LOCAL EVALUATION REPORT

FOR COMMUNITY DEFINED EVIDENCE PRACTICES

Title:

Latino-Based Therapies in California's San Joaquin Valley:

The Relation of *Pláticas* and *Atención Plena* to Academic Success

Grant Period:

May 1, 2022 – September 30, 2025

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Funded by:

California Department of Public Health, Office of Health Equity

Acknowledgements to:

The California Reducing Disparities Project Phase II

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Executive Summary

This Local Evaluation Report (LER) focuses on the effect of ICSI's two (2) cornerstone Community Defined Evidence Practices (CDEPs), *pláticas* and *atención plena*, on the health and educational outcomes of youth. *Pláticas* is a traditional Latino therapeutic practice that is grounded in the Latino Indigenous wisdom tradition and goes back thousands of years. As a therapeutic practice it has been in the Latino community since at least the 1970s. *Pláticas* translates to cultural conversations and is a form of transmitting knowledge regarding well-being, mental wellness, psychological, and healing *trastornos* (emotional imbalances). *Pláticas* also considers the cultural and linguistic needs of the Latino community and provides a format that facilitates the psycho-emotional healing possible. *Atención plena* translates to *mindfulness*. It is the practice of cultural meditation for the purpose of concentration. ICSI therapists use *atención plena* as a progressive relaxation technique and guided meditation in periods of 5 to 15 minutes to prepare participants to academic readiness. The practice of *atención plena* has been in the Latino community for about 10 to 15 years, but has not become mainstream to addressing psychological trauma and/or academic success. *Pláticas* and *atención plena* are practices in our CDEP with youth, particularly Latinx youth, who have a long history of mental health challenges that affect their success in school and life. Our CDEP attempts to provide youth with an approach and framework to mental health that is culturally relevant and client centered, and to disrupt the school to prison pipeline that our youth are destined to travel when they lack proper and appropriate mental health support. Our two (2) CDEPs have been formalized into a 12-session curriculum called the *Bienestar Wellness Program ("Bienestar Curriculum").*

The research question that guided our work was: *How are youth having positive responses to Latino-based prevention/intervention (i.e., pláticas and atención plena) mental health approaches, particularly the Bienestar Curriculum?* Over the last three (3) years and five (5) months, we have collected data on the effectiveness of our Bienestar Curriculum, and this LER will show the results of this data. We collected 128 pre and 142 post surveys. All our data was collected to answer our research question, measure our CDEP's (and the Bienestar curriculum) effectiveness, and learn how we can improve our CDEP. Ultimately, our goal is to increase access to our CDEPs, offer them in more schools and community settings, train others how to deploy them, stabilize and improve the lives of youth, and increase school success for youth. The overarching goal is to transform a school-to-prison pipeline into a school-to-college pipeline.

An overview of our results from our State-Wide Evaluation (SWE) Survey (pre n = 128, post n = 142) showed that youth:

- improved in their connection to their culture as a source as strength and for purposes of mental wellness. Youth showed growth in 4 of 4 items (growth from +0.20 to +0.16 on a 5-point scale).

- improved when asked about protective factors in the last 30 days. Youth showed improvement in 4 of 4 items (growth from +0.31 to +0.19 on a 5-point scale).

- improved when asked about psychological distress in the last 30 days. Youth showed improvement in 6 of 6 items (growth from +0.62 to +0.34 on a 5-point scale). In these items, regression equated to growth because their numbers going down equated to them feeling less psychological stress (see Table 5 for details)

- improved when asked about their overall health in the past 30 days in the numbers of days that did not have good health, and the numbers of youth that did not have good health (see Table 6 for details)

Our data clearly shows the effectiveness of our CDEPs directly, and our disruption of the school-to-prison pipelines indirectly. Undoubtedly, the effectiveness of our CDEPs, and our Bienestar Curriculum, was due to its grounding in Latino culture and historical cultural practices that facilitated students connecting with our counselors and our CDEPs. Our CDEPs were also effective because they are asset-based and rather than focusing on what students cannot do, it focuses on what they can do. Our CDEPs are youth-centered and grounded in affirming youth, their families, and their communities to uplift their confidence, self-efficacy, and improve their condition. Our CDEPs were effectively in destigmatizing perceptions of mental health in the Latino community. Despite our success, we believe there are things we can do to improve the delivery of our CDEP (and Bienestar Curriculum) through better engagement with parents, teachers, and school staff and administrators, and training more therapists on our CDEPs; and we will continue improving on our successes and strengthening our weaknesses.

Introduction/Literature Review

Latinas/os, from recent immigrants to established Americans, have been known to experience issues of mental illness for decades.[1] Along with these mental health issues, Latina/o communities also lack access to mental health services.[2] The prevalence of mental health issues and lack of services to address them, is as prevalent in Fresno County's Latina/o communities as it is nationally.[3] For these reasons, our study focuses on Latina/o communities in Fresno County.

Additionally, Vega et al. (2001) found that it is native-born Mexican Americans that have higher rates of mental and psychiatric disorders than their foreign-born counterparts: (a) Mexican immigrants had about ½ the prevalence rates of major psychiatric disorders of either native-born Mexican American and White American counterparts, and (b) native-born Mexican Americans have approximately the same rates (49%) of mental disorders as the U.S. population. These results clearly show that the longer Mexican Americans live in the U.S., the more likely they are to develop mental disorders, largely due to the deeper understandings of dissonance that Latinas/os experience psychologically, socially, culturally, and economically. In a region like Fresno County with large populations of both established urban and rural Latinas/os, it is important to provide services to both: (a) urban services where Latinas/os clearly have higher rates of mental disorders, and (b) rural services where Latinas/os clearly have less mental disorders than their urban counterparts, but significantly less access to services.[4]

With this data in mind, our Community Defined Evidence Practices (CDEPs)[5] sought to address mental health for youth. All the issues that Latinx youth confront in society, youth confront in schools -lack of belonging, poverty, lack of health care, and school absenteeism and failure. And it is these issues that facilitate the school-to-prison pipeline which our CDEP aims to disrupt.

Disrupting the school-to-prison pipeline, in many ways, is the essence of out CDEP, and our ability to document this was through implementation of our two (2) cornerstone CDEPs, *pláticas* and *atención plena*, on the health and educational outcomes of Latinx youth primarily, but other students of color as well. Our data, collected in Fresno County, shows that our approaches do

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[1] Source: Escobar, J. I., Nervi, C. H., & Gara, M. A. (2000). Immigration and mental health: Mexican Americans in the United States. *Harvard Review of Psychiatry, 8*(2), 64-72.

[2] Sources: Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(3), 316-330; Vega, W. A., Kolody, B., & Aguilar-Gaxiola, S. (2001). Help seeking for mental health problems among Mexican Americans. *Journal of immigrant health*, *3*(3), 133-140.

[3] Source: Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., & Caraveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry*, *55*(9), 771-778.

[4] See Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., & Catalano, R. (1999). Gaps in service utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry, 156*(6), 928-934.

[5] See Aguilar-Gaxiola, S., Loera, G., Mendez, L., & Sala, M. (2012). *Community-defined solutions for Latino mental health care disparities: California reducing disparities project*. Sacramento CA: Latino Strategic Planning Workbook Population Report, UC Davis.

work to improving mental health outcomes. From 2021 to 2025, we collected quantitative data as we deployed our programs and therapies, particularly our Bienestar Curriculum, and this LER will provide evidence over this time period. Our quantitative data was collected through our State-Wide Evaluators (SWE) survey, which also showed positive outcomes, and which we will display.

Our two CDEPs, *pláticas* and *atención plena*, are the treatment approaches that are key to our analysis and measurements. *Pláticas*, as a practice, is grounded in the Latino Indigenous wisdom tradition that goes back thousands of years. It is a form to transmit knowledge regarding well-being, mental wellness, psychological, and healing *trastornos* (emotional imbalances), and related themes addressed through familiar cultural formats such as *canciones* (songs), *dichos* (sayings), *cuentos* (stories), and *poesía* (poetry). A popular method of using *plática* in counseling/therapy is through the use of a group process format, *círculo*.[6] *Círculo* is a broad-based counseling approach where participants commune in a structured dialogue in a circle, to explore identity, unload "cargas," and to learn, share, grow, heal, and cure.[7] This method engages participants in deep reflection about their lives and issues in their lives, to identify and address the whole person-body, mind and spirit. *Pláticas* also considers the cultural and linguistic needs of the Latino community and provides a format that facilitates the psycho-emotional healing possible. The leaders who are guiding the *plática* also engage in evidenced-based group therapy methods and techniques such as: active-listening, reflecting, clarifying, summarizing, facilitating, empathizing, interpreting, questioning, linking, confronting, supporting, blocking, assessing, modeling, suggesting, initiating, evaluating, and terminating.[8]

Our *pláticas* approach has been in practice in the Latino community since at least the 1970s. Aguilar (1970) and Aguilar and Wood (1976) were among the first research practitioners to use *pláticas*, without specifically calling them *pláticas* but technically using a multicultural therapeutic approach.[9] Aguilar was an innovator and used his knowledge as a Mexican immigrant to gain key insights into the Latino psychology and need, and devised multiple therapeutic strategies to address their needs.[10] But little research has been done on *pláticas* -it is a traditional Latino therapeutic practice not a research topic. According to researchers Ortiz and

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[6] See Tello, J., Cervantes, R. C., Cordova, D., Santos, S. M. (2010). Joven noble: Evaluation of a culturally focused youth development program. *Journal of Community Psychology, 38*(6), 799-811.
[7] LivingJusticePress.org. (2016). The indigenous origins of circles and how non-natives learned about them. Retrieved from: livingjusticepress.org.
[8] Source: Corey, G., Corey, M.S., Corey, C., Muratori, M. (2014). *Groups: Process and practice* (9th ed.). Monterey, CA: Brooks/Cole Cengage Learning.
[9] See Aguilar, I. (1972). Initial contacts with Mexican-American families. *Social Work*, *17*(3), 66-70; Aguilar. I., & Wood, V. N. (1976). Therapy through a death ritual. *Social Work, 21*(1), 49-54.
[10] See Garcia, J. (1985). *Madness, therapy, and politics: A Psychosocial study of Hispanic adaptation in a state mental hospital*. PhD Dissertation, Stanford University. UMI Dissertation Information Service.

Torres (2007)[11] and Mohr-Almeida (2009),[12] *pláticas* originated from Mesoamerican *curanderismo*, which is native to Aztec, Mayan, and Spanish cultures in Mexico, and has existed for centuries there as a form of healing. Its main contours are described Roman (2012),[13] in which she describes the conceptual bases for dis-ease, *los aires*. It has only been in the last 10 years where researchers have begun using *pláticas* as a topic of research in mental health.[14]

Atención plena is loosely the Spanish translation of the English term, "mindfulness." Which Kabat-Zinn[15] defined as, "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment." ICSI uses *atención plena*, progressive relaxation technique and guided meditation in periods of 5, 10, or 15 minutes to prepare participants to learn and practice centering meditation (*meditación centrante*), which consists of a period of 20 minutes. It does not all happen at once, but may be considered as steps toward acquiring the practice of *meditación centrante*[16] as part of an attitude towards life, work, and meaning. *Atención plena* has not been evaluated and assessed in the Latino community with recent immigrants, people with farmworker backgrounds as well as urban and rural Latinos.[17] The practice of *atención plena* has been introduced into the Latino community in the last 10 years, but has not become mainstream. Mindfulness has been incorporated into the treatment of psychological trauma and evaluated for treating victims of trauma, but *atención plena* has not been evaluated. *Atención plena* has been used by therapists in a culturally, linguistically, and contextually appropriate manner by ICSI when serving adolescent and family victims of trauma, but has not been empirically evaluated as to its effectiveness. ICSI blends the best of the old traditional psychotherapy, "mindfulness" (*atención plena*) and the new (ACT and DBT) together in terms of combining the culturally-defined evidence practices with the latest research in integral psychotherapy[18] which honors these practices and holds them within a context of mainstream psychotherapy. *Atención plena*, and closely related integral

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[11] See Ortiz, I. E., & Torres, E. C. (2007). Curanderismo and the treatment of alcoholism: Findings from a focus group of Mexican curanderos. *Alcoholism Treatment Quarterly*, *25*(4), 79-90.

[12] See Mohr-Almeida, K. (2009). *An Integration of American Nontraditional and Mesoamerican Traditional Approaches as a Treatment Model for Traumatic Stress and Post-Traumatic Stress Disorder (PTSD)*. Unpublished doctoral dissertation, Union Institute and University, Cincinnati, OH.

[13] Source: Román, E. (2012). *Nuestra medicina: De los remedios para el aire y los remedios para el alma.* Bloomington, IN: Palibrio.

[14] See Piazza, J., & DelValle, C. M. (1992). Community-based family therapy training: An example of work with poor and minority families. *Journal of Strategic and Systemic Therapies*, *11*(2), 53-69; Hendrickson, B. (2014). 5. Mexican American Healing and the American Spiritual Marketplace. In *Border Medicine* (pp. 113-139). New York University Press; and Comas-Díaz, L. (2016). Mujerista psychospirituality. In T. Bryant-Davis & L. Comas-Díaz (Eds.), *Womanist and mujerista psychologies: Voices of fire, acts of courage* (pp. 149–169). American Psychological Association. https://doi.org/10.1037/14937-007.

[15] Source: Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: past, present, and future. Clinical Psychology: Science and Practice, 10(2), 144-156.

[16] *Meditación centrante* is the Spanish translation of Centering meditation.

[17] See Himelstein, S. (2013). *A mindfulness-based approach to working with high-risk adolescents.* New York: Routledge.

[18] See Forman, M. D. (2010). *A guide to integral psychotherapy: Complexity, integration, and spirituality in practice*. Albany: State University of New York.

cultural approaches, are needed in the Latino community to address Latinos' exposure to traumatic events that are impacting their personal, school and community life. Latino students suffering from depression and having suicidal thoughts, are worried about their present situation, concerned about their parents, experiencing poverty, discrimination, and lack of resources. They are angry and concerned that they have no outlets other than alcohol and drug use, abuse and violence within their families and neighborhoods, and are unable to imagine solutions to oppressive schooling tactics which too often lead directly to the school-to-prison pipeline. *Platicás* and *atención plena* will meet Latino youths' needs, their families, and eventually the overall Latino community.

According to ICSI founder, Dr. Juan C. Garcia, *atención plena* is a practice in the field of contemplative religion, but not necessarily commonly embraced by all Christian denominations, especially the Catholic, yet it is deeply embedded in ancient Christian practices. He states that it is "defined as a sense of mental fullness; however, as we understand it, practice it, and disseminate it, it is [a] sense of emptying, not as pessimistic empty glass, but as a fullness…." *Atención plena,* or "mindfulness" in English, has become mainstream with many of the approaches to psychological trauma in recent psychological and counseling applications to treating victims of trauma. A popular method of using *atención plena* in counseling/therapy is using *Oración Centrante*, which essentially means centering prayer in English. Centering prayer is also popular in meditation and some Christian religious circles. According to Contemplative Outreach (2016),[19] a spiritual network of over 40,000 people, centering prayer is a method of prayer that prepares individuals to receive God's presence, and emphasizes prayer as a method to having a personal and deep relationship with God. Everardo Pedraza, an ICSI educator/therapist, and founder of the Mindfulness Club at Sunnyside High School in Fresno, has ingeniously secularized Centering Prayer and introduced it as Centering Meditation or *Meditación Centrante*. In Pedraza and Rodríguez (2018),[20] the authors describe youth experiencing *atención plena* as finding their voice to transform a school narrative from a "we are not dirt" narrative to a "we are human" and personal agency narrative, "remaining poised and calm through daily mindfulness practice and small-group processing of their thoughts and feelings… they cultivated a healthy relationship to power and began their project..[with] their personal and collective vision and sense of purpose." Within this practice there is a healing component described in Thomas Keating's book, *Intimacy with God*, which incorporates a process of *unloading* and *evacuation* of painful memories and intrusive traumatic symptoms interfering with daily life functioning. *Oración centrante* is used in ICSI during *atención plena* session because its western Christian origin resonates best with the Latino population, and of its incorporation of elements of Indigenous knowledge, ceremony, and ritual, and other cultural elements or components

[19] Source: Contemplative outreach. (2016). *Centering prayer*. Available: http://www.contemplativeoutreach.org/category/category/centering-prayer

[20] Source: Pedraza, E., & Rodriguez, R. J. (2018). "We are not dirt": Freirean counternarratives and rhetorical literacies for student voice in schooling. *English Journal*, *107*(6), 75-81.

facilitative in providing culturally consonant therapeutic services.

The delivery of our CDEPs, is now delivered in a more formal and systematic way, through our Bienestar curriculum. This curriculum was developed to allow many therapists to be able to deliver our CDEPs in a similar and systematic way. The Bienestar curriculum focuses on reducing symptoms associated with anxiety and depression amongst Latino youth, but also addresses other components of mental wellness and also with non-Latino youth. Topics associated with the Bienestar Curriculum include trauma, ACEs mitigation, mindfulness, anger management, anxiety, depression, relationships, grief and loss, emotional intelligence, and self-compassion.

CDEP Purpose, Description, and Implementation

CDEP Purpose

The purpose of this Local Evaluation Report (LER) is to highlight our evidence on the effectiveness of our signature therapeutic approaches, *pláticas* and *atención plena*, delivered through our Bienestar Curriculum. In the deployment of our approaches, we aim to disrupt the school-to-prison pipeline directly. Youth in prison often share various characteristics -they are school dropouts and lack mental health wellness. Our CDEP's focus on deploying therapeutic approaches that increase mental health wellness, and in turn positively affect youth's lives. Our evidence shows that our purpose was met over the last three (3) years and five (5) months in which we have deployed our CDEP with at-risk youth through our Bienestar Curriculum.

CDEP Description and Implementation Process

Our description and implementation are very similar for *pláticas* and *atención plena* because they are delivered systematically within our Bienestar Curriculum. For all students going through our Bienestar Curriculum, once they are deemed to need mental health services, their parents are contacted to inform them of their child's need, obtain parental consent, and obtain student background and information about the issues. Parents are also given strategies and feedback to help support students. In all contact with parents, our therapists respect and value their language and cultural backgrounds, and often communicate with parents in Spanish. The core of our students going through our Bienestar Curriculum are high school students. Their participation is voluntary. Students complete the SWE pre-survey at the beginning of the semester, and again at the end they complete the post-survey. Our curriculum is also a way to positively affect student mental wellness, keep them connected to the school, and support their school academic and social journeys.

In our fidelity assessment of our CDEP we go into greater details as to the CDEP dosage/intervention, but in a typical semester students are likely to get 40 hours of dosage per

semester. The 40-hour dosage is for CDEP delivery through our Bienestar Curriculum, but also for one-on-one youth mentoring and support.

It is also important to note that in the delivery of our Bienestar Curriculum we rely on Indigenous knowledge and traditions of oral storytelling. The *cuentos* we use originally derived from Ignacio Aguilar's innovative Latino mental health interventions. The *cuentos* he used were from the classic anthropological work by Walter Miller, *Cuentos Mixes.*[21] Other sources included the work of Clarissa Pinkola Estes (1992), author of *Woman Who Runs with the Wolves*.[22] Other sources of stories were the students themselves, some of which were from their own parents, grandparents, and traditions, such as *la llorona*. In the Latino community we call this storytelling tradition *dichos.*[23] These *dichos* are always packed with mental health knowledge, social emotional support, and cultural lessons from our ancestors that promote mental health healing.

Local Evaluation Question

Our work was guided by the following local evaluation question: *How are youth having positive responses to Latino-based prevention/intervention (i.e., pláticas and atención plena) mental health approaches, particularly the Bienestar Curriculum?*

Our mental health approaches work in the Latinx community because they are culturally relevant and culturally appropriate. They are also delivered by Latinx therapists/counselors who know the culture, have the same background as many of the students we serve, and often deliver our approaches in English and/or Spanish. For measuring the effectiveness of our Bienestar Curriculum, we relied mostly on quantitative data. Our delivery occurred mostly at a traditional high school with a majority minority student population, primarily Latino. All SWE data was collected from our highly successful and ever-growing high school program.

Evaluation Design and Methods

Design

Our evaluation used quantitative methods to answer the research question.[24] We began with the collection of pre-quantitative data to establish initial benchmark measurements, and ended with

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[21] Miller, W. (1956). *Cuentos mixes.* Mexico: Instituto Nacional Indigena: Biblioteca de Folklore Indigena.

[22] Estes, C. P. (1992). *Women who run with the wolves: Myths and stories of the wild woman archetype.* New York: Ballentine Books.

[23] *Dichos* is the Spanish translation of *sayings* or *proverbs*.

[24] Our design was approved by two (2) Institutional Review Boards (IRBs). It was first approved by the IRB board at California State University, Fresno, and then again by the IRB board at the California State Department of Public Health, Office of Health Equity.

post-quantitative data collection. The survey tools and protocols we implemented in this evaluation were shared with us by the State-Wide Evaluators (SWE) team.

We collected 128 pre and 142 post surveys for the SWE team.[25] These measures helped us to document mental health improvement over time. The school site from which we collected data (a traditional high school) agreed to share all the relevant school data that we needed, as well as give us access to the youth receiving the treatment for conducting surveys. Pre data was often collected at the beginning of the semester, and post data at the end of the semester.

Sampling Methods and Size

To collect our evidence, we used quantitative sampling methods, namely the SWE survey. We collected 128 pre and 142 post surveys. The average age from the 69 people that reported an age was 18.0 years. Five (5) people reported having had spent time detained in an ICE facility. The average time living in the United States by the 97 that reported on this was 16.9 years. In terms of race/ethnicity, of the 113 that reported this, 64.6% were Latino, 15.9% were Asian/Pacific Islander, 6.2% Black/African American, 4.4% American Indian/Alaskan Native, 4.4% Multi-Racial, and 4.4% White. The following (Table 1) shows the remaining demographic variables of the participants.

Table 1. Demographics of Participants, By Preferred Language, Birth Place, and Gender, By Number Reporting and Percent

	N	English	Spanish	Eng/Spa	Hmong
Preferred Language:	105	82.8%	11.4%	4.8%	1%
	N	**Born U.S.**	**Born Outside U.S.**	**Don't Know/ Refuse to Say**	
Birth Place:	128	87.5%	3.1%	9.4%	
	N	**Male**	**Female**	**Other**	
Gender:	114	53.5%	45.6%	0.9%	

The purpose of the survey was to capture mental health and wellness amongst high school youth. For all the data collected, youth participation was voluntary, and no one that wanted to participate was excluded. Participants were mostly recruited from other students, and largely grounded on youth that participated in the Mindfulness Club. The Mindfulness Club was the way in which young people were introduced to our Bienestar Curriculum.

Measures and Data Collection Procedures

[25] The State-Wide Evaluators (SWE) data collection was administered and required by our statewide evaluators, based out of Loyola Marymount University. All 25 sites in the State of California doing this mental health work in communities of color were required to collect SWE data.

To collect our evidence, we used the SWE survey. The purpose of the SWE survey is to assess mental health (protective factors, access/utilization, and psychological distress/functioning) and CDEP quality of delivery. The State-Wide Evaluation (SWE) survey data, both pre (at the beginning of the semester) and post (at the end of the semester) were deployed. This was a paper/pencil survey, and we collected this data at the beginning and end of select school semesters. This data was collected by the lead counselors we had at the site, and students were rewarded with pizza and drinks for completing the pre and post SWE surveys. We also had ICSI local evaluator assist with this data collection. For example, if there were errors or missing data, ICSI local evaluator would work with the counselor and the youth to correct the errors prior to sending the data to the SWE evaluators. We deployed the pre and post adolescent versions of the survey, meant for youth 12 to 17 years of age. The pre survey consisted of 34 items. The post consisted of 29 items. In total, we collected 128 pre and 142 post surveys.

Fidelity and Flexibility

The fidelity of our CDEP was traditional in the sense that it was delivered in a controlled setting where participants and dosage (4o hours) are constant. Participation was optional, and the intervention (i.e., dosage) was delivered through our Bienestar Curriculum. Additionally, because our Bienestar Curriculum is delivered in a controlled school setting, the student population consist of primarily, but not exclusively, Latinos students. It is important to note that among the non-Latino students, from the school site where our Bienestar Curriculum was administered, many were members of underserved populations (primarily Southeast Asian Hmong) and benefited from our curriculum. What makes this unique to our CDEP delivery is that when adapted to serve youth from other ethnic backgrounds, it remained effective. However, this may have complicated our fidelity assessment. The following is our attempt to explain the fidelity and flexibility aspects of a CDEP delivered in a controlled setting, with mostly Latino students.

Adherence

For the last three (3) years, we delivered our CDEPs through our Bienestar Curriculum as designed to serve a specific Latino youth population (a convenience sample). One major upgrade from our original design was that our CDEPs used to be delivered in various types of school, in non-controlled settings, and with varying amounts of dosage split between *pláticas* and *atención plena* CDEPs. Now, *pláticas* and *atención plena* CDEPs are infused into every session of our 12-session *Bienestar Curriculum*, with a stable 40-hour dosage, in a controlled setting. ICSI's skilled therapists infuse *pláticas* to *atención plena* in all sessions of our curriculum.

Exposure

High school students from a traditional predominantly-Latino high school were exposed to our Bienestar Curriculum. For our Latino-dominant sample, we were successful in delivering a student-centered culturally/linguistically-grounded curriculum. At the high school, dosage was approximately 40 hours per semester. ICSI considers this amount adequate in ideal conditions where students were not absent or missing for whatever reason. To ensure that the delivery of the intervention is as uniform as possible regardless of the differences in student race/ethnicity, student attendance and reflection on the intervention was monitored. However, attendance and reflection do not necessarily mean the intervention was effective, and more support strategies are needed to achieve stronger fidelity.

Quality of Delivery

ICSI's therapists are master's level professionals with Marriage and Family Therapy (MFT) degrees. These therapists continually participate in professional development at ICSI under the guidance of ICSI's Executive Director in delivering services that are culturally and linguistically appropriate to Latinos in Fresno County. In the same way, quality assurance or improvement strategies, such as ongoing monitoring and feedback to those delivering the CDEP to the intended population, ensures that the Bienestar Curriculum is administered as designed and intended. At a training level, ICSI is recognized by Fresno State as a placement site for pre-masters counseling university students and keeping the quality of delivery current and relevant to the youth being served.

The quality of our CDEP delivery is largely based on youth participation, responsiveness, and willingness to receive the intervention. It should be noted that our youth participants have responded positively to the Bienestar Curriculum. Our CDEP is grounded in the Cultural Wealth Model (CWM) increasing the relevance of our work to our youth participants. For example, when aligning storytelling and hip-hop therapy sessions with CWM, youth participants relate and comply with their treatment plan including modifying behaviors and fulfilling requirements to have school/family academic/social success. Also, the connection between students and our therapists has empowered our youth and put them on a well-being path toward rediscovering, rebuilding, and reconnecting with their lived experiences. So, sharing their stories and their reflections, and ultimately their actions linked to academic achievement is youth responsiveness.

Finally, our program was delivered in as uniform way as possible through our Bienestar Curriculum. Through the delivery of the curriculum, therapists utilized their strengths for optimal delivery, such as hip-hop therapy, storytelling, writing, poetry, rap, short stories, memes, recording, and music performance as sources of therapy. And as we expand, we will continue to deliver the Bienestar Curriculum, with changes in the pedagogical delivery, based on the needs of the clients/students receiving the treatment and the individual strengths of our therapists.

Data Analyses Plan Implemented

For the data analysis of the SWE Survey data, we first calculated means for all items, pre and post, and then rank ordered items from highest growth to lower growth within a particular topic. With all the quantitative data that utilized a pre and post, we used a + and - system to show if there was growth (+) or decline (-) in each of the items we compared. While there is no literature or studies that use a similar system, our rationale for interpreting and describing our results this way is due to ensuring that our Latino community at large, often report having less than a 3rd grade education, can better make sense of our results. It is also our intent to share these findings with our youth population. To assess the readability of our key findings using the +/- system, we conducted several pilot sessions, where we described our findings to our student population. After the presentation, we gave students one table using the +/- system and asked them to each interpret what they were seeing and all students were able to successfully verbally articulate they key findings and describe implications of the findings in impact that our CDEP can have on recognizing the many risk factors associated with mental health issues.

We also utilized the Community Cultural Wealth model to focus on themes of growth, but also not discount areas where we need improvement. Once this +/- system was used to write up a draft of the results, a meeting with key staff and therapists was organized, and the data shared with them, and they were given the opportunity to comment on the data, from their point-of-view and from the point-of-views of their clients/students. This meeting to discuss the results with key ICSI staff and therapists helped because it gave everyone involved in our CDEP an opportunity to comment and contribute their thoughts on the results.

Results

Our State-Wide Evaluation (SWE) data was collected over a three (3) year period, from 2022 to 2025. The following tables show the effects of our Bienestar Curriculum (and CDEPs) on youth mental health.

First, Table 2 shows the n for pre and post, as at times there was a slight difference from pre to post. The table also shows a comparison between pre (collected in the beginning of the semester) and post (collected in the end of the semester), and the change between both. The questions are ranked from factors that were most effective to least. The highest improvement was in the two (2) questions: (a) *At present, your culture gives you strength*, and (b) *At present, you feel connected to the spiritual/ religious traditions of the culture you were raised in*, each with an increase of + 0.20 in the direction of *Strongly Agree.* But, it is also important to note that there was growth in all the questions.

Table 2. Pre, Post, and Change of Protective Factors for Youth, By Mean and Numbers

At present…	Pre/ Post (n)	Pre Mean	Post Mean	Mean Change
your culture gives you strength	123/142	2.14	1.94	+ 0.20
you feel connected to the spiritual/ religious traditions of the culture you were raised in	119/139	2.27	2.07	+ 0.20
your culture is important to you	119/140	1.92	1.75	+ 0.17
your culture helps you to feel good about who you are	119/140	2.03	1.87	+ 0.16

Note: Likert Scale: 1=Strongly Agree; 2=Agree; 3=I am Neutral; 4=Disagree; 5=Strongly Disagree. A +/- system of showing change in growth or decline was used for readability purposes.

In Table 3 (below), the highest level of growth was to the question *About how often during the past 30 days did you feel isolated and alienated from society?,* showing a growth of -0.31. It is important to note that, for some indicators, a negative change represents an improvement, as it reflects a reduction in undesirable experiences (e.g., isolation or marginalization). It is important to note that there was growth in all the questions, and in items representing negative growth, in these questions negative is growth because they ask about feeling that we want students to have less of.

Table 3. Pre, Post, and Change of Protective Factors for Youth During the Past 30 Days, By Means and Numbers

About how often during the past 30 days did you feel…	Pre/ Post (n)	Pre Mean	Post Mean	Mean Change
isolated and alienated from society?	120/140	3.53	3.84	- 0.31
connected to your culture?	122/141	2.34	2.10	+ 0.24
marginalized or excluded from society?	118/140	3.54	3.76	- 0.22
balanced in mind, body, spirit and soul?	118/141	2.55	2.36	+ 0.19

Note: Likert Scale: 1=All the time; 2=Most of the time; 3=Some of the time; 4=A little of the time; 5=None of the time. A +/- system of showing change in growth or decline was used for readability purposes. It is important to note that, for some indicators, a negative change represents an improvement, as it reflects a reduction in undesirable experiences (e.g., isolation or marginalization).

Table 4 shows *access and utilization in the past 12 months* for youth. Approximately 10.9% stated needing help in the last 12 months for emotional/mental health. And only 1.6% stated

having received psychological/emotional counseling from someone outside of school in the past 12 months.

Table 4. Pre-Test of *Atención Plena/Pláticas* Youths' Perceptions of Access and Utilization in the Past 12 Months, By Number and Percent

In the past 12 months…	Yes	No	Don't Know/ Refused / Missing
did you think you *needed help* for emotional/ mental health problems (e.g., feeling sad)	14 (10.9%)	23 (18.0%)	91 (71.1%)
have you received psychological/emotional counseling from *Community helping professionals* (e.g., health worker)	6 (4.7%)	45 (35.2%)	77 (60.2%)
have you *received* psychological/emotional counseling from *traditional helping professionals* (e.g., culturally-based healer)	3 (2.3%)	53 (41.4%)	72 (56.3%)
have you received psychological/emotional counseling from someone *outside of school* (e.g., social worker)	2 (1.6%)	29 (22.7%)	97 (75.8%)

In relation to psychological distress, Table 5 shows how youth felt in the past 30 days. Table 4 not only provides the pre results, but the post, and the change between both. Table 4 is rank ordered beginning with the item with the largest amount of growth, youth feeling *worthless*, beginning at 3.96 (pre) and ending at 4.58 (post). Since these are negative statements, and the Likert scale from *all of the time* (1) to *none of the time* (5), as the numbers increase, youth have less of these feelings. Therefore, while youth began with a high level of feeling worthless (3.96), by the posttest they had less of this feeling (4.58).

Table 5. Pre, Post, and Change of Psychological Distress for Youth During Past 30 Days, By Means and Numbers

During the past 30 days, how often did you feel…	Pre/Post (n)	Fall (Pre) Mean	Spring (Post) Mean	Mean Change
worthless	121/140	3.96	4.58	- 0.62
so depressed that nothing could cheer you up	121/139	4.04	4.45	- 0.41
restless or fidgety	120/139	3.44	3.84	- 0.40

hopeless	122/141	3.83	4.21	- 0.38
nervous	122/141	3.14	3.51	- 0.37
that everything was an effort	120/138	3.53	3.87	- 0.34

Note: Likert Scale: 1=All of the time; 2=Most of the time; 3=Some of the time; 4=A little of the time; 5=None of the time. A +/- system of showing change in growth or decline was used for readability purposes. It is important to note that a negative change represents an improvement, as it reflects a reduction in undesirable experiences (e.g., hopelessness).

In relation to general health, youth were given the following 5-point Likert scale,[26] *During the past 30 days, would you say that in general your health is…?* There were 123 pre and 141 post surveys completed. The mean for the pre was 2.84 and the mean for the post was 2.49, growing 0.35 points in the direction of excellence. Additionally, in regard to general health, Table 6 shows the number of participants that reported not having good health (physical and/or mental), and how their health limited their activities. The three (3) items on Table 6 are rank ordered from items where participants had the largest drop in the number of days (in the past 30 days) in which their health negatively impacted them. The growth shown in the last column shows the drop in the number of days in which participants' health negatively affected them, and also the drop in the number of days in which their health was affected.

Table 6. Pre, Post, and Change of Overall Health for Youth During Past 30 Days, By Number of Youth Affected and Number of Days Affected

	Pre		**Post**		**Growth**	
How many days during the past 30 days…	**N**	**# of days**	**N**	**# of days**	**N**	**# of days**
was your physical health, not good?	10	9.40	7	2.86	-3	-6.54
was your mental health not good?	18	14.61	16	7.06	-2	-7.55
did your physical/mental health keep you from doing your usual activities (e.g., recreation)?	10	10.50	11	6.82	+1	-3.68

The last table (Table 7) only shows post-test data, as these questions were meant to capture youth's feelings about the quality of our Bienestar Curriculum (and CDEPs), and the quality of their lives because of our treatments. The scores on Table 6 show first the number of respondents, and then the mean for each answer. The items in Table 7 are also rank-ordered, beginning with the item that had the highest rating (most impact). The items range from a low of 3.10 to a high of 3.86. The item with the highest rating was *I have people with whom I can do*

[26] Note: The Likert Scale: 1=Excellent; 2=Very Good; 3=Good; 4=Fair; 5=Poor.

enjoyable things (4.02). All in all, students felt good about our services, our staff, how they were treated and respected, and the values learned.

Two of the items that received highest ratings were: (a) *I am better able to do things I want to do* (3.86 rating), and (b) *I am better at handling daily life* (3.81 rating). And two of the items that received low ratings were: (a) *services were available at times that were convenient for me* (3.11 rating), and (b) *staff respected my religious/spiritual beliefs* (3.10 rating).

Table 7. Post-Test of CDEP Quality, By Means

	N	Mean
I am better able to do things I want to do	69	3.86
I am better at handling daily life	67	3.81
I know people who will listen and understand me when I need to talk	70	3.74
I got the help I wanted	70	3.74
I felt I had someone to talk to when I was troubled	66	3.74
I received services that were right for me	65	3.69
Staff spoke with me in a way that I understood	67	3.61
Staff were sensitive to my cultural/ethnic background	66	3.59
Overall, I am satisfied with the services I received	110	3.21
Services were available at times that were convenient for me	129	3.11
Staff respected my religious/spiritual beliefs	133	3.10

Note: Likert Scale: 1=Strongly disagree; 2=Disagree; 3=Undecided; 4=Agree; 5=Strongly agree.

Discussion and Conclusion

Our quantitative findings show the effectiveness of our CDEP over the last three (3) years. Quantitatively, we collected 128 pre and 142 post SWE surveys. In all this data, our findings showed that our CDEP was effective in supporting youth as they improved navigating the school system and improving their mental health and wellness. The SWE survey showed that our CDEP helped youth to improve in accessing the protective factors that help them cope with school and life, and psychological distress and functioning. The SWE data showed improvement in all measures. All in all, we saw growth, excitement about our CDEPs, CDEPs that were delivered effectively, and CDEPs that were positively affecting the lives of youth.

Without doubt, after a thorough discussion of the results with all our staff members that are responsible for deploying our CDEP, the results show the importance and effect of our CDEPs and our Bienestar Curriculum. Our CDEPs changes lives, uplifts youth, and disrupts the school-to-prison pipeline. Particularly when it came to our CDEPs connecting culturally with students, this was a highlight because of how our CDEPs are grounded in valuing the wealth of our youth of color. In all aspects of our CDEPs, our youth felt a connection in how our Latina/o therapists embedded culture in their delivery and our Bienestar Curriculum.

From the beginning, we grounded our CDEP in the cultural wealth model, which focuses on student assets rather than deficits. Even in 2025, most students of color go to school, are taught by White teachers, do not see themselves in the culture, and generally struggle to have cultural continuity from home to school, especially in our rural, immigrant, and English-language learning communities. Our CDEPs go against this current, and place student culture at the center; it reaffirms them, empowers them, and gives them the confidence and self-efficacy to improve their condition. Eight (8) years ago we sought to deploy a Latino-centered CDEPs with the purpose of positively transforming lives. Eight (8) years later, we have seen this success through our evaluation of our CDEPs. We also reduced the stigma associated with mental health in the Latino community by exposing youth and their families to our CDEPs. We provided youth with skills to improve their mental health, but also to feel pride in their culture and cultural backgrounds.

If we had to explicate two (2) critical take-aways from the entirety of our results, they would be that: (a) we were successful, and look forward to expanding on our success, and (b) we now know more clearly our challenges and areas for needed growth, and welcome the opportunity to continue to serve youth. Our data clearly showed growth for always all students, in all areas. Yes, we would like to see greater growth, but the growth was not as strong as we would like and will continue to look for and develop better measurement tools. Recently we developed a survey to specifically measure growth in our Bienestar Curriculum, and we will be launching this survey very soon.

Appendices

Appendix A

Parent Consent to Participate

LMU|LA
Bellarmine College of Liberal Arts

Psychology Applied Research Center

University Hall
1 LMU Drive, Suite 4725
Los Angeles, CA 90045-2659

Tel 310.568.6634
www.lmu.edu

PARENT CONSENT TO PARTICIPATE – 12 to 17 Years of Age
California Reducing Disparities Project Phase 2 Statewide Evaluation
Principal Investigator: Dr. Cheryl Grills, Loyola Marymount University (LMU)

The California Reducing Disparities Project is a statewide project to improve mental health services. Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success is one of 35 programs funded by this project. The Psychology Applied Research Center in Los Angeles is doing a study of the project. The California Department of Public Health funds the study, which it will use to report on the usefulness of programs like Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success. Your child can be in the study because they will be inLatino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success. If your child takes part in the study, they will be one of about 60 people for Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success and 9000 statewide.

If you say yes to the study, your child will take two surveys. One survey when your child starts Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success. Another survey at the end of the program. The surveys ask about your child's mental health, services they have used or need for mental health, alcohol or drugs, and what your child thinks about Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success. The survey also asks for details like your child's age, gender, and sexual orientation. One example of a question is, "In the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" Another example is, "About how often during the past 30 days did you feel nervous?" The first survey should take 15 minutes. The second survey should take 10 to 15 minutes. Both surveys should take 25 to 30 minutes. Program staff can read questions and help your child fill out the surveys if they need help.

Being in the study is optional. You and your child will not be paid or receive any direct benefits. Saying no will not affect your child being in Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success. If you say yes to the study, your child will take two surveys. You can ask questions before you decide if you want your child to be in the study.

The surveys asks some questions that may cause discomfort. They can choose to not answer for any reason. Your child can withdraw from the study at any time by saying, "I do not want to be in the study anymore." Nothing bad will happen if your child withdraws. Withdrawing will not affect your child being in Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success.

If your child feels upset after they do the survey, the Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success can refer them to support services. If you want more support, you can contact Dr. Cheryl Grills at LMU, 310-338-3016.

To protect your child's data, paper surveys are stored in locked file cabinets and destroyed once put on computers. Computer data is stored on secure servers. However, there is a small chance of a data security break that could cause loss of privacy. The law requires us to report child abuse, elder abuse, or plans to for someone to hurt themselves or others.

If you have any questions, you can contact Integral Community Solutions Institute at _____. You can also contact Dr. Cheryl Grills at LMU, 310-338-3016 or cheryl.grills@lmu.edu. If you want to know more about your child's

rights in research, contact the Committee for the Protection of Human Subjects, 916-326-3660 or cphs-mail@oshpd.ca.gov. You will also get a copy of the Participant's Bill of Rights for Non-Medical Research.

Signing below [or clicking the yes button below] means that:

- I understand all of the above information.
- I have received the Participant's Bill of Rights for Non-Medical Research.
- I consent to my child being in the study.

Youth's Name: _____
Signature: _____ Date: _____

Adolescent Assent Form on File: ☐Yes ☐No

Verbal Consent Obtained (if participant is unable to provide written consent): ☐ Yes ☐ No

Witness Signature if Verbal Consent was Obtained: _____ Date: _____

Electronic Consent Obtained (if participant is unable to provide written consent): ☐ Yes ☐ No

Witness Signature if Electronic Consent was Obtained: _____ Date: _____

Appendix B

Informed Assent Form

LMU|LA
Bellarmine College of Liberal Arts

Psychology Applied Research Center

University Hall
1 LMU Drive, Suite 4725
Los Angeles, CA 90045-2659

Tel 310.568.6634
www.lmu.edu

INFORMED ASSENT FORM – 12-17 Years of Age
Principal Investigator: Dr. Cheryl Grills, Loyola Marymount University (LMU)
California Reducing Disparities Project Phase 2

This Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success is part of a statewide project to improve mental health services. Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success is one of 35 programs funded by this project. The Psychology Applied Research Center in Los Angeles is doing a study of the project. The California Department of Public Health funds the study, which it will use to report on the usefulness of programs like Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success. You can be in the study because you will be a part of Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success. If you take part in the study, you will be one of about 60 people for Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success] and 9000 statewide.

If you say yes to the study, you will take two surveys. One survey when you start Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success. Another survey at the end of the program. The surveys ask about your mental health, services you have used or need for mental health, alcohol or drugs, and what you think about Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success. The survey also asks for details like your age, gender, and sexual orientation. One example of a question is, "In the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" Another example is, "About how often during the past 30 days did you feel nervous?" The first survey should take 15 minutes. The second survey should take 10 to 15 minutes. Both surveys should take 25 to 30 minutes. Program staff can read questions and help you fill out the surveys if you need help.

Being in the study is optional. You will not be paid or get any direct benefits. Saying no will not affect you being in Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success. If you say yes to the study, you will take two surveys. You can ask questions before you decide if you want to be in the study.

The surveys ask questions that may cause discomfort. You can choose to not answer. You can withdraw from the study at any time. You can withdraw by saying, "I do not want to be in the study anymore." Nothing bad will happen if you withdraw. Withdrawing will not affect you being in Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success.

If you feel upset after you do the survey, the Latino-Based Therapies in California's San Joaquin Valley: The Relation of Pláticas and Atención Plena to Academic Success can refer you to support services. If you want more support, you can contact Dr. Cheryl Grills at LMU, 310-338-3016.

To protect your data, paper surveys are stored in locked file cabinets. Paper surveys are destroyed once put on computers. Computer data is stored on secure servers. However, there is a small chance of a data security break that could cause loss of privacy. The law requires us to report child abuse, elder abuse, or plans to hurt yourself or others.

If you have any questions, you can contact Integral Community Solutions Institute at _____. You can also contact Dr. Cheryl Grills at LMU, 310-338-3016 or cheryl.grills@lmu.edu. If you want to know more about your rights in research, contact the state of California, 916-326-3660 or cphs-mail@oshpd.ca.gov. You will also get a copy of the Participant's Bill of Rights.

Signing below [or clicking the yes button below] means that:

- I understand all of the above information.
- I have received the Participant's Bill of Rights.
- I agree to be in the study.

Your Signature: _____ Date: _____

Verbal Consent Obtained (if participant is unable to provide written consent): ☐ Yes ☐ No

Witness Signature if Verbal Consent was Obtained: _____ Date: _____

Electronic Consent Obtained (if participant is unable to provide written consent): ☐ Yes ☐ No

Witness Signature if Electronic Consent was Obtained: _____ Date: _____

Appendix C

Adolescent Version (12-17) Pre Survey

ADOLESCENT VERSION (12-17) PRE	ID:	___ ___ - ___ ___ - ___ ___ ___
		Priority Pop Code / IPP Code / CDEP Participant Code
	Date:	_____

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

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

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

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

9. In the past 12 months did you THINK YOU NEEDED HELP for emotional or mental health problems, such as feeling sad, anxious, or nervous?

☐ Yes ☐ No ☐ Refused ☐ Don't Know

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

11. In the past 12 months, HAVE YOU RECEIVED any psychological or emotional counseling from someone AT SCHOOL, such as a school counselor, school psychologist, school therapist, or school social worker?

☐ Yes ☐ No ☐ Refused ☐ Don't Know

12. In the past 12 months, HAVE YOU RECEIVED any psychological or emotional counseling from someone OUTSIDE OF SCHOOL, like a counselor, therapist, psychologist, psychiatrist or social worker?

☐ Yes ☐ No ☐ Refused ☐ Don't Know

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

During the past 30 days, how often did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
13. …nervous?	☐	☐	☐	☐	☐
14. …hopeless?	☐	☐	☐	☐	☐
15. …restless or fidgety?	☐	☐	☐	☐	☐
16. …so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
17. … that everything was an effort (in other words, everything feels like it's too much or too hard)?	☐	☐	☐	☐	☐
18. …worthless?	☐	☐	☐	☐	☐

The next question is about your health during the past 30 days.

19. Would you say that in general your health is?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

20. Now thinking about your *physical health*, which includes physical illness and injury, for how many days during the past 30 days was your

physical health not good?

☐ Number of days _____ ☐ None ☐ Don't know/Not sure

21. Now thinking about your *mental health*, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

☐ Number of days _____ ☐ None ☐ Don't know/Not sure

22. During the past 30 days, for about how many days did *poor physical or mental health* keep you from doing your usual activities, such as self-care/recreation (e.g., dancing, exercising, resting, hanging out with friends), work or school?

☐ Number of days _____ ☐ None ☐ Don't know/Not sure

23. In the past 6 months, have you done any volunteer work or community service that you have not been paid for?

☐ Yes ☐ No ☐ Refused ☐ Don't Know

24. How old are you? Write in your age below:

_____

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

☐ American Indian or Alaska Native

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

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

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

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

☐ Asian. Check your ethnic origin(s):

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

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

☐ Samoan ☐ Tongan ☐ Refused ☐ Other Hawaiian or Pacific Islander.
☐ Guamanian ☐ Fijian ☐ Don't know Please specify: _____

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

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

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

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

☐ Refused

☐ Don't know

26. How well can you speak the English language?

☐ Fluently

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

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

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

☐ Not at all

27. What is your preferred language? Please write in your answer below.

_____

28. Were you born:

☐ Inside the U.S. ☐ Outside the U.S. ☐ Refused ☐ Don't Know

29. What are the first 3 digits of your ZIP code?

☐ The first 3 digits of my ZIP code are ___ ___ ___ ☐ Unstable housing/no ZIP code ☐ Refused ☐ Don't Know

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

☐ Not Applicable ☐ Yes ☐ No

☐ Refused ☐ Don't Know

31. About how many years have you lived in the United States? [For less than a year, enter 1 year]

☐ I have lived in the United States for about _____ year(s). ☐ Not Applicable

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

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

☐ Male/Boy ☐ Intersex (they were unsure about my sex at birth) ☐ My assigned sex at birth is (please specify):_____

☐ Female/Girl ☐ I am not sure about my sex assigned at birth ☐ I do not wish to answer this question

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

☐ Man/Male ☐ Two Spirit

☐ Woman/Female ☐ Intersex (between male and female)

☐ Transgender/Trans ☐ I am not sure about my gender identity

☐ Trans man/Trans male ☐ I do not have a gender/gender identity

☐ Trans woman/Trans female ☐ My gender identity is (please specify):_____

☐ Genderqueer/Gender non-conforming ☐ I do not wish to answer this question

☐ Non-binary (not exclusively male or female)

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

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

☐ Straight/heterosexual ☐ Asexual (I am not attracted to anyone sexually)

☐ Gay ☐ I am not attracted to anyone romantically

☐ Lesbian ☐ I am not sure who I am attracted to sexually

☐ Bisexual ☐ I am not sure who I am attracted to romantically

☐ Queer ☐ Something else: _____

☐ Pansexual/Non-monosexual (I am attracted to all genders) ☐ I do not wish to answer this question

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

Yes ☐ No ☐

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

Appendix D

Adolescent Version (12-17) Post Survey

ADOLESCENT VERSION (12-17) POST

ID: ___ ___ - ___ ___ - ___ ___ ___ ___
Priority Pop Code | IPP Code | CDEP Participant Code

Date: _____

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

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

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

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

During the past 30 days, how often did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9. …nervous?	☐	☐	☐	☐	☐
10. …hopeless?	☐	☐	☐	☐	☐
11. …restless or fidgety?	☐	☐	☐	☐	☐
12. …so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
13. …that everything was an effort (in other words, everything feels like it's too much or too hard)?	☐	☐	☐	☐	☐
14. …worthless?	☐	☐	☐	☐	☐

The next question is about your health during the past 30 days.

15. Would you say that in general your health is?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

16. Now thinking about your *physical health*, which includes physical illness and injury, for how many days during the past 30 days your physical health not good?

☐ Number of days _____ ☐ None ☐ Don't know/Not sure

17. Now thinking about your *mental health*, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

☐ Number of days _____ ☐ None ☐ Don't know/Not sure

18. During the past 30 days, for about how many days did *poor physical or mental health* keep you from doing your usual activities, such as self-care/recreation (e.g., dancing, exercising, resting, hanging out with friends), work or school?

☐ Number of days _____ ☐ None ☐ Don't know/Not sure

Please help us make our program better by answering some questions. Please answer the questions based on the services, program or activities connected to Integral Community Solutions Institute. Indicate if you Strongly Disagree, Disagree, are Undecided, Agree, or Strongly Agree with each of the statements below. If the statement is about something you have not experienced, check the box for Not Applicable to indicate that this item does not apply to you. Please note: the word "service" stands for any program activities or events connected to Integral Community Solutions Institute.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
19. Overall, I am satisfied with the services I received.	☐	☐	☐	☐	☐	☐

20. I felt I had someone to talk to when I was troubled.	☐	☐	☐	☐	☐	☐
21. I received services that were right for me.	☐	☐	☐	☐	☐	☐
22. Services were available at times that were convenient for me.	☐	☐	☐	☐	☐	☐
23. I got the help I wanted.	☐	☐	☐	☐	☐	☐
24. Staff respected my religious/spiritual beliefs.	☐	☐	☐	☐	☐	☐
25. Staff spoke with me in a way that I understood.	☐	☐	☐	☐	☐	☐
26. Staff were sensitive to my cultural/ethnic background.	☐	☐	☐	☐	☐	☐
27. I am better at handling daily life.	☐	☐	☐	☐	☐	☐
28. I am better able to do things I want to do.	☐	☐	☐	☐	☐	☐
29. I know people who will listen and understand me when I need to talk.	☐	☐	☐	☐	☐	☐

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

Yes ☐ No ☐

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