Centro de Apoyo Latino

Implementation Pilot Project - Latinx Priority Population

California Reducing Disparities Project Phase 2 Extension

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

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

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Their implementation of this model has continued to inspire hope.

La Familia Counseling Center - Centro de Apoyo Latino

Rachel Rios, Executive Director

Jessie Armenta, Clinical Director

Elia G. Peralta Landeros, Program Administrator

Cynthia Andrade, Clinician

Leonidas Escobar, Clinician

Rosa Rosas, Community Health Worker/ Promotora

Table of Contents

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Executive Summary

This evaluation report examines the effectiveness of the Centro de Apoyo Latino (CAL) program, operated by La Familia Counseling Center (LFCC) in Sacramento, California. The CAL program is a culturally and linguistically tailored mental health project designed to address the unique needs of Latino adults, particularly Spanish-speaking immigrants, who have historically faced significant barriers to accessing quality mental health care.

Background and Purpose

The CAL program was established as part of the California Reducing Disparities Project (CRDP), a statewide mental health intervention program administered by the California Department of Public Health, Office of Health Equity (OHE). The project aims to reduce behavioral health disparities among underserved populations through Community-Defined Evidence Practices (CDEPs) that can demonstrate the value of culturally and linguistically appropriate treatment and intervention strategies at the community level. CAL's service delivery model, known as "Cultura de Salud" (Culture of Health), is rooted in "Reawakening Therapy," a framework developed by LFCC founders that emphasizes culturally responsive, family- and community-centered care. The CAL program was selected by OHE as an innovative strategy for delivering health and wellness services.

Evaluation Approach

The CAL program helps us to understand the value of integrating cultural principles with wellness into a community mental health program design. The CAL pilot provides an opportunity to empirically demonstrate culture as an important ingredient for wellness. The evaluation sought to answer three primary questions:

1. To what extent does program participation strengthen individual wellness and resilience?
2. To what extent does program participation reduce risk factors for mental illness?
3. To what extent does the program approach improve retention in CAL services?

A mixed-methods approach was used to respond to the research questions. The mixed methods approach helps reduce bias by minimizing reliance on a single method meaning findings are more likely to be trustworthy and robust. The use of mixed methods also allows the evaluator to infuse scientific methods into the evaluation process in a manner that highlights, rather than ignores, important cultural indicators of and for wellness.

- A latent variable analysis was performed using the Statewide Evaluation (SWE) Dataset of client responses from pre- and post-treatment surveys. The method allows us to identify and quantify client outcomes that can be attributed to several coordinated interventions and actions and bundled into a unique "latent" variable. Such outcomes may not be easily measured by a single indicator or variable.
- Ordinal Logistic Regression Analysis was performed using client pre- and post-treatment data from the Sheehan Disability Scale. This method allows us to quantify the client's probability of improved wellness following treatment.
- Feedback Informed Treatment Outcomes data on client responses regarding emotional wellbeing following each therapeutic session was used to measure clinically significant changes in wellness.
- Content Analysis on transcribed and semi-structured interviews was used to identify themes generated from the voices of clients with clients and staff. The experiences of clients are

captured using Inductive Coding methods informed by Grounded Theory and are not normally captured through statistical analysis.

Given the importance of validating the connection between cultural competence and mental wellness, three methods of triangulation were used for this evaluation: Data triangulation with multiple data sources; Methodological triangulation where a mix of qualitative and quantitative methods of analysis are used; and Theory triangulation where three approaches to program design are considered. The three levels of triangulation improve the validity and depth of our findings.

Key Findings

Significant improvement in client wellness: Each method of statistical analysis used on client survey responses showed signs of significant improvement following the client's experience in CAL.

- The Latent Variable Analysis of SWE survey data showed a statistically significant and substantial improvement in client wellness, with a standardized mean difference of 1.118 standard deviations between pre- and post-treatment scores. Generally, a change of 0.5 standard deviations is considered a very high indication of change.
- Ordinal Logistic Regression analysis using the SDS responses indicated that clients were 17 to 31 times more likely to report improved functioning in work, household, social, and family domains after participating in CAL, compared to before treatment. Clients reported significant improvements in their ability to manage their emotions in daily social relations after completing treatment in CAL.
- Fit Outcomes data show that approximately 76% of CAL clients reached or exceeded target scores indicating a positive significant change that is beyond a trivial amount of day-to-day fluctuation.

Culturally responsive, multidimensional care is effective: Qualitative analysis of client interview data revealed a strong connection between improved wellness and cultural competence. Clients valued the program's seamless integration of therapy, education, cultural activities, and navigation services.

- The presence of bilingual, culturally connected staff (Community Health Workers/Promotoras and therapists) was critical in building trust, reducing stigma, and facilitating access to resources.
- Personal connections between staff and clients were important to creating pathways for wellness and client "buy-in" to program activities. Clients reported feeling respected, supported, and part of a community, which interrupted patterns of isolation and promoted utilization and engagement.
- Interconnected services at a site in the community helped remove barriers to access, improved utilization, and encouraged engagement.
- The "Whole Person" approach to care and the emphasis on cultural and family integration was important for clients. Clients reported feeling like they were finally understood and cared for and had a voice in moving forward. The approach improves continuity of care, reduces the gap in services, and allows for better coordination of clients and services.

High client satisfaction and retention remain consistent over time: Interview data reveals a strong relationship between client satisfaction and improved wellness. Positive client outcomes were consistent with those found in the 2021 evaluation, despite the natural staff turnover that occurs over time in organizations.

- 100% of clients reported satisfaction with services, willingness to recommend CAL, and positive experiences with staff.

- The program achieved 100% retention during the evaluation period, with no dropouts from CAL services.
- The program's multidimensional, culturally grounded approach to service delivery was identified as a central mechanism for client healing, wellness, and satisfaction.

Recommendations

The importance of programs like CAL cannot be understated. However, programs like CAL are in constant danger of ending as state funding becomes increasingly challenging. Although the term of the CRDP pilot may end, state staff can and should remain engaged in the on-going support of local programs borne through the CDRP. Two recommendations are offered here that may help in finding new sources of funding for programs like CAL.

- Continue state-level support for data collection and management of SWE data to help justify ongoing funding for sustainability and scalability and to support effective local administrative oversight.
- Develop a standardized cost-benefit analysis templates for local programs to demonstrate long-term program value to potential funders and policymakers.

Conclusion

The CAL program demonstrates that culturally and linguistically tailored mental health services, embedded within the community and delivered by trusted, bilingual staff, can produce significant improvements in wellness, resilience, and satisfaction among Latino adults. The program's success can be directly attributed to its holistic, culturally competent program design and the dedication of its staff who continue to demonstrate a sincere level of caring for each client. CAL also serves as a model for communities experiencing low penetration rates from local mental health systems. Sustained funding and data management support are essential to maintain and expand these critical services for underserved populations.

Introduction

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

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

In 2016, La Familia Counseling Center (LFCC) was one of seven CDEPs selected by the California Department of Public Health to demonstrate the value of culturally and linguistically appropriate treatment and intervention strategies at the community level as important components of mental health services. The Centro de Apoyo Latino (CAL) program addresses Culturally and Linguistically Appropriate Treatment. The premise is that culturally and linguistically appropriate treatment is needed to improve the wellness and resiliency of Latino families and reduce risk factors that, if left unmet, will lead to reduced penetration and retention rates and costly higher-level services and cost.

In 2021, the first evaluation report reviewed La Familia's Cultura de Salud service delivery model used with their CAL program as a community-defined mental health project. The project overall design is to integrate mental health services as a natural public resource that is more accessible to the Latino population now facing crisis conditions in the Sacramento region.

CDEP Purpose and Description

La Familia's approach to community mental health service delivery was formulated and put into practice over 45 years ago by agency founders Zaida Fernandez and Anita Barnes. As early as 1973, Fernandez and Barnes recognized the importance of having community mental health services that were culturally specific. They developed what is known as the *Enchilada Approach to Reawakening Therapy*, which posits that the mental health experience must be understood in relation to both the family and

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

community. This theoretical perspective for community mental health, according to Fernandez and Barnes, "…is distinguished from the contemporary practice of the traditional psychologies by its process: its theoretical views are inferred from daily practice rather than accepted as a theoretical given to be applied in daily practice" (Fernandez and Barnes 1978). This model outlined eight key principles necessary to gain high levels of client response and engagement based on trust. The premise being that a culturally responsive delivery model improves wellness and resiliency of Latino families. With appropriate and timely services, risk factors such as increased anxiety, trauma, and stress would be addressed before becoming critical. The model would also increase retention rates and reduce costly higher-level services for Latino communities.

The Eight Principles

- Community
- Authenticity
- Empowerment
- Mutual Respect
- Ownership
- Awareness
- Family Emphasis
- Cultural Responsiveness

The eight key principles are deemed essential for the effective practice of Reawakening Therapy in community mental health programing and are operationalized through a daily practice now referred to as Cultura de Salud, or Culture of Health. Through this approach, La Familia has long ago established themselves as a trusted partner for community mental health services in the Latino community. La Familia staff are often asked by other local, or state agencies to provide support or coordinate services for this often hard-to-reach community because of the long-standing history of building and maintaining trust, relationships and respect. The principles, as well as methods for practicing them, provide the context for the CAL program and are the tenets tested for the CRDP project.

The creation of CAL as a CDEP can be seen as a complementary extension of the work La Familia has been involved with over the years. When Sacramento County was awarded MHSA funding to implement Prevention and Early Intervention programs, La Familia was selected to provide awareness and intervention services for the Latinx community through the Supporting Community Connections (SCC) programs. The services included suicide prevention, support services, referral and linkage to other community resources, and community building through outreach and engagement activities. Through this effort, La Familia was seen by both community and public agencies as a trusted partner with the capacity for delivering community mental health services to children and adults. However, SCC is focused on prevention and does not provide funding for therapeutic services to adults resulting in an urgent need for adult mental health services in the Latino community. When the opening of CAL was announced as an effort to help fill the gap in community mental health services for Latinos, referrals from agencies and other providers as well as walk-ins were immediate.

Review of Client Needs and Services

In our 2021 evaluation, we noted research dating back to 1978 that details how Latinos have faced difficulties in accessing quality mental health treatment, and how providers have failed to appreciate how mental health needs are directly related to cultural and racial diversity.[2] We know that Latinos experiencing a mental disorder have been less likely than non- Hispanic whites to use mental health services (Hough et al. 1987; Vega et al. 1999). We know about the persistent underutilization and the lack of quality mental health services available to Latinos and the difficulties in getting quality mental health services to Latino consumers and their families (Lopez 2002). Confirming these issues, more recent research from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2019) reported that 6.7 million Latinos in the U.S. experienced some form of mental illness. However, 67

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

percent of them did not receive any form of treatment. Of the 6.7 million, 1.5 million Latinos reported suffering from severe mental illness and 44 percent of this group did not receive any treatment either.[3] Although stigma is usually singled out as a primary deterrent to seeking services, financial barriers also impose huge and persistent impediments to Latinos in accessing mental health services (Aguilar-Gaxiola et al. 2012).

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

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

CDEP Description

CAL's Cultura de Salud (CdS) service delivery model operationalizes the eight culturally responsive principles found in *The Enchilada Approach to Reawakening Therapy* in three ways: 1) Outreach, Education and Awareness programming 2) Individual and Group Therapy and 3) Navigation Services. The CAL program is a program operated by La Familia Counseling Center that oversees a multitude of community services and programs within Sacramento. La Familia utilizes a "no wrong door" approach to services; therefore, clients may enter into services from a variety of entry points. Clients being considered for the CAL program are initially triaged through La Familia's suicide prevention and early intervention program by intake staff and then are referred to CAL for crisis intervention and stabilization activities as needed. While the CAL program staff operates out of one office at La Familia's Maple site with most services provided at that location, La Familia's "no wrong door" approach means that clients may be initially referred and seen in the community, at outreach events or at our main site. Additionally, navigation and outreach services are often conducted at the site of external providers and at events.

Outreach, Education, and Awareness: La Familia provides an array of educational and awareness opportunities to the community that create a nurturing pathway to the CAL program. Through educational programming, La Familia helps to circumvent misinformation and reduce cultural barriers known to impede access to mental health services. Emphasis is placed on making information available that leads to changes in the knowledge, attitudes, beliefs, practices, and behaviors of individuals as well as La Familia's external partners and service providers. Building upon the outreach foundation established through Supporting Community Connections, La Familia's community engagement programs aims to strengthen connections between services and Latino community members in need of critical mental health support. Culturally responsive workshops- often conducted in Spanish, such as *Recognize The Signs and Mental Health First Aid*, provide education on mental health and learning conditions, helping families understand and navigate these challenges. These efforts improve access to and

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

utilization of culturally and linguistically appropriate mental health services, ultimately enhancing family stability, resiliency, community cohesion and individual wellbeing.

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

A strong commitment to community service places La Familia on the front line of important social and public health crises facing Sacramento's Latino community such as political reforms and environmental challenges.

Individual Therapy: Clients who need immediate and urgent interventions as determined by an assessment are provided with individual therapeutic sessions. The sessions focus on crisis intervention and stabilization. Clients attend an average of 3 - 6 individual therapy sessions lasting one hour each generally conducted weekly or bi-weekly. A licensed therapist whose primary language is Spanish leads all sessions. The sessions, conducted in a private room at the CAL office, provide a safe location and setting for clients to discuss the core issues leading to their emotional distress. Clients learn coping strategies that they can utilize to improve functional impairment and the ability to manage day-to-day social interactions with family and work settings. The sessions also inform the development of an individualized care plans, created collaboratively by the mental health therapist and community health worker/promotora to address both clinical needs and the resource supports necessary for stabilization. While therapy sessions are primarily conducted in person, clinicians assess for transportation and other barriers to determine whether telehealth is appropriate. When suitable and with proper security measures and informed consent- telehealth is offered to ensure uninterrupted access to care.

Group Therapy Sessions: For clients with less urgent but critical symptoms of mental illness and family stress care needs, CAL offers 90-minute group therapy sessions guided by a licensed therapist and a community health worker/promotora. This team approach to managing therapy sessions allows staff to observe the type of resources and services clients need to promote long-term stabilization, which in turn can be facilitated through navigation services. Group therapy frequency is once a week for approximately 4-6 weeks. Group therapy provides the opportunity for clients to begin their integration back to healthy social relations in a safe environment. In these support groups, clients share their experiences and discuss strategies to manage their emotional wellbeing. Clients can address problems such as stigma and actual situations of discrimination and domestic violence in a supportive, constructive environment that allows them to regain a sense of community and connectivity, especially for isolated seniors. Clients provide each other with mutual support through shared experiences and together form new and healthy connections with others as well as to resources in their community. Sessions are initially conducted in person at times that meet participants' needs, including evenings and other hours outside typical operations to accommodate work or school schedules. When transportation or accessibility barriers arise, clinicians assess whether Telehealth is appropriate. If determined suitable, and with proper privacy measures and informed consent, Telehealth sessions are offered to ensure continuous, flexible access to care.

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

For CAL staff, navigation activities are a team approach with both therapists and community health workers/promotoras working jointly to create effective therapy and resource plans to reduce immediate danger and risk factors for each client. Discrimination, language barriers, and legal issues such as deportation represent very real fears that prevent individuals from receiving the help they need. Navigation assistance provides a safety net for clients to access essential services and resources and help begin the stabilization process. This "warm handoff" to long-term service providers and other support systems works to intervene in conditions of distress that traditional mental health delivery systems are not designed to address. As clients work with CAL staff to safely access resources, they also learn skills on how to safely navigate the mental health system on their own, thereby building client responsibility, awareness, and increasing the chances of long-term utilization.

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

A bilingual staff is required to properly support the CAL program, from intake to program completion, as language is a key factor in adhering to the culture-based design presented in *The Enchilada Approach to Reawakening Therapy*. All CAL services are administered by diverse portfolio of staff such as therapists, community health workers/promotoras, program manager, clinical director, and front desk/support staff. All meetings and services are conducted in Spanish as staff prefer speaking in the language used by their clients. All documentation and forms provided to clients are in Spanish.

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

Evaluation Questions

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

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

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

Two primary indicators are used to respond to these questions: Improved Wellness and Client Satisfaction. First, we want to know if the CAL program continues to result in positive changes for its clients. Second, we focus on client satisfaction because it is an indicator closely connected to improved wellness. It is here where we use Content Analysis with a Grounded Theory approach to identify the client reported indicators that contribute to wellness. Table 1 below lists these secondary identifiers under the Client Satisfaction indicator. In the Evaluation Results section of this report, we discuss in greater detail how seven characteristics of Client Satisfaction were identified using Content Analysis and Grounded Theory. We also provide a short review of academic literature supporting a deeper investigation into the relationship between improved wellness and client satisfaction and why the use of client satisfaction remains an important evaluation point warranting a higher level of investigation.

Four data sources were used for analyzing these indicators:

- The CDRP Statewide Evaluation Dataset (SWE) contains data collected from pre and post questionnaires for each CAL client. We use data collected on variables from the Kessler Psychological Distress Scale, client general satisfaction, and cultural sensitivity questions captured in the SWE dataset. Client demographic data was also obtained using the SWE dataset.
- The Feedback-Informed Treatment Outcomes (FIT) dataset contains client feedback on their progress in therapy and the connections they establish with their therapist.
- The Sheehan Disability Scale, originally part of the SWE dataset, is used to measure impairment in functioning at the time of intake and to measure changes in the client following their participation in the program.
- Semi-structured interviews with CAL clients and staff provide rich detailed descriptions of the client, their emotional and social conditions, their experiences in the program, and their assessment of the effectiveness and quality of care received.

The following matrix shows how each data source and indicator were used in responding to the evaluation questions.

Table: 1 Evaluation Questions, Indicators and Data Sources				
	Evaluation Questions			
	To what extent does program participation strengthen individual wellness and resilience?	To what extent does program participation reduce risk factors to mental illness?	To what extent does the program approach improve retention in CAL services?	
Measurement Indicators				**Data Source**
Improved Wellbeing	X	X	X	1,2,3,4
Client Satisfaction	X	X	X	1,4
Positive Connections	X	X	X	1,2,3,4
Interconnected Services	X	X	X	4
Navigation Service	X	X	X	4
Whole Health Approach	X	X	X	4
Cultural Integration	X	X	X	4
Family Integration	X	X	X	3,4
Located in Community			X	4
Data Sources				
1. Statewide Evaluation Dataset				
2. FIT Outcomes				
3. Sheehan Disability Scale				
4. Semi-Structured Interviews				

Methods

CDEP Implementation

La Familia receives referrals for assistance from a variety of sources, including walk ins. When clients first arrive at La Familia, staff conduct interviews to determine each client's particular needs and assess the urgency for mental health services. It is at this critical point in the intake process where La Familia staff identify the need for additional non-clinical support services and assistance accessing those services (navigation support). If appropriate, adult clients are then referred to CAL for services and support. CAL staff then inform the client about the CRDP research project. All clients are informed that participation in the study is not a requirement for receiving services. However, for those wishing to participate in the study, signing appropriate consent forms is required.

Three instruments which consist of a series of questions are used as part of a pretest to establish each participant's baseline conditions. The Cultural and Social Impact Scale (CSIS), a form developed and administered by CAL staff is used to document baseline conditions for a "wellness" index that provides an indicator of a client's stability and the urgency for intervention at the time of entering the program. Clients are given the Statewide Evaluation (SWE) pretreatment questionnaire to document health and demographic information and the Sheehan Disability Scale to help understand the client's baseline wellness condition. CAL staff then determine the appropriate level of services for the clients based on information gathered.

Therapists provide short-term counseling services, including therapeutic support groups, and/or individual counseling sessions. Community Health Workers/Promotoras provide navigation services such as hands-on linkages to non-clinical services. At the end of each therapeutic session, participants are asked to complete short questionnaires that documented how the client felt about the CAL service(s) received, the appropriateness of the service(s) and any cultural and linguistic barrier(s) that they experienced.

Following the completion of CAL services, participants are given the SWE Post Treatment Questionnaire and the Sheehan Disability Scale (SDS). The results of both the pre and post questionnaire data are transmitted to the Psychology Applied Research Center (PARC) while the SDS responses are recorded in Excel spreadsheets in-house.

Demographic information from the SWE data indicates a CAL population of 114 clients with 98% reporting their ethnicity as Latino and 2% identifying as multi-racial African American/Latino. Slightly over 92% of clients reported their place of birth was outside of the U.S. However, they were not recent arrivals. Approximately 85% reported living in the U.S. more than ten years with 57% of clients residing in the U.S. 20 years or more. Just under 94% (93.91%) of clients reported their primary language as Spanish with 11% indicating fluency in English. Regarding gender identity, 78% identified as female at birth, 20% as male, and 2% as transgender. Regarding sexual preference, 98% identified as heterosexual. At the time of intake, 97% of clients were without any form of health insurance and 85% of clients were between 30 and 64 years old.

Evaluation Participants and Recruitment

The CAL recruitment process was a natural extension of La Familia's long-standing partnership with Sacramento County. The County's Supporting Community Connections (SCC) program remains an important recruitment tool for the CAL CDEP. Through SCC, La Familia had been providing suicide prevention, awareness and support services, referral and linkage to other community resources, and community building through outreach, education, and engagement activities. However, SCC funding is focused on prevention and unfortunately does not include funding for therapeutic services leaving a gap in services for Latino adults.

The end of in-person meeting restrictions post-COVID now allows La Familia to host on-site an array of social, health, employment, and educational services along with cultural, informational, and recreational public events. Hundreds of community members have sought the services of their career center, their Family Resource Center, youth programs, health programs and mental health services. Each event provides La Familia with the opportunity to market their services to the public and result in new CAL clients. Also important is the 50+ year record of providing community-based services in the area. The countless residents that have received services at La Familia act as effective word-of-mouth referral system and reflects the trust that the community has placed in La Familia staff and its programs.

All these activities increased the demand for services and resulted in a number of CAL clients. These indirect recruitment activities resulted in a waiting list of people for CAL services. Like the 2021 evaluation period, the large demand across all of La Familia's programs indicated that there was a Latino population seeking culturally and linguistically responsive mental health services.

The target population for the program was primarily Latino, Spanish speaking, adults. However, at La Familia, no one is denied services regardless of their background. All of the clients in CAL agreed to participate in the CDEP evaluation. Like the 2021 evaluation report, one concern of this study is that a small client population would compromise the strength of any random sample selected. Therefore, a convenience sample was recommended where 100% of the client population would be used for the evaluation.

Evaluation Measures and Data Collection Procedures

Clients referred to CAL services are given the SWE pretreatment questionnaire. The completed surveys are then forwarded to PARC for data entry. Similarly, the SWE post treatment questionnaire is administered at the time of the client's exit interview and forwarded to PARC for data entry. La Familia staff collected client personal information by administering specific forms such as the CSIS questionnaire,

which aided the work of Community Health Workers/Promotoras through the triage process. Information regarding the Sheehan Disability Scale (SDS) was also collected at this time to establish a baseline of wellness as reported by the client. This information was then entered into an Excel spreadsheet and eventually exported to Stata for statistical analysis by the evaluator.

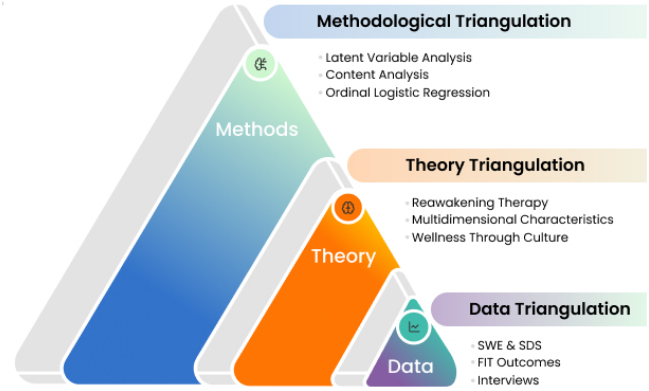
To record the overall progress on client/therapist alliances and client progress, the Feedback Informed Treatment (FIT) data was collected manually using the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) forms to provide immediate, valid, and reliable client feedback following each therapy session. The data were then entered into the FIT Outcomes data system (a proprietary data management system managed by an independent contractor). FIT Outcomes was then used to generate descriptive statistics for analysis by the evaluator.

Navigation services are recorded on the program's Cultural Service Satisfaction Questionnaire (CSSQ) documenting the services and resource connection provided to each client. Designated program staff then entered the data an Excel spreadsheet, which is then exported to Stata for analysis by the evaluator.

As in the 2021 CAL evaluation, three different approaches to triangulation were used in this evaluation. Triangulation refers to the use of *multiple methods, data sources, theories, or investigators* to study a single phenomenon. The idea is that if different approaches converge on similar findings, those findings are more likely to be trustworthy and robust. Triangulation is important because it enhances credibility by confirming findings through cross-verification. It reduces bias by minimizing reliance on a single method or researcher. It also improves depth by offering a more nuanced, multidimensional understanding. And it strengthens the rigor of the research by making the research design more defensible and transparent.

Triangulation helps validate findings by identifying convergence; when different sources support the same theme, it boosts confidence in the results. It helps identify contradictions and discrepancies so that they can be further examined to uncover deeper insights. Triangulation also builds transferability where findings grounded in multiple research perspectives are more likely to apply across contexts. Normally, one method of triangulation is sufficient for a research or evaluation project. However, given the importance of validating the connection between cultural competence and mental wellness, three methods of triangulation are used for this evaluation.

Figure 1: CAL Evaluation Methods of Triangulation



Data triangulation included four different sources of quantitative and qualitative data to analyze the effects of CAL services on clients: 1) the SWE pre and Post Questionnaire dataset with data initially collected by CAL and submitted in batches to PARC for processing; 2) the FIT Outcomes summary data on client reported feedback following every therapeutic treatment session; 3) the SDS data for establishing a client baseline to measure client reported improvement; and 4) 24 client and staff volunteer interviews regarding their experiences in CAL to help understand and interpret the findings of the quantitative methods.

Methodological triangulation incorporated multiple ways of measuring both qualitative and quantitative analysis. Ordinal logistic regression was used on pre and post treatment SDS data to measure client reported changes in wellness and stabilization. Latent variable analysis using structural equation modeling was used to analyze the SWE data as non-matched and matched pairs. Qualitative interview data was used for content analysis on staff and client reported information regarding their program experience.

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

Evaluation Fidelity and Flexibility

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

The first dimension of fidelity was attention to the adherence between services delivered and those proposed. The CAL team spends considerable time clarifying program components, program activities, evaluation design, and the data analysis plan. Since the 2021 evaluation, there has been considerable turnover in staff. This is to be expected as staff pursue career paths and family conditions change. The CAL team has made efforts to ensure administrative procedures, including data collection procedures, are passed down the line to new staff. This ensures that information collected can help determine that the CAL program delivered quality services in a manner consistent with the program purpose: using community and cultural assets and community-defined strategies to improve access, quality of care, and achieve positive mental health outcomes. Following the end of restrictions on public meetings imposed during the COVID-19 pandemic, the CAL team was able to integrate group sessions, education and awareness activities, and cultural events back into the original program design. This evaluation also considered how these program components were activated.

Administrative practices were implemented to facilitate appropriate and efficient data collection methods that allowed for timely program decisions to ensure fidelity. One common theme that carried over from the 2021 evaluation process was to continually emphasize and prioritize the Statewide Evaluation (SWE) data collection process. Regularly scheduled quality control team meetings focused on daily observations and practices to ensure sensitivity to clients during service delivery. As forms for navigation activities were updated, the data dictionary was also reviewed and updated following the periodic review of collected data to ensure its consistent and accurate recording of navigation data. Data collection procedures for staff were continually updated so that the flow of data to the PARC remained in place and any changes in personnel would minimize any problems with data integrity.

Staff have recently completed the development of a comprehensive training curriculum Cultura de Salud: Eight Principles of La Familia Counseling Center Services Delivery Model. The curriculum is an essential tool to help maintain continuity of services, especially given the rapidly changing conditions of community mental health, government funding, and normal rates of staff turnover. The curriculum effectively guides trainees through the eight principles found in Reawakening Therapy and how they become operational via the Cultura de Salud – the day-to-day practice of wellness through culture.

One important adjustment to obtaining SWE data is important to note here. During the 2021 evaluation period, many clients were conscious of the number of therapy sessions allowed by CAL. As a result, Post treatment SWE data collection became problematic because the SWE data collection interview was the signal to clients that their time at CAL was ending. Clients simply did not want their time to end. Many CAL clients would not come to the interview so that they could keep one final session as a reserve, making sure they would still be connected to the program in case they were in need of extra care. To avoid the additional staff time required to locate the "missing" clients, staff began conducting exit interviews prior to the last visit. This ensured that the SWE and SDS data collection would not be compromised. This early Post Treatment exit interview remains in place today and ensures that the required client data is collected prior to the end of the treatment period.

The second dimension of fidelity reviewed here is quality of delivery, which reflects the manner in which a program is delivered. Interview data show that clients were able to effectively engage in treatment and navigation programming. Client interviews indicate that the seamless integration of on-site services created an environment where clients easily accessed therapeutic, educational, health, and social services. Clients reported in interviews that services were delivered with respect and sensitivity to culture. Clients reported that CHW case management services showed an extreme level of care provided to them and that staff engagement was always respectful and sincere. As in the previous evaluation period, clients consistently reported that the level of care and constant attention they received gave them the feeling like they were part of a family.

Post-covid public meeting policies allowed for the roll-out of the full CAL program design. The program is now able to provide services on campus that were previously external to the site. This reduced the number of client referrals to outside service providers and created an efficient and seamless integration between on-campus services. The result was increased utilization of on-campus services while ensuring client retention.

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

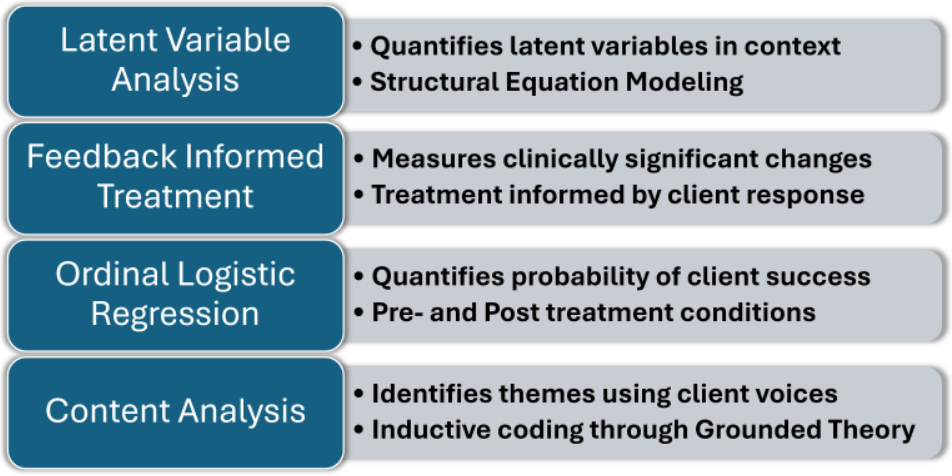
Another important part of the program design impacting all three dimensions of fidelity incorporates feedback from clients receiving therapeutic services. The program uses the Feedback Informed Treatment Protocol that provides continuous client feedback during the course of therapy. Data on client satisfaction from each therapy session was collected from each client using the FIT Outcomes management system, discussed in greater detail in the Evaluation Results Section. Through this process, client progress as well as the alliance between client and therapist was monitored at each treatment session. FIT scores also reflected the client's continuous assessment of the quality of services they

received with the FIT data reflecting clinical progress, high utilization, and positive client/therapist alliances. The FIT data served as an important marker of both adherence to the implementation protocol as well as participant responsiveness.

Qualitative and Statistical Data Analysis

For quantitative data, Ordinal Logistic Regression is used to analyze SDS data. A Latent Variable Analysis using Structural Equation Modeling is used to analyze the SWE data. Descriptive statistics from FIT Outcomes is used to measure therapeutic alliances between therapists and patients and for measuring clinically significant client reported changes in wellness. For qualitative data, a Content Analysis method is used as part of this evaluation to analyze client interview data. Each of these measurement methods were used in the 2021 evaluation and are discussed in greater detail in the Findings section of this report.

Figure 2: CAL Evaluation Mixed Methods Approach



Evaluation Results

The purpose of the pilot CAL CDEP is to determine to what extent do culturally defined service delivery practices improve access and utilization of mental health services for Latino populations." Therefore, the goal of this evaluation is to provide some insight on: 1) the effect of culturally centered mental health service programming on clients in distress, and 2) the extent to which mental health programs designed with a focus on a client's culture can strengthen individual wellness and resilience, reduce risk factors associated with mental illness, and improve client retention in program treatment and related activities. Four data sources are used to evaluate the effectiveness of CAL programming: Statewide Evaluation Data (SWE) Analysis, FIT Outcomes, Sheehan Disability Scale data, and interviews with clients and staff.

Latent Variable Analysis

We learned from the 2021 CAL evaluation that understanding the level of a client's psychological distress or wellness involves going beyond basic questions regarding a client's emotional state. We also learned from interviews with CAL therapists that the design of CAL was intended to be a process of continuous diagnosis and healing rather than simply a dosage-oriented treatment protocol. CAL staff actively look for trends in client behavior or social conditions that could provide clues to guide clients to stabilization and sustain wellness. Concepts such as improved wellness or decreased levels of distress can be

attributed to a number of coordinated interventions and actions. Therefore, these outcomes may not be easily measured by a single indicator or variable.

Self-reporting questionnaires, like the Statewide Evaluation Pre and Post Interview Questionnaires, can often reveal patterns of social and emotional conditions experienced by clients. These patterns suggest that a number of conditions, or variables, can be attributed to broad concepts of wellness rather than one variable. In this section of the evaluation, we bundle observed trending conditions, or variables, into one "latent variable" to measure the hypothesis that CAL services have a positive impact on the level of distress experienced by CAL clients. We replicate the Latent Variable Analysis methodology used in the 2021 evaluation to see if the high level of positive change found in client wellness continues to occur during this second evaluation period.

Latent Variable Analysis (LVA) is a statistical method that combines several observed variables into a single underlying factor, allowing us to assess complex concepts like overall wellness more accurately. The statistical model is often used to understand the effects of a bundle of indicators that could represent a latent trait such as "depression." In practice, LVA is best suited for exploring latent constructs like personality traits or cognitive abilities, where the latent variable is continuous and influences multiple observed variables (See for example Hamilton et al. 2025, Wright 2019). For these reasons, the LVA method remains appropriate for this evaluation.

The SWE data set is used here to analyze the hypothesis that CAL services have a positive impact on the level of distress experienced by CAL clients. Eight questions from the SWE Pre and Post questionnaires are used to develop the latent variable "Depression." The idea is that the level, or impact, of the latent variable "Depression" caused clients to respond as they did to the questions on the pretreatment intake and post treatment exit questionnaires.

Six of the SWE questions constitute what is known as the Kessler Psychological Distress Scale (K6). The K6 is used to screen for serious mental health issues using six basic questions about a person's emotional state. The K6 is also used to flag individuals for further mental health assessment and to track changes in distress levels over time, such as before and after treatment (Kessler et al. 2003). The K6 protocol asks about a person's core emotional condition using the following questions…How often did you feel… nervous, hopeless, restless, distressed, worthless, and feeling like everything was an effort? In the SWE data set, the client response to each question is scored from 1 (All of the time) to 5 (None of the time). These questions are found on the Pre Treatment questionnaire as questions 9 through 14 and questions 13-18 on the Post Treatment questionnaire.

Two additional questions in the SWE data set, "How often did you feel marginalized or excluded from society" and "how often did you feel isolated from society," were also included as part of the "Depression" latent variable as they too represent important indicators of psychological distress. These two questions are intended to capture the clients' own assessment of their condition and therefore have the potential to identify important signs of distress. Like the K6 variables, these questions in the SWE data set are scored from 1 (All of the time) to 5 (None of the time). These questions are found on the Pre and Post treatment questionnaires as questions 7 and 8.

Together, these eight variables from the SWE questionnaires, "marginalized," "isolated," "nervous," "hopeless," "restless," "depressed," "effort," and "worthless" make up the latent construct variable labeled for this experiment as "Depression." These variables were selected based on prior research indicating their strong association with depressive symptoms captured by the SWE data (See for example Kessler et al. 2002, Kessler et al. 2003, Peiper et al. 2016, Lace et al. 2020).

Pretreatment Measurement Model

A more traditional interpretation of K6 questions uses the sum of the client responses resulting in a final score between one and 30. A mean score is calculated for pre and post treatment scores then used to determine if a statistically significant change to the client's mental health has occurred following treatment. However, this method assumes each variable has the same impact or "weight" on the concept of wellness that we are looking to test. Also, we need to avoid questions that may be measuring the same thing (multicollinearity). In a Latent Variable Analysis, we are looking for questions that have a good relationship or interaction (correlation) with each other but do not say the same thing. This will help improve the quality of our hypothesis testing.

A Structural Equation Modeling approach (SEM) is used to test whether the variables used to construct the "Depression" latent variable are appropriate to assess a statistically significant change in behavior from pretreatment to post treatment. SEM utilizes a series of tests that allow for correcting measurement error and help avoid problems of multicollinearity with indicators that are essentially measuring the same thing. A Goodness of Fit test was applied to the eight "Depression" indicators to determine if any of the indicators inhibit a well-fitting model. The test incorporates a process known as confirmatory factor analysis where a series of Chi-Squared tests allows us to evaluate the "fit" or appropriateness of each indicator in the model using a null hypothesis significance test approach.

Our Goodness of Fit tests identified three indicators with high Chi-Squared statistics. The test results for these three indicators: isolation, nervousness, and hopeless; suggested some degree of uncertainty in client responses. After correcting for these ambiguities, the final model for testing the "Depression" variable was reduced to five indicators: marginalized, restless, depressed, effort, and worthless. Although two indicators for the latent variable is acceptable, best practices show that three or more indicators are recommended with the ideal range of four to six indicators often preferred for stability, reliability estimation, and model identification (See for example Bentler and Chou 1987, Bollen 1989, MacCallum et al. 1999, Kline 2015). Figure 3 shows the SEM diagram with weights. Coefficients for the model are shown in Table 2.

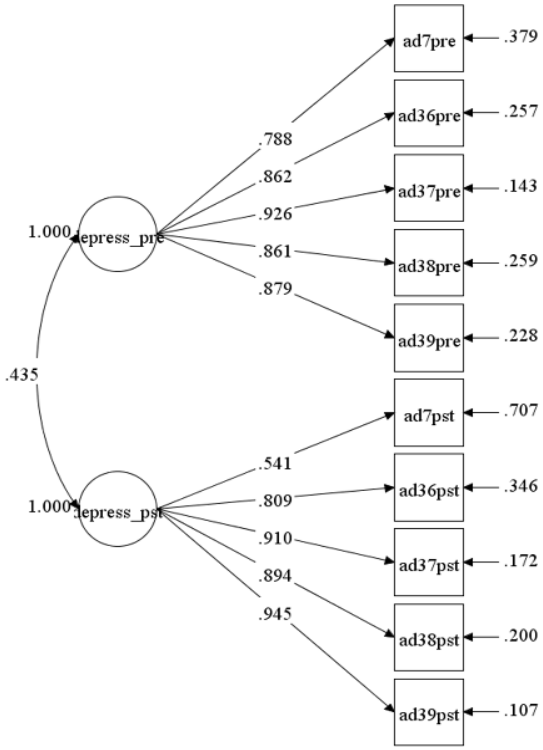


Figure 3 : Pre/Post Measurement Model

Table 2: Pre-treatment Measurement Model

Indicators	Estimate
Marginalized	0.787
Restless	0.862
Depressed	0.926
Effort	0.860
Worthless	0.879

The Goodness of Fit tests also produce several scores or indices to use as benchmarks in establishing the appropriateness of the latent variable indicators. Hu and Bentler 1999 provide thresholds for three of the most widely used indices in determining that there is a good fit between the hypothesized model (latent variable) and the observed data. The threshold values contained in these indices are not hard cutoffs but instead are commonly accepted guidelines for interpretation. All three of the indices described below suggest with a high degree of confidence that the indicators are adequate for the latent variable analysis.[4]

The Root Mean Squared Error of Approximation (RMSEA) measures the appropriateness of the latent variable indicators for the test population. A value of 0.05 suggests the model is an excellent fit for the test population. A value of 0.05 – 0.08 suggests the model is considered to represent a reasonably good fit. The RMSEA for this test is 0.053.

The Comparative Fit Index (CFI) ranges from 0 to 1 and measures how much better the hypothesized model fits the data compared to the baseline or null model. Higher values indicate a greater improvement of the latent variable indicators over the baseline. Values above 0.90 are acceptable with values above 0.95 as indicative of good fit. The CFI for this test is 0.996.

The Standardized Root Mean Residual (SRMR). A low SRMR values means the model's implied correlation structure is very close to reality, indicating a closer match to the data. Values below 0.08 are generally considered acceptable and those below 0.05 indicating a very good fit. The SRMR for this test is 0.013.

Measurement Invariance

In a Structural Equation Modeling framework, Measurement Invariance is commonly used to test the hypothesis of whether the theoretical model fits well to the data across groups or across time, in this case the pre and post treatment data on the "Depression" construct. In simpler terms, measurement invariance is a way of making sure your "measuring tape" works the same way for everyone you're comparing e.g., a 12-inch ruler means the same for both time periods. For this test, we want to make sure that the questions on the pre and post questionnaires are seen as meaning the same thing for each client at the point of pre and post treatment. In this way, we can trust that score differences between the pre- and post-treatment responses are about the client's perceived condition and not because of the questionnaire.

[4] For deeper explanations on Goodness of Fit testing and interpretation in Structural Equation Modeling see Kenny et al. 1988; Hu and Bentler 1995, Kline 2015, Wright 2019, Hamilton et al. 2025

Three tests of Measurement Invariance were used to ensure that the loadings and intercepts were consistent across models. Configural Invariance (structural equivalence) determines that the basic organization (loadings on each latent factor) of the "Depression" construct holds for both pre and post time periods. Metric Invariance (measurement unit equivalence) indicates that the factor loadings (slopes) are the same across pre and post groups. Scalar Invariance (full score equivalence), where the intercepts are the same across pre and post groups, indicates that the latent means can be compared across pre and post groups meaningfully.

The results from the configural and metric invariance tests showed that the latent variable met acceptable thresholds. However, the scalar invariance test revealed that the relative starting point for comparing the responses may differ between the pre and post groups. To address any potential for reducing the explanatory power of the latent variable, we rely on a process called partial scalar invariance. Partial scalar invariance is a statistical condition that allows the comparison of latent means across groups (or in this case, the pre and post points in time), provided that the latent variable has at least two indicators that function equivalently across those groups.

For instance, if a psychological scale measuring "anxiety" has five items, partial scalar invariance would allow latent mean comparisons between groups as long as two of those items measure "anxiety" in the same way across groups. Byrne, et al. (1989) state that meaningful comparisons remain possible when some parameters vary, provided that at least two invariant intercepts per factor are present. In widely cited guidance, Steenkamp, et al. (1998) state that partial scalar invariance can support latent mean comparisons when at least two indicators per construct are invariant. Likewise, Chen (2008), Shi et al. (2019), and Luong and Flake (2022) all support the minimum of two invariant indicators guideline for scalar invariance. The latent variable in our analysis has three of five indicators constrained, which remains well within the best practice guidelines.

Having demonstrated the acceptable level of Partial Measurement Invariance, Table 3 presents the means for the pre and post indicators in the "Depression" latent variable and shows a positive change in the group mean score of 1.118 standard deviations from Pre treatment to Post treatment exit interview. The z-score of 8.056, a p-value of 0.000, and confidence intervals of 0.777 to 1.286 at the 95% confidence level indicate that a statistically reliable and positive change occurred.

Table 3: Latent Variable Analysis
Comparison of Mean Differences between Pre and Post Treatment of CAL Clients

	SD	SE	Z-score	p-value
PreMarginalized	2.000	0.128	15.647	0.000
PreRestless	1.582	0.105	11.110	0.000
PreDepressed	1.916	0.130	14.779	0.000
PreEffort	1.830	0.125	14.624	0.000
PreWorthless	1.988	0.139	14.293	0.000
PostMarginalized	1.395	0.171	8.170	0.000
PostRestless	1.925	0.123	15.599	0.000
PostDepressed	1.916	0.130	14.779	0.000

PostEffort	1.830	0.125	14.624	0.000
PostWorthless	1.988	0.139	14.293	0.000
Mean(post)	1.118			

These findings are considered to be a very strong indicator that a positive change in client wellness has occurred during the time of treatment at CAL. Generally, a change of 0.5 standard deviations is considered to be a high indication of change. The 1.118 difference in the standardized pre and post mean values captured in this latent variable analysis suggests a very high indication of positive change for CAL clients. Also worth noting is that results for the latent variable analysis remain consistently positive and significant over the 2021 and 2025 evaluation periods.

It is important to note here that these findings are specifically for CAL clients at this specific point in time. It is reasonable to suggest that the results may not be the same for a different population in a different location with different circumstances. Therefore, generalization of these findings to a wider population is not recommended. Given the important implications of these findings, it may help to explain how such positive changes take hold with a population that historically has been difficult for therapists to connect with; a problem that has consistently resulted in high dropout rates from mental health intervention programs.

Feedback Informed Treatment

From our 2021 evaluation, we know that clinically significant improvements in wellness of CAL clients may be linked to the culturally focused care they receive through their participation in the program. The evidence also suggests that client wellness may be significantly aided by a strong, culturally responsive client/therapist relationship. In this section of the evaluation, we want to know if this strong client/ therapist relationship is a program characteristic that remains constant from one evaluation period to the next and to what degree does it impact client wellness.

As in the previous evaluation, we use the Feedback Informed Treatment (FIT) protocol, often referred to as FIT Outcomes, an outcome management system that provides immediate, valid, and reliable client feedback during therapy sessions. FIT Outcomes uses a simple but effective data collection method that is user friendly for both therapists and clients. FIT Outcomes is an evidence-based, client-centered approach that integrates routine, formal feedback from clients into every therapy session. FIT formalizes the process of asking clients about their wellbeing and their experience of the therapeutic relationship. This method places clients in a position to use their voices and give immediate feedback on the therapeutic process. In turn, the feedback allows their therapist to make timely adjustments to their treatment plan, which can immediately affect the level of support services a client receives. This makes FIT Outcomes an important interactive tool that helps staff create the necessary balance between therapy and support as initially designed by the program.

The use of FIT at La Familia was initiated by Dr. David Nylund, a certified trainer in FIT through the International Center for Clinical Excellence and currently a Professor in the Department of Social Work at California State University, Sacramento. He has also assisted with clinical supervision and training at La Familia since 1998. His work with marginalized people and their experience with public mental health systems led to his suggesting the use of FIT for clients seeking services at La Familia. Nylund contents that the FIT method of measuring the client/therapist relationship lends itself to culturally responsive principles of partnering with clients – a process that privileges their experience which includes the clients' cultural context. From this view, FIT complements the Cultura de Salud principles used to design

CAL services and delivery practices making it a valuable tool to demonstrate the effectiveness of a community-defined mental health program emphasizing culture as the foundation for program design.

The logic behind the use of FIT is that mental health practitioners are shaped by their own social and economic class, race, ethnicity, sexuality, gender, ability, age, and spiritual/religious traditions (Tilson 2012). FIT provides therapists with the feedback necessary for becoming culturally responsive through ongoing learning, reflection, and consideration of how each client feels about their treatment as well as the relationship with their therapist. FIT Outcomes provides therapists with an immediate and continuous opportunity for self-reflection after every therapy session with client feedback helping them to be aware of and culturally and linguistically responsive to the client's social and emotional condition.

FIT also helps address the high dropout rates from therapy. Pertinent literature shows that populations, historically marginalized by traditional mental health systems, experience higher rates of dropping out of treatment (Spoont et al. 2017), and have poorer outcomes than patients who continue in therapy until treatment goals are achieved (Archer et al. 2000, Klein et al. 2003, Moras, 1986). However, Howard (1996) posits that programs using continuous feedback from clients can directly address retention problems. Subsequent research found that clinician access to feedback regarding the client/therapist alliance, motivation to change, and perceived social support for clients enhances treatment retention and effectiveness for clients most at risk for treatment failure (Whipple et al. 2003, Hawkins et al. 2004, Miller et al. 2005, Harmon et al. 2007, and Slade et al. 2008). Together, these findings underscore how continuous client feedback not only improves overall outcomes but is vital for supporting clients at risk of dropping out.

The FIT Model

The FIT model uses two simple forms (available in Spanish) to obtain continuous client information regarding the therapeutic alliance with their therapist as well as the outcome of care: the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS).[5] The ORS helps monitor therapeutic outcomes by using four basic questions to assess the degree of severity of clients' experience in a number of key areas of life functioning: individual (personal wellbeing), interpersonal (family, close relationships), social (work, school, friendships), and overall (general sense of wellbeing). The responses are captured as scores from one to ten for a maximum score of 40. Low scores represent lower levels of functioning. The ORS in effect represents an early detection system for clients at risk of a negative outcome. The ORS feedback also signals the therapist to explore any external conditions that may be impairing forward progress.

The ORS is completed at the beginning of therapy. It is designed to help a therapist assess what has occurred since the last session and allows a therapist to determine if the present course of action should be maintained or modified. The "clinical cutoff" for the ORS score is 25 for adults and represents a statistical threshold that distinguishes between those in need of help from a therapist from those who do not. (Seidel and Miller 2012).

Analysis of FIT Data for CAL Clients

Client feedback from CAL therapy sessions is recorded in FIT Outcomes. A total of 121 clients completed ORS forms following 587 therapy sessions for an average of 4.9 sessions per client over a two-month

[5] The SRS is a tool designed to routinely and formally solicit feedback from clients to measure the therapeutic alliance between client and therapist. However, for the purposes of this evaluation, our focus is on the ORS and the measurement of client reported wellness associated with program participation.

period. Although FIT Outcomes reports a 15% dropout rate, further analysis shows that these clients chose to end individual therapy before their final session but continued participating in group activities and other CAL services indicating ongoing engagement rather than exiting the program. Consistent with results from the 2021 evaluation, which also found no evidence of program dropouts, the current data reinforces the effectiveness of CAL in retaining participants.

In addition to providing programs with the ability to analyze client specific information, the FIT Outcomes database aggregates client data which in turn provides us with a useful method for assessing the success of the program. Through FIT, CAL program data is compared to global benchmark statistics based on large-scale outcome data for over 500,000 FIT cases. From this benchmark data, six indicators are used to assess the overall effectiveness of programs using the Feedback Informed Treatment protocol. These indicators are discussed below.[6]

Average Intake ORS Scores: The Average ORS Intake score for CAL clients was 18.88 approximately 6 points below the ORS clinical "cut off" score of 25. Scores below 25 indicate clinical distress. Therefore, the score of 18.88 suggests that the average CAL client was experiencing considerable distress, experiencing some degree of instability, and in need of intervention at the time of their first meeting with a CAL therapist. When treatment is successful, scores on the ORS should increase over the client's time in the program. A clinically significant recovery is observed when the ORS score moves above the cutoff score. When clients achieve reliable or clinically significant change, it is likely that it can be attributed to therapy (Miller et al. 2003). The ORS score takes on greater significance when added to the Average Raw Change indicator.

Average Raw Change: The Average Raw Change is simply the difference in a client's Outcome Rating Scale (ORS) total score between two time points, in this case from pretreatment to post treatment. It reflects the magnitude of perceived wellbeing as reported by the client and helps document how clients move from distress into wellbeing. An average raw change between 9 to 12 points indicates a client has moved from distress into a healthy range. The Average Raw Change for CAL clients during this evaluation period is 10.99 and indicates a clinically significant and positive change from the initial therapy session. The Average Raw Change is then used to calculate the program Average Final Score.

Average Final Score: The Average Final Score represents the average difference between ORS scores from the first to last session for clients in the program. It reflects the client's self-perceived wellbeing across four domains—individual, interpersonal, social, and overall life satisfaction—on a scale from 0 to 40. A final score between 28-31 indicates that a client meets/exceeds healthy functioning and that a clinically significant improvement has been achieved. According to Miller et al. (2005), a final score in this range indicates that clients not only cross the clinical cutoff but can sustain wellbeing and are considered to have moved into non-clinical functioning. Clients with a final score within this range can transition out of active care.

The Average Final Score of 29.87 for CAL is arrived at by adding the Average Intake ORS score (18.88) to the Average Raw Change (10.99). The final score suggests that CAL clients at the time of their last therapeutic session are at a lower risk of relapses, rehospitalization, or functional setbacks than when they entered the program. Using the Jacobson Scatterplot Method to interpret the score, (see Figure 4)

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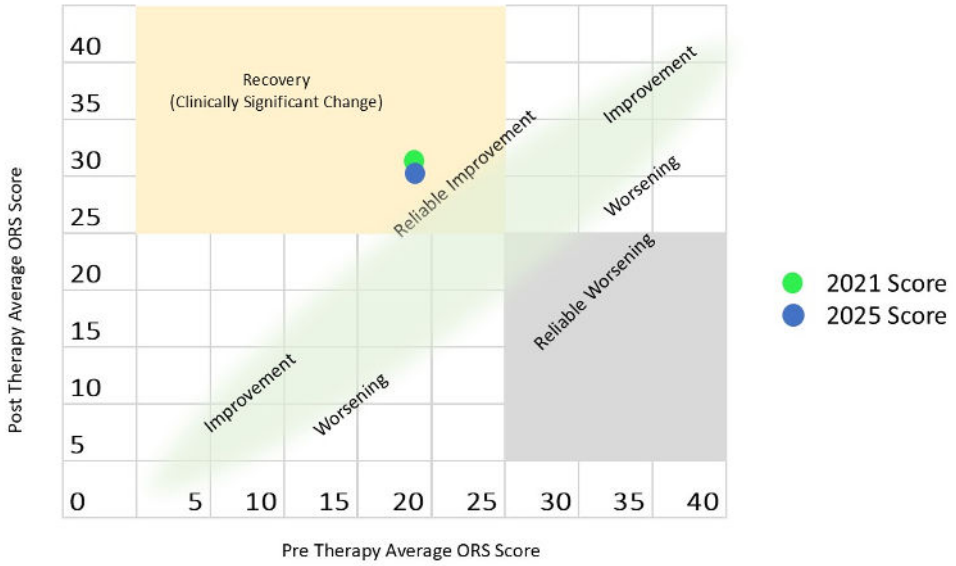
[6] Information for this section was obtained from the six-volume manual series on Feedback-Informed Treatment (FIT) published by The International Center for Clinical Excellence (ICCE). These manuals cover core competencies—from establishing the research foundations through implementing FIT at the system level—and serve as practical guides for practitioners, supervisors, and agency leaders. The manuals are available to FIT licensed users.

the data show that the average CAL client experienced a positive significant change that is beyond a trivial amount of day-to-day fluctuation (Jacobson and Truax 1991). In comparing the Average Final Scores for the 2021 and 2025 evaluation periods, we can see that the results remain consistent over time.

Figure 4: Jacobson Scatterplot for CAL Average Final Score for 2012 and 2025 Evaluation Periods



Percentage Reaching Target: The Percentage Reaching Target indicator represents the percentage of clients above the predictive trajectory of successful cases. In simpler terms, it shows how many clients are improving more than expected when compared to global benchmark data for FIT Outcome users (over 500,000 cases). A percentage greater than 50% indicates strong clinical effectiveness. The Percentage Reaching Target index for CAL is 76%

Effect Size: The Effect Size represents the effect of treatment when compared to no treatment. The Effect Size tells us how much change occurred and whether the change is clinically meaningful. An effect size of 0.8 or greater indicates a large effect, or in other words, a strong clinical change has occurred. The Effect Size for CAL clients is 1.04

Relative Effect Size: The Relative Effect Size compares the effect size of a local program to the global Effect Size (the Grand Mean) for all programs using the FIT system. This global benchmark is generated using data from over 500,000 FIT clients. If the Relative Effect Size is positive, the program delivers a treatment more effective than the norm and is outperforming the benchmark. The 0.27 score indicates that the CAL program is modestly performing above the norm.

Figure 4 below compares the FIT Outcome indicators for the 2021 and 2025 evaluation periods and suggests that the clinically significant and positive change experienced by CAL clients remains consistent over time. The Cultura de Salud principles used in designing CAL service delivery emphasizing responsibilities of awareness to therapists as well as clients appear to come to the surface via the FIT Outcome data. As stated in the previous evaluation, FIT appears to be a useful method for measuring as well as monitoring the effectiveness of an evidenced-based service delivery model designed with attention to culturally based principles that guide service and care.

Table 4: Comparison of FIT Outcome Indices for CAL 2021 and 2025 evaluation periods

Indicator	2021	2025
Average ORS Intake	18.81	18.88
Average Raw Change	11.32	10.99
Average Final Score	30.13	29.87
Percentage Reaching Target	78%	76%
Effect Size	.77	1.04
Relative Effect Size	n/a	0.27

Sheehan Disability Scale

The Sheehan Disability Scale (SDS) is a widely used diagnostic tool in the treatment of many chronic medical illnesses (Sheehan 1983, Sheehan et al. 1996). The SDS provides information regarding functional impairment in three interrelated domains: work/school, social life, and family life. In the previous evaluation, the SDS was initially integrated into the SWE pre and post questionnaires and recorded as part of the SWE data set. For this evaluation, questions related to the SDS were no longer included as part of the pre and post SWE questionnaires. However, recent studies show that the SDS remains a trusted instrument for detecting functional impairment in mental health populations, indicating its ability to capture meaningful changes in patient functioning over time, and support the scale's adequacy for tracking treatment effects across a range of disorders. (See for example Cao et al. 2021, Stein et al. 2021, Abdin et al. 2024, Abdin et al. 2025).

It is clear that the Sheehan Disability Scale continues to be a useful tool in determining levels of psychological distress and functioning in addition to confirming persistent signs of improved client ability to manage emotions when engaged in work, school, social, and family interactions. Also, the SDS data provides us with opportunity to compare results from the previous evaluation with this current analysis to see if positive outcomes for the CAL program remain consistent over time. As in our previous evaluation, our interest lies in the utility of the SDS for monitoring a response to treatment. This ability to measure client reported changes in wellbeing that may occur from pretreatment to post treatment is precisely what makes the SDS a useful tool in evaluating the CAL program. For these reasons, CAL program administrators and the evaluator both agreed that SDS data analysis should remain an important component of this evaluation protocol.

The original SDS questions from the 2021 SWE Pre and Post treatment interview questionnaires were presented to clients following their completion of the SWE Pre and Post questionnaires. Maintaining consistent survey questions ensured that the 2021 and 2025 SDS data would remain comparable. CAL staff developed a data collection form that was integrated into their client intake process and client exit interviews. The SDS forms also included the client's unique program identification number. Data from the forms were posted to excel spreadsheets and then exported into statistical software (Stata) for analysis by the evaluator.

The SDS data captures client responses to four widely used questions in mental health assessment: "Did your emotions interfere A Lot, Somewhat, or Not at All with your performance at work or school; household chores; social life; and relationships with family and friends." Responses to the SDS questions in the SWE data are coded in the form of a Likert Scale where a response is captured in a scale or ranking. Each SDS question provides the client with the following response categories: 1- A Lot, 2- Some, 3- Not at All, 4- Don't Know, 5- Refused. Those responses with "Don't Know " or "Refused" were recoded as missing data. The number of missing observations was very small ranging from one to four

observations per question. From the information gathered at pre-treatment intake interviews, we should expect some indication of clients being affected or impaired by their emotions as they manage daily situations and social interactions during acutely adverse conditions.

Consistent with our 2021 evaluation, Ordinal Logistic Regression is used here to estimate the probability of an event, in this case a client reporting an indication of improved wellness, will happen. Ordinal Logistic Regression is used because of the ordered nature of Likert Scale responses to the SDS questions, which have more than two response categories. This method allows us to consider the values of each response category as they have a meaningful sequential order where one value is higher than the previous one. Through Ordinal Logistic Regression, the SDS responses can be used to estimate the probability of clients reporting improvements in their ability to manage daily interactions after treatment. The use of logistic regression provides a data-driven method to assess the effectiveness of CAL treatment. Table 5 displays the results of the Ordinal Logistic Regression for CAL client SDS responses.

Table 5: Odds Ratio of Higher Post Score as Compared to Higher Pre Score

	Odds Ratio	Std. Err.	Z	p-value	95% Conf. Interval		N
Work/School	19.0556	6.3063	8.91	0.000	9.9616	36.4518	116
Household	17.4538	5.6707	8.80	0.000	9.2329	32.9947	116
Social Life	21.1308	7.0257	9.18	0.000	11.0129	40.5440	118
Family/Friends	31.7746	11.5152	9.54	0.000	15.6172	64.6483	118

Emotions affect performance at work or school.

The SDS data recorded 116 (Pre and Post) responses to the question, “Did your emotions affect your performance at work or school?” The one to three ordinal rankings for the responses will indicate that higher pre-treatment scores reflect periods of time where emotions interfered with work or school. Therefore, if clients report improved ability in work and school performance, the probability of post treatment responses of “A Lot” when questioned about the effect of emotions on work/school performance will be greatly reduced.

Figure 5 displays the probability of responses in client-reported changes on how emotions affect work/school performance. The graph shows that approximately 74% of pretreatment clients are likely to report that emotions affect work/school performance “A Lot.” However, following treatment, that probability decreased to approximately 8% indicating the probability of reporting that emotions have a negative effect on work/school performance is significantly lower after treatment. Also, if treatment is indeed effective, we would expect the probability of responses indicating emotions affect work/school performance in response categories other than “A Lot” to increase following treatment.

Figure 5: Do Emotions Affect Work/School Performance

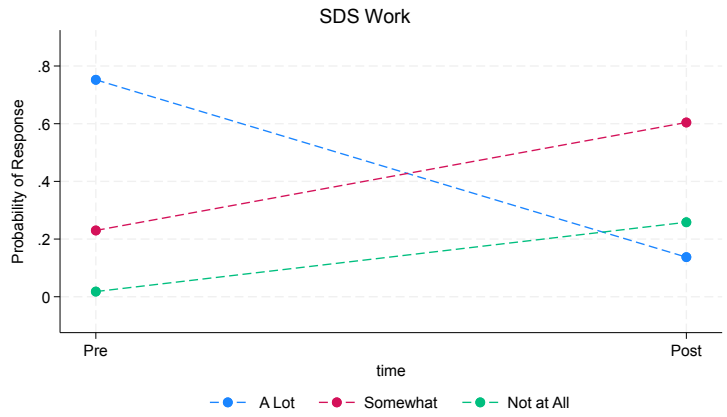


Figure 5 shows that following treatment, an increase in the probability of clients responding "Somewhat" (from 15% to 68%) and "Not at All" (from 8% to 21%) occurred suggesting that treatment has a positive effect on a client's ability to manage emotions. The odds ratio that results from Ordinal Logistic Regression can be interpreted as the effect size, or in this case, the impact upon how a client responds to SDS questions before and after treatment. The odds ratio of 19.0556 shown in Table 5 indicates that a CAL client is approximately nineteen times more likely to report a positive response regarding emotions and work/school performance following treatment than a client responding to the same question prior to treatment. This is a very strong indication that a positive change in a client's ability to manage emotions has occurred during the treatment period. The z-score of 8.91 and the p-value of 0.000 suggest that the findings are reliable.

Emotions affect the ability to perform household chores

The SDS data recorded 116 pre and post treatment respondents to the question, "Did your emotions affect your ability to perform household chores?" Responses with, "Don't Know" or, "Refused" were recoded to missing data. Following the recode of missing data, the one to three ordinal rankings for the responses indicate that higher scores reflect reduced periods of time where emotions interfered with performing household chores. Therefore, if clients report improved ability in performing household chores, the probability of post treatment responses of "A Lot" will be greatly reduced.

Figure 6 displays the probability of responses in client-reported changes on how emotions affect the ability to perform household chores. The graph shows that 75% of pretreatment clients are likely to report that emotions affect performing household chores "A Lot." However, following treatment, that probability has declined to just 8%, indicating the probability of a client reporting that emotions affect household chores is significantly lower after treatment. Also, if treatment is indeed effective, we would expect the probability of responses indicating emotions affect household chores in response categories other than "A Lot" to increase following treatment.

Figure 6 shows an increase in the probability of clients responding "Somewhat" (from 15% to 70%) and "Not at All" (from 8% to 19%) following treatment. These high point increases in the probability of responses for these categories highly suggest that treatment has a positive effect on client's ability to manage emotions. The odds ratio of 17.4538 shown in Table 5 suggests that a CAL client is approximately seventeen times more likely to report a positive response regarding their ability to perform household chores following treatment than a client responding to the same question prior to treatment. This is a

very strong indication that a positive change in managing emotions has occurred during the treatment period. The z-score of 8.80 and the p-value of 0.000 suggest that the findings are reliable.

Figure 6: Do Emotions Affect Household Chore Performance

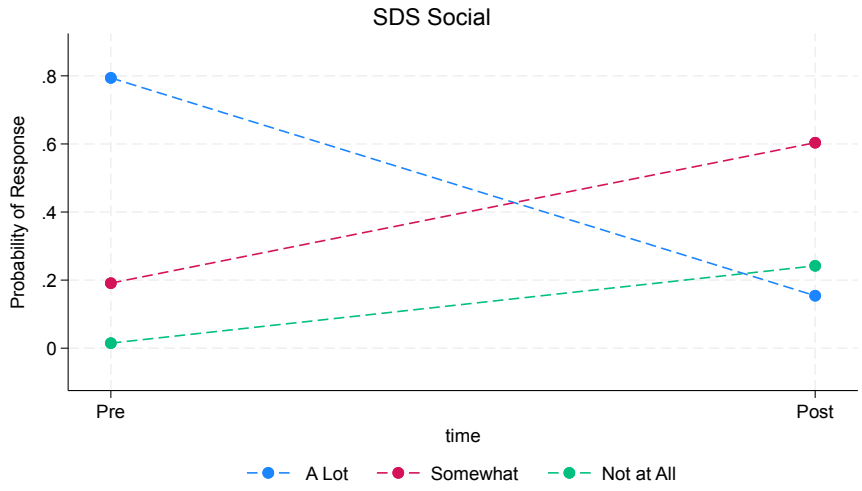
Emotions affect a client's social life

The SDS data recorded 118 pretreatment and post treatment respondents to the question, "Did your emotions affect your social life?" Responses with "Don't Know" or "Refused" were recoded to missing data. Following the recode of missing data, the 1 to 3 ordinal rankings for the responses indicate that higher scores reflect reduced periods of time where emotions interfered with a client's social life. Therefore, if clients report an improved social life, the probability of post treatment responses of "A Lot" when questioned about the effect of emotions on social life will be greatly reduced.

Figure 7 displays the probability of responses in client reported changes on how emotions affect a client's social life. The graph shows that 80% of pre treatment clients are likely to report that emotions affect their social life "A Lot." However, following treatment, that probability decreased to just 10% indicating that the probability of reporting emotions affecting social life is significantly lower after treatment. Also, if treatment is indeed effective, we would expect the probability of responses indicating emotions affect social life in categories other than "A Lot" to increase following treatment. Figure 7 shows an increase in the probability of clients responding "Somewhat" (from 12% to 69%) and "Not at All" (from 8% to 19%) following treatment highly suggesting that treatment has a positive effect on managing emotions.

The odds ratio of 21.1308 shown in Table 5 indicates that a CAL client is approximately 21 times more likely to report a positive response regarding emotions affecting social life following treatment than a client responding to the same question prior to treatment. This is a very strong indication that a positive change in managing emotions has occurred during the treatment period. The z-score of 9.18 and the p-value of 0.000 suggest that the findings are reliable.

Figure 7: Do Emotions Affect Social Life



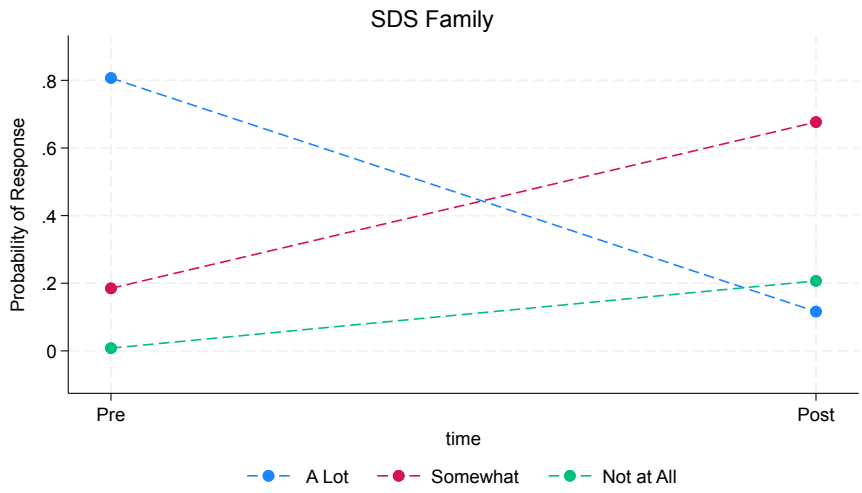
Emotions affect a client's relationships with family and friends

The SDS data recorded 118 pre treatment and post treatment respondents to the question, "Did your emotions affect your relationships with family and friends?" Responses with "Don't Know" or "Refused" were recoded to missing data. Following the recode of missing data, the 1 to 3 ordinal rankings for the responses indicate that higher scores reflect reduced periods of time where emotions interfered with personal relationships. Therefore, if clients report improved personal and family relations, the probability of post treatment responses of "A Lot" when questioned about the effect of emotions on these relationships will be greatly reduced.

Figure 8 displays the probability of responses in client reported changes on how emotions affect personal and family relationships. The graph shows that 80% of pre treatment clients reported that emotions affect their relationships "A Lot." However, following treatment, that probability has decreased to 8% indicating that the probability of reporting emotions affecting personal and family relationships is significantly lower after treatment. Also, if treatment is indeed effective, we would expect the probability of responses indicating emotions affecting personal and family relationships in categories other than "A Lot" to increase following treatment. Figure 8 shows an increase in the probability of clients responding "Somewhat" (from 14% to 72%) and "Not at All" (from 4% to 18%) following treatment suggesting that treatment has a positive effect on managing emotions.

The odds ratio of 31.7746 shown in Table 5 indicates that a CAL client is approximately 31 times more likely to report a positive response regarding personal and family relationships following treatment than a client responding to the same question prior to treatment. This is a very strong indication that a positive change in managing emotions has occurred during the treatment period. The z-score of 9.54 and the p-value of 0.000 suggest that the findings are reliable.

Figure 8: Do Emotions Affect Family Relationships



Putting the Results in Context

As in the previous evaluation, the results of the Ordinal Logistic Regressions on the SDS data suggest that significant and positive changes in the wellness and stabilization of CAL clients may have occurred during their treatment period. Prior to treatment, the probability of emotions affecting social and personal relationships was high for each of the SDS questions. However, client responses to SDS questions following treatment indicate a reduced impact from emotions on their ability to successfully function in social and family settings. Moreover, when compared to SDS findings from CAL's 2021 evaluation report, these positive results appear to be consistently positive over time.

Important to note here is that the comparison of Odds Ratios for the SDS domains between the two evaluations reveal more than just consistent positive program results over time. The findings for the current evaluation period show that client outcomes are significantly higher than the outcomes found in the 2021 evaluation. For example, the 2021 evaluation found an odds ratio of 9.0261 for the Work/ School SDS domain suggesting that clients were 9 times more likely to experience improvements in managing work/school relationships following their treatment in CAL than those without care. The SDS data for the current evaluation period show an odds ratio of 19.0556 for the Work/School domain, an increase of approximately 10 points. The finding suggests that CAL clients are nineteen times more likely to experience improvements in managing work/school relationships following their treatment in CAL. This significant jump in the Odds Ratio is not solely limited to the Work/School domain. In fact, for the current evaluation period, the Odds Ratio for each of the SDS domains increased by a minimum of nine points. The table below compares the Odds Ratio for the 2021 and 2025 evaluations.

Table 6: Odds Ratios Comparison of SDS Domains used for CAL Evaluations

SDS Domains	2021 results	2025 results
Work/School	9.0261	19.0556
Household	8.2740	17.4538
Social Life	9.2772	21.1308
Family/Friends	6.8530	31.7746

The difference in SDS Odds Ratios from the first CAL evaluation to the current evaluation is indeed significant and does warrant some consideration of possible explanations for the increase. In reviewing the additional data sources for this evaluation (client and staff interviews), there are a number of social, political, and operational conditions that come to the surface and help to provide a context for understanding why the increase in positive findings for SDS domains is plausible.

The first evaluation in 2021 took place during the peak of the COVID-19 health pandemic. At that time, human interaction in public places was severely restricted to slow the spread of the virus. Schools, public agencies, work sites, restaurants, and most public facilities were closed to minimize public contact. Public services were administered under these emergency conditions. Job and income loss were widespread, and housing was severely compromised as racially segregated neighborhoods in South Sacramento bore the brunt of COVID's effects (Hernandez 2021). Unusually punitive immigration policies during the first Trump administration also contributed to a rise in job loss as well as the rate of social problems such as domestic violence and legal issues and further limited the in-person connections possible between CAL clients and staff. In a neighborhood with over 50% Latino residents, immigration policy became an important social intervention that altered the lives and activities of all residents.

Because of these constraints, the CAL program was not fully operational as originally designed. Also, access to the network of service providers initially planned to supplement each client's treatment plan was difficult due to the limits on public contact. Staff were forced to abandon much of the original interactive program activities and quickly redesign mental health service delivery for ZOOM or telephone to continue urgent care. Since many clients had limited internet access, staff would literally drive to a client's home to maintain contact and deliver essentials such as food or forms for collecting data critical to keeping the pilot evaluation project in operation. When La Familia became a COVID testing and vaccination site for South Sacramento, CAL staff used the opportunity to connect with clients and provide as much in-person assistance as possible.

In summary, the 2021 CAL program was impacted by a number of external interventions that prevented the full implementation of its culturally based mental health service delivery model. These external interventions also had an impact on the quality of life and mental wellness of CAL clients. Despite these unplanned interventions and reworking of the delivery model to external conditions, CAL clients reported extraordinarily positive results in their ability to manage their mental wellness following their completion of the program.

This second evaluation period now takes place in a somewhat different social and political context when compared to the first evaluation period. The bulk of this evaluation period occurred during the Biden administration when the constraints on in-person contact imposed during the pandemic were ending. Also, the heavy-handed deportation operations of the second Trump administration did not begin in full force until the final two months of the current evaluation period.

Without the physical constraints to public interactions, La Familia was able to fully implement the CAL program as originally designed. In-person educational and awareness programming is now fully operational. Cultural and group activities are now fully in place. When combined with in-person individual and group therapy, clients now experience a seamless connection between therapy, support services and cultural and educational activities. Clients are full participants in therapeutic, educational, cultural and community programming. This environment allows for personal connectivity between clients and staff, and networking between clients in a supportive environment.

Also critical to realizing positive outcomes is how most of the external support services CAL previously used as part of their treatment planning are now "in-house" services. Although this may increase the workload for staff, the in-house services significantly reduce the need to refer clients to third party providers. This keeps clients in a positive controlled setting that allows them to make new personal connections with other clients and build a sense of community conducive to recovery and wellness. A fully operational Community Health Worker/Promotora training program is now in place to help support the interconnected services CAL and La Familia provide in the post-pandemic period. Finally, a reduced population size of 114, approximately 1/3 of the client population for the previous evaluation period (338), helps CAL staff manage the increase in client services and activities.

From the SWE and FIT data, we know that significant and positive changes in the wellness and stabilization of CAL clients have occurred in two consecutive evaluation periods. We also know from the SDS data analysis that the likelihood for clients to better manage their emotions in social and family settings has improved significantly since the first evaluation period. In the following section, client interviews are used to extract information that can help us understand the impact a fully implemented culturally based community mental health program design can have on client outcomes.

Figure 9: Code Cloud for CAL client and clinician interviews

Content Analysis

For this evaluation, the research attempted to focus on whether consistent positive client outcomes continue to exist beyond the 2021 evaluation period and to provide a deeper context on the role of the CHW in the new post-COVID environment. One of the key findings in the 2021 evaluation report revealed how the Community Health Worker (CHW)/ Promotoras played an important role in the success of CAL clients and the CAL program. Interview data from the 2021 evaluation showed how CHWs acted

as navigators providing constant emotional support and encouragement while often assuming the role of protectors to ensure a safe and monitored "hand-off" to external resources. The interviews provided compelling evidence showing how navigators were key to breaking down barriers to accessing services and resources, especially during crisis conditions and the COVID-19 pandemic. Thus, we became aware of the of the CHW"s active role in both client and program success.

For this section of the evaluation, we use a Context Analysis methodology to review transcriptions from 24 qualitative interviews consisting of 21 CAL clients and three program therapists. Context analysis is an accepted widely used method for analyzing complex qualitative data such as client interviews. It allows us to carefully consider and examine the setting and circumstances in which a social event occurs. Context analysis in research is used to understand how meaning is shaped by the surrounding environment—social, cultural, historical, or institutional. It's especially useful when evaluating programs, interpreting texts, or studying experiences that are deeply embedded in real-world settings, or, in the context of this evaluation, the conditions that spur distress and the conditions that promote wellness.

There are important advantages to this qualitative analytical approach. Context analysis allows us to include the voices of participants, staff, and community members as part of the data we need to understand the client's lived experiences and how best to interpret interactions that promote wellness. This method, when used as part of a program evaluation, requires that we incorporate the client's historical & cultural background into our analysis. Through the client's words, we can explore how past events, cultural norms, or traditions shape current behaviors and perceptions of wellness and how the meaning and impact of their experience are influenced by external factors.

Through context analysis, we can also triangulate data from interviews, surveys, and observational notes to gain a better understanding of quantitative findings from the SWE, FIT, and SDS data. This method also allows us to consider and interpret cultural indicators like mutual respect, family emphasis, and language. And it allows us to validate Community-Defined Evidence Practices by linking outcomes to culturally embedded practices. We can move beyond surface-level metrics and uncover the mechanisms driving client change to gain a deeper understanding of how culturally centered community mental health program designs can operate effectively especially when targeting underserved populations with historically low penetration rates.

By using context analysis, we minimize or avoid to the extent possible, misinterpretation by situating findings within real-world conditions. We also enhance validity of the data by acknowledging the complexity and nuances of both client distress and their path to wellness. Finally, the method allows us to acknowledge the importance of community-level practices by valuing knowledge systems and lived realities of both the clients and the staff.

Transcriptions from the qualitative interviews produced 490 pages of data (252 pages in English and 238 pages in Spanish). Each interview was reviewed a minimum of three times to ensure that translations were reasonably accurate and to identify recurring and common themes. These themes, which consisted of text phrases and sentences, described important characteristics or conditions of wellness experienced by CAL clients. The themes were then assigned codes which allow responses to be categorized and transformed into metrics that can be analyzed, compared, and interpreted. The coding process serves as an organized method to label segments of the interview text into manageable units where sentences, phrases, or paragraphs can be analyzed for meaning and relevance to our research questions. These units can also be applied to more than one code. For example, a client quote like "Me escuchan. Y más que todo como familia" might be coded under both "Mutual Respect" and "Feels like Family."

For the 2021 evaluation, Deductive Coding, or the use of predefined categories of code, was the primary guide for assigning codes to text. For that evaluation, the predetermined coding categories specifically targeted how the use of the program's eight foundational principles affected client satisfaction and client utilization. In contrast, our coding framework for this evaluation primarily relies on Inductive Coding where themes emerge directly from client statements. For example: A client repeatedly mentioning "feeling safe" might lead to a new code like "Emotional Safety," allowing the analysis to go beyond the original 2021 coding framework. The Inductive Coding process allows new and under-research topics to emerge and provides a process to capture client lived experiences authentically while remaining receptive to unexpected findings and insights.

Using Dedoose, a software application designed for qualitative research, a total of 132 codes (12 primary or "parent" codes and 111 secondary or "child" codes) were created and applied during the comprehensive review of each interview transcription. A total of 3487 code applications resulted from the review. Table 7 shows the frequencies of code applications applied during the review of the interview transcriptions. Only codes with applications higher than 50 occurrences are shown.

Table 7: CAL Qualitative Code Applications by Frequency

Code Application	Code Counts
Client satisfaction	118
Constant emotional support	94
Fostering trust and safety	90
Sincere engagement	85
Clients experience improved wellness	79
Services embedded in the community	79
Dealing with the whole person	76
Connectivity between therapy and activities	71
Client by-in to program	70
Freedom to move forward	67
Culture and trust interrupt isolation	67
Communication goes beyond therapy	67
Program imparts life skills for productive healthy living	66
Culture and service overlap	65
Staff attentive	62
Able to use toolkit to cope	59
Positive connections	57
Staff follow up and connect with clients	56
Improved wellness	56

Interconnected services	54
Clients want in person services	54
Interrupting isolation	53
Responsibility through education and awareness	52
Feeling safe	51
Building a sense of community for wellness	51
Whole person approach	50
Client is respected	50

The frequency of the code applications gives us an overall view of how the interviewees felt about their experience in the program. Service satisfaction is the code with the highest frequency. The high frequency of this code indicates the priority level of importance placed on it by CAL clients. Clients reported completing the program satisfied with the level of care and the improved wellness they experienced.

Post-treatment SWE data also confirms a high degree of client satisfaction with the CAL program. When asked during the SWE exit interview if they liked the services they received, 100% of clients agreed or strongly agreed. When asked if they would recommend CAL to a friend or family member, 100% of clients agreed or strongly agreed. Likewise, 100% of clients provided positive responses when asked if the staff were easy to talk to, willing to be flexible and provide alternative approaches or services, and services were available at convenient times. Both the SWE data and the interview data strongly suggest that client satisfaction remains an important evaluation point warranting a higher level of investigation.

The academic literature on mental health offers some factors to consider when assessing client satisfaction. Studies examining consumer satisfaction with mental health treatment point to a strong relationship between satisfaction and patient-reported improvements in symptom change, their ability to work, study, care for self, and maintain relationships (Lebow 1983). Lebow (1983) also attributes client satisfaction to an improved quality of life with a sense of wellbeing and meaningful activity. Clients reporting positive experiences with access, program quality, and participation in treatment planning also were more likely to report that they were generally satisfied with the services they received (Sohn et al., 2014). Stamboglis and Jacobs (2020) found that seeing a health professional closer to the community improves satisfaction, with patients seeing a community psychiatric nurse, a social worker or a mental-health support worker being more satisfied. Flynn et al. (1981) and Kidd et al. (2017) posit that confidence with the therapeutic relationship is correlated with improvement in positive client-reported outcomes of community mental health interventions.

Also important to this discussion on client satisfaction is the question of cultural competence. Greene (1996) informs us that the client's cultural and ethnic heritage as well as institutional barriers impact a client's life. Treatment must acknowledge each client's personal barriers and resources by exploring significant figures, relationships, their patterns, and events in their personal lives. Accordingly, Noll and Dubinsky (1984), and Lebow (1983) rightly instruct us to consider satisfaction as multidimensional – there is not one specific factor that leads to satisfaction. Instead, client-reported satisfaction is conditioned upon exposure to a bundle of factors.

It is this multidimensional approach to treatment and care that appears to best define the CAL program design. Like the 2021 evaluation, we note again that the multidimensional approach is not new to La Familia. The indicators of satisfaction outlined in the above literature remain embedded in the CAL program design. It bears repeating that for over 50 years, at a point in time prior to the above academic research, La Familia has intentionally connected their multidimensional approach to culturally based principles that guide their daily practice of community mental health (Fernandez and Barnes 1978). Therefore, a deeper understanding of the factors that clients associate with satisfaction may provide clues on how the CAL culture-based program design can lead to positive outcomes assessment and clinically significant changes in wellness.

Dissecting Client Satisfaction: Code Co-Occurrence and Client Responses

At this point, the evaluation uses Code Co-Occurrence to identify and isolate characteristics or traits of client satisfaction reported in the interviews. Code co-occurrence refers to instances where multiple descriptive codes are applied to the same unit of transcribed interview data - a sentence, paragraph, or transcript segment. This overlap suggests a relationship between the concepts each code represents. For example, in CAL interviews, a client quote coded with both "Mutual Respect" and "Service Satisfaction" implies that feeling respected may contribute to satisfaction.

Code co-occurrence analysis can reveal interdependencies and latent structures that single-code frequency alone would miss. The method reveals conceptual linkages between indicators and uncovers how cultural principles interact with wellness indicators. The use of code co-occurrence to tease out the characteristics of satisfaction can provide a deeper understanding of how the culture-based program design works. This thematic aggregating of codes also provides the structure necessary to organize and analyze 490 pages of interview data within a short period of time.

Figure 10: CAL Interview Qualitative Code Co-Occurrence with Service Satisfaction by Percent

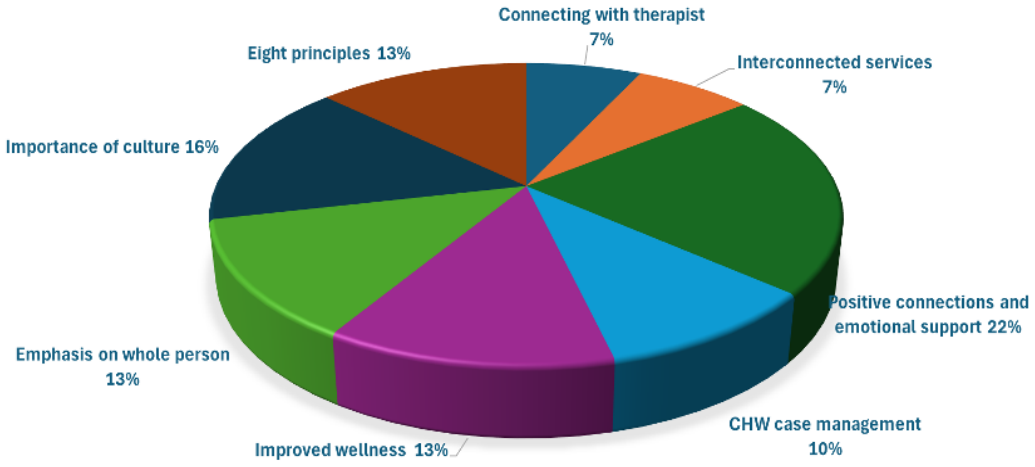


Figure 10 shows the percentage of frequencies for 1,371 code co-occurrences between Client Satisfaction and codes aggregated into eight thematic categories. The eight categories identified in Figure 10 represent common themes shared in threads of coded interview data. For example, the aggregated code category "Importance of culture" includes codes such as "culture is collective," "culture and services overlap," "culture and trust interrupt isolation," and "culture and language are important to wellness."

The high frequency of code co-occurrences and the 490 pages of transcribed interviews provide a very rich set of qualitative data that captures the numerous ways in which CAL clients experience Client Satisfaction. Given the large amount of data generated by the interviews, this section can only briefly scratch the surface of how There is simply insufficient space in this report to properly convey the heartfelt experiences reported by CAL clients in their journey towards wellness. In the sections below, the words of clients and staff are briefly highlighted to demonstrate the multidimensional characteristics of client satisfaction and how the CAL program activates those characteristics through their program design and operations.

Positive connections and emotional support

" I trust them because I know they're here to help."

Approximately 22 percent of code co-occurrences with Client Satisfaction were related to the positive and personal connections clients experienced with staff and other CAL clients. An additional seven percent of code co-occurrences with Client Satisfaction were specifically related to clients experiencing positive connections with their therapists. Together, personal connections account for almost one-third of the total co-occurrences with Client Satisfaction.

Clients often report how personal connections go beyond therapy, making them feel safe and respected like everyone else.

> *"Well, in every way. I mean, it doesn't necessarily have to be therapy. Simply the sense of companionship, the attention… I mean, I'm referring to the staff. Yes, the attention from everyone, the camaraderie, the fact that they don't treat some people better than others. From the very first moment, I felt welcomed… And I'm very happy. And… well, I'm just happy to be here."*

One client explains how staff intentionally engage with clients to forge connections and to make them feel accepted not just as a patient but accepted as part of a community. someone seen.

> *"They listen. That Gloria and the other ladies, Rosie and… I don't even remember the other girls' names, but they're always listening. They're always willing to help me if I need something.*

When the interviewer asks *"What exactly is here that keeps you coming back?"* The client responds:

> *"The people, the people. Not, not just because I always want something. But it's the people. It's, it's the ladies here. They do what they do, and they always make you feel welcome. There's always a hug. There's, I didn't know anything about community, all of that. For you know, I've always been used my whole life. So therefore, uh, so it's a horrible life, but, but I don't get that when I come here. I don't feel like I'm being judged. I don't feel like I'm not welcome to ask for a cup of coffee or anything like that. I don't feel that way. So if I felt that, I then, I probably wouldn't have come back, but I've never had any of that here."*

Sincere and personal connections with staff and other clients also encourages clients to feel safe to participate in program activities at a cautious, comfortable pace consistent with their level of wellness. Both social and therapeutic connections help interrupt patterns of isolation as trust is gained through

increased interactions. Constant support without judgement demonstrates how personal connections foster a sense of trust with CAL leading into their accepting assistance.

> *"Right now, I'm in women's therapy because I don't have any friends, so I spend my time at home. And this helps me talk to other people or listen to other people without having to become friends with them afterward. You understand? It's like you can participate in a group, and then if you don't want to, you don't talk to them, you see. Yes, but you learned from those people without having to commit to being their friend. They also helped me to enroll in school to learn English. And they helped me find a place, and with the documentation. And all that for me and my husband."*

Personal connections and emotional support also interrupt patterns of isolation and depression. Clients in turn feel safe to engage and buy into sincere engagement with the program, which in turn encourages utilization.

> *"Because yes, sometimes one feels alone, one feels that one has no way out, that one has nowhere to turn. One feels, well, disappointed with life or whatever, right? So, I saw the change, and I didn't let it go. I said, "No, it always helps to come here." And since then, I never stopped. I am here. That's why I tell you that I live here, and I don't even pay rent, because really, if a group opened there, if another group opened here, I am there. I saw that it was for my benefit. I participated until today. I still participate in the activities that I see that help me."*

Another client explains how important personal connections lead to sincere engagement and retention.

> "*I feel welcomed. I do. I really feel welcomed and that's been very key to me. Because if most of the time I'll just back out of stuff, and just not show up, I don't do that here for Wednesdays. I don't because I know I'm going to feel better once I've come here. And the fact that Gloria says, Oh, Michelle. Michelle, I need your help. You know, she's she needs my help. You know, for things that you kick the shoe table, she asks me to help follow up and all. This party that we had yesterday, you know, and I'm like, yeah, you know, I need it. I mean, you know… That is very important to me."*

Wellness begins through support and connections as clients feel safe to leave isolation. Here a client reports how new connections are helping create a path towards wellness.

> *"It's not well, but it's way better OK, because of the counseling, and because of coming here on Wednesdays and seeing people, seeing friends."*

Establishing personal connections helps clients trust staff and program treatment plans. In turn, this leads to more respectful and sincere interactions as clients see a meaningful path to wellness.

> *"I think that based on that all that, it has helped me a lot. The people that I still have. For example, outside of Rosie's work, on certain occasions I call her and him [therapist]. He listens to me. He gives me a suggestion... so all that has helped me to overcome all those things that made me bad. Yes, thanks to Rosie that always is there. Well, we have preserved, apart from work, a beautiful friendship."*

Throughout the interviews, clients often stress the importance of the new connections formed during their time in the program helping them gain a new sense of wellness and purpose. Here, a client

recounts their time away from the program due to recovery from a serious medical condition and demonstrates how personal and positive connections made during their time at CAL remain a valued part of their life.

> *"…they gave me 24 hours to live because there was nothing more they could do. They removed my small intestine and sent me home: "Go home to die." But God is great. And as soon as I could —because I had stopped coming for that reason— as soon as I was able, even in a wheelchair, I came back to my group."*

Clients also inform us on how meaningful connections with therapists lead to sincere engagement providing clues to increased client utilization and retention. Simply put, the client felt safe.

> *"So I came here and tried it because I had previously received help, but I didn't like the way they asked me questions, or how the psychologist doctor tried to get my information. That's why I came with Cynthia, the doctor here. I don't know how she did it, but she didn't harm me. The question didn't harm me. Instead, she knew how to ask me, so I stayed. That's how I got here, through the hospital."*

The connections with patients also lead to acceptance of new ways to understand healing for clients. The same client continues…

> "*We didn't just sit there and I started talking and she started asking and listening, no! She brought a different idea or a solution, let's say. She brought me solutions to control anxiety, solutions to sleep, or for when she was going to start perhaps talking about the topic. She brought, I feel that she brought me a different or more modern method for me to feel like myself, not like we were just her asking and me answering. Not like that."*

Similarly, another client states:

> "*I felt, I feel very comfortable when I was talking with the therapist because that is what one needs - someone to listen to you. Someone to listen to you is everything. And she, she was giving me ways all the time. Once, she even gave me a tree so that I could put my life and everything on the tree, my family and everything. It is precious what this girl does, these activities that they do."*

Personal connections also lead to an informal collective group support network that interrupts patterns of isolation and depression. Clients are connecting with other patients while building a sense of group wellness and attachment. A CAL therapist explains:

> *"…And then also like… by them joining these other groups and Wellness groups, it's also exposure. It's a form of exposure for them as well. So you know by them joining these groups and again doing the work, they don't necessarily have to be by themselves. They don't have to be on their own. They can do it with a group, a community supporting them."*

One client neatly summarizes how clients feel about the connections and care they receive from staff.

> … you are seeing the people who are coming in and everything, how they assist young people and everything. Very precious, all of them. I have never seen a person from the workers here treat us badly. Nothing!

Interconnected services

"*Well, they have all of this in the office.*"

A common theme conveyed by CAL clients is the opportunity to access an array of services, knowledge, and cultural events in one location. Clients often recount how they would pass and wave at each other as they go from one class or workshop to another; they simply did not have time to talk as they did not want to be late for their next meeting. They were so busy with a steady dose of program activities it became clear clients were sincerely engaged in something that was changing their lives. At several points during the review of these interview transcriptions, it was clear that line between therapy and educational and cultural events was blurred. Clients simply considered education, awareness training, cultural events and therapy as all parts of the same. More importantly, the interconnected services created a path to interrupt isolation and prevent depression. A CAL therapist explains:

> *"Yeah, I think you know my experience is that all of this is interconnected. It's weaved in, it's weaved in, and you know, for example, if a client comes in and their biggest issue is that they're isolating themselves, that they don't have any support and things like that, then I am going to, you know, encourage them to come to the club here. And I've had quite a few clients that have done that with and the benefit and outcome is huge because even after our therapy, they are still going to those classes. I still kind of run into them and you know they say hi and things like that. And you know, I think that's one of the biggest things that I've seen, especially with the adult population."*
>
> *The therapist continues… "With the older adults that I've worked with is that the theme of isolation is very common. And I hear from many of them say, 'if I didn't attend Gloria's group, if I don't come to these groups over here, I'm just at home by myself and I'm alone. And you know then that leads into other factors of like, OK, it's isolation and then maybe some other things like depression as well. Depression is also very common in older adults. So like, again, I think this is all very like interconnected. And if they are able to come to this place seeking one resource, but they're able to leave with five, yeah, then by all means. I think that's one of the greatest things that we're able to provide for them."*

Often, clients come to La Familia looking for assistance with non-health related problems but eventually wind up receiving mental health services. La Familia's intake process links clients to an array of social and health services that are all located on site. Intake services become opportunities for recruitment. The cross-pollinating or marketing of services takes place with Community Health Workers/Promotoras understanding how clients can benefit from or may need more than one service. One client explains how she unexpectedly found herself participating in CAL.

> "Well, I came wanting to find a lawyer, like to associate me to, well, to see how to do it and everything, but they told me it was a process that I had to do here, that I should come to the classes, and they showed me the classes, and well, I came to the first class they have on Tuesdays and Wednesdays. And I came, and well, I connected with Leo [CAL therapist] too because he had a class, and I loved it. I came when the class had already started, I don't know if it was the third or not, I don't remember. The program had already started, but that class with Leo helped me. They have helped me a lot, I don't know how to explain it. They helped me understand many things I didn't understand."

Similarly, another client explains their exposure to interconnected services and access to resources beyond therapy.

> "Well, I didn't know who I was going to meet, but when I arrived at the office here, they received me beautifully. Right away, they listened to everything, everything that I was asking for. Immediately, they told me, 'Look, we have service every day, we have activities here every day.' If I want, I can come every day… So, we have been coming because of that, that's why I came here. They told me, 'You can come; they have yoga. If one wants to learn about computers, they have many classes.' They have so many services, even for young people. If young people didn't finish their school, they have services here."

Here, a client explains how the array of services allows her a path to engage with others as she feels more comfortable and confident in her progress with the program.

> *"Yes, I started participating more in classes or therapies like yoga, Zumba, or salsa, or dance. I felt the change, and I felt very comfortable; I felt at home. And that's why I kept going. Then, I asked them for help, if they would allow me to help them in the rooms when the group was finished, to arrange things, to volunteer. They accepted me. They said, "Yes, of course." So, everything is blessed. But yes, I felt a lot of support mainly."*

CHW case management

From the 2021 CAL evaluation, we know that the CAL Community Health Worker/Promotora has an important role (or roles) in operationalizing the community focused program design into daily practice. Playing the part of emotional coach, client coordinator, client protector and advocate, program administrator, and everyday problem solver for both program and clients, the CAL CHW ensures that a steady flow between clients and utilization happens. The CHW helps both programs and clients adjust to external conditions such as COVID lockdowns and punitive immigration policies that might impact how a client feels about leaving their home to attend therapy or access other La Familia events.

One problem encountered with reviewing the role of the CHW is that they are involved in virtually every aspect of the CAL program operation from intake to triage to exit interview. Separating the CHW role from other characteristics of Client Satisfaction in this code co-occurrence analysis is virtually impossible as well as counterproductive to understanding the multidimensional characteristics of Client Satisfaction. A second problem with reviewing the role of the CHW is the quantity of relevant data contained in the interview transcriptions and how CHW activity appears in each aspect of what we know as Client Satisfaction. Client responses consistently demonstrate how the CHW is more than just a function of linkage to resources. Here, we briefly use the words of the clients to give insight on how the CHW's persistent attention and communication through navigation and case management activities goes beyond treatment and fosters trust between the clients and staff. A client explains how staff helped her to navigate access to medical care and resources.

> *"Because here they have helped me from filling a form. I come and pick it up. Ah, from the COVID tests, all the people who have helped me here. Rosie, Rosie is a great person too, as well as all the others, Rosie has helped me a lot. Gloria has also helped me on several occasions. Then they suggested the other programs that are there. Here I started to come to the Tuesday program that for me has been a great benefit… Yes, so here they have helped me a lot in all that. For example, Rosie has helped me a lot with doctors' schedules. Any appointment, any call to a doctor, Rosie has always helped me as well. She has helped me fill out the medical forms, apply for the stamps, that is, for me, for me*

this is a great benefit personally for me. And I feel very grateful. Very grateful to all the people because I have had very nice people who gave me all their support and all their help."

Another client explains how staff follow up with communication going beyond treatment and provides clues to understanding how on-going case management activities facilitates a seamless connection to other services.

They pay attention to you, they listen to your needs, and offer the help that they have. In fact, I'm currently attending classes on how to eat better, how to cook healthier. I'm attending classes and I will graduate next week. God willing, and very well. They are very kind. They are very attentive. And I feel comfortable; I don't feel like another number. As you said, I feel like a person who needs help, and they offer help. For example, they call me to remind me so that I don't forget the class. They send reminders. How else can I say? They ask me questions about how I'm doing today and such.

The client continues…. Yes, they gave me a personal appointment and told me, here are the services we have, and I planned many, many, which made me say "Wow," I never knew there were all those programs. And they started offering help like medical aid, too. I actually asked about work because of what I'm going through right now at my job. They have English classes.

Improved wellness

One important characteristic of Client Satisfaction is improved wellness. Signs or indicators of improved wellness can appear through how the client accepts their responsibility for their wellbeing, awareness of their condition, the ability to use the toolkit of approaches for calming episodes of distress, and how clients learn to put value themselves. Improved wellness leads to increased participation, utilization, retention, and improved personal and social relations. As the clients "buy into the program," personal connections and improved wellness appear to be mutually reinforcing experiences with program activities providing a path for success that the client has the freedom to accept on their own terms and at their own pace.

Here is one client reflecting on her progress through the program.

Seeing the results in myself, that they were helping me a lot, that they were bringing me forward, so to speak. And yes, I felt a lot of help.

Another client discusses their improved health and how they share it to convince others around her in similar situations how the program has helped her. Improved wellness is something clients want to share and as they assume a responsibility to help others, they become a recruitment asset for CAL.

"… because it [program] has helped me a lot to move forward. I am no longer afraid of this, afraid of that. It has strengthened my mind a lot. I have felt a lot of relief and confidence in doing things, in not being afraid to do this, and I can help others here. I can help them, and as they come, it gives me the confidence to tell them. I don't help them; I just try to see that they don't stop coming."

Yet again, recruitment by clients demonstrates their experience of improved wellness.

Well, I would tell them what I have done when I have run into people who have certain problems. I recommend that they come here. I tell them, go to La Familia's office. Tell them that you need a person to talk to. Whatever. Go there. I have recommend people to come here. Because here's the good stuff.

One client discusses her improved wellness through acceptance, awareness and learning how to value herself.

"To not be simple. Not be so harsh on myself. OK, he's [therapist] taught me I'm the one. I am the one that hurts myself the most. And that was hard to hear. I wanted to kick him. Because I'm always helping somebody else, I'm taking care of my grandkid. I'm doing things for them, going, doing their errands while they're at work, you know? Or something, going over to my sister's house. Helping them and stuff, you know, and I I'm doing that. But I'm still harsh on myself. And that was one of the things that I learned – to be nicer to myself. I know I'm not a bad person. I would never hurt anybody or abuse anybody or anything. But so I just thought that, you know, I would get that back in the universe. But no, Leo [therapist] says no."

Again, awareness and valuing self help us understand indicators of improved wellness.

Exactly! Here I learned from the people who helped me [understand] that I was worthy. That I, that is, that my person, had value.

When asked how do you feel after participating in the program, one client demonstrates several objectives of the program: improved wellness, awareness, valuing self, retention and provides the program with referrals.

Question: "How do you feel today after participating in the support center?"
Client: "Wow! I can say that tremendously, very, very well. As I said, I want to repeat the classes. Because, if possible, there's just a little time to absorb everything, but it has helped me a lot. It has helped me analyze and think. And OK, when I start having this thought, "Why is this thought coming?" I can reject it, say no! Or change to positive things or just go out and walk. As I said, I'm now recommending the program, telling other friends or even on the street… There was specifically one person I found, and I told her that I started attending classes that are very helpful for mental and emotional health… and now I want to take care of myself. Now I want to take a shower. Very different, very different. And indeed, I was also very worried about my son. And I'm learning to say, "I'm coming to seek help for me so I can help him." And this is helping me to analyze him, to understand, to set limits."

Awareness of one's condition is a clear sign of improvement with acceptance opening up the opportunity to apply the tools for identifying and deescalating episodes of personal crises. Here, a client talks about their experience of gaining insight into their condition.

"… But when they started talking about the topics and everything, I started to identify, like, oh, "Wow," I'm going through this, oh "Wow," this isn't normal. And as the teacher explained to me, it was Leo. He taught us how to identify things and how to deal with them. Getting to know oneself. All the topics we went through were excellent for me."

Seeing the improvement in themselves and in others helps convince clients to engage with the program resulting in increased utilization and retention. When asked what made her keep coming to the program, one client responded:

> *"First, when I saw Cynthia [therapist] talking with my sister, she started to change, even though she couldn't speak—it was difficult for her to communicate. Her self-esteem and personality changed, she became calmer. At first, she was maybe violent, probably because of what happened. But with patience and all the help here, it was different, which is good. 9eng.*

Finally, experiencing improved wellness leads to a path to move forward with sincere engagement and valuing oneself. A client explains:

> *Yes, it has truly helped me. It helps me to remember to value myself, to give myself time, to make space for myself, not just for others. Because I am a person who likes to help, I like to serve, and sometimes I forget about myself. So, that has helped me start setting limits, to say that I need space, and to be able to express that. And I am learning more. I'm currently working on that part with my individual therapist. We are in that phase, moving forward, but yes, truly, it has helped me a lot.*

The Eight Principles

Code co-occurrences between Client Satisfaction and codes similar to the program's Eight Principles accounted for 42%, or approximately 575 of all code co-occurrences. The interview data shows that clients are aware of how the program provides a family-type experience tied to culture and language and how the therapists and staff are attentive to conditions that impact their social, physical and mental health.[7] Or in other words, clients experience a learning and healing experience that deals with the "whole person." Clients express their freedom to engage, receiving care with respect, and constant attention from staff in ways that interrupt patterns of isolation and distress. Clients report how they gain the necessary tools for awareness, accepting responsibility for sincere engagement in their healing, and understanding how to face limitations and move forward.

One client demonstrates her experience with CAL's whole health approach to providing care.

> *"Look, they bring us therapists to teach us about nutrition, nutrition classes. And then, like yesterday, the day before yesterday, we had some people who came to teach us what to do in case of an earthquake or a fire and everything. And then they give us things, they give us the tools so that, in case something happens, or there is some crisis. You see, it's like we sometimes can't manage for some reason, it's true. So here one comes and they give us the vaccines. Here they come and, as I tell you, they take our blood pressure and everything. And it seems to me that all of that is so important for everyone, for everyone,*

The Eight Principles

- Community
- Authenticity
- Empowerment
- Mutual Respect
- Ownership
- Awareness
- Family Emphasis
- Cultural Responsiveness

[7] Using the code co-occurrence method for identifying linkages between Client Satisfaction and the Eight Principles resulted in an unexpected large number of references in the transcribed interview data. Due to the size of the data set, only a small portion of the rich and relevant client stories can be displayed in the report.

because we are all old people now."

Here, one client shows how staff helped her navigate multiple problems she faced while participating in the program

> *"I lost my job. My boss sold the business. I had no money, no money in my pocket for Christmas. Nothing, right? And so, ah, they helped me. They gave me things for her [daughter]. They gave me everything. They gave me Christmas stuff that I could take home and wrap for her and I didn't have to buy any clothes, shoes, coats. Bowls, they said, "What do you need for your house? I said, believe it or not, bowls with the lids. They got me those. They got me a toaster. Because I love toast. But my toaster broke. Just things like that. They see if you need something and then they'll do their best to get it for you. They really will."*

The client continues.

> *"My granddaughter was born addicted to crack. Heavy crack use. She's adopted. And so she's just acting up and I need it [assistance]. And I think that she's OCD, not OCD, but attention deficit disorder. And we didn't realize it before. But now that she's having to go to school and sit down and behave and stuff, she's just acting up and kicking. So I got the information from here. And I signed up and she has a zoom class. I've gotten that information. Yes, she has a zoom class. And I also got the other information about getting her diagnosed because, you know, I've gotten all that information from here."*

Here, a client demonstrates how the program is attentive to both physical and mental health, imparts life skills to take care of self and others/family, all while interrupting patterns of isolation.

> *"Well, I love living together, feeling like as I say… sometimes at home, one is alone. And here there is company, you can talk, I love the programs where you paint, that is, all the activities that are done are very important, the classes also, like yesterday they talked to us about how to take care of people who have diabetes, everything, that is, all the... what would you call them, the classes? Because in each activity there are different teachings. That's what I love. Very good."*

Clients were clear that culture and language have an important role in the path towards wellness. Clients reported how they were able to take a proactive role in their healing once they understood the treatment process. Clients were able to gain awareness and how to apply the toolkits of knowledge and coping skills learned through therapy, education, and group sessions. Clients were asked how important was it that the staff was bilingual and spoke Spanish like us and that they attended to you in your language. Here are a few of their responses.

> *"No, it was what gave me the courage to face things because I was listening to my own language, and I understood perfectly what they wanted to tell me, in the way they wanted to help me, and all that was what helped me, that I could understand everything in my own language."*

> *"Oh, it was everything. I don't speak English. I don't speak English. So, for me, that has been… that's why I don't go to other centers. Because at other places, they speak English. Going to an English class—I'd just sit there with a "what?" face, like "what did*

they say?" No, no way. So, for me, finding this place where they speak Spanish… that was everything."

"A lot! Because, as I told you, it took me about two years to find help in Spanish. Like, oh, finally, finally, yes. And everyone was very friendly, from the entrance, how they receive you. My first interview was like that. They asked me questions, they gave me a questionnaire, they also listened to me, I mean, it was the most Mexican-Latino thing I found here! Oh, I don't know, well, I don't know, the language, the manners, yes."

"Oh, it was very important—so we can understand each other better… Very important, because we know little English, but in our language, we feel more confident to communicate."

"Very important. Some people really struggle with English, so getting help in Spanish is critical. It helps a lot; some people struggle with the language, but even a few words can help them understand the case or problem… It's important because sometimes the speaker doesn't know Spanish or English, but there's usually someone to translate."

Clients also reported how their connection to CAL was made through trusted sources such as the local church or friends and family members. Having services embedded in their neighborhood was important as it increased access to whole bundle of services that were previously inaccessible to them.

"Well, it was something that, as I said, I came to church. The priest spoke about the center and recommended it for all the people who had these problems. And that's where I caught on. I said, "Oh, well," and then it was just across the street. I said, "No, well, here I am." I came and registered. And yes, thank God, I had a very good therapist. They treated me very well, and they still help me to this day."

"Immediately, they told me, "Look, we have service every day, we have activities here every day." If I want, I can come every day, but we only come one day because my husband sleeps a lot now. So, we have been coming because of that, that's why I came here. They told me, "You can come; they have yoga. If one wants to learn computers, they have many classes." ... They have so many services, even for young people. If young people didn't finish their school, they have services here."

"How I found out, well, I found out when I came to the English classes and I saw [everything]. I found out about all the events they offer and I took advantage of them. I joined the seniors' group and I joined the computer classes. I have joined the events that are held here. Like when it's Children's Day, Mother's Day events, for example, and well, Christmas and so on, I have taken advantage of that."

The Whole Enchilada

In their book *The Enchilada Approach to Reawaking Therapy* (1978), La Familia co-founders Fernandez and Barnes emphasize the goal of developing an active, multifaceted approach to community mental health and client care that "reawakens them in relation to family and community." Wellness interventions are directed toward the familial, cultural, ethnic, and socio-economic context of each client ensuring that the purpose of the program is them.

For CAL clients, “The Whole Enchilada” is experiencing the full effect of Reawakening Therapy, a bundle of therapeutic, educational, and social strategies delivered with cultural competence that interrupts patterns of distress and isolation. Clients explain…

> *“A lot of everything, everything has been positive everything, everything. It has been a special place for me here, because here it has a one-like atmosphere, you can clear your mind, everything is wonderful. In everything, in everything they have supported me, I thank God and them, the people all here are very kind.”*
>
> *“Because, you see, inside the room, there are so many activities. Look, there, we do art, we sing, we dance. Many people don't even have—well, poor things—they don't even have a hug from someone, and there, we all hug each other, and it's very nice; it's a family. If they know someone is sick, we even call their homes. There are 70 people in that class.”*
>
> *“Well, I think that these services are here to support anything. That… this is for me. It would be very sad if that disappeared. Because why? I, like many of my colleagues who come here, are already adults, we can no longer just be alone in the house. Yes, so for me it is very important that none of that disappears, because that has helped me to coexist with people. That I feel like what? I needed that a lot. And I still need that. To coexistence, exactly.”*
>
> *“Just this Friday, Pancho—a fellow participant—told me: “Silvia,” and people tell me this often, “Oh Silvia, really, thinking about how you were when you first arrived and seeing you now… it’s just amazing.” And I say, “Yes, I know, I feel it.” That’s why I don’t stop coming. The only reason I miss it is if I have a doctor’s appointment, which is rare. Otherwise, I will never stop coming. I mean… no. Truly, truly. Gloria, Rosie, the assistants, my fellow group members… no, it’s just…It’s something very beautiful.”*
>
> *“Yes, well, look at the… I say we because my husband also tells me that that he feels very supported by the people here. Because whenever we have needed something, they are there for us. They are there for us, that's the word, they are for us because we are not the only ones then. For the people who have always helped us. This, well, it's not so easy to serve so many people too, right? But they have always treated us with that pleasure, with that joy, with that way of helping us… For me personally, especially as I say, Rosie is a person who for us, I don't know, has always been available. Truly.”*

The Whole Enchilada is also about how meaningful personal connections develop from both the client and staff experience. A staff person recently shared how clients responded when CHW Rosie was absent for one session after the unexpected loss of her spouse. “Clients immediately noticed and began asking other CHWs about her whereabouts, even calling or texting her directly until she briefly replied to one person, who then spread the word [to other CAL clients].” By the 2nd week, after management informed staff, CHWs were finally able to share with clients the reason for her continued absence, which many participants had already learned about (even before staff). The staff member recounts how deeply moved and concerned clients were for Rosie, “…clients requested to hold a rosary prayer in his memory and gathered heartfelt cards and messages, which management later delivered to Rosie, a gesture that profoundly touched both her and the CHW team.” We can see how the sense of family and caring unfolds between clients and staff through personal connections, cultural practices, and sincere levels of engagement and trust.

Finally, a client summarizes their time in CAL demonstrating the effects of personal connections, continuous support, and social and educational activities through a cultural lens – the whole enchilada…

> *"It's nice. Everything has been very good, I am very grateful for this, the support that they have given, not only to me, but to many people who come here. Yes, I am very grateful for everything. It has been very good. I'll tell you that for sure. It's been a place - the best place is any Christmas here."*

Discussion

This evaluation revisits questions and findings from the 2021 CAL evaluation where a combination of qualitative and quantitative research methods suggested a strong positive association between mental health treatment outcomes and cultural competence. La Familia's use of Reawakening Therapy as the foundation for the multidimensional program design "Cultura de Salud" that emphasizes culture as an important component of wellness was the starting point for this evaluation. More specifically, this evaluation attempts to respond to the following research questions:

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

As in the 2021 evaluation, four different data sources were reviewed to assess whether mental health programs designed with a focus on a client's culture can strengthen individual wellness and resilience, reduce risk factors associated with mental illness, and maintain client retention in program treatment. This evaluation also seeks insight into whether the 2021 findings came about through intention rather than coincidence.

Like the 2021 evaluation, the statistical analysis of the SWE data in this report suggests that clients experienced significant and positive changes in wellbeing during their participation in CAL. Similarly, regression analysis of the SDS data showed very strong evidence of client improvement following program participation. The review of FIT data on client/therapist alliances shows that strong and positive alliances needed for successful therapy occurred without any dropouts; the FIT data also revealed clinically significant improvements in client wellness.

The academic literature on community mental health referred to earlier in this report argues that positive mental health treatment outcomes reported by patients are indeed related to client satisfaction. Here, the evaluation took a deeper, more focused analysis of client satisfaction using client and staff interview data. Content Analysis was used on the interview data to gain further insight into why the positive outcomes for CAL clients continue to occur. We also want to know and understand the characteristics of Client Satisfaction, which we now know has much to do with positive client outcomes.

In contrast to the previous evaluation where predefined categories were used for coding interview data, Inductive Coding became the primary method to identify and label themes emerging directly from client statements. This method of coding qualitative data introduces a Grounded Theory approach to coding that starts from a clean slate where no preconceived categories exist. Grounded Theory is an inductive approach to qualitative data analysis that builds theory from the ground up—starting with raw data and letting patterns emerge organically from the voices of the clients. It allows us to identify the themes or

characteristics associated with the concept of client satisfaction from the words and feelings of the clients.

Applying the Ground Theory approach to interview data through Code Co-occurrence methods revealed that the approach to a cultural-based community health program is a balanced approach that includes support, connections, and the attention to mind, body, and spirit that cultural practices emphasize. We can now formulate a basic conceptual map of the activities that lead to client satisfaction and wellness that can be seen as a basic theory of change for the program.

Figure 12: Grounded Theory Conceptual Map: CAL Client Satisfaction

The use of grounded theory via the code co-occurrence method allows this analysis to leverage the voices of clients and staff to confirm two basic findings for the CAL program: First, client satisfaction is positively impacted by the use of a multidimensional program design where treatment is centered around the client experience; and second, client satisfaction is contingent upon the ability of the program to implement the multidimensional vision through strong therapeutic alliances, cultural competence (eight principles) and array of seamlessly integrated services that are accessible due to the their location in the community.

Content analysis findings suggest that the integrated cultural approach to the CAL community mental health program design was indeed a **central mechanism** of healing for CAL patients. The integrated approach significantly promotes wellness for clients by addressing the interconnected nature of their needs; emotional, psychological, physical, and social. A CAL clinician explains the advantages of the program design:

> *"Many of our clients face many complex challenges that cannot be effectively treated by just therapy. So by combining services such as therapy, case management, peer support, Wellness groups, group therapy, and others, other things as well, we're able to meet clients where they are and walk with them holistically through the healing process."*

This approach improves continuity of care. It reduces the gap in services and allows for better coordination among staff and with external providers. The CAL clinician informs us that the integrated approach also fosters a sense of safety and trust, especially for clients who have experienced trauma and systemic barriers. The clinician also reports that clients have often expressed feeling more supported and empowered.

The CAL clinician adds:

> *"Because of the team and working collaboratively on their [clients] behalf, I would say that we've seen improved engagement and a greater progress toward towards goals and increase overall functioning and quality of life."*

Although not an intentional goal of the inductive coding methods used for our context analysis, the 2025 results revealed surprisingly similar findings to the 2021 CAL evaluation: a high degree of client satisfaction, increased utilization and participation, 100% retention, and outcomes highly associated with the program's Eight Principles.

As in the previous evaluation, three different approaches to triangulation were used to increase confidence in the findings presented here providing a more comprehensive picture of the results than just one research method can convey. Data triangulation incorporated four different data sources, both quantitative and qualitative, into the analysis. Methodological triangulation incorporated multiple ways of both qualitative and quantitative analysis. And theory triangulation incorporated three theoretical perspectives used to conceptualize and design an evaluation for a culturally centered community mental health program. Together, these approaches provide a clearer picture of the problems encountered in considering the value of cultural assets in the evaluation process as well as increasing confidence in the findings presented in this report.

Conclusion

This evaluation of the Centro de Apoyo Latino analyzed client-reported data following their participation in the treatment program. As in the 2021 evaluation, this evaluation finds that program participants reported significant improvement in their ability to manage emotions when engaged in work, school, social, and family interactions. Multiple sources of client data and multiple methods for analyzing the data used in this evaluation point to a strong connection between culture and wellness. After two consecutive evaluations with similar findings using similar rigorous analytical methods, this culture/ wellness connection appears to be much more than random coincidence.

Two program design components stand out as important to the success of CAL. First Reawakening Therapy, the guiding theoretical lens that requires consideration of a client's complete social and cultural situation, was created at La Familia by its founders in 1978. Treatment begins with focusing on the whole person in relation to the external realities in which they live (Fernandez and Barnes 1978). Clients under this whole person approach are "reawakened" in relation to family and community.

Second, making Reawakening Therapy a reality in the practice of community mental health requires a multidimensional approach to properly activate the factors influencing "whole person" health. Through this pilot, La Familia has demonstrated its seamless integration of education and awareness, access to services, and navigating resources, with therapy and personal connectivity; all guided by a connection to cultural practices that clients know and use in their daily lives. La Familia's Cultura de Salud, or Culture of Health, serves as the multidimensional approach to community mental health that makes the principles found in Reawakening Therapy a daily practice for both clients and staff.

Why is this program so important? Data from the State of California's 2022 report Assessing the Continuum of Care for Behavioral Health Services supports the notion that marginalized groups, including Latinos and the places they live, experience higher rates of behavioral health conditions and

barriers to accessing care. Locally, the Performance of the Sacramento County Mental Health System Report shows how low penetration rates for Latino youth and non-English speakers, continue to increase exacerbating the known equity gaps in service delivery. Sacramento County's suicide prevention data clearly show pronounced equity gaps with the highest rates for emergency room visits for suicidal ideation and attempted suicide in the LFCC service area. In sync with CRDP objectives, the CAL program provides proven strategies for intervention, wellness, and retention that can be used to offset low penetration rates in local target populations and in other communities across the state.

The importance of programs like CAL cannot be understated. However, programs like CAL are in constant danger of ending as funding becomes increasingly challenging; the State's recent $12 billion budget deficit required cuts across 260 state programs provides such evidence.[8] CRDP funding survived those cuts at the last minute. Two recommendations are offered here that may help in finding new sources of funding for programs like CAL.

First, continue the state level collection and processing of SWE data. Local programs do not have the budget or the staffing to support data collection and data management efforts. Efforts should be made at the state level to investigate the cost for continuing this data management function once the project ends. Quality data is critical for justifying the operation of each local program borne though the CDRP and for effective administrative oversight.

Second, the data can be then leveraged to complete a local cost benefit analysis for each program. State staff and PARC should develop a template for a local cost benefit analysis that each program can use to demonstrate cost effectiveness and cost avoidance to potential funders. Since the cost benefit analysis methodology has been developed for the statewide analysis, a similar methodology can be used for developing a template for local programs. Rather than have multiple local versions of a CBA, the state and PARC should take the lead to develop a standardized CBA that local programs can use to create new paths and partners for additional funding. This will add credibility to the CBA instrument and remains an important opportunity for the State, PARC, and the Technical Advisors to bring a high level of much needed technical support to local programs.

The "Secret Sauce"

We have dissected the performance of this program in multiple ways using multiple methods of analysis and multiple data sources and countless hours of onsite observations. The findings are clear. A connection between culture and wellness exists. Leveraging this connection to interrupt distress and improve mental wellbeing can produce positive results. However, the key ingredient – the secret sauce - to the success of this program is the sincere dedication of its staff to their clients. Constant support to clients with a personal connection and their strong focus on the importance of culture to guide strategies for care demonstrate that a dedicated group of people at every level of the organization is essential for client success to happen. From all the workshops, public meetings, educational activities, and family activities that run from early morning into the evening hours to staff generating and responding to emails late into the night/morning and through the weekend, it is evident that the improved wellness of each client and their families comes through an abundance of caring and support from a group of people deeply committed to service.

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[8] See California Closes $12 Billion Budget Deficit With Hit to Migrants. Newsweek, Jun 28, 2025. California Closes $12 Billion Budget Deficit With Hit to Migrants - Newsweek;
California has a multibillion-dollar budget deficit. Here's what you need to know. Associated Press, May 10, 2025. California has a multibillion-dollar budget deficit. Here's what you need to know | AP News

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Appendices - Forms

La Familia Forms

A. Cultural and Social Impact Scale (CSIS) Pre & Post

B. Cultural Services Satisfaction Questionnaire (CSSQ's)

- CSSQ A
- CSSQ B

C. Sheehan Disability Scale (SDS)

- SDS- Pre
- SDS- Post

Feedback Informed Treatment (FIT) Forms

D. FIT Session Rating Scale - SRS

E. FIT Outcome Rating Scale - ORS

California Reducing Disparities Project (CRDP) SWE Forms

F. SWE Pre- Treatment Questionnaire

G. SWE Post- Treatment Questionnaire

Cultural and Social Impact Scale (CSIS) Pre & Post

La Familia COUNSELING CENTER, INC.

CULTURAL AND SOCIAL IMPACT SCALE (CSIS)

Unique ID#:

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

PRE

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

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

POST

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

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

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

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

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

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

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

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

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

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

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

13. How did you hear about us? _____

14. NOTES:

_____

_____

_____

_____

Updated on 11/14/19

Cultural Services Satisfaction Questionnaire
Cultural Services Satisfaction Questionnaire - CSSQ A

CSSQ-A
Centro de Apoyo Latino (CAL)

Instructions:
This form is to be completed during a client's *first* intake session by the CAL Promotora/Community Health Worker/Navigator. Further use is for CAL staff only. Refer to the Policies and Procedures for further information.

Client ID #: 03-05-_ _ _ _ **Date:** _____

Preferred Language: _____

Medi-Cal Beneficiary: ( ) Yes ( ) No

CSIS Scores: _____ (current)/_____ (strengths)

Navigation time spent on this session:

_____ **start time** _____ **end time** (total: _____ minutes)

Indicate whether navigation was ____ in-person (G0019) ____electronic/call

Please circle the levels of urgency: Emergency/Urgency/Priority/Sustainability

[Client Needs]

Based on what the client states they need, mark all that apply:

( ) Law Enforcement ( ) Intervention

( ) Suicide Prevention ( ) Drug & Opioid Prevention

( ) Emergency Shelter Assistance ( ) Natural Disaster Relief Services ( ) Utility Company Calls

( ) Nutrition ( ) Clothing ( ) Permanent Housing ( ) Transportation

( ) Social Welfare Services ( ) Birth and Beyond

( ) Immigration Legal & Law Assistance ( ) Non-Immigrant Legal & Law Assistance

( ) Medical Care- Urgent ( ) Medical Care-Non Urgent

( ) Health Insurance/Medi-Cal ( ) Mental Health Support (Therapy/ Support Group) ( ) Mental Health Urgent

( ) Education ( ) Employment

( ) Other *(Description)*:_____

[Recommended Plan of Care]

Based on client's needs develop a plan that considers 1 or more of the following:

( ) Health Education

( ) Health Navigation

( ) Screening & Assessment

( ) Individual Support & Advocacy

Reviewed on 01/09/2025

[Recommended Referrals]	**Provider Name(s)**
___ Permanent Housing	_____
___ Emergency Shelter Assistance	_____
___ Intervention	_____
___ Drug & Opioid Prevention Services	_____
___ Utility Company	_____
___ Nutrition	_____
___ Education	_____
___ Employment	_____
___ Law Enforcement	_____
___ Health Insurance (circle one) Medi-Cal/ Private	_____
___ Medical Practitioner/Healthcare	_____
___ Non-Immigrant Legal & Law Assistance	_____
___ Immigration Legal & Law Assistance	_____
___ Mental Health Support	_____
___ Transportation	_____
___ Social Welfare Services	_____
___ Medical Care- Urgent	_____
___Medical Care-Non Urgent	_____
___ Mental Health Urgent	_____

[Internal Referral- LFCC Services]

Mark all that apply:

( ) Mental Health ( ) Youth Wellness ( ) Career Center ( ) Wellness ( ) Birth & Beyond

[Session Notes] *Example: Discussed the patient's life story, needs, goals, preferences, and desired outcomes for 30 minutes. Assisted with XYZ application for 5 minutes. Referred and connected the patient to XYZ services for 20 minutes*

Reviewed on 01/09/2025

La Familia COUNSELING CENTER

CSSQ-B

Centro de Apoyo Latino (CAL)

Instructions:
Please complete *each* section of this form when a CAL Promotora/Community Health Worker/ Navigator provides navigation services to a client, not limited to phone calls, home visitations, travel time, etc. *per interactions/service.* Refer to the Policies and Procedures for further information.

Client ID #: 03-05-_ _ _ _ **Date:** _____

Preferred Language: _____

Medi-Cal Beneficiary: ( ) Yes ( ) No

Navigation time spent on this session:

_____ **start time** _____ **end time** (total: _____ minutes)

Indicate whether navigation was ____ in-person ____via electronic/call (G0022)

Please circle the levels of urgency: Emergency/Urgency/Priority/Sustainability

What type of navigation service did CAL staff provide?

( ) Health Navigation

( ) Health Education

( ) Screening & Assessment

( ) Individual Support & Advocacy

Did CAL staff provide language translation during the service? ( ) Yes ( ) No

Was the navigation service billable according to DHCS criteria?

If Yes, mark the following code: ( ) 98960: individual patient

If No, briefly explain in key words: _____

_____

Did the client use the referred services?

(If Yes or No, briefly explain in key words) ( ) Yes ( ) No

_____

_____

_____

Continue on the back page

Reviewed on 01/09/2025

-

[Recommended Referrals]	Provider Name(s)
___ Permanent Housing	_____
___ Emergency Shelter Assistance	_____
___ Intervention	_____
___ Drug & Opioid Prevention Services	_____
___ Utility Company	_____
___ Nutrition	_____
___ Education	_____
___ Employment	_____
___ Law Enforcement	_____
___ Health Insurance (circle one) Medi-Cal/ Private	_____
___ Medical Practitioner/Healthcare	_____
___ Non-Immigrant Legal & Law Assistance	_____
___ Immigration Legal & Law Assistance	_____
___ Mental Health Support	_____
___ Transportation	_____
___ Social Welfare Services	_____
___ Medical Care- Urgent	_____
___Medical Care-Non Urgent	_____
___ Mental Health Urgent	_____

[Internal Referral- LFCC Services]

Mark all that apply:

( ) Mental Health ( ) Youth Wellness ( ) Career Center ( ) Wellness ( ) Birth & Beyond

[Session Notes] *Example: Discussed the patient's challenges accessing healthy foods and options to improve the situation for 15 minutes. Assisted with the SNPA application for 30 minutes. Referred patient to XYZ food pantry."*

Reviewed on 01/09/2025

Sheehan Disability Scale

PRE: Sheehan Disability Scale| *Client ID: 03-05-_____*

Now, think about the month, within the past 12 months, when you were at your worst emotionally. Did your emotions interfere a lot, some, or not at all with your…

1. … performance at work or school?
   A Lot ***Some*** ***Not At All*** ***Refused*** ***Don't Know***
2. … household chores?
   A Lot ***Some*** ***Not At All*** ***Refused*** ***Don't Know***
3. … social life?
   A Lot ***Some*** ***Not At All*** ***Refused*** ***Don't Know***
4. … relationships with friends and family?
   A Lot ***Some*** ***Not At All*** ***Refused*** ***Don't Know***
5. The above items are often used to describe how emotions affect people live. To what extend do the above questions (1-4) match how you would describe the negative effect of emotions on your life?
   A Lot ***Somewhat*** ***Not At All***

Reviewed on 01/09/2025

POST: Sheehan Disability Scale| *Client ID: 03-05-_____*

Now, think about the month, within the past 12 months, when you were at your worst emotionally. Did your emotions interfere a lot, some, or not at all with your…

1. … performance at work or school?
   A Lot ***Some*** ***Not At All*** ***Refused*** ***Don't Know***
2. … household chores?
   A Lot ***Some*** ***Not At All*** ***Refused*** ***Don't Know***
3. … social life?
   A Lot ***Some*** ***Not At All*** ***Refused*** ***Don't Know***
4. … relationships with friends and family?
   A Lot ***Some*** ***Not At All*** ***Refused*** ***Don't Know***
5. The above items are often used to describe how emotions affect people live. To what extend do the above questions (1-4) match how you would describe the negative effect of emotions on your life?
   A Lot ***Somewhat*** ***Not At All***

Reviewed on 01/09/2025

Feedback Informed Treatment- FIT

FIT Session Rating Scale - SRS English Version

Session Rating Scale (SRS V.3.0)

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

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

Relationship

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

Goals and Topics

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

Approach or Method

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

Overall

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

Institute for the Study of Therapeutic Change

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**Visit www.talkingcure.com to view the Spanish version*

FIT Outcome Rating Scale - ORS English Version

Outcome Rating Scale (ORS)

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

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

Individually
(Personal well-being)

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

Interpersonally
(Family, close relationships)

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

Socially
(Work, school, friendships)

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

Overall
(General sense of well-being)

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

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**Visit www.talkingcure.com to view the Spanish version*

State Forms -SWE
Statewide Evaluation Pre

ADULT VERSION (18+) ID: ___ ___ - ___ ___ - ___ ___ ___
PRE Priority Pop Code IPP Code CDEP Participant Code
Date: _____

La cultura significa muchas cosas diferentes para distintas personas, pero se trata de algo que es por lo general compartido por un grupo más o menos grande de personas. Para algunos tiene que ver con las costumbres y las tradiciones. Para otros significa su herencia y un modo de vivir. Puede hacer referencia a creencias, valores y actitudes, su identidad, y a la historia compartida y la pertenencia a un grupo. Las siguientes preguntas son sobre la principal cultura con la que se identifica, específicamente la cultura que influye en sus creencias y valores y en su forma de actuar.

En estos momentos	Muy de acuerdo	De acuerdo	Neutral	En desacuerdo	Muy en desacuerdo
1. La cultura de usted le da fortaleza.	☐	☐	☐	☐	☐
2. Su cultura es importante para usted.	☐	☐	☐	☐	☐
3. Su cultura le ayuda a sentirse bien sobre quién es usted.	☐	☐	☐	☐	☐
4. Usted se siente conectado(a) a las tradiciones religiosas o espirituales de la cultura en la que creció.	☐	☐	☐	☐	☐

Instrucciones: Las siguientes preguntas se refieren a cómo se ha sentido usted en los últimos 30 días.

Durante los últimos 30 días, ¿más o menos con qué frecuencia se sintió...	Siempre	Casi siempre	Algunas veces	Pocas veces	Nunca
5. ...conectado(a) a su cultura?	☐	☐	☐	☐	☐
6. ...balanceado(a) en mente, cuerpo, espíritu y alma?	☐	☐	☐	☐	☐
7...apartado(a) y/o excluido(a) de la sociedad? *(En otras palabras, que le hicieron sentirse sin importancia o que sus pensamientos, sentimientos u opiniones no importaban.)*	☐	☐	☐	☐	☐
8. ...aislado(a) y/o alejado(a) de la sociedad? *(En otras palabras, sentirse solo, separado de o distanciado del mundo más allá de su familia, escuela y amigos.)*	☐	☐	☐	☐	☐

9. ¿Actualmente cuenta con alguno de los siguientes tipos de seguro médico o planes de cobertura médica? Elija todas las opciones que correspondan.

☐ Seguro a través de un empleador o sindicato *(union)* actual o anterior (suyo o de un familiar)	☐ Servicio de salud para nativos americanos
☐ Seguro adquirido directamente de una compañía de seguros (por usted o por un familiar)	☐ Cualquier otro tipo de seguro médico o plan de cobertura de salud
☐ Medicare, para adultos mayores (65 años o más) o personas con ciertas discapacidades	☐ Actualmente, no cuento con ningún plan de cobertura de salud
☐ Medicaid, Medi-Cal Assistance o cualquier tipo de plan de asistencia gubernamental para personas de bajos ingresos o una discapacidad	☐ No sé cuál es mi plan de cobertura de salud
☐ Medi-Cal de emergencia	

Piense en todos los gastos médicos "de su bolsillo" del último año, como citas con el dentista o el médico, visitas al hospital, gastos de salud mental, primas/pagos mensuales del seguro, etc. Si sumaran todos estos gastos...

10. ¿Cuál de estas categorías representa mejor cuánto pagó "de su bolsillo" por gastos médicos en los últimos 12 meses? Puede elegir la opción que mejor estime.

☐ $0 a $99	☐ $500 a $699	☐ $1,100 a $1,299	☐ $1,700 a $1,899
☐ $100 a $299	☐ $700 a $899	☐ $1,300 a $1,499	☐ $1,900 a $2,099
☐ $300 a $499	☐ $900 a $1,099	☐ $1,500 a $1,699	☐ $2,100 o más

11. Debido a problemas de salud mental, emociones, nervios o uso de alcohol o drogas, ¿en los últimos 12 meses hubo algún momento en el que usted SINTIÓ QUE QUIZÁS NECESITABA ver a...	Sí	No	Prefiere no responder	No sabe	No aplica
a. Un(a) profesional tradicional como un(a) curandero(a), líder o consejero(a) religioso(a)/espiritual, naturista, espiritualista o medium, santero(a), psíquico(a), astrólogo(a) o a un(a) sobador(a)	☐	☐	☐	☐	☐
b. Un(a) profesional comunitario(a) de ayuda como un(a) trabajador(a) de la salud, promotor(a), consejero(a) de pares o administrador(a) de casos	☐	☐	☐	☐	☐
c. Médico de atención primaria o de salud general	☐	☐	☐	☐	☐
d. Profesional de salud mental como un(a) consejero(a), terapista, psicólogo(a), psiquiatra, o trabajador(a) social	☐	☐	☐	☐	☐

12. Debido a problemas con su salud mental, emociones o uso de alcohol o drogas, ¿HA VISTO USTED a alguno de los siguientes profesionales de ayuda en los últimos 12 meses?	Sí	No	Prefiere no responder	No sabe	No aplica
a. Un(a) profesional tradicional como un(a) curandera(o), líder o consejero(a) religioso(a)/espiritual, naturista, espiritualista o medium, santero(a), psiquico(a), astrólogo(a) o a un(a) sobador(a)	☐	☐	☐	☐	☐
b Un(a) profesional comunitario(a) de ayuda como un(a) trabajador(a) de la salud, promotor(a), consejero(a) de pares, o administrador(a) de casos.	☐	☐	☐	☐	☐
c. Médico de atención primaria o de salud general	☐	☐	☐	☐	☐
d. Profesional de salud mental como un consejero(a), terapista, psicólogo(a), psiquiatra, o trabajador(a) social	☐	☐	☐	☐	☐

Las siguientes preguntas se refieren a cómo se ha sentido usted durante los últimos 30 días.

Durante los últimos 30 días, ¿más o menos con qué frecuencia se sintió usted...	Siempre	Casi siempre	Algunas veces	Pocas veces	Nunca
13. ...nervioso(a)?	☐	☐	☐	☐	☐
14. ...sin esperanza?	☐	☐	☐	☐	☐
15. ...inquieto(a) o intranquilo(a)?	☐	☐	☐	☐	☐
16. ...tan deprimido(a) que nada podía levantarle el ánimo?	☐	☐	☐	☐	☐
17. ...que todo requería un esfuerzo?	☐	☐	☐	☐	☐
18. ...que no valía nada?	☐	☐	☐	☐	☐

La siguiente pregunta es sobre su salud en los últimos 30 días.

19. Diría que, en general, su salud es...

☐ Excelente ☐ Muy buena ☐ Buena ☐ Regular ☐ Mala

20. En relación con su salud física, que incluye enfermedades y lesiones físicas, ¿durante cuántos días de los últimos 30 días su salud física no fue buena?

☐ Número de días _____ ☐ Ninguno ☐ No sé/No estoy seguro(a)

21. En relación con su salud mental, que incluye estrés, depresión y problemas emocionales, ¿durante cuántos días de los últimos 30 días su salud mental no fue buena?

☐ Número de días _____ ☐ Ninguno ☐ No sé/No estoy seguro(a)

22. Durante los últimos 30 días, ¿durante cuántos días aproximadamente la mala salud física o mental le impidió realizar sus actividades habituales, tales como el cuidado personal/recreación (p. ej., bailar, hacer ejercicio, descansar, salir con amigos), el trabajo o la escuela?

☐ Número de días _____ ☐ Ninguno ☐ No sé/No estoy seguro(a)

23. ¿Cuántos años tiene usted?

☐ entre 18 y 29 ☐ entre 45 y 49
☐ entre 30 y 39 ☐ entre 50 y 64
☐ entre 40 y 44 ☐ 65 años o más

24. ¿Cuál es su raza y origen étnico? *Marque solo una categoría de raz y escoja sus orígenes étnicos.*

☐ Indio americano o nativo de Alaska

☐ Negro o afroamericano. Especifique sus orígenes étnicos:

☐ Afroamericano ☐ Keniano ☐ Nigeriano ☐ No sabe
☐ Caribeño ☐ Sudafricano ☐ Etíope ☐ Otro negro o afroamericano. (por favor especifique): _____
☐ Egipcio ☐ Ghanés ☐ Prefiere no responder

☐ Latino, hispano o español. Especifique sus orígenes étnicos:

☐ Mexicano/chicano ☐ Hondureño ☐ Chileno ☐ No sabe
☐ Salvadoreño ☐ Puertorriqueño ☐ Colombiano ☐ Otro latino. (por favor especifique): _____
☐ Guatemalteco ☐ Cubano ☐ Nicaragüense
☐ Dominicano ☐ Peruano ☐ Prefiere no responder

☐ Asiático: Especifique sus orígenes étnicos:

☐ Afgano ☐ Hmong ☐ Malasio ☐ Prefiere no responder
☐ Bangladesí ☐ Indio (India) ☐ Paquistaní ☐ No sabe
☐ Birmano ☐ Indonesio ☐ de Sri Lanka

	☐ Camboyano ☐ Chino ☐ Filipino	☐ Japonés ☐ Coreano ☐ Laosiano	☐ Taiwanés ☐ Tailandés ☐ Vietnamita	☐ Otro asiático (por favor especifique): _____
☐ Nativo hawaiano o de otra isla del Pacífico. Especifique sus orígenes étnicos:				
	☐ Samoano ☐ Guameño	☐ Tongano ☐ de Fiji	☐ Prefiere no responder ☐ No sabe	☐ Otro hawaiano o isla del Pacífico (Por favor especifique): _____
☐ Multi-racial: Por favor marque todo lo que corresponda y especifique sus orígenes étnicos.				
	☐ Blanco (Por favor especifique): _____ ☐ Negro o afroamericano (Por favor especifique): _____ ☐ Latino, hispánico, o español (Por favor especifique): _____ ☐ Indio americano o nativo de Alaska (Por favor especifique): _____		☐ Asiático (Por favor especifique): _____ ☐ Nativo hawaiano o de otra isla del Pacífico (Por favor especifique): _____ ☐ Prefiere no responder ☐ No sabe	
☐ Blanco: *Por favor especifique sus orígenes étnicos:* _____				
☐ Otra raza: *Por favor especifique su raza y sus orígenes:* _____				
☐ Prefiere no responder				
☐ No sabe				

25. ¿Qué tan bien puede hablar el inglés?

☐ Muy bien
☐ Bien, me puedo hacer entender, pero tengo algunos problemas con ello
☐ No muy bien: conozco muchas palabras y frases, pero tengo dificultades para comunicarme
☐ Conozco algo de vocabulario, pero no puedo expresarme con frases completas
☐ No lo hablo

26. ¿En qué idioma prefiere comunicarse? Escriba su respuesta en la línea a continuación.

_____

27. ¿Dónde nació?

☐ En los EE. UU. ☐ Fuera de los EE. UU. ☐ Prefiere no responder ☐ No sabe

28. ¿Cuáles son los primeros 3 dígitos de su código postal?

☐ Los primeros 3 dígitos de mi código postal son ___ ___ ___ ☐ Inestable/No tiene código postal ☐ Prefiere no responder ☐ No sabe

29. ¿Alguna vez ha pasado tiempo en un asentamiento temporal para refugiados o personas desplazadas o ha estado detenido(a) en un centro de ICE?

☐ No aplica ☐ Sí ☐ No
☐ Prefiere no responder ☐ No sabe

30. Aproximadamente, ¿cuántos años lleva viviendo en Estados Unidos en total? [Si es menos de un año, ingrese 1 año]

☐ He vivido en Estados Unidos por _____año(s). ☐ No se aplica

31. ¿Cuál de las siguientes afirmaciones describe mejor su situación laboral actual?

☐ Trabajo a tiempo completo	☐ Por el momento no estoy trabajando (por ejemplo, tengo licencia por discapacidad, licencia por maternidad sin pago, licencia por despido temporal o estoy buscando trabajo)
☐ Trabajo a tiempo parcial	☐ Otra (por ejemplo, me jubilé, estoy cuidando a un familiar, no estoy buscando trabajo, etc.)
☐ Trabajo por temporadas (durante una parte del año)	☐ Prefiero no contestar

Nosotros usamos palabras como "masculino" o "femenino" o "trans" como una forma rápida para capturar el género de los individuos. Sin embargo, entendemos muy bien que la gente utiliza una amplia gama de etiquetas – algunos prefieren términos como Género fluido, Agénero, No binario (Enby), Andrógeno, etcétera. Para ayudarnos a entenderte personalmente, por favor dinos qué palabra prefieres personalmente para describir tu género. Estas preguntas no tienen una respuesta correcta o incorrecta. Por favor sea honesta(o) y responda lo que realmente piensas o sientes

32. Cuando yo nací, la persona que asistió el parto (por ejemplo, el doctor, enfermera, partera, pariente) pensó que yo era: Marque la mejor respuesta

☐ Masculino/Niño ☐ Intersexual (no estaban seguros sobre mi sexo al nacer) ☐ Mi sexo asignado al nacer es (por favor indique):_____

☐ Femenino/Niña	☐ No estoy segura(o) sobre el sexo que se me asignó al nacer	☐ No deseo responder esta pregunta

33. Si se trata de mi ientidad de género, me considero:

☐ Hombre/Sexo masculino	☐ De dos espíritus
☐ Mujer/Sexo femenino	☐ Intersexual (entre masculino y femenino)
☐ Transgénero/Trans	☐ No estoy seguro(a) de cuál es mi identidad de género
☐ Hombre transgénero/Masculino transgénero	☐ No tengo un género/identidad de género
☐ Mujer transgénero/ Femenino transgénero	☐ Mi identidad de género es (por favor indique): _____
☐ Género queer/Género no conforme	☐ No quiero responder a esta pregunta
☐ No binario (ni exclusivamente masculino ni femenino)	

Todos tenemos una orientación sexual. Algunas personas son heterosexuales y se sienten atraídas por personas del sexo opuesto. Por ejemplo, a una mujer heterosexual "le gustan" los hombres y se enamora de hombres. Otras personas son gays o lesbianas y se sienten atraídas por personas del mismo sexo. Por ejemplo, a un hombre gay "le gustan" los hombres y se enamora de otros hombres. También hay personas que son bisexuales y "les gustan" tanto los hombres como las mujeres. Algunas personas no están seguras sobre sus atracciones o no se sienten atraídas por nadie. Para que quede claro, quiénes le "gustan" y por quiénes se siente atraído(a) es lo que se llama orientación sexual.

34. ¿Cuál es su orientación sexual? Marque todos los que aplican.

☐Heterosexual	☐ Soy asexual (No siento atracción sexual por nadie)
☐ Gay	☐ No siento atracción romántica por nadie
☐ Lesbiana	☐ No estoy segura(o) hacia quién siento atracción sexual
☐ Bisexual	☐ No estoy seguro(a) hacia quién siento atracción romántica
☐ Queer	☐ Otra cosa: _____
☐ Pansexual/No-monosexual (siento atracción por todos los géneros)	☐ Prefiero no responder a esta pregunta

ADULT VERSION (18+) POST

ID: 03 - ___ ___ - ___ ___ ___
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 month.

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

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

The next question is about your health during the past month.

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 was 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 answer the following questions based on the services you have received so far. Indicate if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each of the statements below. If the 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 the program.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
19. I like the services that I received here.	☐	☐	☐	☐	☐	☐
20. I would recommend this agency to a friend or family member.	☐	☐	☐	☐	☐	☐
21. Services were available at times that were good for me.	☐	☐	☐	☐	☐	☐
22. When I first called or came here, it was easy to talk to the staff.	☐	☐	☐	☐	☐	☐
23. The staff here respect my race and/or ethnicity.	☐	☐	☐	☐	☐	☐
24. The staff here respect my religious and/or spiritual beliefs.	☐	☐	☐	☐	☐	☐
25. The staff here respect my gender identity and/or sexual orientation.	☐	☐	☐	☐	☐	☐
26. Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	☐	☐	☐	☐	☐	☐
27. The people who work here respect my cultural beliefs, remedies and healing practices.	☐	☐	☐	☐	☐	☐

As a direct result of my involvement in the program:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
28. I deal more effectively with my daily problems.	☐	☐	☐	☐	☐	☐
29. My symptoms/problems are not bothering me as much.	☐	☐	☐	☐	☐	☐

30. On average, how long did it take you to travel (driving, taking public transit, carpooling, etc.) to participate in a typical activity or service connected to this program?

☐ 0-29 minutes (less than 30 minutes)
☐ 30-59 minutes (30 minutes, but less than an hour)
☐ 60-74 minutes (1 hour, but less than 1 hour 15 minutes)
☐ 75-89 minutes (1 hour 15 minutes, but less than 1 ½ hours)
☐ 90 minutes (1 ½ hours) or more
☐ I was able to attend activities or receive services related to this program virtually instead of in-person