indigenous Mexican migrant females and females of Mexican descent together in safe and supportive space to engage in peer-to-peer learning groups and acquire evidence-based coping skills to identify and manage mental

health issues, particularly to overcome depression, anxiety, and stress as a result of domestic violence and other traumatic experiences. The LwL curriculum is divided into eight modules covering key concepts that previous research suggests can influence self-love, self-empowerment, self-respect, and wellness for women with a history of domestic violence in transition from abusive relationships to a healthier life and full participation in family and community life. It is important to note that LwL is presented as an educational program, not using the term "mental health," in an effort to avoid stigma and shame. Additionally, upon completion of the educational program, all LwL graduates are recognized and receive a certificate of completion. The LwL classes are taught in Spanish with simultaneous interpretation in Mixteco. During each class time period, participants learn about the topic/theme of that class, reflect, and participate in activities related to the specific class theme. For example, participants learn the following elements unique to each class:

- healthy decision making
- self-esteem and compassion
- meditation and mindfulness
- stress reduction
- coping skills
- domestic violence awareness

LwL group sessions teach participants to use cognitive behavioral tools to identify how one's thoughts and emotions influence their behavior, and evaluate options before making a decision and acting. LwL is staffed by trained indigenous Mexican migrant Promotoras, in an effort to create a more comfortable space for indigenous Mexican participants to open up their hearts to other people with similar lived and life experiences. The LwL class is led from the collectivist belief system held by indigenous Mexicans, focusing on the "we" over the "I." Participants are taught that healing oneself is for the higher good of all including family, community, and the earth. The Mayan poem "In Lak'ech" ("You are my other me") forms the philosophical basis of LwL, promoting respect and non-judgment of self and others. At the beginning of each class, participants are encouraged to recite the poem together for the purpose of uniting the group.

Circle of healing and sharing

Another key element of LwL is the importance of creating a non-judgemental space and bringing awareness to how negative concepts (such as, blame, shame, egotism, etc.) not only create more stressful lives, but exclude others from participating. It is at this time that the participants are reminded about confidentiality and the importance of respecting others. LwL utilizes rituals that are familiar to indigenous people as a way to establish a safe (and sometimes spiritual) space. For example, soft background music is played throughout the classes and an electric candle is lit as a symbol to start each class with an open heart and inner light. LwL participants then sit in a circle to create an inclusive, relaxing and safe space. Next, participants share their thoughts and experiences while others listen, learn, and connect with each other. In the middle of the circle, a

table is set with a mantel. The table is set as the base to place the candle that symbolizes openings and unity. The mantel decor symbolizes art made by human beings as recognition of its value and connection to community life. The Promotora starts this activity by asking one participant to light the candle and share what she intends to learn from the group and her participation. If the participants feel uncomfortable sharing their intentions aloud, they are encouraged to think them in silence. Participants learn about the importance of the space arrangement, which is to create a physical environment that supports respect, compassion, kindness, non-judgement, and safety. The Promotora explains to the class that adopting these values is the base to create healthy relationships with dignity, honesty and unconditional love.

Putting into practice

After each class, participants are assigned homework. For example, participants are tasked with reflecting on their personal goals, values, and sense of identity. Given the nature of the LwL topics, participants start by exploring the negative impact of blame, shame, and guilt on themselves and others. They are encouraged to instead utilize the healthier perspective of "what did I learn from this experience, and what will I do differently next time." Participants are also encouraged to make and document small positive changes every day as part of their daily living and efforts to live a better life. In the classes that follow, participants are asked about their self-reflections and steps they are taking to better their lives and those of their families. Self-reflection among the indigenous Mexican community is very important given it encourages people to create a space and time of their own, where they can reflect on their own being and those aspects of their lives that have a negative/stressful impact. Indigenous Mexican immigrants are faced with daily stressful situations as a result of harsh-working conditions, culture shock, family-separation, language barriers, discrimination, etc. Self-reflection has emerged as a strategy for creating awareness of the struggles in their everyday lives and ways to address them. Every class builds on the next class to prepare participants to receive the materials in a timely and appropriate manner. Each lesson includes: (a) learning objectives, (b) materials needed, (c) structured core activities (e.g., group activities, discussions, homework), and (d) additional resources for individuals to practice at home. All lesson plans are interactive and designed to be taught in sequence during a 90-minute weekly class session over an eight-week period.

LwL Curricular modules

Module 1: The importance of wellbeing in your life. This module is designed to present the importance of wellbeing in the life of human beings by introducing four main areas of personal health: mental, physical, emotional, and spiritual. General discussions focus on identifying what in life causes stress and to recognize how one's body reacts to stressful situations. The discussions then move to how one can regulate emotions during a stressful situation to better evaluate one's ability to practice behaviors that help overcome stress. A deep breathing technique is introduced as an important coping skill to help manage stressful situations.

Module 2: Self-love and the connection to cultural identity. Lessons in this module are designed to help participants identify and grow personal strengths that increase their capacity to love themselves and engage in self-love behaviors. The module also includes discussions and activities related to making meaningful connections with individuals and groups. Through these activities, participants learn to advocate for themselves and embrace a cultural identity aligned to their core values, well-being and hope.

Module 3: Healing my inner child. The purpose of this module is to help participants recognize past childhood traumas and work through them by sharing experiences and with the support of a network of people with similar experiences. The aim is to acquire strategies to address past pains and sustain a healthy inner self. This module includes tools and techniques (e.g., visualization) to heal from the traumas by connecting with the multi-dimensional aspects of our inner-child and attending to unhealed wounds, while deepening self-awareness.

Module 4: What do you want for yourself? This module focuses on identifying and connecting with our personal assets and strengths and recognizing them as unique to who we are as a person, and as a part of an intervention and treatment unique to each person. Discovering and prioritizing what matters most to each person and being authentic to ourselves to facilitate personal growth and devotion to our core values (e.g., family, faith, education, job, and happiness).

Module 5: Well-being and mental health. The purpose of this module is to deeply dig into understanding and identifying mental health problems and related symptoms of depression, anxiety, and *nervios*. Through these conversations, participants are also introduced to the social stigma that surrounds mental health in our communities, inviting them to share personal experiences and knowledge of barriers to accessing mental health services.

Module 6: Distinguishing between a healthy and unhealthy relationship. This module is designed to increase healthy habits in relationships that are consistent with respect, vulnerability, trust, kindness and mutual love. It introduces the signs of abuse and violence combined with intimidation, disrespect and trauma that lead to unhealthy relationships and eventually mental health issues. Participants recognize how an abusive relationship evolves as unhealthy love, with increased isolation and dependency. Through these activities, participants learn to identify key markers associated with unhealthy love and how to practice healthy habits linked to well-being.

Module 7: The cycle of domestic violence and impact of abuse on children. The aim of this module is to guide a conversation about the phases and markers of domestic and family violence and child abuse. In this module, participants engage in activities and group discussions analyzing the short-term and long-term impact of household violence on the mental wellness of mothers and their children. At the conclusion of the module, participants work through the sequence of activities designed to break the cycle of violence and child abuse and explore how to create a safety plan to leave an abusive relationship and start healing.

Module 8: The circle of equality and effective communication. This module is used to help participants lead conversations with their life partner and make decisions about sustaining the family, raising children, childcare, making and completing future plans, shared responsibilities and housework. Participants engage in activities that promote women in leadership roles and

demonstrate strength, confidence, effective communication, and the ability to negotiate to achieve equality. This module is essential for parents modeling equality to their children and eliminating gender stereotypes connected to the cycle of domestic and family violence.

Program Promotoras

Trained LwL Promotoras deliver LwL instruction and intervention. These community health workers are trusted members of the community who are deeply familiar with the culture, language, values, and life experiences of the community—who work alongside participants in the agricultural fields and/or endured similar immigration experiences. These lived experiences create a trusting bond, companionship and respect that has enabled Promotoras to access the community. Promotoras' empathy and availability to meet the needs of the community served are significant factors that have contributed to the close connection established with migrant indigenous communities. This connection would not be possible without shared language accessibility. Promotoras are fluent in Spanish and Mixteco and LwL classes are given in either language, or both depending on the group's preferred language, which creates a welcoming space for participants who feel comfortable as they meet other participants and Promotoras who also speak their language. This element is very important as participants feel comfortable to contribute to the group discussions in their native language. Even when there are participants who only speak Spanish, participants who speak their indigenous language feel safe to express in their language. Both Spanish and Mixteco speaking participants respect each other's language, life experiences, beliefs, etc., even when they are not able to communicate with one another verbally creating community and unity. This cultural broker element is essential to the curriculum and classroom instruction being successful and relevant. Trust is a consequence of participants feeling safe and an affiliation of connection with the educator or trainer.

Living with Love during COVID-19

One-on-One Peer Support Sessions:

The COVID-19 world pandemic affected the MICOP/LwL project in unprecedented ways, marking a historical impact on the delivery of our services and connection to the community. In response to the health emergency, LwL restructured and adapted its Peer Support Group Series to include eight One-on-One Peer Support Sessions, conducted in a secure virtual space between the Promotora and interested participants. The format provided a safe space to engage participants in conversation and to facilitate use of, and apply, LwL curriculum themes.

This plan emerged from the need to continue providing mental wellness services to the community and aligning with local mental health agencies' approaches during COVID-19 (i.e., TeleHealth). The Whereby App is a simple, secured, and user-friendly professional platform used to host video meetings and ensure that conversations remain confidential. The App does not require a download or login for guests. Only the host is required to create login credentials and share a special link (via text message, email, etc.) with guests to allow access to the meeting. The

host is able to control who joins the meeting. Access to the video meeting is easily accessible via most phone devices and computers, where the guests only need to tap into the link provided by the host and wait for the host to let them into the private Whereby room. When technology becomes a problem, LwL provides the flexibility of using alternative video platforms, such as WhatsApp, FaceTime, and/or regular phone calls in an effort to adapt to the participants' needs. While adhering to social distancing guidelines, this new project format provides an opportunity for LwL to continue promoting emotional connections. The one-on-one peer support session dynamics are different from the in-person group classes as the Promotora is no longer instructing in front of a group— instead, the Promotora connects digitally with one participant at a time and engages in different types of interactions.

Key curricular elements and tools were modified to serve as the content framework to successfully perform effective classes using digital platforms such as, providing more time for interactions and less instruction to provide a space for the participant to talk and release their thoughts and emotions.. This dynamic focuses on introduction to concepts/topics, interactions, and reinforcement of concepts/topics. This approach allows participants to engage in more dialogue, while articulating the class information/concepts in their own understanding. Each class session topic was edited accordingly to fit into this dynamic. In order to ensure that the one-on-one peer support sessions are implemented in a private and adequate space, LwL Promotoras conduct the sessions from MICOP's main office. The LwL Promotora also ensures that participants have access to a private space to take the classes. Once LwL identifies interested participants, an in-person meeting is scheduled with the participant (following the required health precautions) in the office to explain and review the LwL's virtual approach, evaluation, and the LwL Agreement form, and to obtain consent for participation in the evaluation. If the participant agrees to participate in the LwL class series, the participant is introduced to Whereby and walked through the process of connecting and familiarizing with the platform. This first in-person meeting is very important to establish trust with the participant and to help mitigate the technology challenges that may arise during the virtual class sessions. During this meeting, LwL also administers the pre-program survey and works with the participant in scheduling the most appropriate times and dates in accordance with their needs to take the classes. A calendar of the class sessions is provided to the participant along with the class topics.

Once the above process is completed, participants are ready to start the classes. Each Promotora works with 4-5 participants per week, to allow sufficient time to be able to prepare for each session and responsibly meet the needs of each participant. The One-on-One Peer Support Sessions, begin with a phone call to the participant at the scheduled time where the Promotora conducts a check-in and instructs the participant to access the meeting session using the link provided during the prior, in-person meeting with LwL staff. The participant proceeds to tap into the link and tap the "knock" option to request that the Promotora grant them access to join the meeting. The Promotora then proceeds to begin the class session in Spanish or Mixteco— starting with a greeting, brief check-in, review of Class Agreements, the Class poem, and a

breathing technique to begin the session. The Promotora begins introducing the session topic by engaging the participant in the conversation using key information to open up in-depth discussions. Homework activities are assigned in each class session, which consist of basic activities related to the tools and information learned. The homework is sent out to participants via text or voicemail messages, in keeping with the needs and preferences of the participant.

Each session (eight in total) takes approximately 45-75 minutes. The class time is slightly briefer than the regular in-person approach (approximately 90 minutes) given the more personalized attention that is given to one participant at a time, allowing Promotoras to cover the class materials faster while still allowing enough time for the participant to respond and express themselves. Allowing sufficient time for the participant to process the information, express their emotions and feelings, and ask questions is critically important given the complex topics that are discussed during each class session. As described, the class series are delivered in Spanish or Mixteco based on the participant's preferred language. If the participant opts for the class series in Mixteco, the Promotora provides all the class information in Mixteco, taking the Spanish LwL Curriculum as a guide to interpret and guide the class sessions. The LwL program concludes with a second in-person meeting between the Promotora and participant after the class series is completed. During this meeting, the Promotora provides the participant with their certificate of completion, and administers the post-program survey, including one or two brief questions regarding their experience with the virtual approach. Participants also receive a packet with brief summaries of each class session with key terms and tools for their review. Graduating participants also receive food pantries (if available). The food pantries contain items that are most appropriate for the community, such as seeds and basic grains. Facemasks and hand sanitizer are also included in the pantry. These pantries were possible during the implementation of the One-on-One Peer Support Sessions thanks to the support of a UCLA Seed Grant that provided funds to help the community during COVID-19.

Providing culturally and linguistically accessible services for the community is the Project's number one priority. With the understanding that virtual platforms are not necessarily appropriate for the community given the technology barriers and sensitivity of the information delivered, LwL reinforced the value of trustworthy relations with the community in order to get them interested in virtual services. Trust comes along with safe spaces where the community feels comfortable and welcomed to speak their own language, which the Promotora provides. The recruitment of participants to the class series relies on strategies that, among other aspects, demonstrate support and connection with the community. This is significantly important for a community where trust is key for community engagement.

Case Management:

In response to the COVID-19 pandemic, MICOP/LwL adapted a new core component to better serve the needs of the migrant indigenous communities. LwL turned to the Project's case management as a strategy to establish trust and support and recruit potential participants to the

classes as the health crisis affected the ability to continue with the Project's regular outreach activities. The case management became the most powerful and significant recruitment strategy for the class series throughout the COVID pandemic given the trust and connection that was established with the community. Given the limited services available during the early start of the pandemic, families were struggling to access basic resources and navigate the legal system, in specific the Family Law area. While reconnecting with the community in an effort to show presence and provide emotional support during these uncertain times of COVID-19, LwL Promotoras began to conduct brief check-in phone calls, engaging in conversations with past participants to learn about their well-being and provide any necessary support or connection to resources. During these informal platicas, community members began to express their struggles in accessing services related to domestic violence, filing child custody orders, child support, restraining orders, and navigating the court system. In response to this emerging need, LwL began to provide system navigation, referrals, and follow-ups to support families with their personal cases. Particularly, the adaptation of virtual services, the closure of offices, understanding the legal system, and completing paperwork were among the most cited barriers in the community. This type of tailored case management met an important need for the community during a time of unprecedented barriers to accessing support and services.

In an effort to better understand the needs of migrant indigenous communities, LwL began to promote the availability of case management, which soon increased the community's demand in this area. Families started to arrive at the Project seeking support with managing their personal cases such as, domestic violence, family reunification, child support and custody, etc. Given the sensitivity of the cases, LwL started to meet families in the offices, following strict COVID-19 protocols; this was especially important for cases that required support with paperwork. Through the case management approach, families began to open up about the different situations that they were confronting and the emotional impact that they were going through as a result. LwL began to invite these clients to be part of the class series as an opportunity to have a private space to talk, heal and learn coping skills to deal with their emotional distresses. As mentioned earlier, the Project is not presented as a mental health program, rather as an opportunity to learn, talk and release the emotional impact that their situation may be causing in their lives. The case management in this case, was tailored to the client's needs—sometimes they only needed a private space to be listened to, and were referred to MICOP's internal programs as needed, such as LwL classes.

Other cases required extensive support, especially when families were under a Family Law case, which often involved up to three follow-ups during the week to understand the situations and provide guidance. With these types of cases, oftentimes the Project was in constant communication with the client's social worker providing progress reports of the client involvement in the class series, and providing general follow up of the case requirements. These cases generally would take between 6-8 months to complete, in which the Project supported the

family to ensure that they were understanding the legal process, guidance on completing paperwork, and connecting to necessary resources. There was no single process through which families were referred to LwL case management. As mentioned previously, sometimes families came in from internal references; other times, they came from external agencies, or most recently, we observed that the families were calling in themselves to seek help. Oftentimes, case management meant directly visiting families when they were going through an emotional crisis to ensure that they were mentally and physically safe and connect them to resources at the moment. In other instances, LwL saw the need to directly visit families in their homes to explain certain legal processes and consequences if no action was taken. This was specifically relevant for Family Law related cases as our migrant indigenous families were often unfamiliar with the legal system and did not have the guidance and resources to confront these types of problems. The support that the community received through LwL's case management was the perfect combination to help families. On the one hand, they received the assistance to understand and navigate their cases, while also receiving emotional support to process their situations and gain the information and tools to strengthen themselves. These components were very significant to provide a complete and relevant service given the importance of the case management in the community. Furthermore, through case management, referrals, and efforts to enhance the resource network, LwL increased its visibility and value. Health care and resource agencies began contacting LwL to learn about the classes and to collaborate by referring their clientele to the Project. LwL worked closely with agencies, such as Child Protection Services to help families navigate, understand and complete their case plans in order to reunify with their children. LwL became the bridge between the families and agencies providing families with guidance in their own language and safe spaces where they could talk to people with shared lived experiences. This was highly important given the fact that, occasionally, families do not feel comfortable opening up to social workers due to the fear and lack of trust that exist in our communities related to these types of government agencies, and of course, the language barrier. The case management significantly increased the Project's visibility in the community for the support and guidance they received, making this element one of the Project's core components, especially under the COVID-19 pandemic.

The goal of LwL is to empower victims and survivors of domestic violence by focusing on their personal agency and encourage them to take control of their lives and be able to change the things that impact their health and mental wellness. It is therefore important to look at agency from the understanding that this capacity requires a close examination of the person themselves and "the conditions that produce her self-understanding" (Showden, 2013) to be able to detangle participants' perceptions of themselves and eventually inspire them to take control of their lives. This is accomplished through focusing on the mental and emotional growth of participants, the increase in self-perception of one's own capacities, and the enhancement of self-appraisal and acceptance. LwL also highly relies on the reinforcement and understanding of the concept of self-love to achieve a change in participant's sense of personal agency. LwL analyzes the

development of self-love from the early stage of conception to the present, highlighting key sources that impact self-love growth, and encourages participants to eradicate negative messages from their lives to reconstruct a new perception of themselves. From the understanding that agency requires the availability of good choices in order for it to develop and that "the presence of choices depends on the interrelationships between people and their environment" (Showden, 2013, 2018), LwL takes victims and survivors of domestic violence through a healing process to find their inner power and resiliency to be able to engage in healthy relation with their surroundings. In keeping with the published literature, LwL adopts the view that strong personal agency means a sense of self-efficacy necessary to successfully change and manage lifestyle habits (Hitlin & Johnson, 2015).

Implementation of the LwL Intervention

The eight-session LwL curriculum is delivered where people live (e.g, apartment complex), where their children learn (e.g., schools), and where they worship (e.g., churches). Our LwL curriculum model is grounded in the notion that to create real change, we must engage and work with people where they are most comfortable and where they feel safe. Domestic and family violence is the major theme of LwL. As stated earlier, it is also a social determinant that increases the prevalence of mental health issues and it requires the LwL educators to appropriately manage the domestic violence and mental health conversation with a high degree of sensitivity, in order to avoid discomfort and people walking away from the opportunity to participate in the program. Having the proper team that can connect in Spanish and *Mixteco* is crucial for participants to feel comfortable, connected to the topic, and contribute to group discussions. All LwL curriculum instructors attended a series of training sessions prior to delivering the curriculum focused on mental health, domestic violence, responding to emotional crises, and how to teach LwL. Promotoras received at least 80 hrs of direct training on how to deliver the LwL Curriculum in order to be fully prepared to instruct the LwL class series followed by several 4-hour training sessions. At the completion of the training classes, each trained Promotora received a score of at least 95% on a post-training assessment of key skills and knowledge required to provide effective LwL class instructions. LwL former Promotoras were identified through their participation in the different programs provided by MICOP in the community—such as the domestic violence prevention programs. The process of encouraging community members to become leaders and mentors for their communities is a long process. Most of our Promotoras come from very limited or non-educational backgrounds and from working in the agricultural fields, making it very difficult to navigate the office work environment. Therefore, MICOP is always dedicated to strengthening Promotoras through intensive training tailored to the abilities required for specific programs. As LwL Promotoras, who are working directly with the community bringing sensitive topics (mental health and domestic violence) to discussion, who are seen as mentors and guides, and who are key in this research project, it was very important to continually reinforce their knowledge with information

that will strengthen their role as domestic violence and mental health Promotoras. LwL Promotoras were trained under an empirical methodology based on a series of practical procedures for the Promotora through observation and training related to the role of a prevention and early intervention (PEI) mental health and domestic violence Promotora, and with the purpose of elevating their identity as members of the Mixteco indigenous community. Through these training experiences, Promotoras developed their level of knowledge in different areas that were essential for the LwL Program, such as understanding the barriers of a segregated indigenous immigrant community in public health, education, labor opportunities and public services, and the resultant impact on mental health and family wellbeing. The information offered through the training allowed Promotoras to make connections and reflect on personal experiences or observed community experiences in order to deliver correct and appropriate information in the language of our Mixteco indigenous community. Additionally, LwL Promotoras also received direct training from a Licenced Family and Marriage Therapist in understanding mental health from a clinical perspective, responding to an emotional crisis and available local mental health resources. LwL Promotoras completed the child abuse mandated reporter training, domestic violence trainings and a series of internal leadership sessions tailored to empower and learn about the significance of being a Promotora. LwL Promotoras also engaged in a training focused on identifying strategies to implement outreach approaches to farm workers and their families working in the fields.

EVALUATION METHODS

Program Delivery/Procedure

The Recruitment Phase

A strategy of targeted recruitment in neighborhoods with the largest indegous populations was undertaken to recruit participants to the LwL program. The aim was to recruit individuals of indigenous Mexican heritage, however the Program also aspired to be inclusive and serve all Latinos in need of services. A short recruitment message was constructed based on the indigenous composition of the neighborhood (e.g., mixed indigenous/non-indigenous Latino, variant of indigenous languages, Spanish-speaking groups, origin of indigenous region, and data). The approach was to go where indigenous people live, work, study, worship and age to recruit and deliver LwL. Such settings have also included the agricultural fields and swap meets, community setting where people come to buy or sell and trade goods. This approach is consistent with convenience sampling methods, and all individuals recruited to participate in the program were deemed eligible to participate in the local evaluation.

The innovation: Pan y café (sweet bread and coffee). Using this approach, the LwL staff were able to establish meaningful relationships, engage community members in a conversation about LwL and extend an invitation to participate in the Program. Community rooted media platforms, such as *Radio Indigena* 94.1 FM were also part of the LwL's strategies to reach the hardest-to-reach rural community. In addition, LwL used social media, such as Facebook, as a strategy to connect with the community and promote the availability of the LwL class series. Through a very special dynamic, MICOP/LwL has been able to connect with the community by streaming *Radio Indigena* shows on Facebook live. This is a very important element given the connection established between the community and *Radio Indigena* DJs, and the connection to more people both inside and outside of the country.

On the ground grassroots strategy. As indicated earlier, a message was crafted and delivered by a team of two LwL Promotoras using this grassroots strategy going door-to-door and interacting face-to-face with the community. Time of interaction or conversation was between 2-10 minutes depending on the community member's time and flow (quality) of the connection. In an effort not to interfere with the day-to-day obligations of a parent interested in the program, the Promotora modified the recruitment approach. For example, if parents were running late to drop off a child at school, the Promotora would walk alongside the parents keeping them company while engaging them in conversation and sharing information about LwL. This approach secured a commitment from parents to participate in LwL. It is important to be respectful of people's time and know when to take a step back to allow them space. The door-to-door, face-to-face approach is especially important given indigenous community members value the effort and attention to tailoring a message that is simple and aligned to their cultural, language, context, and social needs. This also includes immersing recruitment activities in the community's settings, such as the agricultural fields and being in close connection with them.

The LwL Promotora team discovered that community members who speak Mixteco were more open to receiving information from someone who spoke their native language. When the Mixteco variants were slightly different, the Promotoras and community members were able to make the necessary adaptations to understand each other. This is important to mention because it strengthens the methodology and is a promising approach for increasing participation. The Promotora generally started the conversation by asking the community member their preferred language (Spanish or Mixteco) and community of origin. This was essential to identify the language variants based on the community member's native region, and to acknowledge them and their diversity. Adapting to the various indigenous language variants was a skill combined with knowledge and lived/life experiences that led to establishing a meaningful connection. These connections are important because the LwL Promotoras must make a unique connection with potential participants within minutes, showing sensitivity and empathy as they do so. This approach builds trust and initiates conversation. Once the Promotora identified the community member's indigenous variant, the next step was to acknowledge the difference of the language

variant and ask the community member using correct pronunciations and words that resonated more in their variant. This translated to respect and mutual understanding.

Another important discovery made by the LwL Promotoras was that community members whose language of origin is Mixteco and who grew up speaking the language are more likely to understand most of the language variants despite the differences from one region to another. In contrast, those who learned Mixteco at a different stage of their lives or grew up also learning Spanish are less likely to understand multiple variants. The complexity of the indigenous languages is important to recognize as part of this methodology. Unlike the Mixteco community, the presence of the Zapoteco community in Ventura County is minimal, and the complexity of the language is more difficult. The Zapoteco language is completely unique across its different communities. In other words, Zapoteco people would not be able to understand each other from one community to another because the Zapoteco language is different in each town; this indigenous language does not have variants like the Mixteco language.

The Evaluation Design Phase

The local evaluation was designed as a collaborative effort between MICOP staff and Promotoras, the local evaluation team at the UCLA Kaiser Permanente Center for Health Equity and the LwL CAB. Together, we worked to develop an approach that would allow for the collection of detailed data related to each of the evaluation questions, as well as for input related to program delivery and guidance for future program modifications. We agreed upon a mixed-method, quasi-experimental, pre/post design that utilized surveys as well as 2-3 month, post-program focus groups to collect the data. We set out to adopt a pragmatic approach that interfered minimally with program delivery and placed limited burden on program participants.

We sought to collect local evaluation data from all program participants, over the full CRDP period. This approach was modified to accommodate other required CRDP evaluation components, such that local evaluation data were collected from every other cohort of LwL participants. With 6-8 participants expected per group, we intended to collect data from approximately 220 participants at baseline, anticipating some attrition at follow-up. All participants were invited to take part in a focus group two-three months after completing the program.

Given MICOP's commitment to serving the community, as well as limited staffing resources for data collection, we determined that it would not be feasible to establish a control group for the project. Moreover, the community itself is relatively small, and MICOPs resources were limited during the start-up phase of this project, so it would have been difficult, if not impossible, to identify a control group of individuals that had not expressed interest in the program. Even if this had been feasible, it is unlikely that individuals not interested in the program would have been comparable to those who wished to participate. As described in other sections of this report, the

data collection process is lengthy, requires a high level of trust established between the Promotora and the participant, and addresses topics that may lead to some level of discomfort or confusion among community members who are not participants in the LwL program. MICOP staff, Promotoras and LwL CAB members felt strongly that a wait-list control was not an acceptable or feasible approach as it may have resulted in some participants missing their scheduled program time, due to the seasonality of agricultural work. In order to ensure that all aspects of the LwL program were delivered equitably, we elected to administer the evaluation to all participants in each class series assigned to the local evaluation during the CRDP timeframe. Promotoras in particular were concerned that inviting only a sample of participants to take part in surveys and/or focus groups may negatively impact their relationships with participants. For example, those who were not selected to participate may have felt that their input was not valued whereas those who were selected may have felt that they were being unfairly burdened.

Our plan was to conduct multiple levels of analyses using the survey data. We intended to capitalize on the repeated cycles of LwL program administration to obtain a greater degree of control in our analyses via a "patched up design" or "recurrent institutional cycle design." (Campbell & Stanley, 1963). This type of design combines aspects of longitudinal and cross sectional designs, and allows for comparisons of similar participants who provide data not been exposed to the program. Given the plan to deliver LwL classes in a rolling fashion, with pre-program data collected from each subsequent cohort at approximately the same time-point as post-program data were provided from the prior cohort, this type of design was elected as the most appropriate for meeting the needs of the project without necessitating collection of data from a true control group that did not receive the program. Focus groups were planned as a means of collecting in-depth feedback and guidance from participants about their experience in LwL, for the purpose of guiding program modifications and future program development.

Internal Review Board

Approval for LwL's local evaluation activities were obtained from two sources: UCLA's Office of the Human Research Protection Program (UCLA OHRP) and the California Health and Human Services Agency (CHHSA)'s Committee for the Protection of Human Subjects (CPHS). MICOP/LwL submitted a request for exemption related to the local evaluation component of the project to CHHSA's CPHS and this request was approved. The statewide evaluation component of the project however, was not granted an exemption and underwent a full review; this process was fairly lengthy and resulted in a shorter timeframe for the statewide evaluation as compared with the local evaluation. The UCLA OHRP approval was specific to the local evaluation and supported the collection of local evaluation data from September 2017 through June 2021.

Design Modifications: Our goal in developing the local evaluation design was to maintain flexibility and adaptability in order to ensure needs of the LwL program as well as the larger CRDP were met. The local evaluation was initially conducted with all LwL cohorts/participants, as planned. After IRB approval was obtained for the Statewide Evaluation, however, this

approach was modified to ensure that both evaluation components were conducted appropriately without placing an undue burden on participants. Due to the length of time required to administer the surveys associated with each evaluation component, a decision was made to adopt an every-other cohort approach such that the local and statewide evaluation alternated. This approach was discussed with, and agreed upon with, the Statewide Evaluation (SWE) Team. Ultimately, this choice combined with the varied duration and sometimes overlapping nature of LwL class series that was adopted to accommodate participants varied schedules and timeframes, generated data that did not fit the requirements of a patched up design. This type of sacrifice in statistical control was necessary to collect all required program data (local and state) and minimize survey fatigue and accommodate participants' needs.

Multiple other modifications to the evaluation approach represented an expansion of planned activities. Namely, the onset of the COVID-19 pandemic and resulting changes in programmatic approach provided an opportunity to examine results in relation to varied program delivery contexts. Toward this end, we expanded our quantitative data analysis plan to include analyses among the full sample as well as a number of stratified analyses (group vs. 1:1 delivery). Focus groups were originally intended to serve as a guide for program development. However, the scope of focus groups broadened considerably early in the course of the program such that they provided rich and nuanced data related to the program evaluation questions.

Fidelity Assessment

Throughout the implementation of the LwL Project, we explored different approaches to assess consistency across the following fidelity dimensions: adherence, exposure, quality of delivery, and participant responsiveness.

Adherence: LwL staff measured adherence to evidence-based practices in LwL class instruction by implementing a checklist of specific steps necessary for a successful delivery of instruction and to ensure continuity of the curriculum across each of the class cohorts. The checklist was applied for each of the eight classes. The checklist was divided into three steps: (1) preparation of key concepts; (2) teaching procedures and methods specific to each class topic, and (3) implementation and translation into practice. Each LwL class checklist was completed by a LwL staff member by documenting in summary-form her observations noting external factors such as time, weather, and facility's availability as impacting the implementation and outcomes of each class session. Eulmesekian and his colleagues (2017), found an increase in adherence to practices over the course of two months when implementing this type of checklist. Overall, checklists demonstrated a high level of adherence to the preparation, teaching procedures and methods, as well as implementation activities required for each LwL class session, by each LwL Promotore.

The Exposure dimension of LwL was measured using a three-prong process. First, participant attendance was documented. Being present to receive and experience instruction translated into engagement. Additionally, we were able to observe changes in participant's perceptions and

behaviors. Second, we administered short pre-test/post-test surveys after each class to get immediate feedback on the participants' reactions as to the effectiveness of the instruction and relevance to their daily lives. Also, the participants' acquired knowledge, skills, attitudes, and confidence in translating classroom knowledge into real-life situations and changes in their behaviors. This is consistent with prior research in measuring exposure via a four-level training evaluation model known as the Kirkpatrick Model (Bates, 2004; Smidt et al., 2009). It is important to mention that we used the results from these short pre-post test tools to make necessary changes to our LwL curriculum and ensure that the delivery for the instruction delivery and activities were more aligned to participants' needs. Finally, we conducted two-month follow-up focus groups using a feedback loop approach to continue checking in with LwL participants and engage them in conversations to improve LwL course materials and its delivery of class instruction in a safe environment.

To ensure quality of delivery LwL staff used journaling and reflection after each class session as a strategy to assess the class delivery through individual staff observations. LwL found this approach most feasible for LwL Promotoras to document their experiences during the implementation of the LwL class series on a consistent basis. After each class session, LwL Promotoras would convene and work together to self-assess their effectiveness related to following the LwL class structure and delivering class content. Participants' responses and reactions to the LwL class were also captured and reflected upon. Based on this self-assessment approach, the LwL Promotoras and staff modified and incorporated experiential learning activities that reinforced the quality of program delivery. LwL staff also built on this approach by issuing participants homework assignments and asking for volunteers to share their homework reflections at the next LwL class. This type of co-learning increased the quality of peer-to-peer delivery of teaching and learning.

We also examined participant responsiveness or how participants respond to, or are engaged by, the LwL intervention. For this dimension, we examined the relevance and utility of the LwL curriculum among our participants. By using a successive structure across the topics and building on each curriculum topic or theme, the participants were able to demonstrate the skills and knowledge acquired both in the classroom and at home through homework assignments. Each topic starts with an agenda describing the necessary elements that must be met before starting the topic, such as the greeting, *conocimiento* (icebreaker), class agreements, class objectives, and a poem. The agenda was an important element that served as guidance for LwL Promotoras to ensure consistency across the different class sessions and cohorts. Regular observations conducted by the Project Manager/Curriculum author also served as the basis to ensure uniformity across the class series implementation.

Significant changes made to CDEP due to COVID-19 meant adaptations to the class series from groups to 1:1 peer support sessions. LwL staff also explored a new approach to continue documenting the consistency of the class series. LwL Promotoras started to complete reflection

forms at the end of each class session, where they documented the participant's interactions, class experience, and suggestions to reinforce each class topic. It is important to keep in mind that even though the Project delivery was implemented with consistency, there were external factors that often impacted the Project's desired implementation. Such factors included LwL class cancelations due to poor weather conditions, low class participation, lack of facility availability, tardiness and absenteeism, and evaluation implementation.

Local Evaluation Research Questions

This local evaluation was guided by five key questions: (1) Did mental health knowledge increase and stigmatization of mental health care decrease among LwL participants? (2) Did knowledge about domestic violence increase among LwL participants? (3) To what extent are cultural factors that may enhance mental health strengthened by LwL? (4) Did LwL participants' capacity to manage daily stressors improve following participation in LwL? and (5) To what extent did LwL participants' knowledge, awareness and use of mental health services (including domestic violence supports and resources) increase? In addition to these questions, we sought to examine participants' symptomatology.

Quantitative Approach

Survey Development

Survey instruments were designed to capture participants' demographic characteristics and to assess each of our evaluation questions. Where possible, items were adapted from existing instruments, and where possible, from instruments that had been validated in Spanish. We were unable to identify appropriate instruments validated in Mixteco or other indigenous languages used by the community members that MICOP serves.

The survey development process was iterative in nature, and entailed a process whereby feedback was solicited from the MICOP/LwL team as well as the LwL CAB. The UCLA team developed a pool of potential items and shared these options with the MICOP/LwL team for review. A more condensed pool of items was then presented to the CAB for the feedback. In particular, we were interested in learning how items would be translated into indigenous languages and whether community members would grasp the intended meaning of the concepts included in the items being considered. Feedback from the LwL Promotoras and CAB was largely related to the inability to translate nuances between various concepts assessed by different items within the same scale. Additionally, guidance from these community experts indicated that having multiple Likert-type scale response options was confusing and would be challenging to translate for community members. This guidance is in keeping with learnings and approaches used previously to collect survey data from indigenous community members served by MICOP (Maxwell, et al., 2015; Young, Gomez & Maxwell, 2019). Use of this type of

feedback loop is consistent with the participatory research bi-directional communication approaches to strengthen the collaborative learnings and sustained engagement in the research processes from indigenous community members (Wallerstein et al., 2008). The collective feedback obtained through this process was used to consolidate the survey item pool, streamline/condense the language used in the survey items and to inform the adoption of limited response options (yes/no; always/sometimes/never) response options throughout the survey instrument. Additional information regarding the survey development and translation process is provided in a subsequent section titled "Oral Translation Framework." Specific details related to item sources are included below, in relation to each of the local evaluation questions. Details related to survey administration and the analytic plan are provided in subsequent sections of the report. The survey instrument is provided in Appendix A.

Qualitative Approach

For the qualitative portion of this evaluation, we used a phenomenological perspective by closely examining participants' lived/life experiences as we recognize that they develop personal meanings that guide their thoughts and behaviors (Flynn et al., 2012). We grounded this qualitative evaluation of Mexican indigenous populations' participation in LwL in phenomenology because of the multidimensionality in their experiences associated with accessing mental health services and domestic violence as a risk factor. Using focus groups, participants connected their experiences with LwL's class series.

We adopted a community-based participatory research (CBPR) approach (Minkler & Wallerstein, 2008; Wallerstein & Duran, 2010; Ursua et al., 2018) to ensure a continuum of community involvement in decision making (McCloskey et al., 2011), allow for bi-directional translational processes involving feedback loops (Hicks et al., 2012), translate the findings into practical strategies for MICOP/LwL to consider in order to improve quality of care and of life in the Latino-indigenous community. When examining health disparities, the CBPR approach is the framework most widely used to describe the lived/life experiences of vulnerable and hard-to-reach populations and for addressing disparities in access, availability, appropriateness, affordability and advocacy as they relate to health care and other social goods and services.

The LwL evaluation team, working alongside UCLA Kaiser Permanente Center for Health Equity (Equity Center), guided the design, data collection, and focus group delivery protocol of this evaluation, including debriefing with our CAB members throughout the data collection and analysis. The focus group guide was developed collaboratively, using an iterative process. A copy of the guide is provided in Appendix B. We worked in small groups to collect data, examine the data using three levels of coding (open coding, focused coding, and thematic coding), highlight emerging themes, review relevant literature, and organize the final manuscript.

A focus group or one-on-one telephone interview was conducted two-three months following the final class session. Focus groups were conducted with each cohort of LwL participants who participated in the small group program format, prior to the onset of the COVID-19 pandemic. Interviews were conducted with participants who experienced LwL via a one-on-one (participant and Promotora), virtual format adopted in response to constraints associated with the COVID-19 pandemic. Trained LwL Promotoras led the focus group conversations while other staff members observed and took notes of other important details conveyed through facial expressions and body language. All focus group sessions were audio recorded with the consent of the participants. All focus groups were conducted in Spanish with simultaneous interpretation in Mixteco. This interpretation approach is consistent with what participants experience during the LwL classes. For purposes of continuity and comfort, all focus groups for this study took place in the same community space where the LwL classes were held. Each focus group was approximately 90 minutes in duration. With the COVID-19 pandemic, the focus groups transitioned to phone interviews to align with the overall Project adaptations. The shift to phone interviews allowed the Project to continue the data collection under a period of strict safety protocols. Prior to making this change, LwL analyzed the possibility of conducting the focus groups through Zoom; however, after analyzing the change to one-on-one sessions, convening participants in a group with people who they have never seen before, would not have been appropriate. Therefore, the Project decided to conduct the phone interviews to capture participants' personal experiences in the Project. Each interview was recorded with the participant's appropriate verbal consent. The approximate duration was between 15-30 minutes and were conducted in either Spanish or Mixteco based on the participant's preferred language.

The UCLA local evaluation team has a history of working alongside MICOP's evaluation staff to train MICOP staff members, including LwL staff and Promotoras (Maxwell et al., 2014), to conduct focus groups. These training sessions emphasize the use of appropriate prompts and probes, strategies to engage all participants in the conversation, and transitioning from one topic to the next. Staff also were trained to take notes during the focus groups, with instructions to document important details conveyed through facial expressions and body language. Focus groups were originally framed as a tool to help refine the LwL curricular components. Ultimately, they served to complement survey data and add valuable details related to participants' experiences in LwL. In the following section, we describe the five primary research questions in more detail:

Operationalization of Local Evaluation Questions

Local Evaluation Question 1: Did mental health knowledge increase and stigmatization of mental health care decrease among LwL participants? To answer this question, we evaluated knowledge of common mental health problems and perceptions related to seeking care for mental health issues. Mental health knowledge was assessed using a series of yes/no questions related to symptoms and treatment of depression and anxiety (e.g., Do you think it is possible to

treat depression?). Participants' general familiarity with depression and anxiety was assessed by directly asking if they knew of the conditions (e.g., "Do you know what anxiety/nervious is?"). Stigmatization of mental health care was assessed with a series of four yes/no items (e.g., Would you be embarrassed to seek help for yourself or a friend/family member?) The items and approach were adapted from the Adolescent Depression Knowledge Questionnaire (Hart, et. al, 2014) and a prior community-based assessment of mental health literacy conducted in India (Sadia, et. al, 2014). Focus group participants were asked to share what mental health means to them, how they believe mental health problems affect people's lives and why they believe people going through a mental health issue do not seek help.

Local Evaluation Question 2: Did knowledge about domestic violence increase among LwL participants? For this question, we assessed participants' knowledge of what constitutes domestic violence and about the impact of domestic violence on family wellness. Overall domestic violence awareness was assessed using two items developed specifically for this project based on information obtained from the National Domestic Violence Hotline (thehotline.org) and the National Coalition against Domestic Violence (ncadv.org). Participants were presented with lists of behaviors and asked to identify those that may be signs of domestic violence and also which behaviors/outcomes may occur among children who witness domestic violence. Participants were also asked how much they know about domestic violence (a lot; some; not at all) and if they had ever heard of a domestic violence safety plan. Focus group participants were asked to share their thoughts regarding domestic violence and whether their view of domestic violence changed following participation in LwL.

Local Evaluation Question 3: To what extent are cultural factors that may enhance mental health strengthened by LwL? We sought to answer this question by assessing pride in Latino indigenous identity, communication, social bonds and social engagement. We also examined satisfaction with family relationships and perceptions of social support. Cultural identity was assessed using a series of six items developed by the LwL evaluation team and CAB (e.g., You are proud of your identity as an indigenous person - always/ sometimes/ never). Family relationships were examined using four items drawn from the Family Adaptability and Cohesion Scale (FACES IV; Gorall, Tiesel & Olsen, 2006). Participants indicated how frequently they were satisfied with their family's communication, problem resolution, time spent together and ability to cope with stress (always, sometimes, never). Social support was assessed using three items adapted from the social connectedness domain of the Mental Health Statistics Improvement Program Survey (MHSIP; Ganju, 1999), social connectedness domain (e.g., During a difficult situation in your life, you would have the support you need from family and friends). Focus group participants were asked to share details related to how spending time with friends or being involved in the community may, or may not, be important for wellbeing.

Local Evaluation Question 4: Did LwL participants' capacity to manage daily stressors improve? With this question, we were interested in LwL participants' perceived ability to

manage daily stressors using the tools and techniques taught through LwL. We used five brief items developed by the LwL evaluation team and CAB to assess participants' confidence in using LwL coping tools (e.g., You are confident that you can stop the thoughts that do not make you feel good; You feel confident in your ability to practice deep breathing). Focus groups sought to understand which tools participants continued to use following completion of the program, and the ways in which they used them.

Local Evaluation Question 5: To what extent did LwL participants' knowledge, awareness and use of mental health services (including domestic violence supports and resources) increase? For this question, we asked LwL participants to indicate which no-cost or low-cost community resources they had heard of (mental health resources). We also asked whether they had received assistance from any of these community groups.

In addition to the outcomes described above, we also sought to examine changes in participants' symptomatology in relation to participation in LwL. Symptoms were assessed using items adapted from the Kessler Psychological Distress Scale (Kessler, et al., 2002) and the Sheehan Disability Scale (Sheehan, 2000). Participants reported on the frequency that they experienced feelings of nervousness, hopelessness, restlessness, worthlessness as well as the extent to which their feelings disrupted their work/school, home and social lives. Focus groups provided an opportunity for participants to share in depth about how their feelings and lives changed after participating in LwL.

The Learning Phase

During the learning phase, translation remains a critical component to ensure that collaboration and inclusion among participants is taking place while they learn, reinforce and put the strategies and interventions into practice. It is also important to note that some Mixteco-speaking participants did not request translation from Spanish to Mixteco so that they could also learn to speak Spanish. After the first two LwL classes, some participants reported feeling a sense of inclusion and greater comfort participating in the group conversations. Spanish-speakers became more interested in the Mixteco language and were also willing to learn. The Mixteco-speaking community members went from feeling inferior to the Spanish-speaking population to a situation in which the groups co-learned from each other. This was an important development that created a sense of belonging among the participants and is connected to personal agency.

As reported in our introduction and literature review, domestic violence is also a social determinant that increases the prevalence of mental health issues in the indigenous and Latino communities. This phenomenon requires the LwL team to appropriately manage the domestic violence and mental health conversation due to its sensitivity. This was important so that LwL Promotoras were able to explain, in the context of mental health and domestic violence, the situations that participants are experiencing in their daily lives. Failure to do so could have meant high attrition rates. Having the proper team that can connect in Spanish and Mixteco and its

variants is crucial for participants to feel comfortable, connected to the topic, contribute to solutions and to reach more vulnerable communities with opportunities to talk about their pain and exposure to violence and to receive help when they need it. In addition to the language, accessibility and community trust, appropriate interpretation became very important especially when many Spanish terms did not have a direct interpretation to Mixteco (e.g., mental health, stigma, and other labels associated with mental disorders). Therefore, LwL Promotoras became key in identifying and defining the appropriate interpretation for these terms. Prior to their interactions with the community, LwL Promotoras identified concepts and worked together with more experienced Promotoras to determine the best interpretation approach. As indicated earlier, terms do not have a direct interpretation to Mixteco, so Promotoras had to exert mental effort to organize words and provide simple descriptions or examples of the meaning and context of a term or relevant ideas to get their point across clearly. For instance, when trying to interpret the term mental health, the LwL Promotoras had to be knowledgeable of symptoms or signs associated with psychological distress such as *nervios o latido*, which are well known terms in the Latino indigenous community. Once there was an understanding of the context and purpose, Promotoras asked community members for their input and suggestions on the best approach to, and interpretation of, such terms and reached community consensus.

The Evaluation Phase

Participants. All participants in a LwL program series delivered within the timeframe of the CRDP were considered potentially eligible for the local evaluation. As described previously, it was intended that local evaluation data would be collected from all eligible participants. However, as described previously, the CRDP also included another required evaluation component (statewide evaluation). In order to minimize the burden on program participants associated with completing lengthy surveys as well as to ensure ample time was available for program delivery, we elected to conduct the local evaluation with every other LwL class series so that the statewide evaluation could also be appropriately administered. Local evaluation data presented in this report were collected from the convenience sample of Latino participants, including those from indigenous backgrounds, recruited in community settings in Ventura County, California to participate in LwL during a timeframe that spanned from September, 2017 and June, 2021. Delays associated with the required IRB approval process for the statewide evaluation resulted in a shorter time frame (August, 2018 through June, 2021) for statewide evaluation data collection activities. As a result, all LwL cohorts participating in the program prior to August, 2018 took part in the local evaluation. From that time forward, the described every other cohort approach, alternating between local and statewide evaluation, was used.

Eligibility criteria included age ($\geq$ 18 years or emancipated minor) and ethnicity/ancestry (Mixteco, Zapoteco, or Mexican ancestry). Eligibility was assessed via a brief screener administered prior to the pre-program survey, at the start of the second LwL class session. All participants screened and who met the eligibility criteria were deemed suitable for participation.

Participant Consent. Given the anticipated limited ability of many LwL program participants to read a written language (i.e., Spanish), we requested a waiver of written consent and instead conducted the consent process in person, in Spanish, Mixteco, and Zapoteco so that all participants understood clearly the voluntary nature of their participation in the evaluation process. Written information sheets were made available in Spanish. Additionally, contact information for the Program Manager and Program Coordinator are available to all participants.

Survey Administration. The first two LwL classes were focused on getting to know each other and building trust among the participants and between participants and the LwL instructors. The trustworthy relations began with a welcoming and by creating a positive environment within the class. The LwL Promotoras then started engaging the participants in a conversation or *plática* by sharing their stories and experiences working in the agricultural fields, living in their hometowns, their traditions, etc. Their stories combined with their charismatic and empathic leadership helped to establish a safe space for the participants to share their stories and to start interacting. After pilot-testing the evaluation instruments in two LwL class series, it was determined that administering the baseline or pre-program survey at the first LwL class session reduced the likelihood that LwL participants would attend future class sessions. Being overburdened with so much information about the evaluation before having established a connection with the project staff caused frustration and irritability among the participants. We recognized that the first LwL class sessions needed to focus exclusively on building a relationship of trust among and/or between participants and the LwL project Promotoras. Having established these relationships, the Promotoras were able to focus on administering the evaluation during the class session that followed. For this reason, the Project shifted to administering the pre-program survey in the second class session, with some participants completing the survey at the third class session. This approach served to avoid being invasive and discouraging LwL participants before having established a relationship of trust. The LwL team also recognized the opportunity for participants to open their hearts and feel connected to the program from the first session. The LwL team administered the post-program surveys during the final (seventh and eighth) class sessions.

LwL Promotoras facilitated the collection of all survey data. Specifically, the Promotoras read the survey items in Spanish and Mixteco and made the necessary adaptations to ensure that the participants were following along and understanding the questions. While the LwL team had an established protocol for collecting data, ultimately the team had to adapt to the language proficiency and education level of the participants. The LwL team realized that in general, following a script was not effective due to participants' different cultural and language interpretation needs. It is important to note that the length of certain survey questions created issues that hindered the interpretation process. That is, the wordier the question, the more complex and confusing for the participants because the interpretation into Mixteco meant a

longer explanation. Simply put, using simple and common words can make the interpretation process less daunting for the LwL Promotoras and participants.

Additionally, the staff had to ensure that sufficient time and examples were provided to make sure that the participants understood the questions to which they were responding. For example, translating the survey question from Spanish to Mixteco followed by finding key words in the Mixteco language most appropriate for that participant's variant. The goal was to manage the survey and not the participant's responses. Also, recognizing people's laughs and smiles (i.e., noverbal communication or bodily cues) as behaviors conveying that they did or did not understand, while reflecting on similar experiences, was particularly important as participants are often ashamed of expressing that they do not understand the questions, and may otherwise continue providing responses despite not clearly understanding the questions asked.

When working with indigenous populations, it is important to note that many English and Spanish terms used in research and data collection protocols do not always translate easily into Mixteco. Failure to recognize this issue too often leads to frustration and anxiety on the part of the indigenous participant. In some cases, the participant can feel offended that such a question is even being considered and/or feel that they are being asked the same question repeatedly. This presented another challenge for the LwL Promotoras when translating in the various Mixteco variants. One strategy was to have pre- and post-survey (data collection) briefings and LwL sessions to discuss pros and cons and find more appropriate ways to ask questions and improve the administration of the survey.

The Oral Translation, Instrument Changes, and Data Collection Phase

The LwL CAB played a critical role in ensuring that LwL, as a community-defined and evidence-based project, remained culturally and linguistically appropriate and that it met the needs of the community being served, especially the Mixteco and Zapoteco communities. The CAB was key for the implementation of LwL in determining the best approaches to take the program to the community, identifying areas in which the target community is concentrated, and ensuring the appropriateness of the evaluation instruments and content. The CAB met three consecutive times during the beginning of the CRDP project period. During the first meeting, the LwL project goals and objectives were presented, highlighting the importance of bringing the CAB together to lead the project. The LwL team members and the UCLA local evaluator met twice with the CAB to review the evaluation design, the questions to be asked, and all potential data collection measures to ensure cultural and linguistic appropriateness.

During these meetings, members of the CAB reviewed and provided feedback on each evaluation question, focusing mainly on identifying cultural sensitivity, language appropriateness, and understanding of the questions. The LwL team and local evaluator took notes of all the CAB suggestions to guide modification/refinement of the evaluation instruments.

In collaboration with the local evaluator, the LwL team edited the evaluation tools incorporating the recommendations made by the CAB. A third meeting was held with the CAB to review their suggestions and for further review/modification of the evaluation measures. During this gathering, new evaluation instruments were presented to the CAB such as an: (1) information sheet, (2) eligibility screener, and the (3) recruitment script for feedback and possible suggestions to improve language and cultural sensitivity. The role of the LwL CAB was critical for the development of LwL and the inclusion of a participatory community. After the first year of evaluation implementation, LwL in collaboration with the CAB and Local Evaluator, reviewed all evaluation instruments to ensure culturally and linguistically appropriateness for assessing the mental well-being of migrant indigenous communities. The LwL team quickly recognized that initial survey items required further modifications to effectively evaluate the program and align with the community's needs. The survey was created from a perspective that participants would be able to identify the themes covered in the LwL class series—for example, understanding or identifying terms such as culture, belonging to a community, issues related to depression, anxiety, etc. It was evident based on observations that participants were able to identify and define these terms within the LwL class series.

However, during a session where participants were completing the pre-program evaluations, our Promotora team reported participants frequently asking for clarification. The Promotoras also observed that participants were answering some questions very casually as if checking boxes at random despite confusion. Several participants reported feeling ashamed of asking for help. LwL recognized the language barrier and worked on revising parts of the evaluation to ensure the questions when translated/interpreted were culturally and linguistically appropriate and reflected the needs of our Mexican indigenous communities. These modifications included use of even more simplified language and further reducing response options where possible.

As previously stated, LwL Promotoras have been trained, and will continue to be retrained for this project, on strategies to appropriately administer and interpret the surveys from Spanish to Mixteco. In other words, the participants were given an option to fill out a Spanish language survey form on their own or to dictate their responses verbally in Spanish or Mixteco to a LwL Promotora. The LwL Promotora then recorded the participant's responses while ensuring that the participants felt comfortable communicating in their indigenous language. Research supports MICOP's interpretation approach, in that an interpreter with the capability to recognize indigenous language tone, geographic location, and make the necessary adaptations that include the extension of the different variations until a general understanding of one word or set of words is achieved. MICOP's interpretation approach is also in line with the community-based participatory research's (CBPR) tenet related to intervention and research. Specifically, with the integration of community knowledge, and involving community (i.e., Promotoras) in research, and ensuring a bidirectional translation/interpretation approach.

Analytic Approach

Survey data collected through the pre- and post- program surveys were examined to understand: who participated in the LwL program (descriptive and bivariate analyses); relationships between participant characteristics and program outcomes, associations between program outcomes, and pre- to post- program changes in program outcomes (bivariate analyses), as well as the role of participant characteristics and program format (e.g., duration of class series) on changes observed in each of the outcomes examined (multivariate analyses). Given the modifications to the programmatic approach undertaken due to the COVID-19 pandemic, the analytic plan was expanded to allow for an in-depth examination of differences in participants and outcomes associated with the program format (group vs. 1:1). Among a subset of participants who took part in the group program format, we were able to collect data at a third time point (2-3 month follow-up). Additional multivariate analyses including these data points provided an opportunity to examine whether changes associated with the program persisted over time.

Data were entered by MICOP LwL staff using the CASES (Computer-Assisted Survey Execution System) software package (cases.berkley.edu), which was programmed by the UCLA data manager. The UCLA team was responsible for all data cleaning activities, and consulted with MICOP staff for guidance when questions arose. Data analyses were conducted using SAS, versions 9.4 (2016) and 9.04 (2021), and R, Version 4.1.0 (2021).

As needed, data obtained from demographic characteristics assessed were combined to construct continuous and categorical variables appropriate for analysis. Survey responses related to birth place included a large number of cities, towns and villages. The MICOP LwL team reviewed these data and provided the corresponding state. A state of origin variable was constructed based on these responses and subsequently coded to indicate Oaxaca, Michoacan and other, thereby representing the majority of program participants. Participants reported on all languages spoken in the home. A language variable was constructed to reflect the most common categories of: Spanish only, Mixteco only, Spanish plus another language, and Any English. A household size variable was constructed by summing the reported number of children in home with the number of adults living in the home.

A continuous variable was also constructed to reflect the duration of program participation, based on the difference between pre- and post- program survey administration dates. We felt it was important to assess this aspect of the program given real world modifications made to the program delivery timeframe throughout the CRDP period in order to accommodate participants' schedules. In particular, we sought to examine the potential influence of program duration on changes observed in program outcomes and therefore included this variable in our multivariate models. Additionally, a variable was constructed to reflect the participants' group to allow modeling of random effects by group in multivariate models. For participants in the 1:1 condition, an indicator was created to denote which Promotora delivered the program.

Composite scores were constructed by summing responses from relevant items for all constructs assessed as study outcomes (mental health knowledge, stigma, cultural identity, social support, family relationships, coping tools, domestic violence awareness, symptoms). Mental health resources was calculated as a proportion of the possible options that were endorsed, to account for modifications made over time to this variable in keeping with changes in relevant community programs and agencies. Pearson correlations of component items were examined and internal consistency of each of the constructs/scores was calculated using Cronbach's alpha (Cronbach, 1951). Additional bivariate comparisons between study variables were made using Welch's Two Sample T-Tests (Welch, 1947), Fisher's Exact Tests (Fisher, 1922), Chi Square Tests, and Pearson Correlations. Effect sizes were determined for pre/post comparisons using Cohen's d (Cohen, 1988).

To assess the relationship between participants' demographic characteristics as well as variations in program delivery (programmatic characteristics) and changes observed in the outcome variables, we fit multivariable models in which the outcome variable was change score (post-test score minus pre-test score) and the predictors were age, marital status, household size, and language spoken at home. To account for the fact that some participants received the intervention in a group setting while others received the intervention from one of two Promotoras in a one-on-one format, the model included a 3-level categorical variable with levels group, Promotora A and Promotora B. To examine the influence of program duration on outcomes, we included a variable reflecting time, in weeks, between pre- and post- program surveys. To account for potential clustering of outcomes within groups, each model included a random effect for group. Separate models were fit for each outcome variable. All models used the restricted maximum likelihood (REML) approach and were fit using the MIXED procedure in SAS 9.4.

The longitudinal data of the participants across three time points were modeled using linear mixed models (LMMs). The LMMs allowed for comparison of outcome variables between pre-program survey (Time 1) and post-program survey (Time 2) and to determine whether observed changes in study outcomes were sustained beyond the conclusion of the program, at 2-3 month follow-up (Time 3). This modelling approach allows for the use of all available data points; analysis need not be restricted to participants measured at all three timepoints. Pairwise comparisons of least-square means at each visit were conducted with Tukey-Kramer adjustment for multiple comparisons to test for significant pairwise differences.

To aid in interpretation of these data, all outcome variables in the LMMs were standardized to units of standard deviation at Pre-Program Assessment (Time 1). As a result, the regression coefficients associated with each predictor variable may be interpreted as the difference in units of standard deviation of the outcome variable associated with a one-unit increase in the predictor. This allows for a more intuitive examination of the relative importance of each predictor in relation to the outcome variable under consideration. The LMMs included random effects for participant ID to account for within-subject correlation, and a random effect for group to capture

clustering of outcomes within groups of participants who experienced LwL as a part of the same cohort. The fixed effects included in each model were age of participant, household size, marital status (yes if married or in serious relationship, no if not), program duration (time elapsed, in weeks, between Visit 1 and Visit 2), time of measurement (3 categories: Time 1, Time 2 and Time 3) as well as language (4 categories: Spanish Only, Mixteco Only, Spanish and Indigenous Language, and Any English). A fixed effect for program format was also included to estimate the difference between receiving the program in a group as compared to a one-on-one format. The Kenward-Roger method was used to determine denominator degrees of freedom for tests of fixed effects, and the covariance structure was selected as Variance Components (VC) based on lowest AIC/BIC.

The MICOP/LwL project team and LwL CAB guided decision-making related to analytic approaches (e.g., stratified analyses) and development of multivariate models (i.e., most appropriate predictors to include in cases of highly correlated independent variables) and partnered in the interpretation of findings.

Focus groups were audio recorded and transcribed in Spanish for data analysis. A qualitative evaluation group consisting of LwL staff and Promotoras, and local evaluator independently and collaboratively read all summaries and transcripts and marked meanings in the text of each transcript. Through numerous meetings, we discussed, developed, negotiated and renegotiated, and ultimately agreed upon a list of potential themes to guide the development of a clear, concise and objective codebook. Five overarching dimensions emerged: (1) recruitment, (2) resilience, (3) sense of belonging, (4) family dynamics, (5) knowledge, and (6) coping skills. The names of the codes reflect language and descriptions from the LwL participants and community engagement literature. With a final codebook we were able to apply codes to the interview transcripts in a consistent manner. In circumstances where codes were not aligned with the content of the interview transcript, the evaluation team met to reexamine the participant's description and let those descriptions redefine and/or inform new code names. We then consolidated the codes to identify themes or points of interest, based on the participant's interpretations. Preliminary findings were shared with LwL CAB members. These community conversations provided opportunities to articulate and clarify ideas and views, gather additional reactions and insights, and ask questions about the dimensions and themes to contextualize the findings (Saldaña, 2011).

To ensure confirmability and trustworthiness of the findings, the evaluation team used three methods: (1) triangulation including gathering and examining information from multiple perspectives and using multiple data collection approaches (i.e., individual semi-structured interviews and community forums) (Patton, 1990); (2) account for researcher frame of reference (Moustakas, 1994); and (3) open-ended questions were asked to capture detailed narratives and ensure concrete descriptions of participant experiences (Creswell, 2006). The evaluation team recognized the importance of practicing reflexivity (Patton, 2002) by continuously checking in as

a team throughout the study and identifying any personal attitudes, biases or beliefs and values related to the voices of the participants.

RESULTS AND DISCUSSION

Outreach efforts, including direct recruitment in the agricultural fields, at swap meets and other community settings combined with flyers posted throughout the community and advertisements on MICOP's own radio station (*Radio Indigena)* were successful in recruiting participants to the program for the group sessions. As described previously, participants included in the 1:1 format of the program administered during the COVID-19 pandemic, were recruited directly from MICOP's case management program. In total, 25 LwL class series and 46 1:1 interactions of the LwL were delivered over the course of the CRDP.

Participants provided survey and focus group data between September, 2017 and June, 2021. During this timeframe, two potential participants were deemed ineligible for participation in the local evaluation due to their ethnicity/ancestry. Survey results are presented below and subsequently discussed. Unless otherwise noted, a significance level of $p<.05$ was used for analyses presented. Tables and figures are included in the Appendices.

Survey Results and Discussion

Table 1 presents descriptive characteristics for all participants who completed the baseline survey, as well as a comparison between participants who also completed the post-program survey and those lost to follow-up (attrition analysis). The pre-program local evaluation survey was completed by 210 women, 99% of whom were born in Mexico. Regarding ancestry, 51% of participants (n=95) were born in Oaxaca, 15% in Michoacán (n=27) and the remaining 34% of participants were born in other regions of Mexico (n=63). In terms of language spoken at home, nearly half of participants reported speaking an indigenous language (Mixteco = 42%; Zapoteco = 3%), 40% reported only speaking Spanish, and 10% reported speaking any English. On average, participants were 38 years old (SD = 11) and had lived in the U.S. for 15 years (SD = 9). Approximately ⅔ of participants (64%) were married or living with a partner.

A total of 168 women completed both the baseline and follow-up surveys (analytic sample), representing a program retention rate of 80%. No significant differences were observed when comparing the baseline demographic characteristics of those who completed the LwL program and post-program evaluation to those who were lost to follow-up. Study outcomes were also comparable at baseline, with the exception of stigma; lower baseline levels of stigma were observed among those lost to follow-up (M=.62, SD=.66) as compared with those who completed LwL and the post-program evaluation (M=.89, SD=.90), $t(84)=-2.2$, $p=.03$.

Table 2 presents demographic and study outcome data for the analytic sample (n=168) and separately for those who completed the small group class series (Group) as compared with those

who completed the one-on-one sessions administered during the COVID-19 pandemic (1:1). Overall, the groups were similar. Significant differences were observed such that participants in the 1:1 cohort were less likely to be married (38% vs. 75% of group participants; $p < .001$) and less likely to have lived in at the same address for a year or more (69% vs. 85% of group participants; $p<.05$). With regard to study outcomes, participants in the 1:1 condition were familiar with a greater proportion of local mental health resources (46% vs. 33% among group participants; $p<.01$) and had a greater mean number of symptoms (2.3 vs. 1 among group participants; $p=.01$).

In addition to these comparisons, we examined participants' demographic characteristics in comparison to those of the LwL participants who took part in the statewide evaluation rather than in the local evaluation (data not shown). Characteristics assessed in both the local and statewide evaluation were included in these comparisons: age, English fluency, country of birth (US vs. other), and years lived in the U.S. For the purposes of these bivariate analyses, local evaluation data corresponding to participant age were considered as a categorical variable, with categories matching those used in the statewide evaluation (18-29; 20-39; 40-44; 45-49; 50-65, 65+ years of age). In comparing all participants at baseline, significant differences were observed in age, such that a greater proportion of local evaluation participants fit within the younger age categories as compared with statewide evaluation participants ($p=.017$), and years lived in the U.S., such that local evaluation participants had lived in the U.S. for 3 fewer years than statewide evaluation participants on average (15.3 years vs. 18.3 years, $p=.008$). When comparisons were restricted only to those participants who provided pre- and post- program data (i.e., were not lost to follow-up), significant differences in age groupings remained but no difference was observed in years lived in the U.S. No other statistically significant differences were observed between the LwL participants who took part in the local versus the statewide evaluation, regardless of whether comparisons were made among all participants at baseline or only among those who completed post-program surveys.

Figures 1-7 present correlograms depicting results of bivariate comparisons of outcome variables calculated using Pearson's correlation coefficients (Freedman, Pisani, & Purves, 2007). Comparisons were made at baseline, for all participants (N=210; Figure 1), the analytic sample (N=168, Figure 2), among group participants (N=129; Figure 3) and 1:1 participants (N=39, Figure 4). Changes in variables from baseline to follow-up were also compared (Figure 5 = analytic sample; Figure 6= group cohort; Figure 7= 1:1 cohort).

Comparisons of baseline values revealed positive relationships between family relationships and coping tools, social support and cultural identity. Cultural identity was also positively associated with family relationships and social support. A positive relationship was observed between the two knowledge outcomes (mental health knowledge and domestic violence awareness) as well. Negative relationships were observed between symptomatology with coping tools and family

relationships. The one-on-one cohort was comparably smaller than the group cohort and fewer significant relationships were observed among these participants; the negative association between symptoms and family relationships was again observed, along with a strong negative association between coping tools and domestic violence awareness.

Several changes in outcome variables (post-pre differences) were also associated with one another. Among group participants, improvements in coping tools were strongly associated with improvements in family relationships, and with increased cultural identity and social support, as well as decreased symptoms. In addition, improvements in social support were significantly associated with improvements in family relationships and cultural identity. Changes in the two knowledge outcomes (mental health knowledge and domestic violence awareness) were also positively related. The associations between increased social support with increased family relationships and cultural identity held among participants in the one-on-one program format.

Table 3 presents internal consistencies of outcome variables generated by summing relevant component items. Acceptable consistency was observed across most constructs, in the complete analytic sample, and in the group and 1:1 cohorts (Cronbach's alpha = .71 - .91; Cronbach, 1951). Lower values were observed for the stigma and social support constructs, particularly in the group cohort.

Table 4 presents pre- to post- program changes in study outcomes, for the analytic sample and stratified by cohort (group; 1:1). Statistically significant improvements were observed across all outcomes, in all groups, with the exception of stigma among participants in the group cohort (p=.17). Nearly all observed changes represent medium to large effects (d = .46 - 1.57; Cohen, 1988). However, small effects were observed for stigma in the full analytic sample (d=.24) and 1:1 cohort (d=.13) and symptoms in the group condition (d=.28). The largest effects overall were observed for coping tools. Within the 1:1 cohort, large effects were observed for mental health knowledge (d=1.19), domestic violence awareness (d=1.57), coping tools (d=1.59), mental health resources (d=1.23) and symptomatology (d=1.22).

Figures 8-10 depict changes in the proportion of participants who report possessing fundamental aspects of mental health and domestic violence knowledge as well as ever receiving assistance from local community-based agencies. Figures are presented separately for the analytic sample (Figure 8), and those in the group (Figure 9) and one-on-one (Figure 10) study conditions. In all groups, increases were observed in the proportion of participants who reported knowing what depression is, what anxiety or nervious is, and ever having heard of a domestic violence safety plan. Nearly all participants reported knowing what depression is at follow-up (92%) and over half (54%) what anxiety/nervious is. Few participants reported ever having heard of a domestic violence safety plan at baseline (9-13%). At follow-up, 42% of group participants and 95% of one-on-one participants reported knowledge of such a plan. Increases in service utilization were

also observed, with the proportion of group participants having received services from a local agency increasing by 21 percentage points among group participants (48% to 69%) and ten percentage points among one-on-one participants (87% to 97%) from pre- to post- program. McNemar's tests were used to examine the changes in the proportion of participants who agreed with the item versus those who endorsed any other response. All observed changes were statistically significant at $p<.001$ or greater, with the exception of ever receiving assistance from local agencies among the 1:1 participants (X^2 (1, N=39)=2.67, p=.10).

Figure 11 provides additional descriptive information related to where participants would go if they were experiencing depression or anxiety. Pre- to post- program increases were observed in willingness/intention to use all resources presented as potential options, with a large majority of participants reporting they would go to a: psychologist (84%), doctor/nurse (86%) or counselor (87%) following participation in LwL. A large proportion of participants also reported they would go to a spiritual center/church (85%) or a small group meeting/peer support group (95%) in the post-program survey.

Tables 5-7 present mixed effects multivariate models for each of the nine key program outcomes: mental health knowledge, stigma, and domestic violence awareness (Table 5), cultural identity, family relationships, and social support (Table 6), coping tools, mental health resources and symptoms (Table 7). Demographic predictors included age, household size (total number children plus adults living in the home), married or living with partner vs. other, and language spoken in the home (Mixteco only, Spanish and an indigenous language, and any English vs. Spanish only). Predictors related to program delivery included program duration (weeks between pre- and post- test) and group format or 1:1 delivery by "Promotora A" vs. 1:1 delivery by "Promotora B." As described above, a random effect for program group was also included. Program duration spanned between 1-8.714 weeks (M=3.375, SD=1.359). A total of 25 program groups were included in the models.

Few significant fixed effects were observed across the models. Given the limited number of significant relationships observed, we highlight these as well as trends with significant levels of $p\leq.10$. A smaller decrease in stigma was significantly associated with larger household size (*B*= -.121, SE= .044, p= .007), and longer program duration (*B*= -.187, SE= .072, p=.011). A trend in the opposite direction was observed among those who were married vs. others (*B*=.351, SE=.206, p=.091). With regard to mental health knowledge, greater improvements were observed among those who spoke Spanish plus an indigenous language vs. Spanish only (*B*= 1.612, SE= .529, p= .003). A number of other trends were observed with regard to language such that speaking Spanish and an indigenous language vs. Spanish only tended to confer greater improvements in domestic violence awareness (*B*= 1.415, SE = .719, p = .052), social support (*B*=.278, SE= .162, p= .089), and coping tools (*B*=.720, SE= .401, p=.075). Speaking Mixteco

only vs. Spanish only was also associated with a trend toward greater improvements in coping tools (*B*=.727, SE=.382, p=.060).

Trends were also observed such that greater reductions in symptoms were observed among those who were married (*B*=.894, SE=.454, p=.052) whereas smaller reductions in symptoms were observed among those who participated in the 1:1 program led by one of the LwL Promotoras versus the other (*B*= -1.611, SE= .883, p= .071). Program group was significantly associated with changes in domestic violence awareness (1.667, SD=2.716), coping tools (.363, SD=.1531), symptoms (.025, SD=2.336), and mental health resources (.009, SD=.249)

Tables 8-10 present the results of linear mixed multivariate models (LMMs). This second set of multivariate analyses was conducted to allow for an examination of how well changes in outcome variables were sustained over time. As such, models provide an indication of the degree and significance of changes immediately post-program (Time 2) and at 2-3 month follow-up (Time 3). Importantly, this modeling approach does not require restricting participants only to those who had data available at all three time-points. Rather, the technique takes advantage of using all available data points. Pairwise comparisons of least-square means at each study time point were conducted with Tukey-Kramer adjustment for multiple comparisons to test for significant pairwise differences.

Additionally, in this series of multivariate models, we standardized all outcome variables to units of standard deviation at the time of the pre-program survey (Time 1, or baseline). This was done to allow for consideration of the relative importance of each significant predictor variable, as regression coefficients can be interpreted as the difference in units of standard deviation in the outcome associated with one-unit increases in the predictor. As in the previously described mixed effects models, we included random effects for group to capture clustering within participants who experienced Living with Love in the same small group when the program was administered in the group format. In these models, we also included random effects to account for within-subject correlation. Fixed effects included the following demographic predictors: age, household size, marital status (married/living with partner vs. other), language (Mixteco only, Spanish + indigenous language, Any English, vs. Spanish only), program duration (weeks between pre- and post- program surveys = Time 1 and Time 2), and survey timepoint (Time 2 = post-program survey and Time 3 = 2-3 month follow-up vs. Time 1 = pre-program survey). A fixed effect for group was also estimated to estimate differences in outcomes associated with receiving the program in a group, vs. one-on-one, format.

The major added value of these models is that they demonstrate that changes observed in outcome variables remained significant over time and that the magnitude of changes remained stable. This consistency was observed across all study outcomes. Results related to demographic

predictors and other fixed effects are consistent with those observed in the previously described mixed effects models. This provides added confidence in the findings given that within-subject correlation was controlled for in each of these models.

True to the spirit of this community driven program, the surveys were developed, modified, administered and evaluated in a pragmatic fashion. As such, community perspectives and needs were prioritized with a large emphasis placed on ensuring that the items included held meaning for the community members. Given the varied languages spoken by participants and the desire to convey shared meaning across the multiple translations used, items used were similar to those on existing instruments but were not identical. Additionally, response options were minimized to the greatest degree possible. Given the number of constructs we sought to examine and the need to strike a balance between time devoted to survey administration versus program delivery, we were unable to maintain all items from existing scales and instruments that we used as item sources. Furthermore, our initial version of the survey included numerous additional items and multiple complete scales, but feedback from program staff and CAB members indicated that the nuances that differentiated many of the items were lost in translation when using indigenous languages, leading to frustration and confusion. We recognize that the approach adopted limits our ability to compare results with those obtained from different study samples. However, we felt that this sacrifice was necessary to ensure a shared understanding of items within our study sample and that our approach allowed us to accurately depict the changes that took place among participants in association with participating in the program given questions and response options used in the final survey version were appropriate for all study participants..

The data obtained through LwL pre- and post- program surveys, and the results presented above, provide strong evidence for the effectiveness of the program in improving outcomes related to mental health and domestic violence knowledge, cultural identity, as well as family and social relationships. Moreover, the program provided participants with important skills for managing stressors and increased familiarity with, and willingness to use, community support services. The strength and robustness of effects observed illustrate the power of LwL for improving mental health and well-being among Mexican immigrant women of varied ages, marital statuses, and family sizes, including those who speak indigenous languages alone or in combination with Spanish. Furthermore, these data provide considerable evidence that adapting the program delivery approach to meet the needs of the community does little to impact effectiveness. Although it was planned that one LwL session would be delivered each week over an eight-week time frame for all participants, the time between pre- and post- test administration ultimately varied by nearly eight weeks. Some participants did take part in weekly sessions but many others completed multiple sessions per week. Yet, most LwL outcomes were not influenced by the duration of the program. Additionally, LwL proved to be effective when delivered in a small group setting, as intended, as well as when delivered in a one-on-one format. Moreover, results demonstrate that changes associated with participating in the program endure over time.

In comparison to other programmatic outcomes, although significant, pre- to post- program changes in stigma were reasonably small. Given the longstanding and pervasive role that stigma toward receipt of mental health services has historically played in Mexican communities, it should be celebrated that stigma was reduced at all over a programmatic period that lasted less than a month on average. Interestingly, a change in stigma was one of the few outcomes that varied significantly in relation to demographic and programmatic characteristics; greater reductions from pre- to post- program were associated with a longer program duration. Family or household structure also influenced changes in stigma such that women with a larger household size realized smaller reductions in stigma over the course of the program. This difference may be associated with a more deeply entrenched stigma in multi-generational households, or more traditional homes with greater numbers of children. In contrast, the trend observed such that being married was associated with greater reductions in stigma as compared with not being married or living with a partner may reflect the powerful role that factors such as masculinity and machismo played in women's stigmatization of mental health issues prior to taking part in LwL.

Delivery of the program sessions in both Spanish and indigenous languages, primarily Mixteco, ensured that all participants were able to reap benefits from the information and skills provided by the program. That trends toward greater improvements in both knowledge constructs (mental health knowledge and domestic violence awareness) as well as social support and coping tools were associated with routinely speaking both Spanish and an indigenous language may be resultant from these participants' ability to fully grasp the vast majority of information shared, and to benefit from information repeated in a second language. Speaking both Spanish and an indigenous language in the home was reported by approximately one-fourth of participants (24%). It is unclear why speaking only Mixteco, versus only Spanish, was associated with greater improvements in coping tools in our initial multivariate models. Perhaps some of the activities and concepts shared in sessions focused on building these skills resonated more when conveyed in Mixteco. When we controlled for within participant correlations however, relationships observed in association with language spoken were minimized. This suggests that multiple, important individual-level factors are associated with participants' linguistic abilities.

The opportunity to deliver and evaluate the program among women who were enrolled in the LwL case management, and received the program in a one-on-one format was not anticipated when the evaluation approach was developed. It was the unwavering commitment of LwL program staff and CAB members to serve the community, meet them where they are, and maintain service delivery even in the face of a global pandemic, that together produced this added program dimension and evaluation component. As described earlier, when community-based recruitments and group program delivery were not feasible or safe due to the COVID-19 pandemic, the LwL team came together and decided to offer the program to women with whom they were connecting through the program's case management, providing the classes in a one-

on-one (Promotora and participant) and virtual format. Women enrolled in case management receive extensive support and navigation to access resources, particularly related to family law services such as child support, child custody, restraining orders, or divorce. As may be expected, women recruited to LwL from this program had greater familiarity with local mental health resources and greater symptomatology as compared with women recruited in community settings. They were also less likely to be married or living with a partner than those recruited in community settings, possibly due to issues related to estrangement or divorce.

As demonstrated in the pre-post program data, not only was LwL effective among this higher need group of women, effects in this cohort were greater than those observed among the group cohort on every measure assessed. Factors associated with the success of LwL in this group may be related to the intimate relationship participants were able to develop with the Promotora and the ability of the Promotora to tailor program content specifically to that participant. In addition, it is important to consider the fact that these women came into LwL having already established relationships and trust with the LwL staff, which may have bolstered the true effectiveness of the program and/or may have resulted in more honest responses (and hence poor scores) provided in baseline surveys. Whatever the reason for the success of the program in this particular cohort of women, it is valuable to understand the benefits that LwL can provide to women who are experiencing crises that merit case management, and that the program can be effectively delivered in both group and 1:1 formats, including in a virtual setting. Moving forward, it will be important to explore options for varied program delivery formats capable of meeting the needs of diverse groups of participants. In so doing, the benefits of participation in LwL may be gained by a wider variety of community members. Given the tremendous size of the Mexican immigrant community in California and nationally, as well as the dearth of programs available to meet the needs of this community, LwL presents a promising approach to reducing mental health disparities in the Latino community at large.

Qualitative data collected from study participants two-three months following participation in LwL provide critical and nuanced details that convey a deeper understanding of the quantitative results presented and discussed above. It is important to mention that the LwL team in collaboration with the UCLA Equity Center partner conducted several community participatory feedback loops with former LwL participants and current CAB members. These feedback loops occurred in three waves to accommodate schedules and COVID-19 limitations. The purpose of these feedback loops was to circle back to participants with preliminary themes that were emerging from the focus groups and get their reactions and feedback. The first wave of community participatory feedback was in 2020 and consisted of three Zoom sessions, the second wave was an in-person session in 2021, and the third also in 2021 and in-person. Each feedback loop session was 90-minutes in duration. A fourth wave of feedback, also in 2021, was done for the quantitative preliminary findings, and qualitative information was obtained to support both quantitative and qualitative interpretation.

While focus groups were initially designed to elicit feedback on the strengths, weaknesses, and areas of improvement of the project, they became a strong data collection approach that captured the impact that LwL was having in participant's lives, and an important complement to the survey data. Focus groups (group participants) and key informant interviews (1:1 participants) were conducted approximately 2 months following the conclusion of the LwL program. A total of 75 participants took part in the focus groups (n=46) and those who participated during the time of COVID-19 served as key informants (n=29). Demographically, these participants were similar to those who completed the program in all respects. Table 11 presents baseline demographic characteristics of participants who took part in this important qualitative component of the local evaluation.

Six key themes were identified by the analysis team, which aligned with the Project's five evaluation goals and helped to contextualize the quantitative results discussed above. After a thorough analysis process facilitated by the LwL team, local evaluator, and Project Promotoras, the LwL participants and CAB members, identified the following themes as the most important: 1) Strengthening the Family Structure, (2) Reducing social, cultural, and linguistic isolation, (3) Living with Love During COVID-19, (4) Attaining Self-Love and Emotional Healing, (5) Knowledge gaps on the attention of mental wellness and the impact of domestic violence, and (6) Strengthening the Capacity to Practice Coping Skills . The LwL participants and CAB members also identified key quotes in support of these topics that are discussed below in the context of its importance for a migrant indigenous community. Themes that emerged in the focus groups are presented and discussed below.

LwL Theme 1: Strengthening the Family Structure

The concept of family for migrant indigenous communities is a fundamental value, defined by CAB members as, "the unconditional support, respect, union, motivation, identity, wellness and strength in the community." Focus group participants reported a positive change in the reinforcement of family relationships and communication as a direct result of the Project. Improvement in family dynamics, especially the verbal expression of warmness and affection were highly observed throughout the different focus groups discussions, in which participants recognized the effectual power dynamic accomplished in the family relations after practicing effective communication skills. A participant noted:

> I learned to talk nicely to my sons and my husband, and to take care of my sons. When they go to school, [I make it a point] to ask them, how did it go? because I did not know how to talk to them [before]. This is what you showed me here [at LwL], that is what I learned, how to get to them. Our adolescents today are very different, boys and girls, and we only tell them, well I hope everything goes well in

> school, and that is it. But, here [LwL classes] I learned that, when they [children] arrive from school, we have to ask them, how was school?
>
> -Living with Love Participant

As shown, participants emphasized the change in communication dynamics, which is highly important to strengthen the family and reduce daily stressors. Before, their perceptions of expressing love and affection were different, they did not see its importance as they grew up with different family and cultural beliefs, where family affection was not shown through hugs, kisses, or affirming verbal expressions. Now, participants recognize the importance of these expressions to reinforce family ties. They see the value and practice saying "I love you" and acknowledging their loved one by saying, "how was your day" or showing their love to their family members through hugs and kisses. In general, participants reported that in LwL they were provided with an educational space to share and learn with others the value of family and living a happy and fulfilling life. "It's about changing unhealthy discipline patterns and learning to control my emotions and behaviors," said one participant. This is an important finding because it highlights a central tenet of LwL and that is facilitating a healing process through a safe and judgment-free space, where participants feel safe to explore, identify, and start working through the impact of their past childhood traumas and experiences.

Participants recognize the impact of growing up in a strict controlling environment with severe punishments, where expression of positive emotions were often not permitted. That kind of environment combined with constant exposure to violence shaped their behaviors and their present family structure and relationships. A participant expressed, "Before, when we were kids, they [parents] would tell us many things, speak down to us making us feel insignificant...we did not know where or who to talk to for advice... LwL helped me a lot, I [now] get along well with my daughters... to avoid name calling" One participant shared how she became more conscious of her own behaviors and recognized that she was repeating the same unhealthy behaviors and affecting the mental wellbeing of her children, "… everything we are doing, good and bad, comes from our own thoughts, what we think it's our responsibility...but our children, they are growing up and seeing the way we are living, if we do not live well, it affects them and they begin to drink and smoke." Others agreed and expressed similar feelings, perspectives, and experiences before and after participating in LwL. What makes these findings significant is the participants connecting their thoughts, emotions, and behaviors with the impact of their family and their children's wellbeing.

Many participants also reported bringing the information learned from LwL back to their families, and engaging in informal "platicas" and began making small changes in their family in particular with communication and emotionally connecting with their children. Participants expressed how their children and significant others started to show interest in learning about the practices, coping skills and information in general from the LwL class series as they began to notice and benefit from the changes individually and as a family unit. Significant others and

children encouraged participants to continue attending LwL. This participant reported the excitement from her daughter about LwL:

> I also applied it with my daughters, especially when we come frustrated from work and everything—you breathe in and relax and that was the way. Before, I would scold them more, but not anymore. My oldest daughter, when I started coming [to LwL], would say 'mom, today is your class, we will be going with the ladies at my school, okay?' … She [daughter] also liked the [LwL] classes, I feel that she saw the change in myself and that is why she would always be like 'let's go, mom.'
>
> –LwL Participant

The personal improvement that participants achieved in Living with Love was clearly reflected in their families who began to see the positive impact. Another participant noted:

> Yeah, whatever we did here [LwL classes] or listened to, I would share it with my husband and he liked it, he would tell me 'it's good, keep going this would help you.' I would stress myself too much before... I had too many nervios or I would suddenly be so stressed, so as I started coming [to LwL] I felt that it did help me.
>
> -LwL Participant

Additionally, participants became more aware of the role of family in their behaviors, whether they were positive or negative, recognizing that the exposure to domestic violence, alcohol abuse, lack of parental affection, etc., are experiences or potential risk factors that affected their mental health, and passed on from one generation to another. Participants have been able to resolve past childhood traumas that were getting in the way of healthy relationships with their family and loved themselves. Participants also identified the negative impact of domestic violence on their children. A participant shared a time when she was contemplating ending her life by suicide due to the violent domestic abuse she was experiencing:

> Yes, that [suicide attempt] was not the solution because at that moment I was going to put an end to my life, but my children were the ones who would suffer. I suffered many blows and abuse, nobody would assure me that my children would not suffer the same thing, so if I had left them alone, who would have taken care of them."
>
> -LwL Participant

Another participant expressed a similar experience, "also when I have a dispute or argue with my husband, if they [children] see us, I try to go out to breath in some air and calm myself." These results show that participants are recognizing and becoming more knowledgeable and aware of the negative impact of domestic violence on their children. One plausible explanation for this is that participants now have access to culturally-relevant information and by sharing their stories with each other, are developing the skill set to improve and engage family members in communication in the household and move toward creating healthier family habits that promote safe spaces and conversation.

Key Implications From this Theme

The LwL course (class series) instruction and activities encourage participants to reflect on their personal experiences and make connections between those experiences and how past experiences shape their current thoughts, behaviors, and their relationships with themselves and their family. On a personal level, it is self-love and acceptance, on a family level is communication, family values (*familismo*), and respect (*respeto*). Participants highlighted the healthy changes they've accomplished in their household through communicating healthy love expressions with their children. For example, dedicating quality time with their children, listening to them without judging, and giving them positive affirmations. The participants were able to create safe spaces at home like what they experienced at LwL and start their healing through self-love and being surrounded by family. For many participants, this was the beginning of breaking the vicious transgenerational domestic violence cycle that led to stressors, depression, anxiety, nervios and loss of community life. While some participants were successful in uniting their families, others found it necessary to leave an abusive relationship and start their own recovery to self-love. "Now that I have left my abusive relationship, I can see my children's reactions differently when I express them verbal affection like saying 'I love you.'" Said one participant. Another participant regretted not having this information earlier to ensure "better relationships with her children and her father."

To strengthen the family structure means having meaningful connections with oneself and family members. Feeling connected as a family unit also meant knowing the long-lasting effects of trauma and domestic violence on one's mental wellness. This theme is consistent with LwL's goal, to increase knowledge about domestic violence as a strategy to reduce social isolation, improve one's capacity to manage daily stressors, and valuing one's strengths and self-worth.

Implementing components of LwL that are culturally and linguistically appropriate helps preserve the cultural strengths and values of migrant indigenous communities. Family can function as a protective factor to overcome domestic violence and other risk factors associated with mental health issues. The family structure is also a shared community value to ensure that every family member is a valued participant in community life. To achieve this, participants stressed the increase the health literacy in their community that provides women with a meaningful role in ending domestic violence, child abuse, alcohol and drug abuse, etc. in their households and communities.

It is important to note that living in isolated rural areas, migrant indigenous communities developed a sense of life that is consistent with past down traditions and beliefs and lived experiences that include child rearing practices, migration journeys, and acculturating in new environments. For example, when it comes to understanding family relations and dynamics. Family love is shown through the provision of basic needs (e.g., food, shelter, clothing) which is a survival mechanism for indigenous communities. However, expressing verbal affection and

physical behaviors that convey gestures of love is often suppressed and neglected. There was consensus among the participants that as a community they need to continue raising awareness and continue fighting for their families to focus more on expressing love and affection as a basic needs priority through physical expression and acts of service. This theme was consistent with CAB members during the feedback loop sessions one participant had this to say, "in our communities, we did not learn to be affectionate from our parents" highlighting the emotional detachment from parents. She continued, [focusing on the small things]… like taking children out to places they like…or connecting with them through facial expressions…blinking an eye or nose wrinkling."

Gender roles and differences also play a huge role in understanding family dynamics within the indigenous community. CAB members emphasized that from an early age, the separation of roles and responsibilities between boys and girls contribute to the view that masculinity or "machismo" as a role for males as providers and not as expressing their emotions. This is an interesting claim by participants that may shed light on males resorting to negative discipline and abuse as an attribute of their dominating presence.

As described before, family is a core value for migrant indigenous communities and aligns with the idea of collectivism that, unlike other individualistic perspectives, family unity and support is at the center of their wellbeing. Thus, the solidification of positive family dynamics through LwL has contributed to the preservation of this community value that signifies serenity and personal wellbeing for migrant indigenous communities.

LwL Theme 2: Reducing Social, Cultural, and Linguistic Isolation

From the content analysis, it was evident that LwL reduced the social, cultural and linguistic isolation among migrant indigenous participants. Participants reported having found in LwL a unique, safe and welcoming space to learn, talk, and connect with other people through lived experiences. A participant self-identified as a domestic violence survivor said this about her participation in LwL:

> I feel more confident, [being here] you realize that you are not alone, you are not the only person, there are many people in similar situations [domestic violence]. When you share with everyone, when you open your heart, we release everything we are carrying that perhaps we had never shared due to shame. At the beginning [of LwL classes] I was ashamed and scared, but then I started to feel confident within the group because we are women, each of us with different ages…you realize that this is something that has been affecting us for generations… These *platicas* help us a lot to value ourselves as women, and to lose the fear and be able to say, this is enough when you are going through a difficult situation.
>
> -LwL Participant

The shared experiences among participants created a very strong connection with one another that encouraged them to continue participating in the class series as they were creating new friendships with similar lived experiences. Participants would arrive to LwL with a need to heal past traumas caused by a variety of circumstances (e.g., family separation, domestic violence, sexual abuse, abandonment, poverty). Participants found a safe space free of judgement and an openness to release emotions without fear:

> At the beginning [of LwL classes], I was ashamed to share what I was going through, I did not have the confidence to talk because I thought that people could share it elsewhere. But, each day, we would receive a list of rules that we had to follow, what you could and could not do, and I started to notice that they were people [classmates]with similar problems like me.
>
> -LwL Participant

Participants found circles of trust and mutual support that helped to reduce their social isolation and feel connected through culture and language. The LwL program became a protective factor where participants felt they were in a safe space with family. “At home, everyone asks me, why do you go to school so much? Well, it’s because these [LwL classes] are not just meetings, we are a community, we are a small family,” stated one participant. This participant highlights the significance of the LwL class modules in building relationships to overcome isolation and increase a sense of belonging. *Pertenencia* or sense of belonging was one of the most cited reasons for feeling more connected and less isolated. For many participants, the LwL classes were the only time they had to dedicate for themselves and they reported looking forward to the class time.

As previously stated, a sense of belonging is directly connected to the reduction of social isolation, which was one of the Project’s evaluation goals. Feeling connected to a group brought positive interpersonal relationships and conversations contributed to an environment of social inclusion. Also, feeling connected and sharing stories increased participant’s need to support others and reach out, “I thought that being tied up at home was normal, but no, we have to look for spaces to share because there might be other people in deeper depression, and they do not know.” LwL opened the opportunity for participants to get involved in the community and find a space where they felt listened and welcomed.

For migrant indigenous communities, the cultural and linguistic essence of the LwL classes resembled unity and community life for participants. The classes were given either in Mixteco, Spanish, or both depending on the group's preferred language, which conveyed a welcoming message and space for participants to feel welcomed and comfortable knowing their culture and language were welcome, and having access to Promotoras who spoke their language. A participant noted, “everything was good because you [Promotoras] talked to us in Mixtec” highlighting the sense of inclusion

through language. Another participant noted "If there was nobody who spoke Mixtec, if everything was in Spanish…I would not understand and would not be able to respond… I am glad you are here because you speak our language…"

This finding is important because it highlights language accessibility as an essential element to increasing inclusion and reducing isolation. Through language we can transmit culture and fully participate in learning and imparting knowledge about one's core values. Language accessibility also plays a significant role when seeking services. Not being able to access health and mental health care because of a language barrier has been described as a social determinant to health and mental health.

Participants also identified the Promotora role model as a significant component in reducing the social, cultural, and linguistic isolation of the community. In the following quote, the participant underlines the Promotoras' empathy and connection with the community:

> Honestly, every class was different, but the person's [the Promotora] interest about what we were talking, her interest in encouraging me to share and have the trust, was what I liked the most because you can always talk with many people, but not everyone has the interest to understand what you are going through nor to provide help.
>
> -LwL Participant

The role of the Promotoras is extremely significant as they come straight from the community, share the same culture, traditions, language, and similar life experiences that can relate to the community. Their connection and understanding of the community's needs has been shown through their compromise and empathy to provide direct support and navigation to help families to access services.

Key Implications From this Theme

Attending LwL classes appeared to have helped participants feel more connected and reduce the social, cultural and linguistic isolation. It is important to note that these initial connections with migrant indigenous communities happen prior to the LwL classes. A unique outreach component of the LwL program is it's grassroots outreach strategy of going inside neighborhoods and interacting with community members in different community settings (e.g., schools, apartment complexes, outside of stores, laundromats, community meetings). For example, going door to door and making personal connections. This unique and tailored outreach activity allowed Promotoras to engage people in short *platicas* in the preferred language and context of the community. This implication is aligned to principles of community engagement that recognize Promotoras as playing a critical role in promoting social inclusion while recruiting for LwL.

It is also possible that these inside community interactions promote three core Latino indigenous cultural values (*familismo*, *personalismo*, and *confianza*). Simply put, interactions based on cultural and language knowledge, trust, empathy, and shared lived experiences can lead people to feel more connected, open to sharing and more understood.

Theme 3: Living with Love During COVID-19

While analyzing the LwL Project adaptations in response to the COVID-19 pandemic, the individual interviews revealed important results that contributed to reducing social, cultural, and linguistic isolation for migrant indigenous communities. This One-on-One Peer Support Sessions adaptation allowed for a private space for the community members to express and share in a more personalized manner their struggles with domestic violence, abuse, and early signs of mental illness. For these participants, 1:1 sessions also provided services and interventions that were more tailored for their cultural, language, and privacy needs when compared to the standard in-person class series. These One-on-One Peer Support Sessions between the LwL Promotora and the participant led to a high demand for mental health care services, especially during the pandemic. A common response from participants was a feeling of openness to express themselves without shame or fear. A participant said that, "there was more intimacy [with the one-on-one class sessions]... [I], was able to release what I was carrying without exposing myself to other people because everything was confidential." This finding is significant because it meant that LwL had a multi-dimensional function and was adaptable to the needs of the community. Moreover, this dynamic was not that evident in the planning and during the regular in-person class series. This finding also expands on the valuable role that LwL Promotoras play in moving from an educational and domestic violence type of prevention focus to a more tailored delivery approach built on trust and connectivity. This approach also highlights the value of in-depth conversations and platicas.Simply put, participants feel safe to share their experiences. One participant had this to say about her connection with a Promotora:

> When I shared with her [Promotora] what I was going through. She [listened closely]... and told me, 'as long as you are good, you will be able to support other people, but if you are not well, you will not be able to help others.'
>
> -LwL Participant

The quote above speaks to the power of building resiliency and conveying in a meaningful way the potential contribution of a participant even in the midst of a pandemic. This is especially important for our migrant indigenous communities where trust is often difficult to establish. Through the Promotora, they were able to express themselves freely with someone who understands and speaks their language. LwL can function as a protective factor for participants who find comfort in someone outside of their families to speak with, someone who shares culture, language, and lived experiences, and communicates with empathy. would be there to listen without judging, and a person they can trust to share personal experiences that they would

not share with anyone else. During the one-on-one sessions, participants reported with deep feelings of pain, that they had never talked about their emotions with no one before. These experiences speak to the need for linguistically appropriate services for the community, and the trust they have in community leaders, such as Promotoras, to share their experiences. As established earlier in this report, language is a barrier to accessing care. The language barrier among migrant indigenous communities was exacerbated by the pandemic resulting in increased isolation due to not having someone who they can trust to share their experiences/problems. LwL became their solution. This was reinforced by this participant who said, , "The truth is that this [the LwL one-on-one class sessions] help[ed] me a lot because I am alone, and sometimes I feel desperate because I have no one to talk to when I feel sad... I think this [1:1 session format] is a great help.".

The combination of the COVID-19 pandemic and one-on-one sessions, staff at LwL was able to identify additional risk factors affecting this population such as drug and alcohol abuse (increased in women), domestic violence, cultural and generational differences among parents and adolescents, elderly abandonment/neglect, suicide, family separation, and a significant number of families under family reunification services. With the transition to virtual one-on-one sessions, the Project transitioned to more tailored intervention services as described above. LwL focused on people whose exposure to more risk factors increased and who were severely impacted by the pandemic . Fear was a common descriptor of a participant in distress and in need of services. One participant reported, , "I was living in emotional distress, without sleeping or eating due to fear of what he [significant other] would do to me. I was afraid to seek help for fear... I thought 'what would people say, that now that I am 60 years old, I want to leave him?'" Throughout the LwL on-on-one approach, this participant found hope and feeling empowered. She continued crediting LwL for her new outlook on life:

> I learned that I did not have to blame myself and [that] helped me get through this [abusive] situation. Now... I feel more comfortable, at peace, and happy. I no longer feel that anxiety that he would do something to hurt me. Even after all the damage he's done to me and my children, we have tried to help him by connecting him to services... I greatly thank [LwL] for the support they provided me during this process, for their kindness, and resources.
>
> -LwL Participant

Key Implications From this Theme

While the one-on-one sessions were successful, our standard in-person group class series has also demonstrated positive results and is effective in prevention and education, gradually introducing sensible topics such as mental health and domestic violence. This allowed the participant to work in groups to process the information and connect their learnings to their life experiences translating to open trustworthy group conversations or platicas. Our results show that it was important for MICOP and LwL staff to shift from in-person group classes to

individual sessions to be more responsive to a more diverse indigenous community and to continue exploring this concept as the program evolves and revitalizes it's community engagement principles.

LwL Theme 4: Attaining Self-Love and Emotional Healing

Emotional healing process learned through participation in the Project class series ultimately translated to self-love. The cornerstone of LwL, this process was achieved through a combination of classroom instruction and experiential learning in their households and neighborhoods. The mental and emotional growth that participants gained through the Project was evident in their active participation in LwL circles of healing. Their sharing and use of information and tools to acknowledge past traumas, and them tapping into their personal and group resiliency and lived experiences as part of their healing. In general, participants arrive to the LwL class series with limited understanding about emotional healing. One plausible explanation for this finding is that the term emotional healing was a new concept for most participants that they had never heard before, either in Spanish and Mixtec. The impact of LwL on participant's holistic healing was described as:

> Leaving our past behind, as well as our sad and bad moments, [we learned] to look at the present and hope for a better future. We learned to stay positive and eliminate negativity in what is to come...if there are negative things, you [Promotoras] showed us how to overcome them so that they do not affect us, and to let them go from our lives.
>
> --LwL Participant

As shown, participants learned and practiced applying the techniques that they were acquiring in class. In particular in recognizing and releasing past emotional traumas by engaging in positive thinking and actions. The participants learned to use their experiences as a learning tool to make meaningful change in their personal lives and their families. "I learned a lot from the *Healing my Inner Child* class session... I learned that, what I had suffered [in my childhood], they [my children] did not have to go through the same things...I have to take more care of my children and be good with them," said one participant. "I felt a deep sadness within myself that [emerged from] a not a very happy childhood... I realized that the past was the past, and [I] needed to heal to enjoy what we have now," expressed another. Through the LwL Project, participants acknowledged the personal responsibility to heal their own emotional sufferings for the wellbeing of themselves and family. Participants began to focus on their self-appraisal and acceptance as a way of starting their healing process. A participant noted, "I learned [in LwL] to value myself...oftentimes I have so many problems that I do not know how to resolve them. I learned to value myself...to love me, and give myself time" emphasizing the importance of embracing oneself as the first step to healing. Indeed, participants were encouraged to find, heal, and embrace their inner child. Participants learned about the mental health impact of traumatic

childhood experiences and unmet emotional needs, such as parental abandonment, child neglect, domestic violence, abuse, alcohol abuse, etc. that may have affected their inner child. Participants realized that they could not change the past, but they could begin to change their future by recognizing their own value, finding spaces of dialog to release stagnated emotions, and practicing positive affirmations. A participant reported,

> In the mornings, when I wake up and I look at the mirror, I always like to sing a song that goes like this, 'I am so pretty, how beautiful I am, I love myself' and every morning I play [and sing] that song and say to myself, today is a new day and we have to start with the right foot thinking positively. I always like to thank God because I am able to think positive.
>
> -LwL Participant

LwL participants practicing self-affirmations in their daily life routines proved to be a very powerful tool that participants learned from the Project that helped to strengthen their self-worth and support their healing. Indeed, positive self-affirmations employed by LwL Promotoras empowered participants when facing difficult life situations. This again illustrates the important role that Promotoras have in the success of this program. Participants reported on healing practices that they found to be culturally relevant and highly beneficial toward their healing and wellbeing. For example, one participant linked the visualization activity as helpful when "Closing our eyes, and [visualizing us] releasing what was happening. We let go of things that do not work and we bring positive things into our minds. [We] close our eyes and relax, thinking positive or listening to relaxing music." An interesting observation is the participant's use of "we" in their statements. This demonstrates a sense of collective agency and recognizing the value of supporting each other in their journey to heal and relearn the meaning of self-love.

As shown, participants emphasized with simple and humble expressions the relevance and significance of these practices to release stress and find healing. Participants started to connect with their inner selves and became more aware of their own qualities and strengths to find their own healing, and subsequently work on the wellbeing of their families. A participant expressed. "I started to listen and to pay attention to the personal qualities I have to be able to share [with others]. The [LwL] program helped me to get to know myself to be able to help my children, husband, and people who surround me." As this participant highlighted, one of the most important skills that are taught throughout the Living with Love class series is to learn to embrace, accept, and love themselves as a protective factor for mental health.

Through the reinforcement of self-love, participants learned to take care of their physical, emotional, mental, and spiritual wellbeing, recognizing its importance to reach a balanced life. Participants began to give themselves a personal time to connect with themselves as this participant highlights, "The [LwL] classes showed us that we need to take a time for ourselves—a time for [me], not just for my children, grandchildren, and other people...[take care of]

myself." This is very important for migrant indigenous communities who often hold strong beliefs about the role of women as the care-givers and managing household chores, all the while expected to ignore their personal wants and enjoyment. This ultimately impacts their wellbeing. In LwL, participants recognized that the first step to achieve family wellness is to work on their personal wellbeing. A participant expressed, "I also liked that one [LwL activity] we learned to increase our self-esteem… [and] not have to feel humiliated by anyone... we need to [learn to] fend for ourselves, to value and love ourselves so that our families are well." Another participant shared her interactions with her co-workers highlighting the moment when they began to see her personal transformation:

> They tell me that they see me very changed, that I came back [to work] very different. I was not like that, I would get mad out of anything, but not anymore. They say that in the mornings... I greet everyone… I arrive with happiness because we [now interact and] share all day together...I tell them, go [to LwL], it's a beautiful experience.
>
> –LwL Participant

Living with Love participants began to strengthen their vision of life and show a positive attitude in their everyday lives. Participants began to reflect themselves in the life experiences of their classmates, which encouraged them to seek their own wellbeing and find solutions to their personal problems. Through the group's shared experiences and personal healing, participants began to develop a sense of personal and group resiliency, in which they all supported and encouraged one another to overcome their situations. A participant expressed, "We reinforced ourselves here [LwL class series] because everyone [classmates] has experienced different difficult situations, and [here] as a group we have strengthened ourselves" stressing the group resiliency that they found among their classmates to remain strong in the face of adversity. Another participant reported:

> In the Living with Love class sessions, my classmates would share their own experiences and what they had done during those moments [to overcome the problem], and I learned [through their experiences] that there are many programs out there. I would share with them about my doubts and they [classmates] would give me their opinions until I would make my own decision of what to do.
>
> –LwL Participant

Key Implications From this Theme

As participants began to make meaningful connections with their LwL peers and share their life experiences, they began to feel comfortable. This key finding reinforces the strategy mentioned earlier about creating safe spaces free of judgment that allows people to open up and share their own struggles while learning from others and supporting one another in their problems.

Additionally, participants began to develop their own resiliency, finding strength in themselves to confront past and present situations that were affecting their wellbeing. Participant's healing is significantly connected to the LwL evaluation goal, to increase mental health knowledge and reduce the mental health stigma, as participants learned to define mental health and to connect the impact of traumas and negative lived experiences to their own emotional wellbeing.

Finally, participants recognized the importance of healing their traumas that were contributing to their mental health. Increasing mental health knowledge for migrant indigenous communities is highly significant due to the lack of access to information for this population. During a feedback loop with members of the community advisory board and LwL Promotoras, they indicated that the term "mental health" is not a known term among migrant indigenous communities. In other words, issues related to one's mental health are commonly described as symptoms affecting the social, physical, and emotional wellbeing of participants. For example, depression means a moment of sadness that the person might be experiencing as a result of ***susto*** (shock), ***mal de ojo*** (negative energy/bad luck), or any other external event, but not associated with mental health. The distinction as well as the association between physical and mental health were explored in the LwL class series, where participants learned about what mental health is and risk factors associated with a mental illness (i.e., depression) while at the same time acknowledging and validating their own cultural perspectives and practices with addressing mental health problems. A key element of the LwL curriculum was to engage participants in conversations about mental health and address the stigma associated with it. This was achieved by creating safe spaces and referrals within MICOP and outside of MICOP (e.g., county behavioral health) that would provide culturally and linguistically appropriate service to meet the needs of a migrant indigenous community.

LwL Theme 5: Knowledge Gaps on Mental Wellness and the Impact of Domestic Violence:

The LwL Project identified a significant increase in participants' knowledge regarding cultural and systemic barriers for accessing mental health and domestic violence support resources. Throughout the focus groups discussions, participants recognized key barriers that have excluded migrant indigenous communities from seeking these services. The lack of access to information regarding mental health and the stigmatizing beliefs regarding mental health were among the most cited barriers within the focus groups discussions. Particularly, the fear and shame of being labeled as "crazy" in the community and family are barriers that discourage people from seeking mental health services. A participant reported, "There are many people out there that could benefit from the LwL Project, but they do not participate due to the lack of information or the culture, 'what they will say' and that is why many people are afraid to seek help or participate [in this type of projects]" highlighting the fear to be subject of discriminatory attitudes if people seek mental health treatments. This was identified as a major barrier that impacts people's behaviors and beliefs regarding mental health. The lack of information about mental health problems was also cited as a barrier as this participant highlighted, "I did not seek help [when I

needed it], I experienced anxiety symptoms for years, [sometimes] I could not swallow the food or water and I did not know [what I was experiencing]. I would go to the doctor to seek help for other illnesses, but I would never talk to them about that until [the anxiety] increased. We are ignorant about those things [mental health problems].” Another participant further commented, “I did not know [about mental health problems], in my family I never heard of anyone suffering from that [mental health problems].” Both participants identified that the lack of familiarity with mental health problems and the fear to talk about feelings are barriers that isolate people from seeking mental health services. The stigma, coupled with the unfamiliarity with the mental health system, cost of service, and unappropriated service hours to meet the needs of a farm working community were also identified, during the focus groups discussions and feedback loop sessions with the CAB, as key barriers that contribute to the challenges that migrant indigenous communities face to access mental health resources.

Participants also recognized the language barrier as a factor that discourages the community to seek professional mental health resources. A participant stressed, “Sometimes we do not seek help because we fear that they [mental health providers] will not be able to understand us… or due to the lack of money because they are [the services] expensive” emphasizing the lack of language access in the mental health system and the elevated cost of service. The language barrier, particularly affects migrant indigenous communities due to the lack of providers that speak an indigenous language or the availability of interpretation services to meet their needs. In addition to the language barrier, there is also the lack of providers who are familiar with the community’s cultural codes (beliefs, traditions, values) that are significant to create culturally relevant services and build trust within this population. While analyzing this topic with CAB members, they identified the community’s mistrust in mental health agencies as a major concern that prevents the community from seeking help. People fear that their information might be shared with government based agencies due to the lack of a legal status. Families also fear that their conversations might not be kept confidential, and that they can affect their families if they speak up, especially when domestic violence is involved.

Focus groups participants further identified the lack of health insurance as a main barrier that has impacted the ability of the community to access professional mental health services. A participant expressed, “There are many people who do not have MediCal or a health insurance, they do not have anything to go in with a doctor or psychologist [because] they are very expensive” elevating once again the systemic barriers that excludes migrant indigenous communities from receiving support. Not being able to access and/or afford health insurance has left out migrant indigenous communities from basic health services, including mental health. A great percentage of our population is undocumented and labors in the agricultural fields. These families do not have the accessibility to economically cover these types of services. Most of our families only earn enough to balance their immediate needs, without much economic flexibility to cover additional expenses. Accessing mental health services is seen as a privilege for only those who can afford their costs.

Participants were more aware of the inequities that migrant indigenous communities confront to navigate and access services, after their participation in the Project. Participants also reflected on the impact of cultural norms (beliefs, customs, prejudices, etc) as a barrier to seek professional mental health resources, recognizing the stigmatizing beliefs that discourage people to speak up and seek services. This knowledge and consciousness is an important step to reduce mental health stigma as participants began to change their personal perceptions of the topic while also changing their families' ideas regarding mental health.

Additionally, participants also increased their understanding regarding the impact of domestic violence on mental wellbeing. Particularly, participants recognized the impact of culture, customs, and religious beliefs as major barriers to leave abusive relationships and seek help. A participant stressed, "Generally, I think people do not seek help due to shame and the culture… we were raised to think that if you marry, you will be married for all your life, and you will have to put up with whatever you get" emphasizing the belief that women must stay with their partners no matter what situation they are confronting. Participants acknowledged that domestic violence is often minimized in the community due to the lack of information and beliefs that intimate partner abuse is normal. "I learned [in LwL] that domestic violence is not only hitting, there are many other things that perhaps we experienced before, but we were like 'oh this is not domestic violence.' Now, I know that words or just a simple push is domestic abuse," a participant stated. LwL Participants learned to identify the different types of abuse and the cycle of domestic violence while acknowledging the negative impact on their mental health and children's wellbeing. Participants gained the strength and courage to seek help to create a healthier life for themselves and family.

One of the many reasons why there are so many unreported cases of domestic violence in our community is the fear of what could happen if they speak up. Many remain silent because of the fear of causing a negative impact on their partners, and the repercussions that could experience their families in their home towns as a result. Participants identified this idea of machismo (male supremacy) as a major barrier that contributes to the control exercised over women that limits their ability to seek help, "Here, you do what I say…you are the woman here, and I am the one in charge here, If you do not listen, then this is what happens [violence]" a participant stressed when referring to the impact of machismo, strict gender roles, and mental abuse that victims of domestic violence are subject to. Oftentimes, family pressure and control also significantly impact the ability of women to seek support resources as this participant emphasized, "You are always thinking what your parents would say because you do not have their support." Women fear the lack of support from their own family given the strong beliefs regarding marriage and family unity.

During the analysis with CAB members, they further validated this information highlighting that indeed, domestic violence is a serious concern that affects migrant indigenous communities due to the devaluation of women, the normalization of domestic abuse within the community, the

isolation of our indigenous women and the lack of familiarity with their rights and the system, immigration status, language barrier, the fear of their partner repercussions, and their reputation in the community. Additionally, the emotional and economic dependency on their partners is a contributing barrier to leaving an abusive relationship despite the changing roles, in which women are now contributing to the economic stability of the home. There is still a lack of valorization of their support to the home creating an emotional impact on themselves that impacts their capacity to seek help.

Key Implications From this Theme:

As described throughout this study, MICOP has identified multiple factors that contribute to the mental health disparities that affect migrant indigenous communities throughout Ventura County. Without a doubt, financial constraints, the lack of health insurance, and the elevated cost of treatment are among the major systemic factors that limit the access to mental health services for migrant indigenous communities. The majority of our population are undocumented, working in low-paying jobs such as the agricultural fields, which restricts their access to MediCal, and the ability to afford any health insurance. Unfortunately, the mental health system is neither prepared to meet the needs of our community given their unfamiliarity and lack of understanding of Mexican indigenous cultures, beliefs, traditions, and ways of living. Mental health providers often tend to place migrant indigenous communities within the general Mexican population disregarding the different belief systems, experiences, and language diversity. The lack of language access further alienates our population from seeking these types of services. They often refuse to be referred to external agencies due to fear that they will not be understood or able to communicate appropriately. Coupled with the cultural mistrust, inconvenient service hours, transportation barriers, the limited understanding of the U.S mental health system, and stigmatizing beliefs regarding mental health, migrant indigenous communities are disproportionately left out of the mental health system.

Equally important, migrant indigenous communities hold different perceptions of mental health that do not necessarily adhere to western mental health beliefs creating further isolation. For instance, the term "mental health" is unknown for our communities. Mental health is more commonly identified with physical symptoms that may be affecting the social, physical, and emotional wellbeing. During the migration process, they confront themselves with the acculturation and new perceptions of mental health that might be confusing to understand.

Additionally, it is important to analyze social determinants of health to understand the mental health needs that our population presents. To begin with, poverty is a major risk factor for mental health problems that affect migrant indigenous communities, increasing stress levels and a sense of hopelessness. With low-paying jobs and high costs of rent in Ventura County, many of our families struggle to afford a decent standard of living, leading them to reside in unsafe neighborhoods and sharing small apartments with multiple families. This leads to no privacy, families' disputes, and elevated stress and anxiety levels. Likewise, rooted in the historical

discrimination and isolation of our indigenous communities in Mexico, the health and education inequities that they have been subject to has left our population with very low literacy skills and poor quality of life. Not to mention the ongoing racism and negative stereotypes against indigenous communities that further contribute to the community's isolation in Mexico and the U.S. Our population comes from segregated communities where mental health and domestic violence awareness is nonexistent placing our community in vulnerable positions to opt for alcohol and drug consumption as a way of confronting the isolation, migratory duel, and socio-economic pressures.

Domestic violence, similar to other populations, is a risk factor affecting migrant indigenous communities, exacerbated by strict gender roles and beliefs affecting predominantly women. Domestic violence is often unreported and women stay within these relations due to cultural and religious beliefs combined with a patriarchal system that undervalues women. While in the U.S., these practices and beliefs remain and increase by fear as immigrants, economic barriers, limited education, unfamiliar with the systems and culture here, low self-esteem, and language differences. Generally, men are more likely to speak Spanish and navigate the systems compared to women. This is because men have been usually the ones who are going out to work and able to socialize beyond their towns. This practice sometimes remains here and women are not allowed to work. Men are also more likely to have had some education compared to women due to the belief that women must stay home and stand for the family. Thus, leaving women with further barriers to navigate. Also, domestic violence is often unreported due to fear of repercussions for their families left behind in their hometowns. Alcohol and drug consumption, restricted mobility, the political climate, and the migratory duel of leaving behind their towns, families, and often children similarly contribute to migrant indigenous mental health needs. Lastly, all of the above-mentioned social characteristics such as gender, racial/ethnic status, and economic and legal status, etc. are key intersectional factors that must be analyzed collectively to better understand the disadvantages that our communities confront with mental health.

LwL Theme 6: Strengthening the Capacity to Practice Coping Skills

While analyzing focus groups discussions, an increased knowledge among Project participants to manage daily stressors was identified. Participants learned strategies, skills, and techniques to cope with stressful situations following participation in Living with Love. Participants gained important tools that they found very useful for their everyday lives as this participant noted:

> When we go out to walk, [we learned] it is important to breathe in because it helps us to reduce our *nervios* [anxiety] and all the things we are carrying on. The breathing [technique] is very useful, especially when we go out to walk. We see the day, the beauty of the little plants, and I always like to thank God for everything we have. When I am driving, I learned [in LwL] to look at the beauty of the mountains.
>
> -LwL Participant

As highlighted, participants learned about the importance of atencion plena (mindfulness) as a powerful tool to bring attention to their surroundings and reduce stress. Participants were highly connected with this technique despite the fact that many of them were unfamiliar with the concept and term. Participants found happiness and meaning within simple activities such as going out for a walk,watering the plants, listening to the birds, etc while also regulating their emotions and stressors. “Something important [that I learned in LwL] was to pay attention to nature, the steps we take, [especially] when we go out to the beach. [I learned] to relax and recognize that I am able to control the stress” a participant emphasized, acknowledging the increased capacity to practice mindfulness.

Being mindful of their own behaviors, thoughts, and emotions allowed participants to recognize its importance to maintain a balanced life. A participant stated:

> Personally, what I liked the most [from LwL] was the breathing technique and being able to enjoy things [mindfulness]. Before [participating in LwL] I was always in a hurry, but now I am able to relax and breathe… Now I take the time to enjoy everything I do, which is what has been helping me the most since I started coming here [LwL classes].
>
> —LwL Participant

As described, participants learned to give meaning to their everyday activities, and to identify their body reactions when they began to make small positive changes. Participants recognized that practicing *atencion plena* created feelings of peace and reconnection with life. They recognized that oftentimes being overwhelmed with so many problems and everyday responsibilities is hard to maintain a balance and look at their surroundings, but this practice has helped them to live more consciously.

Furthermore, participants identified the deep breathing technique as the most important tool learned in LwL to manage stressful situations. Participants recognized the importance of practicing breathing as a tool to reduce stress and and bring clarity to the mind, as this participant stressed:

> Whenever I feel tense, stressed, or like I have so many problems that I cannot resolve, [I learned in LwL] to look for a quiet place, a space only for myself, and I start to practice the breathing exercises. I try to practice once, and if it does not work, then I go back and practice it again and again until I feel [myself] lighter and capable of doing what I want.
>
> –LwL Participant

As this participant emphasized, they learned to use deep breathing to relieve themselves from the everyday stressors, and most importantly, they identified their capacity to regulate their own body using this tool. Learning the power of deep breathing allowed participants to better

understand the connection between the brain and the body as this participant emphasized, “When we are irritated, our head [brain] functions very differently, but when we calm ourselves, the brain calms itself too” highlighting the capacity of oneself to regulate emotions.

Participants also learned the importance of changing negative thoughts to positive and not to overthink as helpful strategies to manage daily stressors. A participant stressed, “Whenever I felt worried or dizzy, I would start to overthink… [imagining] all kinds of brain illnesses and then I would start to have headaches, but you [Promotoras] told me to go out to walk and look at my surroundings.” This highlights the increased learning that participants gained after their participation in the Project, in which they acquired new tools and skills to manage mental health problems such as anxiety and depression. As described before, participants began to recognize the power of thoughts and the impact on their body and emotional state, which is a huge step to bring awareness about the importance of taking care of these areas to prevent mental health problems.

Key Implications From this Theme:

The increased capacity of Project participants to use coping skills in their everyday lives is consistent with the LwL’ evaluation goal of increasing capacity to manage daily stressors. As described, participants learned skills and tools to bring balance to their emotional state and to confront challenging situations. These results also yield important implications for our migrant indigenous communities as they show that deep breathing, *atencion plena* (mindfulness), and positive thinking are relevant tools/skills for managing stress within this population.

Recommendations for future CDEP implementation:

Reflecting on the LwL Project's implementation, challenges and successes, multiple areas of improvement were identified that would help deepen the impact of the Project. To begin with, LwL must continue strengthening the support network and collaborations with diverse resources to extend the Project's capacity to help families navigate local services. With the incorporation of case management, the growing demand of families arriving at LwL hoping to find resources to confront their needs has increased. Thus, building on a family resource network is crucial to provide rapid response, and collaborate to mutually refer clients. An example of this approach is our work alongside the First 5 Program to unite in our service to families and create a resource network that can facilitate access to families. Coupled with the possibility of having multiple Promotoras working in different community areas, this resource network will enable us to identify resources and increase access for the community. Often, families are restricted from accessing services due to transportation barriers, fear, unfamiliarity with the systems, and other factors. So, having Promotoras specifically located in key areas can increase access and utilization of services. Working with schools can also support this process as the community has shown that they trust schools; they are more likely to take services when they come from these institutions.

Additionally, another area of improvement that will contribute to the work of LwL is case management. Although the Project has been able to manage this component with our current number of staff, we need a new staff member that can entirely focus on case management support to fulfill the community's demand in this area, and allow the rest of the team to concentrate on other priorities that have been overlooked as a result. Likewise, building the team's capacity and preparedness to address mental health needs requires ongoing training in multiple topics that is often unavailable, especially in Spanish. LwL struggled to identify pieces of training to continue preparing staff members for the multiple issues that families arrive with, such as alcohol and substance abuse and adolescents' mental health struggles. Hence, we believe that this is one of the areas that require improvement to increase the impact of the Project as we have observed these needs to be increasing among the families that we serve.

Furthermore, because LwL is also a domestic violence prevention project, we need to deepen our resource knowledge and capacity in that area as well, including navigating Family Law services, working with domestic violence support networks, and strengthening our internal strategies to respond to such cases. As an organization, we need to identify potential funding sources that can provide economic relief to domestic violence victims during extreme emergencies. Families often arrive in desperate situations without a place to go to and without any resources. To this, we add the lack of local shelters and domestic violence resources ready to respond to these types of emergencies. Most of the time, these resources are full or unable to support families quickly because of a complex bureaucratic system and complex requirements that do not benefit our families. To strengthen our work in this area, we need to work as an organization to find sources that can help us support our families and ensure that they will be safe.

Additionally, LwL has raised the concern and need to certify the Living with Love class series under Family Law services to provide a more responsive service that meets the needs of the community in this area. One of the main concerns expressed is the fact that we are observing an increased need for certified services that can comply with the court requirements. Although local agencies are providing this service, they do not provide interpretation services in indigenous languages. This creates a huge barrier for our communities who do not speak a language other than their native, indigenous language. This is a constant struggle for LwL as we have the services, yet they are not certified and this discourages families.

Another learning experience associated with the Project as a Prevention Early Intervention Mental Health and Domestic Violence project is that this type of program requires extensive collaborations wherein, schools, social service agencies, health services, and community-based organizations can work together. We know that prevention is associated with the access to information, resources and recreational programs where people can strengthen their self-esteem and self-assurance and embrace the importance of self-care as prevention of mental health problems. Coupled with the implementation of more recreational programs and increased accessibility to childcare centers where children have access to more comprehensive care at an

early age, will help strengthen families' resiliency to address mental health problems and prevent domestic violence. Currently, most of our migrant indigenous families leave children and young adolescents under the supervision of babysitters, which are often neither prepared nor appropriate to provide such care. This starts affecting children's mental health at an early age and exposes adolescents to early substance abuse and gang related problems due to the sense of abandonment, the absence of parental supervision and lack of information. Lastly, during the last months, concerns have emerged regarding the new technology-based approaches established to provide services under COVID-19. MICOP is concerned with how the services are being provided, both internally and externally, and worry that these will remain the same even after COVID-19. We have observed the challenges that our community has been confronting with the current service structures that many agencies have adopted, which are not appropriate nor accessible to the community given technological barriers, limited literacy skills and unfamiliarity with the systems. Although MICOP has remained accessible for the community during this time, we acknowledge that some of the practices adopted have not been very accessible for the community, for example maintaining an appointment-based system. Living with Love will continue providing both virtual and in-person services, to ensure that the community has access and resources during this time, without excessive barriers.

Directions for Future Research

The data gathered through this program evaluation clearly demonstrate the effectiveness of LwL for improving mental health and well-being among Mexican immigrant women, including those from indigenous backgrounds. Given the great promise of this program for improving mental health and reducing mental health disparities, additional research is warranted to examine the program's potential for improving mental health in other groups including men and Native American indigenous groups. Future studies may benefit from use of a mixed-method approach throughout all phases of the data collection timeframe. Qualitative data gathered through this evaluation were exceptionally valuable and seizing the opportunity to collect data of this type immediately prior to and following program delivery may provide additional important insights into the complex drivers of mental health problems among participants, and into the specific aspects of the program that most resonated with community members. Having clearly seen the effectiveness of LwL delivered in a one-on-one context for higher need participants, such as those who are enmeshed in the family court system, it would also be valuable to gather data to promote understanding as to whether participating in a group format is equally as beneficial for those participants who may have more acute needs. Finally, we were able to examine how lasting changes associated with LwL participation were a few months following completion of the program and these results were encouraging. It would be particularly valuable to conduct a longer term follow up of program participants, aided by monetary incentives to promote participation, to understand how enduring the effects of LwL are, both generally and for participants of varied backgrounds.

Conclusions

Living with Love is a valuable resource for our migrant indigenous communities in Ventura County given its cultural relevance and linguistic appropriateness to reduce mental health disparities. Our Project was written, developed, and implemented by migrant indigenous communities based on the needs presenting in mental health and domestic violence. Living with Love incorporates the stories, values and life experiences of the specific community being served while being staffed by members of the community itself to collectively bring healing, education, and the restoration of traditional practices.

Migrant indigenous communities in the U.S., like in Mexico, have continued to be an invisible population, despite the multiple organizations working to achieve equality for minority ethnic populations in the U.S. in particular. Unfortunately, those from indigenous backgrounds are often homogenized within the general Mexican population, without recognizing their unique struggles, cultural practices and language differences. This practice has left the indigenous community lacking inappropriate services. Our Project addresses these issues by providing practices and components that are connected to the specific needs of indignous community members while valuing and respecting their traditional healing practices to achieve well-being. LwL is significant in the process of reducing mental health stigma as it provides a safe healing space where participants have the opportunity to reflect on their life experiences while analyzing how these experiences have contributed to who they are today, their perceptions of life and their overall emotional well-being. The community is respectfully invited to continue practicing their traditional healing practices, and encouraged to explore alternative options to resolve their problems such as therapy, if they feel comfortable in doing so.

Migrant indigenous communities have found a safe and welcoming space in MICOP that has been specifically designed to meet their needs. The stories captured throughout the Project implementation and evaluation speak to the community's satisfaction with LwL, elevating the cultural appropriateness of the Project for its empathy, sense of community and respect and resiliency building. Moreover, the strength, robustness and duration of effects observed illustrate the power of LwL for improving mental health and well-being among Mexican immigrant women from diverse backgrounds. Furthermore, these data provide considerable evidence that adapting the program delivery approach to meet the changing needs of the community does not negatively impact effectiveness. As has been noted, community-based practices are more likely to be successful in reducing mental health disparities for our migrant, and indigenous, communities if they appropriately reflect the cultural uniqueness of our population. We are pleased to have had the opportunity to engage in a culturally and linguistically appropriate, community guided approach to evaluating LwL. The evidence gathered and presented here demonstrates the value that the Living with Love program holds for improving mental health in our community and communities like ours, thereby reducing mental health disparities in the larger population.

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Appendices

MICOP's Living with Love Program: Local Evaluation Final Report

D. Figures

Appendix A: (Baseline Survey + Eligibility Screener

Case ID #_____

Living with Love Pre-Program Assessment

Date of Assessment: _____

Promotor/a Name:_____ Language of administration:_____

I am going to ask you a series of questions. Please respond in the way that most closely reflects your own thoughts, feelings or beliefs. You may choose to skip any question that you do not wish to answer.

First, I would like to ask you a few questions to see if you are eligible to participate in the evaluation of the Living with Love Program.

S1. How old are you? _____

IF 18 OR OLDER, SKIP TO QUESTION S6
IF NO AND BETWEEN 15 AND 17 YEARS OLD, ASK QUESTIONS S2-S4

S2. Do you have a child?	*☐ YES*	*☐ NO*
S3. Do you live separately from your parents?	*☐ YES*	*☐ NO*
S4. Do you manage your own financial affairs?	*☐ YES*	*☐ NO*

IF YES TO S2-S4, CONTINUE TO QUESTION S6

IF YOUNGER THAN 18 AND DID NOT RESPOND YES TO S2-S5, *"*Unfortunately, this evaluation is being conducted only with those who are over 18 years of age or between the ages of 15 and 17 who have children, live independently and manage their own financial affairs. Thank you for your time and willingness to participate, but you will not be eligible to participate in the evaluation of *Living with Love."*

S6. Are you of Mixtec or Zapotec ancestry?
☐ YES
☐ NO ***(CONTINUE TO S7)***

S7. Are you of Mexican ancestry?
☐ YES
☐ NO ***(CONTINUE TO RESPONSE 2)***

IF NOT MIXTECO OR ZAPOTECO OR OF MEXICAN DESCENT "Unfortunately, this evaluation is conducted only with Mixtecos, Zapotecos, and those of Mexican descent. Thank you for your time, but you will not be eligible to participate in the evaluation of *Living with Love."*

ELIGIBLE?	☐ YES	☐ NO

Appendix A: (Baseline Survey + Eligibility Screener

Now, I will read several statements about your friends, community and culture. Please indicate whether you agree or disagree with each statement.

1. **You feel good with the friendships you choose.**

_____ Always _____ Sometimes _____ Never _____*DID NOT UNDERSTAND* _____*REFUSED*

3. **During a difficult situation in your life, you would have the support you need from family and friends.**

_____ Always _____ Sometimes _____ Never _____*DID NOT UNDERSTAND* _____*REFUSED*

5. **Your culture gives you strength.**

_____ Yes _____ No _____*DID NOT UNDERSTAND* _____ *REFUSED*

6. **Your culture is important to you.**

_____Yes _____ No _____*DID NOT UNDERSTAND* _____ *REFUSED*

7. **Your culture helps you to feel good about who you are.**

_____Yes _____ No _____*DID NOT UNDERSTAND* _____ *REFUSED*

8. **You engage in activities to celebrate your traditions.**

_____ Always _____ Sometimes _____ Never _____*DID NOT UNDERSTAND* _____*REFUSED*

9. **You are proud to be an indigenous person.**

____ Always ____ Sometimes ____ Never ____ Does not apply
____*DID NOT UNDERSTAND* _____*REFUSED*

10. **You think that children and/or other young people in your community should learn the traditional indigenous language (Mixteco, Zapoteco).**

____ Yes ____ No ____ Does not apply
____*DID NOT UNDERSTAND* _____*REFUSED*

11. **You regularly take part in community activities outside of your work and your home.**

_____ Always _____ Sometimes _____ Never _____*DID NOT UNDERSTAND* _____*REFUSED*

Now I will ask you a few questions about your family.

12. Please indicate, do you feel satisfied with:

	Always	**Sometimes**	**Never**	*DID NOT UNDERSTAND*	*REFUSED*
12b. Your family's ability to cope with stress?					
12d. The communication between your family members?					
12e. The way problems are resolved in your family?					
12f. The amount of time you spend together as a family					

The next several statements are about you. Please indicate whether you agree or disagree with each statement.

12i. Please answer, what does emotional wellbeing mean to you?

_____

_____

_____

_____*DID NOT UNDERSTAND* _____*REFUSED*

13. You believe that you can manage the daily stress in your life.

_____ Always _____ Sometimes _____ Never _____*DID NOT UNDERSTAND* _____*REFUSED*

14. You are confident that you can stop the thoughts that do not make you feel good.

_____ Always _____ Sometimes _____ Never _____*DID NOT UNDERSTAND* _____*REFUSED*

15. You believe that that you can control yourself when you are feeling nervous.

_____ Always _____ Sometimes _____ Never _____*DID NOT UNDERSTAND* _____*REFUSED*

16. You feel confident in your ability to practice deep breathing.

_____ Yes _____ No _____*DID NOT UNDERSTAND* _____*REFUSED*

17. You are able to focus your mind in the moment.

_____ Always _____ Sometimes _____ Never _____*DID NOT UNDERSTAND* ____*REFUSED*

18. You are satisfied with yourself.

_____ Always _____ Sometimes _____ Never _____*DID NOT UNDERSTAND* ____*REFUSED*

27. During the past 12 months, how often did you feel:

	Always	Sometimes	Never	*DID NOT UNDERSTAND*	*REFUSED*
27a. Nervous?					
27b. Hopeless?					
27c. Restless?					
27d. So depressed that nothing could cheer you up?					
27e. Worthless?					
27f. Excluded from society? *(In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter)*					
27g. Isolated or alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond your family, school, and friends.*)					

28. Think about the month when you were at your worst emotionally. Did your emotions interfere with your:

	A lot	Some	Not at All	*DID NOT UNDERSTAND*	*REFUSED*
28a. Performance at work/school					
28b. Household chores					
28c. Relationships with friends & family					

The next few questions are about your religion and spirituality.

	A lot	Somewhat	Not at All	*DID NOT UNDERSTAND*	*REFUSED*
31. How important is religion in your life?					
Spirituality is the practice of habits that could bring you internal peace. **32. How important is spirituality in your life?**					
33. To what extent do you feel that in your life you are in balance physically, emotionally, mentally and spiritually?					

Next I will ask you several questions about depression and anxiety.

34. Do you know what depression is?

_____ YES _____ NO _____Somewhat _____*DID NOT UNDERSTAND* ____ *REFUSED*

35. Do you think it is possible to treat depression?

_____ YES _____ NO _____Do not know _____*DID NOT UNDERSTAND* ____ *REFUSED*

36. Do you think that talking with others can be helpful for resolving symptoms of depression?

_____ YES _____ NO _____Do not know _____*DID NOT UNDERSTAND* ____ *REFUSED*

37. Do you believe that taking medication can be helpful for resolving symptoms of depression?

_____ YES _____ NO _____Do not know _____*DID NOT UNDERSTAND* ____ *REFUSED*

38. Which of the following items do you think could cause depression? [CHECK ALL THAT APPLY]

_____ PARTNER / FAMILY RELATIONSHIP BREAKUP

_____ WORK RELATED PROBLEMS

_____ PHYSICAL ILLNESS

_____ LONLINESS / LACK OF FRIENDS

_____ DEATH OF LOVED ONES

_____ NONE OF THE ABOVE

_____*DID NOT UNDERSTAND* _____ *REFUSED*

39. Which of the following do you think can be symptoms of depression? ***[CHECK ALL THAT APPLY]***

_____ SLEEP PROBLEMS (EITHER SLEEPING TOO MUCH OR NOT BEING ABLE TO SLEEP)

_____ LOSS OF INTEREST OR PLEASURE IN ACTIVITIES THAT A PERSON USED TO ENJOY

_____ IRRITABILITY OR EXPLOSIVE ANGER

_____ NONE OF THE ABOVE

_____*DID NOT UNDERSTAND* _____ *REFUSED*

39a. Do you know what anxiety or *nervios* is?

_____ Yes _____ No _____*DID NOT UNDERSTAND* _____ *REFUSED*

39b. Which of the following do you think can be symptoms of anxiety or *nervios*?

_____ LOSS OF APPETITE
_____ FEELING VERY NERVOUS
_____ SLEEPLESSNESS
_____ NONE OF THE ABOVE

_____*DID NOT UNDERSTAND* _____ *REFUSED*

40. If you thought that you were experiencing depression or anxiety, would you seek help?

_____ YES _____ NO _____ Do not know _____*DID NOT UNDERSTAND* _____ *REFUSED*

41. Who would you go to for help for yourself or someone else who may be experiencing depression, anxiety/nervios or another mental health issue? *[CHECK ALL THAT APPLY]*

_____ FAMILY (SISTER, BROTHER, PARENT, OTHER FAMILY MEMBER)

_____ COUNSELOR

_____ PSYCHOLOGIST

_____ CHURCH

_____ DOCTOR OR NURSE

_____ FRIEND

_____ WORKSHOP/PEER SUPPORT GROUPS

_____ HEALER

_____*DID NOT UNDERSTAND* _____ *REFUSED*

42. Would you be embarrassed to seek help for yourself or a friend/family member?

_____ YES _____ NO _____*DID NOT UNDERSTAND* _____ *REFUSED*

Please indicate whether you agree or disagree with the following statements.

46. Do you think a person should solve an emotional problem on his/her own.

_____ Yes _____ No _____ Do Not Know _____*DID NOT UNDERSTAND* _____ *REFUSED*

48. Do you think a person who seeks professional help for an emotional problem should keep it secret?

Yes _____ No _____ Do Not Know _____*DID NOT UNDERSTAND* _____ *REFUSED*

I am now going to ask you a few questions about domestic violence.

48a. How much do you know about Domestic Violence?

_____ A lot _____ Some _____ Not at all _____*DID NOT UNDERSTAND* _____ *REFUSED*

49. Which of the following do you think might be signs of domestic violence?
When a spouse/partner of family member: ***[CHECK ALL THAT APPLY]***

_____ REGULARLY SHOWS JEALOUSY OF THE OTHER PERSON'S FAMILY AND FRIENDS

_____ CONTROLS ALL MONEY SPENT IN THE HOUSEHOLD

_____ WANTS TO CONTROL THE OTHER PERSON BY CHECKING THEIR CELLPHONE AND ALWAYS WANTS TO KNOW WHERE THE PERSON IS

_____ HITS, SLAPS OR PUNCHES THE OTHER PERSON

_____ INTIMIDATES THE OTHER PERSON WITH GUNS, KNIVES OR OTHER WEAPONS

_____ PRESSURES THE OTHER PERSON TO DO THINGS SEXUALLY THAT THEY ARE NOT COMFORTABLE WITH

_____ NONE OF THE ABOVE

_____*DID NOT UNDERSTAND* _____ *REFUSED*

50. Children who witness domestic violence may: [CHECK ALL THAT APPLY]

_____ EXPERIENCE FREQUENT HEADACHES OR STOMACH ACHE.

_____ DEVELOP DEPRESSION.

_____ EXPERIENCE ANXIETY AND NERVOUSNESS IN AND OUT OF THE HOME.

_____ HAVE TROUBLE IN SCHOOL.

_____ ISOLATE THEMSELVES FROM FRIENDS AND FAMILY.

_____ ABUSE ALCOHOL OR OTHER DRUGS.

_____ NONE OF THE ABOVE

_____*DID NOT UNDERSTAND* _____ *REFUSED*

51. If you or one of your friends or family members were experiencing domestic violence and needed help, what steps could you take to access community services?

_____

_____

_____

_____*DID NOT UNDERSTAND* _____ *REFUSED*

51a. Have you ever heard of a domestic violence safety plan?

_____ Yes _____ No _____*DID NOT UNDERSTAND* _____ *REFUSED*

52. If you or one of your friends or family members were experiencing domestic violence and needed to get out of the home to be safe (and for children to be safe), what steps could you take to do this?

_____

_____

_____

_____*DID NOT UNDERSTAND* _____ *REFUSED*

We are almost finished. I am going to ask you about your familiarity with local community resources and then a few questions about yourself.

53. Which of the following no-cost or low-cost community resources have you heard of?
[CHECK ALL THAT APPLY]

_____ MENTAL HEALTH OFOXNARD

_____ CLINICAS DE CAMINO REAL

_____ COALITION FOR FAMILY HARMONY

_____ SCHOOL COUNSELING FOR STUDENTS

_____ PROYECTO MIXTECO

_____ INTERFACE

_____ NONE OF THE ABOVE _____*DID NOT UNDERSTAND* _____ *REFUSED*

54. Have you ever received assistance from any of these community services?

_____ YES _____ NO _____ *DID NOT UNDERSTAND* _____ *REFUSED*

Participant Information

Finally, we'd like to know a little bit more about you.

55P. What is your age? _____ YEARS OLD _____ *REFUSED*

56P. Are you:

____Single ____Married ____Divorced ____A Widow ____Separated ____Living with Partner

_____ *DID NOT UNDERSTAND* _____ *REFUSED*

57P. Have you lived at the same address for one year or more?

_____ YES _____ NO _____ *DID NOT UNDERSTAND* _____ *REFUSED*

58P. Do you spend part of the year in another city?

_____ YES _____ NO _____ *DID NOT UNDERSTAND* _____ *REFUSED*

58PA. IF YES, where?_____

59P. Where were you born?

TOWN	STATE	COUNTRY

_____ *DID NOT UNDERSTAND* _____ *REFUSED*

60P. At home, do you speak… ***[CHECK ALL THAT APPLY]***

_____ SPANISH

_____ MIXTECO

_____ ENGLISH

_____ ZAPOTEC

_____ ANOTHER LANGUAGE, IF YES, WHAT LANGUAGE? _____

_____ *DID NOT UNDERSTAND* _____ *REFUSED*

63P. About how many years have you lived in the United States?

Number of years _____ _____ *DID NOT UNDERSTAND* _____ *REFUSED*

64P. What is your zip code? _____ _____ Unstable Housing

____ *DID NOT UNDERSTAND* _____ *REFUSED*

65P. How many adults and children live in your home?

65aP. _____ Adults

65bP. _____ Children

THANK YOU FOR YOUR TIME!

END

FOCUS GROUP GUIDE

MICOP *LIVING WITH LOVE* PROGRAM EVALUATION

CALIFORNIA REDUCING DISPARTIES PROJECT, PHASE 2

- **Once the group is seated, welcome the participants to the focus group.**
  After the welcome, each facilitator/assistant should introduce themselves and explain their roles:

  ("Hello everyone; welcome to the [title of research] focus group discussion. My name is [name]; I am the [title] of [name of agency] and I will be asking questions throughout our discussion. This is (name of note taker) and s/he will be taking notes during our discussion.

  ***Note taker:** "Hello, my name is [name] and I am the [title] at the [agency]. I will be taking notes and be in charge of the tape recorder in our discussion."*

- **Pass out name cards and explain the purpose of the cards:**

  ("I'm now passing out the name cards. For the purpose of confidentiality, please only write your first name on it, or if you wish, you may write an alias that you want us to call you by. During our discussion, if I'm unable to clearly understand or hear your response, I might ask you to please repeat your answer by calling you by the name on your card.")

- **Review the information sheet/consent form**
  (explain confidentiality, voluntariness, the use of audio-recording, and how the information they provide will be used):

  ("Let's now review the information and consent form together [pass out the form and read aloud] …Do you all give consent to participate in this study? [Wait for response from everyone then continue].")

- **Have each participant introduce him/herself:**

  ("To start off our discussion, please introduce yourself by stating only your first name or the name on your card and your favorite food?)

- **Begin Discussion**
  (Ask the following series of questions, using probes and prompts as necessary to engage all group members):

  - 1| *How did you learn about Living with Love?*
  - 2| *Please share a little about your own experience as a participant in the Living with Love program?*
  - 3| *Are there any tool(s) that you learned in the program that you have been using since the program ended?*
    - **(IF YES)** *Please share a little about which tool(s) and how you have been using them?*

- **(IF NO)** *Are there tool(s) that you think you may use in the future? Which ones?*

- 4| *Have you shared any of the information or skills that you learned through Living with Love with your family members or friends?*
  - **(IF YES)** *Please share a little about how this experience went for you?*
  - **(IF NO)** *Do you think you would feel comfortable sharing this type of information if you saw a need?*

- 5| *What information of the Living with Love class series was most beneficial for you?*

- ***Now we are going to talk about more specific themes related to the Living with Love class sessions, please remember that this is a safe space and that everything we share is confidential.***

  - 6| *After having participated in Living with Love*, *what does mental health mean to you?*

  - 7| *How do you think mental health problems affect people's lives?*

  - *8*| *From your experience, why do you think people who are going through a mental health issue do not seek help?*

  - 9| *What are your thoughts regarding domestic violence?*

  - *10*|*After having participated in Living with Love, did your opinion of Domestic Violence change?*
    - ***(IF YES)*** *Please explain how your opinion of Domestic Violence changed?*
    - ***(IF NO)*** *Please explain why?*

  - 11| Do you think that spending time with your friends or being involved in the community is important for your wellbeing?
    - *(IF YES) Please explain why?*
    - *(IF NO) Please explain why not?*

  - *12*| *Would you like to keep participating in this kind of programs?*
    - *(IF YES) Please explain why?*

  - *13*| *Do you have any suggestions for how Living with Love could be improved?*

- ***Only if the group was composed of males and females.***
  - *14*| *How did you feel sharing your experiences within a group of males and females? Please share you experience.*

- **Summarize main points of the discussion and ask participants to confirm their agreement or make corrections:**
  ("From our discussion, I see that many of you perceive X,Y,Z as the most significant health concerns in your community.")

- **Emphasize, one final time, the importance of respecting the privacy of everyone in the group.**
  ("Again, we would like to ask that each of you respect the privacy of everyone in this group")

- **Thank all participants for sharing their thoughts:**
  ("Thank you everyone for your participation in this discussion. If any of you have questions about our discussion in the future, feel free to contact members of our research team using the contact information included on the Information Sheet that we've provided]").

Table 1. Baseline Characteristics of Living with Love Participants and Attrition Analysis

Characteristic	**Overall N = 210**[1]	Follow-Up Status **Completed** N=168[1]	**Lost Follow-Up** N = 42[1]	p-value[2]
		N(%); Mean(SD)		
Demographics				
Age	38 (11)	39 (11)	35 (10)	.069
Years Lived in US	15 (9)	16 (9)	14 (8)	.186
Married *or Live w Partner*	135 (64%)	109 (65%)	26 (62%)	.623
Household size	6.41 (2.30)	6.51 (2.44)	5.97 (1.44)	.085
1+ years @ same address	163 (78%)	132 (79%)	31 (73%)	.469
Spend Part Yr in Another City	25 (12%)	21 (13%)	4 (10%)	.790
Language				.160
Spanish Only	85 (40%)	64 (39%)	21 (57%)	
Mixteco Only	49 (23%)	44 (27%)	5 (14%)	
Spanish + Other	49 (23%)	40 (24%)	9 (24%)	
Any English	20 (9.5%)	18 (11%)	2 (5.4%)	
Country of Birth				>.999
Mexico	184 (99%)	155 (99%)	29 (100%)	
State of Origin				.299
Michoacan	27 (15%)	21 (14%)	6 (19%)	
Oaxaca	95 (51%)	83 (54%)	12 (39%)	
Other	63 (34%)	50 (32%)	13 (42%)	
Study Outcomes				
MH Knowledge	8.89 (2.19)	8.84 (2.27)	9.07 (1.86)	.509
Stigma	.85 (0.86)	.89 (0.90)	.62 (.66)	**.031**
DV Awareness	9.83 (3.09)	9.85 (317)	9.76 (2.83)	.868
Cultural Identity	5.08 (1.15)	5.08 (1.20)	5.08 (0.94)	.998
Family Rltnsp	2.79 (1.21)	2.75 (1.22)	2.95 (1.14)	.334
Social Support	2.40 (0.62)	2.40 (0.59)	2.39 (0.75)	.962
Coping Tools	3.15 (1.49)	3.09 (1.48)	3.37 (1.55)	.295
MH Resources	0.36 (0.25)	0.36 (0.24)	0.37 (0.30)	.922
Symptoms	1.32 (2.14)	1.35 (2.19)	1.17 (1.92)	.598

Note: Rltnsp = Relationship; MH = Mental Health; DV = Domestic Violence; Percentages that do not sum to 100 are due to missing values; [1] Mean (SD); n (%); [2] Welch Two Sample t-test; Pearson's Chi-squared test; Fisher's exact test

Table 2. Baseline Characteristics of Living with Love Analytic Sample and Cohort Comparison

Characteristic	**Overall** N = 168[1]	Cohort (Group vs 1:1) **1:1** N = 39[1]	**Group** N = 129[1]	p-value[2]
		N(%); Mean(SD)		
Demographics				
Age	39 (11)	37 (10)	39 (11)	.154
Years Lived in US	16 (9)	14 (8)	16 (10)	.264
Married *or Live w Partner*	109 (65%)	15 (38%)	94 (73%)	**<.001**
Household size	6.51 (2.44)	6.23 (2.51)	6.60 (2.43)	.430
1+ years @ same address	132 (79%)	27 (69%)	105 (81%)	**.032**
Spend Part Yr in Another City	21 (13%)	4 (10%)	17 (13%)	.785
Language				.285
Spanish Only	64 (39%)	13 (33%)	51 (40%)	
Mixteco Only	44 (27%)	12 (31%)	32 (25%)	
Spanish + Other	40 (24%)	7 (18%)	33 (26%)	
Any English	18(11%)	7 (18%)	11 (9%)	
Country of Birth				.417
Mexico	155 (99%)	36 (92%)	119 (99%)	
State of Origin				.254
Michoacan	21 (14%)	2 (5%)	19 (16%)	
Oaxaca	83 (54%)	22 (56%)	61 (52%)	
Other	50 (32%)	13 (33%)	37 (32%)	
Study Outcomes				
MH Knowledge	8.84 (2.27)	8.94 (2.19)	8.82 (2.30)	.796
Stigma	.89 (0.90)	.95 (1.04)	.87 (0.85)	.12
DV Awareness	9.8 (3.2)	10.5 (2.0)	9.7 (3.4)	.071
Cultural Identity	5.08 (1.20)	4.95 (1.21)	5.12 (1.19)	.427
Family Rltnsp	2.75 (1.22)	2.65 (1.06)	2.79 (1.27)	.520
Social Support	2.40 (0.59)	2.26 (0.57)	2.44 (0.59)	.084
Coping Tools	3.09 (1.48)	2.77 (1.38)	3.19 (1.50)	.108
MH Resources	0.36 (0.24)	0.46 (0.21)	0.33 (0.24)	**.003**
Symptoms	1.35 (2.19)	2.26 (2.52)	1.08 (2.01)	**.010**

Note: Rltnsp = Relationship; MH = Mental Health; DV = Domestic Violence; Percentages that do not sum to 100 are due to missing values; [1] Mean (SD); n (%); [2] Welch Two Sample t-test; Pearson's Chi-squared test; Fisher's exact test

Table 3. Internal Consistency of Living with Love Program Outcome Variables

Outcome Variable (# items):	MH Knowledge (11)	Stigma (4)	DV Awareness (12)	Cultural Identity (6)	Family Relationships (4)	Social Support (3)	Coping Tools (5)	Symptoms (10)
Combined Sample	.76	.46	.89	.62	.82	.46	.80	.89
Group Condition	.78	.32	.91	.50	.81	.39	.80	.90
1:1 Condition	.38	.67	.75	.71	.87	.48	.82	.85

Note: Cronbach's alpha calculated based on pre-program survey responses; MH = Mental Health; DV = Domestic Violence; MH resources not included - this outcome calculated as a proportion of correct responses, calculated as a proportion of possible response options; Ref: Cronbach, L. J. (1951).

Table 4. Pre-Post Program Changes in Living with Love Program Outcomes

		Cohort (Group vs. 1:1)	
	Overall	**1:1**	**Group**
	N=168	N=39	N=129
Outcomes:			
		Mean (SD)	
MH Knowledge			
Pre	8.84 (2.27)	8.94 (2.19)	8.82 (2.30)
Post	10.13 (1.64)	10.82 (.45)	9.91 (1.81)
Effect Size	.65	1.19	.53
p-value	<.0001	<.001	<.0001
Stigma			
Pre	.89 (.90)	.95 (1.04)	.87 (.85)
Post	.68 (.86)	.44 (.68)	.75 (.89)
Effect Size	.24	.58	.13
p-value	<.05	<.01	.17
DV Awareness			
Pre	9.85 (3.17)	10.46 (1.20)	9.66 (3.43)
Post	11.25 (2.26)	11.90 (.50)	11.05 (2.53)
Effect Size	.51	1.57	.46
p-value	<.0001	<.001	<.0001
Cultural Identity			
Pre	5.08 (1.20)	4.95 (1.21)	5.13 (1.19)
Post	5.63 (.75)	5.67 (.63)	5.61 (.79)
Effect Size	.55	.75	.48
p-value	<.0001	<.001	<.0001
Family Relationships			
Pre	2.75 (1.22)	2.65 (1.06)	2.79 (1.27)
Post	3.38 (.97)	3.33 (.91)	3.39 (.99)
Effect Size	.57	.69	.53
p-value	<.0001	<.01	<.0001
Social Support			
Pre	2.40 (.59)	2.26 (.57)	2.44 (.59)
Post	2.68 (.47)	2.55 (.50)	2.71 (.46)
Effect Size	.52	.54	.52
p-value	<.0001	<.05	<.0001
Coping Tools			
Pre	3.09 (1.48)	2.77 (1.38)	3.19 (1.50)
Post	4.31 (.96)	4.49 (.65)	4.26 (1.04)
Effect Size	.98	1.59	.83
p-value	<.0001	<.0001	<.0001
MH Resources			
Pre	.36 (.24)	.46 (.21)	.33 (.24)
Post	.58 (.32)	.73 (.23)	.53 (.33)
Effect Size	.78	1.23	.69
p-value	<.0001	<.0001	<.0001
Symptoms			
Pre	1.35 (2.19)	2.26 (2.52)	1.08 (2.01)
Post	.49 (1.02)	.08 (.27)	.62 (1.13)
Effect Size	.50	1.22	.28
p-value	<.0001	<.0001	<.05

Note: MH = Mental Health; DV = Domestic Violence p-values reflect significance of paired student t-tests used to examine differences between groups; Effect sizes represent values based on Cohen's d

Table 5. Mixed Effects Regression Models Estimating Role of Demographic and Programmatic Characteristics on Living with Love Program Outcomes: Mental Health Knowledge, Stigma, and Domestic Violence Awareness

	Mental Health Knowledge (N=127)			Stigma (N=141)			Domestic Violence Awareness (N=144)		
	B	SE	p	*B*	SE	p	*B*	SE	p
Age	-.003	.018	.860	-.001	.009	.945	-.012	.025	.624
Household Size	.128	.090	.159	-.121	.044	**.007**	.013	.117	.915
Married	.101	.423	.812	.351	.206	**.091**	.563	.550	.308
Mixteco Lang. Only*	.304	.541	.577	-.056	.250	.823	-.240	.683	.726
Spanish + Indigenous Lang*	1.612	.529	**.003**	.074	.265	.780	1.415	.719	**.052**
Any English Lang*	-.017	.647	.979	-.237	.312	.460	-.013	.867	.988
Program Duration	-.163	.149	.275	-.187	.072	**.011**	.093	.210	.660
Promotora A**	-.168	.849	.843	-.175	.400	.663	.811	1.036	.435
Group Program Delivery**	-.728	.646	.271	-.024	.322	.940	.555	.892	.540
Random Effect for Group (SD)		0 (2.048)			0 (1.050)			**1.667** (2.716)	

Notes: MH = Mental Health; DV – Domestic Violence; Lang = Language; *Referent group = Spanish only;
**Referent Group = Promotora B

Table 6. Mixed Effects Regression Models Estimating Role of Demographic and Programmatic Characteristics on Living with Love Program Outcomes: Cultural Identity, Family Relationships, and Social Support

	Cultural Identity (N=143)			Family Relationships (N=144)			Social Support (N=144)		
	B	SE	p	*B*	SE	p	*B*	SE	p
Age	-.006	.010	.589	-.007	.011	.523	-.001	.006	.820
Household Size	-.014	.049	.772	-.067	.053	.207	-.004	.027	.893
Married	.111	.231	.630	.167	.249	.504	.094	.126	.457
Mixteco Lang. Only*	-.149	.283	.599	.236	.304	.440	.226	.154	.144
Spanish + Indigenous Lang*	.136	.298	.650	.341	.320	.288	.278	.162	**.089**
Any English Lang*	.301	.363	.408	.096	.390	.806	.230	.197	.246
Program Duration	.099	.080	.217	.012	.086	.892	.063	.044	.150
Promotora A**	-.242	.448	.590	-.045	.484	.927	-.138	.245	.573
Group Program Delivery**	-.230	.364	.534	-.196	.393	.623	.004	.199	.986
Random Effect for Group (SD)		0 (.375)			0 (1.283)			0 (.649)	

Notes: MH = Mental Health; DV = Domestic Violence; Lang = Language; *Referent group = Spanish only; **Referent Group= Promotora B

Table 7. Mixed Effects Regression Models Estimating Role of Demographic and Programmatic Characteristics on Living with Love Program Outcomes: Coping Tools, Mental Health Resources, and Symptoms

	Coping Tools (N=143)			Mental Health Resources (N=129)			Symptoms (N=143)		
	B	SE	p	*B*	SE	p	*B*	SE	p
Age	-.007	.014	.615	-.002	.002	.355	-.010	.020	.616
Household Size	.006	.065	.930	.014	.011	.209	-.150	.096	.124
Married	-.468	.310	.134	-.046	.051	.369	.894	.454	**.052**
Mixteco Lang. Only*	.727	.382	**.060**	-.069	.066	.296	.680	.557	.225
Spanish + Indigenous Lang*	.720	.401	**.075**	-.090	.069	.196	-.256	.584	.663
Any English Lang*	-.104	.484	.831	-.119	.084	.159	-.512	.712	.473
Program Duration	.035	.115	.760	.020	.019	.302	.024	.158	.880
Promotora A**	.630	.584	.283	.097	.097	.320	-1.611	.883	**.071**
Group Program Delivery**	-.158	.494	.751	-.021	.082	.801	.618	.718	.397
Random Effect for Group (SD)		**.363** (1.531)			**.009** (.249)			**.025** (2.336)	

Notes: MH = Mental Health; DV – Domestic Violence; Lang = Language; *Referent group = Spanish only;
**Referent Group = Promotora B

Table 8. Linear Mixed Models Estimating Association of Demographic and Programmatic Characteristics on Living with Love Program Outcomes: Mental Health Knowledge, Stigma and Domestic Violence Awareness

	Mental Health Knowledge			Stigma			Domestic Violence Awareness		
	B	SE	p	*B*	SE	p	*B*	SE	p
Age	.002	.005	.631	.004	.006	.548	.004	.005	.486
Household Size	-.012	.022	.582	.068	.026	**.010**	.022	.023	.336
Married	.026	.117	.824	.044	.140	.751	-.151	.120	.212
Mixteco Lang. Only*	.023	.141	.873	.431	.166	**.010**	.048	.146	.743
Spanish + Indigenous Lang*	-.060	.170	.724	.165	.204	.421	-.124	.176	.482
Any English Lang*	-.299	.144	**.040**	.120	.172	.488	-.202	.151	.183
Program Duration	.015	.041	.716	-.022	.049	.652	-.041	.046	.370
Time 2**	.634	.078	**<.001**	-.254	.098	**.010**	.478	.073	**<.001**
Time 3**	.627	.139	**<.001**	-.396	.176	**.026**	.591	.136	**<.001**
Group Program Delivery***	-.159	.134	.239	.093	.160	.562	-.211	.142	.140

Notes: Lang= Language; *Referent group= Spanish only; **p-value corresponds to a Type 3 F-Test of Fixed Effects; ***Referent Group= 1:1 Program Delivery

Table 9. Linear Mixed Models Estimating Association of Demographic and Programmatic Characteristics on Living with Love Program Outcomes: Cultural Identity, Family Relationships and Social Support

	Cultural Identity			Family Relationships			Social Support		
	B	SE	p	*B*	SE	p	*B*	SE	p
Age	.0001	.005	.989	.003	.006	.612	.003	.006	.622
Household Size	.009	.023	.705	-.011	.025	.667	.005	.025	.849
Married	.034	.120	.775	.038	.136	.781	.085	.131	.519
Mixteco Lang. Only*	.137	.145	.346	.224	.164	.171	.299	.157	.060
Spanish + Indigenous Lang*	-.469	.175	**.008**	-.046	.172	.790	.047	.191	.804
Any English Lang*	-.033	.151	.827	.030	.201	.881	-.176	.164	.286
Program Duration	-.094	.045	**.044**	-.006	.048	.903	.036	.048	.459
Time 2**	.480	.075	**<.001**	.936	.089	**<.0001**	.499	.085	**<.001**
Time 3**	.452	.139	**.001**	.621	.163	**<.001**	.615	.156	**.000**
Group Program Delivery***	-.104	.139	.456	.070	.154	.223	.293	.150	.053

Notes: Lang= Language; *Referent group= Spanish only; **p-value corresponds to a Type 3 F-Test of Fixed Effects; ***Referent Group= 1:1 Program Delivery

Table 10. Linear Mixed Models Estimating Association of Demographic and Programmatic Characteristics on Living with Love Program Outcomes: Coping Tools, Mental Health Resources, and Symptoms

	Coping Tools			Mental Health Resources			Symptoms		
	B	SE	p	*B*	SE	p	*B*	SE	p
Age	.002	.005	.629	-.002	.007	.728	.0003	.005	.947
Household Size	-.005	.020	.793	.017	.029	.548	.016	.019	.404
Married	-.0002	.107	.998	.157	.151	.300	-.188	.102	.068
Mixteco Lang. Only*	-.207	.131	.116	-.428	.197	**.031**	-.176	.123	.154
Spanish + Indigenous Lang*	-.074	.156	.638	.061	.232	.794	-.115	.150	.444
Any English Lang*	-.255	.134	.059	-.159	.198	.424	-.091	.127	.477
Program Duration	.055	.043	.204	.091	.066	.166	.013	.038	.738
Time 2**	.845	.090	**<.001**	.936	.089	**<.001**	-.427	.087	**<.001**
Time 3**	.035	.159	**<.001**	.621	.163	**<.001**	-.316	.154	**.041**
Group Program Delivery***	.098	.133	.461	-.781	.246	**.003**	-.081	.120	.502

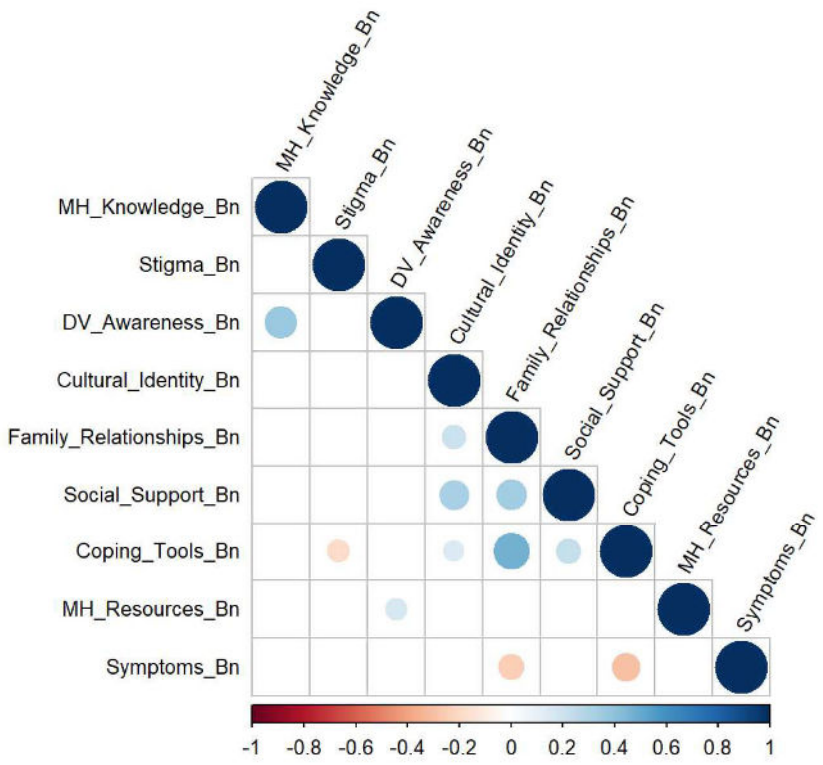
Notes: Lang= Language; *Referent group= Spanish only; **p-value corresponds to a Type 3 F-Test of Fixed Effects; ***Referent Group= 1:1 Program Delivery

Table 11. Baseline Characteristics of Living with Love Focus Group and Key Informant Interview Participants (N=75)

Characteristic	N(%); Mean(SD)
Demographics	
Age	38 (12)
Years Lived in US	15 (10)
Married *or Live w Partner*	42 (58%)
Household size	6.55 (2.65)
1+ years @ same address	58 (81%)
Spend Part Yr in Another City	7 (1.6%)
Language	
Spanish Only	26 (36%)
Mixteco Only	22 (30%)
Spanish + Other	18 (25%)
Any English	7 (9.6%)
Country of Birth	
Mexico	68 (97%)
State of Origin	
Michoacan	5 (7.2%)
Oaxaca	40 (58%)
Other	24 (35%)
Study Outcomes	
Mental Health Knowledge	8.89 (2.23)
Stigma	1.82 (0.98)
Domestic Violence Awareness	10.28 (2.63)
Cultural Identity	5.30 (0.95)
Family Relationships	2.73 (1.17)
Social Support	2.45 (0.56)
Coping Tools	2.75 (1.44)
Mental Health Resources	0.38 (0.25)
Symptoms	1.70 (2.47)

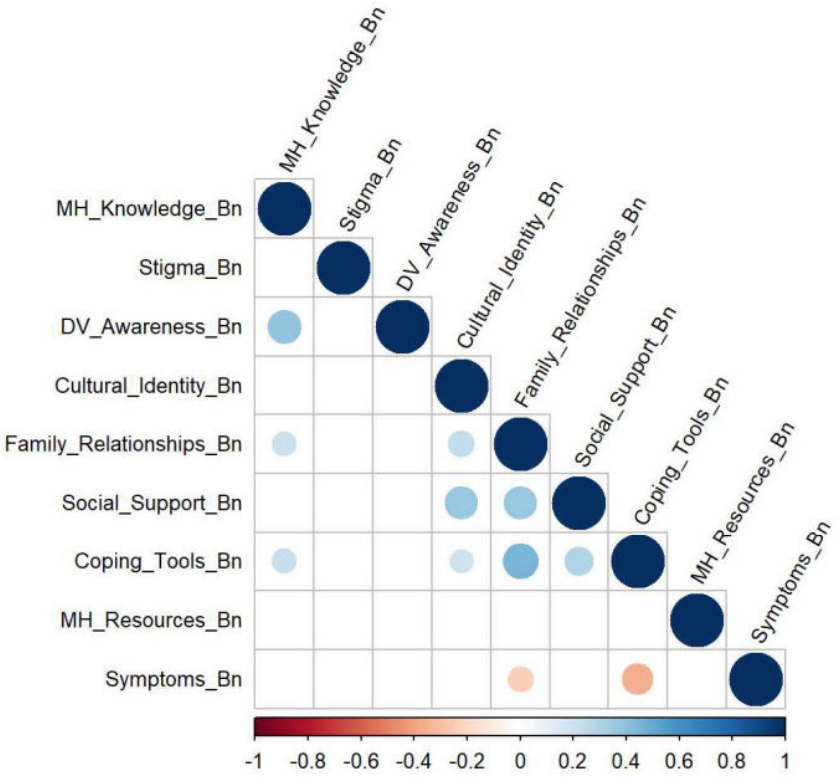
Note: Table includes 46 participants from the group cohort who took part in focus groups and 29 participants from the 1:1 cohort took part in key informant interviews

Figure 1. Correlations between Living with Love Program Outcomes at Baseline
All Participants (N=210)



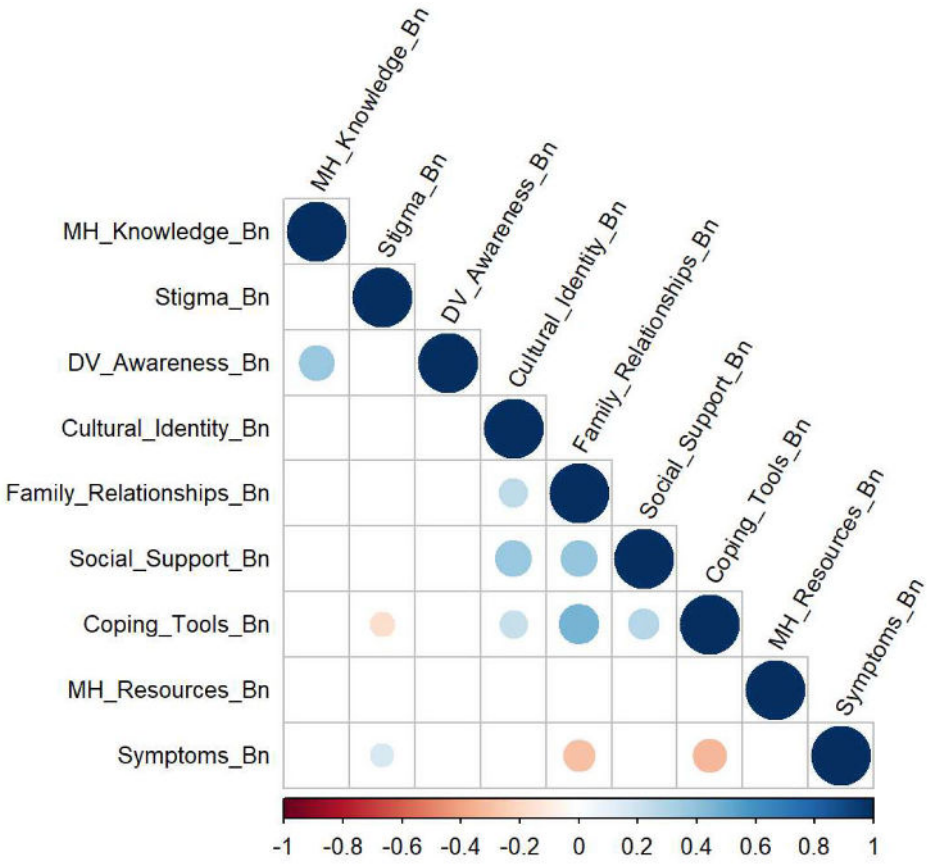
Note: Circles indicate significant Pearson correlations ($p<.05$). The size of the circle indicates degree of significance; larger circles denote greater significance, smaller circles indicate lower significance levels. Color indicates the direction of the relationship; blue circles indicate positive relationships; red circles indicate negative relationships. Bn = Baseline value

Figure 2. Correlations between Living with Love Program Outcomes at Baseline
Analytic Sample (N=168)



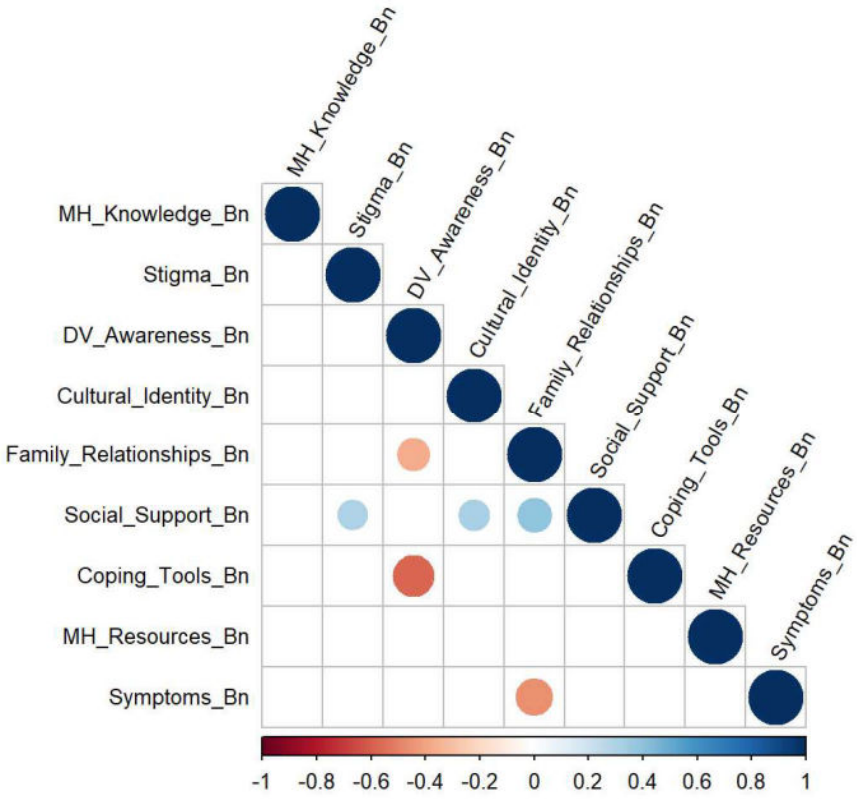
Note: Circles indicate significant Pearson correlations ($p<.05$). The size of the circle indicates degree of significance; larger circles denote greater significance, smaller circles indicate lower significance levels. Color indicates the direction of the relationship; blue circles indicate positive relationships; red circles indicate negative relationships. Bn= baseline value

Figure 3. Correlations between Living with Love Program Outcomes at Baseline Group Participants (N=129)



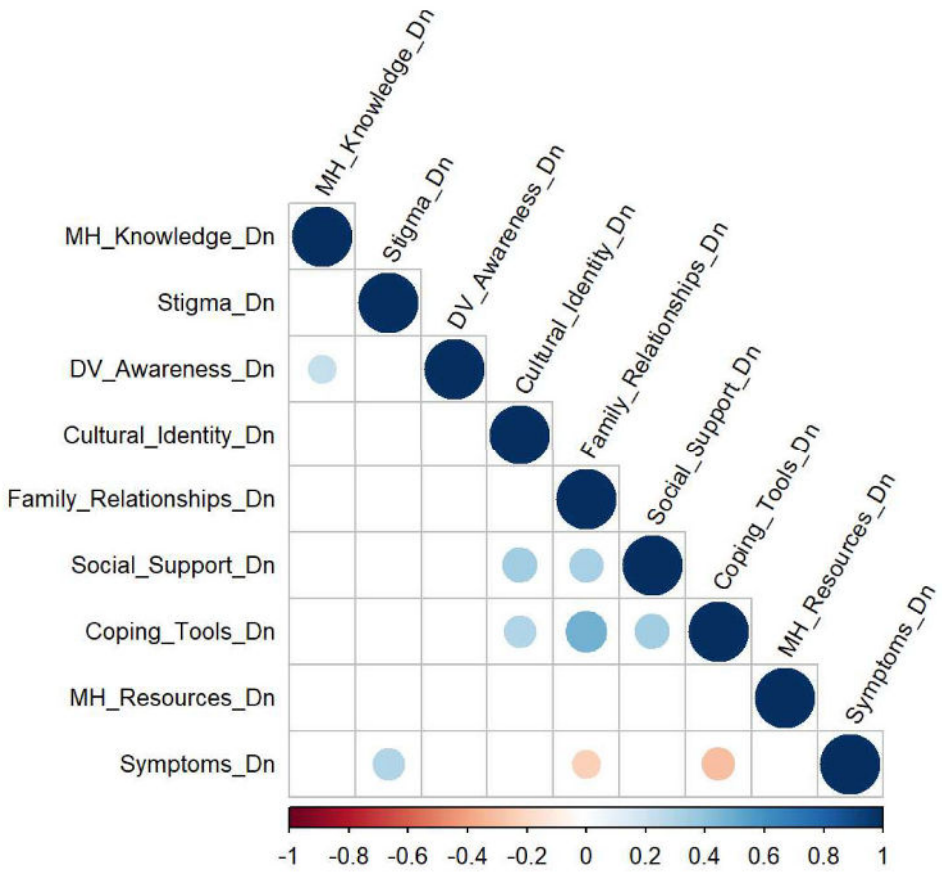
Note: Circles indicate significant Pearson correlations ($p<.05$). The size of the circle indicates degree of significance; larger circles denote greater significance, smaller circles indicate lower significance levels. Color indicates the direction of the relationship; blue circles indicate positive relationships; red circles indicate negative relationships. Bn = Baseline value

Figure 4. Correlations between Living with Love Program Outcomes at Baseline
One-on-One Participants (N=39)



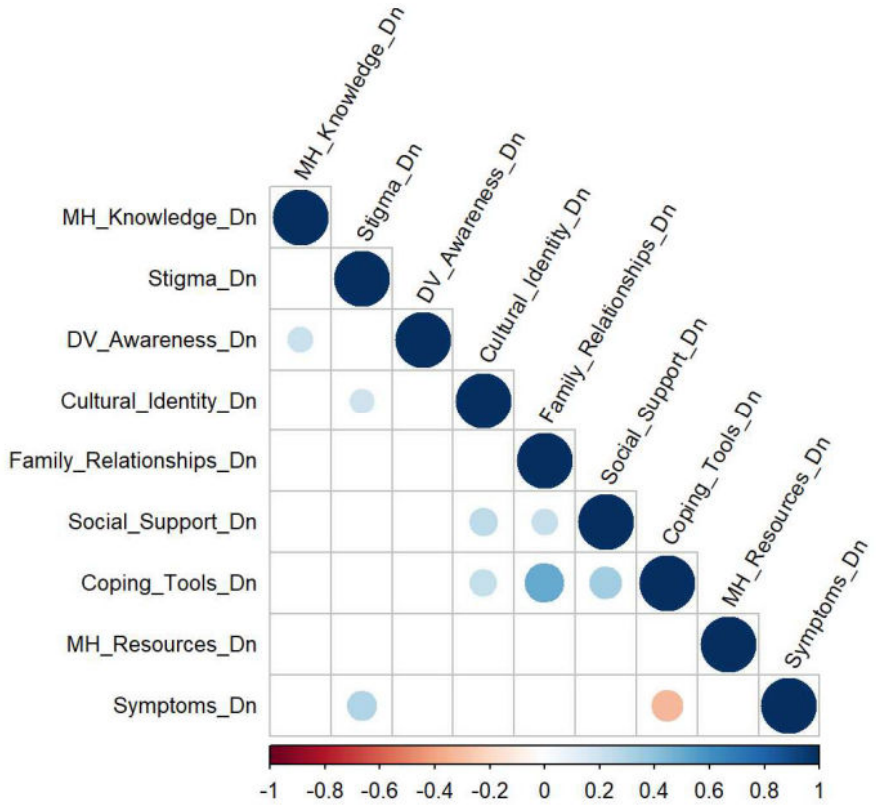
Note: Circles indicate significant Pearson correlations ($p<.05$). The size of the circle indicates degree of significance; larger circles denote greater significance, smaller circles indicate lower significance levels. Color indicates the direction of the relationship; blue circles indicate positive relationships; red circles indicate negative relationships. Bn= baseline value

Figure 5. Correlations between Pre-Post Changes in Living with Love Program Outcomes: Analytic Sample (N=168)



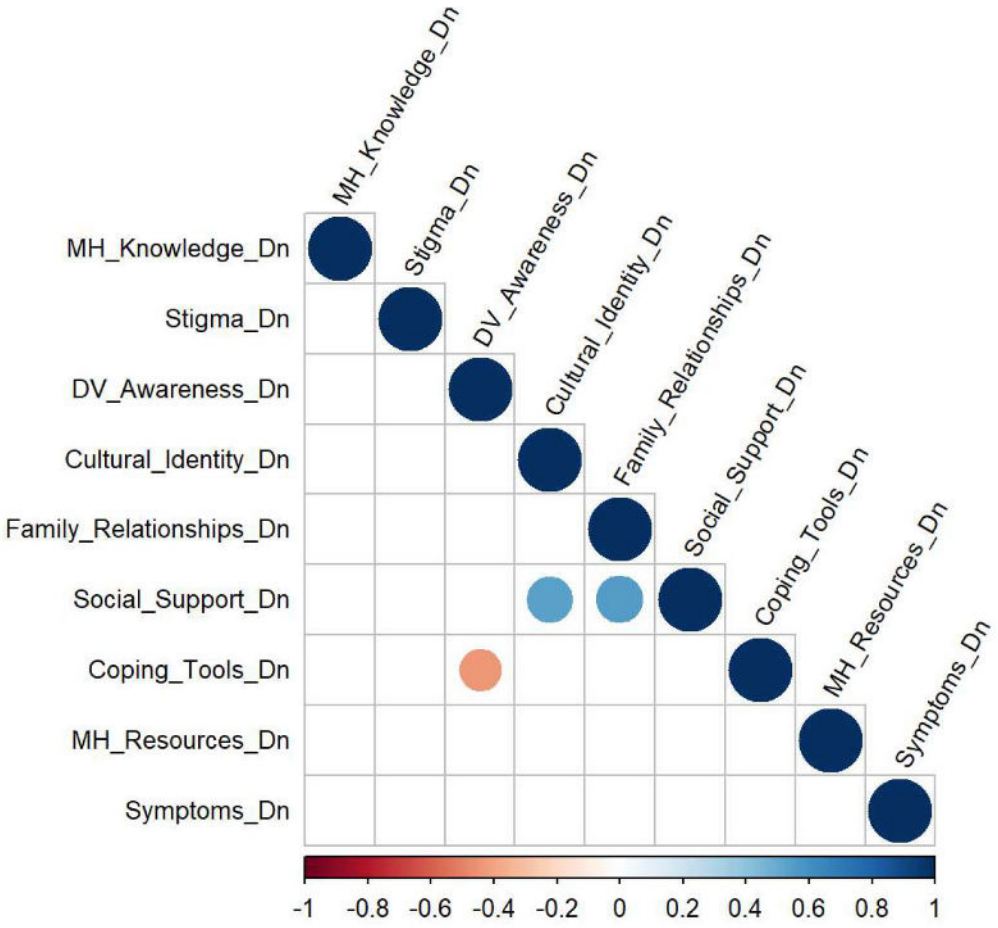
Note: Circles indicate significant Pearson correlations ($p<.05$). The size of the circle indicates degree of significance; larger circles denote greater significance, smaller circles indicate lower significance levels. Color indicates the direction of the relationship; blue circles indicate positive relationships; red circles indicate negative relationships. . Dn = Difference between baseline and follow-up.

Figure 6. Correlations between Pre-Post Changes in Living with Love Program Outcomes: Group Participants (N=39)



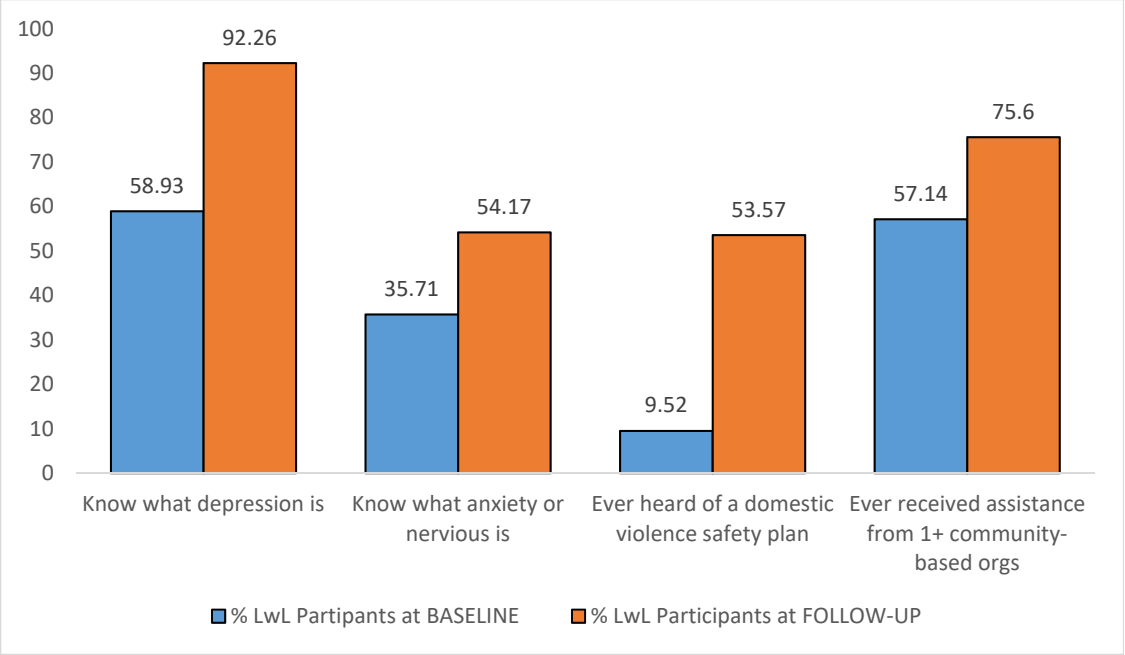
Note: Circles indicate significant Pearson correlations ($p<.05$). The size of the circle indicates degree of significance; larger circles denote greater significance, smaller circles indicate lower significance levels. Color indicates the direction of the relationship; blue circles indicate positive relationships; red circles indicate negative relationships. Dn = Difference between baseline and follow-up.

Figure 7. Correlations between Pre-Post Changes in Living with Love Program Outcomes: One-on-One Participants (N=129)



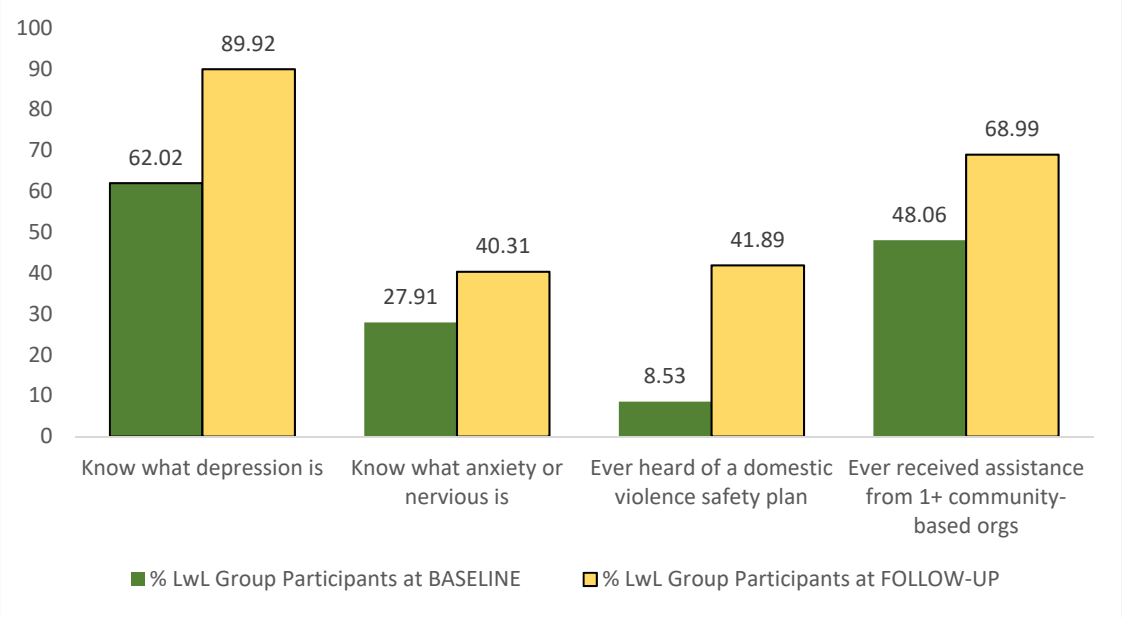
Note: Circles indicate significant Pearson correlations ($p<.05$). The size of the circle indicates degree of significance; larger circles denote greater significance, smaller circles indicate lower significance levels. Color indicates the direction of the relationship; blue circles indicate positive relationships; red circles indicate negative relationships. . Dn = Difference between baseline and follow-up.

Figure 8. Mental Health and Domestic Violence Knowledge and Community Resource Utilization among Living with Love Participants (N=168), Pre- and Post- Program



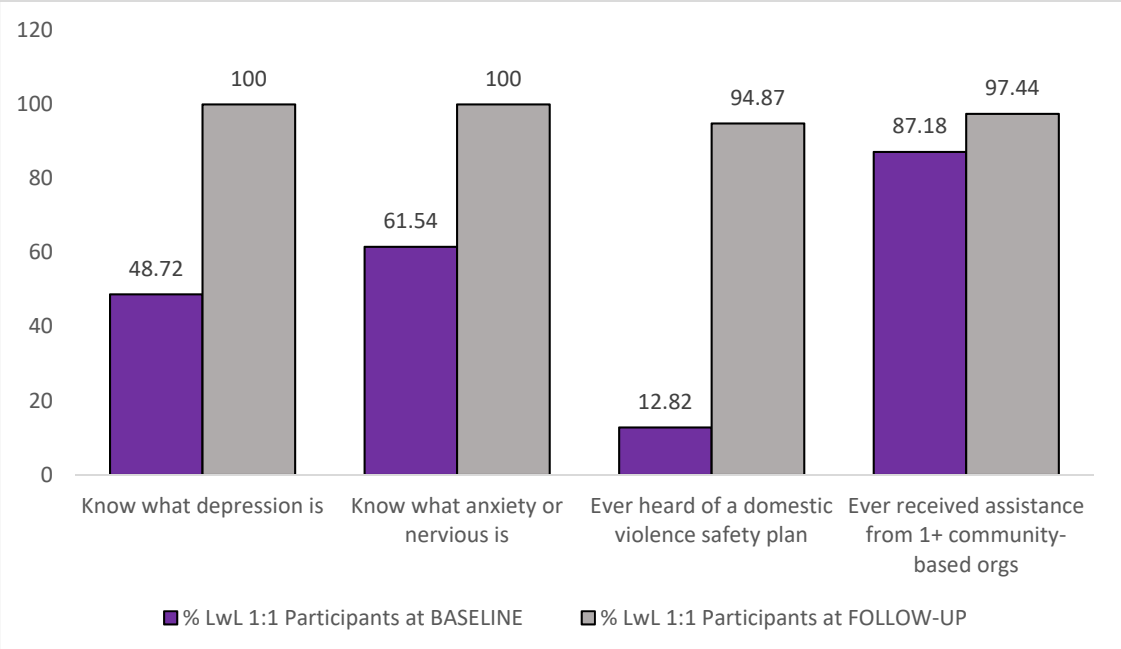
Note: McNemar's Tests used to examine changes in proportion of participants reporting yes vs. all other responses, all changes significant at the p<.001 level or greater

Figure 9. Mental Health and Domestic Violence Knowledge and Community Resource Utilization among Living with Love Small Group Participants (N=129), Pre- and Post-Program



Note: McNemar's Tests used to examine changes in proportion of participants reporting yes vs. all other participants, all changes significant at the p<.001 level or greater

Figure 10. Mental Health and Domestic Violence Knowledge and Community Resource Utilization among Living with Love One-on-One Participants (N=39), Pre- and Post- Program



Note: McNemar's Tests used to examine changes in proportion of participants reporting yes vs. all other options, all changes significant at the p<.001 level or greater

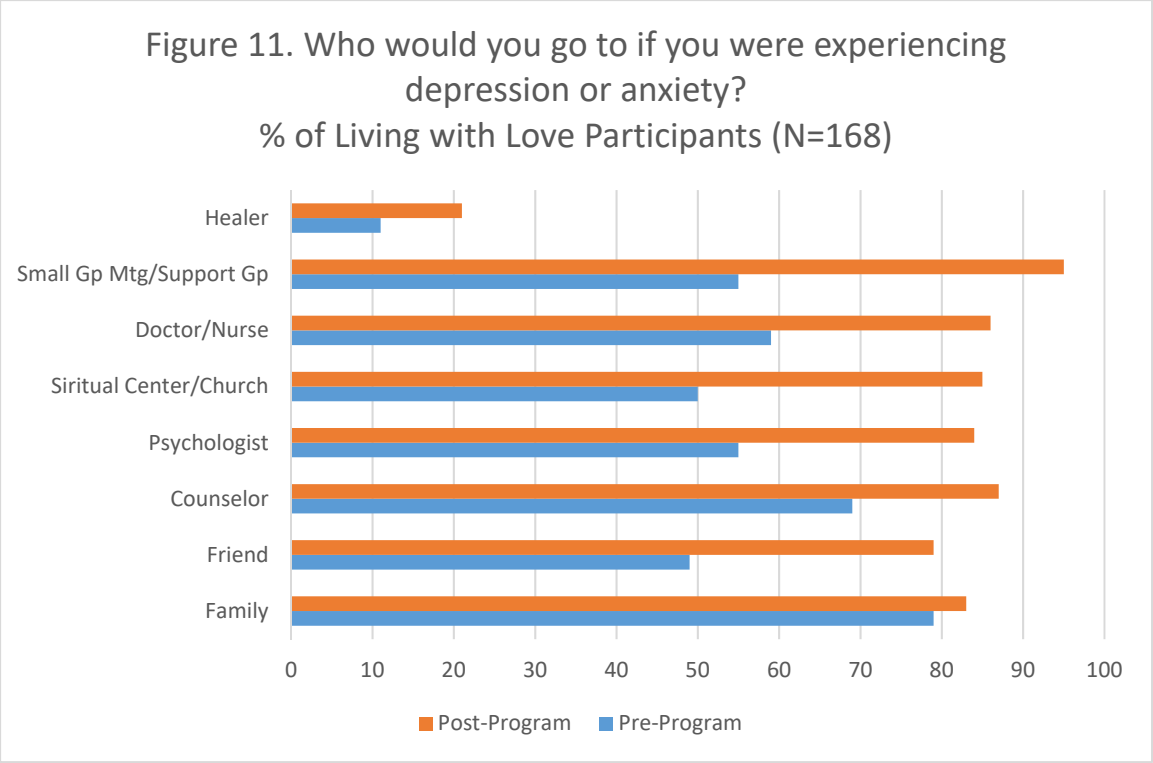


Figure 11. Who would you go to if you were experiencing depression or anxiety?
% of Living with Love Participants (N=168)
Healer
Small Gp Mtg/Support Gp
Doctor/Nurse
Siritual Center/Church
Psychologist
Counselor
Friend
Family
0
10
20
30
40
50
60
70
80
90
100
Post-Program
Pre-Program