KNOW THE SIGNS

EVALUATION OUTCOMES

Evaluation Outcomes Summary

At the end of a Know the Signs training, participants are asked to complete a feedback survey via Google Forms to further understand how participants felt and thought about the training. Below are the results of the feedback survey and additional comments that participants may have provided.

As a result of this training, I feel more confident that I can… *(1=Not confident at all, 3=Somewhat confident…5=Very confident; n=108)*					
Questions	**Responses***				
	1	**2**	**3**	**4**	**5**
1. Recognize the warning signs of suicide.	**	**	5.7%	22.6%	71.7%
2. Ask someone who was exhibiting the warning signs of suicide if they are thinking about suicide.	**	0.9%	3.7%	25.2%	70.1%
3. Connect or refer someone at-risk for suicide to resources.	**	**	4.7%	21.7%	73.6%

Please circle the number that best describes your response *(1=Strongly Disagree, 3=Neutral... 5=Strongly Agree; n=108)*.					
Questions	**Responses***				
	1	**2**	**3**	**4**	**5**
4. Overall, the course goals were clearly communicated.	0.9%	**	1.9%	15.9%	81.3%
5. The presenter demonstrated knowledge of the material presented.	**	0.9%	1.9%	12.1%	85.0%
6. I would recommend this training to someone else.	**	**	1.9%	19.6%	78.5%

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*
***No responses.*

KNOW THE SIGNS ADDITIONAL COMMENTS

"It was very informative and helpful. Great job! Thank you both so much!"

"This training was extremely helpful. The trainers are very knowledgeable, welcoming, and helpful."

"Thank you for sharing this valuable information. I fully support all efforts to stop the stigma of needing mental health support."



APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

Program Description

ASIST is a two-day workshop designed for members of all caregiving groups. Family, friends, and community members may be the first to encounter an at-risk individual, but have little or no training to help. ASIST emphasizes the importance of learning suicide first-aid to keep at-risk individuals safe and to seek further help if needed.

ASIST also helps individuals in formal helping roles with professional development so that they are better prepared to perform suicide first aid help when providing care to others. After completing ASIST, participants will know how to use a suicide intervention model to identify individuals with suicidal thoughts and develop a safety plan with them.

Program Objective: To learn how to prevent suicide by recognizing signs, providing a skilled intervention, and developing a safety plan to keep someone safe.

FY 23-24 OVERVIEW

FY 23-24 ASIST Overview Summary

Overall, for FY 23-24, ASIST had a total of **19 trainings** with **314 participants** who completed the 2-day training. All 19 trainings for ASIST were conducted in collaboration or co-facilitation with **PEI, Helpline, Public Health, Consumer Affairs, WET, school districts,** and **Inland Empire Health Plan (IEHP)**. Additionally, most of the trainings took place at the **Rustin Conference Center** and in the **Western region** of Riverside County.

19
Total Number of Trainings

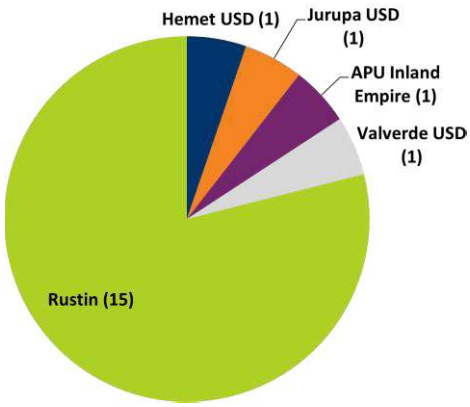
327
Total Number Reached

314
Total Number Completed Training

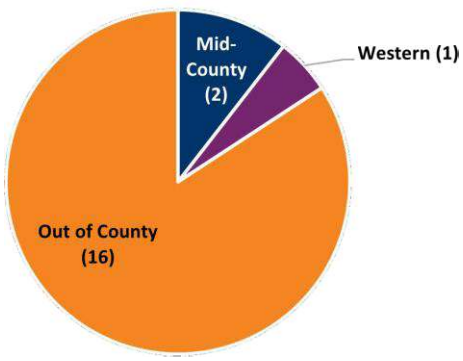
5
Smallest Audience Size

30
Largest Audience Size

Location of Training



Region of Training



**Note:* *"Not reported" includes individuals who chose not to answer.*

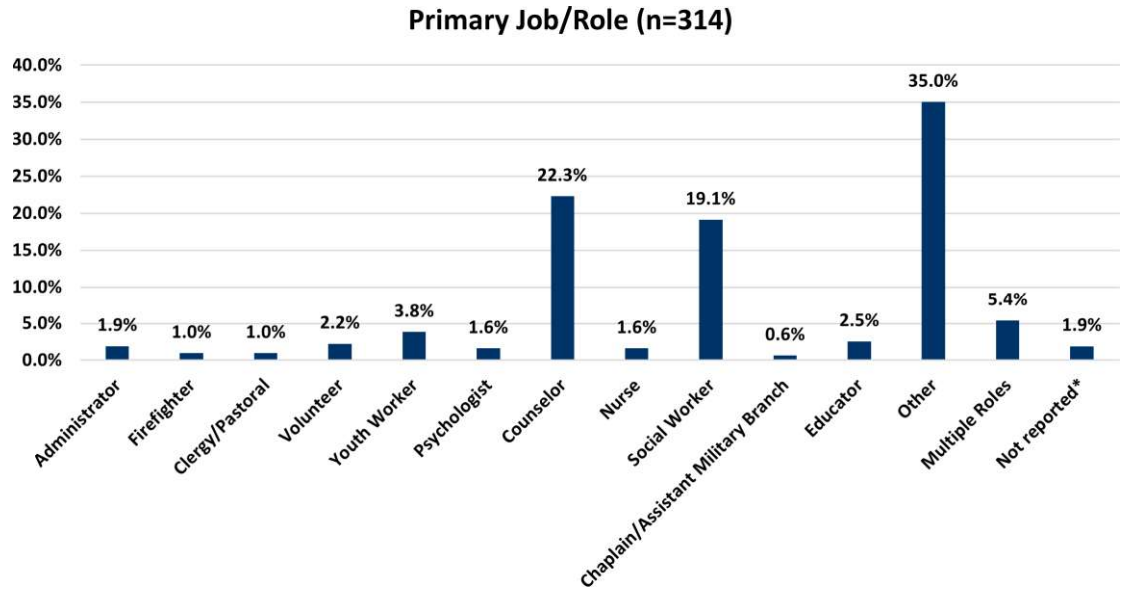
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

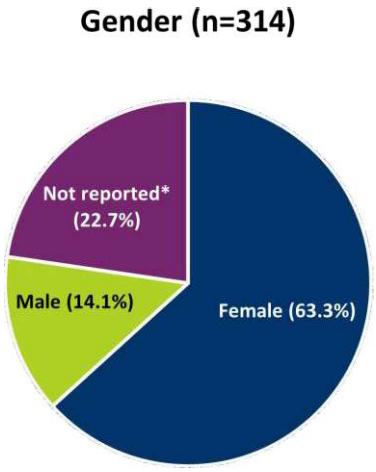
DEMOGRAPHICS

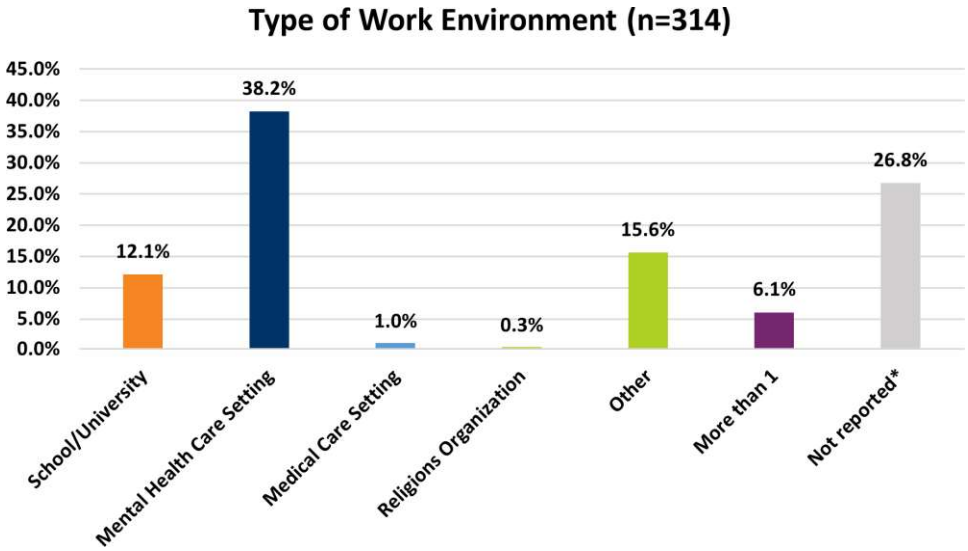
Demographics Summary

Note: There are more "Not reported" counts this fiscal year than there were last fiscal year due to a misunderstanding in providing the demographics section for two trainings for ASIST. Because of this, some demographic information may not be available throughout the demographics section of the report for ASIST.

Many of the ASIST participants come from a diverse range of occupations and primary roles. For example, **35.0% of respondents identified as 'Other'** as their primary job or role. Additionally, the next frequently chosen response was counselor (22.3%), social worker (19.1%), followed by having multiple primary roles (5.4%), youth worker (3.8%), and educator (2.5%). The most frequently chosen type of work environment was **mental health care setting (38.2%)** among ASIST participants. Additionally, the majority of ASIST participants identified themselves **as female (63.3%)**, followed by male (14.1%), and those who did not report on their gender identity (22.7%).







**Note:* "Not reported" includes individuals who chose not to answer.*

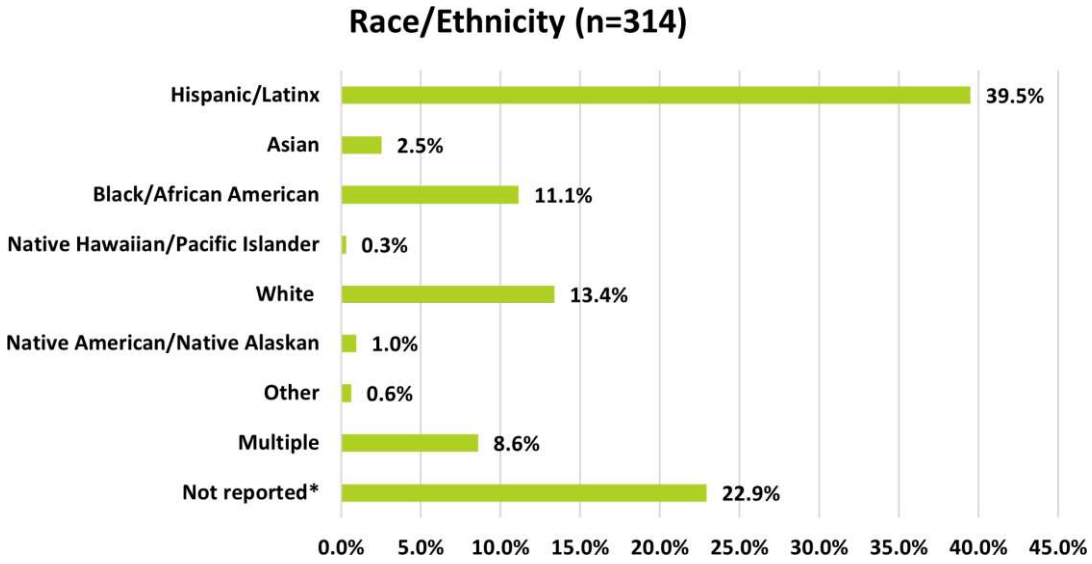
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

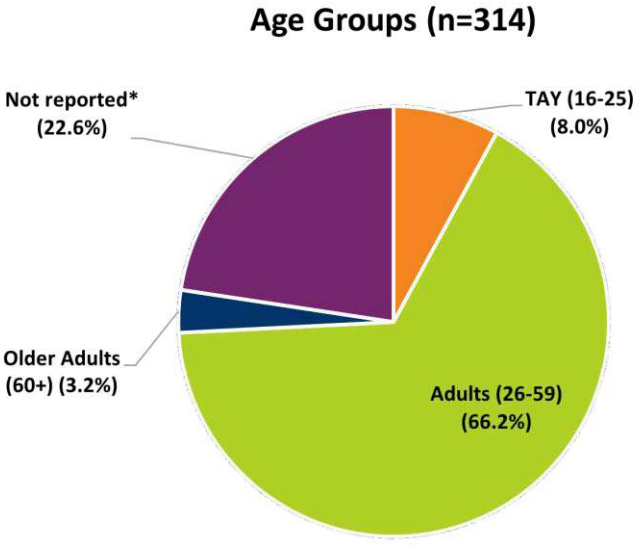
DEMOGRAPHICS (cont.)

Demographics Summary (cont.)

More than half of the ASIST participants identified as **Hispanic/Latinx (39.5%)**, followed by White (13.4%), Black/ African American (11.1%), Multiple (8.6%), Asian (2.5%), Native American/Native Alaskan (1.0%), Other (0.6%), and Native Hawaiian/Pacific Islander (0.3%). Most of the participants reported being in the **26-59 age group (66.2%)**, followed by the Transitional Age Youth (TAY) 16-25 age group (8.0%), and the 60+ age group (3.2%).

In addition, most individuals reported **English as their preferred language (72.3%)**. A great majority of participants reported that they **did not have a disability (70.1%) nor a veteran (76.4%)**. Lastly, most participants did **not identify as LGBTQ+ (64.6%).**





Demographic Characteristic	Percentage
Preferred Language (n=314)	
English	72.3%
Spanish	0.6%
English & Another Language	3.8%
Other	0.6%
Disability (n=314)	
No	70.1%
Veteran Status (n=314)	
No	76.4%
LGBTQ+ Status (n=314)	
Yes	9.2%
No	64.6%

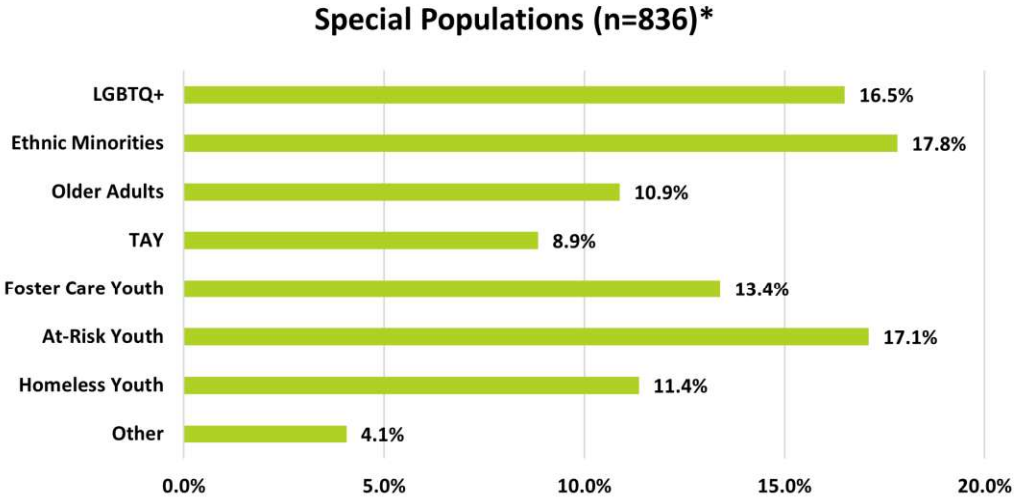
**Note:* *"Not reported" includes individuals who chose not to answer.*

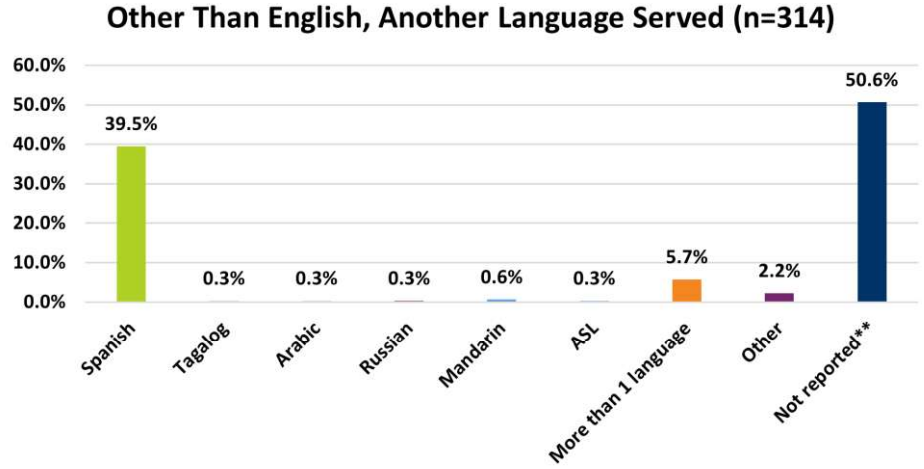
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

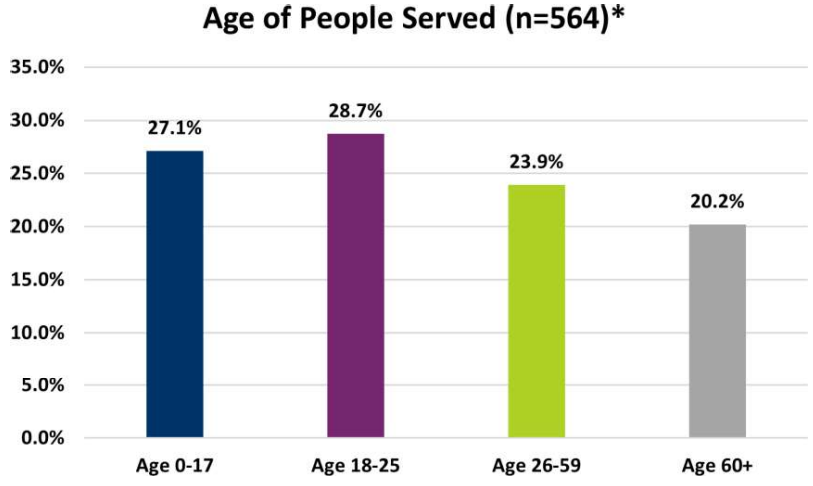
DEMOGRAPHICS—PEOPLE SERVED/WANT TO SERVE (cont.)

Demographics Summary (cont.)

The most frequently reported special population group that ASIST participants serve or want to serve was the **ethnic minorities group (17.8%)**, closely followed by the at-risk youth group (17.1%). Participants were able to choose multiple special population groups for this question. Additionally, participants most frequently chose **Spanish (39.5%) as another language other than English that they serve**. Lastly, participants most frequently responded that they serve or want to serve the **18-25 age group (28.7%)**.







**Note:* Multiple responses are reported here.*

APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

EVALUATION OUTCOMES

Evaluation Outcomes Summary

At the end of ASIST, all participants are encouraged to complete a feedback survey which includes questions about the overall course, how ASIST is helpful to them or others, and a section for additional comments or thoughts about the training.

On a scale of 1 (i.e., did not like at all…) to 10 (i.e., liked a lot), please write the rating that best describes your responses.* (n=314)	Rating (Mean)
1. How would you rate the quality of the ASIST workshop	9.4
2. Would you recommend ASIST to others?	9.6
3. This workshop has practice use in my personal life.	9.2
4. This workshop has practical use in my work life.	9.6

Please circle the number that best describes your response (1=Strongly Disagree… 5=Strongly Agree).* (n=314)					
Questions	Responses				
	1	2	3	4	5
5. If a person's words and/or behaviors suggest the possibility of suicide, I would ask directly if he/she is thinking about suicide.	1.0%	**	0.6%	10.2%	88.2%
6. Before taking the ASIST training, my answer to #5 would have been:	5.7%	12.7%	30.6%	25.2%	25.2%
7. If someone told me he or she were thinking of suicide, I would do a suicide intervention.	1.3%	**	1.3%	14.7%	82.7%
8. Before taking the ASIST training, my answer to #7 would have been:	6.7%	10.5%	23.6%	28.3%	30.9%
9. I feel prepared to help a person at risk of suicide.	60.0%	0.3%	2.2%	23.2%	73.6%
10. Before taking the ASIST training, my answer to #9 would have been:	11.5%	17.2%	24.5%	25.8%	20.7%
11. I feel confident I could help a person at-risk of suicide.	1.0%	0.3%	2.9%	23.6%	72.3%
12. Before taking the ASIST training, my answer to #11 would have been:	13.4%	15.3%	23.6%	28.3%	18.8%

Lastly, a great majority of ASIST participants (n=314) **agreed** with the following statements:

13. I attended two consecutive 8-hour days of training **(100%)**.
14. All trainers were present at the workshop for the full 2 days **(99.3%)**.
15. The "Jack" exercise was done on the afternoon of day 1 **(99.0%)**.

"The training was very smooth and informative. Presenters engaged all and did well. I liked learning the PALS."

"I felt it was very beneficial for my life and future profession."

"ASIST was a fun and helpful training. The guidance and experience obtained is invaluable to me personally and professionally."

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*

***No responses.*

Triple P and Teen Triple P Positive Parenting Programs

FY 2023/2024

MHSA Prevention and Early Intervention

Program Overview

RUHS-BH with MHSA Prevention and Early Intervention (PEI) funding implemented Triple P Positive Parenting Program and Teen Triple P Program, which are multi-level systems of parenting and family support strategies for families with children aged 2-12, and for families with teens aged 12-16, respectively. Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. Teen Triple P aims to promote positive, caring relationships between parents and their teens, and to help parents develop effective management strategies for dealing with a variety of teen behavior problems and common developmental issues. The service delivery method for this implementation of Level 4 Triple P and Teen Triple P is a series of group parenting classes with active skills training focused on acquiring knowledge and skills. The program is structured to provide four initial group class sessions for parents to learn through observation, discussion, and feedback. Presentations and small group practice are utilized during sessions and parents receive constructive feedback in the supportive environment of the group. Following the initial series of group sessions, parents receive three follow-up telephone sessions to provide additional consultation and support as parents put into practice the skills learned in group. The group then reconvenes for the eighth and final session. The Carolyn Wylie Center, a well established Community-Based Organization (CBO), was contracted to provide Level 4 Triple P throughout Riverside County, and Teen Triple P in the West and Mid-County Regions of Riverside County.

Triple P Outcome Evaluation

Evaluation of Triple P parenting focuses on the development and use of positive parenting practices and decreases in the use of negative parenting practices. Evaluation also includes measuring changes in children's disruptive behavior. The following measures are used in the evaluation of Triple P:

- ***Alabama Parenting Questionnaire (APQ)***
  The APQ is a parent completed questionnaire that measures several dimensions of parenting that have proven to be important for understanding the causes of conduct problems and delinquency in youth. Two of six parenting dimensions are used for analysis including: positive parenting, and inconsistent discipline. Parents completed the Alabama Parenting Questionnaire (APQ) before and after completing the program.

- ***Eyberg Child Behavior Inventory (ECBI)***
  The ECBI is a parent completed measure that focuses on child disruptive behaviors and the parent's perception of whether the behavior is problematic. The ECBI includes an Intensity Scale (frequency of disruptive behaviors) and a Problem Scale (parent's perception of problematic behaviors).

- ***Depression, Anxiety and Stress Scale (DASS-21)***
  The Depression Anxiety and Stress Scale (DASS) is a 21-item questionnaire which includes three self-report scales designed to measure parent's negative emotional states of depression, anxiety, and stress.

Teen Triple P Outcome Evaluation

Similar to Triple P, evaluation of Teen Triple P also focuses on the development and use of positive parenting practices and decreases in the use of negative parenting practices. Evaluation also includes measuring changes in teens conflict behavior. The following measures are used in the evaluation of Teen Triple P:

Strength and Difficulties Questionnaire (SDQ)
Parents completed the SDQ before and after completing the program. The SDQ is a behavioral screening questionnaire designed for children and adolescents aged 4-17 years. Each of the five scales of the SDQ (emotional, conduct, hyperactivity, peer problems, prosocial) are scored from 0-10. Four of these (emotional, conduct, hyperactivity and peer problems) creates a total difficulty score. The emotional and peer items together create an internalizing problems score and the conduct and hyperactivity questions together get an externalizing score.

Alabama Parenting Questionnaire (APQ)
Parents completed the APQ before and after completing the program. For the Teen Triple P program, the involvement scale score (10 items), positive parenting scale score (6 items), and poor monitoring and supervision scale score (10 items) are used. The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale (1—never, 2—almost never, 3—sometimes, 4—often, 5—always).

Conflict Behavior Questionnaire (CBQ)
The Conflict Behavior Questionnaire (CBQ) is a 20 item questionnaire that uses a true false scale to assess general conflict between parents and their children. The responses are then scored (and some items reverse scored) to obtain a total score.

A satisfaction survey is also used for both programs to measure the parent's satisfaction in program logistics, program leaders, and program content.

Executive Summary - Key Findings

Enrollment and Demographics

Countywide, Triple P and Teen Triple P combined served 686 parents in FY 23-24. A total of 261 parents were served in the Western region, 236 parents in the Mid-County Region, and 189 parents in the Desert region. By program, Triple P served 542 parents and Teen Triple P served 144 parents Countywide. Demographics information showed that most of the parents in Triple P spoke English as their preferred language (72.2%), and in Teen Triple P, 62.5% of parents identified English as their primary language. The majority of parents served in Triple P and Teen Triple P were Hispanic/Latinx, 64.6% and 71.5%, respectively. The average age of the child of focus in Triple P was 6.3 years, and 13.5 years for Teen Triple P. The majority of parents/caregivers enrolled in both Triple P and Teen Triple P programs were female.

Service data showed that Countywide 80.8% of parents completed the Triple P Program, and 84% of parents completed the Teen Triple P program. Across both programs, parents had a 81.5% program completion rate. Parents were overall highly satisfied with both programs.

Triple P: Positive Parenting Practices Improved

Analysis of the APQ measure indicated that overall, by the end of the program, participants had shown increases in positive parenting practices, and decreases in inconsistent discipline practices. Analysis of the DASS-21 also showed that parents experienced a decrease in their depression, anxiety, and stress levels.

Triple P: Child Disruptive Behavior Decreased

Outcomes from ECBI measures showed overall decreases in the frequency of children's disruptive behaviors. ECBI Intensity Scale scores decreased significantly from pre to post measure. ECBI Problem Scale scores also decreased significantly indicating that parents reported fewer behaviors as problematic.

Teen Triple P: Teen Problem Scores Decreased, Prosocial Skills Increased

Countywide, outcomes of the SDQ indicated that teen total problems of emotional, conduct, hyperactivity, peer problems decreased significantly upon parent completion of Teen Triple P. Teen prosocial behaviors significantly increased pre to post.

Teen Triple P: Increase in Parent Involvement and Positive Parenting

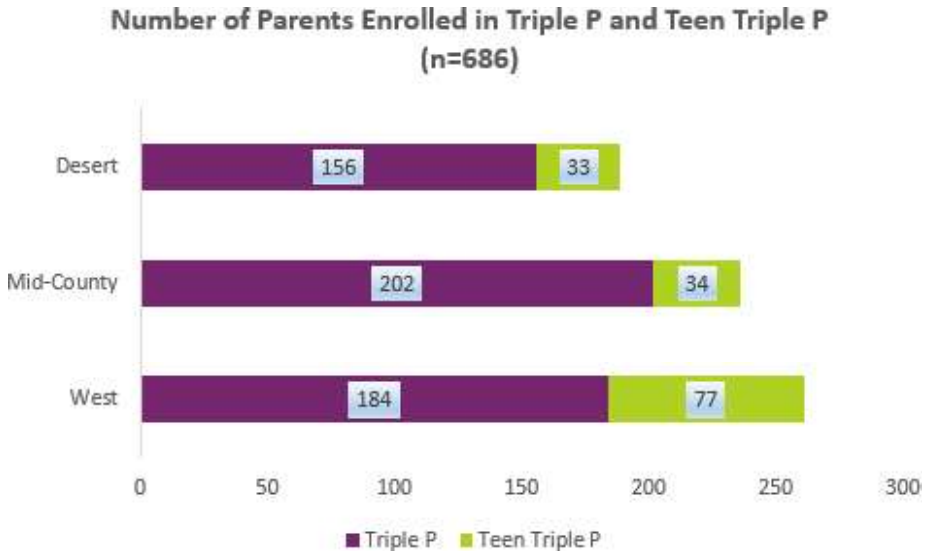
Analysis of the APQ measure indicated that countywide, parents had a significant increase in involvement with their teen and in positive parenting practices. There was a decrease in poor monitoring practices, however this decrease was not statistically significant.

Teen Triple P: Decrease in General Parent-Teen Discord

Countywide, analysis of the CBQ indicated a statistically significant decrease in parent's report of general conflict between parent and teen.

Parent Enrollment

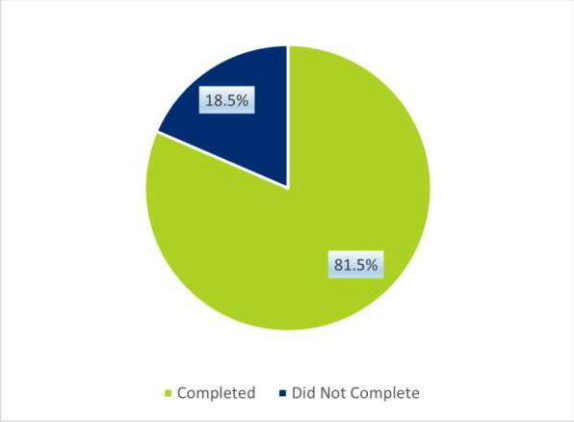
Countywide, Triple P and Teen Triple P combined served 686 parents in FY 23-24. A total of 261 parents were served in the Western region, 236 parents in the Mid-County Region, and 189 parents in the Desert region. By program, Triple P served 542 parents and Teen Triple P served 144 parents Countywide. **Note:** Some parents may not have reside within the County of Riverside, but had an active Child Protection Services (CPS) case within the County. In this case, the parent's region served is based on the location of the CPS case/ location of the child.



Program Completion

Countywide across both programs, parents had a 81.5% program completion rate. Program completion for both Triple P and Teen Triple P is defined as attending at least 6 out of 8 sessions, missing no more than one phone session, and not missing the first Triple P or Teen Triple P session. The table below details the completion rate regionally by program.

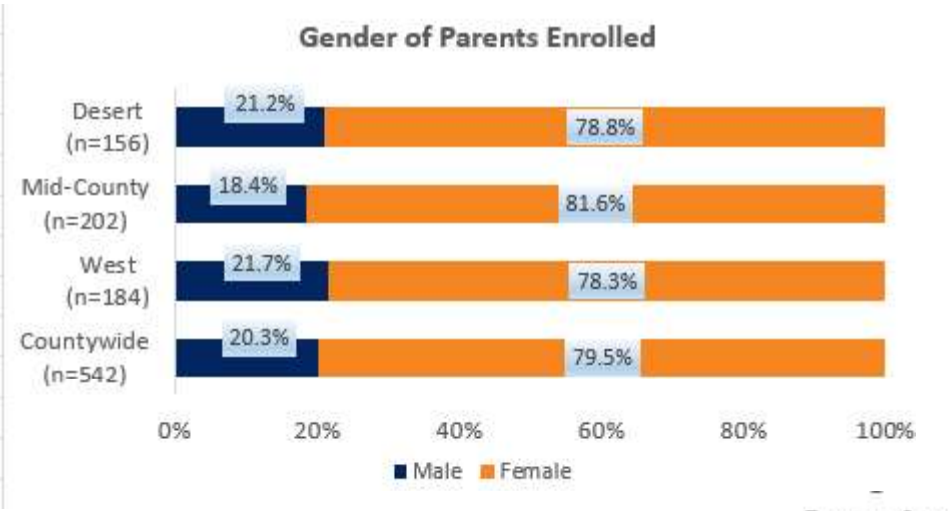
Countywide Completion Rates Triple P and Teen Triple P (Combined) n=686



Triple P Parenting Program Completion				
	Desert	**Mid-County**	**West**	**Countywide**
Completed	124 (79.5%)	165 (81.0%)	148 (81.7%)	438 (80.8%)
Did not Complete	32 (20.5%)	37 (19.0%)	35 (18.3%)	104 (19.2%)
Total Enrolled	156	202	184	542

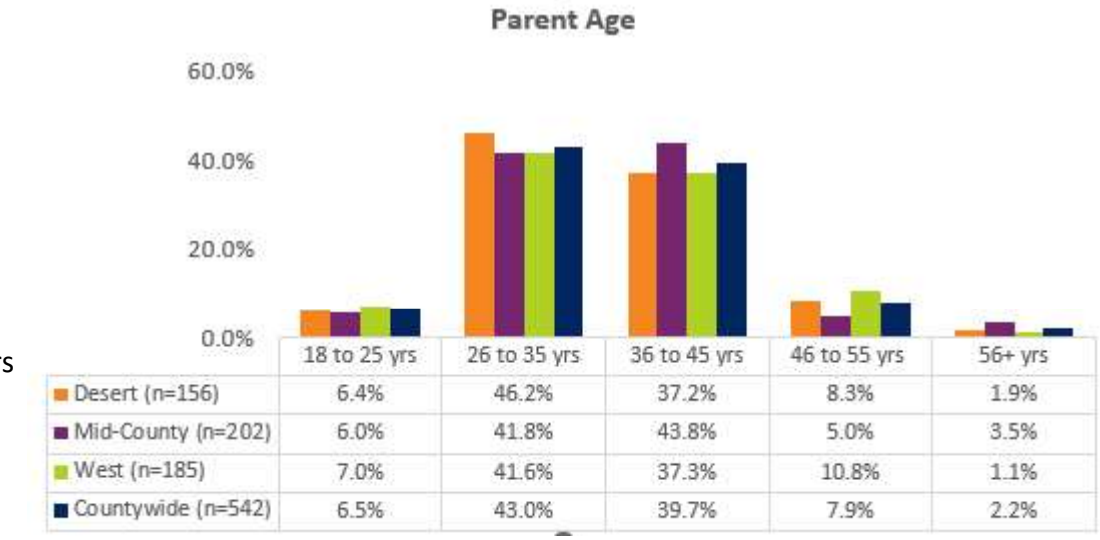
Teen Triple P Parenting Program Completion				
	Desert	**Mid-County**	**West**	**Countywide**
Completed	28 (84.8%)	28 (82.4%)	65 (84.4%)	121 (84%)
Did not Complete	5 (15.2%)	6 (17.6%)	12 (15.6%)	23 (16%)
Total Enrolled	33	34	77	144

Triple P Parent Enrollment and Demographics

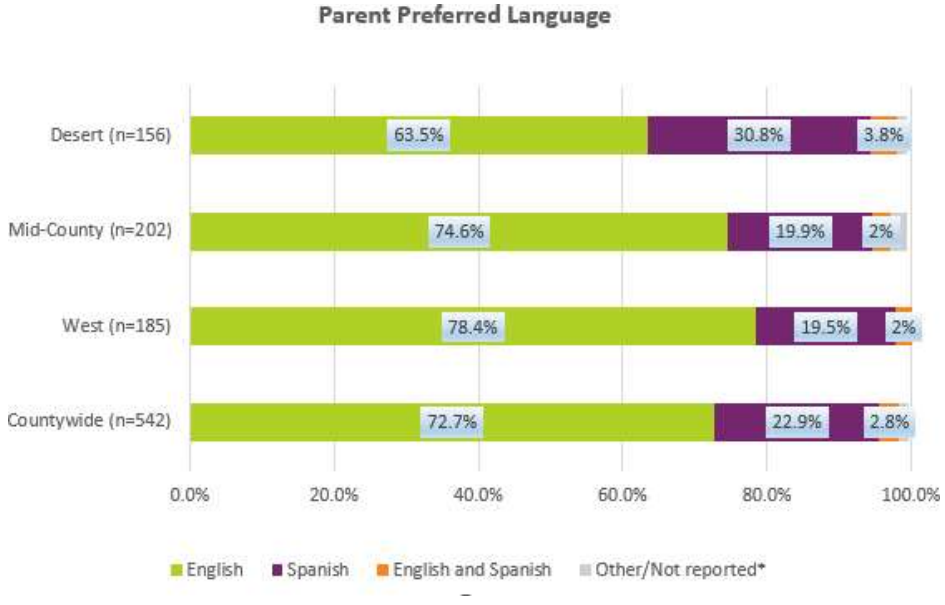


Countywide, the majority of parents/caregivers enrolled in Triple P parenting were females (79.5%).

A majority of parents/ caregivers identified as being a part of the 26 to 35 years old group (43.0%). The average parent age was 36.2 years old.

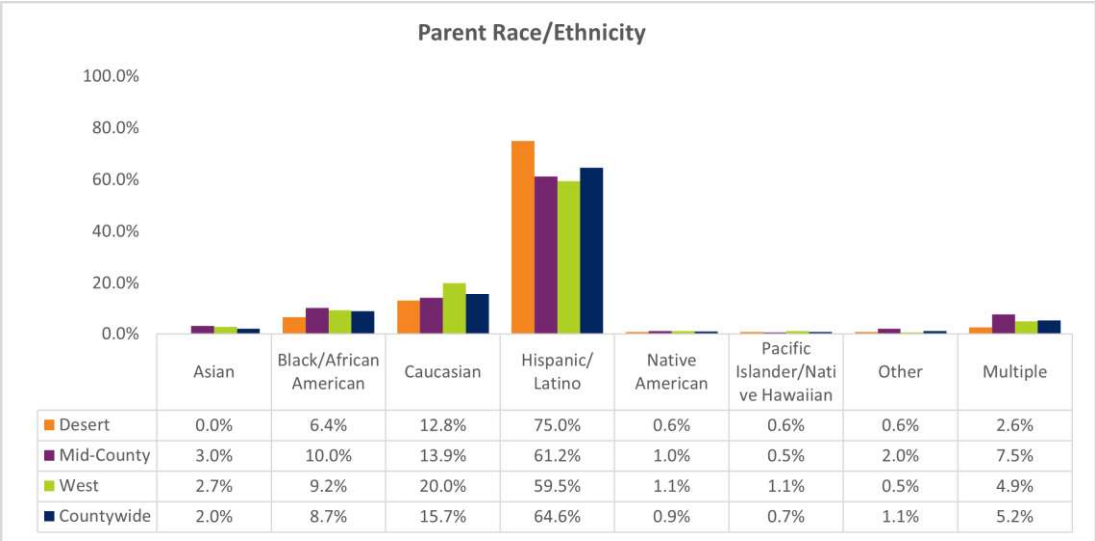


	18 to 25 yrs	26 to 35 yrs	36 to 45 yrs	46 to 55 yrs	56+ yrs
Desert (n=156)	6.4%	46.2%	37.2%	8.3%	1.9%
Mid-County (n=202)	6.0%	41.8%	43.8%	5.0%	3.5%
West (n=185)	7.0%	41.6%	37.3%	10.8%	1.1%
Countywide (n=542)	6.5%	43.0%	39.7%	7.9%	2.2%



Countywide, more than half of participants (72.2%) reported English as their preferred language. Most parents enrolled in classes of their preferred language (English or Spanish).

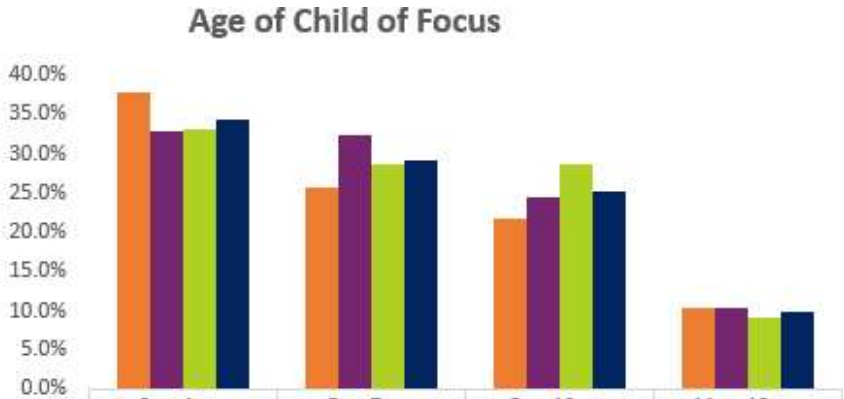
Triple P
Parent and Child Demographics



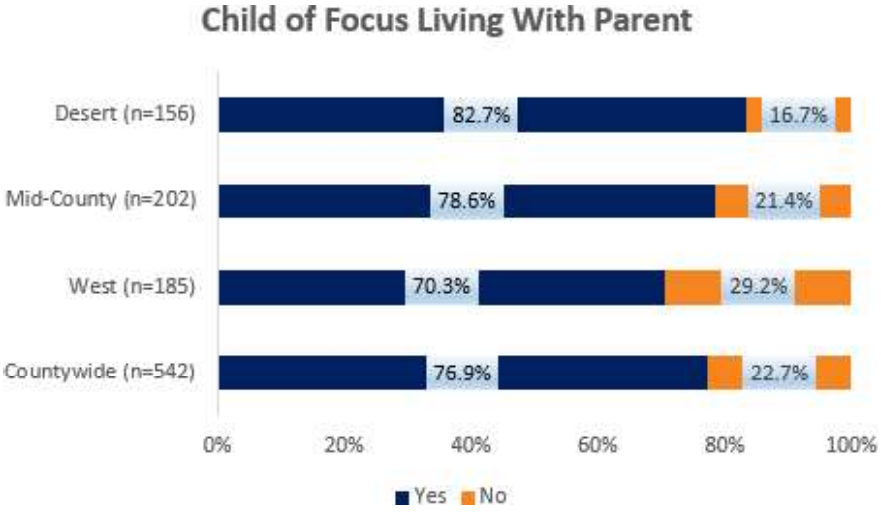
	Asian	Black/African American	Caucasian	Hispanic/ Latino	Native American	Pacific Islander/Native Hawaiian	Other	Multiple
Desert	0.0%	6.4%	12.8%	75.0%	0.6%	0.6%	0.6%	2.6%
Mid-County	3.0%	10.0%	13.9%	61.2%	1.0%	0.5%	2.0%	7.5%
West	2.7%	9.2%	20.0%	59.5%	1.1%	1.1%	0.5%	4.9%
Countywide	2.0%	8.7%	15.7%	64.6%	0.9%	0.7%	1.1%	5.2%

Countywide, the majority of Triple P participants identified as Hispanic/Latinx (64.6%), followed by Caucasian (15.7%) and Black/ African American (8.7%).

Parents/caregivers were asked to identify one of their children who posed the most parenting challenges. This child was considered the primary focus for the program. Countywide, the most reported age group for the child of focus was the 2 to 4 years old age group (34.3%). The average age of the child of focus was 6.3 years old.



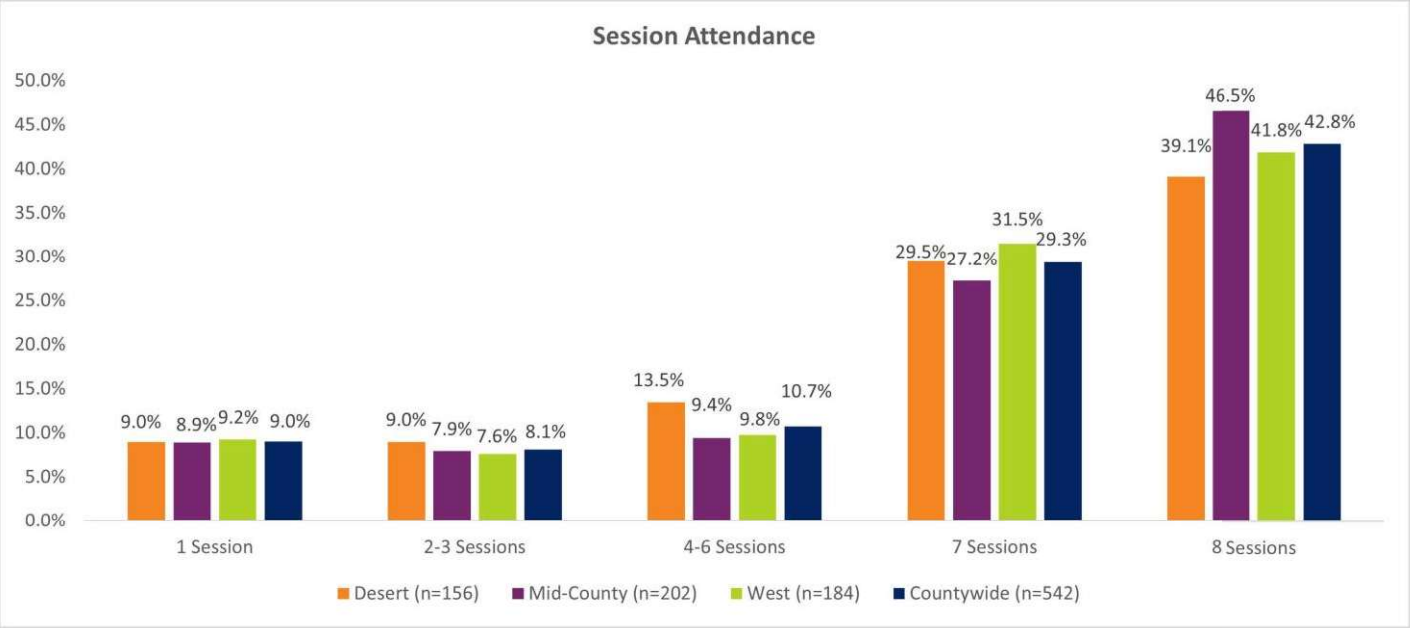
	2 to 4 yrs	5 to 7 yrs	8 to 10 yrs	11 to 13 yrs
Desert (n=156)	37.8%	25.6%	21.8%	10.5%
Mid-County (n=202)	32.8%	32.3%	24.4%	10.4%
West (n=185)	33.0%	28.6%	28.6%	9.2%
Countywide (n=542)	34.3%	29.2%	25.1%	10.0%



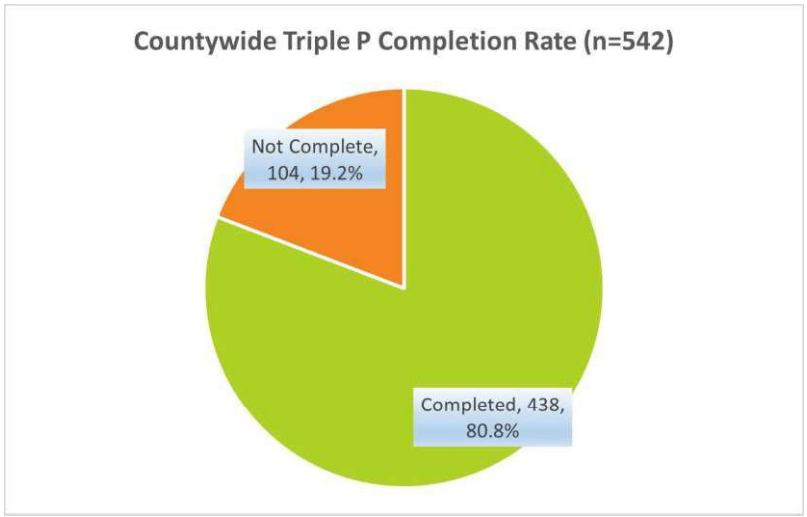
Countywide, 76.9% of parents/ caregivers served in Triple P reported that they lived with their child of focus.

Triple P Program Statistics

Countywide, session attendance showed that 82.8% of participants completed 6-8 Teen Triple P sessions, with 42.8% of participants attending all eight Teen Triple P sessions. Countywide, only 9.0% of the parents attended only one session.

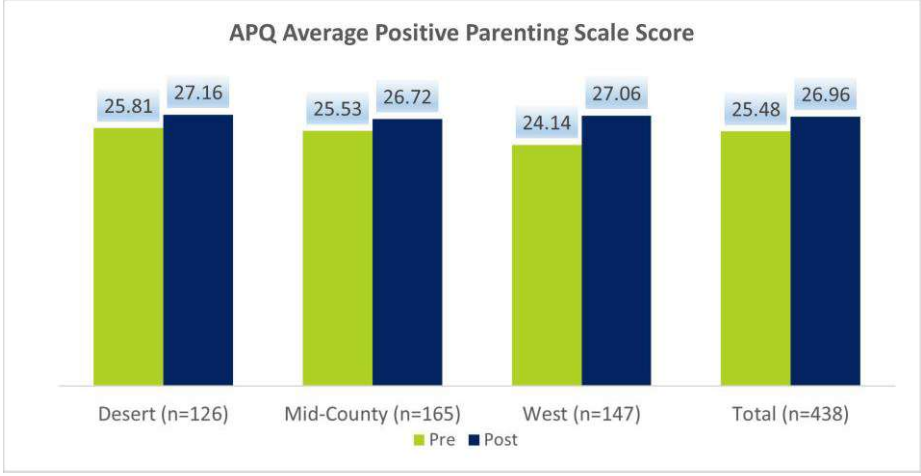


Countywide, 80.8% of parents completed the program. Page 5 of this report details the completion rate by region for the Triple P program.



Alabama Parenting Questionnaire

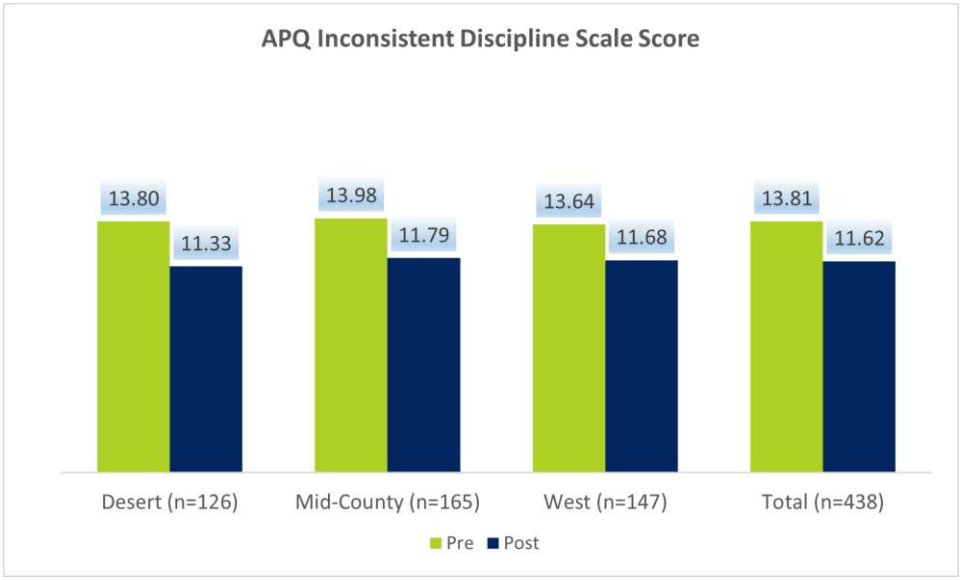
Past research has shown that increasing positive parenting practices and decreasing negative practices have been effective in reducing problem behaviors in children. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. It is a 42-item self-report measure filled out by parents assessing six parenting constructs. For the Triple P program, only the positive parenting (6 items) and use of inconsistent discipline scales (6 items) are used. The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale (1—never, 2—almost never, 3—sometimes, 4—often, 5—always). The APQ was scored for parents whose children are between ages 4-17.



t=-3.71 df=125 p<0.001 | t=-4.25 df=164 p<0.001 | t=-5.60 df=146 p<0.001 | t=-7.87 df=437 p<0.001

Countywide there was a statistically significant increase for practicing positive parenting skills after parents/caregivers had completed the Triple P program. Each region also showed a statistically significant increase in positive parenting skills as well.

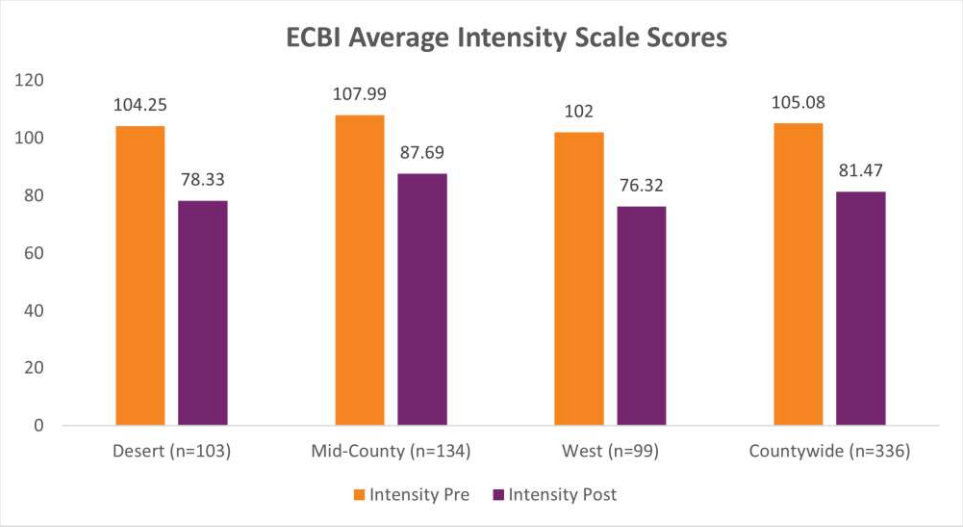
Countywide and across all three regions, there was a statistically significant decrease in the use of inconsistent disciplining practices after parents/caregivers completed the Triple P program.



t=6.29 df=125 p<0.001 | t=6.51 df=164 p<0.001 | t=5.16 df=147 p<0.001 | t=10.35 df=437 p<0.001

Eyberg Child Behavior Inventory

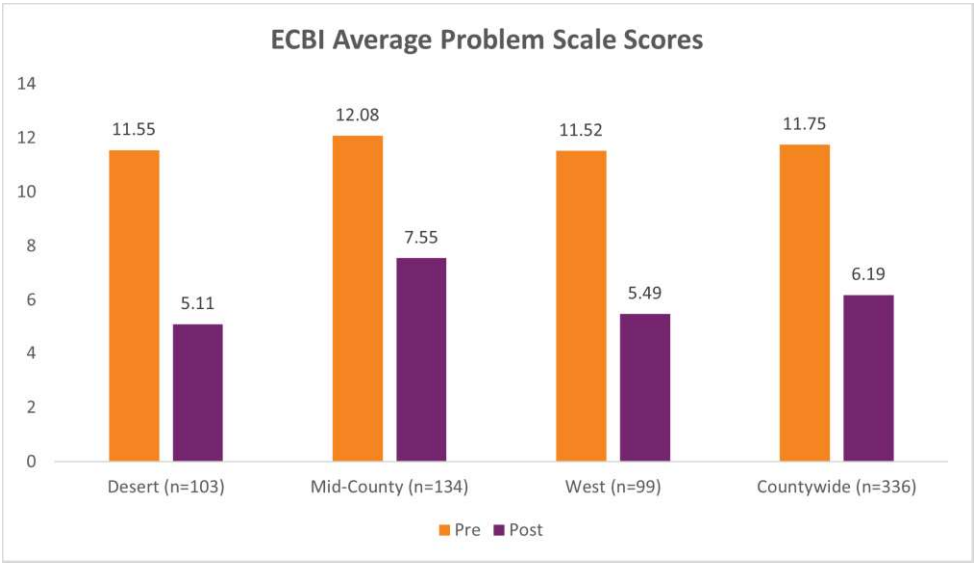
The Eyberg Child Behavior Inventory (ECBI) is a parent-completed rating scale used to measure the frequency of children's disruptive behaviors (Intensity scale) and parent's perceptions of problematic behaviors (Problem Scale). The ECBI consists of 36 items intended to assess "typical problem behaviors" reported by parents of children age 2-16 years. Each behavior is rated on a 7-point scale for intensity, as well as on a yes/no scale to indicate whether the parent perceives the behavior to be a problem or not.



t=7.58 df=102 p<0.001 | t=7.95 df=133 p<0.001 | t=7.91 df=98 p<0.001 | t=13.51 df=335 p<0.001

Countywide and across all three regions individually, there was a statistically significant decrease in child problem behaviors from Pre to Post. For the ECBI intensity scale, the cut-off score is 130. At baseline, about 26.8% of children had a raw score above 130. By post, there was a decrease with only 9.5% of children who had a raw score of above 130.

From the ECBI Average Problem Scale, there was a statistically significant decrease in the parent's perception of their child's behavior as a problem countywide and across all three regions individually. The clinical cut-off is a score of 15. At baseline, about 33.3% of parent's ratings were above the cut-off score; however, by the end of the Triple P program, this decreased to 14.0%.



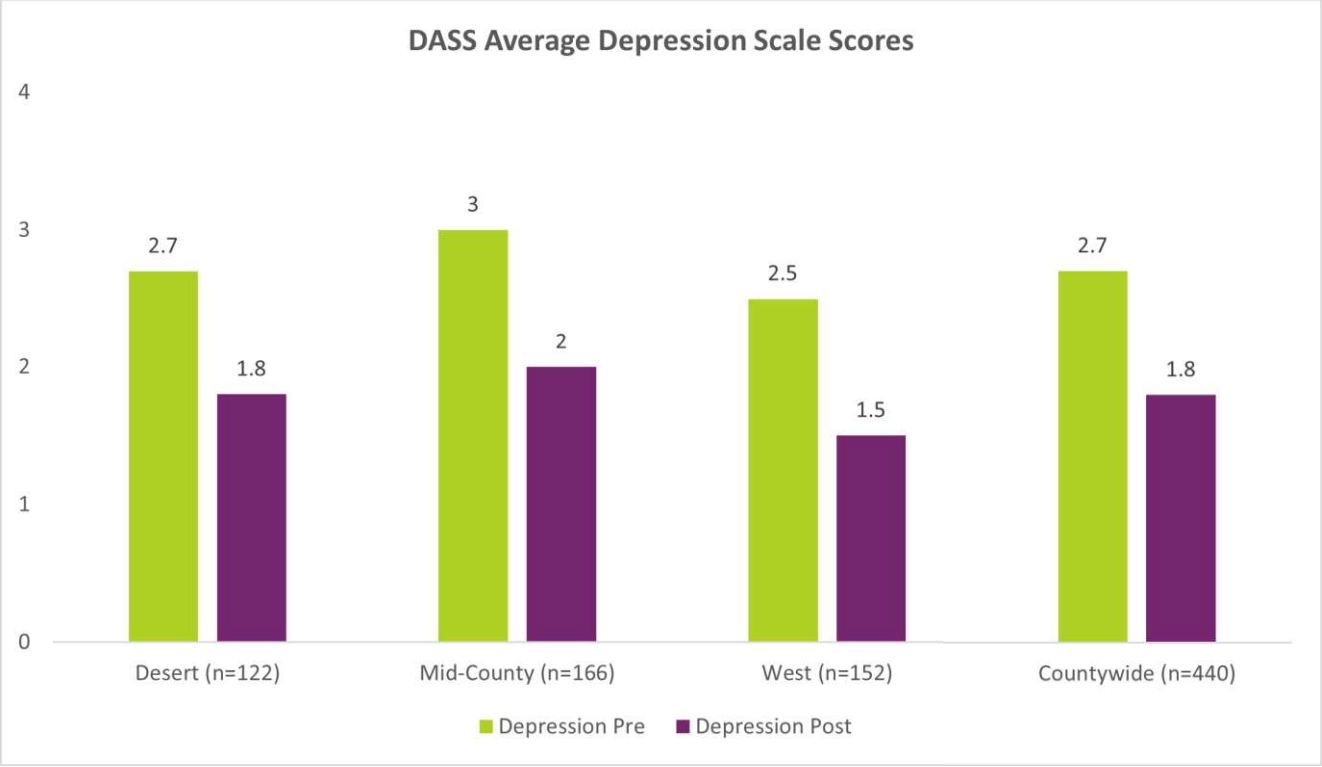
t=9.80 df=102 p<0.001 | t=7.20 df=133 p<0.001 | t=7.43 df=98 p<0.001 | t=13.81 df=335 p<0.001

Depression Anxiety and Stress Scale

The Depression Anxiety and Stress Scale (DASS) is a 21-item questionnaire which includes three self-report scales designed to measure the negative emotional states of depression, anxiety, and stress. In completing the DASS, the individual is required to indicate the presence of a symptom in the previous week. Each item is scored from 0 (did not apply to me at all over the last week) to 3 (applied to me very much or most of the time over the past week). For the DASS-21 the following cut-off scores have been recommended for each subscale:

	Normal	Mild	Moderate	Severe	Extreme
Depression	0-4	5-6	7-10	11-13	14+
Anxiety	0-3	4-5	6-7	8-9	10+
Stress	0-7	8-9	10-12	13-16	17+

All three regions in Riverside County scored in the normal range for the DASS depression subscale in the pre-measures. There was also a statistically significant decrease in reported depression symptoms for the post-measures.

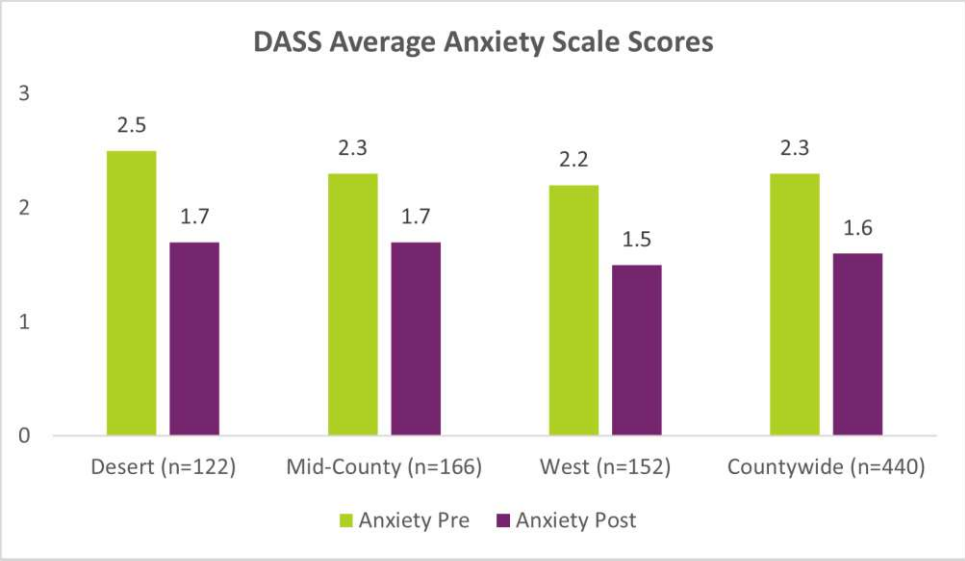


Desert (n=122)	Mid-County (n=166)	West (n=152)	Countywide (n=440)
t=2.95 df=121 p=0.004	t=4.30 df=165 p<0.001	t=3.82 df=151 p<0.001	t=6.37 df=439 p<0.001

Triple P
Depression, Anxiety, Stress Scale

Depression Anxiety and Stress Scale

	Normal	Mild	Moderate	Severe	Extreme
Depression	0-4	5-6	7-10	11-13	14+
Anxiety	0-3	4-5	6-7	8-9	10+
Stress	0-7	8-9	10-12	13-16	17+



All three regions in Riverside County scored in the normal range for the DASS anxiety subscale in the pre-measures. Additionally, there was a statistically significant decrease in the DASS average anxiety subscale for the post-measure.

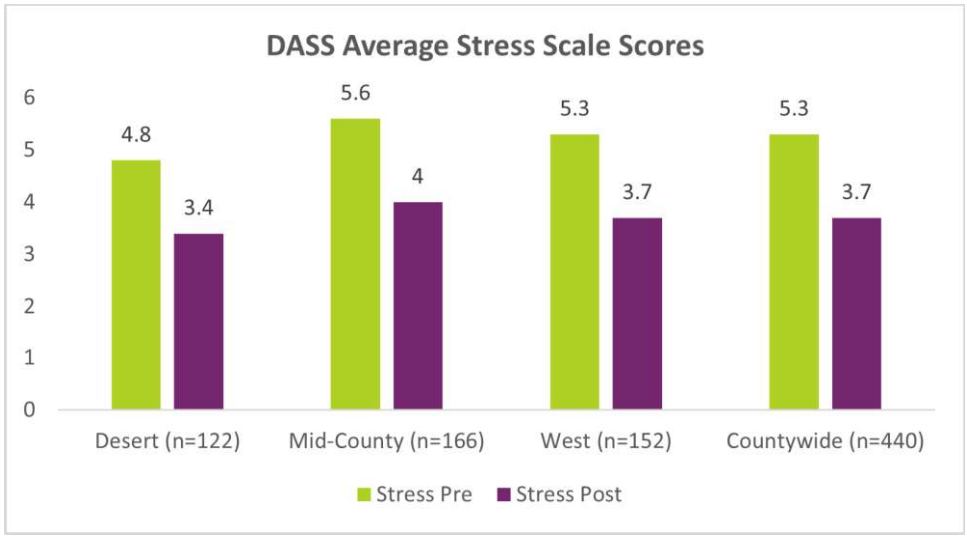
t=2.62 df=121
p=0.010

t=3.58 df=165
p<0.001

t=3.30 df=151
p=0.001

t=5.42 df=439
p<0.001

All three regions in Riverside County scored in the normal range for the DASS stress subscale in the pre-measures. There was a statistically significant decrease in the DASS stress subscale scores for the post-measure.



t=3.17 df=121
p=0.002

t=5.75 df=165
p<0.001

t=5.26 df=151
p<0.001

t=8.05 df=439
p<0.001

Triple P Satisfaction Survey

A total of 438 participants completed the satisfaction survey for the Triple P program. Overall, the majority of participants were highly satisfied with all aspects of the Triple P program including program logistics, quality of group leaders, and overall satisfaction of the program.

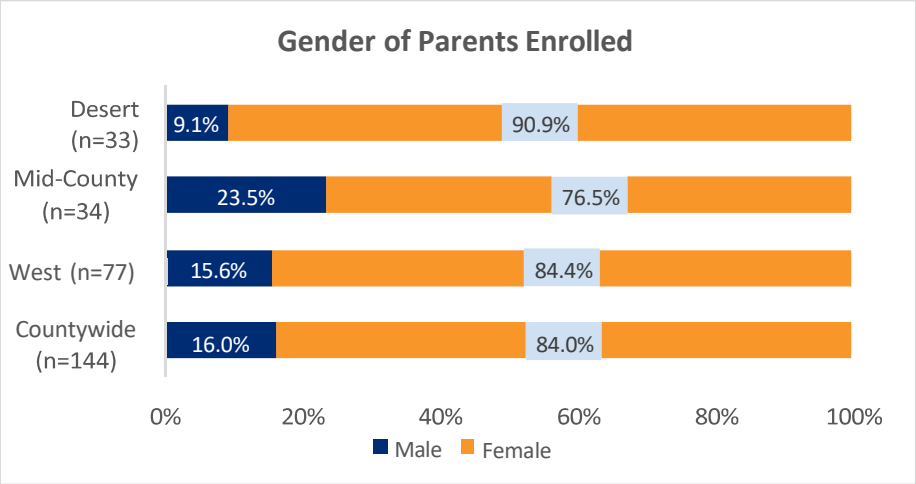
Triple P Countywide Satisfaction Survey Results (*N*=438)	Mean	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
Overall, I am satisfied with the program.	4.90	–	1 (0.2%)	5 (1.1%)	30 (6.8%)	402 (91.8%)
The location of the program was convenient for me and my family.	4.94	1 (0.2%)	2 (0.5%)	3 (0.7%)	9 (2.1%)	423 (96.6%)
The sessions were at a time convenient for me and my family.	4.85	1 (0.2%)	5 (1.1%)	11 (2.5%)	27 (6.2%)	394 (90.0%)
My family got the help we wanted for my child.	4.83	1 (0.2%)	6 (1.4%)	9 (2.1%)	35 (8.0%)	387 (88.4%)
Facilitators treated me with respect.	4.97	–	1 (0.2%)	2 (0.5%)	6 (1.4%)	429 (97.9%)
Facilitators spoke to me in a way that I understood.	4.97	–	–	2 (0.5%)	9 (2.1%)	427 (96.5%)
Facilitators are respectful of my cultural/ethnic background.	4.97	–	1 (0.2%)	3 (0.7%)	6 (1.4%)	428 (97.7%)
As a result of the program, I am satisfied with our family life right now.	4.80	2 (0.5%)	4 (0.9%)	12 (2.7%)	46 (10.5%)	374 (85.4%)
I felt comfortable talking about my child's problems with the staff.	4.91	2 (0.5%)	–	7 (1.6%)	17 (3.9%)	412 (94.1%)
The facilitators listened to what I had to say.	4.97	–	–	3 (0.7%)	7 (1.6%)	428 (97.7%)
The facilitators knew how to help me.	4.91	1 (0.2%)	–	8 (1.8%)	20 (4.6%)	409 (93.4%)

Triple P Satisfaction Survey

The following are comments provided by parents/caregivers from across all three regions of Riverside County about things that they learned, liked, and disliked from the Triple P program.

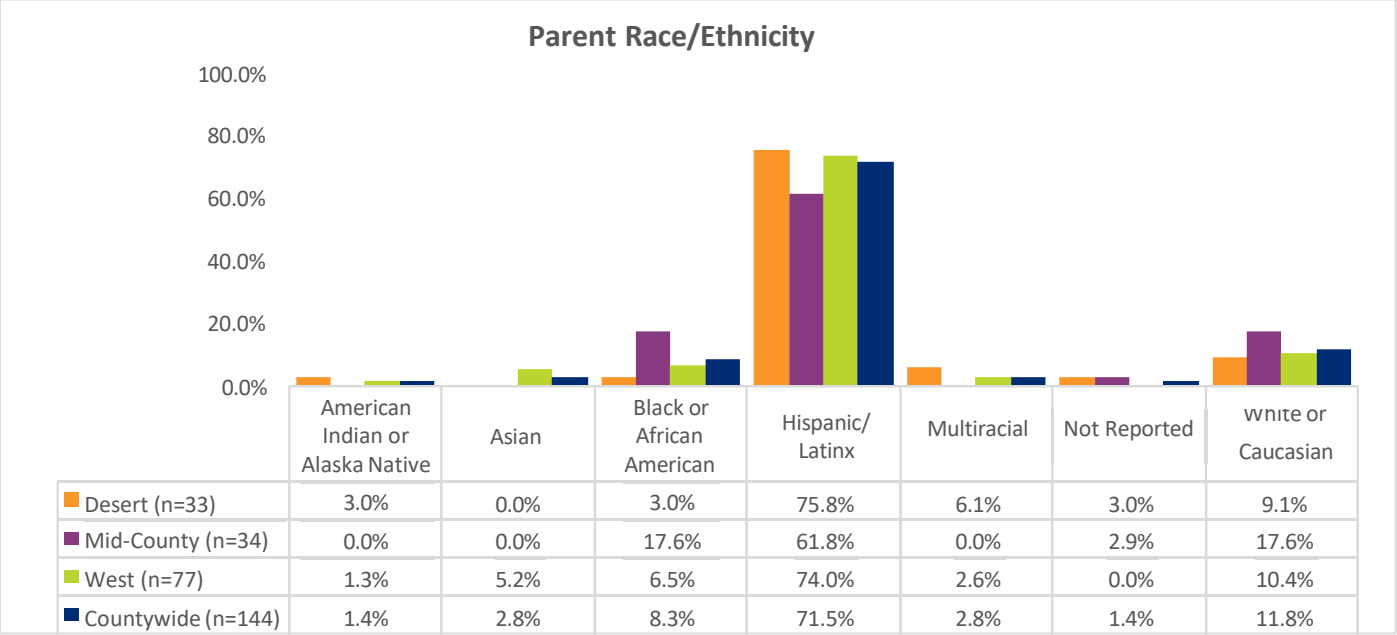
Common Things Learned……
"To praise! The power of praising is definitely a great way to be a positive parent & encourage the behavior tasks we want our children to follow."
"To see things differently with our children. And we should have more love and kindness to them because we don't know what they are going through."
"Be more assertive and to give less accidental rewards to my daughter."
"Better ways to discipline my child based on proper expectations of their age. I learned that my behavior is really a good way to start positivity in our household. Also, learned that slowing down translations in our household for big activities helped us all to stay calm & get ready for morning & bed routine w/ less fights."
Common Things Liked…..
"I liked that everyone comes together, shares the struggles of parenting & also work together creatively to seek positive parenting strategies that help get through that rough patch/milestone."
"Meeting all of the parents in class. Sharing our experiences and helping each other through this process."
"It was a very safe space and I felt extremely comfortable expressing what I felt like were struggles in my household and the array of solutions and perspective I received were extremely helpful."
"I really enjoyed goal-setting, the videos, and the workbook. It was nice when other parents spoke with each other and offered advice, and it was great to see my husband do better because of this."
Common Things Disliked…..
"That it was only 8 wks. I would love to attend other workshops. I enjoyed learning about child development & ways to parent in a positive way."
"I wish there was more information about how to deal with siblings problems."
"I think we could have had better snacks and I would have preferred to do every session in person instead over the phone, maybe with our child present to see the behavior for feedback."
"The time constraint, it was right when I would get home from getting the kids and I had about 10 min before I had to hop on Zoom. I had to get up several time to attend to my child."

Teen Triple P Parent Enrollment and Demographics



Countywide the majority of parents/caregivers enrolled in Teen Triple P parenting were females (84%).

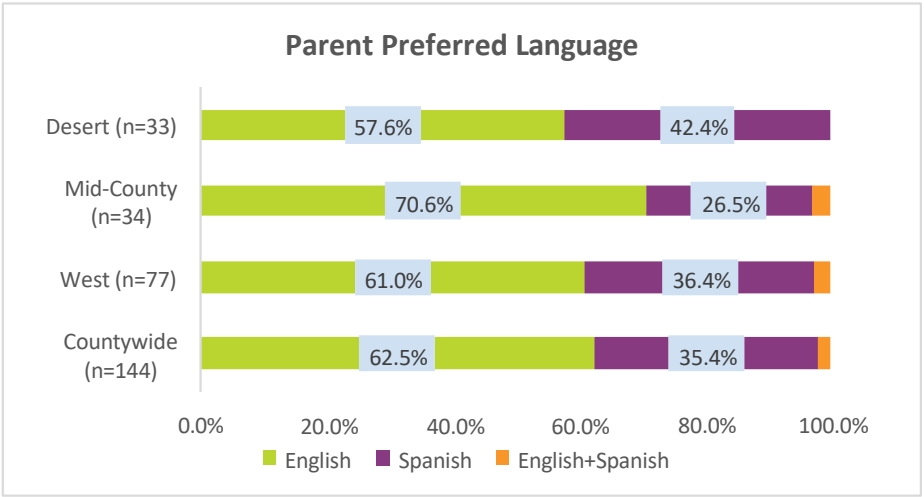
Countywide the majority of parents/caregivers served by Teen Triple P were Hispanic/Latinx (71.5%).



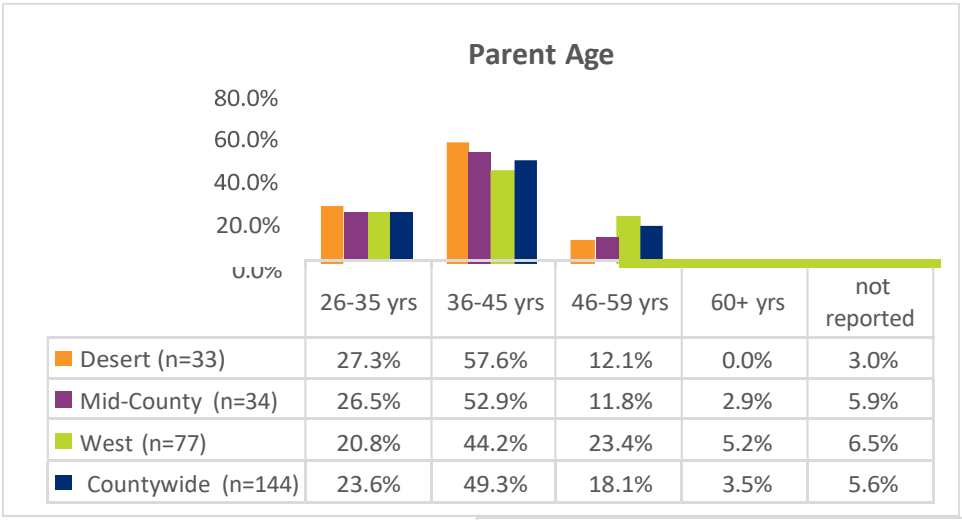
	American Indian or Alaska Native	Asian	Black or African American	Hispanic/ Latinx	Multiracial	Not Reported	White or Caucasian
Desert (n=33)	3.0%	0.0%	3.0%	75.8%	6.1%	3.0%	9.1%
Mid-County (n=34)	0.0%	0.0%	17.6%	61.8%	0.0%	2.9%	17.6%
West (n=77)	1.3%	5.2%	6.5%	74.0%	2.6%	0.0%	10.4%
Countywide (n=144)	1.4%	2.8%	8.3%	71.5%	2.8%	1.4%	11.8%

Countywide, a majority of the parents selected English as their preferred language (62.5%). Slightly over a third of parents preferred Spanish, and a small percentage of parents Countywide indicated they didn't have a preference between English or Spanish and they selected both (2.1%).

Parents were placed in classes conducted in their preferred language (English or Spanish).



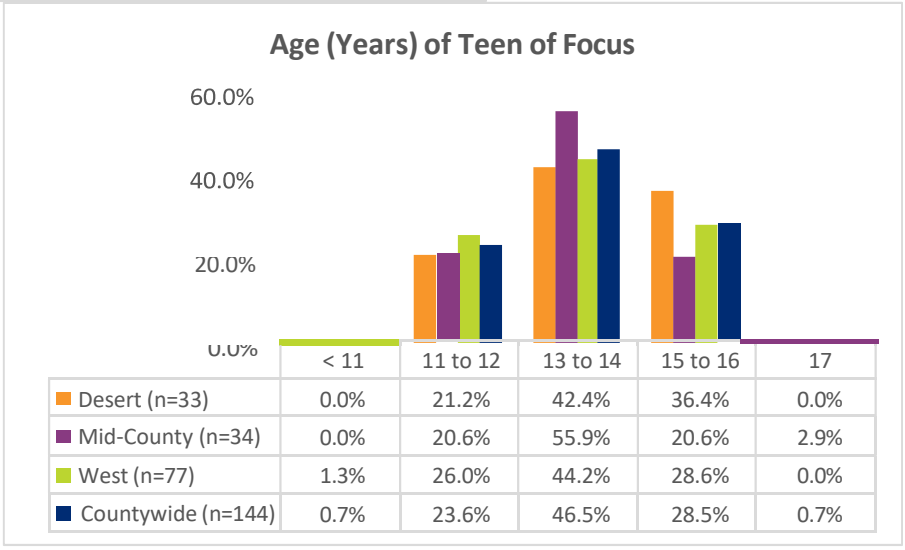
Teen Triple P
Parent and Teen Demographics



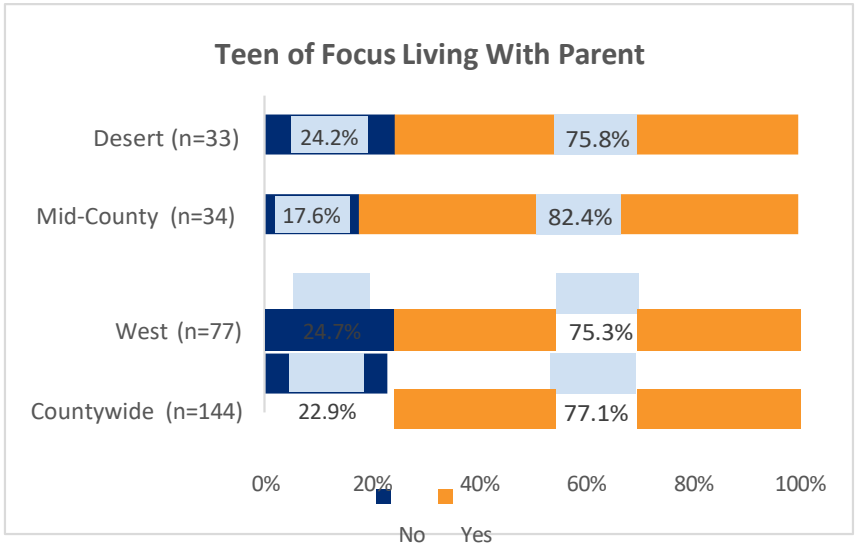
	26-35 yrs	36-45 yrs	46-59 yrs	60+ yrs	not reported
Desert (n=33)	27.3%	57.6%	12.1%	0.0%	3.0%
Mid-County (n=34)	26.5%	52.9%	11.8%	2.9%	5.9%
West (n=77)	20.8%	44.2%	23.4%	5.2%	6.5%
Countywide (n=144)	23.6%	49.3%	18.1%	3.5%	5.6%

Countywide, a majority of parents/caregivers were 36-45 years of age (49.3%). The average age was 41 years.

Parents/caregivers were asked to identify one of their teens who posed the most parenting challenges. This teen would be the primary focus in the program. Countywide, and across all regions the majority of the teens were between 13 to 14 years old (46.5%). The average age of the teen of focus was 13.5 years.



	< 11	11 to 12	13 to 14	15 to 16	17
Desert (n=33)	0.0%	21.2%	42.4%	36.4%	0.0%
Mid-County (n=34)	0.0%	20.6%	55.9%	20.6%	2.9%
West (n=77)	1.3%	26.0%	44.2%	28.6%	0.0%
Countywide (n=144)	0.7%	23.6%	46.5%	28.5%	0.7%



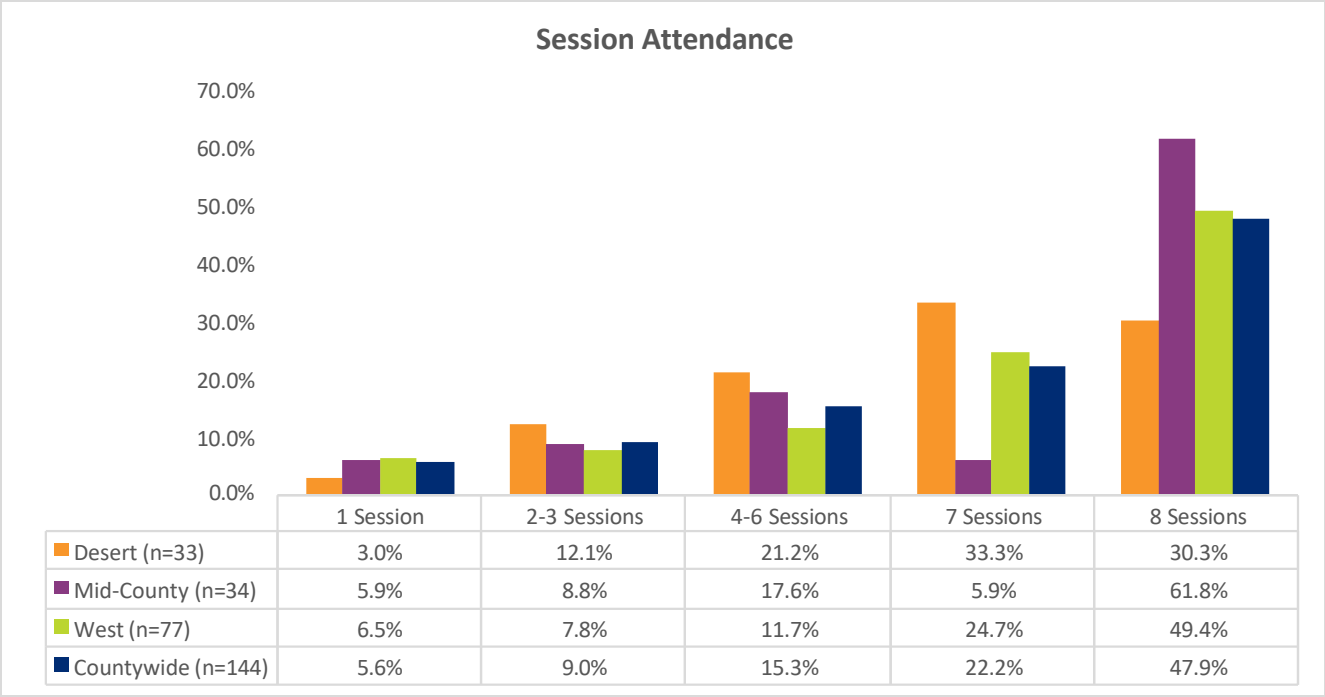
Countywide, 77.1% of parents served had their teen of focus living with them. Of the 33 parents who's teen was not living with them, about half (45.5%) of the parents were receiving services through DPSS (CPS or non-CPS related).

Impact on Other Children in the Household

- 88.2% of parents cared for a child under the age of 25 (not including the teen of focus)
- The parenting program had an impact on 434 kids under the age of 25 (including the teen of focus)

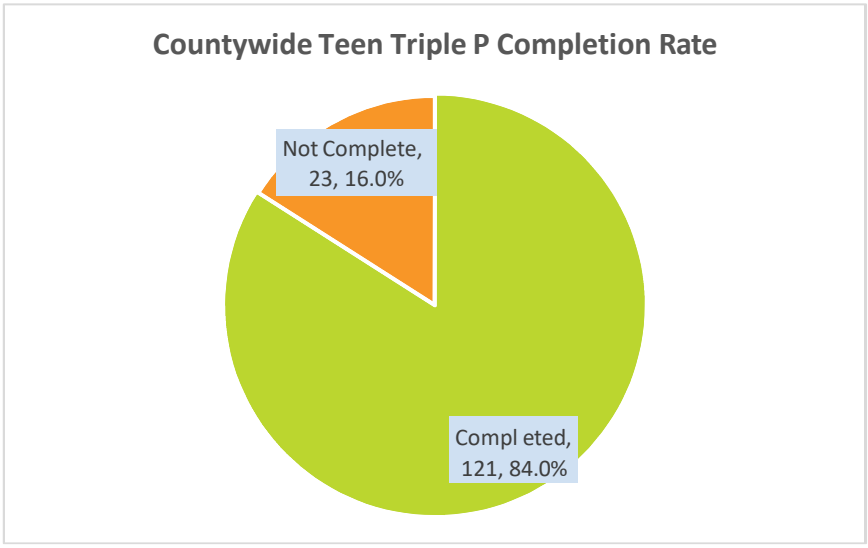
Teen Triple P Program Statistics

Countywide, session attendance showed that 84% of participants completed 6-8 Teen Triple P sessions, with 47.9% of participants attending all eight Teen Triple P sessions. Countywide, only 5.6% of the parents attended only one session.



	1 Session	2-3 Sessions	4-6 Sessions	7 Sessions	8 Sessions
Desert (n=33)	3.0%	12.1%	21.2%	33.3%	30.3%
Mid-County (n=34)	5.9%	8.8%	17.6%	5.9%	61.8%
West (n=77)	6.5%	7.8%	11.7%	24.7%	49.4%
Countywide (n=144)	5.6%	9.0%	15.3%	22.2%	47.9%

Countywide 84% of parents completed the program. Further detail on completion rate by region for the Teen Triple P program is shown on page 5 of the report.

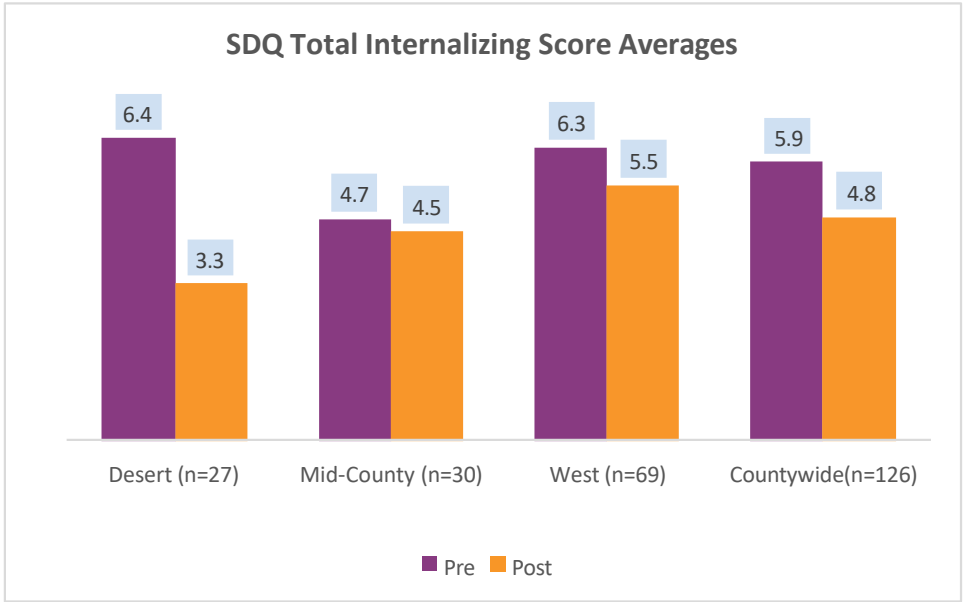


Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a behavioral screening questionnaire designed for children and adolescents aged 4-17 years. Each of the five scales of the SDQ (emotional, conduct, hyperactivity, peer problems, prosocial) are scored from 0-10. Four of these scales (emotional, conduct, hyperactivity and peer problems) create a **total difficulty score** (range 0-40). The emotional and peer items together create an **internalizing problems score** (range 0-20) and the conduct and hyperactivity questions together get an **externalizing score** (range 0-20). Normal, borderline, and abnormal scores are shown below.

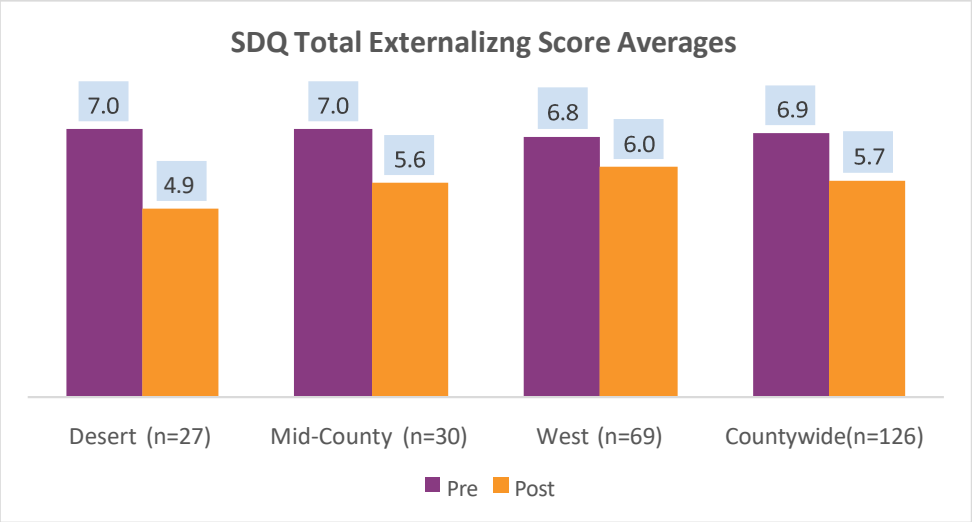
Scale	Normal	Borderline	Abnormal
Total Difficulty	**0-15**	**16-19**	**20-40**
Emotional Symptoms	**0-5**	**6**	**7-10**
Peer Problem	**0-3**	**4-5**	**6-10**
Conduct Problem	**0-3**	**4**	**5-10**
Hyperactivity	**0-5**	**6**	**7-10**
Prosocial	**6-10**	**5**	**0-4**

Key findings from the analysis of the pre-post SDQ data indicated a statistically significant decrease countywide in internalizing and externalizing problem scores, as well as in total difficulties ($p<0.001$). Data also showed a statistically significant improvement countywide in prosocial scores ($p<0.005$). Statistical significance by specific regions are shown in the accompanying tables.



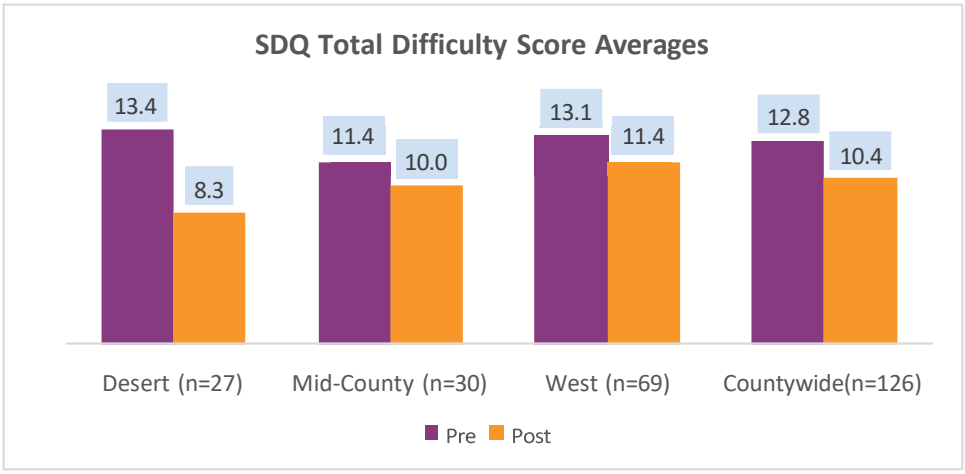
Desert	**Df**	**26**
	t-value	3.82
	p-value	0.001
Mid-County	**Df**	**29**
	t-value	0.643
	p-value	0.526
West	**Df**	**68**
	t-value	1.86
	p-value	0.48
Countywide	**Df**	**126**
	t-value	**3.65**
	p-value	**<0.001**

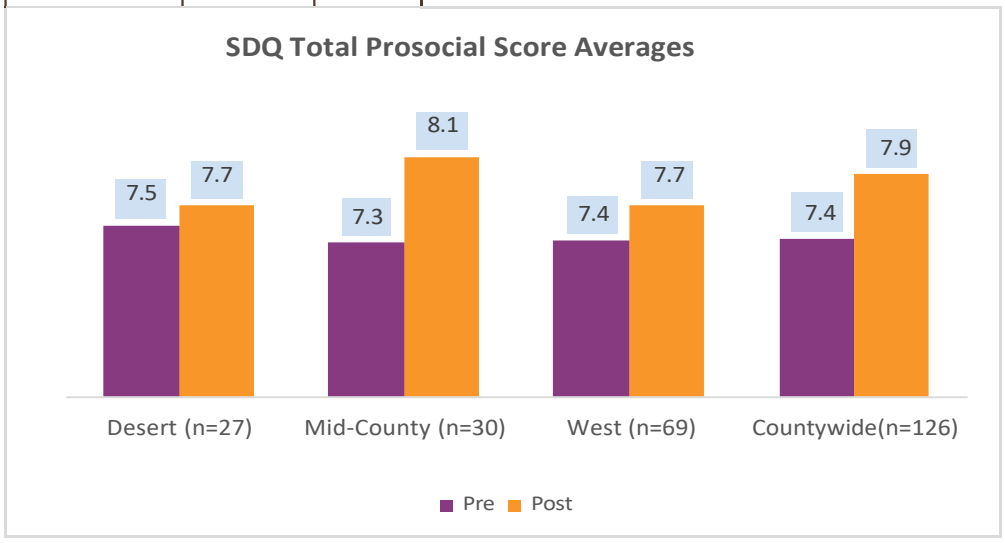
Strengths and Difficulties Questionnaire (SDQ)



Desert	Df	26
	t-value	3.23
	p-value	0.003
Mid-County	**Df**	**29**
	t-value	3.14
	p-value	0.004
West	**Df**	**68**
	t-value	1.94
	p-value	0.06
Countywide	**Df**	**126**
	t-value	**4.20**
	p-value	**<0.001**

Desert	Df	26
	t-value	3.91
	p-value	0.001
Mid-County	**Df**	**29**
	t-value	2.13
	p-value	0.04
West	**Df**	**68**
	t-value	2.34
	p-value	0.02
Countywide	**Df**	**126**
	t-value	**4.53**
	p-value	**<0.001**



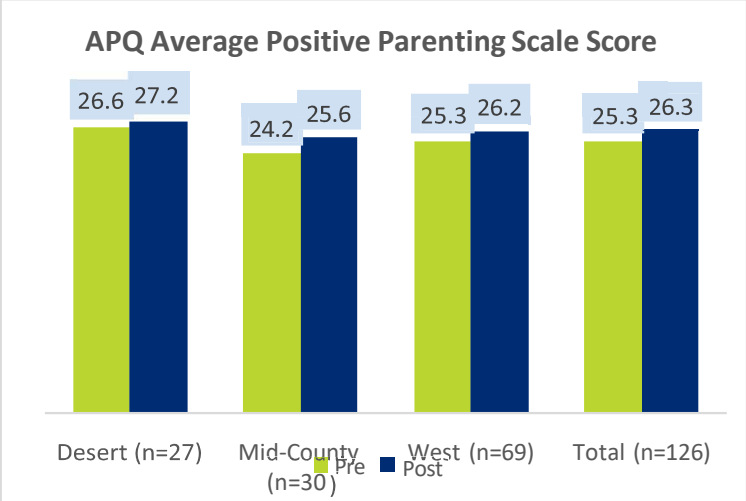


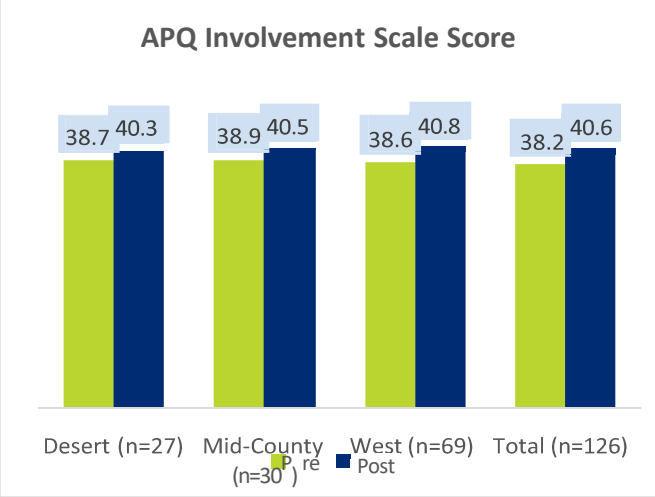
Desert	Df	26
	t-value	-2.89
	p-value	0.008
Mid-County	**Df**	**29**
	t-value	-2.06
	p-value	0.05
West	**Df**	**68**
	t-value	0.24
	p-value	0.27
Countywide	**Df**	**126**
	t-value	**-2.98**
	p-value	**0.004**

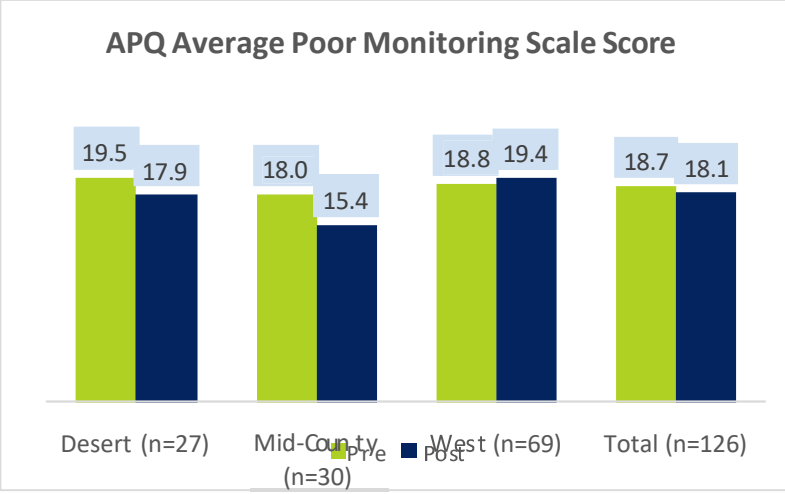
Alabama Parenting Questionnaire

Past research has shown that increasing positive parenting practices and decreasing negative practices have been effective in reducing problem behaviors in children. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. It is a 42-item self-report measure filled out by parents assessing six parenting constructs. For the Teen Triple P program, only the involvement scale score (10 items), positive parenting scale score (6 items), and poor monitoring and supervision scale score (10 items) are used. The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale (1—never, 2—almost never, 3—sometimes, 4—often, 5—always).

Key findings from the analysis of the pre-post APQ data indicated a statistically significant increase ($p<0.05$) countywide in parental involvement and positive parenting, and a slight decrease (not statistically significant) countywide in poor monitoring.



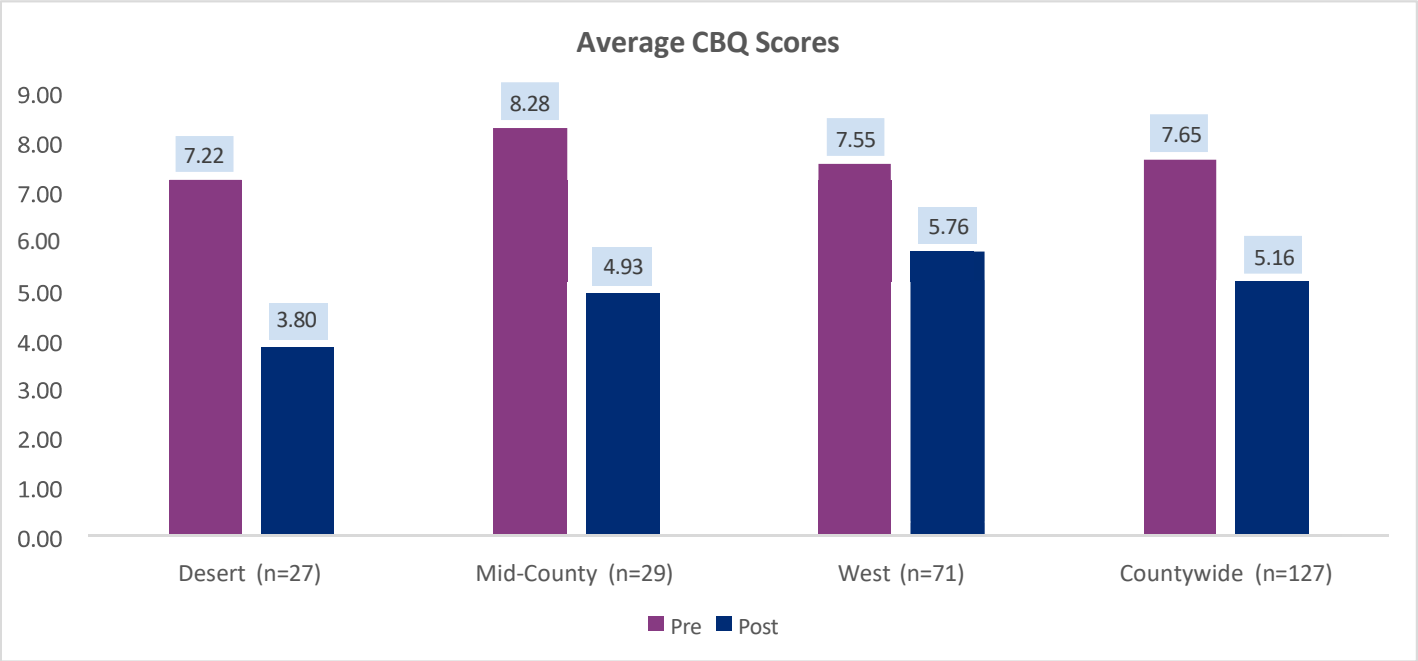




Scale	Region	T-Score	Df	P-Value
Involvement	Desert	-.751	26	0.460
	Mid-County	-3.58	29	0.001
	West	-2.63	68	0.011
	Countywide	**-3.51**	**126**	**<0.001**
Positive Parenting	Desert	-0.92	26	0.364
	Mid-County	-2.52	29	0.018
	West	-1.87	68	0.07
	Countywide	**-2.94**	**126**	**0.004**
Poor Monitoring	Desert	1.55	26	0.134
	Mid-County	1.89	29	0.068
	West	-0.75	68	0.453
	Countywide	1.03	126	0.307

Conflict Behavior Questionnaire

The Conflict Behavior Questionnaire (CBQ) is a 20 item questionnaire that uses a true false scale to assess general conflict between parents and their children. The responses are then scored (and some items reverse scored) to obtain a total score; 126 parents completed the CBQ.



Desert (n=27)	Mid-County (n=29)	West (n=71)	Countywide (n=127)
t=3.39 df=26 p=0.002	t=3.39 df=28 p=0.002	t=3.16 df=70 p=0.002	t= 5.59 df=126 p<0.001

Results showed a statistically significant decrease (improvement) across all regions and Countywide in the parent's rating of general discord between parent and teen youth.

Teen Triple P Satisfaction Survey

A total of 122 participants completed the satisfaction survey. Overall, the majority of participants were highly satisfied with all aspects of the Teen Triple P program including program logistics, quality of group leaders, and overall satisfaction.

Teen Triple P Countywide Satisfaction Survey Results (*N*=122)	Mean	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
Overall, I am satisfied with the program.	4.76	–	1 (0.8%)	2 (1.6%)	22 (18%)	97 (79.5%)
The location of the program was convenient for me and my family.	4.89	–	1 (0.8%)	1 (0.8%)	9 (7.4%)	111 (91.0%)
The sessions were at a time convenient for me and my family.	4.75	–	3 (2.5%)	4 (3.3%)	13 (10.7%)	102 (83.6%)
My family got the help we wanted for my teen.	4.71	–	3 (2.5%)	4 (3.3%)	18 (14.8%)	97 (79.5%)
Facilitators treated me with respect.	4.96	–	–	1 (0.8%)	3 (2.5%)	118 (96.7%)
Facilitators spoke to me in a way that I understood.	4.93	–	–	–	8 (6.6%)	114 (93.4%)
Facilitators are respectful of my cultural/ethnic background.	4.93	–	–	–	9 (7.4%)	113 (92.6%)
As a result of the program, I am satisfied with our family life right now.	4.68	–	3 (2.5%)	6 (4.9%)	18 (14.8%)	95 (77.9%)
I felt comfortable talking about my teen's problems with the staff.	4.82	–	–	4 (3.3%)	14 (11.5%)	104 (85.2%)
The facilitators listened to what I had to say.	4.89	–	–	–	13 (10.7%)	109 (89.3%)
The facilitators knew how to help me.	4.81	–	–	6 (4.9%)	11 (9.0%)	105 (86.1%)

Teen Triple P Satisfaction Survey

Across all sites, the following are comments provided by parents about things they learned, liked, and disliked.

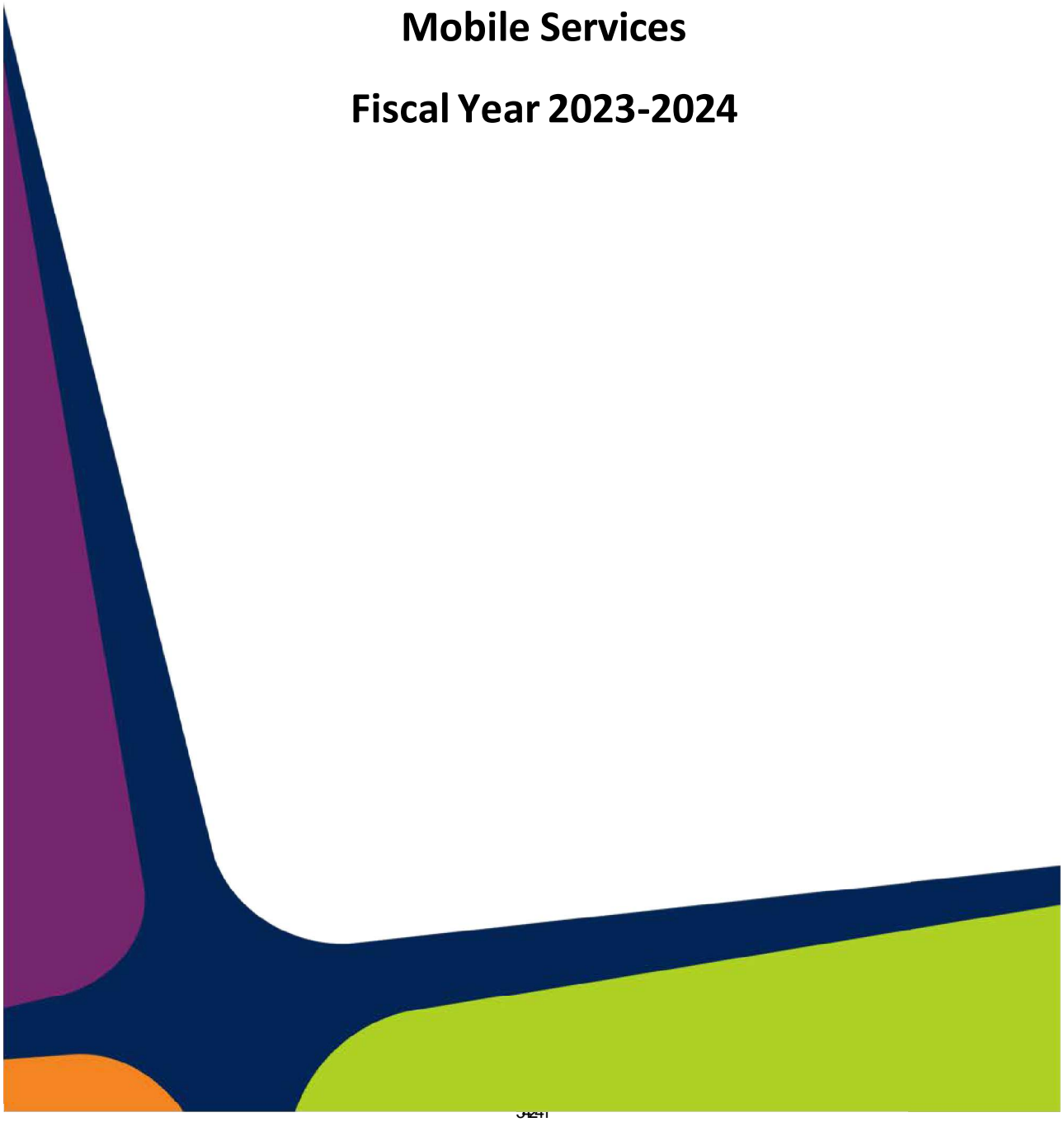
Common Things Learned……
"That we are working as a team and that we can improve our relationship and communication with our child."
"Be more patient and listen to my daughter before making any comments that might make her feel bad."
"The behavior contract. How to validate my teens emotion & what to do; praising the good behavior."
"Maintain consistency in rules, listen more to my teenager without interrupting."
"To allow my teenager to calm down before talking to her. Make sure to praise her when she doing good."
Common Things Liked…..
"I liked that there were parents willing to discuss their troubles and offer insight into things that they do or have tried. Also liked doing the scenarios with the breakout sessions."
"It is very important for families to be able to guide our adolescents to be better people in their future."
"I got to hear from other parents and saw that I wasn't alone in my struggles. They also had good advice and techniques for me to try within my home."
"The convenience (zoom) was very helpful."
"What I liked is that the instructor was really nice & understanding."
Common Things Disliked…..
"The fact that my children are not with me at the moment, and only see them once a month so it's hard to apply what I learned."
"There wasn't anything I didn't like the program was very enjoyable and informative."
"The only thing was that you can't get too deep into each subject due to the time, 2 hrs."

Preschool 0-5 Programs

Prevention and Early Intervention

Mobile Services

Fiscal Year 2023-2024



Program Overview

The RUHS-BH Prevention and Early Intervention (PEI) preschool 0-5 programs, which includes the Mobile Services has overall goals of:

- Helping reduce young children's challenging behaviors, while increasing emotional control; promoting social competence
- Reducing stigma associated with receiving mental health services
- Reducing or eliminating geographical isolation and transportation barriers to services
- Connecting with families with children than might not otherwise qualify for mental health services
- Offering young children the opportunity to develop skills and abilities that will prepare the for school and life

The Preschool 0-5 Clinic offers mental health services which include PCIT, an evidence-based treatment for young children with behavioral problems. It's conducted through coaching sessions during which the caregiver and child are in a playroom while the therapist is in an observation room watching the caregiver interact with the child through a one way mirror. the caregiver wears a device in the ear through which the therapist provides in the moment coaching skills. The clinic also offers parenting groups and child prosocial skills groups.

The clinic also harbors three sprinter vans which are used for providing services at the client's home, school sites, or anywhere that is needed in identified underserved areas as defined by the Prevention and Early Intervention plan. The vans are built with the capacity to hold PCIT sessions, child prosocial sessions and more. For FY 23-24 the vans were not in use as the program was working out the logistics and administrative tasks associated with deploying the vans. Details on the activities of staff dedicated to the mobile unit are discussed further in this report.

Data Collection and Outcome Evaluation for FY 23-24

- Mental Health service enrollment and utilization provided is recorded in the RUHS-BH electronic health record for those children that require clinical mental health services.
- A PCIT enrollment form within the Electronic Medical Health Record captures the progress of PCIT for those receiving that service.
- Data for PCIT and other mental health services is evaluated by examining changes in children's behavior and parents stress as it relates to their parental role. Outcome measures include:

    1. The **Eyberg Child Behavior Inventory (ECBI)** is a 36 item parent report scale that measures the frequency of a child's disruptive behavior and if that behavior is a problem for the parent. Measures are collected pre, post, and sometimes mid treatment. The pre and post measures are used for analysis.
    2. The **Parental Stress Index Short Form (PSI-4-SF)** is a self report 36 item questionnaire that assesses the level of stress experienced by parents as a function of their role as a parent and as a function of their child's behavior. The measure is completed pre and post treatment.
    3. The **Therapy Attitude Inventory (TAI)** is a fifteen question satisfaction survey for the parent/primary caregiver to complete at the conclusion of services.

Data Collection and Outcome Evaluation *Continued*

Parent Consultations (PEI Mobile Services RUs Only)

A parent may be on the phone, or walk in to the mobile unit, request information on a concern for their child and/or information on specific parenting skills. Demographic data, as well as data on the details of the consultation (services, referrals) are tracked using a one page parent consul- tation form.

Provider Consultations (PEI Mobile Services RUs Only)

Provider consultations are also a part of the mobile unit's service and is primarily done at school sites for school personnel. The provider consultation may take the form of general or clinical classroom consultations with optional classroom observation. Details of the consultation was recorded on a provider consultation form, and any referrals made for children during the process were tracked. No provider consultations were recorded for FY 23-24.

Outreach Events (*PEI Mobile Services RUs Only*)

Details of any community outreach events at which the sprinter vans are present are recorded on a one page outreach activities form which gives details of the event type as well as the audience.

Key Findings

MH Services and PCIT

- A total of 300 children (families) received PCIT/MH services in the West, Desert, and Mid-County Regions.
- A total of 11,408 mental health related services totaling to 9,276.2 service hours
- Case management services as well as family therapy with client accounted for the majority of services—38.7% and 31.7%, respectively.

MH Services/PCIT Demographics

- Countywide, two thirds of the participants were male (66.3%).
- Countywide, a majority of participants served were Hispanic/Latinx (44%).
- A majority of children served were 4 years of age (32.7%).

PCIT Specific Outcomes

- 203 families were enrolled in PCIT (or Toddler PCIT or Trauma Directed Interaction).
- Of the 121 clients that closed to PCIT (or PCIT-T, TDI), 29% closed due to completion of one or more phases of the treatment.
- A majority of children served were 4 years of age (32.7%).
- 88% of families had a good or fair prognosis after attending PCIT.
- 57.4% of families met all or some of the goals set by the family and the therapist.

MH Services/PCIT Outcomes

- Countywide there was a statistically significant decrease in the frequency of child problem behaviors and in the extent to which caregivers perceived their child's behavior to be a problem.
- Pre and Post PSI scores showed a statistically significant decrease countywide in parent's stress levels.
- Overall parents felt more confident in their parenting skills and ability to discipline their child. Parents felt their relationship with their child and their child's behavior improved.
- A total of sixteen children and sixteen caregivers (16 families) were served with the Incredible Years Parenting Program and Dinosaur School, a prosocial skills group for children.
- A total of 6 children, (out of 300 served with MH services) were served with TF-CBT as part of the therapy they received.

PEI Mobile Services Parent Consultations

- In the 23-24 fiscal year, 23 parent consultations served 22 parents.
- Average age of the child was 4.1 years with 64% of the parents also reporting they have another child between the ages of 0-18 at home.
- Tantrums and child not listening to parent were the two frequently discussed concerns during parent consultations.
- Parent tip sheets and referral to child pro-social groups constituted a majority of the referrals.

PEI Mobile Services Outreach Events

- PEI Mobile Services recorded a total of 4 outreach events provided to 52 people

Administrative Data and Billing

There were a total of **300 families** served by the Pre-School 0-5 clinic which includes the clinic as well as PEI Mobile Services). A total of **11,408 PCIT/MH services** were provided. For administrative purposes this section analyses the number of families (participants) served by each RU in FY 23-24.

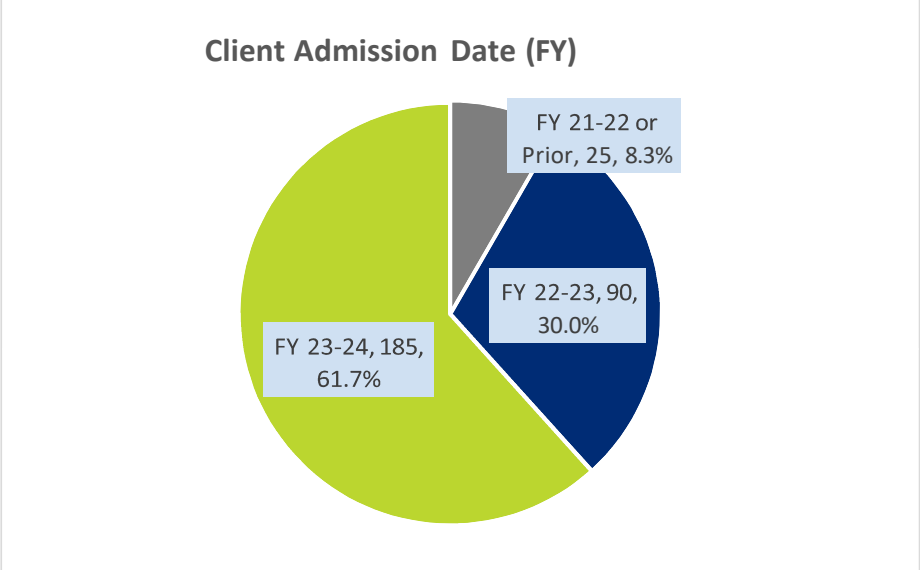
As shown in the table below, a majority of participants served were billed under 33ET01 RU. A total of 5,972 services were billed. Service details are provided in a different section of this report.

For services billed under the PEI Mobile Services RUs (33ETPC, 33HUPC, 33G8PC), services were given to families who resided in the underserved areas of Riverside as defined by the PEI plan. Staff who billed these RUs provided services at the client's home, the closest school site where Preschool 0-5 has a location, or at the nearest outlining clinic. Services for families who were non-Medi-Cal or IEHP were also captured with the PEI Mobile Services RUs.

Given that the team was short staffed, all staff helped with all RUs, and were billing all four RUs based on the population they were serving.

RU	Program Name	# of Participants Served	# of Services
33ET01	Preschool 0-5 Clinic Services	175 (58.3%)	5,972 (52.3%)
33ETPC	PEI Mobile Services-West	67 (22.3%)	3,257 (28.6%)
33HUPC	PEI Mobile Services-Mid-County	43 (14.3%)	1,598 (14%)
33G8PC	PEI Mobile Services-Desert	15 (5%)	581 (5.1%)

Client Admission Date

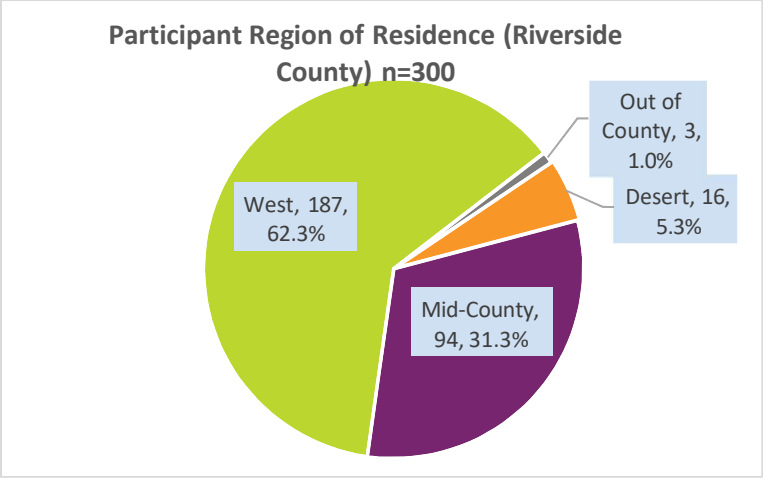


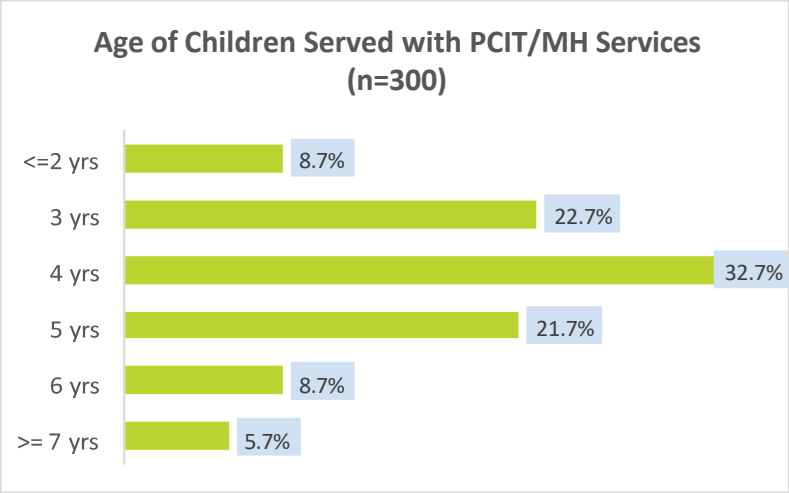
Of the 300 families served, 62% were new in the 23-24 FY. 30% were carry overs from 22-23 FY and 8.3% were open to the program 21-22 FY or prior.

Preschool 0-5 Programs
All MH Services Data

Participant Demographics

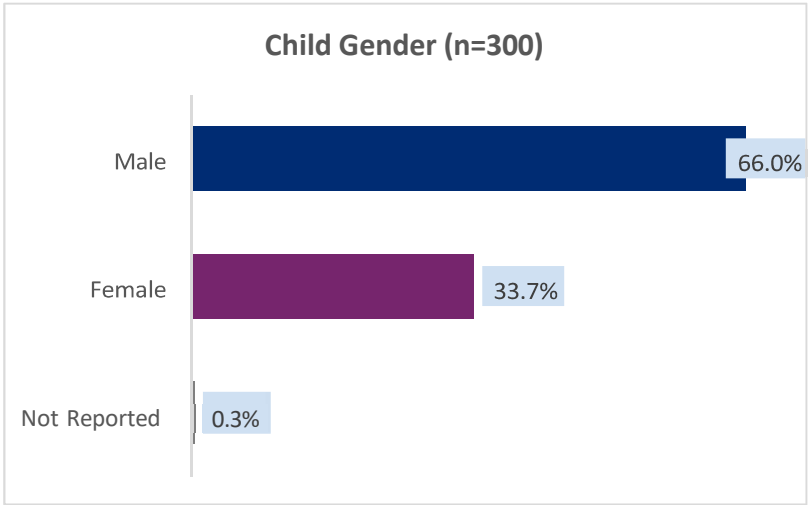
Of the clients served with mental health services, a majority resided in the Western region of Riverside County (62.3%), as determined by their reported residential zip code.

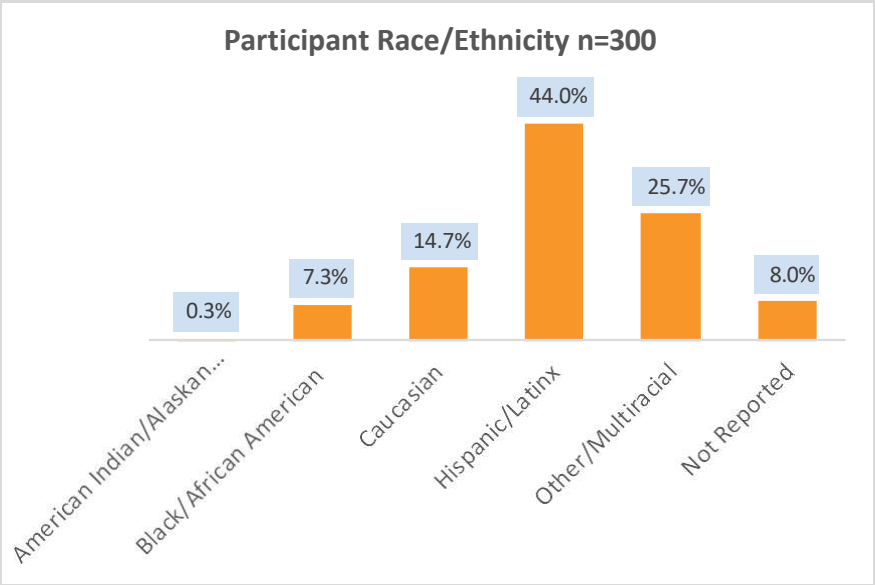




A majority of children served were 4 years of age (32.7%). The age of the oldest children served was 13 years. These children were primarily receiving Trauma Focused CBT Therapy. Children who were under two years of age were primarily receiving toddler PCIT services.

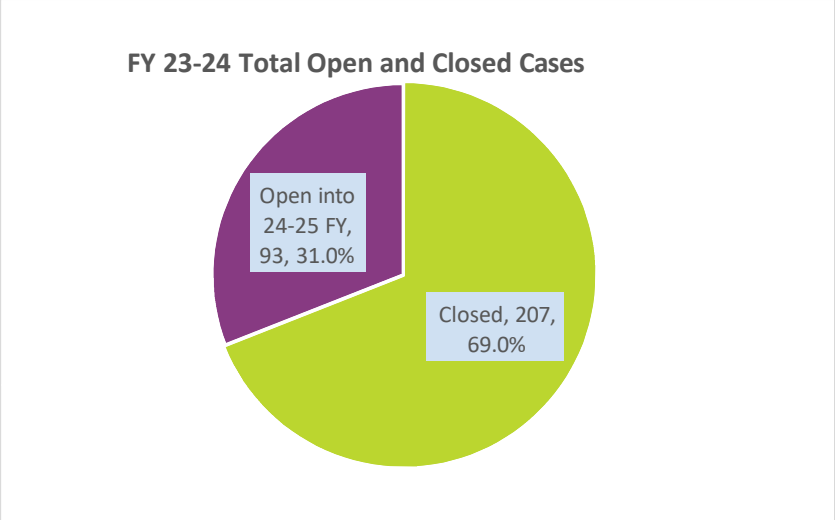
Two-thirds of the children served with mental health /PCIT services were male.





Countywide, a majority of participants served were Hispanic/Latinx (44%).

Participant Program Completion Data



In the 23-24 FY, 69% of the clients closed to the program. 31% will continue to receive services into the 24-25 FY.

The table below summarizes the reason for close for the 207 clients who closed to the program.

As shown on the table to the right, 30 percent of the reasons for close included completed (further tx. or no further tx. recommended), Mutual agreement (goals reached or partially reached) and transfer to another provider.

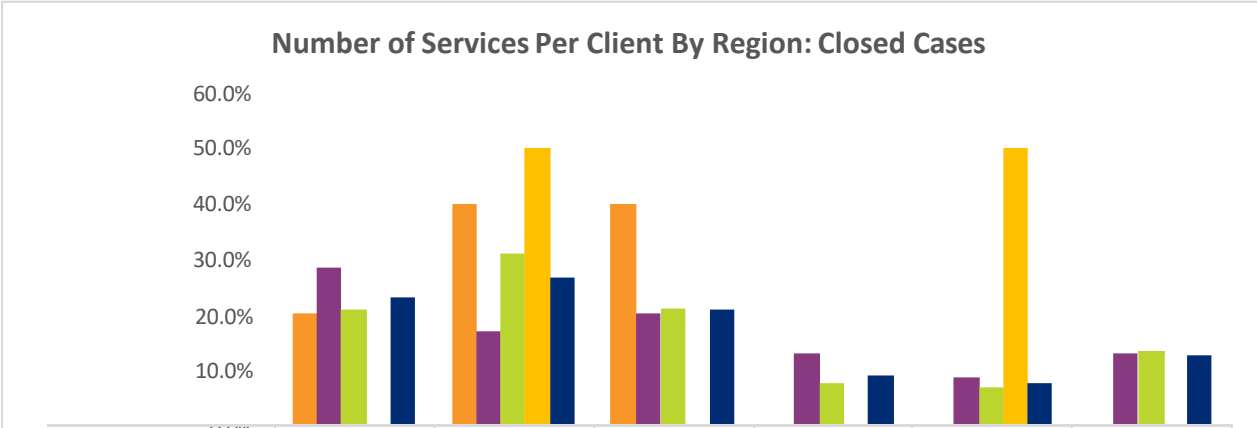
Close Reason	#, %
Client Withdrew	45 (21.7%)
Closed/No Show/No Contact	68 (32.9%)
Completed-No Further Tx Recommended	**23 (11.1%)**
Completed-Referred for Further Tx	**4 (1.9%)**
Did Not Need Service	5 (2.4%)
Moved Out of Area	5 (2.4%)
Mutual Agreement/Goals Not Reached	11 (5.3%)
Mutual Agreement/Goals Reached	**26 (12.6%)**
Mutual Agreement/Partial Completion	**8 (3.9%)**
Transfer to Another Provider	**3 (1.4%)**
Other/Reason Not Available	9 (4.4%)

Preschool 0-5 Programs
All MH Services Data

A total of 11,408 mental health related services totaling to 9,276.2 service hours were provided to 300 clients and their families in FY 23-24. Case management services as well as family therapy with client accounted for the majority of services—38.7% and 31.7%, respectively. Note, if an activity required two therapists and they each billed for the hours, that was counted as two services and the hours billed were also counted for each therapist.

Service	Count of Service	% of Svcs.	Service Hours	Clients Receiving Service
Assessment	283	2.5%	505	156
Case Management Brokerage	**4411**	**38.7%**	**2,017.8**	**278**
Case Management Family	195	1.7%	96.3	89
Family/Non Family Collateral	1	0.01%	1	2
Family Therapy With Client	**3620**	**31.7%**	**4180.7**	**223**
Group MH Service	177	1.6%	279.8	16
Individual Therapy	172	1.5%	178.5	32
Intensive Care Coordination	7	0.1%	1.9	7
Intensive Care Coordination Review	8	0.1%	6.7	7
Intensive Care Coordination with Family	63	0.6%	52.8	18
Intensive Care Coordination Without Family	258	2.3%	130.0	29
Medication Services	28	0.2%	15.3	6
Mental Health Service	1937	17.0%	1592.0	234
Non Family Collateral	1	0.0%	0.3	1
Peer Mental Health Engagement/Activity	247	2.2%	218.1	33
Total	**11,408**	**100%**	**9276.2**	

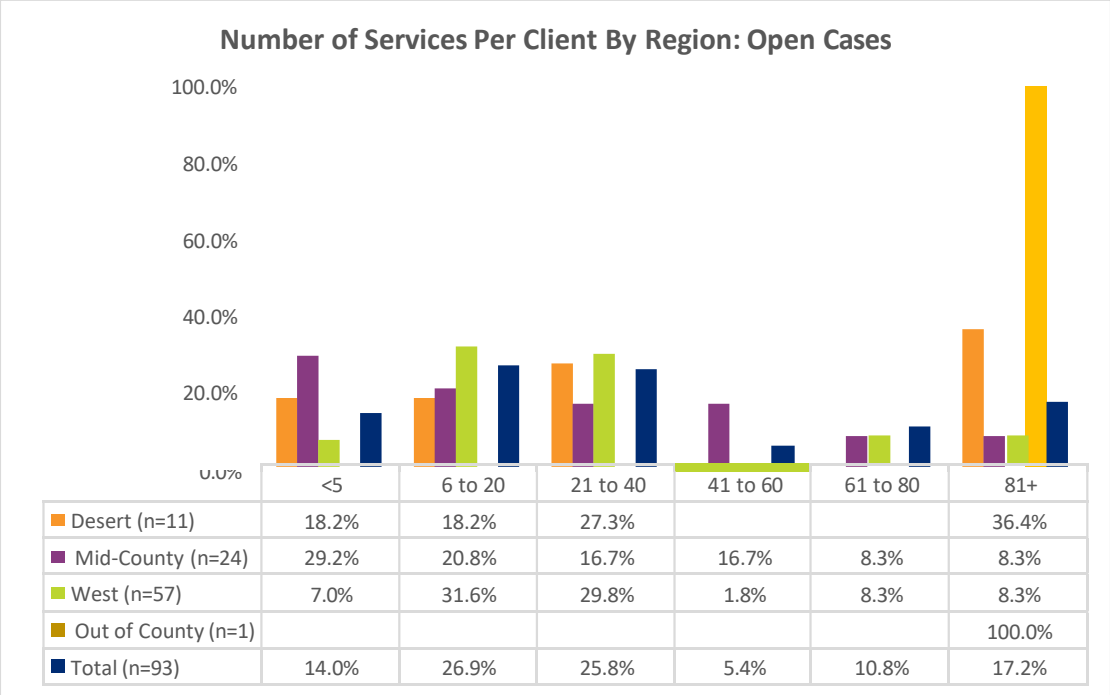
Service data for the 207 children who completed or were discharged from the program showed a total of 7,460 PCIT services in FY 23-24. Countywide, 23.2% of clients had 5 or fewer services, 26.6% received 6 to 20 services, 20.8% received 21-40 services, 9.2% received 41 to 60 services, 7.7% received 61 to 80 services and 12.6% received 61 or more services. The regions indicated on the graph correspond to the participant's region of residence.



	<5	6 to 20	21 to 40	41 to 60	61 to 80	81+
Desert (n=5)	20.0%	40.0%	40.0%			
Mid-County (n=70)	28.6%	17.1%	20.0%	12.9%	8.6%	12.9%
West (n=130)	20.8%	30.8%	20.8%	7.7%	6.9%	13.1%
Out of County (n=2)		50%			50%	
Total (n=207)	23.2%	26.6%	20.8%	9.2%	7.7%	12.6%

Preschool 0-5 Programs
All MH Services Data

The graph below shows the number of services provided in the 23-24 FY for the 93 children who are still continuing the program into the 24-25 FY. In total there were 3,948 services provided to these clients. A majority of these children have received 6 to 20 services (26.9%) or 21 to 40 services (25.8%). There were children who received less than 5 services, but these were newer clients served towards the end of the fiscal year and who are continuing into the new fiscal year.



	<5	6 to 20	21 to 40	41 to 60	61 to 80	81+
Desert (n=11)	18.2%	18.2%	27.3%			36.4%
Mid-County (n=24)	29.2%	20.8%	16.7%	16.7%	8.3%	8.3%
West (n=57)	7.0%	31.6%	29.8%	1.8%	8.3%	8.3%
Out of County (n=1)						100.0%
Total (n=93)	14.0%	26.9%	25.8%	5.4%	10.8%	17.2%

Preschool 0-5 Programs
PCIT Service Data

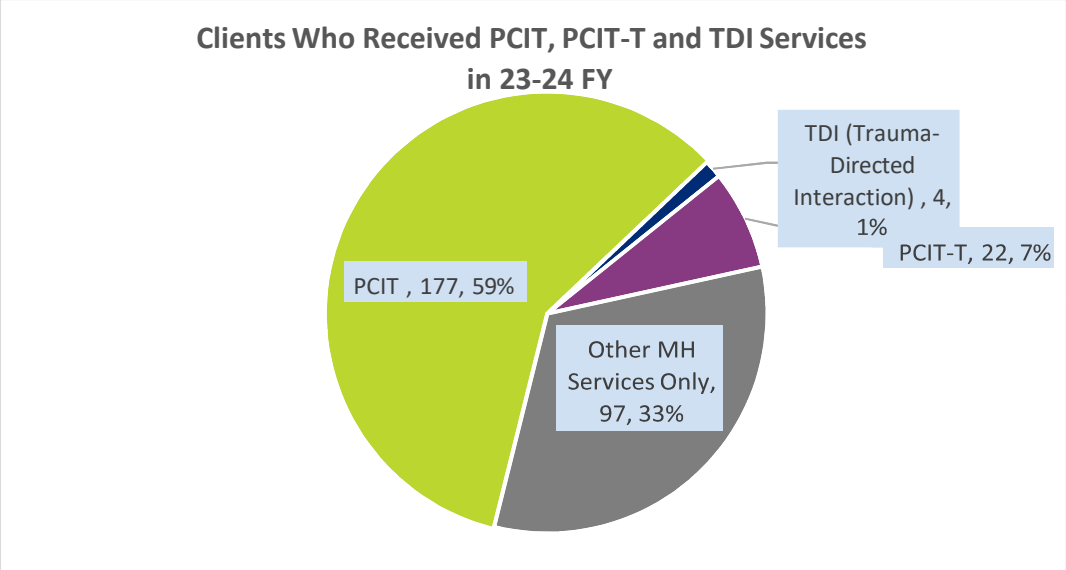
This section takes a closer look at the PCIT (and related) services, primarily using data collected from ELMR's PCIT Enrollment Form. For reference:

- PCIT is an evidence-based treatment for young children with behavioral problems. It's conducted through coaching sessions during which the caregiver and child are in a playroom while the therapist is in an observation room watching the caregiver interact with the child through a one way mirror. the caregiver wears a device in the hear through which the therapist provides in the moment coaching skills. The treatment consists of two phases—the child directed phase (CDI) and the parent directed phase (PDI). The CDI Phase encourages warm, secure caregiver-child relationships. The PDI increases child compliance and decreases child disruptive behaviors.

- Trauma Directed Interaction, or TDI is an adaptation of PCIT therapy for families with a history of trauma. TDI maintains the key elements and theoretical aspects of PCIT and adds sessions to cover psychoeducation about trauma, coping skills to aid child and caregiver of trauma reactions, and caregiver responses to child trauma reactions.

- PCIT toddlers, or PCIT-T is an early intervention program that involves coaching parents while they interact with their 12-24 month old children. Goals include decreasing problematic behaviors, improve attachment, increase children's language and encourage toddlers to follow directions. It also addresses parent stress (anxiety, dissatisfaction, difficulty coping, lack of confidence).

Of the 300 families receiving mental health services from the Preschool 0-5 programs, **a total of 203 families (67.6%) received PCIT (or related models of PCIT) services.** The graph below shows the distribution of clients receiving each type of service. 177 families received PCIT, 4 families received TDI therapy, and 22 clients received PCIT-Toddler.



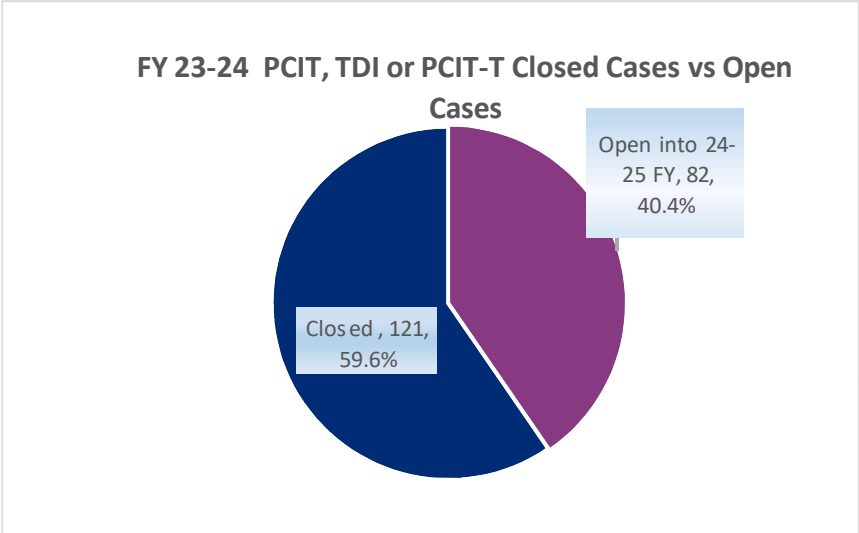
PCIT, TDI or PCIT-T Enrollment By Program (Out of a Total of 203 Clients)

A majority of participants served with PCIT, TDI, or PCIT-T were served by the Preschool 0-5 Clinic, followed by staff using the Western PEI Mobile Services RU.

RU	Program Name	# of Participants
33ET01	Preschool 0-5 Clinic Services	111 (54.7%)
33ETPC	PEI Mobile Services-West	50 (24.6%)
33HUPC	PEI Mobile Services-Mid-County	9 (4.4%)
33G8PC	PEI Mobile Services-Desert	33 (16.3%)

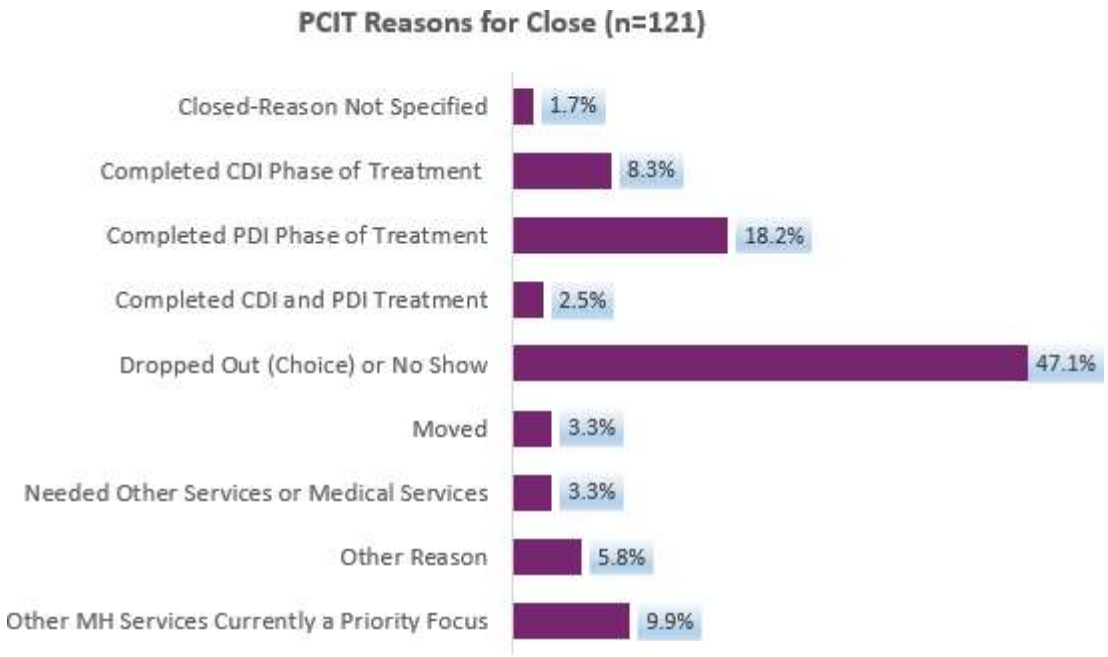
PCIT, TDI or PCIT-T Open Vs. Closed Cases (Out of a Total of 203 Clients)

Nearly 60% of families closed out of PCIT (or related) treatment in the 23-24 FY. Reasons for closed are analyzed on the next page. 40% of families will continue receiving the service into the 24-25 FY.

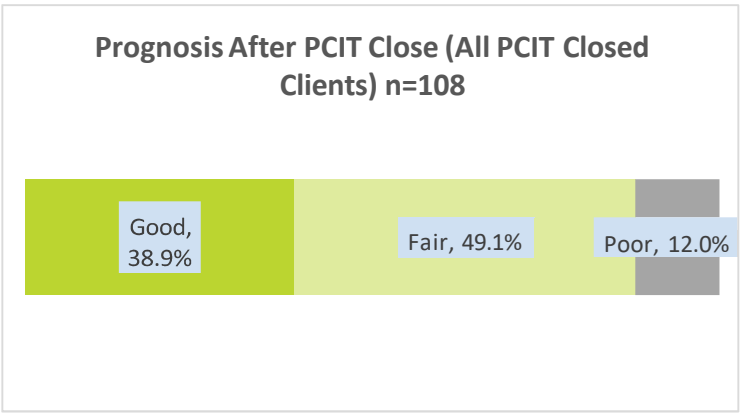


Reasons for Close

Of the 121 clients that closed to PCIT (or PCIT-T, TDI), 29% closed due to completion of one or more phases of the treatment. A little less than half dropped out due to personal choice, or were closed out due to multiple no show appointments after attempts to contact were made. Reasons marked as "Other" included lack of perceived effectiveness, transportation issue or conflict with caregiver's work schedule.



Closed PCIT Cases Only (n=108) Goals met and Prognosis

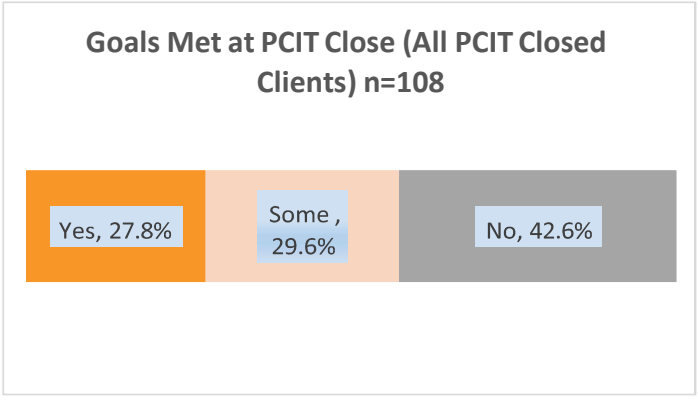


Upon closing a PCIT case, therapists complete a PCIT close form in ELMR. They record the prognosis after treatment for each client.

As shown in the figure to the left, 88% of families had a good or fair prognosis after attending PCIT.

Upon closing therapists noted if the families met goals set at treatment.

As shown in the figure to the right 57.4% of families met all or some of the goals set by the family and the therapist.



Dinosaur School and IY Parenting Classes



Of the 300 families served, A total of sixteen children and sixteen caregivers (16 families) were served with the Incredible Years Parenting Program and Dinosaur School, a prosocial skills group for children. Classes range from 6-8 weeks, and are usually once per week. Parents are attending the parenting group while their child is being provided the dinosaur school session.

- In total, the sixteen children served with Dinosaur school received 24 hours of service
- In total, the sixteen parents served with IY Parenting classes received 27 hours of service
- 3 Cycles consisting of 6-8 sessions were conducted in July, September and February.
- Sessions were provided by staff from the clinic RU (33ET01) or the Western Mobile RU (33ETPC).
- Services were billed as Group MH Service, and is included in the service analysis on page 8 of the report

Trauma Focused Cognitive Behavior Therapy (TF-CBT)

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is a evidenced based practice to help children affected by trauma. TF-CBT helps to resolve behavioral and emotional difficulties that occur with single, multiple, or complex trauma experiences.

- A total of 6 children, (out of 300 served with MH services) were served with TF-CBT as part of the therapy they received
- Children ranged from 4-10 years old
- 5 of the 6 children resided in the Western region of Riverside and were served by the 33ET01 clinic RU; 1 child resided in the Mid-County region of Riverside and was served by the Western Mobile RU (33ETPC).
- Details of TF-CBT outcomes and program statistics are shared in a separate county report.

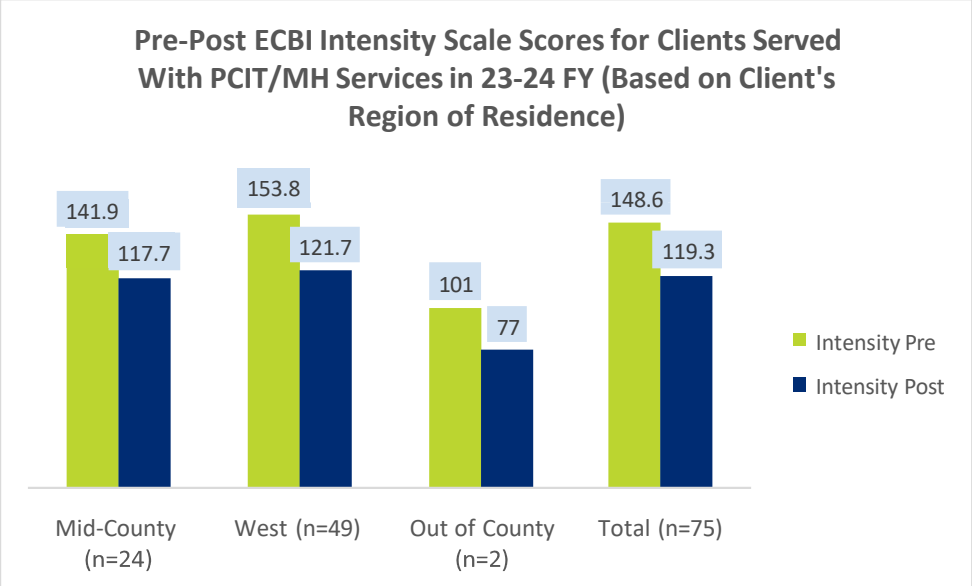
The next section will highlight the outcomes of families receiving all MH services as a whole.

PCIT/MH Services Outcomes ECBI

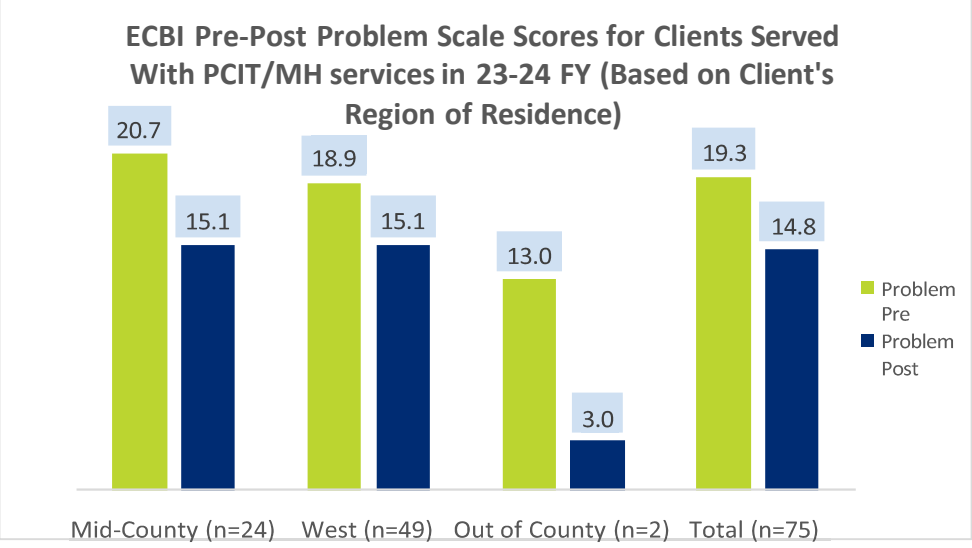
The ECBI rating scale measures the frequency and severity of children's problem behaviors at home and school settings (Intensity Score) as well as the extent to which the parents and teachers find the child's behavior troublesome (Problem Score). A child rated at or above an Intensity raw score of 131 on the ECBI and/or 15 or higher on the Problem raw score is in the clinical range.

There were a total of 75 parents who completed the ECBI measure pre to post (mid-score is considered a post score for clients who haven't closed out of the program). In total, there was a statistically significant decrease in the frequency of child problem behaviors (Intensity scale) as well as a statistically significant decrease in the extent to which caregivers perceived their child's behavior to be a problem (Problem Scale). Statistical significance was not measured for clients who lived Out of County due to the small sample size.

Of the 75 parents who completed the ECBI pre and post, 70 parents (93.3%) received PCIT services.



ECBI Intensity Score (Pre-Post): Statistical Significance			
Region	Df	T-Score	P-Value
Desert	-	-	-
Mid-County	23	3.29	0.003
West	48	5.56	<0.001
Out of County	1	*	*
Total	**74**	**6.46**	**<0.001**



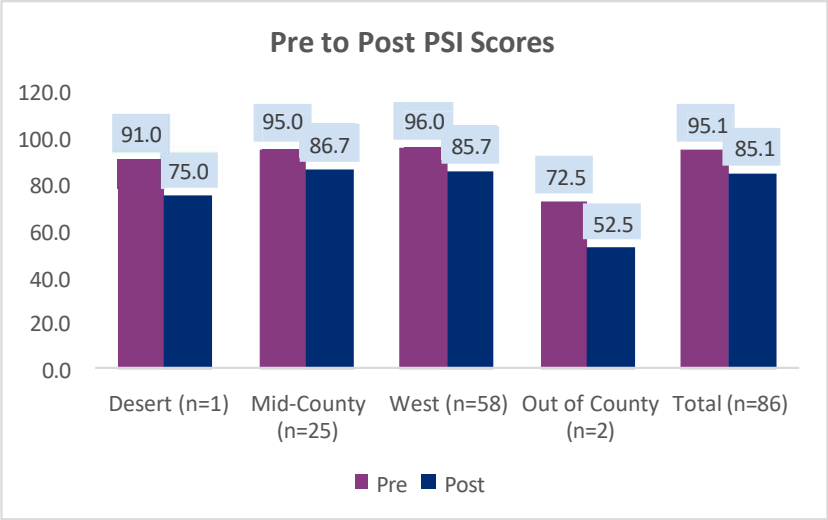
ECBI Problem Score (Pre-Post): Statistical Significance			
Region	Df	T-Score	P-Value
Desert	-	-	-
Mid-County	23	2.77	0.011
West	48	2.17	0.035
Out of County	1	*	*
County-wide	**74**	**3.39**	**0.001**

PCIT/MH Services Outcomes PSI-4-SF

The Parental Stress Index Version 4 Short Form (PSI-4-SF) is a 36 item questionnaire used to measure the overall level of parental stress experienced by parents of children 12 years of age or younger. The PSI-4-SF yields a total stress score that is a combined score of three subscales: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child.

There were a total of 86 parents (91% of whom received PCIT) who completed the PSI pre to post (mid-score is considered a post score for clients who haven't closed out of the program). As shown in the graph below, in total and regionally these parents experienced a decrease in the level of stress pre to post PCIT intervention. Statistical significance was not measured for the desert region and out of county cases due to the small sample size.

The clinical cutoff for the PSI-4-SF is 85. Post scores show that these parents were at the clinical cutoff of 85 post intervention.



ECBI Intensity Score (Pre-Post): Statistical Significance			
Region	Df	T-Score	P-Value
Desert	n/a	*	*
Mid-County	24	2.60	0.016
West	57	4.36	<0.001
Out of County	1	*	*
County-wide	**85**	**5.40**	**<0.001**

Satisfaction

Satisfaction of services is measured by a survey called Therapy Attitude Inventory (TAI). Answers are based on a scale from 1-5.

A total of **28 parents** completed the TAI in FY 23-24. (64.8% of those parents received PCIT services). On average, the parents felt more confident in their parenting skills and ability to discipline their child and felt their relationship with their child and their child's behavior improved. The parents felt the techniques learned were accepted by their family, community and religious beliefs.

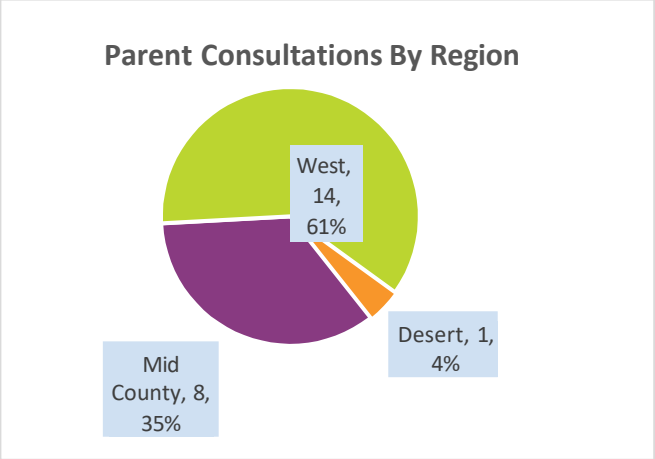
The specific TAI questions, as well as the average scores given to each item by the 28 parents are shown on the following page.

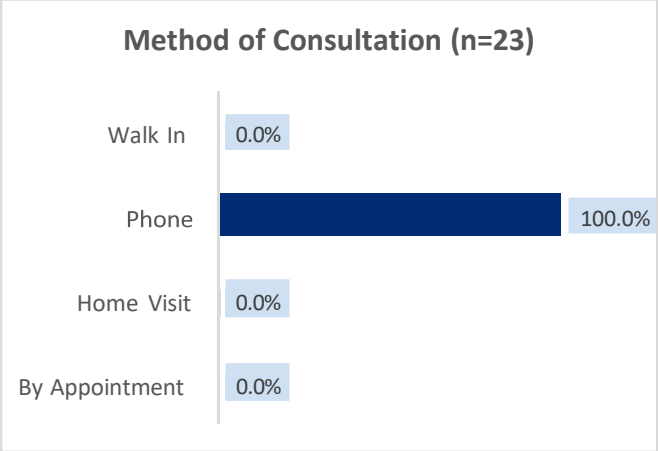
Preschool 0-5 Programs
All MH Services Data

Question	Average Score (n=28)	1	2	3	4	5
Regarding techniques of disciplining, I feel I have learned:	**4.68**	Nothing	Very little	A few new techniques	Several useful techniques	Very many useful techniques
Regarding techniques for teaching my child new skills I feel like I have learned:	**4.75**	Nothing	Very little	A few new techniques	Several useful techniques	Very many useful techniques
Regarding the relationship between myself and my child, I feel we get along:	**4.68**	Much worse than before	Somewhat worse than before	The same as before	Somewhat better than before	Very much better than before
Regarding confidence in my ability to discipline my child I feel:	**4.75**	Much less confident	Somewhat less confident	The same	Somewhat more confident	Much more confident
The major behavior problems that my child presented at home before the program started are at this time:	**4.82**	Considerably worse	Somewhat worse	The same	Somewhat improved	Greatly Improved
I feel that my child's compliance to my commands or requests is at this time:	**4.86**	Considerably worse	Somewhat worse	The same	Somewhat Improved	Greatly Improved
Regarding the progress my child has made in his/her general behavior I am:	**4.89**	Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
To what degree has the treatment program helped with other general, personal, or family problems not directly related to your child in the program?	**4.64**	Hindered much more than helped	Hindered slightly	Neither helped or hindered	Helped somewhat	Helped very much
I feel the type of program that was used to help me improve the behaviors of my child was:	**4.82**	Very poor	Poor	Adequate	Good	Very good
My general feeling about the program I participated in is:	**4.89**	I disliked it very much	I disliked it somewhat	I feel neutral	I liked it somewhat	I liked it very much
Level of comfort with the ethnicity of your therapist/coach:	**5.00**	Not comfortable	Somewhat comfortable	Neutral	Somewhat Comfortable	Very Comfortable
Level of comfort with the ethnicity of the assessment staff:	**4.89**	Not comfortable	Somewhat comfortable	Neutral	Somewhat Comfortable	Very Comfortable
To what degree have the skills you learned in this treatment program been accepted by the people in your family (e.g., mother/father, adult siblings, other extended relatives)?	**4.32**	Not accepted	Somewhat not accepted	Neutral	Somewhat accepted	Very accepted
To what degree have the skills you learned in this treatment program been accepted by the people in your community (e.g., neighbors, other school/Head Start parents, friends)?	**4.36**	Not accepted	Somewhat not accepted	Neutral	Somewhat accepted	Very accepted
To what degree do you feel that the skills you have learned in this program are consistent with your religious or spiritual upbringing and values?	**4.36**	Not consistent	Somewhat not consistent	Neutral	Somewhat consistent	Very consistent

PEI Mobile Staff—Parent Consultations

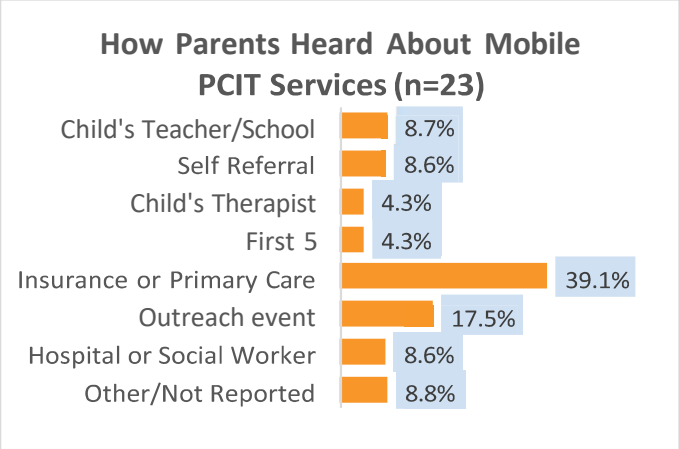
Parent consultations are provided by PEI Mobile staff as a light touch service where parents can, by walk-in or appointment, talk about raising their children, and discuss the social, emotional, and learning issues that they are facing. Clinicians can enroll the child/parent in supportive services that will help foster the child's academic and personal growth, and can refer out to other services when necessary. Consultations are also available by phone.

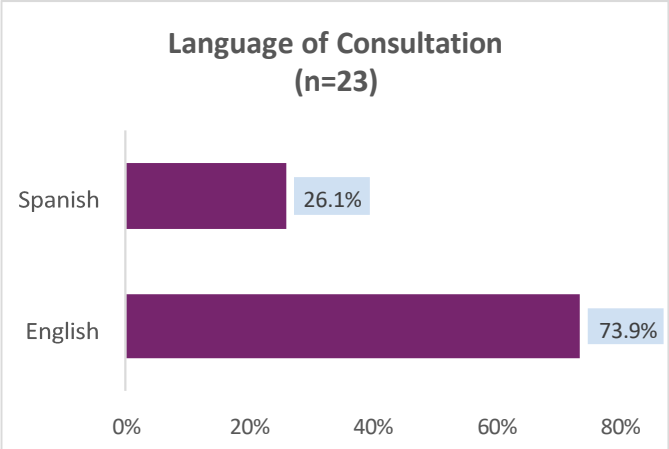


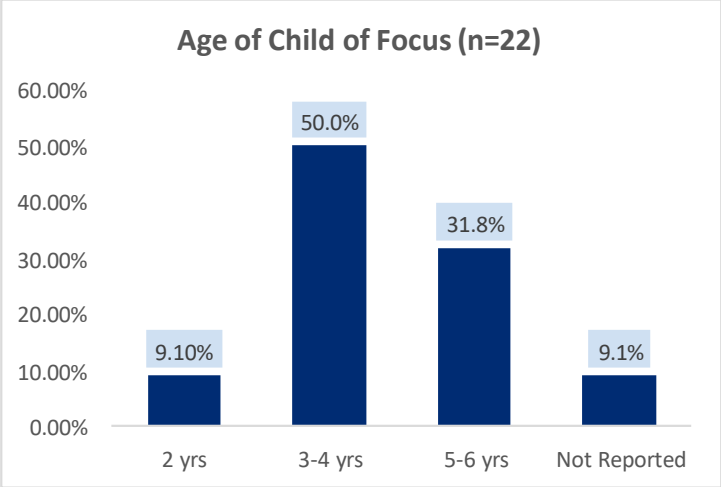


A majority of parent consultations (61%) were provided to parents in the Western region.

In the 23-24 fiscal year, 23 parent consultations served **22 parents**. All parent consultations were provided on the phone (100%).





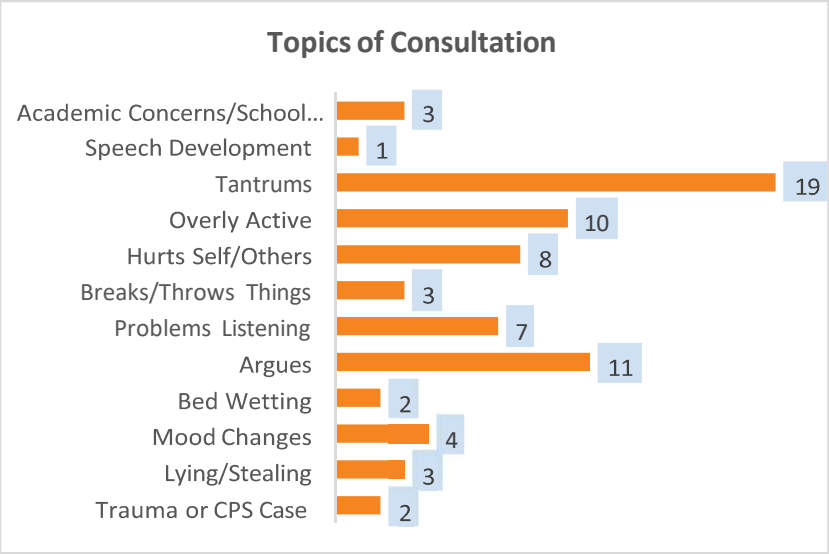


A majority of consultations (73.9%) were provided in English.

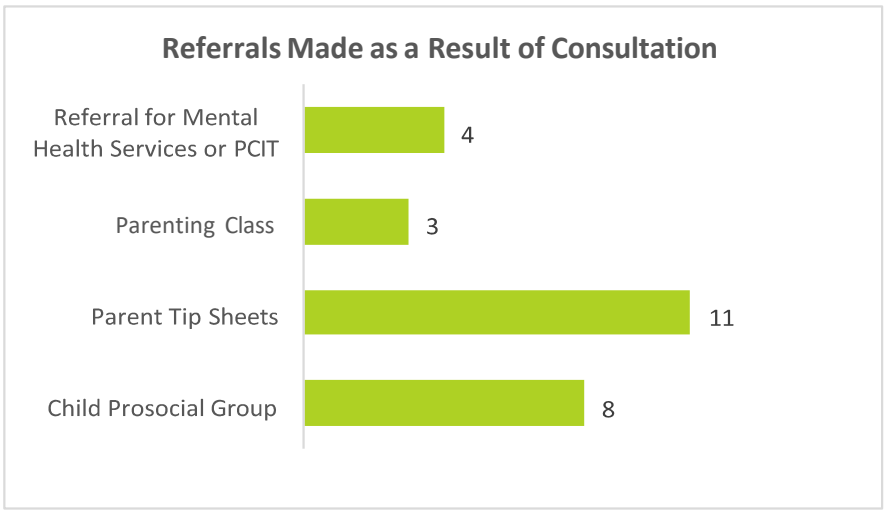
A majority of parents learned of the consultation and other services through their insurance or primary care doctor, or through an outreach event.

Half of the children of focus (50%) were 3-4 years of age. Average age of the child was 4.1 years with 64% of the parents also reporting they have another child between the ages of 0-18 at home.

PEI Mobile Staff
Additional Light Touch Services Data



Tantrums and arguing were the two frequently discussed concerns during parent consultations, followed by being overly active. *(Each parent consultation could focus on multiple topics, so counts are depicted in the graph).*





23 parent consultations resulted in a total of 26 referrals (including tip-sheets/ behavioral charts.). Parent tip sheets and referral to child pro -social groups constituted a majority of the referrals.

PEI Mobile Staff— Outreach Events

- PEI Mobile staff recorded a total of 4 outreach events which included providing an informational presentation to the Comprehensive Autism Center, participating at health and wellness fair, and provided resources and service information at an elementary school
- Outreach was provided to 52 people
- The events were virtual or in the Western region of Riverside County.

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention
Strengthening Families Program (SFP)
Annual Report FY 2023-2024

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Program Overview

Overview

Strengthening Families Program (SFP) is a prevention program for children ages 6-11 and their families. SFP's goals include strengthening parenting skills, building family strengths, enhancing youth's school success, and reducing risk factors for behavioral, emotional, and social problems in high-risk children (those from communities that are underserved, low-income, exposed to violence, trauma, and other stresses). The program consists of 14 sessions. The program completion standard is defined as at least one caregiver per family having attended ten or more sessions. Participants are also given the opportunity to attend a booster session 3 or 6 months after completing the program.

Outcomes Evaluation

Program outcome is evaluated based three measures: the Alabama Parenting Questionnaire (APQ), the Strength and Difficulties Questionnaire (SDQ), and the Family Relationship Index (FRI). The APQ measures three dimensions of parenting: parental involvement, positive parenting, and inconsistent discipline. The SDQ measures both positive and negative psychological attributes among children, including emotional problems, conduct problems, hyperactivity, peer problems, pro-social skills, and total difficulties. The third measure, FRI, measures family cohesion, expressiveness, and family conflict.

Providers

Community-Based Organizations (CBOs) are contracted to provide SFP services. For FY 2023-2024 the providers were: My Family, Inc. (MFI) in the Western region; California Family Life Center (CFLC) in the Mid-County region, and Riverside Latino Commission in the Desert region.

Executive Summary

Enrollment

- Countywide, Strengthening Families enrolled 117 families made up of 144 individual parents/ caregivers.
- 99 of the 117 enrolled families (85%) met the program-completion standard by attending 10 or more sessions.
- Each provider is contractually required to have 40 families complete the program. Latino Commission (Desert) and MFI (Western) each achieved 39 families completed. CFLC (Mid-County) started late in the fiscal year, but was still able to achieve 21 families completed.

Demographics

- Of the 144 enrolled parents/caregivers, the majority (64%) were 26 through 39 years of age.
- The majority (80%) of enrolled parents/caregivers reported being Hispanic/Latinx. 59% selected Spanish as their primary language.
- The majority of enrolled parents/caregivers reported their relationship to the SFP child as “mother” (70%) followed by “father” (18%).
- The majority of enrolled SFP children were 6-7 years old (50%). The median age was 7 years.
- Enrolled SFP children were 52% female and 48% male.
- The majority (85%) of SFP children were identified as Hispanic/Latinx. Their predominant primary language was English (78%).

Family and Child Risk Factors Identified During Screening

- The Family Risk Factors most frequently identified were *Poor Communication* (79%), *Underserved Community* (25%), and *Family Conflict or Neglect* (23%).
- The Child Risk Factors most frequently identified were *Behavior Problems* (58%), *Low Self Esteem* (36%), *Low Academic Motivation* (24%), and *Skill Deficits* (16%).

Outcomes

- Countywide, improvement in all dimensions of the APQ was statistically significant ($p \leq 0.05$). Improvement in the APQ’s *Parental Involvement* dimension, for example, was 15%.
- Countywide, improvement in child behavior as measured by the SDQ was statistically significant ($p \leq 0.05$). The SDQ’s *Total Difficulty* score improved (decreased) 11%.
- Countywide, improvement in all FRI subscales (*Family Cohesion*, *Expressiveness*, and *Conflict)* was statistically significant ($p \leq 0.05$)—evidence that families were strengthened through participation in SFP.

Satisfaction

103 participants completed the satisfaction survey. All reported being either *very satisfied* (92%) or *satisfied* (8%) with the program. All reported being either *very satisfied* (93%) or *satisfied* (7%) with their group leaders. 95% indicated the course helped their family very much. 100% would recommend the course to other families.

Enrollment and Completion

Countywide in FY 2023-2024 the Strengthening Families Program enrolled 117 families made up of 144 individual parents/caregivers. Of the 117 families, 99 (85%) completed the program by attending at least ten of the fourteen sessions. This represents an increase from the FY 2022-2023 values of 92 completed families and 72% completion. Table 1.1 summarizes enrollment and completion countywide and by region. Figure 1.1 shows the distribution of the number of sessions attended for the 117 enrolled families.

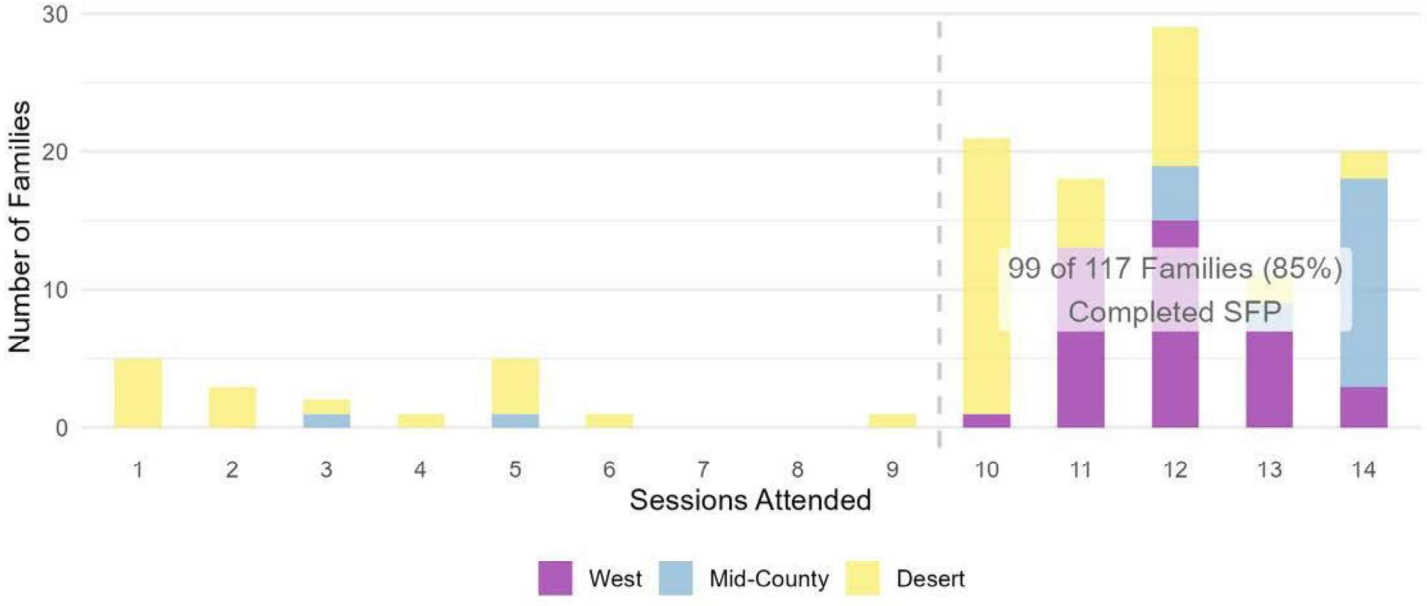
Contract Expectation

SFP's defined standard of completion is attendance of at least ten sessions by at least one enrolled parent/guardian. Each regional provider has a contractual expectation of 40 completed families. Table 1.1 summarizes attendance and completion, including the percentage of contract completion for each provider. Note that Mid-County started late in the fiscal year, thus limiting their available time for outreach and registering groups. Mid-County's enrollment and completion rates, however, demonstrate their capacity to meet the standard of completion given a full year.

Table 1.1: Family Enrollment and Completion by Region

Description	Desert	Mid County	Western	COUNTYWIDE
Family Enrollment	55	23	39	**117**
Family Completion	39	21	39	**99**
Family Completion Contract Expectation	40	40	40	**120**
Percent of Contract Completion	98%	52%	98%	**82%**

Figure 1.1: Family Attendance and Completion



Parent/Caregiver Demographics

Parent/caregiver demographic information is collected as part of SFP screening. Figure 2.1 shows the age distribution for the 144 enrolled parents/caregivers. Countywide, the majority (64%) of parents/caregivers were 26 through 39 years of age. Note that we exclude 3 *not reported.*

Figure 2.2 shows gender for the 144 enrolled caregivers. Countywide, 111 (78%) were female. Note that we exclude 2 *not reported.*

In FY 2023-2024, 2 female parents/caregivers identified as LGB, none as transgender.

Figure 2.1: Age of Enrolled Parents/Caregivers

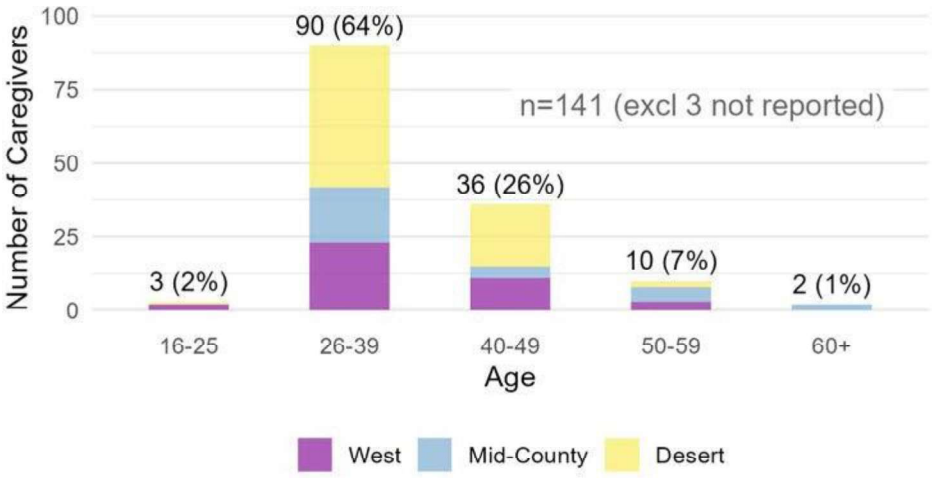
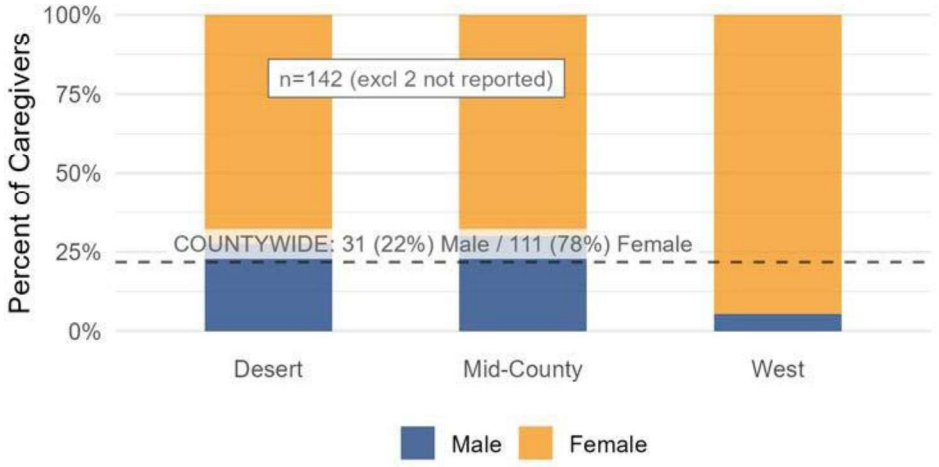


Figure 2.2: Gender of Enrolled Parents/Caregivers



Parent/Caregiver Demographics (continued)

The SFP Demographics and Screening Form lists common race and ethnicity categories. Prospective participants can make multiple selections or fill-in a race and/or ethnicity not listed.

Figure 2.3 summarizes the *unduplicated* races reported by the 144 enrolled parents/caregivers. Note the category *Multiple,* which captures parents/caregivers specifying multiple races. Multiple races counted in this category are not re-counted (duplicated) in specific race categories. Two parents/ caregivers specified multiple races as: (1) Native American and Hispanic/Latinx; and (2) Native American and Black/African American.

In FY 2023-2024, parents/caregivers were predominantly Hispanic/Latinx, with 115 (80%) identifying as such, followed by White with 15 (10%), and Black/African American with 7 (5%).

There were two parents/caregivers identifying as Native American, both subsumed by the *Multiple*-race category as noted in Figure 2.3.

Table 2.1 lists the ethnicity specified by the n= 116 Hispanic/Latinx parents/caregivers. Note we include the one Hispanic/Latinx subsumed by the *Multiple*-race category. The majority, 77 (66%), of Hispanic/Latinx parents/caregivers further identified as Mexican.

Figure 2.3: Ethnicity of Enrolled Parents/Caregivers (Unduplicated)

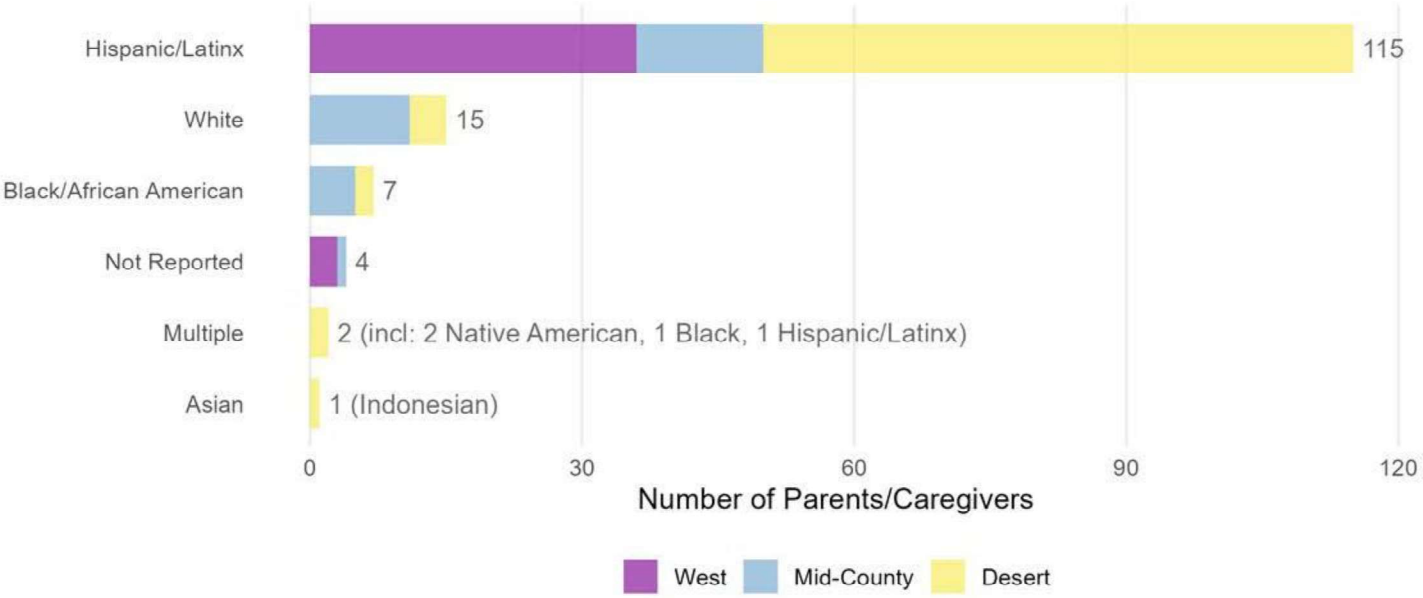


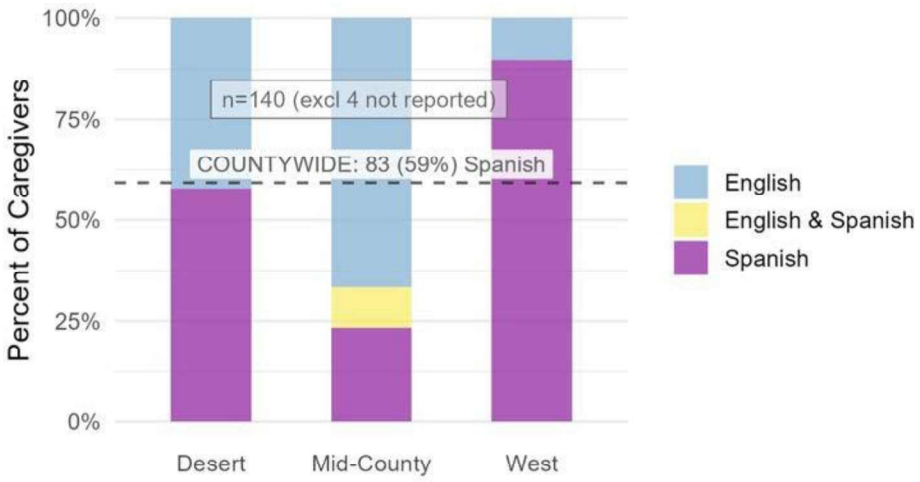
Table 2.1: Hispanic/Latinx Ethnicity of Enrolled Parents/Caregivers

Mexican	77	66%
Central American	3	3%
Venezuelan	1	1%
Not Reported	35	30%

Parent/Caregiver Demographics (continued)

Figure 2.4 summarizes the primary language specified by the 144 enrolled parents/caregivers . Spanish was predominant with 83 (59%) parents/caregivers specifying it as their preferred language.

Figure 2.4: Language of Enrolled Parents/Caregivers



Disability Specification

Countywide, 3 enrolled parents/caregivers (2%) identified as disabled.

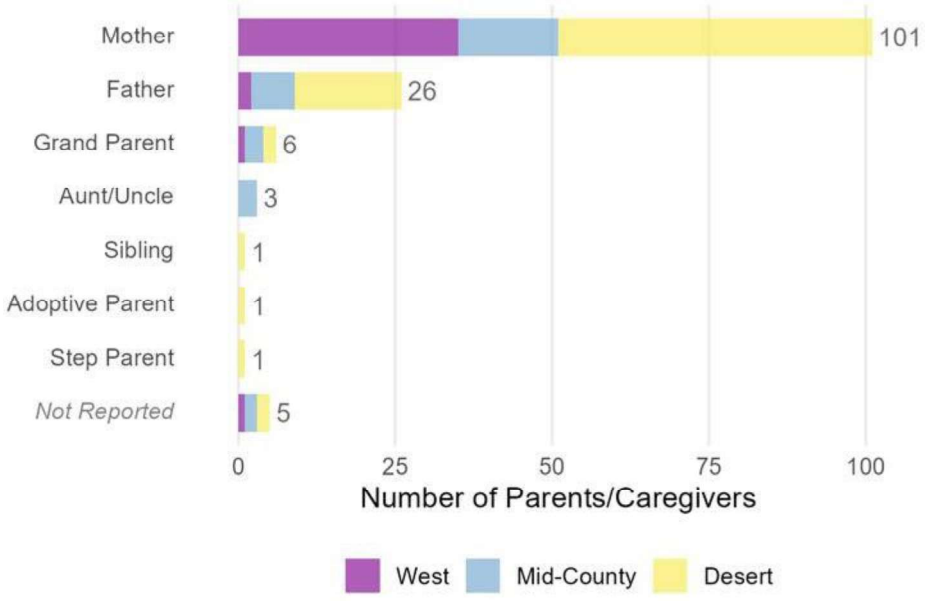
Veteran Status

Countywide, 1 enrolled parent/caregiver claimed veteran status.

Parent/Caregiver Relationship to SFP Child

Figure 3.1 shows relationship to SFP child as reported by the 144 enrolled parents/caregivers. Countywide, the 101 (70%) reporting as “mother” represents a majority, and is a greater percentage than the 66% reported in FY 2022-2023. 26 parents/caregivers (18%) reported as “father”, also greater than the 13% reporting as such in FY 2022-2023.

Figure 3.1: Relationship to SFP Child for Enrolled Parents/Caregivers



Child Demographics

SFP is intended for children ages 6-11. Parents/caregivers are asked to identify one child in the family within this age range, and to focus on this child for the program. This child is referred to as the SFP child. Results below are for the 117 SFP children of the 117 enrolled families.

Figure 4.1 summarizes the age distribution for the SFP children. The majority at 50% were between 6 and 7. In the last fiscal year, this group constituted only 37%. Also in that year, more children occupied higher age categories. Overall, FY 2023-2024 children were younger than in the previous year. The median FY 2023-2024 child age was 7 years, a one-year decrease from last year's median.

Figure 4.2 shows the gender breakdown for the117 SFP children of the enrolled families. 52% were male and 48% female.

Figure 4.1: Age of SFP Child

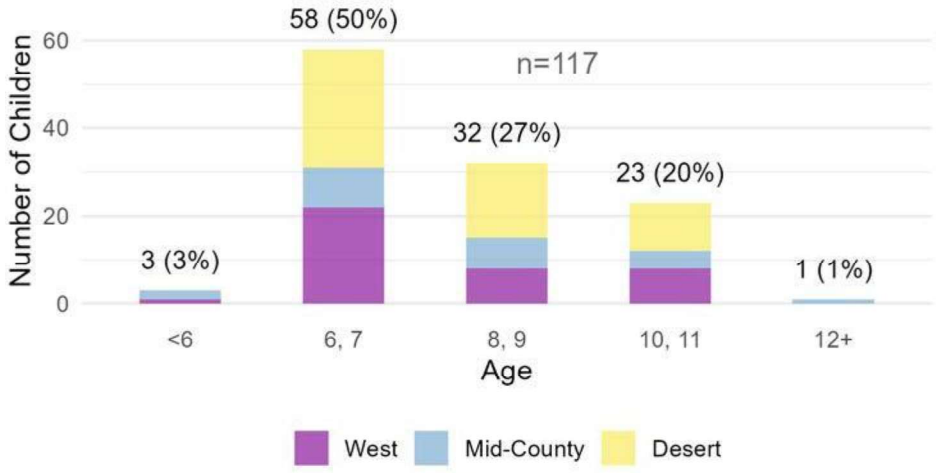
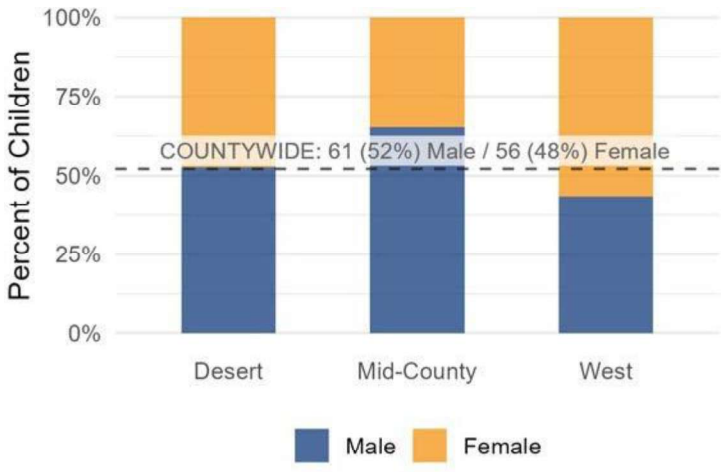


Figure 4.2: Gender of SFP Child



Child Demographics (continued)

Figure 4.3 summarizes the reported race of the 117 enrolled SFP children. Countywide, the children were predominantly Hispanic/Latinx, with 100 (85%) reported as such, and one more subsumed by the multiple-race category (n=101 Hispanic/Latinx total).

For children reported as Hispanic/Latinx, further ethnic specificity may be provided. Table 4.1 summarizes the specification for these 101 Hispanic/Latinx children. Among them, 64 (63%) were further identified as Mexican.

Figure 4.3: Race of SFP Child (Unduplicated)

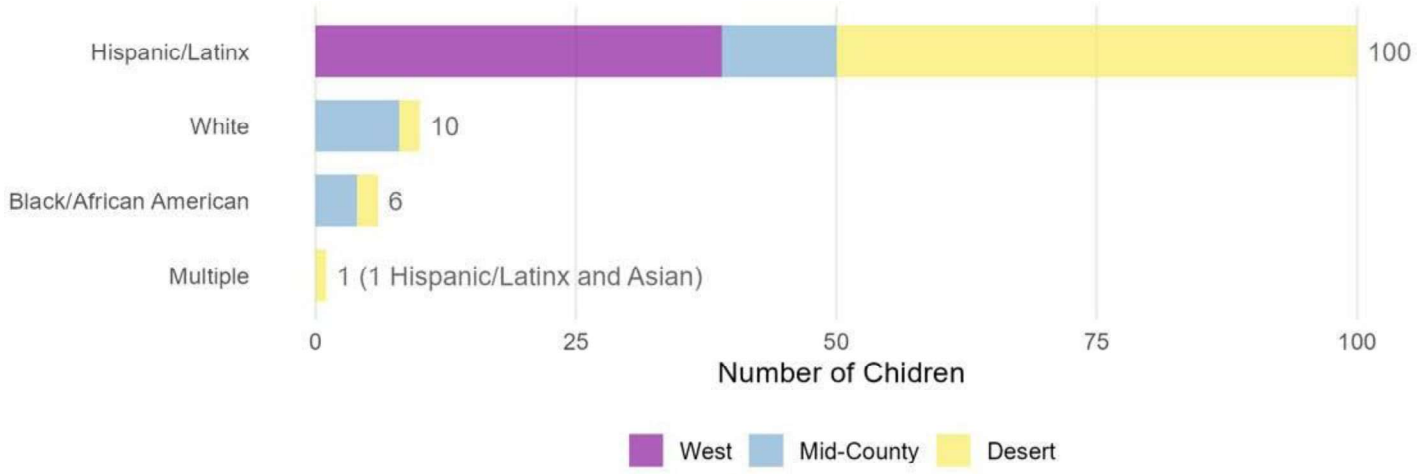


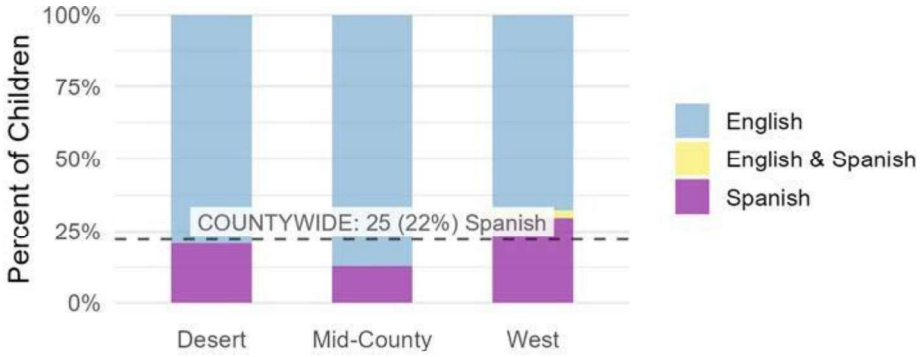
Table 4.1: Hispanic/Latinx Ethnicity of SFP Child

Mexican	64	63%
Central American	5	5%
Venezuelan	1	1%
Not Specified	31	31%

Child Demographics (continued)

Figure 4.4 summarizes the primary language specified for the 117 SFP children. English was predominant at 77% (22% Spanish, 1% both).

Figure 4.4: SFP Child Language



Disability Specification

Countywide, of the 117 enrolled SFP children, 2 were reported as disabled. One included a specification, which was autism. For comparison, in FY 2022-2023, 9 children were reported as disabled, 4 specified as autism.

Risk Factors

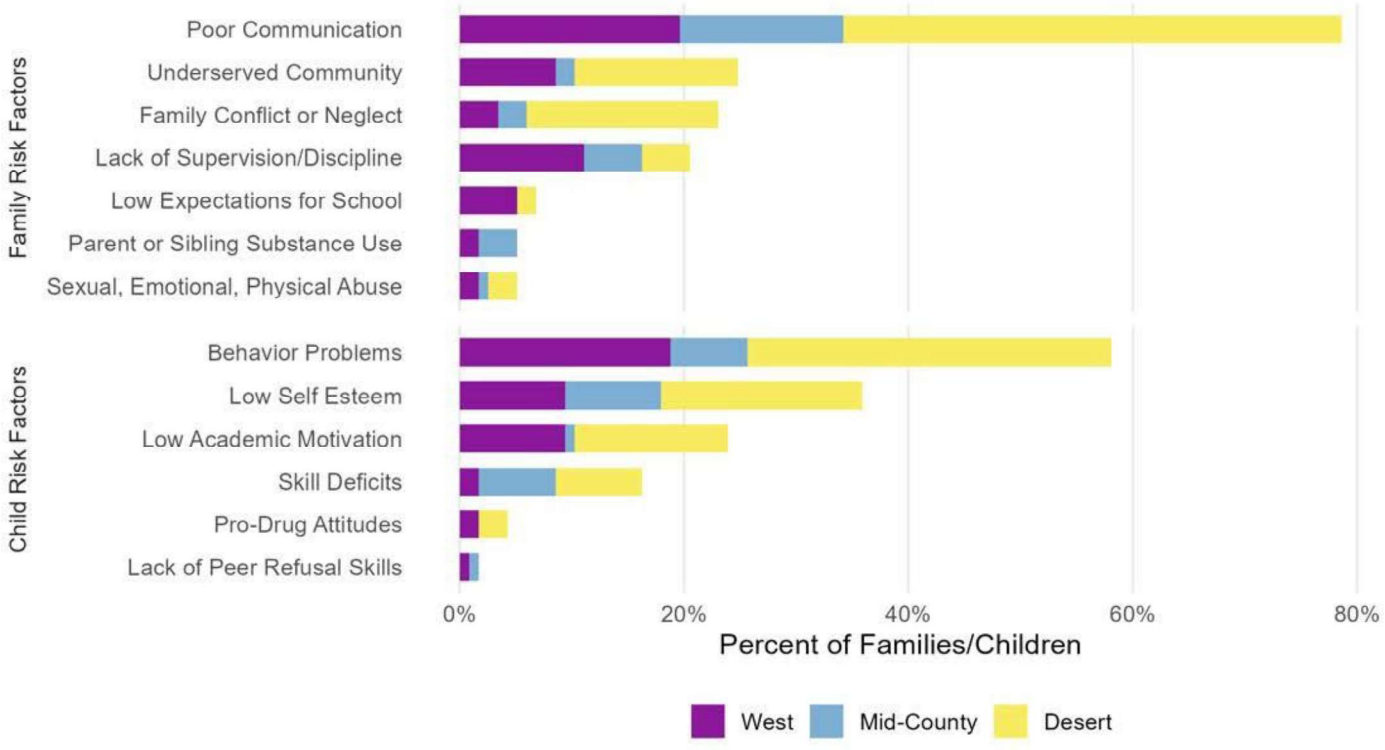
The SFP screening form includes a *Risk Factors* section listing seven possible *Family Risk Factors* and six possible *Child Risk Factors*. During screening, site coordinators have a conversation with prospective SFP parents/caregivers both to determine eligibility as well as to identify likely risk factors.

The identification of risk factors is useful during the program; the knowledge can help providers better connect with participants based on individual needs. The identification of risk factors also helps reveal prevailing issues in the community.

Figure 5.1 summarizes the frequency of occurrence of each risk factor among the 117 enrolled families during FY 2023-2024.

The Family Risk Factor most frequently cited was *Poor Communication* at 79%. The Child Risk Factor most frequently cited was *Behavior Problems* (58%).

Figure 5.1: Risk Factors



Program Outcomes

For the outcomes analysis, we include only parents/caregivers in families meeting the criteria of completion (attendance of ten or more sessions and completion of both pre and post inventories by at least one enrolled parent/caregiver in the family). For FY 2023-2024, 99 families met the criteria of completion. These families consisted of n=107 individual parents/caregivers. Unanswered questions, however, result in loss of data points. FY 2023-2024 completion rates were very good as revealed by the COUNTYWIDE n values included in the figures below.

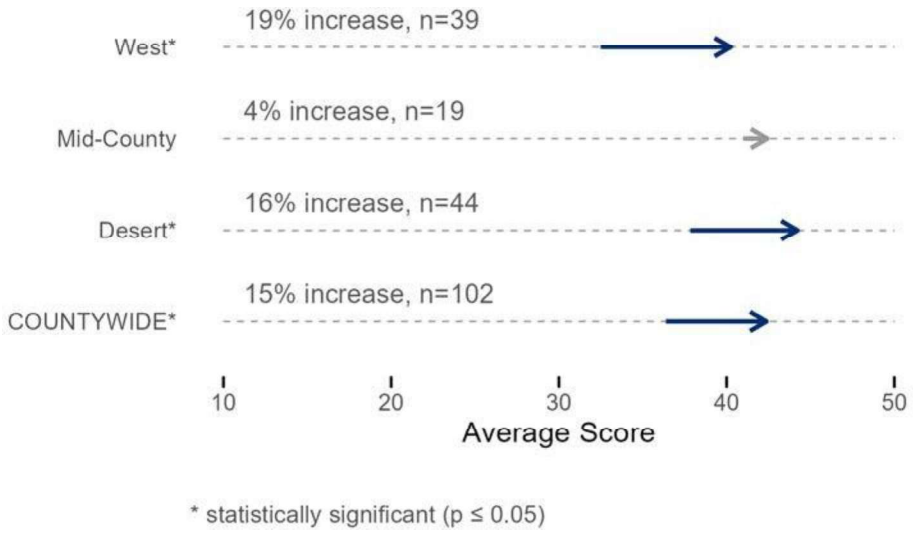
Program Outcomes: APQ

The Alabama Parenting Questionnaire (APQ) consists of 22 questions covering three distinct parenting dimensions summarized below.

1. The *Parental Involvement* dimension includes items such as, “you play games or do other fun things with your child” and “you ask your child about his/or day in school”.
2. The *Positive Parenting* dimension includes items such as, “you praise your child when he/she is doing a good job with something”.
3. The *Inconsistent Discipline* dimension represents negative aspects of parenting. Improvement thus corresponds to a decline in the score. This scale includes items such as “you threaten to punish your child and then do not actually punish her/him” and “you feel that getting your child to obey you is more trouble than it’s worth”.

Figures 6.1 through 6.3 show the outcomes for each of the three dimensions. Arrows point from the average pre to the average post score.

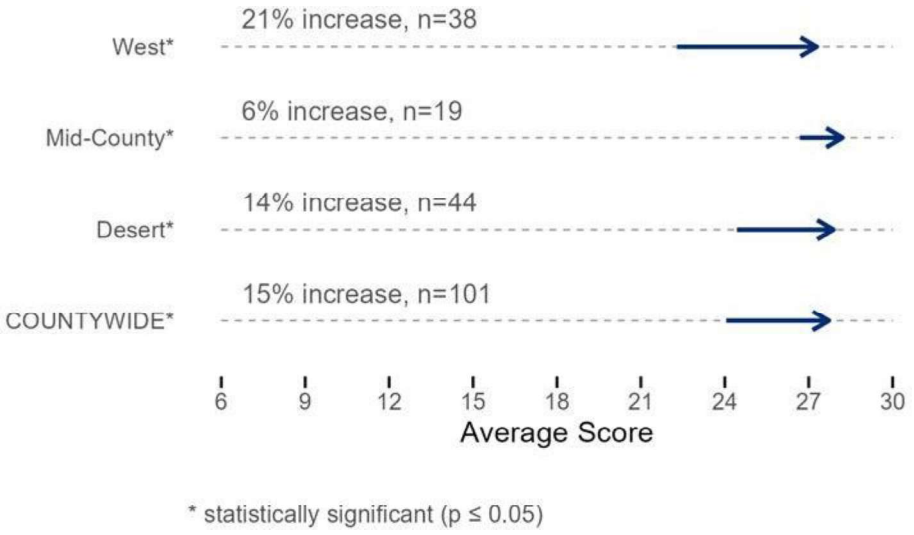
Figure 6.1: APQ Parental Involvement



The *Parental Involvement* dimension is scored from 10 to 50 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, parental involvement as measured by the APQ improved 15%.

Program Outcomes: APQ (continued)

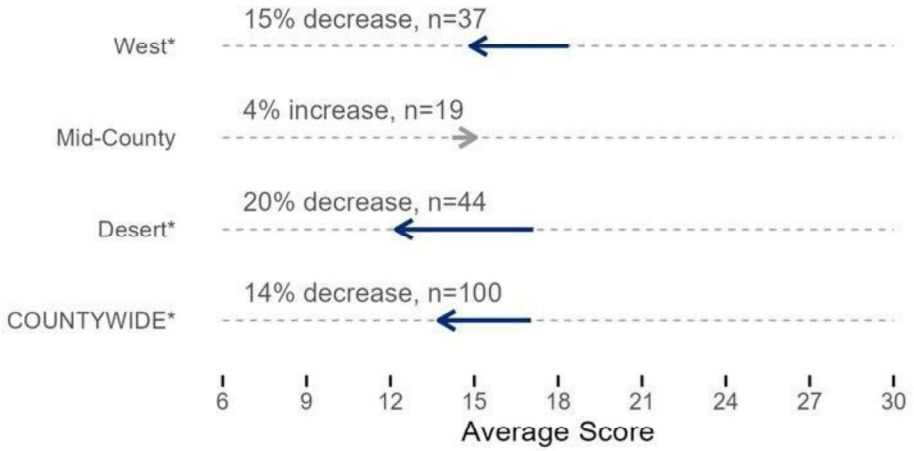
Figure 6.2: APQ Positive Parenting



* statistically significant ($p \leq 0.05$)

The *Positive Parenting* dimension is scored from 6 to 30 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for all regions. Countywide, positive parenting as measured by the APQ improved 15%.

Figure 6.3: APQ Inconsistent Discipline



* statistically significant ($p \leq 0.05$)

The *Inconsistent Discipline* dimension is scored from 6 to 30 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, inconsistent discipline as measured by the APQ improved 14%.

Program Outcomes: SDQ

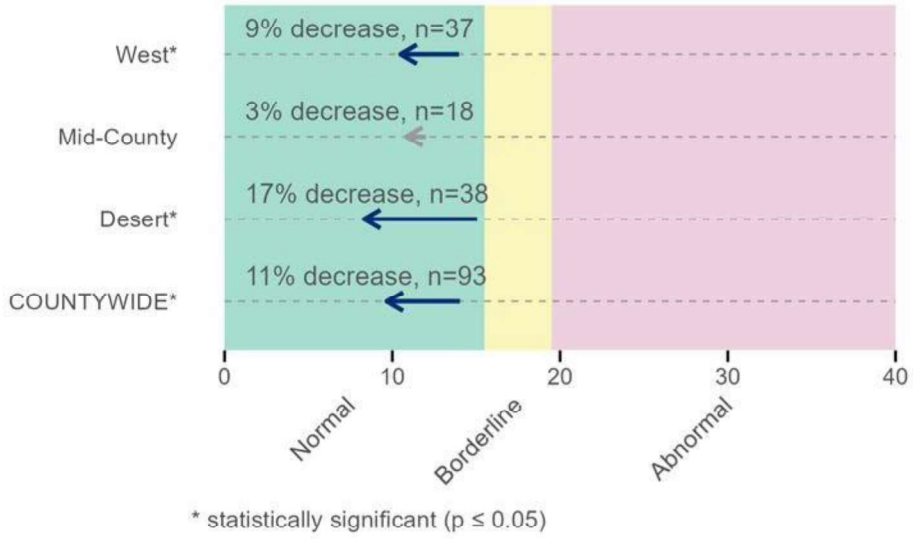
The Strength and Difficulties Questionnaire (SDQ) is used to quantify both positive psychological attributes (strengths) and negative ones (difficulties). SFP uses the Parent Version of the SDQ.

Scoring for the 25 questions includes a total score (total difficulty) and four subscale scores consisting of (1) emotional symptoms, (2) conduct problems, (3) hyperactivity, and (4) peer-relationship problems. Higher scores on these behavioral-difficulty subscales suggest greater negative psychological attributes. Decreases represent improvement in these subscales.

There is also an independent pro-social scale not used in the total score. For the pro-social scale, higher scores suggest greater positive social behaviors (increases represent improvement).

Figure 7.1 shows the pre/post change in the overall *Total Difficulty* score. Figures 7.2 through 7.5 show the changes in the four subscale scores. Finally, Figure 7.6 shows the change in the *Pro-Social* score. Arrows point from the average pre to the average post score.

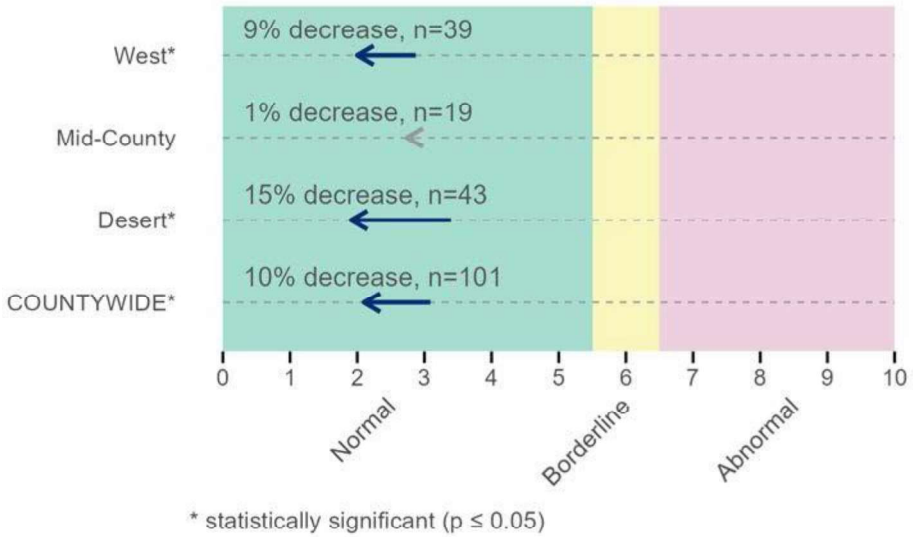
Figure 7.1: SDQ Total Difficulty



The *Total Difficulty* score ranges from 0 to 40 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, total difficulty as measured by the SDQ improved by 11%.

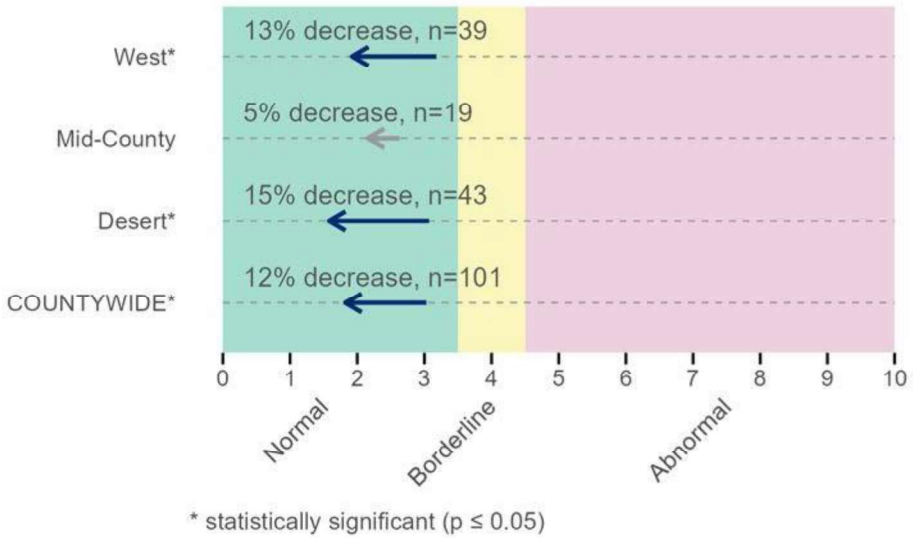
Program Outcomes: SDQ (continued)

Figure 7.2: SDQ Emotional Symptoms



The *Emotional Symptoms* score ranges from 0 to 10 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and the West and Desert regions. Countywide, emotional symptoms as measured by the SDQ improved by 10%.

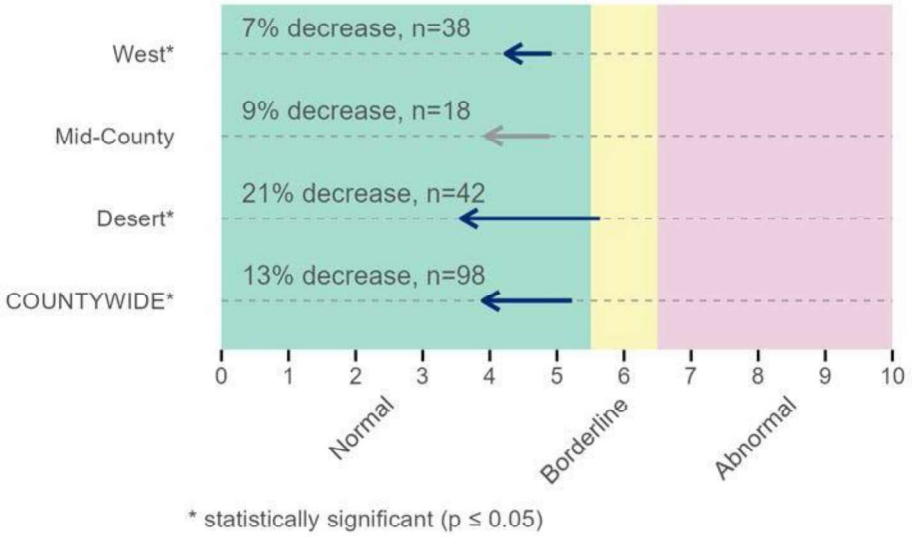
Figure 7.3: SDQ Conduct Problems



The *Conduct Problems* score ranges from 0 to 10 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, conduct problems as measured by the SDQ improved by 12%.

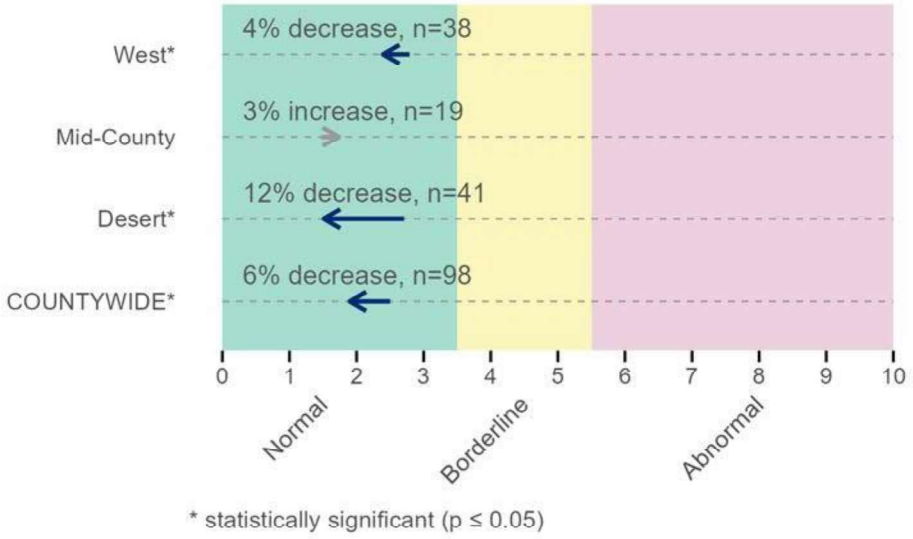
Program Outcomes: SDQ (continued)

Figure 7.4: SDQ Hyperactivity



The *Hyperactivity* score ranges from 0 to 10 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and the West and Desert regions. Countywide, hyperactivity as measured by the SDQ improved by 13%.

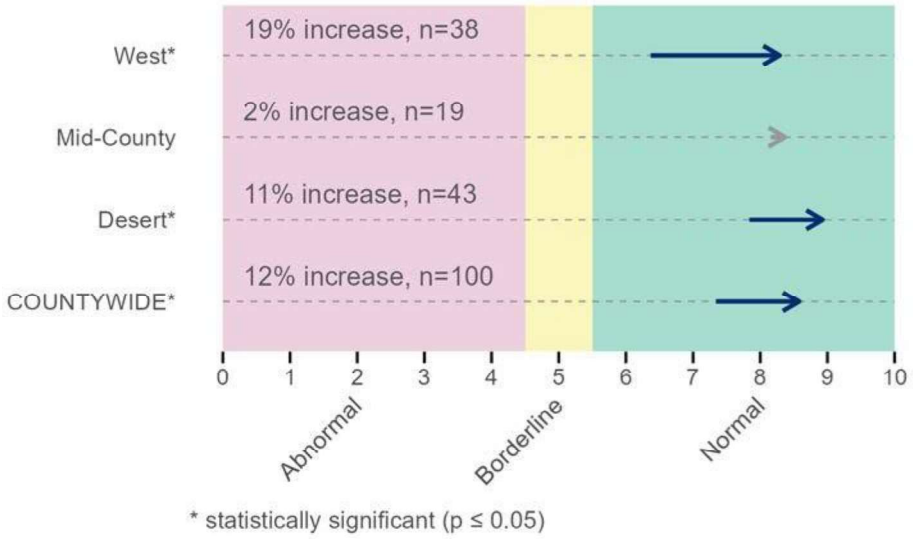
Figure 7.5: SDQ Peer Problems



The *Peer Problems* score ranges from 0 to 10 with a **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, peer problems as measured by the SDQ improved by 6%.

Program Outcomes: SDQ (continued)

Figure 7.6: SDQ Pro Social



The *Pro-Social* score ranges from 0 to 10 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, pro-social behavior as measured by the SDQ improved by 12%.

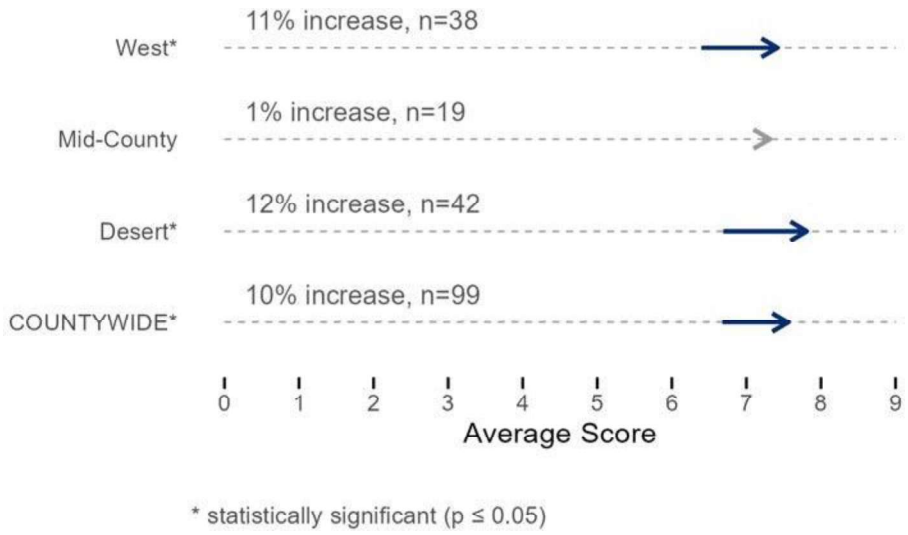
Program Outcomes: FRI

The Family Relationship Index (FRI) uses true/false questions (scored 1 or 0) to measure the quality of the family environment. There are three subscales: (1) family cohesion, (2) expressiveness, and (3) conflict. The three scales are summarized below.

1. The *Family Cohesion* scale includes items such as, “family members really back each other up” and “there is a feeling of togetherness in our family”.
2. The *Expressiveness* scale includes items such as, “we tell each other about our personal problems” and “there are a lot of spontaneous discussions in our family”.
3. The *Conflict* scale represents negative aspects of family relationships. Improvement thus corresponds to a decline in the score. This scale includes items such as “we fight a lot in our family” and “family members often criticize each other”.

Figure 8.1 through 8.3 show the outcomes for each of the three scales. Arrows point from the average pre to the average post score.

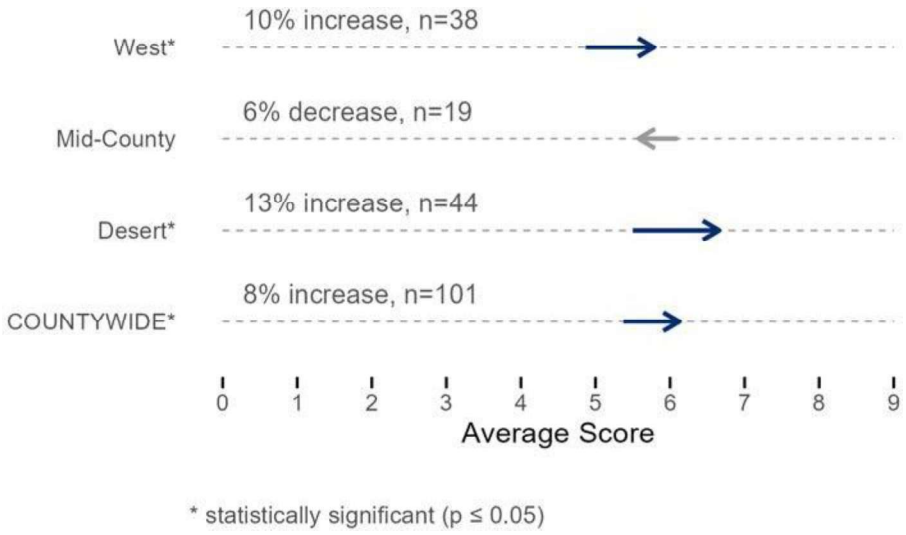
Figure 8.1: FRI Family Cohesion



Family Cohesion is scored from 0 to 9 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, family cohesion as measured by the FRI improved 10%.

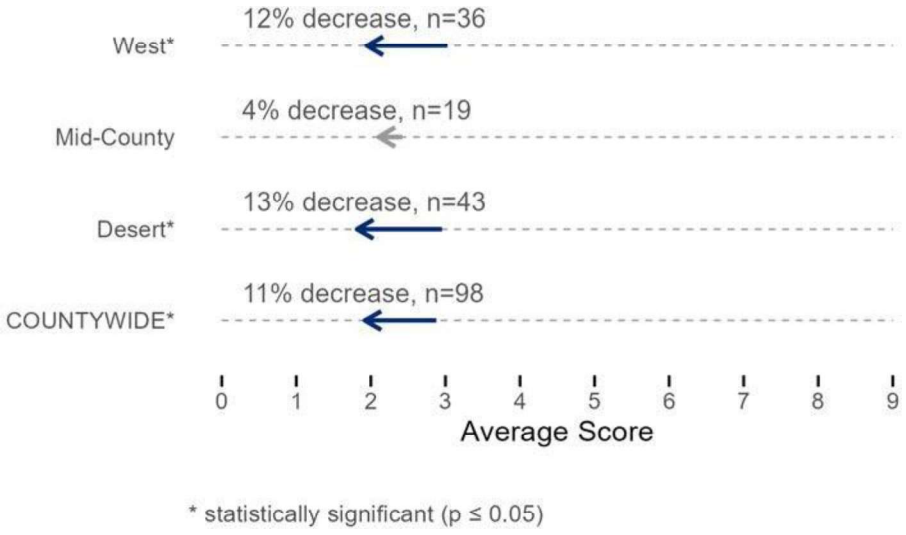
Program Outcomes: FRI (continued)

Figure 8.2: FRI Expressiveness



Expressiveness is scored from 0 to 9 with **increases** representing **improvement**. Results were statistically significant (p ≤ 0.05) countywide and for the West and Desert regions. Countywide, expressiveness as measured by the FRI improved 8%.

Figure 8.3: FRI Conflict



Conflict is scored from 0 to 9 with **decreases** corresponding to **improvement**. Results were statistically significant (p ≤ 0.05) countywide and for the West and Desert regions. Countywide, conflict as measured by the FRI improved 11%.

Post Program Satisfaction Survey Results

The inventory questionnaires given at the conclusion of the program includes a satisfaction survey. 110 parents/caregivers completed this survey.

Figures 9.1 through 9.3 summarize the results of the multiple choice questions. The results are favorable. Additionally, in response to the question “Would you recommend this course to other families?”, 100% responded in the affirmative.

Figure 9.1: How Satisfied Were You With This Program?

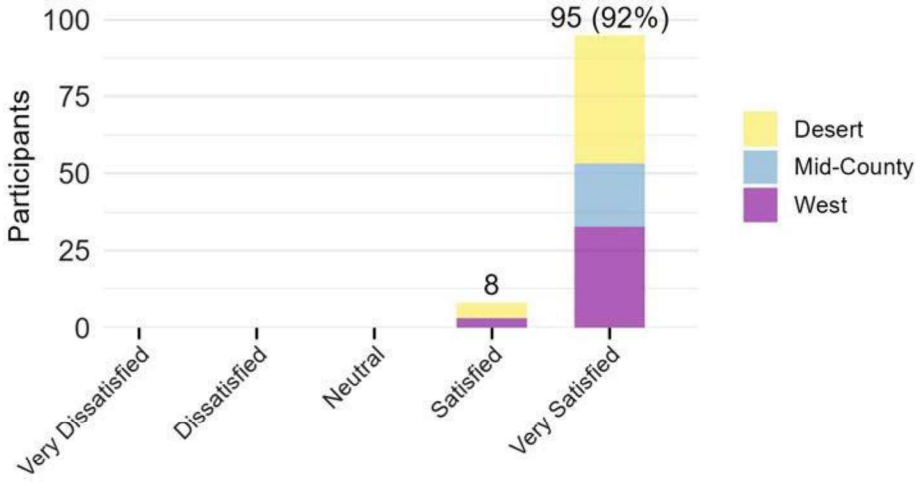
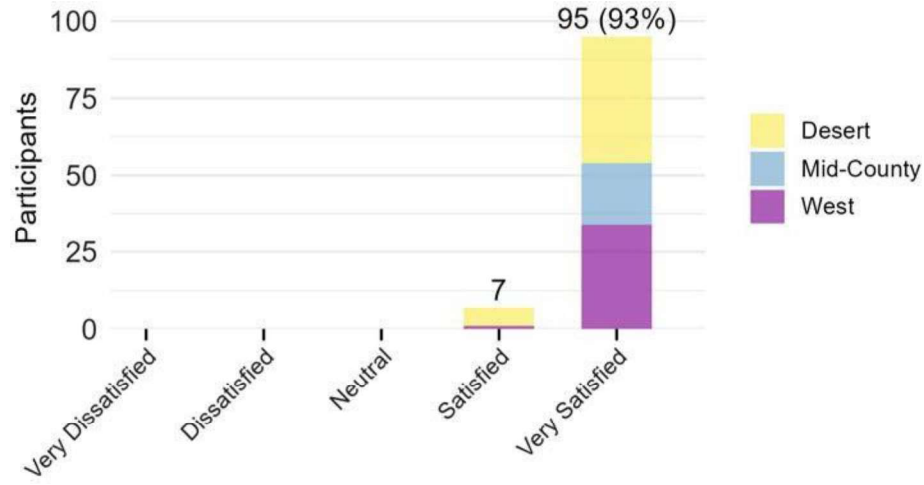
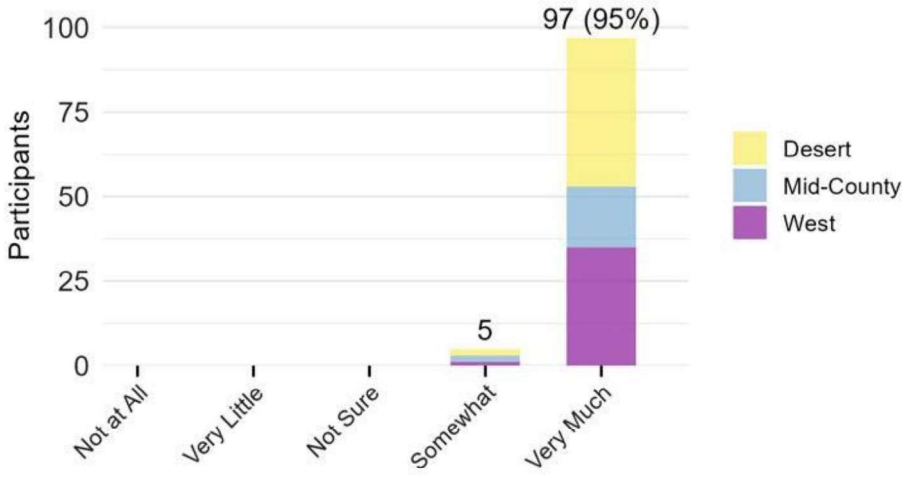


Figure 9.2: How Satisfied Were You With Your Group Leaders?



Post Program Satisfaction Survey Results (continued)

Figure 9.3: How Much Has This Course Helped Your Family?



Post Program Comments

Selected Comments

- I loved this program and would love to do another booster class. My daughter has also loved this program and doesn't want it to end.
- All the kids grew a strong bond together.
- (The program) helped me a lot with communication with the family, and to have greater communication with everyone.
- SFP helped a lot and opened my eyes on how to identify problems and how to solve them. Thanks from my entire family to the SFP team.
- The group leaders are very good at their jobs. They are very nice people, professional and kind not only with parents but with children. I am very grateful for the patience with my 6-year-old. May God always bless you so that you can continue helping more families with this program.
- Loved this class. It has helped out more than I expected.
- I enjoyed learning coping skills and how to manage behaviors with appraisals and nice compliments when children are on task.
- This program was very encouraging and very helpful with all the adults we had. They gave a lot of advice and a lot of tips to help with our children.
- I loved the program and I believe these programs are important and great for parents. With parents, there can never be too much learning. This class has helped me better understand my kids and become a better parent. The group leaders were awesome!
- I wanted to thank you for these programs that help us improve as people and that integrate children, it is very good, thank you very much!
- Thanks for everything. For helping us to be better in the family, and giving us different ways to help our children.
- My entire family loved coming weekly to the sessions. We loved getting involved with other parents as well as the children of other kids. It really helped with our communication as a family. We always looked forward to coming to the sessions to learn more on different approaches for parenting. My girls understood their lessons equally. We'd discuss our classes at the end as a family and speak on how we could work together to implement them.
- This class has been very helpful to me and my son. We have a better relationship now than when we first started the class.
- So beneficial. This group was really amazing and might I say it turned my whole life around. I will never forget y'all.
- This program helped us a lot. We never got along well and now we do. Very grateful for everything. The children were very happy with the teachers.

Booster Attendance and Satisfaction

Booster sessions for FY 2023-2024 families could not be scheduled in time for this report. Results will therefore be included in the FY 2024-2025 report.

MHSA Prevention and Early Intervention
Stress and Your Mood (SAYM)

Annual Outcomes Report
FY 2023-2024

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Program Overview

Stress and Your Mood (SAYM) is an early intervention for depression based on a Cognitive Behavioral Therapy (CBT) Model, with modifications for adolescent-age youths. SAYM was developed to improve access to evidence-based treatment for youth with depressive disorders and sub-clinical depressive symptoms. Specifically, this program targets transition age youth (TAY), or those between the ages of 16-25 years old.

SAYM services have three phases: "***Conceptualization***," "***Skills and Application Training***," and "***Relapse Prevention***." SAYM services are low-intensity and time limited, in accordance with the CBT model, and can either be provided in a group, individual sessions, or combination of both. Consistent with the CBT model, providers will refer to TAY as appropriate for medication-related evaluation and work closely with the prescribing psychiatrist to ensure continuity of care.

Program Provider Overview

Operation Safehouse, a community-based organization, was awarded prevention and early intervention funds to implement Stress and Your Mood (SAYM) Program. Operation Safehouse provides services in the Western, Desert, and Mid-County regions of Riverside County.

Evaluation Overview

A summary of SAYM Program's demographics, service data, and outcomes measurement is included in this report. This page describes the general methodology of the program's data collection methods.

Process Evaluation

A process evaluation includes collecting descriptive information related to the program, which describes what the program provided, how many people were served, the amount of service time provided, and basic demographic characteristics of the program. The process evaluation data is assessed using electronic health records and the group sign-in sheets, which record basic information on the SAYM topic and the number of participants in attendance. This data is collected by the Operation Safehouse staff at each session.

Outcome Evaluation

The outcomes evaluation measured a reduction in depressive symptomatology and improvements in general mental health function. Embedded in the program design, is also a measurement instrument that apprehends the assessment of each participant by the clinician. Satisfaction surveys included items on overall helpfulness of the SAYM program and overall helpfulness on specific components of the SAYM program. Evaluation measures are summarized below:

- **Centers for Epidemiological Studies Depression Scale (CES-D):** this measure utilizes to measure changes in depressive symptoms. Previous studies used the CES-D as a baseline and follow-up measure to examine outcomes. Intake and final CES-D measures were collected to examine changes in depressive symptoms following participation in the intervention.
- **Clinical Global Impression Improvement Scale (CGI-I):** this measure represents the clinician's assessment of how much the participant's symptoms have improved or worsened relative to a baseline state at the beginning of the intervention. The CGI-I is embedded in service delivery and is completed at the conclusion of each module. Intake and final CGI-I ratings are used for outcomes evaluation.
- **Youth Outcome Questionnaire-Self Report (Y-OQ®-SR):** this is a youth measure of global mental health functioning. Y-OQ®-SR measures were collected from youth under the age of eighteen at intake and at the conclusion of services to evaluate improvements in overall emotional well-being.
- **Behavior and Symptom Identification Scale (BASIS-24®):** this is an adult measure of global mental health functioning. BASIS-24® measures were collected for TAY age eighteen and older at intake and at the conclusion of services to evaluate any changes in emotional well-being.

Executive Summary

Enrollment/Demographics

Demographics information showed that the SAYM program served the intended target population of Transition Age Youth (TAY). A total of 244 participants enrolled in the SAYM program in FY 2023-2024, and 100% of the participants were TAY. The majority of those enrolled in the SAYM program were Female (66.7%), chose English as their preferred language (93.9%), and were predominantly Hispanic/Latino (63.1%). Of the youths served, the majority of participants were 16-17 years of age (83.3%), and 25% identified as LGBTQIA+.

Service Information

SAYM services were provided in both group and individual formats. There were a total of 1,448.27 hours provided to participants, and the most widely used SAYM services were for Individual Therapy Sessions (806.02 hours, or 42% of total services), and 28.2% of the participants received between 4.01 to 8 hours of service. Overall, SAYM Program met 79% of contract expectations. The program completion rate was 68% with 166 out of 244 youths completing the program, and 2 participants continuing their SAYM services in the fiscal year 2024-2025. The Mid-County region had the highest enrollment (39.8%) in FY 2023-2024, followed closely by the Western region (39.3%).

Depression Symptoms

Centers for Epidemiological Studies Depression Scale (CES-D)

Participants in the SAYM program showed decreases in the frequency of depression symptoms. Overall, the CES-D scores decreased from pre-test (30.77) to post-test (23.35), an improvement of 7.42 points. These changes were statistically significant (t = 9.511, df = 172, p = .000).

Clinical Global Impression Improvement Scale (CGI-I)

Clinicians' ratings also showed that the youth psychiatric status improved following the SAYM Program. The CGI-I was completed by clinicians after each module (1 and 2) and at conclusion of the SAYM services. The rating is based on the level of improvement compared to the youth's status at enrollment. By the conclusion of SAYM Program, 87.7% of participants improved in some capacity. The majority of youths (a total of 59.8%) were noted as "Much Improved" (33.2%) and "Very Much Improved" (26.6%). Across modules, there seems to be a cumulative affect where clients' level of improvement kept increasing they continued in the program. This illustrates the importance of clients completing the SAYM program.

Overall Functioning Improved

Youth Outcome Questionnaire (Y-OQ-SR®)

Youth global functioning also improved following SAYM intervention. Since the SAYM Program serves TAY (Youths ages 16-25), two measures of general mental health were used: one for adults–the *Behavior and Symptom Identification Scale* (BASIS-24®), and one for youth–the *Youth Outcome Questionnaire Self-Report* (Y-OQ®-SR). On the Y-OQ®-SR, higher scores indicate more impairment. Pre- to post-comparisons on Y-OQ®-SR total scores showed statistically significant decreases on the majority of subscales. On average, the decrease on the Y-OQ®-SR Total Score was 12.87 points. Although this change was not considered notable enough for showing clinical improvement (i.e. more than 13 points), it still showed a statistically significant change (t = 7.028, df = 134, p = .000). All the subscales, except for *Social Problems*, also showed statistically significant decreases.

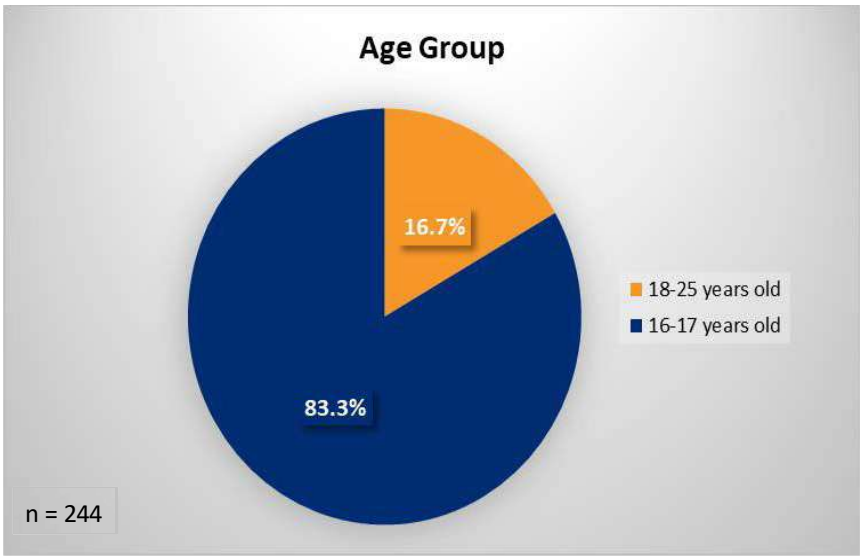
Behavior and Symptom Identification Scale (BASIS-24®)

Using BASIS-24® scale, baseline measurement scores showed heightened spectrum of difficulty with the *Emotionally Labile Scale* (2.52 points) and *Depression and Functioning Scale* (2.1 points) . Overall, the sub-scales were shown to decrease (0.86 points or less), although it is noted that the 2 scales with the highest

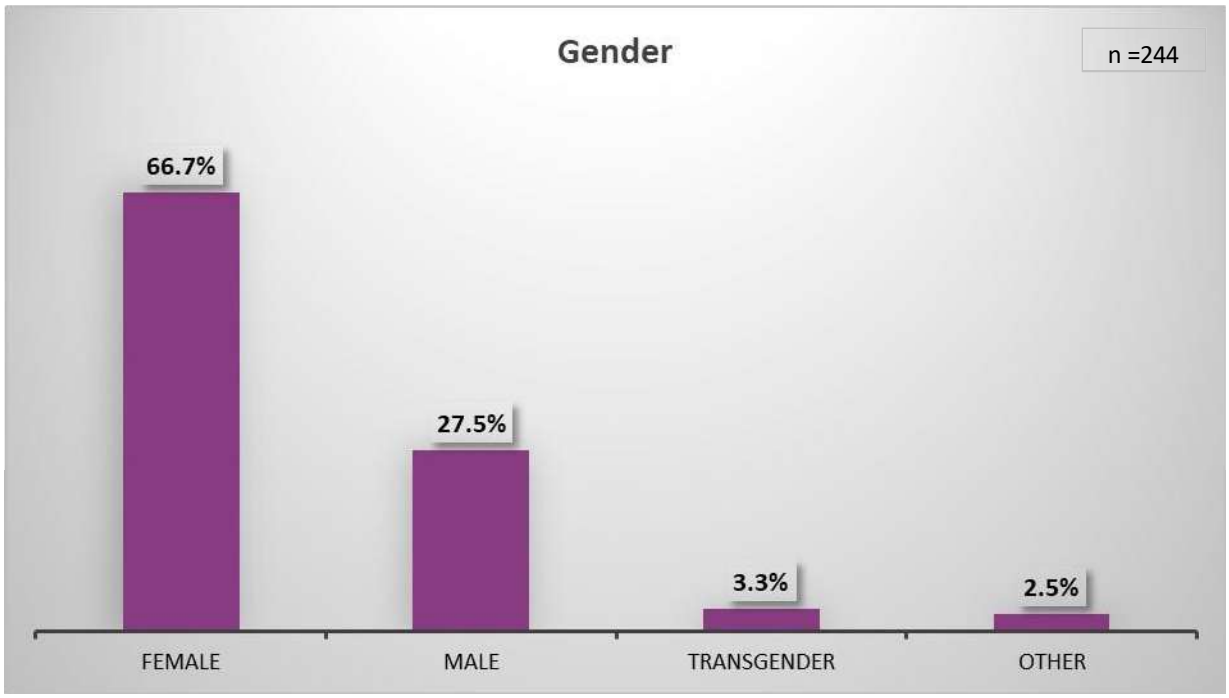
scores at intake have shown the most decrease at post measures.

Demographics: Age Groups, TAY and Gender

During the fiscal year 2023-2024, there were a total of 244 participants who enrolled in the Stress and Your Mood (SAYM) program, which includes 2 rollover participants from FY 2022-2023. Basic demographic information was collected for enrolled participants during the screening process and is summarized on the figures below.

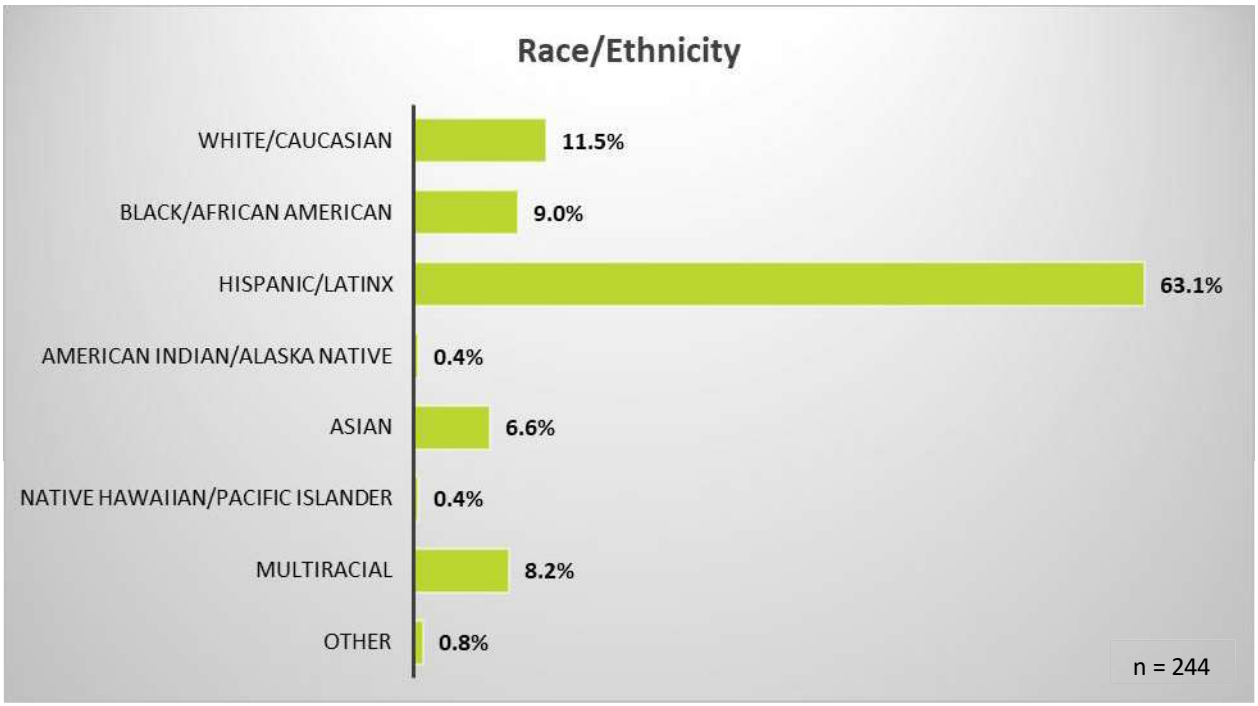


Enrollment data shows that the majority of SAYM participants were between 16-17 years old (83.3%, n = 203). A Few youth were between the ages of 18 and 25 years old (16.7%, n = 41). Additionally, when categorizing between Non-TAY and TAY population, all FY 2023-2024 SAYM participants were within the TAY category (100%).

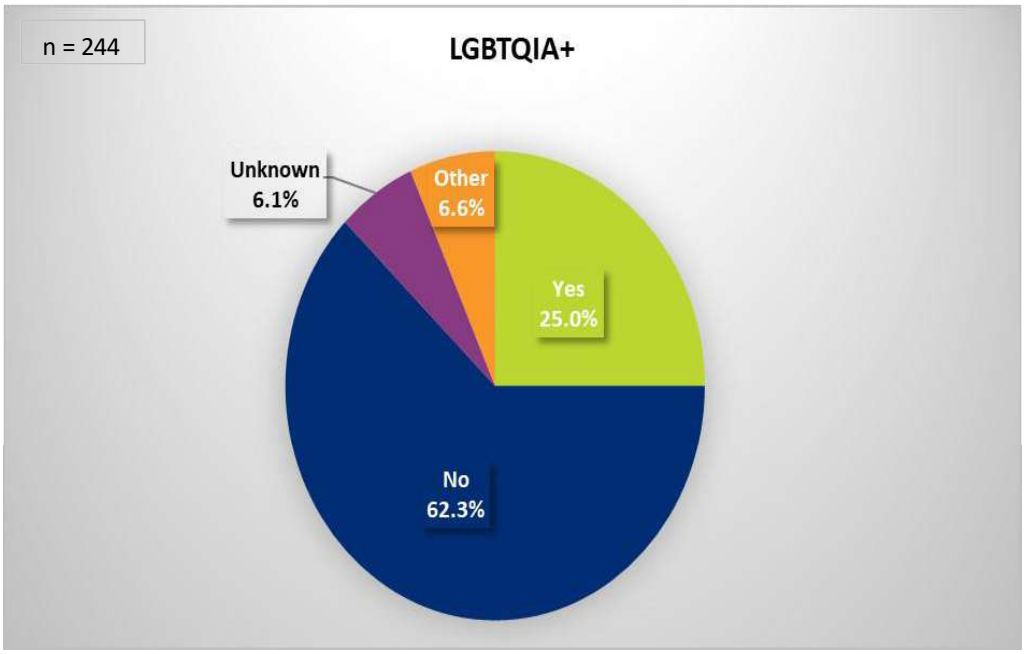


The majority of SAYM participants were Female (66.7%, n = 163), followed by Male (27.5%, n = 67). There were also smaller percentages of participants who identified as Transgender (3.3%, n = 8), and Other (2.2%, n = 6). Of those who categorized as Transgender, 6 specified as Transfeminine, 1 specified as Gender Fluid, and 1 participant chose not to respond.

Demographics: Race/Ethnicity and LGBTQI Category



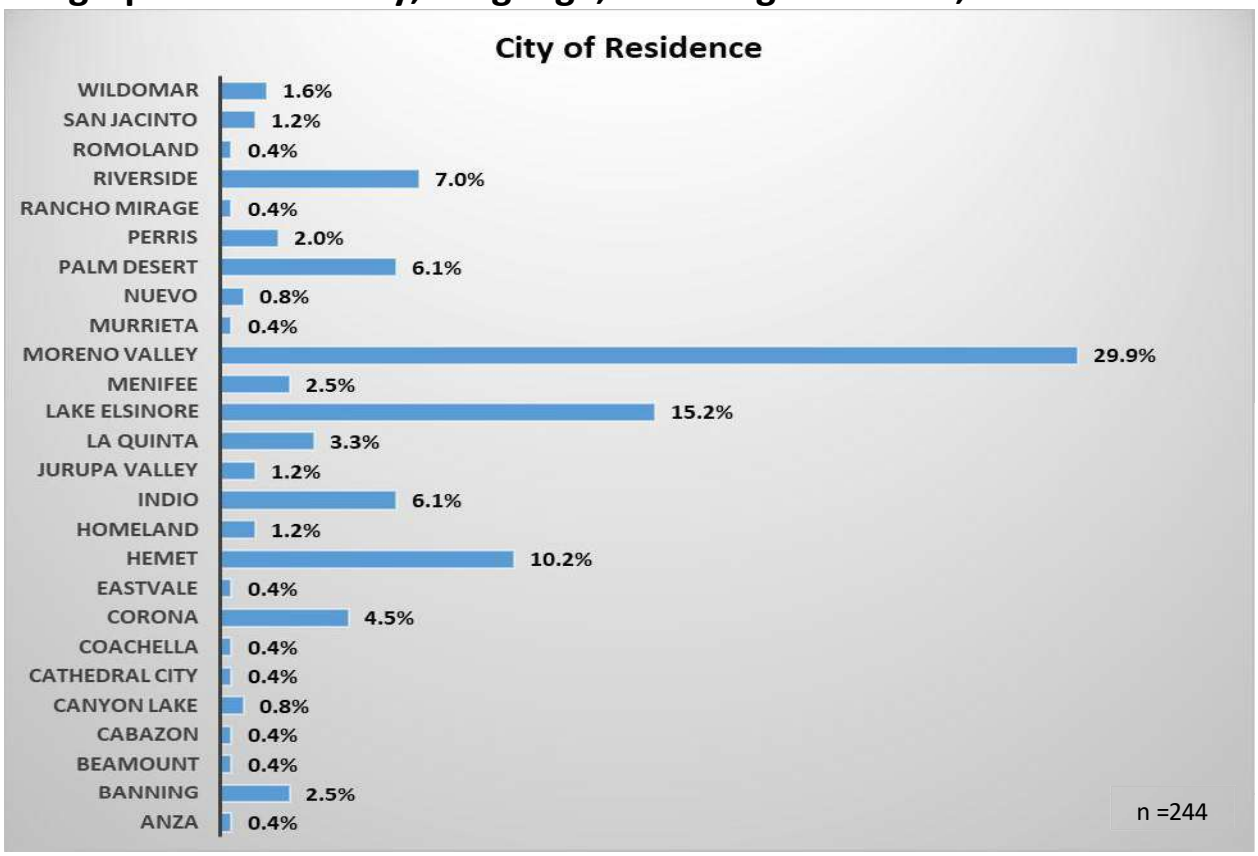
During the fiscal year 2023-2024, the majority of SAYM participants categorized as Hispanic/Latinx (63.1%, n = 154), followed by White/Caucasian (11.5%, n = 28), Black/African American (9%, n = 22), Multiracial (8.2%, n = 20), and Asian (6.6%, n = 16), respectively. There were also smaller percentages of participants who categorized as Other (0.8%, n = 2), Native Hawaiian/Pacific Islander (0.4%, n = 1), and American Indian/ Alaska Native (0.4%, n = 1).



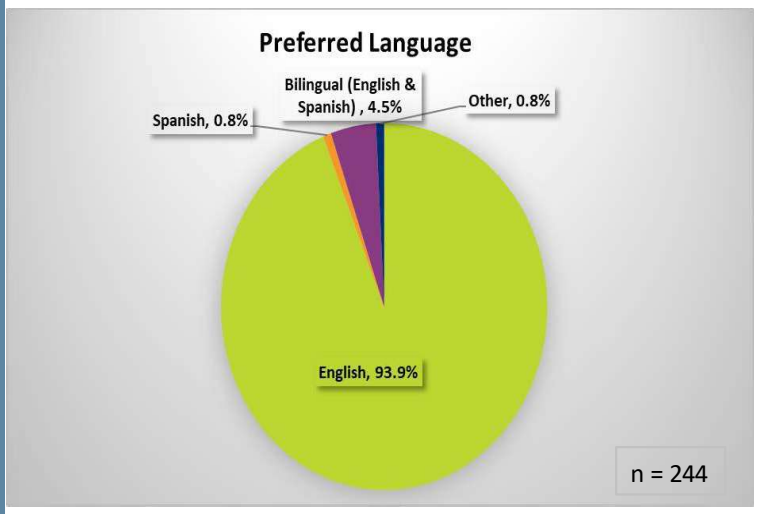
LGBTQI Categories	Percentage
Asexual	0.9%
Bisexual	14.3%
Gay	1.6%
Lesbian	2.5%
Omnisexual	1.2%
Pansexual	4.5%
Total (n = 61):	**25.0%**

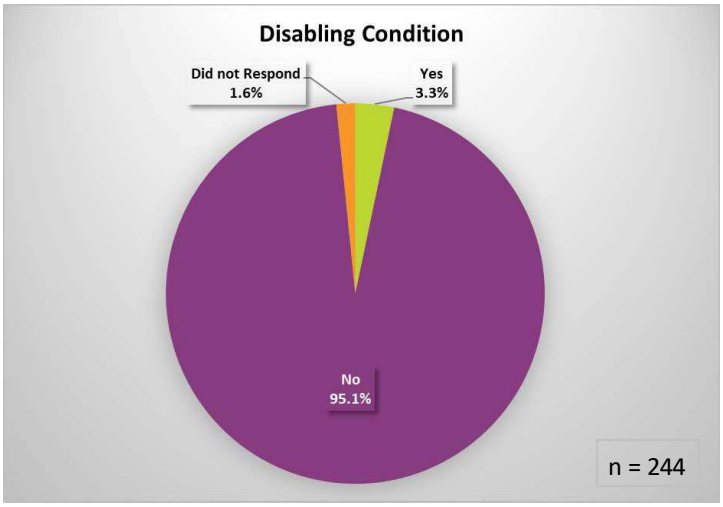
Participants were also asked if any of them identified themselves as LGBTQIA+. Results showed that the majority of participants responded "No" (62.3%, n = 152), while the remaining participants identified themselves as LGBTQIA+ (25%, n = 61), Other (6.6%, n = 16), and Unknown (6.1%, n = 15). Of those who did identify themselves as LGBTQIA+ (n = 61), the majority categorized themselves as Bisexual (14.3%, n = 35), as shown on table above.

Demographics: Residency, Language, Disabling Condition, and Veteran Status



During the fiscal year 2023-2024, the majority of SAYM participants lived in Moreno Valley (29.9%, n = 73), Lake Elsinore (15.2%, n = 37), and Hemet (10.2%, n = 25).

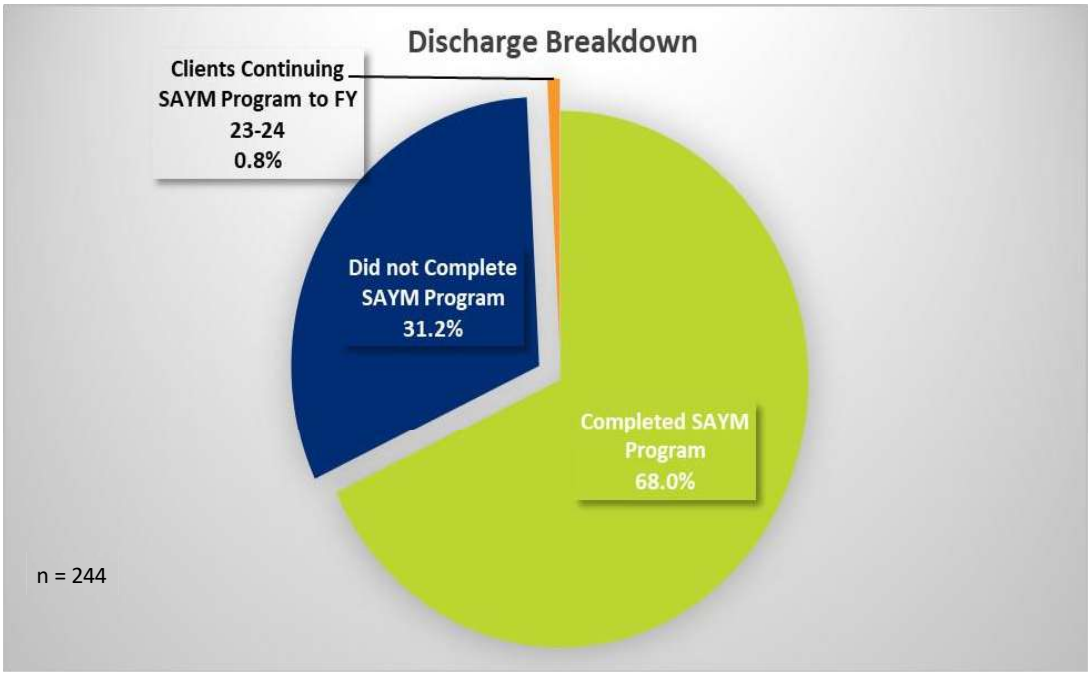




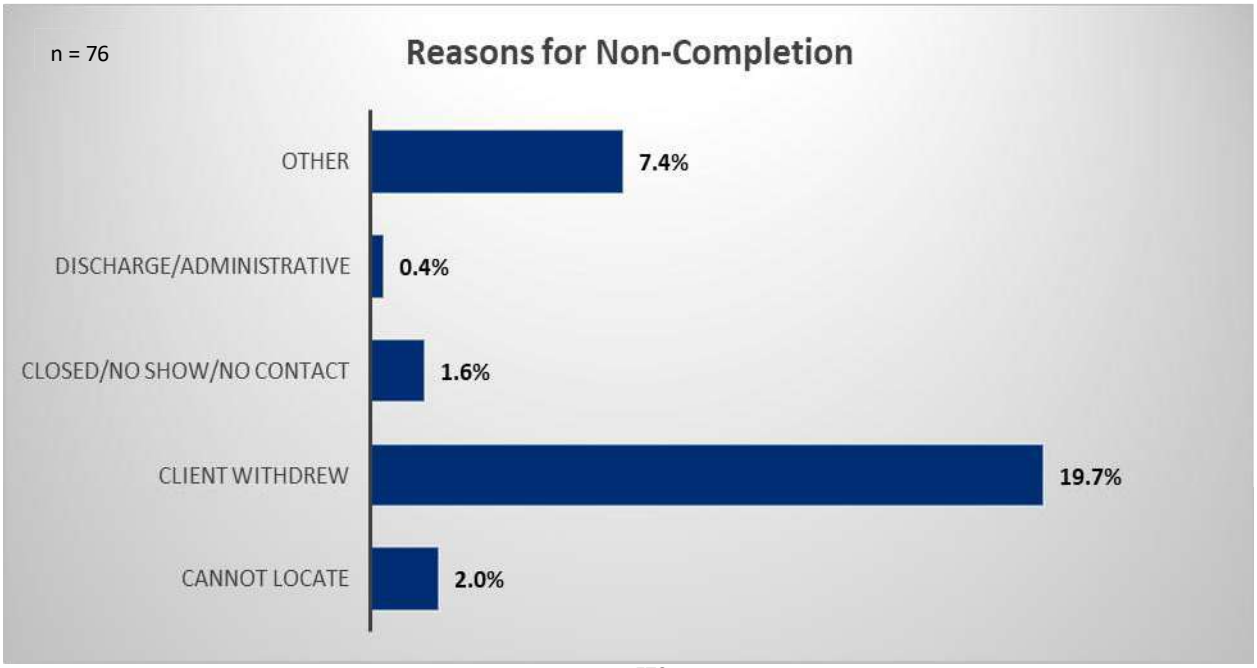
- The majority of SAYM participants responded that their preferred language is English (93.9%, n = 229), followed by Bilingual-English and Spanish (4.5%, n = 11), Spanish (0.8%, n = 2), and Other (0.8%, n = 2) respectively.
- The majority of SAYM participants indicated that they did not have any disabling condition (95.1%, n = 232), while a small percentage of participants responded as having a disabling condition (3.3%, n = 8), and 4 participants (1.6%) chose not to respond. Of the 8 participants who responded as having a disabling condition, 4 specified "ADHD" as the type of disability, while the remaining participants indicated as having Bad Vision, Dyslexia, Learning Disability, and Speech Impairment.
- In regards to veteran status, all SAYM participants (100%) indicated that they were not Veterans.

Service Information: Discharge & Non-Completion

The figure below pertains to the closed cases of SAYM Program in the fiscal year 2023-2024. There were two possible values: (1) *Did Not Complete*, and (2) *Completed*. A total of 166 participants (68%) completed the SAYM Program, while 76 participants (31.2%) did not. Of the total SAYM participants who completed, the majority (66.4%, n = 162) *completed with no further treatment required*, and 4 participants (1.6%) *completed with referral for further treatment*. Additionally, there are also 2 participants (0.8%) who are currently continuing in the FY 2024-2025 SAYM Program.

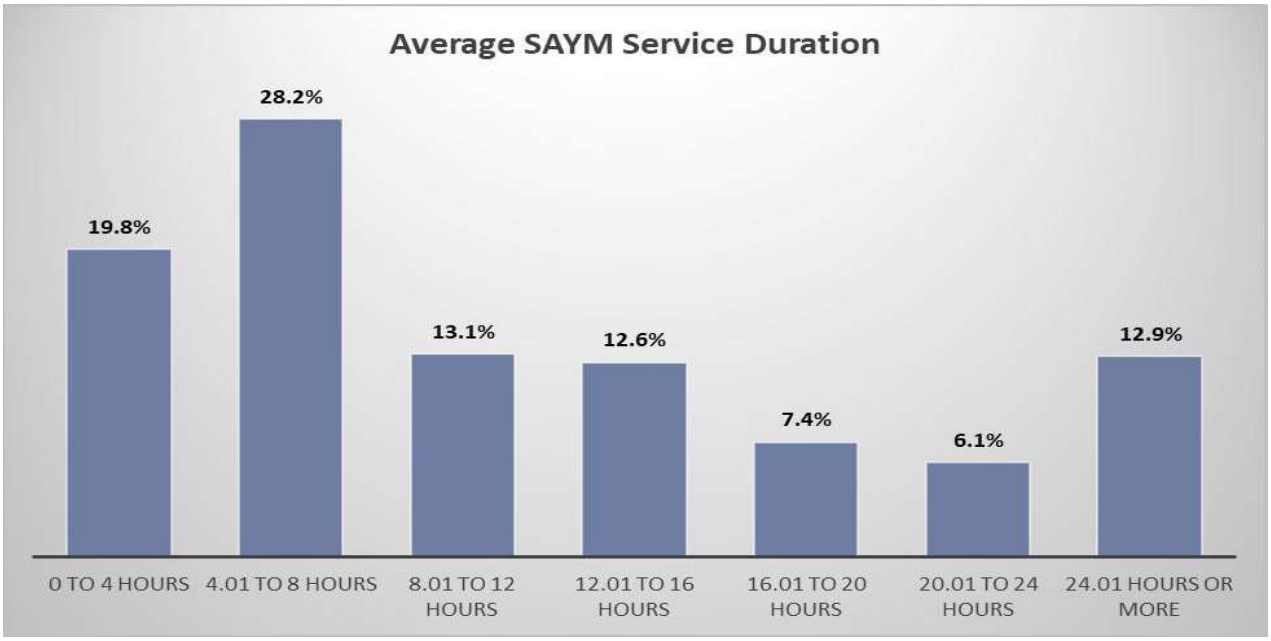


The discharge data on reasons for non-completion are shown in graph below. Overall, there were a total of 76 SAYM participants who did not complete the program during the fiscal year 2023-2024. The majority of participants *chose to withdraw from program* (19.7%, n = 48). There were also smaller percentages of participants who did not complete due to *unable to locate* (2%, n = 5), *no show/no contact* (1.6%, n = 4), or *administrative discharge* (0.4%, n = 1).

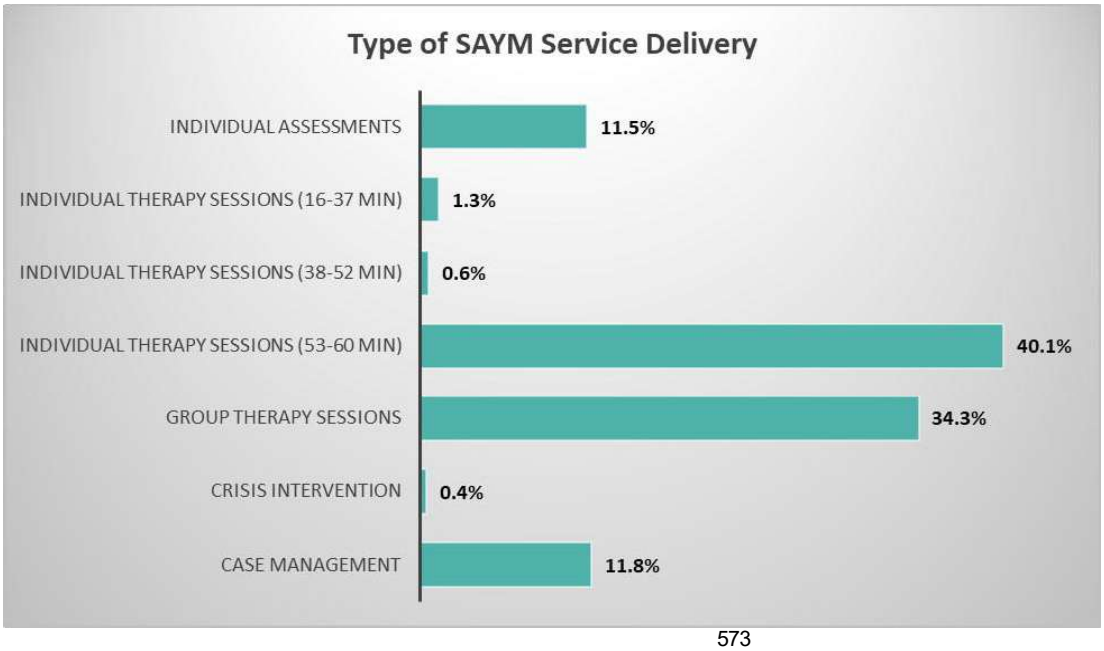


Service Information: Duration and Type of Delivery

Stress and Your Mood Program services can be provided as follows: group sessions, individual sessions, or a combination of both group and individual sessions. The graph below represents the average length of service hours provided for all SAYM participants during fiscal year 2023-2024. The majority of participants received between 4.01 to 8.0 hours of service (28.2%) and between 0 to 4.0 hours of service (19.8%), while the smallest percentage is for 20.01 to 24 hours of service (6.1%).



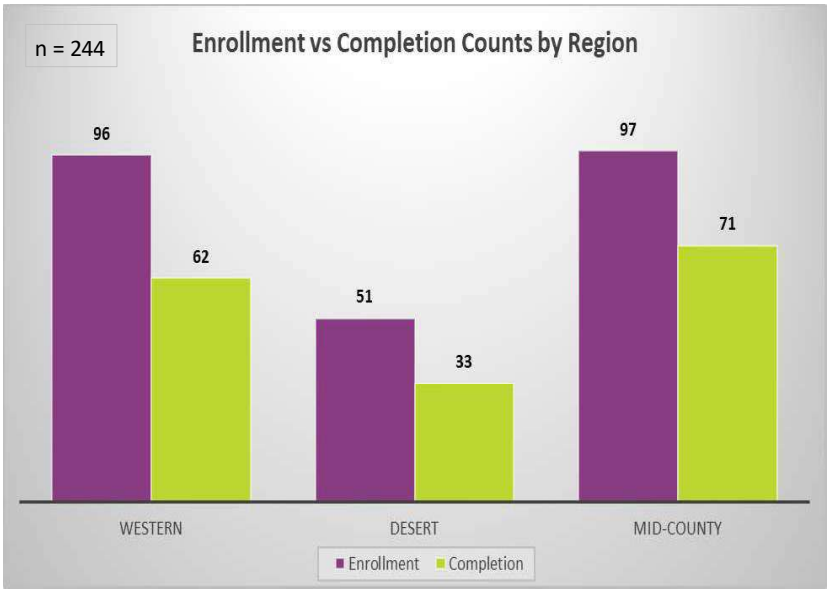
The graph and table below represent the type of SAYM services delivered: Individual Assessments, Individual Therapy Sessions (which have been categorized into different lengths: *16-37 minutes*, *38-52 minutes*, and *53-60 minutes*), Group Therapy Sessions, Crisis Intervention, and Case Management. Overall, the total service time provided during SAYM Program in FY 2023-2024 was **1,448.27** hours. Of these, the majority of service time provided was in *Individual Therapy Sessions* (a combined total of 806.02 hours), followed by *Group Therapy Sessions* (252.50 hours), *Individual Assessments* (203.58 hours), *Case Management* (180.42 hours) and *Crisis Intervention* (5.75 hours), respectively.

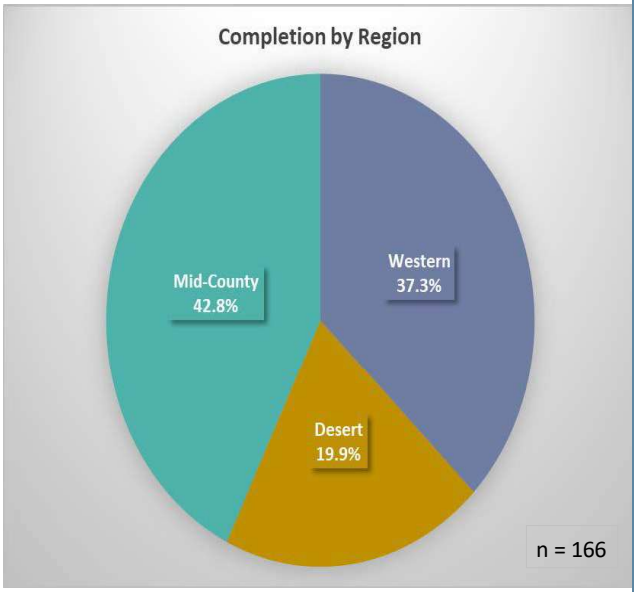


Type of Service Delivery	Total Hours Provided
Individual Assessment	203.58
Group Therapy	252.50
Individual Therapy (16-37 min)	12.27
Individual Therapy (38-52 min)	8.25
Individual Therapy (53-60 min)	785.50
Case Management	180.42
Crisis Intervention	5.75
Total Hours of Service Delivery	1,448.27

Program Completion

The figures below pertain to the total number of participants who completed the SAYM Program during the fiscal year by region.





There were a total of 244 participants enrolled in the Stress and Your Mood Program during the fiscal year 2023-2024. Of these, 166 participants completed the program, and 2 participants are continuing into the fiscal year 2024-2025. The majority of SAYM participants enrolled in the fiscal year 2023-2024 were from the Mid-County region (39.8%, n = 97), followed by the Western region (39.3%, n = 96), and the Desert region (20.9%, n = 51), respectively.

Overall, the completion rate of SAYM Program in FY 2023-2024 is 68% (166 out of 244 enrolled participants). The enrollment and completion counts by regions are summarized below:

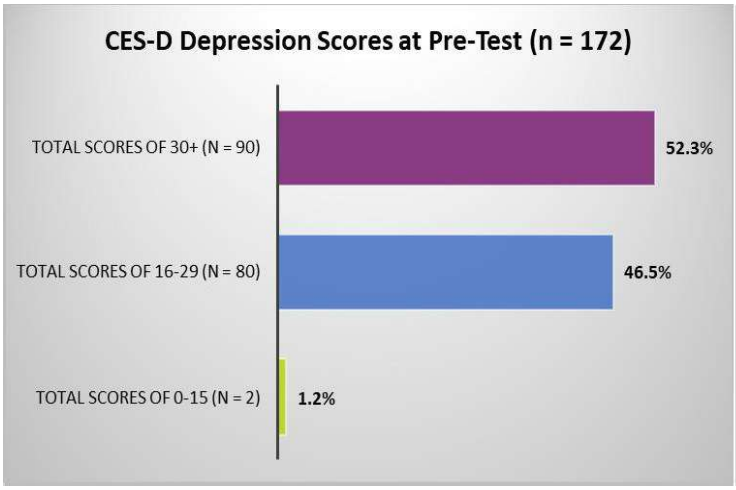
- In Mid-County region, 71 out of 97 participants completed the SAYM Program (42.8%)
- In Western region, 62 out of 96 participants completed SAYM Program (37.3%)
- In Desert region, 33 out of 51 participants completed SAYM Program (19.9%)

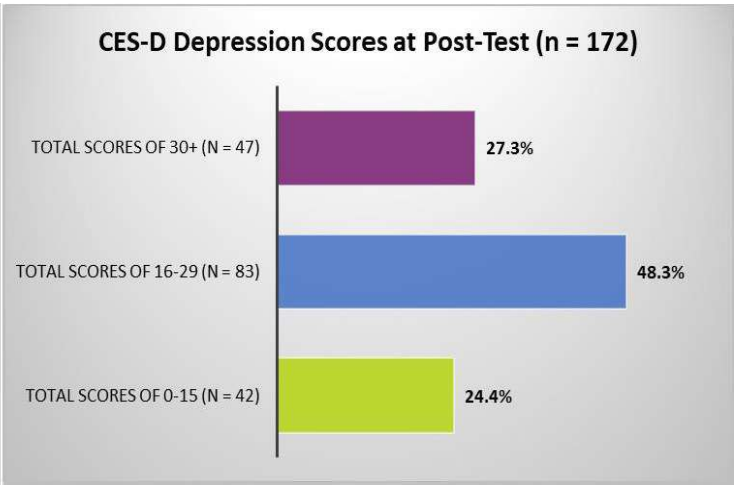
The table below displays the SAYM Program contract expectations, as well as the completion results (n = 166) during the fiscal year. Overall, there was a decrease in the enrollment of SAYM Program in comparison to FY 2022-2023 (from 274 enrolled participants enrolled in FY 22-23 to 244 enrolled participants in FY 23-24). In terms of contract expectation and percent completion, only Mid-County region exceeded the contract expectation in FY 2023-2024 (101.4%). Both Western region (88.6%) and Desert region (47.1%) did not meet their contract expectations in FY 2023-2024. Cumulatively within all regions of Riverside County, SAYM Program had an overall 79% contract completion rate.

SAYM Program Completions (N = 166)			
Source:	**Completed**	**Contract Expectations**	**Percent Completed**
Mid-County	**71**	**70**	**101.4%**
Western	**62**	**70**	**88.6%**
Desert	**33**	**70**	**47.1%**
Countywide	**166**	**210**	**79%**

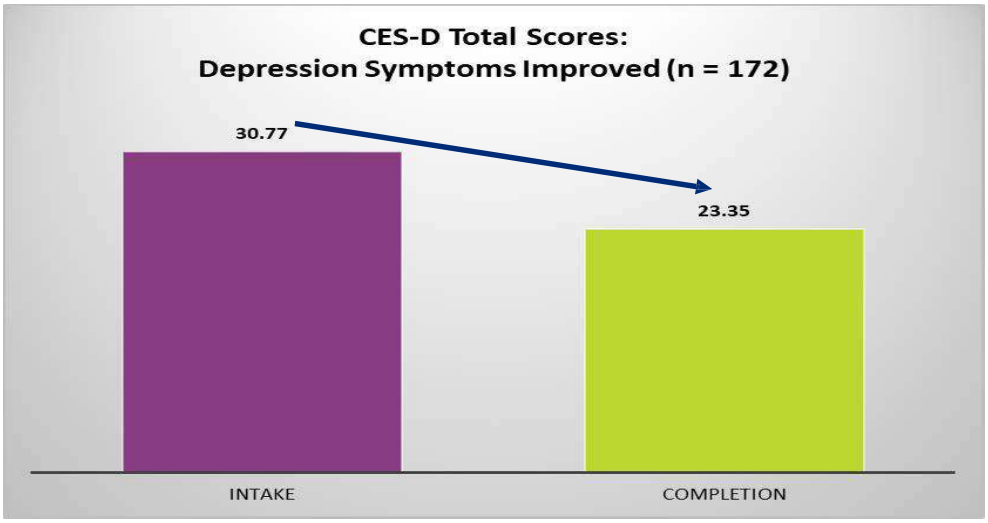
CES-D Scale: Pre to Post Analysis

The **Centers for Epidemiological Studies Depression (CES-D) Scale** is a measure of depression that assesses various depression symptoms experienced by participants during the SAYM Program. Responses are organized in a Likert-scale, where participants were asked to report a typical frequency in which a particular symptom occurs throughout the duration of the SAYM Program. Higher total scores could indicate a higher level of distress. Additionally, a score of 16 or more suggests a clinically significant level of psychological distress, although it does not necessarily mean that the participant has a clinical diagnosis of depression. The total of CES-D scores can range from 0 to 60, with higher scores indicating higher level of distress on the participants.





The graphs above represent the CES-D scores comparison from pre– to post-intervention, and only included participants who had completed both pre-tests and post-tests. A total of 172 participants had matched CES-D pre-and post-measures. Results from pre-tests indicated that there were 2 participants (1.2%) who had scored below 16 points, while the majority scored above 30 points (52.3%, n = 90), followed by those with scores between 16 and 29 points (46.5%). Results from post-tests showed improvements in CES-D scores. Participants who scored below 16 points had increased to 42 participants (24.4%), participants who scored between 16 and 29 points had increased to 83 (48.3%), and participants who scored 30 points or more decreased to 47 (27.3%). These results suggest that overall, the SAYM Program had greatly helped participants to decrease their depression symptoms.



Further analysis using paired samples t-test is reflected on the graph above. Overall, results showed that on average, participants' depression symptoms improved after participating in the SAYM Program. The decrease in average CES-D scores at post-tests are also shown to be 7.42 points lower than the pre-tests, and based on the analysis, this change was shown to be statistically significant, $t = 9.511$, df = 171, p = .000.

CES-D Scale: Item-by-Item Analysis

The CES-D is a robust test that measures many aspects related to depression, and the table below shows an item-by-item analysis of the CES-D measures. The matched pairs t-test results indicated the improvements on every facet of CES-D criteria, and except for 1 item ("You felt that everything you did was an effort"), all other items showed to be statistically significant ($p < .05$). CES-D results on table below also illustrates the success ***and*** the improvements of the SAYM program across all depression statements, which suggest that the SAYM program has helped participants to significantly decrease their symptoms of depressions.

CES-D Item	Average Decrease	*t*	df	p
You were bothered by things that usually don't bother you	-0.33	4.235	171	.000
You did not feel like eating; your appetite was poor	-0.27	2.963	171	.003
You felt that you could not shake off the blues even with help from your family or friends	-0.43	4.761	171	.000
You felt that you were just as good as other people	-0.41	4.410	171	.000
You had trouble keeping your mind on what you were doing	-0.48	6.113	171	.000
You felt depressed	-0.46	5.892	171	.000
You felt that everything you did was an effort	-0.12	1.358	171	.176
You felt hopeful about the future	-0.27	3.173	171	.002
You thought your life had been a failure	-0.57	6.133	171	.000
You felt fearful	-0.39	4.690	171	.000
Your sleep was restless	-0.28	3.063	171	.003
You were happy	-0.27	3.245	171	.001
You talked less than usual	-0.40	4.485	171	.000
You felt lonely	-0.55	6.279	171	.000
People were unfriendly	-0.19	2.549	171	.012
You enjoyed life	-0.15	2.137	171	.034
You had crying spells	-0.28	3.379	171	.001
You felt sad	-0.53	6.823	171	.000
You felt that people disliked you	-0.45	4.812	171	.000
You could not "get going"	-0.59	7.091	171	.000

Clinical Global Impression—Improvement Scale

The Clinical Global Impression Improvement (CGI-I) Scale measures the clinician's assessment of how much the participant's symptoms have improved or worsened compared to the baseline measurement at the beginning of the intervention.

The CGI-I scale is used to track the progress of participants across three periods of the SAYM intervention:
1. Module 1 Intervention
2. Module 2 Intervention
3. Post Intervention

Clinicians rate total improvement in overall depressive symptomatology since initial enrollment. Total scores ranging from **1** (***very much improved***) to **7** (***very much worse***) measure the participants' improvement or de-crease in their overall depressive symptomatology since enrollment.

The following are descriptions of the scores participants can receive on the CGI-I scale.
CGI-I Rating Levels:

1) *Very Much Improved* - All or most of the target symptoms have been improved to a significant degree. Changes have a major and discernible impact on functioning, both subjectively and as observed by others. Clinicians are comfortable administering a simple maintenance treatment regiment, where there is little or no room for further improvement. Does not meet criteria for psychiatric disorder.

2) *Much Improved* - Several symptoms have improved to a degree that the participant feels an important change has occurred. The change is large enough that it's distinctly noticeable by others; however, there is still some room for improvement. Does not meet criteria for psychiatric disorder.

3) *Minimally Improved* - Only 1 or 2 symptoms (at most) show improvement, and the degree of change is not sufficient. Improvements may not be consistent across informants or domains of functioning. Thus, there is considerable room for improvement, clearly requiring further therapeutic adjustments. Possibly meets criteria for psychiatric disorder.

4) *No Change* - No symptoms are showing improvement compared to the baseline state, or changes are so minimal as to be completely inconsequential. Meets criteria for psychiatric disorder.

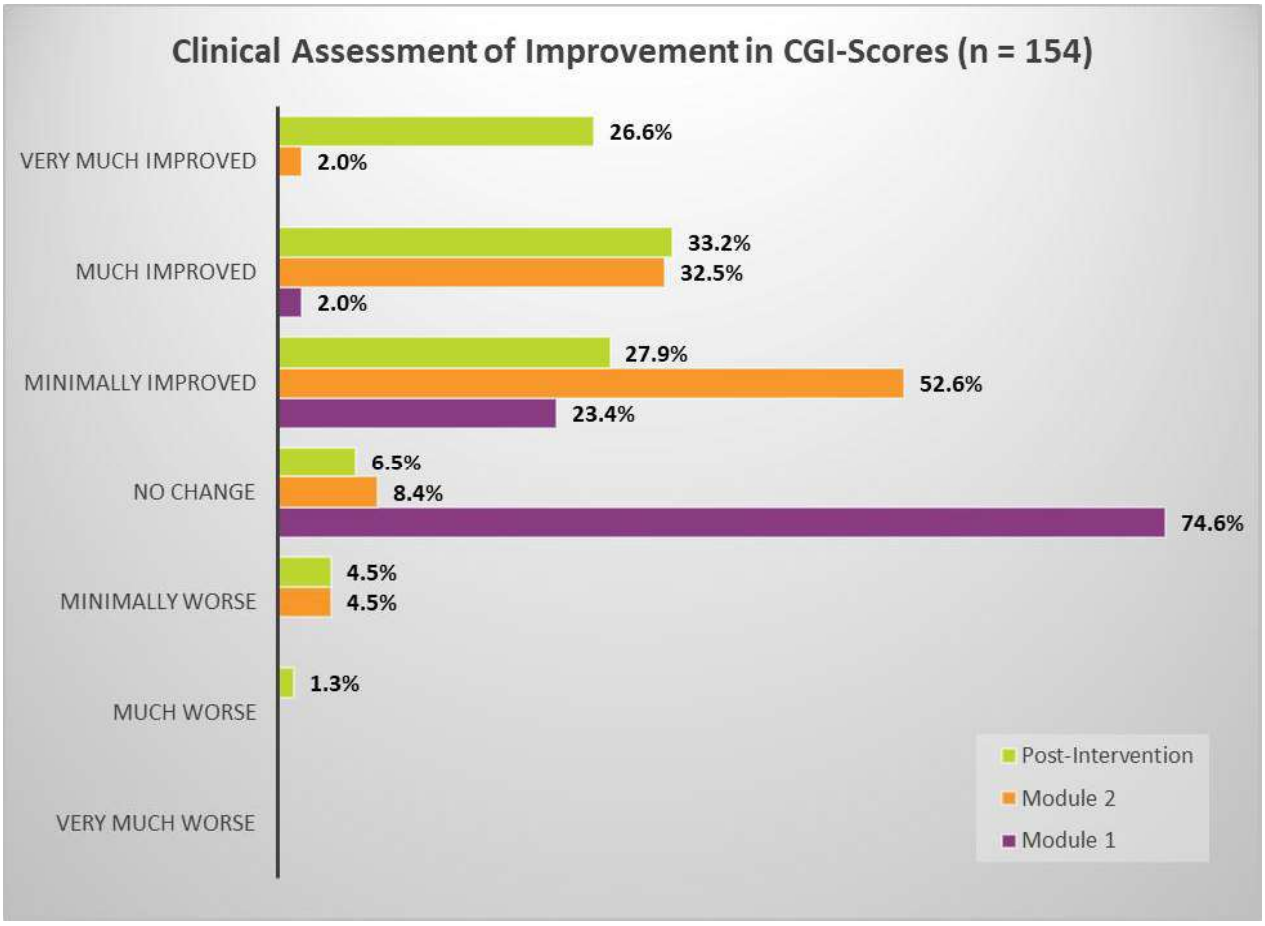
5) *Minimally Worse* - There is some worsening over the baseline state in the target symptoms, though not to a degree that one would wish to completely stop treatment. Nevertheless, changes in treatments need to be considered. Meets criteria for psychiatric disorder.

6) *Much Worse* - Participants condition is worse enough that stopping or changing treatment should be heavily considered, even though not all target symptoms are worse. Worsened condition is clearly discernible by the youth and other observers. Meets criteria for psychiatric disorder.

7) *Very Much Worse* - Most target symptoms are worse, where stopping, changing and/or adding new treatments is clearly apparent. Meets criteria for psychiatric disorder.

CGI-I Clinical Assessments: Pre to Post Intervention

Clinician ratings across each of the three time periods (i.e. *Pre-Intervention or Module 1*, *Module 2*, and *Post-Intervention*) are shown on the graph below. CGI-I scores were provided for the 154 participants who had a rating for all three time periods. Overall, there are notable improvements from Pre-Intervention/Module 1 to Post-Intervention. The graph below is structured so that the top bar represents positive outcomes and the bottom portions represent negative outcomes, showing 3 different modules: Pre-Intervention/Module 1, Module 2, and Post-Intervention.



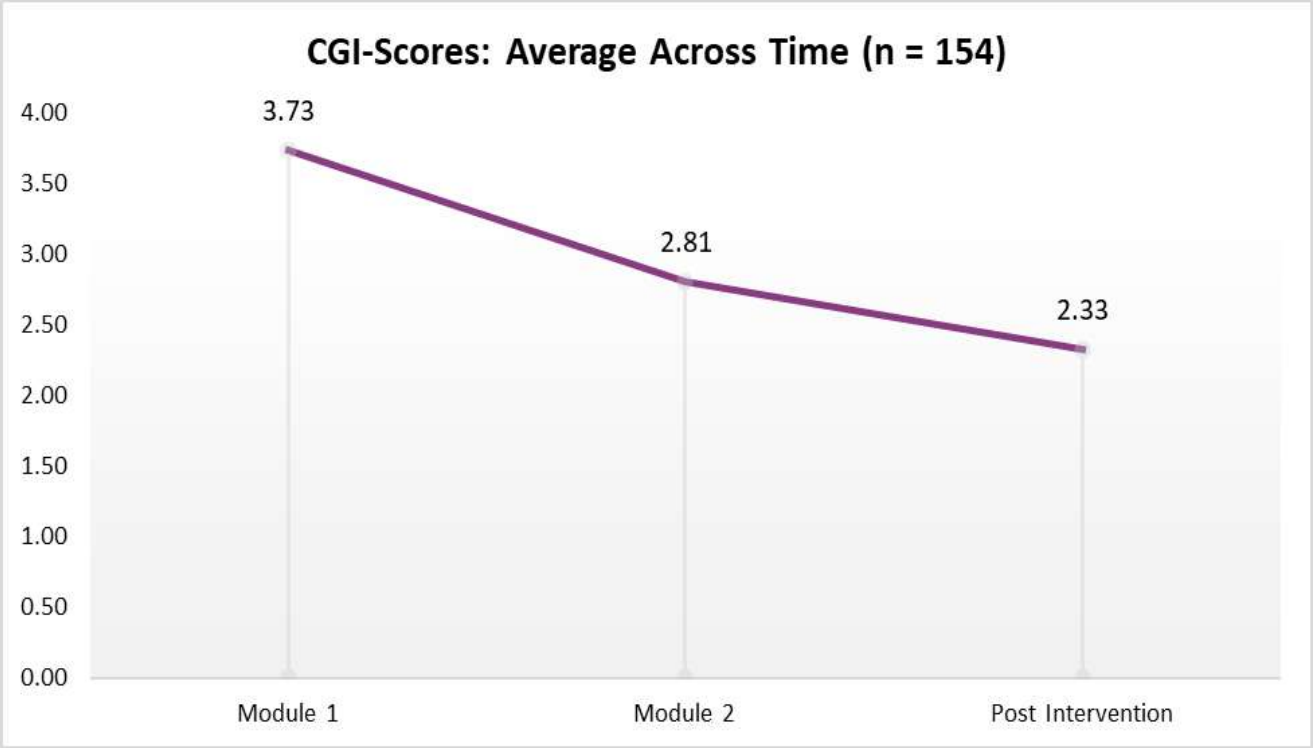
At the conclusion of Module 1, a total of 23.4% of SAYM participants were recorded as "Minimally Improved" and 1.9% of participants were recorded as "Much Improved"(25.3% combined), while 74.7% showed "No Change" on their symptoms.

After Module 2 completion, the improvements were much higher, where a total of 52.6% of SAYM participants were "Minimally Improved", 32.5% "Much Improved", and 1.9% "Very Much Improved" (87% combined). Additionally, there were only 8.4% of participants recorded as"No Change" and 4.5% recorded as "Minimally Worse" on their symptoms.

After SAYM completion, at the conclusion of Module 3, participants showed significant improvements. There were a total of 87.7% participants with improved symptoms in some capacity, in which a large portion of 33.1% were "Much Improved", 26.6% "Very Much Improved", and 27.9% "Minimally Improved". There were only 6.5% participants with "No Change", 4.5% participants were"Minimally Worse", and a small percentage 1.3% were" Much Worse" symptoms. Further analysis on the CGI-I scores are shown on the following page.

CGI-I Results: Pre to Post Analysis

The following graph reflects the change in scores from Pre-Intervention (Module 1) to Post-Intervention (Module 3). Lower scores represent lower Depression Symptomology in 183 participants who completed all three modules. These scores significantly improved as recorded by clinicians, from pre-intervention (3.44) to post-intervention (2.07).



CGI-I Scores Measurement: T-Test Pre to Post					
Interval	**Pairs**	**1st Level**	**2nd Level**	**Difference**	**Significance**
Module 1 (Pre) to Module 2 (Mid)	**154**	**3.73**	**2.81**	**-0.92**	**.000**
Module 2 (Mid) to Module 3 (Post)	**154**	**2.81**	**2.33**	**-0.48**	**.000**
Module 1 (Pre) to Module 3 (Post)	**154**	**3.73**	**2.33**	**-1.4**	**.000**

Further comparison analysis using the paired-samples t-tests indicated that there were more improvement in participants' psychiatric symptoms from Module 1- to Module 2-Interventions with a difference of 0.92 points (t = 16.132, df = 153, p = .000), compared to Module 2 to Post-Interventions with a difference of 0.48 points (t = 0.661, df = 153, p = .000), with a difference of 0.44 point.

Both results also showed statistical significance across all modules, which suggests that the SAYM Program did help to reduce participants' depression symptoms to "Much Improved" (based on the clinicians' assessments across all modules shown on previous page). Additionally, the highest significant improvements were shown from Module 1 to Post-Interventions, with a difference of 1.4 points (t = 15.198, df = 153, p = .000), which suggests that participants would benefit the most significant decrease in their symptoms if they were to complete the entire SAYM Program, as noted on table above.

Youth-Outcome Questionnaire Self-Report (Y-OQ®-SR)

The Youth-Outcome Questionnaire Self-Report (Y-OQ®-SR) is a measure of a wide range of behaviors, situations, and moods which commonly apply to youth. Five sub-scales analysis are included in the Y-OQ®-SR that were used in the SAYM Program, which measures behavioral problems as well as elements of healthy behaviors:

- ***Intrapersonal Distress***
- ***Somatic***
- ***Interpersonal Relations***
- ***Social Problems***
- ***Behavioral Dysfunction***

Each subscale on the Y-OQ®-SR questionnaire is a summation of selected items as shown on table below, and the total score reflected on the Y-OQ®-SR questionnaire is the summation of items from each sub-scale and is designed to reflect the total amount of distress a child or adolescent is experiencing.

Y-OQ®-SR Scales and Item Numbers

Scales Measured in Y-OQ®-SR Questionnaire	Item Numbers
Interpersonal Distress	1,3,5,9,15,17,25,32,33,34,41,49,53,57,61,62,63,64
Somatic	2,10,18,26,35,42,50,54
Interpersonal Relations	4,7,11,16,20,24,27,36,37,43
Social Problems	6,13,22,29,31,39,47,55
Behavioral Dysfunctions	8,14,23,30,40,45,48,52,56,59,60

General Uses/Advantages-YOQ

- Risk assessment. High scores on critical items scales indicate those who may need an immediate intervention beyond standard outpatient treatment.
- Subscale scores can be used to identify and target particularly problematic areas such as a focus of treatment and cues on treatment planning.
- Overall change can be tracked from total scores, and specific symptoms or behaviors can be tracked using subscale scores.
- The Self Report Youth-Outcome Questionnaire (Y-OQ®-SR) can be used to track participant's therapeutic progress.

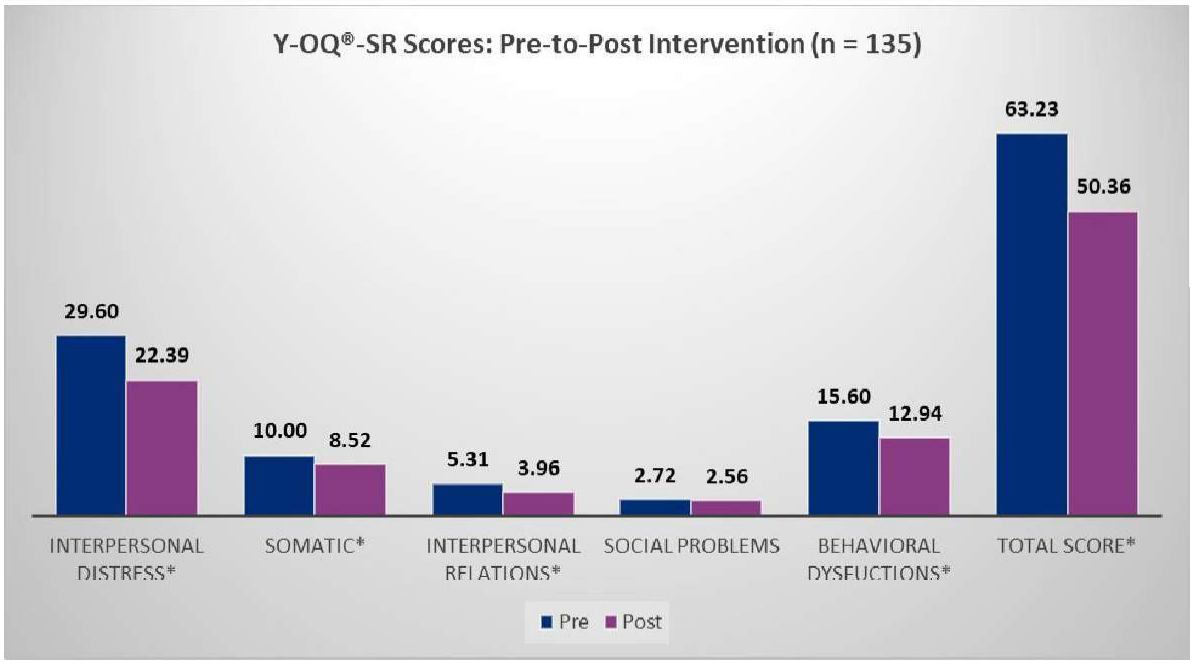
Guidelines for Clinical Interpretation

The Y-OQ®-SR total score quantifies overall level of disturbance. A total score of 46 or higher is considered within the clinical or dysfunctional range, while a total score under 46 is considered to be normal or within the non-clinical range. The satisfactory change index for the Y-OQ®-SR is 13 points, which means that the participants must report a minimum change of 13 points in their ***total score*** from pre- to post- measures in order for that change to be considered clinically significant.

Y-OQ®-SR: Pre to Post Analysis

The table below shows the average decrease on all subscales measured in the Y-OQ®-SR analysis from pre– to post intervention. There were a total of 135 participants between the ages of 15 to 17 years of age, who completed both pre and post measures. Overall, participants' average scores showed statistically significant decreases across all subscales. The average total scores also decreased significantly by 12.87 points, which is slightly less than the YOQ satisfactory change index of 13 points. This indicates that the average improvements were slightly below clinically significant. In the table, an asterisk indicates significant changes within that particular scale. All scales except "Social Problems" scale, were shown to be statistically significant.

Y-OQ®-SR Scales	Average Score Decrease	*t*	df	p
Interpersonal Distress*	-7.21	7.732	134	.000
Somatic*	-1.48	4.032	134	.000
Interpersonal Relations*	-1.36	3.336	134	.001
Social Problems	-0.16	0.594	134	.553
Behavioral Dysfuctions*	-2.66	5.315	134	.000
Total Score*	**-12.87**	**7.028**	**134**	**.000**



Average pre to post Y-OQ®-SR scores for the SAYM Program were analyzed with paired samples t-tests from 135 participants. Based on the statistical analysis, all post-test scales showed statistically significant changes from pre-test scores (p = .000), except for "Social Problems" scale. The total scores represent the summation of all items in the survey, and the rest of the sub-scales are sums of selected questions within the survey. Overall, the decreases in the total score signifies that there were reductions in the general level of distress. The total scores also showed a statistically significant decrease from pre-test (63.23) to post-tests (50.36), $t = 7.028$, df = 134, p = .000. Although all the scores showed statistically significant decreases from pre– to post measures, participants on average are still considered within the clinical or dysfunctional range after the SAYM Program completion (i.e. the average total scores are still shown as higher than 46 points). This result is consistent with the result of CES-D analysis on page 10, which suggests that participants were significantly depressed prior to starting the SAYM Program, and also suggests that by completing the SAYM program, participants have actually shown improvement in their depression symptoms and general mental health functioning.

BASIS-24® Scale

The BASIS-24® scale is a twenty-four item self-report questionnaire designed to assess treatment outcomes by measuring symptoms and functional difficulties. Scores can be computed for the overall BASIS-24®, as well as for the following six scales:

- ***Depression and Functioning***
- ***Interpersonal Relationships***
- ***Psychosis***
- ***Substance Abuse***
- ***Emotionally Labile***
- ***Self-Harm***

BASIS-24® Scales and Item Numbers

Scales Measured in BASIS-24® Questionnaire	Item Numbers
Depression and Functioning	1,2,3,9,10,12
Interpersonal Relationships	4,5,6,7,8
Psychosis	14,15,16,17
Substance Abuse	21,22,23,24
Emotionally Labile	13,18,19
Self-Harm	11,20

Outcomes evaluation of SAYM Program included a general measure of functioning for Adults 18 to 25 years of age. Participants were asked to take the BASIS-24® tests before starting the SAYM Program and after program completion (i.e. pre- and post-interventions).

BASIS-24® questions are scored on a 5-point Likert scale (i.e. score values from 0 to 4) reflecting either a spectrum of difficulty with the behavior in question or the frequency with which someone engages in a particular behavior.

Difficulty spectrum of responses: (*e.g. difficulty sleeping, coping with life problems*)
0 = “no difficulty”
1 = “a little difficulty”
2 = “moderate difficulty”
3 = “quite a bit of difficulty”
4 = “extreme difficulty”

Frequency spectrum of responses: (*e.g. feeling confident in yourself, feeling sad/depressed*)
0 = “none of the time”
1 = “a little of the time”
2 = “half of the time”
3 = “most of the time”
4 = “all of the time”

Lower scores indicate more normative, non-clinical aspects of general mental health functioning, while higher scores indicate greater symptomatology. The average intake scores for all SAYM participants on the BASIS-24® tests on both the subscales and total scores are shown on the table and graph on the following two pages.

BASIS-24® Subscales and Results

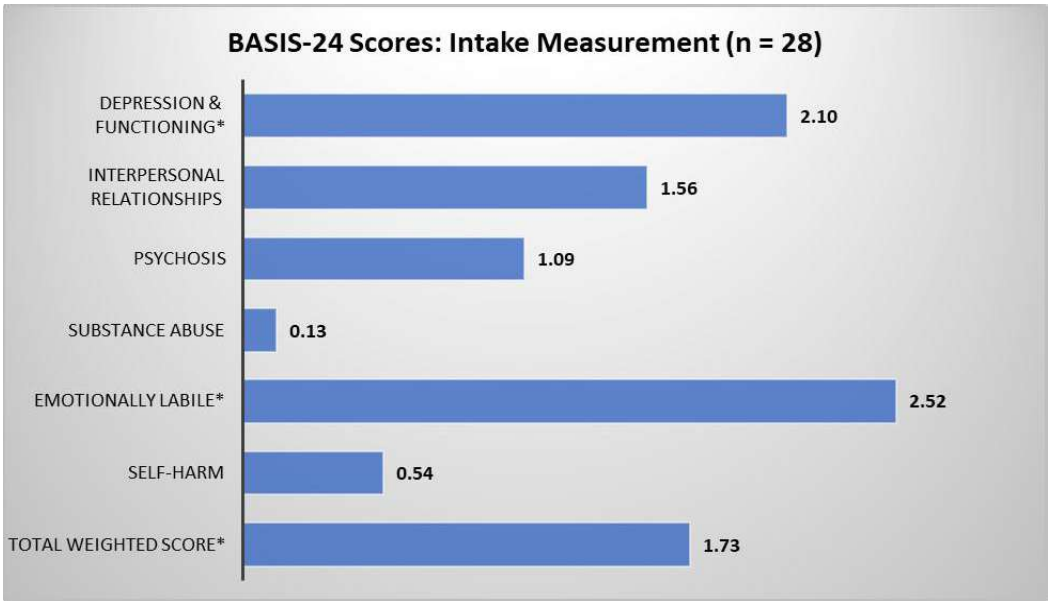
There are a total of 28 participants between the ages of 18 to 25 years old who completed the BASIS-24® during intake. Overall, participants showed low scores for "Psychosis", "Substance Abuse", and "Self-Harm" subscales. Given that SAYM is designed for Early Intervention for depression, the low scores in these subscales showed that the population served matches the intended target population. Based on analysis at intake, the following subscales presented difficulties to participants:

Depression and Functioning Scale: 2.10

Participants are experiencing some difficulty in their functioning due to depressive symptomatology.

Emotionally Labile: 2.52

The average participant is experiencing excessive emotional reactions and frequent mood changes on a periodical basis, indicating that participants are experiencing some debilitation by not being able to control their emotions.



The table below shows the results of only the participants ages 18 to 25 years of age who had matched pre– and post measures. There were a total of 12 participants who completed and were included in the analysis. Since the sample size is relatively small, it may be challenging to make a solid conclusion based on these results. With a low number of participants for this analysis, it is not typical to do statistical tests. Generally, the differences in the average scores on all subscales and total weighted score from pre-tests to post-tests showed decreases. The most decreases were shown on the *Depression and Functioning Scale* (0.86 points) and *Emotionally Labile Scale* (0.56 points). Despite the low sample size, considering these 2 sales were shown to have the highest scores at intake, it is still worthwhile to note that the improvements at post-measures are also shown on these 2 scales, which suggests that SAYM Program helped participants to decrease their Depression and Emotional Distress.

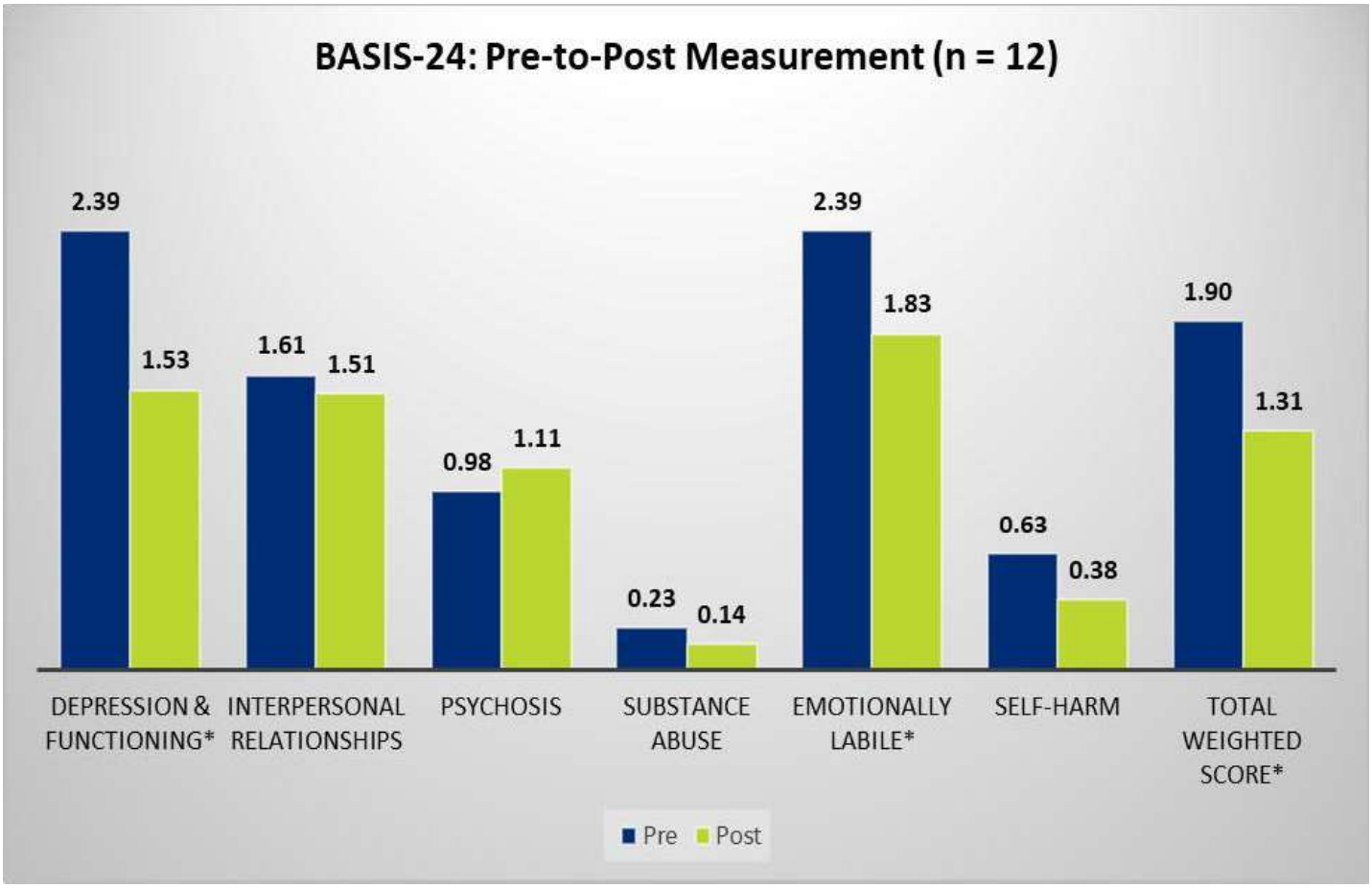
BASIS-24 Scales	Pre-Post Score Difference
Depression & Functioning*	-0.86
Interpersonal Relationships	-0.10
Psychosis	0.13
Substance Abuse	-0.09
Emotionally Labile*	-0.56
Self-Harm	-0.25
Total Weighted Score*	-0.59

BASIS-24® Pre-to Post– Analysis

The graph below shows how SAYM participants who are over 18 years of age before and after the SAYM Program. There were a total of 12 SAYM participants between the ages of 18 to 25 years old who completed both pre– and post-BASIS-24® measures. Overall, there are decreases across all subscales except Psychosis which was very low at intake. Furthermore, participants had relatively low or zero scores for the following subscales: "Substance Abuse" and "Self-Harm" at intake. These symptoms were not reported to be a significant issue for those served.

Since there were only 12 participants who completed and had matched pairs of BASIS-24® measures, the statistical significance test was not possible. Overall, results showed decreases across all subscales, although they were only 0.9 points or lower. However, this does not mean that the SAYM Program did not help the participants, and conclusions should not be made based on the results due to the small sample size. It should also be noted that the analysis was only based on the participants who are over 18 years of age. The overall "Total Weighted Scores" across subscales are also low at intake, and shown as deceased at post-measures (0.59 points).

In sum, these subscales are useful in understanding SAYM participants' other areas of mental functioning. decreases are seen across most subscales and the total score.



Post-Satisfaction Surveys

The Post-Satisfaction Surveys for the Stress and Your Mood Program were collected from participants at the conclusion of the program's services. Participants were asked to rate nine satisfaction survey items on a five-point Likert scale, where: ***1*** *= Strongly Disagree,* ***2*** *= Disagree,* ***3*** *= Neutral,* ***4*** *= Agree, and* ***5*** *= Strongly Agree*. A total of 169 SAYM participants completed the post-satisfaction surveys during the fiscal year 2023-2024, The post-satisfaction survey results are shown on table below, with a corresponding graph that illustrated the survey results shown on the next page.

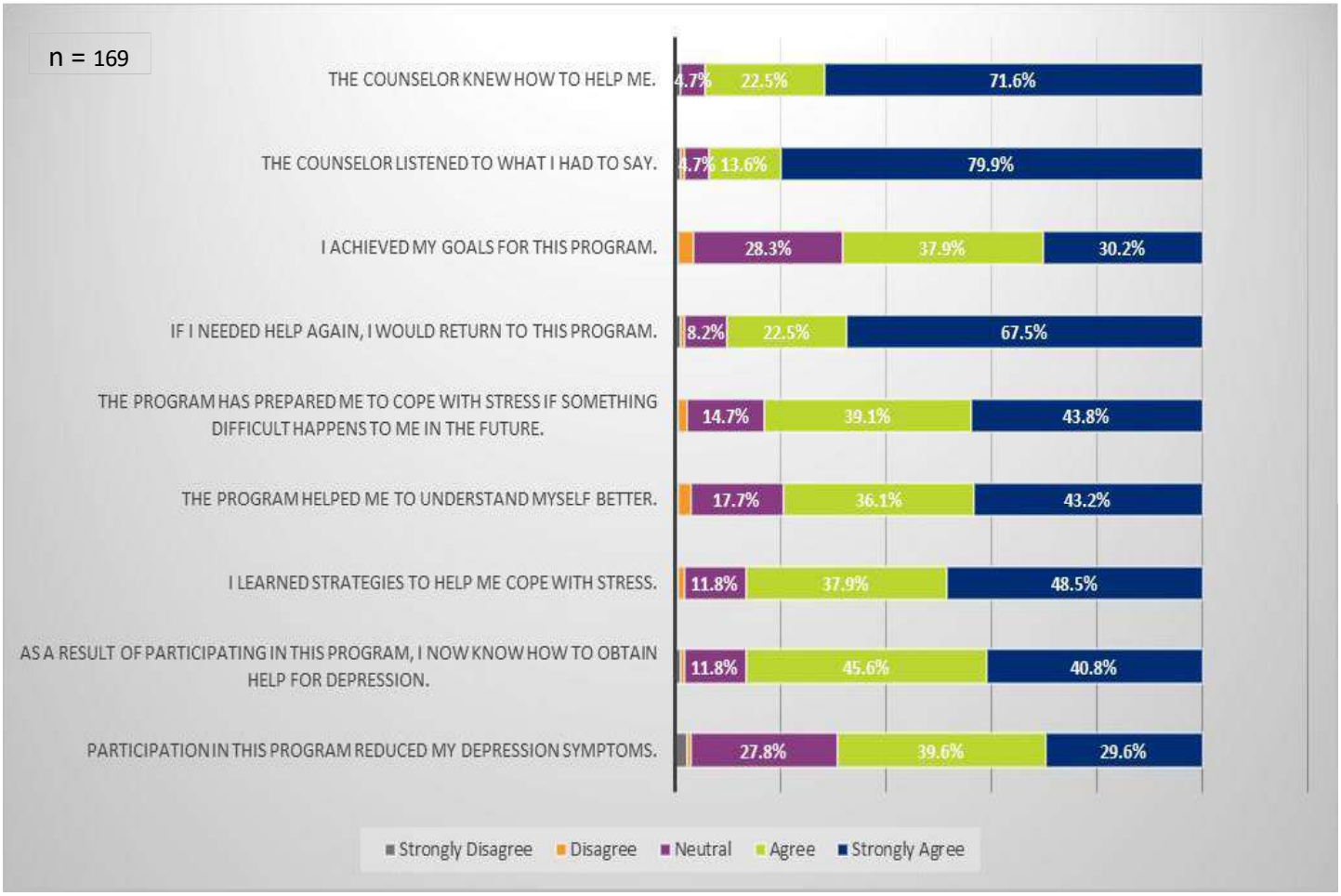
Post-Satisfaction Survey Results

Item No.	Countywide (n = 169)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	Participation in this program reduced my depression symptoms.	2.4%	0.6%	27.8%	**39.6%**	**29.6%**
2	As a result of participating in this program, I now know how to obtain help for depression.	1.2%	0.6%	11.8%	**45.6%**	**40.8%**
3	I learned strategies to help me cope with stress.	0.6%	1.2%	11.8%	**37.9%**	**48.5%**
4	The program helped me to understand myself better.	0.6%	2.4%	17.7%	**36.1%**	**43.2%**
5	The program has prepared me to cope with stress if something difficult happens to me in the future.	0.6%	1.8%	14.7%	**39.1%**	**43.8%**
6	If I needed help again, I would return to this program.	1.2%	0.6%	8.2%	**22.5%**	**67.5%**
7	I achieved my goals for this program.	0.6%	3.0%	28.3%	**37.9%**	**30.2%**
8	The counselor listened to what I had to say.	1.2%	0.6%	4.7%	**13.6%**	**79.9%**
9	The counselor knew how to help me.	1.2%		4.7%	**22.5%**	**71.6%**

The SAYM post-satisfaction survey results are summarized below:

- **69.2%** of participants "Agreed" or "Strongly Agreed" that the SAYM Program reduced their depression symptoms, while **27.8%** of participants felt "Neutral" about this statement.
- **86.4%** of participants "Agreed" or "Strongly Agreed" that they know how to obtain help after completing the SAYM Program.
- **86.4%** of participants "Agreed" or "Strongly Agreed" that they learned strategies in the SAYM Program to help them with coping with stress.
- **79.3%** of participants "Agreed" or "Strongly Agreed" that the SAYM Program has helped to understand themselves better.
- **82.9%** of participants "Agreed" or "Strongly Agreed" that the SAYM program helped them to cope with stress if something difficult happens in the future.
- **90%** of participants "Agreed" or "Strongly Agreed" that they would return to the SAYM Program if they felt that they needed help.
- **68.1%** of participants "Agreed" or "Strongly Agreed" that they achieved their goals after participating in the SAYM Program, while **28.3%** of participants felt "Neutral" about this statement.
- **93.5%** of participants "Agreed" or "Strongly Agreed" that the counselors listened to what they had to say.
- **94.1%** of participants "Agreed" or "Strongly Agreed" that the counselors knew how to help them.

Post-Satisfaction Survey Results



As illustrated on the previous table, the general responses to the SAYM Program are overwhelmingly positive, with more than 79% of participants either "*Agreed*" or "*Strongly Agreed*" to most of the statements on the post-satisfaction surveys, except for the following:

- "Participation in this program reduced my depression symptoms" (where 69.2% responded *Agreed or Strongly Agreed,* and 27.8% still felt *Neutral* about this statement).
- "I achieved my goals for this program" (where 68.1% responded *Agree or Strongly Agreed*, and 28.3% still felt *Neutral* about this statement).

Additionally, more than 93% of participants responded that they either "*Agreed*" or "*Strongly Agreed*" in regards to statements about their counselors:

- "The counselor listened to what I had to say."
- "The counselor knew how to help me."

Post-Satisfaction Survey Comments

Youth satisfaction surveys included additional spaces for write-in comments. SAYM Participants were asked to comment on aspects of the program they liked, did not like, and what they learned from the program. Most of their comments are detailed below and on the next three pages.

1. Things I learned in the program are...

"Attending this group I've learned many things. Having self love, focusing on my mental health, being open minded, and keeping in mind that it's okay to cry and bounce back."
"How to communicate my emotions cope with situation."
"New ways to cope with anger towards someone."
"Want to cope with stress and want to stop having negative thoughts."
"Something I learned from this program is what causes my moods and how to cope with stress."
"I learned if my mind is racing to write my thoughts down."
"How to get help if I think about hurting myself or others."
"To not be afraid to reach out for guidance for mental health."
"I learned how to not to self sabotage."
"I learned many ways to cope with stress, how to help others, and really just understand myself better."
"How to cope with my feelings as well as understanding myself."
"That I'm not alone and I can always talk about my problems with someone."
"How to help myself get through life easier."
"That I'm not alone and I can do this."
"How to identify and manage positive self-disclosures or negative ones, and stopping cognitive disclosures."
"I learned to finally speak about my feelings and to not bottle everything up."
"How to cope with my emotion."
"How to cope with stress and ways to be more confident."
"I learned how to cope with my emotions and learned about ones people experiences."
"Healthy coping skill for careful situations, how/who to reach out If I need help with mental issues."
"I learned ways to cope with sad emotions I also learned different ways people's mind works."
"Exercise on how to control yourself methods on mental health."
"How to ask for help, cope with stress, way to distress myself."
"How to cope with negative and positive thoughts breathing techniques."
"How to deal with my stress and any irrational thoughts."
"How to communicate better, be more understanding with how others feel."
"I learned how to focus on myself, and how to distress."
"I learned I'm not alone and always have someone."
"How to understand myself and others when going through situations."
"I learned about mental illness and staying in a moment to calm down. Using coping skills I learned in the program."
"How to communicate not to depend on people to change, how to cope, spend time with friends."
"I learned ways to control my anger on the spot."
"Ways to cope with negative thoughts as well as doing activities to improve myself."
"Thinking more positively, social speaking/sharing and coping strategies."
"The point of realization about my problems, ways to know what the problem is and some how reflect on it."
"Thanks to the counselor I was able to relax and be able to control my emotions, actions, and feeling."
"How to deal with thoughts how actions can change my thoughts and emotion; and that it's okay to reach out for help."
"Finding ways to cope with myself, reflect on my actions, helped me set a goal for myself."

1. Things I learned in the program are… (continued)

"I learned how to be more aware of my emotions and to deal with them more."
"How to deal with negative thoughts and how to get over them."
"How to love myself and appreciate life."
"How to cope with boredom, stress and feeling alone"
"How to manage my thoughts and knowing it's okay to feel a certain way that it's not always wrong to say or do."
"What I learned in the program is how to take care of ourselves physically and mentally. Breathing techniques, exercises, and how to relax our mind."
"Learning how to start putting myself first."
"Coping with anxiety and coping with emotions."
"Learned how to cope with activating events and resolve problems in life."
"How to handle my emotions and dealing with my problems with others."
"How to manage stress, different kinds of research spiraling and learning to second things in a positive way. I also learned to deal with depression, and how to respond quickly to certain situation, in order for me to communicate."
"I learned that it is okay to talk to someone abut how you are feeling or what your going through."
"That feelings should be managed and not disregarded no matter how insignificant it may seem."
"Ways to manage my emotions and how to communicate them to others effectively."
"How to communicate better with both adults and people my age. How to manage my thoughts and outlook. Feeling more comfortable being myself."
"How to view criticism from certain family members/people and not internalize it."
"I learned how I was feeling when I didn't know what it was."
"How to cope with stress and anxiety through coping mechanisms such as meditation."
"How to set small realistic goals that helps you keep going everyday."
"How to manage stress and alleviate negative feelings."
"I learned physical ways to calm down by feeling and thinking about my surroundings/mediation skills."
"Different ways to calm down and cope with stress like thinking of a good place, tightening and releasing muscles and breathing exercises."
"I learned how to cope and how to recognize my flaw and where I need room to improve."
"How to cope with stress and depression."
"How to manage stress and anxiety while in difficult situations."
"I learned how to communicate and I learned that I and control how I think and therefore control how I feel."
"List of things on how to cope with things and not worry about anything and just enjoy life."
"How to not be so fearful of change and appreciate it. Learned how to deal with losing people. How to not let others worry about me."
"Positive counter thoughts; breathing techniques to help my anxiety and thinking with the logical mind, and identifying emotion and separating school work from my own time outside of school."
"How to talk with someone who's having a bad day and be the person to talk to."
"Participating in this program reduced negative thoughts."
"How to stay calm and positive."
"How to think and control my anger"
"Ways to think positively, how to relax and destress, and journaling my feelings/thoughts."
"I learned to deal with my stress and worrying what I have, and that's it's okay to talk about my feelings and how to calm myself down."
"I learned how to recognize my feelings, negative thoughts into positive ones, etc."
"I learned how identify my tell-tale signs. Once I learned them, then I learned how to cope."
"I learned ways to communicate with those around me so that relationships are stronger and filled with trust. I also learned how to know when my thoughts were irrational and how to change them to be more positive."

2. What I liked about the program is…

"Our counselor is Awesome! She's so caring, and gives the best advice. She's never made me feel uneasy or anything I felt so safe and cared for when expressing myself to her."

"Our counselor! He is super sweet and coping and listens to what we say."

"Having a calm space to be able to talk."

"What I liked about this program was the methods. They wasn't boring but simple enough to understand."

"I liked the group because it's very welcoming."

"I was comfortable with everyone in the group."

"I felt heard, the program made me feel like I had voice."

"Love the snacks, activities, and people in here were all so great. I also love my counselor, overall he's a good listener and knows what to say, and he's also funny."

"Hearing what others say when they go through their problems."

"How fun and honest it is. I can be very honest."

"I liked that I got to met new people and I learned a lot more about my friends."

"Being able to talk about our weeks with no judgement."

"I loved the program it was such an amazing stress reliever, I felt safe."

"I like the counselor, she listened to me and made me feel comfortable. I like how I'm not alone, knowing others shared and I can relate."

"How I got to meet new people from my school I didn't know before."

"Being able to talk with and relate with others."

"It was a safe place, everyone was understanding."

"I liked that I can relate to the people's problems."

"That I felt comfortable and it was welcoming."

"I liked how it was very active and everyone participated."

"Being able to be comfortable around others. Not being shy feeling safe around others."

"My counselor, made me very comfortable to talk to."

"It was welcoming. I felt like I was able to open up about my issues."

"I liked that it was a group and I had people in here that I knew which they helped us along the way."

"My counselor very understanding and 10/10 person."

"I was able to engage with someone and not feel like I was able to be confident."

"How kind our counselor is."

"How my counselor was able to respond and help me when I was down at night and I felt heard."

"I like how it was able to work out with my schedule and if I could not make it to the session there was no trouble."

"I got to see the others improve with me."

"I liked that I got to hear about other people's problem and how to deal with it."

"It felt like a safe space where I was able to be myself."

"I made new friends and had amazing time here."

"How nice and caring the counselor was. I always had the best day."

"You get to talk about your feelings you get helped if needed."

"Everyone was open with what they were feeling and it was a very comfortable experience."

"The energy and good vibe I got every time I walked in."

"My counselor was a really good presenter."

"Being able to have a safe space as well as someone who understood me, and being vulnerable without judgment."

"I felt supported when people listen to me."

"I learned how to confront my issues with others rather than let my emotions build up."

2. What I liked about the program is… (continued)

"I loved how my counselor took time to get to know each one of us. It made me feel more comfortable talking about my problems to her. She was always so welcoming. Loved the snacks, and I learned so much."

"How it let me to allowed me to express my feelings and to get them off my chest."

"It was a really friendly environment despite whatever was going on."

"That the counselor listened to everything we had to say."

"I had a safe space to talk to someone and it helped me very much."

"How understanding and comfortable I felt while talking."

"I didn't feel forced to share my past traumas, I could be myself. I felt listened to and my counselor really, really is sweet. I was able to put my coping skills to use."

"I don't feel alone because hearing everyone also go through similar things that I go through is comforting."

"How I always felt listened to and what I said and thought was valid."

"It was all very personal and suited for what I needed."

"My counselor really understood me and let me be heard."

"My counselor, being able to talk about issues or feelings being able to view things differently."

"I like that I finally felt like someone was listening to me and actually cared for me and what I had to say. I liked feeling wanted and I got to have someone hear me out."

"That my counselor cared about me and listened while still helping me."

"I liked that I was able to express how I feel without being judged."

"I liked that I can talk about anything without judgment and that really helps me."

"It helped me feel comfortable with myself and helped me come out a little more."

"Liked that I could talk about whatever without being judged."

"That there are no wrong answers."

"I liked was I met wonderful people who matched the same vibe as me and it was very fun."

"I was able to talk abut my feelings and not feel judged."

"I like how comfortable we got and I made so many good friends here. It helped me get closure and help me understand myself better."

"I liked being able to talk about my feelings, finding a way to speak up for myself and voice my boundaries. Being able to notice my emotions also feeling them and finding solutions to the things they may have cause them. Understanding how my mind works and that some of the things I'm thinking are normal amongst people."

"I liked that I didn't feel judged when speaking about my personal life."

"I feel very safe and speak freely and not be judged."

"I liked how they taught me how to relax during stressful times."

"I liked everything I liked the people the counselor the activities and everything we learned."

"The closeness/felt with the group sessions and the new people I have met."

"It's a great way to be social and connect with people my age going through the same things."

"I liked how open people are and some understand what you are going through."

"Everyone was really nice and helpful."

"That the counselor listened to me and gave me advice on how to cope."

"The counselor made me feel validated and important. She listened to what I had to say and provided me with comfort whenever I was having a hard time."

"Everyone was very nice and listened to everything I had to say."

"I always felt like it was a safe space."

"The counselor cared for all group members equally."

"I liked that it's a small group and confidential."

"I liked how the counselor interacted with the group. It helped us open up more and felt like a welcoming environment."

3. What I didn't like about the program is...

"Nothing, it was super helpful actually!"
"Nothing, This program made me get out of my comfort zone but it felt comfortable."
"Absolutely nothing this class helped me so much and was so much fun."
"What some people had to say about conversation topics I disagree on."
"The schedule being once per week."
"Sometimes it felt we where going to slow."
"How it felt a bit uncomfortable for random student at the same school to hear my issues. I have nothing against them but it feels awkward when some of us have mutual friends."
"Not enough time."
"Sometimes I forget about my objective because I forget to write in my notebook."
"That time went by fast."
"Sometimes I wish the things I share are a little personal and the only reason I don't say to much is because I want someone to listen to me."
"Nothing, maybe it could be longer."
"It ended so soon."
"The check in."
"Missing some assignments in class time."
"I wish it was longer."
"It wasn't often."
"Missing class."
"It's only every other Thursday."
"How infrequent the meeting were."
"A lot of paperwork."
"Being in 2 groups makes it difficult to really open up or say anything."
"Our group is big so we had to split it up and I couldn't see my counselor every week. Also, I should be longer than 10 weeks because 2nd semester is always the worst."
"The county not letting us have the program longer. I will miss my counselor."
"Sometimes I got called out of important periods."
"The time limit."
"I wish we had more time."
"That it's ending."
"That there was not a lot of meetings."
"I still feel depressed (getting progressively worse). Though I thing its my own issue and not the fault of the program."
"Just how short it felt, finally finishing all my sessions with the person assigned to help me."
"I need longer sessions."
"A lot of sitting."
"I don't like that it's over and that it's not a permanent thing."
"That more people don't know about it. I have a couple friends I've referred the program too."
"That it took me out of class at some new environment."
"Sometimes I get nervous talking in front of other people."
"I can't really think of a negative thing about it. It helped me a lot."
"How it is very structural. Rather than just talking about ourselves we had to follow a bunch of guidelines."
"I didn't enjoy the amount of time limit."
"I didn't like that sometimes certain people didn't get their pass on time."

Riverside University HEALTH SYSTEM Behavioral Health

Peer-to-Peer

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

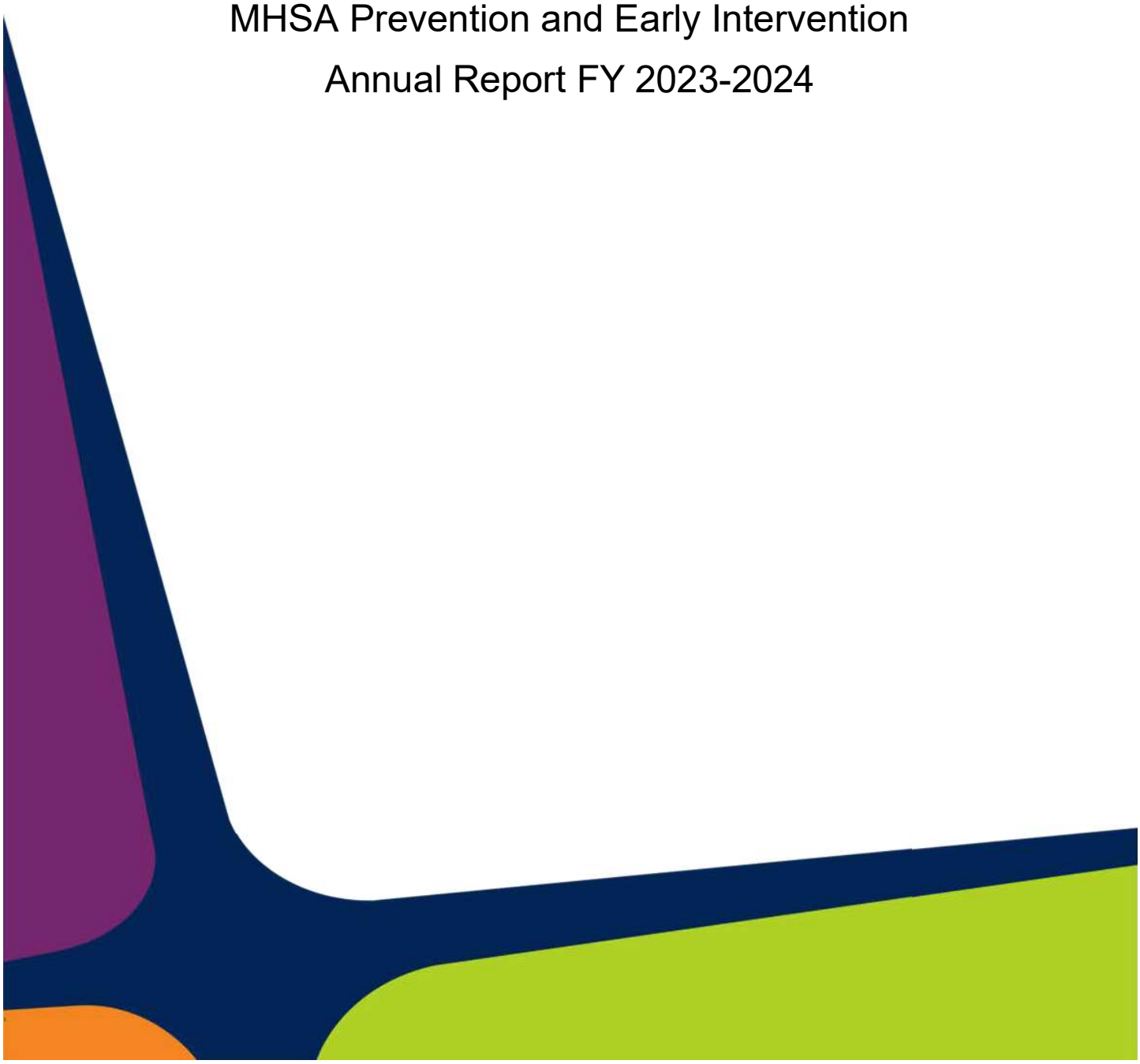


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Program Overview and Provider

Program Overview:

Riverside University Health System - Behavioral Health (RUHS-BH) is contracted with Operation SafeHouse to provide specific activities designed to reach transition age youth (TAY) - defined as youth between the ages of 16 and 25 years old. Specific target populations within TAY include homeless, foster or former foster, transitioning to college, and LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Questioning) individuals. The Peer-to-Peer program is designed to provide formal outreach, informal counseling, and support/informational groups to at-risk youth and families. Additionally, the program is designed to educate the public about mental health, depression, and suicide, while also working to reduce stigma towards mental illness among TAY individuals who are considered to be at high-risk. The program outreaches to Gay/Straight Alliances, social services agencies, and the community-at-large, in order to organize and facilitate small and large TAY group presentations and discussions to local community-based locations, school districts, and college campuses, with activities that include Directing Change outreach and workshops, Speaker's Bureau presentations, LGBTQ+ support groups, Peer Mentoring program, and Coping and Support Training (CAST).

- Directing Change workshops are aimed to emphasize the importance of understanding the signs and symptoms of mental health and suicide, and developing a story in a digital public service announcement (PSA) format to promote that understanding and participation in submitting PSAs to the state Directing Change program.
- Speaker's Bureau presentations are utilized to educate and outreach to at-risk TAY, caregivers, educators, and TAY service providers on the unique issues that at-risk TAY experience as it relates to mental health and interpersonal issues, with the aim of reducing stigmatizing attitudes.
- LGBTQ+ support groups are provided by trained peers based on the My Identity My Self (MIMS) curriculum.
- The Peer Mentoring program is utilized to encourage and monitor progress with individualized goal setting through one-on-one interactions with a peer mentor.
- Coping and Support Training (CAST) is an evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and Using School Smarts. Each CAST group consists of an initial screening session followed by nine (9) sessions facilitated by TAY Peer Youth Specialists.

Provider:

Operation SafeHouse has been providing emergency shelter, intervention, and outreach services to youth and families in crisis for over 20 years through its established locations in Riverside and the Coachella Valley. It has served as a haven for runaway and homeless youth, and more recently has expanded to include a counseling center. Operation SafeHouse works within the community, offering their resources with the goal of supporting positive shifts in the lives of at-risk youth and families in the area. Operation SafeHouse in the Riverside area will be noted as *Western*, whereas Operation SafeHouse in the Coachella Valley will be noted as *Desert*.

Executive Summary: Key Findings

There was a total of 86 Directing Change outreach presentations in the Desert, Mid-County, and Western regions. Additionally, there were 13 Directing Change workshops with five held in the Desert region, one in the Mid-County region, and seven in the Western region.

- A total of 229 participants attended a Directing Change workshop; 82 of whom were TAY in the Desert region, 5 we TAY in the Mid-County region, and 124 were TAY in the Western region, with the average age being 16.5 years old.
- Countywide, the majority of workshop participants identified as a girl/woman (52%), Hispanic/ Latinx (78%), and that their preferred language is English (80%).
- Satisfaction surveys were collected from 226 participants. Participants felt the workshops were a good use of their time and that they would recommend this workshop to a friend. Below are some youth comments:
  - ⇒ "I liked everything about this workshop. I personally struggle with mental health and hearing it be normalized is really important."
  - ⇒ "Thank you for coming! This made me realize so much."

There was a total of 25 Speaker's Bureau presentations in the Desert, Mid-County, and Western regions of Riverside County.

- A total of 420 individuals attended a Speakers Bureau event; 80.2% of whom were TAY, with the average age being 16.9 years old.
- The most frequently reported race/ethnicity for each region was Hispanic/Latinx.
- The highest reported zip codes for Desert, Mid-County, and Western regions were for the cities of Indio 92201 (n=2), Hemet 92544 (n=5), Riverside 92506 (n=4) and Corona 92882 (n=4), respectively.
- Pre- and post-tests were collected from 392 individuals. Pre- and post-tests included a compilation of four different questionnaires to measure stigmatizing (AQ-9), recovery (RS-3), empowerment (ES-3), and care-seeking attitudes (CS-6). Sample sizes for each questionnaire varied due to incomplete items between the pre- and post-tests. Meaningful improvements were found for stigmatizing, recovery, and empowerment attitudes. In other words, stigmatizing attitudes significantly decreased from pre- to post-tests whereas recovery and empowerment attitudes increased from pre- to post-tests thus suggesting participants' attitudes towards people with mental illnesses improved from the presentation. Care-seeking attitudes slightly increased but were not statistically significant.

There were 10 LGBTQ+ support groups utilizing the "My Identity My Self" curriculum to support TAY youth.

- There were a total of 78 attendees of which 71 were TAY. The majority were in the 16 to 17 age group (72%).
- Transgender, nonbinary, and gender fluid youth accounted for 38% of those attending (11.5% transgender, 12.8% nonbinary, and 14.1% gender fluid).
- Over half of the youth attending were Hispanic/Latinx (64.1%).
- Satisfaction surveys were collected for these support groups (n=42). Approximately 93% of participants reported that they would participate in this program again; and 95% of participants reported that participating in the support group has been an affirming experience for them.

Executive Summary: Key Findings (cont.)

There were 51 youth screened, 45 youth enrolled in, and 26 who completed the Peer Mentoring program.

- Session attendance varied: 58% attended all 12 sessions, 2% attended between 9 to 11 sessions, 18% attended between 5 and 8 sessions, 13% attended between 2 and 4 sessions, and 9% attended one session.
- The majority of mentees identified as a girl/woman (64%, n=29), were Hispanic/Latino (60%, n=27), and the preferred language for almost all of the mentees was English (91%, n=41). Additionally, 15 mentees (33%) identified as LGB+. Lastly, most were TAY (96%, n=43) where the average age was 17 years old.
- Improvements were found in mentees ratings of goal achievement with 81% reporting improvements in relationships/support, 88% in school/work activities, and 77% in coping/ mood.
- The pre-and post-surveys are used to document the mentees' experiences and feelings for goal settings and accomplishment behaviors. There are a total of 18 questions, related to: Social Support (how they feel about the presence of social supports in their lives), Self (how they feel about themselves in different scenarios), Goal Setting (how they view and act upon their own life goals), and Coping (how they cope with different life situations presented to them). Overall, increases in average scores can be seen across all four domains, with the highest increases in the area of Self (23%) followed by Coping (21%), Social Support (16%), and Goal Setting (14%). All four areas showed a statistically significant increase after completing the program.
- 100% of mentees reported that the mentoring program has helped them define their current goals. 92% of mentees have come to understand the importance of self-praise throughout the goal-setting process, that the program has helped them learn new ways to cope, and that as a result of participating in this program, they now know how to make realistic and reachable goals in the future. 85% of mentees reported that the program has allowed them to build stronger relationships with those whom they depend on. 100% of mentees were satisfied with the Peer Mentoring program.

There were 11 CAST groups where 95 youth were screened with a total of 87 enrolled participants; 83 of whom attended at least one session. Of those 83 participants, 62 completed CAST, representing a 75% completion rate.

- Countywide, the majority of participants were Hispanic/Latinx (71%, n=59), female (58%, n=48), and the average age of entry into CAST was 17 years old.
- Monitoring Group Goals consist of survey items regarding participants' management of their feelings of depression and anger, school smarts, and drug use. Countywide, participants' average post-test scores significantly increased from their pre-test scores for mood, school behaviors, and drug use suggesting meaningful improvement from the start of participation in the program to the end.
- For How Are We Doing in Group surveys, the largest increase was in participants' sense of "belonging" from the pre (Session 2) to post (Session 9) with a mean difference score of 0.63.
- There were statistically significant increases in the Recognition of Progress items from pre to post for the self esteem item specifically "being positive with myself, recognizing my strengths", for the personal control item on depression specifically "getting 'unstuck' from negative moods", and for the personal control item on anger specifically "controlling my thoughts, feelings, and actions."

Event Statistics

Type of Events by Region

Each event was categorized into one of the following five activities: Directing Change outreach or workshop, Speaker's Bureau presentation, LGBTQ+ support group, Peer Mentoring, and Coping and Support Training (CAST). A total of 536 various Peer-to-Peer events and activities were held throughout the County during FY 2023-2024.

Activity:	Desert (n=166)	Mid-County (n=274)	Western (n=96)	Countywide (n=536)
Directing Change Outreach Events	43	20	23	86
Directing Change Workshops	5	1	7	13
Speaker's Bureau Presentations	4	7	14	25
LGBTQ+ Support Groups	5	2	3	10
Peer Mentoring Sessions	108	240	43	391
CAST Groups	1	4	6	11

Participants by Region

Countywide, a total of 3,637 individuals participated in Peer-to-Peer activities. Of the total participants:

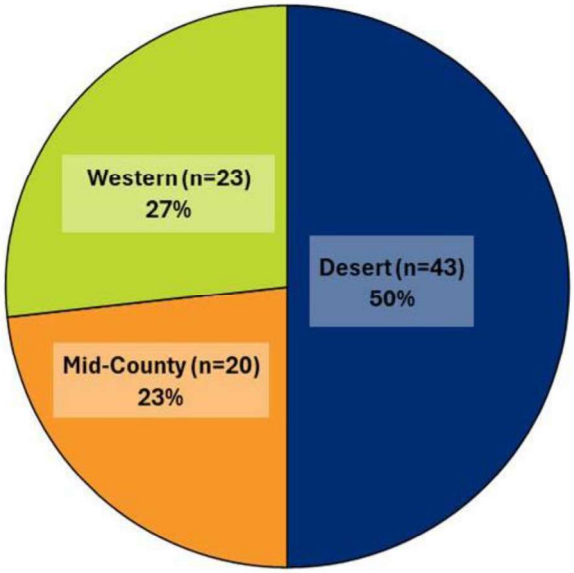
- 1,706 (46.9%) were in the Desert region
- 747 (20.5%) were in the Mid-County region
- 1,184 (32.6%) were in the Western region

Participants by Activity	Desert (n=1,706)	Mid-County (n=747)	Western (n=1,184)	Countywide (n=3,637)
Directing Change Outreach Participants	1,483	566	733	2,782
Directing Change Workshop Participants	100	5	124	229
Speaker's Bureau Participants	58	117	245	420
LGBTQ+ Support Group Participants	39	12	27	78
Peer Mentoring - Mentees	17	24	4	45
CAST Group Participants	9	23	51	83

Directing Change Outreach Event Statistics

During FY 2023-2024, a total of 86 Directing Change Outreach (DCO) events were held throughout Riverside County reaching 2,782 participants. The majority of Directing Change Outreach events occurred in the Desert region (50%, n=43) followed by the Western (27%, n=23) and Mid-County (23%, n=20) regions.

Directing Change Outreach Events by Region (n=86)



Region	Participants	Percentage
Desert (n=43)	1,483	53.3%
Mid-County (n=20)	566	20.3%
Western (n=23)	733	26.3%
Countywide (n=86)	**2,782**	

Directing Change Outreach Event Locations: Cities and Zip Codes

Of the 86 Directing Change Outreach events countywide, 43 were in the Desert region within 11 zip codes, 20 were in the Mid-County region within nine zip codes, and 23 were in the Western region within eight zip codes. The zip codes and cities for each event by region are listed below.

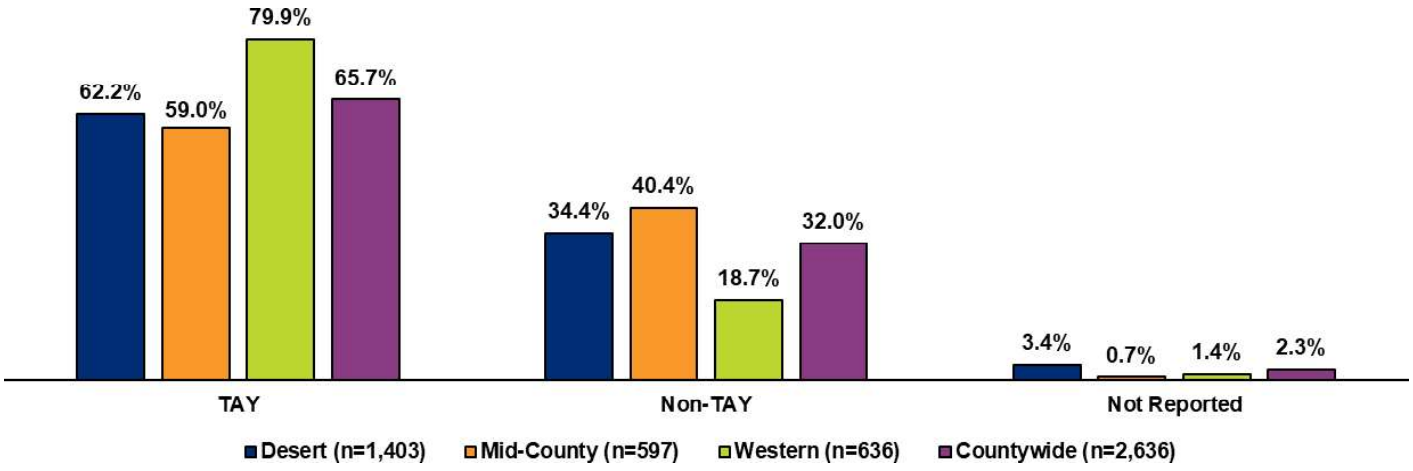
Desert (n=43)		Mid-County (n=20)		Western (n=23)	
92201 Indio	23 (26.7%)	92530 Lake Elsinore	1 (1.2%)	92501 Riverside	3 (3.5%)
92211 Indio	1 (1.2%)	92532 Lake Elsinore	1 (1.2%)	92503 Riverside	1 (1.2%)
92220 Banning	7 (8.1%)	92543 Hemet	3 (3.5%)	92504 Riverside	1 (1.2%)
92225 Blythe	1 (1.2%)	92544 Hemet	3 (3.5%)	92506 Riverside	11 (12.8%)
92234 Cathedral City	1 (1.2%)	92545 Hemet	4 (4.7%)	92507 Riverside	2 (2.3%)
92253 La Quinta	2 (2.3%)	92562 Murrieta	4 (4.7%)	92551 Moreno Valley	3 (3.5%)
92254 Mecca	1 (1.2%)	92570 Perris	1 (1.2%)	92553 Moreno Valley	1 (1.2%)
92260 Palm Desert	2 (2.3%)	92583 San Jacinto	2 (2.3%)	92860 Norco	1 (1.2%)
92270 Rancho Mirage	1 (1.2%)	92585 Menifee	1 (1.2%)		
92274 Thermal	1 (1.2%)				
92276 Thousand Palms	3 (3.5%)				

Directing Change Outreach: Demographics

Attendance

Countywide, 2,636 unduplicated individuals signed-in to a Directing Change outreach (DCO) event attendance sheet. There were 1,403 individuals (53.2%) from the Desert region, 597 individuals (22.6%) from the Mid-County region, and 636 individuals (24.1%) from the Western region who were reached through a DCO event. Countywide, 65.7% (n=1,732) of participants reported as TAY and 32% (n=843) were Non-TAY with 2.3% (n=61) unknown.

TAY and Non-TAY Attendance



Countywide, 2,575 participants reported their age. Participants were between the ages of 11 and 65, with the average age being 16.5 years old. From the TAY Age Breakdown table below, most TAY participants reported being in the 16 and 17 age groups (81.5%).

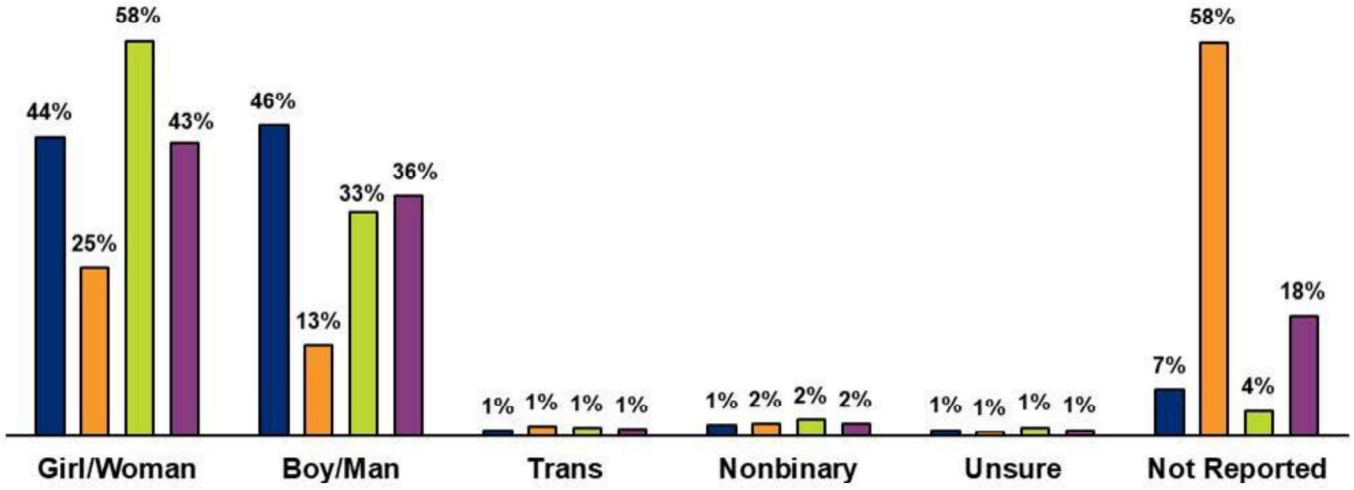
Age	Desert (n=1,403)	Mid-County (n=597)	Western (n=636)	Countywide (n=2,636)
11-15	473 (33.7%)	239 (40.0%)	99 (15.6%)	811 (30.8%)
16-25 (TAY)	**872 (62.2%)**	**352 (59.0%)**	**508 (79.9%)**	**1732 (65.7%)**
26 and Older	10 (0.7%)	2 (0.3%)	20 (3.1%)	32 (1.2%)
Not Reported	48 (3.4%)	4 (0.7%)	9 (1.4%)	61 (2.3%)

TAY Age Breakdown	Desert (n=872)	Mid-County (n=352)	Western (n=508)	Countywide (n=1,732)
16	444 (50.9%)	179 (50.9%)	128 (25.2%)	751 (43.4%)
17	345 (39.6%)	128 (36.4%)	187 (36.8%)	660 (38.1%)
18-21	78 (8.9%)	45 (12.8%)	169 (33.3%)	292 (16.9%)
22-25	5 (0.6%)	0 (0%)	24 (4.7%)	29 (1.7%)

Directing Change Outreach: Demographics cont.

Gender

Countywide, 43% (n=1,141) of the participants identified as a girl/woman, and 36% (n=936) identified as a boy/man. The remaining participants reported identifying as transgender (0.9%, n=25), nonbinary (1.7%, n=46), or were unsure (0.8%, n=22). Additionally, 18% (n=466) had no response.



Sexual Orientation

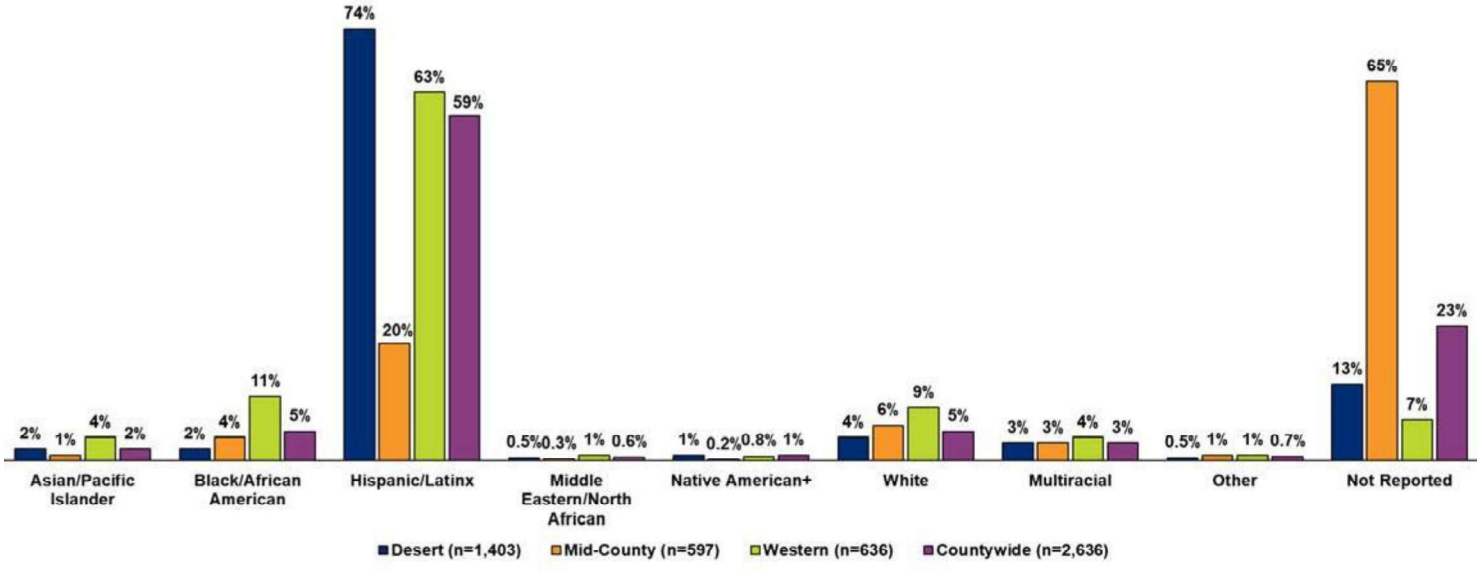
Countywide, among the total of 2,636 individuals, 11% of participants identified as lesbian, gay, or bisexual (Desert: n=132; Mid-County n=56; Western: n=110).

Sexual Orientation	Desert (n=1,403)	Mid-County (n=597)	Western (n=636)	Countywide (n=2,636)
Straight	855 (60.9%)	120 (20.1%)	399 (62.7%)	1374 (52.1%)
Lesbian	22 (1.6%)	12 (2.0%)	13 (2.0%)	47 (1.8%)
Gay	33 (2.4%)	4 (0.7%)	9 (1.4%)	46 (1.7%)
Bisexual	77 (5.5%)	40 (6.7%)	88 (13.8%)	205 (7.8%)
Unsure	41 (2.9%)	15 (2.5%)	32 (5.0%)	88 (3.3%)
Not Reported	375 (26.7%)	406 (68.0%)	95 (14.9%)	876 (33.2%)

Directing Change Outreach: Demographics cont.

Race and Ethnicity

Countywide, 58.8% (n=1,551) of participants identified as Hispanic/Latinx, 5.2% (n=138) as White, 4.6% (n=122) as Black/African American, 3.4% (n=90) as Multi-racial, 2.4% (n=63) as Asian/Pacific Islander, 0.9% (n=24) as Native American (and one other race), 0.6% (n=17) as Middle Eastern/ North African, 0.7% (n=19) as Other, and 23.2% (n=612) was not reported.



Language

Countywide, English (60%) was the most frequently reported primary language.

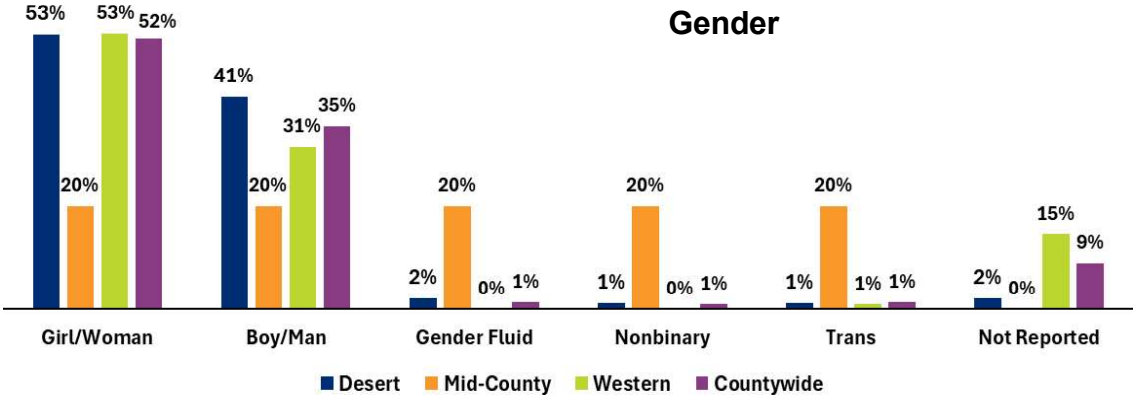
Language	Desert (n=1,403)	Mid-County (n=597)	Western (n=636)	Countywide (n=2,636)
English	884 (63.0%)	200 (33.5%)	484 (76.1%)	1568 (59.5%)
Spanish	60 (4.3%)	4 (0.7%)	26 (4.1%)	90 (3.4%)
English and Spanish	256 (18.2%)	7 (1.2%)	75 (11.8%)	338 (12.8%)
Other or Multiple	11 (0.8%)	0 (0%)	9 (1.4%)	20 (0.8%)
Not reported	192 (13.7%)	386 (64.7%)	42 (6.6%)	620 (23.5%)

Directing Change Workshop Demographics

The Directing Change workshops are intended to encourage and equip TAY with the technical skills to prepare a personalized or informative public service announcement (PSA) for submission in the annual Directing Change Student Film Contest. The workshops aim to emphasize the importance of understanding the signs and symptoms of mental health and suicide, and to assist in the development of a digital PSA to promote that understanding. The workshops focus on providing TAY with technical assistance in producing a digital film as a means of increasing mental health and suicide awareness.

During FY 2023-2024, a total of 13 Directing Change workshops were held countywide where five (5) were held in the Desert region, seven (7) in the Western region, and one (1) in the Mid-County region. The Desert region had 100 participants in attendance of whom 82 were TAY, the Western region had 124 participants, of whom 72 were TAY, and Mid County had five (5) participants all of which were TAY.

Gender

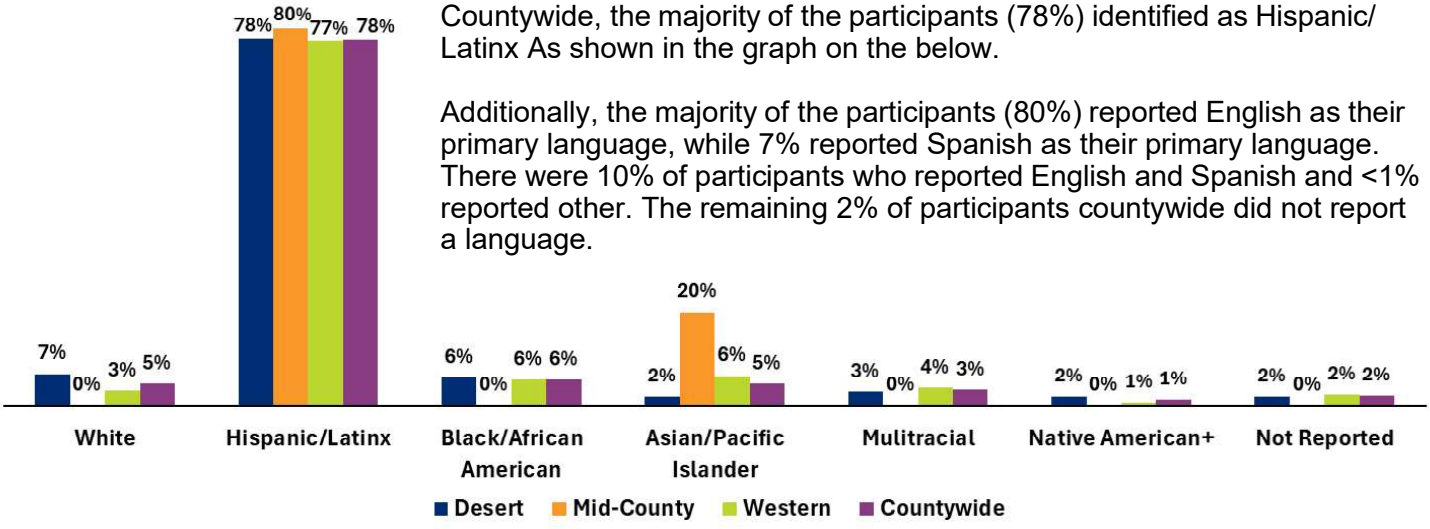


A majority of participants identified as a girl/woman (52%, n=120). Not shown on the graph, 13% of participants reported they were LGB.

Age and Race/Ethnicity

Age	Desert	Mid-County	Western	Countywide
13-15	17 (17.0%)	0 (0.0%)	48 (38.7%)	65 (28.4%)
16	24 (24.0%)	1 (20.0%)	20 (16.1%)	45 (19.7%)
17	40 (40.0%)	3 (60.0%)	38 (30.6%)	81 (35.4%)
18-25	18 (18.0%)	1 (20.0%)	14 (11.3%)	33 (14.4%)
26+	0 (0.0%)	0 (0.0%)	1 (0.8%)	1 (0.4%)
Not Reported	1 (1.0%)	0 (0.0%)	3 (2.4%)	4 (1.7%)

As shown to the left, approximately 69.4%% of the participants were within the TAY age range, with the average age being 16.5 years old.



Countywide, the majority of the participants (78%) identified as Hispanic/ Latinx As shown in the graph on the below.

Additionally, the majority of the participants (80%) reported English as their primary language, while 7% reported Spanish as their primary language. There were 10% of participants who reported English and Spanish and <1% reported other. The remaining 2% of participants countywide did not report a language.

Directing Change Workshops: Satisfaction Survey

Satisfaction surveys were collected at the end of Directing Change Workshops. Participants were asked to rate their experiences with the workshop using a 5-point Likert Scale, where **1=*Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree*,** and ***5=Strongly Agree***. The satisfaction surveys consist of 7 questions, which include 4 rating questions and 3 open-ended questions to gather participants' feedbacks regarding the Directing Change Workshop. Overall, there were a total of 226 participants completed the satisfaction survey, and the results are summarized below:

- 71% of participants felt that the workshop was a good use of their time.
- 55% of participants felt connected and involved in the workshop.
- 50% of participants would participate in the workshop again.
- 70% of participants would recommend this workshop to a friend

It is also noted that about 33% and 32% of participants chose to rate "Neutral" for question #2 (*I felt connected and involved in the workshop*) and question #3 (*I would participate in this workshop again*), respectively.

Countywide (n=226)	Avg.	(1) Strongly Disagree	(2) Disagree	(3) Neutral	(4) Agree	(5) Strongly Agree	No Response
1. The workshop was a good use of my time.	**4.03**	1.3%	4.0%	23.0%	34.1%	37.6%	0.0%
2. I felt connected and involved in the workshop.	**3.63**	4.4%	7.5%	32.7%	31.4%	23.9%	0.0%
3. I would participate in this workshop again.	**3.60**	4.4%	12.4%	32.3%	19.9%	30.5%	0.4%
4. I would recommend this workshop to a friend.	**3.98**	2.2%	7.1%	20.8%	30.1%	39.8%	0.0%

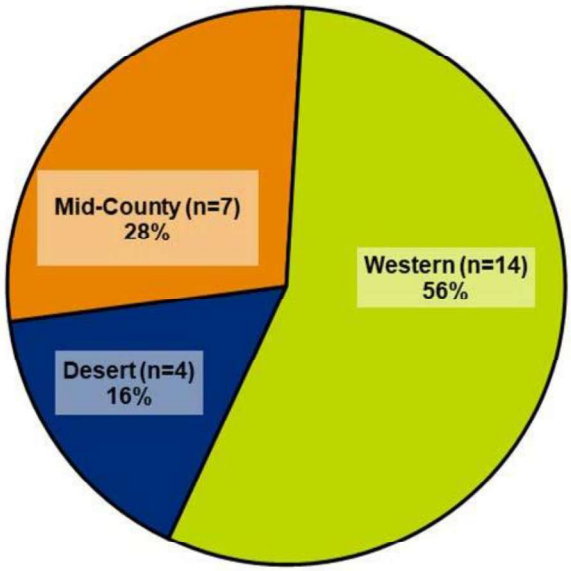
Some of the participants' responses on the additional feedback questions are listed below:

5. What did you like about your workshop experience?
   - "I enjoyed learning about the many different ways to cope with our mental health"
   - "I liked that there was good examples and to show how to handle suicide even if it's not for you and for a friend."
   - "Something I liked about the workshop is how positive everyone is and bringing good energy to a negative topic."
   - "I liked everything about this workshop. I personally struggle with mental health and hearing it be normalized is really important."
   - "I liked how engaged everyone was and the fact the presenters had experiences that related to us."
6. What could have made your workshop experience better?
   - "I personally have been in desperate need before, and there workshops tend to isolate people - maybe the kids could have interacted w/ each other & the staff to establish trust"
   - "If we had some type of icebreaker to feel less awkward"
   - "Something that could have made the workshop experience better would have been on class engaging in it a bit more"
   - "People asking questions and sharing their own experiences would have made it better since it would have made me feel connected."
   - "It could have been better if it was more interactive."
7. Any additional comments?
   - "I really liked all the speakers and how they all shared their personal experiences"
   - "You guys did amazing. Thank you. I appreciate you"
   - "Thank you for coming! This made me realize so much."

Speaker's Bureau Event Statistics

Each year, Peer-to-Peer contractors are expected to hold 35 Speaker's Bureau presentations reaching 525 participants, per region for a total of 105 presentations and 1,575 unduplicated TAY. During FY 2023-2024, a total of 25 events, reaching 420 unduplicated individuals, were held throughout the County. No region reached contract expectations.

Speaker's Bureau Events by Region (n=25)



Region	Participants	Percentage
Desert (n=4)	58	13.8%
Mid-County (n=7)	117	27.9%
Western (n=14)	245	58.3%
Countywide (n=25)	**420**	

City/Zip Code Locations

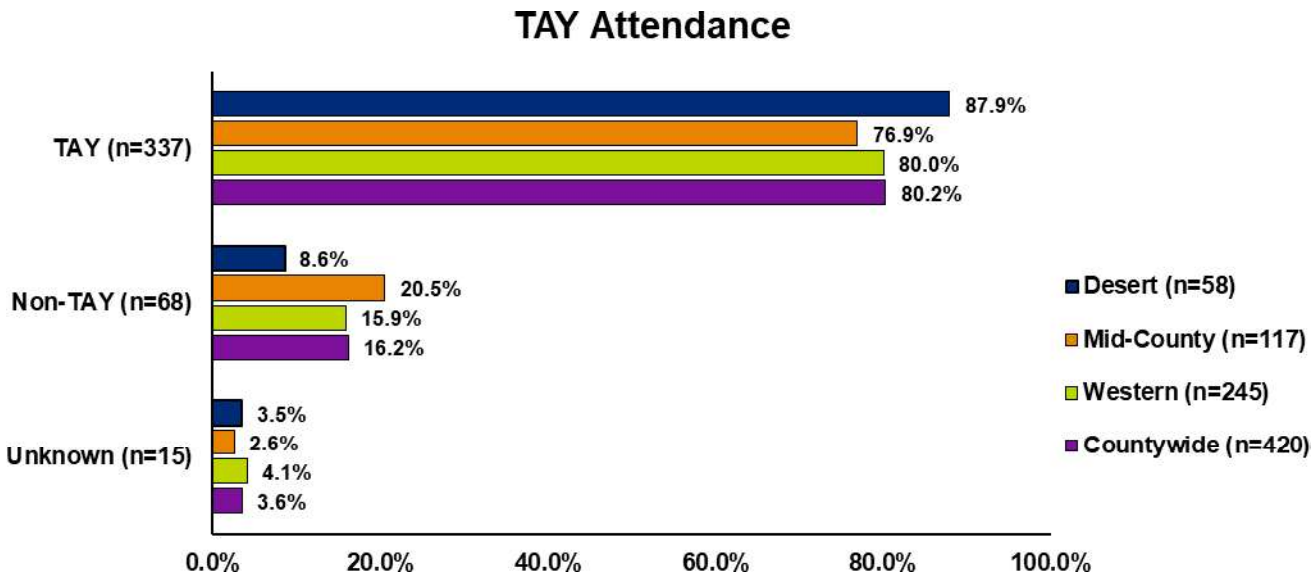
Of the 25 Speaker's Bureau presentations countywide, 4 were in the Desert region within three zip codes; 7 were in the Mid-County region within two zip codes, and 14 were in the Western region within seven zip codes. The zip codes and cities for each region are listed below.

Region	Zip Code and City	Countywide (n=25)
Desert (n=4)	92201 Indio	**2 (8%)**
	92260 Palm Desert	**1 (4%)**
	92276 Thousand Palms	**1 (4%)**
Mid-County (n=7)	92532 Lake Elsinore	**2 (8%)**
	92544 Hemet	**5 (20%)**
Western (n=14)	92501 Riverside	**2 (8%)**
	92503 Riverside	**1 (4%)**
	92506 Riverside	**4 (16%)**
	92507 Riverside	**1 (4%)**
	92509 Riverside	**1 (4%)**
	92551 Moreno Valley	**1 (4%)**
	92882 Corona	**4 (16%)**

Speaker's Bureau: Demographics

Attendance

Countywide, there were a total of 420 unduplicated individuals that attended a Speaker's Bureau event where 58 (13.8%) were in the Desert region, 117 (27.9%) were in the Mid-County region, and 245 (58.3%) were in the Western region. Countywide, the majority (80.2%, n=337) of the participants were TAY. TAY attendance was higher than non-TAY attendance in all regions. These participants' attendance and information were



Countywide, 405 participants who attended Speaker's Bureau events reported their age which ranged from 10 to 60+ years old, with the average age being 17 years old. Among the TAY individuals, most participants reported their age as 16-17 within the Desert (70.6%, n=36), Mid-County (62.2%, n=56), and Western (78.1%, n=153) regions. The second largest group of TAY individuals was 18-19 within the Desert (25.5%, n=13), Mid-County (37.8%, n=34), and Western (19.9%, n=39) regions. Less than 2% of the Countywide TAY population fell between 20 to 25 years of age.

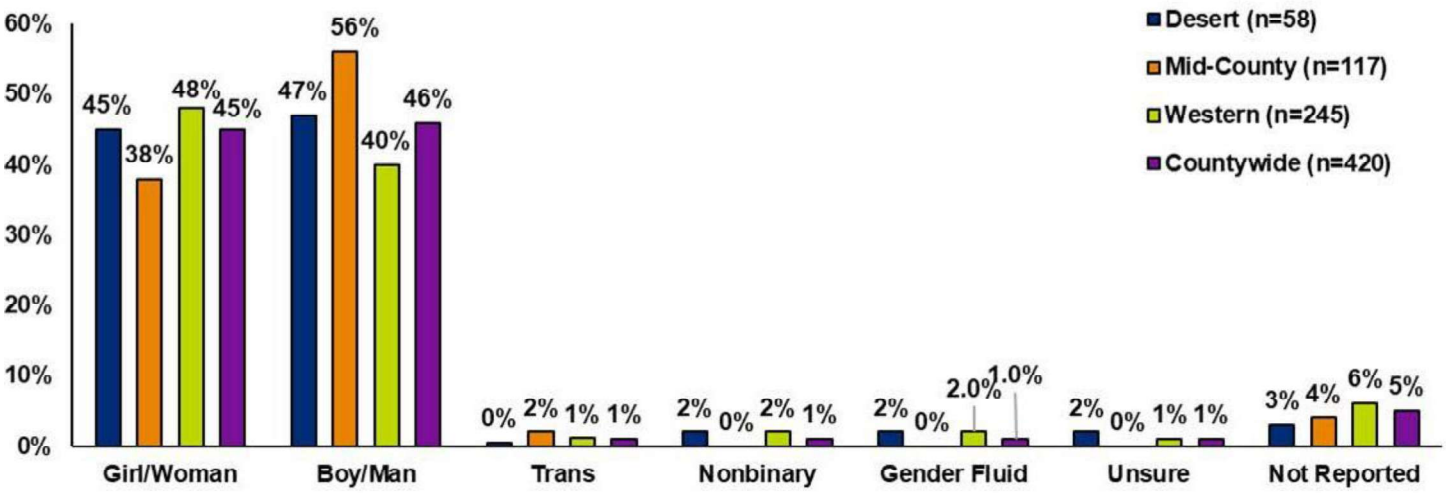
Age	Desert (n=56)	Mid-County (n=114)	Western (n=235)	Countywide (n=405)
12-15	5 (8.9%)	24 (21.1%)	37 (15.7%)	66 (16.3%)
TAY 16-25	**51 (91.1%)**	**90 (78.9%)**	**196 (83.4%)**	**337 (83.2%)**
26 and Older	0 (0%)	0 (0%)	2 (0.9%)	2 (0.5%)

TAY Age Breakdown	Desert (n=51)	Mid-County (n=90)	Western (n=196)	Countywide (n=337)
16-17	36 (70.6%)	56 (62.2%)	153 (78.1%)	245 (72.7%)
18-19	13 (25.5%)	34 (37.8%)	39 (19.9%)	86 (25.5%)
20-21	1 (2.0%)	0 (0%)	3 (1.5%)	4 (1.2%)
22-25	1 (2.0%)	0 (0%)	1 (0.5%)	2 (0.6%)

Speaker's Bureau: Demographics cont.

Countywide, 45% (n=188) of participants identified as a girl/woman, and 46% (n=192) identified as boy/man. The remaining participants identified as transgender (1.0%, n=4), as nonbinary (1.2%, n=5), as gender fluid (1.4%, n=6), were unsure (0.7%, n=3), or did not respond (5%, n=22).

Gender



Sexual Orientation	Desert (n=58)	Mid-County (n=117)	Western (n=245)	Countywide (n=420)
Straight	42 (72.4%)	96 (82.1%)	154 (62.9%)	292 (69.5%)
Lesbian	2 (3.4%)	1 (0.9%)	8 (3.3%)	11 (2.6%)
Gay	0 (0.0%)	0 (0.0%)	8 (3.3%)	8 (1.9%)
Bisexual	3 (5.2%)	6 (5.1%)	20 (8.2%)	29 (6.9%)
Pansexual	1 (1.7%)	1 (0.9%)	5 (2.0%)	7 (1.7%)
Other	1 (1.7%)	0 (0.0%)	2 (0.8%)	3 (0.7%)
Unsure	1 (1.7%)	1 (0.9%)	7 (2.9%)	9 (2.1%)
Declined	4 (6.9%)	4 (3.4%)	19 (7.8%)	27 (6.4%)
Not Reported	4 (6.9%)	8 (6.8%)	22 (9.0%)	34 (8.1%)

Countywide, 29 participants reported having a disabling condition and one participant reported being a veteran.

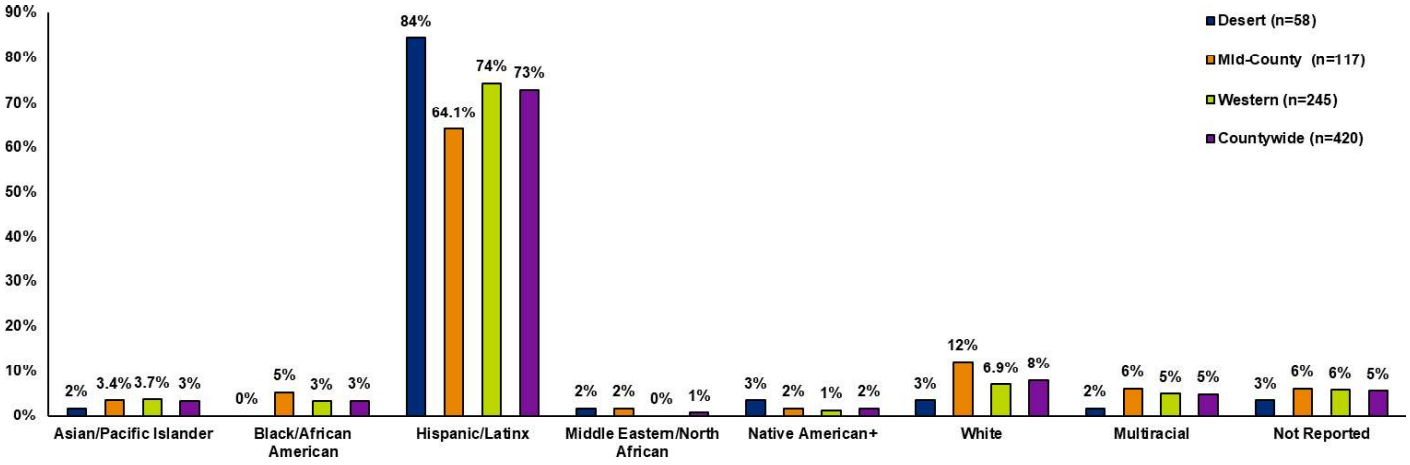
	Desert (n=58)	Mid-County (n=117)	Western (n=245)	Countywide (n=420)
Disabled	3 (5.2%)	4 (3.4%)	22 (9.0%)	29 (6.9%)
Veteran	0 (0.0%)	0 (0.0%)	1 (0.4%)	1 (0.2%)

Speaker's Bureau: Demographics

Race/Ethnicity

Countywide, 72.9% (n=306) of participants identified as Hispanic/Latinx, 7.9% (n=33) White, 4.8% (n=20) Multiracial/ethnic, 3.3% (n=14) Asian/Pacific Islander, 3.3% (n=14) Black/African American, 1.7% (n=7) Native American (and one other race), 0.7% (n=3) Middle Eastern/North African, and 5.5% (n=23) was not reported.

Countywide, there were 225 (53.6%) participants who reported their specific ethnicity as Mexican, followed by 15 (3.6%) Central American, 6 (1.4%) Guatemalan, 2 (0.5%) Salvadoran, 1 (0.2%) Cuban, 1 (0.2%) Puerto Rican, 5 (1.2%) Filipino, 2 (0.5%) Vietnamese, 1 (0.2%) Cambodian, 2 (0.5%) South Asian, 2 (0.5%) Irish, 1 (0.2%) Arab, and 9 (2.1%) Multi-ethnic. Lastly, 35.2% (n=148) of participants did not report a specific ethnicity.



Language

Countywide, as well as in all regions, English (79.5%) was the most frequently reported primary language, with Spanish at 6.2%, English and Spanish at 8.3%, multiple languages 1.0%, and <1% of other languages. A total of 4.8% of the participants countywide did not report a primary language.

Language	Desert (n=58)	Mid-County (n=117)	Western (n=245)	Countywide (n=420)
English	41 (70.7%)	98 (83.8%)	195 (79.6%)	334 (79.5%)
Spanish	6 (10.3%)	5 (4.3%)	15 (6.1%)	26 (6.2%)
English and Spanish	8 (13.8%)	9 (7.7%)	18 (7.3%)	35 (8.3%)
Multiple Languages	1 (1.7%)	0 (0.0%)	3 (1.2%)	4 (1.0%)
Other	0 (0.0%)	0 (0.0%)	1 (0.4%)	1 (0.2%)
Not Reported	2 (3.4%)	5 (4.3%)	13 (5.3%)	20 (4.8%)

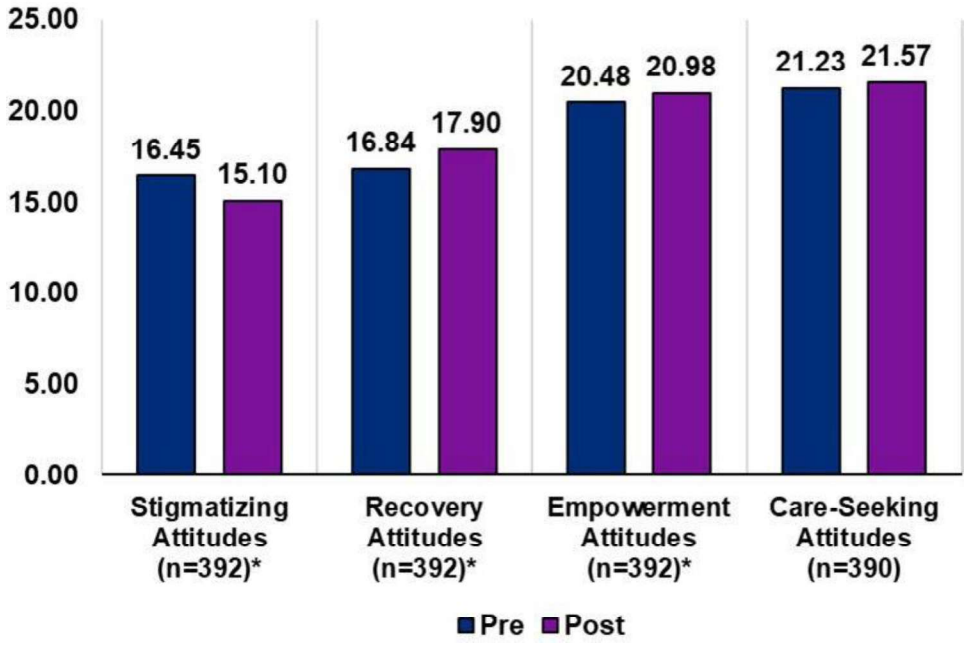
Speaker's Bureau Pre/Post Test Questionnaire

A total of 392 individuals who attended a Speaker's Bureau presentation completed pre- and post-test outcomes measures. Pre and post-tests were administered immediately before and after each presentation in order to assess their impact on the attendees. The questionnaire consists of four measures of stigma: Stigmatizing Attitudes (AQ-5), Recovery Attitudes (RS-3), Empowerment Attitudes (ES-3), and Care-Seeking Attitudes (CS-4).

Measures of Stigma	Questionnaire	9-Point Rating Scale
Stigmatizing Attitudes (AQ-5)	Five-item Attribution Questionnaire (AQ-5) assessing participants' cognitive, affective, and behavioral reactions to a person with schizophrenia. *Example:* "I think that most people with mental illness are to blame for their problems"	Score range: 5-45 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Recovery Attitudes (RS-3)	Three-item Recovery Scale (RS-3) assessing participants' attitudes toward people with mental health conditions' capabilities to overcome psychological challenges. *Example: "People with mental illness are hopeful about their future."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Empowerment Attitudes (ES-3)	Three-item Empowerment Scale (ES-3) assessing participants' attitudes about people with mental illness relative to people without. *Example: "I see people with mental illness as capable people."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Care-Seeking Attitudes (CS-4)	Four-item Care Seeking Questionnaire (CS-4) assessing participants' willingness to seek out mental health services if they were experiencing impairing anxiety and/or depression. *Example: "If I were significantly anxious or depressed, I would speak to a mental health professional."*	Score range: 4-36 1 = 'Strongly Disagree' 9 = 'Strongly Agree'

An average score for all questions within each of the four questionnaires were computed for pre/post-test comparisons. Higher average scores for the AQ-5 represent greater stigmatizing attitudes, whereas higher average scores on the RS-3, ES-3, and CS-4 represent positive attitudes toward the described constructs. The graph below depicts the means and paired t-test results for participants who completed pre- and post-test measures. However, not all individuals completed all of the items within the pre-test and/or post-test, thus accounting for less total outcomes within each of the four measures of stigma questionnaire sections. Meaningful improvements were found for Stigmatizing, Recovery, and Empowerment Attitudes. In other words, Stigmatizing Attitudes significantly decreased from pre to post whereas Recovery and Empowerment Attitudes increased from pre to post thus suggesting participants' attitudes improved from the presentation. Care-Seeking Attitudes slightly increased but were not statistically significant.

Speaker's Bureau Average Pre vs Post Results



Speaker's Bureau Presentations: Comments

Additional Comments…

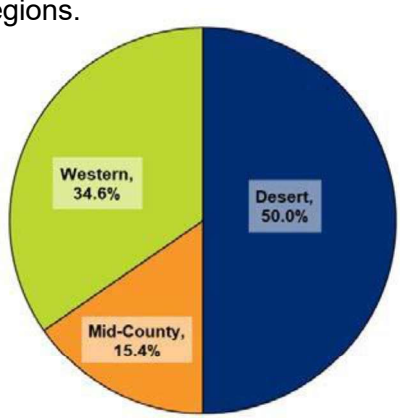
- "A lot of these questions are to vague or general, not one answer fits all mental illnesses."
- "Good presentation"
- "Great job on the performance, even if you feel rusty it sounded amazing. Keep it up."
- "I believe that a person with mental problems cannot take care of themselves because they need someone's help to be able to do the necessary things by themselves."
- "I feel like people with mental illness can do just as much as we do I had a homie with one leg went down and came back up."
- "I hope everyone finds happiness and find their true selves."
- "I loved the presentation. (heart symbol)"
- "I personally like the lady and Her story, it is inspiring and gives me Hope in myself."
- "I really liked the first story that was shared. I also liked how open the second story was."
- "I really liked the presentations, they were informative (two heart symbols)"
- "I really loved the Presentation and how open they were that takes alot."
- "I think it was nice how she shared her story with the class to help us understand."
- "I think that many can't or wouldn't get professional help because of financial problems, sense of hurting their pride, family members not believing in professional help."
- "I think you guys should speak to younger teens more often. Kids can experience mental illness at any age and they may benefit from some of the advice you're giving. Thanks for sharing (smiley face and heart symbol)"
- "I'm really happy you guys talk about this! It's so important and I'm really glad and proud of you guys."
- "It was a nice and enlightening presentation, I hope everything works out in your future."
- "I've been dating a mentally ill person for 7 months. The experience recount I just heard reminded me slightly of my partner's past with her almost 20 ex's."
- "Loved the presentation!"
- "Lovely Presentation!"
- "My point of view on this has changed now that I've heard an impackedful story first hand and how people can grow and better themselves."
- "No just thank you for sharing the storys with us and everything."
- "People can get better if they seek help. Also to manage how to cope."
- "People with mental illness are very special people who need to be cared for in the best possible way, whether by family members, relatives or doctors." [Translated from Spanish]
- "People with mental problem cannot help themselves that is to say they do not know what they are doing whether it is correct or not and that is why they cannot have a determined future or help other people."
- "Personal recognition from me, I also resignated with your speech, me myself dealt with problems as said from this story, I had a bad past partner that made me have to do some deep healing to move on from what I was forced in."
- "Thank you for presenting to us!"
- "Thank you for sharing your story I admire being able to be vulnerable and public speaking."
- "Thank you guys for coming especially since you don't do freshmen but thank you a lot I've learned a ton and you all are amazing."
- "Thanks for sharing your personal story [facilitator]."
- "Thanks for todays presentation"
- "The beginning of the presentation made it hard to focus a bit. Because it was quiet & low energy."
- "The Cup of Happy team is doing an AMAZING job!"
- "The only thing I gotta say is that like since were heath academy we already learned this. But I feel like other Freshmen to should know about this. I know a lot of Freshmen who don't have resources."
- "The woman in the green romper is very strong!"
- "This helped"
- "We love you [facilitator] & [facilitator] thank you for sharing your stories"
- "You guys are so strong! (heart symbol)"

LGBTQ+ Support Groups

Attendance by Region

In FY2023-2024, there were a total of **10** LGBTQ+ support groups held within Riverside County. From these groups, a total of **78** youth attended, with a majority of attendees from the Desert region (50.0%, n=39), followed by the Western (34.6%, n=27) and Mid-County (15.4%, n=12) regions.

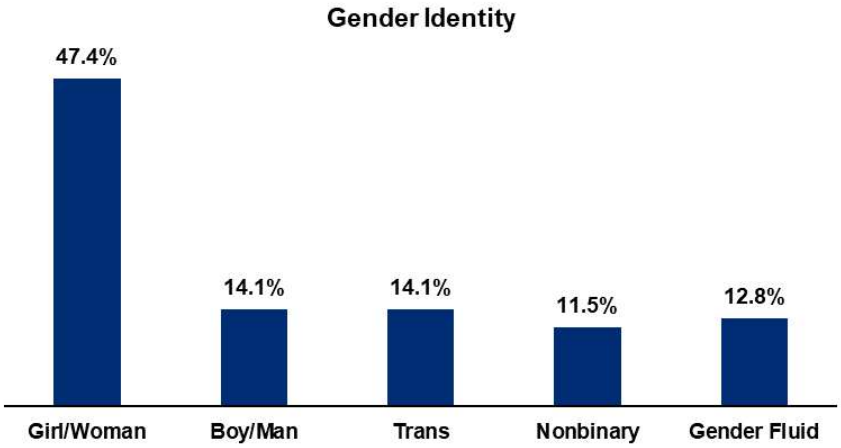
Region	Number of Groups	Number of Attendees
Desert	5	39
Mid-County	2	12
Western	3	27
Countywide	**10**	**78**

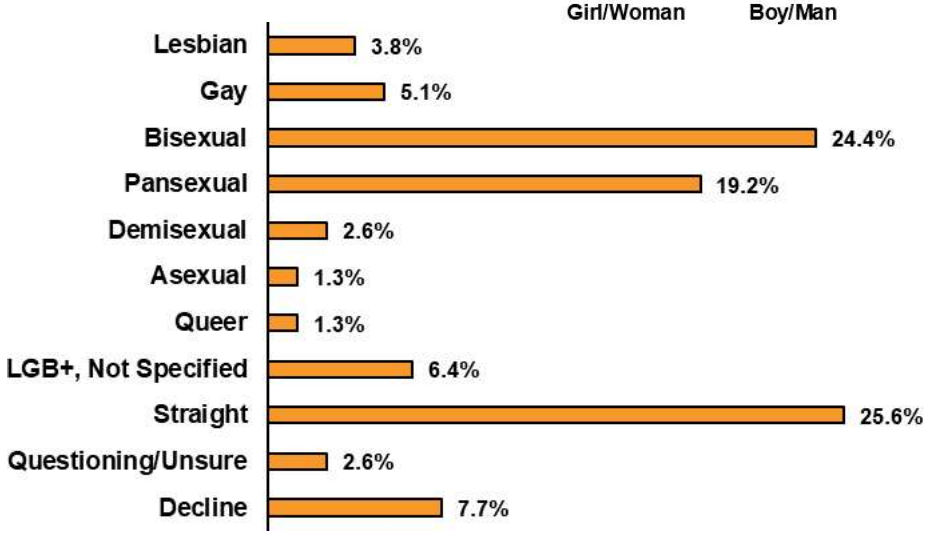


LGBTQ+ Support Groups: Demographics

Gender and Sexual Orientation

The 47.4% (n=37) of attendees identified as a girl/woman, 14.1% (n=11) as a boy/man, 14.1% (n=11) as transgender, 12.8% (n=10) as gender fluid, and 11.5% (n=9) as nonbinary.



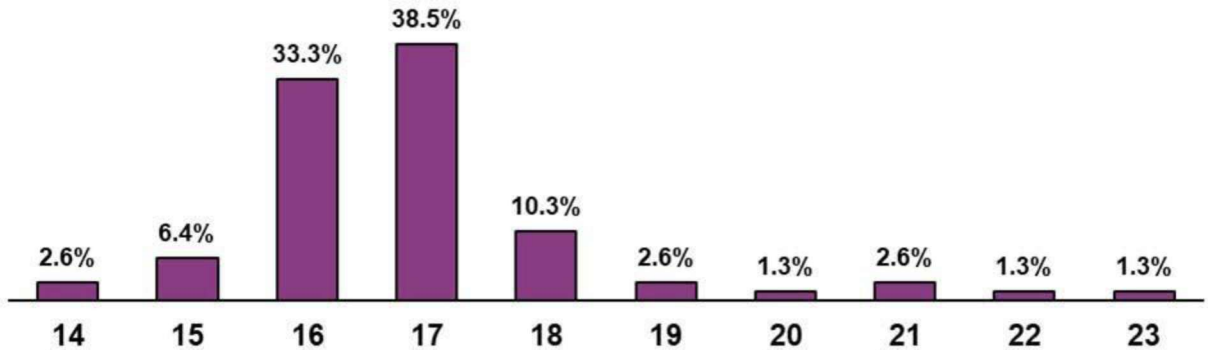


Countywide, most of the LGBTQ+ Support Groups' attendees identified as LGBTQ+ (64.1%, n=50), while 25.6% (n=20) participants identified as straight, 7.7% (n=6) declined to answer, and 2.6% (n=2) were unsure.

LGBTQ+ Support Groups: Demographics cont.

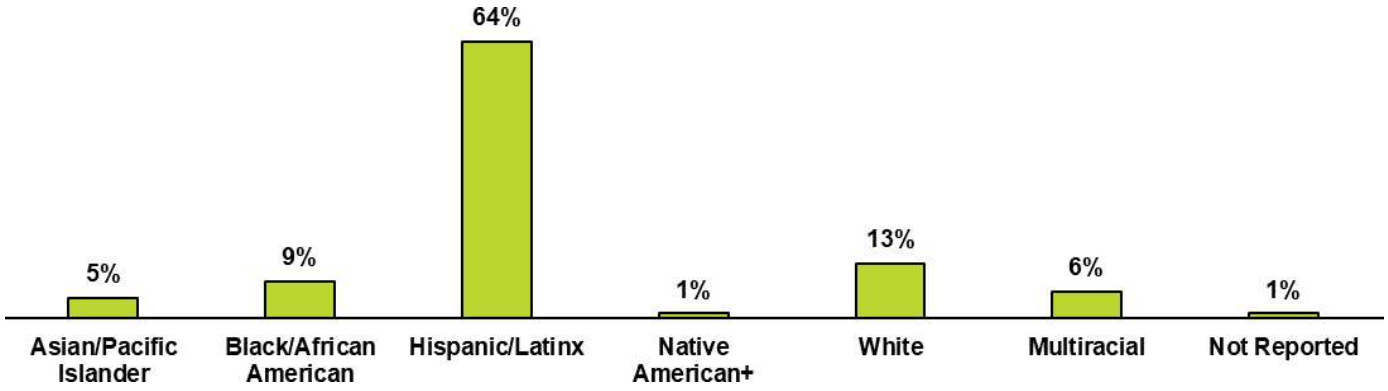
Age of Attendees

Countywide, the ages of attendees in the LGBTQ+ Support Groups were between 14 to 23 years old, with the majority being 17 years old (38.5%, n=30). From the figure below, most TAY participants Countywide reported being in the 16 to 17 age groups (71.8%, n=56). Overall, 91.2% (n=71) of the attendees were TAY.



Race/Ethnicity

Countywide, 64.1% (n=50) of participants identified as Hispanic/Latinx, 12.8% (n=10) as White, 9.0% (n=7) as Black/African American, 6.4% (n=5) as Multiracial, 5.1% (n=4) as Asian/Pacific Islander, 1.3% (n=1) as Native American (and one other race), and 1.3% (n=1) was not reported.



Language

The majority of attendees reported English as their preferred language (91.0%, n=71), followed by 6.4% (n=5) reporting both English and Spanish, 1.3% (n=1) Spanish, and 1.3% (n=1) was not reported.

Language	n	%
English	71	91.0%
Spanish	1	1.3%
English and Spanish	5	6.4%
Not Reported	1	1.3%

LGBTQ+ Support Groups: Satisfaction Surveys

At the end of each group, attendees were asked to fill out satisfaction surveys to gather feedback on their experience. Each survey consists of **11** satisfaction items, rated on a 5-point Likert scale, where ***1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree,*** and ***5=Strongly Agree***. There were a total of **42** attendees who completed the satisfaction surveys, and the results are summarized below:

- **74%** of participants Agreed or Strongly Agreed that the support group changed how they think about themselves in a positive way
- **83%** of participants Agreed or Strongly Agreed that learning "SELF" skills was helpful to them
  - ◊ **76%** are more aware of their emotional and physical safety
  - ◊ **60%** experienced emotional growth
  - ◊ **62%** feel more comfortable discussing loss
  - ◊ **79%** developed a healthy self-identity that will be useful in the future
- **95%** of participants Agreed or Strongly Agreed that participating in this group has been an affirming experience for them
- **88%** of participants Agreed or Strongly Agreed that group topics were engaging and **83%** felt that the facilitator helped them feel safe in a group environment
- **93%** of participants Agreed or Strongly Agreed they would participate in this program again and **95%** would recommend this program to a friend who relates to them

Countywide (n=42)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Reported
1. This group has changed how I think about myself in a positive way	2.4%	2.4%	21.4%	42.9%	31.0%	-
2. Learning "SELF" skills has been helpful to me	4.8%	-	9.5%	35.7%	47.6%	2.4%
3. I am more aware of my emotional and physical safety	-	-	9.5%	35.7%	40.5%	14.3%
4. I experienced emotional growth	-	2.4%	23.8%	40.5%	19.0%	14.3%
5. I feel more comfortable discussing loss	-	7.1%	16.7%	21.4%	40.5%	14.3%
6. I developed a healthy self-identity that will be useful in the future	4.8%	-	16.7%	33.3%	45.2%	-
7. Participating in this group has been an affirming experience for me	4.8%	-	-	35.7%	59.5%	-
8. Group topics were engaging	2.4%	2.4%	4.8%	21.4%	66.7%	2.4%
9. Facilitator helped me feel safe in this group environment	-	-	2.4%	4.8%	78.6%	14.3%
10. I would participate in this program again	2.4%	2.4%	2.4%	4.8%	88.1%	-
11. I would recommend this group to a friend who can relate to me	2.4%	2.4%	-	9.5%	85.7%	-

Note: Some participants completed an older version of the survey which did not have all the same questions on the satisfaction survey so those responses were excluded for items 3, 4, 5, and 9 (n=6).

LGBTQ+ Support Groups: Satisfaction Survey Comments

Participants were also asked in what way has the program brought a helpful change in them, if there was anything they did not like about the program, and any additional comments. Below are some comments from the participants.

What Participants found helpful…

- "Although I haven't been here I learned not to judge others."
- "Being able to talk about more sensitive topics. To come out of my shell."
- "By thinking more positive than negative"
- "Helped me talk to people more about my problems and helped me be in group settings."
- "I feel more inspired to help younger people with the same issues that I had felt before."
- "I felt seen"
- "I has helped with my self confidence and well being."
- "I know a few more people who are similar to me and feel a bit more comfortable talking about my experience in the LGBTQ community"
- "I talked to more people"
- "I'm more social and more aware of my emotions."
- "It has brought helpful change in me by making me more appreciative of others experiences."
- "It has given me a place to be myself and a place to stay. It has also given me a great community."
- "It has helped me have a better understanding of my self and others. I am more comfortable in talking about sensitive topics."
- "It has helped me understand things and be more confident/meet new people."
- "It helped me be way more social"
- "It helped me grow confidence in myself. I also look at life differently."
- "It helped me open up and be more comfortable talking about issues"
- "It helped me understand my friend's experiences."
- "It made me think more about my identity and how to accept myself."
- "It made me understand what other people are going through and helped me to learn to comfort people"
- "It showed me not to feel bad about who I am"
- "It taught me to be more open and how to help a friend through any identity crisis."
- "It's helped me talk to people and helped me engage as my true self at times."
- "Made me realize other's emotions"
- "Stable medication, better mental health, community"
- "The people were fun to be around."
- "The program has helped me open up and talk about some of my issues."
- "They made me feel more seen!"
- "This program brought me a lot of comfort and safety that I don't usually experience during class."
- "This program has been a very safe environment that I look forward to coming to because I feel like I can just be myself."
- "This program has made me more confident to speak in a room full of people"
- "This program has made me realize that people have different struggles and made me change my perspective on certain topics."
- "This program really helped me understand that I wasn't the only one who felt bad emotions."

LGBTQ+ Support Groups: Satisfaction Survey Comments (cont.)

Participants were also asked in what way has the program brought a helpful change in them, if there was anything they did not like about the program, and any additional comments. Below are some comments from the participants.

What Participants Disliked…

- "Besides the changes, no."
- "I had no problems with the program."
- "I know a lot of this stuff already."
- "I like everything!!"
- "I really enjoyed this program."
- "I'm quite anti-social and I guess talking but I could always get past it."
- "t was fine the way it was."
- "No I think everything was fair and a good opportunity."
- "No, I did not see anything that would make me feel like I did not like the program."
- "No, I liked everything."
- "Not much the program is great"
- "That the times to come were midday it would be better near last period."
- "There could be more people here, but it did as much as it could."
- "There wasn't anything I particularly didn't like. I really enjoyed the entire group! It was really fun."
- "We got off task a lot other then that it was a good group."

Additional Comments…

- "Best group ever. Everyone was nice and they are the best (smiley face)"
- "Everything was so fun and engaging, Thank You for doing this for us and making a safe environment."
- "Give [facilitator 1] and [facilitator 2] a raise"
- "I enjoyed listening to everyone's expirances"
- "I enjoyed this program."
- "I really loved this group and I hope it comes back next year!!! (heart symbol)"
- "I will miss you guys! (Imk when the next meeting/program for this will be!)"
- "I would love to join this group again for my next two years of high school"
- "I'm greatful I got this experience (smiley face) I love everyone here (heart symbol)"
- "It was very fun, the facilitators made the experiences very enjoyable."
- "Love their dynamic, they're really nice and make me feel safe"
- "[Facilitator 1, facilitator 2, and facilitator 3] were super sweet, and I hope to see them again"
- "Much Love"
- "Our instructors were amazing (smiley face)"
- "They are so nice (smiley face)"
- "This group is extremely helpful to me!"
- "This is a very safe environment that I personally believe a lot of people would enjoy!"

Mentoring: Eligibility Screening and Enrollment

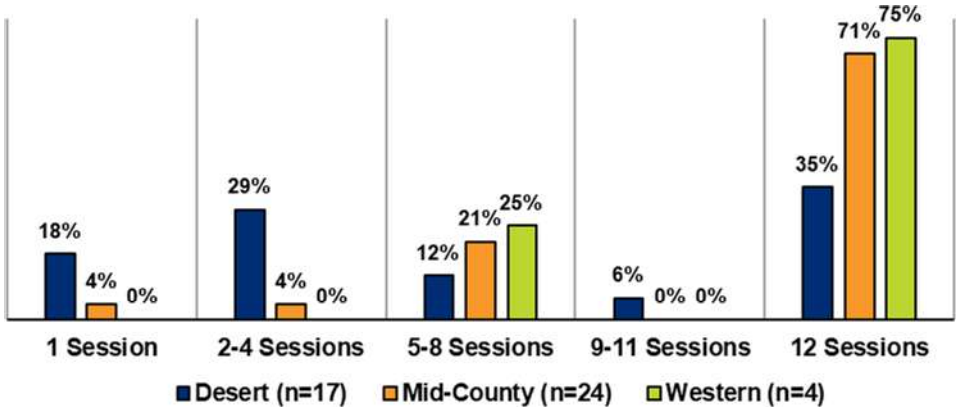
Mentoring is an individualized weekly activity provided by TAY Peer Youth Specialists. Mentors meet with youth once a week for three months and it is expected that mentor and mentees will have 12 contacts. An integral part of the mentoring program is goal setting with mentoring activities focused on supporting each mentees individualized goals. A goal setting action plan is used to set individualized goals and to monitor progress. Measurement of the participants perceptions of progress in the goal areas is assessed at the beginning, middle, and end of the mentoring period. Evaluation involves a pre and post survey that measures TAY mentees experiences with goal setting and goal obtainment during their participation in mentoring. In FY 2023-2024, TAY Peer Youth Specialists were to provide TAY peer mentoring to at least 20 youths per region for a total of 60 youths countywide. TAY youth are screened for eligibility into the program. In total, **51 youths were screened** for the mentoring program, of which **45 were enrolled** and **26 completed** the mentoring program.

Peer-to-Peer Mentoring Program				
	Desert	Mid-County	Western	Countywide
Screened	23	24	4	51
Enrolled	17	24	4	45
Completed	6 (35%)	17 (71%)	3 (75%)	26 (58%)

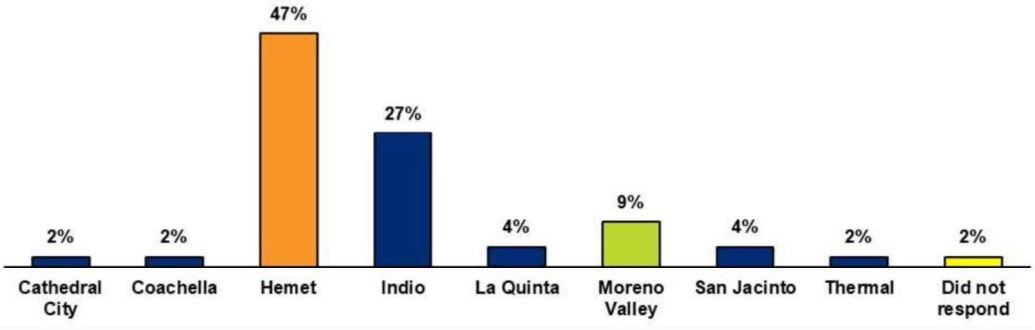
Session Attendance

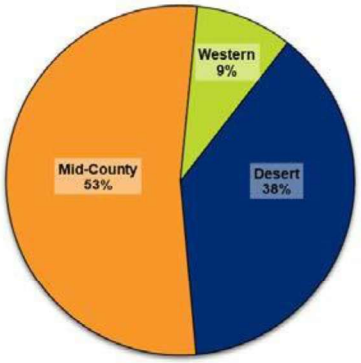
The session attendance in the Mentoring program varied. The goal is for youths to receive mentoring for 12 weekly sessions. The number of sessions per participant are shown in the following table and figure. A total of 391 sessions were provided during the 2023-2024 FY. The majority of the participants completed all 12 sessions (58%).

Number of Sessions	Number of Youths	%
1	4	9%
2 to 4	6	13%
5 to 8	8	18%
9 to 11	1	2%
12	26	58%



Mentees' City and Region



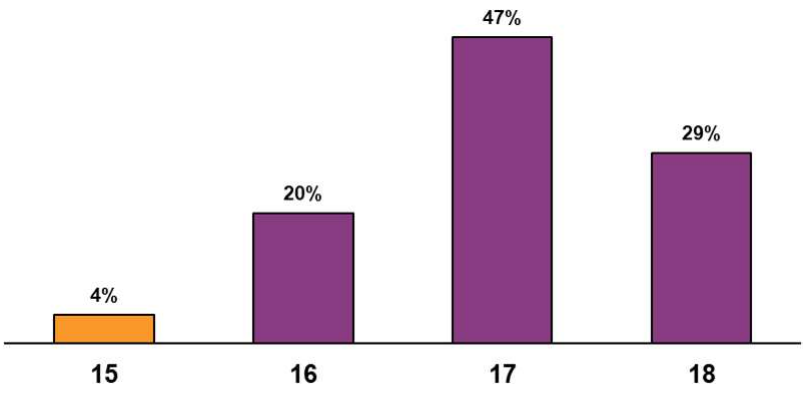


The majority of the mentees were from Hemet (47%, n=21) and Indio (27%, n=12).

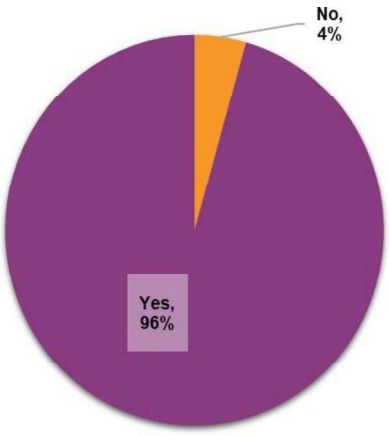
Mentoring: Demographics

The demographics for the enrolled youth are shown below. The majority of the mentees were TAY (96%, n=43) where the average age was 17 years old.

Age



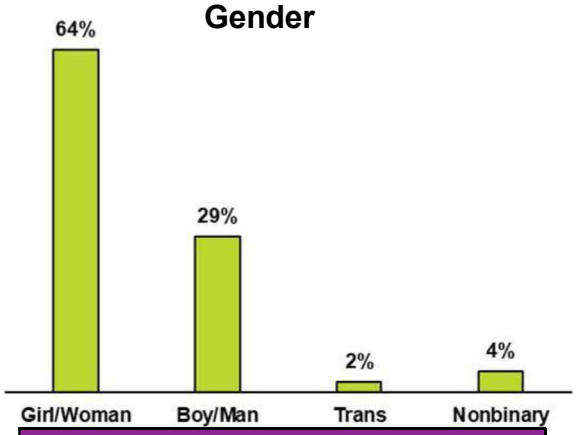
TAY/Non-TAY



The majority of mentees identified as a girl/woman (64%, n=29), followed by 29% (n=13) as a boy/man, 4% (n=2) as nonbinary, and 2% (n=1) as transgender. Additionally, 15 mentees (33%) identified as LGB+.

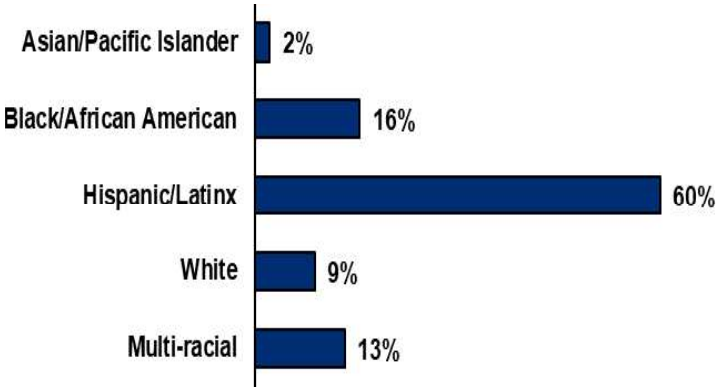
The majority of the mentees were Hispanic/Latino (60%, n=27) and the preferred language for almost all of the mentees was English (91%, n=41).

Gender



Sexual Orientation	n	%
Straight	24	53.3%
Gay	3	6.7%
Bisexual	10	22.2%
Demisexual	1	2.2%
Omnisexual	1	2.2%
Unsure	2	4.4%
Decline	4	8.9%

Race/Ethnicity



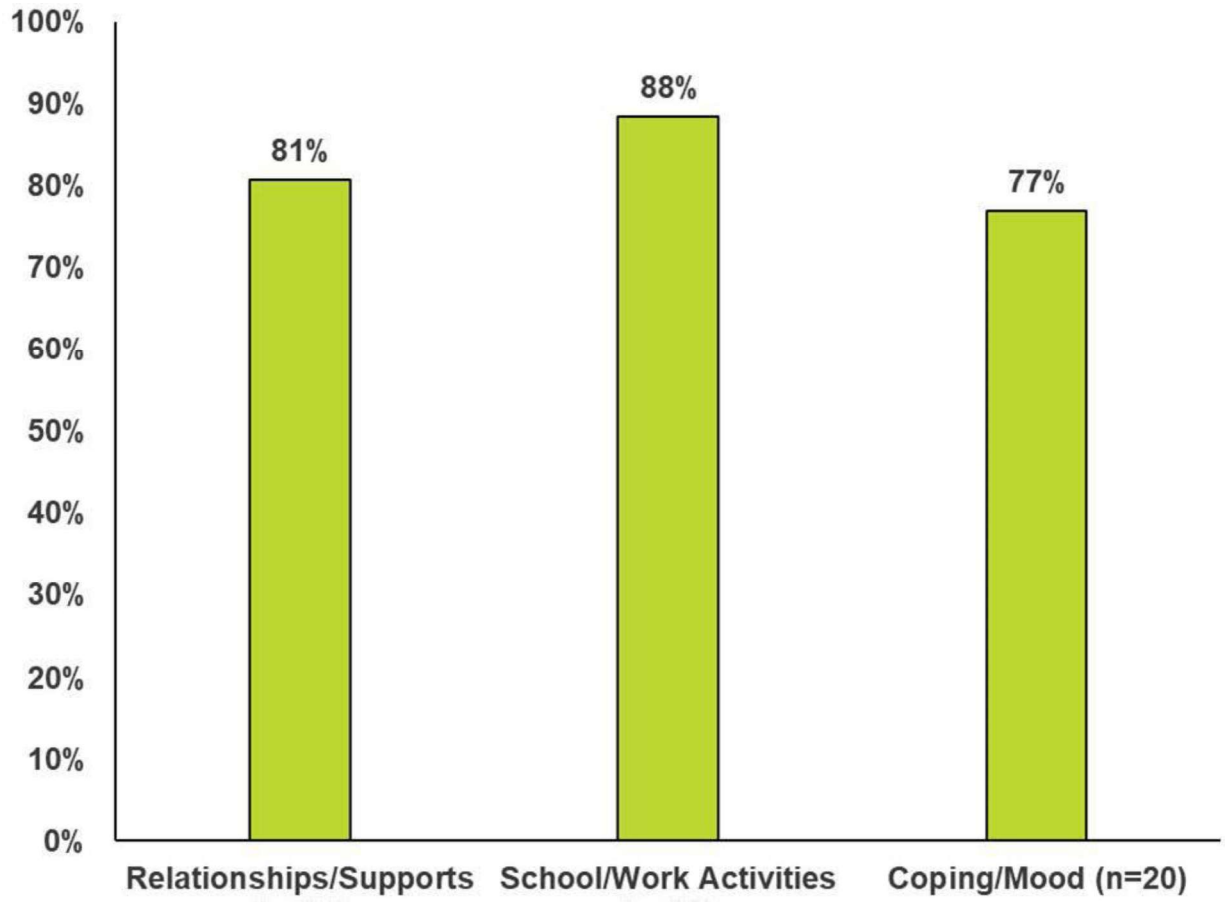
Language	n	%
English	41	91.1%
Spanish	3	6.7%
English and Spanish	1	2.2%

Mentoring: Goal Action Plan

Mentees were asked to complete a Goal Action Plan at the start, mid-way, and at the conclusion of mentoring sessions. At the beginning of the program, each mentee works with their mentor to complete the first Goal Action Plan. The participant sets three goals to work on during the mentoring time. While the goals are individualized, they define a goal for each of the following domains: **Relationships and Supports**, **Improvement in School/Work Activities**, and **Coping and Mood**. After creating the goals, the mentee then rates their feelings about each goal. There ratings are on a Likert scale of 1 to 4, where **1=Very Disappointed, 2=Somewhat Disappointed, 3=Somewhat Pleased**, and **4=Very Pleased**. During the program, once a mentee was pleased with the progress of a goal, it was replaced with a new goal.

Countywide, there were 26 mentees with pre- and post-goal ratings. The following figure represents the percentage of youth with improvement in goal ratings. In comparing goal achievements from pre to post of the 26 youth with data submitted, 16 mentees showed improvements for all three goal areas (61%). The domain with the most improvement was in **School/Work Activities** (88%), followed by **Relationships/Supports** (81%), and **Coping/Mood** (77%), respectively. Overall, mentees showed improvements and felt that they were very pleased with their own progress on their goals at the conclusion of the mentoring program, in comparison to how they felt about their goals at the beginning of the program.

Percentage of Youth with Improvements Pre to Post (n=26)

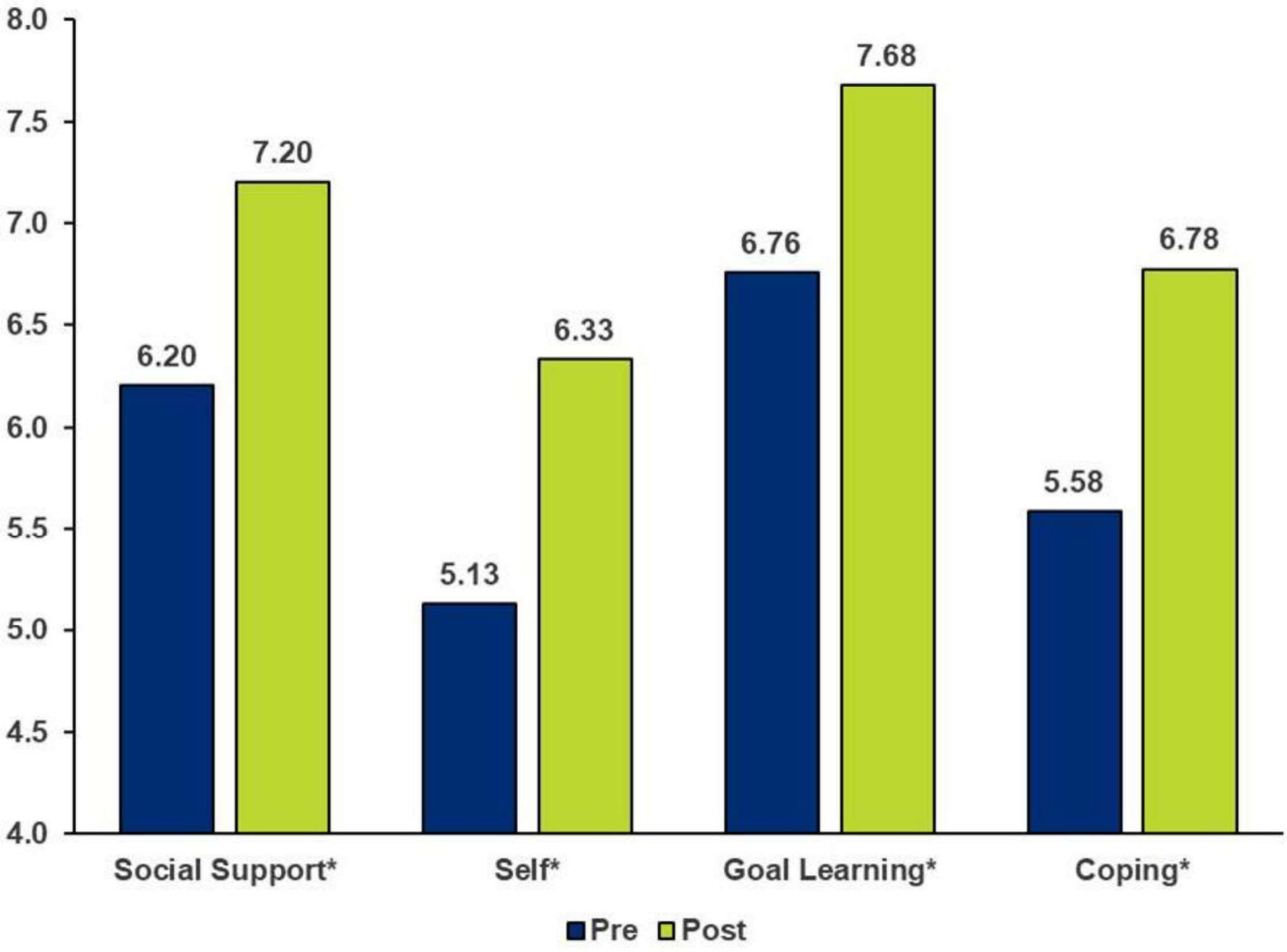


Mentoring: Pre/Post Surveys

The pre-and post-surveys are used to document the mentees' experiences and feelings for goal settings and accomplishment behaviors. Each mentee was asked to fill out a pre-survey during the first session, and then a post-survey at the last session. There are a total of 18 questions, related to: **Social Support** (how they feel about the presence of social supports in their lives), **Self** (how they feel about themselves in different scenarios), **Goal Setting** (how they view and act upon their own life goals), and **Coping** (how they cope with different life situations presented to them). Mentees rated themselves on a Likert scale of 1 to 9, where **1**=**Strongly Disagree** to **9**=**Strongly Agree.**

There were a total of 26 matched pairs of pre- and post-surveys. The majority of mentees with pre- and post-surveys completed were from the Mid-County region (65%, n=17). Overall, increases in average scores can be seen across all domains, with the highest increases in the areas of **Self** and **Coping**. The increases across all domains are statistically significant ($p < .05$).

Mentoring Program Average Scores Pre to Post (n=26)



Note: * indicates statistical significance

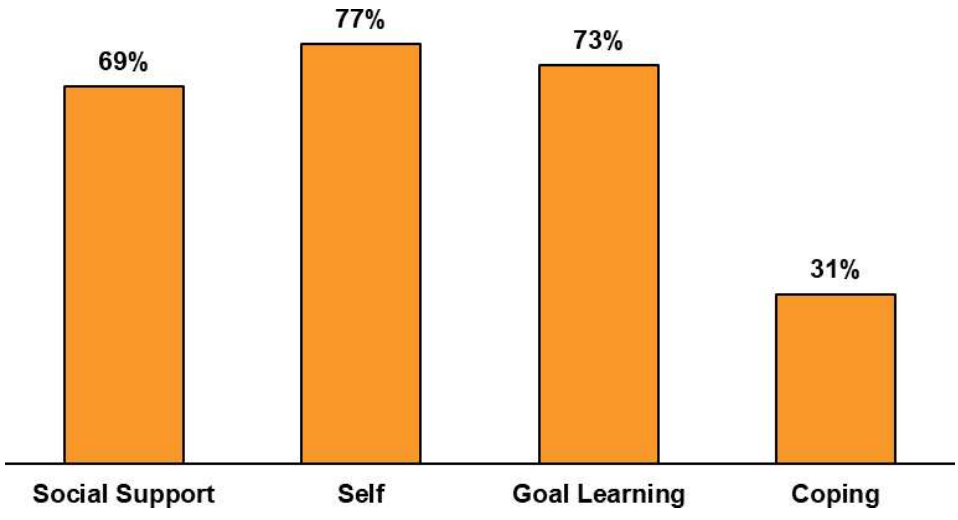
Mentoring: Pre/Post Questionnaire cont.

The following table shows the percent increase on mentees' average scores where all four domains increased. The "Self" domain increased the most (23%) on average scores in comparison to the other three domains.

Countywide (n=26)	% Increase on Average Scores
Social Support Having family members to rely on Having a friend to rely on Having someone to share most private worries and fear Knowing someone to turn to when dealing with personal problems	**16%**
Self Getting emotional support from friends or relatives Talking to someone about feelings Being optimistic in spite of what happened Refusing to let negative emotions drag them down Staying positive even when things look bad	**23%**
Goal Setting Having goals they want to reach Seeking something else to strive for after completing a goal Succeeding in reaching goals in school and/or work Succeeding in reaching goals in extracurricular activities	**14%**
Coping Concentrating efforts in reaching goals Taking action to get around problems when they arise Doing what has to be done when facing an issue, one step at a time Coming up with strategies when planning Thinking hard about what steps to take when planning	**21%**

The following chart shows the percentage of mentees who have shown improvement from pre- to post-measures in all four areas. "Self" had the largest proportion of mentees' who improved (77%, n=20), which suggest that the mentees' feeling about themselves increased by participating in the mentoring program.

Percentage of Mentees with Improvements from Pre to Post (n=26)



Mentoring: Satisfaction Surveys

The satisfaction survey is used to gather feedback from mentees on their experience in mentoring program and with their mentor. Each mentee was asked to rate 10 satisfaction items on a 5-point Likert scale, where **1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree**, and **5=Strongly Agree**. There were a total of 26 mentees who completed the satisfaction survey for the mentorship program, and their responses are summarized below.

In terms of feedback regarding the mentoring program:

- **100%** of mentees "Agreed" or "Strongly Agreed" that the mentoring program has helped them define their current goals.
- **92%** of mentees "Agreed" or "Strongly Agreed" that through the program, they have come to understand the importance of self-praise throughout the goal-setting process, that the program has helped them learn new ways to cope, and that as a result of participating in this program, they now know how to make realistic and reachable goals in the future.
- **85%** of mentees "Agreed" or "Strongly Agreed" that the program has allowed them to build stronger relationships with those whom I depend on.
- **81%** of mentees "Agreed" or "Strongly Agreed" that they felt as though this program was personalized towards reaching their specific goals.

In term of feedback regarding the mentors:

- **100%** of mentees "Agreed" or "Strongly Agreed" that the mentors were knowledgeable when sharing information, their mentors met them at convenient times and locations, and their mentors kept their scheduled appointments.

Overall, **100%** of mentees reported being satisfied with the mentoring program.

Countywide (n=26)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Participation in this program has helped me define my current goals.	-	-	-	50.0%	50.0%
2. I feel as though this program was personalized towards reaching my specific goals.	-	-	19.2%	26.9%	53.8%
3. Through the program, I have come to understand the importance of self-praise throughout the goal-setting process.	-	-	7.7%	26.9%	65.4%
4. This program has allowed me to build stronger relationships with those whom I depend on.	-	-	15.4%	42.3%	42.3%
5. The program has helped me learn new ways to cope.	3.8%	-	3.8%	23.1%	69.2%
6. As a result of participating in this program, I now know how to make realistic and reachable goals in the future.	-	-	7.7%	30.8%	61.5%
7. The mentor was knowledgeable when sharing information.	-	-	-	3.8%	96.2%
8. My mentor met with me at convenient times/locations.	-	-	--	11.5%	88.5%
9. My mentor kept our scheduled appointments.	-	-	-	3.8%	96.2%
10. Overall, I am satisfied with the mentoring program.	-	-	-	-	100%

Mentoring: Comments

Mentees were also asked to comment on aspects of the mentoring program. Below are some comments from the participants.

What have been the most helpful things about the mentoring services that you've received?

- "Advise on life stuff."
- "Being able to feel heard about certain situations."
- "Being able to learn to open up and having someone to talk to and learn from."
- "Coping and how to improve."
- "Help doing things differently in my life."
- "Helping me set goals for the things I need to achieve."
- "Helping with my homework."
- "How I can be proud of myself and have realistic goals."
- "How to focus on my goals and grades."
- "How to keep my emotions in control during my activity and while at home."
- "I have learned a lot of things about myself that I would not have known without this program and my mentor. I have grown a lot from when I first started versus now. I allow myself to feel my emotions and be less damaging and harsh on myself for everything, especially the things I can't control. I feel like I have more control over my life instead of letting it pass by me and letting the things or people that happen to me choose my emotions for me. I know I care about things too much sometimes but I've come to realize that some things about me that may seem like a curse can actually be blessings."
- "I was able to build new relationships and try and get my future together."
- "It helped me be more comfortable with who I am. My mentor was the best too."
- "Just helping me realize that I have many options in life."
- "Just mainly keeping me on track and helping me improve things in my life."
- "Overall just listening to me speak and helping me through my problems also being understanding."
- "Some of the coping activities helped when I did use them, and some of the things that were meant to help me get homework done."
- "Talking really it's nice to have someone to talk to outside of home with problems."
- "Talking to them and he helped me and gave me advice and told me what to work on."
- "The coping skills being self praise."
- "The fact of talking freely with someone about the things I like to talk about." [Translated from Spanish]
- "The journaling."
- "The most helpful thing about mentoring was being able to improve myself and work towards my goals."
- "The most helpful thing is the realness and honesty of what we talked about."
- "The positive feedback from my mentor."
- "They gave me advice in situations I wasn't to sure about."

Additional comments:

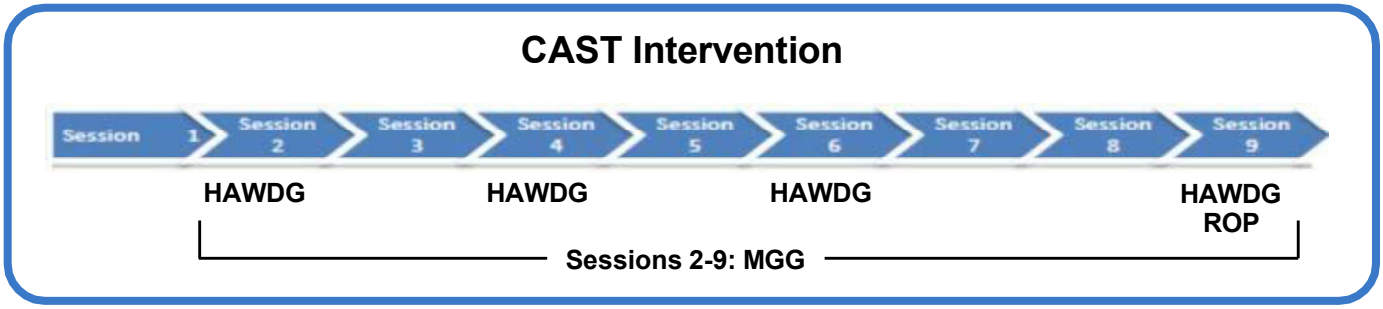
- "All in all, it helped out a lot. Most importantly it has helped me stay on track and keep up with school work."
- "Best mentor ever"
- "He was the best mentor I could ask for he was always there for me and I wish we had more time."
- "I love my mentor."
- "I'm glad I was able to participate in this program."
- "[Facilitator] was the best and helpful during the mentoring."
- "My mentor has helped me a lot with facing my problem and how to better my relationship with loved ones."
- "Overall I'm glad to have this opportunity to better myself."
- "Thank you so much, [facilitator]!! You have been a light in my life especially in the dark parts of it and I couldn't thank you more for the impact you've left on me."

Coping and Support Training (CAST)

Coping and Support Training (CAST) is an evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and School Achievement. It was first implemented in the Peer-to-Peer program during FY 2013-2014. For FY 2023-2024, each CAST group consisted of a screening session, followed by 9 sessions facilitated by PEI TAY Peer Youth Specialists. Each year, Peer-to-Peer contractors are expected to hold a minimum of 6 groups, with at least 60 participants meeting completion standards, per region.

CAST uses three process evaluation measures to determine if the program was delivered as designed and obtained the desired outcomes. The process evaluation measures included:

- **Monitoring Group Goals (MGG)**
  - A survey rating, by session, on how well the student is doing in each of the 3 major CAST goals:
    1. Mood Management
    2. Drug Use Control
    3. School Achievement
- **How Are We Doing In Group? (HAWDG)**
  - A 12-item evaluation of CAST Leader and CAST peer group support and help, belonging, and student responsiveness.
- **Recognition of Progress (ROP)**
  - A survey where participants rate their current performance compared to when they first began CAST and identify areas in which they still need work. It measures specific acquisition related to CAST skill areas and progress goals (self-esteem, decision making, and personal control of moods, school, and drug use).



**Please Note: Since FY2015-2016, the 12-week session content was condensed into 9 weeks.*

CAST: Participation

In order to participate in the CAST program, participants first complete a "Demographic, Screening, and Enrollment Form" during a screening session. Eligibility into the program is determined by participant's reported age (must fall within TAY ages of 16-25 years), priority population (LGBTQ+, Homeless, Transitioning to college, Foster or former foster youth), and their self-rating scores in the Self-Esteem, Mood, and School sections of the Recognition of Progress (ROP) survey which are embedded into the screening form. If participants score 4 or less on the Mood section of the ROP they may not be appropriate for the CAST program since it indicates that the participant is experiencing high levels of distress. Those scoring 4 or less on the Mood section of the ROP will then be asked to complete the Center for Epidemiologic Studies Depression Scale (CES-D) to determine referral into the "Stress and Your Mood," or other appropriate programs. For FY 2023-2024, a total of 95 screenings were completed where 85 were TAY aged individuals and 10 were non-TAY aged individuals. Of those 95 screenings, 83 attended a group, 4 declined services, 0 were referred to other programs, and 8 did not meet criteria for participation.

	Desert	Mid-County	Western	Countywide
Attended	9	23	51	83
Declined	1	0	3	4
Referred	0	0	0	0
Did not meet criteria	4	0	4	8

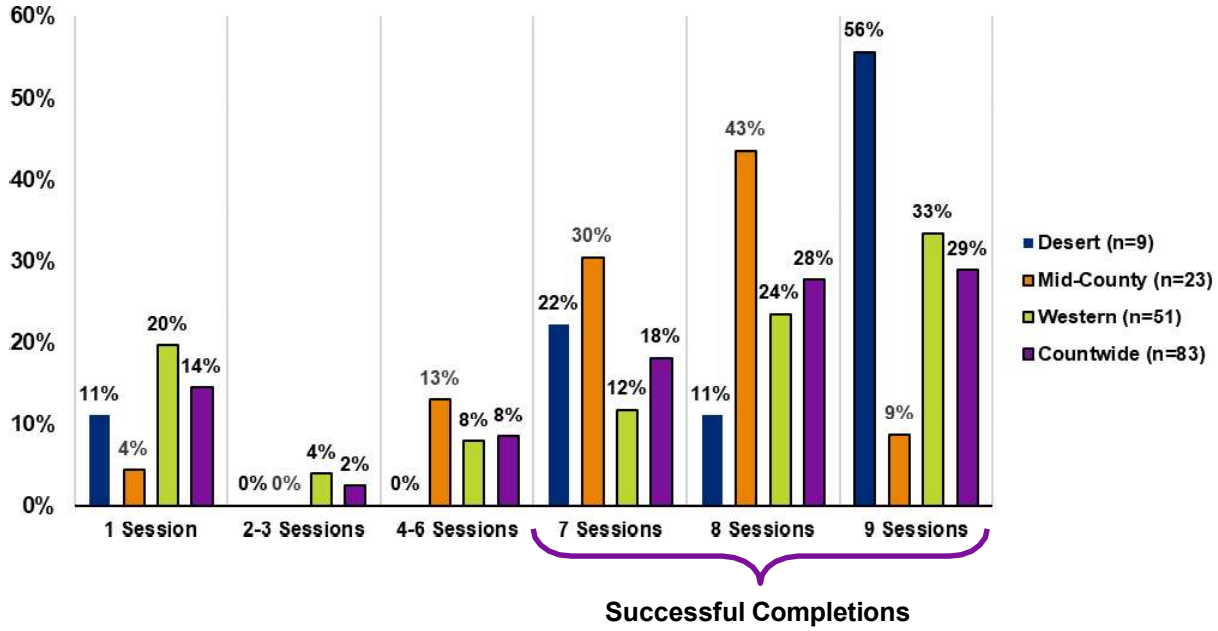
CAST: Attendance and Program Completion

Peer-to-Peer contractors are expected to hold a minimum of 6 groups, with at least 60 participants meeting completion standards, per region. During FY 2023-2024, countywide there were 95 individuals who were screened for CAST with 87 who were enrolled in CAST. Of the 87 individuals who were enrolled, 95% (n=83) attended at least one session. The Desert region held 1 group with 9 participants, the Mid-County region held 4 groups with 23 participants, and the Western region held 6 groups with 51 participants. Completion of CAST was defined as completing seven or more sessions. Of the total 83 participants who enrolled *and* attended at least one session in a CAST group offered throughout the county, 75% (n=62) completed the program.

Peer-to-Peer CAST Program				
	Desert	**Mid-County**	**Western**	**Countywide**
Screened	14	23	58	95
Enrolled	10	23	54	87
Attended ≥ 1 Session	9 (90%)	23 (100%)	51 (94%)	83 (95%)
Completion of ≥ 7 Sessions	8 (89%)	19 (83%)	35 (69%)	62 (75%)

In the Desert region, a total of 9 individuals enrolled and attended a CAST session with 8 (89%) attending 7 or more sessions. In the Mid-County region, a total of 23 individuals enrolled and attended a CAST session with 19 attending 7 or more sessions. In the Western region, a total of 51 individuals enrolled and attended a CAST session with 35 (69%) attending 7 or more sessions.

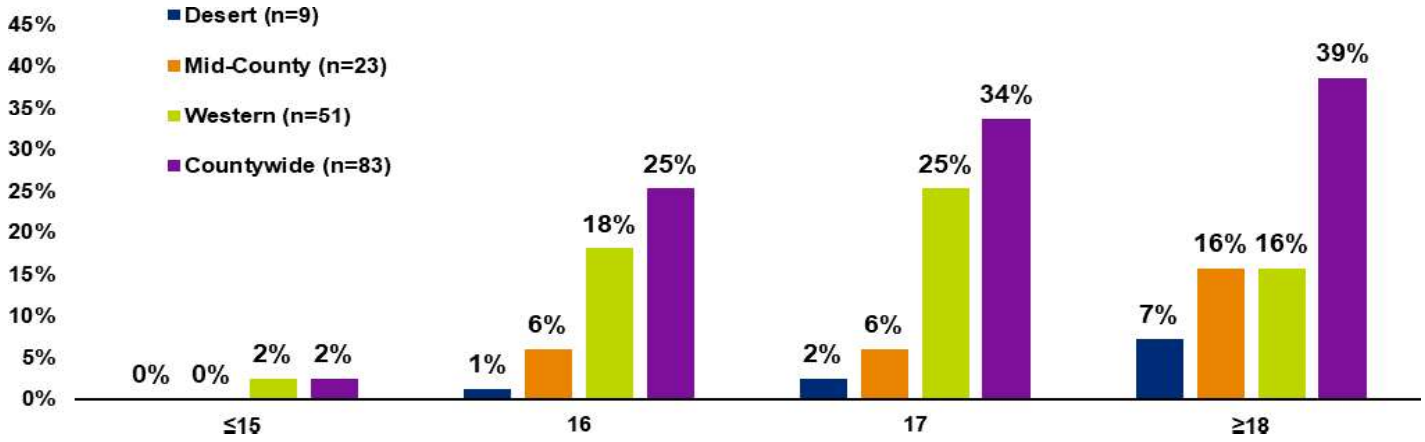
Number of CAST Sessions Attended (n=83)



Since CAST is typically held on school campuses, Peer-to-Peer staff had challenges with schools allowing access to some campuses to conduct CAST groups. Specifically, in the Desert region, two CAST group were started where 21 youth were screened and enrolled. Of those 21 enrolled, 17 attended at least one session and 4 declined services. However, after completing four of the nine sessions, the school revoked permission to conduct the program, therefore these participants were not included in the descriptive and outcome data.

CAST: Demographics

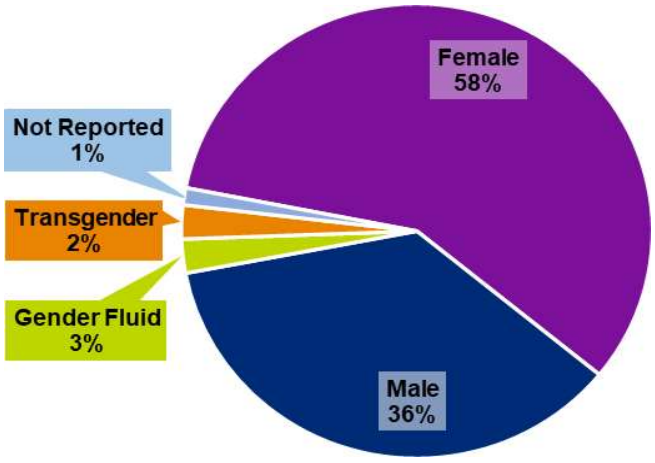
Age



Participants from the Desert region were primarily 18+ with 7% (n=6). In the Mid-County region, the largest age group was also 18+ with 16% (n=13), and Western region reported 25% (n=21) of their participants were 17. Of the 83 participants enrolled countywide, 98% (n=81) were TAY while the remaining 2% (n=2) were not TAY.

Gender and Sexual Orientation

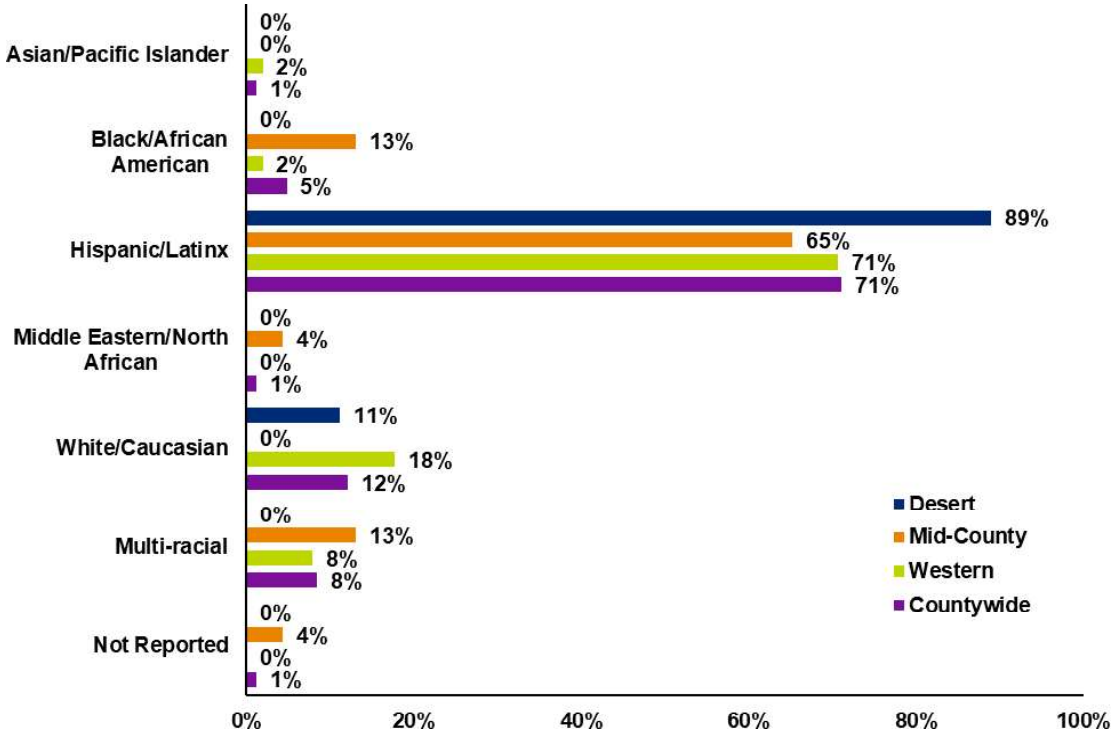
Countywide, the majority of youth enrolled in CAST were female (58%, n=48). Additionally, 36% (n=30) were male, 2% (n=2) identified as transgender, 2% (n=2) identified as gender fluid, and 1% (n=1) chose not to respond. There were 4% (n=3) of participants in Desert region who identified as LGB, 8% (n=7) in Mid-county region, and 19% (n=16) in Western region.



Countywide, most participants (96%, n=80) reported not having disabling condition, while a few participants (4%, n=3) reported having a disabling condition (these participants noted as having Asthma, Dyslexia, and Stuttering). Additionally, almost all participants (99%, n=82) indicated that they were not Veterans, while 1 participant chose not to respond to this question.

LGB	Desert (n=9)	Mid-County (n=23)	Western (n=51)	Countywide
Yes	3 (4%)	7 (8%)	16 (19%)	26 (31%)
No	4 (5%)	16 (19%)	26 (31%)	46 (55%)
Not Reported	0 (0%)	0 (0%)	2 (2%)	2 (2%)
Unknown	2 (2%)	0 (0%)	7 (8%)	9 (11%)

CAST: Demographics

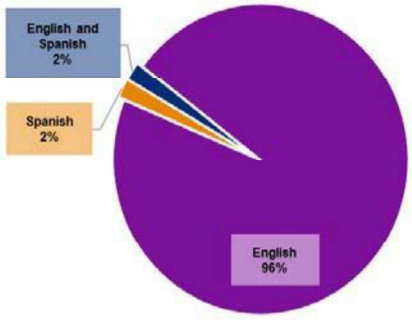


Race/Ethnicity

Countywide, the majority of youth enrolled in CAST were Hispanic/ Latinx (71%, n=59). About 12% (n=110) of youth identified as White/Caucasian, 5% (n=4) identified as Black/ African American, and 18% (n=15) identified as Multiple Races. There were 3 participants who identified as Asian/ Pacific Islander, Middle Eastern/North African, and chose not to respond (1%, n=1 in each category).

Countywide, 47% (n=39)

Language



Ninety-five percent (n=79) of participants reported English as their primary language countywide. This was followed by 2% (n=2) of participants reporting both English and Spanish as their primary language, and 2% (n=2) reported Spanish only.

Participants' City of Residence

Countywide, the majority of CAST participants reported their residences as the city of Riverside (51%,n=42), followed by Hemet (22%, n=18). For the Desert region, the reported cities were Indio (10%, n=8) and Thermal (1%, n=1). In the Mid-County region, the reported cities were Hemet (22%, n=18), San Jacinto (5%, n=4), Perris (2%, n=2), and Winchester (1%, n=1). For the Western region, the reported cities were Riverside (51%, n=42), Jurupa Valley (7%, n=6), and Rubidoux (1%, n=1).

Cities	Desert (n=9)	Mid-County (n=23)	Western (n=51)	Countywide (n=83)
Hemet	0 (0%)	18 (22%)	0 (0%)	18 (22%)
Indio	8 (10%)	0 (0%)	0 (0%)	8 (10%)
Jurupa Valley	0 (0%)	0 (0%)	6 (7%)	6 (7%)
Perris	0 (0%)	2 (2%)	0 (0%)	2 (2%)
Riverside	0 (0%)	0 (0%)	42 (51%)	42 (51%)
Rubidoux	0 (0%)	0 (0%)	1 (1%)	1 (1%)
San Jacinto	0 (0%)	4 (5%)	0 (0%)	4 (5%)
Thermal	1 (1%)	0 (0%)	0 (0%)	1 (1%)
Winchester	0 (0%)	1 (1%)	0 (0%)	1 (1%)

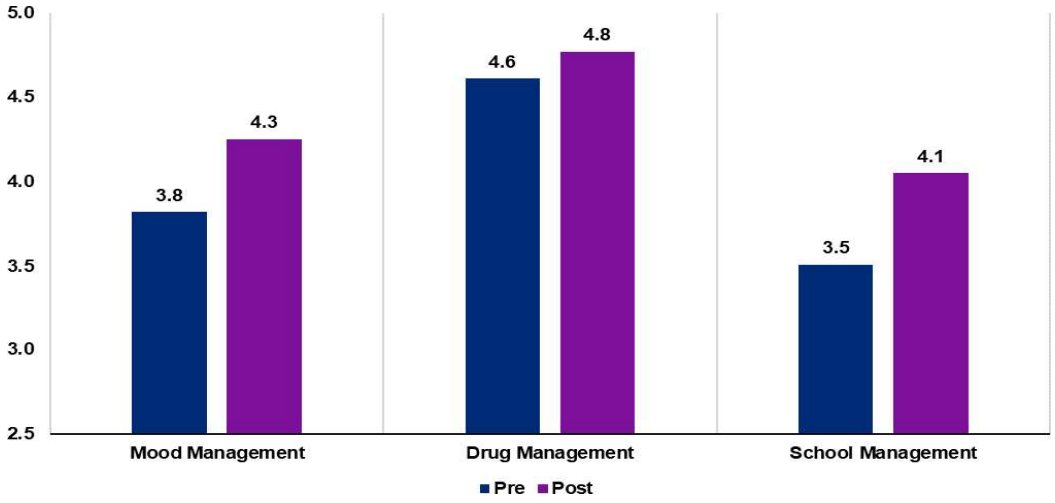
CAST Outcome Measures

Monitoring Group Goals (MGG)

MGG surveys were collected from participants at the end of sessions 2 through 9, in order to measure participants' performance in the three major CAST goal areas of mood management, drug-use control, and school achievement. Surveys collected at the end of sessions 2 and 9 were used for pre- to post-test analysis. There are some instances in which participants did not attend nor complete items for sessions 2 and/or 9, therefore means are reported for other sessions (3-8) but no other comparisons will be completed.

Of the 62 participants who completed the program, a total of 61 participants submitted MGGs for pre to post comparisons for some or all three items. Of the total 61 participants, 57.4% (n=35) attended CAST sessions in the Western region, 29.5% (n=18) attended CAST in the Mid-County region, and 13.1% (n=8) attended CAST in the Desert region, respectively.

MGG Pre/Post Results



The MGG surveys consist of survey items regarding participants' management of their feelings of depression and anger, drug use, and school smarts. All three questions are rated on a scale of 1-5; where lower ratings indicate poor management, and higher ratings indicate more positive management of the CAST goals. Countywide, participants' average post-test scores significantly increased from their pre-test scores for Mood Management, School Smarts Management and Drug Use Management suggesting meaningful improvement from the start of participation in the program to the end. High scores in Drug use management overall indicate little to no use of drugs and/or controlled substances.

Countywide Mean Differences and Percentage of Change

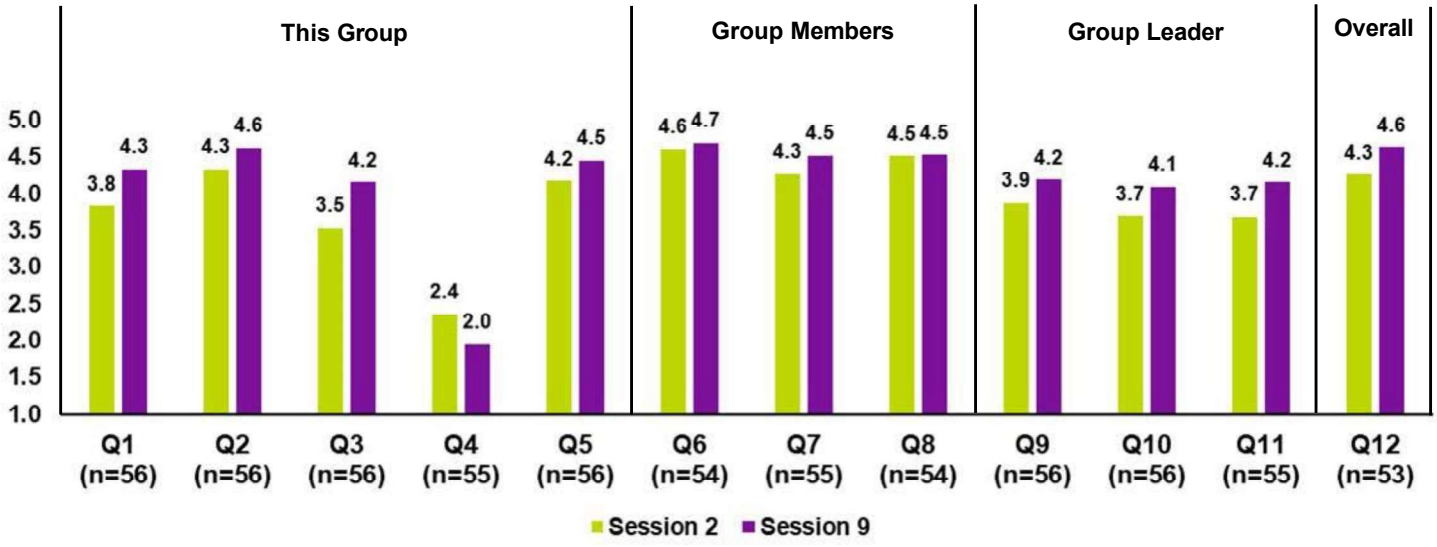
	Mean Difference	Worsened	Same	Improved
Mood (Depression/Anger) Management: (1) Feeling super depressed (or super angry), (2) Feeling depressed (or angry), (3) Feeling sort of sad (or a little angry), (4) Feeling OK, and (5) Feeling great	**0.44***	10 (16%)	22 (36%)	29 (48%)
Drug-Use Management: (1) Using way too much, out of control, (2) Using too much, (3) Using a little, (4) Not using, but tempted, and (5) Not using, in control	**0.17***	1 (2%)	51 (83%)	9 (15%)
School Smarts Management: (1) Messing up big time, (2) Just barely passing, (3) Doing fair, but could be better, (4) Doing OK, and (5) Doing great	**0.54***	8 (13%)	23 (38%)	30 (49%)

Note. * indicates significant mean difference from pre to post measure. It is important to note each management item does not contain the same participants even though the "n" is the same for each item.

CAST Outcome Measures

How Are We Doing in Group? (HAWDG)

HAWDG surveys were collected from participants at the end of sessions 2, 4, 6, and 9, in order to measure the participants' feelings of support and help in group. Of the 62 participants who completed the program, a total of 56 participants submitted at least one item pair from the HAWDG survey for sessions 2 or 9. Of the 56 participants, 60.7% (n=34) attended CAST sessions in the Western region, 30.4% (n=17) attended CAST sessions in the Mid-County region, and 8.9% (n=5) attended CAST sessions in the Desert region.



The HAWDG surveys include general items about the participant's feelings toward the group, the group leader, other group members, and the overall experience. It is rated on a scale from 1-5, with lower ratings indicating less frequency and higher ratings indicating more frequency (1-Never/Very Rarely, 2-Seldom/Sometimes, 3-About 1/2 the Time, 4-Often/Typically, and 5-A Lot/Always). The mean difference scores reflect the average difference between Session 2 and Session 9. All items except Q2 and Q8 showed meaningful increases in frequency. Countywide, the largest increase was in participants' sense of "belonging" for item 3. Below is the table showing percentages of increase and decrease in frequencies for participants.

	Mean Difference	Decreased	Same	Increased	No Response
In This Group					
1. The topics we cover interest me	**0.5***	3 (5%)	28 (50%)	25 (45%)	0 (0%)
2. I really want to do my best	**0.29***	4 (7%)	35 (63%)	17 (30%)	0 (0%)
3. I have a real sense of "belonging"	**0.63***	4 (7%)	23 (41%)	29 (52%)	0 (0%)
4. We have serious conflicts and tensions	**-0.42***	17 (30%)	29 (52%)	9 (16%)	1 (2%)
5. I learn something useful each Session	**0.29***	9 (16%)	27 (48%)	20 (36%)	0 (0%)
The Group Leader (Teacher)					
6. Encourages and supports me	0.09	6 (11%)	37 (66%)	11 (20%)	2 (4%)
7. Is someone I can count on to help me	**0.26***	7 (13%)	34 (61%)	14 (25%)	1 (2%)
8. Offers useful points of view about topics we discuss	0.02	12 (21%)	32 (57%)	10 (18%)	2 (4%)
The Other Group Members					
9. Encourages and support me	**0.32***	7 (13%)	28 (50%)	21 (38%)	0 (0%)
10. Give me advice or information I need	**0.43***	11 (20%)	20 (36%)	25 (45%)	0 (0%)
11. Get support and encouragement from me	**0.47***	10 (18%)	22 (39%)	23 (41%)	1 (2%)
Overall					
12. I am satisfied with the support and encouragement I get	**0.38***	2 (4%)	33 (59%)	18 (32%)	3 (5%)

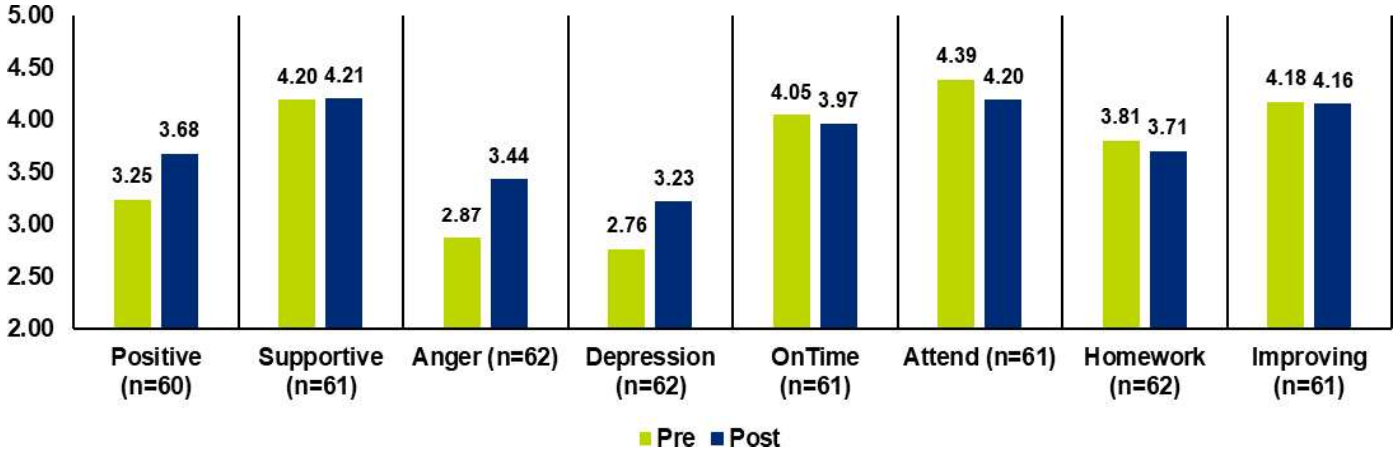
Note. Mean Difference items that are in bold and have asterisks (*) are statistically significant.

CAST Outcome Measures

Recognition of Progress (ROP)

ROP surveys were collected from participants during the initial screening session and the final session, in order to measure participants self rated skills in the following areas: self-esteem and personal control with moods, school work, and drug use. A total of 62 participants completed CAST and submitted pre-and post-surveys. Of the 62 participants who submitted pre- and post-surveys, 57% (n=35) completed CAST in the Western region, 31% (n=19) completed CAST in the Mid-County region, and 13% (n=8) completed CAST in the Desert region. Please note that the graph below does not depict Personal Control or Drug Use items as they had relatively low scores. Mean differences for these items are still reported in the table below.

ROP Pre/Post Results



ROP evaluates items in the skill areas of self-esteem and personal control of moods, school, and drug use. It is rated on a scale from 1-5, with lower ratings indicating lower frequency and higher ratings indicating higher frequency (1-Never/ Very Rarely, 2-Seldom/Sometimes, 3-About 1/2 the Time, 4-Often/Typically, and 5-A Lot/Always). For analysis of self-esteem and personal control of moods, school, and drug use, post-test scores completed at the end of the program were compared to pre-test scores from their ROP survey at screening. Countywide, average post-test scores showed statistically significant ($p<.05$) improvement over the average pre-test scores to post-test scores in one item of self-esteem, both items of personal control in moods, and in one item of personal control in drug use. The mean differences in these four items that showed significance are shown in bold below.

Countywide (n=62)	Mean Difference	Worse	Same	Improved	No Response
Self-Esteem:					
Being positive with myself, recognizing my strengths	**0.43***	8 (12.9%)	26 (41.9%)	26 (41.9%)	2 (3.2%)
Praising and being supportive of others	0.02	13 (21%)	34 (54.8%)	14 (22.6%)	1 (1.6%)
Personal Control - Moods:					
Anger-controlling my thoughts, feelings and actions	**0.57***	9 (14.5%)	17 (27.4%)	36 (58.1%)	0 (0.0%)
Depression-getting "unstuck" from negative moods	**0.47***	13 (21.0%)	19 (30.6%)	30 (48.4%)	0 (0.0%)
Personal Control - School:					
Being on time for class	-0.08	18 (29.0%)	25 (40.3%)	18 (29.0%)	1 (1.6%)
Attending class daily	-0.20	19 (30.6%)	31 (50.0%)	11 (17.7%)	1 (1.6%)
Doing my assignments, homework	-0.10	15 (24.2%)	35 (56.5%)	12 (19.4%)	0 (0.0%)
Working on improving my grades, school achievement	-0.02	13 (21.0%)	35 (56.5%)	13 (21.0%)	1 (1.6%)
Personal Control - Drug Use:					
Smoking (cigarettes)	0.10	1 (1.6%)	53 (85.5%)	4 (6.5%)	4 (6.5%)
Using Alcohol	0.05	4 (6.5%)	50 (80.6%)	4 (6.5%)	4 (6.5%)
Using Marijuana	**0.20***	1 (1.6%)	49 (79.0%)	9 (14.5%)	3 (4.8%)
Using other drugs	0.05	1 (1.6%)	56 (90.3%)	1 (1.6%)	4 (6.5%)

Note. Mean Difference items that are in bold and have asterisks (*) are statistically significant.

Annual CAST Program Reviews

CAST Screening, Enrollment, Attendance, and Completion

A total of 95 participants were screened for enrollment into the CAST program in FY 2023-2024 as opposed to 133 and 117 who were screened in FYs 2022-2023 and 2021-2022, respectively. Additionally, of the total participants who attended a CAST group during FY2023-2024, 75% completed the program, compared to 58% and 55% in FYs 2022-2023 and 2021-2022, respectively.

FY 2023-2024 CAST Program				
	Desert	Mid-County	Western	**Countywide**
Screened	14	23	58	**95**
Enrolled	10 (71%)	23 (100%)	54 (93%)	**87 (92%)**
Attended ≥ 1 Session (% of Enrolled Participants)	9 (90%)	23 (100%)	51 (94%)	**83 (95%)**
*Completion of ≥ 7 (of 9) Sessions	8 (89%)	19 (83%)	35 (69%)	**62 (75%)**

FY 2022-2023 CAST Program				
	Desert	Mid-County	Western	**Countywide**
Screened	53	14	66	**133**
Enrolled	47 (89%)	10 (71%)	64 (97%)	**121 (91%)**
Attended ≥ 1 Session (% of Enrolled Participants)	41 (87%)	9 (90%)	62 (97%)	**112 (93%)**
*Completion of ≥ 7 (of 9) Sessions	21 (51%)	0 (0%)	44 (71%)	**65 (58%)**

FY 2021-2022 CAST Program				
	Desert	Mid-County	Western	**Countywide**
Screened	50	17	50	**117**
Enrolled	50 (100%)	0 (0%)	47 (94%)	**97 (83%)**
Attended ≥ 1 Session (% of Enrolled Participants)	37 (74%)	0 (0%)	36 (77%)	**73 (75%)**
*Completion of ≥ 6 (of 9) Sessions	15 (41%)	0 (0%)	25 (69%)	**40 (55%)**

MHSA
Prevention and Early Intervention
Youth Outreach Report

FY 2023-2024

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YOUTH OUTREACH PROJECT

Program Description

Through the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding, Operation Safehouse, Inc. is contracted to provide services in Riverside County to Transition Age Youth (TAY) who are homeless, a run away or at of risk of running away, through their Safe Place and Street Outreach to Youth Program. The Youth Outreach Program is dedicated to the safety and well being of youth in crisis and is committed to providing comprehensive support services for at-risk youth and those struggling with crisis situations. MHSA PEI funding is focused on two components of Operation Safehouse programming which are described below.

Operation Safehouse Safe Place Project



Operation Safehouse, Inc. was funded through MHSA-PEI to train and educate the community on the Safe Place program. This program is based on "Project Safe Place", a national program found in communities all across the United States, which creates Safe Place location designations within the local the community organizations and businesses centers, for youth to seek assistance.

Safe Place is a community prevention initiative where Safe Place trains and then designates businesses and organizations as Safe Place locations, making help readily available to youth in the community. Safe Place locations include: libraries, community centers, public buses, various businesses and social service facilities. Designated Safe Place locations display the Safe Place sign, the universal symbol of youth safety. Safe Place designated sites are trained to respond to youth that ask for assistance. Safe Place outreach, training and education are targeted to business owners, bus drivers, and other community agencies who are already a designated site or who could become a Safe Place designated site for at-risk youth in need of immediate help and safety.

In Riverside County, there are currently over 250 Safe Place locations, including all the fire stations, police stations, Riverside Transit Agency (RTA) and Sunline buses. Safe Place allows Operation Safehouse to have "virtual doors" throughout the community, by displaying the "Safe Place" symbol in various locations, their goal is to provide assistance to youth who see the sign and ask for help at any of these locations. Operation Safehouse trains staff at the designated Safe Place sites to ensure people at those locations know the resources and how to help a youth in need. Presentations on Safe Place are also provided to the community to educate community members and organizations on what Safe Place sites do.

Operation Safehouse Street Outreach

In addition some PEI funding also supports targeted street outreach to homeless and runaway youth to facilitate the reunification of the Transition Age Youth (TAY) with an identified family member or to a safe environment. Operation Safehouse staff provide youth with information on available resources and where they can seek assistance including Safe Place sites.

DATA COLLECTION

Operation Safehouse staff submitted data on a monthly basis from July 2023 to June 2024. Activities in the Western and Mid-County regions were summarized into one report, while the Desert region had its own separate monthly report. The Emergency Solutions Grant (ESG) team was the only team working with clients in both the Desert and Western/Mid-County regions, primarily focusing on youth aged 11 to 24.

In month of July 2023, for the Desert region, there was no staff to provide a monthly report for the month.

The monthly data includes the following components:

- ***Safe Place Training Information Report***
  To document the Safe Place training to Safe Place sites, including location, agency, date, and number of attendees.
- ***Safe Place Educational Presentation Report***
  To document outreach Educational presentations done to market Safe Place, at which Operation Safehouse staff present information on what Safe Place does for the community. Information recorded includes: date, location, staff presenting, number of attendance, pamphlet distribution, etc.
- ***Operation Safehouse Street Team Activities Report***
  To document street outreach activities to youth. Information recorded includes: date, type of street outreach, names of youths, race/ethnicity, age, gender, type of referrals provided, and shelter programs entered.
- ***Operation Safehouse Street Outreach Monthly Shelter Placement Report***
  To document the client name, shelter/program entered, and the total counts on the type of referrals Provided by Operation Safehouse on a monthly basis.
- ***Operation Safehouse Street Outreach Community Involvement Report***
  To document the Partnership/Community Involvement meetings attended by Operation Safehouse staff members.
- ***Operation Safehouse Staff Training Report***
  To document the RHYTTAC trainings attended by Operation Safehouse staff members.

SAFE PLACE TRAINING INFORMATION

There was no training conducted and/or no training data submitted for Safe Place Trainings between July 2023 to June 2024 for Desert region and Western/Mid-County region.

SAFE PLACE EDUCATIONAL PRESENTATIONS

Operation Safehouse conducted a total of **37** Educational Presentations, with a total attendance of **2,348** people. The table below shows the summary of all Safe Place Educational Presentations completed by Operation Safehouse staff during the fiscal year 2023-2024.

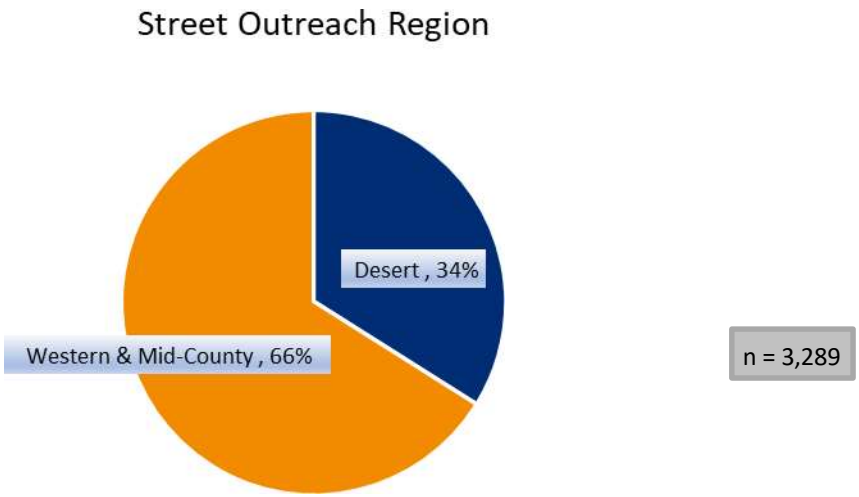
Month/ Year	Region	Team	Location of Education Presentations Conducted	Counts of Presentations	Number of Participants
Sep-23	Desert	ESG	DHS Rotary, Desert Recreation District	2	75
Oct-23	Desert	ESG	Eastside Fall Festival at Bobby Bonds, Expanding Horizons Youth Summit, Mayor's Initiative, CES Meeting	5	360
Nov-23	Western & Mid-County	ESG	Mayor's Initiative To End Youth Homelessness, Coordinated Entry System Community Partnership, Active Shooter Training, All County Outreach Coordination Meeting	4	288
Dec-23	Western & Mid-County	ESG	PRCSD Snow Day, CES Community Partnership Meeting, YAC/YAB Meeting	3	300
Jan-24	Western & Mid-County	ESG	Mayor's Initiative To End Youth Homelessness, Project Bridge, County Outreach Meeting	3	169
Feb-24	Desert	ESG	Transgender Wellness Center Presentation	1	2
	Western & Mid-County	ESG	Mayor's Initiative To End Youth Homelessness, CES Community Partnership Meeting	3	146
Mar-24	Western & Mid-County	ESG	Mayor's Initiative, Community Partnership (Fair), Spark Meeting, Project Bridge Meeting, Community Initiative Partnership (CES)	5	282
Apr-24	Western & Mid-County	ESG	All County Outreach (Boots on Ground)	1	186
May-24	Western & Mid-County	ESG	Mayor's Initiative to End Youth Homelessness, CES, Youth Advisory Committee & Youth Action Board	4	185
Jun-24	Western & Mid-County	ESG	Mayor's Initiative to End Youth Homelessness, Community Partnership, Lutheran Social Services Meeting, Roots on the Ground, KIK Summit at YOC Rubidoux	6	355

Total Number of Educational Presentations: 37
Total Number for Attendees : 2,348

* Several presentations were conducted more than once in a single month.

STREET OUTREACH PROGRAM: REGION AND TEAMS CATEGORIES

The graphs shown below, and on the following two pages, describe the street outreach activities/services provided by the Operation Safehouse staff members during fiscal year 2023-2024. Daily activity forms were submitted on a monthly basis to document the activities as well as the basic demographic information of the youth and adults who were provided street outreach. It is noted that the counts of youth and adults may be duplicated due to different types of services that may be provided to the same people within the same fiscal year.

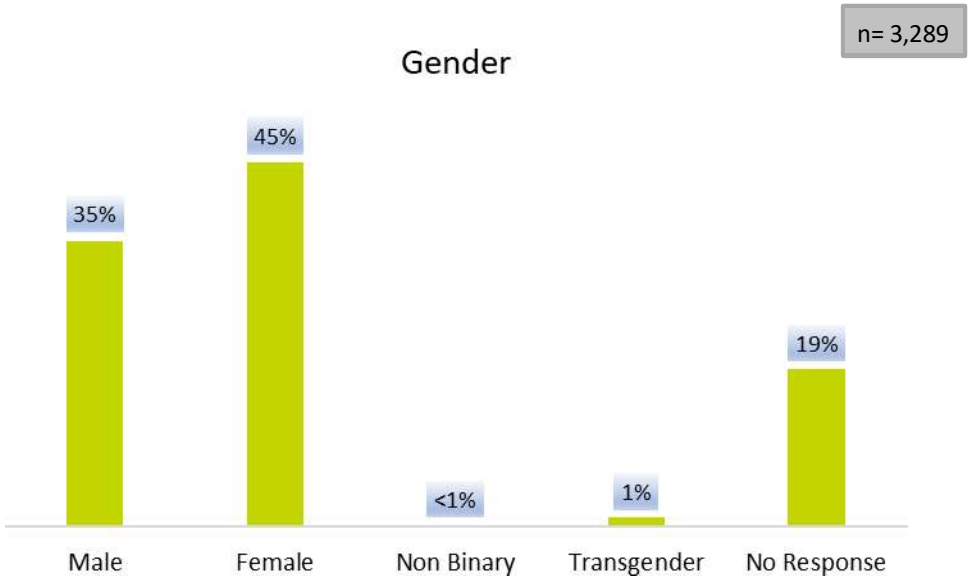


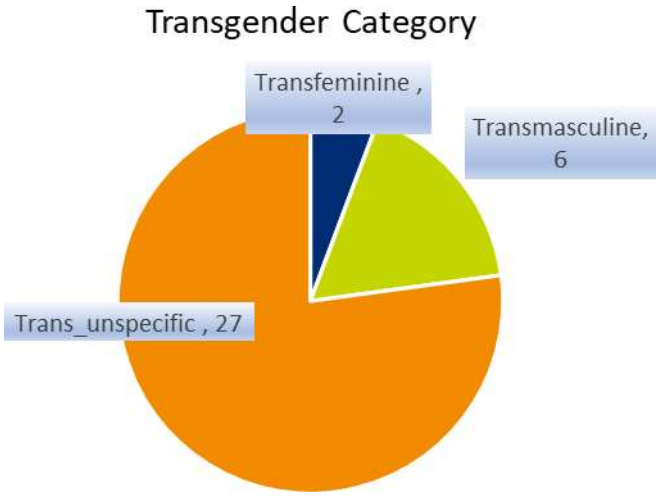
Overall, there were a total of 3,289 youth and adults who were provided street outreach services during fiscal year 2023-2024. The majority of street outreach services were provided by the Western/Mid-County Region, which served 2,174 youths and adults (66%), while the Desert Region provided services to 1,115 (34%).

This fiscal year one team provided services within Operation Safehouse, the ESG Team of the Street Outreach services between July 2023 to June 2024.

STREET OUTREACH PROGRAM: GENDER AND LGBTQI CATEGORIES

The majority of youth and adults who were provided street outreach were *Female* (45%, n = 1,465), followed by *Male* (35%, n = 1,148). There was a small percentage of youths and adults who reported themselves as *Non-Binary* (0.213%, n = 7) and *Transgender* (1%, n = 36), while 19% (n = 633) chose not to respond. Of those who indicated Transgender, 2 people reported *Transfeminine* (Male to Female), 6 people reported *Transmasculine* (Female to Male) and 28 people did not chose otherwise.

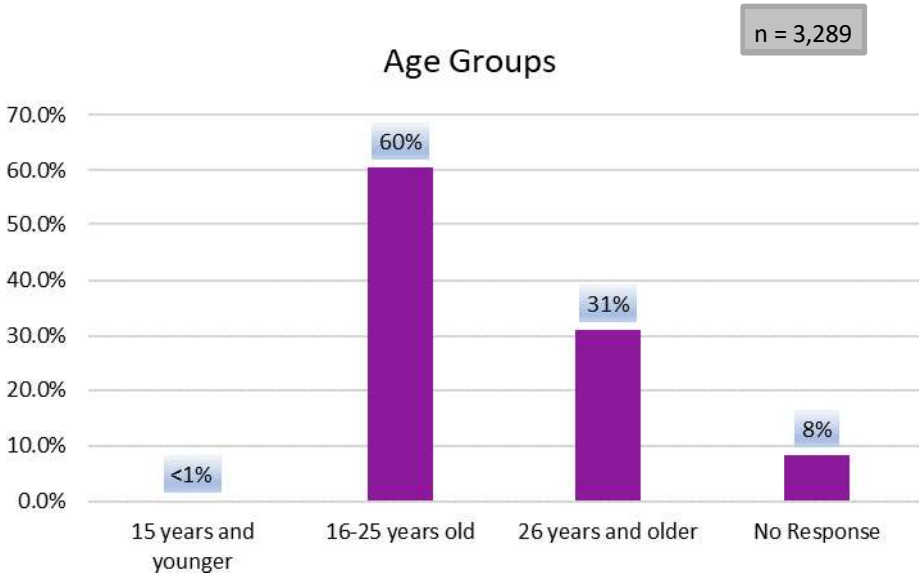




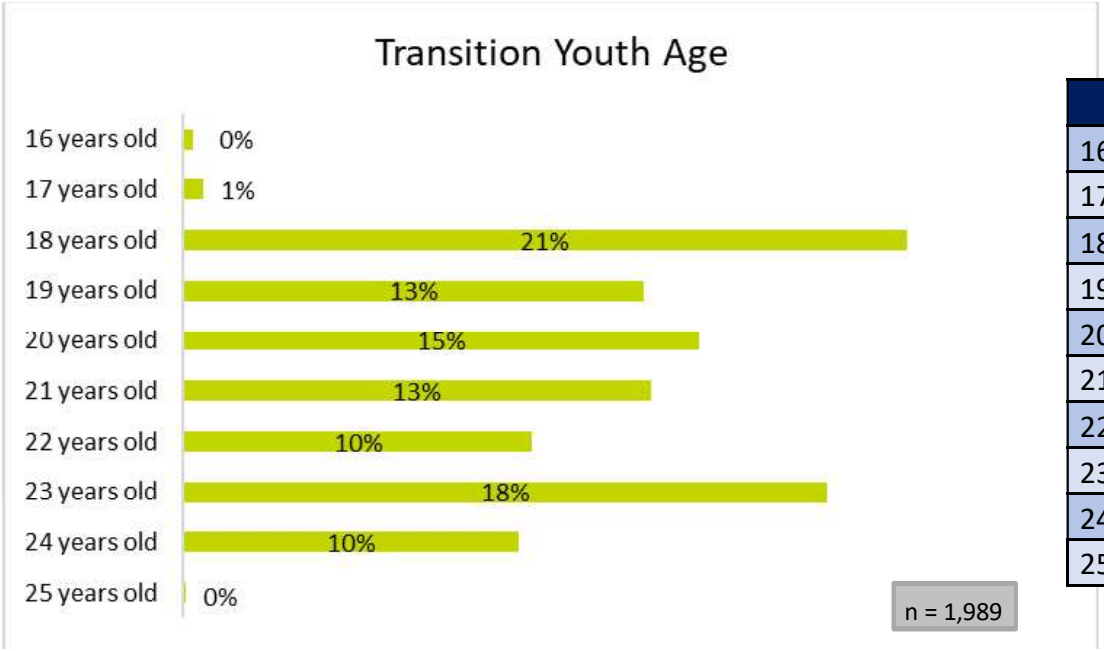
n= 36

STREET OUTREACH PROGRAM: AGE GROUPS AND TRANSITION AGE YOUTH (TAY)

Categorizing into age groups, the majority of street outreach services were provided to Transition Age Youth (*16 to 25 years*) with 60% (n = 1,989), followed by, Adults (*26 years and older*) with 31% (n = 1,021), and Adolescents (*15 years and younger*) with 0.2% (n = 7). There were also 272 people (8%) who chose not to respond to the age question.



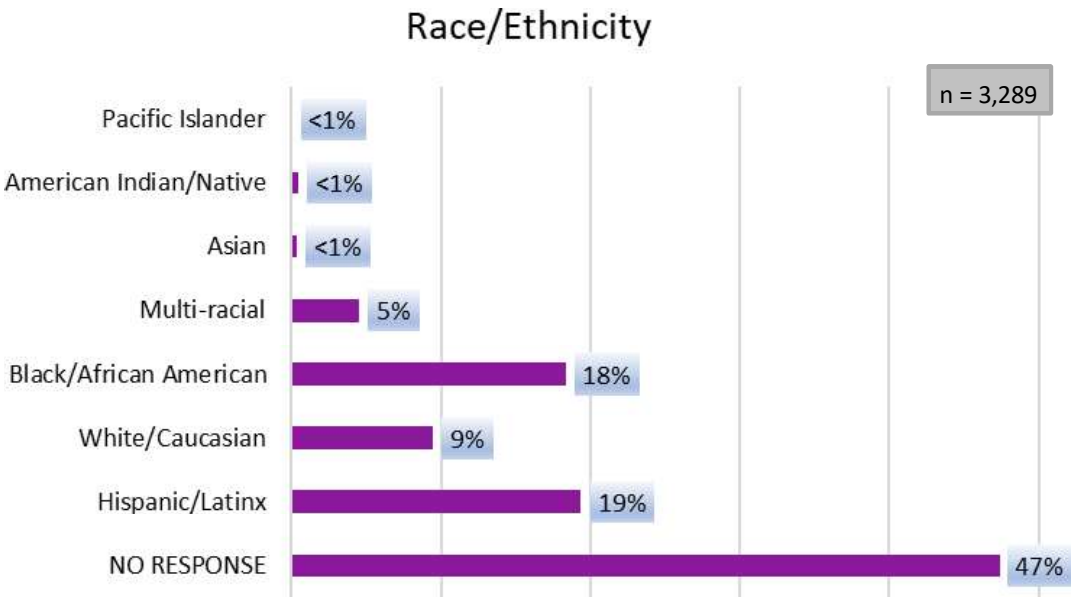
Within the Transition Age Youth (TAY) category, there were a total of 1,989 youths who were provided street outreach services. As shown on the graph and table below, the majority of these youth were 18 years old (21%, n = 264).



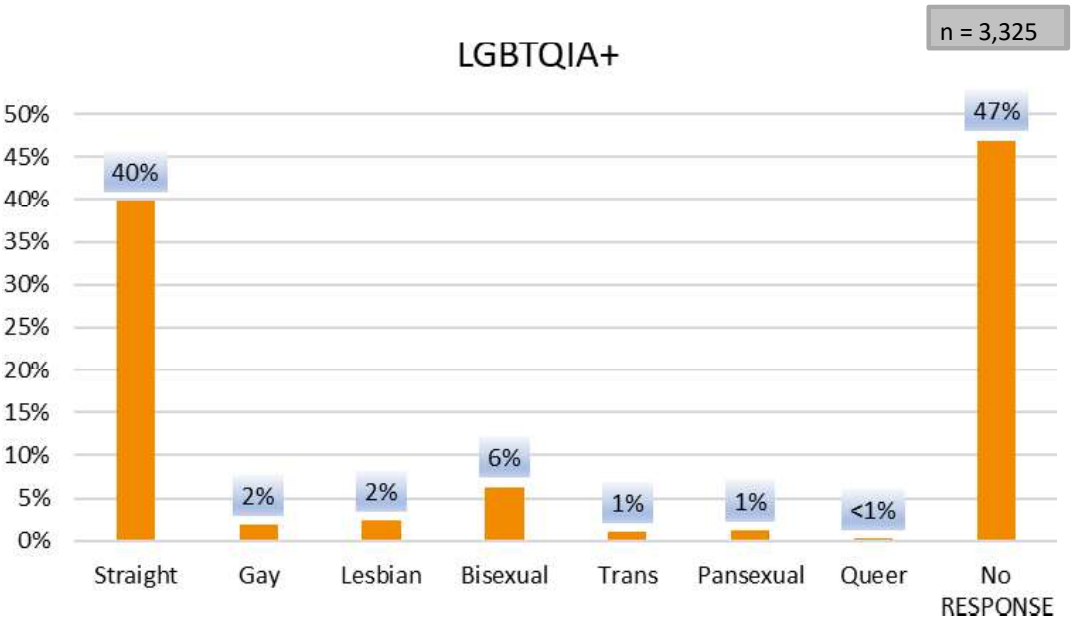
TAY Age	TAY Counts
16 years old	5
17 years old	11
18 years old	408
19 years old	260
20 years old	291
21 years old	264
22 years old	197
23 years old	363
24 years old	189
25 years old	1

STREET OUTREACH PROGRAM: RACE/ETHNICITY AND LGBTQI CATEGORY

The youth and adults who responded to the Race/Ethnicity question were mainly *Hispanic/Latino* (19%, n = 637), followed by *Black/African American* (18%, n = 603), *White/Caucasian* (9%, n = 311), and *Multiracial* (5%, n = 149). Less than 1% were *Asian* (0.36%, n = 12) and *American Indian/Native* (0.46%, n = 16).The majority of youth and adults (47%, n = 1,560) chose not to respond.



The majority of youth and adults (47%, n = 1,561) chose not to respond, while 40% (n = 1,326) categorized as *Straight*. There are also smaller percentages of youths and adults who categorized themselves as *Bisexual* (6%, n = 210), *Gay* (2%, n = 63), *Lesbian* (2%, n = 77), *Pansexual* (1%, n = 1), and *Trans* (1%, n=36) while the remaining >0.1% (n = 9) categorized as *Queer*. The total population size is higher to account for the 36 individuals identified as trans, as well as those disclosing their sexual orientation in the figure shown below.



STREET OUTREACH PROGRAM AND ACTIVITY DESCRIPTIONS

The Street Outreach program provided by Operation Safehouse staff members was developed to help homeless and runaway youth with referrals to services, hygiene products, gift cards, and transportation to homeless shelters or transitional living programs, when it is possible to these youth to move into a more safe and stable environment. The Street Outreach team is in the community seven days a week at locations where runaway and homeless youths are known to congregate.

Transitional Living Program (TLP)

The Transitional Living Program (TLP) is a transitional program for youths to provide them with a more permanent living/housing situation. Currently, there are 3 main TLP locations provided by Operation Safehouse:

- ***Main S.T.A.Y Emergency Shelter***
  This TLP is a 30-day emergency shelter program for older homeless youths between the ages of 18 and 24 years old. This program assists youths in their journey from the streets into shelter and/or housing.
- ***Main Street TLP, Riverside***
  This TLP is for older homeless youth between the ages of 18 to 22 years old, for up to 18 months. Services provided include: continuing educational assistance, individualized therapy, financial education, employment assistance, and access to medical and dental healthcare.
- ***Harrison House, Thousand Palms***
  This TLP is an 18-month program designed to support homeless young adults between 18 and 22 years old who are seeking assistance in their movement from the streets to becoming independent and self-sufficient adults.

Vulnerability Index-Service Prioritization Decision Assistance pre-screening Tool (VI-SPDAT)

The VI-SPDAT is a risk and prioritization database where an individual needing housing assistance is enrolled. It includes information on emergency shelter, homelessness, and the client's basic demographic and identifying information, and is a tool used to help with housing placements. Operation Safehouse uses this database to enroll new clients and to count total clients receiving their outreach. This tool also helps identify who should be recommended for each housing and support intervention, moving the discussion from simply who is eligible for a service intervention, to who is eligible and in greatest need of that particular intervention.

Street Cards

The Street Cards is an informational tool in a form of a card/mini brochure that lists Operation Safehouse outreach program, as well as the important phone numbers and locations that are available for youth who need help.

Gateway Products

The "gateway products" refers to any services provided by Operation Safehouse staff members, which could be anything from a hygiene kit and bus passes to actual housing placements for youths.

What's Up App Cards

The "What's Up Safehouse" is a downloadable mobile phone application that provides anonymous counseling by text-communication from 7 AM to 11 PM, seven days a week, 365 days a year, with a Licensed Mental Health professionals from Operation Safehouse. This app is mainly designed to help young people ages 11 to 24 years old, but there are no actual age restrictions. It is meant to help young people who are struggling with drug/alcohol abuse, depression, difficult family situations, bullying, and other issues, while maintaining anonymity.

OPERATION SAFEHOUSE STREET OUTREACH ACTIVITIES AND REFERRALS SUMMARY

The table below shows the summary of Street Outreach activities provided to youths and adults by Operation Safehouse's staffs during the fiscal year 2023-2024. The descriptions for these activities are listed on the following page.

Operation Safehouse Street Outreach Activities	Total Counts for Western & Mid-County Regions	Total Counts for Desert Region	Total ALL Regions
Number of Intakes Completed	212	160	372
Number of TLP (Transitional Living Program) Applications Submitted	15	65	80
Number of VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance pre-screening Tool) Completed	37	27	64
Number of Clients entered Shelter/ Program *(refer to page 11 for TLP Placements table)*	72	45	117
Number of Safehouse/Street Cards Provided	1036	606	1642
Number of Gateway Products Provided	276	329	605
Number of Individuals Educated on SafePlace	1034	753	1787
Number of What's Up App Cards Provided	1034	487	1521
Youth Referrals (Ages 11-17)	26	6	32
Youth Referrals (Ages 18-21)	958	144	1102
Youth Referrals (Ages 22-25)	404	116	520
Adult Referrals (Ages 26+)	992	43	1035
Number of Families Assisted	67	9	76

OPERATION SAFEHOUSE SHELTER PROGRAM PLACEMENTS REPORT

There were a total of **117** youth (72 were in Western/Mid-County region, and 45 were in Desert region) who either entered the Operation Safehouse shelter, or were placed/referred to a safe location (TLP) during the fiscal year 2023-2024. The table below shows the summary report of outreach clients and shelter placements completed by month.

Month/Year	Region	Team	Shelter/Placement Location	Number of Placements
Jul-23	Western & Mid-County	ESG	The Main Stay, OSH Youth Shelter, Phoenix Rescue Mission	8
Aug-23	Desert	ESG	Family Assist, Harrison House	2
	Western & Mid-County	ESG	Mercy House, The Main Stay, Illumination Foundation	3
Sep-23	Desert	ESG	Martha's Village, Harrison's Village	2
	Western & Mid-County	ESG	The Main Stay, Lutheran Social Seniors, Path of Life Family Shelter, Chess Program, Path of Life	8
Oct-23	Western & Mid-County	ESG	Chess Program, The Main Stay, Path of Life	9
	Desert	ESG	The Main Stay, Family Reunification, Lagos CSU, Rapid-housing (LA)	6
Nov-23	Western & Mid-County	ESG	The Main Stay, Path of Life	4
Dec-23	Western & Mid-County	ESG	The Main Stay, Chess Program, Cherished UA	6
	Desert	ESG	CVRM, The Main Stay	2
Jan-24	Western & Mid-County	ESG	The Main Stay	7
	Desert	ESG	Project Touch, Harrison House, CVRM, Hernandez Room and Board,	6
Feb-24	Western & Mid-County	ESG	Just Us 4 Youth, CVRM, Youth Shelter, The Main Stay, Path of Life, Path of Life Family Shelter	7
	Desert	ESG	Chess Program, CVRM	2
Mar-24	Western & Mid-County	ESG	The Salvation Army, CVRM, The Main Stay	5
	Desert	ESG	Mainstreet, Martha's Village and Kitchen, The Main Stay, OVRM	6
Apr-24	Western & Mid-County	ESG	CVRM	2
	Desert	ESG	Path of Life, Main Stay, Navigation Center/Access Center	5
May-24	Western & Mid-County	ESG	The Main Stay, Youth Hope Foundation, Project Touch, Path of Life, TLP, CVRM	8
	Desert	ESG	CVRM, RUHS Behavioral Health, The Stay, PS Navigation Center, CEDR	7
Jun-24	Western & Mid-County	ESG	The Main Stay, Path of Life	5
	Desert	ESG	Martha Village, CVRM, Path of Life, The Stay, Main Stay, Lages	7

OPERATION SAFEHOUSE PARTNERSHIP/COLLABORATIVE MEETINGS

There were a total of **96** partnership/collaborative meetings attended by Operation Safehouse staff during the fiscal year 2023-2024. The table below shows the summary of Outreach Community Involvement/ Meetings attended by Operation Safehouse staff members, which include the regions, teams, and locations.

Month/ Year	Region	Team	Partnership/Collaborative Meetings Attended*	Number of Meetings Attended
Aug-24	Western & Mid-County	ESG	CES Community Partnership Meeting, Back to School Resource Fair, Uplift Riverside Conference, Mayor's Initiative To End Homelessness, Youth Advisory Committee & Youth Action Board, City of Riverside Case Conferencing, GCCA	8
	Desert	ESG	DHS Rotary, Back to School Resource Fair, Bobby Bonds YOC Resource Fair, Rubidoux YOC Table, CES, Rotary	6
Jul-23	Western & Mid-County	ESG	CES Community Partnership Meeting, Youth Advisory Committee & Youth Action Board	2
Sep-23	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness Conferencing, Waiden Rapid Re-housing Collaboration, CES Community Partnership Meeting, City of Riverside	4
	Desert	ESG	WIN Center, DHS Rotary, Desert Recreation District Mtg	4
Oct-24	Western & Mid-County	ESG	Eastside Fall Festival at Bobby Bonds, Expanding Horizons Youth Summit, Mayor's Initiative, CES Meeting	5
	Desert	ESG	Eastside Fall Festival at Bobby Bonds, Expanding Horizons Youth Summit, Mayor's Initiative, CES Meeting	5
Nov-22	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, Coordinated Entry Services Community Partnership, Active Shooter Training, All County Outreach	4
	Desert	ESG	All County Outreach Meeting, Rotary DHS, RISE, SAP	4
Dec-23	Western & Mid-County	ESG	PRCSD Snow Day, YAC/YAB Meeting, CES Community Partnership Meeting	3
	Desert	ESG	City of Riverside Snow Day Event, Rotary, Saturation Day and Tabling City of Riverside, Ribbon Cutting - Coachella Valley BH, YAC/YAB Meeting, Riverside	6
Jan-24	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, Project Bridge, County Outreach Meeting	4
	Desert	ESG	City Of Riverside Snow Day Event, Community Resource Fair, Rotary Meeting	3
Feb-23	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, CES Community Partnership Meeting	3
	Desert	ESG	DHS Rotary, Transgender Wellness Center Presentation, Desert Hot Springs Recreation Center, CES Meeting, All County Outreach Meeting	5

* Several partnerships/collaborative meetings were conducted more than once in a single month.

OPERATION SAFEHOUSE PARTNERSHIP/COLLABORATIVE MEETINGS *(continued)*

Month/ Year	Region	Team	Partnership/Collaborative Meetings Attended*	Number of Meetings Attended
Mar-24	Western & Mid-County	ESG	Mayor's Initiative, Community Partnership (Fair), Spark Meeting, Project Bridge Meeting, Community Initiative Partnership (CES)	5
	Desert	ESG	RISE, Homelessness and Foster Youth Services Summit, YAC/YAB Meeting, DGS Rotary	4
Apr-24	Western & Mid-County	ESG	All County Outreach Meeting (Boots on the Ground)	1
	Desert	ESG	Mayor's Initiative to End Homelessness, CES Meeting, RISE Meeting, Desert Hot Springs Meeting, COD Foster Youth Presentation, All County Outreach Meeting	6
May-24	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, CES (Coordinated Entry System), Youth Advisory Committee & Youth Action Board	4
	Desert	ESG	District 5 Homeless Symposium, DHS Rotary, YAC/YAB Meeting, CES Meeting	4
Jun-24	Western & Mid-County	ESG	Mayor's Initiative to End Youth Homelessness, Community Partnership, Lutheran Social Services Meeting, Roots On The Ground, KIK Summit at YOC Rubidoux	6

* Several partnerships/collaborative meetings were conducted more than once in a single month.

OPERATION SAFEHOUSE STAFF TRAININGS REPORT

During the fiscal year 2023-2024, Operation Safehouse staff members also attended a total of **10** staff trainings at the Operation Safehouse Technical Assistance Center. The tables below and on the next page show the summary of monthly RHYTTAC trainings attended by Operation Safehouse staff members.

Month/ Year	Region	Team	Monthly Runaway & Homeless Youth Training & Technical Assistance Center (RHYTTAC) eLearning/Trainings Competed by Operation Safehouse Staff Members
Jul-23	Western & Mid-County	ESG Team	SAMHSA Efforts to Support Youth Experiencing Homelessness, What Can RHY Programs Do To Identify & Prevent Labor Trafficking, Harassing Data & The Power or Youth to
Mar-24	Western & Mid-County	ESG Team	Identifying and Responding to Sexually Exploited Children, A Participatory Approach to Make Movement Meaningful, 2022 RHY Program Specific Training: Street Outreach Program, 2023 Runaway and Homelessness Youth, Presentation, Demonstration
Apr-24	Western & Mid-County	ESG Team	Transforming Trauma into Trust

* Several trainings were conducted more than once in a single month.

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention

Cognitive Behavioral Therapy (CBT) for Late Life Depression

FY 2023-2024 Annual Report





CBT-LLD FY 2023-2024

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Provider & Program Overview

Program Overview

CBT for Late Life Depression is an active, directive, time-limited, and structured problem-solving program that follows the conceptual model and treatment program developed by Aaron Beck and his colleagues. It includes specific modifications for older adults experiencing symptoms of depression. The intervention includes strategies to facilitate learning within this population; such as repeated presentation of information using different modalities, slower rates of presentation, and greater use of practice along with structure in modeling behavior. Clients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and redevelop them to be more adaptive and flexible thoughts. Emphasis is also placed on teaching clients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 (approximately 60 minute) sessions, following a structured manual.

Community-based organizations were contracted to provide Cognitive Behavioral Therapy (CBT) for Late Life Depression services to older adults experiencing symptoms of major depression:

The Center (TC) is a community-based organization that offers a safe and supportive environment for its members. Their mission is to enrich the lives of the LGBTQI community. They advance this mission by providing senior-specific programming, clinical counseling, social offerings, and much more.

Inland Caregiver Resource Center (ICRC) helps families and communities cope with and manage the challenges of aging and caregiving. Their mission is to respect the dignity of all people [including LGBTQI community] and provide assistance so clients and family members can continue to live productive, active, and enriched lives.

Provider & Program Overview

Outcomes Evaluation

CBT for Late Life Depression uses the Patient Health Questionnaire-9 (PHQ-9) as the depression screening tool and the Quality of Life (QOL) Survey to assess participants perception of the lives quality. These measures are described below. Measures are administered at the beginning of program services (Pre) and at the conclusion of services (Post).

- **Patient Health Questionnaire-9 (PHQ-9)**
  PHQ-9 is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents age 12 years. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV. The PHQ-9 can function as a screening tool, an aid in diagnosis, and as a symptom tracking tool that can help track a patient's overall depression severity as well as track the improvement of specific symptoms with treatment. The PHQ-9 is scored by summing the ratings for the 9 items. A total score of:
  - 0-4 is considered as having minimal levels of depression and is described as 'non-depressed'
  - 5-9 indicates symptoms of mild depression
  - 10-14 indicates symptoms of moderate depression
  - 15-19 indicates symptoms of moderately severe depression
  - 20-27 indicates symptoms of severe depression

- **Quality of Life (QOL) Survey**
  The QOL survey includes general quality of life items and questions on participation in pleasant and social activities. This survey is an important and integral part of measuring outcomes, as it specifically collects feedback from participants on social behavior, relationships, activities, etc.—all aspects that CBT for Late Life Depression is directed at increasing. Thus, this survey provides very relevant information on outcomes when considering the goals of the program.

Executive Summary: Key Findings

The Center (TC) located within the Desert region and Inland Caregiver Resource Center (ICRC) located within the Western region, provide services to older adults experiencing depression. A total of 120 participants were provided CBT for Late Life Depression (CBT- LLD) within Fiscal Year (FY) 2023-2024. The CBT for Late Life Depression program serves participants for a number of weeks throughout the year; thus, some participants who start the program later in the fiscal year will continue services into the next fiscal year (FY 2024/2025). Therefore, not all of the cases will be, or are expected to be, closed by the end of the fiscal year. *Pre to post outcomes data reflects those cases that not only received service within the fiscal year, but were also closed within the fiscal year. Enrollment and demographic data reflect a higher number served as it includes all clients enrolled in the fiscal year.*

The Center (*n*=22) and Inland Caregiver Resource Center (*n*=98) provided CBT for Late Life Depression to a total of **120** participants within FY 23/24.

∴ Overall, there were more female (*n*=84) participants than male (*n*=36) participants. Most participants were between the ages of 65 and 70. For the Center this was 37% of their participants and 34% for ICRC. Participants were mostly English-speaking (59%) with some Spanish-speaking (40%). Race/ethnicity was mostly Caucasian (95%) at The Center and (58%) Hispanic/Latino at ICRC. At The Center, a majority of participants identified as LGBTQI and 'Gay' sexual orientation (82%) whereas a majority of participants at ICRC identified as 'Straight' (92%).

∴ Seventy-three percent (*n*=87) of the clients served were closed during the fiscal year; 56% of whom, successfully completed the program (*n*=49). The remaining 28% will carry into the FY 24/25.

∴ Statistically significant ($p < 0.001$) change was observed between the pre-test and post-test PHQ -9 measures. Depression scores decreased from moderate to minimal levels overall (pre *M*=14; post *M*=4).

∴ All of the items on the Quality of Life survey showed improvement, with most (85%, *n*=11) of the total 13 items showing statistically significant ($p<.01$) positive change, indicating that participants were engaging in more social behavior and pleasurable activities.

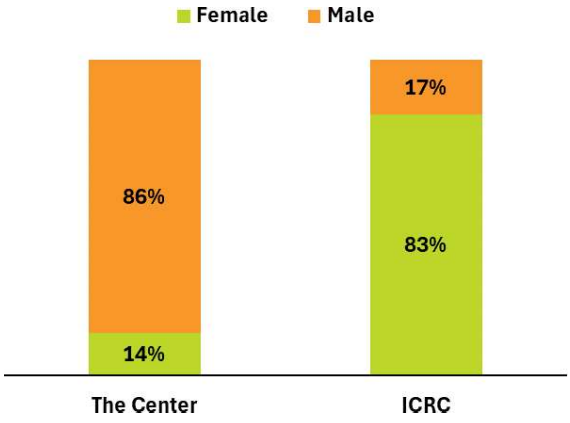
∴ The satisfaction surveys that were administered show positive ratings across all items— the highest ratings being that they would return to the program if they needed help again, the quality of service they received from their practitioner, and how satisfied they were with the program.

PROGRAM ENROLLMENT

The Center provided CBT for Late Life Depression to a total of 22 participants, whereas The Inland Caregiver Resource Center (ICRC) served 98 individuals within FY 23/24.

DEMOGRAPHICS

Participant Gender



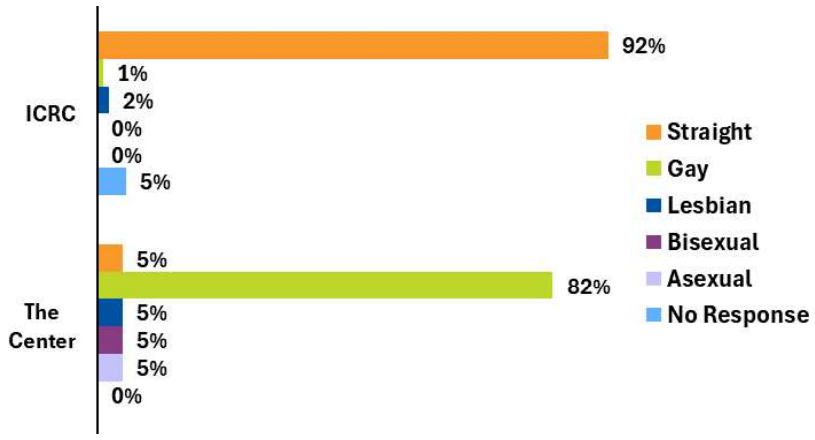
Overall, there were more female (*n*=84) participants than male (*n*=36) participants in FY 23/24. ICRC served the majority of the females, making up 83% (*n*=81) of their participants compared to males (*n*=17). Whereas, The Center served 86% males (*n*=19, 14% females (*n*=3).

Participant Age

Age	The Center (n=22)	ICRC (n=98)
59-64	5 (23%)	10 (11%)
65-70	8 (37%)	33 (34%)
71-74	5 (23%)	20 (21%)
75-79	3 (14%)	20 (21%)
>80	1 (5%)	15 (16%)

Participants ranged between the ages of 57 to 94. The majority of participants (34%) overall were within the ages of 65 and 70 (*n*=41).

Sexual Orientation



Most participants served by The Center (*n*=21) identified as part of the Lesbian, Gay, Bisexual (LGB) community—which is consistent with the agency's target population. Specifically, consumers identified as Gay (*n*=18, 82%), Lesbian (*n*=1, 5%), Bisexual (*n*=1, 5%), or Asexual (*n*=1, 5%). Whereas, the ICRC predominantly reported 'Straight' (*n*=90, 92%), Gay (*n*=1, 1%), and Lesbian (n=2, 2%). Five participants did not disclose their sexual orientation (5%). All consumers are welcomed to join program regardless of disclosing sexual orientation status.

Demographics

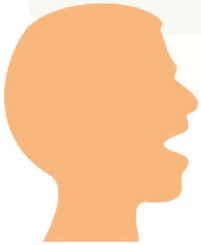
Frequently Reported Cities

City	Frequency (count, %)
Riverside	28 (23%)
Palm Springs	13 (11%)
Moreno Valley	9 (8%)
Corona	8 (7%)
Banning	6 (5%)
Hemet	6 (5%)
No Response	5 (4%)
Other	45 (38%)

The table above indicates the top six residential cities. Many of the participants resided in Riverside 23% (*n*=28). 'Other' specifies smaller samples among nineteen cities that are spread (range: 1-5) out in Riverside County (e.g. Indio, Coachella, Mira Loma, Perris, etc.).

Language

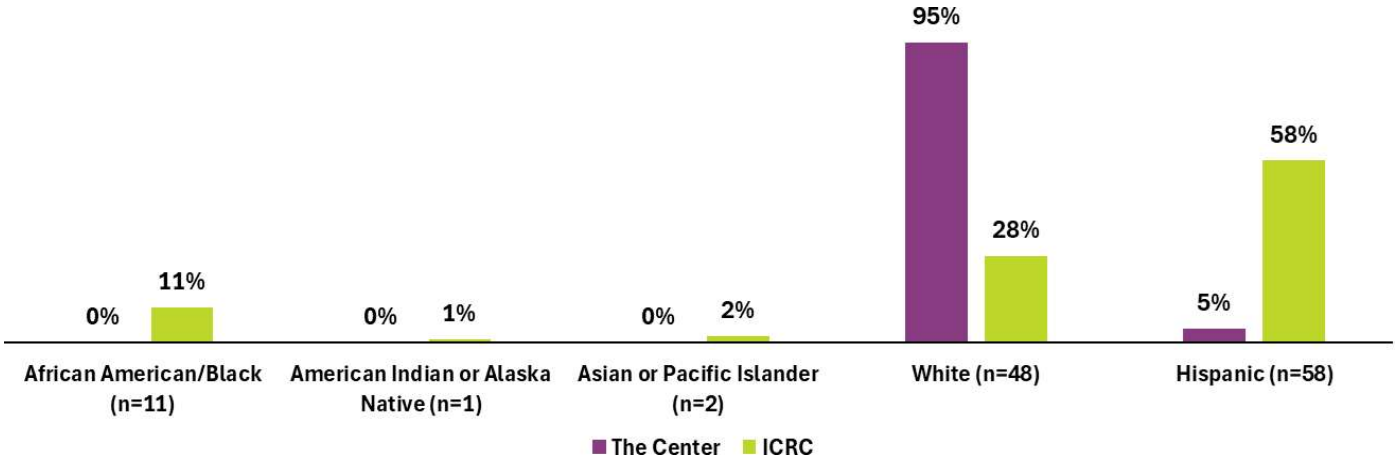
59% of participants (71) indicated primary language as English, whereas the remaining 40% (48) spoke Spanish.



The majority of the participants reported English (*n*=71) as their primary language and 48 participants noted Spanish as their primary language. There was one participant who did not indicate their primary language.

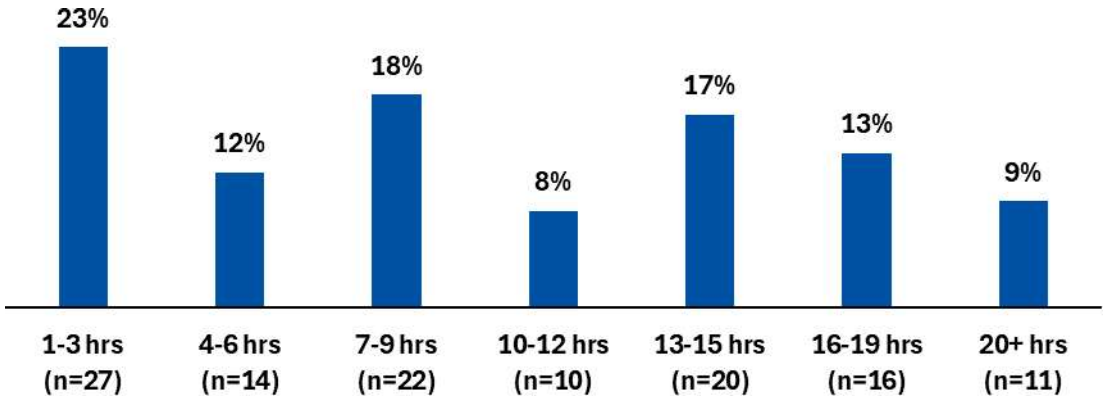
Participant Race/Ethnicity

The participants primarily identified as White at The Center (*n*=21) and there was one participant who identified as Hispanic. At ICRC the majority of participants identified as Hispanic (*n*=57) following were participants who identified as White (*n*=27). Finally, at ICRC eleven participants identified as African American/Black, one identified as American Indian or Alaska Native, and two identified as Asian or Pacific Islander.



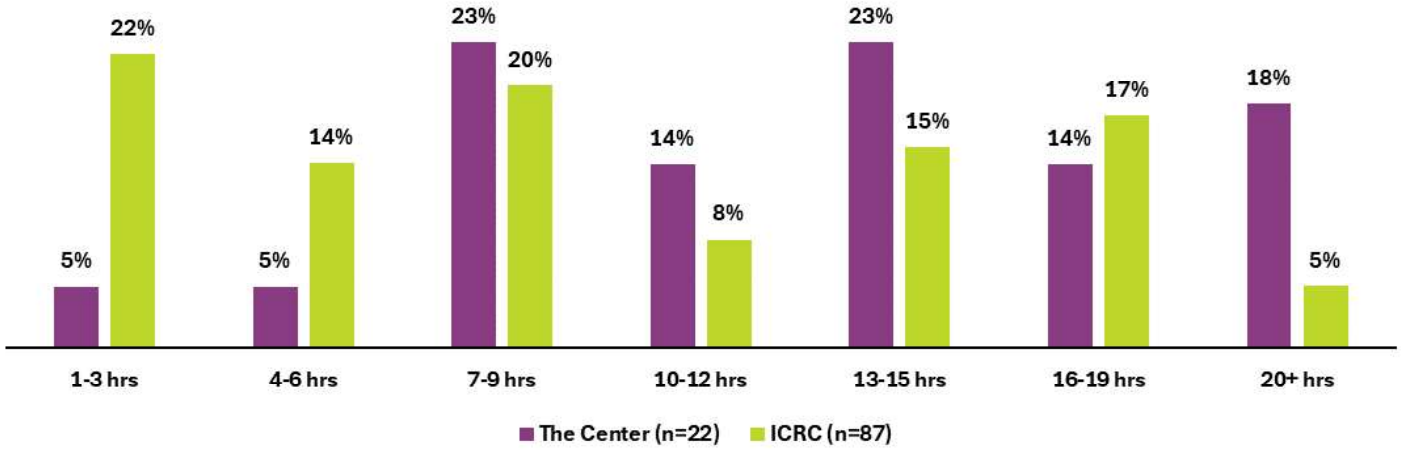
Service Data

A total of **1189.75** hours of service was reported for the **120** participants. Nearly 70% of the participants received over 6 total hours of service. Over a third of participants received 7 -15 hours of service (*n*=52, 43%); whereas nearly a quarter received 1-3 hours of service (*n*=27, 23%). Of the 42 participants who received 6 hours or less of total service, 29% were clients who carried over from the previous 22/23 FY (*n*=12) and 36% are carrying over into the next 24/25 FY (*n*=15) which can account for some of the low service hours. *Since some cases may not open and close within the same fiscal year, the total number of service hours recorded for the 23/24FY does not include services that the client may have received in previous or subsequent fiscal years.*



Service Data by Service Type

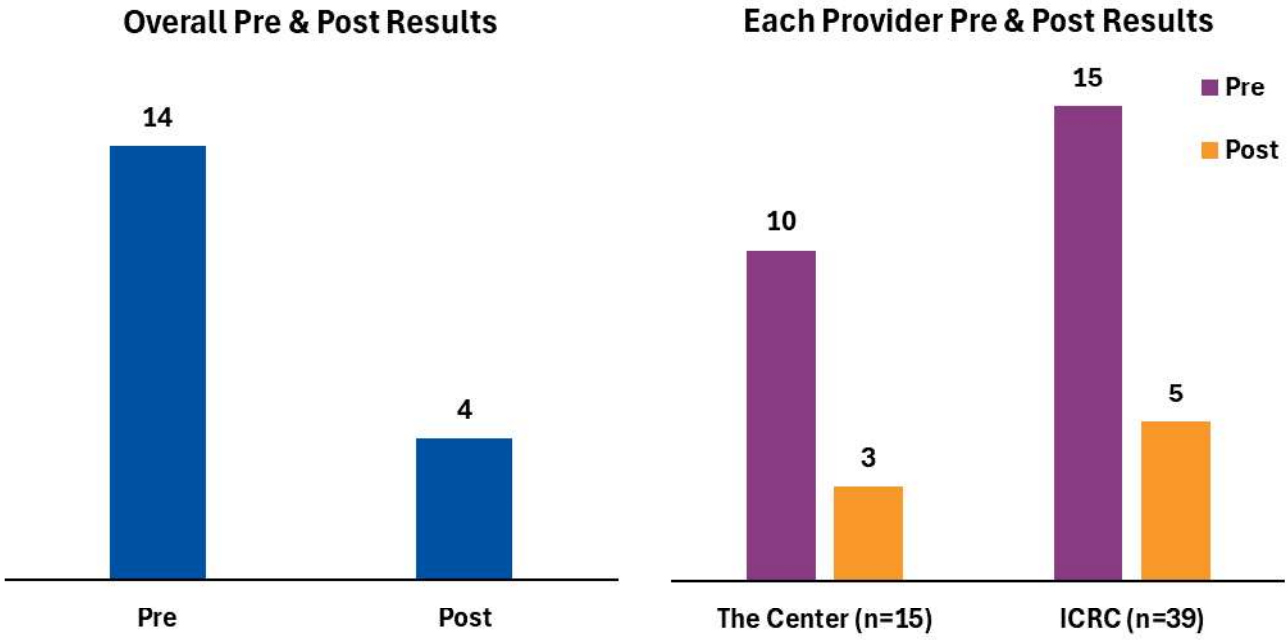
The Center provided CBT therapy sessions to all of their 22 participants totaling 299 services, amounting to 299 hours, while ICRC provided therapy services to 87 of the 98 total participants served. Furthermore, ICRC had a total of 884 services, totaling 891 hours. Of the total 884 services provided by ICRC, 62 were assessments which summed to 59 hours. The remaining 822 services were CBT therapy sessions equaling 832 hours. The graph below depicts only CBT therapy session services. This year's services were neither submitted nor compiled in the same manner as in previous years, so they will be organized by total hours per client by program, as shown in the figure below. *The current fiscal year's service hours do not include the services clients received from previous or subsequent fiscal years, this data only reflects participants services in the FY23/24.*



Patient Health Questionnaire-9 (PHQ-9) Pre & Post Results

Patient Health Questionnaire-9 (PHQ-9) is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents age 12 years. This shorter test is derived from the original and longer PHQ assessment that addresses multiple mental health concerns including depression, panic disorder, anxiety, sleep disorders, and others. Each item is scored on a scale of 0-3, ranging from the least severe clinical response to the most severe clinical response.

The PHQ-9 is scored by summing the ratings for the 9 items. A total score of 0-4 is considered as having minimal levels of depression—generally describing those, whose scores fall within the range, as 'non-depressed.' A total score of 5-9 indicates symptoms of mild depression; a total score of 10-14 indicates symptoms of moderate depression; a total score of 15-19 indicates symptoms of moderately serve depression; and a total score of 20-27 indicates symptoms of severe depression.



The Center (n=15) and ICRC (n=39) showed a significant decrease ($p < 0.001$) in depression symptoms from the beginning (M=14) to the end of the program (M=4). Sometimes post measures could not be collected due to participants leaving the program without completing the accompanying post measures.

Score Interpretation for PHQ-9:

- 0-4 is considered as having *minimal* levels of depression
- 5-9 indicates symptoms of *mild* depression
- 10-14 indicates symptoms of *moderate* depression
- 15-19 indicates symptoms of *moderately severe* depression
- 20-27 indicates symptoms of *severe* depression

Quality of Life Survey

The Quality of Life (QOL) survey includes general quality of life items and questions on participation in pleasant and social activities. It is rated on a scale from 1-7, with higher ratings indicating more positive results. The QOL survey is an important and integral part of measuring outcomes as it specifically collects feedback from participants on social behavior, activities, etc. all relevant aspects of outcome information that CBT for Late Life Depression is directed at increasing.

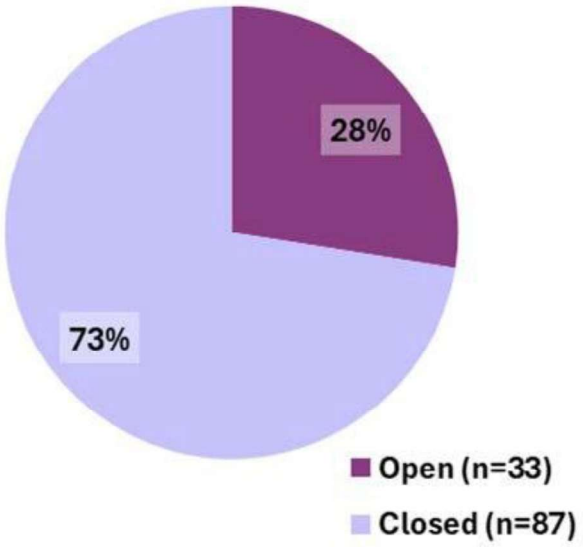
Participants reported an improvement in quality of life from pre- to post-test, as can be seen in the statistically significant (p<.05) changes found for each item as indicated in bold. All the QOL items showed improvement. However, participants experienced statistically significant (p<.05) improvements for most items such as how they felt about the things they do socially with others; life in general, and emotional well-being. Since the Quality of Life survey is not evaluated based on the total sum of participants' scores, it is shown below as individual items.

	QOL Items	Pre	Post
1	How do feel about your life in general? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.72	**4.96**
2	How do you feel about the amount of relaxation in your life? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.64	**4.96**
3	How do you feel about the things you do with other people? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	4.77	**5.85**
4	How do you feel about the amount of time you spend with other people? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	4.26	**5.11**
5	How do you feel about the people you see socially? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	5.34	**5.77**
6	How do you feel about the amount of friendship in your life? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	4.65	**4.96**
7	How socially active would you say you have been in the past month? (1=None 2=A little 3=Fairly Active 4=Quite Active 5=Very Active 6=Extremely Active)	2.58	**3.51**
8	In general how would you say your health is? (1=Poor 2=Fair 3=Good 4=Very Good 5=Excellent)	2.47	**2.72**
9	How do you feel about your health in general? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.68	4.51
10	How do you feel about your physical condition? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.60	**4.25**
11	How do you feel about your emotional well-being? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	2.96	**4.77**
12	How much bodily pain have you had during the past month? (1=Very Severe 2=Severe 3=Moderate 4=Mild 5=Very Mild 6=None)	3.06	3.70
13	In the past month, how much has your physical/emotional health interfered with your normal social activities with family, friends, neighbors or groups? (1=Extremely 2=Quite a bit 3=Moderately 4=Slightly 5=Not at all)	2.60	**3.68**

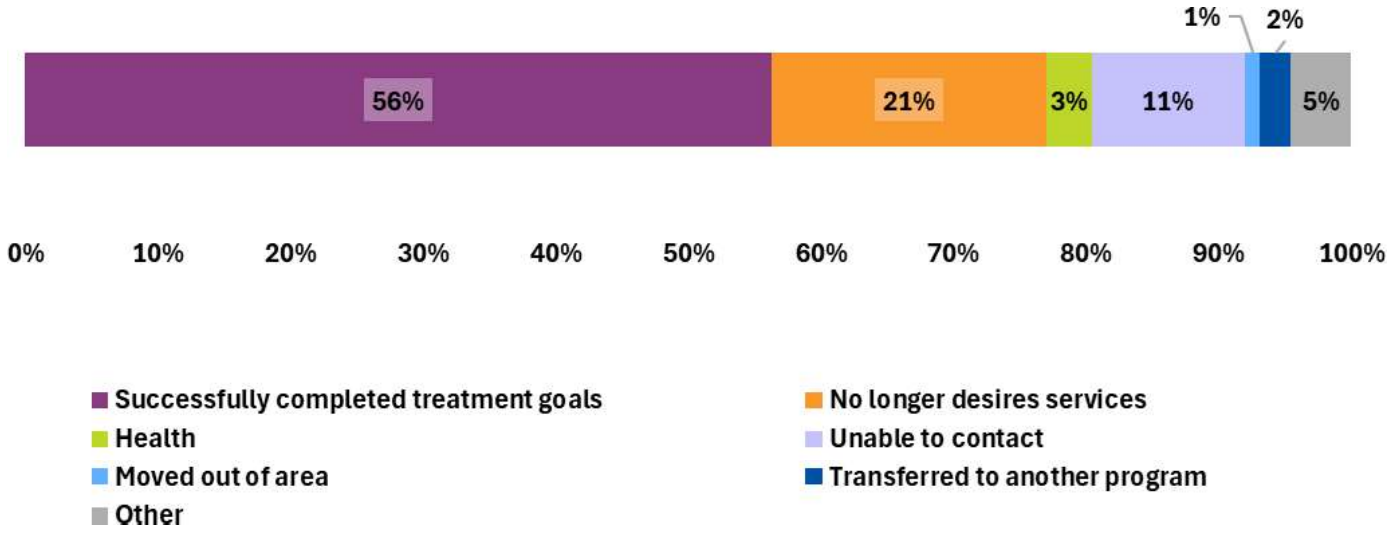
BOLD Numbers indicate statistically significant (p < 0.05) change Pre to Post

Discontinuance Summary

Of the 120 participants served, 87 closed during this 23/24 FY. At closing, Discontinuance Summary forms were completed, listing the reason for discontinuance of service, as shown below. Of the total closed participants, over half (56%, *n*=49) were reported as having successfully completed their treatment goals. The remaining 33 participants will carry over into the next 23/24 FY.



Reason	(*n=87*)
Successfully completed treatment goals	49 (56%)
No longer desires services	18 (21%)
No show	-
Health	3 (3%)
Unable to contact	10 (11%)
Moved out of area	1 (1%)
Transferred to another program	2 (2%)
Death	-
Other	4 (5%)



Satisfaction Surveys

Of the 87 participants who closed from the program, 57 (66%) completed Satisfaction Surveys, as sometimes participants may leave the program without completing the Satisfaction Survey or other post-program measures.

Participants gave the highest ratings to the quality of the service they received from their practitioner, their likelihood to return to the program if they were to seek help again, and the satisfaction they felt in the support they received from the program. The lowest rated item was for "Did this program help you to cope better?" (*M* =3.39). Other items relating to whether the participants felt that the program helped them improve their quality of life were among the lower ratings that were given but all questions were still in the Good/Satisfied range. Overall, the satisfaction surveys show positive feedback from participating in the CBT for Late Life Depression program.

Survey Items & Results (n=57)

Question	Average	1	2	3	4	5	*M
How would you rate the quality of service you have received from your practitioner? (Excellent=4, Good=3, Fair=2, Poor=1)	**3.84**	-	-	16%	84%	-	-
In a general sense, how satisfied are you with the support you have received from this program? (Very Satisfied=4, Mostly Satisfied=3, Mildly Dissatisfied=2, Quite Dissatisfied=1)	**3.82**	-	4%	18%	82%	-	-
Did this program help you to cope better? (Almost all of my needs have been met=4, Most=3, Only a few=2, None=1)	**3.39**	-	-	54%	42%	-	-
Did you gain strategies to help you cope? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.77**	-	-	23%	77%	-	-
Did you gain strategies to help you improve your quality of life? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.75**	-	-	25%	75%	-	-
Has participation in the program reduced your depression symptoms? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.75**	-	-	25%	75%	-	-
**Would you say, as a result of the program, you now know how to get help for depression? (Yes, Definitely=5, Yes, I think so=4, Not Sure=3 No, I don't think so=2, No, Definitely not=1)	**4.70**	-	-		30%	70%	-
If you were to seek help again, would you return to this program? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.93**	-	-	7%	93%	-	-

**M represents missing values*
***Questions on a scale of 1-5*

Satisfaction Surveys– Comments

The program helped me to understand why I react the way that I do to some life situations. Helped me to cope with some of my home issues with my husband. [Therapist] is very kind.

My therapist has been a valuable resource to me.



This therapy worked very well for me. I had reached the end of my resilience and was quite lost and depressed, short on hope. The skills I learned put me on a better path fairly quickly...Thanks very

[Therapist] is a wonderful therapist understanding a lot of the issues she was faced with me. I would come back to her when I need counseling again. Thanks!!

I appreciated the consistency and the opportunity to be heard, the program exceeded my expectations

APPENDIX: Annual Program Reviews

Participant Service and Completion Rates				
Program Service	***FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served	21	50	128	120
Total # Hours Served	256.42	814.66	2484.27	1189.75
Average Hours per Participant	12.21	16.29	19.41	
# of Participants CLOSED (% of Total Served)	17 (81%)	19 (34%)	71 (55%)	87 (73%)
Successfully Completed Treatment Goals	*10 (59%)*	*9 (47%)*	*41 (58%)*	*49 (56%)*

Outcomes Evaluation				
Percentage of Participants Improved	***FY 20/21**	**FY 21/22**	**FY 22/23**	**FY23/24**
BDI-II (%)	100%	100%	—	—
PHQ-9 (%)	—	—	93%	99%
QOL (%)	100%	95%	91%	85%

**Service was provided by one contractor.*

A total of 120 participants were served with CBT for Late Life Depression during FY 23/24. The CBT-LLD program has two community-based organizations, which expanded enrollment this year. Additionally, FY 23/24 had a 73% close rate for participants who closed within the fiscal year, which increased from 55% in the previous fiscal year. Of the participants who were closed, 56% successfully completed their treatment goals, which is lower than last fiscal year 22/23.

As can be seen in the Outcomes Evaluation table, the majority (85%) of participants reported improvements within their pre to post QOL measures which is lower than fiscal year 22/23 (93%). For PHQ-9, 99% of participants showed improvement from their pre to post measure which is higher than fiscal year 22/23 in which 91% showed improvement.

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention Program to Encourage Active and Rewarding Lives (PEARLS) Annual Report FY 2023-2024

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Provider and Program Overview

Program Overview

The **P**rogram to **E**ncourage **A**ctive and **R**ewarding **L**ive**S** (**PEARLS**) is an evidence-based program designed for people aged 60 years or older who are experiencing minor depression or dysthymia (an ongoing, low-grade level of depression lasting two or more years). PEARLS is an in-home intervention that utilizes an empowering, skill-building approach based on three core elements: (1) problem solving treatment (PST); (2) social and physical activation; and (3) pleasant-activity scheduling. These three elements contribute to the empowerment of participants by encouraging them to engage in behaviors that will help them reach their goals.

The PEARLS intervention is time limited and ideally distributed over a 19-week period. Each session is structured and designed to assist participants in defining and solving their problems, becoming more socially and physically active, and experiencing more pleasant activities. PEARLS provides a substantial, straightforward, and empowering approach to solving problems and reducing depression. Participants are encouraged to continue with the approach after the sessions have ended. PEARLS facilitators make brief follow-up calls to support and encourage participants in this transition.

PEARLS participants are recruited through outreach. Several screening tools are used to help determine eligibility and whether a client would benefit from the program. The screening tools include the nine-item Patient Health Questionnaire (PHQ-9), a set of questions to identify dysthymia, and a set of exclusion-criteria questions to screen out clients who'd be better served by other programs. An attempt is made to refer clients to such programs.

Outcomes Evaluation

The Patient Health Questionnaire (PHQ-9) is embedded in PEARLS program sessions to determine if an individual's depression symptoms are improving. Changes between the baseline intake score (pre) and final score (post) are used in evaluating the program outcomes. Similar evaluations in (1) generalized anxiety; (2) participation in social and pleasant activities; (3) physical activities; and (4) quality of life are also included in the outcomes evaluation. The measures used are summarized below:

- The PHQ-9 (Patient Health Questionnaire) is administered at each session. Changes in scores over the sessions gauge whether session activities are reducing depression symptoms. The difference between intake and final PHQ-9 scores are used to determine success in the reduction of depression symptoms.
- The GAD-7 (Generalized Anxiety Disorder) is administered at the beginning and conclusion of program services to gauge reduction in generalized anxiety.
- RAPA (Physical Activity Survey) is administered at the beginning and conclusion of program services, to gauge the increase in frequency of physical activitie.
- A pre/post program survey is administered at the beginning and conclusion of program services. It covers general quality of life, including participation in pleasant and social activities. The post questionnaire includes additional items related to satisfaction with the PEARLS program.

Executive Summary

Enrollment/Demographics

1. 133 prospective participants were screened in FY 2023-2024.
2. 109 participants were served (received one or more program services) in FY 2023-2024. This represents a 36% increase from the FY 2022-2023 total of 80.
3. All 109 served participants were of the target 60-and-over demographic.
4. Gender for the 109 served participants remained predominantly female (76%).
5. The predominant race percentages for served participants were 49% White, 33% Hispanic/Latinx, 14% Black/African-American. There was one Asian participant. There were two Native Americans, one specifying multiple races.

Services

1. The 109 served participants received an average of 5.9 total hours of service.
2. In FY 2023-2024, no participant received more than 8 PEARLS program services.
3. Of the 109 FY 2023-2024 served participants, 95 closed from the program (the remaining 14 were still active in the program). 53 of the 95 closing participants (56%) successfully completed the program. This represents an improvement over last year's 46% completion rate.

Outcomes

1. Countywide, the reduction in depression symptoms as measured by the PHQ-9 was statistically significant ($p \leq 0.05$) for PEARLS participants completing the program. Furthermore, average depression as measured by the PHQ-9 was reduced 29% from "moderate" to "mild" countywide.
2. Countywide, the reduction in anxiety symptoms as measured by the GAD-7 was statistically significant for PEARLS participants completing the program. Furthermore, average anxiety as measured by the GAD-7 was reduced 40% from "moderate" to "minimal" countywide.
3. Countywide, the increase in physical activity as measured by the RAPA was not statistically significant for PEARLS participants completing the program.
4. The Quality-of-Life survey showed statistically-significant improvement for participants in eight of the nine questions: "health", "life in general", "emotional well-being", "spare time", "time with others", "friendship", "social activity", and "pleasant activities". Changes in "family" were not significant.

Selected Participant Comments

- PEARLS lowered my level of depression. I learned how to manage certain situations in my home and at work.
- (My practitioner's) calm and friendly approach has helped me as a caregiver to not see things in an awful way. It has helped me focus on things I have control over.
- It helped improve my quality of life and my self-esteem, and helped me sleep better. I'm more social and I have faith in myself. I have courage to express myself.

Screening and Service Overview

Individuals interested in participating in PEARLS are screened to determine if they are eligible for the program. The screening consist of: (1) a PHQ-9 to determine the participant's level of depression; (2) a dysthymia screen, which may establish eligibility if the PHQ-9 fails to indicate depression; (3) an additional exclusionary screen for the presence of psychosis, bipolar disorder, drug addiction, or alcoholism; (4) a brief six-item memory cognition screen to indicate possible memory or cognitive impairment. Individuals presenting with exclusionary conditions, including **major** depression, are instead referred to treatment services appropriate for those conditions. As shown in Table 1.1, a total of 133 individuals were screened in FY 2023-2024 countywide.

Screened individuals who meet the criteria outlined above may go on to participate in PEARLS. After receiving their first PEARLS program service, individuals are referred to as *participants* and considered *served*. By continuing to receive the prescribed number of services, participants complete the program.

As shown in Table 1.1, of the 133 screened individuals, 88 both met criteria for participation, and received at least one program service. Thus 66% of screenings resulted in participation.

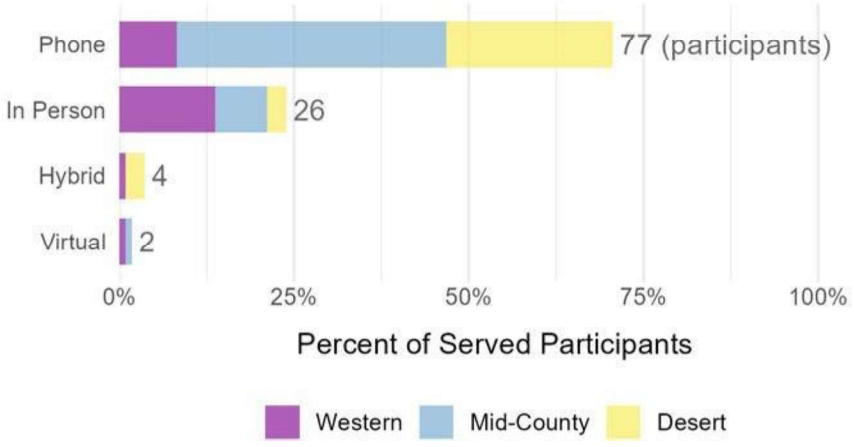
During FY 2023-2024, active participants from the previous fiscal year also received services. These participants are referred to as *carryovers* and totaled 21. Thus, the total number of participants served in FY 2023-2024 was 109, a 36% increase from the FY 2022-2023 total of 80.

Figure 1.1 shows the mode of service for the 109 participants served in FY 2023-2024.

Table 1.1: Participant Summary

Description	Desert	Mid-County	Western	COUNTYWIDE
Individuals Screened FY 2023-2024	46	54	33	**133**
Participants Screened/Served FY 2023-2024	26	44	18	**88**
Participants Active from FY 2022-2023 (Carryovers)	6	7	8	**21**
TOTAL Participants Served	32	51	26	**109**

Figure 1.1: Mode of Service



Countywide, the majority of participants 77 (71%) received service by phone, followed by in person with 26 (24%).

Service Summary

During FY 2023-2024, PEARLS delivered a total of 585 services consisting of 135 screening and 450 program services. Screenings for all individuals were completed in a single service. Two participants, however, were re-screened after leaving the program but later requesting to return. 133 distinct individuals were therefore screened in FY 2023-2024.

Figure 2.1 shows the service-duration breakdown for the 135 screening services. Figure 2.2 shows the service-duration breakdown for the 450 program services.

Figure 2.3 shows the number of program services received by a typical PEARLS participant. We exclude 34 active participants who have not yet completed their ultimate number of services. The 96 closed PEARLS participants received 406 program services distributed as shown in Figure 2.3.

Figure 2.1: Distribution of Screening Service Duration

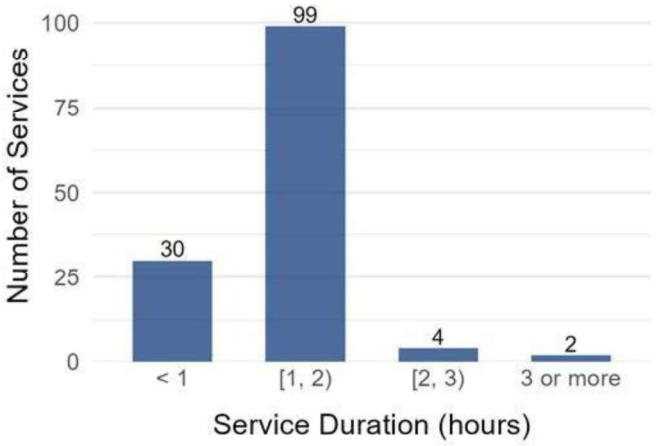


Figure 2.1 shows that the majority (73%) of the 135 screening services were between 1 and 2 hours in duration.

Figure 2.2: Distribution of Program Service Duration

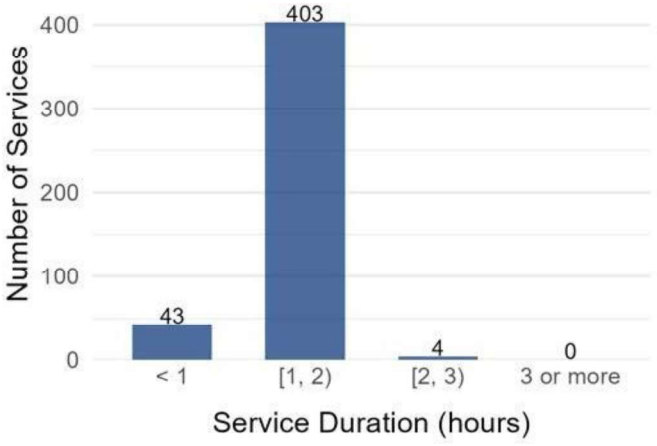


Figure 2.2 shows that the majority (90%) of the 450 program services were between 1 and 2 hours in duration.

Figure 2.3: Number of Program Services

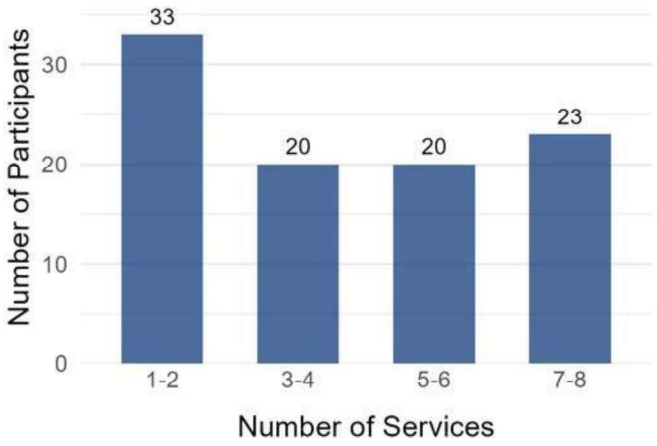


Figure 2.3 shows the distribution of 406 program services among the 96 closed (completed or terminated) participants.

Demographics

The average age of the 109 distinct PEARLS participants served in FY 2023-2024 was 74.5, an increase from the FY 2022-2023 average of 69.5.

Figure 3.1 shows age distribution. Countywide the distribution shifted to older participants compared to FY 2022-2023.

Figure 3.2 shows the gender ratios of the n = 109 served participants by region. Countywide, males constituted 24% of PEARLS participants.

Figure 3.1: Age of PEARLS Participants

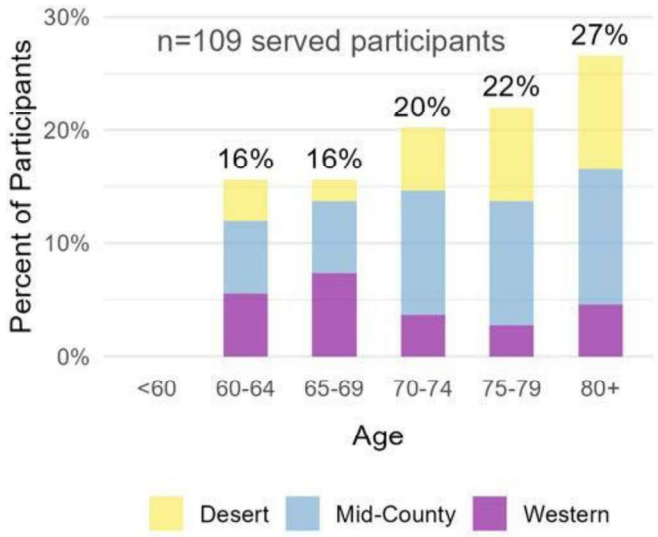


Figure 3.1 shows the age distribution of PEARLS participants by region. Countywide the distribution shifted to older participants compared to FY 2022-2023. Participants in the 75-79 cohort increased from 19% to 22%. Participants in the 80+ cohort increased from 19% to 27%. The Desert and Mid-County regions were mostly responsible for this shift.

Figure 3.2: Gender of PEARLS Participants

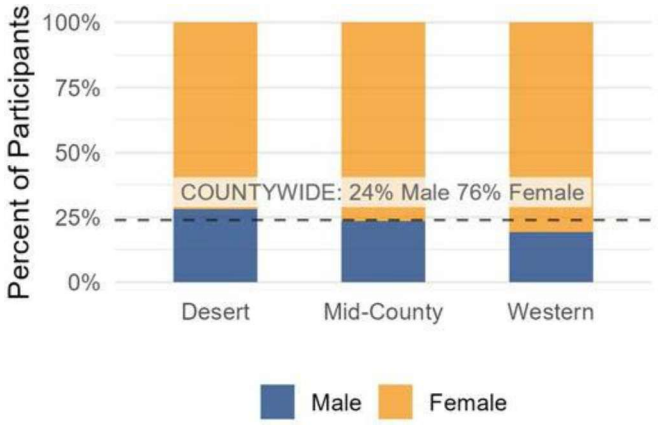


Figure 3.2 shows the gender ratios of the n = 109 served participants by region. Countywide, males constituted 24% of the PEARLS participants. This represents an increase from the FY 2022-2023 value of 19%. Prior research has shown that older male adults are at greater risk of suicide, underscoring the need to promote intervention-type programs in this population.

Demographics (continued)

The PEARLS *Demographics and Screening Form* lists common race and ethnicity categories. Prospective participants can make one or more selections from the list or choose "Other" and provide one.

Figure 3.3 shows the breakdown of race as specified by the 109 PEARLS participants. Two FY 2023-2024 participants identified as *Native American*, with one subsumed by the *Multi-Racial* category (additionally identifying as *Hispanic/Latinx*). 49% of participants identified as *White/Caucasian*, followed by 33% *Hispanic/Latinx*, followed by 14% *Black/African American*.

Of the 109 served participants, 36 (33%) identified as *Hispanic/Latinx*. This total includes one participant also identifying as Native American, and thus subsumed by the *Multi-Racial* category in Figure 3.3. Table 3.1 lists the ethnicity specified by the 36 participants identifying as *Hispanic/Latinx*.

Figure 3.3: Race of PEARLS Participants

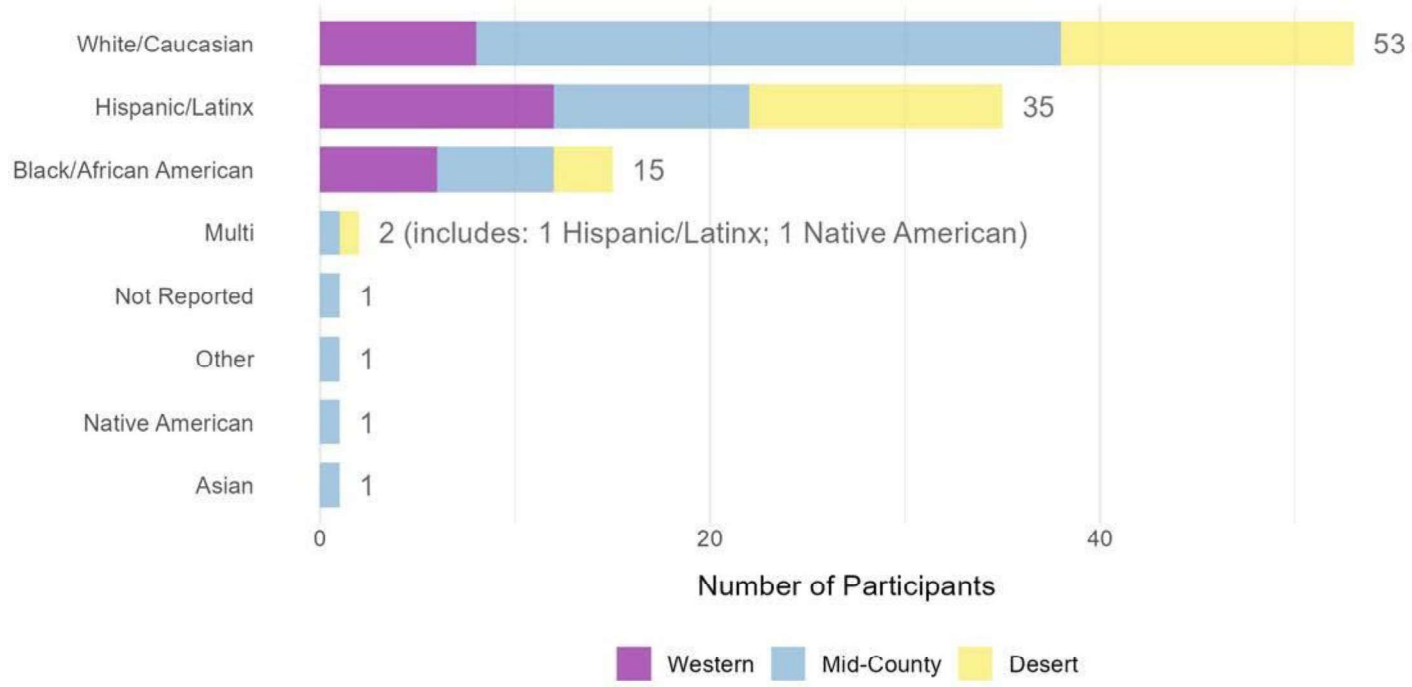


Table 3.1: Ethnicity Specified by Hispanic/Latinx PEARLS Participants

Mexican	23 (64%)
Colombian	2
Peruvian	2
Honduran	1
Salvadorean	1
Venezuelan	1
Not Specified	6

Closing of Participants

A closing disposition is documented when a participant: (1) completes the PEARLS program, (2) explicitly discontinues service, or (3) can no longer be contacted. Of the 109 participants served during FY 2023-2024, 95 had a closing disposition (the remaining 14 were still receiving services). Of the 95 closings, 53 completed the program, and 42 either explicitly discontinued or could no longer be contacted.

Figure 4.1: Completion Rates

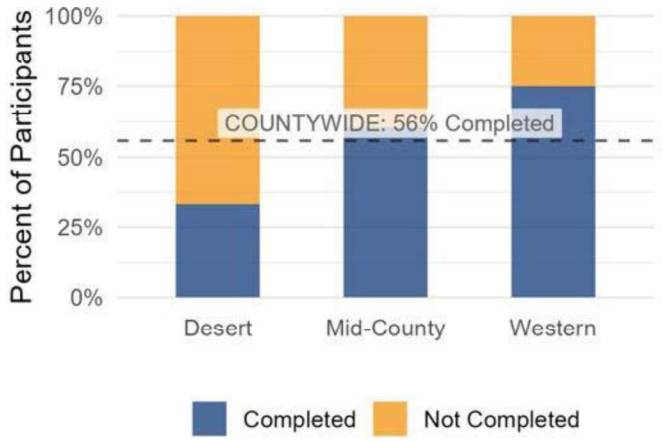
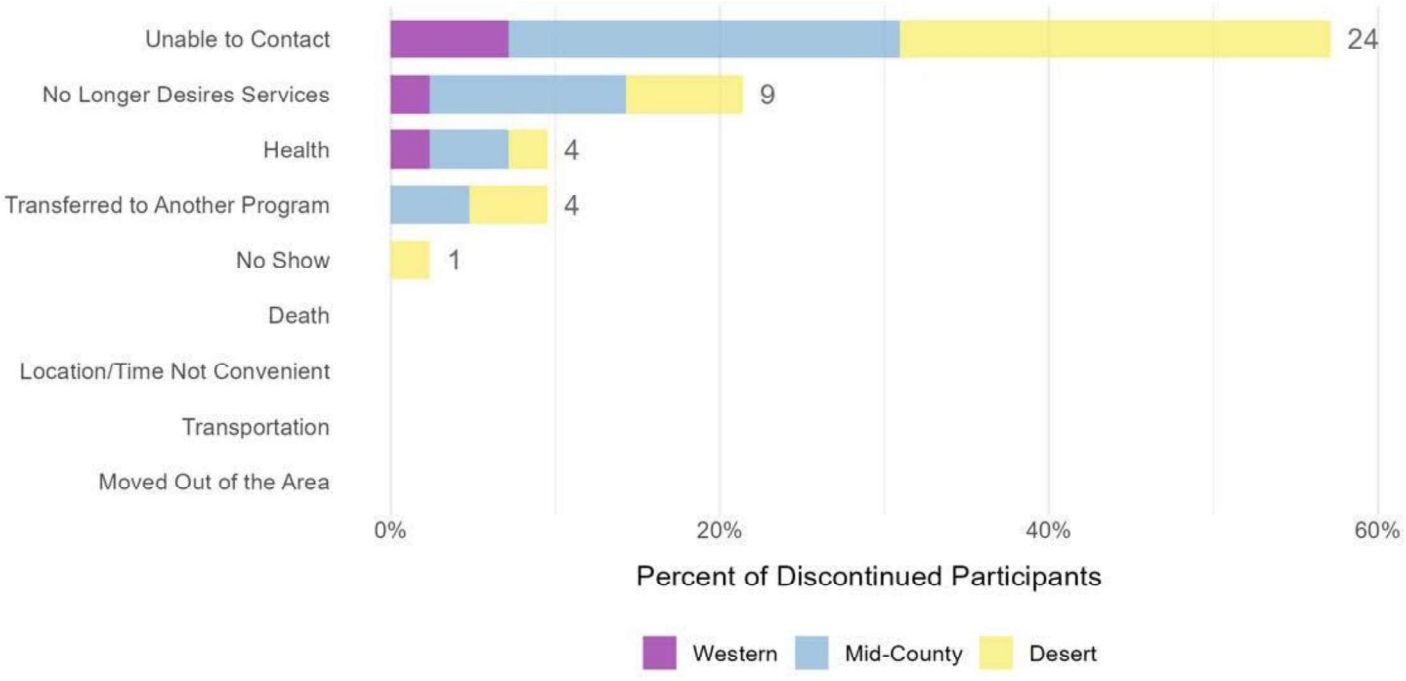


Figure 4.1 shows the completion rates for the 95 participants closed during FY 2023-2024. Countywide, 53 or 56%, completed the PEARLS program. This represents an improvement over the FY 2022-2023 completion rate of 46% .

For clients discontinuing service, an attempt is made to determine the reason. Figure 4.2 shows the reason breakdown for the 42 participants not completing the program. The majority (57%) simply could not be contacted. Reasons related to inconvenience (transportation and location/time) were not cited at all.

Figure 4.2: Reason for Not Completing



Program Outcomes: PHQ-9

The PHQ-9 measures symptoms of depression using nine questions in which participants rank on a 0-3 point scale the degree to which they've been bothered by issues related to depression. The issues include (1) loss of interest or pleasure in doing things; (2) feeling down, tired, or bad about oneself; (3) trouble concentrating, sleeping, or speaking; (4) loss of appetite; and (5) thoughts of hurting oneself.

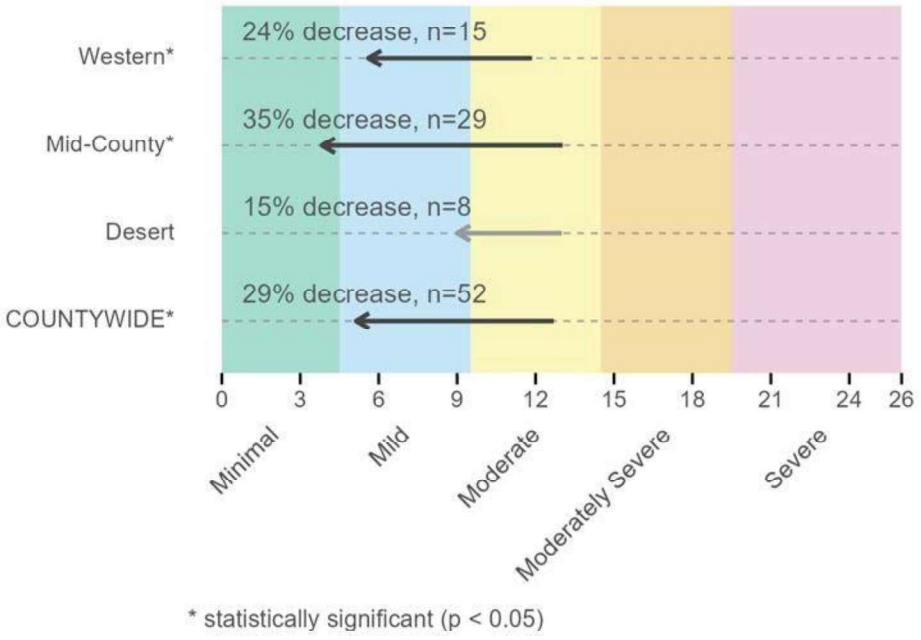
Of the 109 FY 2023-2024 PEARLS participants, 53 completed the program. We use these participants for the analysis. One participant didn't fully complete both the pre and post PHQ-9, leaving n = 52 participants for the analysis. There were no outliers.

Figure 5.1 displays the PHQ-9 results using arrows to point from the average-pre to average post-score.

The one-sided paired T test provides an indication of whether or not the change in average pre to post score is sufficiently significant to be attributable to the program. Statistical significance ($p \leq 0.05$) was achieved countywide and for all regions except Desert.

Furthermore, Figure 5.1 shows that average depression as measured by the PHQ-9 was reduced 29% from "moderate" to "mild" countywide.

Figure 5.1: PHQ-9 Mean Pre to Post Score Outcomes



Program Outcomes: GAD-7

The GAD-7 measures symptoms of anxiety using seven questions in which participants rank on a 0-3 point scale the degree to which they've been bothered by issues related to anxiety. The issues include (1) feelings of nervousness, irritability, fear, and restlessness; (2) not being able to control worrying; and (3) trouble relaxing. Scores are calculated by adding the rank (0-3) selected for each question.

Of the 109 FY 2023-2024 PEARLS participants, 53 completed the program, and n = 32 fully completed both the pre and post GAD-7. There were no outliers.

Figure 6.1 displays the GAD-7 results using arrows to point from the average-pre to average-post score.

The one-sided paired T test provides an indication of whether or not the change in average pre to post score is sufficiently significant to be attributable to the program. Statistical significance ($p \leq 0.05$) was achieved countywide and for Desert and Mid County regions.

An additional question following the GAD-7 is presented to quantify the impact of anxiety on the participant's life. Figure 6.2 shows the pre-to-post results. These were not statistically significant.

Figure 6.1: GAD-7 Mean Pre to Post Score Outcomes

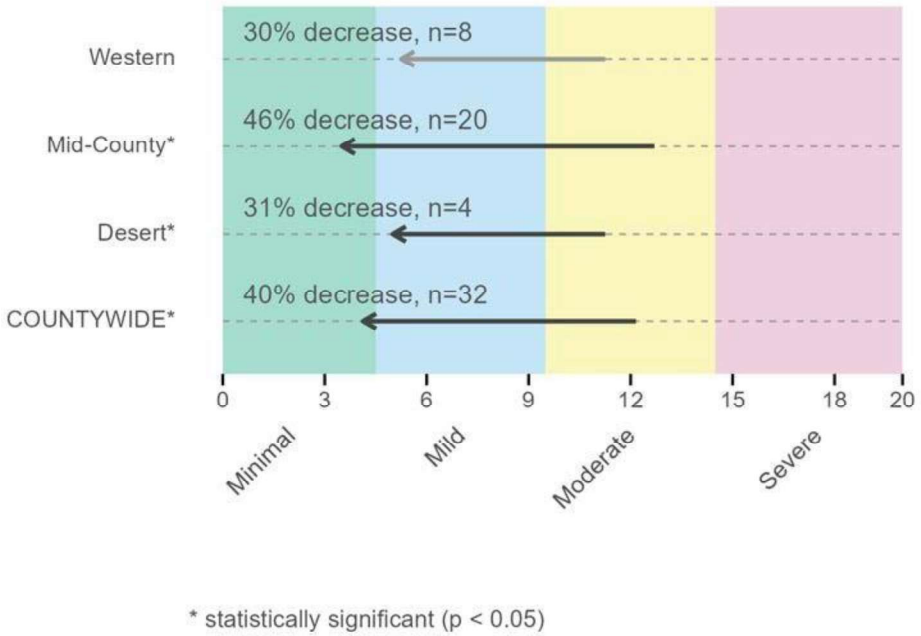


Figure 6.1 shows that average anxiet y as measured by the GAD-7 was reduced 40% from "moderate" to "minimal" countywide.

Figure 6.2: GAD-7 Extra Question

How difficult have these made it for you to do your work, take care of things at home, or get along with other people?



Program Outcomes: Physical Activity (RAPA-I)

PEARLS participant physical activity is assessed using the Rapid Assessment of Physical Activity (RAPA) questionnaire, which consists of nine yes/no questions depicting differing levels and intensity of activity. The participants check off whether or not each question is representative of their usual activity. Questions 1-7, the RAPA I, or "aerobic" section, describe aerobic activities of progressively greater duration and intensity. In contrast, the last two questions, the RAPA II or "strength and flexibility" section, simply indicate the inclusion of strength and flexibility in the participant's normal routine. RAPA II (Strength and Flexibility) outcomes are not currently analyzed.

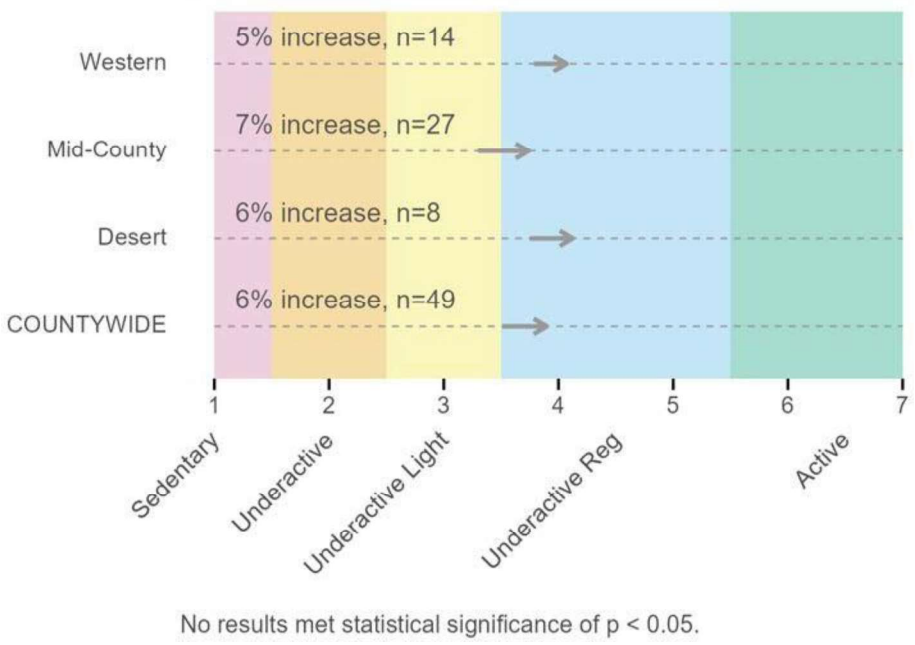
Of the 109 FY 2023-2024 PEARLS participants, 53 completed the program, and n = 49 fully completed both the pre and post RAPA. There were no outliers.

Figure 7.1 displays the RAPA-I results using arrows to point from the average-pre to average-post score.

The one-sided paired T test provides an indication of whether or not the change in average pre to post score is sufficiently significant to be attributable to the program. Statistical significance ($p \leq 0.05$) was not achieved for any region or countywide.

Figure 7.1 displays the progression of average pre to post scores using arrows. Improvement in physical activity as measured by the RAPA-1 was minimal for FY 2023-2024.

Figure 7.1: RAPA-I Mean Pre to Post Score Outcomes



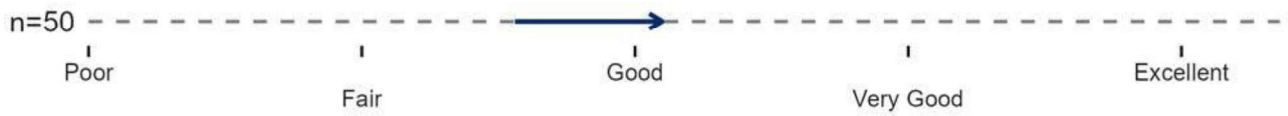
No results met statistical significance of $p < 0.05$.

Program Outcomes: Quality of Life Survey

A nine-question quality of life survey is given to PEARLS participants at the beginning of the program and upon completion. Table 8.1 shows the average pre/post survey results for the 53 participants completing the program. Each arrow points from the average pre to the average post score. For each question, the number of participants completing both a pre and post survey is designated by *n*. Results were statistically significant ($p \leq 0.05$) for all questions except question 5, *How do you feel about the way things are in general between you and your family?*

Figure 8.1: Survey Outcomes

1. In general, would you say your health is:



2. How do you feel about your life in general?



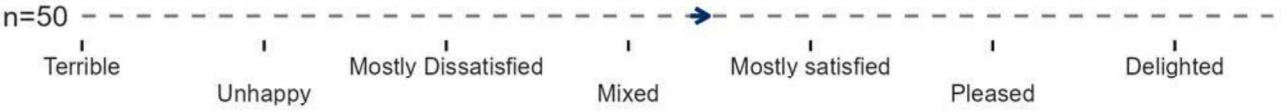
3. How do you feel about your emotional well being?



4. How do you feel about the way you spend your spare time?



5. How do you feel about the way things are in general between you and your family?



6. How do you feel about the amount of time you spend with other people?



Program Outcomes: Quality of Life Survey (continued)

7. How do you feel about the amount of friendship in your life?



8. During the past month, which statement describes how socially active you have been?



9. During the past month, how often have you participated in pleasant activities?



Post Program Satisfaction Survey Results

Five questions related to satisfaction with the PEARLS program and practitioners are included only in the post survey. The first four questions are specific to (1) quality of service, (2) knowing how to get help, (3) likelihood to return to the program, and (4) reduction in depression. Responses to these four questions are summarized in Figures 9.1 through 9.4 below.

Figure 9.1: How Would You Rate the Quality of Service You Have Received From Your Practitioner?

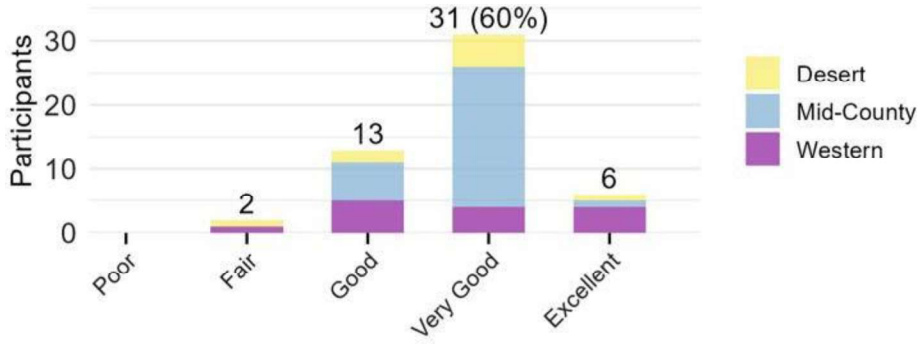


Figure 9.2: In a General Sense, How Satisfied Are You With the Support You Have Received From This Program?

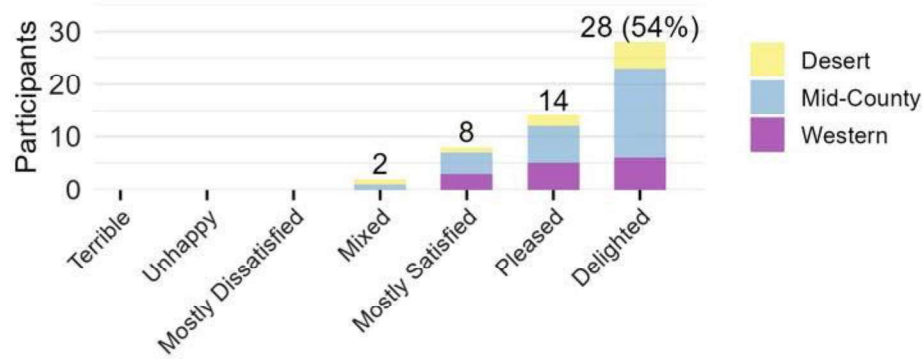
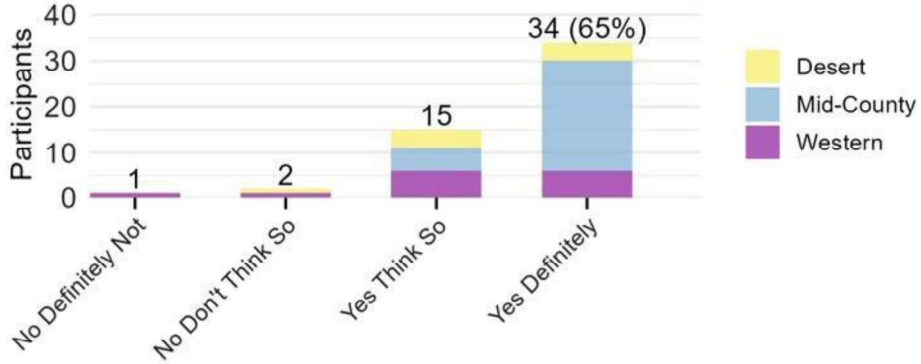


Figure 9.3: Would You Say as a Result of the Program You Now Know How to Get Help for Depression?



Post Program Survey Questions (continued)

Figure 9.4: If You Were to Seek Help Again, Would You Return to This Program?

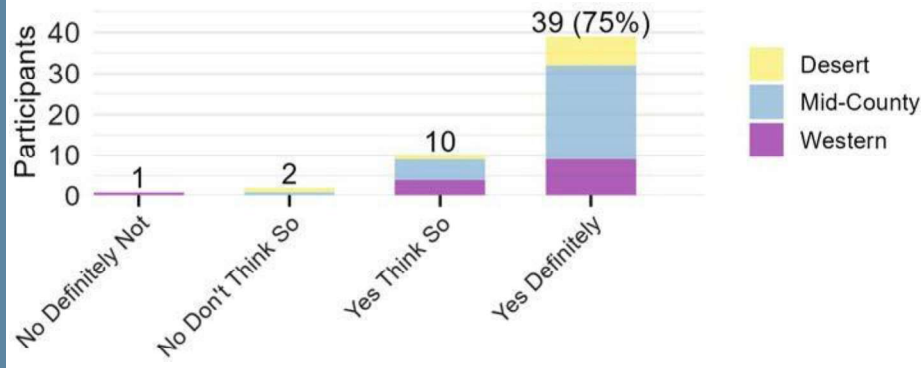
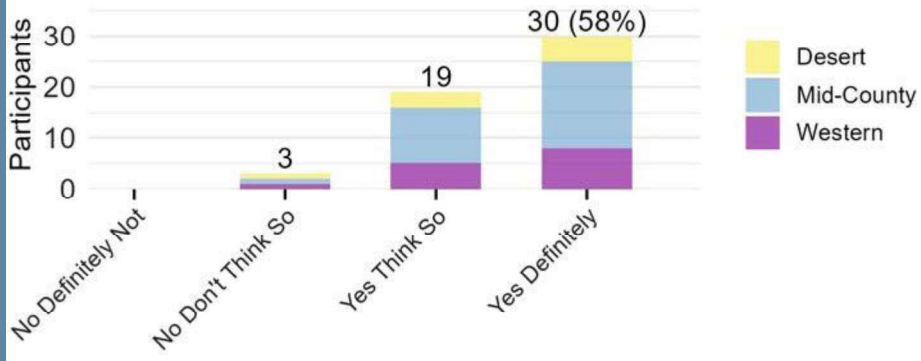


Figure 9.5: Has Participation in This Program Reduced Your Depression Symptoms?



Post Program Comments

The post-program survey includes two fill-in question. Selected responses are reproduced below with minimal edits.

"**If you did benefit from the PEARLS sessions, please describe why.**"

- PEARLS lowered my level of depression. I learned how to manage certain situations in my home and at work.
- I have been able to make some decisions that I was not able to make before as a result of this program.
- I was able to talk to someone with knowledge in guiding me through different scenarios.
- It gave me options that I never thought about before I started the program.
- (My practitioner) was there for me and my husband. I have learned so much that I can use in my day to day life. I really appreciate PEARLS.
- This program helped me learn about my feelings. I learned to find solutions to help me feel better when stressed.
- PEARLS helped me step back and think.
- (My practitioner) motivated me to do the things I wanted to do and now I'm doing them
- (My practitioner's) calm and friendly approach has helped me as a caregiver to not see things in an awful way. It has helped me focus on things I have control over.
- It really benefited me and I have made life changes that have made my day to day better
- It helped improve my quality of life and my self-esteem, and helped me sleep better. I'm more social and I have faith in myself. I have courage to express myself.
- It re-enforced ability to redefine problems and how to solve them

"Do you have any additional comments you would like to share regarding your experience with the PEARLS program."

- I am absolutely so satisfied and happy to have had an avenue to speak openly about my feelings and emotions as I age.
- It has been a blessing that this program exists.
- I was pleasantly surprised how well it works. It wasn't easy at first but through the process it got easier and I got more comfortable.
- Your support is very valuable to improve our quality of life and you all have a gift in the way you provide support.
- I want to thank you for helping me to get out and make friends.

Historical Service and Completion

Figure 11.1: Participants Served

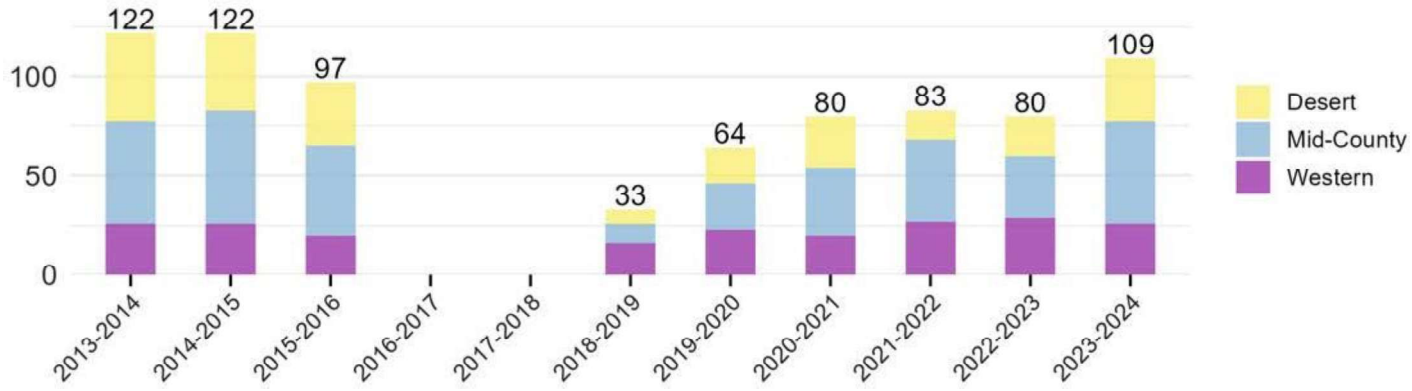
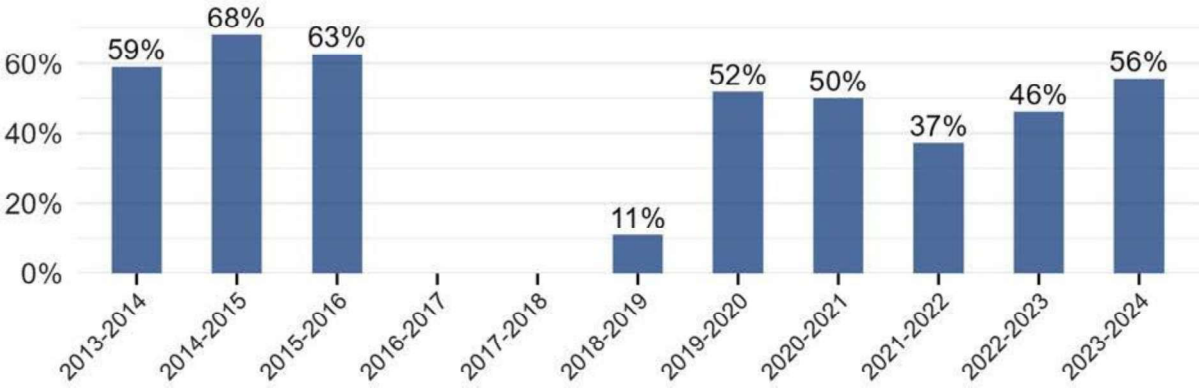


Figure 11.2: Completion Rates



Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention Care Pathways (Caregiver Support Groups) Annual Report FY 2023-2024

Program Overview

The Riverside County Office on Aging (OoA) serves as the main gateway for information and referral assistance to seniors countywide, as well as to family caregivers. The OoA provides supportive services through its Family Caregiver Support Program (FCSP). OoA fully implemented the Care Pathways program, with MHSA Prevention and Early Intervention (PEI) funding, in June 2011. Care Pathways is a 12 week, two-hour class offering education and group support to caregivers of a friend or loved one, 60 years of age or older. The program holds scheduled meetings in the targeted areas of Western region (Rubidoux, East-Side Riverside, Casa Blanca, and Moreno Valley); Mid-County region (San Jacinto, Lake Elsinore, Perris, Romoland, and Winchester) and Desert region (Thermal, Mecca, Coachella, Palm Springs, Indio) of Riverside County. The classes are provided in English and in Spanish.

There is a maximum capacity of 15 participants per class. The program is structured to accommodate caregivers throughout the workshop series. If a participant misses a class within a 12 week session, the facilitator of the group will follow-up to encourage attendance and document any challenges he or she may be experiencing. Workshop Support Group Topics include: Living with Dementia; Signs of Stress & Stress Reduction Techniques; Communicating in Challenging Situations; Legal Issues Related to Challenging Situations; Managing Medications; How to Talk to the Doctor; Learning From Our Emotions; Taking Charge of Your Health; Grieving—Natural Reaction to Loss; Health Lifestyles; and Preventing Caregiver Burnout.

Outcomes Evaluation

The Care Pathways program's main goals are to reduce the risk for depression and to impact the caregivers' sense of well-being by reducing the emotional distress of caregivers. This is accomplished by providing useful information and providing the opportunity to share and bond with others. Two measures are used to evaluate program outcomes.

- Centers for Epidemiological Studies-Depression Scale-20 (CES-D 20) — a 20-item scale developed by the National Institute of Mental Health. The CES--D 20 is designed to measure current levels of depressive symptomology with emphasis on the affective component. The measure is administered at the start of participation in Care Pathways and at the conclusion of the program.

- American Medical Association's (AMA) Caregiver Self-Assessment Questionnaire — is designed to measure indices of emotional and physical distress. This measure is completed at the beginning of the program and at the conclusion of the program.

Executive Summary

Enrollment

During the 2023-2024 fiscal year, 133 individuals participated in the Care Pathways program support groups. Care Pathways enrollment showed 29% of participants were from the West, 23% from Mid-County, and 35% from the Desert region. Seven of the participants were from out of the County (5%) and ten participants (8%) were missing data on location and have not be included in this report. Of those residing in the three county regions, 116 caregivers participated in the Care Pathways program with a majority (75%) of participants enrolled completing the program. The majority (78%) of participants were female and 43% were age 60 or older. Most participants were either Caucasian (41%) and Hispanic/Latino (40%). Half (50%) of the support group participants had been providing care for 2 years or less. The caregiver's relationship to the person being cared for was often a parent (51%) or a spouse (28%).

Depression Decreased

Countywide and in the Mid-County region, there was a statistically significant decrease in Care Pathways participants' average CES-D 20 depression scores from intake to follow-up. Depression scores in the Mid-County region decreased from a mean score of 20.3 to 13.3, a decrease of 34%. Countywide depression scores decreased from 17.0 to 14.1, a 17% decrease.

Feelings of Distress Decreased

Caregivers' average AMA-Caregiver Self-Assessment Questionnaire scores showed a statistically significant decrease from pre to post Countywide and in the Mid-County region. The Mid-County region showed a 26% decrease in scores while Countywide, scores decreased 11%. In the Western region, caregivers reported a non-statistically significant decrease in current levels of stress from pre to post as measured by question 17 of the AMA-Caregiver Self-Assessment Questionnaire.

Caregiver Satisfaction was High

Caregivers reported high levels of satisfaction with 76.5% of participants who completed a satisfaction survey reporting that the support groups helped them in reducing the stress associated with being a caregiver and 96.1% of participants reporting that they would recommend the support group to friends in need of similar help.

The Care Pathways program enrolled 116 participants during the 2023-2024 fiscal year across the county's three regions. The Desert region enrolled the most caregivers. See Figure 1.

Figure 1. Enrollment by Region

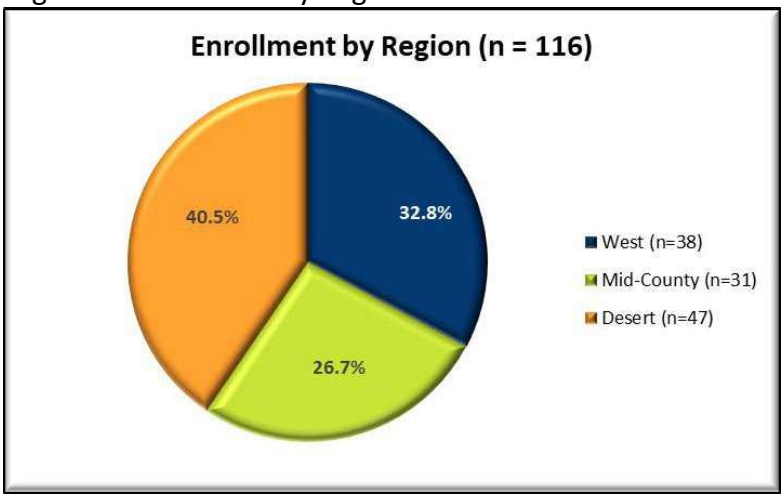
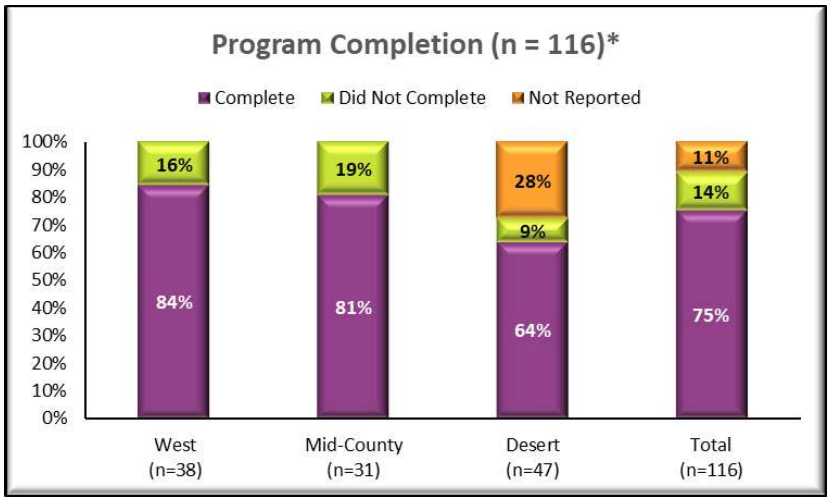


Figure 2. Program Completion



Countywide, 75% of participants completed the program. The Western region had the highest rate of completion 84%, while the Desert region had the lowest rate of completion 64%, see Figure 2.

Table 1. Contract Completion

Actual Total Completed	Contract Expectations	Contract Completion
87	144	60%

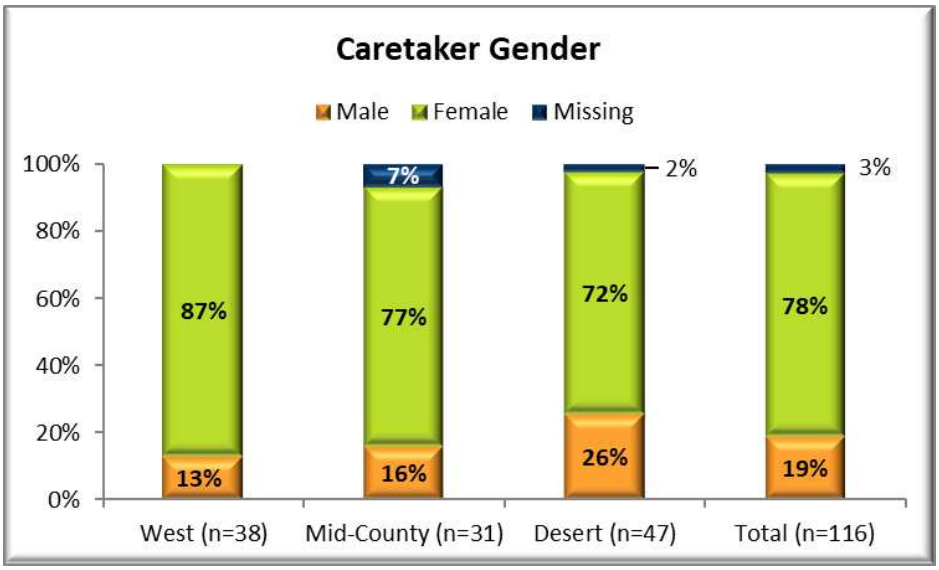
Table 2: Program Completion History

Fiscal Year	Enrolled	Completed	Percent Completed
2018-2019	250	203	81%
2019-2020	183	142	78%
2020-2021	92	80	87%
2021-2022	117	88	75%
2022-2023	97	77	79%
2023-2024	116	87	60%

Countywide, the Office on Aging was contractually obligated to have 144 participants complete the program. Across all three regions, 87 participants completed the program, which accounts for 60% of the contract expectation. Contract expectations and completion can be seen in Table 1. Table 2 provides enrollment,

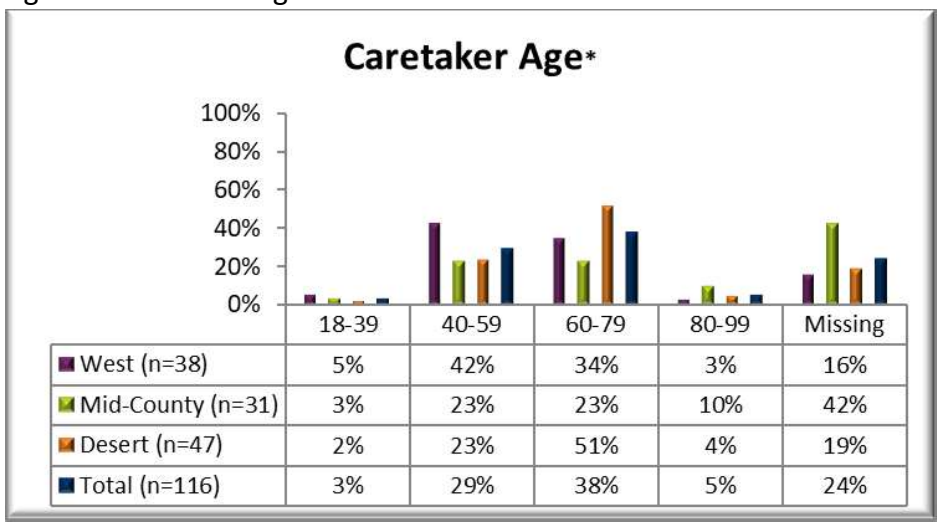
completion, and the completion rate for several fiscal years.

Figure 3. Caretaker Gender



Countywide, the majority of caregiver participants reported being female (78%). The Western region served the highest percentage of females (87%).

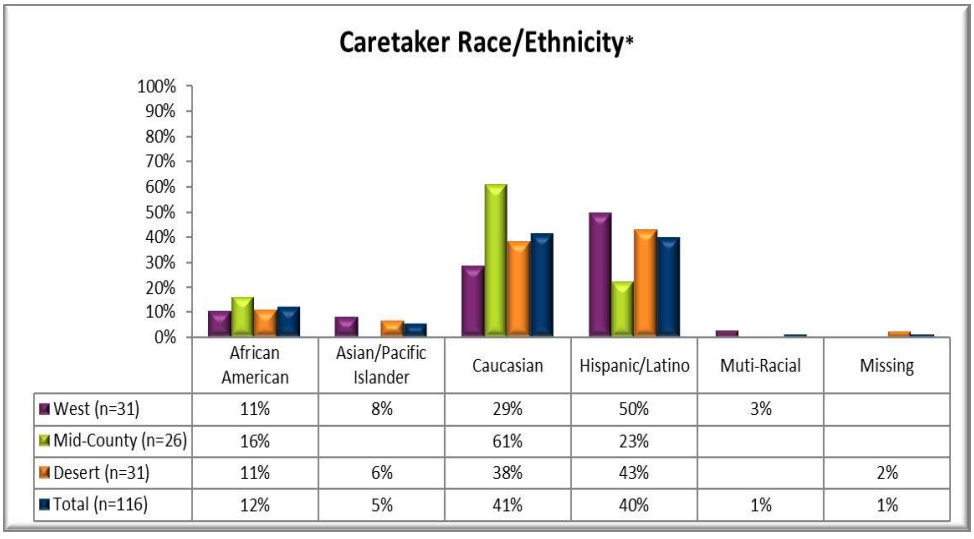
Figure 4. Caretaker Age



	18-39	40-59	60-79	80-99	Missing
West (n=38)	5%	42%	34%	3%	16%
Mid-County (n=31)	3%	23%	23%	10%	42%
Desert (n=47)	2%	23%	51%	4%	19%
Total (n=116)	3%	29%	38%	5%	24%

The majority (67%) of the caregivers participating in support groups were between the ages of 40 and 79. The average age of participants was 61 years old. Age was missing for 28 individuals.

Figure 5. Caretaker Race/Ethnicity

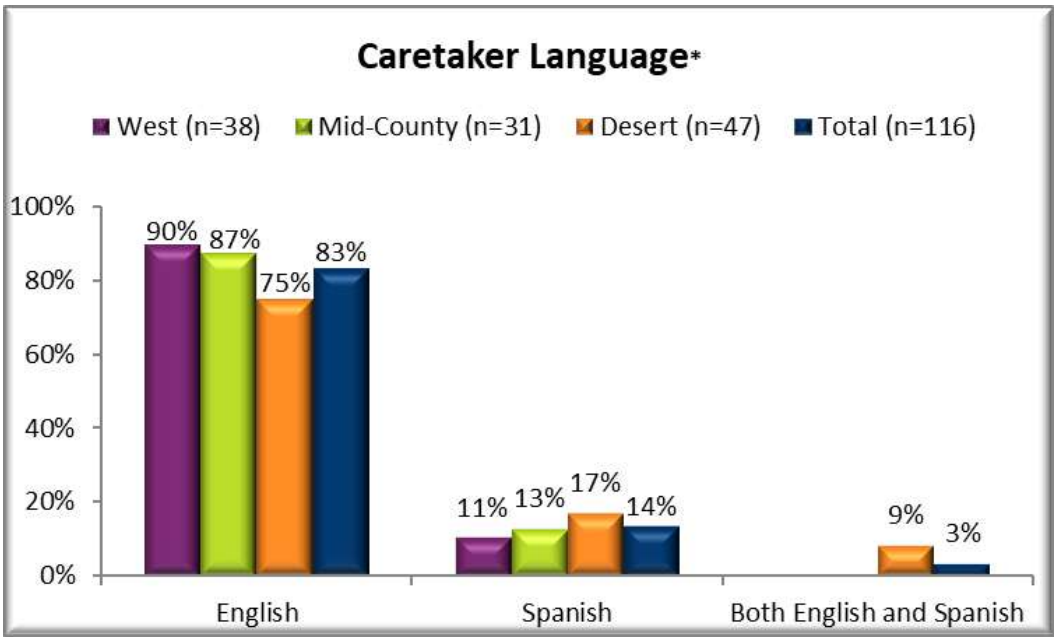


	African American	Asian/Pacific Islander	Caucasian	Hispanic/Latino	Muti-Racial	Missing
West (n=31)	11%	8%	29%	50%	3%	
Mid-County (n=26)	16%		61%	23%		
Desert (n=31)	11%	6%	38%	43%		2%
Total (n=116)	12%	5%	41%	40%	1%	1%

Overall, 41% of caregivers were Caucasian and 40% were Hispanic/Latino. One of the participants who identified as Hispanic/Latino specified being Mexican-American.

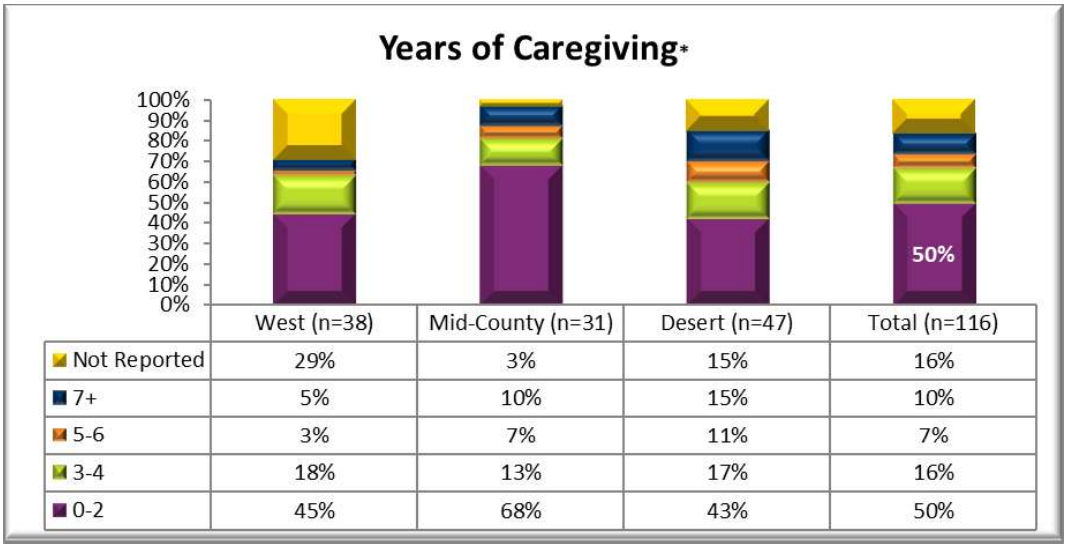
*percentages might not add to 100% due to rounding

Figure 6. Caretaker Language



The majority of participants spoke English as their primary language (83%). Classes were provided in both English and Spanish as needed.

Figure 7. Years of Caretaking



	West (n=38)	Mid-County (n=31)	Desert (n=47)	Total (n=116)
Not Reported	29%	3%	15%	16%
7+	5%	10%	15%	10%
5-6	3%	7%	11%	7%
3-4	18%	13%	17%	16%
0-2	45%	68%	43%	50%

Half (50%) of all caregivers had spent 2 years or less providing care at the time of enrollment. The average time spent providing care was 3.2 years.

Table 3 details the relationship of the Caregivers and Loved Ones. The relationship of the Caregivers and Loved Ones was not reported for four participants. The most common Loved Ones cared for were parents and spouses, respectively.

Table 3. Love One Cared for by Caretaker

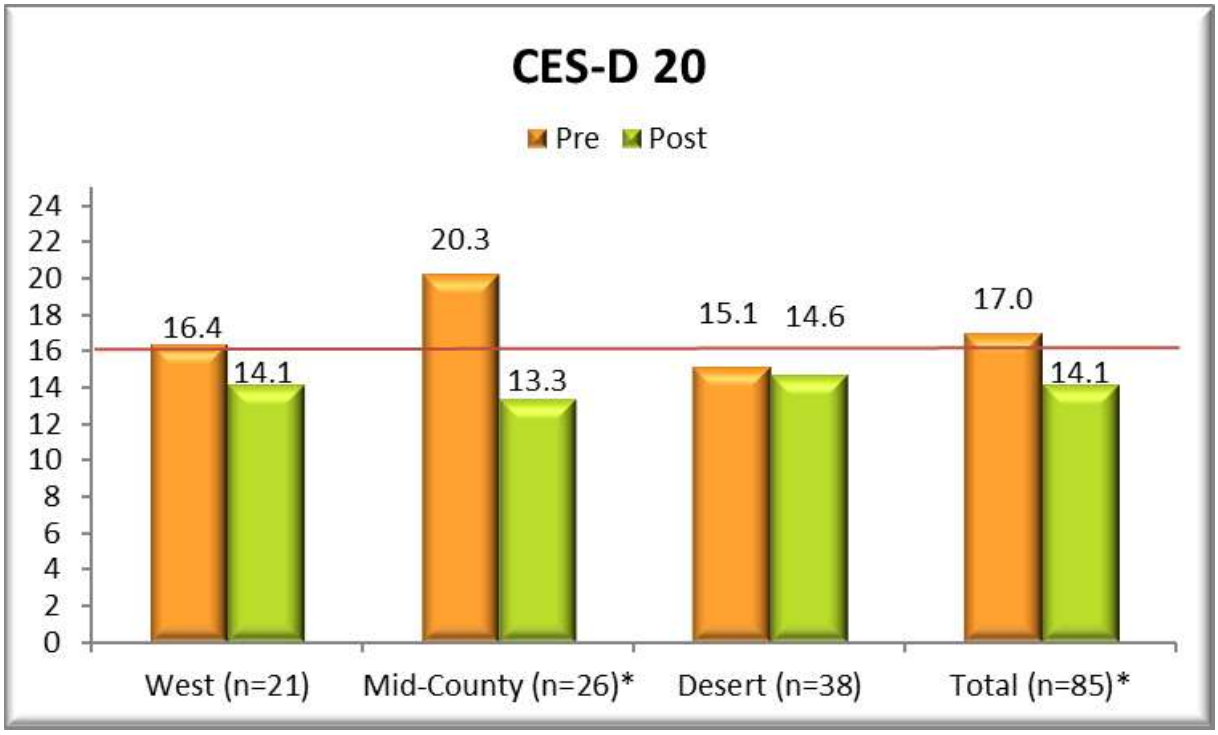
	Loved One Cared For							
	Sibling	Spouse/Partner	Parent	Parent-in-law	Family Member	Friend	Multiple	Missing
West (n=38)	-	16%	55%	11%	11%	-	-	8%
Mid-County (n=31)	-	29%	52%	3%	10%	-	7%	-
Desert (n=47)	2%	36%	47%	2%	6%	4%	-	2%
Total (n=116)	1%	28%	51%	5%	9%	2%	2%	3%

*percentages might not add to 100% due to rounding

The Center for Epidemiological Studies-Depression Scale (CES-D) is a 20-item scale that was developed by The National Institute of Mental Health. Respondents are asked to choose from four possible responses in a Likert scale format, where "0" is "rarely or none of the time (less than 1 day)" and "4" is "almost or all of the time (5-7 days)." Scores range from 0 to 60. Higher scores reflect greater levels of depressive symptoms while lower scores reflect lower levels of symptoms. A score of 16 or greater suggests a clinically significant level of psychological distress. However, it does not necessarily mean that the participant has a clinical diagnosis of depression. In the general population, about 20% would be expected to score in this range.

There were a total of 85 matched pairs of pre to post measures. Countywide and in the Mid-County region, there was a statistically significant decrease in depression scores from intake to follow-up. Countywide, average CES-D 20 scores decreased by 17% from 17.0 to 14.1. In the Mid-County region scores decreased 34% from 16.4 to 14.1.

Figure 8. CES-D 20



*Significance <.05

The Caregiver Self-Assessment Questionnaire is an 18-item, caregiver self-report measure that was created by the American Medical Association (AMA) to aid physicians in the assessment of stress-levels of family caregivers who accompany chronically ill older adult patients to medical visits. The Office on Aging adopted the measure to assist in assessing caregivers perceptions of stress and emotional well-being. Caregivers are asked to respond either "Yes" or "No" to a series of statements, such as "During the past week or so, I have felt completely overwhelmed" and "During the past week or so, I have felt strained between work and family responsibilities." In addition, for questions 17 and 18, family caregivers are asked to rate their level of stress, and perception of their current health on a 1-10 scale, respectively.

Countywide and in the Mid-county region, self-assessment scores showed a statistically significant decrease from intake to follow-up. Countywide, self-assessment scores decreased 11%, while in the Mid-County region, scores decreased 26% from intake to follow-up. Figure 9 shows pre to post means for question items 1-16.

Figure 9. Total Self-Assessment

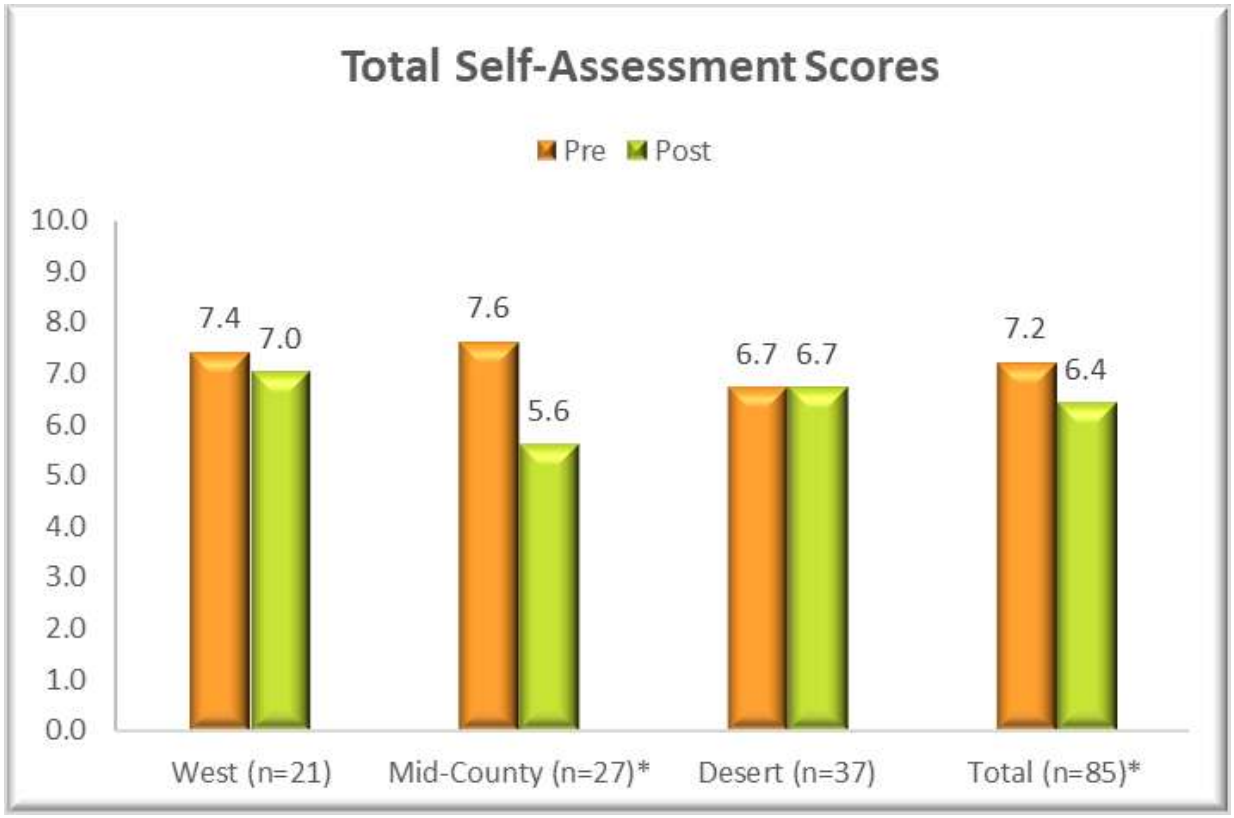
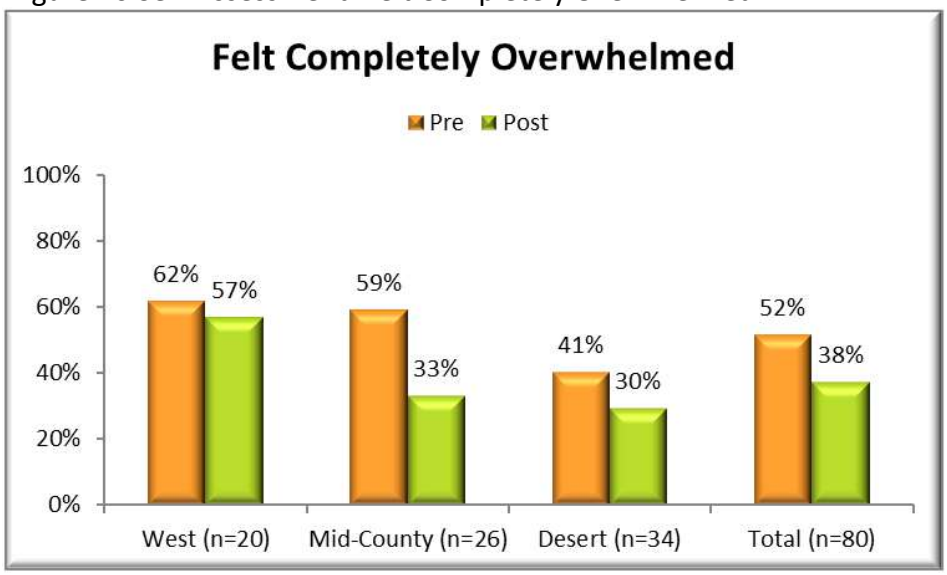


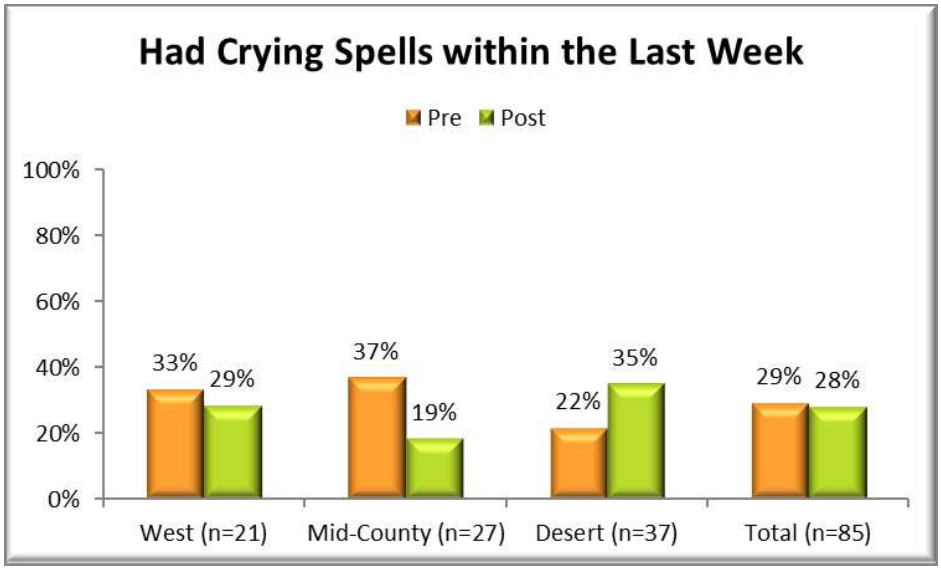
Figure 10 Self-Assessment: Felt Completely Overwhelmed



Caregivers' distress could also be indicated from answering yes to question #4 "Felt completely overwhelmed," or question #11 "Had crying spells" within the past week.

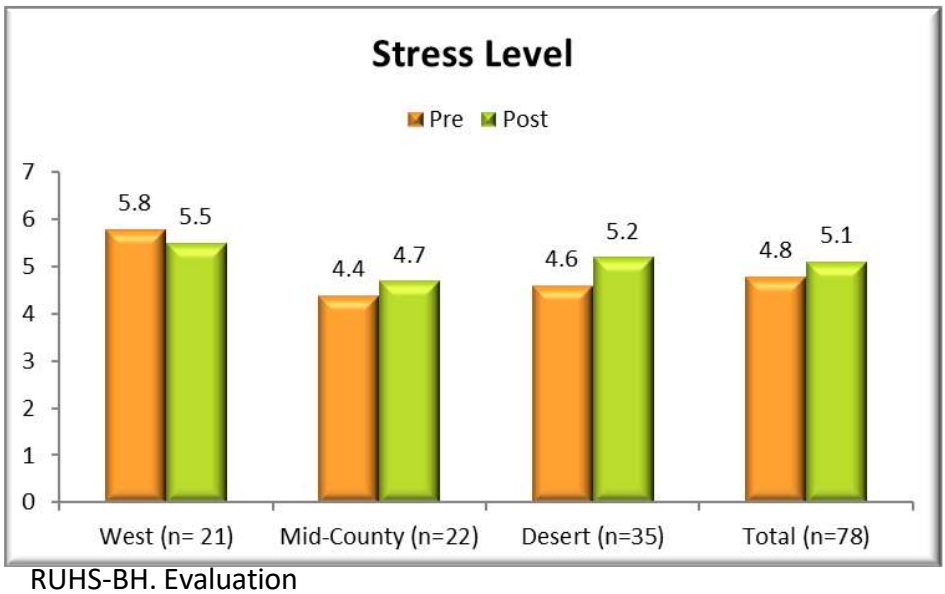
Countywide and within regions, participants reported feeling less overwhelmed at the end of the program (See Figure 10).

Figure 11. Self-Assessment: Had crying spells within the last week



Countywide, and in the Western and Mid-County regions, participants reported a decrease in crying spells (See Figure 11).

Figure 12. Self-Assessment: Stress Level



Question #17 asks caregivers to rate their current level of stress "On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful." Figure 12 provides the mean Caregiver scores for question #17. Although not statistically significant, stress levels in the Western region decreased 5% from pre to post.

A total of 104 caregivers completed a satisfaction survey at the conclusion of the caregiver support groups. Results are shown in Table 4 below. Overall, caregivers were highly satisfied with the support received from the program. Caregivers also reported having reduced levels of stress and being able to cope more effectively in their caregiver role as a result of the program. Participants would recommend the program to a friend.

Table 4. Satisfaction

	Poor	Fair	Good	Excellent
1. How would you rate the quality of service you have received from the support group leader?	-	-	6.8%	93.2%
	No, definitely not	No, generally not	Yes, generally	Yes, definitely
2. Has the support group helped to reduce some of the stress associated with being a caregiver?	-	2.0%	21.6%	76.5%
	None of my needs have been met	Only a few of my needs have been met	Most of my needs have been met	Almost all of my needs have been met
3. To what extent has the support group met your needs?	-	4.9%	32.0%	63.1%
	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
4. If a friend were in need of similar help, would you recommend this support group to him or her?	-	1.0%	2.9%	96.1%
	No, definitely not	No, not really	Yes, generally	Yes, definitely
5. Has attending the support group given you methods to solve problems in your role as caregiver?	-	-	17.8%	82.2%
	No, this seemed to make things worse	No, this really didn't help	Yes, this helped	Yes, this helped a great deal
6. Has attending the support group with other caregivers been helpful?	-	1.0%	12.4%	86.6%
	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
7. If you were to seek help again, would you return to this support group?	-	3.1%	6.2%	90.7%
	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
8. Has attending the support group helped you to cope more effectively in your role as caregiver?	1.0%	1.0%	17.3%	80.6%
	Quite dissatisfied	Mildly dissatisfied	Mostly satisfied	Very satisfied
9. In an overall, general sense, how satisfied are you with the support you have received from this group?	5.1%	2.0%	6.1%	86.9%

Comments
"Thank you for this resource and the presenters were wonderful. This program came at the right time for me. I had so many unanswered questions and they helped fill in the gaps. Many thanks!"
"I needed this to help me with my coping skills. I'm so grateful for all of the help I have gotten."
"Relief of my stress level and depression of my dad getting old and losing his ability of hearing, sight and mobility. Glad to talk to others in my same situation."
"Excellent instructor great selection of topics: ELDER Law, Death, Stress Management Etc…"
"The class has been very helpful to me to helping me identify some of the emotions that I've felt with being a caregiver."

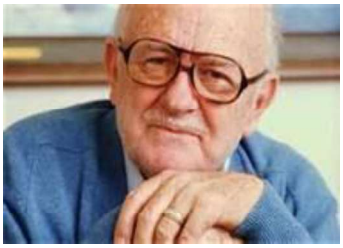
Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention

Office on Aging Liaisons

FY 2023-2024 Annual Report





Office on Aging Liaisons FY 2023-2024

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Program Overview

Office on Aging Liaisons

The primary goal of this program is for the Riverside University Health System-Behavioral Health (RUHS-BH) 'Mental Health Liaisons' and the Riverside County Office on Aging to:

1) work collaboratively to identify older adults who are either at risk of depression or are experiencing the first onset of depression.
2) ink these older adults with early intervention programs, such as Cognitive Behavioral Therapy for Late Life Depression (CBT-LLD).

In addition to referring older adults to early intervention programs, the Mental Health Liaisons are trained to provide CBT and CBT-LLD. MH Liaisons also link older adults with other resources and services, as needed, to reduce depression and suicide risk.

CBT for Late Life Depression

CBT for Late Life Depression is an active, directive, time-limited problem-solving program that follows the structure of the conceptual model and treatment program developed by Aaron Beck and his colleagues. It includes specific modifications for older adults who are experiencing symptoms of depression. The intervention includes strategies to facilitate learning within this population; such as slower rates of, or repeated, presentation of information using different modalities; greater use of practice; greater use of structure; and behavior modeling. Clients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and shift them to being more adaptive and flexible. Emphasis is placed on teaching clients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 (approximately 60 minute) sessions following a structured manual.

Outcomes Evaluation

Referrals and Outreach

A significant amount of the Mental Health Liaisons' time is expected to be focused on completing referrals and participating in outreach events. Data collected for these activities includes referral forms with a final disposition and information on the types of outreach events that the staff participated in.

'CBT for Late Life Depression' Outcomes Evaluation

Each year, Mental Health Liaisons are expected to provide CBT for Late Life Depression to some people who are not referred out to Community-Based Providers of CBT.

1. **Patient Health Questionnaire (PHQ-9)** is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents ages 12 years and older. Each item is scored on a scale of 0-3, ranging from the least severe clinical response to the most severe clinical response. The PHQ-9 is scored by summing the ratings for the 9 items. A total score of 0-4 indicates minimal; 5-9 indicates mild; 10-14 indicates moderate; and ≥ 20 indicates severe symptoms of depression.

2. **Quality of Life (QOL)** survey includes general quality of life items and questions on participation in pleasant and social activities. This survey is an important and integral part of measuring outcomes as it specifically collects feedback from participants on social behavior, activities, etc.—all aspects that CBT for Late Life Depression is directed at increasing. Thus, this survey provides very relevant information on outcomes when considering the goals of the program.

3. **General Anxiety Disorder-7 (GAD-7)** is a 7-item questionnaire that measures generalized anxiety disorders and assesses its severity. Each item is scored on a scale of 0-3, ranging from no frequency to high frequency. The GAD-7 is scored by summing the ratings for the 7 questions. A total score of 0-4 indicates minimal; 5-9 indicates mild; 10-14 indicates moderate; and 15-21 indicates severe symptoms of anxiety.

Executive Summary: Key Findings

Referrals and Outreach

Within the fiscal year (FY) 2023-2024, Embedded Staff held 111 outreach events for a total of 160.5 hours. The majority of the events took place at community meetings (64.9%) and at public events (11.7%).

The Mental Health Liaisons processed 422 referrals in FY 23/24; where approximately 2.8% led to CBT-LLD (n=12) enrollment. Nearly 96% of the total referrals were to 'Other' (e.g. private insurance).

Cognitive Behavioral Therapy for Late Life Depression

Office on Aging liaisons provided CBT-LLD services to a total of 18 participants. The majority of the CBT-LLD participants were female (78%), and between the ages of 75-79 (27.8%). Sixty seven percent (n=12) of the participants closed from the program within FY 23/24. Since some participants start the program services later in the fiscal year, not all cases close by the end of the fiscal year. Enrollment and demographic data reflects a higher number of participants, as it includes all clients who were served in the fiscal year; whereas pre to post outcomes data only reflect those cases that were closed with post measures completed within the fiscal year. From the 12 closed cases, 50% reported successfully completing their treatment goals (n=6) while the remainder did not complete. The remaining participants discontinued the program due to changes in personal circumstances (e.g. moved out of area) or partially completed their goals.

Decrease in Depression Symptoms

- PHQ-9 pre to post scores showed a statistically significant improvement in symptoms of depression. Based on the average pre to post PHQ-9 scores, symptoms of depression decreased from moderate (m=12) to minimal (m=4) after completing the program.

Improved Quality of Life

- QOL survey results showed that participants felt significantly ($p<.05$) better in most (n=10) QOL items. In these items, participants reported improvements in how they felt about the amount of time they spend with other people, the amount of friendship in their lives, and about their emotional well being.

Decrease in Anxiety Symptoms

- GAD-7 pre to post scores showed a statistically significant decrease in anxiety symptoms. Based on the average pre (m=11) to post (m=4) GAD-7 scores, symptoms of anxiety decreased from moderate to minimal levels.

OUTREACH

Embedded Staff participated in a total of 111 outreach events. *Table 1* provides the number of outreach events that were held in each region. The majority of outreach events took place in the Desert region (78.4%), followed by Western (15.3%) and Mid-County (0.9%). A small amount of outreach events took place across all regions (5.4%; see Table 1).

Table 1: Regional Outreach Percentages

Agency	All	Mid-County	Desert	Western
Embedded Staff OOA (N= 111)	5.4% (n= 6)	0.9% (n=1)	78.4% (n=87)	15.3% (n=17)

Between all 111 events, Embedded Staff spent a total of 160.5 hours on outreach, averaging approximately 1.46 hour per event, reaching a total audience of 2,697 people (see *Table 2)*.

Table 2: *Outreach Totals*

Agency	Total # of Outreach Events	Total Time (Hrs)	Average Time (Hrs)	Total People in Attendance
Embedded Staff OOA	111	160.5	1.46	2,697

Table 3: *Types of Outreach Events*

Type of Outreach Events (N=111)	(n)	(%)
Community Meeting	72	64.9%
Public Event	13	11.7%
Phone	3	2.7%
Presentation	7	6.3%
Other	9	8.1%
Unknown	7	6.3%

As shown in *Table 3*, the majority of outreach events were identified as either Community Meetings (64.9%, n=72) or Public Events (11.7%, n=13).

Table 4: *Outreach Venues*

Type of Outreach Venues (N= 111)	(n)	(%)
C.A.R.E	16	14.4%
Community Health/ Resource Center	77	69.4%
Faith-based Organization	2	1.8%
One-On-One Outreach	1	0.9%
Senior Center/ Collaborative Meetings	13	11.7%
Senior Housing Complex	2	1.8%

Of the 111 Outreach Events, Embedded Staff completed the most outreach events through Community Health/ Resource Centers (69.4%, n=77; *See Table 4).*

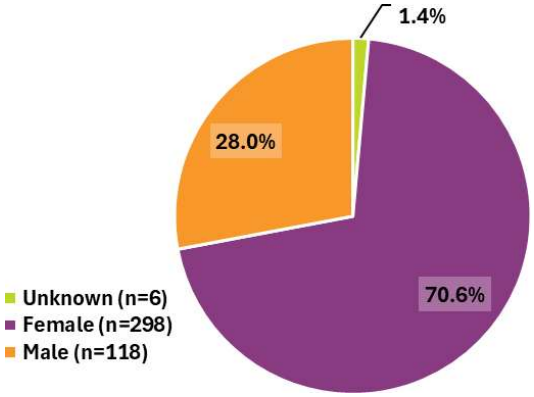
Other popular outreach venues included C.A.R.E. (14.4%) and Senior Center/ Collaborative Meetings (11.7%).

REFERALS

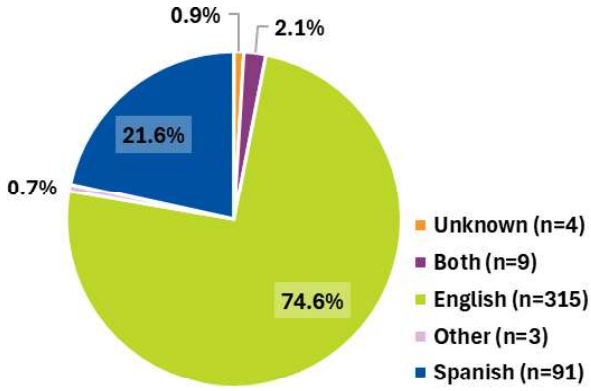
Mental Health Liaisons processed a total of 422 referrals within FY 23/24. All of the referrals were internally from the Office on Aging— such as the InfoVan, Adult Protective Services, In-Home Support Services (IHSS), Senior Centers (Coachella, Mecca, Mizell), Catholic Charities, and Sunny Adult Day Health Care. Additionally, Case Consultations were made for 159 people, which may or may not have resulted in a referral.

Characteristics of Referred Persons

Gender



Primary Language



The majority of the referrals were provided to females (n=298, 70.6%), while 118 identified as male (28.0%). A smaller amount did not report on gender (n=6).

The primary languages reported were English (n=315, 74.6%), and Spanish (n=91, 21.6%). Less than 1% did not report language whereas nine reported both English and Spanish as their primary language.

Referral Final Disposition

Among the 422 referrals that were made- some clients were referred to more than one program *(please note that the percentages in Table 5 do not sum to 100% due to stated multiple referrals)*, while others were not referred to any programs, as some referrals were unable to be completed (see Table 5.2). A total of 10 referrals were to CBT-LLD, all of which led to enrollment into the CBT-LLD program within the 23/24 fiscal year. Two additional participants were enrolled who did not come in through the referral process. *A majority of referrals had the final disposition of "Other" indicated (n=406) which was* 96.2% of total referrals. These primarily consisted of clients being referred back to their existing Primary Care Physicians and insurance (17.2%) , or the participant decided to delay referrals for the time being (22.9%).

Table 5: *Referral Dispositions*

Referral Disposition (N= 422)	n	%
Referred to a Non-PEI Program	16	3.8%
Referred to CBT-LLD	10	2.4%
Enrolled	*12*	2.8%
Did Not Meet Criteria	0	0.0%
Referred to Another PEI Program	6	1.4%
Referred to PEARLS	4	0.9%
Enrolled	*2*	0.5%
No Disposition Recorded	3	0.7%
Other (see Table 5.2 for break-down)	*406*	*96.2%*

Referral Disposition "Other" (N= 406)	n	%
Already receiving BH	25	6.2%
Declined Services	93	22.9%
Given/Mailed Resources	*44*	10.8%
Insights	51	12.6%
Other	28	6.9%
PEARLS	1	0.2%
Private Insurance/Referred to PCP	*70*	17.2%
Referred to RUHS	11	2.7%
Thrive	7	1.7%
Unable to Complete	76	18.7%

CBT Demographics

During FY 23/24, a total of 18 participants were enrolled and 17 received services from the Embedded Staff Office on Aging (ES-OOA) CBT program. The majority of the clients who received services were female (78%, n=14) and between the ages of 75-79 (27.8%).

Gender

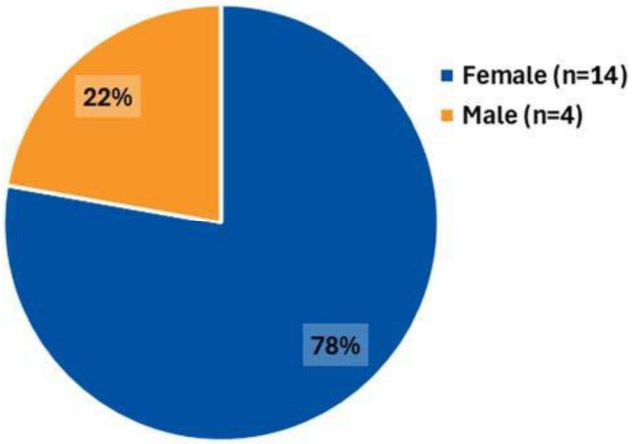
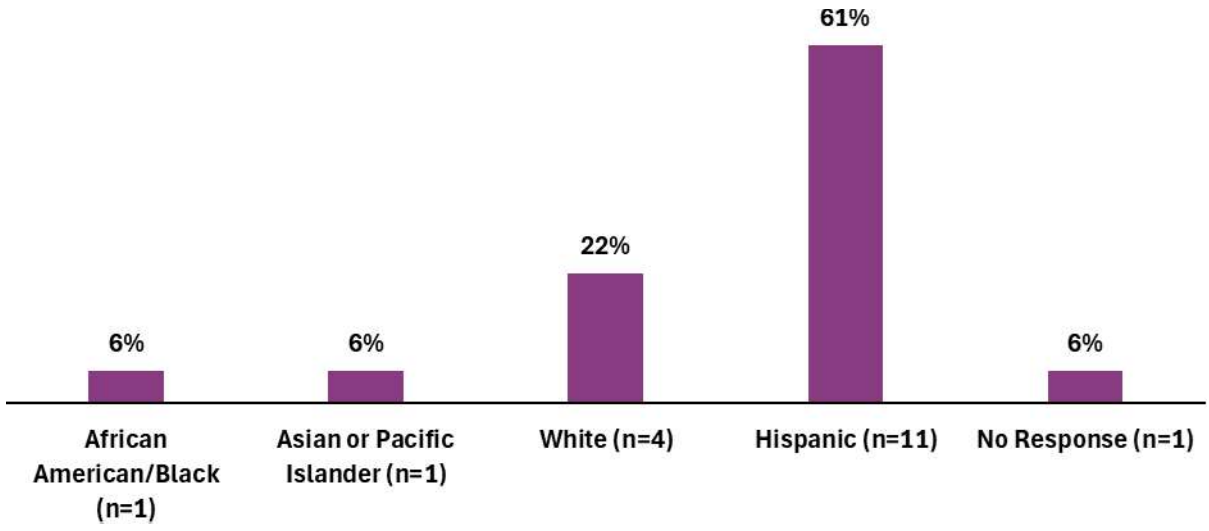


Table 6: CBT–LLD Age

Participant Age Range (*n= 18)*	n	%
59-64	4	22.2%
65-69	2	11.1%
70-74	4	22.2%
75-79	5	27.8%
>80	3	16.7%

Participant Race/Ethnicity

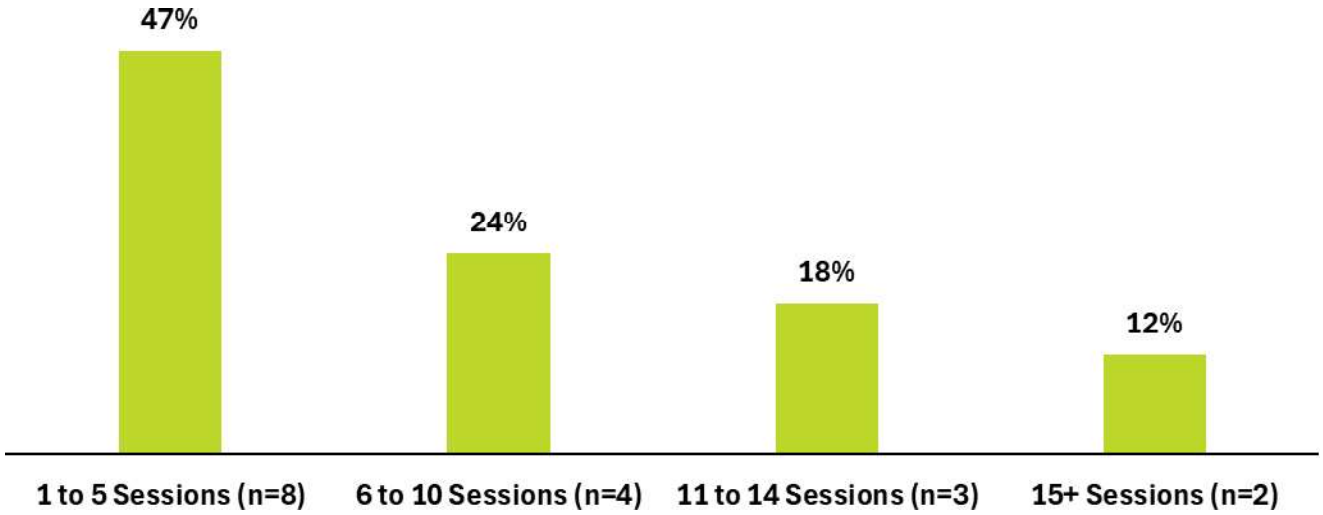


The majority participants identified as Hispanic (61%) followed by White (22%). Whereas, the remaining two participants identified themselves as and African American (6%) and Asian (6%). One participant did not disclose their Ethnicity.

CBT Program Participation

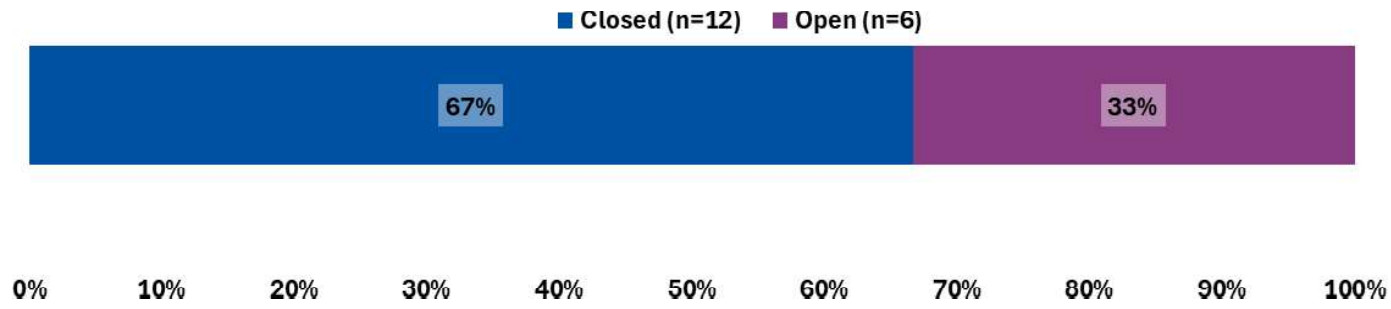
Number of Sessions Provided

Of the 18 participants who were open in FY 23/24, 17 received services. The graph depicts the number of CBT sessions that each participant (n=17) received. The range of session attendance was between 1 and 18 sessions.



Program Completion

Of the 18 participants enrolled, 67% (n=12) of the cases closed within the fiscal year, while the rest (n=6) carried into FY 24/25.

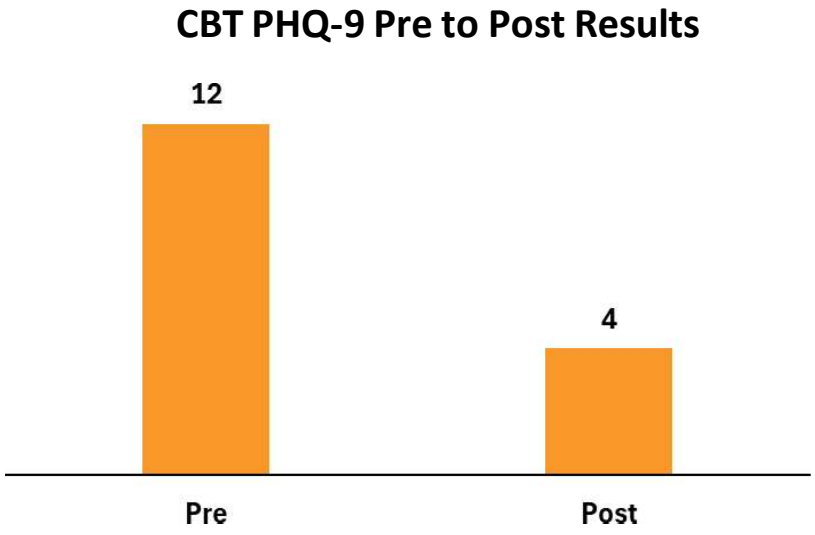


Outcomes CBT for Late Life Depression

Patient Health Questionnaire-9 (PHQ-9) Pre & Post Results

Patient Health Questionnaire-9 (PHQ-9) is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents age 12 years. This shorter test is derived from the original and longer PHQ assessment that addresses multiple mental health concerns including depression, panic disorder, anxiety, sleep disorders, and others. Each item is scored on a scale of 0-3, ranging from the least severe clinical response to the most severe clinical response.

The PHQ-9 is scored by summing the ratings for the 9 items. A total score of 0-4 is considered as having minimal levels of depression—generally describing those, whose scores fall within the range, as 'non-depressed.' A total score of 5-9 indicates symptoms of mild depression; a total score of 10-14 indicates symptoms of moderate depression; a total score of 15-19 indicates symptoms of moderately serve depression; and a total score of 20-27 indicates symptoms of severe depression.



Of the 12 participants with closing dates in FY 23/24, 75% (n=9) completed pre and post PHQ-9 measures. The pre and post PHQ-9 scores among participants showed on average a statistically significant (p <0.05) decrease in depression symptoms from the beginning to the end of the program. On average, participants reported experiencing moderate symptoms of depression at the beginning of the program (pre PHQ-9 score of 12), to experiencing minimal symptoms of depression by the end of the program (post PHQ-9 score of 4).

Table 7: ***Score Interpretation for PHQ-9***

Score Range	Depression Symptoms
0-4	Minimal symptoms of depression
5-9	Mild symptoms of depression
10-14	Moderate symptoms of depression
15-19	Moderately Severe symptoms of depression
20-27	Severe symptoms of depression

Outcomes CBT for Late Life Depression

Quality of Life Survey

The Quality of Life (QOL) survey includes general quality of life items and questions on participation in pleasant and social activities. This survey is an important and integral part of measuring outcomes as it specifically collects feedback from participants on their social behavior, activities, physical/emotional health, etc.—all aspects that CBT for Late Life Depression is directed at improving. Thus, this survey provides very relevant information on outcomes considering the goals of the program. The QOL Survey is rated on a scale of 1-7, with higher ratings indicating more positive results.

A total of 8 participants who had enrolled in the Embedded Staff's CBT-LLD program, completed both pre and post QOL surveys. For 76.9% of items (n=10), participants' scores significantly increased in the QOL survey items. There were significant improvements reported in how participants felt about the amount of time they spend with other people, the amount of friendship in their lives, and about their emotional well being (*See Table 8*). For items four and six, there was noticeable improvement from pre to post however it did not reach statistical significance.

Table 8: ***ESOOA & PE/CBT Quality of Life Results***

Quality of Life Survey Items (n=8)	Pre	Post
1. How do you feel about your life in general? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4.125**	**5.125**
2. How do you feel about the amount of relaxation in your life? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**3.375**	**5.375**
3. How do you feel about the things you do with other people? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4.5**	**6**
4. How do you feel about the amount of time you spend with other people? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	3.75	5.125
5. How do you feel about the people you see socially? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4**	**6**
6. How do you feel about the amount of friendship in your life? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	5.25	5.875
7. How socially active would you say you have been in the past month? (1=None; 2=A little; 3=Fairly Active; 4=Quite Active; 5=Very Active; 6=Extremely Active)	**2.375**	**3.875**
8. In general how would you say your health is? (1=Poor; 2=Fair; 3=Good; 4=Very Good; 5=Excellent)	2.875	3.25
9. How do you feel about your health in general? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4.375**	**5.25**
10. How do you feel about your physical condition? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**3.75**	**5**
11. How do you feel about your emotional well-being? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**3.125**	**5.125**
12. How much bodily pain have you had during the past month? (1=Very Severe; 2=Severe; 3=Moderate; 4=Mild; 5=Very Mild; 6=None)	**2.625**	**4**
13. In the past month, how much has your physical/emotional health interfered with your normal social activities with family, friends, neighbors or groups? (1=Extremely; 2=Quite a bit; 3=Moderately; 4=Slightly; 5=Not at all)	**2.75**	**3.875**

BOLD Numbers indicate statistically significant ($p < 0.05$) change Pre to Post.

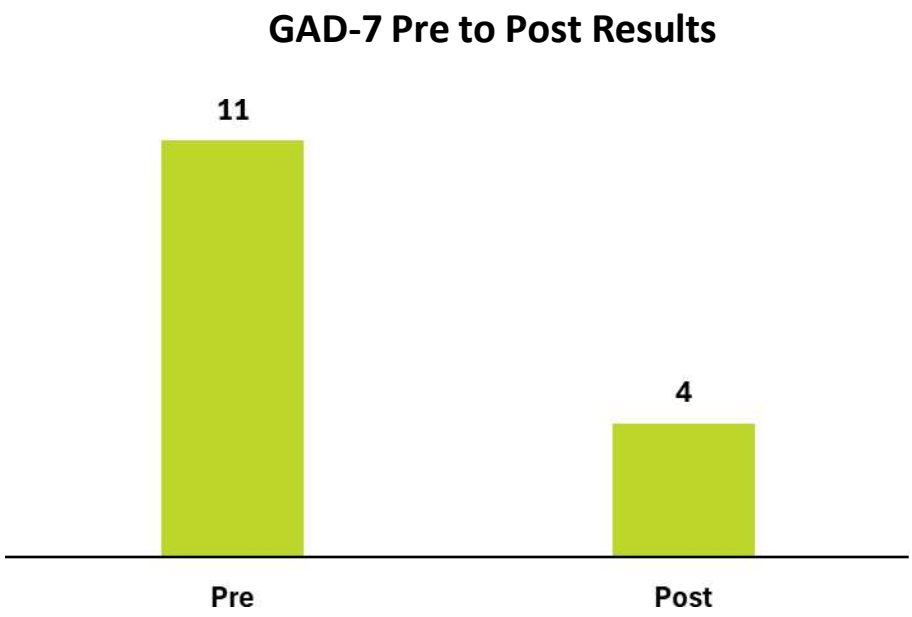
Outcomes CBT for Late Life Depression

GAD-7 Measure

The General Anxiety Disorder-7 (GAD-7) measures generalized anxiety disorders and assesses its severity. The GAD-7 measures participants' symptoms of anxiety with seven questions that ask participants to rank the degree to which, over the last two weeks, they had been bothered by: feelings of nervousness, irritability, fear, and restlessness; not being able to control worrying; and trouble relaxing.

The questions are ranked on a 0 to 3 point scale:

"0" = not at all, "1" = several days, "2" = more than half the days, "3" = nearly every day



A total of 8 participants completed both a pre-test GAD-7 survey at the beginning of the program and a post-test GAD-7 survey at the end. Countywide, participants experienced a statistically significant reduction in anxiety symptoms, with their average pre-test GAD-7 score of 11 (indicating moderate anxiety) decreasing to an average post-test score of 4 (within the minimal anxiety range).

Table 9: ***Score Interpretation for GAD-7***

Score Range	Level of Anxiety Severity
0-4	Minimal
5-9	Mild
10-14	Moderate
15-21	Severe

Discontinuance Summary

Out of the 12 cases closed within the fiscal year, there was a total of 10 participants for which MH liaisons submitted a discontinuance form. For the remaining 2 participants it was necessary to use the electronic health record to determine discontinuance reasons. The primary cited reason for discontinuance was 'Successfully completed treatment goals' (n=6, 50%). The remaining participants (50%) discontinued the program due to changes in personal circumstances (e.g. moved out of area) or partially referred for further treatment.

Table 10: *ESOOA CBT Discontinuance*

Reason For Discontinuance (N=12)	n	%
Successfully Completed Treatment Goals	6	50%
Referred for further Tx	2	17%
Unable to Contact	1	8%
Client Withdrew	2	17%
Moved out of Area	1	8%

Satisfaction Survey

A total of 8 participants completed satisfaction surveys with Embedded Staff. Participants gave positive ratings to all items of the survey, with 'good' ratings given to their feelings of satisfaction and support received from the program and gaining coping strategies.

Embedded Staff Satisfaction Items & Results (N=8)	Avg	1	2	3	4	5	*m
1. How would you rate the quality of service you have received from your practitioner? (Excellent=4; Good=3; Fair=2; Poor=1)	**4.00**	-	-	-	100%	-	-
2. How satisfied are you with the support you have received from this program? (Very Satisfied=4; Mostly Satisfied=3; Mildly Dissatisfied=2; Quite Dissatisfied=1)	**3.88**	-	-	13%	88%	-	-
3. Did this program help you to cope better? (Almost all of my needs have been met=4, Most=3, Only a few=2, None=1)	**3.50**	-	-	50%	50%	-	-
4. Did you gain strategies to help you cope? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**4.00**	-	-		100%	-	-
5. Did you gain strategies to help you improve your quality of life? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**3.88**	-	-	13%	88%	-	-
6. Has participation in the program reduced your depression symptoms? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**3.63**	-	-	38%	63%	-	-
7. Would you say, as a result of the program, you now know how to get help for depression? (Yes, Definitely=5; Yes, I think so=4; Not sure=3; No, I don't think so=2; No, Definitely not=1)	**4.38**	-	-	-	63%	38%	-
8. If you were to seek help again, would you return to this program? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**4.00**	-	-	-	63%	-	38%
***missing data**							

Participant Comments:

- *It was a positive change in my life but I received many recommendations to overcome and put them into practice in my life. Thank you so much. [Translated from Spanish]*
- *The program is good, I would recommend it [Translated from Spanish]*
- *The program helped me. I liked that [Therapist] understood me and helped me to cope with my problems. I am grateful for the program*
- *[Therapist] has been a great help for me. A am very comfortable with her & opening up to her*
- *I like the support and will continue to look for BH as needed*
- *I was satisfied with this program, it helped me a lot. [Translated from Spanish]*

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention
Healthy IDEAS (**I**dentifying, **E**mpowering, **A**ctivities for **S**eniors)
Annual Report FY 2023-2024

Program Overview

The Riverside County Office of Aging (OOA) with MHSA Prevention and Early Intervention (PEI) funding, implemented an evidenced-based practice to reduce the risk of depression and suicide among older adults throughout Riverside County. Under a Memorandum of Understanding (MOU) with the Riverside University Health System—Behavioral Health (RUHS--BH), the OOA integrated the Healthy IDEAS (**I**dentifying, **E**mpowering, **A**ctivities for **S**eniors) program into their existing CareLink case management program. The intent of the CareLink Prevention and Early Intervention Initiative was to embed the Healthy IDEAS program into the existing CareLink case management program with the goal of preventing premature institutionalization of functionally impaired adults and the frail at risk elderly. CareLink provides care management as well as comprehensive information and assistance services. The Office on Aging trained their staff to implement the Healthy IDEAS model intervention to clients receiving case management services. State funding supporting the original CareLink program was withdrawn; and with the inclusion of PEI, the primary focus shifted to individuals at risk for mental health concerns such as depression and anxiety. Literature supports that adults dealing with functional loss, chronic illness, grief and loss issues, or psycho/social stressors, if not already in the early stages of depression, are at greater risk for depression. Frail older adults and disabled adults are screened through the OOA Information and Assistance Intake Center for Care Management. In addition, individuals referred to the CareLink program receive screening for depression. Those individuals that qualify for CareLink and meet screening criteria for depression receive the additional Healthy IDEAS program services.

***Outcomes Evaluation* Measures**

Outcomes evaluation measures for Healthy IDEAS included the use of tools provided by the developers of the evidenced based practice. The CES-D 20 depression measure and a quality of life survey were used to measure outcomes.

The Centers for Epidemiological Studies-Depression Scale-20 (CES-D 20) measures depression symptoms. The measure is administered at the beginning and at the conclusion of program services.

The Healthy IDEAS Quality of Life Survey measures quality of life and participation in social activities. The survey is administered at the beginning and at the end of the program. The post questionnaire includes additional items on satisfaction with the Healthy IDEAS program.

Executive Summary

Demographics

One hundred fifty-one participants were enrolled in CareLinks during 2023-2024 Fiscal Year. Twenty-three CareLink participants were identified as being at risk for depression and were enrolled into the Healthy IDEAS program. The majority (65%) of Healthy IDEAS participants were between the ages of 50 and 79. Healthy IDEAS participants were mostly White (48%) and Hispanic/Latino (39%).

Services

Healthy IDEAS participants had an average of 4.8 sessions and received an average 8.6 hours of service. A little over a quarter (26%) of clients completed the program in FY2023-2024. Some participants (n = 7, 30%) were not closed during the 2023-2024 fiscal year, and will carry over into FY2024-2025.

Healthy IDEAS Outcomes

Depression symptoms for Healthy IDEAS participants showed a statistically significant decrease. In addition, participants' satisfaction with their emotional well-being increased.

Care Link Satisfaction

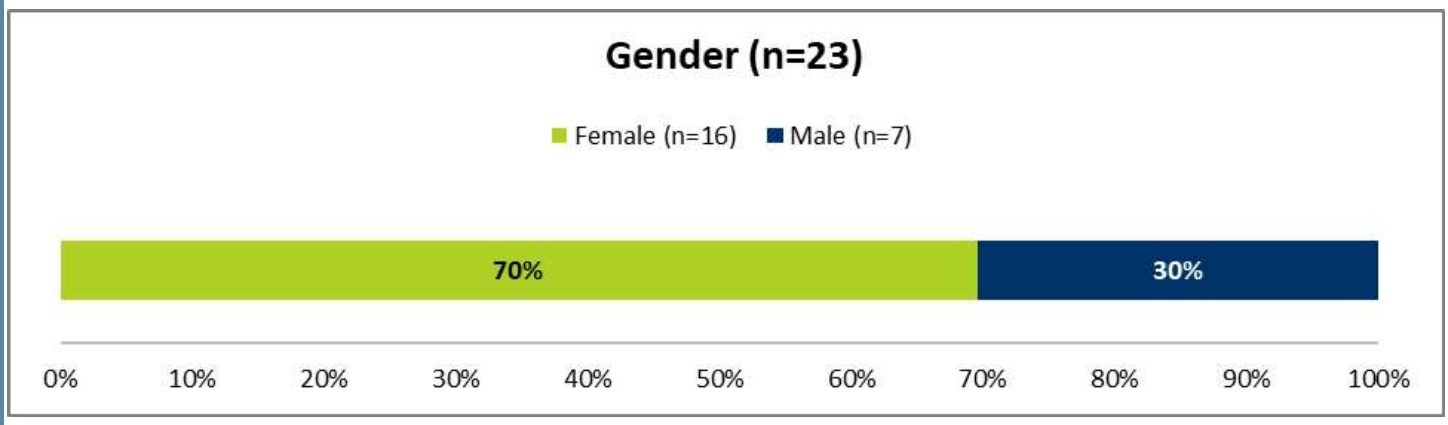
CareLink participants reported they were satisfied with many aspects of the program. Participants reported home visits and telephone contacts as being the most helpful features of the program. CareLink participants reported that the CareLink staff were courteous, efficient, caring, knowledgeable, respectful, accessible, and helpful.

Healthy IDEAS

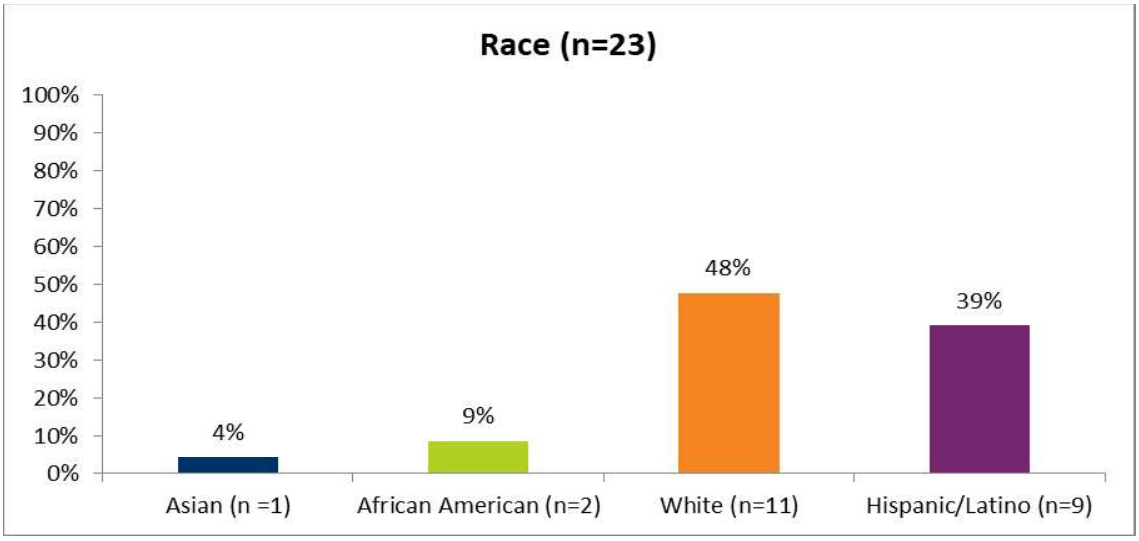
Healthy IDEAS (**I**dentifying **D**epression, **E**mpowering **A**ctivities for **S**eniors) is an evidence-based program that integrates depression awareness and management into existing case management services provided to older adults. Healthy IDEAS ensures older adults get the help they need to manage symptoms of depression and live full lives.

Demographics

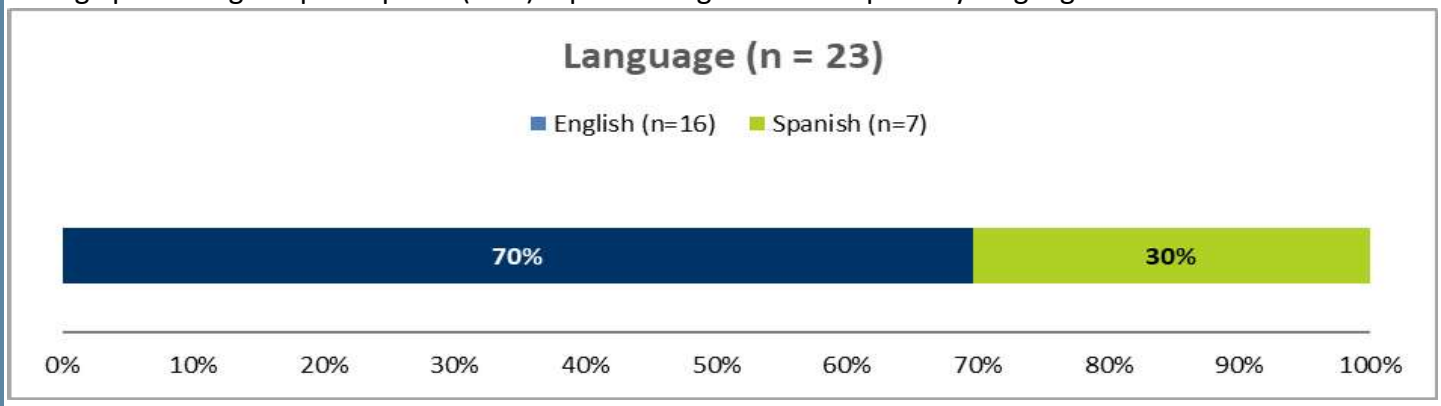
There were 151 Carelink clients during the 2023-2024 fiscal year. Twenty-three (23) Carelink clients met the screening criteria for depression and were enrolled into Healthy IDEAS program. More females than males participated in the Healthy IDEAS program.



The majority of Healthy IDEAS participants (48%) were either White or Hispanic/Latino (39%).

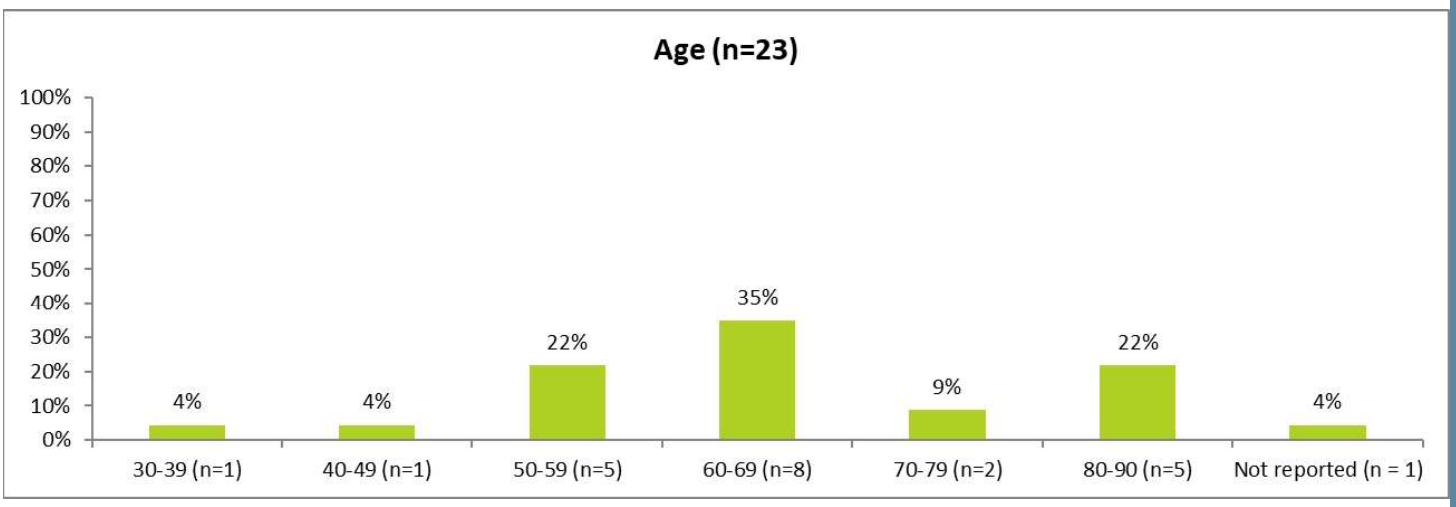


A large percentage of participants (70%) reported English as their primary language.



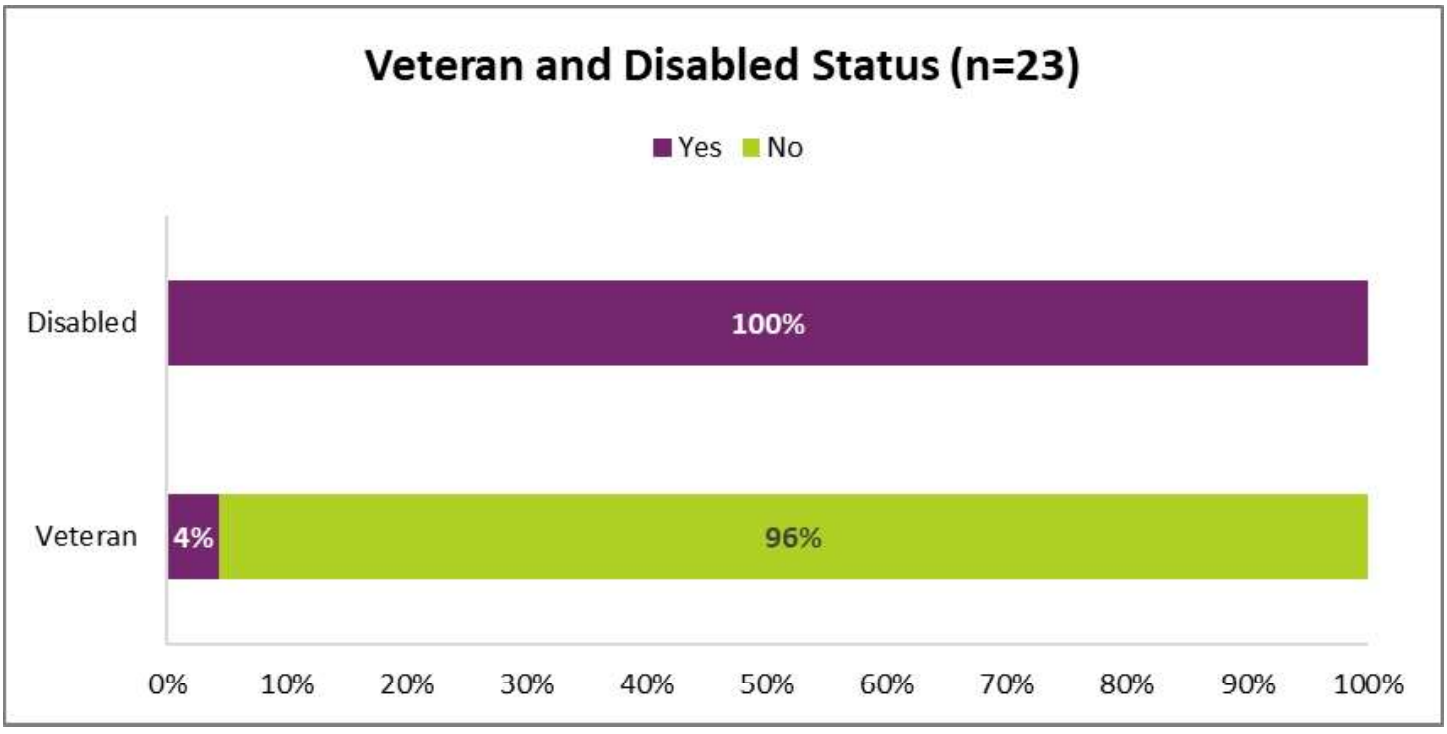
Demographics (cont.)

The majority of participants (83%) were between the age of 50 and 89 at the time of program entry. The average age of participants was 68.

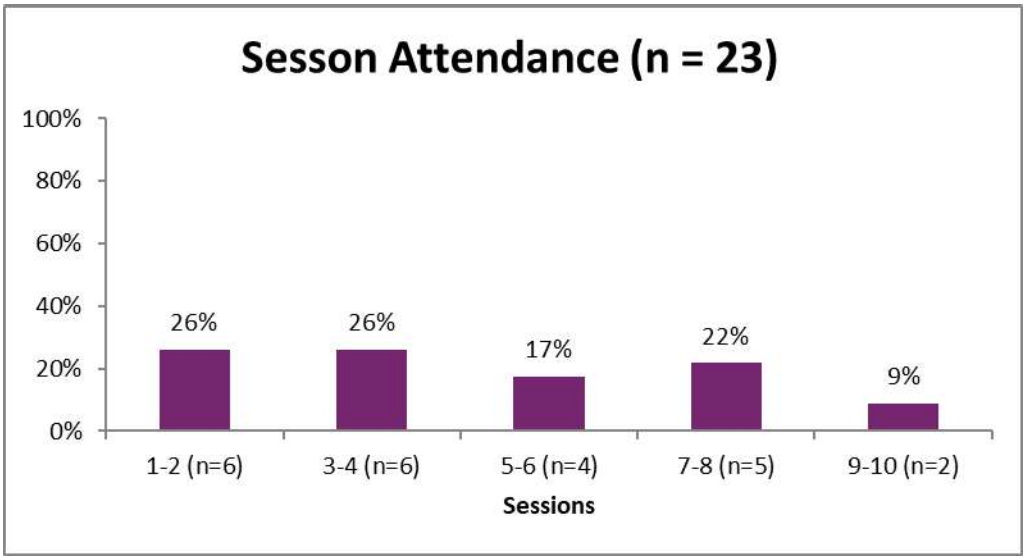


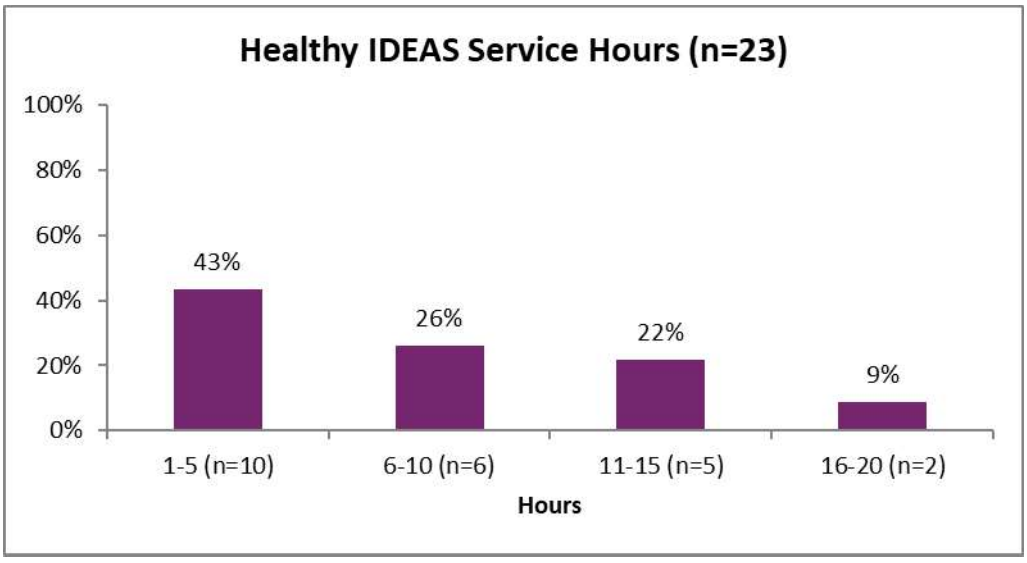
Participants were asked to report if they had a disabling condition. All participants reported having a disabling condition.

Participants were also asked to report their status as a veteran. Four (4%) percent of the participants in the 2023-2024 fiscal year reported being a veteran.



Clients attended an average 4.8 Healthy IDEAS sessions and received an average of 8.6 service hours.





Program Completions

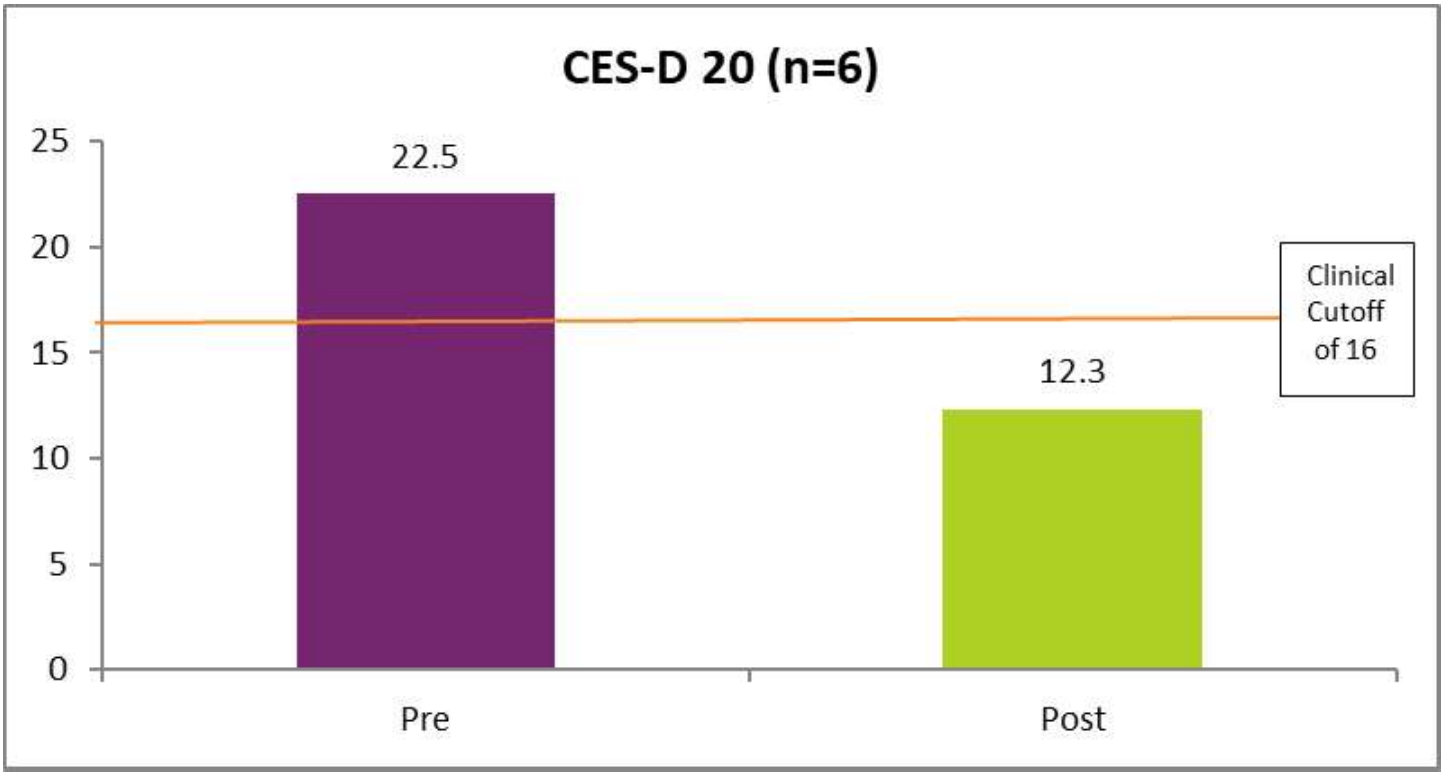
Of the 23 participants enrolled in Healthy IDEAS, 6 (28%) completed the program and 10 closed without completing. Some participants were still open at the end of the fiscal year (n = 7, 30%) and will carry over into the next fiscal year.

Disposition (n=23)		
Completed	Closed	Open
6 (26%)	10 (43%)	7 (30%)

CES-D 20

The Center for Epidemiological Studies-Depression Scale (CES-D) is a 20-item scale that was developed by the National Institute of Mental Health. Respondents select from four possible responses in a Likert format, where “0” is “rarely or none of the time (less than 1 day)”, and “4” is “almost or all of the time (5-7 days)”. Scores range from 0 to 60 with higher scores reflecting greater levels of depressive symptoms, while lower scores reflect lower levels of symptoms. A score of 16 or greater suggests a significant level of psychological distress. However, It does not necessarily mean that the participant has a clinical diagnosis of depression. In a general population, about 20% would be expected to score in this range.

There was a 45% decrease in depression scores from pre to post.



Quality of Life Survey

The Healthy IDEAS survey is administered at the beginning of and at the conclusion of program. The survey includes general quality of life items, knowledge concerning accessing resources for depression, and questions on participation in social activities. The table below shows the average pre to post ratings on the Healthy IDEAS survey.

1-No,definitely not; 2-No, I don't think so; 3-Not Sure; 4-Yes, I think so; 5-Yes,definitely	Average Rating	
	Pre	Post
1. Would you say you know how to get help for depression? (n=5)	2.6	4.6

1-Poor; 2-Fair; 3-Good; 4-Very Good; 5-Excellent	Average Rating	
	Pre	Post
2. In general, how would you say your health is? (n=5)	4.6	5.0

1-None; 2-A little; 3-Fairly Active; 4-Quite Active; 5-Very Active; 6-Extremelly Active	Average Rating	
	Pre	Post
3. During the past month which statement describes how socially active you have been? (n=5)	4.8	5.0

1-Terrible; 2-Unhappy; 3-Mostly Dissatisfied; 4-Mixed; 5-Mostly Satisfied; 6-Pleased; 7-Delighted	Average Rating	
	Pre	Post
4. How do you feel about your life in general? (n=5)	3.6	5.4
5. How do you feel about the amount of relaxation you have? (n=5)	4.2	5.8
6. How do you feel about the way you spend your spare time? (n=5)	5.8	6.0
7. How do you feel about the way things are in general between you and your family? (n=5)	5.6	6.0
8. How do you feel about the amount of time you spend with other people? (n=5)	2.0	2.8
9. How do you feel about the amount of friendship in your life? (n=5)	3.6	4.6
10. How do you feel about your emotional well-being? (n=5)	2.6	3.8
11. How do you feel about your health in general? (n=5)	4.0	4.6

Participants' satisfaction with the amount of time they spent with other people and how they feel about their health in general increased. The greatest improvement was seen in the participants' knowledge of how to get help for depression, how they felt about their life in general, and the amount of relaxation time they had.

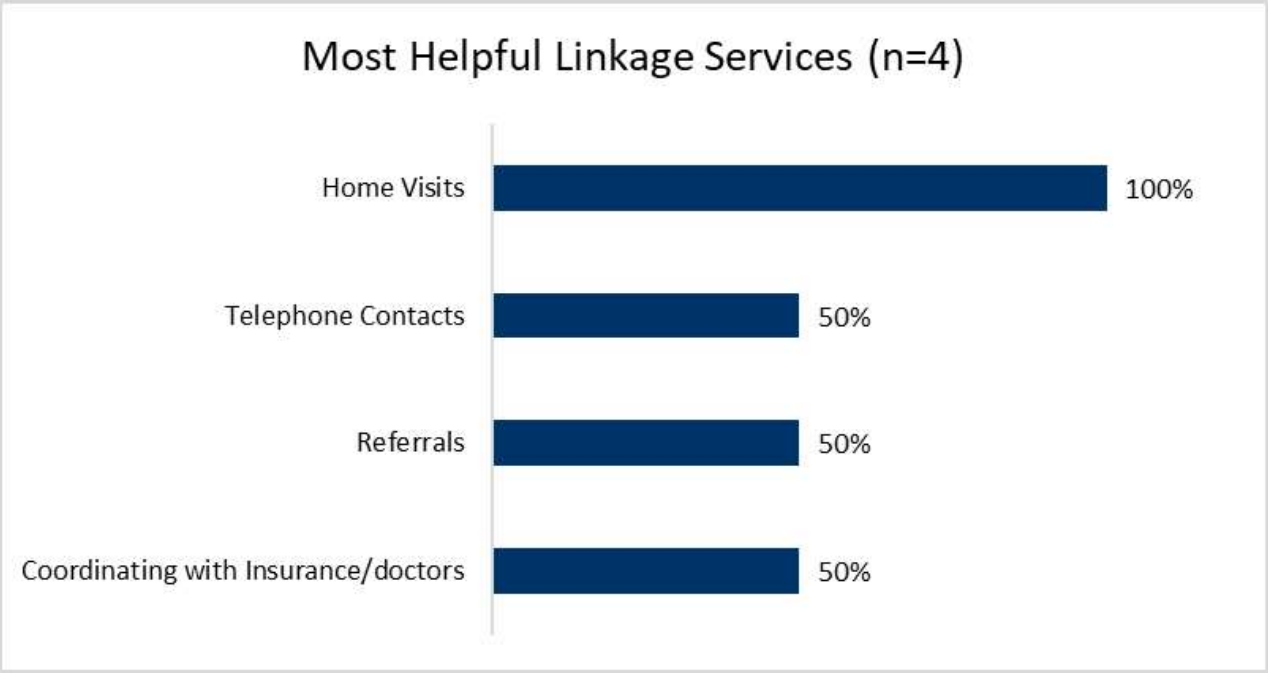
Healthy IDEAS Satisfaction Survey

Satisfaction items were collected for those participants enrolled in Healthy IDEAS and closed from the program. Participants reported that the most helpful aspects of the program were the home visits, phone contacts, and coordinating with insurance or doctors. The majority of those participating in the CareLink/Health IDEAS program reported that the program helped to reduce their depression symptoms and helped them to function better. All of the participants said they would recommend Healthy IDEAS to friends.

n = 6	No, Definitely Not (1)	No, I don't think so (2)	Not Sure (3)	Yes, I Think so (4)	Yes, definitely (5)
Has participating in the care link program helped you	-	-	-	1 (17%)	5 (83%)
Would you say the program activities in which you participated helped to reduce your depression symptoms?	-	-	-	2 (33%)	4 (67%)

CareLink Satisfaction

CareLink participants reported they were satisfied with many aspects of the program. All of the participants reported home visits to be the most helpful part of the program. Other helpful services included: telephone contacts, referrals, and coordinating with insurance companies or doctors.



CareLink participants reported that the CareLink staff were courteous, efficient, caring, knowledgeable, respectful, accessible, and helpful. Participants were pleased with the quality of service that they received from the program and would recommend the program to a friend.

Please grade the CareLink staff on the following items:	A	B	C	D
Courteous	100%	-	-	-
Efficient	100%	-	-	-
Caring	100%	-	-	-
Knowledgeable	100%	-	-	-
Respectful	100%	-	-	-
Accessible	100%	-	-	-
Helpful	100%	-	-	-

n = 4	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
Recommend CareLink to friend?	-	-	-	100%

n = 4	Poor	Fair	Good	Excellent
Quality of service received	-	-	33%	67%

n = 4	Quite Dissatisfied	Mildly Dissatisfied	Mostly Satisfied	Very Satisfied
Satisfaction with CareLink	25%	-	-	75%

Riverside University HEALTH SYSTEM Behavioral Health

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

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Program Overview and Providers

Program Overview and Providers

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is designed to reduce the duration and harmful effects of trauma for youth (ages 10-15 years) most at risk of developing mental health problems as a result of direct and/or indirect traumatic experiences. CBITS aims to increase resiliency and the development of coping strategies for program participants, reduce symptoms resulting from exposure to traumatic experiences, and reduce the need for ongoing services within the mental health system. Four providers were contracted to provide CBITS services:

- **Operation Safehouse (OSH)** was contracted to deliver the program in Western, Mid-County, and Desert regions of Riverside County. OS worked collaboratively with school districts and individual schools to identify and engage youth that would benefit from CBITS services.
- **Jurupa Unified School District - Behavioral Health (JUSD-BH)** was contracted to deliver the program in the Western region of Riverside County. JUSD-BH delivered the program to schools within the Jurupa Unified School District.
- **Special Services for Groups (SSG)** was contracted to deliver the program in the Western region of Riverside County. SSG delivered the program to schools within the Moreno Valley Unified School District.
- **Riverside County Latino Commission (RCLC)** was contracted to deliver the program in the Desert region of Riverside County. RCLC delivered the program to schools within the Coachella Valley Unified School District.

Prior to receiving services, participants are screened for trauma symptoms. Youth with a trauma symptom severity falling below the criteria threshold become ineligible for CBITS, where they are then referred to other services that better suit their needs. Eligible youth who decide to enroll in the program receive ten group sessions and one to three individual sessions in the school setting. For the purposes of Prevention and Early Intervention (PEI), completion of the program was defined as attending 8 or more sessions. In addition, parents and guardians participate in two educational sessions with the clinician. CBITS uses cognitive-behavioral techniques, including: psycho-education, relaxation, social problem solving, cognitive restructuring, and exposure to help children reduce symptoms related to traumatic experiences and depression.

Evaluation

Evaluation of program outcomes include measuring decreases in the frequency of trauma symptoms experienced by youth and decreases in depression symptomology. The following outcome measures were collected prior to the start and at the conclusion of group sessions (i.e. pre to post).

- Child Post-Traumatic Stress Disorder (PTSD) Symptom Checklist - This is the initial measure administered for determining eligibility into CBITS. It is a two part self-report assessment that identifies exposure to traumatic events and then measures the severity and frequency of the PTSD symptoms arising from those events. Scores are aggregated to yield a PTSD score, as well as scores on the re-experiencing, avoidance, and hyperarousal subscales.
- Children's Depression Inventory (CDI-II) - A self-report assessment that measures the severity of depression symptoms among youth. The CDI-II has 28-items with two scales: Emotional Problems and Functional problems. Each scale has two subscales where Negative Mood and Negative Self-esteem are subscales for Emotional Problems and Interpersonal Problems and Ineffectiveness are subscales for Functional Problems.

Executive Summary: Key Findings

Enrollment and Completion

A total of 313 youth participated in CBITS during the 2023-2024 FY with 84% completing the CBITS program. 50 participants did not complete the program. Of those who did not complete, eleven attended 5-7 sessions.

Demographics

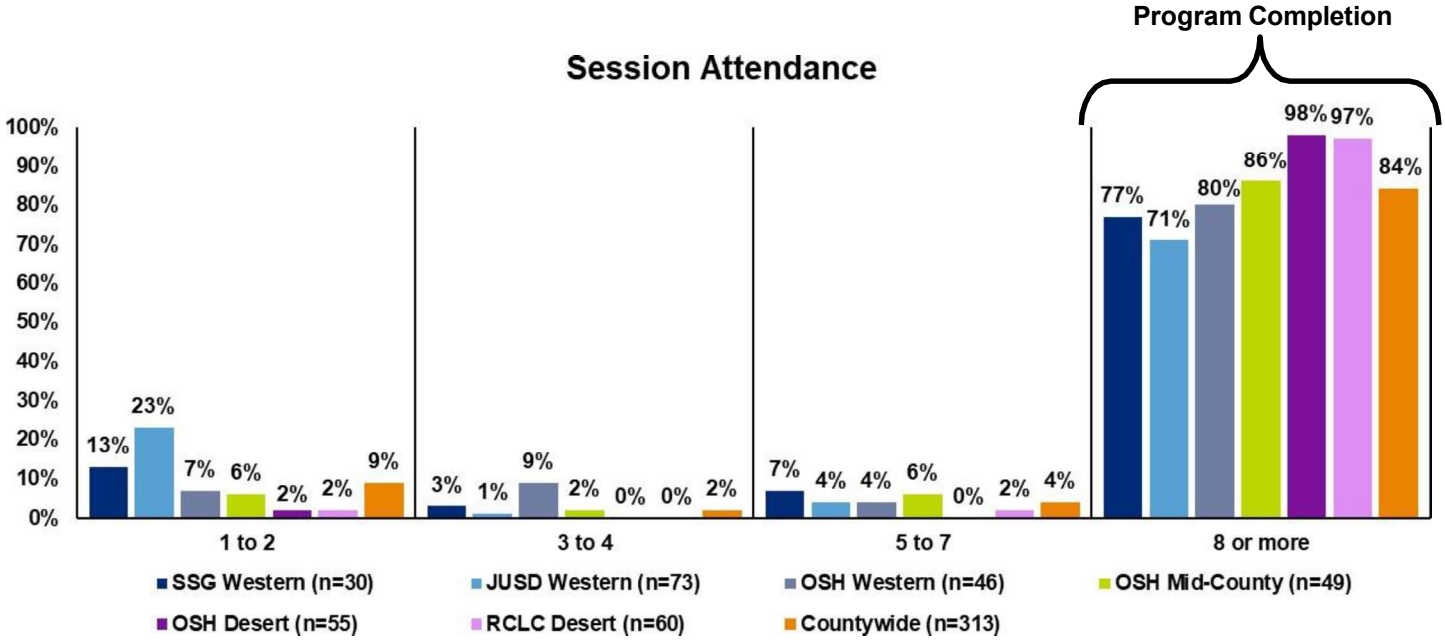
- Over half of participants were female (59%).
- Over two-thirds of the participants were Hispanic/Latinx (77%).
- English was the preferred language for 83% of participants.

Outcomes

- **Traumatic Symptoms Improved -** Intake data showed that 62% of participants had witnessed physical trauma and 79% had someone close to them die. Most youth reported multiple types of trauma. Baseline PTSD symptom scores indicated that all participants were at or beyond the 14-point threshold exhibiting moderate to severe PTSD at the beginning of the program. This percentage decreased to 64% by the end of the program. While only 36% of youth showed a decrease to below the cutoff score of 14, overall 78% of youth who completed the program showed a decrease in their total Child PTSD Symptom Checklist score.
- **Depression Improved** - CDI-II average scores showed that depression symptoms improved with total CDI-II scores countywide decreasing. Additionally, CDI-II average scale scores for Emotional Problems and Functional Problems decreased. Countywide, the total score and each CDI-II scale score showed statistically significant decreases in symptoms.
- **Participants were satisfied with CBITS** - 72% of youth agreed or strongly agreed that the program taught them how to better cope with stress. 77% of youth agreed or strongly agreed that the program has prepared them to cope with stress if something difficult happens in the future. Below are some participant comments on what they learned in the program:
    - "Coping mechanisms, how to manage stress better, viewing things in a calmer way, seeing the bigger picture."
    - "How to stay calm during a scary situation. Or how to think twice before reacting to something."
    - "How to understand my own feelings and that I can take little steps to start doing things I stopped myself from doing after the incident."
    - "I learned that I'm not always alone in difficult situations and there is always someone that is here for me no matter what."
    - "I learned that pushing away my problems will just make them harder to get through later."
    - "I learned that there are many ways to look at situation. You can make a bad one be a good problem. Knowing what helps you cope with stress can really help when in need."
    - "That a lot of kids I know from school sometimes feel how I feel so it made me not feel alone."

Enrollment and Completions

Enrolled was defined as having experienced a traumatic event, having a qualifying PTSD symptoms score of 14 or higher, and having attended at least 1 session. For FY2023-2024, countywide a total of 313 attended at least one group session in the CBITS program. Overall, 263 (84%) completed the program, defined as attending 8 or more sessions with completed outcome measures



Special Services for Groups (SSG) was contractually obligated to complete 48 participants within the Moreno Valley Unified School District. Jurupa Unified School District-Behavioral Health (JUSD-BH) was contractually obligated to complete 48 participants within the Jurupa Unified School District. Operation Safehouse (OSH) was contractually obligated to complete 48 participants in the Western region, 48 participants in the Mid-County region, and 48 participants in the Desert region from multiple school districts. Riverside County Latino Commission (RCLC) was contractually obligated to complete 48 participants within the Coachella Valley Unified School District. The table below details to what extent the providers met contract expectations for program completion based on how many participants completed the program.

Agency	Contract Expectations	Enrolled	Completed Program	% Contract Expectations
SSG Western	48	30	23	48%
JUSD-BH Western	48	73	50	104%
OSH Western	48	46	37	77%
OSH Mid-County	48	49	42	88%
OSH Desert	48	55	54	113%
RCLC Desert	48	60	57	119%
Countywide	288	313	263	91%

Meetings

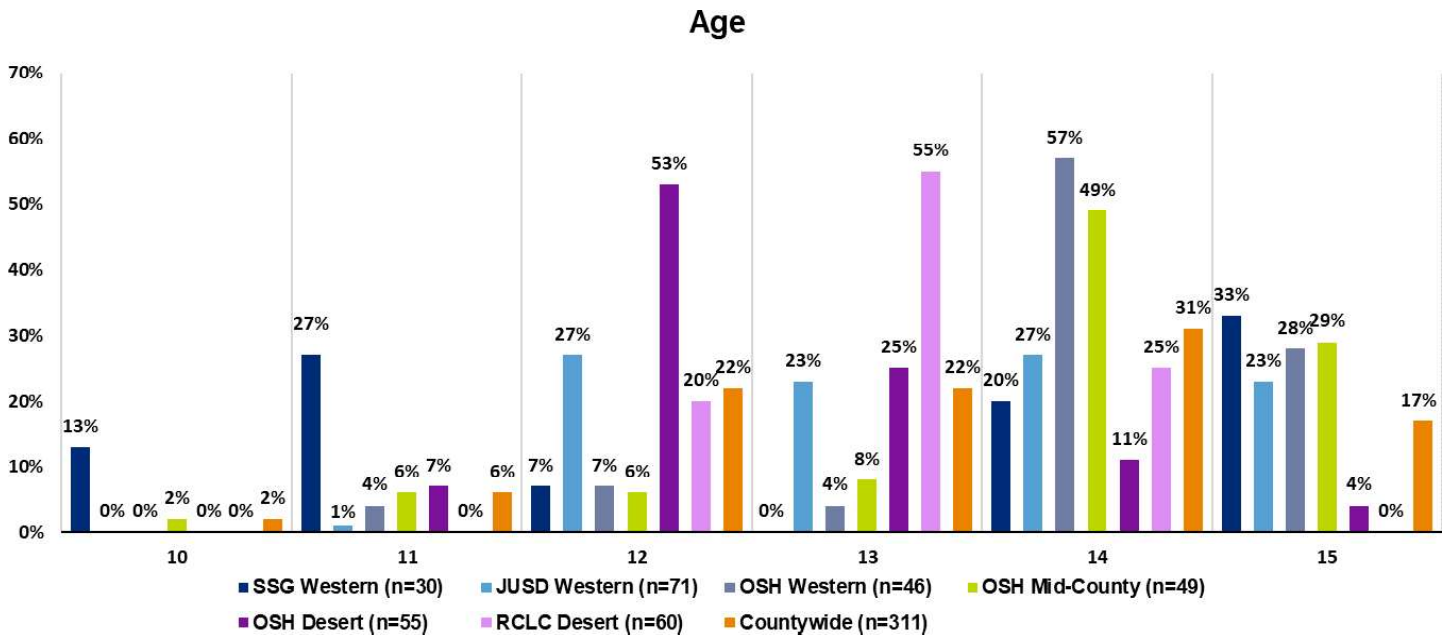
The program is designed to provide participants 1-3 individual sessions with a clinician. Additionally, parents/guardians and teachers are also given the opportunity to meet with the clinician for educational sessions. The parents/guardians are provided up to two meetings with the clinician, while teachers are provided one. The tables below show the documented student, parent/guardian, and teacher meetings with the clinicians.

Meetings	Individual Youth Meetings			
Agency	1 Meeting	2 Meetings	3 Meetings	No Meetings
SSG Western (n=30)	26	5	2	4
JUSD-BH Western (n=73)	55	28	2	18
OSH Western (n=46)	42	0	0	4
OSH Mid-County (n=49)	43	13	0	6
OSH Desert (n=55)	54	0	0	1
RCLC Desert (n=60)	58	7	0	2
Countywide (n=313)	278	53	4	35

Meetings	Parent Meetings			Teacher Meetings	
Agency	1 Meeting	2 Meetings	No Meetings	1 Meeting	No Meetings
SSG Western (n=30)	28	18	2	24	6
JUSD-BH Western (n=73)	57	0	16	68	5
OSH Western (n=46)	0	0	46	0	46
OSH Mid-County (n=49)	46	14	3	42	7
OSH Desert (n=55)	0	0	55	0	55
RCLC Desert (n=60)	60	20	0	60	0
Countywide (n=313)	191	52	122	194	119

Demographics

During the screening process or at the first class session, the participants are asked to complete a demographic questionnaire. This section will highlight the basic demographics of 311 participants since two participants did not share their demographics. The age distribution is shown below where the average age of participants was 13 years old.

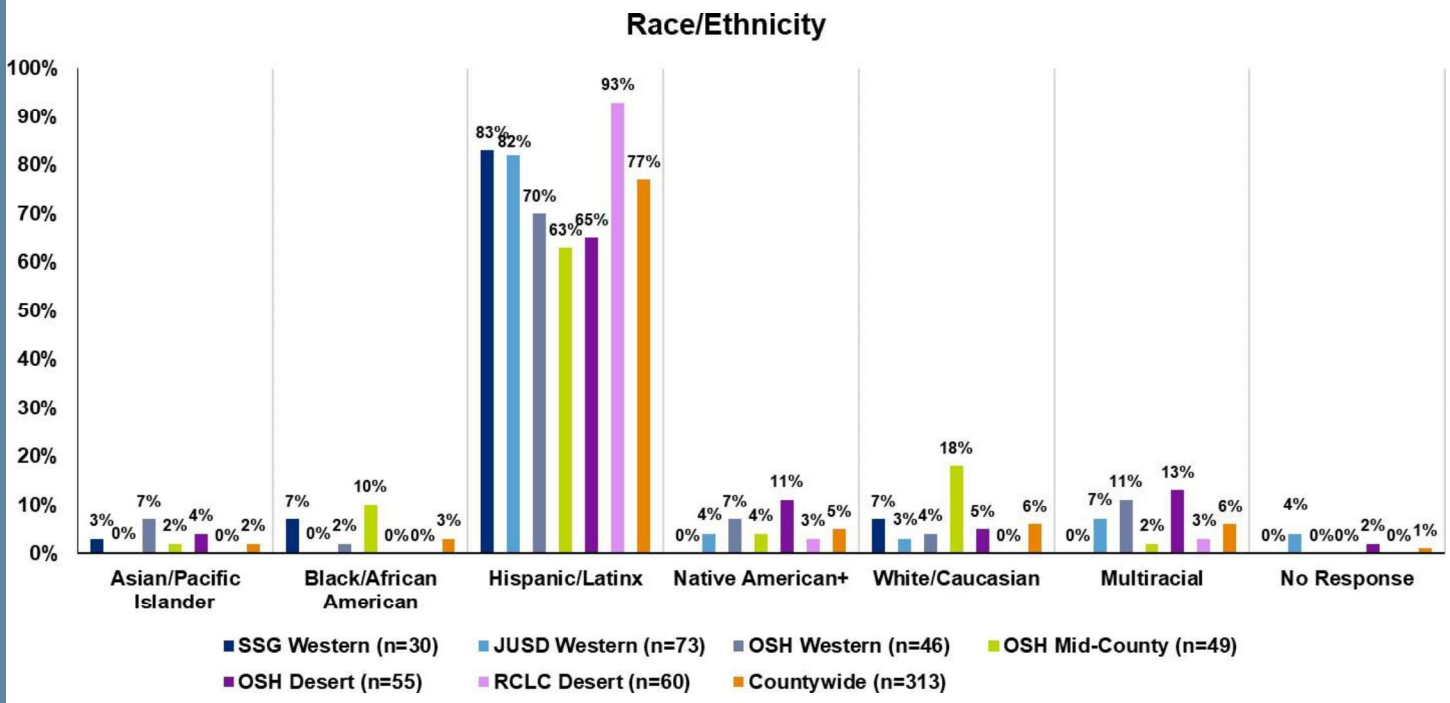


Grade level of participants was collected on the CDI-II measure. This measure is administered to youth when they enrolled in the program and at the end of the program. The participants were from 5th through 10th grade. The table below shows the grade level of the participants.

Grade Level							
Agency	**5th**	**6th**	**7th**	**8th**	**9th**	**10th**	**Not Reported**
SSG Western (n=30)	10	4	0	0	15	1	0
JUSD-BH Western (n=73)	0	0	36	2	33	0	2
OSH Western (n=46)	0	2	5	2	37	0	0
OSH Mid-County (n=49)	1	4	4	3	34	3	0
OSH Desert (n=55)	0	10	32	13	0	0	0
RCLC Desert (n=60)	0	0	21	39	0	0	0
Countywide (n=313)	11	20	98	59	119	4	2

Demographics cont.

Countywide, 77% of the program participants identified as Hispanic/Latinx, 6% White/Caucasian, 6% Multiracial/ethnic, 5% Native American (and one other race), 3% Black/African American, 2% Asian/Pacific Islander, and 1% was not reported.



Most participants reported their preferred language was English (83%), while 13% reported both English and Spanish, and six reported Spanish alone (2%).

Preferred Language				
Agency	**English**	**Spanish**	**English and Spanish**	**No Response**
SSG Western (n=30)	25	0	5	0
JUSD-BH Western (n=73)	54	0	15	4
OSH Western (n=46)	42	1	1	2
OSH Mid-County (n=49)	46	1	1	1
OSH Desert (n=55)	45	1	7	2
RCLC Desert (n=60)	47	3	10	0
Countywide (n=313)	259	6	39	9

Demographics cont.

Countywide, of the 313 participants in the CBITS program, 59% identified as female, 35% identified as male, eight identified as transgender, eleven identified as nonbinary, one as gender fluid, and two were not reported.

Gender						
Agency	**Female**	**Male**	**Trans**	**Nonbinary**	**Gender Fluid**	**No Response**
SSG Western (n=30)	16	9	2	3	0	0
JUSD-BH Western (n=73)	44	22	2	3	0	2
OSH Western (n=46)	29	17	0	0	0	0
OSH Mid-County (n=49)	37	9	2	1	0	0
OSH Desert (n=55)	29	22	1	3	0	0
RCLC Desert (n=60)	28	29	1	1	1	0
Countywide (n=313)	183	108	8	11	1	2

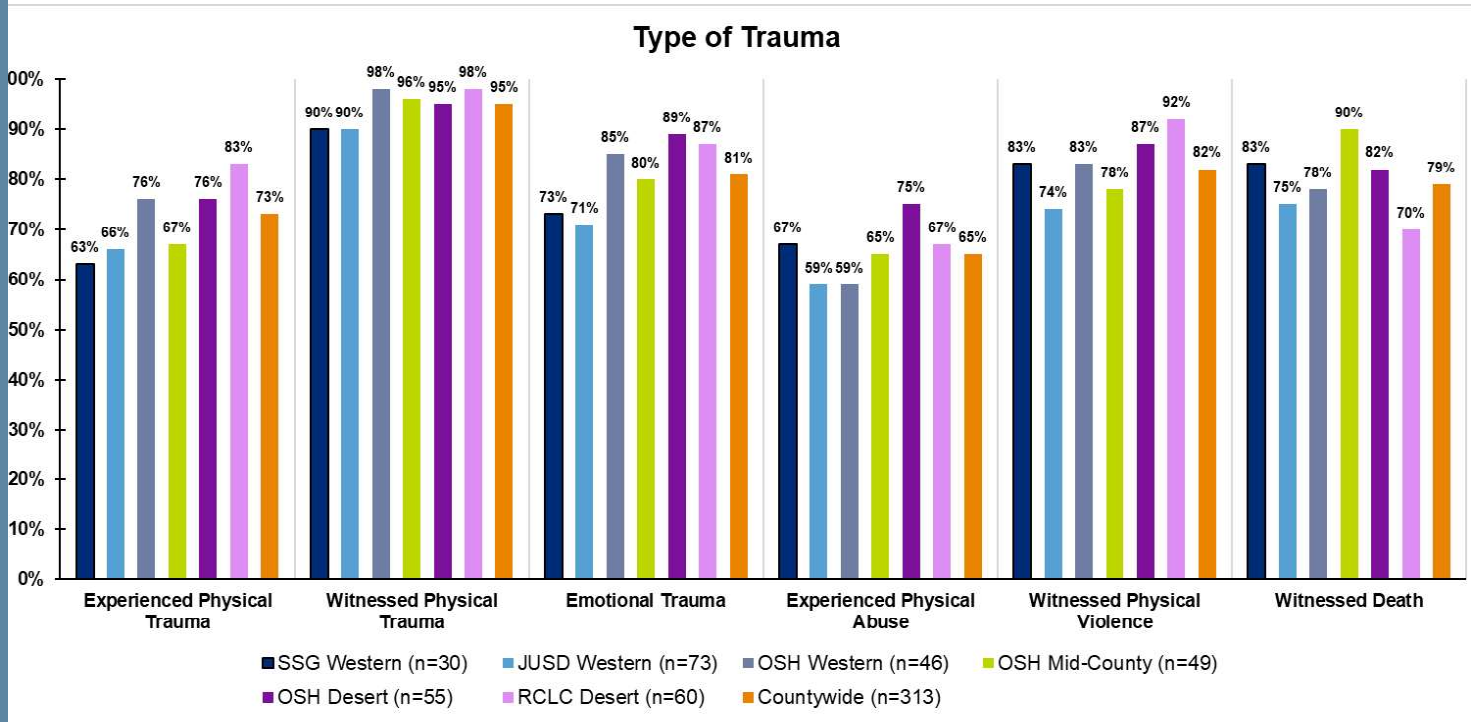
Countywide, 16% of youth indicated they were LGBTQ+ (n=51), while most of the participants (74%, n=231) reported they did not identify as LGBTQ+.

LGBTQ+								
Agency	**Lesbian**	**Gay**	**Bisexual**	**Pansexual**	**Yes**	**Asexual**	**Unsure**	**No Response**
SSG Western (n=30)	1	0	5	1	1	0	6	1
JUSD-BH Western (n=73)	0	1	4	2	4	0	3	7
OSH Western (n=46)	0	0	3	1	1	0	5	1
OSH Mid-County (n=49)	1	1	6	3	0	1	2	1
OSH Desert (n=55)	2	0	3	0	3	0	2	0
RCLC Desert (n=60)	0	0	4	0	3	0	2	1
Countywide (n=313)	4	2	25	7	12	1	20	11

Outcomes: Child Post Traumatic Stress Disorder (PTSD)

The Child Post Traumatic Stress Disorder (PTSD) Screener is used to assess exposure to traumatic experiences, as well as measure the severity of PTSD symptoms in participants exposed to trauma. The measure was used at the beginning and conclusion of the program to evaluate reductions in PTSD symptoms. The traumatic experience screener has 17 questions with a Yes/No format. If a youth answers 'Yes' to any one of these questions, this indicates exposure to a traumatic event and the youth then completes the second section. The second section measures the frequency and severity of PTSD symptoms the youth is experiencing and includes 17 questions. Higher scores indicate increased frequency and greater severity of post traumatic symptoms. The graph below displays the frequencies of trauma exposures, and the following page shows the severity of PTSD symptoms.

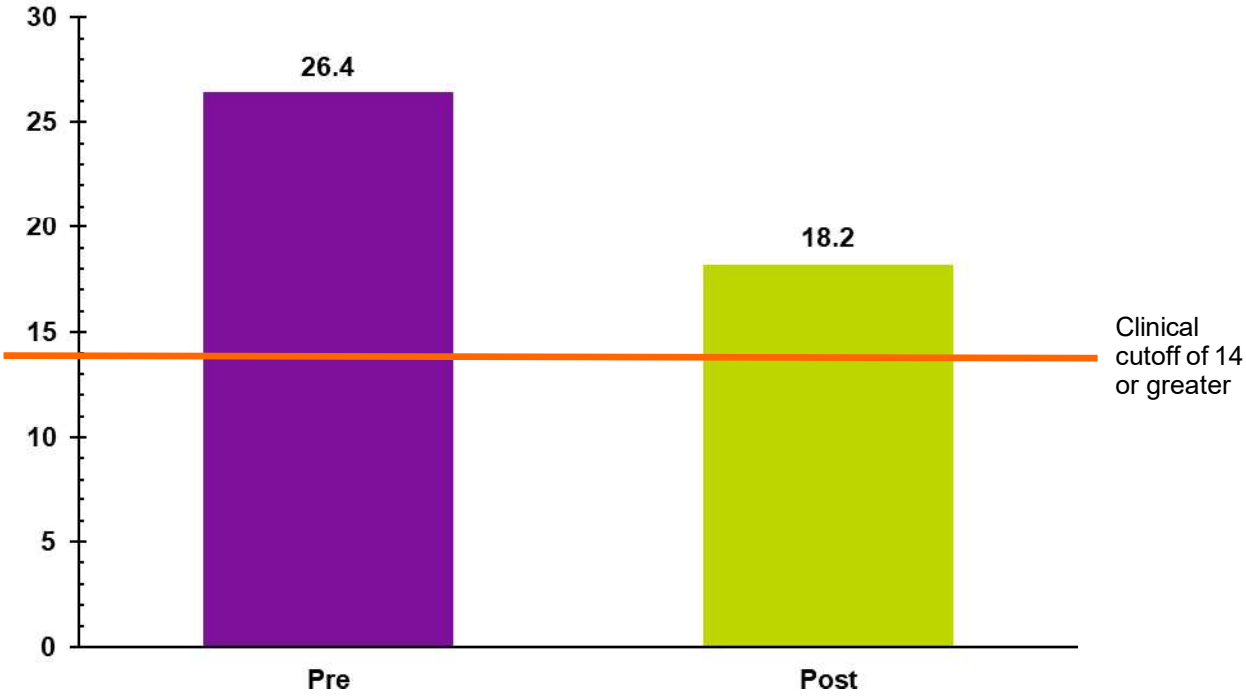
Out of the total 313 participants countywide, almost all of the participants witnessed physical trauma (95%, n=296), followed by witnessed physical abuse (82%, n=258), emotional trauma (81%, n=253), witnessed death (79%, n=247), experienced physical trauma (73%, n=227), and experienced physical abuse (65%, n=203).



Outcomes: Child Post Traumatic Stress Disorder (PTSD) cont.

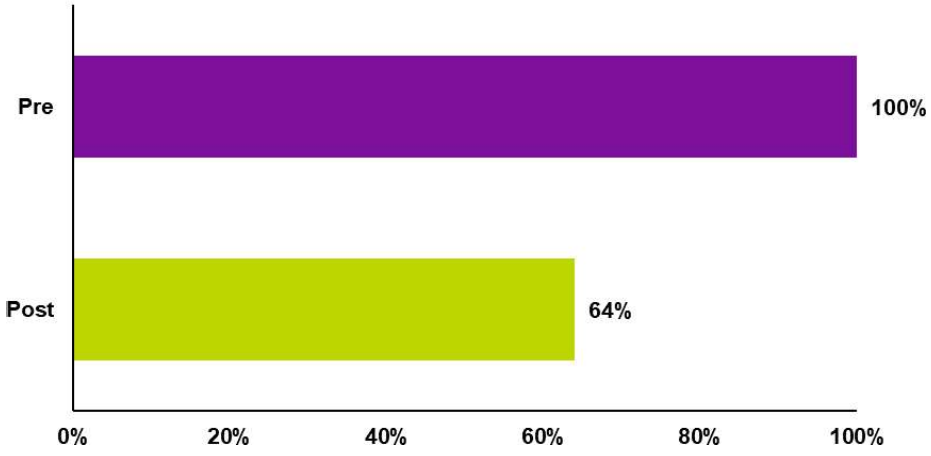
Analysis of the countywide PTSD symptom measure scores was performed on youth having both a pre and post measures, and at least 8 CBITS sessions. Scoring a 14 or higher on the Child PTSD Symptom Checklist indicates moderate to severe PTSD symptoms in the clinical range, represented by the red line in the figure below. Youth at the beginning of the CBITS program had, on average, high PTSD symptom scores above 14 points. After completing the program, youth average PTSD symptom scores showed a statistically significant decrease.

PTSD Symptoms Countywide (n=263)



Upon entering the program, 100% of youth countywide were at or above the 14 point clinical cutoff indicating moderate to severe PTSD. This percentage decreased to 64% by the end of the program (see below). While only 36% of youth showed a decrease to below the cutoff score of 14, overall 78% of youth who completed the program showed a decrease in their total Child PTSD Symptom Checklist score.

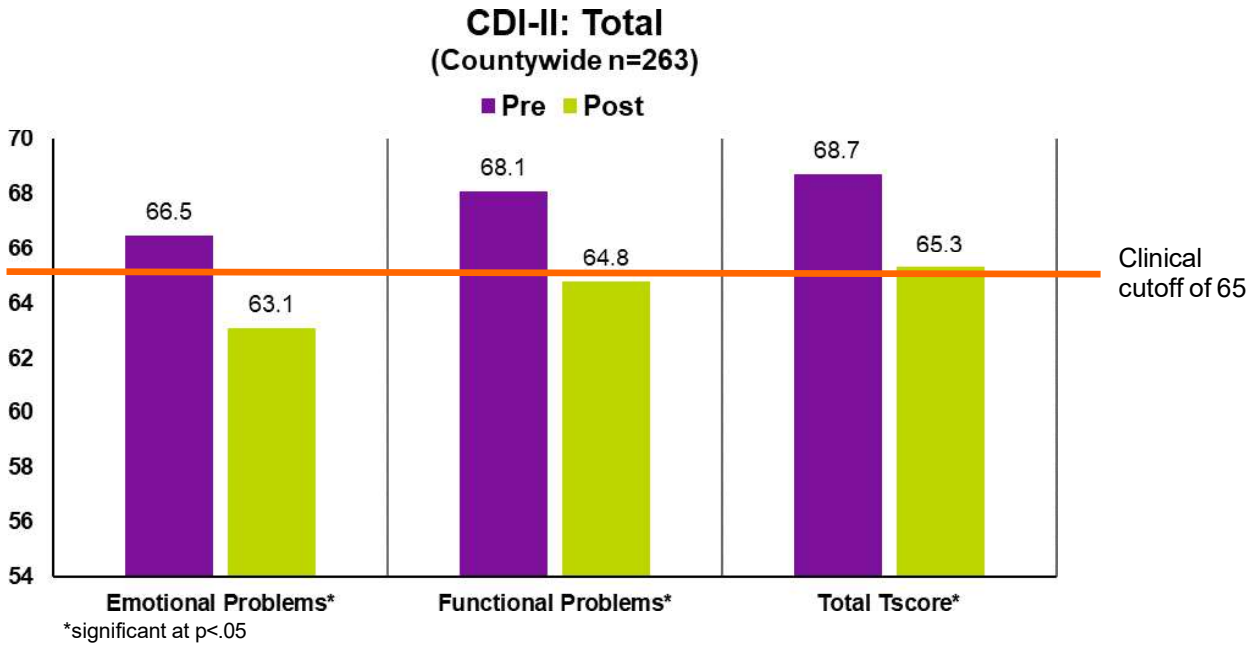
Participants with PTSD Countywide (n=263)

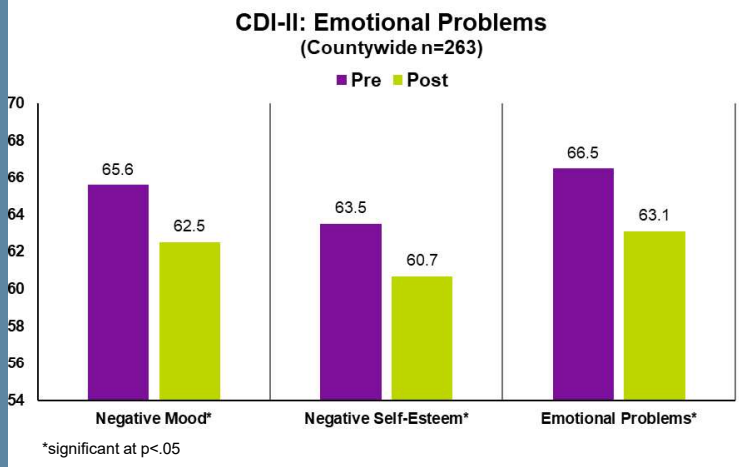


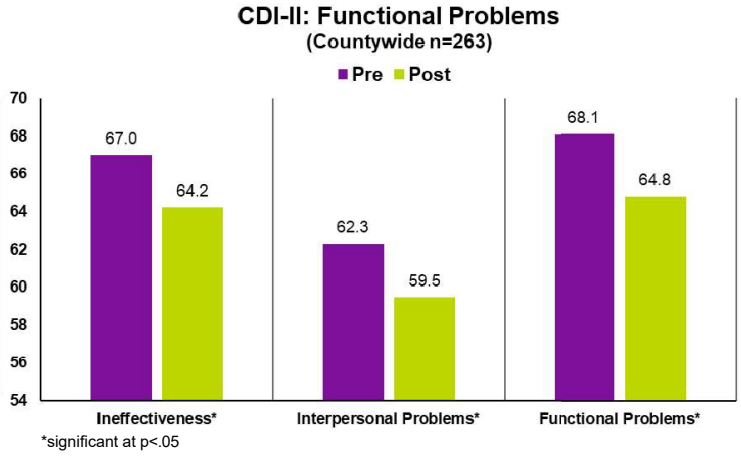
Outcomes: Children's Depression Inventory (CDI-II)

The Children's Depression Inventory 2nd edition (CDI-II) is used to measure the severity of depression symptoms in children. It is a self-reported assessment that program participants complete, both at the beginning and at the conclusion of the program. The CDI-II has 28-items with two scales: Emotional Problems and Functional problems. Each scale has two subscales where Negative Mood and Negative Self-esteem are subscales for Emotional Problems and Interpersonal Problems and Ineffectiveness are subscales for Functional Problems. Each question or 'item' has three different sentence descriptions. The participant marks which of the 3 sentences best describes them. Higher scores suggest higher depression symptomology. The raw scores for each child's CDI-II is plotted on a scoring grid and converted to a T-score. The T-score reflects how a child's score compares to other children of similar age and gender. T-scores greater than 65 are clinically significant (represented by the line on the graph below), meaning the youth meets criteria for clinical intervention.

Analysis was based on participants who completed both a pre and post CDI-II measure and attended at least 8 CBITS sessions. On average, CBITS participants' total scores were above the clinical cutoff of 65 at intake (68.7) and decreased at post (65.3). Scores decreased across all scales and subscales, where paired-samples t-tests revealed statistically significant changes in average scores from pre- to post-test. Additionally, the total score demonstrated a statistically significant decrease.







Outcomes: Children's Depression Inventory (CDI-II) cont.

CDI-II Total scores, Emotional Problems and Functional Problems scales, and their respective subscales scores varied by region and provider. Below are tables showing the scores from pre- to post-tests for each region by provider.

CDI-II Scores by Provider in the Western Region of Riverside County									
	SSG Western			JUSD-BH Western			OSH Western		
Scales and Subscales	n	Pre	Post	n	Pre	Post	n	Pre	Post
Total	23	70.4	65.6	50	68.9	65.8*	37	66.6	64.0
Emotional Problems	23	67.1	64.2	50	64.1	60.6*	37	65.9	62.7
Negative Mood	23	66.7	63.7	50	66.7	62.1*	37	65.5	62.3
Negative Self-Esteem	23	63.1	62.0	50	64.0	60.8	37	61.7	60.0
Functional Problems	23	70.0	63.7	50	67.3	65.7	37	66.5	63.1
Ineffectiveness	23	67.6	62.3	50	66.6	65.1	37	64.4	61.5*
Interpersonal Problems	23	68.0	61.4	50	61.3	60.0	37	62.3	60.0

*Significant at p<.05

CDI-II Scores by Provider in the Mid-County and Desert Regions of Riverside County									
	OSH Mid-County			OSH Desert			RCLC Desert		
Scales and Subscales	n	Pre	Post	n	Pre	Post	n	Pre	Post
Total	42	67.8	63.4*	54	71.3	70.2	57	67.5	62.5*
Emotional Problems	42	64.9	61.3	54	69.4	67.9	57	64.5	59.6*
Negative Mood	42	63.7	60.4	54	68.4	67.4	57	63.2	59.5*
Negative Self-Esteem	42	62.5	59.9	54	66.1	65.1	57	62.9	56.9*
Functional Problems	42	67.9	63.0*	54	69.8	68.7	57	67.5	63.2*
Ineffectiveness	42	66.3	62.8	54	68.7	67.6	57	67.4	63.7*
Interpersonal Problems	42	62.9	58.2*	54	63.4	62.9	57	59.5	55.8*

*Significant at p<.05

Satisfaction Surveys

Countywide, 260 participants completed the satisfaction survey. They were asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey.

Coping with Stress

- 72% of youth agreed or strongly agreed that the program taught them how to cope with stress.
- 77% of youth agreed or strongly agreed that the program has prepared them to cope with stress if something difficult happens in the future.

Personal

- 64% of youth agreed/strongly agreed that the program helped them to understand themselves better.
- 55% of youth agreed/strongly agreed that they achieved their goals for the group.
- 69% of youth agreed/strongly agreed that they will use what they learned in the program in their life.

Group Leaders

- 90% of youth agreed or strongly agreed that the leaders listened to what they had to say.
- 82% of youth agreed or strongly agreed that the leaders knew how to help them.

Question	Avg.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	No Response
The program taught me how to cope with stress. (n=258)	3.94	4 (1.5%)	4 (1.5%)	64 (24.6%)	**118 (45.4%)**	68 (26.2%)	2 (0.8%)
The program helped me to understand myself better. (n=257)	3.82	7 (2.7%)	14 (5.4%)	69 (26.5%)	**95 (36.5%)**	72 (27.7%)	3 (1.2%)
The program has prepared me to cope with stress if something difficult happens to me in the future. (n=259)	4.07	2 (0.8%)	10 (3.8%)	46 (17.7%)	**110 (42.3%)**	91 (35.0%)	1 (0.4%)
I achieved my goals for the group. (n=254)	3.73	4 (1.5%)	15 (5.8%)	**91 (35.0%)**	80 (30.8%)	64 (24.6%)	6 (2.3%)
The group leaders listened to what I had to say. (n=257)	4.58	1 (0.4%)	4 (1.5%)	17 (6.5%)	59 (22.7%)	**176 (67.7%)**	3 (1.2%)
The group leaders knew how to help me. (n=258)	4.32	2 (0.8%)	8 (3.1%)	34 (13.1%)	76 (29.2%)	**138 (53.1%)**	2 (0.8%)
I will use what I learned in the program in my life. (n=257)	4.00	3 (1.2%)	12 (4.6%)	62 (23.8%)	85 (32.7%)	**95 (36.5%)**	3 (1.2%)
I would recommend the program to a classmate. (n=255)	4.26	4 (1.5%)	11 (4.2%)	35 (13.5%)	70 (26.9%)	**135 (51.9%)**	5 (1.9%)

Note: Some participants completed an older version of the survey which had only the first six questions on the satisfaction survey (n=3).

Satisfaction Survey: Comments

Participants were also asked what they learned from the program, what they liked about the program, as well as what they disliked about the program. Below are some comments from the participants.

What Participants Learned…

- "#1: How to deal with Stress #2: How to talk with People #3: Calming down an angered Person."
- "A small game for to relax/distraction or whenever not in a good mindset (name colors, characters, shows, etc) they were simple and not to hard to remember."
- "Coping mechanisms, how to manage stress better, viewing things in a calmer way, seeing the bigger picture."
- "Finding someone to talk to if I need someone to hear me out, dealing with stress, and not overthinking."
- "Hot Seat - helpful other thoughts; Feelings Thermometer; Breathing Exercises; Thoughts, Actions, and Emotions Triangle."
- "How to calm myself down and how to deal with tough situations I may have in the future."
- "How to calm myself down when needed and become more social. I also learned how to understand myself better."
- "How to comfort others, make solutions to my problems, and how to be respectful when someone is sharing trauma."
- "How to communicate how you feel and not bottle it up."
- "How to control myself in hard situations."
- "How to cope with stress and express myself to people."
- "How to cope with stress, how to use different strategies to calm down and just how to have a better mindset in general."
- "How to cope, and think before I do anything dumb."
- "How to focus during a stressful time like breathing."
- "How to stay calm during a scary situation. Or how to think twice before reacting to something."
- "How to take bad thoughts and make them into helpful thoughts."
- "How to understand my own feelings and that I can take little steps to start doing things I stopped myself from doing after the incident."
- "How to understand myself, how to cope with stress. (I learned how to understand myself, how to handle my stress, and how to react in a difficult situation.)"
- "I didn't really learn anything I just talked about stuff that happened in the past."
- "I learned how to handle stress and how to solve it in the future."
- "I learned how to tell people how I feel."
- "I learned how to think more logically about my bad thoughts. Finally talking about what's been going on has made me feel better. I've met people that made me feel safe when I speak about my problems."
- "I learned that even though people look happy they have a hard past."
- "I learned that I could control how I feel."
- "I learned that if you are having a stress full time to talk to people and using strategies to help you"
- "I learned that I'm not always alone in difficult situations and there is always someone that is here for me no matter what."
- "I learned that pushing away my problems will just make them harder to get through later."
- "I learned that there are many ways to look at situation. You can make a bad one be a good problem. Knowing what helps you cope with stress can really help when in need."
- "I learned way of coping which was really good. I learned what to do when I don't feel good and very thankful for it."
- "I'm not alone in my experiences. That there's people like me going through similar things."
- "Nothing really helped me."
- "That a lot of kids I know from school sometimes feel how I feel so it made me not feel alone."
- "The steps of thinking something out before resorting to a negative thought/finding the positive in things."
- "To always deal with problems and not to avoid them"
- "To focus on yourself and that you yourself matter and ways to not think bad all the time and ways to calm yourself down if you ever feel scared or stressed."

Satisfaction Survey: Comments

What Participants Learned…cont.

- "To not kill myself"
- "To talk out my problems with a person that is trust worthy."
- "To think positive, facing my fears, and trying to solve the problems without fighting."
- "Ways to calm myself, Think and Question my thoughts."
- "We all have the same problems and we learned how it comes out in us."
- "We aren't the same all around."
- "We have to deal with trauma now."
- "What to do when I feel bad or stressed."
- "When there is a fight Leave from it"
- "You cant be afraid about everything and you can over come it."

What Participants Liked…

- "100% of it"
- "A break from some classes that stress me."
- "Being able to see how I can control myself and my emotions."
- "Being with a friend and food."
- "Every body was nice and so hope-full and helpful. Every one was patient with me."
- "Every one shared stories, We laughed and shared"
- "Everybody was very welcoming and they were very positive and wanted to hear what we had to say."
- "Everyone listened to what I had to say, everyone was so kind and funny, and helped me understand others go through things too."
- "Everything, This group was awesome."
- "Having the chance to meet everyone here and learning about them."
- "Hot seat-change way of thinking, Food, Other Students
- "How I could be comfortable with telling people about my problems, how you can feel safe talking about stuff."
- "How it was fun and relatable."
- "How it was very easy to become friends with the others and that the leaders always had time for us to speak."
- "How kind and understanding the leaders are. I really liked the group because my leaders made it fun and not scary."
- "How the group leaders listen people in the group give good compliments /or responses to your incident."
- "How to calm down and breath in and out"
- "How understanding they are being patient and be considerate towards the situations and advice (helpful majorly)"
- "I could share what Ive been through and no one can Judge because we've all been through the same situations."
- "I felt connected with everyone in a way"
- "I felt like I matter"
- "I got to be heard and understood by people who went through similar situation."
- "I got to have a laugh with everyone, and had a great time. Learned things to help me."
- "I learned how to deal with my stress."
- "I like how everyone was under standing and open minded."
- "I like that we learned how to deal with stressful situations."
- "I like the teachers and how I made friends"
- "I liked about the program is the copius amount of candy and hearing about how other people felt."
- "I liked how I feel like I can talk about anything and they listen and give great advice about what I can work on to become better."
- "I liked how I was able to help my stress go away."

Satisfaction Survey: Comments cont.

What Participants Liked…cont.

- "I liked how nice the teachers were and how I learned many things."
- "I liked it I was kinda glad in a way that I'm not the only one that goes threw bad stuff and it was helpful"
- "I liked that I didn't feel like I was judged and that I could actually talk without worrying as much."
- "I liked that it was a nice break from school."
- "I liked that it was like a period where we were able to talk about our problems."
- "I liked that nobody judges you."
- "I liked that the group leaders were understanding they let every voice be heard. They were super nice and caring."
- "I understood that other students were kind of in the same situation as I was."
- "It was a big stress reliever."
- "If your upset they won't talk to you they will give you a sticky note asking if your okay and if you wanna talk."
- "It is good to talk out what you dont want anyone to know"
- "It teaches you how to cope with your trauma as well as see other peoples view of things that happen."
- "It was fun I got to eat donuts and enjoy Thursdays now."
- "Just talking about stuff that we don't normally talk about in school or class."
- "Showing us many skill we can use for the future."
- "That everybody listened, nobody judged me, or spread my info around school."
- "That the ladies are super nice and chill, the music is very relaxing, they let us use figet toys during a session. I feel safe."
- "That they helped me through tough places"
- "That when you were down they will bring you up."
- "That you don't feel alone and feel like there is someone there for you when you really need it."
- "The group leaders being Amazing & Awesome. I will always remember how great & Amazing they are. The solutions are helpful! makes me feel less alone."
- "The group leaders cared about us and listened to our feelings. I was able to learn multiple new ways to cope."
- "The snacks in all honestly but I liked getting to hear other experiences close to mine."
- "What I like about the Program is that they are nice, caring, very calm, and of course the snacks. I also love the stuff we do. Sometimes it helps just being in there and away from a class."
- "What I like about the program is that they give you confidence in yourself."
- "What I like was how we learned coping strategies but in a fun way."

What Participants Disliked…

- "At first I didn't like that I had to share about my life but I'm glad I did. Thank you."
- "Facing my problems."
- "Feeling like there just here for the money"
- "Forgot drinks twice"
- "Having to makeup the work that I missed because of the group."
- "Having to share thing that you don't want to."
- "Homework"
- "How long and what period it takes place in."
- "How quiet it is in each session."
- "I did not like how it was an 1hrs long."
- "I didn't get along/talk to anyone really."
- "I didn't like that I only really knew 1 person to hangout."
- "I didn't like that it was the same period, I don't like missing work."

Satisfaction Survey: Comments cont.

What Participants Disliked…cont.

- "I didn't really get to speak with the other students."
- "I didn't really have icks about it so I don't know."
- "I didn't really like that people would hear about my situation, other than that I actually really liked it."
- "I don't have anything to say I liked everything from the program and it helped me."
- "I don't like leaving class when I have to do something important."
- "I don't like sharing about what happen."
- "I felt different like my own opinion was not good."
- "I got a little bored but the program is great."
- "I honestly liked everything about the program."
- "I honestly loved the program."
- "I liked alot of things about this program I can't think of something that I didn't like about this program."
- "I love this program their nothing to hate about it"
- "I loved everything there wasnt a single thing I didnt like."
- "I Loved The Program."
- "I was still scared I would get judged."
- "It felt too long"
- "It requires me to come to school."
- "It takes me out of class."
- "It was a little silent through out the class."
- "It was boring at points"
- "It was kind of short."
- "It was my fault but being marked absent because I would forget to show my teachers my passes."
- "Missing the same class period every week."
- "Most of the people didn't take the program seriously. Felt like I was judged a bit."
- "Not enough time"
- "Nothing I loved this group."
- "Nothing I'm a miss this program for real"
- "Nothing its fun! & great for one of my friends."
- "Nothing really. I just depends if it works for you or not."
- "Nothing was bad about the program I would recommend."
- "Nothing you guys were awesome."
- "Probs the socializing but I got used to it."
- "Sharing personal information."
- "Some of the coping skills didn't really work for me."
- "Sometimes it was in a class period I liked."
- "Talking about most things that remind me of stress."
- "Talking in front people."
- "That I don't really feel comfortable and I don't really feel sure about telling them personal things."
- "That it is not longer."
- "That they reminded me about stressful things."
- "The people don't talk that much."
- "The teacher would side eye me a lot."

Satisfaction Survey: Comments cont.

What Participants Disliked…cont.

- "There is nothing wrong about this program it is a group to help you get throw the things are scared of or what happened to you."
- "There isn't a thing I can say I hated because I honestly did enjoy the group."
- "There was nothing I didn't like I think it would also help other people out."
- "There's nothing I didnt like about the program except the asking question the personal question to much."
- "There was a big gap that we didn't go."
- "To be honest, I didn't dislike anything, everyone is so kind."
- "To much writing."
- "We didn't get to meet very often."
- "What I didn't like about the program is the insermountable ways of trying to cope with stress that didn't work for me."
- "What I didn't like about the program was that it's only for a short time."
- "What I don't really like is how we had to share. Yes I do understand why but I was very nervous."
- "When People would laugh about something that wasn't funny."
- "When we had to talk about our trauma but it wasn't that bad."
- "You had to talk about past events."
- "We only get 30 minutes to stay."

Riverside University HEALTH SYSTEM Behavioral Health

Seeking Safety and Seeking Strength

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

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Program Overview

Program Overview:

Seeking Safety focuses on improving the lives of people who have experienced a traumatic event. One of the goals of RUHS-Behavioral Health Prevention and Early Intervention plan is to reduce the detrimental effects of trauma for individuals at risk of developing mental health problems as a result of experiencing a traumatic event. Trauma is defined by the DSM-5 as:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event(s); witnessing, in person, the traumatic event(s) as it occurred to others; learning that the traumatic event (s) occurred to a close family member or close friend (in case of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental); or experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (American Psychiatric Association, 2013, p. 271).

This harm includes events such combat, childhood physical or sexual abuse, serious car accident, life-threatening illness, natural disaster, or terrorist attack. Approximately 20-30% of people who experience such trauma go on to develop Post Traumatic Stress Disorder (PTSD; Adshead, 2000). In the United States, among men who develop PTSD, 52% develop alcohol use disorder and 35% develop a drug use disorder; among women these rates are 28% and 27% (Kessler et al., 1995). According to The National Child Traumatic Stress Network's Making the Connection: Trauma and Substance Abuse report (2008), studies indicate that up to 55% of young people with PTSD also subsequently develop substance abuse problems. Unfortunately, people with a dual diagnosis of PTSD and SUD, compared to those with either disorder alone, have more legal and medical problems, greater risk of suicidality, and increased rates of future trauma (Najavits, 2007).

Seeking Safety is an evidenced-based practice, identified by the PEI Steering Committee, that aims to help participants avoid or interrupt that cycle. Seeking Safety is an integrated therapy treating both PTSD and substance use disorders. This program is based on the cognitive-behavioral model of relapse prevention. It teaches present-focused coping skills designed to simultaneously help people with a history of trauma and substance abuse. It has been conducted in group or individual format; for people with both substance abuse and dependence issues; for people with PTSD; and for those with a trauma history that do not meet criteria for PTSD. The program has a highly flexible format: session topics can be completed in any order, clients can join in at any point, and both professionals and paraprofessionals (i.e., peers) can conduct the sessions.

Seeking Safety focuses on coping skills and psycho-education with the following key principles: (1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment (working on PTSD and substance abuse at the same time); (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; and (4) four content areas: cognitive, behavioral; interpersonal, and case management. The intervention consists of 25 treatment topics that cover cognitive, behavioral, and interpersonal domains. Session topics include: Introduction to Treatment/Case Management, Safety, PTSD: Taking Back Your Power, Detaching from Emotional Pain (Grounding), When Substances Control You, Asking for Help, Taking Good Care of Yourself, Compassion, Red and Green Flags, Honesty, Recovery Thinking, Integrating the Split Self, Commitment, Creating Meaning, Community Resources, Setting Boundaries in Relationships, Discovery, Getting Others to Support Your Recovery, Coping with Triggers, Respecting Your Time, Healthy Relationships, Self-Nurturing, Healing from Anger, The Life Choices Game, and Termination. Successful program completion does not require completing all topics—program completion for PEI is defined as 6 or more topic sessions.

Program Providers

Providers:

Operation SafeHouse has been providing emergency shelter, intervention, and outreach services to youth and families in crisis for over 20 years through its established locations in Riverside and the Coachella Valley. It has served as a haven for runaway and homeless youth, and more recently has expanded to include a counseling center. Operation SafeHouse works within the community, offering their resources with the goal of supporting positive shifts in the lives of at-risk youth and families in the area. Operation SafeHouse was contracted to serve TAY youth (ages 16-25) in the Seeking Safety program.

RUHS-Behavioral Health PEI Peers is a division of Prevention and Early Intervention (PEI) that aims to reach out to the community with mental health needs, by facilitating access to services and supports. RUHS-BH PEI Peers Support Specialists serve Adults (ages 26+) in the Seeking Strength program.

Evaluation Overview

Screening Method

Potential participants in the Seeking Safety program are asked about whether they have recently experienced a traumatic event. Additionally, they are asked if they have been diagnosed with PTSD and if they are actively in therapy. For those individuals who have recently experienced a traumatic event and have not been diagnosed, they are asked to complete a PTSD checklist (PCL-5).

PTSD Checklist (PCL-5): a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). Research has demonstrated the PCL-5 exhibits strong internal consistency, test-retest reliability, and convergent and discriminant validity (Blevins et al., 2015). In addition, confirmatory factor analyses indicated adequate fit for the final 20-item scale with the DSM-5 4-factor model: re-experiencing; avoidance; negative alterations in cognitions and mood; hyper-arousal. The Seeking Safety program used this screening to qualify participants into the program, utilizing a scoring criteria. The PCL-5 is scored by summing the scores for each of the 20 items to get a total symptom severity score (range—0-80). A PCL-5 score of 20 and above is the criterion for admission into the program.

Process Evaluation

The process evaluation collected descriptive information related to the program, which describes what the program provided, how many people were served, and basic demographic characteristics. Process evaluation data is assessed using group sign-in sheets, individual attendance logs, and demographic forms.

Outcomes

The outcome evaluation included measures of PTSD symptoms and coping mechanisms. Satisfaction surveys included items on overall helpfulness of the program and satisfaction with specific components of the program. Outcome evaluation measures are summarized below.

- **PTSD Checklist (PCL-5):** a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). Research has demonstrated the PCL-5 exhibits strong internal consistency, test-retest reliability, and convergent and discriminant validity (Blevins et al., 2015). In addition, confirmatory factor analyses indicated adequate fit for the final 20-item scale with the DSM-5 4-factor model: re-experiencing; avoidance; negative alterations in cognitions and mood; hyper-arousal.
- **Coping Skills Inventory (CSI):** a 38-item self report measure of coping mechanisms developed to assess a range of positive and negative coping responses to life stressors. The CSI was adapted from the Revised COPE Scale (Zuckerman & Gagne, 2003) and Coping Strategy Inventory (Reid, 2007).
- **Satisfaction Survey:** a 17-item questionnaire was given to participants to complete once they had attended six or more sessions. Responses to this Conclusion of Services questionnaire were rated on a Likert scale. Items included “Overall, how helpful was Seeking Safety to you?” and “Staff treated me with respect.” Additionally, feedback was elicited by asking participants what they liked and disliked about the program.

Executive Summary: Key Findings

Screening

Enrollment in the Seeking Safety program requires a screening process to determine program eligibility. A total of 249 individuals were screened for the Seeking Safety program by asking questions related to their experiences with traumatic events and using the PTSD Checklist (PCL-5). Participants with a score of 20 or above on the PCL-5 were eligible for the program. Of all the individuals screened, 97.2% (n=242) scored at or above a 20 on the PCL-5.

Process Evaluation

Enrolled and served individuals were derived from the receipt of demographic information, questions related to their experiences with traumatic events, PCL-5 scores, and attendance data. A total of 154 participants attended at least one Seeking Safety session. Of those 154 participants, 79.2% (n=122) met the completion criteria of attending six or more sessions which include the five core program sessions of Safety, PTSD: Taking Back Your Power, Detaching from Emotional Pain (Grounding), Asking for Help and either When Substances Control You, Setting Boundaries in a Relationship, or Healthy Relationships.

Demographic information is reported for those who attended at least one session (n=154). Countywide:

- Most participants were transition age youths between the ages of 16-25 years old (n= 124, 80.5%).
- A majority of participants identified as Hispanic/Latino (n= 114, 74%).
- The majority of participants identified as female (n= 101, 65.6%).
- A quarter of the participants identified as LGBTQ+ (n= 47, 30.5%).

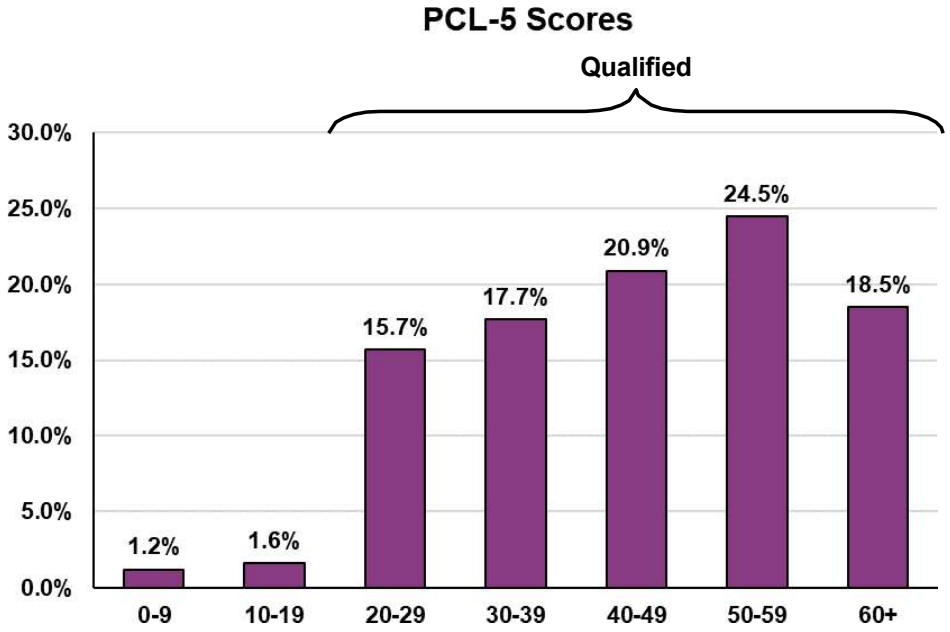
Outcomes

- **PTSD Symptoms Decreased:** Comparison of pre to post scores showed a decrease in PTSD symptoms following participation in the program. Participants' scores showed a statistically significant decrease in the total average score.
- **Coping Skills Improved:** Comparison of pre to post scores showed an improvement in positive coping response subscales (expressing emotion, understanding emotion, maintaining optimism, and goal replacement) and a decrease in negative coping responses (self blame, other blame, self-punishment, self harm, and aggressive behavior) to life stressors.
- **Participants were satisfied with the program:** Overall responses to the satisfaction survey, given upon completion of the program, were positive. Participants found the program to be helpful and would recommend the Seeking Safety program to others.

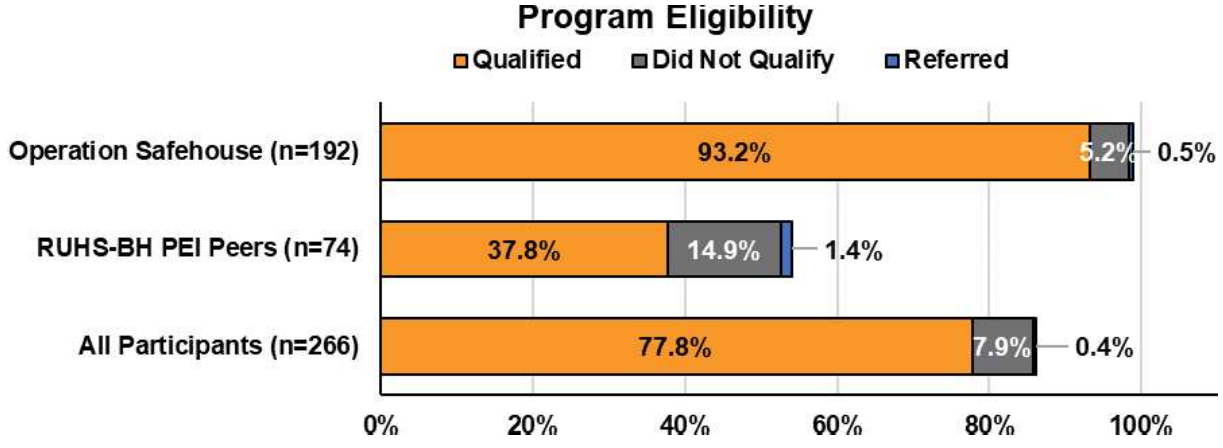
Screening

Countywide, 249 Transition Age Youths and Adults were screened for enrollment into the Seeking Safety program. To determine eligibility, participants were asked two questions: (1) if they have ever experienced a traumatic event and (2) if they have been diagnosed/received treatment for PTSD. Though there were some exceptions, participants were given a PTSD Checklist (PCL-5) screening tool if they answered yes to the first question and no to the second question about their trauma experience.

The PCL-5 is a 20-item self-reported measure that assesses DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). The measure was used as part of the criteria to qualify participants into the program. The PCL-5 is scored by summing the responses of the 20 items to get a total symptom severity score (range of 0-80). A score of 20 or more on the PCL-5 determined if that participant was eligible to enroll in the Seeking Safety program. A total of 249 people (93.6% of those who were screened) completed the PCL-5. Of the 249 people, 97.2% (n=242) scored a 20 or above. **The average score on the PCL-5 was 45**.

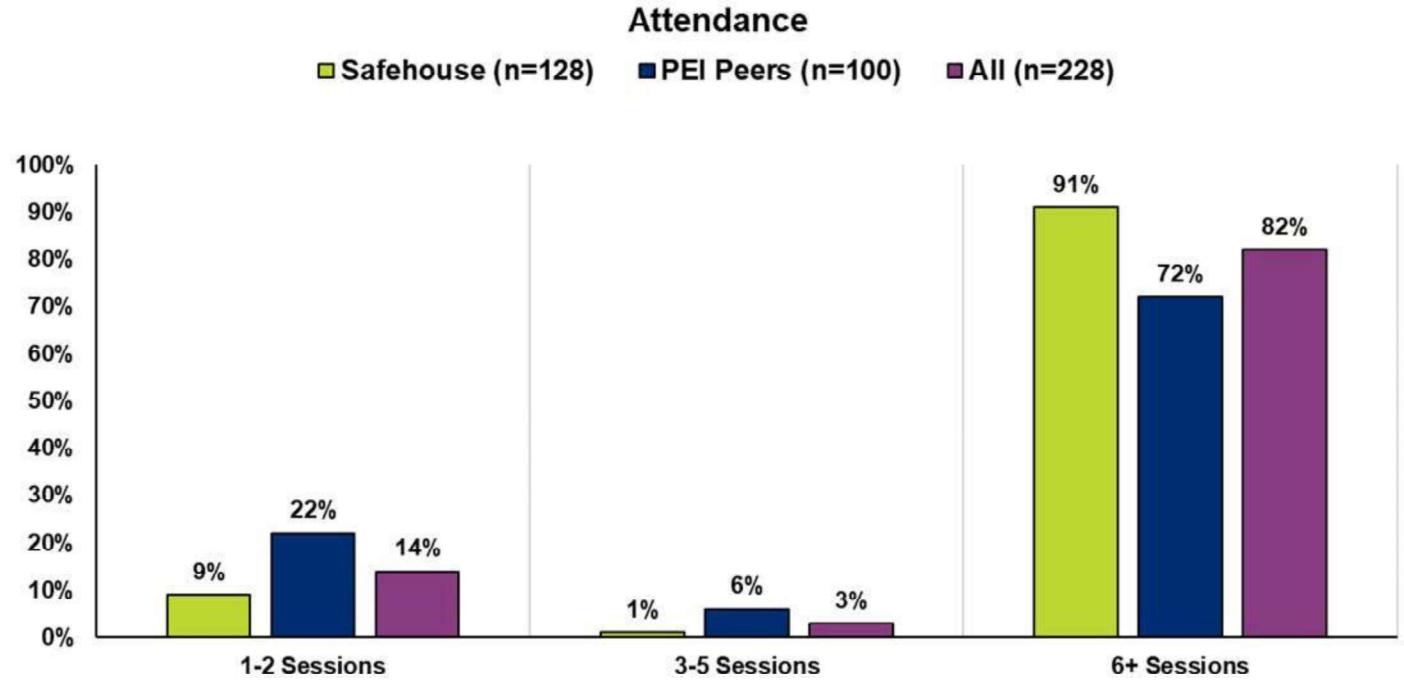


Countywide, 77.8% (n= 207) of those screened were eligible, 7.9% (n=21) were not eligible, and 0.8% (n=2) were referred to another program by request or because it was better suited to their needs.



Enrollment and Completions

Enrolled was defined as having collected demographic information, having a qualifying PCL-5 score of 20 or higher, and having attended at least 1 session. For FY2023-2024, a total of 154 participants were enrolled into the Seeking Safety program where 126 were served by Operation Safehouse and 28 were served by RUHS-BH PEI Peers. Of the 126 participants served by Operation Safehouse, 105 (83.3%) completed the program. Of the 28 participants served by RUHS-BH PEI Peers, 17 (60.7%) completed the program. Overall, of the 154 participants that were enrolled countywide, 122 (79.2%) completed the program, where completion was defined as attending 6 or more sessions (including 5 core program sessions). The figure below shows the frequency of attendance of Seeking Safety sessions.



Contract Expectations and Completions

Operation Safehouse was expected to have 180 Transition Age Youth (TAY) that are 16-25 years old complete the program and RUHS-BH PEI Peers was expected to have 180 Adults that are 26-59 years old complete the program throughout Riverside County. Overall, neither provider met the contract expectations. The table below shows the number of TAY and Adults for each provider that had completed the program compared to the number they were contracted to complete.

		Western	Mid-County	Desert	Countywide
Expected	Transition Age Youth 16-25	60	60	60	180
Completed	**Operation Safehouse**	**34 (56.7%)**	**56 (93.3%)**	**36 (60.0%)**	**126 (70.0%)**
Expected	Adults 26+	60	60	60	180
Completed	**PEI Peers**	**17 (28.3%)**	**6 (10.0%)**	**5 (8.3%)**	**28 (15.6%)**
Expected	Total	120	120	120	360
Completed	**Total**	**51 (42.5%)**	**62 (51.6%)**	**41 (34.2%)**	**154 (42.8%)**

Attendance

The program has a highly flexible format: session topics can be completed in any order, clients can join in at any point, and both professionals and paraprofessionals (i.e. peers) can conduct the sessions. The program provider decides which topic to cover at each group or individual session. Successful program completion does not require completing all of the topics. However, the program model does recommend that each participant attend the Safety, PTSD: Taking Back Your Power, Detaching from Emotional Pain (Grounding), When Substances Control You or Setting Boundaries in a Relationship, and Asking for Help. In order for participants and program providers to keep track of session topic attendance, there are group sign-in sheets and each participant has an individual attendance log. The table below details the frequency of attendance by topic.

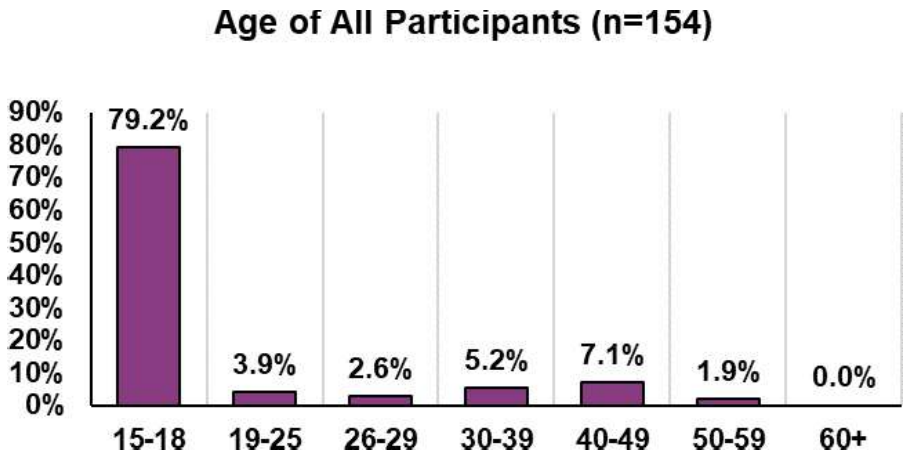
Attendance by Topic

Topic	Op Safehouse (n=126)	PEI Peers (n=28)	All Ages (n=154)
***Safety**	**123 (97.6%)**	**27 (96.4%)**	**150 (97.4%)**
***PTSD: Taking Back Your Power**	**126 (100%)**	**28 (100%)**	**154 (100%)**
***Detaching from Emotional Pain (Grounding)**	**126 (100%)**	**28 (100%)**	**154 (100%)**
***Asking for Help**	**108 (85.7%)**	**18 (64.3%)**	**126 (81.8%)**
***When Substances Control You** or	**34 (27.0%)**	**1 (3.6%)**	**35 (22.7%)**
***Healthy Relationships** or	**89 (70.6%)**	**21 (75%)**	**110 (71.4%)**
***Setting Boundaries in a Relationship**	**8 (6.3%)**	**13 (46.4%)**	**21 (13.6%)**
Taking Good Care of Yourself	21 (16.7%)	-	21 (13.6%)
Compassion	76 (60.3%)	8 (28.6%)	84 (54.5%)
Red and Green Flags	23 (18.3%)	-	23 (14.9%)
Honesty	3 (2.4%)	8 (28.6%)	11 (7.1%)
Recovery Thinking	-	-	-
Integrating the Split Self	-	-	-
Commitment	1 (0.8%)	-	1 (0.6%)
Creating Meaning	6 (4.7%)	1(3.6%)	7 (4.5%)
Community Resources	-	-	-
Discovery	-	-	-
Getting Others to Support Your Recovery	-	-	-
Coping with Triggers	36 (28.6%)	-	36 (23.4%)
Respecting Your Time	-	-	-
Self Nurturing	13 (10.3%)	13 (46.4%)	26 (16.9%)
Healing from Anger	18 (14.2%)	-	18 (11.7%)
Life Choices Game	17 (13.5%)	11 (39.3%)	28 (18.2%)
Termination	59 (46.8%)	-	59 (38.3%)

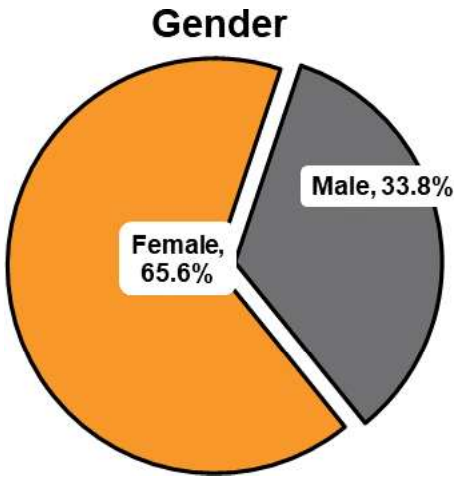
Note: * denotes core program session

Demographics

For FY2023-2024, 154 participants countywide received services in the Seeking Safety program, where 126 participants (81.8%) were served by Operation Safehouse and 28 participants (18.2%) were served by PEI Peers. This section will highlight the basic demographics of all the participants.



The majority of participants were 15-25 years old (83.1%, n=128) and 16.9% were 26-63 (n=26).



Overall, 101 participants identified as female, 52 identified as male, six identified as gender fluid, six identified as nonbinary, three identified as transgender, and two was unsure.

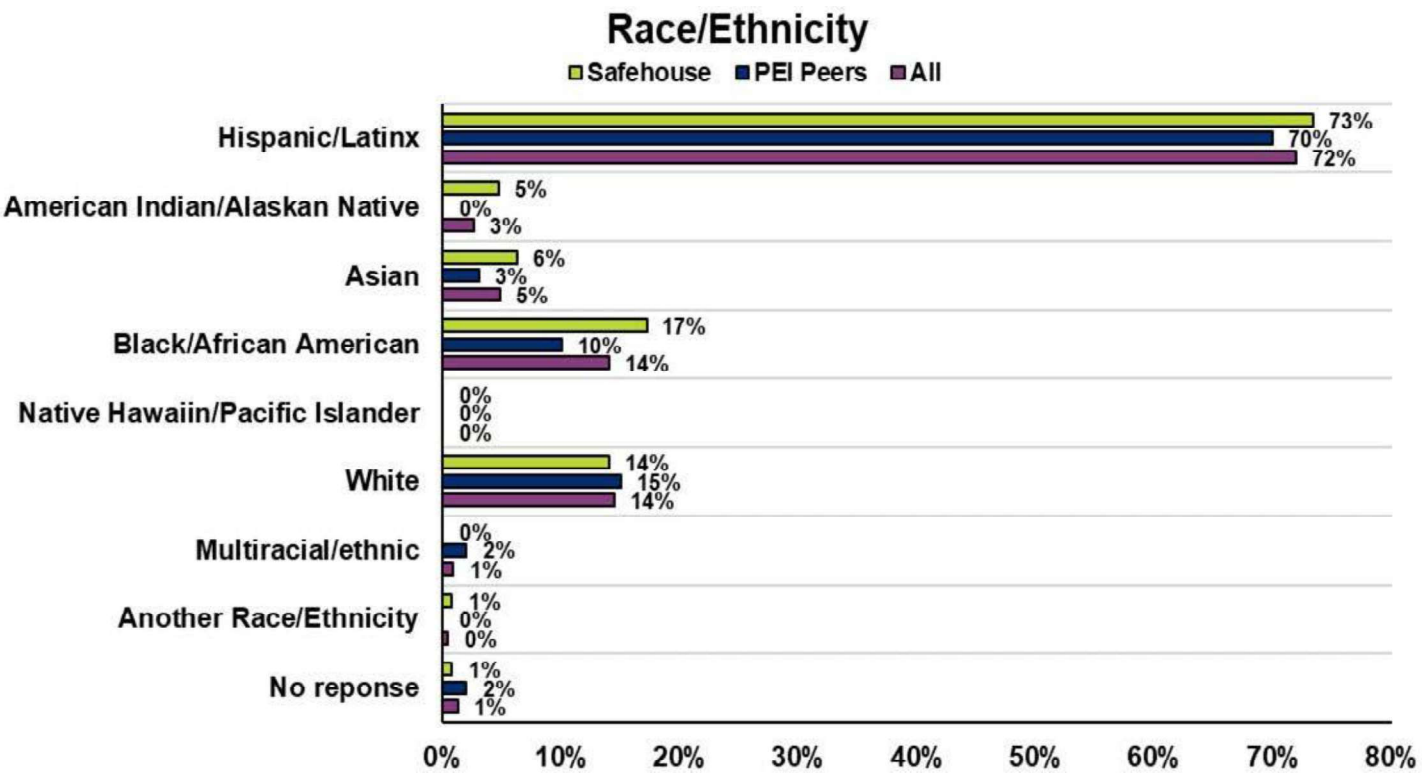
Specifically, among those served by Operation Safehouse, 79 identified as female, 46 identified as male, six identified as gender fluid, six identified as nonbinary, three identified as transgender, and two was unsure. Additionally, among those served by PEI Peers, 22 identified as female, 6 identified as male.

37% of participants (57) reported identifying as LGBTQ, 8 reported having a disabling condition, and 3 participants reported being veterans.

Disabled and Veteran Status	Safehouse (n=126)	PEI Peers (n=28)	All (n=154)
Disabled	5	3	8
Veteran	0	3	3

LGBTQ+	Safehouse (n=126)	PEI Peers (n=28)	All (n=154)
Lesbian	5	1	6
Gay	5	1	6
Bisexual	19	1	20
Pansexual	-	-	-
Asexual	-	-	-
Unsure	2	-	2
Self-Describe	15	-	15
Declined to answer	6	2	8

Demographics cont.



Overall, 74% of the program participants identified as Hispanic/Latinx, 6.5% White, 8.4% Black/African American, 2.6% Asian, 1.3% American Indian/Alaskan Native, 5.8% Multiracial/ethnic, 0.6% Native American or Pacific Islander, and 0.6% did not provide a response. Please note, some participants chose more than one response. Additionally, of all the participants who shared their specific ethnicity, 61.7% identified as Mexican/Mexican American and 5.8% as Central American with the remaining each being less than 1%.

Specific Ethnicity

	Mexican American	Central American	Vietnamese	Chinese	Filipino	Thai
Safehouse (n=126)	76	6	1	1	1	0
PEI Peers (n=28)	19	3	0	0	0	1
All (n=154)	95	9	1	1	1	1

Preferred Language

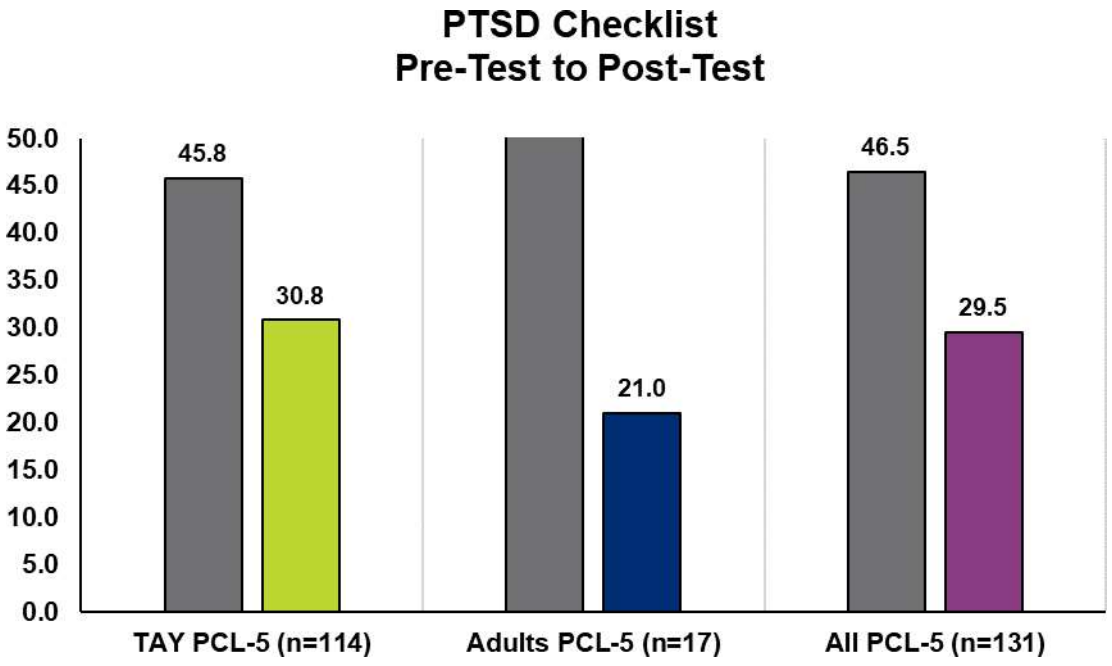
	Safehouse (n=126)	PEI Peers (n=28)	All (n=154)
English	117	20	137
Spanish	8	8	16
Declined to Answer	1	-	1

The majority of program participants (75.9%, n=117) reported a preference for English as their primary language, while 24.1% (n=16) indicated a preference for Spanish. One participant opted not to provide a response.

PTSD Checklist (PCL-5)

The PCL-5 is a 20-item self-reported measure that assesses DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). The measure was used as part of the criteria to qualify participants into the program and to measure symptom change after completing the Seeking Safety program. Each checklist consists of **20** symptoms, rated on a 5-point scale, where ***0=Not at all, 1=A little bit, 2=Moderately, 3=Quite a bit***, and ***4=Extremely***. The PCL-5 is scored by summing the responses of the 20 items to get a total symptom severity score (range of 0-80).

For all program participants throughout the county, a total of 131 matched pairs were used in the analysis. The difference in average scores for the PTSD Checklist showed a statistically significant decrease from pre- to post-test for all participants. Overall, PTSD symptomatology improved after program completion.



	Difference in Average Scores	*t*	df	p
Safehouse (n=110)	15.0	8.8	113	.000
PEI Peers (n=52)	29.8	8.3	16	.000
All Participants (n=162)	16.9	10.5	130	.000

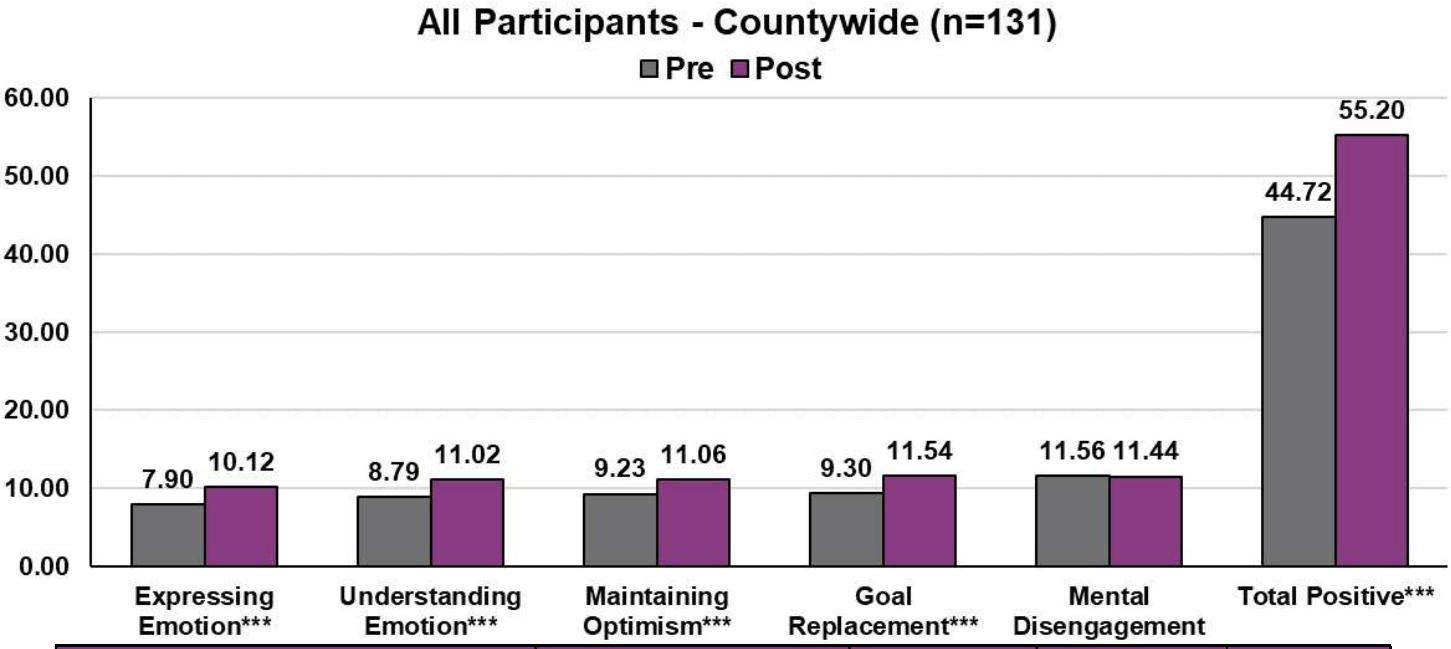
Coping Inventory: Positive Coping Skills

The Coping Inventory was used to measure positive and negative coping skills at two time-points (pre to post-test). After participating in the Seeking Safety program, it is expected that positive coping mechanisms/ responses will increase. Specifically, the positive coping skills are measured in total and using the following subscales:

Positive Coping Styles

- **Expressing Emotion**: display of feelings; none of the items refer to the experience and/or expression of negative affect.
- **Understanding Emotion**: attending to and clarifying feelings.
- **Maintaining Optimism**: represents mood regulation when facing a negative event. It describes attempts to maintain a positive attitude and optimism under adverse conditions.
- **Goal Replacement**: an acceptance of a loss and a search for some alternative source of satisfaction.
- **Mental Disengagement**: related to the person being able to distract from thinking about the behavioral dimension or goal with which the stressor is interfering.

For all program participants throughout the county, a total of 131 pre- to post-test matched pairs were used in the analysis. Participants reported significant increases in total positive coping skills, specifically in the areas of expressing emotion, understanding emotion, maintaining optimism, and goal replacement. There was no significant change in mental disengagement.

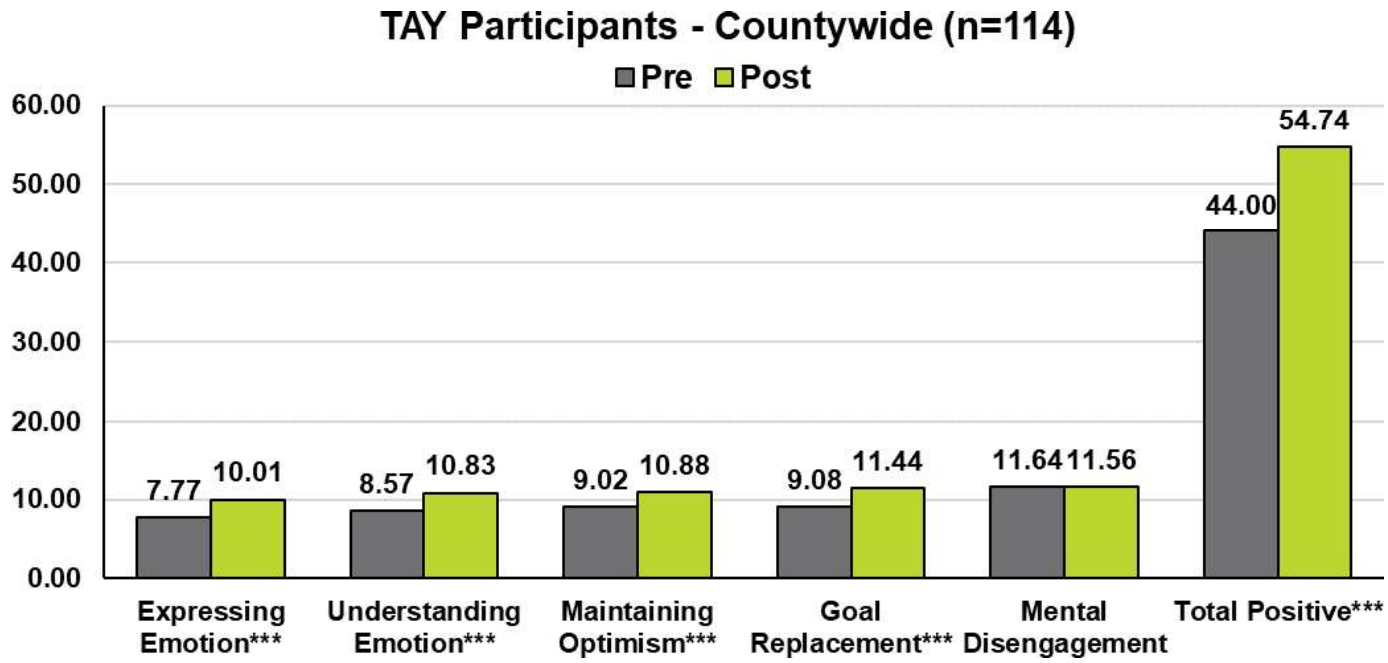


Measured Scales	Difference in Average Scores	*t*	df	p
Expressing Emotion	-2.16	-7.10	130	.000
Understanding Emotion	-2.23	-8.29	130	.000
Maintaining Optimism	-1.83	-6.09	130	.000
Goal Replacement	-2.23	-6.71	130	.000
Mental Disengagement	0.12	0.45	130	.652
Positive Coping Skills Total	-10.48	-10.20	130	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: TAY Positive Coping Skills

For TAY participants throughout the county, a total of 114 pre- to post-test matched pairs were used in the analysis. Participants reported significant increases in total positive coping skills, specifically in the areas of expressing emotion, understanding emotion, maintaining optimism, and goal replacement. There was no significant change in mental disengagement.

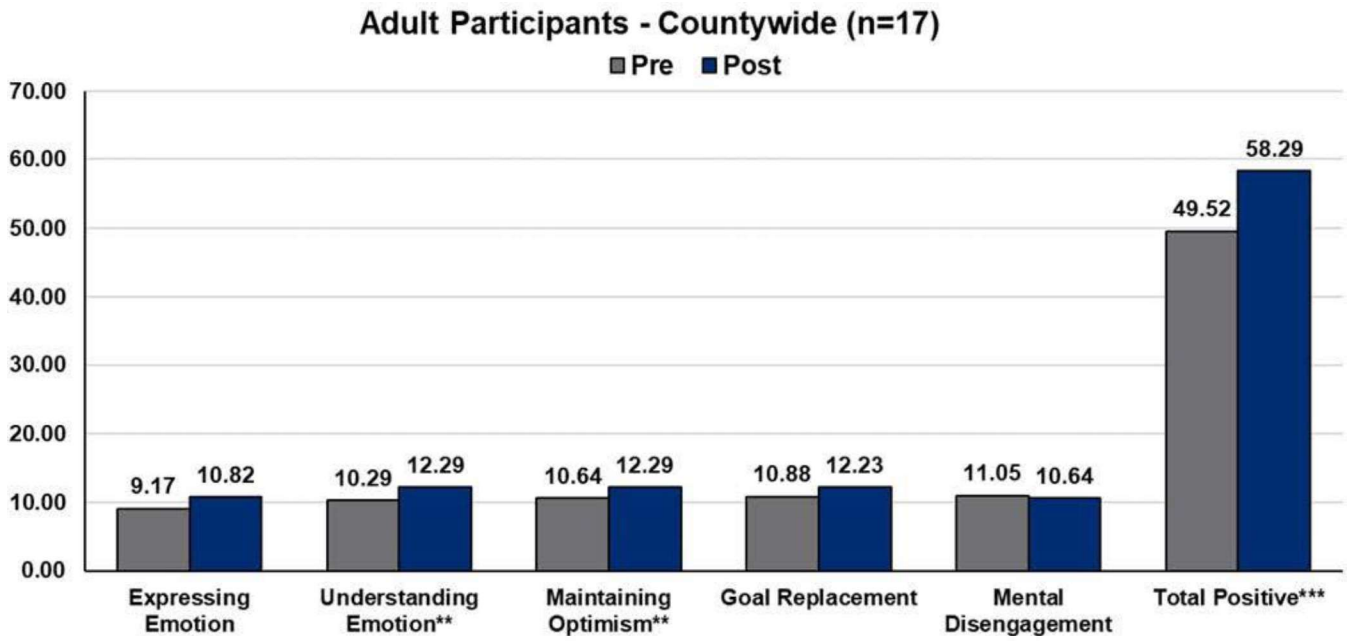


Measured Scales	Difference in Average Scores	*t*	df	p
Expressing Emotion	-2.24	-6.83	113	.000
Understanding Emotion	-2.26	-7.90	113	.000
Maintaining Optimism	-1.85	-5.59	113	.000
Goal Replacement	-2.35	-6.47	113	.000
Mental Disengagement	0.08	0.27	113	.783
Positive Coping Skills Total	-10.73	-9.55	113	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: Adults Positive Coping Skills

For adult participants throughout the county, a total of 17 pre- to post-test matched pairs were used in the analysis. Participants reported significant increases in total positive coping skills, specifically in the areas of expressing emotion, understanding emotion, maintaining optimism, and goal replacement. There was minimal change in mental disengagement.



Measured Scales	Difference in Average Scores	*t*	df	p
Expressing Emotion	-1.64	-1.97	16	.066
Understanding Emotion	-2.00	-2.50	16	.024
Maintaining Optimism	-1.64	-2.54	16	.022
Goal Replacement	-1.35	-1.81	16	.089
Mental Disengagement	0.41	0.49	16	.629
Positive Coping Skills Total	-8.76	-3.57	16	.003

Note: Each * denotes higher significance from pre– to post–

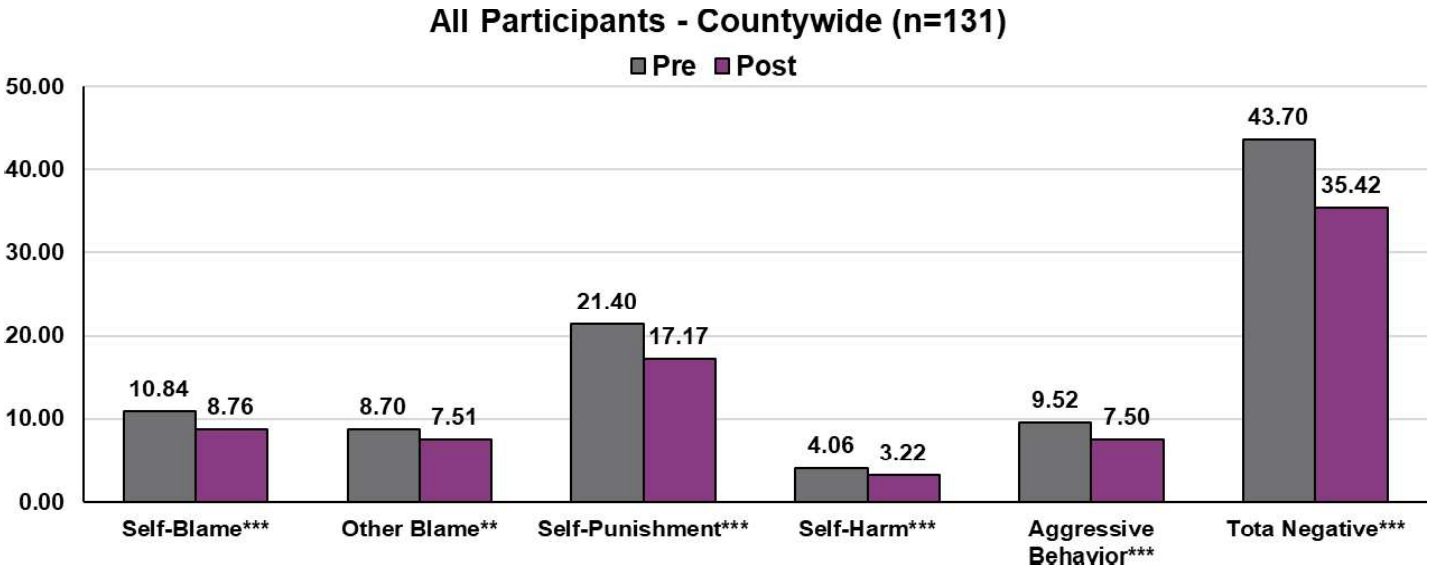
Coping Inventory: Negative Coping Skills

The Coping Inventory was used to measure positive coping skills and negative coping skills at two time-points (pre to post-test). After participating in the Seeking Safety program, it is expected that negative mechanisms/ responses will decrease. Specifically, the negative coping skills are measured in total and using the following subscales:

Negative Coping Styles

- **Self-Blame**: a tendency to criticize the self for negative events.
- **Other Blame**: includes items about causality, responsibility, and blameworthiness.
- **Self-Punishment**: tendency to inflict punishment on oneself.
- **Self-Harm**: the practice of injuring yourself in order to relieve emotional distress.
- **Aggressive Behavior:** tendency to inflict harm onto others

For all program participants throughout the county, a total of 131 pre- to post-test matched pairs were used in the analysis. Participants reported significant decreases in total negative coping skills specifically in the areas of self-blame, other blame, self-punishment, self-harm, and aggressive behavior.

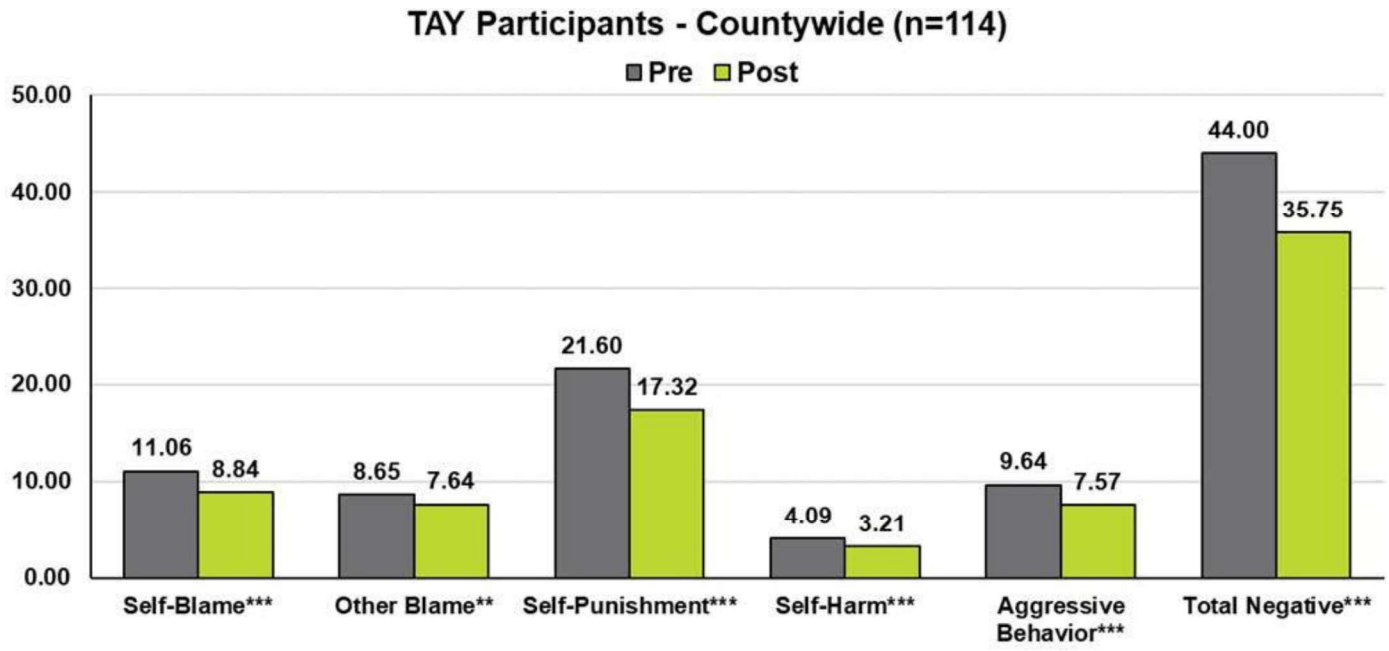


Measured Scales	Difference in Average Scores	*t*	df	p
Self -Blame	2.08	6.58	130	.000
Other Blame	1.19	4.09	130	.000
Self-Punishment	4.22	7.33	130	.000
Self-Harm	0.83	5.45	130	.000
Aggressive Behavior	2.02	6.79	130	.000
Negative Coping Skills Total	8.28	8.06	130	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: TAY Negative Coping Skills

For TAY participants throughout the county, a total of 110 pre- to post-test matched pairs were used in the analysis. Participants reported significant decreases in total negative coping skills specifically in the areas of self-blame, self-punishment, self-harm, and aggressive behavior.

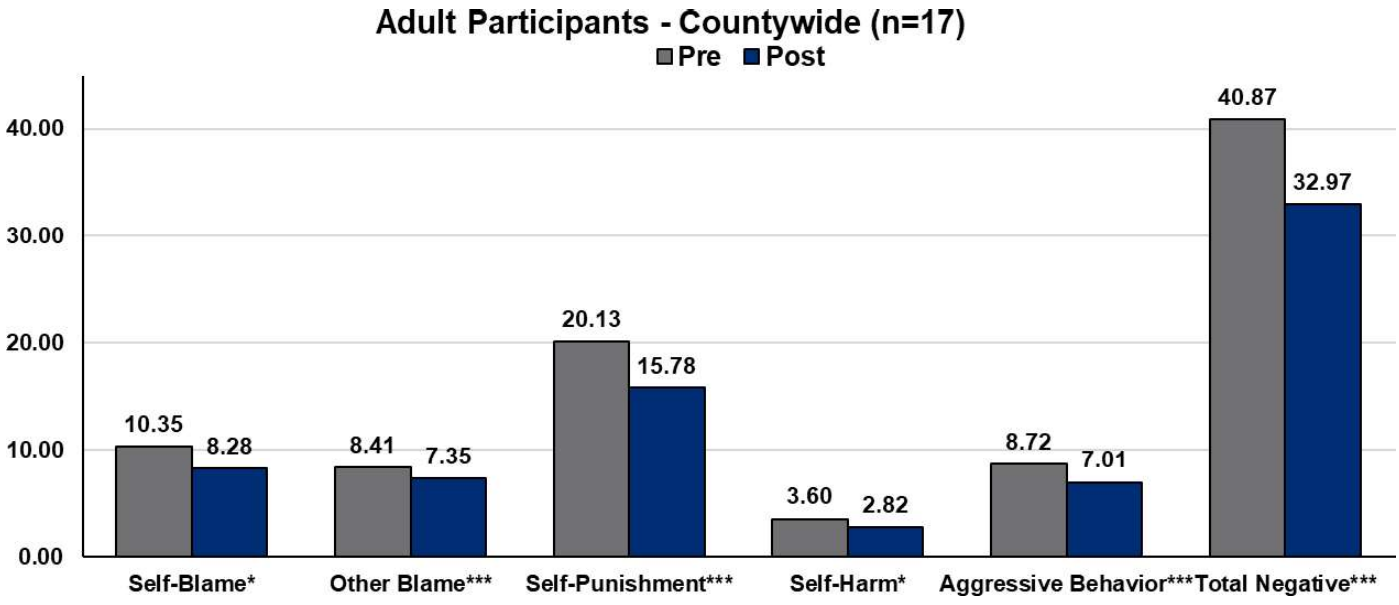


Measured Scales	Difference in Average Scores	*t*	df	p
Self -Blame	2.21	6.26	113	.000
Other Blame	1.01	3.17	113	.002
Self-Punishment	4.28	6.65	113	.000
Self-Harm	0.88	5.14	113	.000
Aggressive Behavior	2.06	6.17	113	.000
Negative Coping Skills Total	8.24	7.12	113	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: Adults Negative Coping Skills

For adult participants throughout the county, a total of 17 pre- to post-test matched pairs were used in the analysis. Participants reported significant decreases in total negative coping skills specifically in the areas of self-blame, other blame, self-punishment, self-harm, and aggressive behavior.



Measured Scales	Difference in Average Scores	*t*	df	p
Self -Blame	1.17	2.21	16	.041
Other Blame	2.41	3.93	16	.001
Self-Punishment	3.88	3.54	16	.003
Self-Harm	0.47	2.21	16	.041
Aggressive Behavior	1.76	3.40	16	.004
Negative Coping Skills Total	8.52	5.27	16	.000

Note: Each * denotes higher significance from pre– to post–

Conclusion of Service Questionnaire: Satisfaction Surveys

A total of 126 participants completed the satisfaction survey. Most participants agreed or strongly agreed that Seeking Safety reduced their trauma symptoms and was helpful. Most participants agreed that the components of Seeking Safety were helpful such as learning new skills to help function better, the amount and type of written material provided, and the structure of the program. Nearly every participant agreed that they would recommend Seeking Safety to others.

Question (n=126)	Avg.	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree	N/A	No Response
Overall, the Seeking Safety program was helpful for me	4.51	1 (0.8%)	1 (0.8%)	10 (7.9)%	35 (27.8%)	79 (62.7%)	-	-
The Seeking Safety program helped reduce my trauma symptoms	4.07	1 (0.8%)	5 (4.0%)	28 (22.2%)	42 (33.3%)	50 (39.7%)	-	-
The Seeking Safety program helped reduce my substance use	4.00	3 (2.4%)	3 (2.4%)	10 (7.9%)	17 (13.5%)	25 (19.8%)	68 (54.0%)	-
The Seeking Safety program helped in managing my stress	4.25	1 (0.8%)	1 (0.8%)	21 (16.7%)	45 (35.7%)	58 (46.0%)	-	-
Staff treated me with respect	4.86	-	-	5 (4.0%)	7 (5.6%)	113 (89.7%)	-	1 (0.8%)
Staff spoke to me in a way that I understood	4.77	1 (0.8%)	2 (1.6%)	2 (1.6%)	14 (11.1%)	106 (84.1%)	-	1 (0.8%)
I liked the variety of topics offered	4.63	-	2 (1.6%)	8 (6.3%)	24 (19.0%)	92 (73.0%%)	-	-
The sessions were well organized	4.63	1 (0.8%)	2 (1.6%)	4 (3.2%)	28 (22.2%)	91 (72.2%)	-	-
I found the written material provided helpful	4.42	-	3 (2.4%)	16 (12.7%)	32 (25.4%)	75 (59.5%)	-	-
I found the Safe Coping Skills helpful	4.48	1 (0.8%)	2 (1.6%)	12 (9.5%)	31 (24.6%)	80 (63.5%)	-	-
I found the focus on abstinence from all substances helpful	4.06	2 (1.6%)	3 (2.4%)	12 (9.5%)	17 (13.5%)	28 (22.2%)	63 (50.0%)	1 (0.8%)
I learned new coping skills that help me to function better	4.40	-	5 (4.0%)	11 (8.7%)	38 (30.2%)	72 (57.1%)	-	-
The location of the Seeking Safety program was convenient for me	4.61	-	2 (1.6%)	8 (6.3%)	27 (21.4%)	89 (70.6%)	-	-
The time of the Seeking Safety program was convenient for me	4.51	-	5 (4.0%)	9 (7.1%)	29 (23.0%)	83 (65.9%)	-	-
I will use what I learned in the Seeking Safety program in my life	4.59	-	1 (0.8%)	7 (5.6%)	34 (27.0%)	83 (65.9%)	-	1 (0.8%)
					No	Yes	N/A	No Resp.
Would you recommend Seeking Safety to a friend?		-	-	-	-	125 (99.2%)	-	1 (0.8%)

Satisfaction Survey: Comments

Participants were also asked in what way has the program brought a helpful change in them, if there was anything they did not like about the program, and any additional comments. Below are some comments from the participants.

What Participants found helpful…

- "It helped me find other ways to deal with stress and talk with someone trusted."
- "Every session taught gave me at least one meaningful coping skill and I often learned surprising insights about myself and my situation."
- "I came in broken and leaving more confident. [Facilitator] was amazing. I am grateful for this program"
- "The program helped me understand that it's ok to feel a certain type of way but you have to know how to safely cope with it"
- "Helping me connect with others, develop better coping skills, have more patience with myself"
- "Bringing a positive change in how I deal with stress and how I cope"
- "Taught me methods to find better approaches with my anger causing less conflict to me"
- "This program helped me break down conflicting feelings and learned to work through them in a healthy way"
- "It helped me understand more about trauma and allowed me to realize that I was not alone"
- "The program opened my perspective that talking your problems out loud doesn't make you "weak" or perceived bad. I also really like the drug abuse advice, I'm trying to help myself more."
- "The program brought a helpful change in me."
- "This program helped me by opening up to my emotions and how to cope with the topics in my life that are hard to face"
- "It helped me understand that I shouldn't overthink things people say to me and try to be more open to others"
- "It helped me more positive of myself and not be to negative and it helped me ease my stress at home"
- "It helped me realize that I should stop focusing on the bad stuffs"
- "It helped me stop smoking and be a better person overall"
- "It was a safe space for me to express my emotions"
- "The program helped express my feels and set boundaries for myself"
- "The program gave me a safe place to express myself and helped me with how I cope"
- "The program helped with teaching me ways to cope with my problems. Helped me to realize that everyone goes through similar issues and there are ways around these issues. "
- "It let me realize things about myself that I never did"
- "The program brought a helpful change in me because before I felt as if I didn't really have anyone to talk to but when I'm with my friends in session, it is okay to talk"
- It was helped me realize everyone goes through a trauma in their lifetime and it is okay to not be okay. It changed the way I view my own trauma and the way that I deal with my trauma"
- "When I get really stressed, I realize what I'm doing, take a breath, and identify some colors, textures and sounds to keep me calm"
- "Helped me calm down when I am angry or sad"
- "It helped give my brain a break"

Satisfaction Survey: Comments cont.

What Participants Disliked…

- "Just the time, I would like the session to last longer than an hour"
- "One day in the program was rough, the day we discussed PTSD and so I felt like I was dealing with panic attack symptoms during that session and I was relieved when it was over but I still got good insights when I looked at the material later on."
- "Limited time"
- "Too short of a time"
- "It was out of control of the staff, but the atmosphere was a bit awkward"
- "How short it was"
- "Sometimes it was uncomfortable to be vulnerable"
- "I didn't like some of the other people or maybe I'm just mean"
- "Maybe the class period was inconvenient"
- "There wasn't enough sessions"
- "Sometimes it's too long"
- "In the beginning, I didn't really think it was going to work for me and I didn't want to give it a shot but I'm glad I did"

Additional Comments…

- "The instructors were kind and helped a lot."
- "We need more programs that help us"
- "I am very thankful for this program and for the information. I'm thankful for [facilitator] for easily explaining to be able to understand. Thank you."
- "Thank you for offering this. I am glad that I participated."
- "Thank you [facilitator] for your patience and allowing for me to be myself. For this to be a class on zoom, you were able to make me feel like you were in the room with me with your energy"
- "Thank you for your time and being flexible with the time."
- "It made me change for the better and i am thankful for it"
- "Awesome people"
- "[Facilitator] was great when talked about my problems. She didn't write it down or make me feel uncomfortable."
- "My mentor [facilitator] was great."
- "I think it's a very fun group. You learn a lot but the vibe is also very welcoming"
- "I really enjoyed the program, thank you"
- "I appreciate the staffs time really nice person"
- "Nothing much. Thank you for being a root to helping me be a better person with better ways"
- "No critically bad things to say and I do think even mentally healthy people can learn something here"
- "My staff was very helpful and kind. She kept it real"
- "very sweet. I enjoyed my time here"
- "It's a good program and it also helps with the stress at high school"
- "Would 100% do this again"
- "I wish it lasted longer, will be coming back when it's available."
- "10/10 recommended"

Riverside University HEALTH SYSTEM Behavioral Health

Mamás y Bebés

MHSA Prevention and Early Intervention

Report 2023/2024 FY

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Program Overview

Mamás y Bebés (MyB) is a prenatal intervention program, focused on both Spanish and English speakers, designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The intervention is an 8-session course that uses a cognitive-behavioral mood management framework, and incorporates social learning concepts, attachment theory, and socio-cultural issues. The program helps participants create a healthy physical, social, and psychological environment for themselves and their infants.

Three community-based organization (CBO) were funded by the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) to implement the program. Reach Out is a local non-profit CBO serving underserved communities; Riverside Community Health Foundation which is a nonprofit organization supporting health and well-being in Riverside communities through a variety of programs; and California Health Collaborative which is a non-profit organization supporting and enhancing the quality of life and health for people of California particularly the underserved and underrepresented.

As we navigate the complexities of the post-COVID-19 environment, MHSA PEI programs continue to adapt as they shift toward more in-person services. A steadfast commitment to community well-being has consistently prompted modifications to the approach, opting for virtual services when necessary. While the crisis initially reduced the range of planned group classes, there has been a successful increase in the number of these classes available via Zoom. To ensure both accessibility and convenience, phone call services are also maintained as an option for those who find this method more suitable. Additionally, the program now offers both Zoom and in-person classes to cater to diverse needs, providing flexibility and support for all community members.

Evaluation Overview

Process Evaluation
The process evaluation included descriptive information related to the program, provided services, number of people served, and basic demographics.

The process evaluation data is collected using the group sign-in sheets, which records basic information on the topic and the number of participants in attendance. This data is collected by the community health workers at each session.

Outcome Evaluation
The outcome evaluation included a pre to post measure on depression symptoms. In addition, satisfaction surveys were given to participants that included items on overall helpfulness of the program, as well as overall program satisfaction.

The outcome measures included:

Major Depressive Episode Status (MDE): also known as the Mood Screener, is administered at intake and is used to determine if the potential participant is experiencing a major depressive episode.

Center for Epidemiologic Studies Depression Scale (CES-D): the CES-D is a 20-item measure that measures depression by assessing various depression symptoms that participants were experiencing in the past week.

Executive Summary

Program Enrollment & Completion Rate:

A total of 329 women were screened by the program in FY 23-24. Of the 329 screened, 255 were enrolled and 231 fully graduated from the program. Most of the women (83.1%) identified as Hispanic/Latinx, followed by those identifying as White (6.7%), African American (3.5%), Multiple (2.7%) and Asian American (2.0%); 51.4% reported English as their primary language, while 41.6% reported Spanish and 6.7% reported bilingual with both English and Spanish.



91%
(n=231)
Graduated from the program

Of the participants who enrolled in the program: 91% (n=231) completed the program. Western Region graduated 105 women, Mid-County region graduated 74 women, and Desert region graduated 52 women. To graduate and complete the program, pregnant or postpartum moms were expected to attend 6+ sessions. From the graduates, 166 completed all 8 sessions.

Outcome Evaluation:

Major Depressive Episode Status (MDE)



Since Mamás y Bebés is a prevention program, screening at intake is used to rule out symptoms consistent with a major depressive episode. The participants scoring below a 5 were eligible to enroll in this preventive program. Screening data showed 78% (n=255) of the women who were screened and enrolled into the program were experiencing symptoms consistent with having mild depression. Note: In January 2020, RUHS-PEI changed the eligibility criteria to screen for mild depression and not enroll moderate to major depression to follow the PEI model.

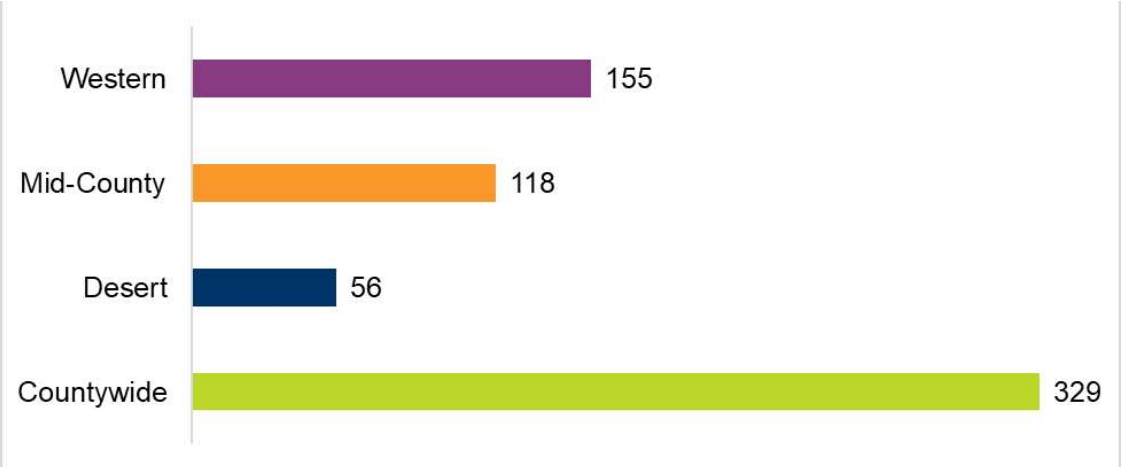
Center for Epidemiologic Studies Depression Scale (CES-D)



Pre and post scores were available for 231 women. 26% (n=60) scored between 16 and 24 at intake, which indicates clinically meaningful depression symptoms; 24.7% (n=57) scored above 24, which may be an indicator of major depression. From pre-test to post-test, outcomes data indicated that depression symptoms decreased and it was a statistically significantly decrease, p-value >0.001. At intake, the average CES-D score was 13 and after completing Mamás y Bebés the score decreased to 8.43.

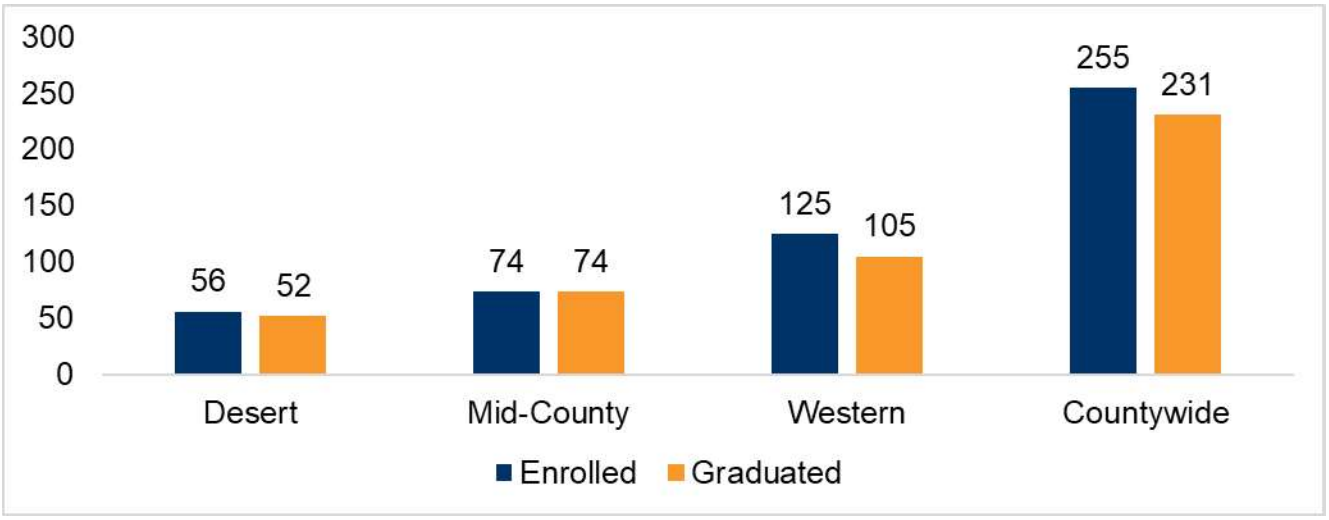
Program Enrollment and Completion

Total Screened (n=329)



Together Reach Out, Riverside Community Health Foundation and California Health Collaborative screened 329 pregnant or post-partum women to enroll in the Mamás y Bebés program. After using the mood screener questionnaire to determine eligibility, 255 women were eligible, enrolled and attended at least one group session. To be eligible for this prevention and early intervention program, women would need to complete the Mood Screener and score lower than a 5 in their current state score or a minimum of 1 in lifetime score and a 0 in current state.

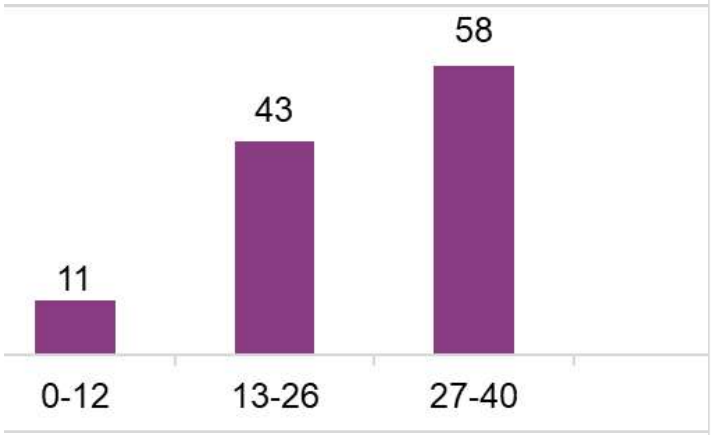
Program Completion (enrolled n=255, completed n=231)



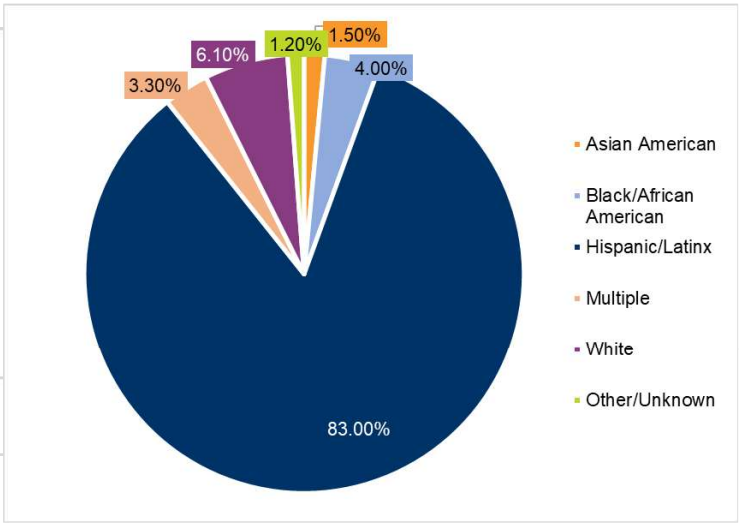
From the 255 women enrolled and served in the program, 231 successfully graduated by completing more than 6 sessions. There were eight that enrolled but never attended. The Desert region, California Health Collaborative, served 56 women while 6 dropped out of the program and one enrolled but never attended. Reasons for dropping range from conflict with time, did not feel fit for the group, and transportation. Mid-county region, Riverside Community Health Foundation, enrolled and served 74 women, 9 enrolled but never attended and only 17 dropped out of the program. Western region, enrolled and served 123 women, 4 enrolled but never attended and 22 dropped out of the program. Not all women screened and enrolled in the program attend, therefore data is based on those that attend at least one session.

Screening Demographics

Number of Weeks Pregnant
n=112



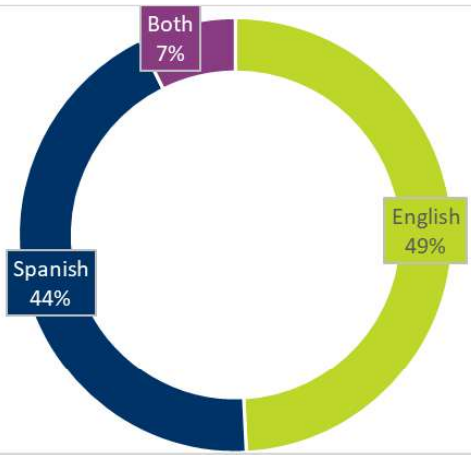
Race/Ethnicity
n=329



MyB is offered to women who are pregnant or going through post-partum. 112 of the 329 screened women were pregnant. Eleven were in their first trimester, forty-three in their second tri-mester, and fifty-eight in their third trimester. The majority of women 21 had a child under one.

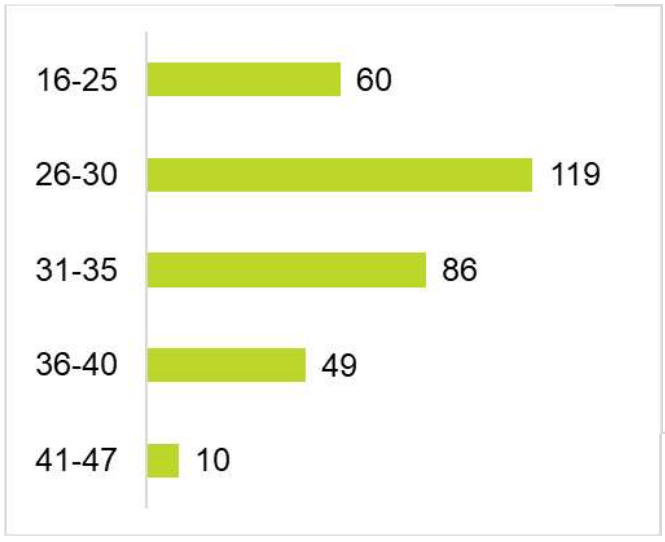
83% of the women screened were Hispanic, 6.1% White, 4% African American, 3.3% Multiple and 1.5% Asian American.

Primary Language
n=329

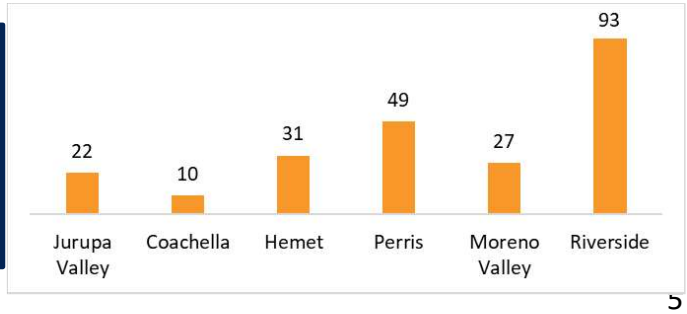


The primary language spoken by most women was English, followed by Spanish as the second most common language. All material was available in Spanish to eliminate a language barrier

Participant's Age
n=329



City of Residency
n=329

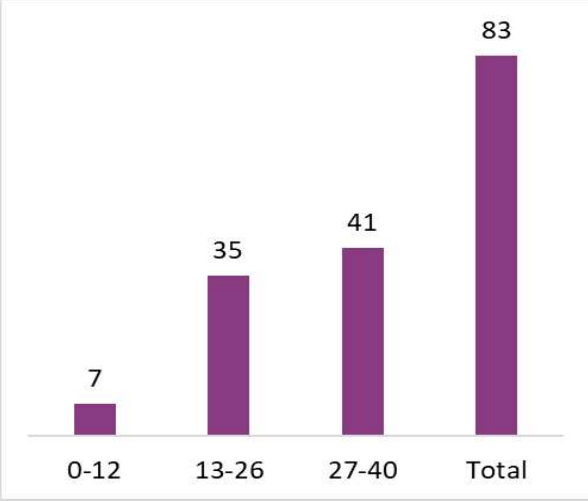


The majority of the women were under 35 years old. The youngest screened was 15 years of age, and the oldest was 43 years of age.

28.3% of the women screened were Riverside City residents.

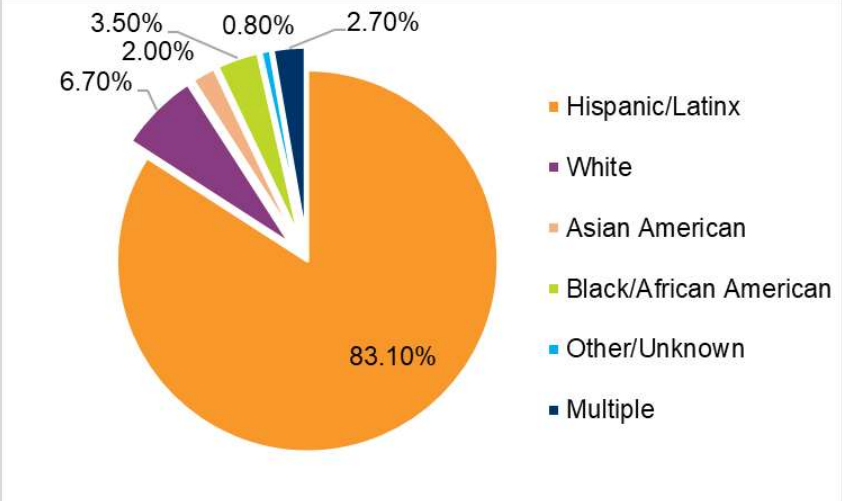
Enrolled Demographics

Number of Weeks Pregnant



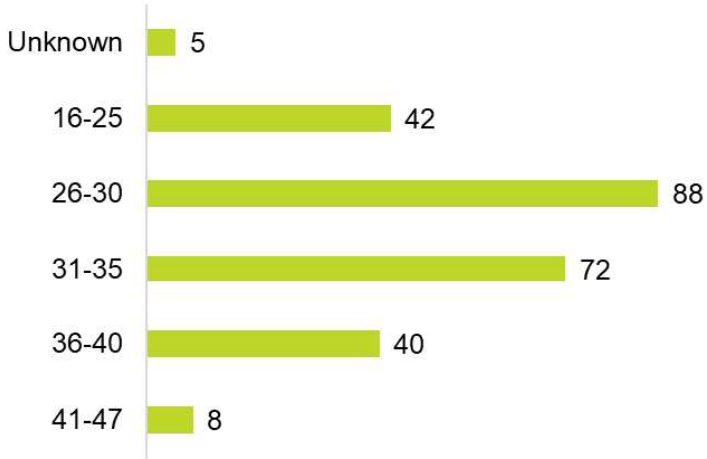
MyB is offered to women who are pregnant or going through post-partum. 83 of the 255 enrolled women were pregnant. Seven were in their first trimester, 35 in their second trimester, and 41 in their third trimester. The majority of post-partum women 172 had a child under one

Race/Ethnicity n=255



83.1% of the women enrolled were Hispanic/Latinx, 6.7% White, 3.5% African American, 2.7% Multiple and 2% Asian American

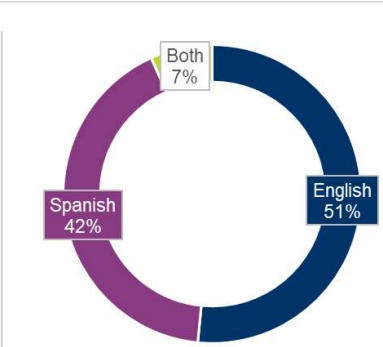
Participant's Age n=255



The majority of the women were under 35 years old. The youngest enrolled was 15 years of age, and the oldest was 43 years of age. Age was missing for 5 participants.

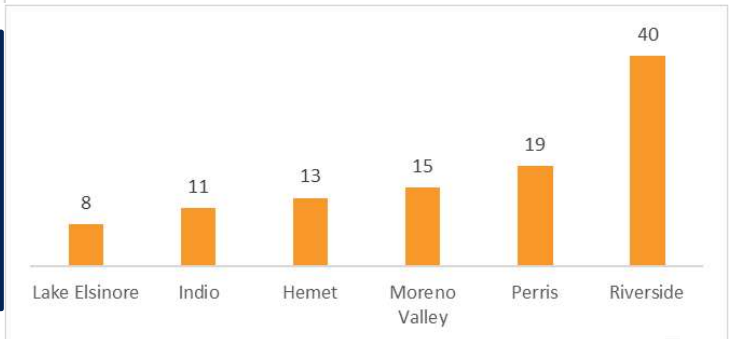
28.2% of women enrolled were Riverside City residents.

Primary Language n=255



English was the primary language most women spoke compared to Spanish. All material was available in Spanish to eliminate a language

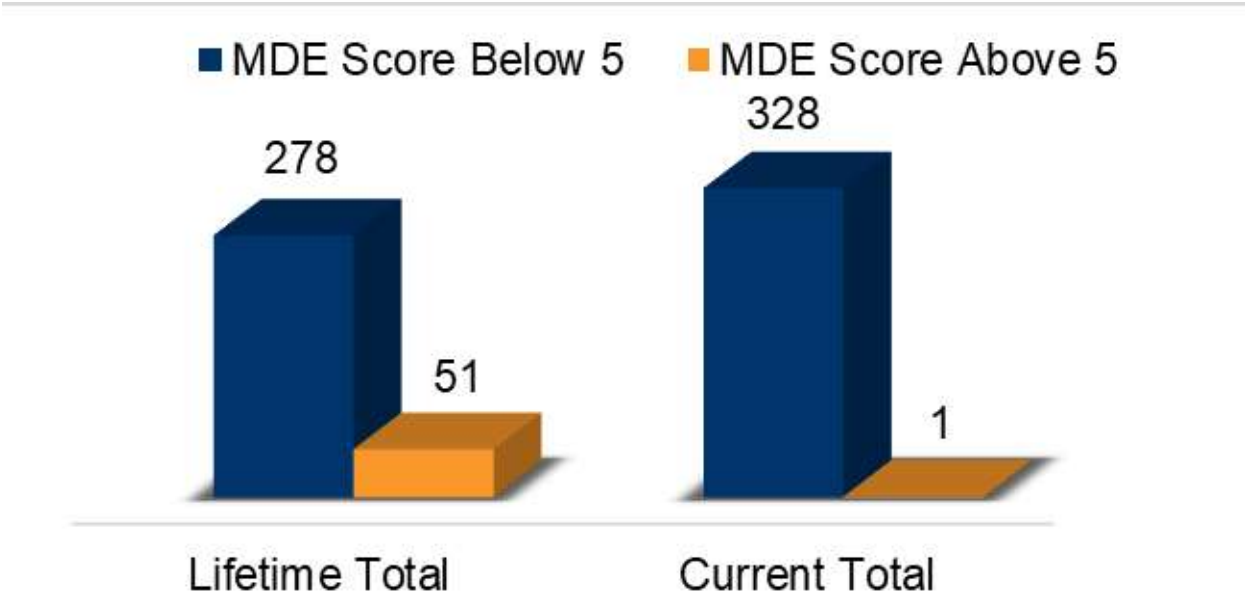
City of Residency n=255



Mood Screener

The Mood Screener for major depressive episodes (MDE) is a self administered questionnaire that helps identify symptoms that may indicate whether a person is currently or in their lifetime suffered from major depression. A score of 5 of more in either the current or lifetime category, along with answering “yes” to “Did these problems interfere with your life or activities a lot?”, may be indicative of a person who is currently experiencing, or has in the past, experienced major depression. Women scoring under a 5 but answering yes to the question quoted above fit the eligibility criteria for this prevention program and a referral to seek further help is provided along with enrollment into the program.

Major Depressive Episode Score (n=329)



Did these problems interfere with your life or activities a lot?

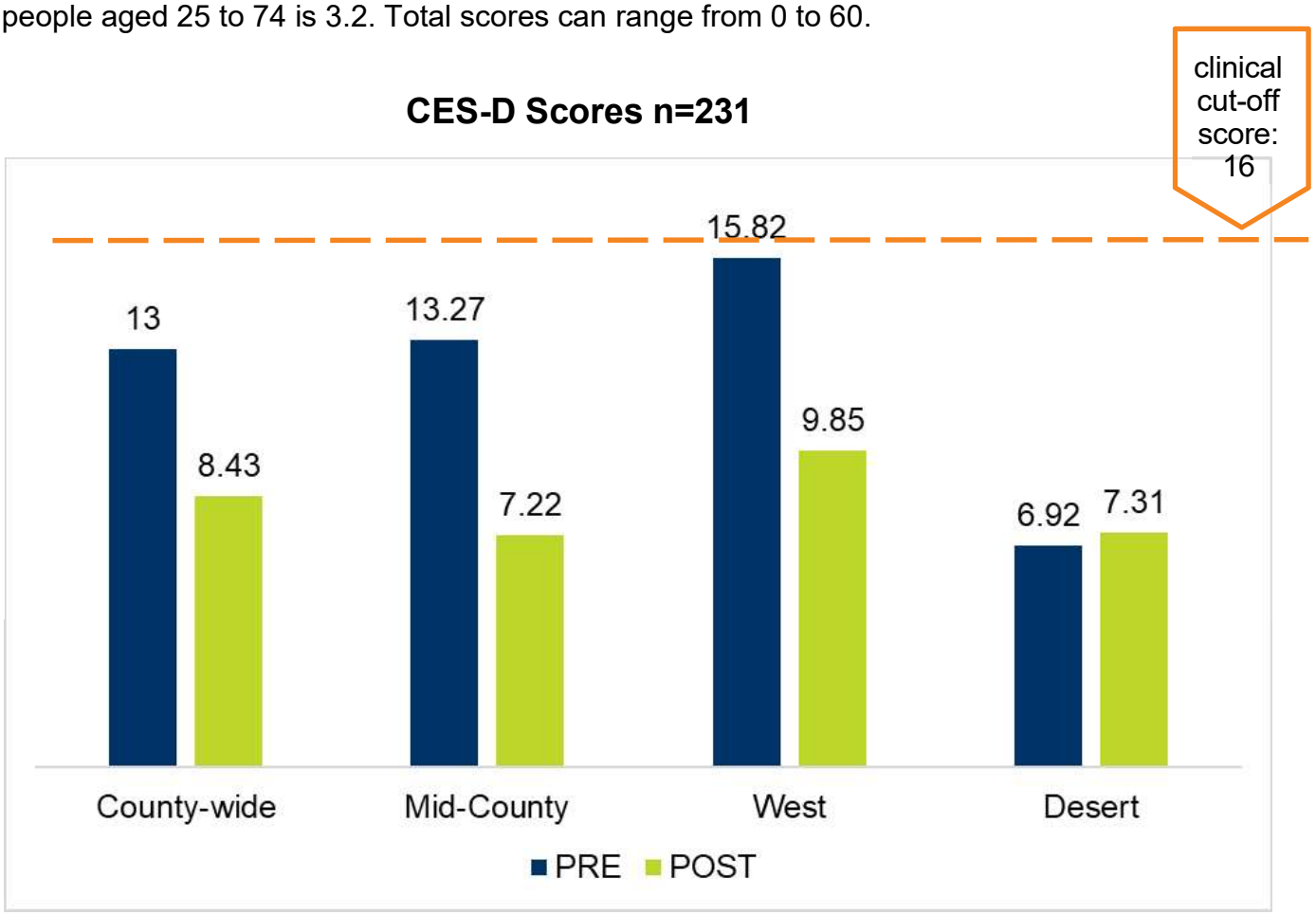
75%

Of the women who scored above a 5 on the MDE answered yes

For a women to be eligible to receive services, they must score below a 5 on the MDE screener in the “current” subscales. 328 of the screened women did score below a 5. From the 40 women scoring a zero in the “current” subscale, 37 women scored under a 5 and three scored above a 5. The total number of women enrolled in the MyB program for this 2023-2024 fiscal year was 255. There were n=329 Mood Screeners analyzed, and 38 of the 51 who scored above a 5 (75%) answered yes to the question “did these problems interfere with your life or activities a lot?”.

CES-D

The CES-D looks at a range of depressed mood that is measured by assessing various depression symptoms that participants were experiencing in the past week. Responses are organized in a Likert scale, where respondents are asked to report the typical frequency in which a particular symptom occurs. A total score is calculated, where higher scores indicate high levels of distress. A score ≥ 16 suggests a clinically significant level of depressive symptoms. It does not necessarily mean that the participant has a clinical diagnosis of depression, but that the person has an elevated level of depression symptoms, compared to other adults. The average score in the overall population for people aged 25 to 74 is 3.2. Total scores can range from 0 to 60.



CES-D scores for those who completed both a pre and a post measure indicated that depression symptoms significantly decreased among the women who participated in the program (t=6.793, df=230, p-value < 0.001). Average scores at intake (pre) indicated that women were within clinically meaningful levels of depression with an average score of 13.0. The post measure provides evidence of a significant decrease in depression levels as the score reduced to an average of 8.43, which has both clinical and statistical significance.

When comparing CES-D scores across regions, the Mid-County region showed a statistically significant improvement from pre- to post-scores (t = 6.722, df = 73, p < 0.001). The Desert region, however, did not demonstrate a significant change between pre- and post-scores (t = -0.346, df = 51, p = 0.730). In contrast, the Western region also exhibited a significant improvement (t = 5.143, df = 104, p < 0.001). Despite these findings, all three regions had post-test scores below the clinical cut-off score, indicating overall improvement. However, only the Mid-County and Western regions had statistically significant results (p < 0.05), while the Desert region did not.

Satisfaction Survey

Item Description (n=227)	1	2	3	4	5	Mean
1. The materials I received from the instructor were easy to understand.	-	-	-	9.7%	90.3%	4.90
2. I am satisfied with the information I received from this program.	-	-	-	7.9%	92.1%	4.92
3. I will use the information I learned during the program in my daily life.	-	-	-	10.1%	89.4%	4.90
4. This program helped me to cope with the moods I have experienced during pregnancy.	-	-	1.8%	17.2%	80.2%	4.79
5. I learned new methods to help me cope with feelings of sadness.	-	-	-	15.0%	85.0%	4.85
6. This program taught me how to get help for depression while I am pregnant and after the birth of my baby.	-	-	0.9%	15.9%	83.3%	4.82
7. I would recommend this program to someone else who is pregnant.	-	-	-	5.3%	94.7%	4.95
					Overall Average	4.87

**Scored on a 5-point Likert scale, where 1 represents strongly disagree and 5 is strongly agree.*

Comments:

"This program has helped me in multitude of ways. I looked forward to coming to the meetings/ classes. The only suggestion I have is to host the classes in a bigger space to allow ample space for the mamas and babies. Thank you ! ."

"I liked all the topics and conversations with the teacher. The reflections were always good. I really liked taking the class. ."

"This class helped my mental health so strong that I can manage to do a little beautiful things every-day. Thank you !"

"This program has helped me feel like I am not alone. It made me feel like a part of a community and has taught me new methods to help me cope with sadness, over whelming feeling and stress. Thank you."

"Motherhood is hard, full of challenges and it was nice to hear that other moms have same challeng-es as me. I learned new ways to cope with situations. Thank you for this program."

Riverside University HEALTH SYSTEM Behavioral Health

Building Resilience in African American Families

B.R.A.A.F. Boys Program

2023/2024 FY

MHSA Prevention and Early Intervention

Project Overview

What is B.R.A.A.F.?

Building Resilience in African American Families project (B.R.A.A.F.) was implemented by Riverside University Health System Behavioral Health, Prevention and Early Intervention (PEI) through funding under the Mental Health Services Act. This project is a multi-intervention strategy with prevention and early intervention programs being provided throughout Riverside County. The primary program goals of this project are to reduce the risk of developing mental health problems and to increase resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. The target population served is African American male youth and their parents/guardians that live in communities with high rates of poverty and community violence. The B.R.A.A.F. Project utilizes three evidence-based practices: Africentric Youth and Family Rites of Passage Program (ROP), Cognitive-Behavioral Therapy (CBT), and Guiding Good Choices (GGC) in three different Riverside County regions.

Rites of Passage

The Africentric Youth and Family Rites of Passage Program is designed for African American males between ages 11 and 13. The goal of the ROP program is empowerment of black adolescents through a nine-month rites of passage program. The program provides a multi-faceted, prevention based program to youth; a major component of the program is the after school program, held for three hours, three days per week.

Outcome Evaluation

The **Africentric Youth and Family Rites of Passage Program** is a program developed by the MAAT (an ancient Egyptian word meaning an ethical way of life) Center for Human and Organizational Enhancement, Inc. of Washington, D.C. In ROP, data was collected before intervention and 9 months after the intervention was implemented. Topics such as African culture, African proverbs, etiquette, hygiene, and family togetherness were practiced for 9 months and evaluated using the outcome measures below.

Objective	Measures	Measure Targets
Outcomes evaluation focused on resiliency, positive identification with culture, and family Cohesion, as well as peer relations and school climate.	Resiliency Scale for Children and Adolescents	Three scale tool that measures the personal attributes of the child that are critical for resiliency. ROP will focus on Sense of Mastery and Sense of Relatedness.
	The Multidimensional Inventory of Black Identity	Assesses the dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). In this program, only the Centrality subscale was used.
	Multigroup Ethnic Identity Measure	Responses to this instrument reveal the extent to which an individual feels connected to his or her ethnic group
	Family Adaptation and Cohesion Scales III	Measures perceptions of cohesion and flexibility within the participant's family unit.
	Social, Emotional, and Bullying Behavior Survey	This measure covers social and emotional skills, peer relations/bullying behaviors, school climate, and substance abuse.

Building Resilience in African American Families (B.R.A.A.F.)

Executive Summary: Key Findings

Rites of Passage (ROP): In the 2023-2024 fiscal year, 24 participants enrolled in the Rites of Passage Program, with 71% (17 youth) completing the 9-month program, the completion goal was 30 youth. Across Riverside County, serving only the Desert and Western regions, approximately 192 sessions were conducted, with the majority of attrition occurring in the initial months of the program. Pre-program and post-program assessments indicated that 88% of participants maintained high academic performance, with only 12% exhibiting below-average grades by the program's conclusion. Notably, the percentage of parents indicating a need for emotional support decreased from 35% to 0% post-assessment.

Resilience measures were completed by 16 participants, demonstrating no statistically significant changes in "sense of mastery" (mean difference of 2.56, $p = 0.486$) or "sense of relatedness" (mean difference of 2.12, $p = 0.580$), both remaining within the "Average" range. Scores from the Multidimensional Inventory of Black Identity (MIBI) reflected a slight decrease; however, participants ($n = 17$) continued to demonstrate high levels of identity centrality. Importantly, the Cohesion subscale ($n = 16$) exhibited a statistically significant improvement ($t(15) = -2.101$, $p = 0.053$), indicating enhanced familial connections as a result of program participation.

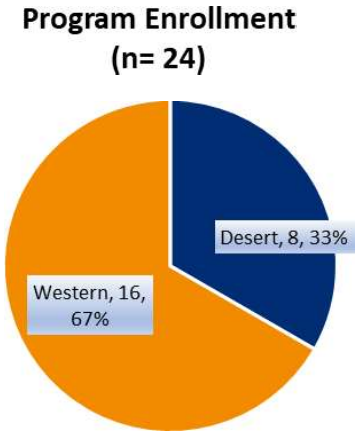
Guiding Good Choices (GGC): A total of 19 parents participated in the GGC program, with a graduation rate of 90% (17 parents). Before and after the course, the parents completed the Alabama Parenting Questionnaire (APQ). The results indicated significant improvements in parental involvement ($t(20) = -3.250$, $p < .05$) and reductions in inconsistent discipline ($t(20) = -3.485$, $p < .05$) and corporal punishment ($t(20) = -3.068$, $p < .05$). Furthermore, parents reported a notable 67% increase in practicing refusal skills to resist peer pressure and adapting to new parenting styles that create healthy habits with their children. Overall satisfaction averaged 4.9 on a scale of 5 countywide.

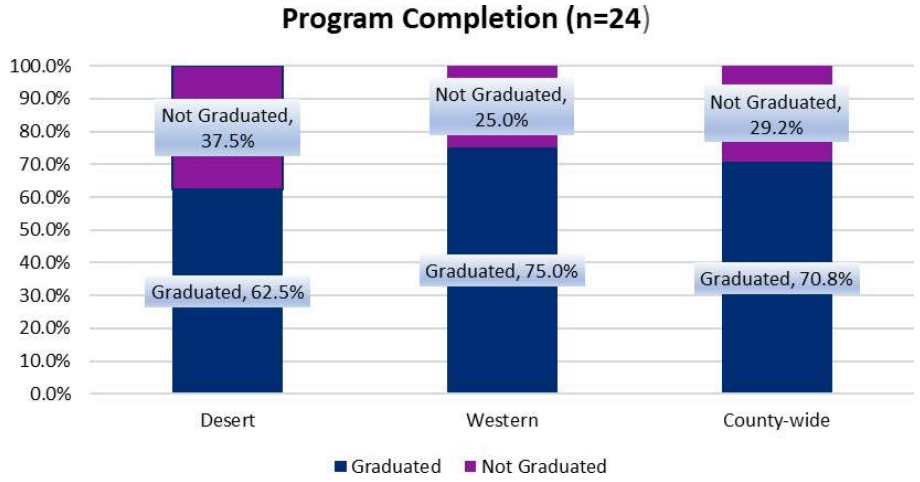
Parent Support Groups (PSG): While no satisfaction survey was conducted, qualitative feedback collected from focus groups highlighted a sense of community and support among participating parents.

Parent Empowerment Dinner: This monthly meeting focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. The Desert region hosted four dinners, while the Western region organized seven.

Cognitive Behavioral Therapy (CBT): Sixteen youth participated in CBT, delivered either in-person or via video conferencing. The effectiveness of CBT was evaluated using the Strengths and Difficulties Questionnaire (SDQ) and the Children's Depression Inventory-II (CDI-II). Fourteen parents completed pre- and post-SDQ surveys for their children, indicating significant decreases in emotional symptoms ($p < 0.05$) and overall difficulties, suggesting positive trends in mental health outcomes. While decreases in depressive symptoms were observed, comparisons of pre- and post-CDI-II scores showed participants remaining within the average range of depression severity.

Program Enrollment





A total of 24 participants were enrolled in the Rites of Passage Program; eight in the Desert, and eighteen in the Western region. The goal is to enroll 20-25 youth each year to account for attrition with the goal of graduating a minimum of 15 youth per program/region.

Most participants (71%) completed the 9 month program, while 29% were discontinued and/or did not graduate from the program. Of the completed participants, 5 were from the Desert region and 12 were from the Western region. A total of 17 youth graduated from ROP. Some of the reasons participants discontinued the B.R.A.A.F. program were relocation or being withdrawn by their parent(s).

ROP Attendance Distribution:
Number of Sessions Attended by Youths per Region

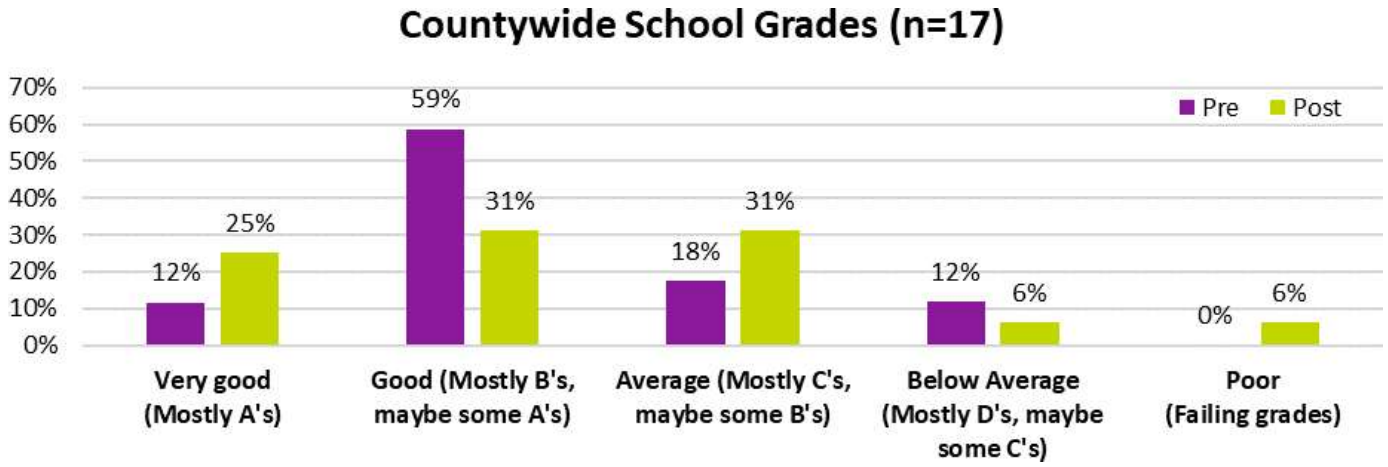
Sessions	Desert	Western	County
0-20	3	3	6
21-40	1	0	1
41-60	0	1	1
61-80	9	2	11
81-100+	3	2	5
Youths per Region	16	8	24

ROP is a 9-month program that is offered 3 times a week, with a target of 108 sessions per year/per program/per region. Approximately, 96 sessions were offered depending on each region's start date. Together, all two regions hosted approximately 192 ROP sessions throughout Riverside County.
Due to attrition the majority of participants dropped during the first half of the B.R.A.A.F. program.

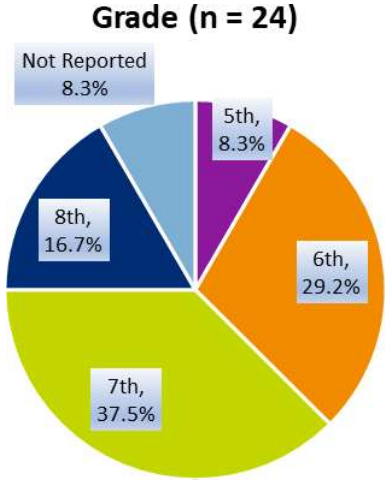
School Information

Countywide Results	*Pre		*Post	
	Yes	No	Yes	No
In the last 3 months, has the youth had a sudden drop in school performance?	29%	71%	13%	88%
Has the youth ever been suspended?	0%	100%	6%	94%
In the past year, has the youth been: in contact with law enforcement?	0%	100%	0%	100%
In the past year, has the youth been: arrested?	0%	100%	0%	100%
In the past year, has the youth been: on probation?	0%	100%	0%	100%
In the past year, has the youth been in any programs to help them with emotional problems?	35%	65%	0%	100%
In the last year, has the youth exhibited any violent or aggressive behaviors with which their parent or guardian was concerned?	12%	88%	18%	82%
In the last 3 months, has the youth used/experimented with drugs and/or alcohol?	0%	100%	13%	88%
Is the youth affiliated with a gang?	0%	100%	6%	94%

*Some items for some youth are missing. Only averages across each questions were calculated from 17 participants that completed the R.O.P. Intake Form (pre) and Program Completion/Discontinued Form (post).

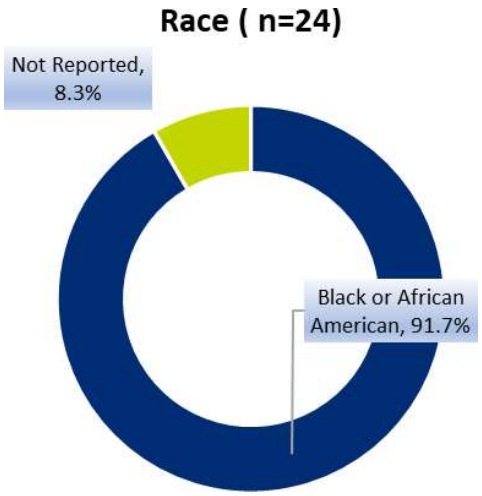


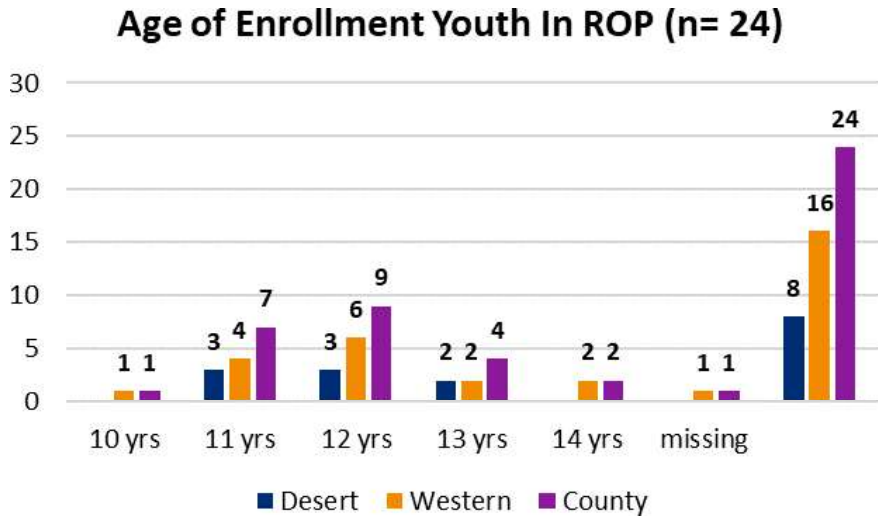
*Some items for some of the youth are missing for the School Performance. Only the 17 participants completing the R.O.P. Intake Form (pre) and Program Completion/Discontinued Form (post) were used to calculate the School Performance Chart.



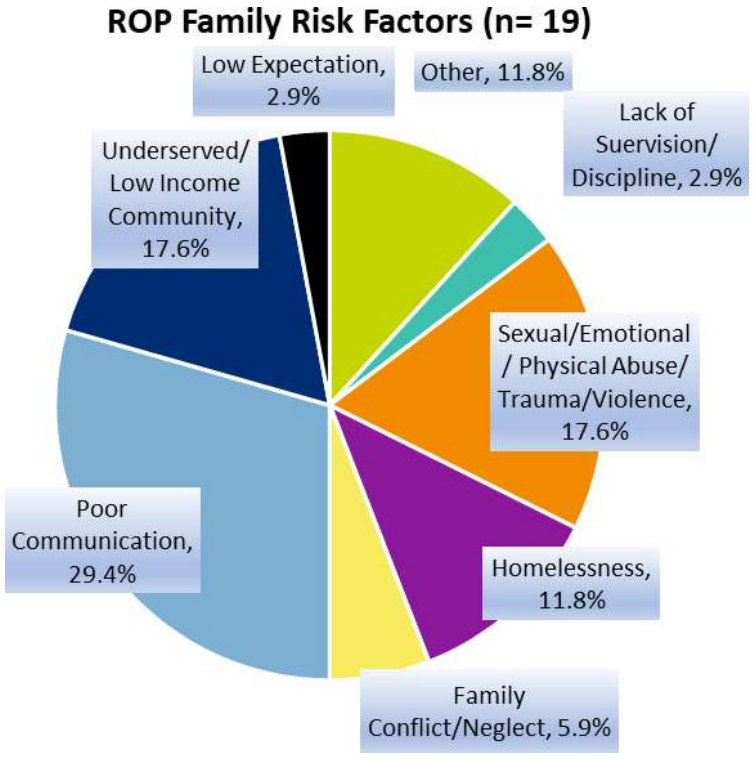
The majority of the boys in R.O.P. were in 6th, 7th, or 8th grade. Before R.O.P. began, parents were asked to complete a questionnaire regarding their youth's school performance. Once R.O.P. ended, the parents completed the same questionnaire to analyze whether being in B.R.A.A.F. had an impact on school performance. Most youth had high grades prior to the program, and this trend remained consistent by the end, with only 12% having below average to poor grades. Additionally, there was a slight decrease in support programs for emotional problems. Before R.O.P., 35% of the parents answered "yes," but after the program ended, all parents answered "no" regarding behavioral support programs for youth.

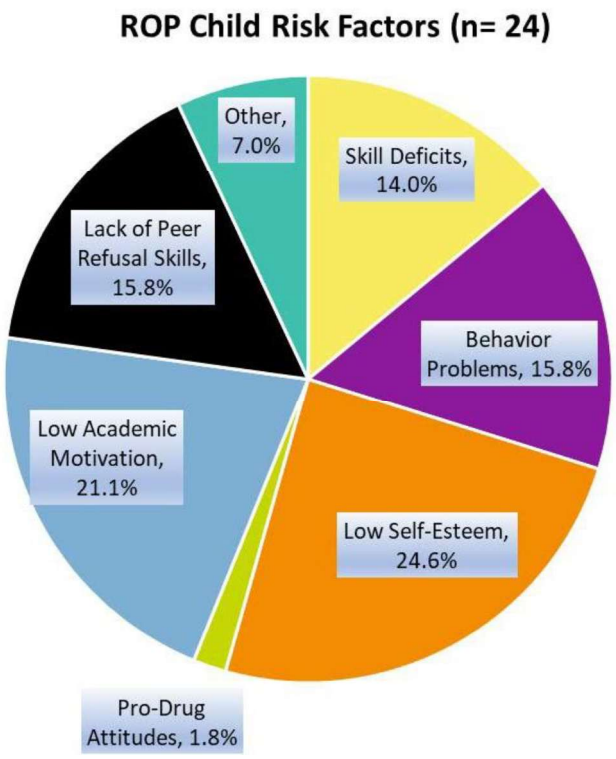
Demographics





It is important to note that 24 youth enrolled and have attended at least one session. The target enrollment for both regions was 40-50.

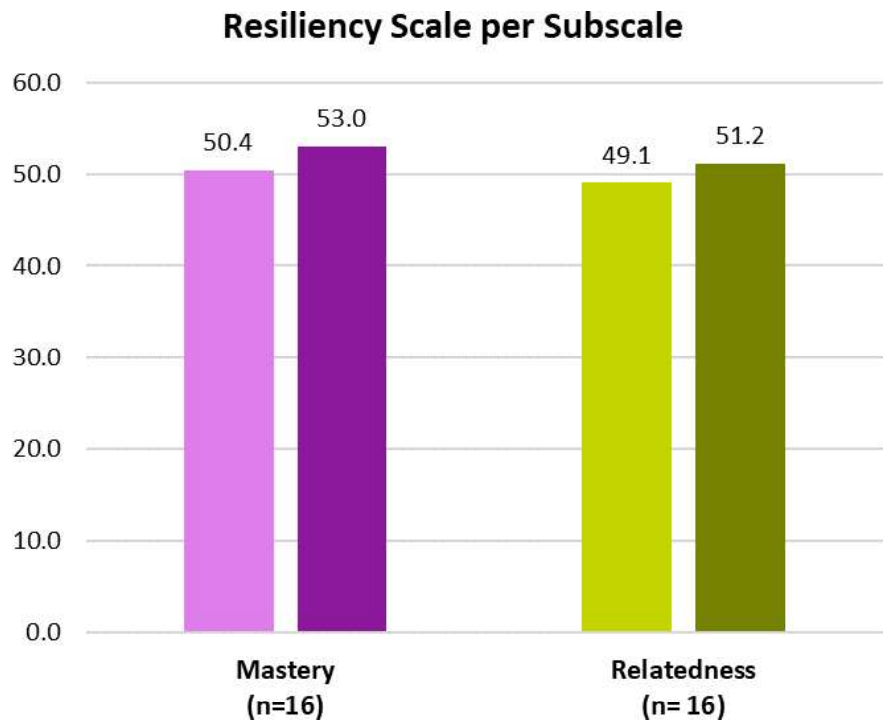




Risk Factors are based on participants that have provided at least one or more responses on the ROP Demographic Form.

Resiliency Scale for Children and Adolescents

The Resiliency Scales for Children and Adolescents is a tool that measures the personal attributes of the child that are critical for resiliency. The measure is composed of two stand-alone global scales, Sense of Mastery having 20 questions and Sense of Relatedness having 24 questions. The Sense of Mastery scale measures the likelihood that the individual will be able to cope with adverse circumstances. The Sense of Relatedness scale measures relationships with others that serve as a buffer against stress. Participants' self reported answers are summed and converted into normalized T-scores. Scores are categorized as 60+ is High; Above average 56-59 ; Average 46-55; Below Average 41-45; and less than 40 is Low.

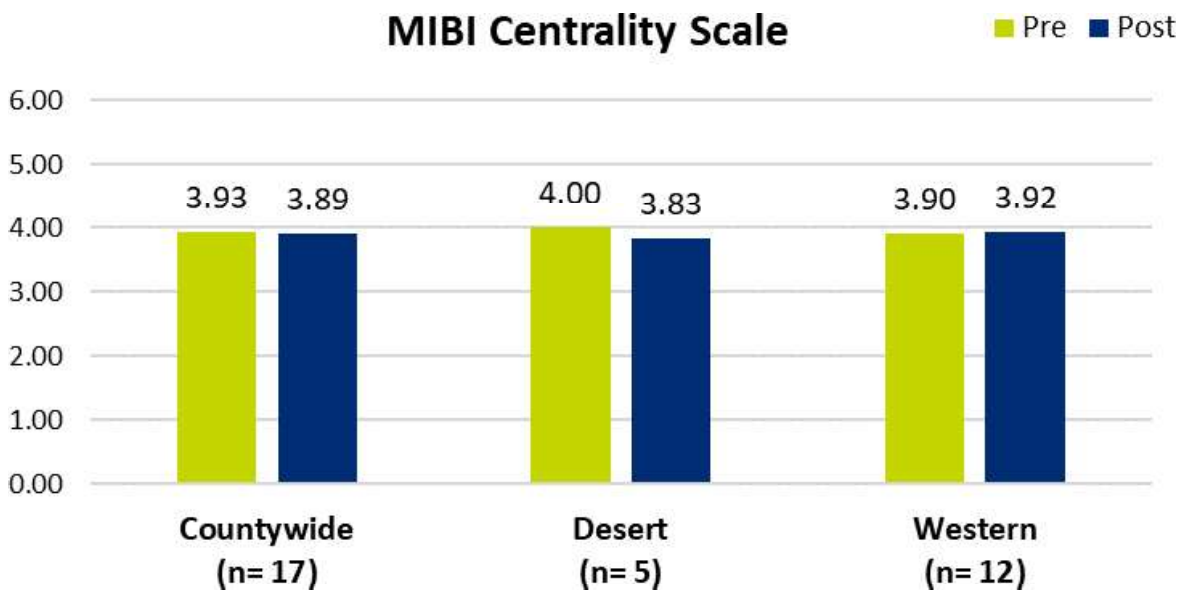


There were 16 participants from the Desert and Western regions who completed both pre- and post-measures for the chart above. Countywide, the scores for "sense of mastery," which reflects an individual's belief in their ability to manage challenges and achieve goals, slightly increased, with a mean difference of 2.56 ($t(15) = -0.715$, $p = 0.486$), indicating no statistically significant change ($p > 0.05$). The total scores suggest that youth reported an "Average" sense of mastery at both intake and follow-up, according to the Resiliency Scale scoring categories.

Similarly, there were also 16 participants with completed pre- and post-measures for the Sense of Relatedness scale, which involves feelings of connection and belonging to others. The scores on the relatedness subscale increased slightly, with a mean difference of 2.12, but there was no statistically significant change from pre- to post-measure ($t(15) = -0.565$, $p = 0.580$, $p > 0.05$). Both at intake and follow-up, youth reported an "Average" sense of relatedness, according to the Resiliency Scale scoring categories.

The Multidimensional Inventory of Black Identity

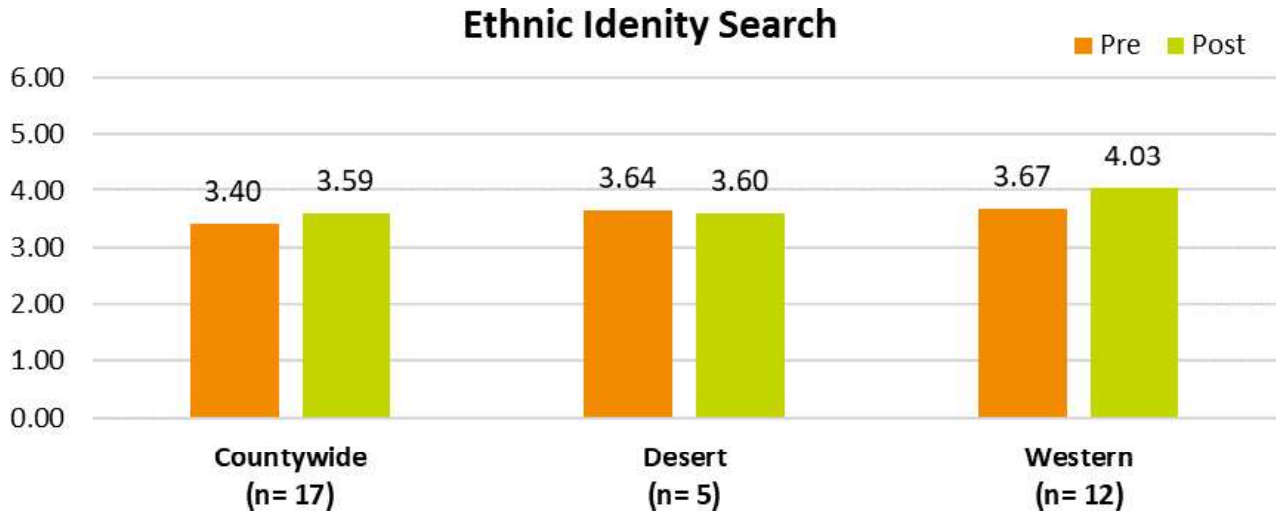
The Multidimensional Inventory of Black Identity (MIBI) measures dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). For the Rites of Passage program only the Centrality subscale was used. The Centrality scale consists of items measuring the extent to which being African American is central to the respondents definition of himself/ herself. The higher the scores on Centrality, the more the respondent views being African American as a central definition of himself. The highest possible average one can score on Centrality is 5.

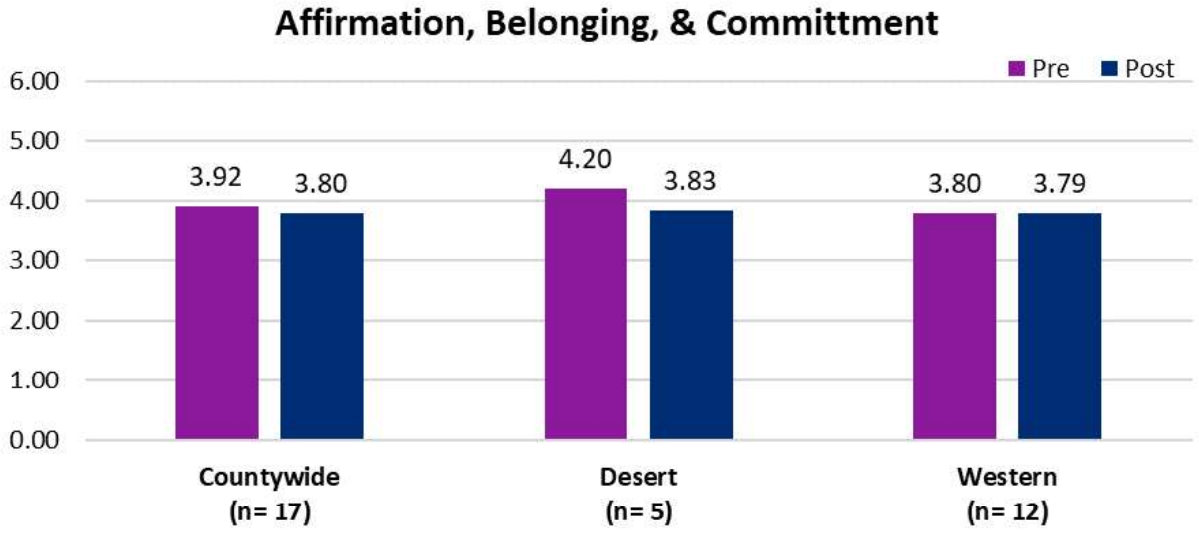


All regions were required to use the Teen MIBI measure, which consists of 9 items. Countywide, participants (n = 17) scored an average of 3.93 at the pre-assessment, and post-ROP, their average score was 3.89. This change was not statistically significant ($p = 0.913$, $p > 0.05$). Overall, the participants' scores remained around 4, indicating a strong sense of centrality regarding the importance of their Black/African American identity. In the Desert region, there was a slight decrease from pre to post, but the small sample size (n = 5) limits the reliability of any statistical comparison. Consequently, both the Desert and Western regions had small sample sizes, making it difficult to compare regional differences in racial identity. However, the average pre- and post-scores across both regions suggest that participants continued to maintain a high level of self-esteem associated with their Black/African American identity, as reflected in the MIBI Centrality Scale.

The Multigroup Ethnic Identity Measure

The Multigroup Ethnic Identity Measure (MEIM) was developed to measure the process of ethnic identity development among adolescents and young adults. It is a valid and reliable survey instrument that is one of the most common measures of ethnic identity. It has two subscales: ethnic identity search and affirming, belonging, and commitment. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). Higher scores indicate higher levels of ethnic identity.

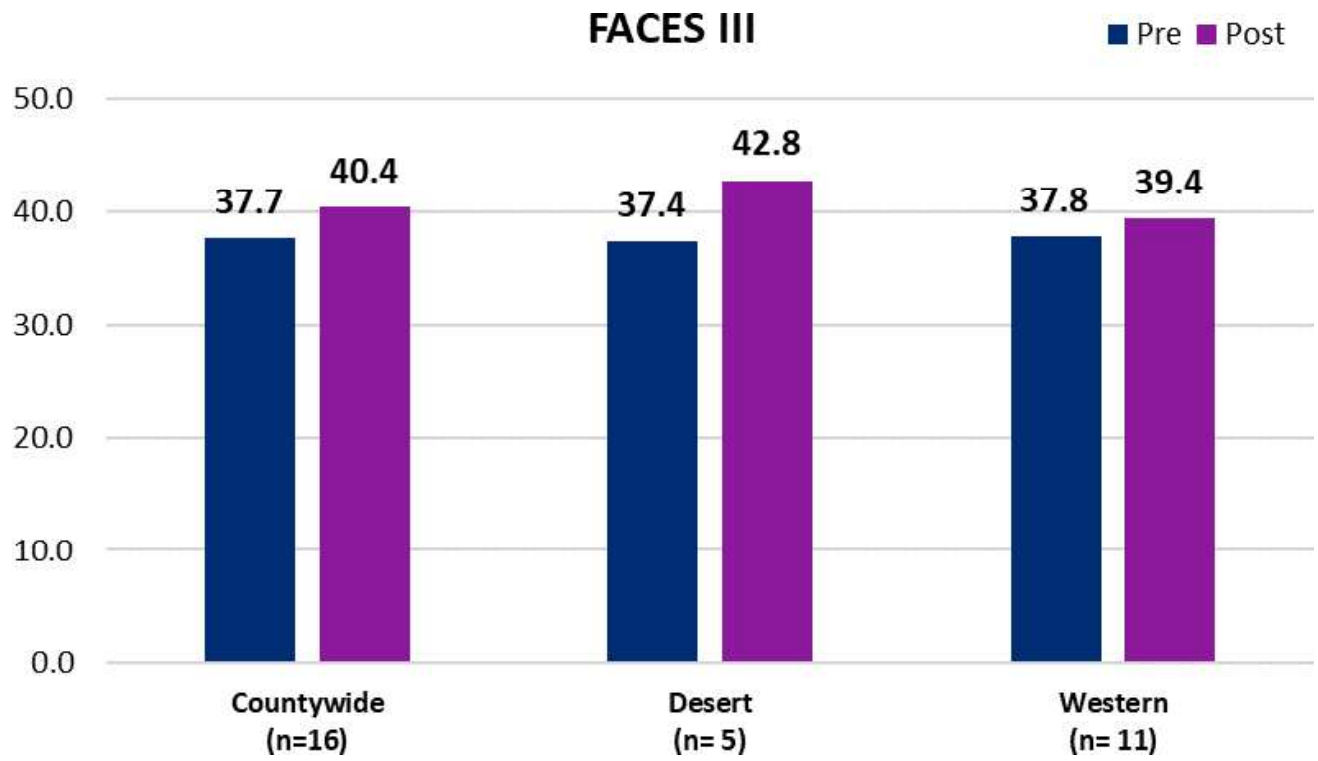




Overall, countywide, there was no change in the Multigroup Ethnic Identity Measure (pre-test = 3.40 and post-test = 3.59). In Affirmation, Belonging, and Commitment; countywide, there was no significant change with a mean difference of 0.12 (pre-test = 3.92 and post-test = 3.80). Though, there was no statistically significant change in either subscale, average scores across regions illude positive ethnic identity development in the R.O.P. youth.

Family Adaptation and Cohesion Scale III

The Family Adaptation and Cohesion Scale III (FACES III) is a self-reported 10 item scale that measures perceptions of cohesion within the family unit. The *Cohesion* subscale measures the strength of family members attachment to one another. The FACES III is completed by a parent, relative, or caregiver. Participants respond via 5 point Likert scale (1 = Almost Never; 5 = Almost Always). Scores are summed for the cohesion subscale. Interpretation of the *Cohesion* subscale is as follows: 10-34, disengaged; 35-40 separated; 41-45 connected; 46-50 involved.



The results indicate that countywide scores on the Cohesion subscale showed a statistically significant improvement from pre to post-assessment ($t(15) = -2.101$, $p = 0.053$). This suggests that families experienced a shift in their sense of connection over the course of the program.

Initially, families reported feeling somewhat separated, with a pre-score of 37.70. However, after participating in the R.O.P., their post-score increased to 40.4, indicating a stronger sense of cohesion and connection among family members.

Although the sample sizes for each region were small, the average scores reflect a positive trend, demonstrating that families felt more united and engaged after the program. This improvement in cohesion suggests that the R.O.P. effectively fostered family bonds and enhanced the sense of togetherness within families.

Overall, these findings suggest the potential impact of the program on family dynamics, emphasizing the importance of fostering connections for overall family well-being.

Youth Satisfaction

Towards the end of the program, the majority (n= 17) of youths who graduated from ROP completed a satisfaction survey. Overall, the majority of youth who completed the satisfaction survey agreed that participating in the program was a positive experience. Also, respondents reported "good" with regard to staff treatment towards the youth.

Item Description (Score range: 1—5)	County-Wide n= 17	Desert n= 5	Western n=12
1. Overall, how satisfied were you with the type of activities in the Africentric Rites of Passage Program?	3.82	4.00	3.75
2. Since attending the Africentric Rites of Passage program, I feel more involved in school.	3.59	4.00	3.42
3. Since attending the Africentric Rites of Passage program, I feel I get along better with my teachers	3.29	3.60	3.17
4. Participating in this program has been a positive experience for me.	3.82	4.40	3.58
5. Participating in this program has changed how I think about myself in a positive way.	4.06	4.40	3.92
6. Please rate your satisfaction with how staff, in the Rites of Passage program, treated you.	4.12	4.20	4.08
7. Rites of Passage staff presented the program information in a way I understood.	4.19	4.25	4.17
8. Rites of Passage staff presented the program information in a fun way.	3.59	3.80	3.50

How this program may have affected participants
"It helped me be accountable for my actions."
"Program has changed me in a positive way by teaching me how to manage my emotions."
"This program changed me mentally and helped me deal with suicide."
What participants liked about the program
"Learning about my culture."
"The things we talked about and to trip fields."
"Good things to learn and food and activities."
What participants did not like about the program
"Having to memorize the *Nguzo Sabas* was something I didn't enjoy."

Parent/Caregiver Satisfaction

Overall, 100% of parents were satisfied with the program. Furthermore, 100% of parents indicated that they would recommend the program to a friend or relative.

Item Description (Score range: 1 - 4)	County-Wide n =15	Desert n= 5	Western n= 10
1. The program's ability to assist your child.	3.7	3.6	3.8
2. Your child's progress/accomplishments/achievements. while in the program.	3.9	4.0	3.8
3. The philosophy and approach of the program.	3.9	3.8	4.0
4. Opportunities for parents to meet together for support and share information.	3.9	3.8	4.0
5. Overall Satisfaction.	3.8	3.4	4.0

What has been most helpful to you and your child?
"My sons learned more about their African roots, and has empathy for others."
"What I loved the most was learning our African Culture. Teachings/lessons of our great pioneers and inventors that contributed to society globally. Being proud of our African Heritage and knowing our origin. Teaching cooking lessons, learning effective communication, build strong bonds with parent and son. Very enriched principles and values."
"Parent module sessions which helped support our family with ways to communicate and approach different situation with our son."
What changes can you suggest?
"Transportation needs to be upgraded for safety reasons."
"I would suggest more men mentors leading the lessons, also add a physical activity such as baking that helps with developing discipline. Build self-confidence. More outings such as hiking, camp-learn nature."
"More parent participation and more outings."
Is there anything else you want us to know?
"This program is effective in its lesson taught by the coordinators/staff. [Staff members] did a fantastic job. Continue program."
"My sons were pleased with the respect and concern they received from the staff members. My sons seemed to have enjoyed the retreats and outings."

Program Information

What is Guiding Good Choices (GGC)?

The GGC curriculum was developed under the name *Preparing for the Drug-Free Years®* by Dr. David Hawkins and Dr. Richard Catalano of the University of Washington for parents of children in grades four through eight. With GGC, parents learn specific strategies for promoting healthy behaviors in children and reducing risks that predict adolescent health and behavior problems.

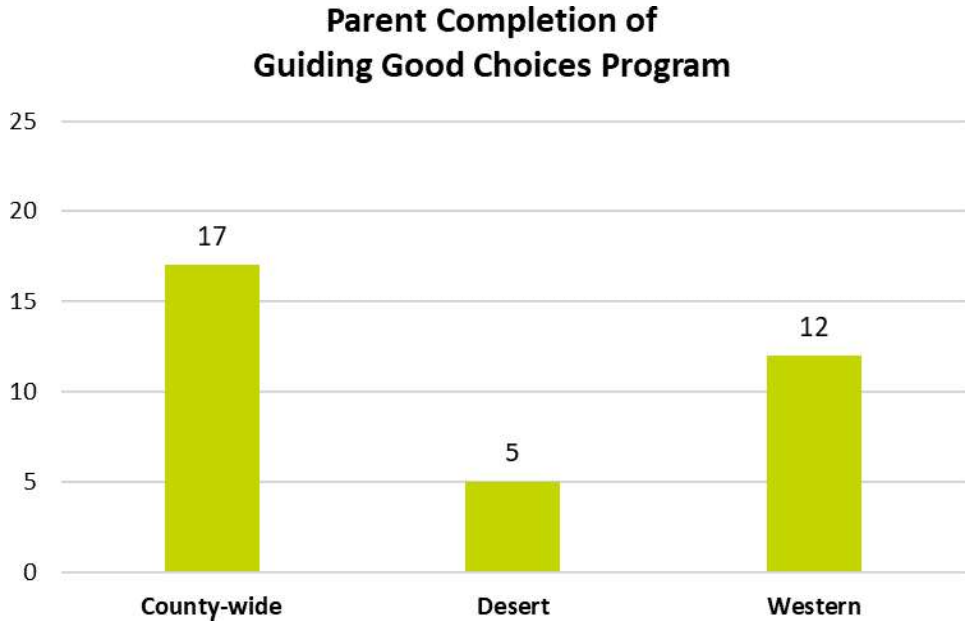
Children are exposed to risks in their schools and communities, and sometimes in their families and with peers. Some children start using alcohol, tobacco or other drugs. Some drop out of school, have sex (and risk pregnancy), or become involved in delinquency or violence. Others, while exposed to similar risks, do not develop these adolescent heath and behavior problems because they are protected by factors like strong family bonds and healthy beliefs and clear standards for behavior.

In GGC, parents learned how to strengthen family bonds, set a clear family position on drugs, teach children skills they will need to make healthy choices, and increase children's involvement in the family. GGC was offered once a week for five weeks at the start of the program. To congratulate the parents on their accomplishments, a small ceremony and certificate is presented to acknowledge their participation. The five sessions are as following:

1. Getting Started: how to Prevent Drug Use in Your Family
2. Setting Guidelines: How to Develop Healthy Beliefs and Clear Standards
3. Avoiding Trouble: How to Say No to Drugs
4. Managing Conflict: How to Control and Express Your Anger Constructively
5. Involving Everyone: How to Strengthen Family Bonds

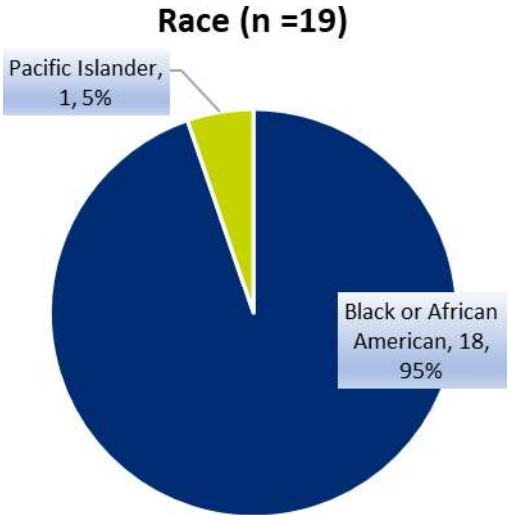
GGC Program Completion

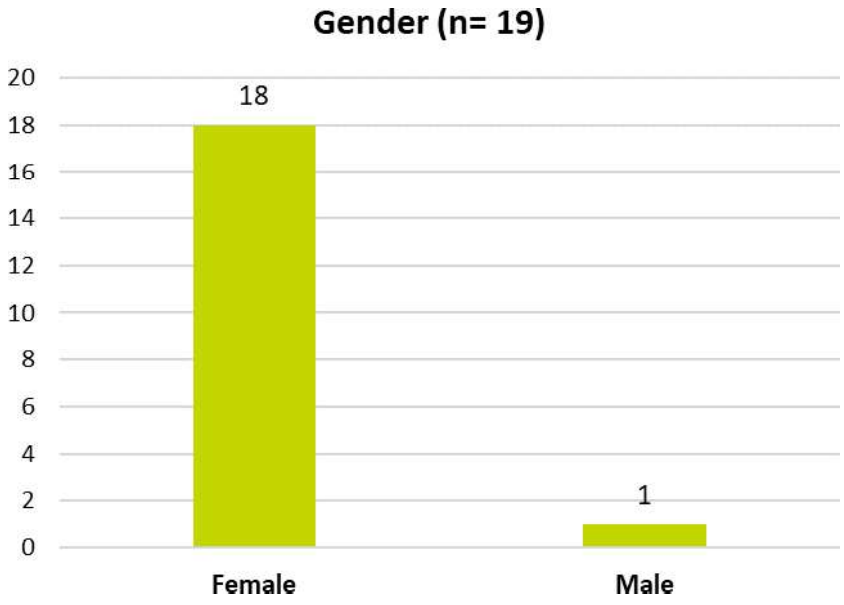
At least one parent of the child enrolled in ROP was required to complete all five sessions of GGC.

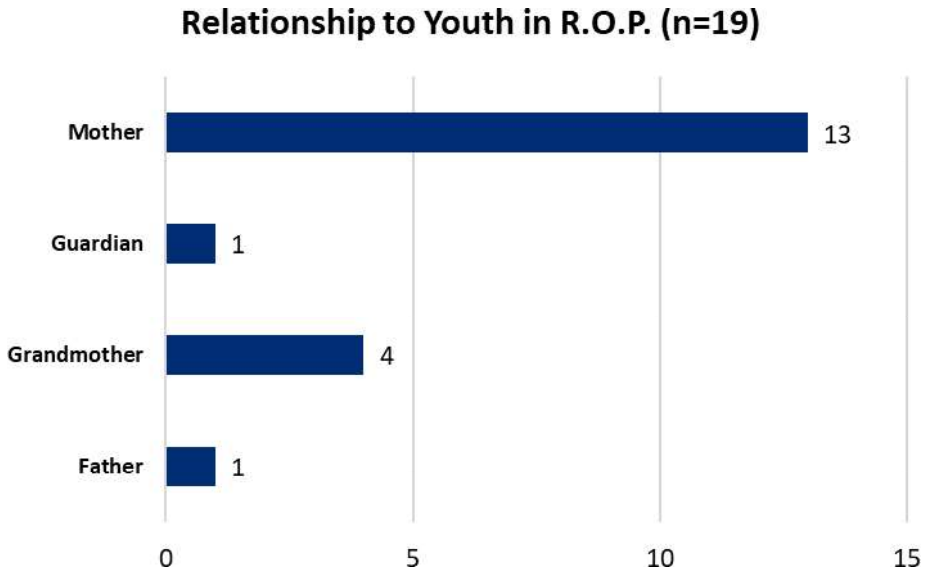


19 parents attended at least one session of GGC and 17 parents (90 % of the cohort) completed the program in 2023-2024 FY.

Demographics



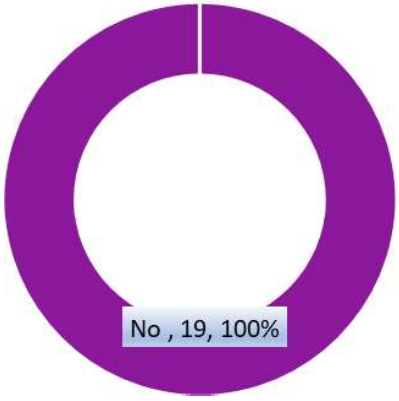




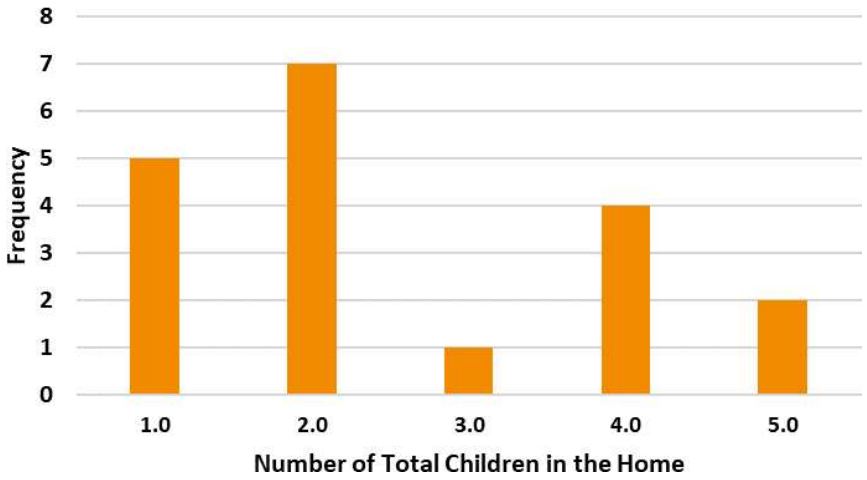
Of the self-reported data collected from GGC, 95% of the participants were African American, and 5% were Pacific Islander regarding race on the demographic form. The male-to-female ratio was, approximately, 1 to 18, respectively. Mothers (n= 13) were the primary participants, followed by grandmothers (n= 4), one father (n =1), and one guardian (n= 1).

Demographics cont.

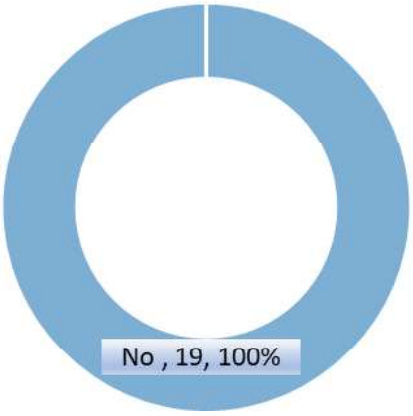
Disabling Condition? (n=19)



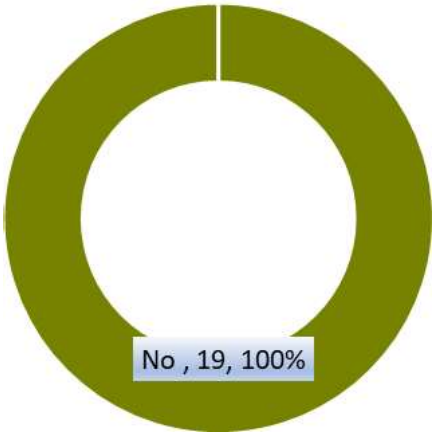
# of Children per Household (n= 19)



Child Actively Uses Drugs/Substances? (n=19)



Veteran? (n=19)

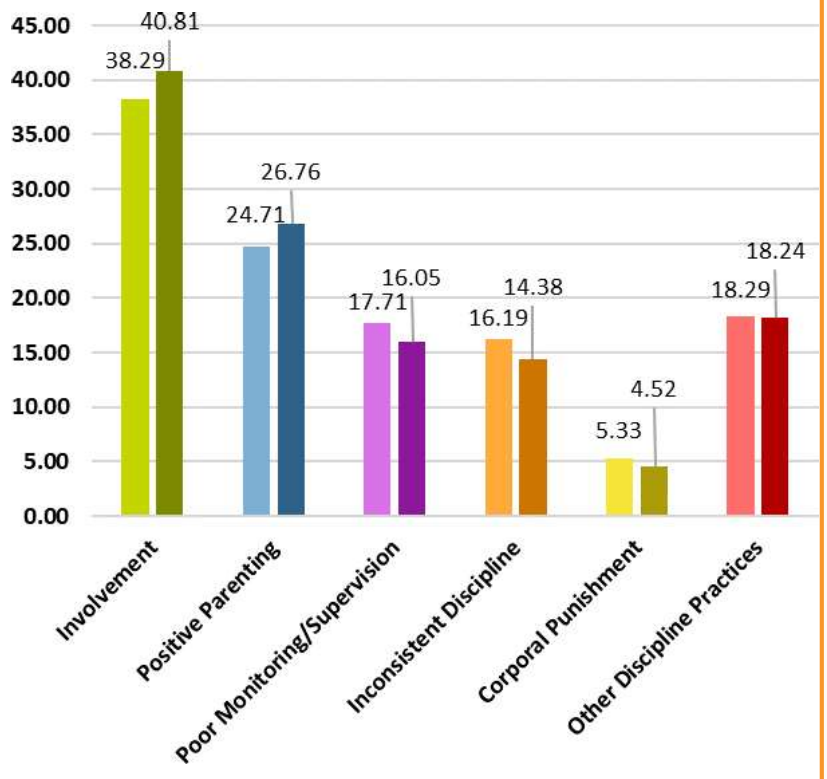


Overall, 19 parents were served in GGC and 17 parents completed the program. Of the 19 who enrolled, approximately, parents reported none of their children actively use substances (n =19). Most parents had two children in their homes.

Alabama Parenting Questionnaire

Past research has shown that increasing positive parenting practices while decreasing negative parenting practices have been effective in reducing problem behaviors in children at least 4 years old. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. The APQ is a 42-item parent self-report measure assessing five parenting constructs: parental involvement (10 items), use of positive reinforcement (6 items), poor parental monitoring and supervision (10 items), use of inconsistent discipline (6 items), and corporal punishment (3 items). The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale from 1 (*never*) to 5 (*always*).

Alabama Parenting Questionnaire Countywide Results (n=21)



Nineteen parents/caregivers had a pre and post APQ measure. Two parents had two siblings in the program (n =21).

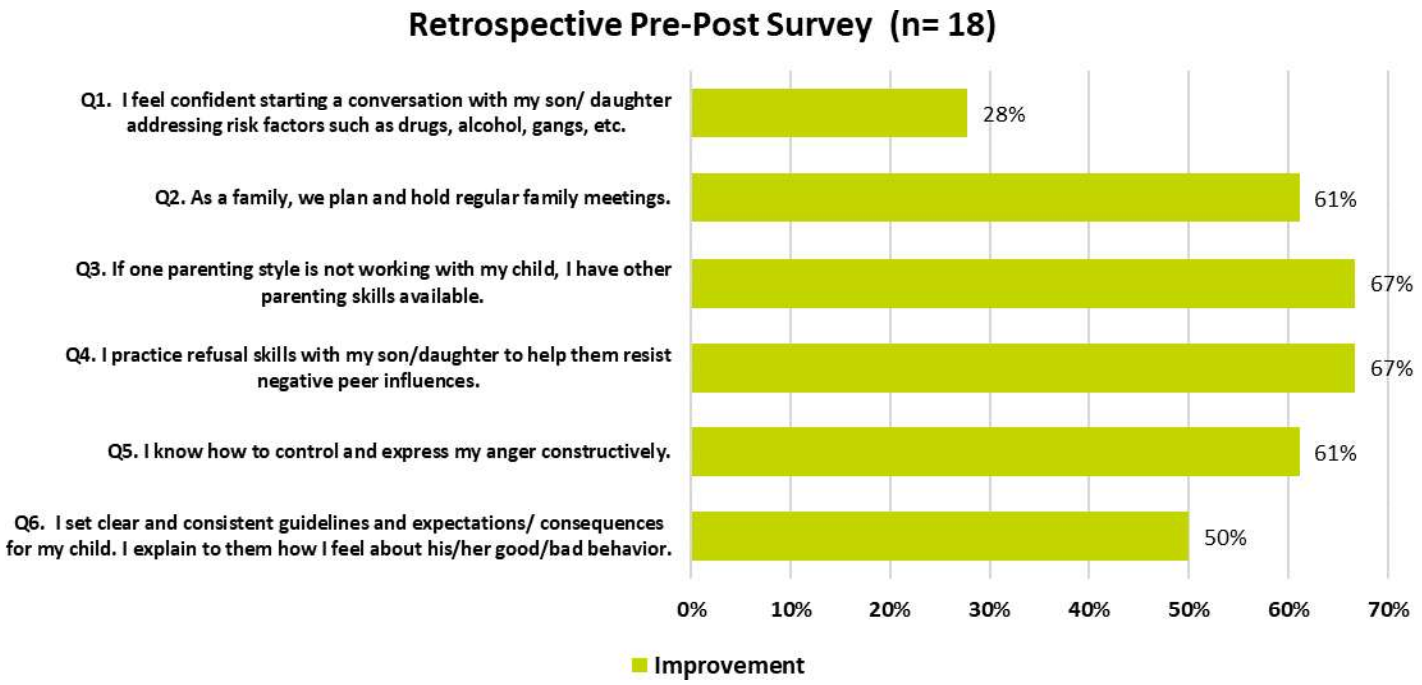
To demonstrate improvement in the six scales, the post means should be greater than the pre means for involvement, positive parenting, and other discipline practices. However, poor monitoring/supervision, inconsistent discipline, and corporal punishment, should exhibit lower post means than pre means to indicate that the parents do not agree with the "poor parenting" item questions from the APQ.

Overall, county results exhibited statistically significant differences in the following areas: parental involvement scale significantly improved, (t (20)= -3.250 , p< .05), inconsistent discipline significantly decreased, (t(20) = -3.485, p< 0.05) and corporal punishment significantly decreased, (t (20)= 3.068, p < 0.05).

		Involve-ment	Positive Parenting	Poor Monitoring/ Supervision	Inconsistent Discipline	Corporal Punishment	Other Discipline Practices
		Mean	Mean	Mean	Mean	Mean	Mean
Desert	Pre	36.38	21.75	22.13	14.38	5.75	16.75
	Post	38.63	25.38	18.13	13.88	5.25	16.75
Western	Pre	39.46	26.54	15.00	17.31	5.08	19.23
	Post	42.15	27.62	14.77	14.69	4.08	19.15

Satisfaction Survey

A satisfaction survey is administered at the conclusion of the GGC program. The first six questions are retrospective pre and post, and the following 12 (on the next page) are post scores only. Results are provided in the following tables. Participants' comments are also included on the satisfaction survey. Overall, participants indicated that they were satisfied with course instructors and the effectiveness of GGC classes.



Likert scale breakdown: 1=strongly disagree, 2=disagree 3=neutral, 4=agree, 5=strongly agree

Question	Retro-Pre	Post	P-value	Question	Retro-Pre	Post	P-value
Q1	4.44	4.94	.058	Q4	3.33	4.50	<0.001
Q2	3.00	4.33	<0.001	Q5	3.28	4.17	<0.001
Q3	3.50	4.56	.002	Q6	3.83	4.44	.045

For the retrospective pre to post-survey, the parents in GGC answered six questions after the completion of the five-session program. Eighteen parents answered the questions by comparing their parenting skills at the end of the program to their parenting skills before GGC. Based on the results, parents increased the most (67% increase) in practicing refusal skills to resist peer pressure and adapting to new parenting styles that create healthy habits with their children. Parents showed significant overall improvement (p <.05) after GGC regarding the following items: meeting regularly as a family, increasing parenting skills, practicing refusal skills, regulating emotions and setting clear/consistent expectations and consequences. To note, those parents that did not show improvement had scores that were high in the pre-assessment.

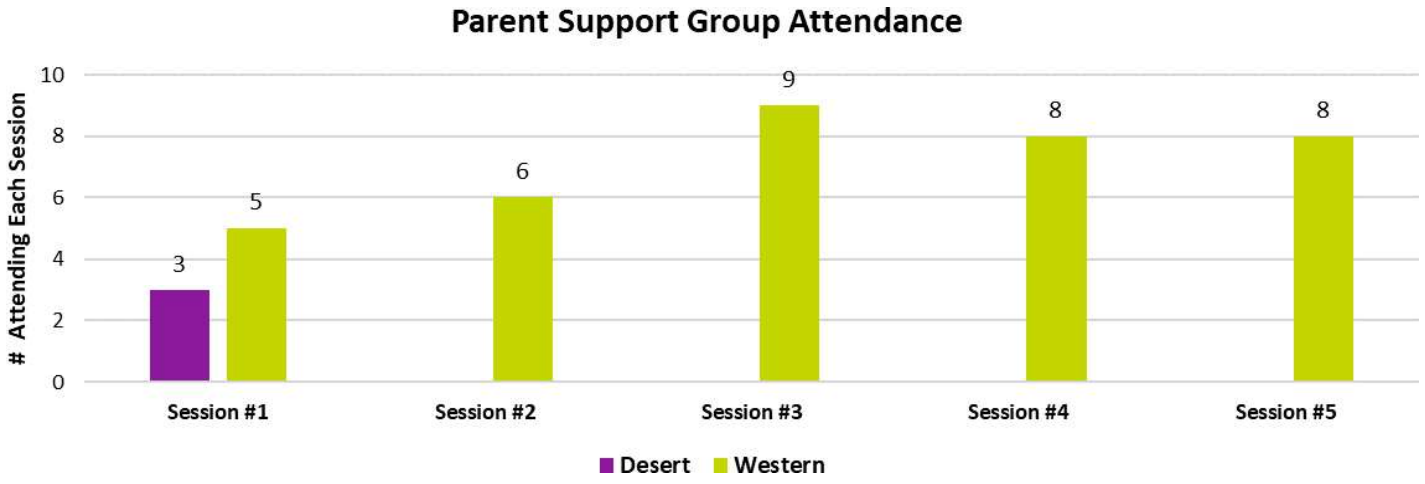
Satisfaction Survey

Item Description (Score range: 1– 5)	County-wide n= 19	Desert n=8	Western n=11
1. Overall, I am satisfied with the program.	4.9	4.9	4.9
2. The location of the program was convenient for me.	4.2	5.0	3.6
3. The sessions were at a time convenient for me and my family.	4.7	4.8	4.6
4. My family got the help we wanted for my child.	4.6	4.5	4.7
5. As a result of the program, I am satisfied with our family life right now.	4.7	4.6	4.8
6. I felt comfortable talking about my child's problems with the staff.	4.5	4.8	4.3
7. The facilitators listened to what I had to say.	4.9	4.9	4.9
8. Facilitators spoke to me in a way that I understood.	4.9	5.0	4.9
9. Facilitators are respectful of my cultural/ethnic background.	5.0	5.0	5.0

Things I learned in the GGC program are:
"Too much for these 2 lines! The importance of family meetings, involving my child in decisions, expressing my feelings about his behavior in a healthy manner, etc."
"How to set boundaries, also to stick to my guns, say what I mean and mean what I say."
"It's a program that has helped me to understand my sons on a different level of trying to understand them."
"How to communicate better with my child."
What I liked about the GGC program is:
"Hearing the experiences of other parents and how different topics and challenges can be addressed constructively."
"I was given tools to deal and take my child in different situations."
"The help and info from the other parents."
"The positive change with my child."
What I didn't like about the GGC program is:
"At times, there were hot topics where time did not allow a full conversation, though it was still a discussion."

Parent Support Groups

Once Guiding Good Choices parenting classes ended, the parents were encouraged to attend weekly parent support groups. These groups were designed to be an open space where the parents can share parenting skills and seek advice on how to overcome family difficulties in raising a young teenage child. Topics discussed were about drugs, lying, bullying, weapons, etc. Every week the parents were called and invited to attend the support group. By the end of B.R.A.A.F., parents were committed to keeping in touch with each other, and continue to provide support to each other when needed as they really felt like the additional support meetings have helped them become better parents overtime.

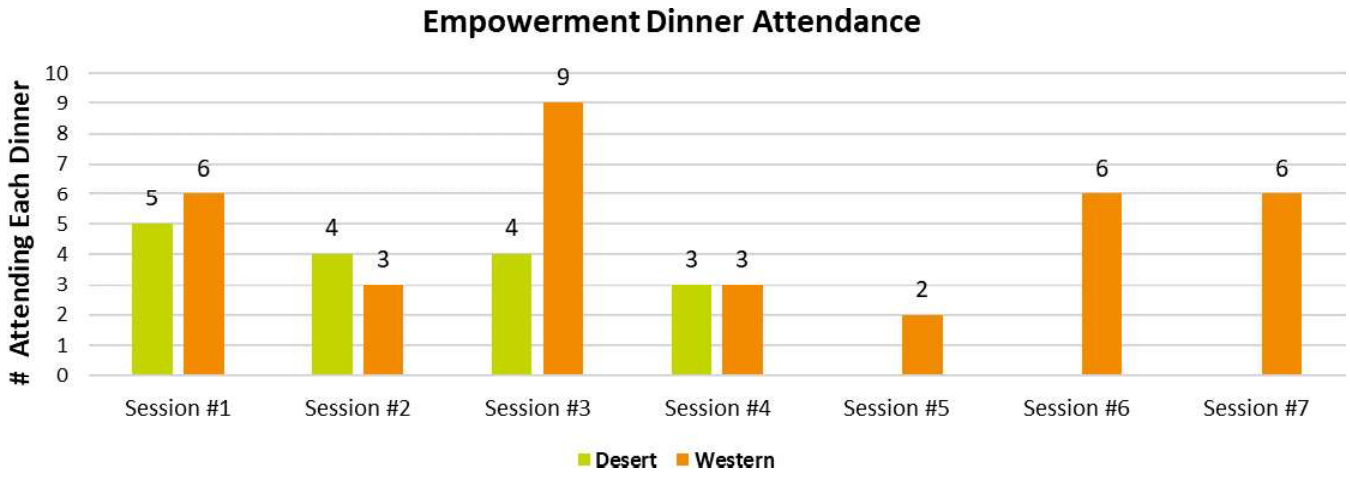


	Total Number of Sessions Hosted	Group Size Range
Desert	1 Session	1—3 People
Western	5 Sessions	1—9 People

No Parent Support Group Satisfaction Survey was conduct for Desert and Western regions at the end of the program. Refer to Parent Focus Group section for responses regarding PSG feedback.

Empowerment Dinner

The B.R.A.A.F. program's Parent Empowerment Dinner is a monthly meeting that focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. Discussions on resources, strategies for empowerment, and ways to enhance the parent-child relationship further enrich the experience. Overall, these gatherings are essential for building a supportive community and maximizing the program's impact. Each program/region should host 9 empowerment dinners per year.



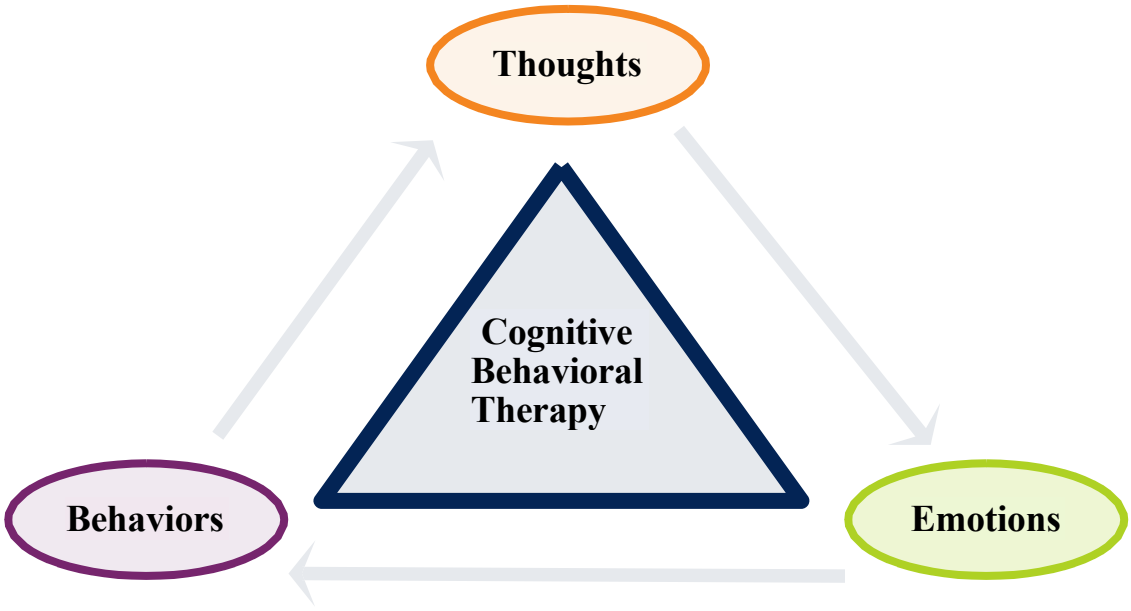
	Total Number of Sessions Hosted	Group Size Range
Desert	4 Session	1—5 People
Western	7 Sessions	1—9 People

Cognitive Behavioral Therapy

Cognitive –Behavioral therapy is designed for the youth in ROP who need further assistance with behavioral issues, anger control, depression, and other behavioral management concerns. Clinical therapists structure one-on-one therapy with the youth to address their behavioral concerns. Not everyone enrolled in CBT has a behavioral health condition warranting this type of intervention. It can be an effective tool to help those youth with behavioral concerns learn how to better manage their behavior and stressful life situations.

CBT can explore painful feelings, emotions, and experiences. The youth may feel emotionally uncomfortable at times. The youth may cry, get upset, or feel angry during a challenging session. Some forms of CBT, such as exposure therapy, may require the youth to confront situations they'd rather avoid. This can lead to temporary stress or anxiety. However, working with a skilled therapist minimizes any risks. The coping skills the youth learns in CBT will help them to manage and conquer negative feelings and fears.

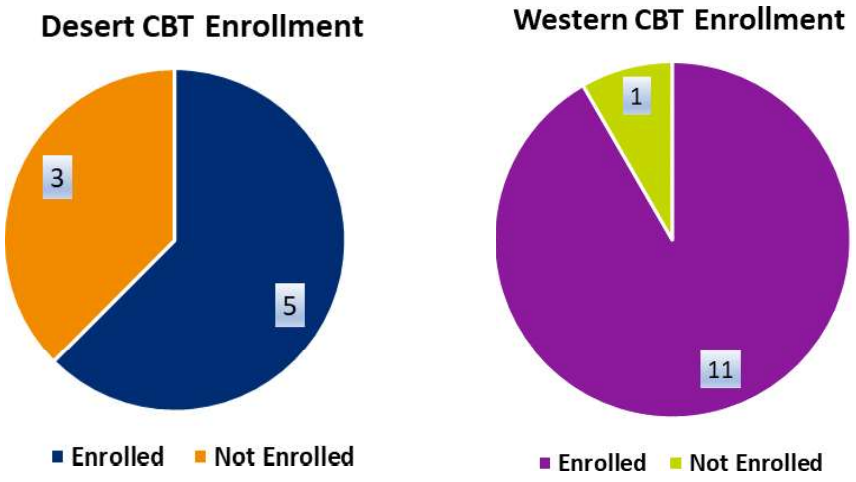
www.mayoclinic.com/cbt

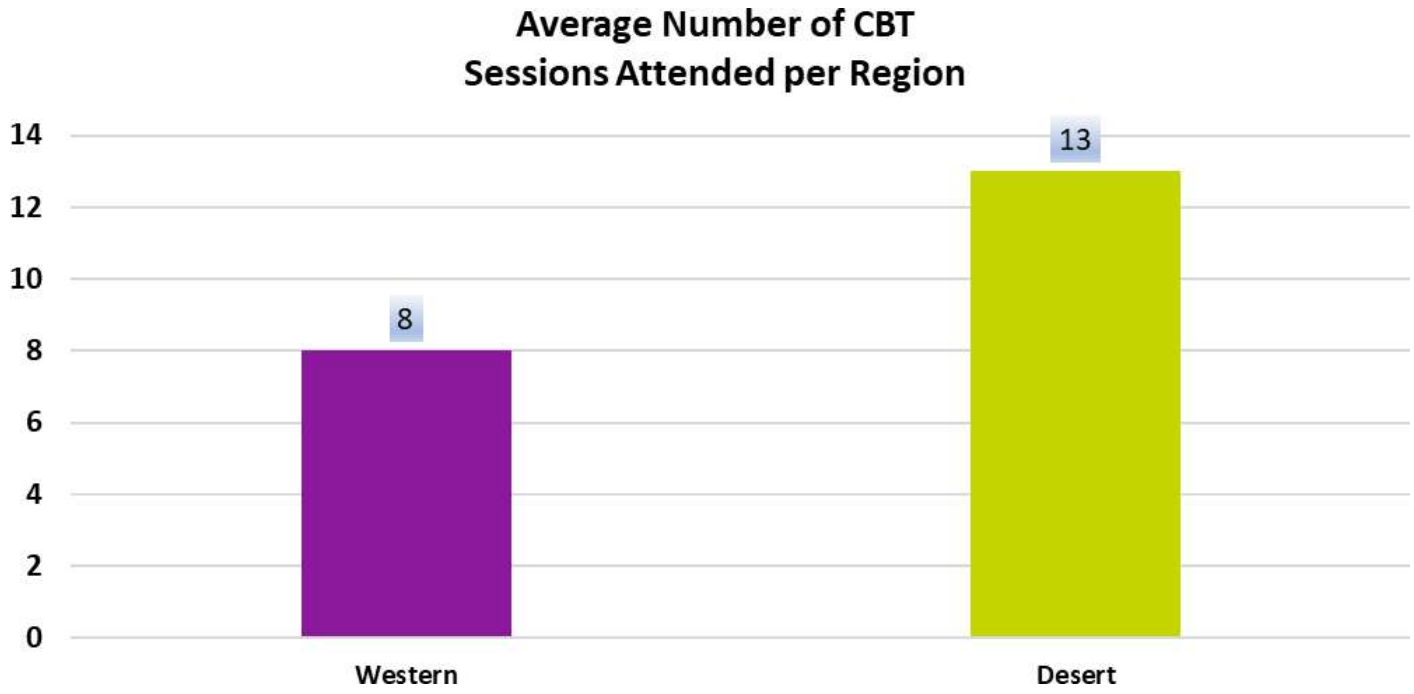


Outcome Evaluation

Children's Depression Inventory (CDI-II)	A self-report assessment that measures the severity of depression symptoms among youth. The measure includes five components of depression: Negative Self Esteem, Negative Mood, Anhedonia, Ineffectiveness, and Interpersonal Problems.
Strength and Difficulties Questionnaire (SDQ)	A parent completed measure, where they are asked to assess the positive and negative psychological attributes about their children enrolled in the program. Consisting of 25 Likert Scale items assessing the client's behavior over the previous month.

CBT Enrollment

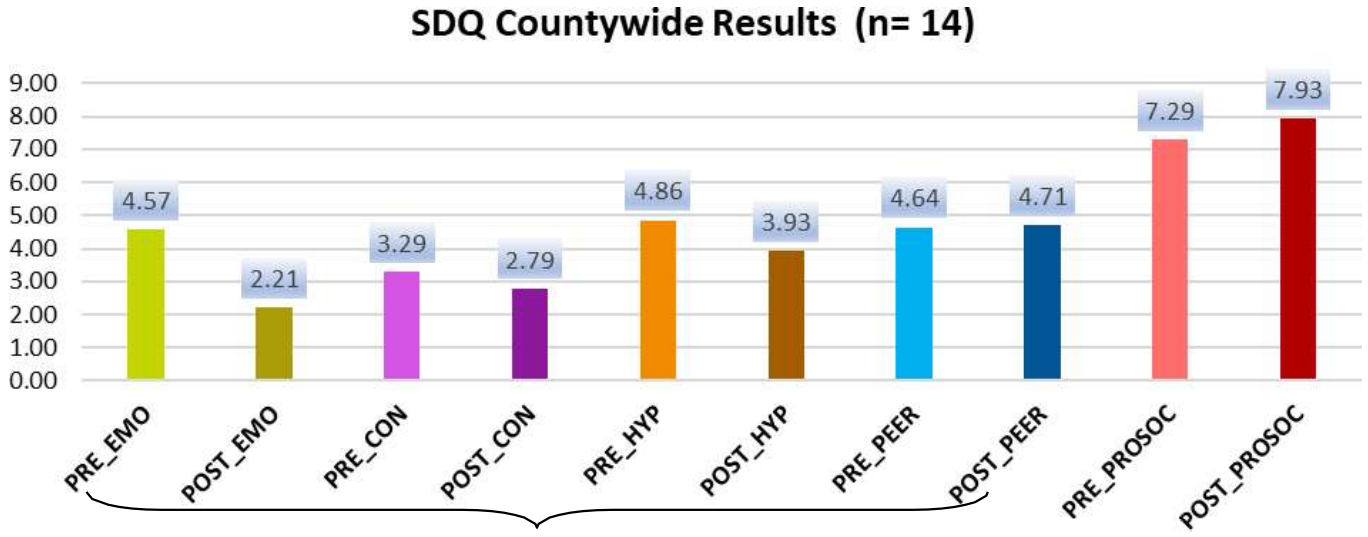




This fiscal year, CBT was offered as part of the B.R.A.A.F. program, and 16 youth received at least one session in CBT. The Desert region had 5 youth and Western region had 11 youth who received CBT sessions during the 22-23 fiscal year. On average, participants from Desert region attended 13 CBT therapy sessions and those from Western region attended 8 CBT sessions. These sessions were conducted in-person and via video-conferencing depending on the region and flexibility of the clinician and youth.

Strength and Difficulties Questionnaire

The Strength and Difficulties Questionnaire (SDQ) is used to screen for both positive and negative psychological attributes among program participants. There are multiple versions of the SDQ measure. This program used the SDQ Parent Version, for adolescents between 11 and 17 years of age. The SDQ emphasizes both strengths (pro-social behavior) as well as behavioral difficulties, and it can be used both as an assessment and as a program evaluation tool. The SDQ is completed by parents at the beginning and at the conclusion of the program, in order to measure the change in participants' behavior problems over time. Higher scores on the four behavioral subscales: emotional symptoms, conduct issues, hyperactivity/ inattention, and peer relationship problems, suggest a higher incidence of negative psychological attributes. There is also a Pro-Social scale which is an independent scale from the other four, higher scores suggest greater pro-social behaviors. The total score was calculated by summing the averages of the emotion, conduct, hyperactivity, and peer problems subscales.



Total Score: Pre=17.36 , Post=13.64

The four behavioral subscales were expected to decrease in average sub-scores; whereas, the prosocial subscale was expected to increase. The total score slightly increased, this change from pre– to post– score was statistically significant, ($t(13)= 2.460$, $p > 0.05$), and can suggest the youth faced less difficulties after completing one-on-one CBT sessions. The participants exhibited a significant decrease in the following subscales: **emotional symptoms**, $t(13) = 0.002$, $p <0.05$).

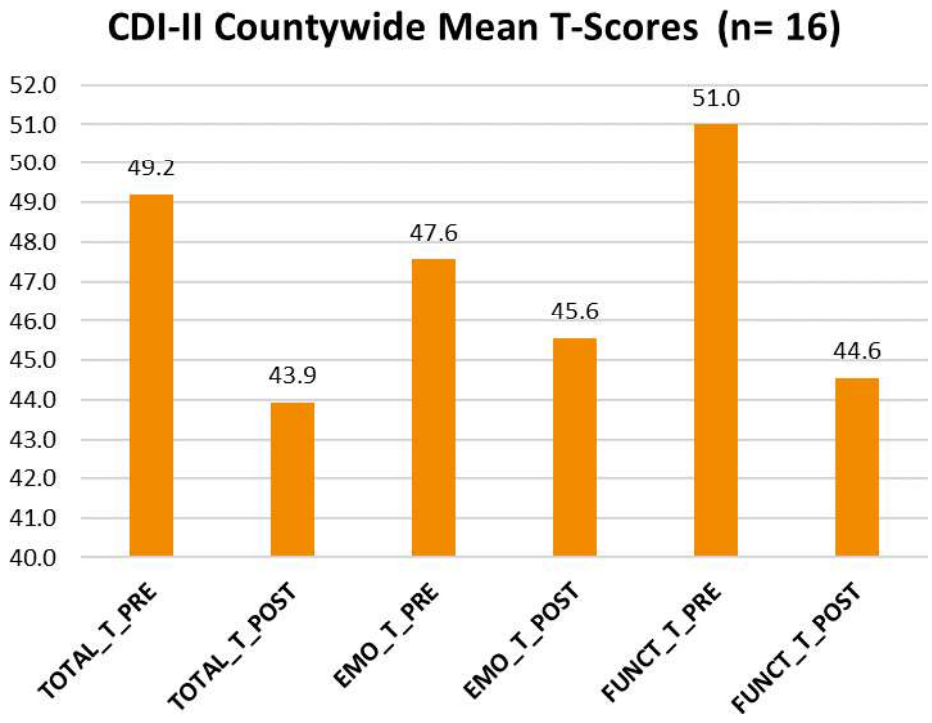
Although the results showed no statistically significant change from pre to post-measure, the decreases in conduct issues, hyperactivity/inattention, and peer relationship problems suggest a trend that could indicate the program's potential effectiveness and highlights the need for further exploration.

Children's Depression Inventory II

The Children's Depression Inventory (CDI-II) is used to measure the severity of depressive symptoms in children. The participants complete this self-reported survey before and after CBT. The CDI-II is a 28-item questionnaire with four initial subscales: Negative Mood, Negative Self-esteem, Ineffectiveness, and Interpersonal Problems. During scoring, subscales are combined to create two additional subscales using the following steps:

- Negative Mood + Negative Self-Esteem = Emotional Problems
- Ineffectiveness + Interpersonal Problems = Functional Problems
- Emotional Problem + Functional Problems = Total Score

Each item in the survey has three different descriptors in which the participants select the description that best matches his personality. Higher scores (70 and above) suggest very elevated levels of depression for all subscales and the total score. Whereas, scores 65-69 are elevated, 60-64 are high average, 60- 64 are average, scores 59-40 are considered average and <40 are low. A paired-samples t-test is utilized to assess the significant differences between the pre and post test scores.



All participants were required to complete both pre and post-CDI-II. When comparing the pre and post-test total scores, there was a statistically significant decrease in Total Score and Emotional Problems (p<.05). The youth displayed a decrease in depressive symptoms; youth remained at the average range of severity of depression, according to the Children Depression Inventory (2nd edition) assessment.

Satisfaction Survey

Satisfaction surveys data of individuals who completed at least 1 sessions were utilized for the following table.

Item Description (Score range: 1—5)	County-Wide n= 16	Desert n= 5	Western n= 11
1 The program taught me how to cope with stress.	3.31	4.00	3.00
2 The program helped me to understand myself better.	3.38	4.40	2.91
3 The program has prepared me to cope with stress if something difficult happens to me in the future.	3.44	4.60	2.91
4 I achieved my goals for the group.	3.44	4.20	3.09
5 The facilitator listened to what I had to say.	4.38	4.80	4.18
6 The facilitator knew how to help me.	3.69	4.60	3.27

Things I learned in the program are:
"How to react in touch situations, how to talk to people and code switching."
"I learned about my ancestors and how some of them helped us and rest wasn't beneficial because I already knew most of it."
"To turn a negative to positive."
What I liked about the program is:
"Getting to tell my thoughts and feelings."
"How to facilitator took care of me."
"That someone other than my family would check up on me."
What I didn't like about the program is:
"I had to write a lot."

Focus Groups

Focus groups are used in qualitative research to collect data by conducting a form of group interviews that focuses on communication from participants in the program. Focus groups can reach a depth and dimension that quantitative tools such as questionnaires or surveys can miss. Through analyzing responses, evaluations staff can identify shared and common knowledge which allows culturally sensitive topics to be discussed in a safe environment. Participants often provide mutual support in expressing feelings and help the more shy members to open up. The focus group session may last one to two hours and consist of a RUHS-BH program staff to help lead the discussion and multiple evaluation staff as note takers.

Purpose and Objectives:

The Prevention and Early Intervention team evaluated the Africentric Rites of Passage programs throughout Riverside County. The goal of the focus group was to gather participant feedback regarding the program. The feedback will be utilized to inform implementation and make adjustments where necessary and feasible for this program.

Data Collection:

Qualitative data was collected from the youth participants who had completed the 9 month ROP program in B.R.A.A.F., as well as the parents who actively attended empowerment dinners and parenting classes. The youth and parent focus groups were conducted at the site where their weekly sessions took place.

The youth focus groups and parent focus groups were conducted separately and were designed to last approximately 30 minutes each. There were seven predetermined questions youth were asked to answer and seven predetermined questions for the parents to answer. There was one group facilitator and a scribe recording comments.

The following youth focus groups were conducted from Western and Desert regions. The parent focus groups were conducted from Desert region. The focus groups were conducted in-person.

Youth Focus Groups

Questions and Analysis

Focus Group Questions:

The following questions were asked during each **youth** focus group:

1. *Think about something difficult that you have had to deal with in the past year. (Pause to think). How has the program helped you with that difficulty? If you have used any of the program's principles, could you explain that?*

2. *What did you learn in this ROP program that has helped you get along better with your family at home? Did you notice a change in your parents?*

3. *How has the program changed how you feel about yourself and your own culture?*

4. *Do you think you have changed in any way after going through this program? In what way (s)?*

5. *What about this program will you remember the most? Was there anything in B.R.A.A.F. that you disliked or did not meet expectations?*

Focus Group Analysis:

Both youth and parent questions did not have correct or incorrect answers. The responses were analyzed to find themes that were reoccurring across participants. Each region shared different experiences but all were asked the exact same questions.



Youth expressed positive changes in themselves and their family:

- The program helped with "my uncles death, and they got me to talked the *Mamas* and *Babas*, it helped me with it. The principle that helped me was Imani [one of the seven principles of Kwanzaa]."
- "I'm more confident in myself."
- The program helped me "be more concentrated and motivated."
- "...being more respectful"
- "One thing that was difficult for me was with my parents. *Mama* [staff] helped me with what I need to do."
- "A difficulty that I have is anger issues, but during the program, the staff helped me maintain my composure."
- "A difficult in school was learning, during the program, I talked to [staff] about it and they helped me try new stuff."
- "I used self-determination to help me reach confidence"
- " It taught me how to do it and without being told, so I started to do chores at home without being told."
- "I have stress about home, so [staff] helped me with tools to help with that."
- "My parents don't yell all the time as much."
- "My parents are more calm and start asking things in a different way."
- … "to cherish my parents."
- … "being more calm and not acting all the time."

Youth explained changes and additional comment about the BRAAF program:

- "Code-switching, means to act different around different people, doing things that would follow certain types of people."
- I liked "the retreat, everything, the activities, the ridings,"
- I liked "how we act in the program and in the retreats."
- "*Momma* [staff], she's nice."
- I disliked "the trust, they don't leave us alone, there's always some one watching the room."
- "First day of program, I did not like it, now I am excited to come to program."
- "The start of program, I looked at things at a different perspective then now."
- I dislike the program because "it felt like doing a 7th class."
- I disliked the program because "it was a lot of work."

Parent Focus Groups
Questions and Analysis

Focus Group Questions:

The following questions were asked during each **parent** focus group:

1. *Can you tell us your favorite activity to do as a family?*

2. *Based on what you learned and practiced during the five Guiding Good Choices classes: How has your relationship with your son in ROP changed?*

3. *Do you think your child has changed in any way by going through this B.R.A.A.F. program? If yes, in what way?*

4. *For those who attended the parent support groups, what did you value and benefit from the group?*

5. *What did you gain from Unity Day? Are there any areas we need improvement to meet your expectations for Unity Day?*

6. *Is there any other feedback you would like to share, both positive and negative?*

Focus Group Analysis:

The youth and parent questions did not have correct and incorrect answers. The responses were analyzed to find themes that were reoccurring across participants. Each region shared different experiences but all were asked the exact same questions by the same facilitator to reduce moderator bias.



Changes parents saw in their children after going through the program:

Many parents noted their sons changed their behavior and self-expression.

- "I've see changing with myself and my son, better communication, my boys are more out spoken, the things that they say to me, they say in a more respectful matter. Throughout the program, they've learned to speak to someone that is older than them. And little more teamwork with themselves."
- Last year was very tough, now I have seen a growth… he explains to me about what he needs from me to be more social. I've notice he has boundaries and respecting those. After identifying what we need from each other, it turned out pretty ok so far. Definitely communication has improved from since we've started the program."
- .."confidence, before he would hate people looking at him, public speaking during activities, proud to see him in front of stranger."
- "[Youth] surprised me, he got on a horse. At camp, he was able explore something new with positive peer pressure with the *Bobbas* and *Mommas* and other kids but he did it. I was proud of him for doing that."
- "My son enjoyed the program, had a good time, enjoyed the staff and enjoyed his peers, glad he was able to attend this year."

Value and benefit from parent support groups and GGC:

Parents report a sense of camaraderie and mutual benefit from the support groups.

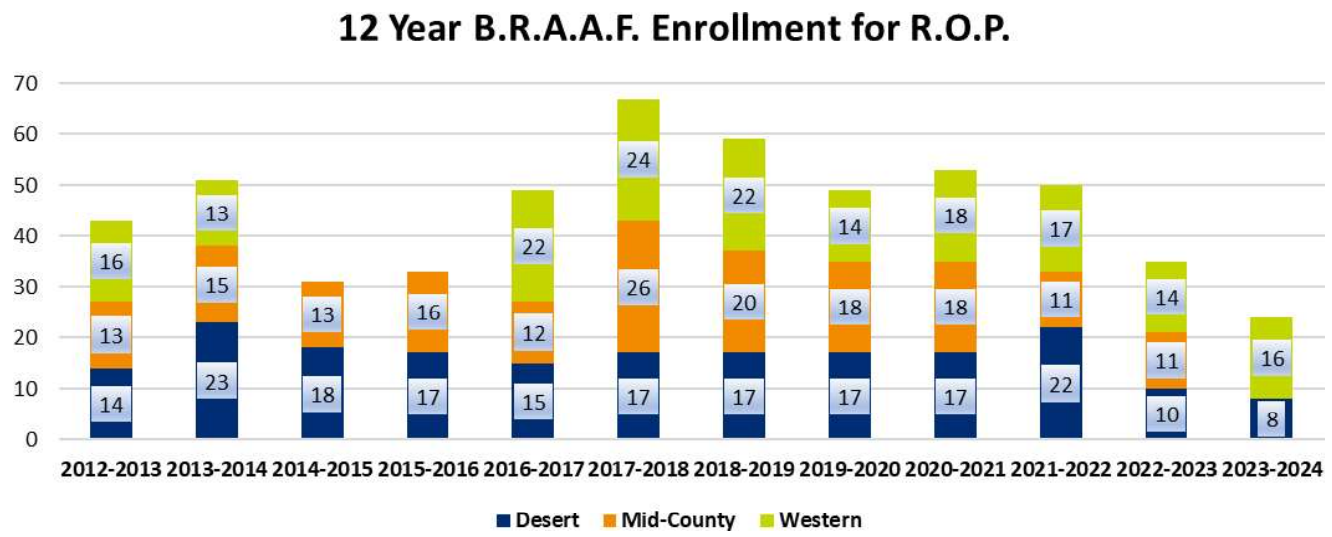
- I learned with the classes and clinicians and learned to set expectations with the boys, I know now that I need to teach them how to do things. This is what I want you to do, this is how I want you to do it, this is the time frame that I want you to do it. Also learned how to set them."
- "I have more patience, when I listen to him, and getting him to understand my point of view. We are getting better."
- Aware in how I react with my son, and better communicate with how things can go differently.
- "How to communicate with my grandson more and not to be judgmental."

Other feedback parents shared either negative or positive:

- "I wanted to see that I could get order in the house and set rules/consequences and how talk to my son better, and control myself and how I treat my son and see his perspective."
- I loved it and that we celebrate these children [on Unity Day] and how we can get together and not have any issues and have a good time. And that's what we need more in the community and wish it was longer and more activities going on.
- During Unity Day, "I liked the games they had for the boys and it was really nice, would like to see more activities for the parents.
- I "would like parents to show up to support groups."
- "The driving hours to the program was an issue."
- " I was told that it was going to be more of a male presence, like a father-brother type, there was really no males in the program, mostly women who still did great though."
- "Be more aware of dates, and schooling different school districts."
- "The communication was off and in the beginning it was not explained much so in the beginning. No list of what is going on through the year."

Conclusion

RUHS-BH PEI is funded through the Mental Health Services Act (MHSA) to provide B.R.A.A.F. throughout Riverside County. B.R.A.A.F. was offered in the Desert and Western region during FY23/24. Sigma Beta Xi was the Western region organization and Family Health & Support Network was the Desert region organization. Program target is 3 boys programs (one per region) with 45 youth completing per year countywide. Below is the enrollment of African American youth who have enrolled and completed B.R.A.A.F. Rites of Passage program over multiple fiscal years:



B.R.A.A.F. changed parenting program curriculum over the course of several fiscal years shifting from Effective Black Parenting (EBP) to Guiding Good Choices (GGC). The goal is for every enrolled family (minimum 45) to complete all 5 sessions of GGC. A total of 19 parents were served in GGC this fiscal year. Below is the enrollment break-down of previous fiscal years for parenting classes:

Parenting Program											
EBP	EBP	EBP	EBP	GGC	GGC	GGC	GGC	GGC	GGC	GGC	GGC
2012-2013 N = 52	2013-2014 N = 41	2014-2015 N = 31	2015-2016 N = 28	2016-2017 N = 66	2017-2018 N = 47	2018-2019 N = 58	2019-2020 N = 45	2020-2021 N = 44	2021-2022 N =55	2022-2023 N= 32	2023-2024 N= 19

B.R.A.A.F. included Parent Support Groups following GGC. Parents had the opportunity to continue meeting with a clinician and other parents from B.R.A.A.F. to talk about parenting styles and general support. All parents were encouraged to attend and share their questions and concerns.

Cognitive Behavioral Therapy has always been a component of B.R.A.A.F. Below is the distribution of enrollment from previous years:

CBT Enrollment											
2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
N = 19	N = 19	N = 0	N = 0	N = 13	N = 23	N = 17	N = 26	N = 28	N= 36	N= 11	N= 16

Riverside University HEALTH SYSTEM Behavioral Health

Building Resilience in African American Families

B.R.A.A.F. GIRLS Program

2023/2024 FY

MHSA Prevention and Early Intervention

Project Overview

What is BRAAF?

Building Resilience in African American Families project (BRAAF) was implemented by Riverside University Health System Behavioral Health, Prevention and Early Intervention (PEI) through funding under the Mental Health Services Act. The primary program goals of this project are to reduce the risk of developing mental health problems and to increase resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. The target population served is African American female youth and their parents/guardians that live in communities with high rates of poverty and community violence. The BRAAF Project utilizes three evidence-based practices: Africentric Youth and Family Rites of Passage Program (ROP), Cognitive-Behavioral Therapy (CBT), and Guiding Good Choices (GGC) in three different Riverside County regions.

Rites of Passage

The Africentric Youth and Family Rites of Passage Program is designed for African American females between ages 11 and 13. The goal of the ROP program is empowerment of black adolescents through a nine-month rites of passage program. The program provides a multi-faceted, prevention based program to youth; a major component of the program is the after school program, held for three hours, three days per week.

Outcome Evaluation

The **Africentric Youth and Family Rites of Passage Program** is a program developed by the MAAT (an ancient Egyptian word meaning an ethical way of life) Center for Human and Organizational Enhancement, Inc. of Washington, D.C. In ROP, data was collected before intervention and 9 months after the intervention was implemented. Topics such as African culture, African proverbs, etiquette, hygiene, and family togetherness were practiced for 9 months and evaluated using the outcome measures below.

Objective	Measures	Measure Targets
Outcomes evaluation focused on resiliency, positive identification with culture, and family Cohesion, as well as peer relations and school climate.	Resiliency Scale for Children and Adolescents	Three scale tool that measures the personal attributes of the child that are critical for resiliency. ROP will focus on Sense of Mastery and Sense of Relatedness.
	The Multidimensional Inventory of Black Identity	Assesses the dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). In this program, only the Centrality subscale was used.
	Multigroup Ethnic Identity Measure	Responses to this instrument reveal the extent to which an individual feels connected to his or her ethnic group
	Family Adaptation and Cohesion Scales III	Measures perceptions of cohesion and flexibility within the participant's family unit.
	Social, Emotional, and Bullying Behavior Survey	This measure covers social and emotional skills, peer relations/bullying behaviors, school climate, and substance abuse.

Executive Summary: Key Findings

Rites of Passage (ROP): Sixteen youth between the ages of 11 and 14 enrolled in the B.R.A.A.F. program during the 2023-2024 fiscal year. Of the 16 youth, 12 completed the B.R.A.A.F. program. The completion goal was 15. Program target is 3 girls programs (one per region) with 45 youth completing per year countywide. This fiscal year the girls program was only available in the Desert region, approximately 96 sessions were conducted, with most attrition occurring in the initial months of the program. Pre-program and post-program assessments indicated that youth had average to very good grades before the program, and these positive academic results were maintained by the program's conclusion.

Resilience measures were completed by 12 participants, demonstrating no statistically significant changes in "sense of mastery" (mean difference of 1.2, $p = 0.758$) or "sense of relatedness" (mean difference of 1.0, $p = 0.779$), both remaining within the "Average" range. Scores from the Multidimensional Inventory of Black Identity (MIBI) reflected a slight increase, indicating that participants ($n = 12$) continued to demonstrate high levels of identity centrality. Additionally, there was no statistically significant difference in scores on the Cohesion subscale from pre- to post-assessment ($t(11) = -1.960$, $p = 0.076$), with scores consistently remaining within the 'separated to connected' range on the subscale. Overall, the average satisfaction score for the youth was 4.2, indicating they were satisfied at the conclusion of the program.

Guiding Good Choices (GGC): A total of 19 parents participated in at least one session of GGC, and 7 parents (37%) completed the five-session parenting course during the 2023-2024 fiscal year. The goal is for every enrolled family (minimum 45) to complete all 5 sessions of GGC. Before and after the course, the parents completed the Alabama Parenting Questionnaire (APQ). The APQ is a 42-item self-reported measure assessing five parenting constructs: parental involvement (10 items), use of positive reinforcement (6 items), poor parental monitoring and supervision (10 items), use of inconsistent discipline (6 items), and corporal punishment (3 items). The results showed a statistically significant decrease in *corporal punishment* and in *other disciplinary practices*, suggesting that parents shifted towards less harsh disciplinary methods. However, across the remaining subscales, no significant changes were observed from pre- to post-assessment. Overall, the parents reported high satisfaction, with an average score of 4.71 after GGC.

Parent Support Groups (PSG): While no satisfaction survey was conducted, qualitative feedback collected from focus groups highlighted a sense of community and support among participating parents from support group sessions.

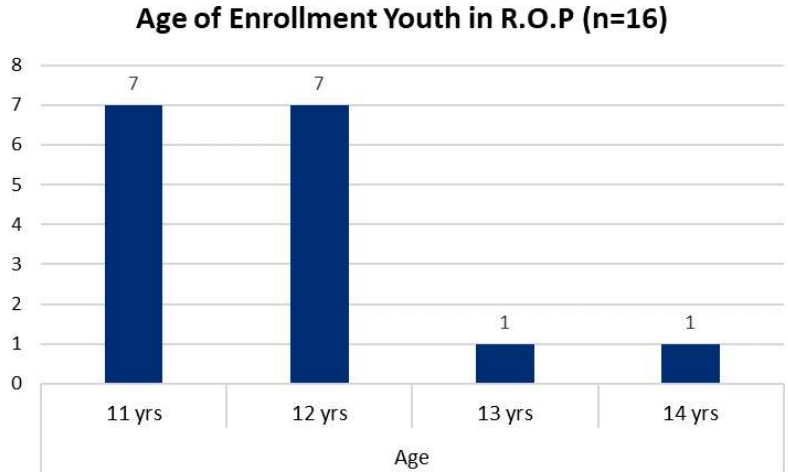
Parent Empowerment Dinner: This monthly meeting focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. The Desert region hosted five dinners throughout the program.

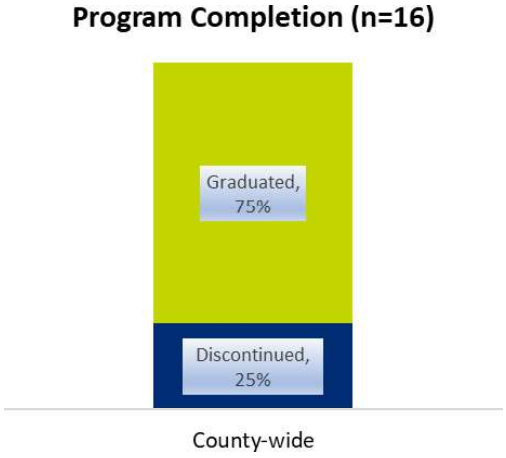
Cognitive Behavioral Therapy (CBT): This fiscal year, CBT was offered as part of B.R.A.A.F., serving 12 youth. These sessions were conducted in person and via video conferencing, depending on the flexibility of the clinician and youth. CBT effectiveness was measured with the Strengths and Difficulties Questionnaire (SDQ) and Children's Depression Inventory-II (CDI-II). Higher scores in the SDQ's four behavioral subscales and total score suggest higher risks of mental health disorders.

Twelve parents of youth served in CBT completed the pre- and post-SDQ survey for their youth. The results indicate a statistically significant change in emotional symptoms, suggesting that the youth improved their behavior even after completing one-on-one CBT sessions. Additionally, there was a statistically significant change in peer relationships. While decreases in depressive symptoms were observed, comparisons of pre- and post-CDI-II scores showed participants remaining within the average range of depression severity.

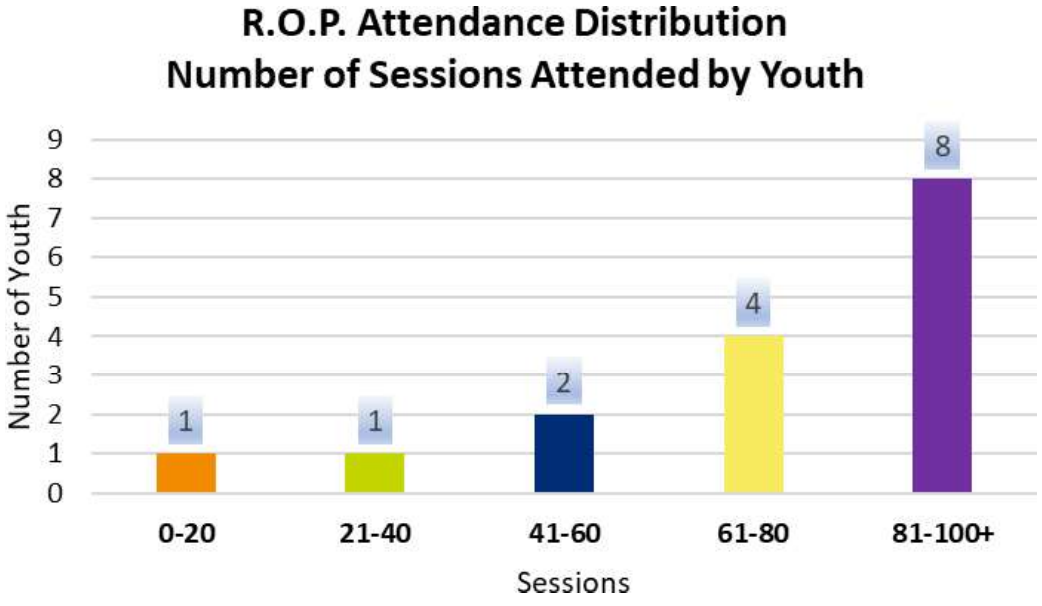
Overall, the average satisfaction score for the youth was 4.25, indicating they were satisfied at the conclusion of CBT.

Program Enrollment





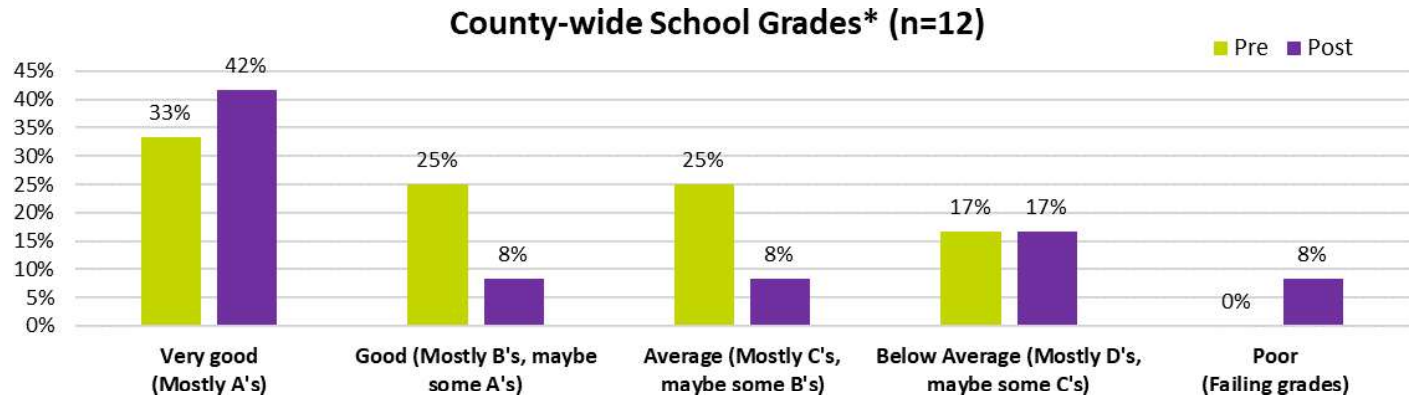
During the 2023-2024 fiscal year, a total of 16 participants aged 11 to 14 engaged in at least one session of the program. Of this group, 12 successfully completed the program. Unfortunately, the reasons for the non-completion were not provided. The goal is to enroll 20-25 youth each year to account for attrition with the goal of graduating a minimum of 15 youth per program/region.



The chart above illustrates the distribution of youth participants who attended various sessions throughout the 9-month program. The target number of session is 108 per year/per program/per region. To note, those who dropped out attended fewer than half of the total sessions offered.

School Information

Countywide Results*	Pre			Post		
	Yes	No	Not Provided	Yes	No	Not Provided
In the last 3 months, has the youth had a sudden drop in school performance?	33%	50%	17%	17%	75%	8%
Has the youth ever been suspended?	0%	100%	0%	3%	75%	0%
In the past year, has the youth been: in contact with law enforcement?	0%	100%	0%	0%	100%	0%
In the past year, has the youth been: on probation?	0%	100%	0%	0%	92%	8%
In the past year, has the youth been in any programs to help them with emotional problems?	8%	92%	0%	8%	92%	0%
In the last year, has the youth exhibited any violent or aggressive behaviors with which their parent or guardian was concerned?	0%	100%	0%	8%	92%	0%
In the last 3 months, has the youth used/experimented with drugs and/or alcohol?	0%	92%	8%	8%	83%	8%
Is the youth affiliated with a gang?	0%	100%	0%	0%	100%	0%

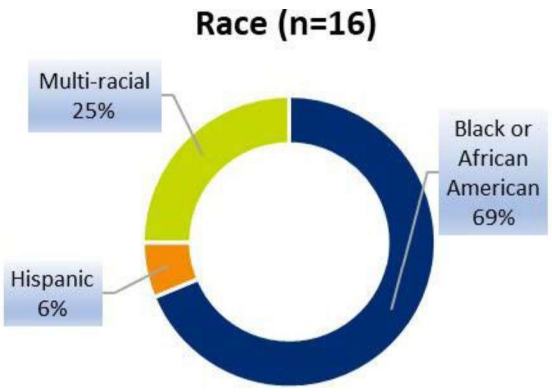


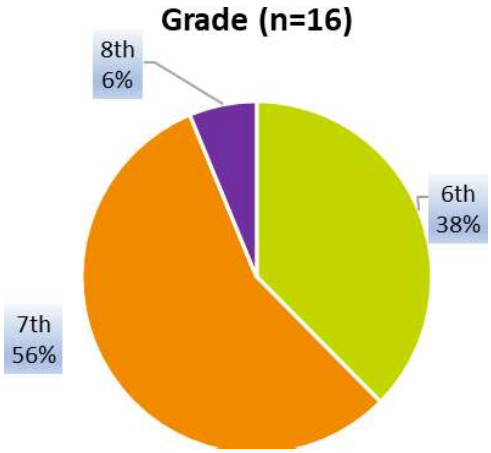
**Regarding school performance, it's important to mention that some items from the youth forms were missing. As a result, the averages calculated for each question were based on data from 12 participants who completed both the ROP Intake Form (pre) and the Program Completion/Discontinued Form (post) for school information.*

Questionnaire Results:
Before the B.R.A.A.F. program (ROP), 33% of parents reported a sudden decline in their daughters' school performance. After the program, this figure decreased to 17%, indicating a positive change. Most responses were consistently "no" to questions regarding suspension, arrest, probation, drug use, and gang affiliation throughout the program.

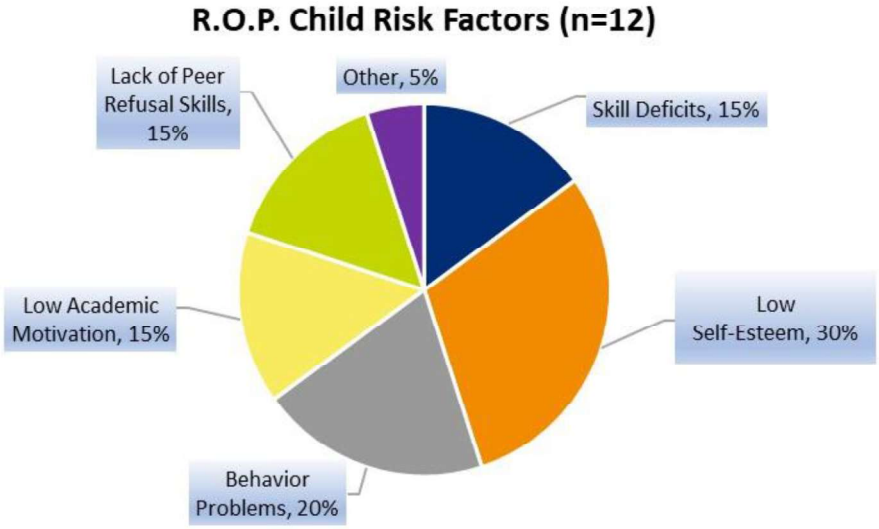
Academic Performance:
The School Performance Chart indicates that youth had average to very good grades before the program, and these positive academic results were maintained throughout the 23-24 fiscal year.

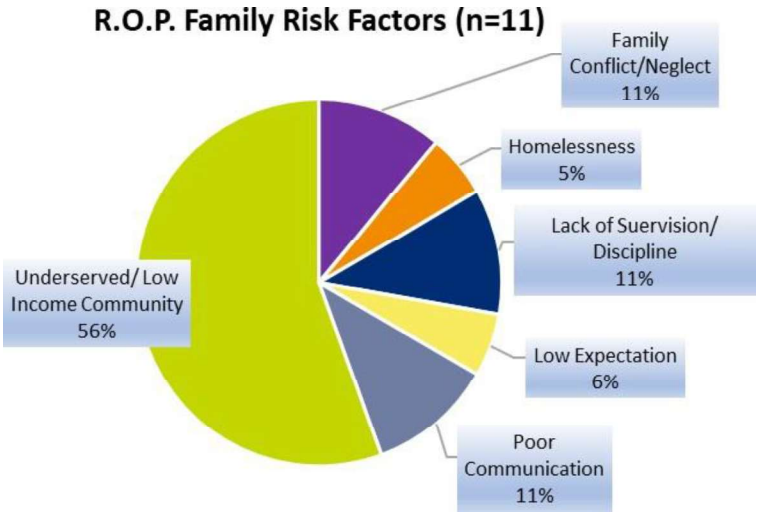
Demographics





It is important to note that 16 youth enrolled, and have attended at least one session. The target enrollment was 25-30 youth.

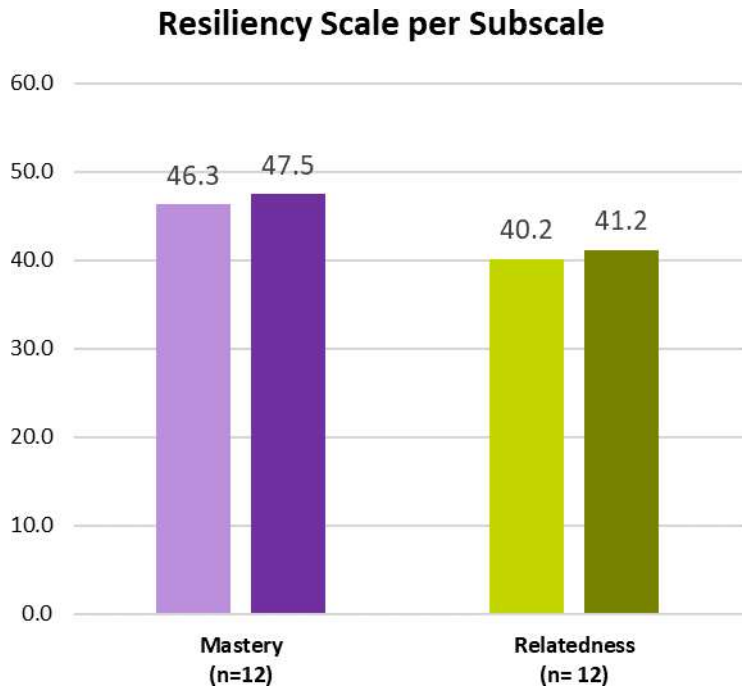




Risk factors are based upon parents/ caretakers that have provided at least one or more responses on the *Family and Child Risk Factors* on the ROP Demographic Form.

Resiliency Scale for Children and Adolescents

The Resiliency Scales for Children and Adolescents is a tool that measures the personal attributes of the child that are critical for resiliency. The measure is composed of two stand-alone global scales, Sense of Mastery having 20 questions and Sense of Relatedness having 24 questions. The Sense of Mastery scale measures the likelihood that the individual will be able to cope with adverse circumstances. The Sense of Relatedness scale measures relationships with others that serve as a buffer against stress. Participants' self reported answers are summed and converted into normalized T-scores. Scores are categorized as 60+ is High; Above average 56-59 ; Average 46-55; Below Average 41-45; and less than 40 is Low.



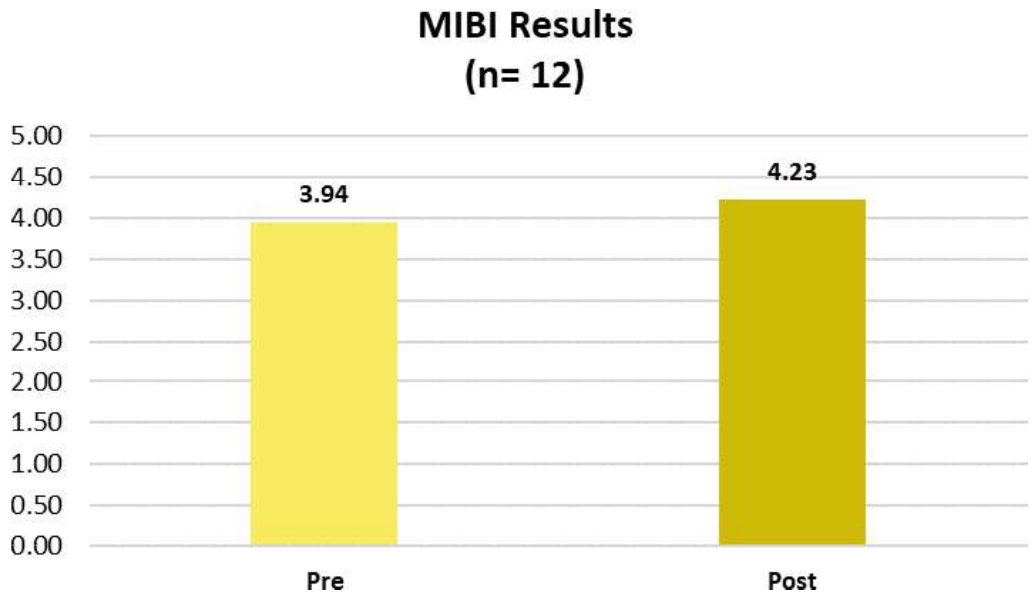
The analysis included 12 participants from the Desert region who completed both the pre- and post-measures of the Resiliency Survey.

Sense of Mastery Scale: The scores on the Sense of Mastery scale increased with a mean difference of 1.2 points. However, this increase was not found to be statistically significant based on the t-test ($t(11) = -0.316$) with a p-value of 0.758. This suggests that there was no significant improvement in participants' Sense of Mastery from pre-measure to post-measure; rather, participants maintained an average ability to cope with adverse circumstances.

Sense of Relatedness Subscale: The Sense of Relatedness subscale showed an increase of 1.0 point, but this change was also not found to be statistically significant ($t(11) = -0.288$, p-value = 0.779, $p < 0.05$). This indicates that there was no statistically significant change in participants' sense of relatedness from pre-measure to post-measure. The scores suggest that participants have a below-average sense of relatedness with others.

The Multidimensional Inventory of Black Identity

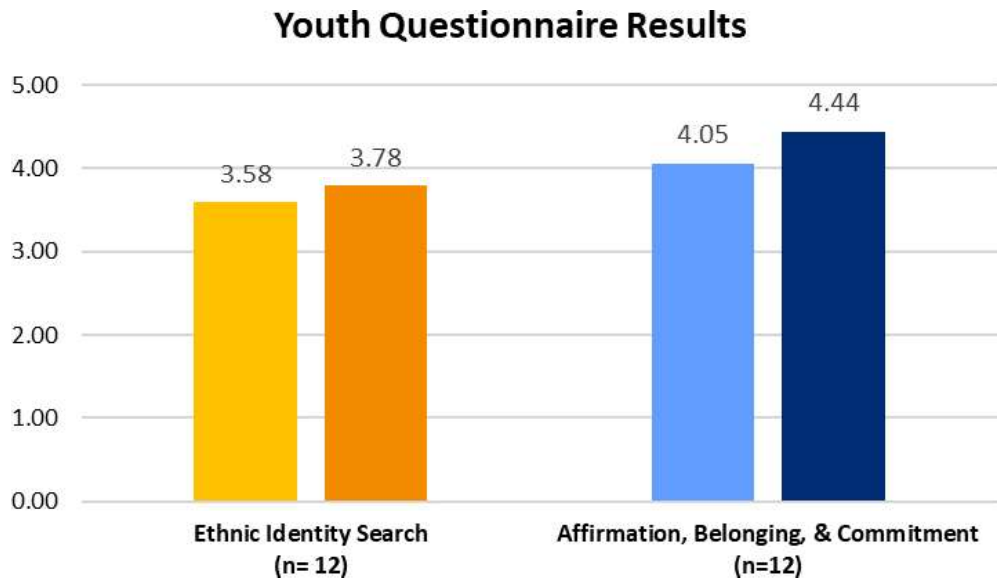
The Multidimensional Inventory of Black Identity (MIBI) measures dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). For the Rites of Passage program only the Centrality subscale was used. The Centrality scale consists of items measuring the extent to which being African American is central to the respondents definition of himself/ herself. The higher the scores on Centrality, the more the respondent views being African American as a central definition of herself. The highest possible average one can score on Centrality is 5.



The Desert region administered the Teen MIBI measure, consisting of 9 items. The total scores averaged 3.94 at the pre-program assessment and 4.23 post-program. However, this change was not found to be statistically significant ($t(10) = -1.738$, $p = 0.113$, $p > 0.05$). In general, participants' scores hovered around 4, indicating a relatively high level of centrality placed on their Black/African American identity.

The Multigroup Ethnic Identity Measure

The Multigroup Ethnic Identity Measure (MEIM) was developed to measure the process of ethnic identity development among adolescents and young adults. It is a valid and reliable survey instrument that is one of the most common measures of ethnic identity. It has two subscales: ethnic identity search and affirming, belonging, and commitment. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). Higher scores indicate higher levels of ethnic identity.



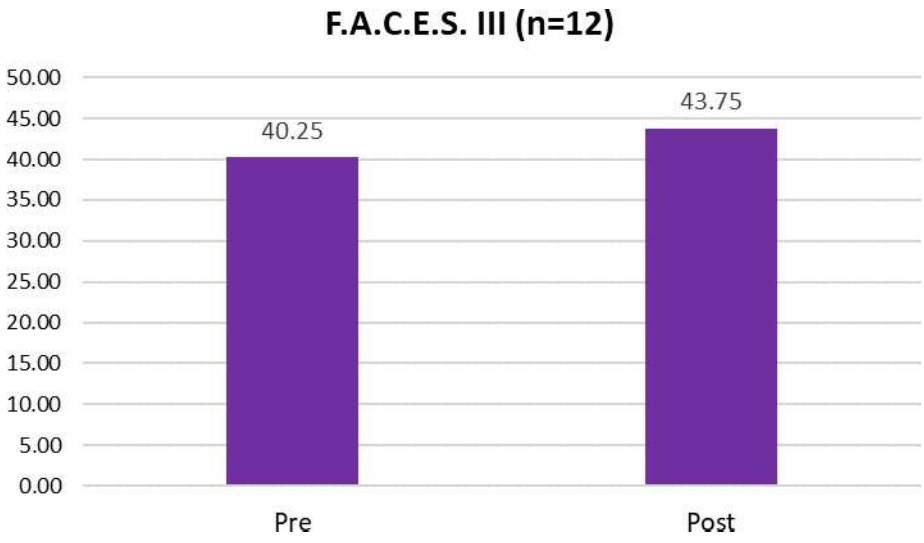
The Desert region showed a slight increase in the Ethnic Identity Search scale of the MEIM measure, with scores rising from 3.58 in the pre-test to 3.78 in the post-test. However, this change did not reach statistical significance ($t(11) = -0.957$, $p = 0.359$).

In contrast, there was an improvement in Affirmation, Belonging, and Commitment. Countywide, participants' scores increased from 4.05 in the pre-test to 4.44 in the post-test ($t(11) = -2.146$, $p = 0.055$). It's worth noting that scores in this subscale were already relatively high at the beginning of the program and remained positive at the conclusion. These findings suggest that youth continued to hold a strong view of their ethnic identity throughout their participation in ROP.

It's important to acknowledge that the sample sizes were limited to participants from the Desert region.

Family Adaptation and Cohesion Scale III

The Family Adaptation and Cohesion Scale III (FACES III) is a self-reported 10 item scale that measures perceptions of cohesion within the family unit. The *Cohesion* subscale measures the strength of family members attachment to one another. The FACES III is completed by a parent, relative, or caregiver. Participants respond via 5 point Likert scale (1 = Almost Never; 5 = Almost Always). Scores are summed for the cohesion subscale. Interpretation of the *Cohesion* subscale is as follows: 10-34, disengaged; 35-40 separated; 41-45 connected; 46-50 involved.



There was no statistically significant difference in scores on the Cohesion subscale from pre to post ($t(11) = -1.960$, $p = 0.076$). Nonetheless, it's worth noting that there was a modest increase in scores from the pre-assessment (40.25) to the post-assessment (43.75).

On average, the scores consistently stayed within the 'separated to connected' range on the subscale, showing slight improvements with no statistical significance.

Youth Satisfaction

Towards the end of the program, 12 youth who completed ROP submitted a satisfaction survey. Overall, youth who completed the satisfaction survey agreed or strongly agreed that participating in the program was a positive experience.

Item Description (Score range: 1—5)	Countywide (N=12)
1 Overall, how satisfied were you with the type of activities in the Africentric Rites of Passage Program?	4.33
2 Since attending the Africentric Rites of Passage program, I feel more involved in school.	3.92
3 Since attending the Africentric Rites of Passage program, I feel I get along better with my teachers	3.50
4 Participating in this program has been a positive experience for me.	4.25
5 Participating in this program has changed how I think about myself in a positive way.	4.50
6 Please rate your satisfaction with how staff, presented the program information in a way I understood.	4.25
7 Rites of Passage staff presented the program information in a way I understood.	4.50
8 Rites of Passage staff presented the program information in a fun way.	4.42
How this program may have affected participants:	
"It made me more confident in myself and my race."	
"I changed me because I used to hate being black and now I'm not."	
"I used to think negative of myself, now I think positive."	
What participants liked about the program:	
"What I did like about the program was the bonding having fun."	
"Everything activities, spending time with different people."	
"When I learned how to set boundaries."	
What participants did not like about the program:	
"Really nothing because the program was great."	

Parent/Caregiver Satisfaction

Overall, 96% of parents were satisfied with the program. Moreover, every single parent indicated their satisfaction with the program's philosophy and approach

	Item Description (Score range:1 - 4)	Desert N=11
1	The program's ability to assist your child with eliminating the problems that prompted enrollment into the program...	3.82
2	Your child's progress/accomplishments/achievements while in the program...	3.82
3	The philosophy and approach of the program...	3.91
4	Opportunities for parents to meet together for support and share information...	4.00
5	Overall Satisfaction...	3.82

What has been most helpful to you and your child?
"The parts of the program that have been most helpful is interactions with my child and communication. We have learned to better communicate and articulate our thoughts and feelings openly without misunderstanding."
"The family group sessions together. I can see that my daughter like/enjoyed the time we spent together while at BRAAF wit the other families."
"Learning about our black history. Gaining confidence and better communication skills. Also new experiences."
What changes can you suggest?
"More counselors."
"To keep the program, families need it parent, and need to know truth about their kids' feelings."
Is there anything else you want us to know?
"Very satisfied with program and all in charge running it. No issues."
"I'm so grateful to have been apart of the BRAAF family. Thankful for how much help I've been giving and proud of the work yall have done and on my daughter. I am very appreciative."

Program Information

What is Guiding Good Choices (GGC)?

The GGC curriculum was developed under the name *Preparing for the Drug-Free Years®* by Dr. David Hawkins and Dr. Richard Catalano of the University of Washington for parents of children in grades four through eight. With GGC, parents learn specific strategies for promoting healthy behaviors in children and reducing risks that predict adolescent health and behavior problems.

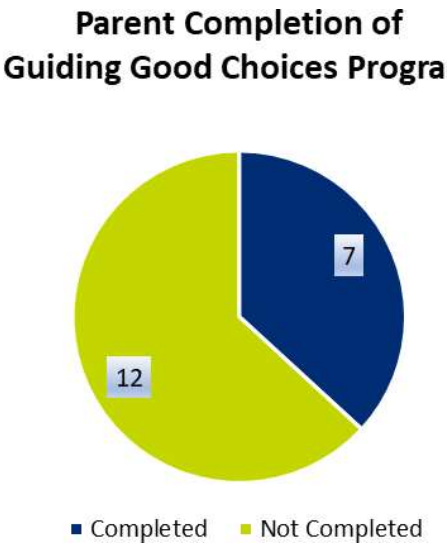
Children are exposed to risks in their schools and communities, and sometimes in their families and with peers. Some children start using alcohol, tobacco or other drugs. Some drop out of school, have sex (and risk pregnancy), or become involved in delinquency or violence. Others, while exposed to similar risks, do not develop these adolescent heath and behavior problems because they are protected by factors like strong family bonds and healthy beliefs and clear standards for behavior.

In GGC, parents learned how to strengthen family bonds, set a clear family position on drugs, teach children skills they will need to make healthy choices, and increase children's involvement in the family. GGC was offered once a week for five weeks in the month of September. To congratulate the parents on their accomplishments, a small ceremony and certificate is presented to acknowledge their participation. The five sessions are as following:

1. Getting Started: How to Prevent Drug Use in Your Family
2. Setting Guidelines: How to Develop Healthy Beliefs and Clear Standards
3. Avoiding Trouble: How to Say No to Drugs
4. Managing Conflict: How to Control and Express Your Anger Constructively
5. Involving Everyone: How to Strengthen Family Bonds

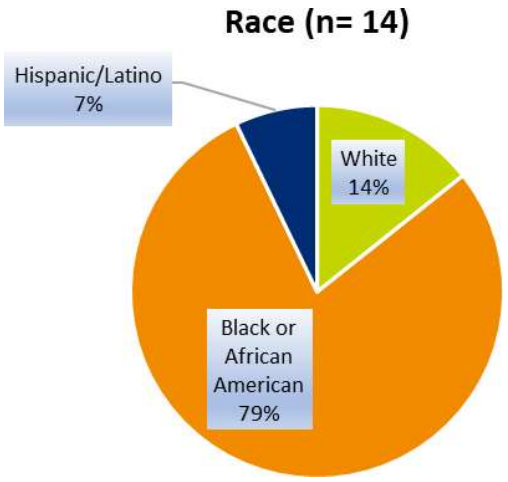
GGC Program Completion

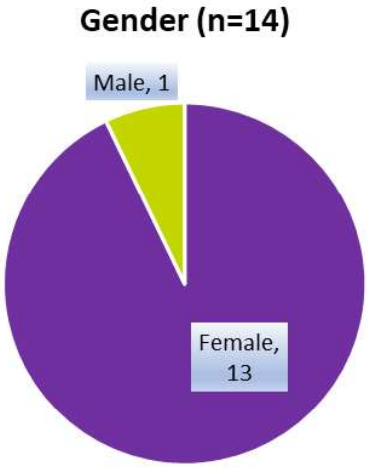
At least one parent of the child enrolled in ROP was required to complete all five sessions of GGC.

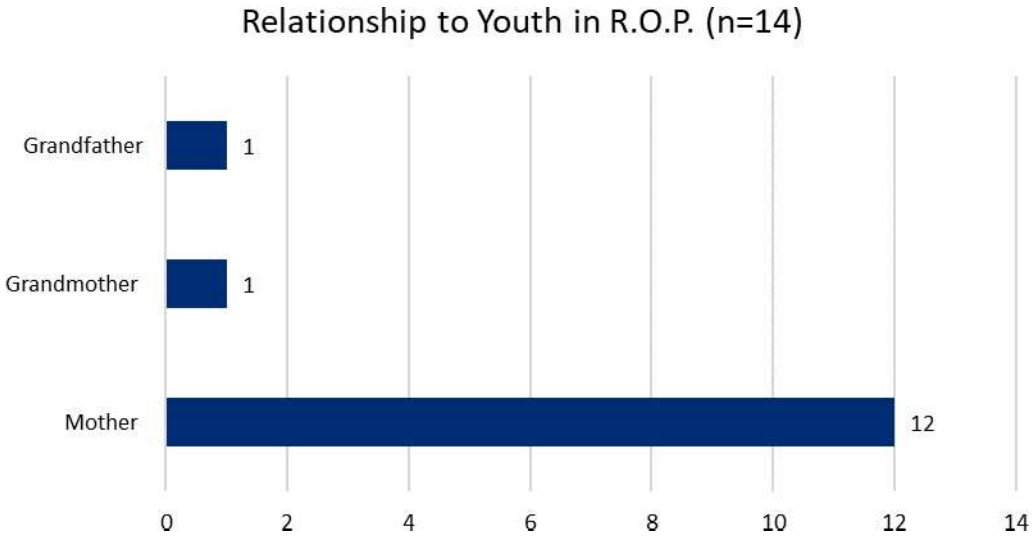


19 parents attended at least one session of GGC and 7 parents (37% of the cohort) completed the program in 2023-2024 FY.

GGC Demographics



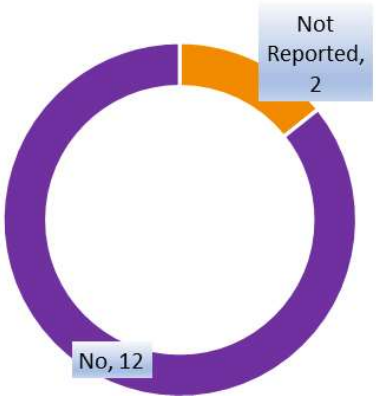




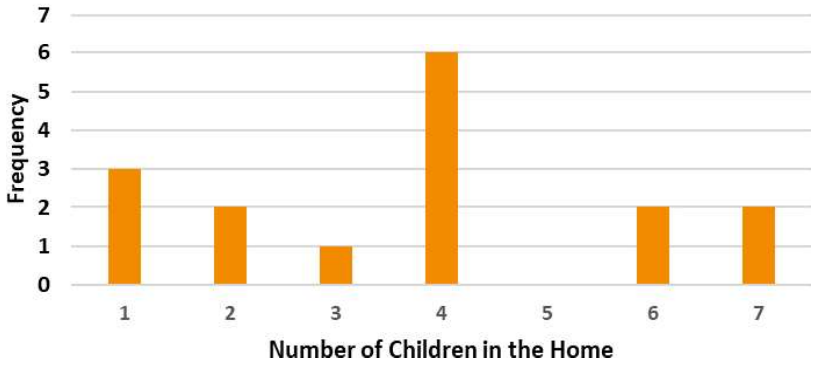
The charts above are representative of 14 parents who completed GGC Demographic form prior to the 5-week program. Based on the self-reported data, 79% of the participants identified as African American, 7% as Hispanic, and 14% as White . The gender distribution showed a ratio of approximately 1 male to 13 female. Among the GGC cohort, mothers constituted the largest group (n=12), followed by grandparents (n=2).

GGC Demographics Cont.

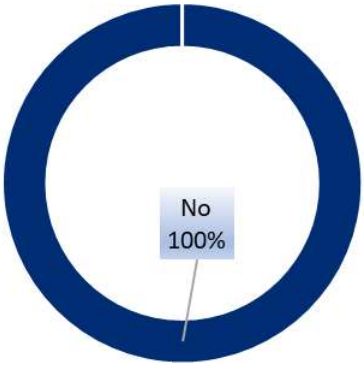
Disabling Condition? (n= 14)



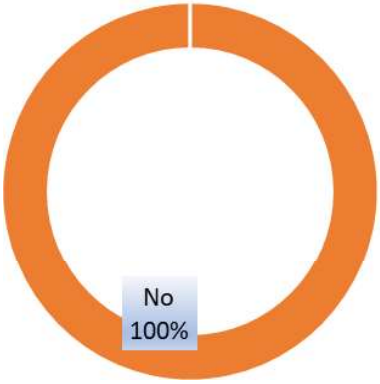
# of Children per Household (n= 14)



Child Actively Uses Substances? (n= 14)



Are you a Veteran? (n=14)

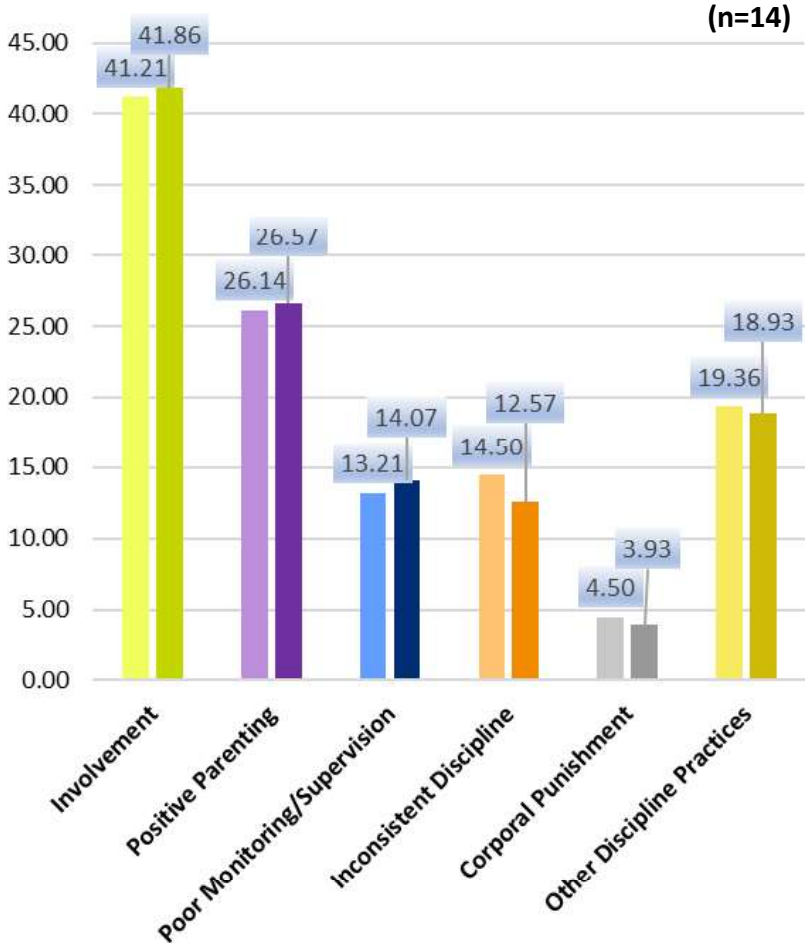


The majority of respondents answered 'no' (85%), while 15% did not provide a response. Notably, all children were reported by their parents as not actively using substances. Among the 14 enrolled parents who shared the number of children in their households, the average reported was four children per household.

Alabama Parenting Questionnaire

Past research has shown that increasing positive parenting practices while decreasing negative parenting practices have been effective in reducing problem behaviors in children at least 4 years old. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. The APQ is a 42-item parent self-report measure assessing five parenting constructs: parental involvement (10 items), use of positive reinforcement (6 items), poor parental monitoring and supervision (10 items), use of inconsistent discipline (6 items), and corporal punishment (3 items). The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale from 1 (*never*) to 5 (*always*).

Alabama Parenting Questionnaire Countywide Results (n=14)



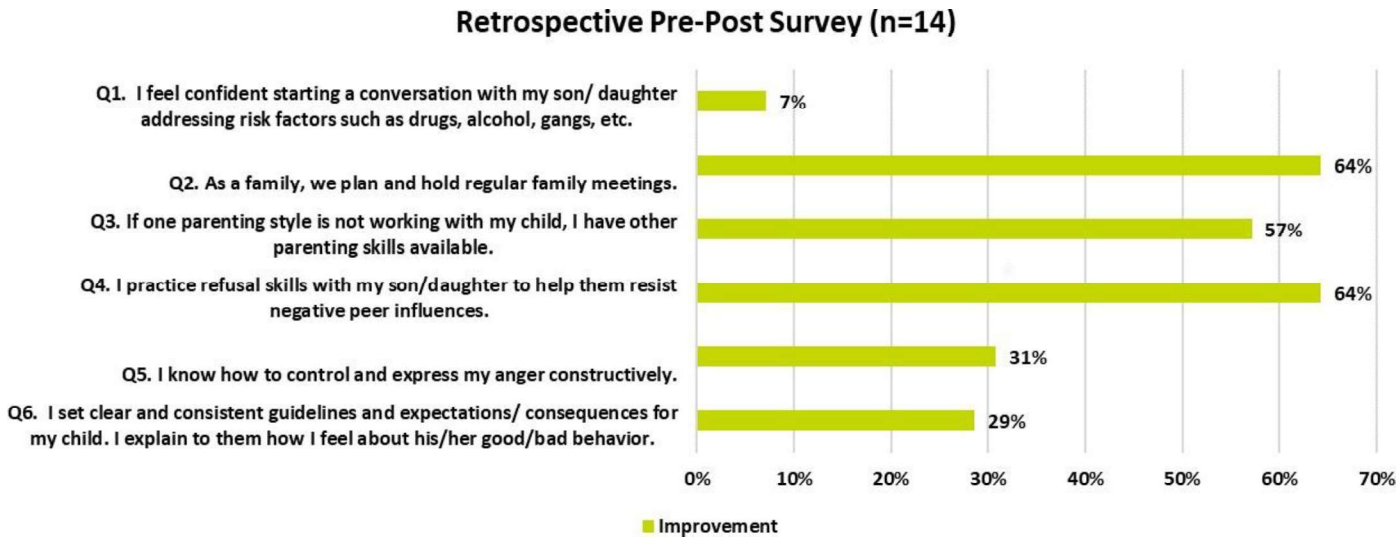
Fourteen parents/caregivers completed a pre and post APQ. To demonstrate improvement across the six scales, post-assessment scores for **involvement, positive parenting, and other discipline practices** should be higher than the pre-assessment scores, indicating improvements in these positive parenting behaviors. However, **poor monitoring/supervision, inconsistent discipline, and corporal punishment**, would reflect a decrease in agreement with the "poor parenting" items, signaling better parenting practices.

The results showed a **statistically significant decrease** in corporal punishment (t(14) =.591, p= .026) and in other **discipline practices** (t(14) =.607, p=0.021), suggesting that parents shifted towards less harsh disciplinary methods. However, across the remaining subscales, no significant changes were observed from pre– to post-assessment. These findings suggest that parents have altered their disciplinary methods, as reflected in the decrease in corporal punishment.

		Involvement	Positive Parenting	Poor Monitoring/ Supervision	Inconsistent Discipline	Corporal Punishment	Other Discipline Practices
		Mean	Mean	Mean	Mean	Mean	Mean
Desert	Pre	41.21	26.14	13.21	14.50	4.50	19.36
	Post	41.86	26.57	14.07	12.57	3.93	18.93

Satisfaction Survey

A satisfaction survey is administered at the conclusion of the GGC program. The first six questions are retrospective pre and post, and the following 12 (on the next page) are post scores only. Results are provided in the following tables. Participants' comments are also included on the satisfaction survey. Overall, participants indicated that they were satisfied with course instructors and the effectiveness of GGC classes.



Likert scale breakdown: 1=strongly disagree, 2=disagree 3=neutral, 4=agree, 5=strongly agree

Question	Retro-Pre	Post	P-value	Question	Retro-Pre	Post	P-value
Q1	4.86	4.79	p>0.05	Q4	3.00	4.36	p<0.05
Q2	3.07	4.21	p<0.05	Q5	3.46	3.69	p>0.05
Q3	3.64	4.36	p>0.05	Q6	3.93	4.43	p>0.05

For the retrospective pre-to-post survey, parents in the GGC responded to a series of six questions following the completion of the five-session program. Fourteen parents assessed the changes in their parenting skills, comparing their abilities at the program's conclusion to those before joining GGC.

Based on the results, parents increased the most (64% increase) in the adjustments towards parenting practices. Parents showed significant overall improvement after GGC regarding the following items: meeting regularly as a family and setting refusal skills with their child. It's worth noting that parents who did not experience improvement initially had high scores in the pre-assessment.

Satisfaction Survey

Item Description (Score range:1 - 5)	Countywide N=14
1. Overall, I am satisfied with the program.	4.71
2. The location of the program was convenient for me.	4.79
3. The sessions were at a time convenient for me and my family.	4.79
4. My family got the help we wanted for my child.	4.43
5. As a result of the program, I am satisfied with our family life right now.	4.50
6. I felt comfortable talking about my child's program with the staff.	4.86
7. The facilitators listened to what I had to say.	4.92
8. The facilitators spoke to me in a way that I understood.	5.00
9. The facilitators are respectful of me and my cultural/ethnic background	4.94

Things I learned in the GGC program are:
"To let her have more of a voice."
"How to better open/start conversations in different ways."
"How to communicate, efficiently with children."
What I liked about the GGC program is:
"Being able to come together as adults and learning new skills. See different perspective."
"The community coming together to help raise our children in a better manner and on to the right path."
"Opened eyes to more parenting styles, more family meeting ideas."
What I didn't like about the GGC program is:
"The drive, transportation difficulties."

Parent Support Groups

Once Guiding Good Choices parenting classes ended, the parents were encouraged to attend weekly parent support groups. These groups were designed to be an open space where the parents can share parenting skills and seek advice on how to overcome family difficulties in raising a teenage child. Topics discussed included drugs, lying, bullying, weapons, etc. Every week the parents were called and invited to attend the support group. By the end of BRAAF, parents had a strong bond together and many plan to continue meeting with their support group.

	Total Number of Sessions Hosted	Group Size Range
Desert	3 Sessions	6-8 People

Empowerment Dinners

The B.R.A.A.F. program's Parent Empowerment Dinner is a monthly meeting that focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. Discussions on resources, strategies for empowerment, and ways to enhance the parent-child relationship further enrich the experience. Overall, these gatherings are essential for building a supportive community and maximizing the program's impact. Each program/region should host 9 empowerment dinners per year.

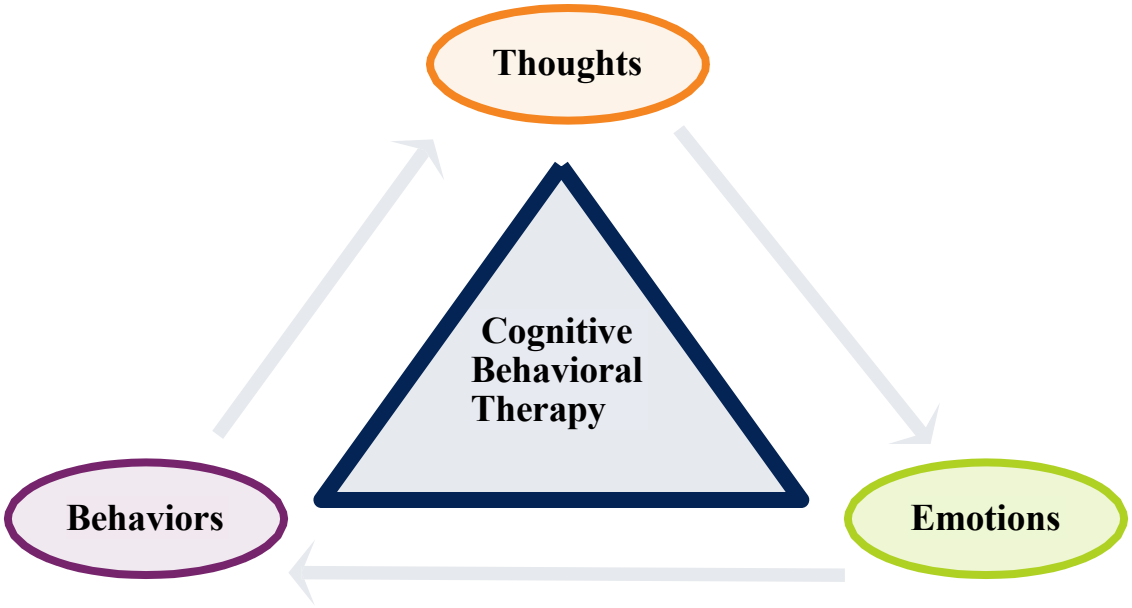
	Total Number of Sessions Hosted	Group Size Range
Desert	5 Session	1—10 People

Cognitive Behavioral Therapy

Cognitive –Behavioral therapy is designed for the youth in ROP who need further assistance with behavioral issues, anger control, depression, and other behavioral management concerns. Clinical therapists structure one-on-one therapy with the youth to address their behavioral concerns. Not everyone enrolled in CBT has a behavioral health condition warranting this type of intervention. It can be an effective tool to help those youth with behavioral concerns learn how to better manage their behavior and stressful life situations.

CBT can explore painful feelings, emotions, and experiences, where the youth may feel emotionally uncomfortable at times. The youth may cry, get upset or feel angry during a challenging session. Some forms of CBT, such as exposure therapy, may require the youth to confront situations they'd rather avoid. This can lead to temporary stress or anxiety. However, working with a skilled therapist minimizes any risks. The coping skills the youth learns in CBT will help them to manage and conquer negative feelings and fears.

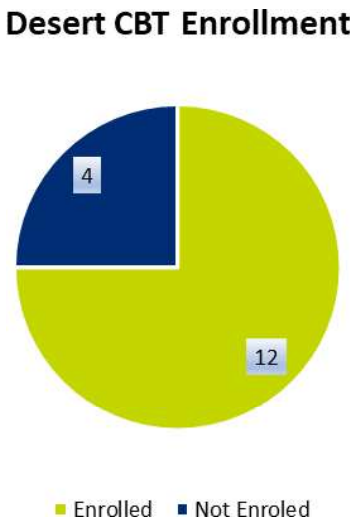
www.mayoclinic.com/cbt



Outcome Evaluation

Children's Depression Inventory (CDI-II)	A self-report assessment that measures the severity of depression symptoms among youth. The measure includes five components of depression: Negative Self Esteem, Negative Mood, Anhedonia, Ineffectiveness, and Interpersonal Problems.
Strength and Difficulties Questionnaire (SDQ)	A parent completed measure, where they are asked to assess the positive and negative psychological attributes about their children/students enrolled in the program. Consisting of 25 Likert Scale items assessing the client's behavior over the previous month.

Number of Youth Enrolled in CBT

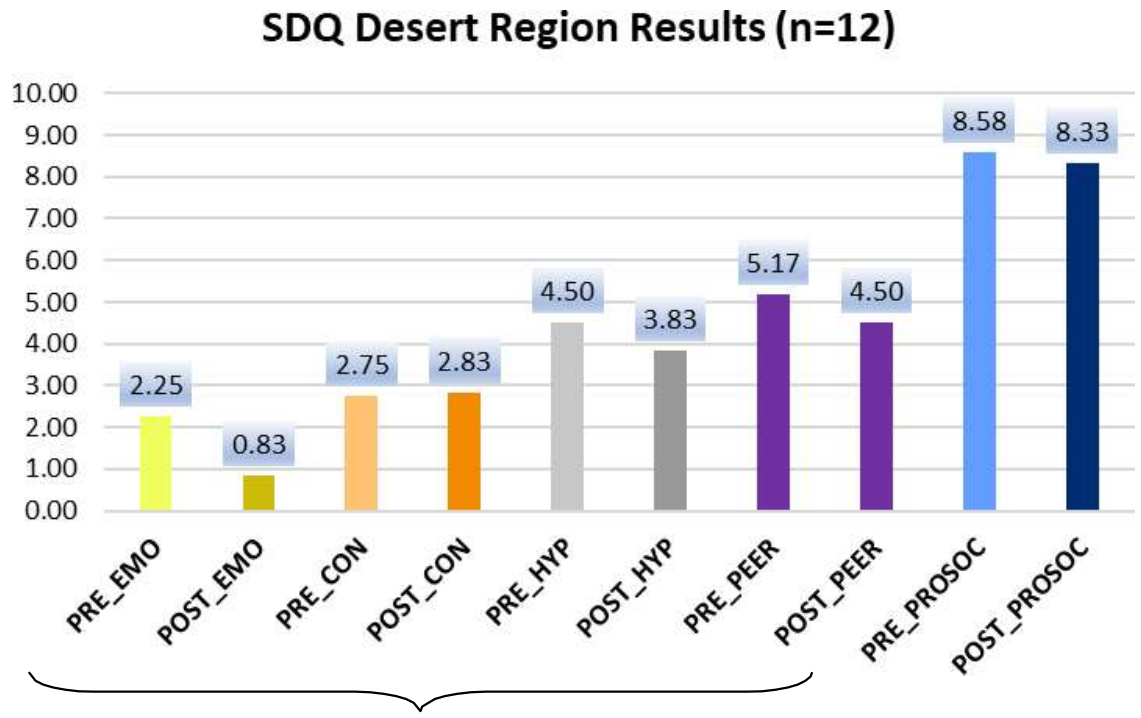


	Average CBT Sessions per Region
Desert	8 Sessions

This fiscal year, CBT was offered as part of B.R.A.A.F., benefiting 12 participants in the Desert region who each received at least one CBT therapy service. On average, participants from the Desert region attended 8 CBT therapy sessions. These sessions were conducted in-person and via video-conferencing, depending on the flexibility of the clinician and youth.

Strength and Difficulties Questionnaire

The Strength and Difficulties Questionnaire (SDQ) is used to screen for both positive and negative psychological attributes among program participants. There are multiple versions of the SDQ measure. This program used the SDQ Parent Version, for adolescents between 11 and 17 years of age. The SDQ emphasizes both strengths (pro-social behavior) as well as behavioral difficulties, and it can be used both as an assessment and as a program evaluation tool. The SDQ is completed by parents at the beginning and at the conclusion of the program, in order to measure the change in participants' behavior problems over time. Higher scores on the four behavioral subscales: emotional symptoms, conduct issues, hyperactivity/ inattention, and peer relationship problems, suggest a higher incidence of negative psychological attributes. There is also a Pro-Social scale which is an independent scale from the other four, and higher scores suggest greater pro-social behaviors. The total score was calculated by summing the averages of the emotion, conduct, hyperactivity, and peer problems subscales.



Total Score: Pre=14.67, Post=12.00

A total of twelve youth who completed both pre and post assessments were included in the analysis. The primary expectation was a decrease in average scores across the four behavioral subscales (emotional symptoms, conduct problems, hyperactivity/inattention, and peer relationship problems) from their intake assessment to their post-CBT assessment, with an anticipated increase in the pro-social subscale.

The results indicate a statistically significant change in **emotional symptoms** ($t(11) = 3.742$, $p = 0.003$, $p < 0.05$), suggesting that the youth improved their behavior after completing one-on-one CBT sessions. Additionally, there was a statistically significant change in **peer relationships** ($t(11) = .442$, $p=.005$, $p<0.05$).

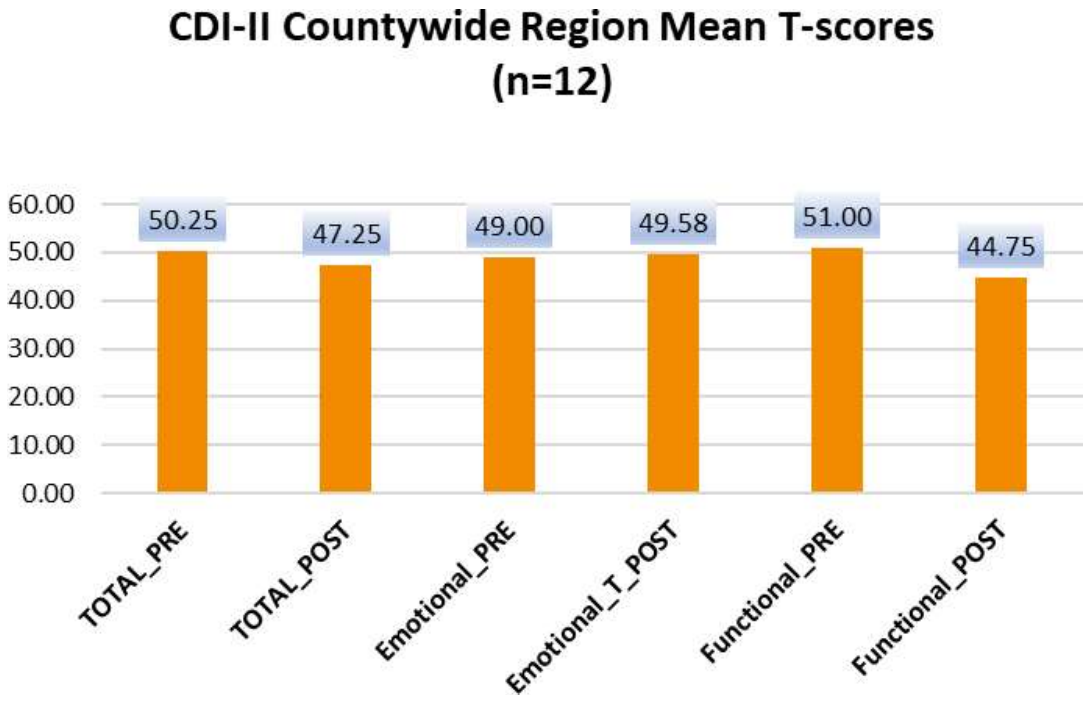
Although there were observed changes in other areas, these changes were not significant. Overall, the program had a notable impact on the participants' emotional well-being and peer interactions.

Children Depression Inventory II (CDI II)

The Children's Depression Inventory (CDI-II) is used to measure the severity of depressive symptoms in children. The participants complete this self-reported survey before and after CBT. The CDI-II is a 28-item questionnaire with four initial subscales: Negative Mood, Negative Self-esteem, Ineffectiveness, and Interpersonal Problems. During scoring, subscales are combined to create two additional subscales using the following steps:

- Negative Mood + Negative Self-Esteem = Emotional Problems
- Ineffectiveness + Interpersonal Problems = Functional Problems
- Emotional Problem + Functional Problems = Total Score

Each item in the survey has three different descriptors in which the participants select the description that best matches their feelings. Higher scores (70 and above) suggest higher levels of depression for all subscales and the total score. Whereas, scores 59 and lower are considered average or below average. A paired-samples t-test is utilized to assess the significant differences between the pre and post test scores.



Out of the 12 youth who received CBT services, they were asked to complete both the pre and post CDI-II assessments. For this fiscal year, when comparing the scores from CDI-II, there was no statistically significant change in Emotional behavior. On the another hand, there was a significant decrease in Functional Problems area (p<.05). It's important to note that the small sample size may have limited our ability to detect significant improvements resulting from the CBT sessions.

Satisfaction Survey

Satisfaction surveys data of individuals who completed at least 1 sessions were utilized for the following table.

Item Description (Score range: 1—5)	Desert Region N= 13
1 The program taught me how to cope with stress.	4.1
2 The program helped me to understand myself better.	4.5
3 The program has prepared me to cope with stress if something difficult happens to me in the future.	4.0
4 I achieved my goals for the group.	4.3
5 The facilitator listened to what I had to say.	4.3
6 The facilitator knew how to help me.	4.3
Things I learned in the program are:	
"What I learned was how to calm down."	
"I learned how to set boundaries and how to pick the right group of people."	
"That to talk it out with them and that I could do better and I am enough."	
What I liked about the program is:	
"That it cheers me how to be and how I am changing myself and that when I save something it will be funny or that it will be just to talk it out."	
"What I liked was we would always take a minute to breath and relax."	
"I can state how I felt in that moment and how I feel now."	
What I didn't like about the program is:	
"Sometimes it was a short session."	

Focus Groups

Focus groups are used in qualitative research to collect data by conducting a form of group interviews that focuses on communication from participants in the program. Focus groups can reach a depth and dimension that quantitative tools such as questionnaires or surveys can miss. Through analyzing responses, evaluations staff can identify shared and common knowledge which allows culturally sensitive topics to be discussed in a safe environment. Participants often provide mutual support in expressing feelings and help the more shy members to open up. The focus group session may last 30 minutes to an hour and consist of a RUHS-BH program staff to help lead the discussion and multiple evaluation staff as note takers.

Purpose and Objectives:

The Prevention and Early Intervention team evaluated the Africentric Rites of Passage programs throughout Riverside County. The goal of the focus group was to gather participant feedback regarding the program. The feedback will be utilized to inform implementation and make adjustments where necessary and feasible for this program.

Data Collection:

Qualitative data was collected from the youth participants who had completed the 9 month ROP program in BRAAF, as well as the parents who actively attended empowerment dinners and parenting classes. The youth and parent focus groups were conducted at the site where their weekly sessions took place.

The youth focus groups and parent focus groups were conducted separately, and were designed to last approximately 30 minutes each. There were seven predetermined questions youth were asked to answer and seven predetermined questions for the parents to answer. There was one group facilitator and one scribe recording comments.

The following focus groups were conducted for Desert region. The focus groups were conducted in-person.

Youth Focus Groups
Questions and Analysis

Focus Group Questions:

The following questions were asked during each **youth** focus group:

1. *Think about something difficult that you have had to deal with in the past year. (Pause to think). How has the program helped you with that difficulty? If you have used any of the program's principles, could you explain that?*

2. *What did you learn in this ROP program that has help you get along better with your family at home? Did you notice a change in your parents?*

3. *How has the program changed how you feel about yourself and your own culture?*

4. *Do you think you have changed in any way after going through this program? In what way (s)?*

5. *What about this program will you remember the most? Was there anything in BRAAF that you disliked or did not meet expectations?*

Focus Group Analysis:

Both youth and parent questions did not have correct or incorrect answers. The responses were analyzed to find themes that were reoccurring across participants.



Youth Focus Groups

The girls' responses to the focus group questions are loosely organized in the following themes and include some quotes of the girls responses.

Youth expressed positive changes in themselves:

- "A difficulty in school, in volleyball, it helped be more mindful of my teammates."
- "BRAAF taught me to stop before responding to other people."
- "I had problems with boundaries and BRAAF helped me with that."
- "BRAAF helped me with my grades, in school, [staff] helped me figure that out."
- "BRAAF helped me to let things go and not care about it."
- "I used to let people define me, now I don't let that be the case."
- "I learn to take responsibility and to work with others in a team."
- One of the seven principles of Kwanzaa that helped me was "Imani because I believe more in myself, and I feel more accomplished."

Changes in how youth felt about their culture:

- "The program has helped me feel more confident in myself and that we are all Kings and Queens."
- "The program has helped me change the way I feel about culture, we didn't just come from slavery. We were Kings and Queens."
- "People don't know about African American culture, we are inventors."
- "They taught us about code-switching during one of the sessions."

Youth explained changes and additional comment about the BRAAF program:

- "I think that my attitude and my way of thinking changed."
- "To stand up for myself and to communicate what I need."
- " I did not like the lessons."
- "I will remember the most is the [staff]."
- "I liked the outings and the games we played."
- "I will remember the sisters in the program."
- "I will remember the trips."
- "I will remember how we can be friends and respect others."

Parent Focus Groups
Questions and Analysis

Focus Group Questions:

The following questions were asked during each **parent** focus group:

1. *Can you tell us your favorite activity to do as a family?*

2. *Based on what you learned and practiced during the five Guiding Good Choices classes: How has your relationship with your son in ROP changed?*

3. *Do you think your child has changed in any way by going through this BRAAF program? If yes, in what way?*

4. *For those who attended the parent support groups, what did you value and benefit from the group?*

5. *Is there any other feedback you would like to share, both positive and negative?*

Focus Group Analysis:

Both youth and parent questions did not have correct or incorrect answers. The responses were analyzed to find themes that were reoccurring across participants. Groups shared different experiences but all participants were asked the exact same questions by the same facilitator to reduce moderator bias.



Comments/Feedback made by Parents during Focus Groups:

Parents noted that their daughter became more confident and communicative. Many parents noted their daughters grew to be more mature and changed their behavior:

- "This program, instilled confidence in her, she has learned how to make friends and more confidence in socializing and communication in how she feels. BRAAF helped her focus on specific things, BRAAF help her achieve more and seek more. It helped her influence on the world and mindfulness. The meetings and parent support groups, BRAAF is a great program for us."
- This program helped my daughter to be "aware of their feelings and what's going on and a open line of communication."
- "The BRAAF staff did their best in teaching our children, and their availability."
- "The scheduling is hard, more parent involvement, help with staff more so that the staff continue doing most of the work."
- "My daughter's confidence, I see it more with people, outcoming of her shell more, doing a lot better. She is more confidence, speaking up for her beliefs and her opinions of things and dealing with others."
- "Two children did BRAAF, did a great job at engaging and accommodate for each cluster of children. Each of boys and girls, matched the program to the child. The topic definitely fit for my daughters each time. I think they did a great job with that."
- "I valued other parents in the same schools and grade , going to the same things, hearing others ideas and other ways to solve problems. Cause I'm working I am not around other parents so now in the groups- I learned from others.

MHSA Prevention and Early Intervention
Celebrating Families: Strengthening the Circle

Annual Outcomes Report
FY 2023-2024

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Executive Summary

Wellbriety Celebrating Families (WCF)

During the fiscal year 2023-2024, there were a total of 37 eligible parent participants enrolled in the WCF program. A total of 7 WCF class cycles were completed Countywide: Mid-County (21 families enrolled), Western (8 families enrolled), and Desert (8 families enrolled). Of these, 23 participants completed the WCF Program (62.2% completion rate); however, only 12 matched/completed pre-post measures were submitted and analyzed. In this outcomes report, the demographic data analysis is based on the 37 enrolled participants, while the measures analysis is based on the 12 completed pre-post data.

The majority of parent participants were Female (73%), between 30 years old and 39 years old (32.4%), and did not identify as LGBTQI (81.1%). Most enrolled participants (81.1%) identified themselves as American Indian/Alaskan Native with 13 different tribes represented in the WCF program, while the remaining participants (18.9%) reported Multiracial with American Indian/Alaskan Native. All participants (100%) indicated that their preferred language is English, and that they were not Veterans. The majority of parent participants indicated that they did not have any disabling condition (83.8%). Most of the parent participants also indicated that they have at least 1 child in the "0 to 15 years" age range, as well as 1 child in the "16 to 25 years" age range.

A total of 12 pre-post matched pairs were completed by WCF parent participants for the Alabama Parenting Questionnaire (APQ) measure. The **Parenting Involvement** scale showed a 6.6% increase, and the **Positive Parenting** scale showed a 5.4% increase. On the Guiding Good Choices Total Scores, it was shown that there was an increase of 2.58 points (a 3.3% increase) in the average scores from pre-to post-measures. However, due to the small sample size, these results could not be analyzed for statistical significance.

A total of 12 pre-post matched pairs were completed by WCF parent participants for the **Guiding Good Choices** (GGC) and **Family Strength/Resilience Scale** (FSRS) measure. For the GGC measure, there was a minor increase of 1.8% on the average Total Scores from 49.67 to 50.58 (0.92 points), from pre-to-post measures. For the FSRS measure, the average Total Scores increased 7.5% from 47 to 50.83 (3.83 points), from pre-to-post measures. However, due to the small sample size, these results could not be analyzed for statistical significance.

A total of 12 pre-post matched pairs were completed by WCF parent participants for the **Opinions Survey**, where increases are expected across all items except for Item# 9 (which explored Alcohol/Chemical Dependency topic). Overall, analysis from pre-to-post measures showed increases (i.e. more parent participants chose "Yes", "Always", or "Agreed/Strongly Agreed" to the statements) across all items.

Overall, the **Post-Satisfaction Survey** analysis from 12 participants showed high satisfaction (i.e. responded to either "Satisfied" or "Very Satisfied") with the WCF program (91.7%) and the group leaders (91.7%). The majority also responded that they thought the WCF program has "Somewhat" or "Very Much" helped their families, and 100% responded "Yes", that they would recommend the WCF program to other families.

Cognitive-Based Therapy (CBT)

There was no CBT activity completed for the fiscal year 2023-2024, due to less interest from clients, employee turnover, as well as the lack of a clinician who could be solely assigned for this program from the contracted organization.

Gathering of Native Americans (GONA)

A total of 1 GONA event was completed for the fiscal year 2023-2024, with a total of 89 attendees conducted at Noli Indian High School on May 13th, 2024. From this event, a total of 64 post-GONA satisfaction surveys were submitted by attendees. Overall, the survey analysis showed highly positive results from all parent participants. Additionally, a total of 21 Facilitator Debrief Surveys were collected from the GONA event, and

those surveys also showed positive feedback from the facilitators about the events.

Program Goals

The primary goals of the "Celebrating Families: Strengthening the Circle" program are to increase positive family interactions, decrease risk of future substance abuse, and to foster the connection to culture in order to prevent the development of behavioral health challenges for the Native American/American Indian population in Riverside County who are highest at risk. The setting for service delivery would not be traditional mental health settings, and would assist participants in feeling comfortable seeking services from staff that are knowledgeable and capable of identifying needs and solutions for Native American/American Indian families. The contractor for this program is Riverside-San Bernardino County Indian Health, Inc. (RSBCIHI), which is expected to utilize targeted outreach to engage the Native American/American Indian community by working within the community and collaborating with the Tribal Temporary Assistance for Needy Families (TANFs), tribal organizations, tribal leaders, tribal elders, schools, community organizations, non-profit organizations, faith-based organizations, and other individuals, groups, and/or services that have the trust of and connection with this population.

RSBCIHI is contracted to provide two (2) evidence-based practices, and one (1) culturally-based intervention which are briefly described below:

1. **Wellbriety Celebrating Families!™**
   This is a cognitive behavioral, support group model written for families in which there are risks for alcohol/substance use, domestics violence, child abuse, or neglect. RSBCIHI is expected to provide the following level of service to each of the geographic regions of Riverside County:
   - At least 2 cycles of group, per region, per year.
   - A cycle will consist of 11 weeks, and each cycle shall serve a minimum of 6 families, and shall not exceed 15 families.
   - A family shall consist of parent(s)/caregiver(s) and at least one child age 3 to 17 years of age.
   - The total number of families expected to complete the Wellbriety Celebrating Families curriculum are at least 20 per year, per region.
   - Completion is defined as a family completing 7 out of 11 sessions.

2. **Cognitive-Behavioral Therapy (CBT)**
   This is a time-sensitive, structured, present-oriented form of psychotherapy that has demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol, and drug use problems, and other behavioral health challenges. RSBCIHI is contracted to provide CBT to an individual, family, and/or group interventions as determined by screening as well as clinical assessment. A Mental Health Clinician shall provide CBT interventions for 6 to 8 sessions, and/or on as needed basis.

3. **Gathering of Native Americans (GONA)**
   This is a culture-based intervention and planning process where community members gather to address community-identified issues. It uses an interactive approach that empowers and supports the Native American/American Indian tribes with traditional songs, drumming, prayers and stories. There are four elements of the GONA curriculum that incorporate the values of human growth and responsibility that are found in Native cultures: Belonging, Mastery, Interdependence, and Generosity. RSBCIHI is expected to plan 1 GONA event per year. The GONA event will be conducted over 2 days, at a safe, non-stigmatizing location, which will be rotated among the 3 regions on an annual basis.

Wellbriety Celebrating Families!™

The Wellbriety Celebrating Families!™ (WCF) program is based on the Wellbriety Movement and Celebrating Families curriculum, which is listed on the federal Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Effective Programs and Practices (NREPP) since 2008. It integrates traditional Native teachings and cultural practices, including the Healing Forest Model, as a framework allowing each community to include traditional practices. It also emphasizes the importance of a community service and individual spirituality, and integrates parenting skills with strategies to break the cycle of addiction.

The WCF program fosters the development of safe, healthy, fulfilled, and addiction-free individuals and families by increasing resiliency factors and decreasing risk factors while incorporating addiction recovery concepts with healthy family living skills. It listed works with every member of the family, from ages 3 years of age through adult, to strengthen recovery from alcohol and/or other drugs, break the cycle of addiction and increase successful family reunification.

The WCF curriculum was originally designed for 16 weeks, that addresses the needs of children and parents in families that have serious problems with alcohol and other drugs, and to serve 6 to 15 families depending on the site's physical facilities, referral process and intake of eligible families. It was later expressed by RSBCIHI as well as the feedback from previous participants that the 16 weeks was lengthy and it was harder to gain interests from ongoing participations. Similar to the previous fiscal year, for the fiscal year 2023-2024, the WCF program was also condensed to a 11-week program, by combining 2 sessions into the weeks of 2, 3, 8, 9, and 10. A full attendance of at least 7 sessions is required to complete the WCF program. Each session of the program begins with a family meal. Afterwards, family members break into age group for developmentally appropriate activities led by the group facilitators. At the end of each session, all family members reconnect in activities to learn how to apply these new skills and interact in healthy ways.

Class Curriculum

The curriculum for WCF program is listed below, which was originally designed for 16 weeks, and then later condensed into 11 weeks by combining 2 sessions into Weeks 2, 3, 8, 9, and 10:

Week 1: Orientation and Getting Started
Week 2: Healthy Living
Week 3: Nutrition
Week 4: Communication
Week 5: Feeling and Defenses
Week 6: Anger Management
Week 7: Facts about Alcohol, Tobacco, and Other Drugs (ATOD)
Week 8: Chemical Dependency is a Disease
Week 9: Chemical Dependency Affects the Whole Family
Week 10: Goal Setting
Week 11: Making Healthy Choices
Week 12: Healthy Boundaries
Week 13: Healthy Friendships and Relationships
Week 14: How We Learn
Week 15: Our Uniqueness
Week 16: Celebration

Data Collection and Outcome Measures

The following forms and measures are to be completed by parent participants, in order to gather basic demographic information, as well as how they view their parenting skills and their relationship with their child. Additionally, a post-survey will be collected to gather participants' feedback on their perception of the WCF program.

- **Demographic Screening Form** (at the beginning of each WCF program)
- **Alabama Parenting Questionnaire** (at the beginning and at the completion of WCF program)
- **Guiding Good Choices and Family Strength/Resilience Scale** (at the beginning and at the completion of WCF program)
- **Opinions (Focus Questions) Survey** (at the beginning and at the completion of WCF program)
- **Post-Satisfaction Survey** (at the completion of the WCF program)

Alabama Parenting Questionnaire (APQ), is used to measure positive and negative parenting practices. More specifically, it is meant to measure several different dimensions of parenting that have proven to be important for understanding the causes of conduct problems and delinquency in youth. There were 42 items on the original version of APQ measure; however, for the purpose of WCF program, a modified format of the APQ measure was adopted for the WCF Program, with 22 items that would measure the following scales:

- **Parental Involvement** (Items No. 1, 4, 6, 8, 9, 12, 13, 16, 18, and 20)
- **Positive Parenting** (Items No. 2, 5, 11, 14, 15, and 21)
- **Inconsistent Discipline** (Items No. 3, 7, 10, 17, 19, and 22)

The **Guiding Good Choices (GGC) Scale** is taken from the GGC Program that aims to prevent teen substance use and risky behaviors by training parents to develop parenting and family management skills. Additionally, the **Family Strength/Resilience Scale** is taken from the Strengthening Families Program, an evidence-based parenting skills, children's social skills, and family life skills training program specifically designed for high-risk families. The combined measure has 22 questions, which consist of Guiding Good Choices (10-questions) and Family Strength/Resilience Scale (12 questions) which were taken from these two separate programs and have been modified to fit the WCF program.

WCF Class Cycles, Class Enrollment and Completion

There were a total of 7 WCF class cycles completed Countywide during the fiscal year 2023-2024. The total number of parent participants who qualified to enroll in the WCF program was 37. Of these, 23 participants completed the program (62.2% completion rate). All enrolled participants were asked to complete pre packets at intake, and post packets at completion; however, only 12 matched pre-post measures could be used for comparison of pre to post scores. Some of the measures were either missing from the packets, or were not completed entirely. For this outcomes report, only 12 matched pre-post measures were analyzed. A list of all WCF class cycles that were completed during the fiscal year 2023-2024 is shown on table below:

Class Cycle#	Start Date	End Date	Class Name/Location
1	8/22/23	11/14/23	Tuesday PM Virtual #1
2	9/6/23	11/22/23	Soboba Virtual
3	9/6/23	12/5/23	Pechanga #1
4	1/19/24	3/19/24	Tuesday Zoom Group
5	1/17/24	3/24/24	TM TANF San Jacinto
6	10/31/23	2/6/24	Pechanga #2/#3
7	4/23/24	7/2/24	Tuesday PM Virtual #2

WCF Class Cycles, Class Enrollment and Completion (*continued*)

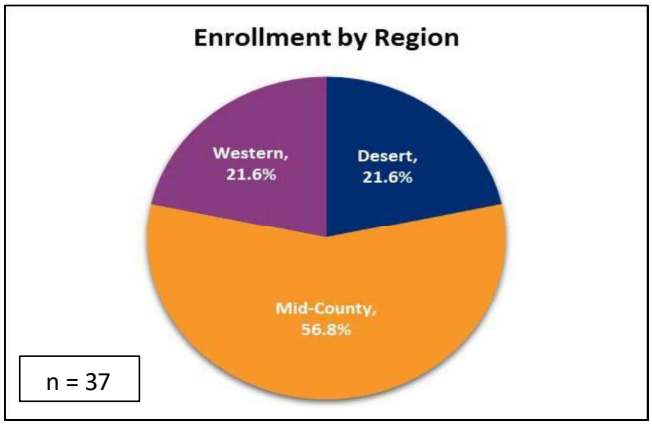
A summary of all WCF class cycles and enrollment counts for fiscal year 2023-2024 by Region, as well as Countywide are shown on the table below:

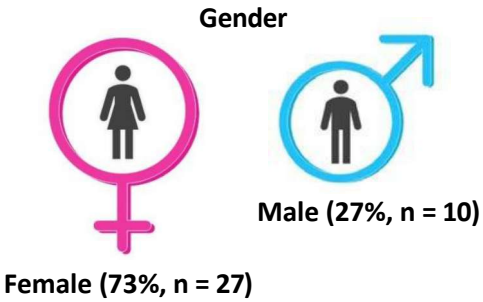
Region	Number of Families Enrolled	Number of Completion	Matched Pre-Post Data Sets Submitted	Contract Expectation	Percentage of Contract Expectation	Participants Completion Rate
Western	8	6	4	20	30%	75%
Mid-County	25	14	5	20	70%	56%
Desert	4	4	3	20	20%	100%
Countywide	37	23	12	60	38.3%	62.2%

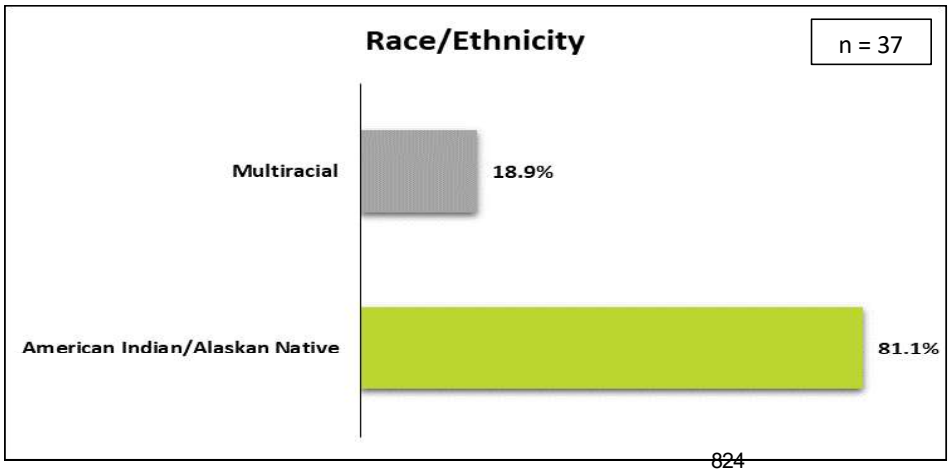
Demographics

During the fiscal year 2023-2024, a total of 7 WCF cycles were completed Countywide. The total number of participants who enrolled were 37, and the demographics data collected and analyzed were based on the total enrollments of 37 participants. The demographics data for *Enrollment by Region*, *Gender*, *Race/ Ethnicity*, and Preferred Language are summarized and shown below:

- 21 families enrolled in the Mid-County region (56.8%), 8 families enrolled in the Western County region (21.6%), and 8 families enrolled in the Desert region (21.6%)
- The majority of parent participants were Female (73%, n = 27), while the remaining participants were Male (27%, n = 10).
- 30 participants (81.1%) categorized themselves as American Indian/Alaskan Native, while 7 participants (18.9%) responded as being Multiracial.
- A total of 13 different tribes were represented across all the class cycles (as indicated by participants).
- All participants (100%) indicated that their preferred language is English.





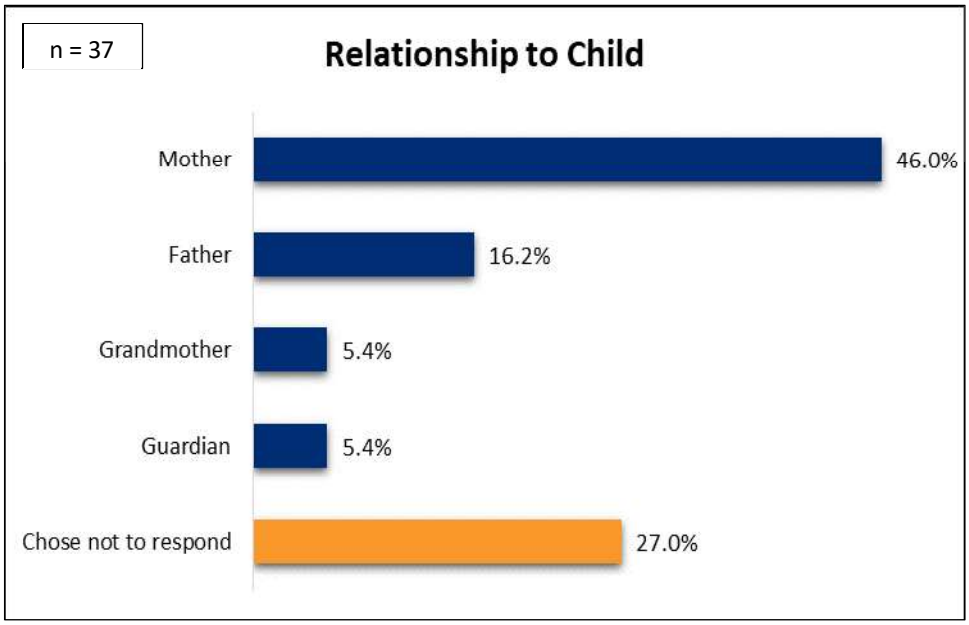


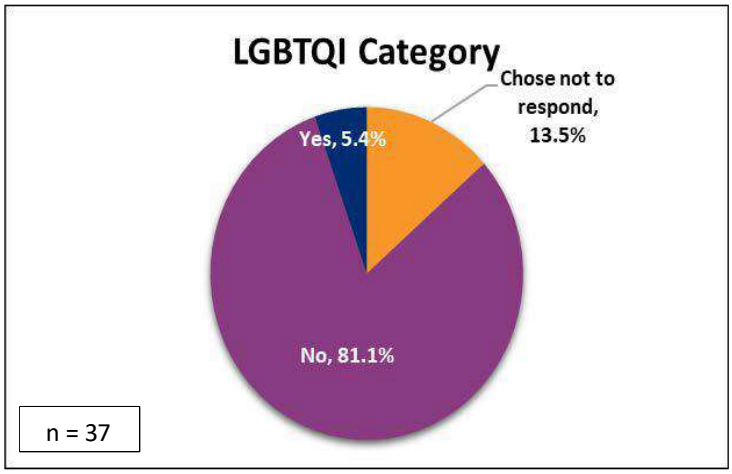
Specification of American Indian/Alaska Native Tribes
Cahuilla
Choctaw
Ely Shoshone
Hualapai
Hoopa
La Jolla
Navajo Nation
Oneida
Quechan
San Luis Rey
San Pasqual
Santa Rosa Band of Cahuilla
Torres Martinez

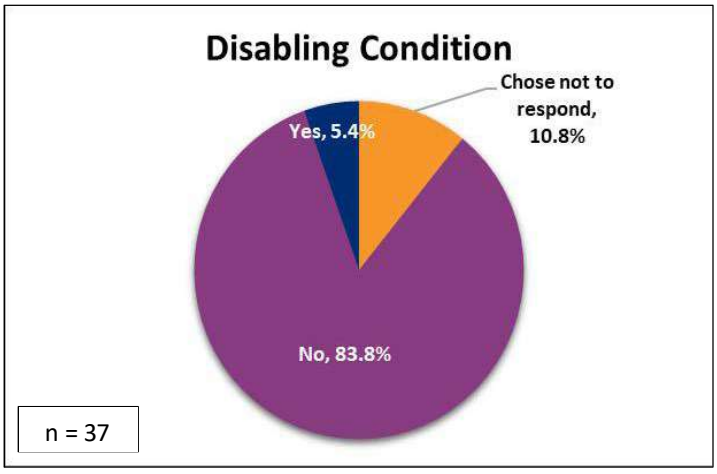
Demographics (*continued*)

The demographics data showing *Relationship of Participants to Children*, *LGBTQI Category*, *Veteran Status*, and *Disabling Condition* are summarized and shown on graphs below:

- The majority of parent participants indicated that their relationships to their children were as their "Mother" (46%, n = 17), "Father" (16.2%, n = 6), "Grandmother" (5.4%, n = 2), and "Guardian" (5.4%, n = 2), respectively. It is also noted that 10 participants (27%) chose not to respond to this question.
- Within the LGBTQI category, the majority of participants indicated "No" (81.1%, n = 30) on their responses, while 2 participants (5.4) indicated "Yes", and noted Bisexual as the category. It is also noted that the remaining 5 participants (13.5%) chose not to respond to this question.
- All participants (100%) indicated that they were not Veterans.
- A total of 31 parent participants (83.8%) indicated that they did not have any Disabling Condition, while 2 participants (5.4%) indicated that they have a Disabling Condition, and 4 participants (10.8%) chose not to respond to this question. Of those who responded "Yes", Fibromyalgia was noted as the specification of disability.



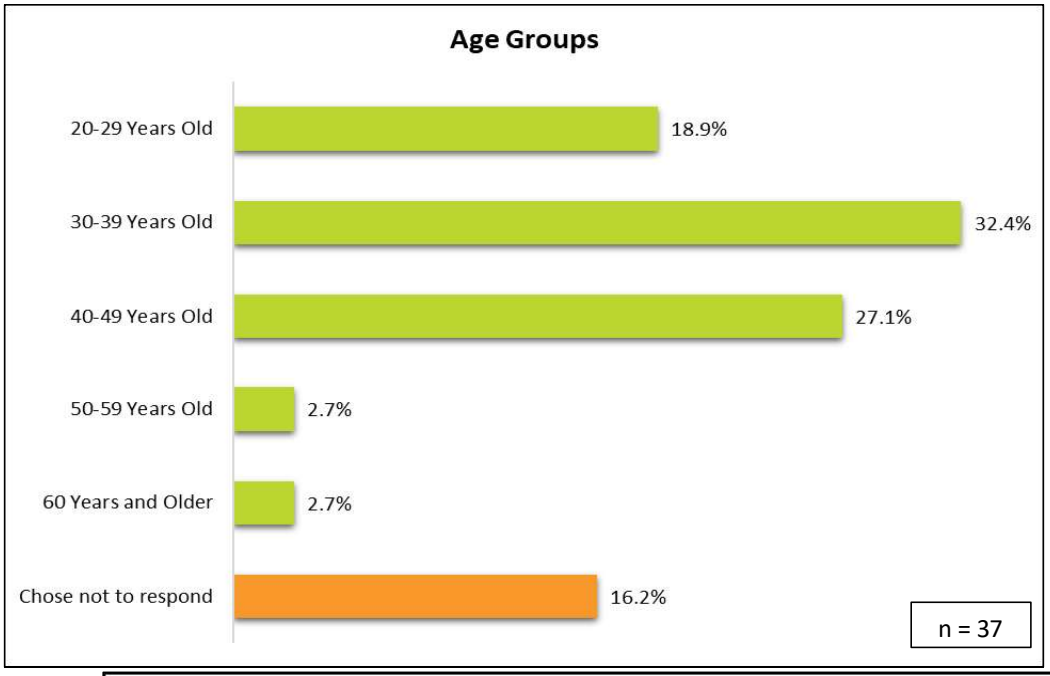




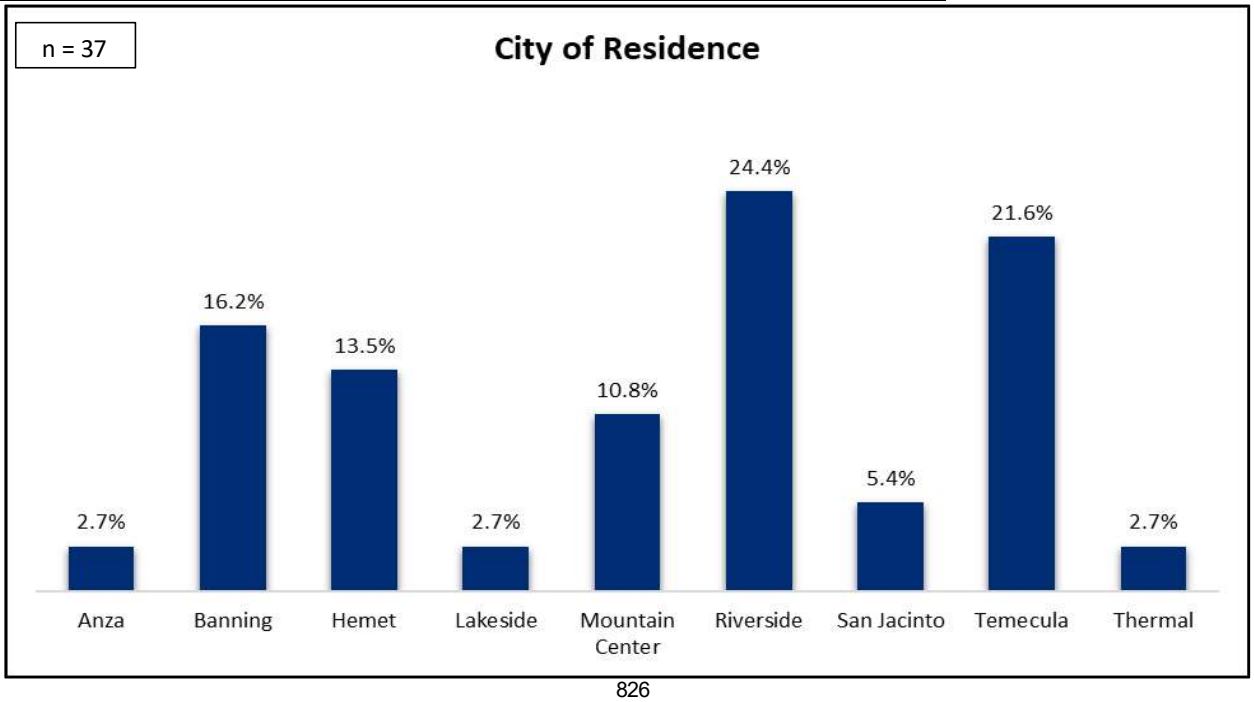
Demographics (*continued*)

The demographics data showing parent participants' Age Group and City of Residence are summarized and shown on graphs below:

- The majority of parent participants (32.4%, n = 12) were between 30 to 39 years of age. It is also noted that 6 participants (16.2%) chose not to respond. The number of participants in each age group is shown on the table below.
- Parent participants indicated that they had at least 1 child between 0 to 15 years old, and 1 child between 16 to 25 years old.
- The majority of parent participants indicated that they lived in Riverside (24.4%, n = 9), followed by Temecula (21.6%, n = 8), and Banning (16.2%, n = 6). Other cities noted were as follows: Anza, Hemet, Lakeside, Mountain Center, San Jacinto, and Thermal.



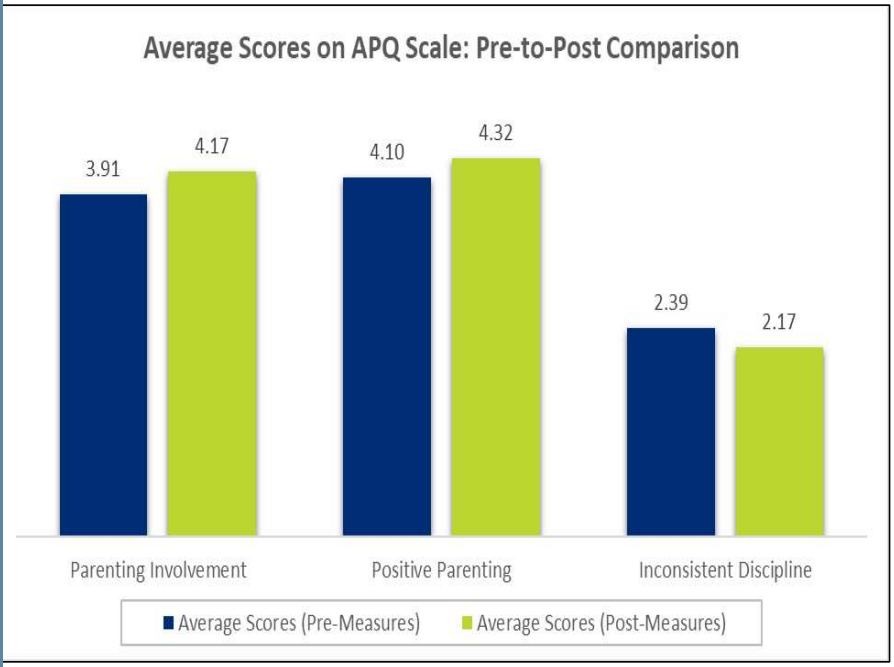
Age Groups	Counts
20-29 years old	7
30-39 years old	12
40-49 years old	10
50-59 years old	1
60 years and older	1
Chose not to respond	*6*



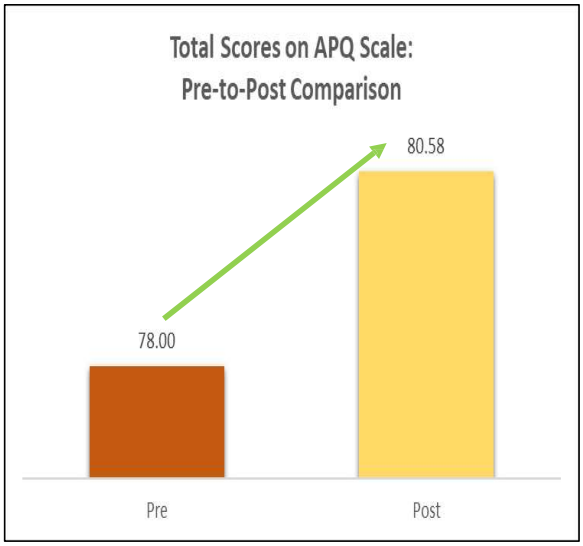
Alabama Parenting Questionnaire

The questions on APQ measure are structured on a 5-point Likert Scale, where parents choose between 5 options, where: 1="Never", 2="Almost Never", 3="Sometimes", 4="Often", and 5="Always". Each parent participant is asked to complete the APQ measure at the start of the WCF program, and at the end of the program. Each question on the APQ measure is a different statement about parenting practices, and each parent participant is asked to choose the option that best represents his/her parenting practices. The higher the score, the more likely parents viewed themselves as having positive parenting practices with their children. For analysis purpose, the average scores of these above scales on the modified APQ measures were then compared from pre-to-post measure. Ideally, we would like to see *increases* in the average scores for both "Parenting Involvement" and "Positive Parenting" scales, and *decreases* in the average scores of "Inconsistent Discipline" scale from pre-to-post.

A total of 12 pre-post matched pairs were completed by parent participants for the APQ measure. The graph below shows the APQ Scale results. The **Parenting Involvement** scale showed a 6.6% increase (0.26 points) from 3.91 to 4.17, and **Positive Parenting** scale showed a 5.4% increase (0.22 points) from 4.10 to 4.32. Conversely, **Inconsistent Discipline** scale showed a decrease of 9.3% (-0.22 points) from 2.39 to 2.17). All scales showed positive results from pre-post; however, due to the insufficient sample size, analysis using Paired Samples T-Tests was not possible. Overall, the average Total Scores showed an increase of 2.58 points (3.3% change) from 78 to 80.58.



n = 12



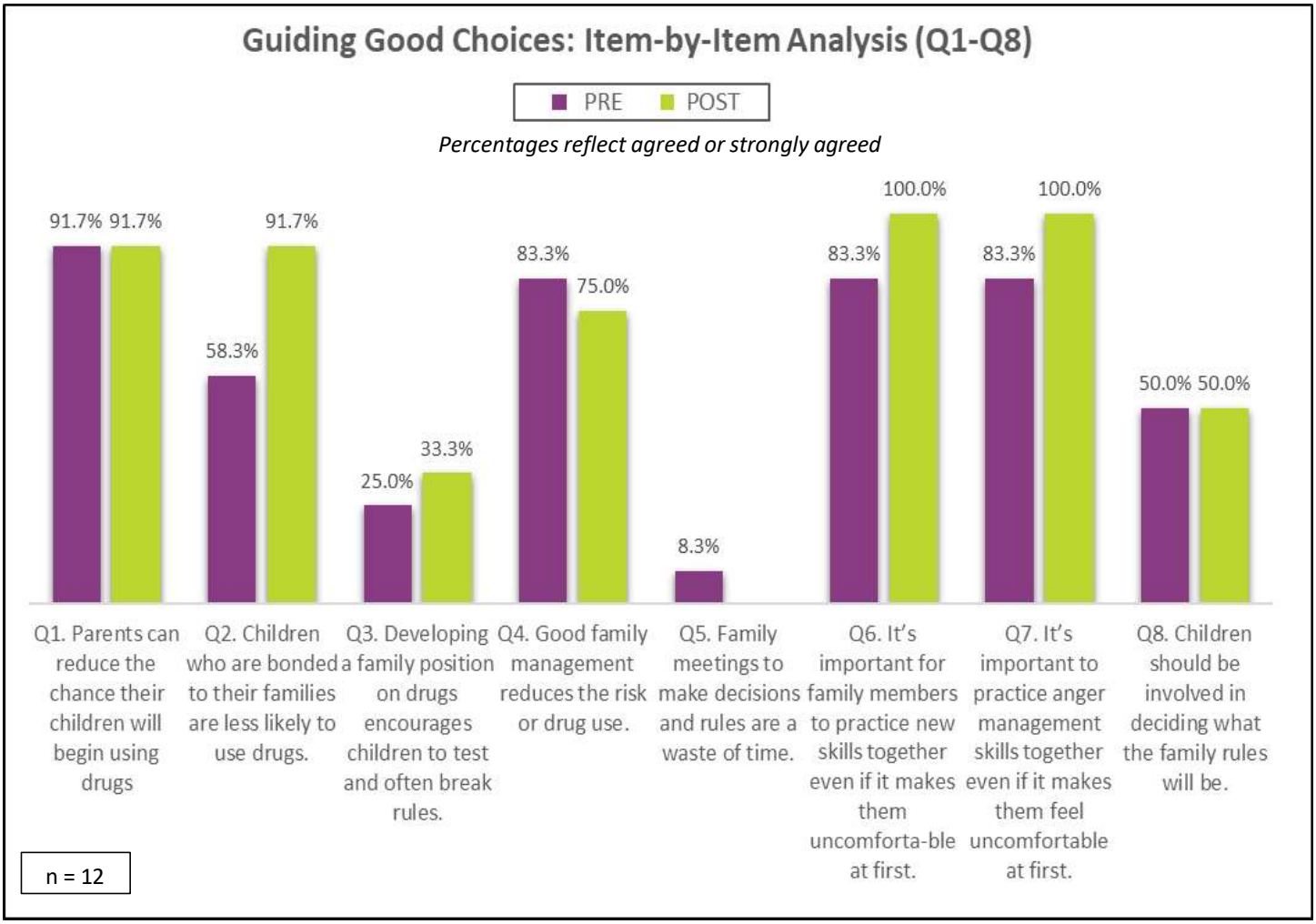
APQ Scales	Percent Change	*t*	df	p
Parenting Involvement	6.6%	-1.015	11	.332
Positive Parenting	5.4%	-0.818	11	.431
Inconsistent Discipline	-9.3%	1.310	11	.217
Total Scores	**3.3%**	**-0.681**	**11**	**.510**

Guiding Good Choices and Family Strength/Resilience Scale

On the Guiding Good Choices and Family Strength/Resilience Scale measure, parent participants were asked their opinions about how often the statements would best describes their families. Ideally, we would like to see an increase in all items from pre-to post-measures, except for Item# 5 (*Family meetings to make decisions and rules are a waste of time*), on parent participants' who selected Options 5, 6, and 7 ("Tend to Agree", "Agree", and "Strongly Agree"). For the Guiding Good Choices measure (Questions 1 to 10), the questions are structured on two types of Likert Scales, and results are shown below:

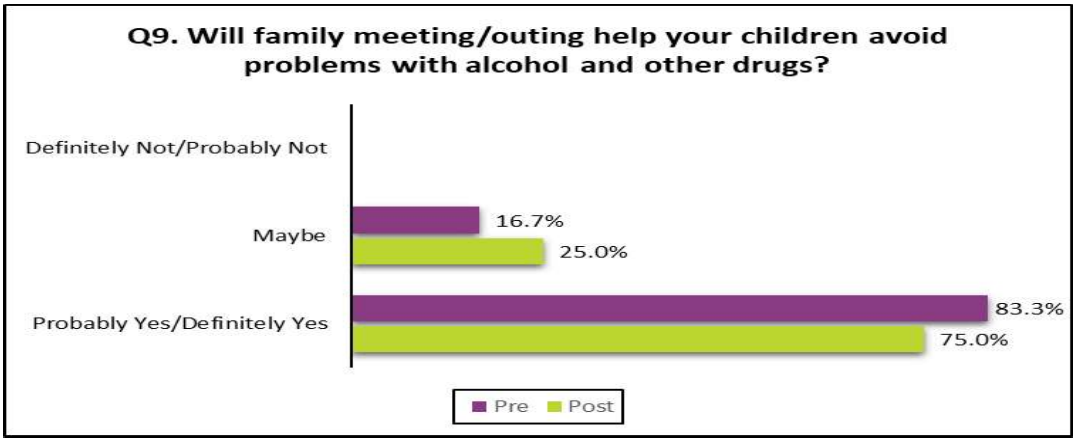
- On **Questions 1 to 8**, parents are asked to choose between 7 options, where: 1="Strongly Disagree", 2="Disagree", 3="Tend to Disagree", 4="Neutral", 5="Tend to Agree", 6="Agree" and 7="Strongly Agree".
- On **Questions 9 and 10**, parents are asked to choose between 5 options, where 1="Definitely Not", 2="Probably Not", 3="Maybe", 4="Probably Yes", and 5="Definitely Yes."

There were a total of 12 pre-to-post surveys submitted for the Guiding Good Choices measure. Overall, there are increases on parents' choices from pre– to post-measures, with the highest percent increase of 57.3% is shown on Item# 2 (*Children who are bonded to their families are less likely to use drugs*). Item#5 (*Family meetings to make decisions and rules are a waste of time*) is shown as the highest percent decrease of 100%, which is considered as ideal. Item-by-item analysis from Questions 1 to 8 on the GGC scale is shown below, while the analysis for Questions 9-10 as well as the average on Total Scores are shown on the following page.

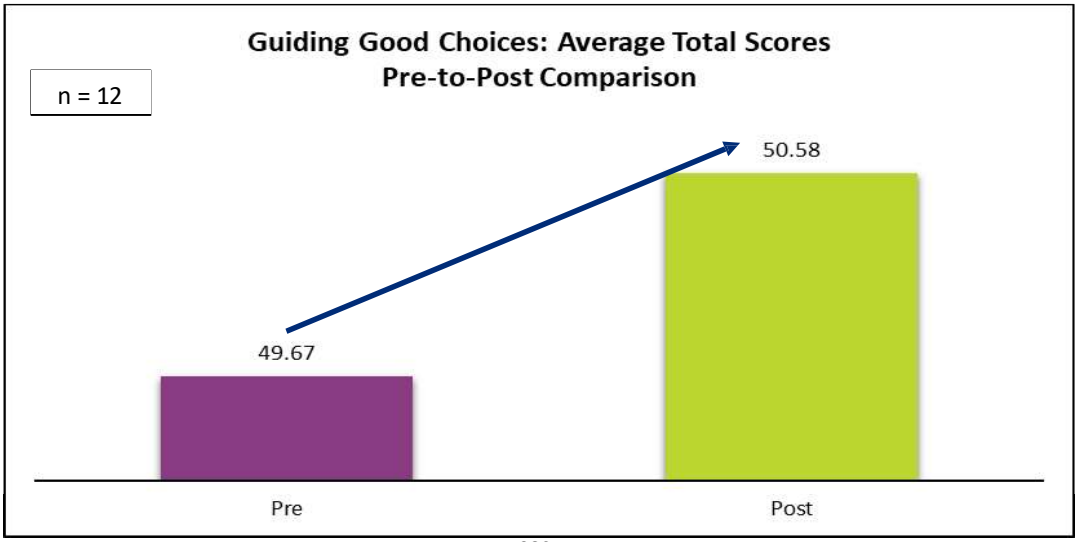


Guiding Good Choices and Family Strength/Resilience Scale (*continued*)

From 12 pre-to-post measures submitted, analysis for questions 9 and 10 showed increases in parent participants' who selected "Maybe" from pre measures to post measures. For both Questions 9 and 10, none of the parent participants selected Options 1 and 2 ("Definitely Not" or "Probably Not"). On Question# 9, the percentage of "Probably Yes" or "Definitely Yes" responses (i.e. those who chose Options 4 and 5) decreased from 83.3% to 75%. On Question# 10, the percentage of "Probably Yes" or "Definitely Yes" responses (i.e. those who chose Options 4 and 5) also decreased from 91.7% to 75%. Overall, the average Total Scores on Guiding Good Choices measure also showed an increase of 0.92 points from 49.67 to 50.58 (a 1.8% increase). However, due to the small sample size, this result is not shown to be statistically significant.

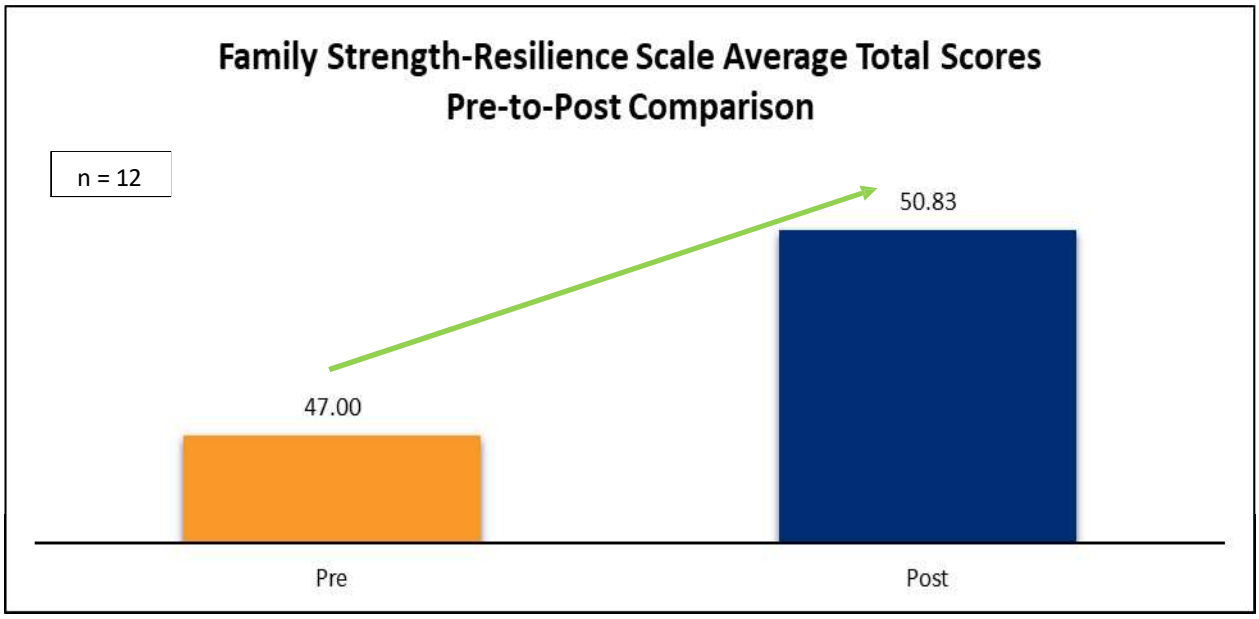






Guiding Good Choices and Family Strength/Resilience Scale (*continued*)

On the Family Strength/Resilience Scale Questions 11 to 22, parent participants were asked to select from 5 Likert Scale options, where 1="Very Little Strength", 2="Some Strength", 3="Neutral", 4="Good Strength", and 5="Very Strong". Ideally, we would like to see increases across all items (i.e. from participants selecting options 1 or 2 on pre-measures, to selecting 4 or 5 on post-measures). Based on the analysis from 12 paired pre-post measures submitted at the completion of WCF program, the average Total Scores showed an increase of 3.83 points from 47 points to 50.83, which is a 7.5% increase from pre-to post-measure. However, due to the small sample size, this result is not shown to be statistically significant. An item-by-item analysis of Item numbers 11 to 22 are shown on table the below. Item numbers 12, 14, 15, 16, 17, and 21 showed percent increases of 25% or more (i.e. percent increases in parent participants selecting "Good Strength" and "Very Strong" from pre-measures to post-measures).



Family Strength and Resilience Scale Items	*Very Little Strength-Some Strength PRE*	*Very Little Strength-Some Strength POST*	*Good Strength-Very Strong PRE*	*Good Strength-Very Strong POST*	*Good Strength-Very Strong %DIFFERENCE*
11. Family Supportiveness, love and care	0.0%	8.3%	91.7%	91.7%	0.0%
12. Positive Family Communication (clear directions, rules, praise)	16.7%	8.3%	66.7%	91.7%	**37.5%**
13. Effective Parenting Skills (reading to child, rewarding)	16.7%	8.3%	75.0%	83.3%	11.1%
14. Effective Discipline Style that is consistent with love and respect	8.3%	8.3%	66.6%	83.3%	**25.1%**
15. Family Organization (rules, chores, self responsibility)	8.3%	16.6%	41.7%	66.6%	**59.7%**
16. Family Unity (togetherness, cohesion)	8.3%	8.3%	66.7%	91.6%	**37.3%**
17. Positive Mental Health (generally good feeling about own self)	25.0%	16.6%	66.6%	83.3%	**25.1%**
18. Physical Health	8.3%	8.3%	66.7%	75.0%	12.4%
19. Emotional Strength	25.0%	0.0%	58.3%	66.7%	14.4%
20. Knowledge and Education	8.3%	8.3%	75.0%	83.4%	11.2%
21. Social Networking (making or talking with friends, building community)	25.0%	16.7%	58.4%	75.0%	**28.4%**
22. Spiritual Strength	0.0%	8.3%	83.3%	75.0%	-10.0%

WCF Pre-Post Opinions Survey

In the Wellbriety Celebrating Families™ (WCF) program curriculum, there is one question named as "Focus Question" for each week or each different topic that is selected to be discussed with parent participants. There are a total of 10 questions selected and condensed into an "Opinions Survey", which participants are asked to complete at both at intake and at the completion of the WCF program. Generally, we would like to see if there is any change (either an increase or a decrease) in the participants' opinions from pre– to-post-measures, in regards to the topic and/or selected focus questions. More specifically, the goal is for participants' opinions to increase to a higher percentage of "Yes" (i.e. more people selecting "Yes" as an option, instead of selecting "Don't Know" or "No") at the completion of the WCF program in comparison to at intake, *except* on Question 9 when the alcohol/chemical dependency topic is introduced. Increases indicate an improvement in knowledge after program completion. Overall, there are a total of 12 pre-post measures that were analyzed and the results are shown below and on the following page.

WCF Opinions Survey Q1-Q6	Don't Know		No		Yes	
	PRE	POST	PRE	POST	PRE	POST
1. What I eat and drink changes the way my brain works.	8.3%	0%	0%	0.0%	91.7%	100%
2. A can of beer, a bottle/can of flavored alcoholic beverage, a glass of wine, and a shot of hard liquor all contain the same amount of alcohol.	50%	33.3%	16.7%	16.7%	33.3%	50%
3. People with blood relatives who have the disease of "Chemical Dependency" are at High Risk to become addicted themselves if they drink or use.	8.4%	8.4%	33.3%	8.3%	58.3%	83.3%
4. If one member of a family is chemically dependent, all other family members are affected.	0%	0%	41.7%	16.7%	58.3%	83.3%
5. If my children talk to other adults, they are less likely to become addicted.	50%	50%	16.7%	16.7%	33.3%	33.3%
6. I have a safe person who will listen when I need to talk about my problems.	8.3%	8.3%	0%	8.4%	91.7%	83.3%

For questions 1 to 6, participants are asked to select either "Don't Know", "No", or "Yes" for the selected Focus Questions as listed on table above, which can be summarized below:

- Participants' opinions changed from 91.7% to 100% on those who selected "Yes" (9.1% increase) on Question #1.
- Participant's opinions changed from 33.3% to 50% on those who selected "Yes" (50.2% increase) on Question #2.
- Participants' opinions changed from 58.3% to 83.3% on those who selected "Yes" (42.9% increase) on Question #3.
- Participants' opinions changed from 58.3% to 83.3% on those who selected "Yes" (42.9% increase) on Question #4.
- Participants' opinions remained the same (33.3%) on those who selected "Yes" (0.1% decrease) on Question #5.
- Participants' opinions changed from 91.7% to 83.3% on those who selected "Yes" (9.2% decrease) on Question #6.

WCF Pre-Post Opinions Survey (*continued*)

On Questions 7 and 8, participants are asked to select between "Never", "Sometimes", "About half the time", "A lot of the time", or "Always" on the selected Focus Questions as listed on table below, and the summary is as follows:

- On Question 7, 50% of participants selected "A lot of the time" or "Always" at intake, and this has increased to 75% at completion (50% increase in opinions).
- On Question 8, 50% of participants selected "A lot of the time" or "Always" at intake, and this has increased to 66.7% at completion (33.4% increase in opinions).

WCF Opinions Survey Q7-Q8	Never		Sometimes		About half the time		A lot of the time		Always	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
7. I am able to talk about my feelings.	8.3%	0.0%	0.0%	8.3%	41.7%	16.7%	33.3%	41.7%	16.7%	33.3%
8. I express my anger safely.	8.3%	0.0%	0.0%	0.0%	41.7%	33.3%	33.3%	41.7%	16.7%	25.0%

On Question 9, participants are asked to select between "25%", "40%", "50%", "60%", or "More Than 60%" on the selected Focus Question as listed on table below. Overall, there are slight increases across all options in parents' opinions in regards to alcohol/chemical dependency.

WCF Opinions Survey Q9	25%		40%		50%		60%		More than 60%	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
9. What percentage (%) of children live in a home with a parent who drinks heavily or has a problem with alcohol or other drugs?	33.3%	16.7%			33.3%	16.7%	8.4%	24.9%	25.0%	41.7%

On Question 10, participants are asked to select between "Strongly Disagree", "Disagree", "Neutral", "Agree", or "Strongly Agree" on the selected Focus Question as listed on table below. Overall, there was no participant who selected either "Strongly Disagree" or "Disagree" at both intake and completion, and 91.6% of participants selected either "Agree" or "Strongly Agree" at intake, and this has increased to 100% at completion (9.2% increase in opinions). This indicates that there are more parent participants who Agreed or Strongly Agreed at completion that "*Providing Rules and Limits help their children to build their self-esteem*."

WCF Opinions Survey Q10	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
10. Providing Rules and Limits help my children build their self-esteem.					8.4%	0.0%	58.3%	66.7%	33.3%	33.3%

WCF Post-Satisfaction Survey

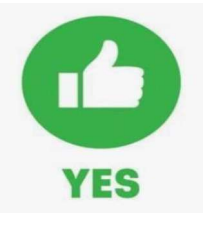
A post-satisfaction survey was created to evaluate the Wellbriety Celebrating Families™ (WCF) program effectiveness and to gather attendees' feedback on how the program has impacted their relationship with their children. The post-satisfaction surveys were distributed to all attendees and collected at the end of the WCF program. There are a total of 8 questions on the post-satisfaction surveys:

- The first two questions use Likert scale ranging from 1 to 5, where: 1 = Very Dissatisfied, 2 = Dissatisfied, 3 = Neutral, 4 = Satisfied, and 5 = Very Satisfied
- The third question also uses Likert scale ranging from 1 to 5, where: 1 = Not At All, 2 = Very Little, 3 = Not Sure, 4 = Somewhat, and 5 = Very Much
- The fourth question provides two options, "Yes" or "No"
- Questions 5 to 8 are open ended questions, which are meant to gather participants' opinions on their thoughts about the WCF program, whether they did or did not like the WCF program, and if they had any additional comments.

At the completion of WCF Program, there are a total of 12 post-satisfaction surveys submitted by attendees, and the results are shown below.

Post-Satisfaction Survey Results

In regards to the satisfaction with both the program and the group leaders, the majority of participants (83.4%, n = 10) responded that they were "Very Satisfied". Additionally, 10 participants (83.4%) felt that the WCF program has helped their families. In regards to participants' feedback on whether they would recommend the WCF program to other families, all participants (100%) responded "Yes". A summary of their responses is shown below, and their survey comments are shown on the following three pages.

	 Neutral	 Satisfied	 Very Satisfied
Q1. How satisfied were you with this program?	**8.3%**	**8.3%**	**83.4%**
Q2. How satisfied were you with your group leaders?	**8.3%**	**8.3%**	**83.4%**
	 Not Sure	 Somewhat	 Very Much
Q3. How much has this class helped your family?	**0%**	**16.7%**	**83.3%**
Q4. Would you recommend this program to other families?		**100%**	

Post-Satisfaction Survey Comments

The remaining 4 questions of the post-satisfaction surveys (Questions 5 to 8) were related to participants' opinions regarding the WCF program. The participants' feedback are summarized below:

Q5. Things I learned in the Wellbriety Celebrating Families™ program are:

"I learned that disciplining while angry is inappropriate. It's best to calm down first."
"Mental health is important."
"Family boundaries and the importance of teaching kids values and morals, taking care of physical, mental, spiritual, and emotional well-being."
"Do not turn to substances for coping mechanisms."
"Managing my emotions, family connections tips, and that I am an amazing parent."
"That our group are handling the sane things in life that are positive,"
"How to work on stress and historical trauma."
"How to have a healthier family living and to be stronger in my society."
"HALT, prayer."
"To open up."
"How much what I do have a say on the next generation, healthy boundaries, and living skills on family and community."

Q6. What I liked about the Wellbriety Celebrating Families™ program was:

"I liked the Zoom class but also enjoyed getting to see everyone in person."
"Learning about how to recognize growing up in unhealthy forest."
"That there was no judgment."
"Attending with my kids."
"Being able to be open and honest and receiving thoughtful feedback on issues I'm dealing with."
"Everything! Sharing and hearing others' experiences."
"That our counselors, also group, understood each other."
"The staff really connected with you and really heartfelt."
"Openness, great leaders."
"The group."
"Variety and openness of topic."

Q7. What I didn't like about the Wellbriety Celebrating Families™ program was:

"That I struggled with Zoom sometimes."
"Nothing, it was very convenient."
"It was on Zoom."
"Mainly centered around substance abuse issues rather than co-parenting."
"It was on a work day."

Q8. Any additional comments?

"This is my first time in a group program. The Zoom was great! But I prefer in person. I believe that these program should be consistent for all other reasons."
"Instructors were amazing!"
"The leaders are very open, considerate, patient, knowledgeable, respectful, and understanding."
"Thank you!"

Cognitive-Behavioral Therapy

The Cognitive-Behavioral Therapy (CBT) is directed toward solving current problems and teaching clients skills to modify maladaptive thinking and behavior. It is included as an element of the Celebrating Families: Strengthening the Circle Project, in order to provide individual, family, and/or group interventions to participants who are identified through clinical assessment as having emerging symptoms of depression or anxiety, present for less than one (1) year. Generally, the CBT interventions will be determined by a Mental Health clinician, which may vary from participant to participant. Generally, it will be offered from 6 to 8 sessions, and/or on as needed basis.

Data Collection and Outcome Measures

Both adults and children can participate in the CBT program, and the following data collection and outcome measures are to be completed by each participant:

For each adult participant:

- **Demographic Screening Form** (at the beginning of each program)
- **PHQ-9 Questionnaire** (at the beginning and at the completion of each program)
- **OQ Form** (at the beginning and at the completion of each program)
- **Post-Satisfaction Survey** (at the completion of each program)

For each child participant:

- **Demographic Screening Form** (at the beginning of each program)
- **PHQ-9 Questionnaire** (at the beginning and at the completion of each program)
- **YOQ Form** (at the beginning and at the completion of each program)
- **Post-Satisfaction Survey** (at the completion of each program)

The clinician assigned to each participant is also expected to complete a Participant Log and Program Completion Summary Form, which will be submitted to RUHS-BH along with each participants' pre and post packets.

The **PHQ-9**, or **Patient Health Questionnaire-Nine**, is a self-reported depression scale that's used to screen clients for major depressive disorder. This measure consists of nine questions that ask about the frequency of symptoms over the past two weeks. Each question is rated on a scale from 0 to 27, with higher scores indicating more severe symptoms:

- 0-13: indicates *mild depression*
- 14-19: indicates *moderate depression*
- 20-27: indicates *severe depression*

The **OQ**, or the **Outcome Questionnaire**, is a 45-item multiple-choice self-report inventory used to measure psychotherapy progress in adult clients (ages 18 and older). It provides a quick by comprehensive snapshot of the client's current functioning across a wide variety of disorders, and it measures three subscales:

1. **Symptom Distress (SD)**, or subjective discomfort: intrapsychic functioning with an emphasis on client's depression and anxiety.
2. **Interpersonal Relations (IR)**: loneliness, conflict with others, and marriage and family difficulties.
3. **Social Role (SR)**: difficulties in the workplace, school, or home duties.

The Total Score for OQ ranges from 0 to 180, with a clinical cutoff of 64 points.

Data Collection and Outcome Measures *(continued)*

The **Y-OQ**, or the **Youth Outcome Questionnaire**, is a 64-item self-report completed by the parent/guardian that measures the treatment progress for children and adolescents (ages 4 to 17 years old) receiving mental health intervention. It is designed to reflect the total amount of stress a child or adolescent is experiencing, and its utility across many populations, treatment types, and modalities allows for non-invasive clinical application in nearly all settings of care. The total score of Y-OQ ranges from –16 to 240 with a clinical cut off of 47 points. There are six subscales in the YOQ measure:

1. **Intrapersonal Distress** (emotional distress).
2. **Somatic Distress** (distress presenting physically).
3. **Interpersonal Relations** (relationship with parents, other adults, and peers).
4. **Critical Items** (flags need for those requiring immediate intervention beyond standard outpatient treatment)
5. **Social Problems** (socially-related problematic behaviors)
6. **Behavioral Dysfunction** (unhealthy behaviors)

Enrollment

During the fiscal year 2023-2024, there were no participants enrolled in the CBT Program, due to less interest from clients, employee turnover, as well as unavailability of clinician who could be solely assigned for this program from the contracted organization.

Gathering of Native Americans (GONA)

A Gathering of Native Americans (GONA) is a culture-based planning process where community members gather to address community-identified issues. It uses an interactive approach that empowers and supports Native American/American Indian tribes with traditional songs, drumming, prayers, and stories. There are four elements of the GONA curriculum that incorporate the values of human growth and responsibility that are found in Native cultures: Belonging, Mastery, Interdependence, and Generosity.

The overall goals of the GONA process are to:

- Provide Native communities with a framework to examine the effects of historical trauma.
- Provide an integrative experience that offers hope, encouragement, and a positive foundation for Native community action and healing.
- Provide an experience that emphasizes skill transfer and supports Native community empowerment.
- Reinforce cultural continuity with families living on tribal reservations and in urban or rural areas.
- Increase protective factors linked to healthy and safe development of Native children and their families.
- Offer Native communities a strategic framework and planning process that supports the values of *Belonging*, *Mastery*, *Interdependence*, and *Generosity*, which are inherent in Native cultures and lead to the reduction of risk behaviors contributing to mental and substance use disorders and suicide.

By utilizing SAMHSA Tribal training and Technical Assistance Center's GONA Curriculum and Facilitator Guide and Toolkit, RSBCIHI is contracted to plan one (1) GONA event per year. The identified program leadership will participate in a trans-regional GONA planning process, and the regions shall work collaboratively to plan, host and hold the event. The GONA event will be conducted over 1 –2 days, at a safe, non-stigmatizing location, which will be rotated among the three regions on an annual basis. The GONA will occur at the conclusion of the year and include Wellbriety Celebrating Families!™ program graduates, as well as the larger Native American/American Indian community in order to address the community-identified issues.

As part of data collection procedure, the following are to be collected from the GONA event:

- **Participant Sign-In Form**
- **GONA Post-Satisfaction Survey**
- **GONA Facilitator Debrief Form**

Event Sign-Ins

During the fiscal year 2023-2024, there was one GONA events completed, with a total attendance of **89** people, which was completed at Noli High School.

Date	Location	Total Attendance
5/13/2024	Noli Indian School	89

GONA Post-Satisfaction Surveys

A post-satisfaction survey was created to evaluate the Gathering of Native American (GONA) event for its effectiveness, and to gather attendees' feedback on how the program has impacted their relationship with their children, family, as well as their community. The post-satisfaction surveys were distributed to all attendees and collected at the end of the GONA event. There are a total of 12 questions on the post-satisfaction surveys, using a Likert scale ranging from 1 to 5, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly Agree. At the completion of the GONA event, there were a total of 64 post-satisfaction surveys submitted by attendees. The survey results and summary of attendees' comments are shown on the following two pages.

GONA Post-Satisfaction Survey Results

	Satisfaction Survey Items (n = 64)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	I received a positive portrayal of Native American culture.	3.1%	1.6%	14.1%	35.9%	45.3%
2	Gathering of Native Americans encouraged us to draw closer as a community.	1.6%	1.6%	19.0%	30.2%	47.6%
3	I learned about Native American values and culture in each of the activities.	1.6%	3.1%	26.6%	32.8%	35.9%
4	I learned about how historical trauma impacts my community.	4.8%	3.2%	23.8%	44.4%	23.8%
5	The gathering gave me a sense of belonging.	1.6%	6.3%	25.4%	31.8%	34.9%
6	An event like this one brings hope in our community.	1.6%	1.6%	31.7%	27.0%	38.1%
7	I learned about substance use disorders.	3.2%	6.3%	30.2%	38.1%	22.2%
8	I learned about mental health issues (e.g. suicide prevention, mental health disorders).	3.3%	1.6%	18.0%	42.7%	34.4%
9	I learned how to promote mental wellness.	1.6%	4.8%	28.5%	41.3%	23.8%
10	I had fun participating in Gathering of Native Americans.	3.2%	4.8%	17.4%	22.2%	52.4%
11	The event was well organized.	1.6%	6.3%	31.7%	23.8%	36.6%
12	Staff members were knowledgeable.	3.2%	4.8%	15.8%	36.5%	39.7%

Overall, the analysis from post-satisfaction surveys showed positive results from all participants. For the following survey statements, attendees showed positive results of about *75% or higher* on the combined "Agree" and "Strongly Agree" responses:

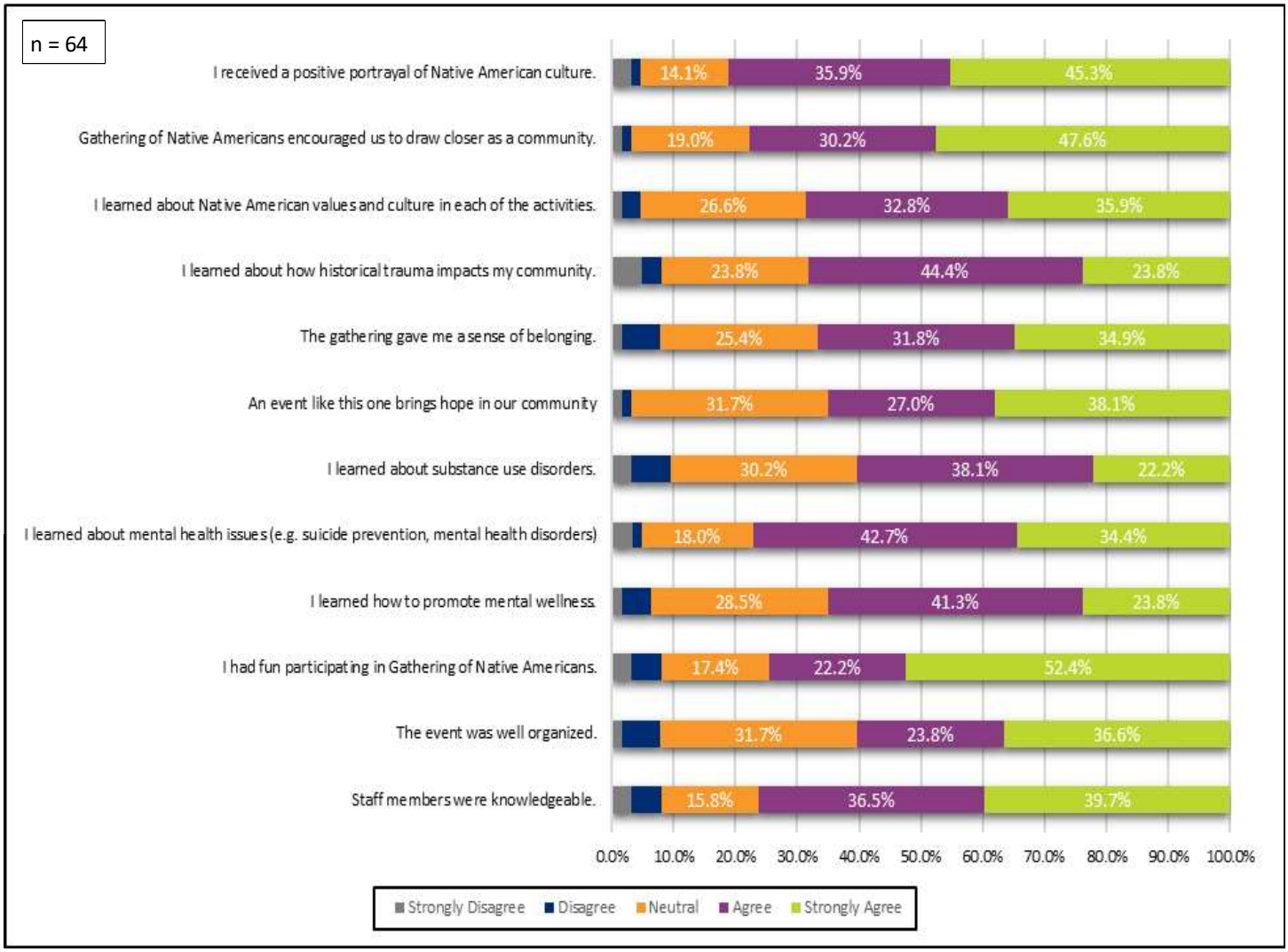
- **81.2%** responded "Strongly Agree" or "Agree" that they received positive portrayals of Native American culture from the GONA event.
- **77.8%** responded "Strongly Agree" or "Agree" that the GONA event encouraged them to draw closer as a community.
- **77.1%** responded "Strongly Agree" or "Agree" that they learned about mental health issues from the GONA event.
- **76.2%** responded "Strongly Agree" or "Agree" that the staff members were knowledgeable.
- **74.6%** responded "Strongly Agree" or "Agree" that they had fun participating at the GONA event.

For the following survey statements, attendees showed positive results of about *60% or higher* on the combined "Agree" and "Strongly Agree" responses, while some also responded "Neutral":

- **68.7%** of attendees reported "Strongly Agreed" or "Agreed" that they learned about Native American values and culture from the GONA activities, while **26.6%** felt "Neutral".
- **68.2%** of attendees reported "Strongly Agreed" or "Agreed" that they learned about how historical trauma impacts their community, while **23.8%** felt "Neutral".
- **66.7%** of attendees reported "Strongly Agreed" or "Agreed" that the GONA event gave them a sense of belonging, while **25.4%** felt "Neutral".
- **65.1%** of attendees reported "Strongly Agreed" or "Agreed" that the GONA event brings hope in their community, while **31.7%** felt "Neutral".
- **60.3%** of attendees reported "Strongly Agreed" or "Agreed" that they learned about substance abuse disorders from the GONA event, while **30.2%** felt "Neutral".
- **65.1%** of attendees reported "Strongly Agreed" or "Agreed" that they learned how to promote mental wellness from the GONA event, while **28.5%** felt "Neutral".
- **60.4%** of attendees reported "Strongly Agreed" or "Agreed" that the event was well organized, while **31.7%** felt "Neutral".

GONA Post-Satisfaction Survey Graph

The graph below shows the GONA post-satisfaction survey results in a graph format:



GONA Post-Satisfaction Survey Comments

A few of the attendees also wrote their comments in regards to the GONA event, as shown below:

"Good talk about mental health."
"It was really fun!"
"I like how much information there was. I feel like I learned a lot."
"It was nice."
"Felt like I could share without getting judged."

GONA Facilitator Debrief Surveys and Comments

Additional post-GONA evaluation tool was collected so that the GONA committee can use it to debrief the facilitators and staff. There were a total of 21 Facilitator Debrief Surveys collected from the GONA event. Their comments are listed below and on the next three pages.

Q1. What worked well about the preparation for the GONA?

"Speakers knew their topics and how they would present it."
"All of it."
"Teacher and session timing. The break also worked well to keep students calm."
"The communication."
"The organization went well as I knew where I was supposed to be and what was expected of me."
"What worked was that the presenters were engaging with the students. They would give students the chance to speak and participate."
"Agenda and planning."
"Prayers."
"The open space to be free to conduct the class; however, we deemed appropriately and concisely."
"That we had a meeting a week before the event to know what was being asked of us."
"Teamwork and people helping out."
"Being able to choose classroom."
"Close teacher-student ratio in class."
"I love the separate moms session and the outside activity, as well as the raffle."
"Having opportunity for the student to talk and answer questions."
"The overall structure was good."
"The topics chosen were appropriate for the students."

Q2. What, if anything, would you suggest to improve preparation for the GONA?

"Plan more hands-on or interactive activities."
"Timing. Plan for longer session so that students stay engaged if time is running longer that expected."
"Maybe have a presentation slide or give out information and give some student the chance to engage not all presenter did."
"Having more things to talk about."
"Maybe a little more communication through circles to how the event is going to be structured so that we can specialize the class more."
"More meetings to communicate."
"More interactions with students."
"Sending out topics in more advanced notice, discuss and prepare students."
"Maybe prep the students on the topic/content ahead of time so they would be more interactive."
"More engagement activities during the preparations, be more warm and inviting."
"Having a better setting for each workshops, like more chairs, etc."
"They needed to plan debrief for suicide session."
"Use skits, for example, how does one respond when receiving 988 call."

GONA Facilitator Debrief Survey Comments *(continued)*

Q3. What worked well about the content and format of the GONA?

"Topics were relevant to students."
"It was perfect."
"Very informative."
"Good content."
"I like how much cultural was incorporated."
"It was well presented, love the information!"
"It worked well."
"That we had enough time with each class for a back-and-forth discussion."
"Presenters were well informed and ready to present."
"The content is appropriate. I would suggest less lecture and more interaction or student engagement."
"Easy to follow and understand."
"The outdoor part got the kids excited."

Q4. What, if anything, would you suggest to improve content and format of the GONA?

"It was great the way it was."
"No lecture but have more interactions."
"It went very smoothy."
"Slide presentation, maybe do things to bring students to engage in games."
"No improvement needed."
"Less talking by presenter, more student engagement."
"I would suggest more time for the student to speak or share out. Encourage them to participate and interact more."
"Having speakers that were advocating for their culture."
"Have a debrief and more heartwarming."

Q5. What activities seemed to impact GONA participants toward healing?

"Prayer ties, talking about grief, conversation."
"Culture, prayer ties."
"Most went well."
"Connecting with everyone."
"Encouraging more self-care allowed more participants to focus on prevention."
"Opening up and talking about our problems. Doing certain exercises."
"Talking circles and prayer ties."
"Adventure involving group dynamics."
"Hands on activities, sharing of stories."
"The prayer ties seemed impactful. I wish there was more to it or more student talk/interaction. I love the conversation; it's very healing."
"Going outside and the talking circle. A few students even asked to talk to the counselor afterwards."
"Movement and the overall body healing."
"I don't feel like there was much healing, they felt like informational clumps."
"Physical activity story telling."

GONA Facilitator Debrief Survey Comments *(continued)*

Q6. What activities seemed to impact GONA participants toward community building?

"Students sharing ideas, introducing themselves, sharing about themselves."
"Being open."
"Talking circle and the selfcare section was really good, and the power of prayer too."
"Connecting."
"Movement is medicine."
"I think the talking circle was impactful but I didn't hear much from the students talking. Encourage more student speech."
"The students seemed to like the frisbee and the talking circle."
"The talking circle was really opening to how important community is."
"Sharing stories, make more connections with students."

Q7. Do you have any suggestion for the next steps of this community?

"Incorporate my learning in hands-on activities."
"More of these."
"Continuing education and healing."
"More story-telling would be great, having elders come in and tell their stories."
"More time to plan."
"More talking about how to cope with the heavy topics and more discipline."
"Having a post discussion on how everything went."
"More hands-on and student involvement. Simplify slide show and have student read bullet points—not the presenter."
"The raffle thing is cool and exciting for the kids. Perhaps more outside activities and less lecturing and more hands-on activities or making something or cultural things."
"Everything went well."
"More culture building involving the youth."
"We should have a leadership team composed of students to speak out for these topics and advocate for mental health."

Summary Report FY 2023-2024

The Asian American Pacific Islander Mental Health Resource Center (*formerly known as Perris Valley Filipino-American Mental Health Resource Cente*r) began their MHSA PEI funded activities in the fiscal year of 2017-2018. The resource center provides mental health resources to the Asian American and Pacific Islander populations in Riverside, Perris, Moreno Valley, Menifee, and other surrounding cities with a high density of the target community. Additionally, the resource center was funded to educate, support, and link Filipino-American families and other Asian American and Pacific Islander individuals who reside in Riverside County experiencing emotional and mental health crises with the Riverside University Health Systems-Behavioral Health (RUHS-BH) mental health services. The resource center is located in Moreno Valley and is run by the Perris Valley Filipino-American Association (PVFAA). In 2022, in response to the COVID-19 Pandemic, PVFAA partnered with a local organization, Asian Pacific Counseling and Treatment Center (APCTC) to establish a COVID-19 Awareness Program to support the community through the pandemic.

The type of services that Resource Center staff provide may include but are not limited to:

1. Community Outreach
2. Recruitment and communicating activities and available services, through combinations of:
   Ads in Filipino-American generated newspapers, E-mail blast announcements, E-mail articles reflecting issues that concern the Filipino/Asian American community, Text Messages, Social Media, Phone Campaigns, Handing out Flyers and Postcards, and Distribution of Annual Newsletter by mail/e-mail
3. Information and Referral
4. Quarterly mental health community seminars, symposia, and workshops on mental health awareness and stigma
5. Monthly Mental Health Support Groups

For the fiscal year 2023-2024, the data collection tool used includes:

- Walk-In Sign-In Sheet
- Initial Contact and Referral Form
- Offsite Outreach Activities Form
- Quarterly Seminar or Mental Health Support Group Sign-In
- Presentation Post-Satisfaction Surveys

This report summarizes the counts of activities provided by AAPI MHRC staff, which include submissions of online and paper forms from the data collection tools listed above. The data from walk-in sign-ins, offsite outreach activities form and the list of Mental Health events and presentations are summarized on pages 2 to 4 of this report. It is noted that there may be missing data from either the following: data not being collected for a particular event/activity, data not submitted to RUHS-BH staff, or missing data from attendees who chose not to sign-in for an event and/or chose not to respond to a demographic question on the form provided. For the Mental Health Events/Presentations provided in the fiscal year 2023-2024, attendees were encouraged to fill out the post-satisfaction surveys at the end of each event. The analysis of the surveys, as well as the comments from attendees, are summarized on pages 5 to 7 of this report.

AAPI MHRC Information of Walk-In Clients

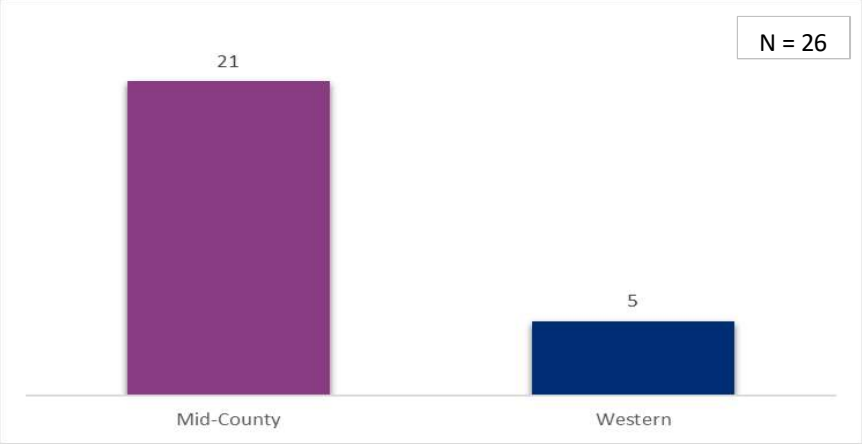
Based on the AAPI MHRC Contact List for those individuals who requested further support in Mental Health, there were a total of 2 people who were referred to RUHS-Behavioral Health. AAPI MHRC staff indicated that they received other requests for help or assistance for various needs, such as housing, employment, and social security concerns, which were not documented for this program.

AAPI MHRC Events and Presentations

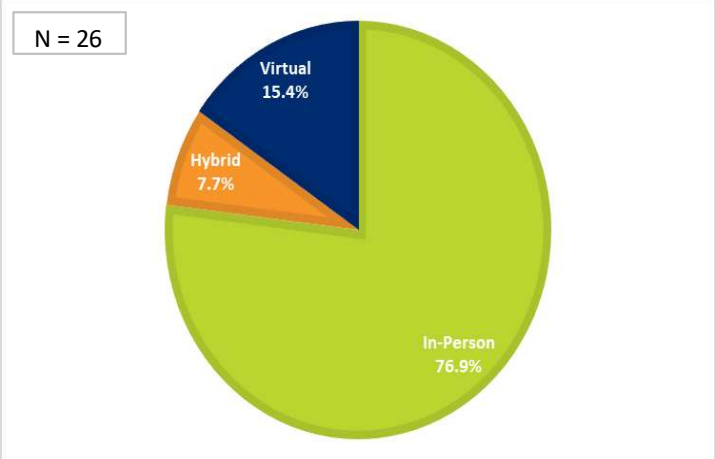
During the fiscal year 2023-2024, there were a total of 26 events conducted by AAPI MHRC. The activity forms were submitted by e-mail or online using Google forms. All of these events were conducted either In-Person, Virtual, or Hybrid, with the majority of the events being conducted In Person (76.9%, n = 20), mostly at the AAPI MHRC main office in Perris. A total of 21 events were completed in the Mid-County region (80.8%), while the remaining 5 events were completed in the Western region (19.2%). The majority of the events were completed in English (80.8%, n = 21), while the remaining 5 events were completed in combination of English and Tagalog. It is also noted that there may be other events that were held by AAPI MHRC but the information was not submitted via online or paper forms.

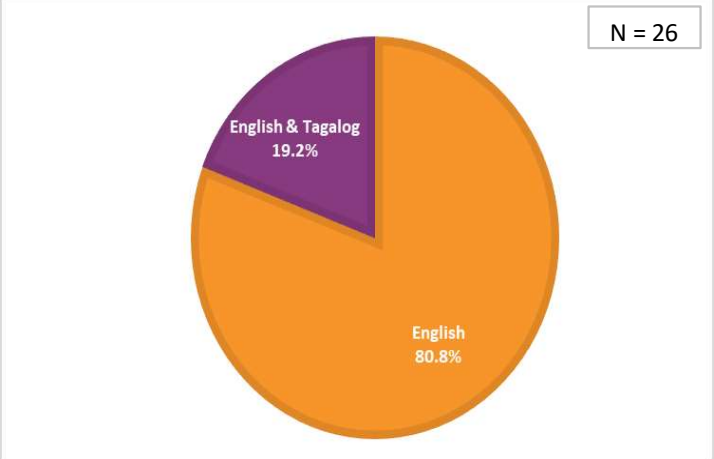
Sign-in sheets from AAPI MHRC events were submitted by either using an online forms or paper forms, by AAPI MHRC staff, and the total number of attendees for each event are listed on the table on the following page. It is also noted that some of the AAPI MHRC presentations were collaborative efforts, with AAPI MHRC staff hosting the events and other RUHS-BH and/or AAPI providers contributed to the events.

Regions of AAPI MHRC Events



Type and Language of AAPI MHRC Events





AAPI MHRC Events and Presentations

Event Date	Event Name/Title/Topic	Event Type/Description	#People in Attendance
07/28/23	Self-Care In Community: Movie Screening "Turning Red"	AAPI Community Movie Screening Series "Turning Red" (geared towards AAPI Teens)	9
07/29/23	AAPI Luau Picnic Event at Lake Perris	AAPI Marketing Presentation & PVFAA Annual Picnic Celebration	43
08/26/23	Self-Care in Community: Movie Screening "A Man Called Otto"	AAPI Community Movie Screening Series "A Man Called Otto" (for Suicide Prevention Month)	3
08/30/23	AAPI MHRC Marketing Presentation	AAPI Marketing Presentation via Zoom	24
09/09/23	Self Care in Community: AAPI Karaoke Night	AAPI Marketing Presentation and Self-Care Activity in honor of Suicide Prevention Awareness Month	18
09/30/23	Film Screening and Talk on Asian Family Mental Health with Dr. Ma	AAPI Marketing Presentation in honor of Suicide Prevention Awareness Month	25
10/21/23	Self-Care in Community: Self-Affirmations in Baybayin	AAPI Marketing Presentation	69
10/25/23	Annual Harvest Festival by Avalon Elementary School	AAPI Health Fair/Community Wellness Event	137
11/18/23	Hands-On Parol (Lantern) Making for the Holidays - Connecting Tradition and Culture and Managing Stress during the Holidays	AAPI Marketing Presentation	32
11/18/23	AAPI Workshop on “Making Gender-ational Mosaics” (MH Workshops on Gender Euphoria Intergenerational Queer Community and Digital Collage)	AAPI Educational Workshop	*Not listed*
12/02/23	Hands-On Parol (Lantern) Making for the Holidays - Connecting Tradition and Culture and Managing Stress during the Holidays	AAPI Marketing Presentation	18
12/03/23	AAPI Parol (Lantern) Festival	AAPI Marketing Presentation	200
01/13/24	AAPI Educational Workshop on MH Wellness and Challenges that AAPI young adults face today	AAPI Educational Workshop	29
02/03/24	AAPI Educational Workshop on MH Awareness and Self-Concept through community storytelling and Asian Diasporic Futurist Framework	AAPI Educational Workshop	21
03/23/24	AAPI Educational Workshop - All the Feels: Unlocking Emotions through K-Dramas	AAPI Educational Workshop	17
04/13/24	AAPI Community Wellness & Yard Sale Event at Faith Community Church-Perris	AAPI Health Fair/Community Wellness Event	35
04/13/24	AAPI Educational Workshop - Mindful Melodies: Nurturing Community Wellness through Music	AAPI Educational Workshop	27
04/25/24	Let's Get Together, Mental Health Matters: Introduction to Chika Chika Connection	AAPI Educational Workshop	8
05/04/24	AAPI Community MH Wellness Event: Daisy Walk a Sysco Riverside	AAPI Health Fair/Community Wellness Event	27
05/09/24	Let's Get Together, Mental Health Matters: 2nd Chika Chika Connection	AAPI Educational Workshop	12
05/13/24	AAPI Film Screening: Nurse Unseen (Honoring Filipino Heroes that served on the front lines of the COVID-19 Pandemic	AAPI Marketing Presentation	30
05/17/24	AAPI Luau Event at Val Verde High School-Perris	AAPI Health Fair/Community Wellness Event	48
05/27/24	Let's Get Together, Mental Health Matters: 3rd Chika Chika Connection	AAPI Educational Workshop	12
06/01/24	AAPI Community Garden Event	AAPI Health Fair/Community Wellness Event	15
06/10/24	Let's Get Together, Mental Health Matters: 4th Chika Chika Connection	AAPI Educational Workshop	10
06/24/24	Let's Get Together, Mental Health Matters: 5th Chika Chika Connection on "The 10 Guideposts to Wholehearted Living"	AAPI Educational Workshop	10

Total Number of Mental Health Events: 26

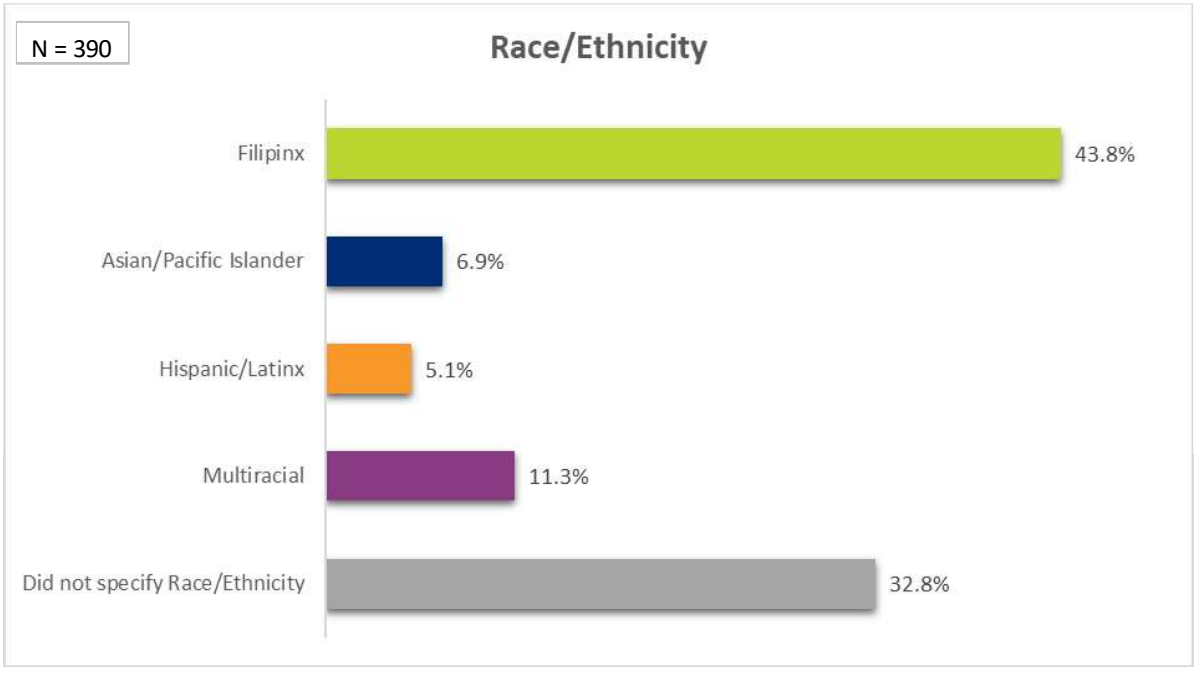
Total Counts of Event Attendees: 390 *(based on sign-in sheets submitted)*

AAPI MHRC Demographic Information of Event Attendees

Based on the online and paper sign-in sheets and demographic forms submitted, there were a total of 390 people who attended the AAPI MHRC mental health events during the fiscal year 2023-2024. It is noted that on some of the events, some attendees may chose not to fill out the sign-in forms, or there may be missing data from forms not being submitted. The event sign-in form provides a section where attendees can choose to respond to the basic demographic questions. The graphs below summarized the *Age Group*, and *Race/ Ethnicity* of the AAPI MHRC events' attendees, based on the data submitted.

The majority of the events' attendees left the *Gender* question unanswered, therefore, there was not enough data to count. When categorizing attendees into different *Age* groups, the majority of the attendees also chose "not to respond" (64.9%, n = 253). Of those who did respond to the *Age* question, the majority "60 years or older" (12.3%, n = 48). In regards to the *Race/Ethnicity* question, the majority indicated that they were "Filipinx" (43.8%, n = 171), followed by "Multiracial" (11.3%, n = 44), "Asian/Pacific Islander" (6.9%, n = 27), and "Hispanic/Latinx" (5.1%, n = 20), respectively. It is also noted that 32.8% of the attendees (n = 128) chose not to respond to this question.

Age Category (n = 390)	Number of People/Percentage
17 years old or younger	**22 (5.6%)**
18 to 29 years old	**23 (5.9%)**
30 to 39 years old	**10 (2.6%)**
40 to 49 years old	**17 (4.4%)**
50 to 59 years old	**17 (4.4%)**
60 years or older	**48 (12.3%)**
Chose not to respond	**253 (64.9%)**
Total	**390**



AAPI MHRC Events: Post-Satisfaction Survey Results

After each AAPI MHRC presentation, attendees were asked to complete the post-satisfaction surveys. For the FY 2023-2024, a total of 58 satisfaction surveys were completed and submitted using both online and paper formats.

Satisfaction Survey Items (n = 58)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The information presented was easy to understand.				6.9%	93.1%
2. The presenter was engaging when presenting the information.				6.9%	93.1%
3. I would recommend to my friend and family members that they attend a presentation like this.	1.7%			5.2%	93.1%
4. As a result of this presentation I feel I am better able to talk about mental health issues with my family and friends.			5.1%	19.0%	75.9%
5. I view mental illness as something to be ashamed off.	51.7%	10.3%	6.9%	12.1%	19.0%
6. Mental illness can be managed and treated.			3.5%	24.1%	72.4%
7. I would feel comfortable seeking help for myself or a family member regarding mental health issues.		1.7%	6.9%	22.4%	69.0%

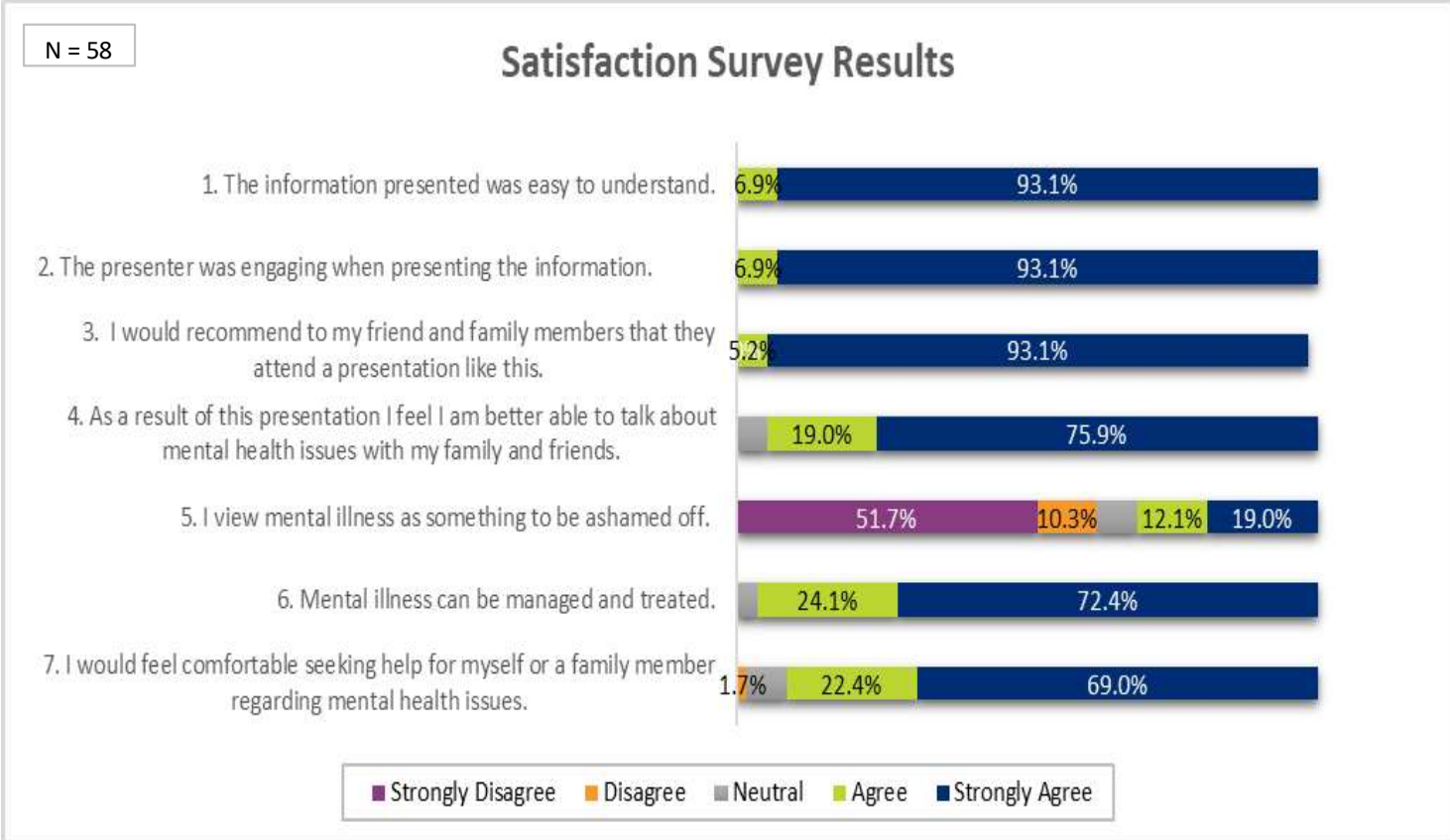
Summary of Survey Results:

The results of post-satisfaction surveys collected from AAPI MHRC event attendees can be summarized below:

- **100%** attendees responded "Strongly Agreed" or "Agreed" that ***the information presented during the presentation was easy to understand***, and that ***the presenter was engaging when he/she presented the information***.
- **98.3%** of the attendees "Strongly Agreed" or "Agreed" that *they* ***would recommend their friends and family members to attend a similar presentation***.
- After the presentation, **94.9%** of the attendees felt "Strongly Agreed" or "Agreed" that ***they were better able to talk about mental health issues with their family and friends***.
- After the presentation, **51.7%** of attendees "Strongly Agreed" that ***they did not view mental illness as something to be ashamed of***, while **19%** "Strongly Agreed" that ***they viewed mental illness as otherwise***.
- After the presentation, **96.5%** of attendees felt "Strongly Agreed" or "Agreed" that ***mental illness can be managed and treated***.
- **91.4%** of attendees felt "Strongly Agreed" or "Agreed" that ***they would feel comfortable seeking help for themselves or their family members regarding mental health issues after the presentation***.

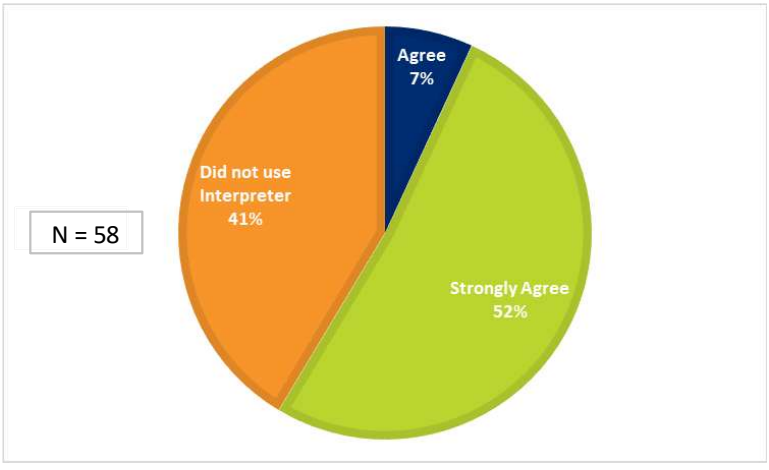
AAPI MHRC Events: Post Satisfaction Survey Results (*continued*)

The figure below shows the post-satisfaction survey results in a graph format to better illustrate the attendees' responses after the AAPI MHRC events/presentations.



Optional question:
The interpretation service was easy to understand.





The last question on the satisfaction survey was for attendees to indicate whether or not they used the interpretation service while attending AAPI MHRC events, and if so, whether or not the interpretation service was easy to understand. This was an optional question since not all attendees needed the interpretation service, although it was still offered during the events. Based on survey data collected from 58 attendees, **34** (**58.6%**) responded that they were either "Strongly Agreed" or "Agreed" that ***the interpretation service was easy to understand***, while 41.4% (n = 24) indicated that they did not use the interpretation service.

AAPI MHRC Events: Post-Satisfaction Survey Comments

The post satisfaction survey also has a section where participants could write comments on whether or not "***the presentation was helpful***", as well if to comment if they had any other feedback regarding the program. Below are the comments from participants that were gathered from the satisfaction surveys:

"Great Event! Made mental health a more "family-friendly "topic for something that is usually so taboo. Very impactful!"
"Liked the open communication across generations."
"The material presented was relevant and good information to be heard and learned."
"Liked the group interaction, and the support group to look forward."
"Good reminder to find your support and do self-care."
"I liked everything that was discussed during the event."
"The presenter was understandable, did a great job and helpful!"
"I really appreciate the open and supportive atmosphere. Thank you for making through the mental health awakening management in a very clear and supportive way."
"I liked how they tried to get through the mental wellness plan together and the collaborative nature in multiple AAPI community organization."
"I learned a lot from this event."
"All of the topics are very helpful. Dr. Navarro is very knowledgeable."
"Now I understand the meaning of othering, how that affects me and others without knowing it."
"Very Satisfied! Learned a lot of great ideas and principles. Applicable to daily life."
"Movie and captivity were great demonstration on identifying signs of mental health challenges, how to offer help and how to develop skills and relationships to improve outlook."
"They made the environment very comfortable to talk & interact both very welcoming new talks."
"The physical resources are helpful. I'll definitely take them hoe to share with my family."
"I liked the Chika Chika connection with other Filipina women."
"Good event and set-up. Very well coordinated and planned out."
"There is a solution of everything, and acceptance is very important, being honest of oneself."
"I liked the breathing exercise, affirmations, using digital collage to explore feelings and expressions."
"I felt like it gave me a space to deep-dive and reflect on some buried thoughts. It was comforting to share it with a community of people with similarities."
"A lot of opportunities to share, spotlight on how Asian culture adds additional layers of complexity to the conversation, very validating and real stance of presenter/well researched current events examples, actionable takeaways of what to try and what to avoid."
"It was really nice to be in a community of people with similar experiences."
"I liked the activities as well as learning about the connection of art, narratives, and mental health."
"I had so much fun today. It was a stress reliever, I laughed a lot, and what a great way to connect! Would love another session to join anytime soon."
"The interaction and activities were really good. I was a little shy at first, but the facilitators were welcoming and broke the ice for participants to jump in and participate."
"I liked being in community and listening to healing music"
"It was very affirming to connect with others regarding the connect we all share with music, and connecting it to how we cope, express, create, and live. Thank you very much!"
"I liked using music as a way to cope with mental health was a very creative concept! Thanks!"
"The connection between music and mental health."
"This presentation was so warm and welcoming, I had fun making a playlist :) Thank you so much!"

MHSA Prevention and Early Intervention
Keeping Intergenerational Ties in Ethnic Families (KITE)

Annual Outcomes Report
FY 2023-2024

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Executive Summary

Intergenerational/Intercultural conflict is a significant stressor in immigrant families that occurs because of differential acculturation between migrant parents and their children (Ying, 2007). More specifically, Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF) is a community-based educational intervention that aims to strengthen the intergenerational relationship between immigrant parents and their school-age children and adolescents. Parents are introduced to methods that may be used to cope with the stresses of parenting and migration, that are adapted from a course on the prevention of depression (Munoz & Ying, 2002).

Keeping Intergenerational Ties in Ethnic Families (KITE) Program, formerly known as SITIF, is funded by RUHS Behavioral Health MHSA-PEI that started in the fiscal year 2019-2020, and is currently in its fifth year of funding. The KITE program was built to address the needs of our culturally diverse Asian-American Pacific Islander (AAPI) community, and was awarded to Asian Pacific Counseling and Treatment Center (APCTC) to begin in July 2019. More specifically, the KITE program was designed to offer Prevention and Early Intervention services for Asian-American Pacific Islander (AAPI) parents with school aged children and adolescents (ages 6 to 17 years old).

During the fiscal year 2023-2024, there were a total of 67 parent participants within Riverside County enrolled in a total of 5 KITE parenting program series (2 class series were offered in Chinese, and 2 class series were offered in combination of Tagalog and English, and 1 class series was offered in Korean). Of these, a total of 54 parent participants successfully completed the program. For FY 2023-2024, KITE parenting classes were completed using a combination of virtual via Zoom, as well as in-person (offered at churches or local schools), depending on participants' schedules and preferences. Despite the fact that some of the parent participants were unable to complete the program due to scheduling conflict or other personal reasons, the total completion percentage for the KITE program during the fiscal year 2023-2024 was still relatively high at 80.6%.

Additionally, during the fiscal year 2023-2024, KITE program workshops were offered to the Asian-American Pacific Islander (AAPI) communities, and KITE program outreach activities were also conducted. Similar to the KITE parenting program, these workshops were offered in combination of virtual and in-person methods, depending on parents' and/or coordinators' schedules. KITE outreach activities were also in combination of in-person as well as virtually via Facebook groups and WeChat. In fiscal year 2023-2024, there were a total of 21 KITE workshops offered with a total of 273 AAPI attendees.

Executive Summary

Based on the demographic data submitted from 67 enrolled parent participants for the fiscal year 2023-2024, the demographic data shows that the majority of participants for the KITE Program were Female (64.8%, n = 35), who mostly resided in the city of Eastvale (40.7%, n = 22). The KITE parent participants were predominantly Chinese (61.1%, n = 33), who preferred to use Mandarin/Chinese as their primary language. Additionally, there were 39 participants (72.2%) who responded that they were the "First-Generation Americans," and 50% of the total participants (n = 27) responded "Yes," that they do have conflicts with their children due to different cultural beliefs. Based on responses on their children's ages, parent participants indicated that their children were between the ages of 6 and 11 years old (48.2%, n = 26) and between the ages of 11 and 17 years old (46%, n = 25), while the remaining 3 participants indicated that their children were under the age of 6 (3.8%), and over the age of 17 (1.9%).

There were three survey measures collected at the beginning and at the end of the KITE Program, as well as post–satisfaction surveys collected at the completion of the program. The pre-post *Strength and Difficulties Questionnaire (SDQ)* analysis showed that there were decreases on the average scores in **Hyperactivity Scale** (11.3% change from 1.93 to 1.71), **Emotional Symptom Scale** (11.1% change from 1.57 to 1.39), **Peer Problems Scale** (8.9% change from 1.53 to 1.40), and **Conduct Problems Scale** (7.5% change from 1.43 to 1.33). Additionally, there was an increase on the **Prosocial Scale** (9.6% change from 2.34 to 2.57). Overall, average scores on the SDQ pre-measures were within the normal range across all SDQ scales, which suggest that parent participants did not view their children's strength and difficulties as an issue, at enrollment into the KITE program. The pre to post analysis using a paired samples T-Test showed statistically significant results ($p < .05$) on all items on the of the SDQ scale, as well as the **Total Difficulties** scale.

Additionally, the pre-post *Alabama Parenting Questionnaire (APQ)* analysis showed a 6.7% increase on the **Parenting Involvement Scale** (from 3.50 to 3.74) and a 5.1% increase on the **Positive Parenting Scale** (from 4.06 to 4.27), while **Inconsistent Discipline Scale** showed a 7.5% decrease (from 2.74 to 2.514, and **Other Discipline Practices Scale** showed a 2.9% decrease (from 2.61 to 2.53). Furthermore, both **Parenting Involvement** and **Positive Parenting** scales showed statistically significant results ($p < .05$).

The pre-post *Relationship* analysis showed that the total scores increased 2.52 points from pre-to-post measures, from 32.39 to 34.91, and a paired samples T-Test showed that this result is statistically significant ($p < .05$). An item-by-item analysis showed the highest percent differences was shown on items number 9 (**I am satisfied with our relationship**), with a 18.5% increase from pre-to-post measures, followed by item number 3 (**My child obeys me**), with 14.8% increase from pre-to-post measures. Further analysis using paired samples T-tests also showed that 7 out of 9 APQ scale items showed statistically significant results at or below $p < .05$.

Overall, analysis on the post-satisfaction surveys showed highly positive results, that the majority of parent participants (92% or more) responded to either "Strongly Agree" or "Agree" to all of the survey statements. The majority of parent participants also provided very positive feedback regarding the KITE parenting programs, with many commenting that they understood their children more, that their relationships with their children were much closer, that they communicated better, and that they were able to bridge the cross-cultural gaps with their children.

Program Description

Keeping Intergenerational Ties in Ethnic Families (KITE) Program, formerly known as SITIF, is funded by RUHS Behavioral Health MHSA-PEI to address the needs of our culturally diverse Asian-American Pacific Islander (AAPI) community. This program first started in the fiscal year 2019-2020, and currently in its third year of funding. KITE Program offers Prevention and Early Intervention services for Asian-American Pacific Islander (AAPI) parents with school-aged children and adolescents (ages 6 to 17 years old). Furthermore, the KITE program is built as a community-based educational intervention that aims to strengthen the inter-generational relationship between Asian-American Pacific Islander (AAPI) immigrant parents and their school-aged children and adolescents.

The KITE program is designed to target on the parents' affection, cognition, and behaviors. Through KITE program, parents are expected to learn to effectively empathize with their child's perspective, to cognitively understand variations in the ethnic and American Cultures and its impact on their child's development, values and their intergenerational relationship, as well as to develop effective behavioral parenting skills. Parents are introduced to methods that may be used to cope with stresses of parenting and migration. The KITE program also incorporates cultural competency principles, including but not limited to, awareness of cultural differences, knowledge of cultural contents (i.e. norms, customs, language, lifestyle, etc.), accurate assessment and differentiation of culture and pathology, and use of culturally competent interventions.

The community based organization assigned for this program is Asian Pacific Counseling and Treatment Center (APCTC), which is contracted to provide education and skill development for parents by conducting parent education workshops to Asian-American Pacific Islander parents within community organizations, such as schools, churches, homes, and other natural settings that are non-threatening/non-stigmatizing locations for participants. KITE is an 8-session program, with 2-hour sessions usually held weekly in the evening, and offered in the parents' preferred language. Currently, they are offered in Simplified Chinese, Korean, and combination of English/Tagalog languages. It is an intensive program where detailed curriculum is followed, in which parents need to complete weekly homework assignments, and are individually reviewed by the trained instructors.

The KITE program goals include: strengthening parenting skills, building family strengths, enhancing youth's school success, and reducing risk factors for behavioral, emotional and social problems in children and adolescents; i.e. those from communities that are underserved, low-income, exposed to violence, trauma, and other stresses. Currently the services are provided in the Western and Mid-County Regions of Riverside County, in the target communities identified below:

- **Western Region**: Riverside, Jurupa, Moreno Valley, Norco, Rubidoux, Pedley, Sunnyslope, Mira Loma, Glen Avon and other surrounding unincorporated areas.
- **Mid-County Region**: Hemet, San Jacinto, Lake Elsinore, Perris, and other surrounding unincorporated areas.

APCTC is contracted to provide parenting educational group series, for a combined minimum of 40 parents per region, per year. Each group will have a minimum of 6 parents enrolled and a maximum of 20 parents enrolled (Ratio: 1 Facilitator to 10 Parents). The KITE program completion is defined as completing 6 out of 8 sessions. Additionally, APCTC is expected to implement at least 10 "Community Education/Outreach Workshops" per region, per year, with each specific Asian immigrant parent group (i.e., Chinese, Korean, or Filipino).

Class Curriculum

The KITE class curriculum is based on the SITIF program, which was developed and validated by Dr. Yu-Wen Ying of UC Berkeley, and has been translated in Chinese, Korean, Vietnamese, and Spanish. In KITE program curriculum, different skills have different objectives, and parents are invited to employ the skills that are most likely to yield the desired outcome, so all of the methods covered in KITE program focus on parenting process of "how-to" and not specific parenting content of "what-to." For example, while immigrant parents may prefer a hierarchical unidirectional method of communication that is sanctioned by their ethnic culture, their children may prefer a more interactive style that involved less lecturing and more active listening (Ying, 2007). Generally, the KITE program is designed to bring parents' awareness, promoting greater cross-cultural competence, to improve their sense of control in parenting and developing effective parenting skills, particularly in the area of communication, and to help them cope better with the stresses of cross-cultural parenting.

The KITE class curriculum developed by Dr. Ying was originally designed to be a 10-session curriculum for first -generation immigrant parents, and it is a culturally sensitive, community-based intervention. For the KITE program, the curriculum has been modified and condensed into an 8-session program, where parent participants are expected to complete 6 out of 8 sessions in order to complete the parenting series. The aim of KITE class curriculum is to improve the intergenerational relationship, and discusses the following:

- Parents sense of self-efficacy (i.e. emotional awareness and empathy for their children's experiences)
- Knowledge and understanding of differences between the native and American cultures
- Teaches behavioral parenting skills, including self-care

The KITE program's 8-session class schedule and topics are as follows:

- *1st Session: Introduction & Learning about Cultural Differences*
- *2nd Session: Understanding Your Child*
- *3rd Session: Promoting Parent-Child Understanding*
- *4th Session: The Use of Structuring and Reinforcement*
- *5th Session: The Use of Rules, Limits, Consequences, and Punishment*
- *6th Session: The Use of Special Time*
- *7th Session: Review of Parenting Skills*
- *8th Session: Coping with Stress & Strengthening the Intergenerational Relationship-Conclusion*

After each KITE class session, parent participants are required to do the assigned homework related to the current week's topic, which is then discussed together as a group on the following class session. Overall, the KITE class curriculum highly encourages parent participants to be actively involved in the following, but not limited to, sharing their cultural background, family background, opinions about raising their child in a different culture than the one the parents were raised in, experiences in communicating with their child, and any challenges they may encounter when trying to strengthen their relationship with their child.

Data Collection

The RUHS-BH Demographic form is to be collected at the beginning of each KITE parenting class series (1st session/Week 1), as well as the Pre-Measures. Additionally, Post-Measures and Post-Satisfaction Surveys are to be collected at the end of each class series (8th session/Week 8). Other forms such as, Weekly Sign-In Form, Master Attendance Roster Form, Data Submission Checklist Form, and Justification for Missing Performance Measures Form are additional documents to be collected and submitted to RUHS-BH at the completion of each KITE parenting class series.

There are three different measures used for the KITE program that are collected at the beginning of the KITE program, and at the completion of KITE program:

- ***Strength and Difficulties Questionnaire (SDQ)***
- ***Alabama Parenting Questionnaire (APQ)***
- ***Relationship Questionnaire***

These three measures are used to document participant's thoughts and challenges prior to and after the KITE program has been completed, and will be analyzed to measure and compare the changes in participants' thoughts and relationships with their children before and after completing the KITE program. The post-satisfaction surveys are also distributed and collected at the end of the KITE program, with the purpose of documenting the participants' feedbacks on their perception of the KITE Program.

On all of the measures, we asked each parent participant to list the child name and age, and to focus on their current relationship with that particular child. When parents have more than one child, we asked the parent to list the child's name and age on which the parents would like to focus their current relationship on. The child's age must be between the ages of 6 and 17 years old. Generally, the oldest child is used as the "target child", on whom parent participants would practice their parenting skills as part of their weekly homework assignments. For families with more than one child, the target child can also be the child with whom the parent participant has the most relationship challenges.

There were a total of 5 KITE parenting class series completed during the fiscal year 2023-2024, and a total of 67 parent participants enrolled in the KITE program. Of these enrolled participants, a total of 54 completed the KITE program, a completion rate of 80.6%. The classes were offered in the following groups, using the group's native language:

- Chinese (2 class series were completed, offered in Chinese Simplified/Mandarin)
- Filipino (2 class series was completed, offered in combination of English and Tagalog)
- Korean (1 class series were completed, offered in Korean)

In addition to the KITE parenting class series, KITE workshops were also offered to AAPI parents who were interested to participate prior to joining the KITE parenting program. The KITE workshops are generally shorter, consist of 1 session or more, depending on the type of workshop, and last approximately one hour. There were a total of 21 KITE workshops completed during the fiscal year 2023-2024, where 13 workshops were offered in the Western region, and 8 workshops were completed in the Mid-County region, with a total of 273 attendees:

- 12 workshops were completed in Mandarin/Simplified Chinese for Chinese groups
- 6 workshops were completed in combination of English and Tagalog for Filipino groups
- 3 workshops were completed in Korean for Korean groups

The detailed description for KITE Program Completion, as well as the lists for KITE Parenting Class Series and KITE Workshops are shown on pages 7 to 10.

KITE Parenting Class Series and Workshop Completions

The contract expectations for the KITE program were to complete the following: 10 "Community Education/ Outreach Workshops", 3 "Bicultural Parenting Class Series", as well as a combined minimum of 40 parents completed per region, per year, with each specific Asian immigrant parent group (i.e. Chinese, Korean, or Filipino). Tables below describe the total completion and contract expectations from KITE Program during the fiscal year 2023-2024.

Due to the widespread of COVID-19 pandemic since early 2020, all outreach activities, workshops and parenting class series were conducted entirely online for the fiscal years 2020-2021 and 2021-2022. For the fiscal years 2022-2023 and 2023-2024, a combination of virtual and in-person outreach activities, workshops, and parenting class series were conducted. There were a total of 21 KITE workshops completed (a 105% completion rate), in which 13 workshops were completed in the Western region and 8 workshops were completed in the Mid-County region. Overall, the total workshops completion for fiscal year 2023-2024 exceeded the contract expectation of completing 20 workshops in the fiscal year. Additionally, there were a total of 5 KITE parenting class series completed (a 83.3% completion rate) during the fiscal year 2023-2024, in which 3 of the parenting class series were completed in the Western region, and 2 parenting class series were completed in the Mid-County region.

It is also expected that the assigned contractor would provide a KITE parenting class series to a minimum of 40 parents per region, per year. During the fiscal year 2023-2024, a total of 54 parent participants completed the KITE parenting class series, out of 67 parent participants within Riverside county regions (a 80.6% completion rate). Based on the total counts of class completion, the Western region met 66.7% of the contract expectation (40 parents completed), while the Mid-County region met 23.3% of the contract expectation (14 parents completed). Overall, the Countywide percent completion for KITE parenting program is 45% in regards to the contract expectation.

KITE Workshop Completion (n = 21)			
Source:	Number of Workshops Completed	Contract Expectations	Percent Completed
Western/Riverside	13	10	130%
Mid-County	8	10	80%
Countywide	21	20	105%

KITE Parenting Class Series Completion (n = 5)			
Source:	Number of Parenting Classes Completed	Contract Expectations	Percent Completed
Western/Riverside	3 series	3 cycles	100%
Mid-County	2 series	3 cycles	66.7%
Countywide	5 series	6 cycles	83.3%

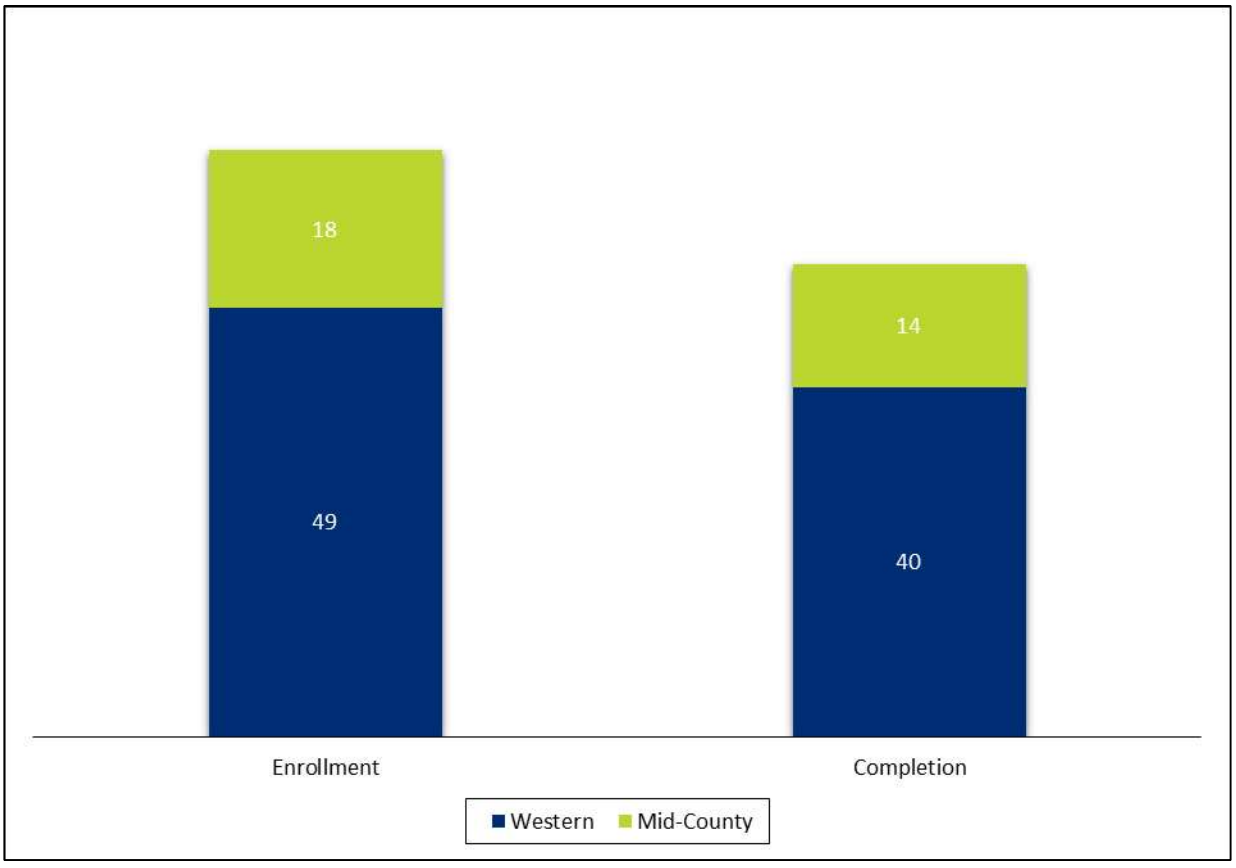
KITE Parenting Class Participants Completion (n = 54)			
Source:	Number of Parent Participants Completed	Contract Expectations	Percent Completed
Western/Riverside	40	40	100%
Mid-County	14	40	35%
Countywide	54	80	67.5%

KITE Parenting Classes—FY 2023-2024

Language	Location/Group Site	Number of Cycles	Region		Start Date	End Date	Number of Enrollment	Number of Completion
			Mid-County	Western				
Chinese	Eastvale Elementary School	2	0	2	07/20/23	09/28/23	11	9
	Riverside Unified School District (Zoom)				01/31/24	03/27/24	30	26
Korean	Riverside Korean Baptist Church	1	0	1	10/18/23	12/20/23	8	5
Filipino	New Hope Community Church	2	1	0	10/14/23	01/13/24	10	8
	New Hope Community Church		1	0	03/27/24	05/15/24	8	6
Total:		**5**	**2**	**3**	**Total:**		**67**	**54**

Completion Rate: 80.6%

KITE Parenting Class Enrollments by Region—FY 2023-2024



KITE Workshops—FY 2023-2024

Language/ Ethnicity	Number of Workshops	Region		Date	Location	Topic	Attendees
		Mid-County	Western				
Korean	3	2	1	4/10/2024	Calvary Church Murrieta (Zoom)	5 Love Languages of Children	6
				5/19/2024	Riverside Korean Baptist Church	5 Love Languages of Children	41
				5/30/2024	Calvary Church Murrieta	Bicultural Identity	3
Filipino	6	6		09/30/23	New Hope Community Church Temecula	Family Ties	27
				11/18/23	San Manual Filipino Association	Showing Understanding	7
				01/23/24	Liberty High School	Showing Understanding	4
				02/23/24	Crown Hills School	Bicultural Identity	4
				05/18/24	Bataan Association	5 Love Languages of Children	9
				06/22/24	Onward Zion	KITE Parent Class Preview	13
Chinese	12		12	07/27/23	Eastvale Elementary School	Bicultural Identity	11
				08/03/23	Eastvale Elementary School	Understanding Your Teens	13
				09/14/23	Eastvale Elementary School	5 Love Languages of Children	8
				09/21/23	Eastvale Elementary School	Self-Care: Mindfulness	7
				09/27/23	Roosevelt High School	Understanding Your Teens	9
				10/12/23	Riverside Unified School District (Zoom)	5 Love Languages of Children	2
				02/07/24	Riverside Unified School District (Zoom)	Understanding Your Teens	25
				03/13/24	Zoom	Self-Care: Mindfulness	22
				03/20/24	Zoom	5 Love Languages of Children	20
				05/19/24	Norco Community Christian Church	Cross-Cultural Identity of Chinese American	20
				05/23/24	Norco Community Christian Church (Zoom)	Cross-Cultural Identity of Chinese American	19
				06/04/24	Eastvale Library	KITE Parent Class Preview	3
Total Number of Workshops: 21		**8**	**13**				**Total Workshop Attendees: 273**

Demographics

There were a total of 67 parent participants who enrolled in the KITE program in Riverside County for the fiscal year 2023-2024. Of these, 54 participants completed the parenting class series and submitted the complete demographic forms, pre measures, post measures, as well as satisfaction surveys. The remaining 13 participants did not complete the program due to scheduling conflicts or personal reasons. The overall completion rate for the KITE parenting program in FY 2023-2024 was 80.6%.

Gender

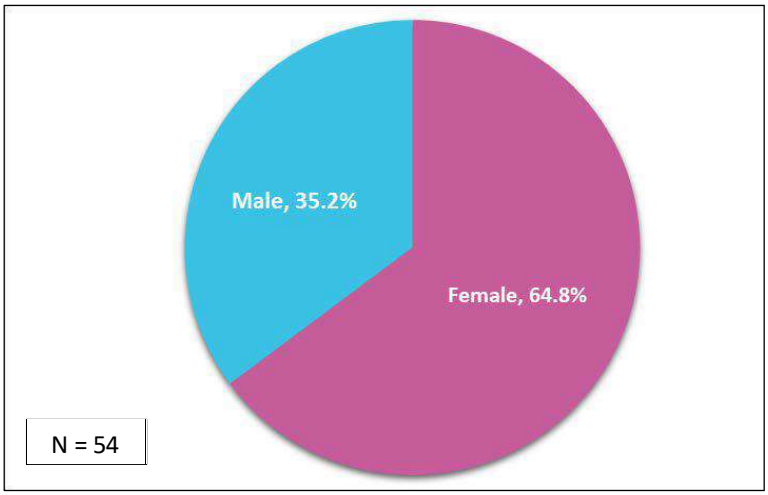
The majority of KITE parent participants were Female (64.8%, n = 35), while the remaining participants were Male (35.2%, n = 19).



Female (n = 35)

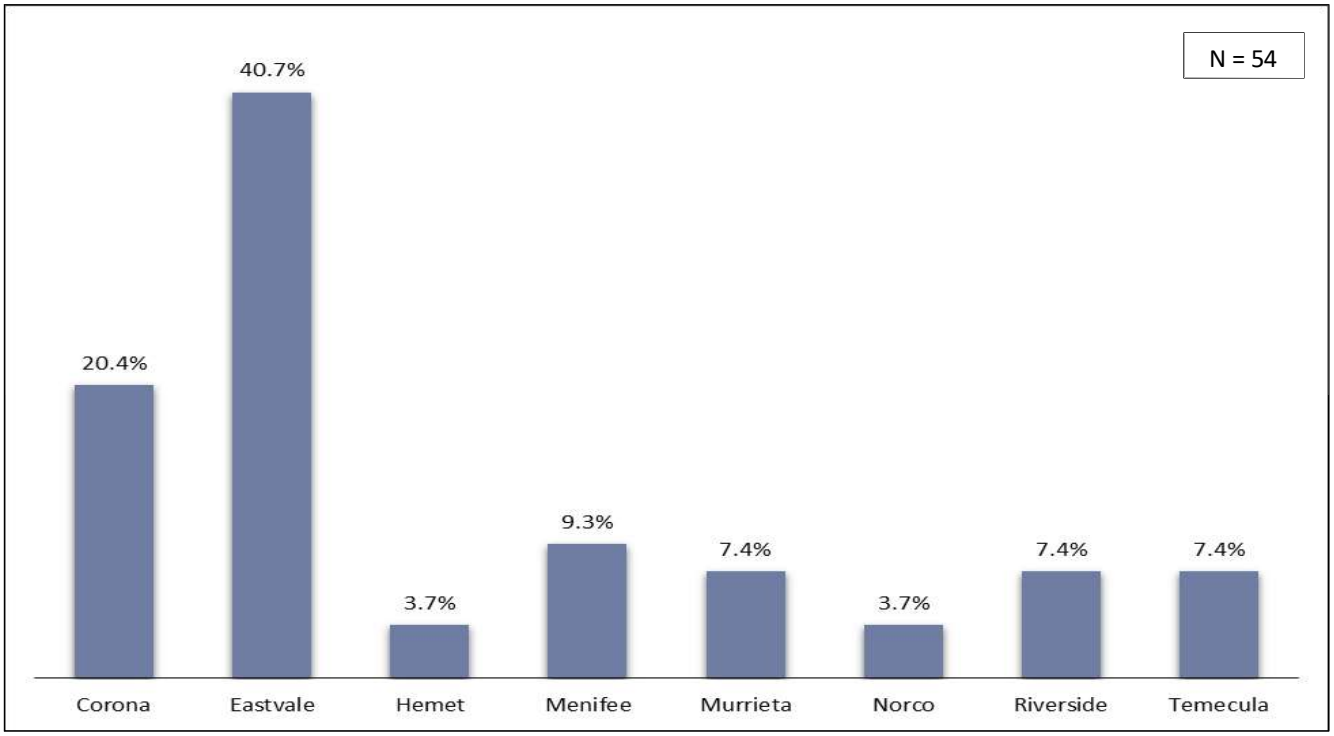


Male (n = 19)



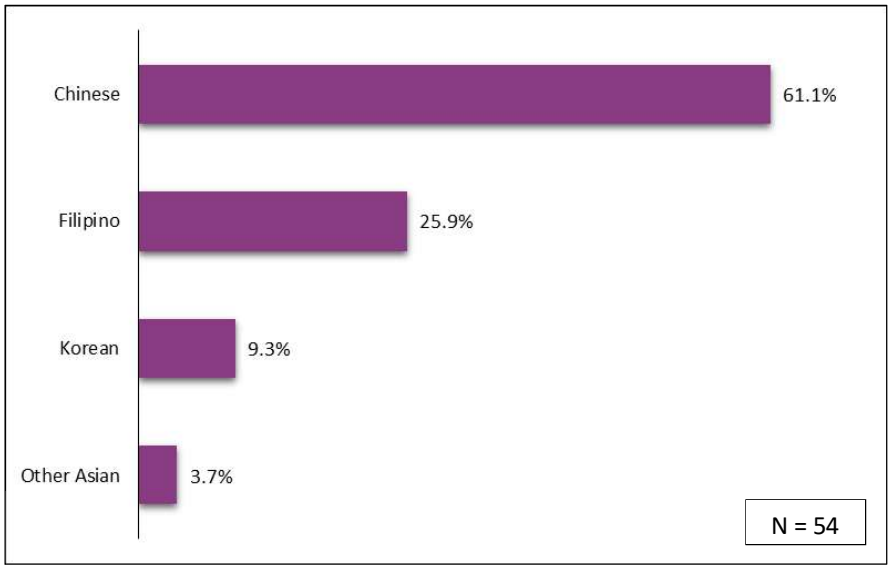
City of Residence

The majority of KITE parent participants indicated that they reside in Eastvale (40.7%, n = 22). Smaller percentages of parent participants resided in Corona (20.4%, n = 11) and Menifee (9.3%, n = 5), while the remaining participants indicated that they resided in Murrieta, Riverside, Temecula, Hemet, and Norco.



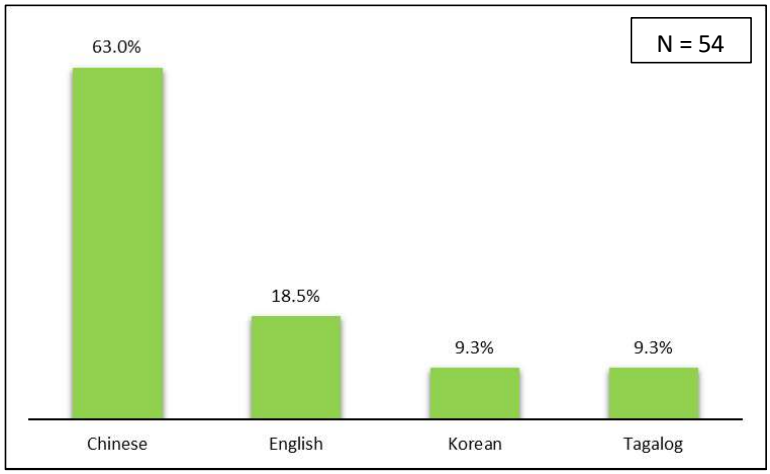
Race/Ethnicity

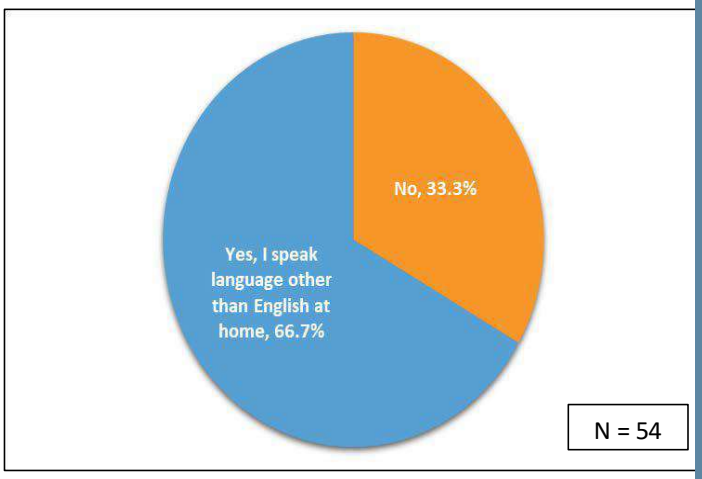
The majority of parent participants enrolled in the KITE Program were Chinese (61.1%, n = 33), while the remaining participants reported they were Filipino (25.9%, n = 14), Korean (9.3%, n = 5), and Other Asian (3.7%, n = 2).



Preferred Language and Language Spoken at Home

The majority of parent participants indicated that their preferred language was Chinese (63%, n = 37), while other languages spoken were English (18.5), Korean (9.3%), and Tagalog (9.3%). We also asked participants if they speak a non-English Language at home, and 66.7% (n = 36) responded "Yes". Participants listed the languages used at home as follows: Chinese, Korean, and Tagalog.





Disabling Condition, LGBTQI, and Veteran Status

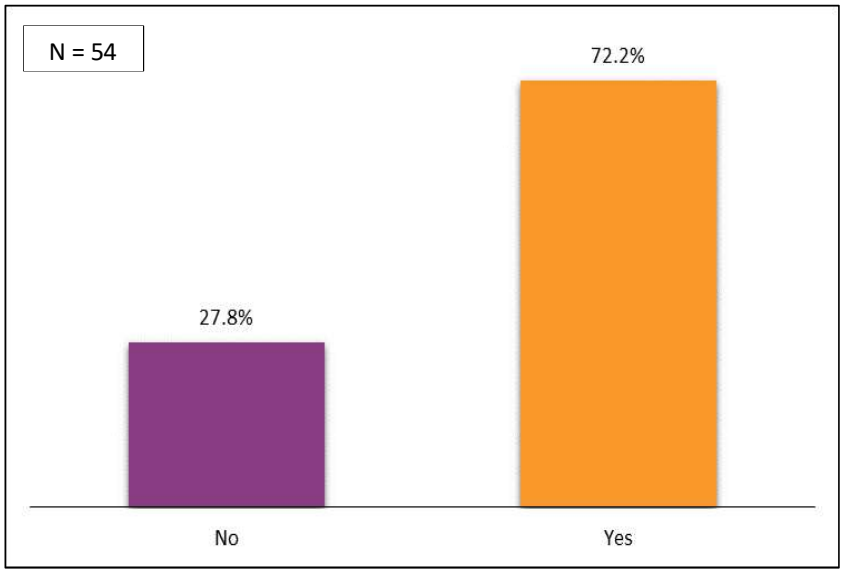
In response to demographic questions related to whether or not they have identified themselves as having Disabling Condition, identified as LGBTQI, and identified as Veterans, the results can be summarized as follows:

- 92.6% participants (n = 50) responded "No", in regards to whether or not they have any disabling condition. The remaining 4 participants who responded "Yes", noted that they have the following conditions: PTSD, Aneurysm, Psoriatic Arthritis, and Hearing Loss.
- 100% participants responded that they did not identify themselves as LGBTQI.
- 94.4% participants (n = 51) responded that they were not Veterans.

First Generation Americans and Conflicts due to Cultural Beliefs

One of the demographic question was for parent participants to indicate whether they were either "First Generation" or "Second Generation" Americans. First-generation Americans are defined as being born outside of the United States, while second-generation Americans are born in the United States but have parents who are born abroad. In response to this question, the majority (72.2%, n = 39) responded "Yes", that they are First-Generation Americans. Parent participants were also asked whether they had conflicts with their children due to different cultural beliefs, and 50% responded "Yes".

Are you 1st Generation Americans?

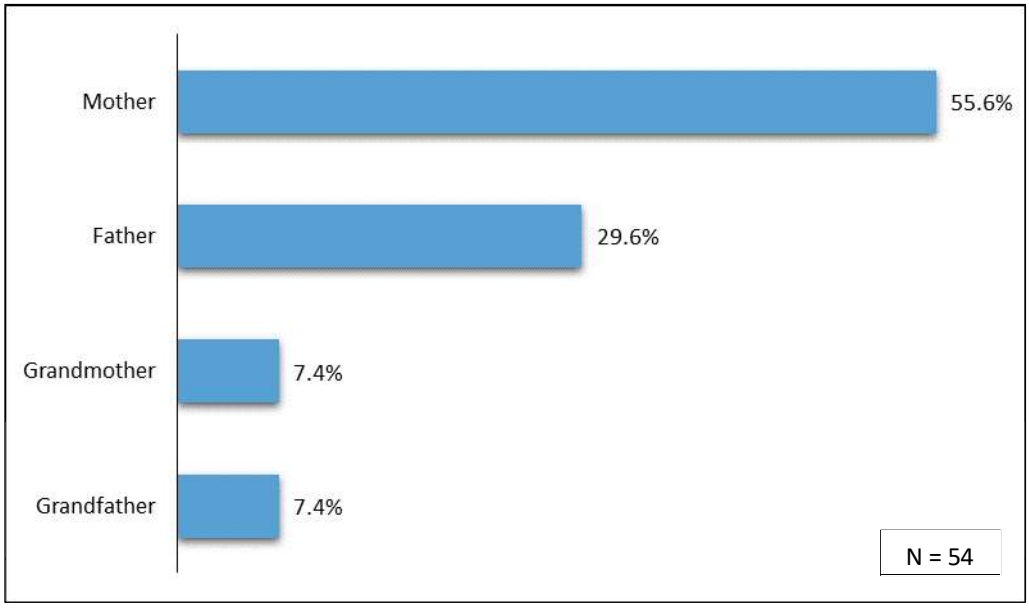


Do you have conflicts with your children because of different cultural beliefs?



50% **50%**

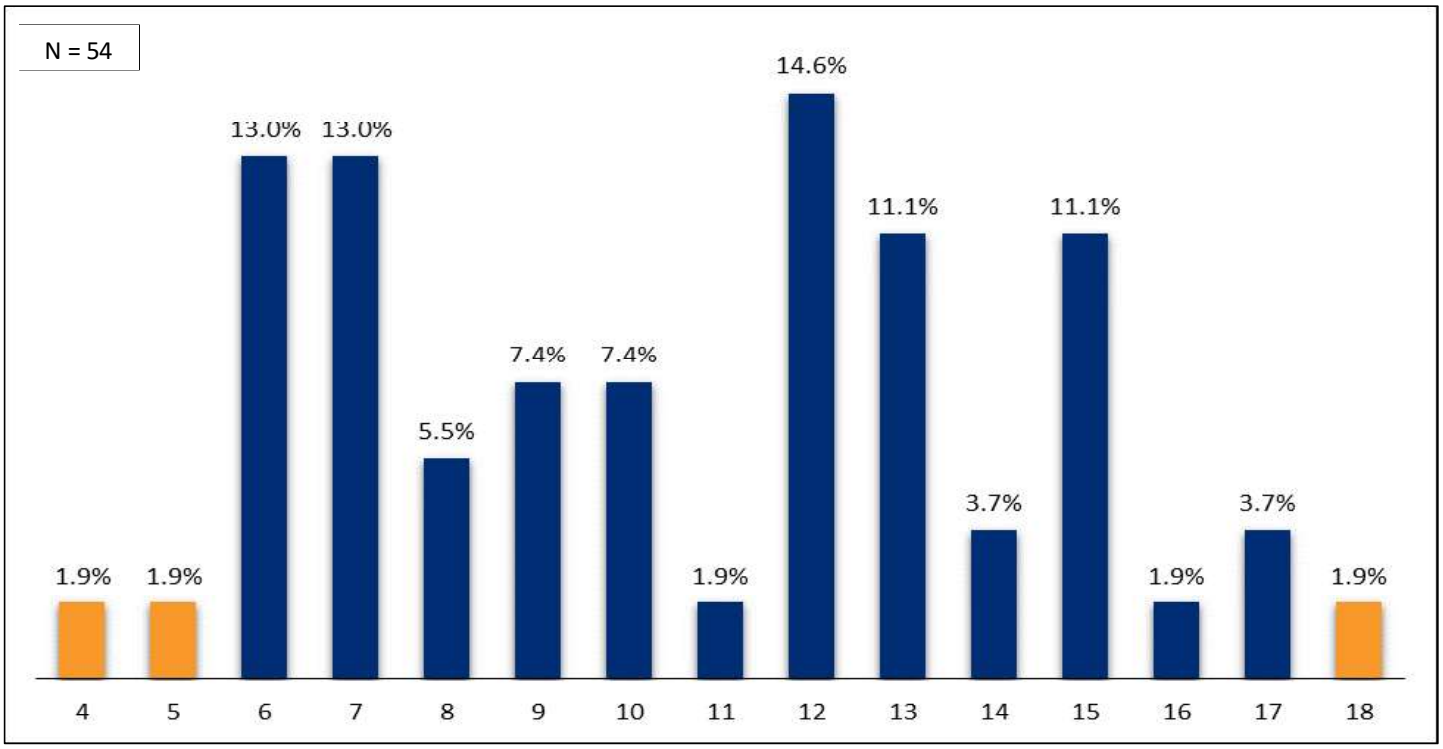
Role of Parents Completing KITE Program



Parent participants were also asked the type of role/relationship they had with their children, and the results are as follows: 30 participants (55.6%) indicated their roles as the child's "Mother", 16 participants (29.6%) indicated their roles as the child's "Father", and the remaining 8 participants indicated as the child's

"Grandmother" (7.4%), and the child's "Grandfather" (7.4%), respectively.

Ages of Participants' Children



We were also interested in knowing the ages of the participants' children, to confirm that they were indeed between the ages of 6 and 17 years old, and whether there was any correlation between the ages of their children and the level of intergenerational conflicts due to cultural beliefs between the two generations, which was shown on the previous page.

We asked parent participants to list the name and age of children of whom they would like to focus their relationship on. This question is listed on all of the KITE's pre- and post- measures. When parents have more than 1 child, they are asked to list the oldest child, or the child with whom they view as having the most challenges, as the "target child". The graph above only shows the total number of participants who completed the pre-and post-questionnaires and included in the analysis. Based on the current ages of children that parent participants have listed on their measures, the results are divided almost equally, where 26 participants (48.2%) responded that their children were between the ages of 6 and 11 years old, and 25 participants (46%) responded that their children were between the ages of 12 and 17 years old. It is also noted that 3 participants indicated that their children were under 6 years old (3.8%, n = 2) and older than 17 years old (1.9%, n = 1).

On page 13, it is shown that 50% of parent participants had indicated "Yes", that they do have conflicts with their children due to different cultural beliefs, and the majority of parent participants indicated that their children are indeed between the ages of 6 and 17 years old (94.3%, n = 51), which shows that the KITE program did meet the goal to provide services to the target audience of AAPI parents with school-aged children and adolescents within the ages of 6 to 17 years old. Furthermore, it is hoped that the KITE program would help to address the parents' needs in bridging the intergenerational gap due to different cultural beliefs, which then aims to strengthen biculturality and intergenerational relationship between the AAPI Parents and their children.

Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaires (SDQ) are used to measure the degree of strengths and difficulties that the child has, as viewed by their parents. On the SDQ form, we asked each parent participant to list the child name and age, and to focus on their child's strengths and the difficulties that parents are experiencing with the child, if any. When parents have more than one child, we asked the parent to list the child's name and age with whom the parent participants would like to focus the strengths and difficulties questionnaires on. The SDQ measure has a total of 25 questions, which comprises 5 scales of 5 items each. The scales measured in SDQ are as follows:

- **Emotional Symptoms**
- **Conduct Problems**
- **Hyperactivity**
- **Peer Problems**
- **Prosocial Scales**

Detailed explanation of the scales, average scores, and the item numbers which correspond to each scale are shown on tables below. Moreover, the SDQ measure is structured on a 3-point a Likert Scale, where parents choose between three choices, where: 1 = "Not True", 2 = "Somewhat True", and 3 = "Certainly True".

Each question on the SDQ measure is a different statement/questionnaire that we asked each parent to choose the option that represents their child the most. The higher the score, the more likely parents viewed their child as having strengths or difficulties towards the statements. Each parent participant is asked to fill out SDQ form on the first day of KITE parenting class series (pre-measure) and on the last day of the KITE parenting class series (post-measure).

SDQ Scales and Item Numbers

Scales Measured in Strength and Difficulties Questionnaire	Item Numbers
Emotional Symptoms	3, 8, 13, 16, 24
Conduct Problems	5, 7, 12, 18, 22
Hyperactivity Scale	2, 10, 15, 21, 25
Peer Problems Scale	6, 11, 14, 19, 23
Prosocial Scale	1, 4, 9, 17, 20

SDQ Scales and Average Scores Interpretation

SDQ Scales	Normal	Borderline	Abnormal
Emotional Symptoms Scale	0-3	4	5-10
Conduct Problems Scale	0-2	3	4-10
Hyperactivity Scale	0-5	6	7-10
Peer Problems Scale	0-2	3	4-10
Prosocial Scale	6-10	5	0-4
Total Difficulties	0-13	14-16	17-40

***Possible score: 0 to 10 for each scale, or up to 40 for total scores*

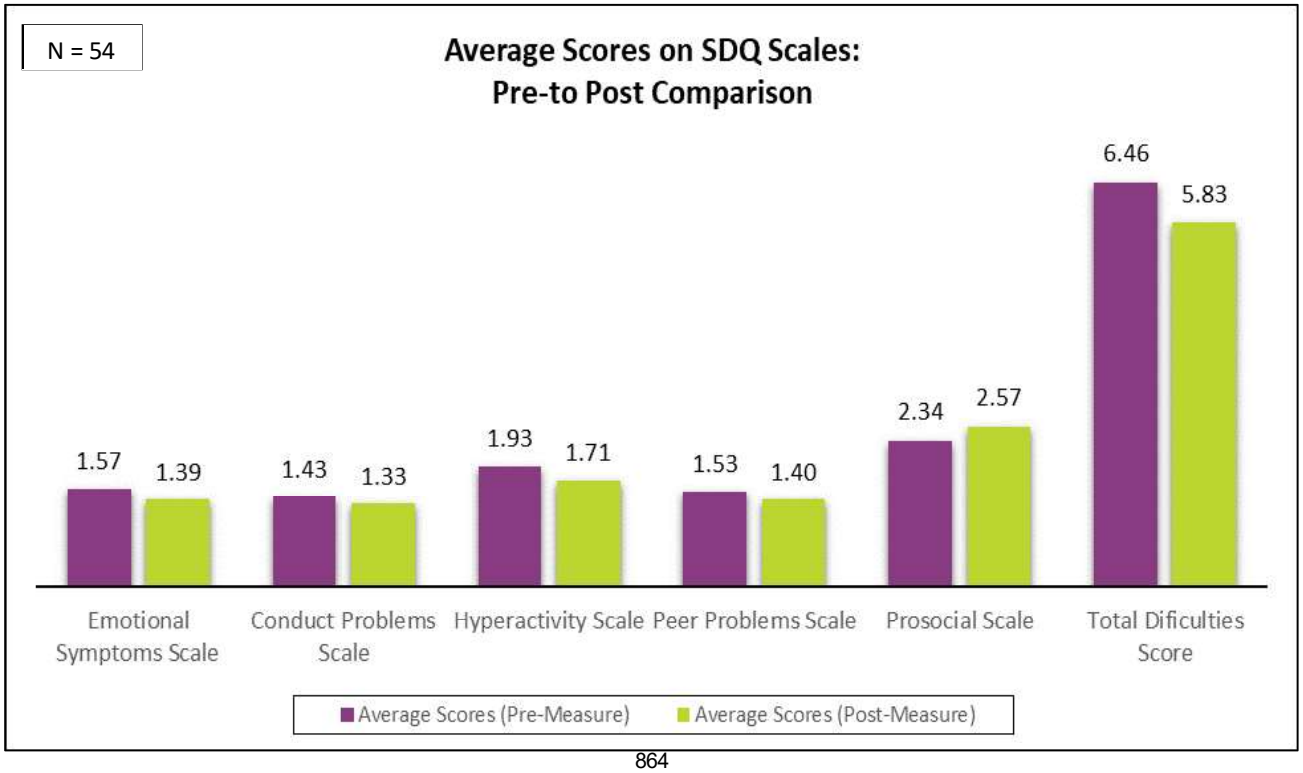
Strengths and Difficulties Questionnaire (SDQ) Scale Analysis and Results

There were a total of 54 pre-post matched pairs completed for the SDQ measure. Overall, changes were shown on the average scores across all scales, scores were found to be in the "normal range" at pre and post. Ideally, we would want to see a ***decrease*** in the Emotional Symptoms Scale, Conduct Problems Scale, Hyperactivity Scale, and Peer Problems Scale, and an ***increase*** in the Prosocial Scale.

The pre-post analysis showed that there were decreases on the average scores on the **Emotional Symptoms Scale** (11.1% decrease from 1.57 to 1.39), **Conduct Problems Scale** (7.5% decrease from 1.43 to 1.33), **Hyperactivity Scale** (11.3 % decrease from 1.93 to 1.71), as well as on **Peer Problems Scale** (8.9% decrease from 1.53 to 1.40). Overall, pre-scores fell within the normal range across all scales measured, which suggest that parent participants did not view their children's strength and difficulties as issues to them. The analysis also showed the ideal decreases on the 4 scales, and an increase on 1 scale listed above, as we would have expected. The pre-post analysis using paired samples T-Test showed that all changes in SDQ scales were *statistically significant* ($p < .05$).

In addition to the 5 scales measured in SDQ measure, we also compared the **Total Difficulties' Average Scores** from pre-to-post. The Total Difficulties Score is generated by adding the scores from all scales, *except* for **Prosocial Scale**, and this score can range from 0 to 40. Based on the pre-to post analysis, the Total Difficulties' average scores for all participants decreased from 6.46 to 5.83 (a change of 9.9%), and analysis using paired samples T-Test showed this decrease to be statistically significant ($t = 4.733$, $p < .05$), highlighted in green on table below. All pre– and post–scores on all scales are also shown within the normal range.

APQ Scales	Percent Change	*t*	df	p
Emotional Symptoms Scale	-11.1%	3.168	53	.003
Conduct Problems Scale	-7.5%	4.087	53	.000
Hyperactivity Scale	-11.3%	3.884	53	.000
Peer Problems Scale	-8.9%	2.750	53	.008
Prosocial Scale	9.6%	-3.984	53	.000
Total Dificulties Score	**-9.9%**	**4.733**	**53**	**.000**



Alabama Parenting Questionnaire (APQ)

The second measure collected during the KITE Program, Alabama Parenting Questionnaires (APQ), is used to measure positive and negative parenting practices. More specifically, it is meant to measure several different dimensions of parenting that have proven to be important for understanding the causes of conduct problems and delinquency in youth.

There were 42 items on the original version of APQ measure; however, for the purpose of KITE program, a modified format of the APQ measure was adopted for the KITE Program, with 29 items that would measure the following scales:

- **Parental Involvement**
- **Positive Parenting**
- **Inconsistent Discipline**
- **Other Discipline Practices (Harsh Discipline)**

The questions on APQ measure are structured on a 5-point Likert Scale, where parents choose between 5 options, where: 1 = "Never", 2 = "Almost Never", 3 = "Sometimes", 4 = "Often", and 5 = "Always". Each parent participant is asked to fill out APQ form on the first day of KITE parenting class series (pre-measure) and on the last day of the KITE parenting class series (post-measure).

Similar to the SDQ measure, each parent was asked to list the child name and age on the APQ measure, and to focus on their child's strengths and difficulties that parents are experiencing with the child, if any. When parents have more than one child, we asked the parent to list the child's name and age with whom the parent participants would like to focus the parenting practices on.

Each question on the APQ measure is a different statement about parenting practices. For the KITE Program, each parent participant is asked to choose the option that best represents his/her parenting practices. The higher the score, the more likely parents viewed themselves as having positive parenting practices with their children. The scales measured on the modified APQ measure and the corresponding item numbers that belong to each score are shown on table below.

APQ Scales and Item Numbers

Scales Measured in Alabama Parenting Questionnaire	Item Numbers
Parenting Involvement	1 to 10
Positive Parenting	11 to 16
Inconsistent Discipline	17 to 22
Other Discipline Practices (Harsh Discipline)	23 to 29

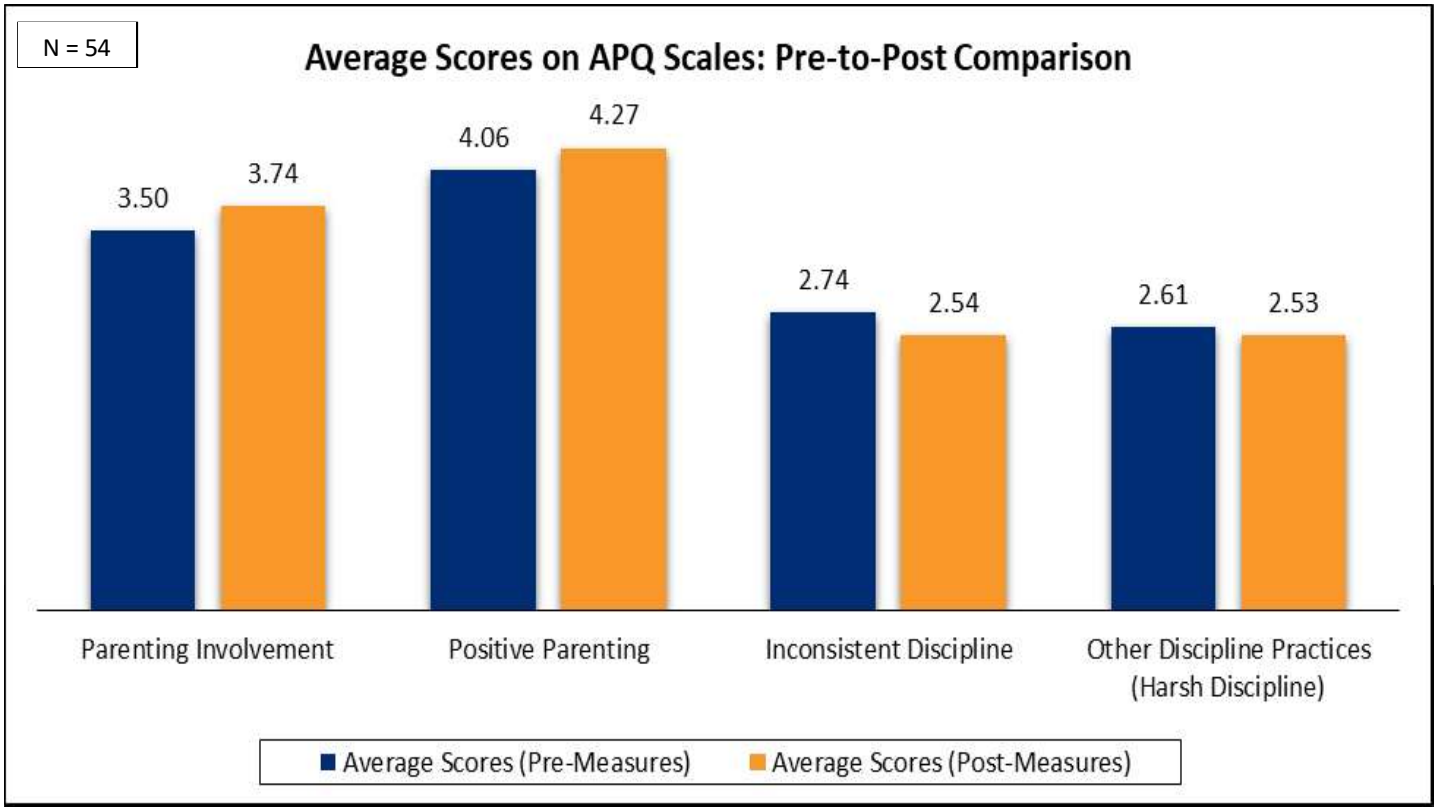
For analysis purpose, the average scores of these above scales on the modified APQ measures were then compared from pre-to-post measure. Ideally, we would like to see that the average scores in "Parenting Involvement" and "Positive Parenting" scales to increase, and for the average scores in "Inconsistent Discipline" and "Other Discipline Practices (Harsh Discipline)" scales to decrease from pre-to-post.

Alabama Parenting Questionnaire (APQ) Scale Analysis and Results

A total of 54 pre-post matched pairs were completed by parent participants for the APQ measure. The table and graph below show the APQ Scale analysis and results. Based on the paired-samples T-Test analysis, the results showed improvements in the expected directions. The **Parenting Involvement** scale showed a 6.7% *increase* from 3.5 to 3.74 (which was a slight increase of parents' choices from "*Sometimes",* that changed towards "*Often"*) and a 5.1% *increase* on **Positive Parenting** scale from 4.06 to 4.27 (which was a slight *increase* of parents' choices from "*Often"*, that changed towards "*Always"*).

Additionally, **Inconsistent Discipline** scale showed the largest change, which is a *decrease* of 7.5% from 2.74 to 2.54), and **Other Discipline Practices** scale also showed a *decrease* of 2.9% from 2.61 to 2.53). Further analysis using paired samples T-tests for each of the APQ scale items are shown on the table below. Both **Parenting Involvement** and **Positive Parenting** scales, which showed increases from pre-to-post, also showed statistically significant results at or below $p < .05$, as shown on table below (highlighted in green). In sum, these overall results from APQ Scales showed positive improvements in parenting practices, from pre-measures to post-measures.

APQ Scales	Percent Change	*t*	df	p
Parenting Involvement	6.7%	-2.280	53	.027
Positive Parenting	5.1%	-2.020	53	.048
Inconsistent Discipline	-7.5%	1.944	53	.057
Other Discipline Practices (Harsh Discipline)	-2.9%	0.966	53	.339

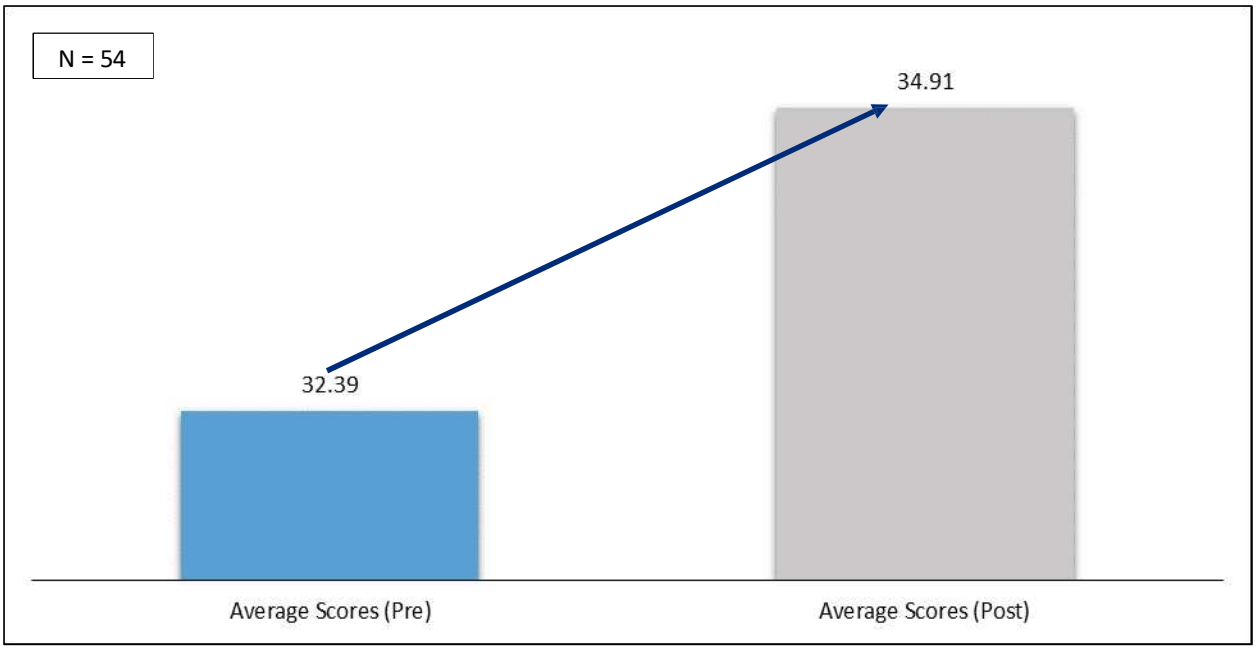


Relationship Scale

The Relationship Scale, the third measure used in the KITE program, is used to measure the degree of positive relationship that parent participants have with their children. Similar to APQ and SDQ measures, all parent participants were asked to list the child's name and age on the Relationship measure, and to focus on their relationship with their "target child" when responding to the questions. When parents have more than one child, we asked the parent participants to list the child's name and age with whom their current relationship is the most challenging, and to focus on the target child when responding to the relationship questions. The Relationship Scale was also collected at the beginning of the KITE parenting class series, and at the end of the KITE parenting class series.

The Relationship Scale has a total of 9 questions, structured on a 5-point Likert Scale, where parents choose between 5 options, where: 1 = "Strongly Disagree", 2 = "Disagree", 3 = "Neutral", 4 = "Agree", and 5 = "Strongly Agree". For this Relationship measure, higher scores indicate a more positive relationship between the parent participants and their children.

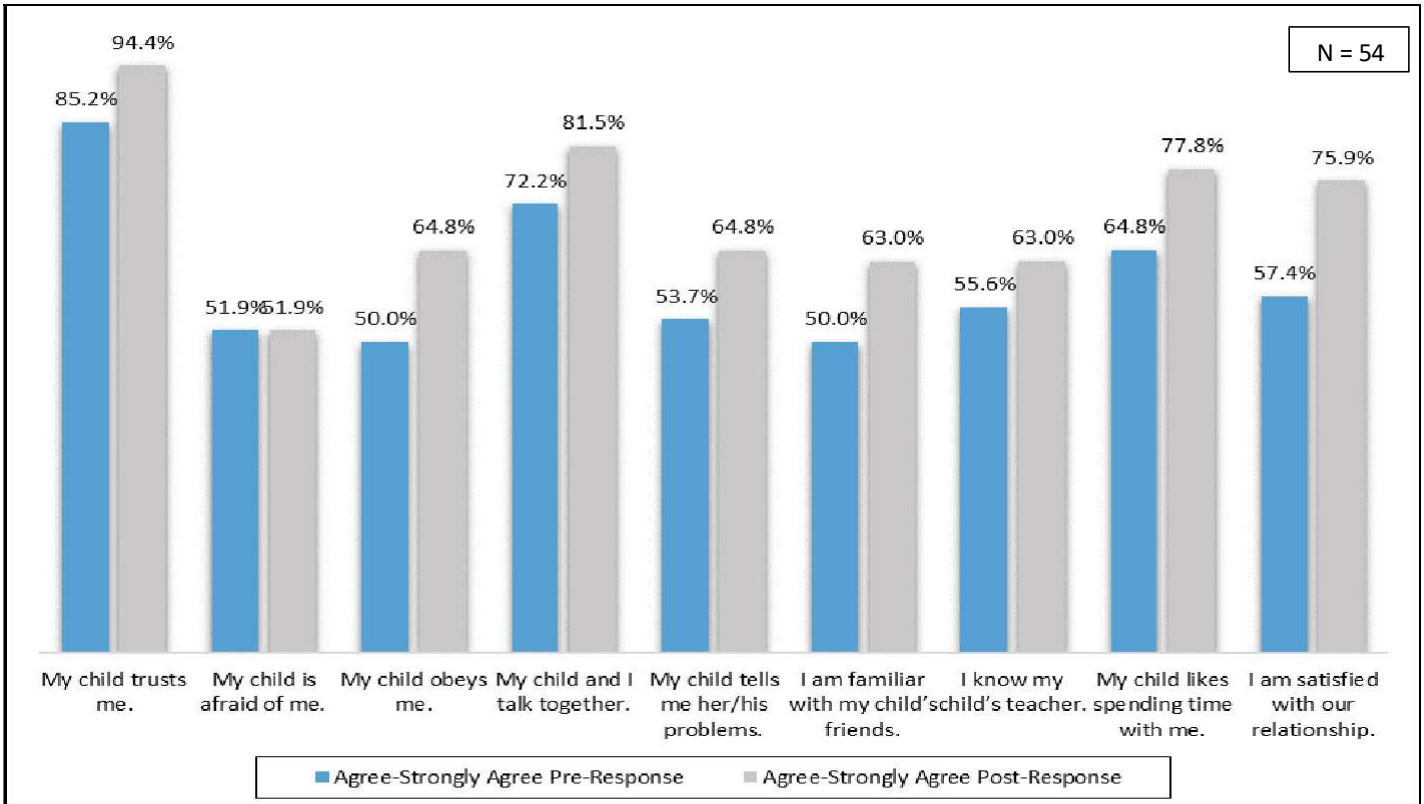
Relationship Scale
Average Total Scores: Pre-to-Post Comparison



Overall, the average total scores on Relationship Scale increased 2.52 points from pre-to post-measure, from 32.39 to 34.91. The pre survey total scores were already relatively high at the beginning of the KITE Program, which showed that parent participants already had a positive relationship with their children. Further analysis using paired samples T-Test also showed a *statistically significant* result, $t(53) = -3.529$, $p = < .05$. An item-by-item analysis on the Relationship Scale will be shown on the following page.

Average Total Scores on Relationship Scale— Pre to Post Analysis	Percent Increase	*t*	df	p
	7.8%	-3.529	59	0.001

Relationship Scale Analysis: Pre-to-Post Comparison



Relationship Scale—Survey Items (n = 54)	Percent Change	*t*	df	p
1. My child trusts me.	9.2%	-2.281	53	.027
2. My child is afraid of me.**	0.0%	-0.327	53	.745
3. My child obeys me.	14.8%	-2.131	53	.038
4. My child and I talk together.	9.3%	-2.530	53	.014
5. My child tells me her/his problems.	11.1%	-2.700	53	.009
6. I am familiar with my child's friends.	13.0%	-2.745	53	.008
7. I know my child's teacher.	7.4%	-1.237	53	.222
8. My child likes spending time with me.	13.0%	-3.792	53	.000
9. I am satisfied with our relationship.	18.5%	-3.041	53	.004

***** = Item #2 has a reversed scale***

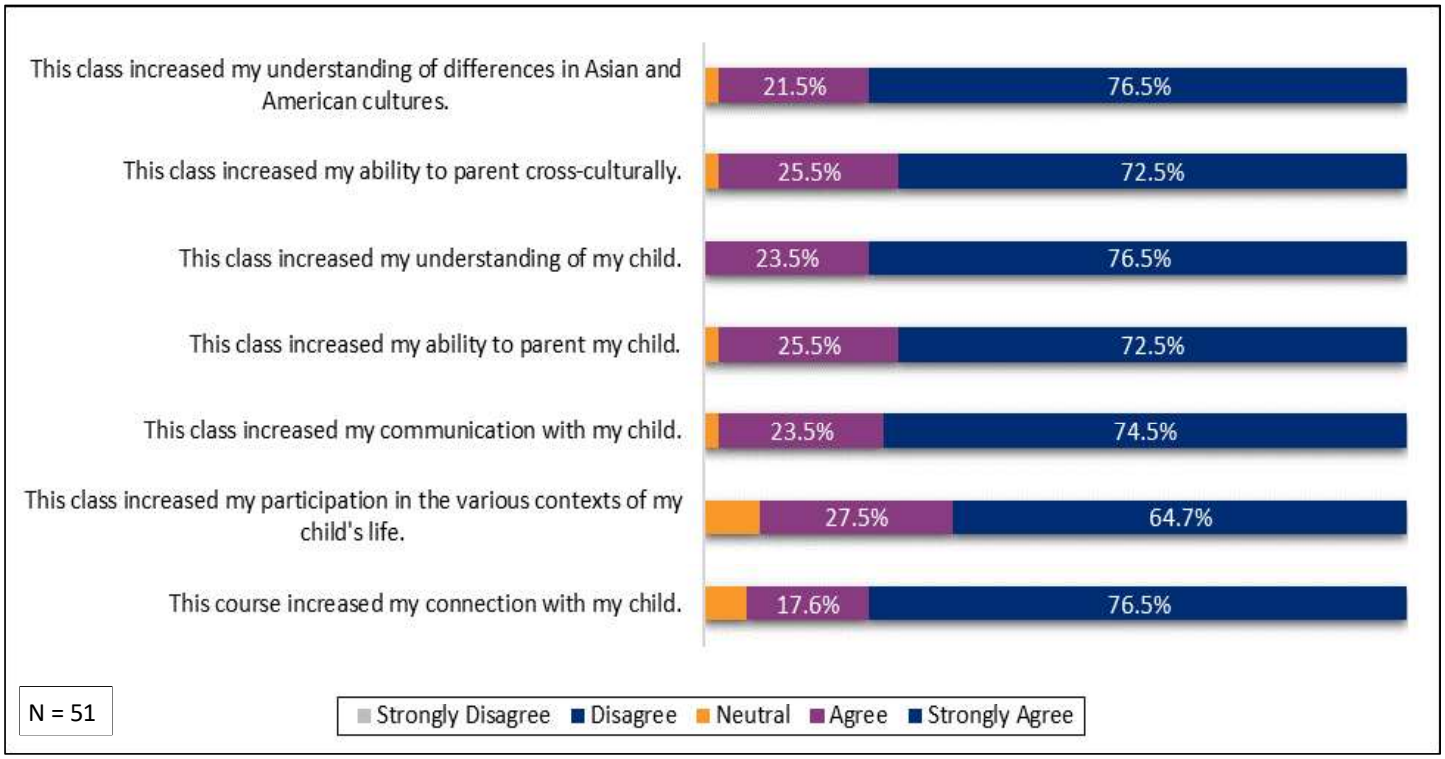
Similar to SDQ and APQ measures, there were a total of 54 pre-post matched pairs completed for the Relationship Scale. Figures above showed the Relationship Scale Analysis from pre-to-post measures, and ideally, we would like to see increases across all questionnaire items, except for number 2 (**My child is afraid of me**). This item has a reverse scale, and ideally, we would like to see a decrease, although a pre-post analysis on this scale item showed that the percentages from pre-to-post remained the same. Overall, based on the pre-post analysis, all scale items have shown increases from pre-to post-measures, which suggests that parents' views on their relationships with their children have generally increased at the conclusion of the KITE parenting program, in comparison to the beginning of the program.

The highest percent difference was shown on item number 9 (**I am satisfied with our relationship**), which showed an increase of 18.5% from pre-to-post measures. Item number 3 (**My child obeys me**) also showed a increase of 14.8%, and both item number 6 (**I am familiar with my child's friends**) and item number 8 (**My child likes spending time with me**) showed an equal increase of 13.0% from pre-to-post measures. Further analysis using paired samples T-tests are shown on the table above. Overall, 7 out of 9 items on the Relationship Scale (highlighted in green on table above) showed *statistically significant* results at ($p < .05$).

Post-Satisfaction Surveys

A post-satisfaction survey was created to evaluate KITE program effectiveness and to gather participants' feedback on how the program has impacted their relationship with their children. The post-satisfaction surveys were distributed to participants and collected at the end of each KITE parenting class series. There are 7 questions on the post-satisfaction surveys, using a Likert scale ranging from 1 to 5, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly Agree. There were a total of 51 post-satisfaction surveys completed at the end of all KITE parenting class series, and the results are shown below.

Survey Results



Overall, the analysis from post-satisfaction surveys showed highly positive results from all parent participants who responded "Strongly Agree" or "Agree" to all of the survey statements, as summarized below:

- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their understanding of differences in Asian and American cultures.***
- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their ability to parent cross-culturally.***
- 100% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their understanding of their children.***
- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their ability to parent their children.***
- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their communication with their children.***
- 92.2% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their participation in the various contexts of their children's lives.***
- 94.1% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their connection with their children.***

Post-Satisfaction Survey Comments for Question #1

There were a total of five follow-up questions on the KITE post-satisfaction surveys, which were created to measure the effectiveness of the KITE program. Selected responses from participants for each question are shown below and on pages 23-26.

1. ***How did you change personally?***

"I put my child's feelings first and empathize according to the content of the courses."
"The way of communicating with my children has changed."
"Standing in my child's perspective to view issue."
"Through the study of the course, I am no longer anxious. If I change my mood as a parent, everything will change."
"Through communication with teacher and parents in class, I identify the differences of Chinese culture."
"I improved my tone and patience when talking to my child."
"Use the time during school pick up/drop to communicate more with my child, and talk about what happened in the day."
"I became a little more patient with my child."
"A chance to take a moment in a situation where you're angry or about to be angry."
"I try not to immediately get mad and making an effort to be more patient."
"I became more attentive to my child."
"I will look at things from my child's perspective"
"Have confidence in educating my children."
"Through the study in the parent-child class, I learned that the needs of children and the responsibilities of parents in raising children are actually unified. If you think about the demands and demands behind the behaviors of the children from another angle, you can better understand the children and form a good parent-child relationship with them.
At the same time, I also learned a lot of parenting skills, encourage and praise children more, and interact with children with high-quality companionship. Don't always use punishment to make children obedient. Properly letting children bear natural consequences is a required course for their growth!"
"In the end, the parent-child relationship is more important than academic performance, always remember this and raise our children from there."
"Be more understandable to kids."
"I began to care about her feelings and try my best to help her within my ability."
"Pay more attention to your approach when talking to your children."
"Begin to learn to praise children."
"Recognize cultural differences and psychological changes in children."
"I tried to use the method taught by the teacher, and it was very pleasant to get along with the children several times."
"In the past, I would get very angry when my child did something wrong and would yell at him. After class, I would change. When he did something wrong, I would express my understanding of his feelings and then make an evaluation."
"I've learned to think about things from my child's perspective when we have disagreements."
"Learn to take deep breaths. Only by adjusting your mentality can you deal with children happily."
"Suitable for another way to communicate with children."
"Do special time as much as possible."
"When there is a conflict, try your best to calm down first and then deal with it."
"Put yourself more from the child's perspective and consider his situation at that time."
"Understand the child's difficulties."
"Talk to your child calmly."
"More aware of my interaction to my kids, be more present to them."
"I became more aware of how to parent cross culturally."
"I became more aware of the way I parent, spoke and interacted with my grandchild. "
"Learned to be more understanding and use parental message better."
"I became more understanding and accepting of the situation."

Post-Satisfaction Survey Comments for Question #2

2. How did you change in the way you parent?

"Through the scientific parenting method in the curriculum, if my children have behavioral problems, as parents should reflect on changing the bad parts of traditional Chinese education methods if they want to have a healthy parenting relationship and physical and mental health."
"After learning the courses, I learned how to use the right communication method to communicate with children. I try to express my understanding first, and then express my needs, so my children will be more acceptable."
"Listen to my children's thoughts first, and then consider their views as parents."
"Parenting knowledge and workshops learned in class."
"I don't know how to praise my daughter before studying the courses. After studying, I often praise her, and the effect is very good."
"When I find that my child has done something wrong. I will calm down and communicate with the child."
"I became a better listener."
"I have gained more patience when communicating with my child."
"I became a parent who waits."
"Will change the way of educating children, insist on praising, discover strengths and actively communicate."
"Will see things from the child's perspective and understand and help them."
"Everything starts from the child's feelings and is educated based on the content learned."
"Learn to listen, encourage and praise more."
"I began to want to know her perspective on everything."
"Start learning to make friends with your children."
"Change by learning to understand the child's growth process."
"How to get along and communicate with children."
"After taking the class, I feel that as a parent, we should focus on encouragement and try to impose as few punishments as possible."
"Learn to communicate with children in short words."
"Listen more and start with "I." Special time effectively improves quality sharing time."
"See things from a child's perspective."
"Treat children more calmly."
"Need to be more concerned with children's psychology"
"Read a lot of books about children's education through continuous exploration."
"Understand the reasons for her rebellious period."
"Praise a lot."
"Better interaction with children."
"Understanding more and listening."
"Listen, pause, look at them more, less yelling."
"I am more patient and understanding."
"I became a better listener."
"Be more friendly to my children."
"I'm more conscious in how I parent my children."
"More understanding."
"I begin to think of his feeling instead of mine."
"Just being aware not all about me, but my child has the say as well."
"Better in understating of the situation."
"More communication and interaction between us."

Post-Satisfaction Survey Comments for Question #3

3. What was the most helpful topic we covered?

"Emotions, discipline methods, parenting communication methods."
"Use structure and encouragement, rules, limits, consequences and punishments, special time."
"Structuring intervention."
"Understand the cultural differences."
"How parents cope with stress."
"Parenting communication methods and coping with stress."
"Understand the importance of the tone and attitude of parents in the communication process between their children."
"Understanding between parents and children."
"Conversations with my child have become smoother."
"How to communicate with my children."
"We became more understanding of each other."
"Build a structure express understanding."
"Use expressive understanding and parent messages and teach children rules, limits and consequences."
"Practical and effective communication skills."
"Parent-child relationship, natural consequences, multi-cultural conflict."
"Quality time with kid."
"Structure makes me feel like I can relax occasionally in life."
"Ways to encourage children."
"I think what was helpful for me was learning about how to express love to my children."
"Cross-cultural differences and how to integrate into mainstream culture."
"Empathy and Understanding Asian Children."
"The "I message" I find most useful."
"Learn to use the word you as little as possible when speaking."
"Understand cultural differences. Introduce different effective ways to deal with various situations encountered in life."
"Build a bridge of communication between children and parents."
"Special time and love languages."
"Less punishment, and as many natural consequences as possible."
"Methods of educating children and their five languages."
"If you want to communicate more deeply with your children, it's not through the surface."
"Understand children's thoughts."
"Communicating with children."
"Showing understanding."
"Bonding each of my kids, self-care."
"How to use punishment correctly."
"Special time with my child."
"The one where I can see her, and I understand her."
"Special Time."
"All of the topics."
"Talking to my child more and get care for his feeling."
"Understanding and Communication."
"Understanding the differences in culture and generation."
"Understanding and Acceptance."

Post-Satisfaction Survey Comments for Question #4

4. What was the least helpful topic we covered?

"It is very suitable."
"None. All are useful."
"How to use special time to build a good relationship with children."
"Coping with stress."
"I don't have any."
"None. All very good and useful."
"Understand the self-identity of children and second-generation Chinese."
"Homework."
"Punishment. Because I started letting my child know when she would be punished when she was young."
"Most of them are useful, but we are new immigrants, so the temporary cross-cultural differences do not apply to us."
"Communication skills with children are difficult to achieve."
"The content of the class is very useful."
"All very effective."
"All practical."
"No, they are all quite useful."
"All topics were helpful."
"Nothing! All are very important."

Post-Satisfaction Survey Comments for Question #5

5. How did your relationship with your child change?

"Increased intimacy and trust with my children."
"My children are more willing to communicate with me, and I am more patient with them."
"Through me changing, my child has slowly positively change. We respect each other more and have a closer relationship."
"The relationship with my children becomes more understandable and will consider problems from each other's perspective."
"The relationship with my children is getting better and better."
"Become more patient. When I found the child's needs, the child trusted me even more."
"I give my child a hug every day."
"We have come to understand each other."
"I am trying as of right now."
"There isn't a huge change right now."
"We have more personal time for ourselves now."
"Through my changes, my children have also gradually changed. Our relationship has become closer and we respect each other."
"My children trust me more and our relationship becomes closer."
"Through learning, we can better communicate with children and better understand their needs and feelings."
"More harmonious, less anxious."
"More talkative."
"She is more willing to express herself. We developed some rapport, and maybe she's grown up a little and knows how to express her thoughts."
"I communicate a little more than before."
"She started talking to me about her relationships with her friends."
"I become more friendly and equal."
"I think my children are more willing to take the initiative to communicate with me."
"The child seems much happier."
"It still takes time and practice, but the change in mentality and attitude is relatively big."
"Easier to communicate than before."
"It becomes more harmonious."
"Unite knowledge and action, act immediately, correct mistakes when they are known."
"Give each other more respect and understanding."
"Know each other more."
"There are a lot less conflicts."
"She would be more patient and talk to me about the details of class and classmates."
"More harmonious."
"More in tune."
"We gotten more closer."
"My relationship was already strong. This class just allowed me to be more aware."
"Strengthened my communication skills with her. I became more aware of her emotions."
"It's still in progress."
"We have better communication with my sons."
"More communicative."
"We are working on a good relationship of talking each night."
"Great outcome. Conversing more with enthusiasm."
"It has changed for the best communication."

References

Ying, Y. (2007). *Strengthening intergenerational/intercultural ties in immigrant families (SITIF): Testing a culturally-sensitive, community-based intervention with Chinese American parents*. Journal of Immigrant and Refugee Studies, Vol. 5(2) 2007, The Haworth Press.

Munoz, R.F. & Ying, Y. (2002). *The prevention of depression: Research and practice.* Baltimore, MD: Johns Hopkins University Press.

PEI Overview

Prevention and Early Intervention (PEI) aims to prevent the development of mental illness or intervene early when symptoms first appear. Our goals are to:

- Increase community outreach and awareness regarding mental health within unserved and underserved populations.
- Increase awareness of mental health topics and reduce discrimination.
- Prevent the development of mental health issues by building protective factors and skills, increasing support, and reducing risk factors or stressors.
- Address a condition early in its manifestation that is of relatively low intensity and is of relatively short duration (less than one year).
- Increase education and awareness of Suicide Prevention; implement strategies to eliminate suicide in Riverside County; train helpers for a suicide-safer community.

Programs need to be provided in places where mental health services are not traditionally given, such as schools, community centers, faith-based organizations, etc. PEI programs intend to engage individuals before the development of serious mental illness or serious emotional disturbance or to alleviate the need for additional or extended mental health treatment The PEI unit includes an Administrative Services Manager, five Staff Development Officers (SDOs), one Clinical Therapists (CT), two Social Service Planners (SSPs), one Behavioral Health Specialist (BHS), five Peer Support Specialists



PEI

(PSS), one Executive Assistant, and two Office Assistants (OA). The SDOs have completed the process of becoming trained trainers in many of the funded programs, which allows for local expertise as well as cost savings. Each SDO works with their assigned PEI providers to offer training and any needed problem solving and technical assistance, as well as monitoring of model fidelity. The SSP/CTs also offer ongoing support to the PEI providers through technical assistance including, but not limited to, support surrounding outcome measures. The PEI unit was built into the overall PEI implementation plan to ensure that model fidelity remains a priority as well as to support providers in the ongoing implementation of new programs within the community. In FY23/24 two Requests for Proposals (RFP) were released and one new contract was awarded for PEI programs.

In addition to training and technical assistance to PEI providers, the PEI unit coordinates and implements a variety of community-wide activities. Activities include suicide prevention training and coordination including co-leadership of the Riverside County Suicide Prevention Coalition, education, and awareness events such as the local Directing Change Screening and Recognition ceremony, the Dare to be Aware Youth Conference, Send Silence Packing exhibits and community presentations, May is Mental Health month activities, Suicide Prevention Awareness week activities including an awareness walk and more. PEI staff carry out outreach activities focusing on mental health awareness and suicide prevention. Additionally, PEI staff educate the community about mental health and reduce stigma while encouraging help-seeking behavior throughout the year. The PEI team attended 53 outreach events reaching 11,810 community members.



In Riverside County, PEI programs have been in place since September of 2009. The annual update and community planning process has allowed for ongoing community and stakeholder input regarding the programs that have been implemented, an opportunity to evaluate programs and look at new and expanded programs and services. Stakeholder feedback is a critical element in the success of PEI programming. We take the voice of the community seriously and look for ways to improve our communication. To this end, quarterly PEI Collaborative meetings are held to share program highlights and outcomes, current and upcoming PEI activities, receive feedback from the community, and provide a space for provider networking and partnership development to improve the delivery of services. Additionally, a quarterly newsletter, the PEI Pulse, is disseminated electronically and available on our website.

Each year MHSA Administration, including PEI, meets with many stakeholder groups, RUHS-BH committees, and the community to share the MHSA plan, mental health outcomes, and plans for the upcoming year during the community planning process. These diverse groups review the outcomes of programs currently being implemented to make informed decisions about programs and services for the upcoming fiscal year. This input is then shared with the Prevention and Early Intervention Steering Committee. The PEI Steering Committee is made up of subject matter experts who utilize their knowledge to provide feedback, oversight, and recommendation for the

PEI plan The PEI Steering Committee provides recommendation and feedback on the plan for the final draft. The PEI Steering Committee supports the plan as described below.

PEI is largely outreach-based. Programs and providers are typically in the community at natural gathering spaces. Post-COVID, contract providers continue to struggle with recruitment and enrollment across programs. Virtual options are offered, when appropriate. Outcome data demonstrates positive impacts in the lives of participants. This will be further detailed below in each work plan and can also be found in the PEI program and evaluation report in the PEI Appendix to this document.

In Fiscal Year 23/24, program implementation continued serving many communities throughout Riverside County. The PEI Unit continues its commitment to providing training and technical assistance for the evidence-based and evidence-informed models that are being implemented as well as booster trainings related to those models and other PEI topic-specific trainings. In FY23/24, there were 138 training days with 1,767 people trained. Staff Development Officers continued to work closely with PEI contract providers to maintain fidelity to evidence-based/informed models while offering both virtual and in-person services to the community. Our virtual training menu continued into FY23/24 available to anyone who lives and/or works in Riverside County at no cost. The trainings were created and facilitated by PEI Admin staff. Trainings have been available since the fall 2020 and include: Mental Health 101, Self-Care and Wellness, Know the Signs, and Building Resiliency and Understanding Trauma.



The PEI website, https://www.ruhealth.org/behavioral-health/prevention-early- intervention, includes comprehensive information about prevention and early intervention and the variety of services available to the community. This information is easy to find and community friendly. This site serves as the PEI Directory of Services, ensuring contact and program information is up-to-date and readily accessible to the community. The community can also access our training calendar and can easily register for training with the click of a button making it easier to access and benefit from our free community education, both virtually and in-person.

The Annual Prevention and Early Intervention Summit is also provided. The overall purpose of the Summit is to (1) address any challenges PEI providers have been facing in the past year and provide skills they can directly apply to their work in PEI, (2) educate providers about all PEI programs and increase their understanding



of how their program fits into the PEI plan, (3) to increase collaboration, partnership, and referrals between PEI providers, and (4) recognize the contributions of PEI providers in Riverside County and motivate providers to continue the work in the year to come. The Summit was held in the Desert region at the Hilton in Palm Springs. The Summit's theme was "Working Together", with keynote presentations from Mary Obideyi on "Reigniting Connections – Innovative Outreach Strategies for Community Mental Health Services" and Dr. Yvonne Ator on "How to Serve Sustainably and Thrive as A Mission-Driven Professional in a Chaotic Burnout Inducing World." We also had a panel discussion with our Cultural Community Liaisons to discuss helpful and effective engagement strategies for our underserved communities.

Prevention and Early Intervention Statewide Activities – Joint Powers Authority
Program Type: Prevention Program



California counties collectively pool local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the PEI Project at a statewide level. The PEI Project is a collection of campaigns which seek to expand the awareness of mental health needs and supports, reduce stigma, prevent suicides, and teach individuals how to achieve mental wellness. These campaigns are: Know the Signs, Directing Change, and Take Action for Mental Health. The Take Action for Mental Health campaign helps individuals learn how to take action for the mental health of themselves and those around them through three pillars: Check In, Learn More, and Get Support. In FY23/24, CalMHSA did not renew their contract with Youth Creating Change for the Directing Change Program and Film Contest. CalMHSA has since stated that they do not intend to contract with or provide funds to support Directing Change in the future. Riverside County plans to continue to support this program directly, separate from the JPA.



In 2010, Riverside County Department of Mental Health committed local PEI dollars to the statewide effort. This commitment has continued through the years of PEI program implementation. The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of *Take Action for Mental Health* is critical for creating a culture of mental wellness and wellbeing regardless of where individuals live, work, or play. Riverside County stakeholders agreed to maintain this commitment for the current 3-Year plan. Stakeholders see the benefit of supporting the statewide efforts and explore ways the statewide campaigns can make the biggest impact at a local level as a way of leveraging on messaging and materials that have already been developed. In FY23/24, the statewide project focused on diversity, equity and inclusion, with a particular emphasis on supporting marginalized communities. Key initiatives included:

- Juneteenth micro-campaign - The Juneteenth Digital Toolkit promotes mental wellness and raises awareness about the significance of Juneteenth, which

celebrates the emancipation of enslaved African Americans. The toolkit includes social media content, activity ideas, and educational resources. These materials encourage conversations, foster unity, and support mental health in Black communities, emphasizing both historical reflection and contemporary issues.

- Collaborations with streetwear designer and influencer Khano Ngo for the AAPI community

- Pride Month (July) - The Pride Digital Toolkit provides resources to support mental health and well-being within the LGBTQIA+ community during Pride Month and beyond. The toolkit includes social media content, educational materials, and activity ideas. These resources promote inclusivity, reduce stigma, and celebrate LGBTQIA+ identities. The goal is to create supportive environments, raise awareness about mental health challenges, and crucial resources. And support for Transgender day of Remembrance.

- Suicide Prevention Week and Month (September) - The Suicide Prevention Activation Kit (digital and physical) provides a range of resources to support individuals and organizations in raising awareness during National Suicide Prevention Awareness Week and throughout the year. Key materials in the kit include guides for creating social media posts, Infographics for awareness campaigns, activity Tip Sheets for community engagement, and downloadable posters tailored for diverse communities. These resources aim to help individuals recognize warning signs, initiate meaningful conversations, and connect with local suicide prevention resources. The goal of the kit is to empower everyone to take action and promote the importance of suicide prevention.

- Winter Wellness (December-January) - The Winter Wellness Digital Toolkit (digital and physical) offers resources designed to help individuals maintain their mental well-being during the colder months. This toolkit addresses the unique challenges of winter, including seasonal affective disorder (SAD) and isolation. It includes practical materials such as wellness tips for managing winter-related stress, activity guides to promote engagement and connection, social media content to raise awareness and encourage self-care. These resources support individuals in prioritizing self-care, staying connected, and engaging in positive activities that promote mental health during the winter season.

- May is Mental Health Matters Month (May) - The May is Mental Health Matters Month 2024 Toolkit (digital and physical) includes essential resources to raise awareness and promote mental health during Mental Health Matters Month in May. The toolkit contains social media content, educational resources, and activity ideas. These resources are designed to reduce stigma, increase

understanding, and encourage open conversations about mental health. They equip individuals and organizations with the tools to engage communities, raise awareness, and create a supportive environment for mental well-being, with a focus on inspiring action year-round.

- Take Action 4 Mental Health also disseminated physical and digital materials for National Rural Health Day and Student Athlete Suicide Prevention.

The PEI Project continues to prioritize outreach to younger populations, with approximately 61.67% of support provided to individuals under 25 years old. Below are the estimates for outreach and program evaluation within this demographic:

- Outreach: 55% of participants are under 25 years old (social media); 55% toolkits and collateral

- Evaluation: 65% of individuals served are under 25

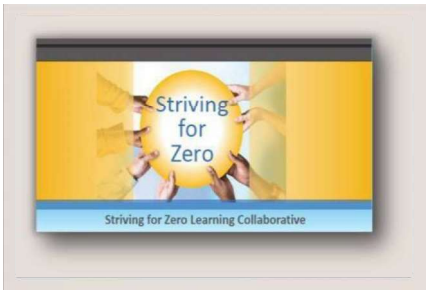
The Take Action for Mental Health website has become a key resource for individuals seeking mental health information and tools with 105,558 sessions and 9,133 resources downloaded.

Funding to the PEI Project supported programs such as:

- Continued production, promotion, and dissemination of the Take Action for Mental Health campaign's materials and messages, providing technical assistance and outreach to members contributing to the PEI Program.

- Providing mental health and suicide prevention trainings to diverse audiences.

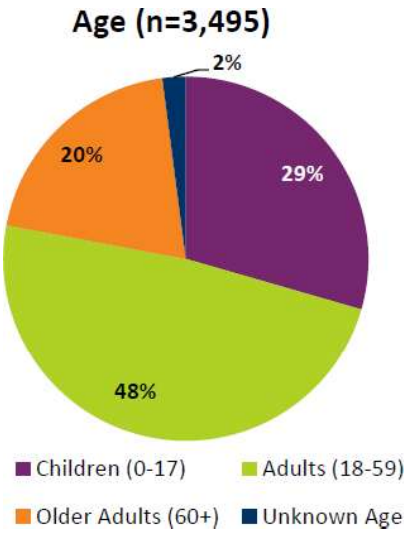
In FY23/24, Riverside County concluded participation in the Suicide Prevention Learning Collaborative through CalMHSA, Striving for Zero. This opportunity provided subject matter experts in the area of suicide prevention to give guidance and support to our local efforts in the implementation of our local suicide prevention strategic plan and assisting with the ongoing work of our local Suicide Prevention Coalition. RUHS-BH continues to leverage the resources provided at the state level and enhance local efforts with these activities.

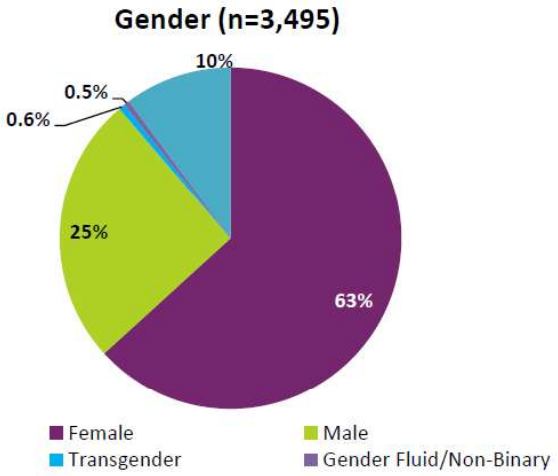


Who We Serve – Prevention and Early Intervention

In FY23/24 121,438 individuals were reached by PEI from a variety of Outreach activities including, depression screening at Community Health Centers. Riverside County residents were engaged by Prevention and Early Intervention outreach and service programs. Of those, A total of 3,495 individuals and families participated in PEI programs (excluding outreach) and an additional 2,878 middle school and high school age youth and 374 school staff, parents and community members participated in suicide prevention training on school sites. This resulted in a total of 6,747 served (not including outreach).

The following details the demographics of the PEI program participants.





Race/Ethnicity	PEI Participants (n=3,495)	County Census (n=2,458,774)
Caucasian	11.9%	32.2%
Hispanic/Latinx	47.0%	51.4%
Black/African American	7.1%	6.3%
Asian/Pacific Islander	3.5%	7.2%
American Indian	1.7%	0.46%
Other/Unk/ Multi-Racial	28.7%	2.5%

PEI programs are intended to engage underserved cultural populations. In Riverside County, the target ethnic groups are Hispanic/Latinx, Black/African American, Asian/Pacific Islander, and American Indian/Native American. The table above lists each of the groups and the percentage of PEI participants from each in comparison to the County census for Riverside. The table demonstrates that PEI services are reaching the intended un/underserved ethnic groups at appropriate rates.

Each PEI program has an annual outcome report with detailed data outcomes that are available upon request. Specific demographic information, by program, can be found in the PEI Appendix to this document.

PEI-01 Mental Health Outreach, Awareness, and Stigma Reduction

The programs that are included in this Work Plan are wide reaching and include activities that engage unserved and underserved individuals in their communities to increase awareness about mental health with an overarching goal to reduce stigma related to mental health challenges.

Cultural Competency Program - Outreach and Engagement Activities
Program Type: Prevention Program
The Cultural Competency Program (CCP) is dedicated to eliminating barriers and increasing access for underserved and underrepresented populations through the MHSA values of:

1. Equal access for diverse populations
2. Wellness, Recovery & Resilience
3. Client/Consumer and family-driven
4. Strength-Based and Evidence-Based Practices
5. Community-Driven Based Practices
6. Innovative and Outcome-Driven
7. Cultural Humility and Inclusivity

Research indicates that culturally informed care works. The more people are reached and connected to needed care, the less likely they are to experience the consequences of untreated mental health needs, such as repeated hospitalizations, the use of expensive emergency services, incarceration, school failure, and homelessness. Service delivery would be easier if we were all exactly alike and had the same experiences, but meeting people where they are increasing the likelihood of opening the door to healthier and more productive lives. Some folks do better when matched with a provider who shares or understands their worldview. This can be based on a shared perspective like religion or spirituality, a shared experience like being a military veteran, or a shared cultural history such as being an ethnic minority.

Some of the highlights from this year's Cultural Competency Plan include:
We hired a full-time Veteran Services Liaison or VSL. Our long-standing VSL resigned almost 2 years ago, leaving a vacancy that was difficult to recruit. The VSL is a therapist who not only provides therapeutic and case management services to Riverside County Vets but also promotes behavioral health awareness and stigma reduction to seek care for our military veterans and their families. The incumbent holds a degree to provide psychotherapy and has their own lived experience in the military. In August 2024, we re-filled the position with a veteran Navy corpsman and have begun the process of rebuilding the infrastructure of his role.
We also improved crisis engagement for the Deaf and Hard-of-Hearing Community. In partnership with Hanna Interpreting Services, our program developed remote video American Sign Language interpretation for our 24/7 mobile crisis teams. This allows quality ASL interpretation at any time of day or night when dispatched to assist an ASL speaker in a behavioral health crisis.

We ensured the voices of our 10 identified communities were part of MHSA plan development. Our Cultural Community Liaisons (CCLs) are people from these 10 communities who are

contracted to reduce access barriers to behavioral health care. The CCLs actively provide community education, build care bridges, and make referrals to support and services. They host their own community advisory committees, serve on the steering committee of this PEI plan, and on the steering committee for the MHSA Innovation plan serving people with eating disorders.

We refined and standardized the Cultural Competency Program evaluation protocols. Collaborating with the Department's Evaluation unit, we developed standardized data protocols to create consistent measurements of program outcomes. We measure audiences' responses to training and presentations and the number of direct referrals our program makes to service providers.

We sustained and developed a 10-month cross-county collaboration with San Bernardino County's Department of Behavioral Health. The collaboration focused on capacity building of Black-owned community-based organizations to help fill the gaps in behavioral health care program options. This collaborative continues by looking at capacity building for Asian/Pacific Islander and LGBTQ communities.

We look forward to partnering even more with the community to ensure every Riverside has the opportunity to thrive and contribute to building Riverside County's future.

The collective efforts of the CCP Staff, cultural community liaisons (CCLs), and cultural advisory committees bring a breadth of knowledge and expertise, strengthening our capacity to reduce disparities throughout our behavioral health system of care and barriers to accessing services.

Cultural Competency Reducing Disparities Advisory Committee

The Cultural Competency Reducing Disparities (CCRD) Advisory Committee is a committee including RUHS-BH staff, members of the cultural subcommittees, community-based organizations, community leaders, and consumers. CCRD works to identify cultural barriers and unmet needs with underrepresented populations. Partnering with Workforce Education and Training, CCRD promotes and hosts workforce training.

The CCRD committee prioritized the recommendations as follows:

1. Hiring bilingual staff
2. Cultural Competence Staff Training
3. Sustainability
4. Dissemination of information
5. Availability of Resources

CCRD reviews the updated Cultural Competency Plan on an annual basis. The plan addresses adherence to CLAS Standards, commitment to cultural competence, strategies, and efforts to reduce racial-ethnic, cultural, and linguistic mental health disparities, assessment of service

needs and adaptation of services, culturally competent training activities, hiring and retaining culturally and linguistically competent staff, and language capacity.

The subcommittees for cultural communities have been established and convene regularly, with the active participation of community members.
Through their collaboration with the CCLs, these subcommittees have secured sponsorships worth approximately $160,000 to support community service providers in delivering culturally appropriate mental health workshops and outreach events in the identified communities:

- **Asian Pacific Islander Desi American & Native Hawaiian (APIDANH) –** Dr. Ernelyn Navarro
- **African American Family Wellness Advisory Group (AAFWAG)** – Hazel Lambert
- **Middle Eastern and North African (MENA) –** [currently vacant, managed by CCP team]
- **Native American Council –** Dr. Sean Milanovich
- **Wellness and Disability Equity Alliance (WADE) –** Dakota Brown
- **Hispanic/Latinx (HISLA) –** Shirley Guzman
- **Deaf Collaborative Advisory Network (DCAN) –** [currently vacant, managed by CCP team]
- **Community Advisory on Gender and Sexuality Inclusion (CAGSI) –** [currently vacant, managed by CCP team]
- **Spirituality & Faith-Based –** Rev. Benita Ramsey
- **Veterans (hosted by the Behavioral Health Commission) –** Felix Gbagbo, MSW, Navy Corpsman

Inland SoCal Crisis and Suicide Helpline and 211
Program Type: Suicide Prevention Program

Inland SoCal United Way

A program of Inland SoCal United Way & 211+, the Inland SoCal Crisis and Suicide Helpline is available 24/7 by calling 951-686-HELP (4357). The service is a bilingual hotline staffed by highly trained and compassionate Crisis Counselors who are as diverse and representative as the Inland SoCal Region. They assist with emotional support, suicidality assessment and prevention, coping skills, resource referrals and warm hand-off for mental health services, and help for a range of other mental health related crises and experiences such as suicide loss grief, abuse, domestic violence, struggles with aspects such as identity and relationships, and other sensitive topics. The Helpline also conducts trainings across the region to teach and support residents in identifying and responding to mental health needs in their communities. Mental health services are essential to healthy communities. Everyone deserves access to respect, dignity, and wellbeing – especially in moments of crisis. Understanding the nature of that kind of intervention – who calls and why – informs better response systems.

The Inland SoCal Crisis Helpline has achieved significant success in responding to mental health crises through the implementation of a community point of access (aka front door) to the RUHS-BH 24/7 mobile crisis response. This initiative enhances immediate access to crisis stabilization services and supports community resilience. Key achievements include:



- Enhanced Crisis Response: The 24/7 mobile crisis team provides timely, on-site intervention, reducing the need for emergency department visits and law enforcement involvement. This aligns with best practices in crisis care, prioritizing de-escalation and connection to appropriate community-based services.

- Trauma-Informed and Evidence-Based Training: Comprehensive training for crisis responders emphasizes de-escalation techniques, trauma-informed care, and culturally competent practices. This specialized training has contributed to a reduction in the need for law enforcement intervention, promoting a person-centered approach.

- Increased Community Awareness and Utilization: Community outreach efforts have significantly increased awareness of helpline services, resulting in a substantial increase in call volume. This demonstrates the effectiveness of proactive communication in promoting help-seeking behaviors. Data collected also showed a significant reduction in 911 call rates, emphasizing the effectiveness of preventative care and proactive intervention in addressing mental health crises before they escalate.

- Data-Driven Outcomes: Data indicates a positive impact on crisis system utilization, with a significant increase in calls to the helpline and requests for mobile crisis services and Mental Health Urgent Care. Critically, the data also shows a low percentage of calls involving active rescues for imminent risk to life, suggesting that the mobile crisis services are effectively de-escalating situations and providing appropriate support.

Despite these successes, several challenges must be addressed to ensure the long-term sustainability and effectiveness of the crisis helpline:

- Funding Instability: Consistent and adequate funding is essential for maintaining service quality and meeting increasing demand. The transition from MHSA to BHSA requires careful navigation to ensure continued support for essential crisis services.

- Workforce Development and Retention: As call volumes rise, ensuring sufficient staffing levels with qualified and well-trained responders is crucial. Ongoing training in evidence-based practices, such as crisis intervention, trauma-informed care, and culturally competent care, is essential. Addressing staff burnout through robust support systems, including supervision, debriefing, and self-care resources, is also a priority.

- Data Collection and Outcome Measurement: Strengthening data collection and outcome measurement processes will allow for more robust evaluation of program effectiveness and identification of areas for improvement.

A key lesson learned is the critical importance of ongoing training and support for crisis responders. While initial training is essential, continuous professional development is necessary to keep staff up to date with evolving best practices and address the diverse needs of individuals experiencing mental health crises. Furthermore, prioritizing staff well-being through robust support systems is crucial for mitigating burnout and maintaining team effectiveness.
A total of 8,312 calls were made to 951-686-HELP for FY23/24. The number of calls went up by 128% from July 2023 (407 calls) to June 2024 (928 crisis calls). Active rescues have decreased by 16% since the prior year (from 62 in 2022-2023 to 52 in 2023-2024). This decrease from all prior years demonstrates that the launch of 24/7 crisis mobile services provided a less intrusive intervention in most situations. In this first partnership year, the Crisis Helpline assessed and warm transferred 174 calls to Riverside County Crisis Mobile Units for in-person support. The number of BIPOC callers has increased by 20% in the last 12 months (although there was no proportional increase in crisis callers).

Inland SoCal Crisis Helpline Annual Report 2023-2024

EXECUTIVE SUMMARY

The Inland SoCal Crisis Helpline (951-686-HELP) is a project of Inland SoCal United Way and Inland SoCal United 211+. Services include 24/7 someone to call, routing to somewhere to go (Mental Health Urgent Care) or warm hand-off to someone to come to you (Riverside County Crisis Mobile). The Inland SoCal Crisis Helpline also provides a statistical dashboard, evidence-based training, such as Mental Health First Aid, and social work field placements through six universities.

The goal of this annual report is to increase access to local data and evidence about community mental health trends and to enhance dialogues for suicide prevention regional planning.

To illustrate the types of situations that require support, this report also includes real stories.

KEY FINDINGS:

- The number of calls to 686-HELP went up by 128% from July 2023 (407 calls) to June 2024 (928 Crisis Calls).

Calls for Crisis Mobile services increased by 444.2% within two fiscal quarters, from December 2023 (43 calls) to June 2024 (234 calls).

• Calls for Mental Health Urgent Care grew by 351% over two fiscal quarters, from December 2023 (51 calls) to June 2024 (230 calls).

• Overall, we had 53% more calls this year than last year and 67% more calls compared to two years ago. Most of these new calls came after we launched the 24/7 mobile service.

• Active rescues for imminent risk to life made up only 0.63% of total calls, despite the increase in call volume. This marks a decline from all previous years, showing that the launch of 24/7 crisis mobile services provided a less intrusive intervention in most situations.

• The number of BIPOC callers in the past 12 months increased by 20% compared to the previous year, although there was no proportional increase in crisis callers.

• Crisis Helpline internships support the next generation of behavioral health professionals. In the 2023/2024 school year, 26 social work students completed a suicide prevention internship, and 100% of recent graduates expressed a desire to continue working in crisis care.

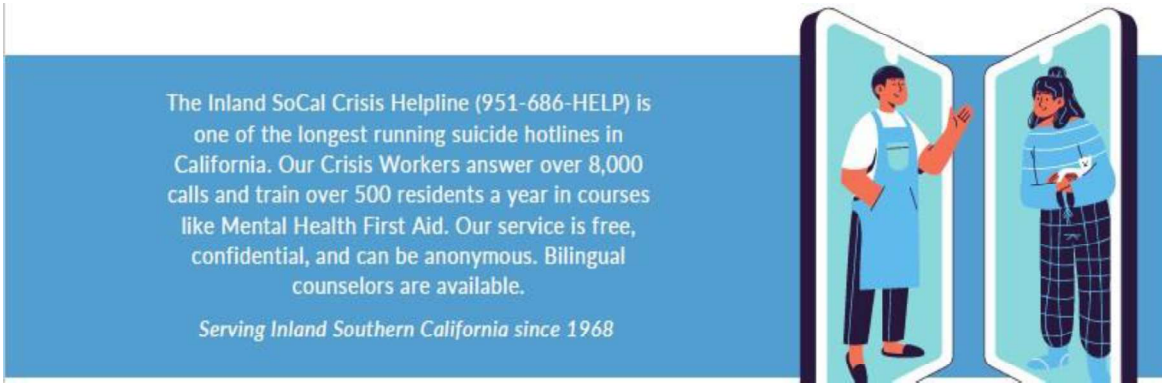




PEI

PEI

COMMUNITY CRISIS CARE



TELEPHONIC EMOTIONAL SUPPORT

24/7 Crisis Counseling with highly trained, compassionate Crisis Workers. We make mental health crises and suicide prevention easily accessible through locally operated tele-help. 951-686-HELP offers active listening, emotional support, suicide prevention, collaborative problem solving, and a connection to in-person support via the verified 211 database.

CRISIS CONTINUUM OF CARE

On January 1, 2024, Riverside County launched a new 24/7 Crisis Mobile Unit, accessible through our Inland SoCal Crisis Helpline, 951-686-HELP. The expanded service, provided by our primary funder, the Riverside University Health System, also offers telephonic crisis intervention and connects callers to three 24/7 Mental Health Urgent Care Centers. Aligned with SAMHSA's Crisis Continuum of Care, Inland SoCal United Way ensures individuals in crisis have someone to call, somewhere to go, and someone to come to them around the clock and for free.

PREVENTION & POSTVENTION

The Inland SoCal Crisis Helpline also trains 500 people a year to help prevent suicide via Mental Health First Aid (8 hours), safeTALK (4 hours), ASIST (16 hours), and QPR (60 minutes). In addition, we partner on postvention services with the Trauma Intervention Team to respond to suicide deaths.

SOCIAL WORK FIELD PLACEMENTS

Social work internships are an invaluable part of practical training and supervised experience to deliver mental health and social services. Since starting the internship program in 2020, the Inland SoCal Crisis Helpline has trained more than 100 graduate and undergraduate students from 6 universities.

What's next?

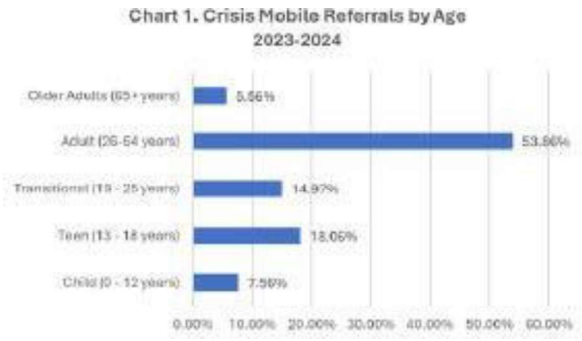
With 56 years of local crisis care service, the AAS and Inform USA Accredited Inland SoCal Crisis Helpline seeks to expand our reach by joining the 988 network. We also seek to expand our service area to the entire Inland Southern California region.

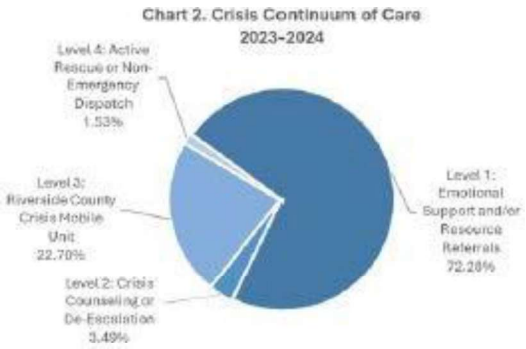
CRISIS CONTINUUM OF CARE

17.81% of calls were referred to Mental Health Urgent Care

The Inland SoCal Crisis Helpline and the Riverside County (RUHS) Crisis Mobile Unit expanded the continuum of crisis care in 2024. In this first partnership year, the Crisis Helpline assessed and warm transferred 174 calls to RCCMU for in-person support.

The Substance Abuse and Mental Health Services Administration (SAMHSA), a Crisis Continuum of Care, consists of three core components: 1) Regional Crisis Call Centers, 2) Local Mobile Crisis Response Teams, and 3) Local Crisis Stabilization Centers. This creates a Continuum of Care, providing community members with Someone to Call, Someone to Come, and Somewhere to Go during a mental health crisis. The model decouples mental health crisis response from law enforcement. In Riverside County, the Inland SoCal Crisis Helpline (951-686-HELP) serves as the front door phone number for community members and helping professionals to request screening and prospective dispatch of the Mobile Crisis Unit or referral to a Mental Health Urgent Care Center.





IMPACT

Topics of Crisis/Importance

The following are real-life issues of diverse needs that were addressed in the last year that illustrate the type of calls needing in-person crisis support:

- Economic Despair
- Personal Relationship Conflict
- Substance Misuse Disorder
- Isolation/Loneliness
- Elder/Child Care Stress
- Major Life Events
- Grief/Loss
- Chronic Mental Illness
- Physical Illness/Pain
- Work/School Stress

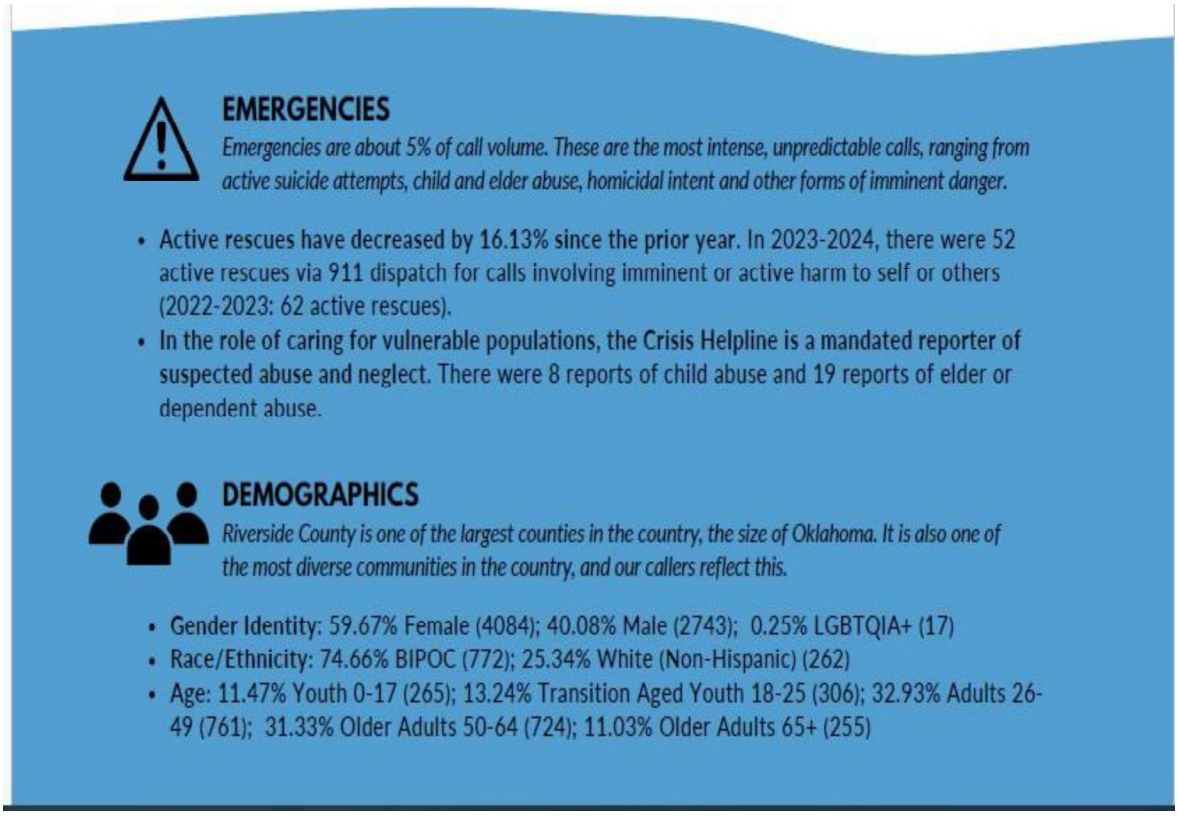
RAPID REPORTING

Crisis Helpline Annual Report 2023-2024

As part of the Youth Suicide Rapid Reporting and Response Pilot via the California Department of Public Health and Riverside UHS Public Health, Inland SoCal Crisis Helpline launched a dashboard to share with the public data on:

- Total Calls to 951-686-HELP
- Calls with Suicidal Content Active Rescues via 911 Referrals to Mental Health Urgent Care
- Calls Transferred to Crisis Mobile Unit
- Total Calls to 951-686-HELP by Date



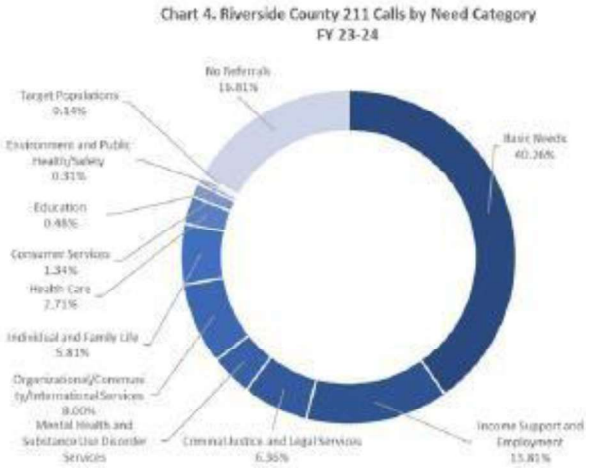


ECONOMIC INSECURITY
Crisis Helpline Annual Report 2023-2024

Economic security and mobility are protective factors for mental health. Inland SoCal 211+ callers frequently discuss stressors associated with meeting basic needs, including needing services for food, housing, clothes, and other essentials. Inland SoCal Crisis Helpline (951-686-HELP), a program of Inland SoCal 211+, provides specialized behavioral health crisis support. Callers to this line are primarily individuals experiencing mental health or substance use crises. For callers requiring additional social services, such as food, housing, or utility assistance, 686-HELP Crisis Counselors transfer them to 211 Referral Specialists for appropriate support. Conversely, 211 Referral Specialists transfer individuals presenting with immediate behavioral health crises to 686-HELP. During the last fiscal year, Riverside County residents placed 48,111 calls to 211 seeking social services. Among these, 40.26% expressed urgent needs related to necessities like food, utilities, and housing. The United Way of California Real Cost Measure finds that 1/3 of residents in Riverside and San Bernardino Counties do not have enough income for daily living needs, like food, housing, utilities, and other essentials.

Despair is a feeling of hopelessness, in this case resulting from an external factor over which callers have very little control—their economic position:

- Older adults express that housing unaffordability and homelessness cause suicidal thoughts.
- Parents express that they cannot make ends meet and provide for their children, causing emotional distress.
- Children and teens feel distraught due to financial stress that puts added pressure on families.
- Unhoused crisis calls show that extreme chronic stress damages mental health and causes depression, anxiety, and emotional distress.



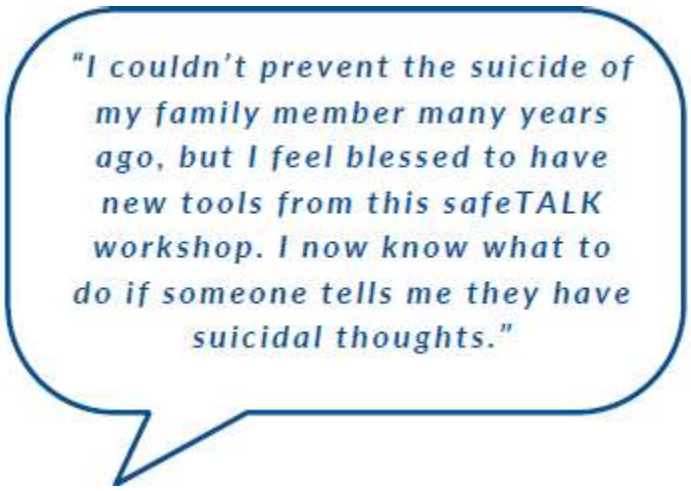
IMPACT
Topics of Crisis/Importance

The following are real examples of economic despair issues needs that were addressed in the last year that illustrate the type of calls needing in-person crisis support:

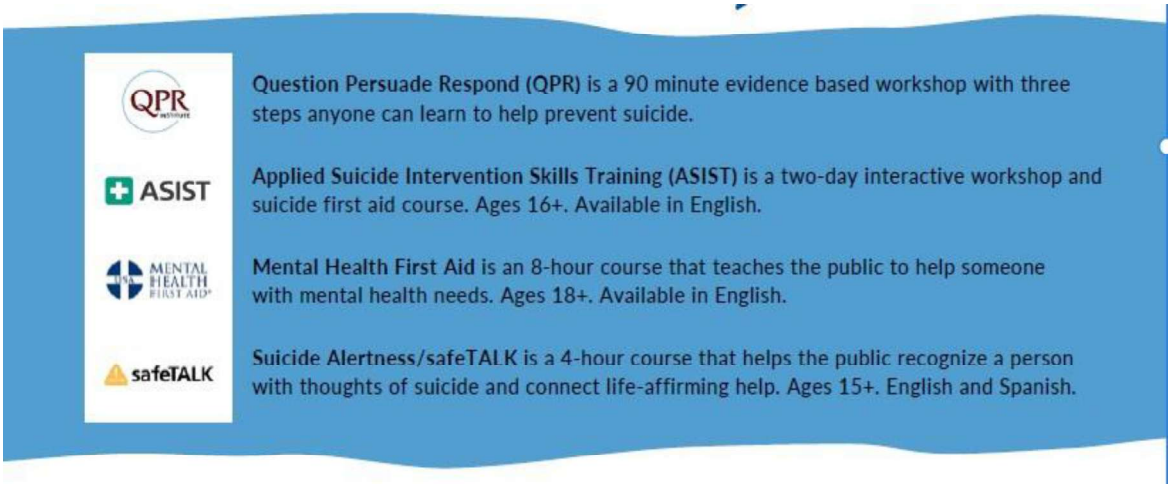
- Housing (Lack of stable housing or lack of shelter or living with unsafe individuals)
- Employment (unemployment, underemployment, or holding multiple jobs)
- Basic Needs (lack of food, utilities, elder care, child care, or medical care)
- Transportation (lack of transportation to work or medical appointments)

PREVENTION & POSTVENTION
Crisis Helpline Annual Report 2023-2024

In addition to responding to active crises, the Inland SoCal Crisis & Suicide Helpl ine provides trainings, courses, and workshops to prepare the general publ ic, schools, businesses, and other providers to identify and respond to mental health needs and suicide signs. In the 2023-2024 program year, Inland SoCal Crisis Trainers conducted 320 hours of training across 39 days to 29 cohorts.



Training Courses:



In 2023-2024, we also continued to support postvention services to help individuals heal from suicide loss and other situations. We are proud to partner with the Trauma Intervention Program (TIP) Riverside Chapter. TIP is a dedicated group of everyday people helping everyday people in traumatic crises. Their group of helpful, supportive volunteers is here to serve the needs of anyone when requested by a first responder, hospital personnel, paramedic, or coroner's office to bring emotional first aid to survivors, friends, and family in crisis.

United Way
Inland SoCal United Way

2·1·1
Inland SoCal 211+

FIELD PLACEMENTS
Crisis Helpline Annual Report 2023-2024

Mental health services are essential for community wellness. However, the number of licensed therapists in California declined by 20% from 2016 to 2020 (CalHHS). This puts additional pressure on mental health care systems that are already overwhelmed by increased demands caused by the pandemic, inflation, wildfires, gun violence, racism, the housing crisis, and other stressors. In 2020, to address the need for more mental health workers, the Inland SoCal Crisis & Suicide Helpline launched a workforce development initiative. The program provides mental health career students with a fieldwork site and behavioral health work experience while focusing on developing their own protective factors to remain in the field.



Interns and Staff represent Crisis Helpline at the Out of Darkness Suicide Prevention Walk at Fairmont Park, September 2023.

Participating Universities:

- California Baptist University
- La Sierra University
- Grand Canyon University
- Chamberlain University
- Western New Mexico University
- University of Louisville

Preparing the Next Generation:

- More than 100 students have completed the program since its launch.
- 26 students completed a behavioral health internship with Crisis Helpline in 2023-2024.
- 24 of the 26 students were Masters of Social Work graduate student interns. The remaining 2 were undergraduate students completing a bachelor's degree in social work.
- 100% completed over 60 hours of suicide prevention and crisis intervention training and assisted thousands of community members in crisis.
- 100% of program graduates report having a long-term goal to remain in the behavioral health profession, and many report wanting to work long-term in crisis care.

PEI

ACKNOWLEDGEMENTS

Crisis Helpline Annual Report 2023-2024

In recognition of their contributions, the Inland SoCal Crisis & Suicide Helpline acknowledges and is grateful for support from all community partners in the 2023-2024 program year.

With special thanks to:

Riverside County Behavioral Health (RUHS) for their 56 years of funding and partnership support to the Crisis Helpline services in Riverside County.

Kristin Miller of the Riverside County Crisis Mobile Unit for developing and launching our joint effort to make mobile crisis accessible to the public through the Crisis Helpline.

Riverside County Public Health (RUHS) for their 2023-2025 grant focused on expanding Crisis Helpline awareness and suicide prevention training in Eastern Riverside County.

Dr. Charles Lee-Johnson, Froylana Miller, and Judy Latham of California Baptist University's Department of Social Work for our 6th year anniversary of partnership with their department. Approximately 75% of the Crisis Helpline's social work interns each year join us from their respective programs. With training and supervision by Crisis Helpline staff, their interns answer roughly half of all calls.

Prof. Daphne Thomas and Dr. Marni Straine of La Sierra University's Department of Social Work for supporting our team with additional training and development opportunities.

Riverside County Suicide Prevention Co-Chairs, Diana Gutierrez (RUHS-BH) and Rebecca Antillon (RUHS-PH), for their ongoing collaboration and support of regional suicide prevention.

Magda Stewart of the Riverside Trauma Intervention Program (TIP) for partnering on postvention services to survivors of suicide loss.

United Way
Inland SoCal United Way

2·1·1
Inland SoCal 211+

Take My Hand Peer Chat

Program Type: Suicide Prevention

TakemyHand™ is a peer-to-peer live chat interface operated by RUHS-Behavioral Health Certified Medi-Cal Peer Support Specialists, providing anonymous live chat support using real-time conversations for people 16 years of age or older who are seeking non-crisis emotional support in Riverside County. TakemyHand™ website also offers resources and promotional materials (https://helpathand.info) to the Riverside County community. Access to the LiveChat is available Monday-Thursday 8:00-5:00 and Fridays 8:00-4:00. LiveChat is accessed through the TakemyHand™ website. Website visitors can respond to the LiveChat invitation or utilize the resources available on the website. The program was developed under MHSA Innovations funding. The Tech Suite Innovations project has come to an end. Due to the success of Take My Hand, and in order to keep these services in our County, Take My Hand will be supported, in part, through PEI funding which will cover the chat service technology component only. Details of this service are shared in the Innovation section of the MHSA plan.



Network of Care

Program Type: Stigma and Discrimination Reduction Program

Network of Care is a user-friendly website that is a highly interactive, single information place where consumers, community members, community-based organizations, and providers can easily access a wide variety of important information. The Network of Care is designed so there is "No Wrong Door" for those who need services. In FY23/24 the website had an average of 611 Website visits per day and a total of 428,238 page views. Visitors viewed approximately 1,170 pages daily on average. Each visitor viewed nearly 2 pages per visit. Visitors spent an average of over 9 minutes on the site per session, reflecting strong user engagement.



May is Mental Health Matters Month

Program Type: PEI Stigma and Discrimination Reduction Program

The 2024 May is Mental Health Events were held in all three





regions of Riverside County. "The Art of Wellness" themed events took place at Fairmount Park in Western Riverside, the Coachella Valley History Museum in the Desert Region, and Valley Wide Regional Park in Mid-County. The events featured free food, culturally diverse music, art and activities to engage roughly 3800 community members in mental health wellness education and resources. Also included in this year's events were screening areas for Directing Change, highlighting video submissions from Riverside County youth that address stigma reduction for mental health, help seeking, and suicide prevention.
Roughly 300 partner agencies across the County shared their services and resources to community members of all ages and walks of life.

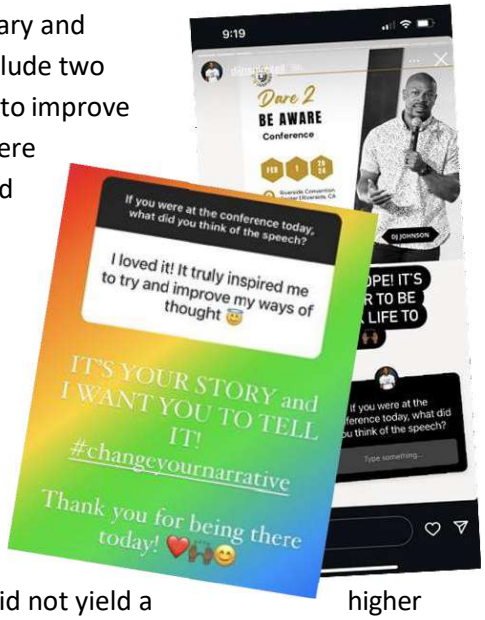


To help increase the reach into the Desert and Mid-County regions, contract providers that have strong ties to their local communities were contracted to organize outreach and help coordinate volunteer efforts. Riverside County Latino Commission covered the Desert region, and California Family Life Center covered the Mid-County region.

"Dare to Be Aware" Youth Conference
Program Type: PEI Stigma and Discrimination Reduction Program



This is a full-day conference for high school and middle school students. The day includes presentations on mental health-related topics along with activities. The 2024 Dare to be Aware youth conference was hosted in February and expanded to include two events this year to improve access. There were conferences held in Riverside and Palm Springs. There was a total of 23 schools countywide that attended the events and a total of 500 youth and advisors in attendance. Both events featured two keynote speakers (DJ Johnson and Gentre Adkins) that shared messages of hope and resilience, giving attendees tools to use in their lives to help bolster their own innate resilience. Students and advisors also received an inspirational activity of chair yoga by Dat Yoga Dude, James Woods, to also add mindfulness, movement, and breathing to their toolbox. Two events did not yield a higher than typical attendance and with the high costs associated with two event venues, the 2025 event will return to one location.



Stand Against Stigma:

Program Type: PEI Stigma and Discrimination Reduction Program

The program goals of this project are to reduce stigma regarding mental illness and to increase community awareness within target populations regarding mental health information and resources. This is an interactive public education program in which consumer speakers share their personal stories about living with mental illness and achieving recovery. The target audiences and goals are:

- Employers: to increase hiring and reasonable accommodations
- Landlords/Housing officials: to increase rentals and reasonable accommodations
- Health care providers: for provision of the full range of health services
- Legislators and other government-related individuals: for support of greater resources for mental health
- Faith-based communities: for greater inclusion in all aspects of the community
- Media: to promote positive images and to stop negative portrayals
- Community (e.g., students, older adults, service clubs, etc.): to increase social acceptance of mental illness
- Ethnic/Cultural groups: to promote access to mental health services



The program consists of a small team of presenters who share their lived experience with mental illness and their recovery journey to reduce stigma and spread messages of hope. Overall, the Stand Against Stigma program saw an increase in their presentations by 24% compared to last fiscal year. This included reaching a total of 248 community members. The most frequently reported race/ethnicity for all regions was Hispanic/Latinx (59.6%), which is one of our underserved communities. Furthermore, most of the presentations and attendance were from the Desert region (65.1%), which is a region in the County that has a high need for support and services. Program outcomes showed a statistically significant increase in participants' affirming attitudes regarding recovery from mental health conditions, as well as a greater willingness to seek mental health services and support if they experience psychological challenges. Attendees reported strong satisfaction with the enthusiasm and knowledge of the presenters, and a high likelihood of recommending the program to others. To help increase community access to presentations, the provider worked on promoting open, virtual presentations for community members to attend. Efforts were made to advertise and promote those regional, virtual presentations; however, it proved to be a challenge to have people attend these events. Oftentimes no one would show to these open, virtual presentations. Furthermore,

when virtual presentations were held, the program did not see high completion rates of outcome measures. Additionally, the program saw a lot of staff turnover, resulting in an even smaller pool of presenters that were able and available to share their lived experience. The biggest lesson learned from FY23/24 was that the open, virtual community presentations were not successful in generating attendance from community members, and that a better, more strategic approach would be to decrease these offerings, and focus on approaching other organizations to host for their members. Additionally, due to the small presenter pool, it is important for the team to communicate and coordinate upcoming presentations to help avoid presenter burnout and to properly care for their own mental health and wellbeing.

One of our presenters shared the following experience from one of their presentations in the Desert region: "During one of our presentations for the Desert community, a listener shared that although her experiences were different, my story helped her understand why some people struggle to open up to therapists or other trained professionals. She mentioned that she had previously believed people who didn't seek help were sometimes responsible for staying in unsafe situations; however, after hearing about my negative experience with a therapist, she said she became more empathetic toward those who have difficulty going to or returning to therapy. I believe this example is significant because I felt like I was able to help reduce stigma and offer a new perspective to this community member."

Feedback from community members who attended the presentation:

- "I love that the presenters shared true life stories. It was a heartfelt presentation."
- "Thank you for sharing your life experience. I believe we are capable of things. Most people need the support to know that they can be successful."
- "Great job! Thank you for sharing your stories. They were powerful and can help so many to learn and feel less alone."
- "Your honesty and vulnerability are appreciated. Thank you for your time."
- "Thank you! This was wonderful to see and hear that there are people fighting the good fight."
- "Life is a miracle if we can experience it."

Riverside University HEALTH SYSTEM Behavioral Health

Stand Against Stigma

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

PEI

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Program Overview and Provider

Program Overview and Provider:

MHSA Prevention and Early Intervention has funded stigma reduction programing focused on specific presentations that are aimed at: (1) reducing stigma regarding mental illness, and (2) increasing community awareness within target populations regarding mental health information and resources. “Stand Against Stigma” is an anti-stigma program based on leading researchers’ previous studies about the importance of increasing community awareness about mental health information and resources, that suggests five principles that effectively decrease the consequences of public stigma, referred to as TLC3 (Targeted, Local, Credible, Continuous, Contact). This program is provided by RUHS-Behavioral Health Prevention and Early Intervention Peer Support Specialists known as PEI Peers. They provide services throughout the three regions of Riverside County: Desert, Mid-County, and Western.

Peer Support Specialists promote the consumer perspective in all their presentations. Stand Against Stigma is designed to provide anti-stigma presentations to individuals and organizations by specifically outreaching and collaborating with schools, businesses, community organizations, and faith-based organizations throughout the county to bring presentations to as many people as possible.

“Stand Against Stigma” presentations are utilized to educate and outreach to target audiences to share the unique stories of those with mental illness with the aim of reducing stigmatizing attitudes. Presentations are evidence-supported and structured to discuss mental health through presenters sharing their lived experience with mental health challenges and including an ‘on-the-way-up’ message to discuss strengths and recovery because of services, supports, and/or treatment. Presentations are aimed at reaching the following target audiences: community members, employers, landlords/housing officials, health care providers, other government-related entities, faith -based communities, and media.

Executive Summary: Key Findings

During the fiscal year 2023-2024, there were a total of 14 “Stand Against Stigma” presentations held by RUHS-Behavioral Health PEI Peers in the Desert (n=8), Mid-County (n=1), and Western (n=5) regions, for a total service of 14 hours. The majority of events targeted the general community.

- There were a total of 248 people who attended “Stand Against Stigma” presentations. The presentations were held either in-person or virtually via Zoom (n=14), the total number includes attendees from outside Riverside County regions. Due to the Stand Against Stigma program being provided to people who reside, work, or study in Riverside County, one (1) individuals who resided outside of Riverside County was excluded for analysis purposes. Additionally, one (1) individual who did not provide information regarding their residence was excluded as well. Moreover, 139 attendees did not complete the demographic and pre/post questionnaires. This resulted in only 109 attendees who were included in the analysis for this report.
- Most attendees resided in the Desert region (n=71, 65.1%).
- The attendees’ ages ranged from 19 to 68 years old, with an average age of 40 years old.
- The most frequently reported race/ethnicity for all regions was Hispanic/Latinx (n=65, 59.6%).
- The majority of attendees were female (n=72, 66.1%).
- Post-test results revealed a statistically significant increase in participants’ affirming attitudes regarding recovery from mental health conditions, as well as a greater willingness to seek mental health services and support if they experience psychological challenges. Paired samples T-test showed statistically significant results for Stigmatizing Attitudes and Care-Seeking Attitudes scales ($p<=0.001$).
- Speaker’s Bureau attendees reported strong satisfaction with the enthusiasm and knowledge of the Speaker’s Bureau presenters, and a high likelihood to recommend the program to others.

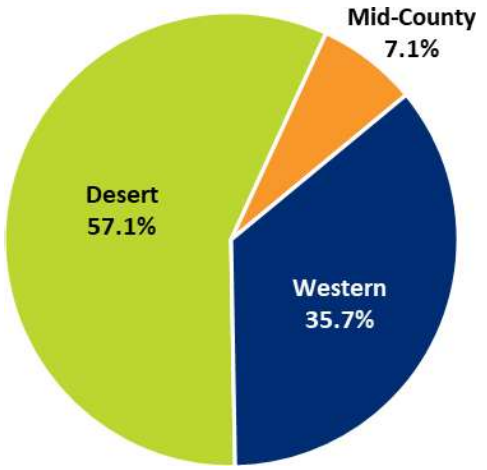
Event Statistics

RUHS-Behavioral Health PEI Peers are expected to hold 40 “Stand Against Stigma” presentations per region each year. During FY 2023-2024, a total of 14 presentations were held throughout the County and no region met expectations.

RUHS-BH PEI Peers FY 2023-2024 Speaker’s Bureau Events Countywide			
Presentation Format	**Contract Expectation**	**Current Total**	**Percent Completion**
Speaker’s Bureau	**120**	**14**	**11.7%**

Event Statistics by Region

Out of the 14 total "Stand Against Stigma" presentations conducted by RUHS-BH PEI Peers, the majority took place in the Desert region (n=8), followed by the Western region (n=5), and the Mid-County region (n=1).



The presentations were evenly split between virtual and in-person formats, with 7 of each. The PEI Peers collaborated with a variety of community venues, including libraries, family engagement centers, colleges, social services organizations, and other community locations.

Event Duration by Region

Region	Total Time
Countywide	**14 Hours**
Desert	**8 (57.1%)**
Mid-County	**1 Hour (7.1%)**
Western	**5 Hours (35.7%)**

The total presentation time that was spent on Speaker’s Bureau events across all regions was 14 hours, with the Desert, Western, and Mid-County regions making up 57.1%, 35.7%, and 7.1% of the total time, respectively. The average time was 1 hour for presentations. Most of the presentations were conducted only in English (n=12, 85.7%), while an additional one presentation were conducted in American Sign Language (7.1%), and one more presentations were conducted in Spanish (7.1%).

Event Statistics cont.

City/Zip Code Locations

Region	City and Zip Code	Countywide
Desert		**8 (57.1%)**
	Indio, Palm Desert, Thermal	5 (62.5%)
	Virtual	3 (37.5%)
Mid-County		**1 (7.1%)**
	Virtual	1 (100%)
Western		**5 (35.7%)**
	Riverside, 92507	2 (40.0%)
	Virtual	3 (60.0%)

In FY 2023-2024, a total of 14 “Stand Against Stigma” presentations were delivered by providers, either virtually via Zoom or in-person. Of the seven in-person presentations, five took place in the Desert region and two in the Western region, with one event occurring in the Mid-County region.

Target Population

Target Population	Countywide (n=14)
Community	12 (85.7%)
Peers	1 (7.1%)
Other	1 (7.1%)

Speaker’s Bureau presentations were intended to target particular populations in non-traditional settings. The largest target population reached by the program was to the “Community” (n=12, 85.7%), followed by “Peers” (n=1, 7.1%) and “Other” (n=1, 7.1%). The community was reached through libraries, community organizations, and colleges.

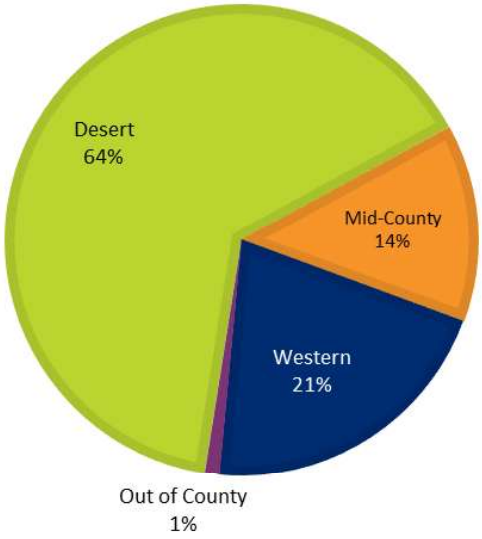
Participant Demographics

Attendance

A total of 248 individuals participated in the 14 “Stand Against Stigma” presentations during the fiscal year 2023-2024. Attendees were asked to complete demographic forms and pre/post surveys at each event. In total, 111 demographic forms and surveys were submitted, including responses from non-Riverside County residents, employees, or students (n=1) and individuals with unknown residency (n=1). Since the program is exclusively available to Riverside County residents, employees, and students, the analysis was based on 109 valid responses. Countywide analysis revealed a small percentage of attendees who identified as LGBTQ+ (n=14, 12.8%) or as having a disability (n=9, 8.3%), with no attendees identifying as veterans.

Residence by Region

Of the 109 total attendees who live, work, or study within Riverside County, most were from the Desert region (n=71, 64.5%), followed by the Western (n=23, 20.9%), and Mid-County regions (n=15, 13.6%) of Riverside County with the remaining living outside of the county (n=1, 1.0%). The figure below shows the total attendance by region of residence.



Language

Language	Countywide (n=109)
English	97 (89.0%)
Spanish	9 (8.3%)
Both	2 (1.8%)
Not Reported	1 (1.0%)

Age

Age Range	Countywide (n=109)
18 to 29 years old	16 (14.7%)
30 to 39 years old	34 (31.2%)
40 to 49 years old	38 (34.9%)
50 to 59 years old	16 (14.7%)
60 to 69 years old	3 (2.8)
70 years or older	0 (0%)
Not Reported	2 (1.8%)

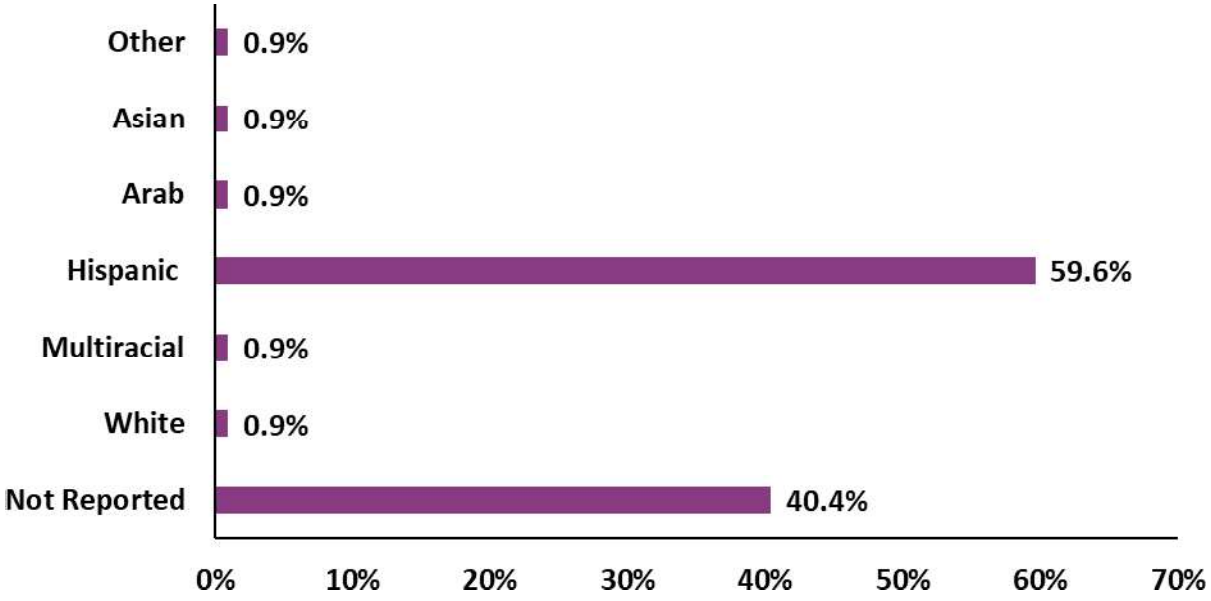
The table above presents the distribution of reported ages. Among the 109 attendees residing, working, or studying within Riverside County, the average age was 40 years, the median age was also 40 years, and the most frequently reported age was 39 years.

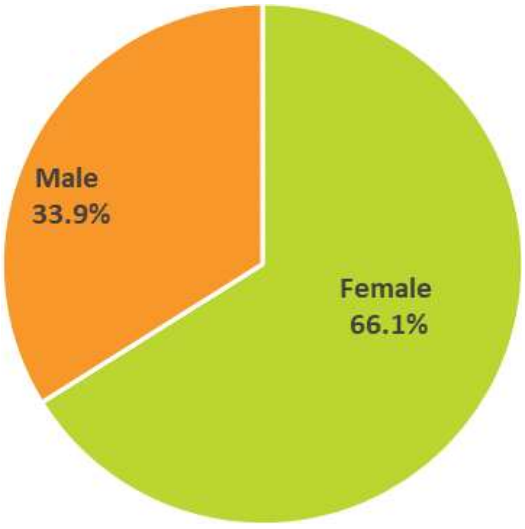
Among the 109 attendees residing, working, or studying in Riverside County, the majority (n=97, 89.0%) indicated that English was their preferred language, while 8.3% (n=9) preferred Spanish. One attendee selected both English and Spanish as their preferred languages, and another declined to respond.

Participant Demographics cont.

Race/Ethnicity

Of the 109 total attendees who live, work, or study within Riverside County, the majority of attendees identified as Hispanic or Latino/Latina (n=65, 59.6%). A small fraction of attendees identified as White (n=1, 1.0%), Asian American (n=1, 1.0%) and Multiracial (n=1, 1.0%). The rest of the attendees declined to report (n=44, 40.4%)





Gender

The majority of attendees identified as female (n=72, 66.1%), followed by male (n=37, 33.9%).

"Stand Against Stigma" Pre/Post Test Questionnaire

Pre-tests and post-tests were administered immediately before and after each "Stand Against Stigma" presentations in order to assess its impact on the attendees. The pre and post questionnaires were designed using a Likert Scale of 1 to 9, where 1 represents "Strongly Disagree" and 9 represents "Strongly Agree". There are a total of 15 questions in the pre and post questionnaires, in which four stigma sections were measured:

- 5 Questions on Stigmatizing Attitudes (AQ-5)
- 3 Questions on Recovery Attitudes (RS-3)
- 3 Questions on Empowerment Attitudes (ES-3)
- 4 Questions Care-Seeking Attitudes (CS-4)

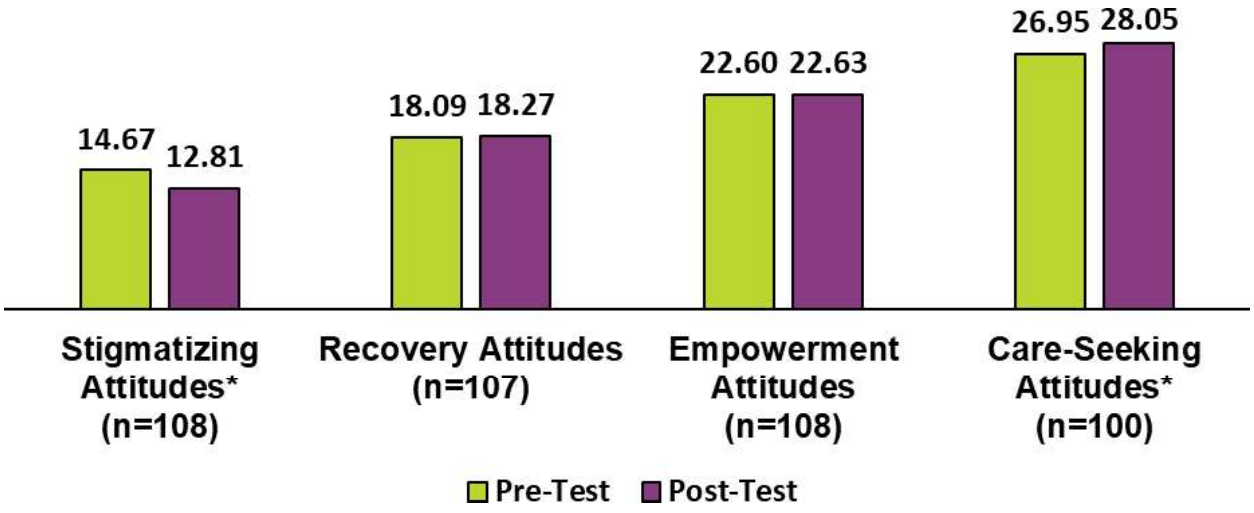
Measures of Stigma	Questionnaire	Rating Scale
Stigma Change (AQ-5)	Five-item Attribution Questionnaire (AQ-5) assessing participants' cognitive, affective, and behavioral reactions to people with mental illnesses. *Example: "I think that most people with mental illness are to blame for their problems."*	Score range: 5-45 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Recovery Attitudes (RS-3)	Three-item Recovery Scale (RS-3) assessing participants' attitudes toward people with mental health conditions' capabilities to overcome psychological challenges. *Example: "People with mental illness are hopeful about their future."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Empowerment Attitudes (ES-3)	Three-item Empowerment Scale (ES-3) assessing participants' attitudes about people with mental illness relative to people without. *Example: "I see people with mental illness as capable people."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Care-Seeking Attitudes (CS-4)	Four-item Care Seeking Questionnaire (CS-4) assessing participants' willingness to seek out mental health services if they were experiencing impairing anxiety and/or depression. *Example: "I would speak to a counselor if I were significantly anxious or depressed."*	Score range: 6-54 1 = 'Strongly Disagree' 9 = 'Strongly Agree'

A total of 109 attendees participated in a "Stand Against Stigma" presentation and completed pre- and post-test outcome measures. However, one attendee did not complete all items in the Stigmatizing Attitudes scale (n=108), two attendees did not complete all questions related to Recovery Attitudes (n=107), one attendee did not fully complete the Empowerment Attitudes scale (n=108), and nine attendees did not complete all items on the Care-Seeking Attitudes scale (n=100).

Scores for all items within each of the four questionnaire sections were summed, with pre/post-test comparisons based on the cumulative scores. Higher cumulative scores for the AQ-5 represent greater stigmatizing attitudes and higher cumulative scores on the RS-3, ES-3, and CS-4 represent more positive attitudes toward the described constructs.

"Stand Against Stigma" Average Scores: Pre-Tests vs. Post-Tests

In order to measure the effectiveness of the presentations, ideally there would be a decrease in the average scores of the Stigmatizing Attitudes scale from pre- to post-measures and an increase in the average scores of the Recovery Attitudes, Empowerment Attitudes, and Care-Seeking Attitudes from pre- to post-measures. Overall, the average scores across all scales showed improvements from pre -tests to post-tests. Further analysis using paired samples t-tests shows the improvements were statistically significant (p<=.001) for two scales as shown on graph and table below.



Note: Significance levels * = Numbers indicate statistically significant (p<=.001) change from Pre to Post

Measured Scales	Difference in Average Scores	*t*	df	p
Stigmatizing Attitudes (AQ-5)	1.86	4.200	105	.000
Recovery Attitudes (RS-3)	-0.18	-0.406	105	.685
Empowerment Attitudes (ES-3)	-0.03	-0.080	105	.936
Care-Seeking Attitudes (CS-4)	-1.10	-2.699	99	.008

When comparing the pre- and post-test results across the scales, the Care-Seeking Attitudes scale demonstrated the most significant increase, with an average score change of 1.10 points, followed by a 0.18-point change in the Recovery Attitudes scale. However, the small increase in Recovery Attitudes was not statistically significant. Additionally, the minimal change in scores on the Empowerment Attitudes scale may be attributed to the relatively high baseline scores of attendees (average of 22.60 points, with a range of 3-27), and this change was also not statistically significant.

Overall, statistically significant improvements were observed in both the Stigmatizing Attitudes and Care-Seeking Attitudes scales. These findings suggest that the "Stand Against Stigma" presentations were effective in positively shifting attendees' perceptions of individuals with mental health conditions, increasing their belief in recovery and empowerment, and enhancing the likelihood of attendees seeking help when facing anxiety and/or depression.

Satisfaction Surveys

Additional satisfaction questions were included at the end of the "Stand Against Stigma" post-test questionnaire. Using a scale of 1-9, with 1 representing the poorest satisfaction and 9 representing the greatest positive satisfaction, participants were asked to rate the presenters' level of enthusiasm and knowledge (n=109), and their likelihood to recommend others to participate in a similar "Stand Against Stigma" presentation (n=109). Their responses are summarized below:

- With an average score of 8.25, 72.5% of attendees strongly agreed that the presenters were enthusiastic and knowledgeable when sharing the information
- With an average score of 8.17, 70.6% of attendees strongly agreed that they would recommend others to participate in similar activities

The table below shows the percentages of attendees' responses to each satisfaction survey question. On average, all participants who completed the satisfaction questions reported positive feedback (over 87.6% of attendees chose "6" or higher). Additionally, their comments about the events are shown below and continue on the next page.

		1=Strongly Disagree								9=Strongly Agree	
Countywide (n=103)	**Average**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**No Response**
1. The presenters were enthusiastic and knowledgeable when sharing the information.	8.25	3.7%	-	-	0.9%	4.6%	1.8%	1.8%	11.9%	72.5%	2.8%
2. I would recommend an activity like this to my friends, family members, and colleagues.	8.17	3.7%	-	-	0.9%	6.4%	0.9%	3.7%	11.9%	70.6%	1.8%

Comments

Additional Comments

- I love that the presenters shared true life stories. It was a heartfelt presentation.
- Thank you for sharing your life experience. I believe we are capable of things. Most people need the support to know that they can be successful .
- Thank you for sharing. You are so brave and strong.
- Great job ! Thank you for sharing your stories. They were powerful and can help so many to learn and feel less alone.
- Your honesty and vulnerability are appreciated. Thank you for your time.
- Thank you! This was wonderful to see and hear that there are people fighting the good fight.
- Brave speakers !
- Thank you for sharing.
- Thank you to [facilitator] and [facilitator] for sharing your stories. Thank you for still being here, and congrats on the work you have done so far. I hope the best for the work ahead.
- Presenters were very brave.
- Very touchful stories.
- Each of their stories was very touching and overall highly recommended.
- Life is a miracle if we can experience it.
- Able to change the cycle, learn from it and grow. Be the best person, sibling, parent, wife.
- The experiences with life were very valuable.
- I would love to see PowerPoint from families.
- Thank you for sharing your stories.

Up2Riverside Media Campaign
Program Type: PEI Stigma and Discrimination Reduction Program



RUHS - BH continued to contract with a marketing firm, Civilian, to maintain and expand Up2Riverside.org, a paid media campaign for mental health awareness, stigma reduction, and suicide prevention (as well as substance use and prevention) in Riverside County. The campaign included television and radio ads and print materials reflective of Riverside County and included materials reflecting various cultural populations and ages as well as individuals, couples, and families. Up2Riverside.org includes social media in its overall digital presence. This website has many resources for community members to access. There are downloadable mental wellness kits, the Mental Health Back to School Toolkit, and information about important campaigns such as May is Mental Health Month and Suicide Prevention Awareness Month.

In FY23/24, Civilian designed a new website for a more modern/current look and feel, and refreshed/reworked content throughout the site, creating an overall better user experience for website viewers. The campaign would benefit from updating the commercial ads, but production (video shoot) was not able to move forward.



Emails continued to be responsible for the largest volume of site sessions (38% of total paid sessions), with the lowest Cost Per Click ($0.45) and cost per session ($0.52), making this channel a very cost-effective manner to share a longer form message and entice users to learn more on the website. The campaign introduced Spotify as a new tactic and while the primary Key Performance Indicators for Spotify is awareness (impressions), it is worth noting that the Spotify companion banner outperformed the industry benchmark of 0.05% and generated a total of 853 site sessions, proving the success of this tactic and need to include it in future plans to test further. In doubling Paid Search's budget Year-Over-Year this campaign saw a 2.36x increase in site sessions while maintaining the overall Cost Per Click benchmark of $1.35 (Paid Search was responsible for generating 13.51% of all paid sessions). Success of this tactic was due to both the increase in budget, as well as optimizations throughout the campaign.
The FY 23/24 paid media campaign delivered a total of 61M+ impressions and 344K+ clicks and was responsible for 81% of all website sessions. The campaign also sustained 242 total display points at 113 venues in Hemet and San Jacinto through narrowcasting efforts to share educational and resource information for the campaign with the general public.

Promotores de Salud Mental y Bienestar Program and Community Mental Health Promotion Program (CMHPP)

Program Type: Outreach for Increasing Recognition of Early Signs of Mental Illness Program



The Promotores(as) de Salud Mental y Bienestar program is an outreach and education approach to build a relationship with the Latinx community and increase access to mental health services while reducing the stigma associated with mental illness. Because Promotores(as) come from the communities they serve, they can address access barriers that arise from cultural and linguistic differences, stigma, and mistrust of the system. Furthermore, since they usually provide services in the community when and where it is convenient to community members, they help decrease barriers due to limited resources, lack of transportation, and limited availability. In addition to coming from the communities they serve, Promotores(as) can be characterized by three Ps: Presence in the community, Persistence, and Patience – these build trust in the community. Relationships with the community is one of the key factors that distinguish Promotores(as) from other health workers. The program includes a series of 10 mental health topics that are offered to the Latinx community in 1-hour presentations. The topics include anxiety, depression, mental health, schizophrenia, self-care, substance abuse, suicide prevention, trauma, bipolar disorder, and grief & loss. The schizophrenia presentation has been replaced with the culturally specific La Clave curriculum. Resources are also provided.

The Community Mental Health Promotion Program (CMHPP) is an ethnically and culturally specific mental health promotion program that targets: Native Americans, Asian Americans/Pacific Islanders, and Middle Eastern/North African (MENA). A similar approach to the Promotores model, the program focuses on reaching un/underserved cultural groups who would not have received mental health information and access to support and services. The promotors received a 40-hour training in which they are educated on topics in mental health, given a list of culturally competent local resources, and are empowered to create a plan of action as a group to address the unique mental health needs of their community. They provide 1-hour presentations on 10 different mental health topics in non-stigmatizing community locations such as local churches, community centers, schools, and parks. The topics include anxiety, depression, mental health, schizophrenia, self-care, substance abuse, suicide prevention, trauma, bipolar disorder, and grief & loss. Resources are also provided.

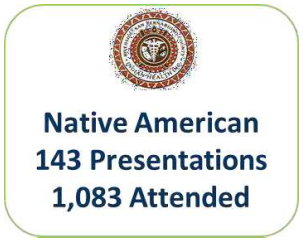
In fiscal year 2023/2024, the following agencies provided the CMHP Program to each of their respective underserved populations: Visíon y Compromiso (Hispanic/Latiné); Riverside-San Bernardino County Indian Health, Inc. (Native American); Special Services for Groups (Asian American/Pacific Islander); Sahaba Initiative (Middle Eastern/North African). Each of our providers worked to utilize community engagement effectively by continuing to cultivate and strengthen relationships with important stakeholders and key leaders, ensuring that their goals were aligned with the community's needs and priorities to foster interest and investment. Many of our providers were able to make inroads with different faith-based organizations, workplaces,

and community organizations and collaborated with them to tailor their presentations to best meet the needs of the culture and social context of their communities.

Visíon y Compromiso established a new MOU with Jurupa Valley Unified School District and began partnering with the goal of supporting the district's parents, increasing their awareness and education around the different mental health topics. Throughout the County, the majority of those in attendance indicated Spanish as their primary language (85%). Furthermore, the program expanded to include service to the Mid-County region in FY23/24, and the provider was able to provide a total of 3,476 presentations with a total of 11,862 people in attendance.



Riverside-San Bernardino Indian Health, Inc. continued to collaborate with community organizations and found new resources to share with their Native American community members. A strong partnership continued during FY23/24 with the University of California, Riverside and their Native American Student Programs. Other relationships with local colleges were developed during this fiscal year as well. The provider held a total of 143 presentations countywide with 1,083 in attendance, 85.6% of whom identified as American Indian or Alaskan Native.



Special Services for Groups found innovative ways to make their presentations appealing for their diverse AA/PI community. They found much success with infusing culturally relevant activities with their presentations to draw in more AA/PI community members. They centered their presentations around culturally tailored workshops, such as traditional dance, traditional crafting, and healthy living clubs. Community members were attracted by the different cultural activities and attended the mental health presentations that were related to those different activities (e.g., choreography and self-care and wellness, candle making and suicide prevention, etc.). In FY23/24 the provider held a total of 47 presentations in English, Korean, and Chinese with 1,028 in attendance. immerse



Sahaba Initiative started their contract approximately halfway through FY23/24 and were able to establish an office location in the Riverside area and hire two full-time staff to serve in Western and Mid-County regions of the county. During their first 6-months they were able to have both staff complete their 40-hour promoter training to be able to provide culturally tailored presentations to the Middle Eastern/North African community.



Some of the challenges that the providers faced during FY23/24 included finding key organizational leaders that they could connect with to champion their programs and bring them to the community members for presentations. Other providers faced staffing challenges and had pauses in service delivery to hold interviews, find the right fit for the team and community, undergo the onboarding requirements (e.g., DOJ background checks), and to conduct the extensive 40-hour training. Whether starting these services brand new in the County (e.g.,

Sahaba Initiative for the MENA community), or expanding services to new regions (e.g., Visíon y Compromiso 's expansion into Mid-County), the providers faced challenges with sharing their program in areas that were not familiar with the services provided. It took time to establish a presence and build relationships in the different communities. Additionally, some communities are more conservative than others, making it difficult to overcome the stigma associated with mental health and discussions around mental illness and suicide prevention. The providers encountered challenges with gathering community specific resources for their different underserved cultural groups, particularly for underserved groups with a lot of intragroup diversity (e.g., the many different tribes in Native American, the different cultures that make up Asian American/Pacific Islander, etc.). At times providers faced challenges with locating community spaces in which to host presentations. An alternative was to provide virtual presentations via Zoom when it was found to meet community need; however, this was often found to not be a lucrative option for many community members, who were fatigued of virtual services since the pandemic, and often yielded in low attendance and low completion of demographic forms and satisfaction surveys.

The providers in the CMHP program learned the importance of persevering with their efforts to identify the leaders of each community to assist them in collaborative efforts to deliver the needed presentations to the underserved populations. They also found value in their continued work with churches and temples where audiences are already mobilized to raise awareness about their CMHP programs and other available resources. Overall, the providers learned how to establish credibility by being transparent, consistent, and respectful. They involved diverse stakeholders, ensuring all community groups were represented, especially marginalized voices. This led to them being able to more effectively utilize culturally appropriate approaches to remove barriers to participation.

The outreach efforts have been a great success in leading workshops and building relationships within the different communities.

Feedback from participants includes:

- "It helps me understand more about my sister and to know how to help her."
- "It is very useful to know the symptoms so we can help someone or detect the disease early."
- "Making me more comfortable to talk about depression with my friends and family."
- "It brings awareness and helps people understand where others are coming from."
- "The mindset to think about things again and make an effort to put into practice."
- "Learned different ways to cope with stress."
- "The information shared in the training series were useful."

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention (PEI)

Community Mental Health Promotion Program

FY 2023-24 Annual Report



Introduction

The ethnically and culturally specific Community Mental Health Promotion Program (CMHPP) trains lay workers in the community (promoters) to outreach to their communities, bring awareness to mental health topics, reduce stigma and provide resources and/or referrals to prevention and early intervention services.

The selected promoters go through a 40-hour training in which they are educated on various mental health topics, given a list of culturally competent local resources and are empowered to create a plan of action as a group to address the unique mental health needs of their community. They provide services in non-stigmatizing community locations such as local churches, community centers, schools and other community locations. The promoters reach out to the Desert, Mid-County, and Western regions of Riverside County, and are especially focused on neighborhoods and communities identified by the MHSA Prevention and Early Intervention (PEI) planning committee as areas of high need. Outreach and education is provided to a range of age groups from middle/high school students, transitional age youth (TAY), adults, and older adults.

Contracted Partner Agencies

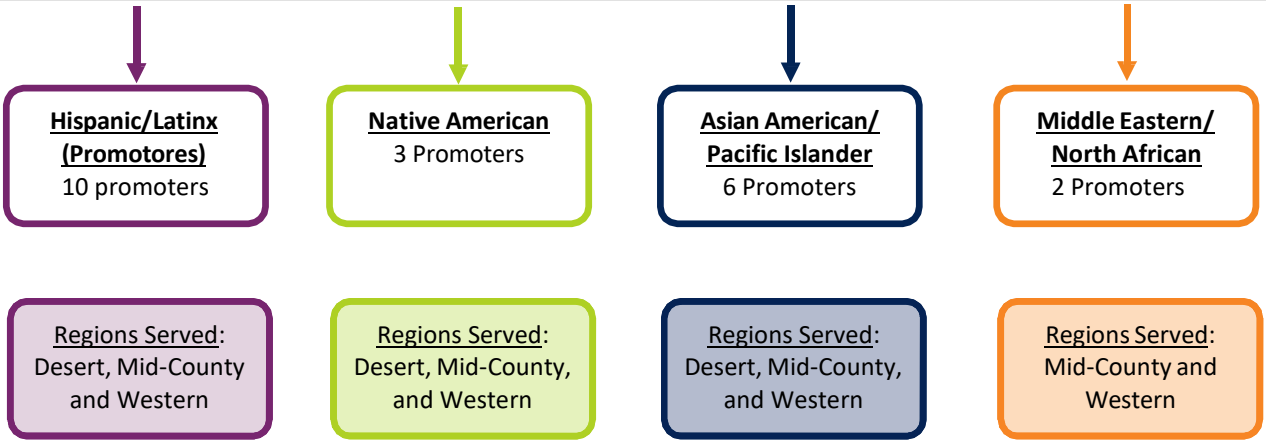
MHSA PEI formed partnerships and contracted with key community agencies. The agencies were responsible for selecting culturally competent promoters who have an understanding of the values, beliefs and language of the community, ensuring that all staffing needs were met and ensuring that the promoters received training as required by MHSA-PEI. They were responsible for program implementation and documentation.

Promotores Latinx/Latino	MHSA-PEI partnered with Visión y Compromiso, who's committed to community well being by supporting Promotores and Community Health Workers. Visión y Compromiso also have a vision towards a healthy and dignified life.
Native American RSBCIHI	MHSA-PEI partnered with Riverside/San Bernardino County Indian Health Inc. The organization advocates on behalf of American Indians through the delivery of quality health care services, which honor spiritual and cultural values.
Asian American/Pacific Islander Asian Pacific Counseling & Treatment Centers is a division of ssg Special Service for Groups	MHSA-PEI partnered with Asian Pacific Counseling and Treatment Centers, a division of Special Service for Groups, Inc. (SSG), specializing in culturally sensitive approaches to address the social and psychological needs of Asian and Pacific Islander communities.
Middle Eastern/North African SAHABA INITIATIVE Sahaba Initiative nurturing healthy families	MHSA-PEI partnered with Sahaba Initiative who outlines a vision for the Middle Eastern/North African (MENA) communities where mental health is valued and acknowledged with an emphasis on the importance of mental health education and ensuring everyone has access to necessary resources.

Other contracted agencies have provided Outreach in the past to the Black African American community and LGBTQI community, these contractors were unable to continue so this report includes the current contracts.

Staffing By Program and Region

Overall in FY 2023-24, **21** promoters provided outreach and presentations across the CMHP programs in the Desert, Mid-County, and Western regions of Riverside County.



Promoter Training Requirements

As mentioned in the introduction, per contract guidelines, all new promoters are required to complete a 40-hour training which includes topics of safety, community outreach, PEI and community resources, the role of a promoter, mental health topics review, promoter presentations review and data collection. Upon completion of the trainings, program directors complete and submit a performance review of the promoter including strengths and areas of improvement. The promoters also complete an evaluation scoring on a scale of 1-5, if the trainings were effective and helpful in their development as a promoter and if they were confident in their ability to provide community resources and answer questions on mental health issues in a culturally competent way.

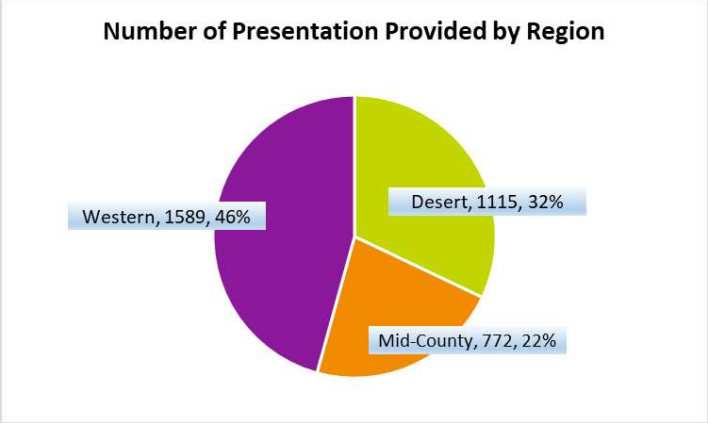
Promotores Hispanic/Latinx CMHPP

Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Promotores Hispanic/Latinx CMHP program provided a total of **3,476** 1-hour mental health presentations across the Desert, Western and Mid-County regions of Riverside County.

A majority of presentations were provided in the Western region of Riverside County **(46%).** Presentations were available in Spanish and English.

Most presentations were in-person (96%), while presentations were also provided virtually (4%). In-person presentations included residential homes or at public locations such as churches, clinics, community centers, libraries, parks, schools, and shopping centers.



Participants were welcomed to attend more than one presentation. A total of **11,862** people were recorded as attending, which includes those who attended multiple times. Among them, **9,658** reported that attending one of the nine presentation topics was their first time, while **1,879** indicated that they had attended more than one topic, while **325** participants did not response.

Half of the presentations **(54%)** provided by Promotores CMHPP were on Mental Health, Anxiety, and Depression. The remainder of topics **(46%)** discussed were Trauma, Effects of Drugs and Alcohol, Bipolar Disorder, Suicide Prevention, Grief & Loss and Schizophrenia, collectively.

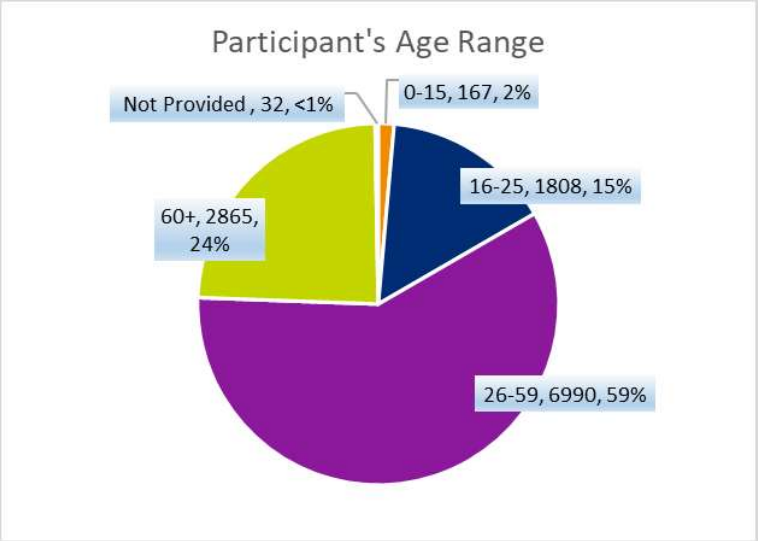
Topic	n (%)
Anxiety	**577 (16.6%)**
Bipolar Disorder	311 (8.9%)
Depression	**581 (16.7%)**
Effects of Drugs and Alcohol	215 (6.2%)
Grief and Loss	159 (4.6%)
Mental Health	**735 (21.1%)**
Schizophrenia	301 (8.7%)
Suicide Prevention	215 (6.2%)
Trauma	382 (11.0%)



Promotores Hispanic/Latinx CMHPP

Mental Health Presentations: Demographics

This section highlights the basic demographics of participants provided for FY 2023-24. All data is based on the total number of participants who have attended presentations, including duplicated counts since participants can attend more than one presentation. The graphs below display totals for those participants that provided a response in the presentation sign-in demographic form.

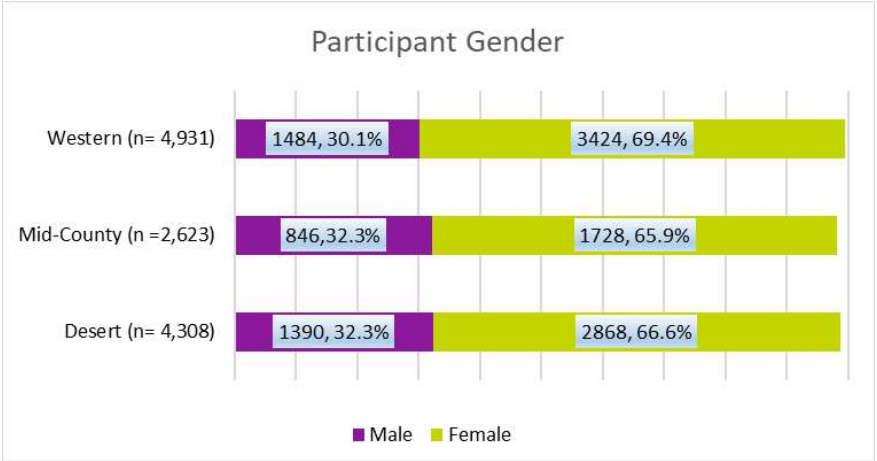


59% of the participants who attended the presentations reported being adults aged 26 to 59 years old. 15% were youth aged 16 to 25, and 24% were 60 and older, while 2% were 15 years old or younger.

Most participants indicated Spanish as their primary language (85%), 5% selected being fluent in both English and Spanish and 9% of participants spoke only English, while <1% did not provide a response.



Regardless of region, the proportion of females reached was greater than the proportion of males. This occurrence could be by chance or influenced by stigma. Hispanic/Latinx male individuals may be less inclined to talk publicly about challenges at home compared to the female member(s) of the household. Overall (not shown in this graph), across all regions, 115 individuals did not self– identify, 6 participants identified as trans, and 1 participant identified as non-binary. Additionally, a very small percentage of participants identified as Lesbian, Gay, or Bisexual (n=37).

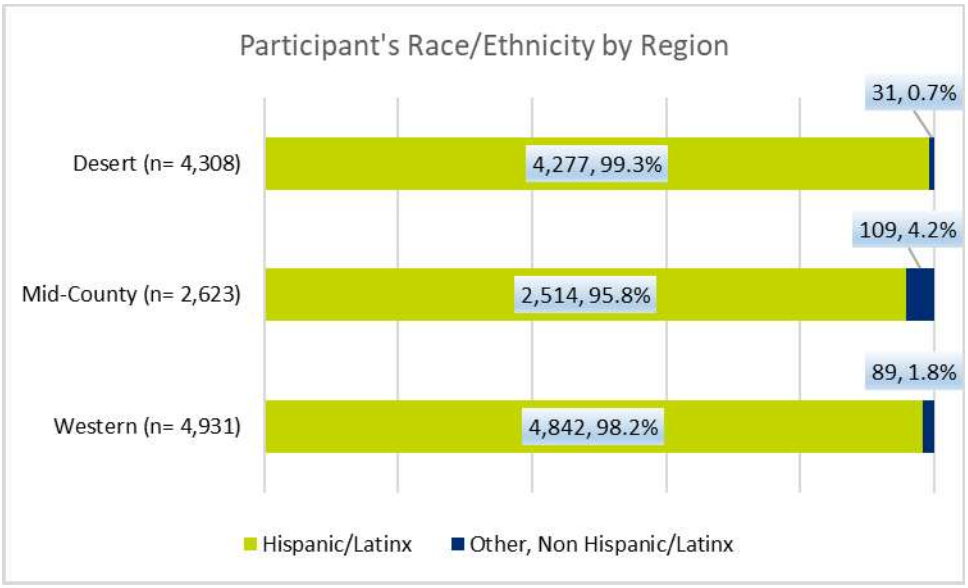


**This data does not include individuals that have self-identified as non-binary, trans, or those who have not provided a gender identity, due to the small number breakdowns. Please refer to text for additional information. Note that totals do not add to 100%.*

Mental Health Presentations: Demographics (cont.)

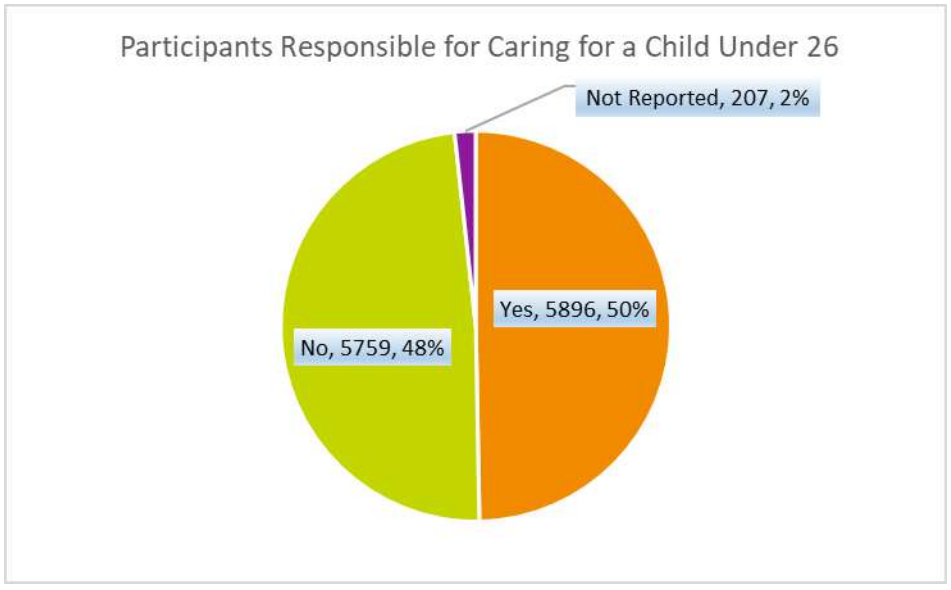
In the Desert, Mid-County, and Western regions, participants in the Promotores CMHP program identified as Hispanic/Latinx (**n=11,633**). Across all regions, 84 self-identified as Caucasian, 23 as Black/African American, 7 as Asian/Pacific Islander, 3 as Native/Indigenous, 48 as Other/Non-Specific, and 48 chose not to self-identify.

While the CMHP program focused on Hispanic/Latinx individuals, it welcomed anyone who felt they would benefit. The graphs below display totals for participants who provided a response on the presentation sign-in demographic form.



**Individuals that did not self-identify as Hispanic/Latinx were categorized as Other, Non Hispanic/Latinx. Please refer to text for additional information regarding racial breakdowns.*

A total of **11,862** responses were submitted regarding caring for a child under 26 years old. Approximately 1 in 2 participants reported having a child under 26. The graph below provides a detailed breakdown of responses across all regions.



Promotores Hispanic/Latinx CMHPP

Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the promoter, class content, and their confidence in talking about and seeking help for their mental health. They were asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey.

A randomized sample of 500 participants from the 8,527 who completed the satisfaction survey was used to evaluate satisfaction. Surveys from individuals who attended multiple presentations were included, as their experiences may have varied between sessions.

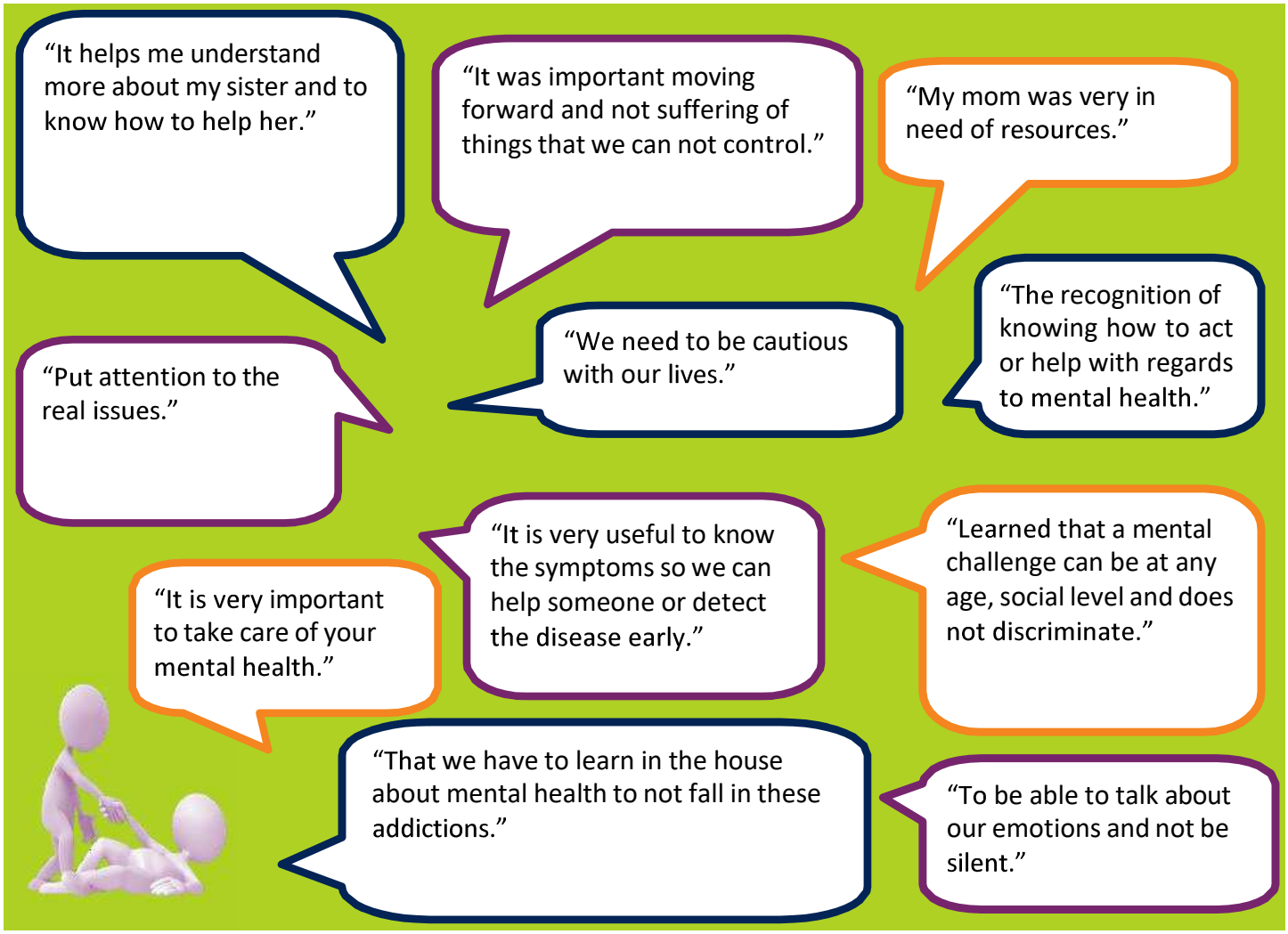
As shown below, a majority of participants strongly agreed with all statements in the survey, indicating they felt confident in seeking help and finding resources, and that they could share the information with family and friends, that they got a better understanding of mental health issues, and that they had a great experience with the promoter.

Questions (n= 500)	Avg Score	1	2	3	4	5	No resp.
The information presented was easy to understand	**4.93**	–	1 (0.2%)	4 (0.8%)	26 (5.2%)	**467 (93.4%)**	2 (0.4%)
The presenter understands the needs of my community	**4.93**	–	1 (0.2%)	4 (0.8%)	26 (5.2%)	**467 (93.4%)**	2 (0.4%)
I would recommend to my friends and family members that they attend a presentation like this in the future	**4.92**	–	1 (0.2%)	5 (1.0%)	29 (5.8%)	**461 (92.2%)**	4 (0.8%)
The material in this presentation gave me a better understanding of the early signs of mental health issues within my culture	**4.92**	–	1 (0.2%)	4 (0.8%)	27 (5.4%)	**466 (93.2%)**	2 (0.4%)
As a result of this presentation							
I feel I am better able to talk about this topic with my family and friends	**4.85**	–	1 (0.2%)	9 (1.8%)	54 (10.8%)	**433 (86.6%)**	3 (0.6%)
I know mental illness can me managed and treated	**4.87**	–	1 (0.2%)	7 (1.4%)	49 (9.8%)	**440 (88.0%)**	3 (0.6%)
I feel comfortable seeking help for a family member, friend, or myself	**4.87**	–	2 (0.4%)	6 (1.2%)	48 (9.6%)	**442 (88.4%)**	2 (0.4%)
I know where to seek resources for a family member, friend, or myself	**4.90**	1 (0.2%)	1 (0.2%)	4 (0.8%)	37 (7.4%)	**455 (91.0%)**	2 (0.4%)

Promotores Hispanic/Latinx CMHPP

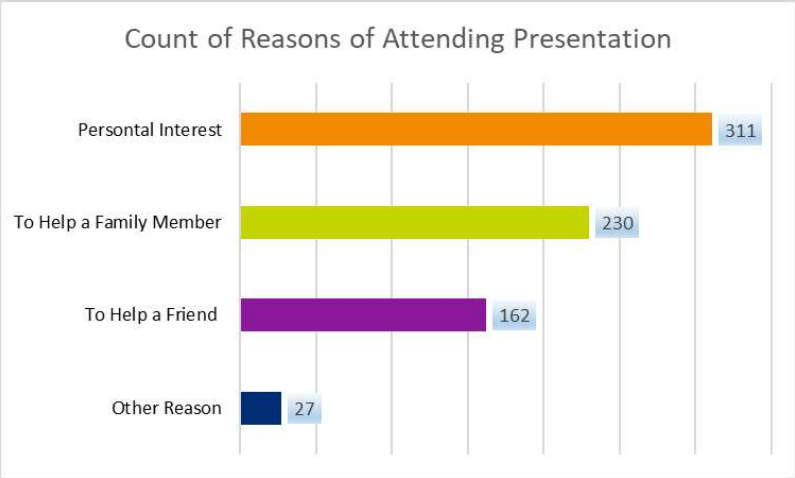
Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well CMHPP was in the community. Below are some of the comments made by participants when asked what was helpful and if they had any other comments.



Mental Health Presentations: Feedback (cont.)

Reasons for Attending



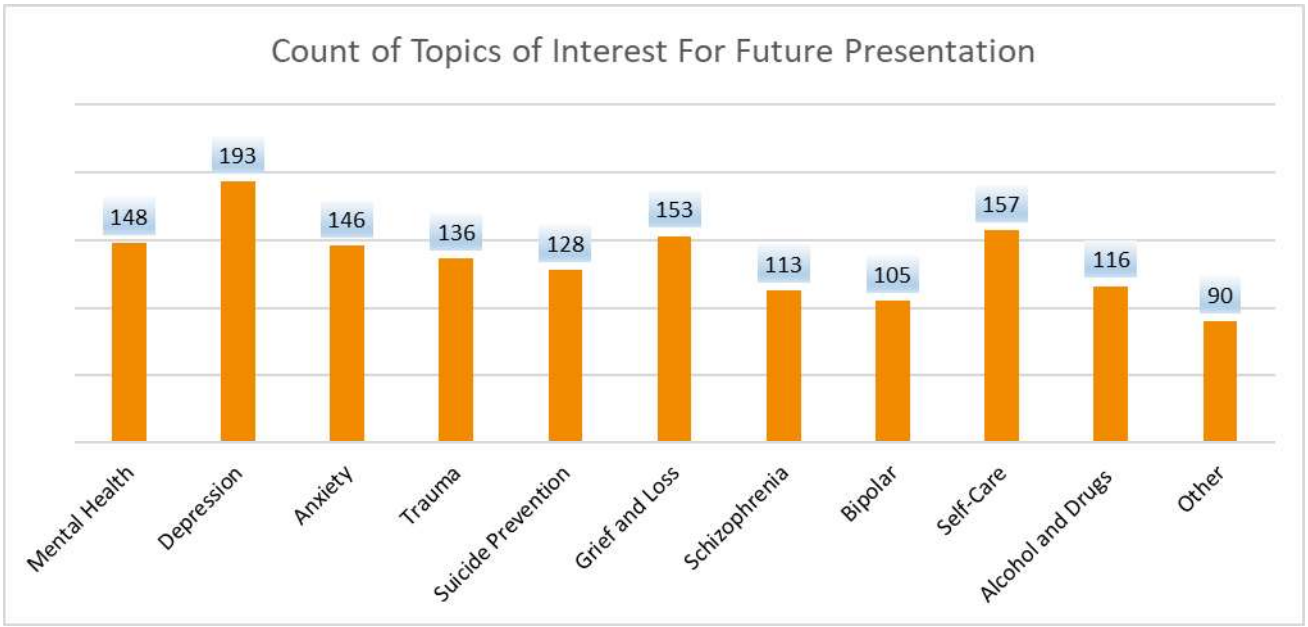
Out of 8,527 participants who completed the satisfaction survey, a randomized sample of 500 provided their reasons for attending the presentation. Participants could select more than one response.

The majority indicated that personal interest was their primary reason for attending, followed by a desire to help a family member. Among those who selected "other reason," the most common response was receiving an invitation from a friend or family member.

Topics for Future Presentations

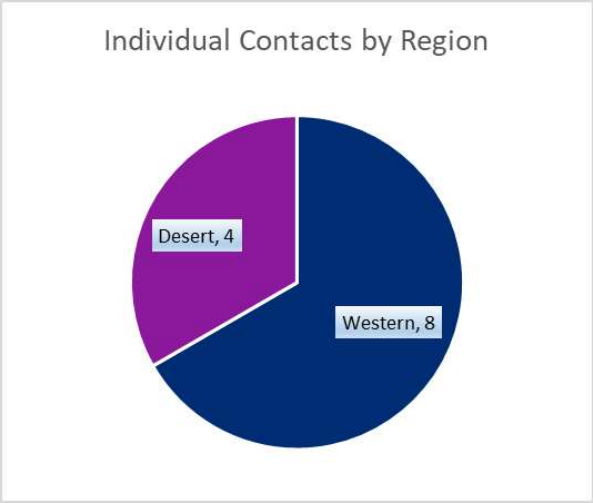
Among sample size of participants who completed the satisfaction survey, a majority expressed interest in learning about Depression, followed by Self-Care, and then Grief & Loss. Additional topics of interest not listed included Autism, Self-Esteem, and Obsessive-Compulsive Disorder. Participants were allowed to select more than one topic.

Feedback from these surveys will be considered by promoters when planning presentations on these topics for the 2024-2025 fiscal year.

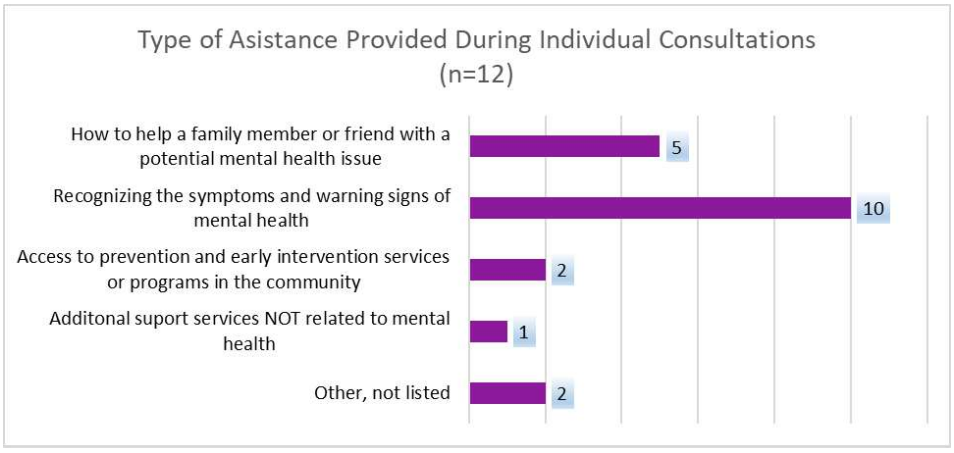


Promotores Hispanic/Latinx CMHPP

Individual Contacts: Type of Assistance



Individual contacts for the CMHP program are defined as when a promoter provides more in-depth one-on-one assistance upon outreach or after presentations to help an individual or family with specific needs and provide referrals to help meet those needs. For FY 2023-24, the Promotores Hispanic/Latinx CMHP program completed **12** individual consultations. Although not shown, all twelve individuals contacts were in-person and occurred as a result of presentations.



The chart above summarizes the types of consultation that were provided. A majority of mental health-related consultations involved recognizing the symptoms/warning signs of mental health issues and providing services to help a family member or friend with a potential mental health issue. Additionally, many participants asked for access to prevention and early intervention services or programs in the community. Only frequencies are displayed here, as there could have been multiple reasons for a consultation.

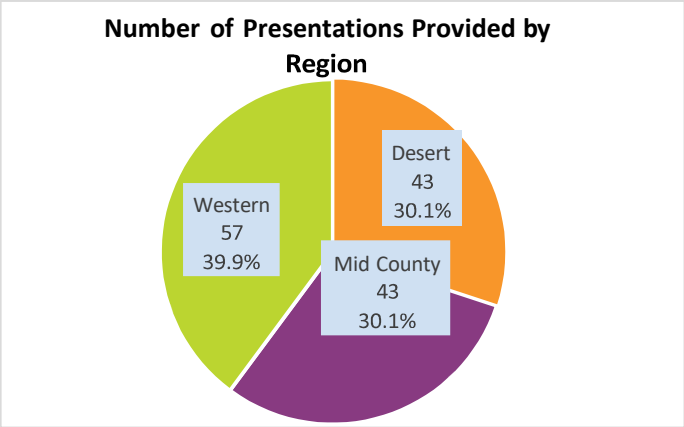
Resources and Referrals Type	Count
Mental Health Education Material	5
Medical Resources	1
Support Groups	1
Housing/Shelter/Homeless Shelter	1
Other Resources *(2-1-1 Connect IE, CARES Line, Take-My-Hand)*	24

The table to the left indicates the frequency of the types of referrals and resources provided as a result of the individual consultations. A total of **32** different resources and referrals were provided during the consultations. Participants requested information on mental health education materials, support groups, housing assistance, and other resources.

Native American CMHPP

Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Native American CMHP program provided a total of **143** 1-hour mental health presentations across the Desert, Mid-County, and Western regions of Riverside County. Most presentations were provided in person (78%) at schools/universities, libraries, coffee shops, recreation centers and tribal offices, with 21% conducted virtually through Zoom. Participants were informed about these presentations through various community outreach methods which included tabling, social media, putting fliers in community areas and reaching out to key community leaders at planning meetings.



A majority of presentations were provided in the Western region (39.9%), followed by the Desert (30.1%) and Mid-County (30.1%) regions. All presentations were provided in English.

Presentations were provided to **1,083** participants. Of these participants, 930 participants attended the presentation for the first time, 122 participants attended presentations two or more times (different presentation topics), and 31 participants did not report how many times they attended the presentation. The majority of participants attended presentations conducted by the Desert region (35.9%, n=389), followed by Mid-County (33.3%, n=361) and Western (30.7%, n=333) regions. While most of the participants were from the target region of the presentations, there were a small number of participants from out of county as well as some participants who attended presentations of a targeted region different than their region of residence. For these reasons, we have included an analysis of the cities of residence of the people (duplicated) that attended the presentations in each region below.

# of people who attended presentations in Desert: 389 Cites of Residence

Banning	208 (53.5%)
Beaumont	84 (21.6%)
Cathedral City	8 (2.1%)
Palm Springs	8 (2.1%)
Thermal	26 (6.7%)
Other Desert	3 (0.7%)
Mid/West Riv.	12 (3.1%)
Out of County	7 (1.8%)
Not Reported	33 (8.5%)

# of people who attended presentations in Mid-County: 361 Cites of Residence

Anza	25 (6.9%)
Hemet	28 (7.8%)
Lake Elsinore	8 (2.2%)
Menifee	7 (1.9%)
San Jacinto	217 (60.1%)
Temecula	31 (8.6%)
Other Mid Cty.	15 (4.2%)
Out of County	2 (0.6%)
Not Reported	28 (7.8%)

# of people who attended presentations in Western: 333 Cites of Residence

Corona	3 (0.9%)
Jurupa Valley	1 (0.3%)
Moreno Valley	41 (12.3%)
Riverside	263 (79%)
Other Desert	1(0.3%)
Other Mid Cty.	1(0.3%)
Out of County	19 (5.7%)
Not Reported	4 (1.2%)

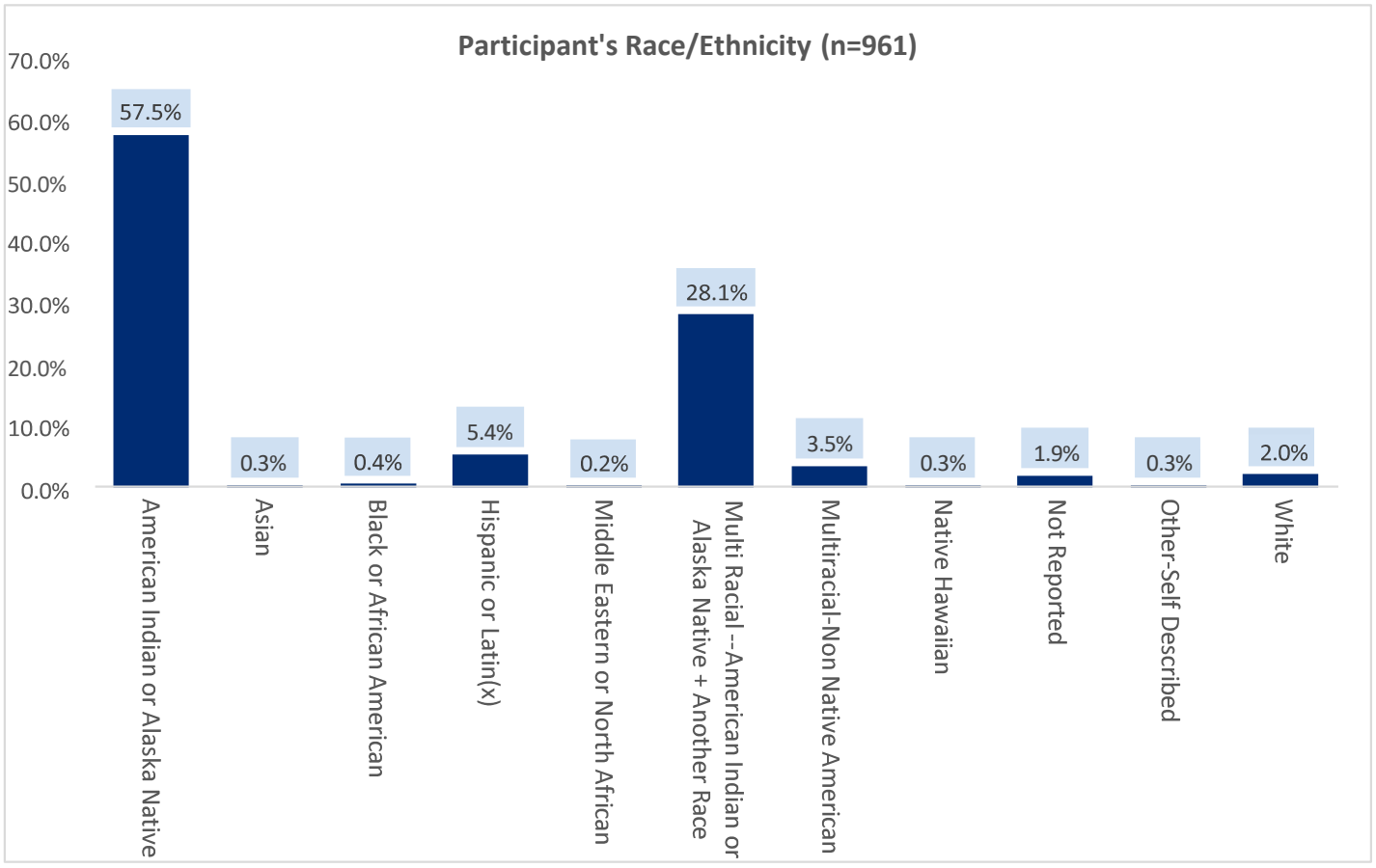
Mental Health Presentations: Topics

Countywide, a majority of the presentations provided by promoters in Native American CMHPP was on General Mental Health (48.3%) followed by Self Care (17%) of presentations.

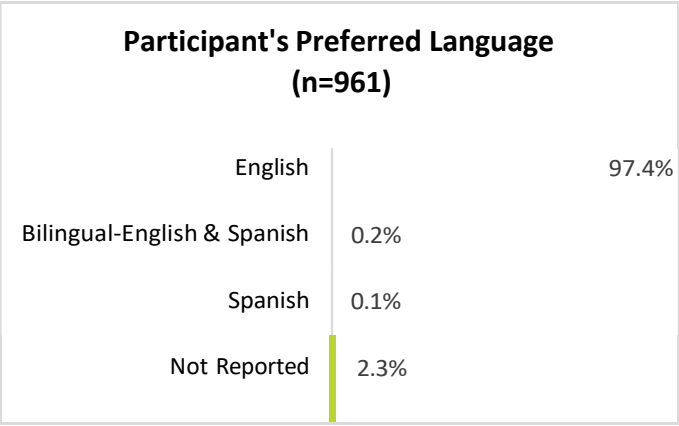
Topic	# and % of Presentations	Topic	# and % of Presentations
Anxiety	13 (9.1%)	Mental Health and Stigma	7 (4.9%)
Bullying	2 (1.4%)	Self Care	24 (16.8%)
Depression	14 (9.8%)	Substance Use and Abuse	2 (1.4%)
Grief and Loss	7 (4.9%)	Suicide Prevention	2 (1.4%)
Mental Health 101	**69 (48.3%)**	Trauma	3 (2.1%)

Mental Health Presentations: Demographics

This section highlights the basic demographics of participants provided for FY 2023-24. All numbers are based on the unduplicated count of **961** participants (including participants who did not report the number of times they attended a presentation - Desert n=323, Mid-County n=312, and Western n=326). Countywide 85.6% of the participants served were American Indian or Alaskan Native (or American Indian or Alaskan Native + Another Race). While the program was focused towards individuals from the Native American community, the program welcomed anyone who felt they would benefit.

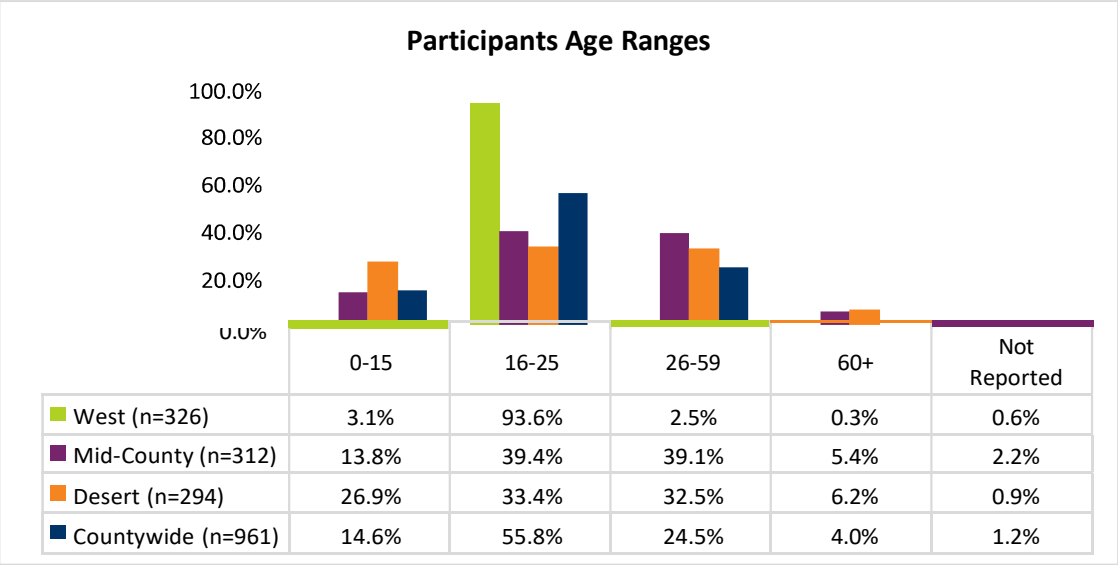


Mental Health Presentations: Demographics cont.



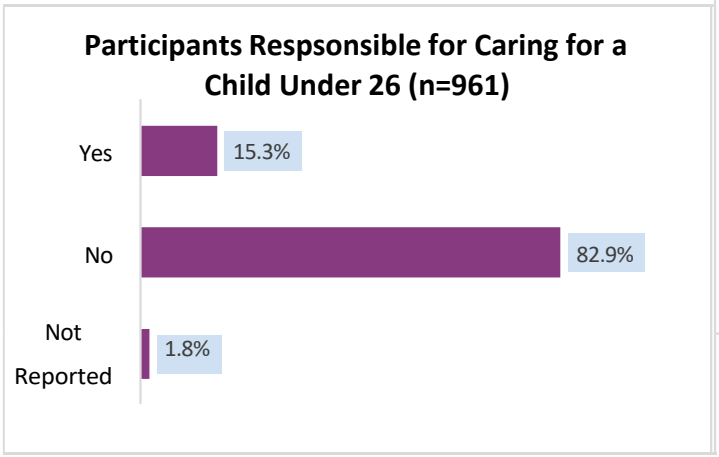
Countywide, a majority of participants indicated English as their primary language (97%).

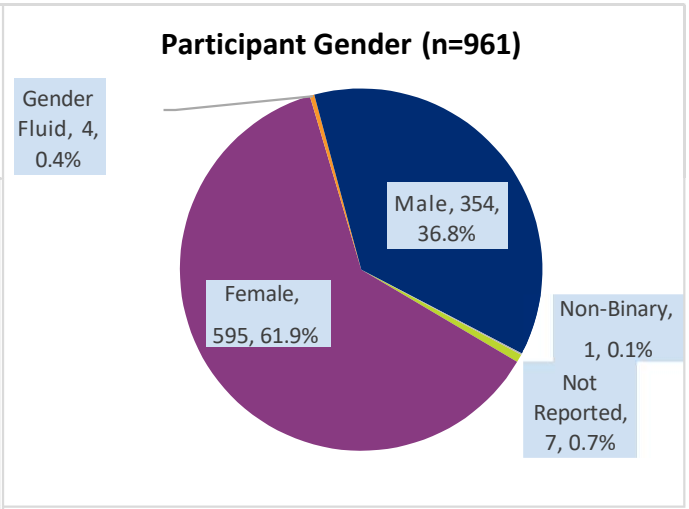
Since there were differences in age demographics by region, the graph below shows participant age by region. Countywide, a majority of participants reported they were 16-25 years old (56%).



	0-15	16-25	26-59	60+	Not Reported
West (n=326)	3.1%	93.6%	2.5%	0.3%	0.6%
Mid-County (n=312)	13.8%	39.4%	39.1%	5.4%	2.2%
Desert (n=294)	26.9%	33.4%	32.5%	6.2%	0.9%
Countywide (n=961)	14.6%	55.8%	24.5%	4.0%	1.2%

Countywide, 15% of participants reported they were responsible for caring for at least one child aged 25 and younger.





Countywide, a majority of participants reached by presentations were female (62%).

Countywide (not shown in this graph) 2.5% of participants identified as LGBTQ.

Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the presentation delivery/cultural sensitivity, class content, and their confidence in talking about and seeking help for their mental health or the mental health of family members/friends. They were asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey. 1,080 participants completed the survey. Surveys of people who attended more than one presentation were included as they may have had a different experience each time.

As shown below, a majority of participants agreed or strongly agreed with all statements in the survey—that they felt able to find help and get resources, that they could share the information with family and friends, that they got a better understanding of mental health issues in a culturally relevant way.

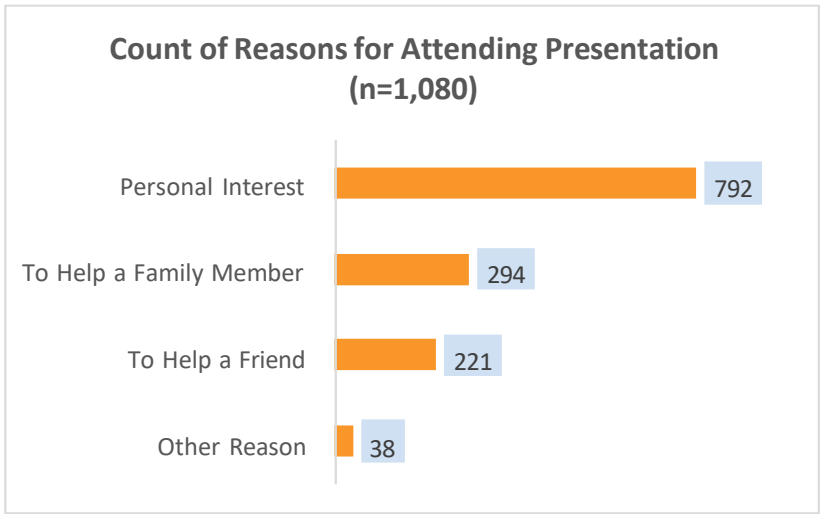
Question (n=1,080)	Avg Score	1	2	3	4	5	No resp.
The information presented was easy to understand	**4.66**	—	1 (0.1%)	42 (3.9%)	283 (26.2%)	**754 (69.8%)**	—
The presenter understands the needs of my community	**4.58**	—	2 (0.2%)	51 (4.7%)	343 (31.8%)	**684 (63.3%)**	—
I would recommend to my friends and family members that they attend a presentation like this in the future	**4.55**	—	2 (0.4%)	57 (5.3%)	364 (33.7%)	**655 (60.6%)**	—
The material in this presentation gave me a better understanding of the early signs of mental health issues within my culture	**4.60**	—	1 (0.1%)	71 (6.6%)	287 (26.7%)	**717 (66.4%)**	4 (0.4%)
As a result of this presentation							
I feel I am better able to talk about this topic with my family and friends	**4.45**	4 (0.4%)	8 (0.7%)	101 (9.4%)	355 (32.9%)	**608 (56.3%)**	4 (0.4%)
I know mental illness can be managed and treated	**4.53**	—	3 (0.3%)	69 (6.4%)	358 (33.1%)	**648 (60.0%)**	2 (0.2%)
I feel comfortable seeking help for a family member, friend, or myself	**4.49**	3 (0.3%)	4 (0.4%)	86 (8.0%)	349 (32.3%)	**633 (58.6%)**	5 (0.5%)
I know where to seek resources for a family member, friend, or myself	**4.63**	1 (0.1%)	—	61 (5.6%)	277 (25.6%)	**737 (68.2%)**	5 (0.5%)

Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well CMHPP was in the community. Below are some of the comments made by participants when asked what was helpful and if they had any other comments.



Mental Health Presentations: Reasons for Attending

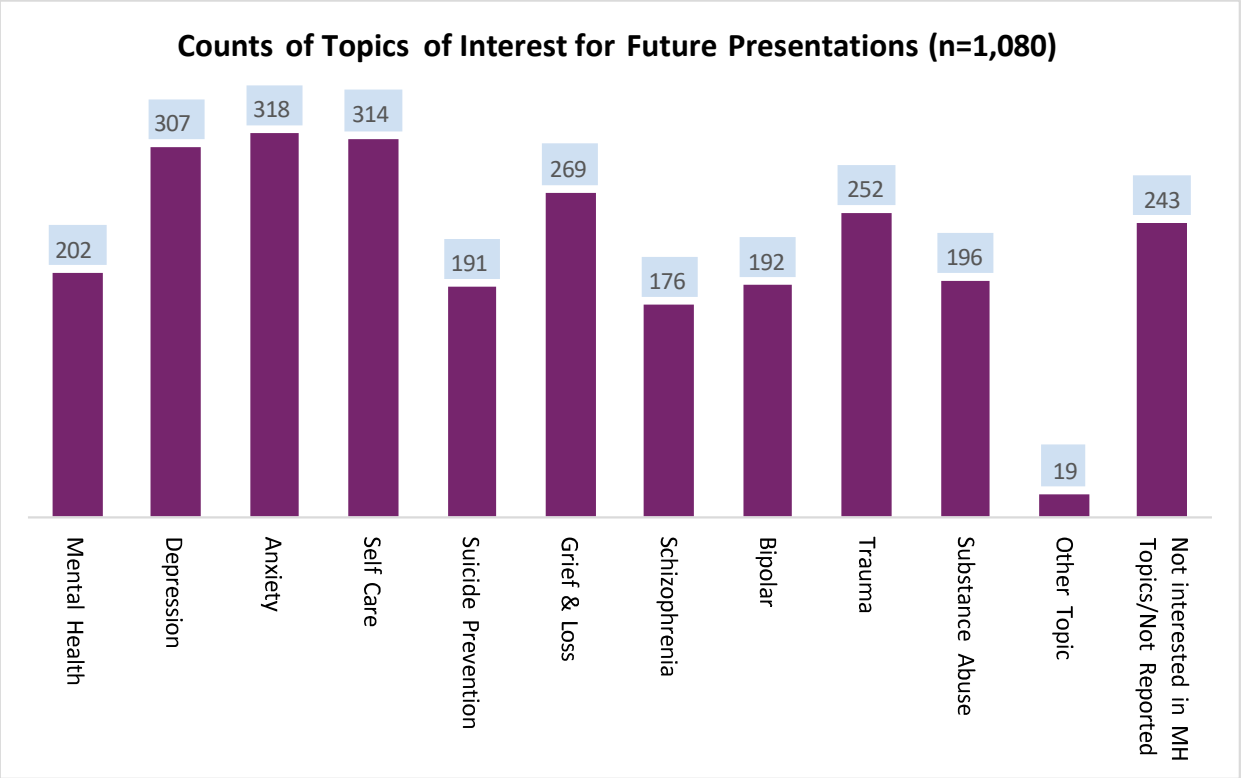


Of the 1,080 people completing the survey, a majority of the people indicated personal interest as a reason for attending the presentation. People were allowed to select more than one response.

For participants that marked "other reason," the most common reasons were that it was required by their school, that they attended with their friend or that they were interested in helping the community.

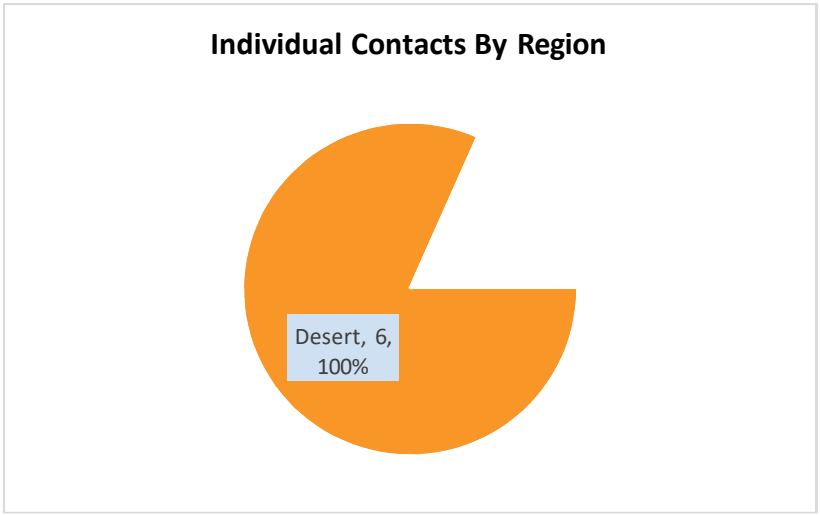
Mental Health Presentations: Topics for Future Presentations

A majority of participants expressed interest in learning about anxiety followed by self care, depression and grief/loss.



Individual Contacts

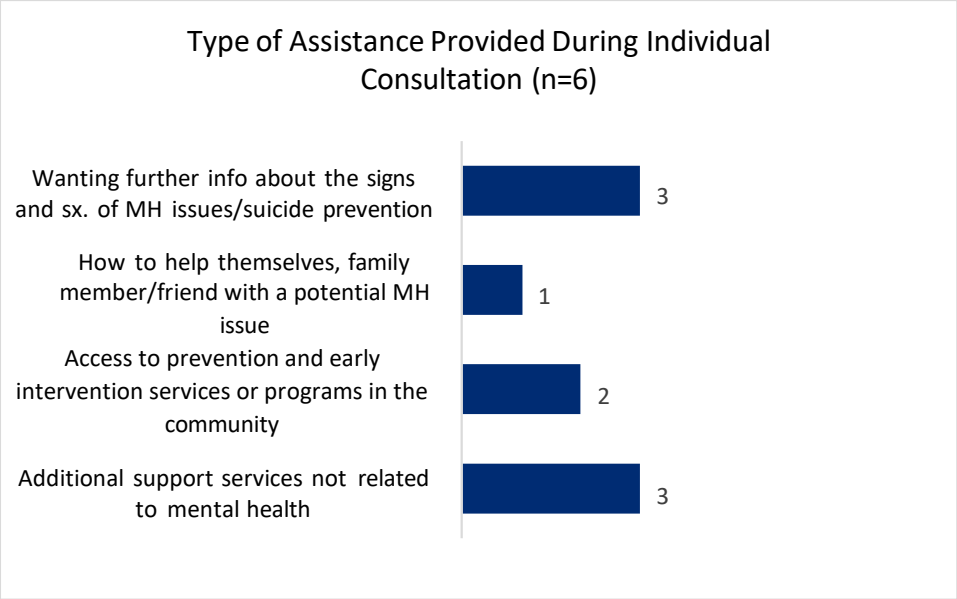
Individual contacts for the CMHP program are defined as when a promoter provides more in depth one-on-one assistance upon outreach or after a presentation to help an individual or family with specific needs and provides referrals to help meet those needs. For FY 2023-24, the Native American CMHP program completed **6** individual consultations. All individual contacts took place face-to-face in person, following the presentations.



The majority of the individual contacts took place in the Desert region of Riverside County (100%).

Individual Contacts cont.

The chart below summarizes the types of assistance that were provided. A majority of mental health related consultations involved wanting further information about the signs and symptoms of mental health issues and suicide prevention. Only frequencies are displayed here, as there could have been multiple reasons for a consultation.



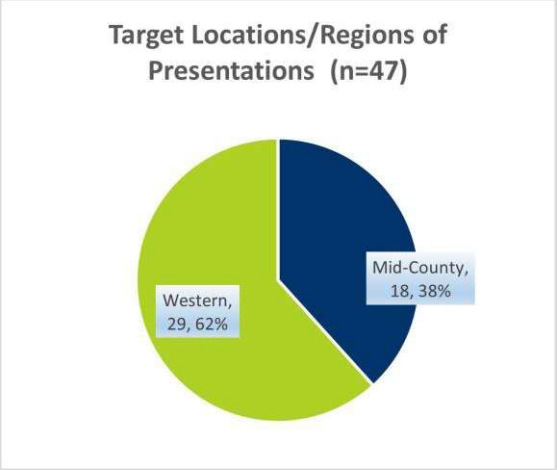
The table below shows the frequency of the type of referrals and resources provided as a result of the individual consultation. A total of **8** different resources and referrals were provided as a result of the consultations.

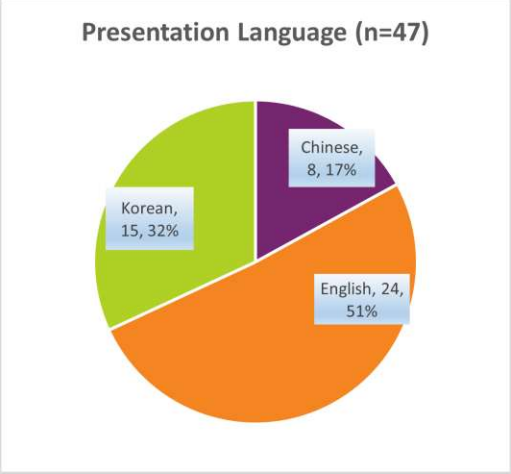
Resources and Referrals Type	Count
Food (*HELP Inc, WIC)*	3
Support Group (*Soboba talking circles*)	1
Cares Line	1
Behavioral Health Specialist (RSBCIHI)	1
Native Challenge	1
PEI Program *(Celebrating Families)*	1

Asian American/Pacific Islander CMHPP

Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Asian American/Pacific Islander CMHP program provided a total of **47** 1-hour mental health presentations across the Desert, Mid-County, and Western regions of Riverside County. The majority of presentations targeted the Western region of Riverside County (61.7%). Additionally, a little over half (51%) of the 47 presentations were targeted for the English-speaking community, followed by the Korean-speaking community (32%), and the Chinese-speaking community (17%).





For FY 2023-24, there was a total of **1,028** attendees for the presentations. Out of the 1,028 attendees, 915 attendees had completed a demographic form with 144 people who had attended more than one presentation. As a result, **771** unique individuals are included within the unduplicated count for the demographics portion of the report.

City of Residence

As some presentations were available virtually, it was possible that participants could have joined from outside of Riverside County. The table below reports on the zip codes of the 771 participants who provided demographic information. Of the people who provided their zip code information, the majority of participants reside in the cities of Corona and Riverside. The Asian American/Pacific Islander CMHP program also reached individuals outside of Riverside County, such as San Bernardino, Los Angeles, Orange and many other counties.

City of Residence Riverside County	n, (%)	City of Residence Outside of Riverside County	n, (%)
Riverside	**188 (24.4%)**	San Bernardino County	28 (3.6%)
Corona	**86 (11.2%)**	Los Angeles County	38 (4.9%)
Murrieta	59 (7.7%)	Orange County	20 (2.6%)
Temecula	40 (5.2%)	Other/Not Reported*	231 (30.0%)
Moreno Valley	20 (2.6%)		
Winchester	15 (1.9%)		
Other Cities in Riverside County	76 (9.9%)		

**Includes participants who did not respond to this question and those who lived outside of the cities/counties of interest above (e.g., Santa Barbara County, etc.).*

Mental Health Presentations: Service Delivery and Attendance cont.

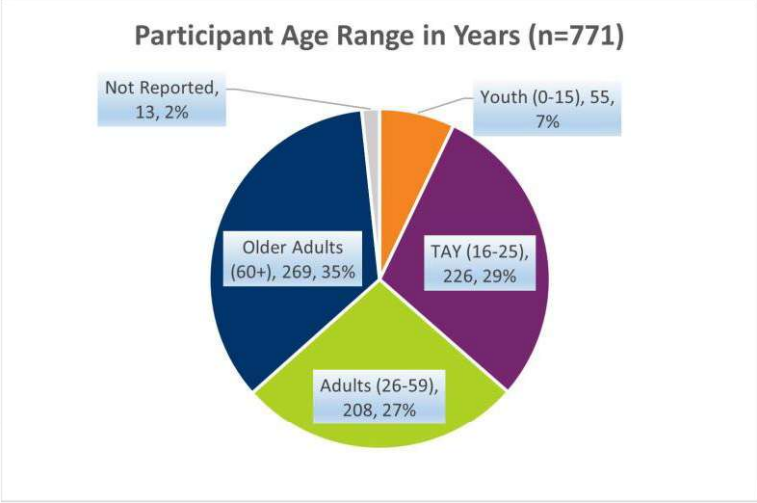
Countywide, most of the presentations that were done by promoters from the Asian American/Pacific Islander CMHP program were on the topic of Mental Health (40.4%), followed by Self-Care (21.3%). Some presentations were tailored to specific audiences. For example, for the Mental Health topic, promoters presented on material for Children's Mental Health.

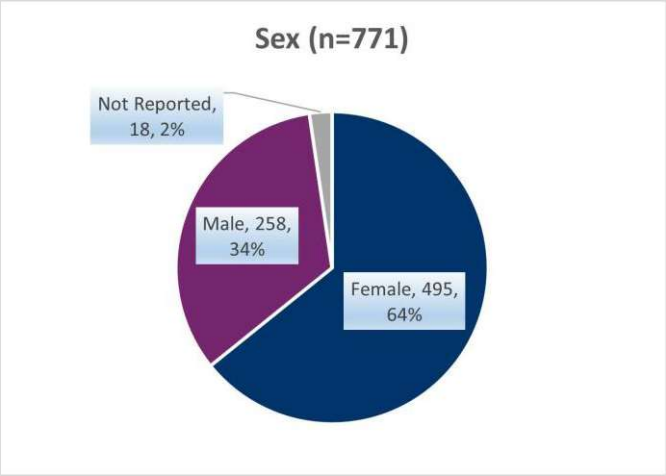


Topic	# and % of Presentations	Topic	# and % of Presentations
Anxiety	2 (4.3%)	Self-Care	10 (21.3%)
Depression	2 (4.3%)	Stress Management	5 (10.6%)
Mental Health	19 (40.4%)	Suicide Prevention	3 (6.4%)
Psychosis	1 (2.1%)	Trauma	5 (10.6%)

Mental Health Presentations: Demographics

This section highlights the basic demographics of participants provided for FY 2023-24. There was a total of 915 individuals who provided demographic information; however, the following demographic data is based on the unduplicated count of participants (**n=771)**. Additionally, all of the demographic data is analyzed on a countywide level.

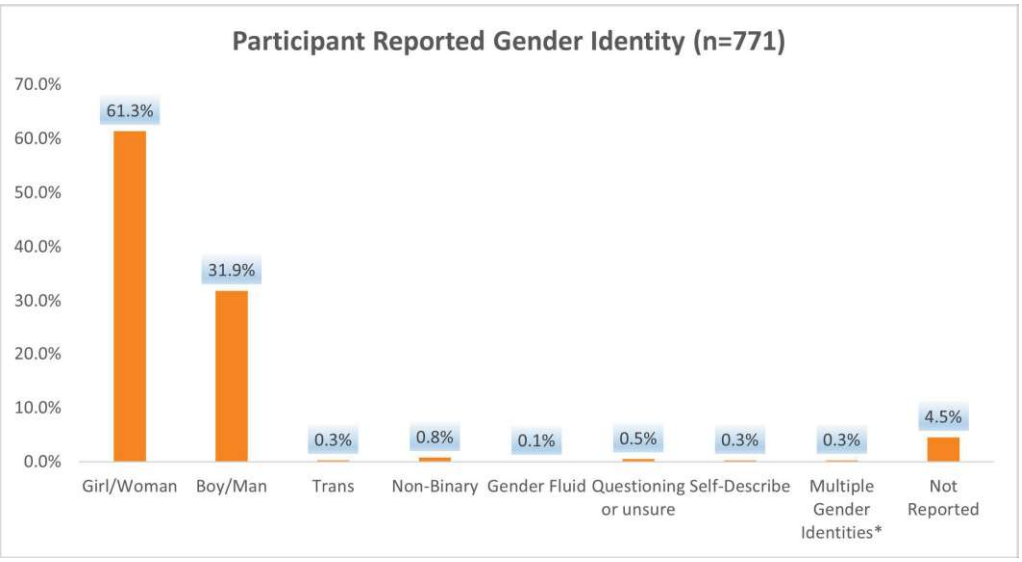


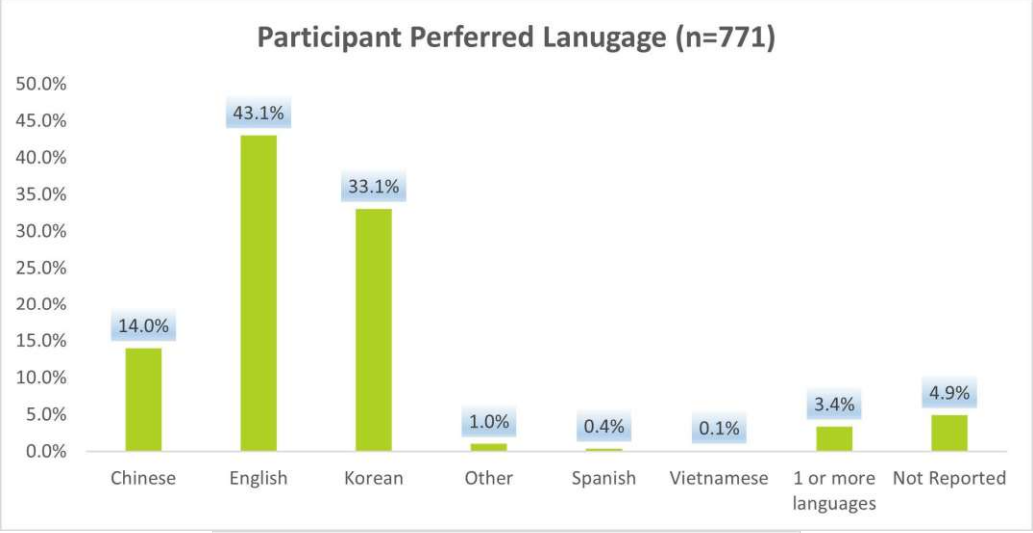


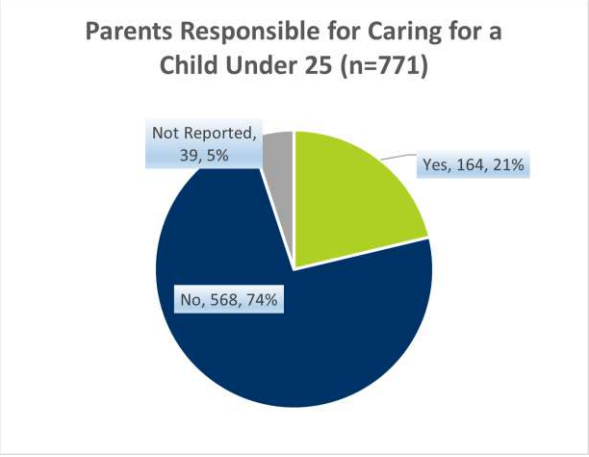
There was a wide variety of ages of those who attended the CMHP Asian American/Pacific Islander presentations. A little over one-third of participants reported being in the 60+ age group (35%), closely followed by the Transitional Age Youth (TAY) age group of 16-25 years old (29%). Almost one-third of participants identified being in the 26-59 age group (27%) and lastly, participants identified being in the 0-15 age group (7%). In addition, the majority of participants who attended the presentations reported their sex as female (64%), followed by male (34%).

Mental Health Presentations: Demographics cont.

Countywide, most participants identified their gender as Girl/Woman (61.3%), followed by Boy/Man (31.9%). In addition, there was variation in participants' preferred languages with about 43.1% of participants having a preference for English, followed by Korean (33.1%), Chinese (14.0%), and more than one language as their preferred language (3.4%). Notably, a majority of participants said that they are not responsible for caring for a child who is 25 years old and under (74%).

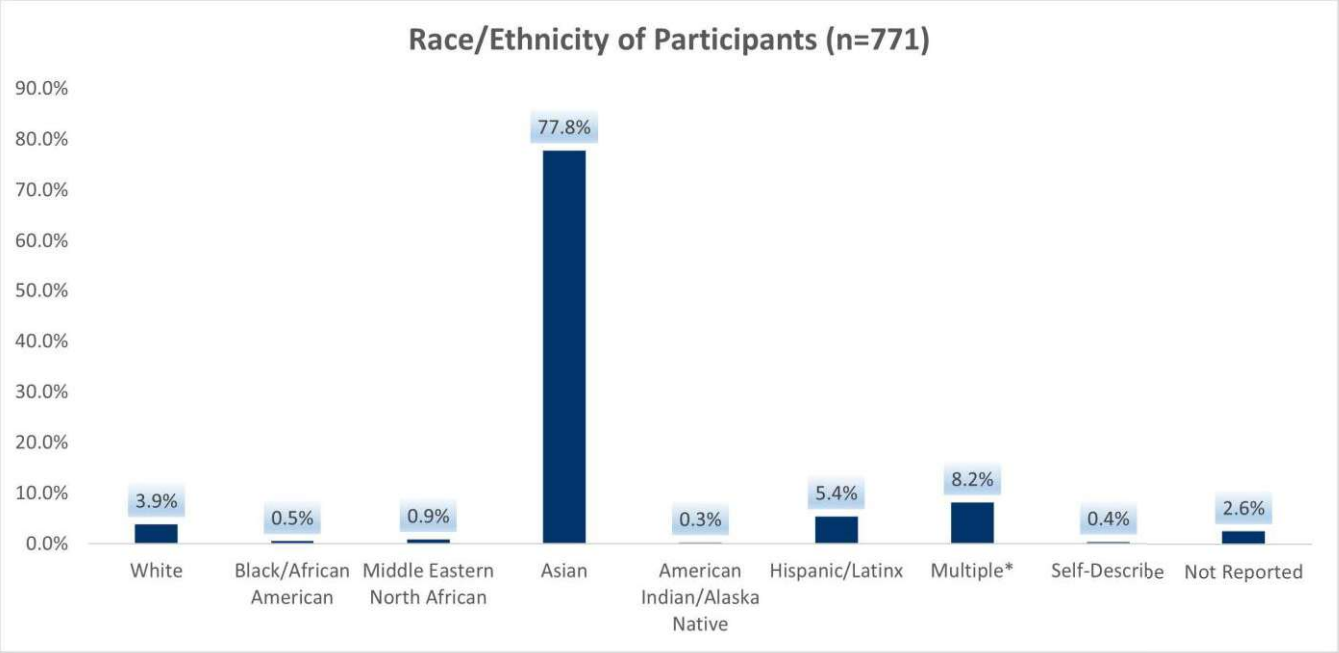




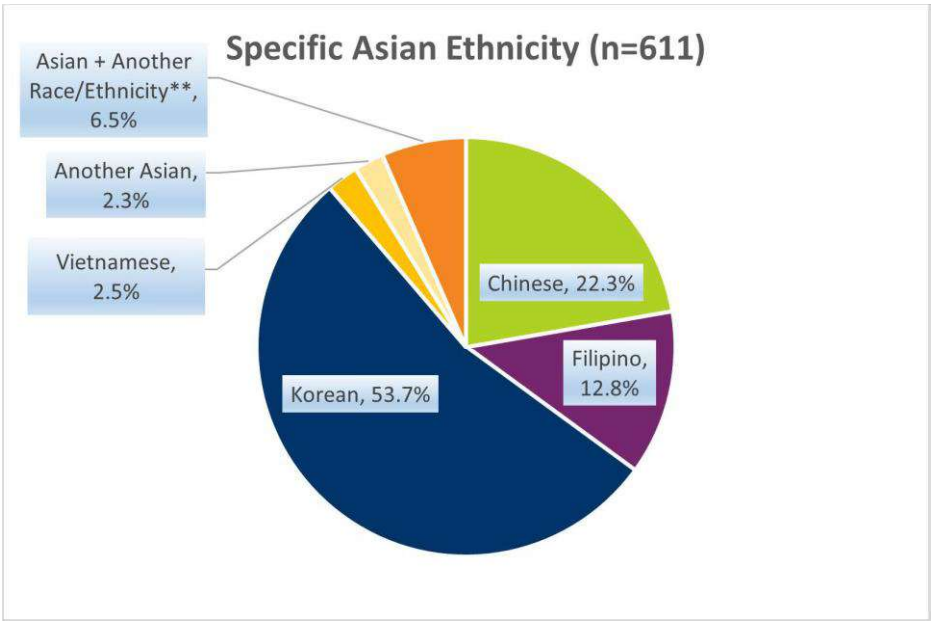


Mental Health Presentations: Demographics cont.

Most respondents identified their race/ethnicity as Asian (77.8%), followed by Multiple Race/Ethnicities (8.2%). Within the breakdown of the categories for the Asian race/ethnicity group, most individuals identified as Korean (53.7%), followed by Chinese (22.3%), Filipino (12.8%), Asian + Another Race/Ethnicity (6.5%), Vietnamese (2.5%), and Another Asian ethnicity (2.3%). Although not shown here, the majority of participants identified as Heterosexual or Straight (70.9%). Lastly, the majority of participants indicated that they did not have a disabling condition (88.2%) nor a veteran (90.8%).



**Includes individuals who identify with multiple race/ethnicities.*



***Includes individuals who identified generally as Asian or a specific Asian identity + another race/ethnicity.*

Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the promoter, class content, and their confidence in talking about and seeking help for their mental health. They were asked on a scale of 1-5 *(1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree*) about how much they agreed with the statements in the survey. There was a total of **913** participants who completed the satisfaction survey. Surveys of people who attended more than one presentation were included as they may have had a different experience each time they attended a new presentation.

The average rating scores for all statements in the survey were above a score of 4, indicating that most participants agreed with the statements on seeking help and finding resources, being able to talk about the presentation topic with friends and family, and having a better understanding of mental health issues.

Question (n=913)	Avg Score	1	2	3	4	5	No Resp.
The information presented was easy to understand	**4.44**	11 (1.2%)	5 (0.5%)	27 (3.0%)	158 (17.3%)	**695 (76.1%)**	17 (1.9%)
The presenter was enthusiastic when presenting the information	**4.58**	11 (1.2%)	7 (0.8%)	55 (6.0%)	199 (22.8%)	**629 (68.9%)**	12 (1.3%)
I would recommend to my friends and family members that they attend a presentation like this	**4.58**	9 (1.0%)	7 (0.8%)	67 (7.3%)	184 (20.2%)	**635 (69.6%)**	11 (1.2%)
The material in the presentation gave me a better understanding of the early signs of mental health issues	**4.59**	9 (1.0%)	11 (1.2%)	50 (5.5%)	197 (21.6%)	**631 (69.1%)**	15 (1.6%)
As a result of this presentation							
I feel I am better able to talk about this topic with my family and friends	**4.46**	10 (1.1%)	10 (1.1%)	86 (9.4%)	238 (26.1%)	**550 (60.2%)**	19 (2.1%)
I know mental illness can me managed and treated	**4.60**	7 (0.8%)	5 (0.5%)	46 (5.0%)	223 (24.4%)	**612 (67.0%)**	20 (2.2%)
I feel comfortable seeking help for a family member or myself	**4.47**	8 (0.9%)	17 (1.9%)	87 (9.5%)	213 (23.3%)	**569 (62.3%)**	19 (2.1%)
I know where to seek resources for a family member or myself	**4.54**	11 (1.2%)	8 (0.9%)	55 (6.0%)	232 (25.4%)	**584 (64.0%)**	23 (2.5%)

Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well received the CMHP program was in the community. Below are some of the comments made by participants when asked what was helpful about the presentation and if they had any other comments about the presentations.

"I think that it was very helpful to hear terms such as 'kapwa' and to hear mental health described as affected by the collective history of my community."

"Looking forward to attending many more mental health related seminars in the future. Much appreciated!"

"Learned different ways to cope with stress."

"The mindset to think about things again and make an effort to put into practice."

"Learning about how different Asian communities handle trauma and mental health issues."

"Made easy for children to understand and kept them engaged with game."

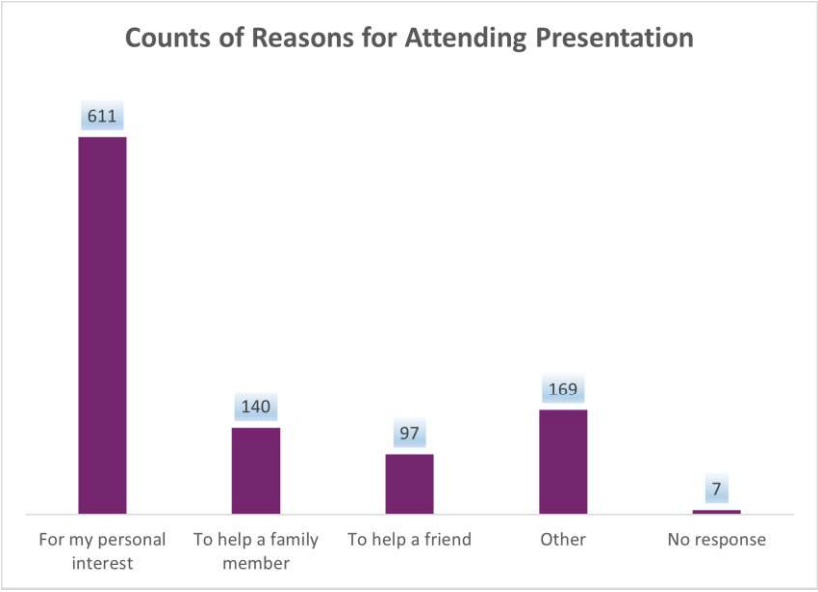
"A warm and welcoming space was created to allow us to be vulnerable and open."

"The presentation was good at bridging some gaps and making the intersectionality between mental health, trauma, and layers of colonization + systemic violence."



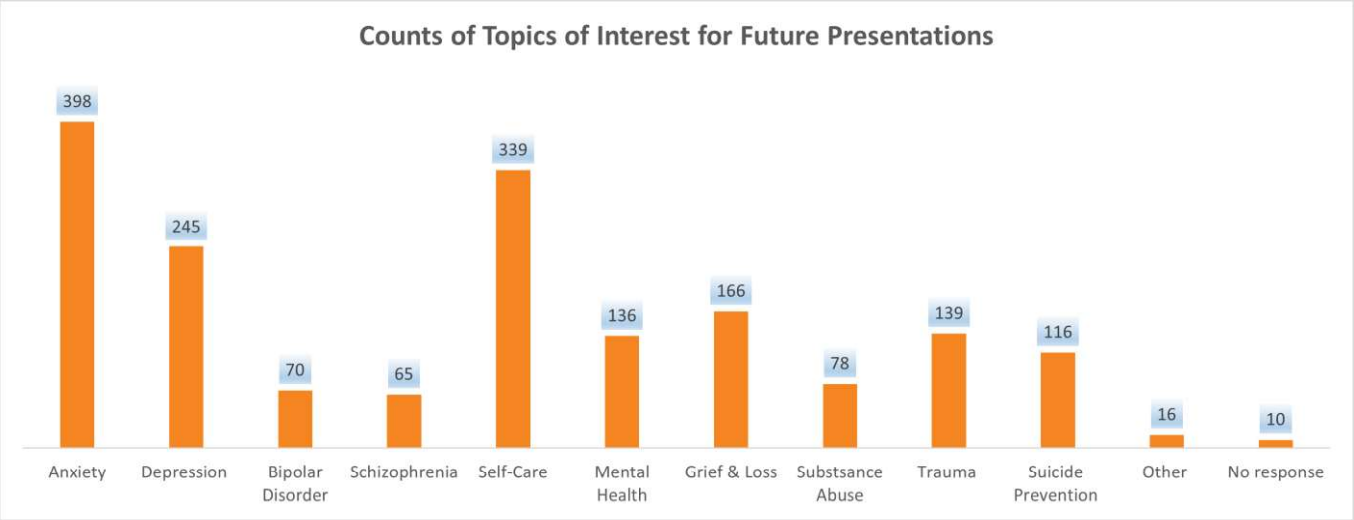
Mental Health Presentations: Reasons for Attending

Of the 913 people who completed the satisfaction survey, **906** participants provided reasons as to why they attended a CMHP AAPI presentation. The most frequently chosen response among participants was "for my personal interest".



Mental Health Presentations: Topics for Future Presentations

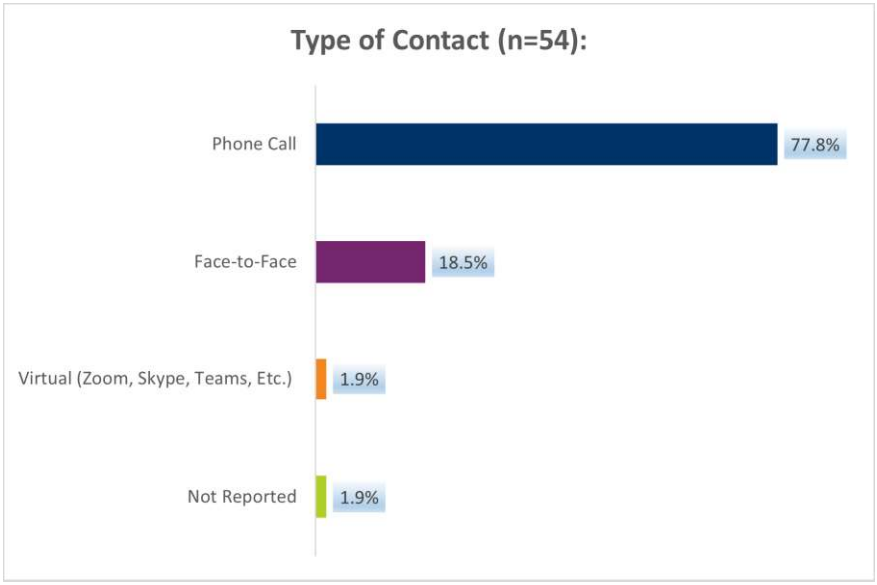
Of the 913 people who completed the satisfaction survey, **903** participants expressed interest in learning about different topics in future presentations. The most frequently chosen response for a topic of interest for future presentations was anxiety, closely followed by self-care.



Individual Contacts

Individual contacts for the CMHP program are defined as when a promoter provides more in-depth, one-on-one assistance upon outreach or after presentations to help an individual or family with specific needs and provide referrals to help meet those needs. For FY 2023-24, the Asian American/Pacific Islander CMHP program completed **54** individual consultations.

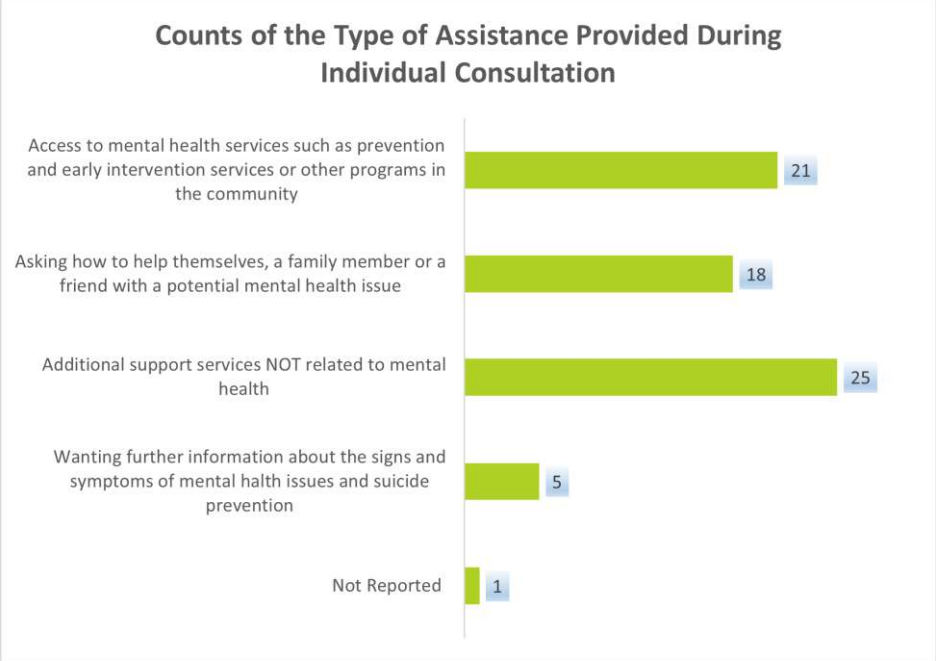
The most frequent type of contact that a promoter made with CMHP participants was through phone call (77.8%), followed by face-to-face interaction (18.5%), and then through virtual platforms such as Zoom, Skype, Teams, etc. (1.9%).





Individual Contacts cont.

Most participants indicated that they received more than one type of assistance during an individual consultation. This means that an individual had assistance with any of the types of assistance listed down below. In addition, the most frequent type of resource/referral that participants received was mental health education material, followed by individuals who were referred to a private mental health service, such as the SSG-APCTC's Riverside Counseling Center.



Resources and Referrals Type	Count
Mental Health Education Material	17
Prevention and Early Intervention Program(s)	9
Housing/Utilities Assistance	3
Food/Clothing Assistance	3
Employment/Education Services	1
Transportation Services	2
Medical Resources	6
Support Groups	3
Referral to Private Mental Health Services *(SSG-APCTC's Riverside Counseling Center)*	16
211	2
CARES	1
988/Helpline	1
Other Resources *(SSDI resources, disability services, legal inquiries, etc.)*	25

Middle Eastern/North African CMHPP

Promoter Training

For FY 2023-24, there were two promoters from Sahaba Initiative's MENA CMHP program who completed all 40 hours of required training as required by RUHS-BH MHSA PEI.

Topics included:

- CMHPP overview
- Community Outreach Strategies
- Presentation Tips
- Mental Health Basics
- Mental Health Needs of MENA
- Suicide Prevention, Anxiety
- Trauma
- Grief and Loss
- Psychosis/Schizophrenia
- Bipolar Disorder
- Depression
- Substance Misuse
- Self-Care and Wellness



Director's Feedback

The program director had a very positive experience training the community mental health promoters and preparing them for program implementation in the community. The promoters were highly engaged throughout the training days and asked thoughtful questions to help deepen their understanding of the material.

One promoter had a reaction of discomfort to the psychosis and bipolar disorder presentations, and shared that the reaction was largely due to learning about more severe case examples of psychosis and bipolar disorder during the discussion portion of the training. The director provided support by welcoming discussion about their reactions, checking in with them on the day of and afterwards, and responding to any questions that came up.

Additionally, the promoters demonstrated great skill when presenting the material back during practice presentations, not only when it came to presentation style and presence, but also in conveying the relevant information appropriately and accurately. The promoters found the training beneficial and they demonstrated great enthusiasm for bringing the presentations to the community. Overall, the director felt the training went well.

Promoter Training cont.

Promoter's Feedback

After completion of their 40 hour training, promoters participated in a survey in which they rated their agreement with statements on a scale from 1-5 (1-strongly disagree to 5-strongly agree). Their responses are shown in the table below. The promoters strongly agreed that the trainings were effective and helpful in their development as a promoter. They are confident in their knowledge of mental health, their ability to work with the community, and answer questions on mental health issues in a culturally competent way. In addition, the promotor provided comments based on the trainings.

Question	Avg. Score
I felt like an active participant in my development as a Promotor.	5
The training will help me to be an effective Promotor.	5
I feel able to utilize the materials presented in the training.	5
The trainers were knowledgeable and communicated clearly and effectively.	5
How would you rate your ability to do community mental health presentations?	5
How would you rate your ability to talk to people and answer questions about mental health issues?	5
How would you rate your knowledge of community resources and your ability to provide these resources to the community?	5
How would you rate your overall knowledge of mental health and about being a Promotor?	5
How would you rate your ability to understand cultural and linguistic diversity issues?	5



PEI

Suicide Prevention Activities

Program Type: Suicide Prevention Program

The past several years has included a larger focus on suicide prevention in Riverside County. A local strategic plan was developed, and the goals/objectives of the plan are being addressed through the Riverside County Suicide Prevention Coalition. Our local efforts are designed to align with and enhance the statewide goals for suicide prevention.

Building Hope and Resiliency: A Collaborative Approach to Suicide Prevention in Riverside County is the Riverside County suicide prevention strategic plan. As part of our statewide partnership, PEI participated in a suicide prevention learning collaborative. The plan was created through a data-driven process with community stakeholder feedback. In June 2020, the strategic plan was released. The plan identifies specific goals and objectives to address suicide in Riverside County and is in line with the California statewide strategic plan, *Striving for Zero.* In September 2020, the Riverside County Board of Supervisors passed a resolution adopting this strategic plan as a countywide initiative.

Riverside County Suicide Prevention Coalition: To bring the strategic plan to life, a Suicide Prevention Coalition was established. The Coalition kicked off in October 2020. Currently, the Coalition is led in partnership by RUHS Behavioral Health (PEI) and Public Health (Injury Prevention) and includes eight (8) sub-committees: Measuring & Sharing Outcomes, Effective Messaging & Communications, Upstream, Prevention-Trainings, Prevention-Engaging Schools, Prevention-Higher Education, Intervention, and Postvention. The Coalition meets quarterly and offers learning opportunities in suicide prevention best practices and is where sub-committees share ongoing progress.

Riverside County is one of 10 counties selected by the California Department of Public Health (CDPH) for a grant: The Youth Suicide Prevention and Response Network (YSPRN) pilot focused on developing a system flow map for supporting youth in suicidal crisis with the goals of filling any gaps in support identified in Riverside County. It is a partnership with RUHS-PH, RUHS-BH, RCOE, and United Way (Helpline). This funding supported the development of the Suicide Fatality Review Team, rapid surveillance data collection, suicide risk screening training for schools, development of a crisis call dashboard for our local Helpline, development of a system flow map to improve understanding and services for youth in suicidal crisis, and a portion of the annual SPC conference in October 2024.

Sub-committees meet monthly. Below is an update on the activities of each sub-committee for this reporting period.

Measuring & Sharing Outcomes (Data) sub-committee

- Data Brief: Suicides in Riverside County 2018-2022
    - RUHS-PH and BH worked together to develop this brief and it can be found by scanning the QR code

- CDPH grant: Monthly Rapid Surveillance of youth suicides and attempts shared with county partners to better inform our work.

- CDPH grant: Suicide Fatality Review Team

    - The review team is currently focused on youth 25 years old and younger. This multi-disciplinary team works together to review 2-3 suicide deaths per meeting looking for opportunities to prevent future suicides. Shared data from involved partners is used to identify risk and protective factors for suicide that are unique to Riverside County with the goal of making recommendations for local policy and practice changes to help reduce suicide risk and promote safety.

Effective Messaging sub-committee

- Supported sub-committees with ensuring work product utilized best practices for messaging safety, coordinated press releases for the annual SPC conference and local Directing Change event resulting in local media coverage of both events. Hosted a Safe and Effective Messaging and Communication Workshop in January 2025 for Public Information Officers and individuals that interact with the media and public to report out after a suicide loss.

Upstream sub-committee

- Concluded the Kindness Kit initiative with older adults focused on reducing social isolation and worked with local social work students at La Sierra University to develop a social media campaign for youth.

Prevention: Trainings sub-committee

- Developed and released a Public Service Announcement commercial for the gatekeeper trainings that are offered at no cost to anyone who lives or works in Riverside County. Facilitated 84 suicide prevention gatekeeper trainings throughout the year, training a total of 1,150 new helpers.

    - Know the Signs – 17

    - Mental Health First Aid (Youth & Adult) – 17

    - ASIST – 19

    - safeTALK - 31

- CDPH grant funding will allow RUHS-BH to bring Collaborative Assessment and Management of Suicidality (CAMS) training to our staff. CAMS is an evidence-based approach to treating people suffering from serious thoughts of self-harm. The goal is to have 140 RUHS-BH clinicians and RUHS-BH contracted clinicians certified in this model by June 2025.

Prevention: Engaging Schools sub-committee

- Increased school district participation in the sub-committee
- Co-chairs completed the school-based Suicide Risk Screening T4T making this training available to school districts throughout Riverside County, through a grant with CDPH.
    - The goal of the training is to provide educators and other adults with the confidence and tools to assess suicide risk in youth.
    - The training prepares educators and outreach staff how to effectively identify and respond to suicide risk. School staff are trained how to use the Columbia-Suicide Severity Rating Scale to determine the risk of suicide and how to deliver assistance to the youth once assessing their risk.
    - Partnership between RCOE, PH, and BH with trained facilitators to provide this to school districts throughout Riverside County.

Prevention Higher Education sub-committee

- Created a series of videos for students and staff including “How to Help a Student in Distress” and “Employee Self-Care.”
- Hosted Art with Impact workshops which aim to promote mental wellness by creating space for young people to learn and connect through art and media.
- The Active Minds Send Silence Packing traveling exhibit is an immersive experience utilizing mixed mediums to guide the visitor through the mental health journey of several American youth and young adults in an effort to increase awareness and reduce stigma associated with mental health concerns and suicide. In October 2023 PEI funded an exhibit at University of California, Riverside and Mt. San Jacinto College. The exhibits were well received by students and faculty.



Intervention sub-committee

- Continued distribution and advertisement of the Care Transitions Flyer as well as the launch of the Firearm Lock Distribution project distributing nearly 1,000 gun locks and attending approximately 10 community events this fiscal year.

Postvention sub-committee

- Active Postvention response continued with on-scene support from the Trauma Intervention Program (TIP) volunteers following a loss to suicide. Volunteers provide resource kits to loss survivors. For FY23/24 TIP received a total of 649 calls to their dispatch center. Of those 55 were suicide deaths. 62 LOSS kits were distributed.

- Clinical Bereavement Counseling for Suicide Loss, launched in November 2024, is short-term grief counseling for survivors of suicide loss provided at no cost to residents of Riverside County. This pilot project will offer 6-8 free sessions to suicide loss survivors through community-based clinicians who are trained in a specific approach to support suicide bereavement. The manual was developed specifically for Riverside County by Dr. Sally Spencer-Thomas, a leader in the field of suicide prevention and bereavement. This is the first program of its kind in the country. PEI partnered with IEHP to train several of their providers to offer this as a benefit to their members. Suicide Loss survivors can request this service by visiting the TIP website at: https://tiprivco.org/bereavement-counseling/. Applications for clinicians who would like to get trained to provide this service for PEI are being accepted on an ongoing basis, until the County determines it has obtained enough providers to adequately address the needs of the County, issues a new procurement for this program, or funding is no longer available. You can find the application at www.rivcospc.org.

- Peer Support Groups for Suicide Loss launched in January 2025. The SPC and PEI partnered with the American Foundation for Suicide Prevention (AFSP) to train community members/volunteers to facilitate support groups for suicide loss survivors. This support was nearly non-existent in Riverside County up to this point. PEI will provide ongoing support for facilitators, in partnership with AFSP, to ensure groups are available to community members in need.

- **Out of Darkness Walks** - For the second year the Suicide Prevention Coalition was a Regional Lifesaver Sponsor for the American Foundation for Suicide Prevention's (AFSP) three Out of Darkness Walks, the events were in Riverside, Coachella Valley, and Inland Empire (Rancho Cucamonga). There was great community participation in the walks and resulted in raising a substantial amount of funds for AFSP research. The coalition hosted an outreach table at each event to spread awareness about our current efforts. Through our outreach, several individuals expressed interest in becoming facilitators for Peer Support Groups for survivors of suicide loss here in our county.





The SPC offers quarterly virtual presentations to build awareness, knowledge, and increase best practices regarding suicide prevention in Riverside County. The quarterly webinars are free, offered virtually, and recordings remain available on our website (www.rivcospc.org). This fiscal year, the following topics were offered:

- July 2023 – Workplace Suicide Prevention

- The October quarterly presentation is our full-day in-person conference. In October 2023, the conference theme was "Creating Hope Through Action: Bridging the Gap Between Spirituality and Suicide Prevention." The event hosted over 350 attendees. The conference included one keynote presentation focused on the essentials of suicide prevention in faith communities and two panels with 11 local faith leaders to discuss the role that faith communities can play in stigma reduction and suicide prevention efforts.



- January 2024 - #safesocial: Social Media's Impact on Mental Health
- April 2024 – Suicide Prevention for Children and Pre-Teens: Why is it necessary and what can we do?

Man Therapy - The SPC/PEI continued to support Mantherapy.org with local advertisement and resources. Man Therapy is a web-based campaign focused on men that uses humor and male stereotypes to start the conversation and get men to think differently about their mental health. Man Therapy aims include helping men to explore how gender socialization influences their relationships and mental health, to reduce stigma about mental health and suicide, to empower men to seek help, and to reduce suicide risk. Its approach is around hope and resilience, while integrating humor throughout the website. Nearly 5,000 head inspections (online risk screening) were completed this fiscal year.



Suicide Prevention and Mental Health Awareness Trainings

The PEI Administration team coordinates and facilitates the following trainings for individuals who live and/or work in Riverside County. You can find out more and register for free for any of these trainings here: https://www.ruhealth.org/behavioral-health/prevention-early-intervention. In FY23/24, the training team delivered the following trainings:

safeTALK

- In-person 3-hour suicide alertness training
- **31 trainings; 503 participants for FY23-24**

Applied Suicide Intervention Skills Training (ASIST)

- In-person 2-day suicide intervention skills training
- **19 trainings; 327 participants for FY23-24**



Mental Health First Aid

- Offered with Youth and Adult focus
- In-person 8-hour mental health awareness and crisis support training
- **17 trainings; 231 participants for FY23-24**



Mental Health 101

- Mental Health vs. Mental Illness
- 90-minutes
- **7 trainings; 77 participants for FY23-24**



Self-Care and Wellness

- Interactive activities to promote self-care and wellness
- 2-hours
- **5 trainings; 79 participants for FY23-24**



Building Resiliency and Understanding Trauma

- Understanding Adverse Childhood Experience; Impact of trauma on well-being and health; building resiliency
- 2-hours
- **8 trainings; 185 participants for FY23-24**



Know the Signs

- Suicide prevention training – learn the signs, find the words, reach out to resources to support someone.
- 2-hours
- **17 trainings; 108 participants for FY23-24**

Some comments from participants include:

- “Knowing how to approach & speak to someone in crisis.”
- “Loved both instructors, both of their styles went well together. I appreciate how realistic they are too. Thank you.”
- “This training helped my school community to not be afraid and it [the training] will help them build capacity within their role.”
- “Very informative, kept my attention & was engaging which made it more comfortable to speak out & participate.”
- “Thank you for sharing this valuable information. I fully support all efforts to stop the stigma of needing mental health support.”
- “This training was extremely helpful. The trainers are very knowledgeable, welcoming, and helpful.”
- “The training was very smooth and informative. Presenters engaged all and did well. I liked learning the PALS.”
- “ASIST was a fun and helpful training. The guidance and experience obtained is invaluable to me personally and professionally.”

MHSA Prevention and Early Intervention (PEI)

PEI Suicide Prevention Trainings

Mental Health First Aid (MHFA)

safeTALK

Know the Signs

Applied Suicide Intervention Skills Training (ASIST)

FY 2023-2024 Annual Report

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OVERVIEW DESCRIPTION OF TRAININGS

Riverside County currently offers four suicide prevention trainings through the help of the Mental Health Service Act Prevention and Early Intervention (MHSA PEI) Department.

- **Applied Suicide Intervention Skills Training (ASIST)** is a two-day workshop designed for members of all caregiving groups. Family, friends, and community members may be the first to encounter an at-risk individual, but have little or no training to help. ASIST emphasizes the importance of learning suicide first-aid to keep at-risk individuals safe and to seek further help if needed. ASIST also helps individuals in formal helping roles with professional development so that they are better prepared to perform suicide first aid help when providing care to others. After completing ASIST, participants will know how to use a suicide intervention model to identify individuals with suicidal thoughts and develop a safety plan with them.

- **The Mental Health First Aid (MHFA)** program is an 8-hour long interactive session and can be conducted in three different ways: one-day 8-hour seminar, two-day 4-hour seminar, or a four-day 2-hour seminar. The program covers risk/protective factors, warning signs of mental health problems, prevalence data, stigma, assessment, intervention, and how to connect individuals in crisis with appropriate care. Additionally, the MHFA program provides evidence-based professional, peer, social, and self-help resources for individuals with a mental health illness. For specific target populations, there are two courses that are offered for training and certification, the Adult MHFA and the Youth MHFA. Each certification must be renewed every three years.

- **safeTALK** is a half-day training program that teaches participants to recognize and engage with individuals who possibly have suicidal thoughts and to connect them with community resources. safeTALK emphasizes safety while challenging the stigma in openly discussing suicide. It is recommended that individuals trained in ASIST or other suicide prevention programs to be at all safeTALK trainings. This program provides gradual exposure to practice actions and to help participants understand how false societal beliefs can cause otherwise caring and helpful people to miss, dismiss, or avoid warning signs of suicide. safeTALK also helps participants practice the TALK step actions in overcoming these barriers.

- **Know the Signs** is a statewide suicide prevention social marketing campaign built on three key messages: *"Know the signs. Find the words. Reach out."* This campaign is intended to educate on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources.

The goal for MHSA PEI is to have various Riverside County department employees and community-based organizations trained in these suicide prevention courses so that each department or organization has the ability to host the trainings for communities at large.

EXECUTIVE SUMMARY

FY 2023-2024 TOTAL NUMBER OF SUICIDE PREVENTION TRAININGS: 84

Pain Isn't Always Obvious
KNOW THE SIGNS
Suicide Is Preventable.org

17
Total Number of Trainings

Mental Health FIRST AID
from NATIONAL COUNCIL FOR MENTAL WELLBEING

17
Total Number of Trainings

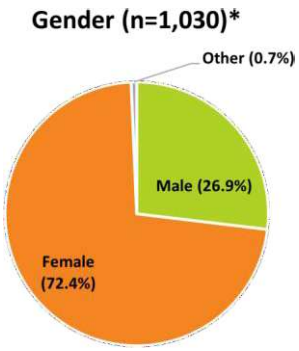
ASIST

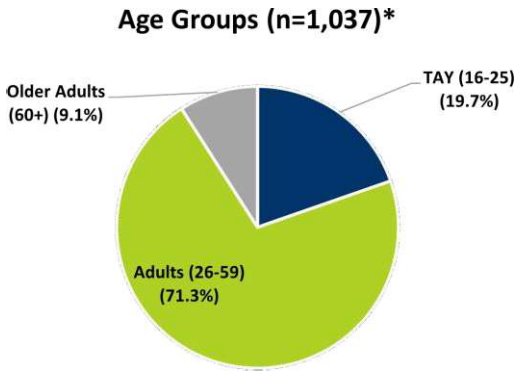
19
Total Number of Trainings

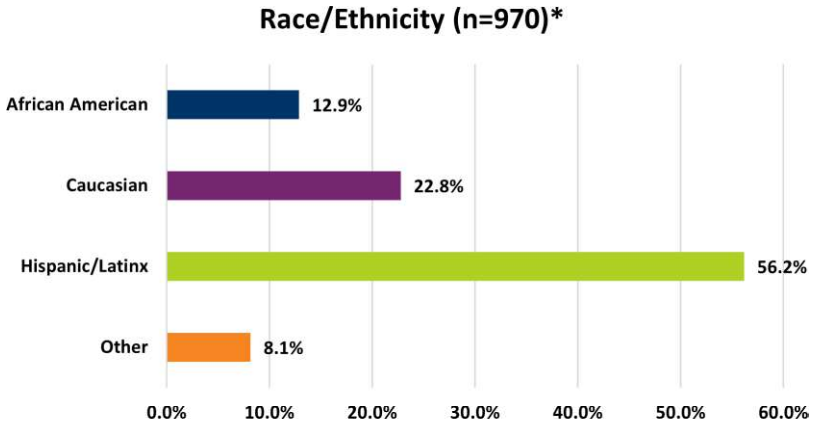
SUICIDE safeTALK

31
Total Number of Trainings

FY 2023-2024 TOTAL NUMBER OF PARTICIPANTS TRAINED: 1,150







**Note:* *Some categories are not shown here, including not reported/unknown.*



EXECUTIVE SUMMARY (cont.)

FY 23-24 PEI SUICIDE PREVENTION TRAININGS OVERVIEW

Mental Health FIRST AID from NATIONAL COUNCIL FOR MENTAL WELLBEING

- Total of 17 trainings for FY 23-24
- Audience reached was 231 participants with 225 participants (97.4%) who completed the training
- The smallest audience size for a training was 6 people while the largest audience size for a training was 28 people

- Total of 31 trainings for FY 23-24
- Total audience reached was 503 with *all* participants completing the training (100%)
- On a scale of 1 (i.e., very bad) to 10 (i.e., very good), the average rating for this training was 9.6

SUICIDE safeTALK

Pain Isn't Always Obvious KNOW THE SIGNS Suicide Is Preventable.org

- Total of 17 trainings for FY 23-24
- Total audience reached was 108 with *all* participants completing the training (100%)
- About 98.1% of Know the Signs participants would agree or strongly agree that they would recommend this training to someone else

- Total of 19 trainings for FY 23-24
- Total audience reached was 327 participants with 314 participants completing the training (96.0%)
- On a scale of 1 (i.e., did not like) to 10 (i.e., liked a lot), participants (n=314) rated the quality of ASIST as 9.4 out of 10

ASIST

MENTAL HEALTH FIRST AID (MHFA)

Program Description

The **Mental Health First Aid (MHFA)** program is an 8-hour long interactive session and can be conducted in three different ways: one-day 8-hour seminar, two-day 4-hour seminar, or a four-day 2-hour seminar. The program covers risk/protective factors, warning signs of mental health problems, prevalence data, stigma, assessment, intervention, and how to connect individuals in crisis with appropriate care.

Additionally, the MHFA program provides evidence-based professional, peer, social, and self-help resources for individuals with a mental health illness. For specific target populations, there are two courses that are offered for training and certification, the Adult MHFA and the Youth MHFA (YMHFA). Each certification must be renewed every three years.

Program Objective: MHFA teaches about *recovery* and *resiliency*—the belief that individuals experiencing these challenges can and do get better because they utilize their strengths to stay well.

FY 23-24 OVERVIEW

FY 23-24 MHFA Training Overview Summary

All **17 Adult MHFA and Youth MHFA trainings** were conducted in collaboration with **PEI, WET, Public Health, HelpLine, RUHS-BH Crisis, Moreno Valley College** and **other organizations**. Additionally, all trainings took place in either the **Western or Mid-County** regions. Specific audiences/groups that were targeted were the MHSA provider groups, law enforcement, as well as WET interns.



17
Total Number of Trainings



231
Total Number Reached



225
Total Number Completed Training



6
Smallest Audience Size



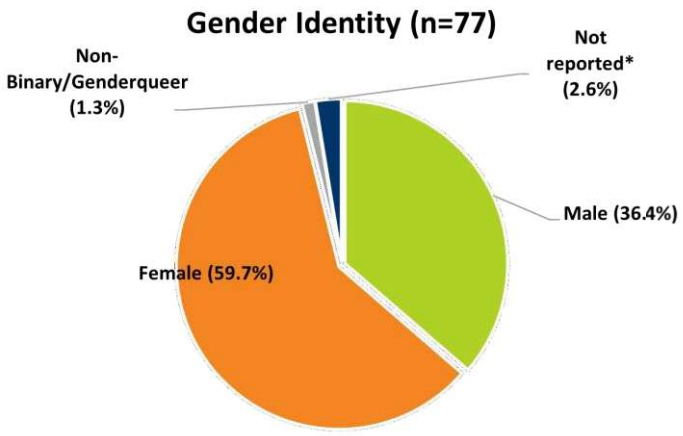
28
Largest Audience Size

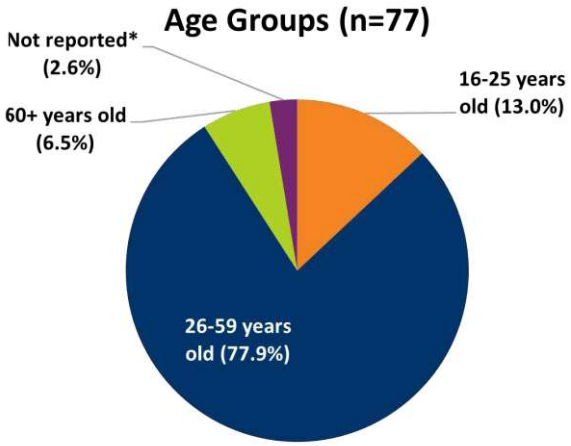
MENTAL HEALTH FIRST AID (MHFA)

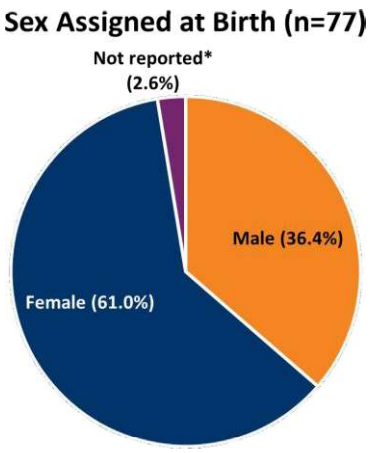
ADULT MHFA DEMOGRAPHICS

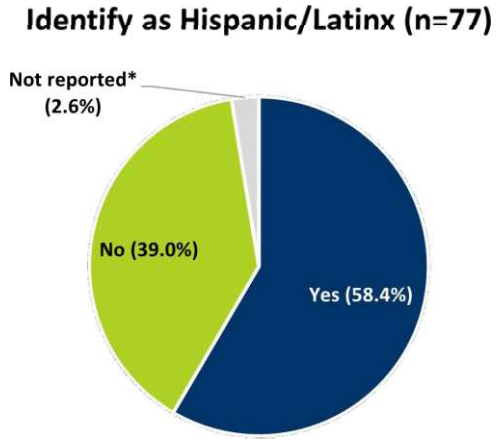
Demographics Summary

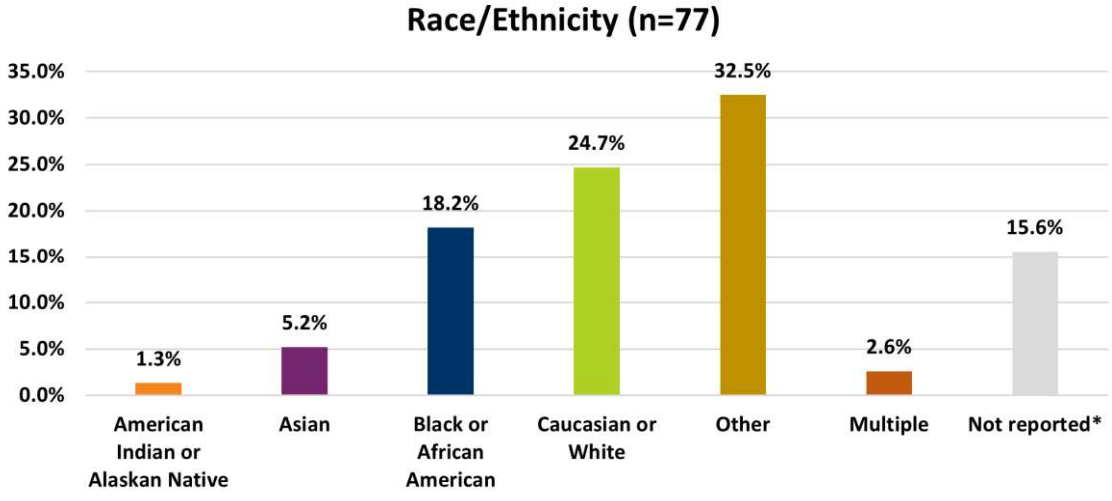
Most Adult MHFA participants identified their gender as **female (59.7%)** and half of the participants reported **female as their sex assigned at birth (61.0%)**. The majority of Adult MHFA participants were in the **26 to 59 years old age group (77.9%)**. Additionally, most participants identified as **Other (32.5%)** followed by White (24.7%), Black/African American (18.2%), Asian (5.2%), Multiple (2.6%) and American Indian or Alaskan Native (1.3%). More than half of participants identified as **Hispanic/Latinx (58.4%).**











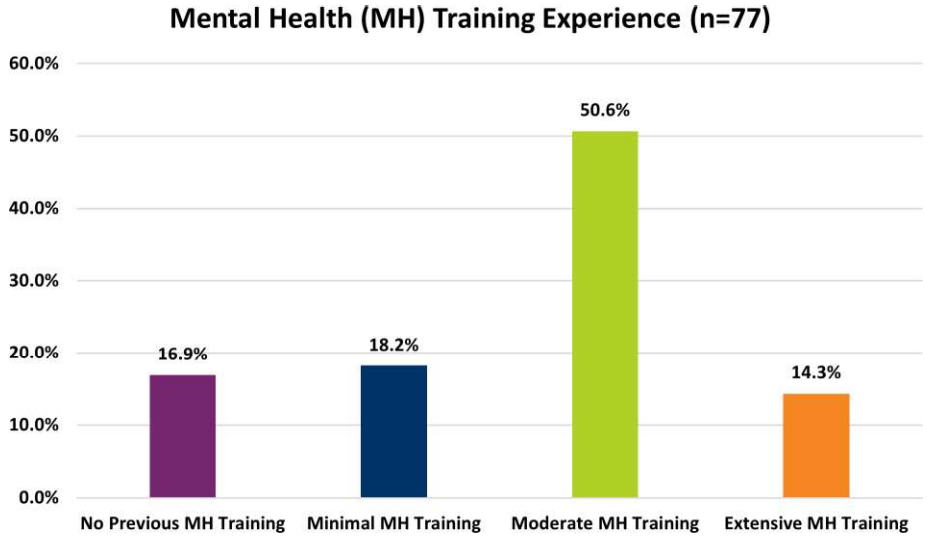
**Note:* *"Not reported" includes individuals who chose not to answer.*

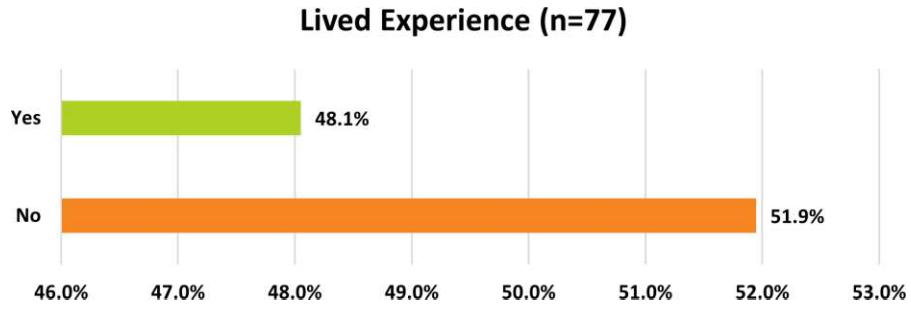
MENTAL HEALTH FIRST AID (MHFA)

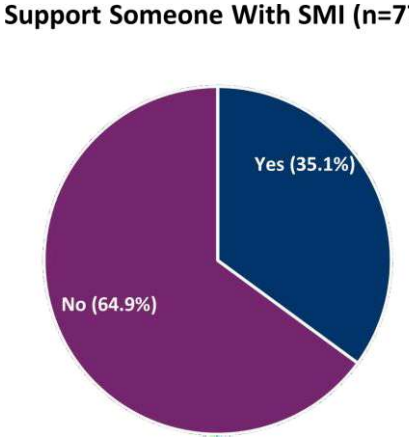
ADULT MHFA DEMOGRAPHICS (cont.)

Demographics Summary (cont.)

Of the participants that reported their mental health level experience, about **50.6% of participants had reported that they had moderate mental health training**, which includes several workshops, trainings, or classes about mental health. In addition, about 51.9% of the participants reported that they do not identify as a person with lived experience or a person in long-term recovery. And lastly, over one-third of participants (35.1%) reported that they support a family member with lived experience, serious mental illness, or in long-term recovery.







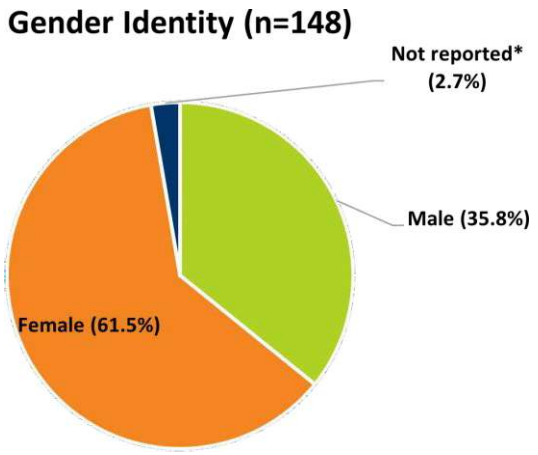
**Note:* *"Not reported" includes individuals who chose not to answer.*

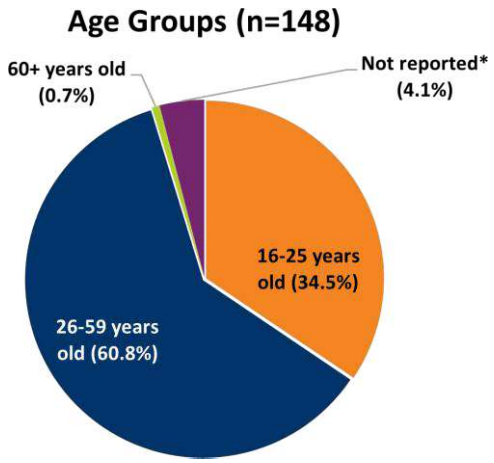
MENTAL HEALTH FIRST AID (MHFA)

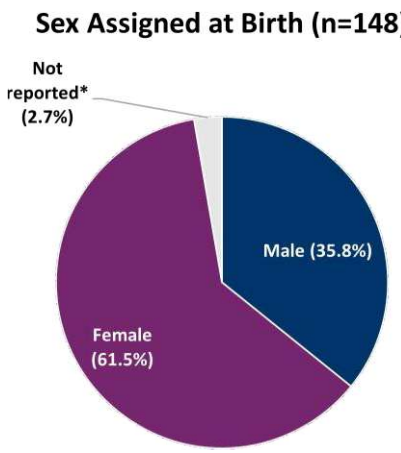
YOUTH MHFA DEMOGRAPHICS

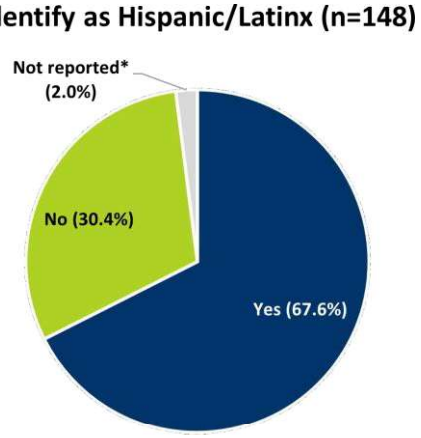
Demographics Summary

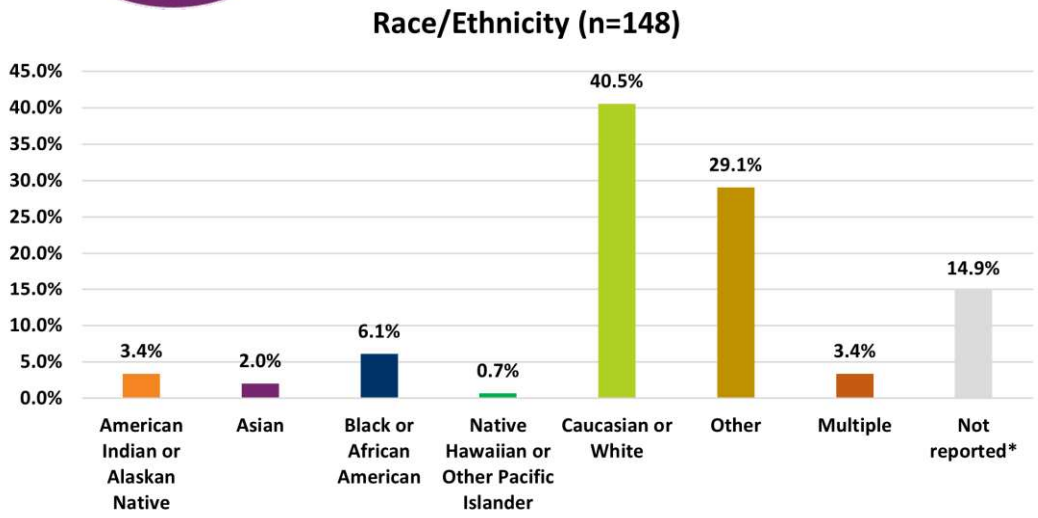
Most Youth MHFA participants identified their gender as **female (61.5%)** and half of the participants reported **female as their sex assigned at birth (61.5%)**. The majority of Youth MHFA participants were in the **26 to 59 years old age group (60.8%)**. Additionally, most participants identified as **White (40.5%)** followed by Other (29.1%), Black/African American (6.1%), Multiple (3.4%), American Indian or Alaskan Native (3.4%), Asian (2.0%), and Native Hawaiian or Other Pacific Islander (0.7%). More than half of participants identified as **Hispanic/Latinx (67.6%).**











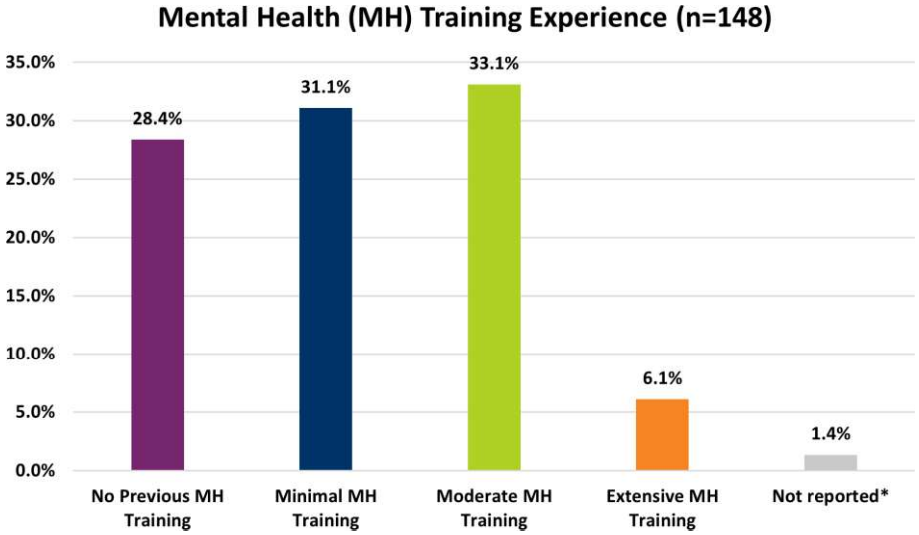
**Note:* *"Not reported" includes individuals who chose not to answer.*

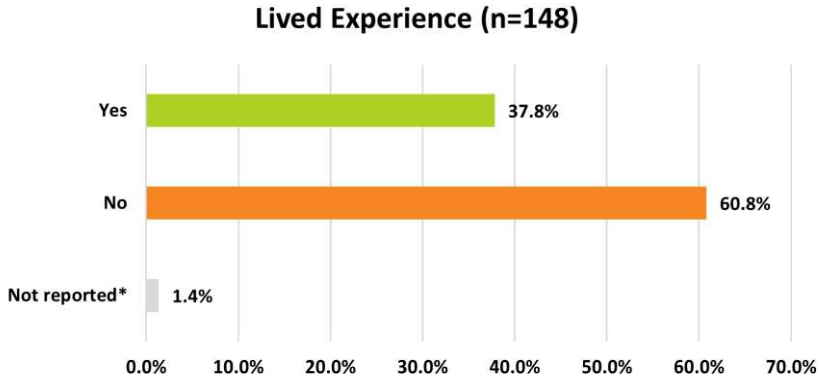
MENTAL HEALTH FIRST AID (MHFA)

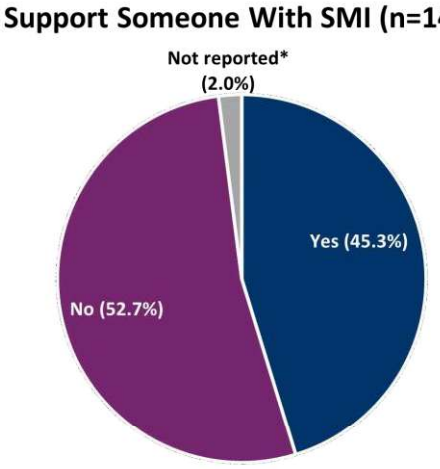
YOUTH MHFA DEMOGRAPHICS

Demographics Summary (cont.)

Of the participants that reported their mental health level experience, about **33.1% of participants had reported that they had moderate mental health training**, which includes attending several workshops, trainings, or classes about mental health. In addition, **60.8% of participants reported that they do not identify as a person with lived experience** or a person in long-term recovery. And lastly, about **45.3% of participants reported that they support a family member** with lived experience, serious mental illness, or in long-term recovery.







**Note:* "Not reported" includes individuals who chose not to answer.*

MENTAL HEALTH FIRST AID (MHFA)

ADULT MHFA PRE/POST OUTCOMES

Adult MHFA Pre/Post Outcomes Summary

As a part of the outcomes evaluation, the MHFA training requires individuals to complete a Mental Health First Aid Pre-Evaluation and Post-Evaluation form before and after the training.

Within the Pre and Post Evaluation forms, participants indicated to what extent they agree or disagree with specific statements regarding various mental health concepts. There were a total of **76 individuals** who completed both the Pre and Post measures from the Adult and Youth MHFA trainings. The Pre and Post scores from the evaluation forms are shown on the next page with their respective questions shown down below.

Your Beliefs About Mental Health and Substance Use (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
1. In general, I believe that…
1a. I intend to take action to help anyone I work with to address their mental health or substance use challenge(s).
1b. I intend to reach out and express my concerns to anyone I work with that might be experiencing mental health or substance use challenge(s).
1c. I intend to listen without expressing my judgement to anyone I suspect of experiencing a mental health or substance use challenge(s).
Your Beliefs About Mental Health First Aid Actions (1=Not Difficult At All; 2=Somewhat Not difficult; 3=Unsure; 4=Somewhat Difficult; 5=Extremely Difficult)
2. Currently I believe that for me…
2a. Giving practical resources (e.g., self-help information, crisis hotline number) to anyone showing signs and symptoms of a mental health or substance use challenge(s) is:
2b. Referring anyone experiencing a mental health or substance use challenge(s) to a health professional is:
Your Beliefs About Mental Health First Aid Actions (1=Extremely Unlikely; 2=Somewhat Unlikely; 3=Neither Likely Nor Unlikely; 4=Somewhat Likely; 5=Extremely Likely)
3. For each statement below, please circle the response that best describes your opinion.
3a. If I express my concerns to any person about the mental health signs and symptoms that they are experiencing, it will help that person to seek timely support.
3b. If I give information about mental health professionals in the community to any person experiencing mental health or substance use challenge(s), it will assist that person to get help.
Your Confidence in Performing Mental Health Actions (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
4. Currently, I am confident that I can…
4a. Have a supportive conversation with anyone about mental health or substance use challenges.
4b. Ask anyone directly whether they are considering killing themselves.
4c. Respond to a substance use crisis including an overdose and know what to do keep an individual safe.

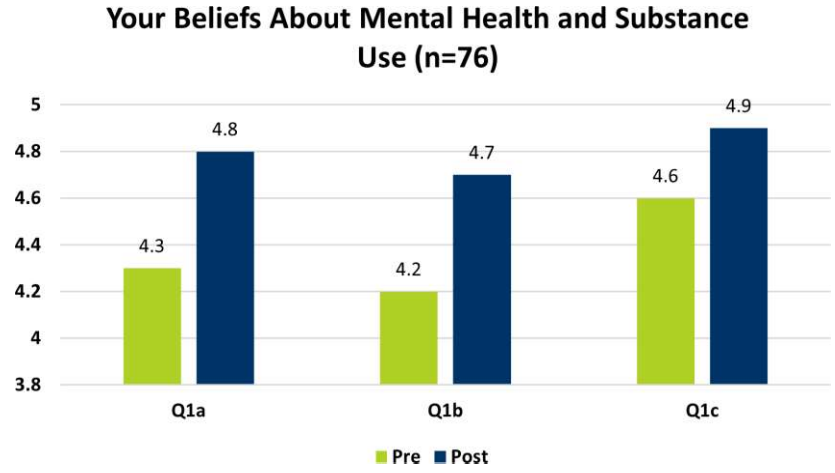
**Note: Pre and Post analysis was only conducted for individuals who completed both measures.*

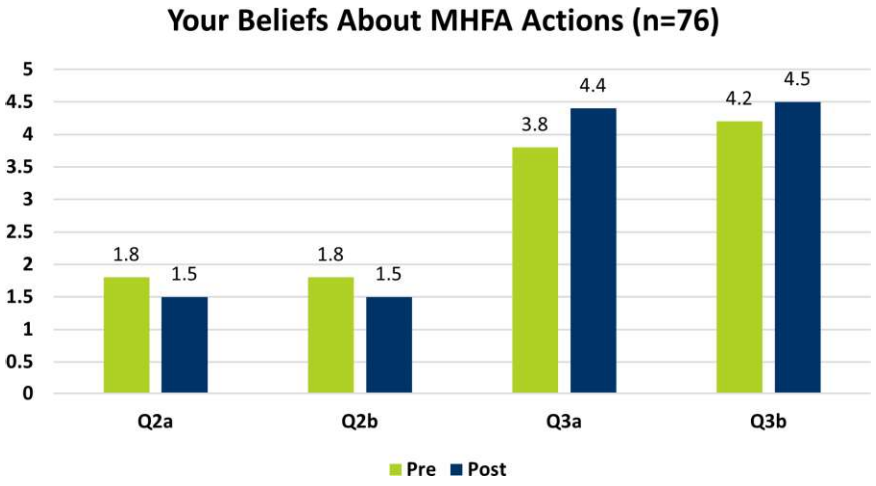
MENTAL HEALTH FIRST AID (MHFA)

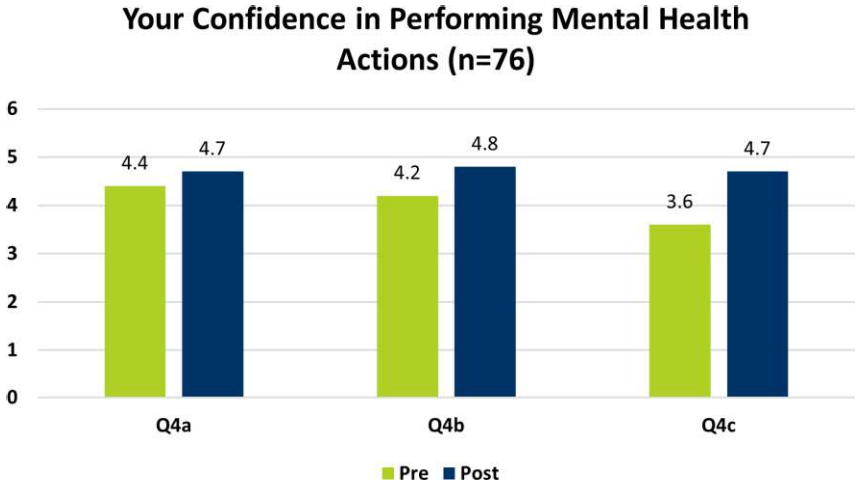
ADULT MHFA PRE/POST OUTCOMES

Adult MHFA Pre/Post Outcomes Summary (cont.)

Across all domains, the majority of participants had increased confidence, knowledge, and intention in helping individuals who may be experiencing a mental health crisis. It should be noted that questions 2a and 2b asked individuals how *difficult* it might be to perform MHFA actions. Participants responded that there was an overall decrease in difficulty in conducting those actions after completing the training.







MENTAL HEALTH FIRST AID (MHFA)

YOUTH MHFA PRE/POST OUTCOMES

Youth MHFA Pre/Post Outcomes Summary

Similar to the requirement made for Adult MHFA, as a part of the outcomes evaluation, the MHFA training requires individuals to complete a Mental Health First Aid Pre-Evaluation and Post-Evaluation form before and after the training.

Within the Pre and Post Evaluation forms, participants indicated to what extent they agree or disagree with specific statements regarding various mental health concepts. The Pre and Post scores from the evaluation forms are shown on the next page with their respective questions shown down below.

Your Beliefs About Mental Health and Substance Use (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
1. In general, I believe that…
1a. I intend to take action to help anyone I work with to address their mental health or substance use challenge(s).
1b. I intend to reach out and express my concerns to anyone I work with that might be experiencing mental health or substance use challenge(s).
1c. I intend to listen without expressing my judgement to anyone I suspect of experiencing a mental health or substance use challenge(s).
Your Beliefs About Mental Health First Aid Actions (1=Not Difficult At All; 2=Somewhat Not difficult; 3=Unsure; 4=Somewhat Difficult; 5=Extremely Difficult)
2. Currently I believe that for me…
2a. Giving practical resources (e.g., self-help information, crisis hotline number) to anyone showing signs and symptoms of a mental health or substance use challenge(s) is:
2b. Referring anyone experiencing a mental health or substance use challenge(s) to a health professional is:
Your Beliefs About Mental Health First Aid Actions (1=Extremely Unlikely; 2=Somewhat Unlikely; 3=Neither Likely Nor Unlikely; 4=Somewhat Likely; 5=Extremely Likely)
3. For each statement below, please circle the response that best describes your opinion.
3a. If I express my concerns to any person about the mental health signs and symptoms that they are experiencing, it will help that person to seek timely support.
3b. If I give information about mental health professionals in the community to any person experiencing mental health or substance use challenge(s), it will assist that person to get help.
Your Confidence in Performing Mental Health Actions (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
4. Currently, I am confident that I can…
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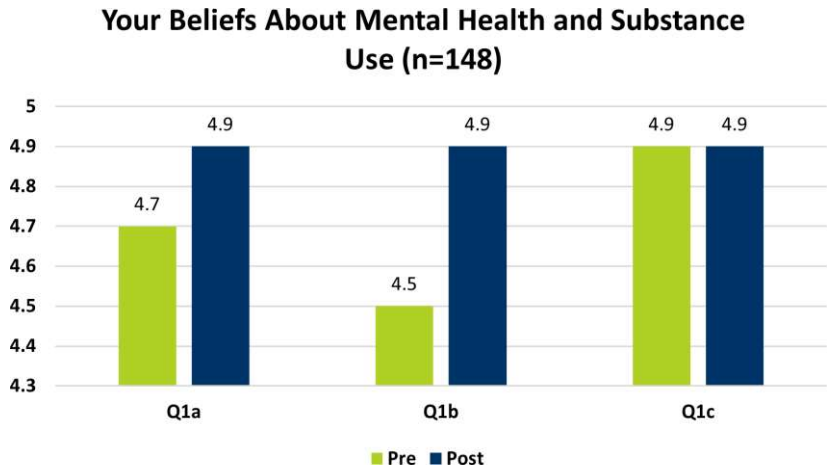
**Note: Pre and Post analysis was only conducted for individuals who completed both measures.*

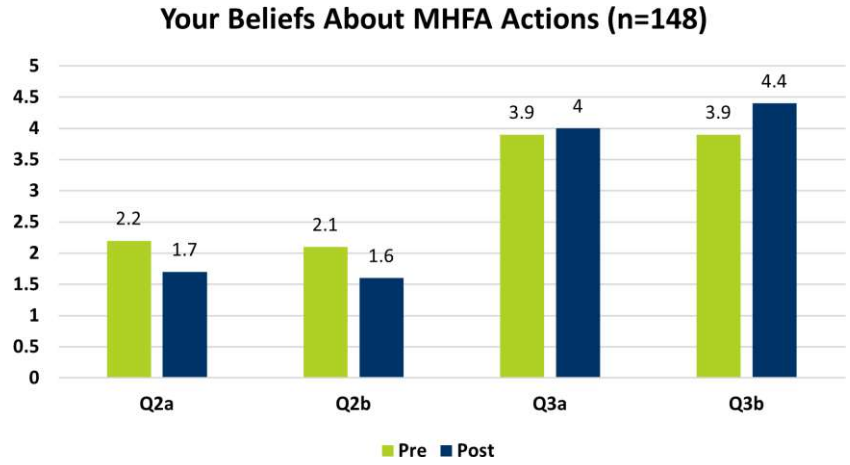
MENTAL HEALTH FIRST AID (MHFA)

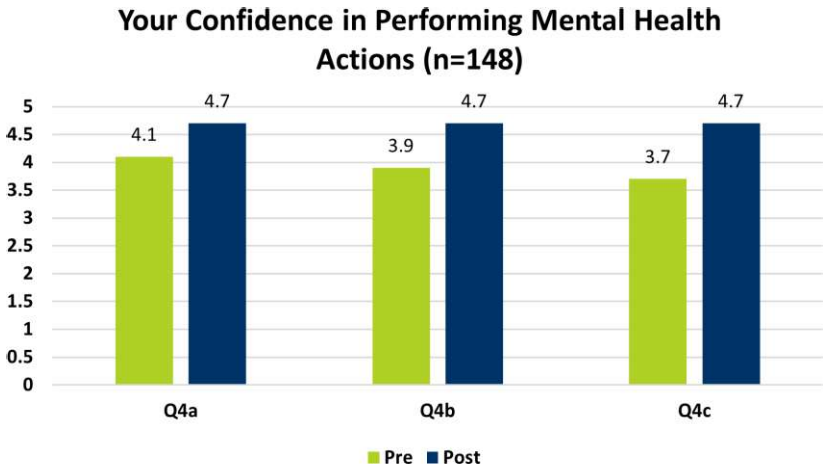
YOUTH MHFA PRE/POST OUTCOMES

Youth MHFA Pre/Post Outcomes Summary (cont.)

Similar to the results shown in the Adult MHFA Pre/Post Outcomes, across all domains, the majority of Youth MHFA participants had increased confidence, knowledge, and intention in helping youth who may be experiencing a mental health crisis. It should be noted that questions 2a and 2b asked individuals how *difficult* it might be to perform MHFA actions, and participants responded that there was an overall decrease in difficulty in conducting those actions after completing the training.







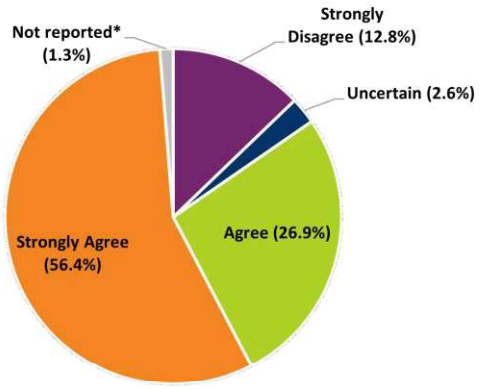
MENTAL HEALTH FIRST AID (MHFA)

ADULT MHFA OVERALL SATISFACTION

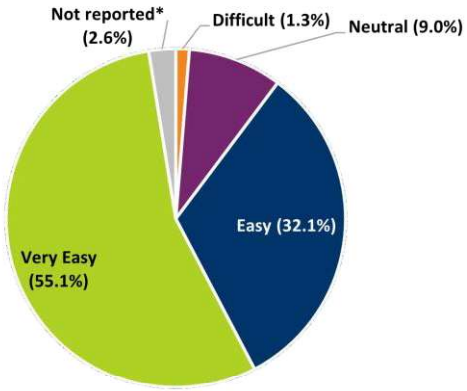
Adult MHFA Satisfaction Summary

Participants are also asked to complete a program evaluation feedback form at the end of the training. Some of the responses to the satisfaction questions are shown below. Individuals reported that they **strongly agree (54.4%)** that there was an adequate opportunity in practicing their skills that they learned from the training. More than half of the participants found that navigating the coursework was **very easy (55.1%)**. Additionally, more than half of the respondents found that the existing scenarios from the training were **very relevant (76.9%)** to the populations that they primarily work with and about **67.9%** indicated that the pace of the coursework was **neutral**. Although not shown below, a great majority said yes to **taking another MHFA course (97.4%).**

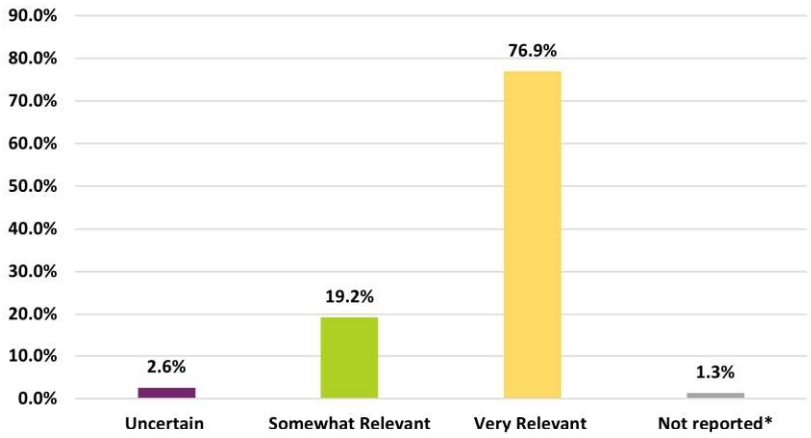
Adequate Opportunity to Practice Skills Learned (n=78)



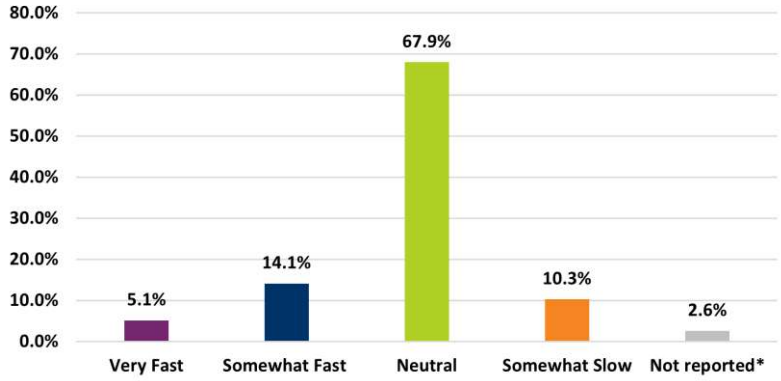
Overall Experience Navigating Coursework (n=78)



How Relevant the Existing Scenarios Are (n=78)



Pace of the Coursework (n=78)



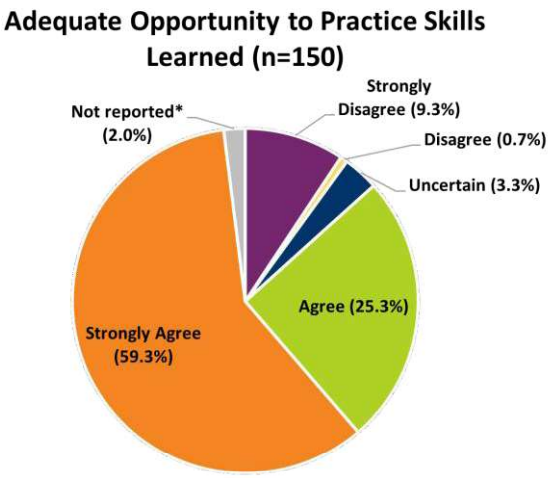
**Note:* "Not reported" includes individuals who chose not to answer.*

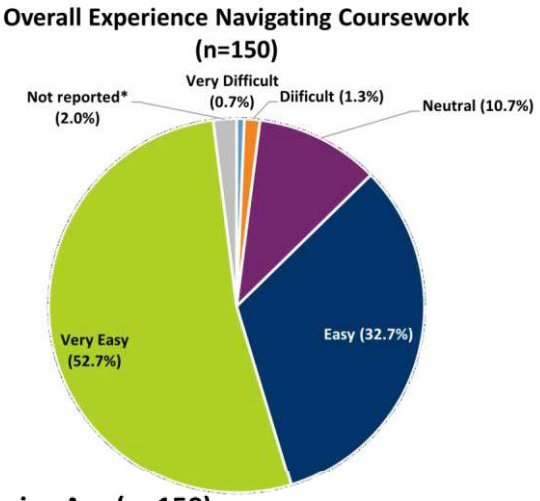
MENTAL HEALTH FIRST AID (MHFA)

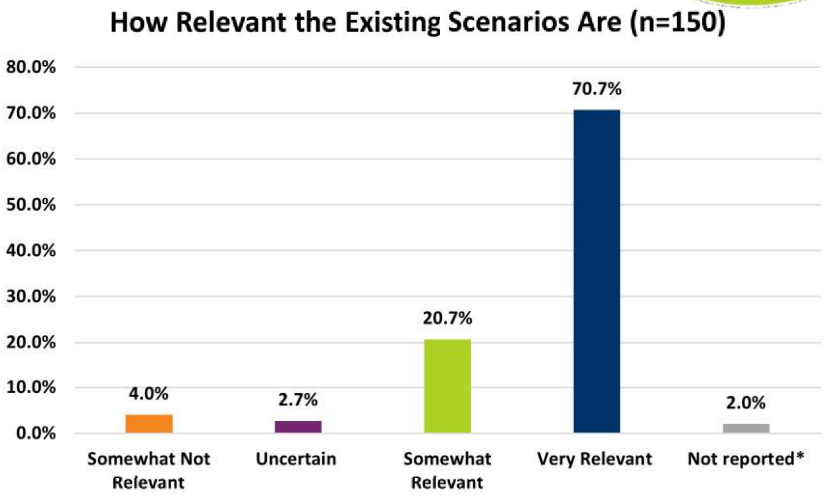
YOUTH MHFA OVERALL SATISFACTION

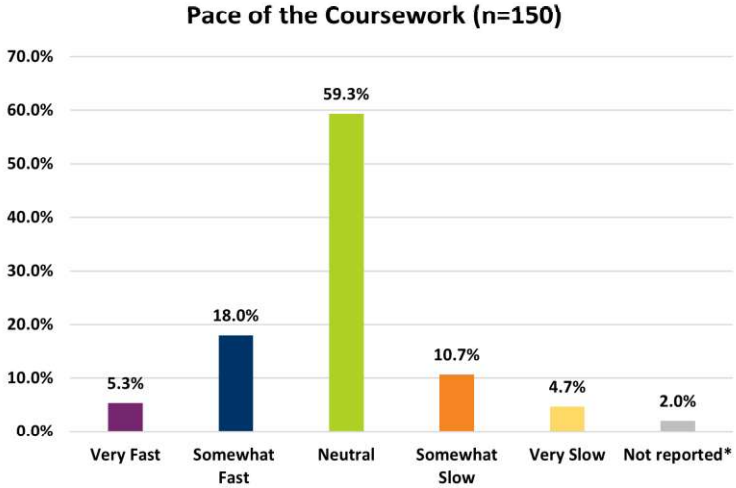
Youth MHFA Satisfaction Summary

Individuals reported that they **strongly agree (59.3%)** that there was an adequate opportunity in practicing their skills that they learned from the training. Almost half of the participants found that navigating the coursework was very **easy (52.7%)**. Additionally, more than half of the respondents found that the existing scenarios from the training were **very relevant (70.7%)** to the populations that they primarily work with and about **59.3%** indicated that the pace of the coursework was **neutral**. Although not shown below, a majority said yes to **taking another MHFA course (90.7%).**









**Note:* "Not reported" includes individuals who chose not to answer.*

MENTAL HEALTH FIRST AID (MHFA)

ADULT & YOUTH MHFA ADDITIONAL COMMENTS

Adult MHFA and Youth MHFA Quiz Outcomes

To complete a MHFA training, participants were required to take the Adult MHFA Quiz, which evaluates participants' understanding of the MHFA program, overall knowledge, stigmatizing attitudes, and helping behaviors in assisting someone experiencing a mental health or substance use condition. The quiz is taken at the end of the training and a score of 6 out of 10 is required to pass the course. **For FY 23-24, all 225 Adult and Youth MHFA participants passed the quiz with a rate of 100%.**

Adult & Youth MHFA Additional Comments Summary

Below are the participants' comments from the program evaluation feedback forms. These comments highlight the importance of the program and other thoughts that participants had about the overall program, instructors, and training.

"I appreciated reading closely about a disorder and sharing findings with the group."

"Thank you for the examples on how we may respond to specific situations."

What Was Most Helpful About the Course?

"Knowing how to approach & speak to someone in crisis."

"Very friendly, warm, welcoming, supportive and awesome!"

"Loved both instructors, both of their styles went well together. I appreciate how realistic they are too. Thank you."



SAFETALK

Program Description

safeTALK is a half-day training program that teaches participants to recognize and engage with individuals who possibly have suicidal thoughts and to connect them with community resources. safeTALK emphasizes safety while challenging the stigma in openly discussing suicide. It is recommended that individuals trained in ASIST or other suicide prevention programs to be at all safeTALK trainings.

This program provides gradual exposure to practice actions and to help participants understand how false societal beliefs can cause otherwise caring and helpful people to miss, dismiss, or avoid warning signs of suicide. Additionally, 'Safe' stands for 'Suicide Alertness For Everyone' and 'TALK' stands for 'Tell, Ask, Listen, and KeepSafe'. This program helps participants practice the TALK step actions in overcoming these barriers.

Program Objective: To learn how to prevent suicide by recognizing signs, engaging someone, and connecting them to an intervention resource for further support.

FY 23-24 OVERVIEW

FY 23-24 safeTALK Training Overview Summary

For FY 23-24, there were a total of **503 individuals** who completed the safeTALK training. All **31 safeTALK trainings** were conducted in collaboration with **RUHS-BH PEI staff** and many other departments, such as **RUHS-Public Health, HelpLine, Loma Linda Health University, Special Service for Groups—Asian Pacific Counseling & Treatment Center (SSG-APCTC),** and **WET.** Additionally, most trainings took place in the **Western region**, while a few were conducted in **San Bernardino County**.



31
Total Number of Trainings



503
Total Number Reached



503
Total Number Completed Training



4
Smallest Audience Size



37
Largest Audience Size



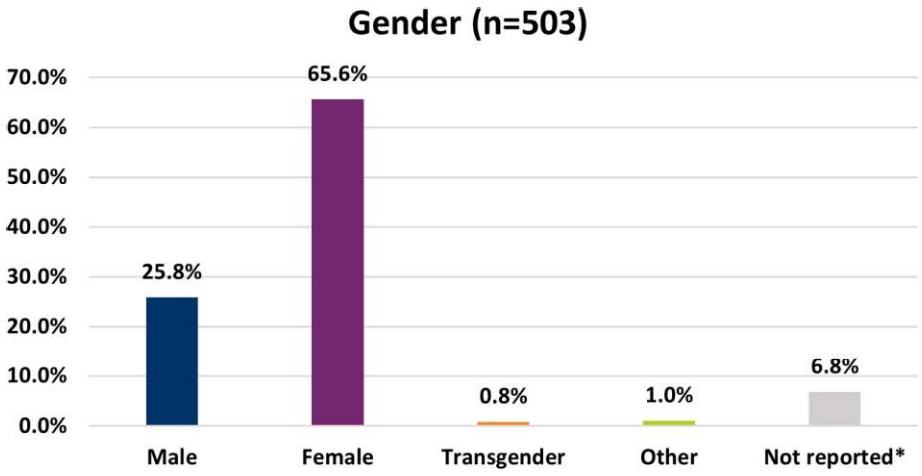
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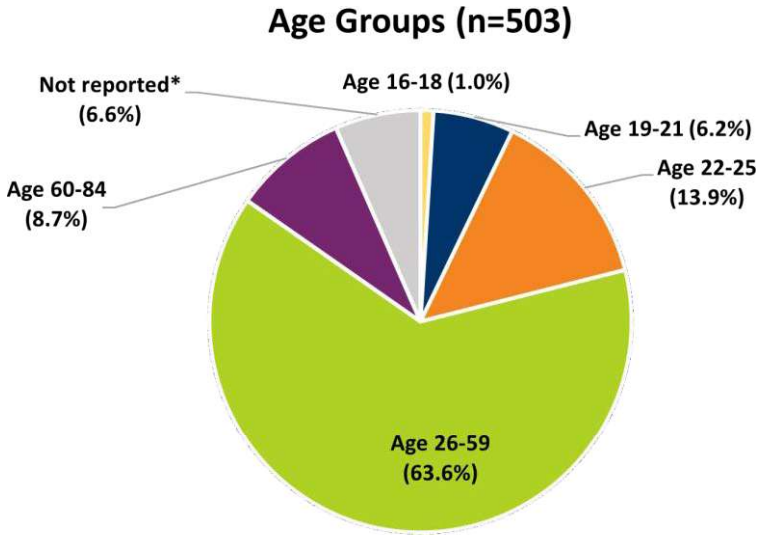
SAFETALK

DEMOGRAPHICS

Demographics Summary

More than half of the safeTALK participants identified as **female (65.6%)**, followed by male (25.8%), transgender (0.8%), and other (1.0%). In addition, most of the participants were in the **26-59 age group (63.6%)**, followed by the 22-25 age group (13.9%), 60-84 age group (8.7%), 19-21 age group (6.2%), and 16-18 age group (9.1%).





Note: "Not reported" includes individuals who chose not to answer.

SAFETALK

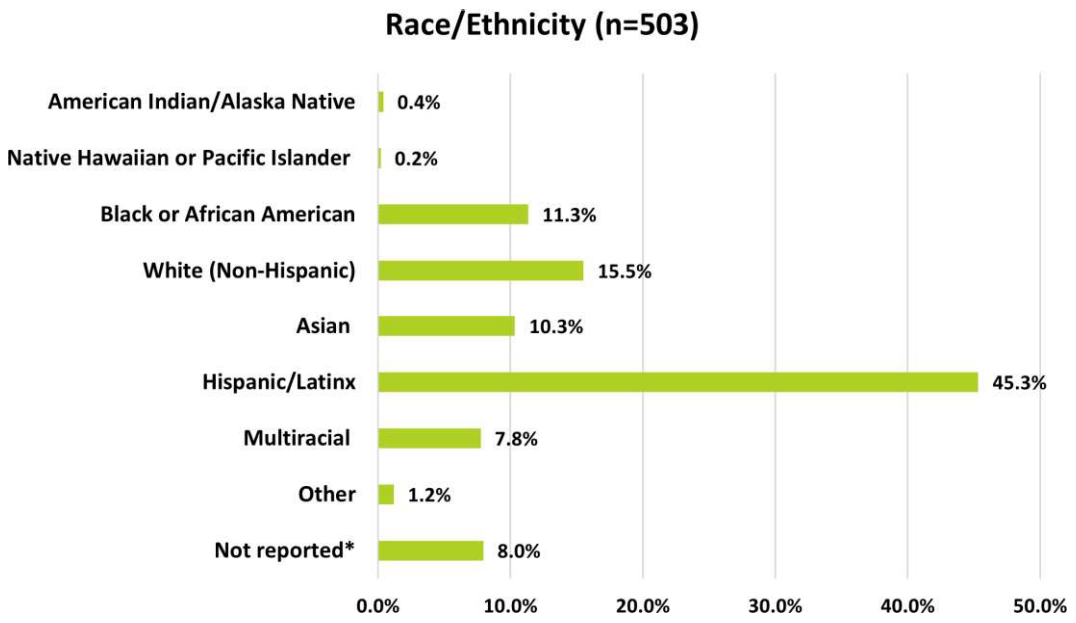
DEMOGRAPHICS

Demographics Summary

The majority of participants identified as **Hispanic/Latinx (45.5%)**, followed by White—Non Hispanic (15.5%), Black or African American (11.3%), Asian (10.3%), Multiracial (7.8%), Other (1.2%), American Indian/Alaska Native (0.4%), and Native Hawaiian or Pacific Islander (0.2%). Additionally, 8.0% of participants chose to not answer the race/ethnicity question and are included in the "not reported" category down below.

Individuals reported that they **work in a mental health care setting (22.1%),** followed by working in a school or university (16.3%), other setting (16.1%), more than one setting (11.7%), medical care setting (8.9%), and religious organization setting (2.2%).

The safeTALK trainings reached out to a diverse range of audience groups; however, the most frequent type of audience that was reported are individuals from the **community at large (35.4%)** Some examples of "other" groups include folks from nonprofit organizations, training centers, etc. Although not shown here, most participants reported that they **do not have a disabling condition (87.9%)** and that they are **not a veteran (90.5%)**. Lastly, **safeTALK participants reported that did not identify as being a part of the LGBTQ+ community (82.5%).**



Type of Work Environment	Count	Percentage
School/University	82	16.3%
Mental Health Care Setting	111	22.1%
Medical Care Setting	45	8.9%
Religious Organizations	11	2.2%
Other	81	16.1%
More than 1	59	11.7%
Not reported*	114	22.7%
Total	**503**	**100.0%**

Type of Audience Reached	Count	Percentage
An interested parent	41	8.2%
Consumer of services	47	9.3%
Community at large	178	35.4%
Other	122	24.3%
More than 1	67	13.3%
Not reported*	48	9.5%
Total	**503**	**100.0%**

**Note:* "Not reported" includes individuals who chose not to answer.*

SAFETALK

EVALUATION OUTCOMES

Evaluation Outcomes Summary

All safeTALK participants are asked to complete a feedback form at the end of the training presentation to complete their training. The feedback form includes questions about participant satisfaction of the training and any additional comments that participants would like the safeTALK program to know.

Please circle the choice that best describes your response *(1=Strongly Disagree, 2=Partly Agree, 3=Agree, 4=Strongly Agree; n=503).**				
Questions	**Responses**			
	1	**2**	**3**	**4**
1. My trainer was prepared and familiar with the material.	**	0.4%	7.8%	91.7%
2. My trainer encouraged participation and respected all responses.	**	0.4%	4.4%	94.8%
3. I intend to tell others that they will benefit from this training:	**	1.0%	9.9%	86.9%
Please circle the choice that best describes your response *(1=Not Prepared, 2=Partly Prepared, 3=Mostly Prepared, 4=Well Prepared; n=503).**				
Questions	**Responses**			
	1	**2**	**3**	**4**
4. How prepared do you now feel to talk directly and openly to a person about their thoughts of suicide?	**	1.8%	32.6%	64.2%
On a scale of 1 *(i.e., very bad)* to 10 *(i.e., very good)*, how would you rate this training *(n=503)*?				
5. How would you rate this training?	**Average Rating (Mean)**			9.6

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*

***No responses.*

SAFETALK ADDITIONAL COMMENTS

"This training helped my school community to not be afraid and it [the training] will help them build capacity within their role."

"Going over the slides and having the videos were helpful to understand the steps. Resource are also very helpful and useful to provide to others who are in need."

"Very informative, kept my attention & was engaging which made it more comfortable to speak out & participate."



KNOW THE SIGNS

Program Description

Know the Signs is a statewide suicide prevention social marketing campaign built on three key messages: *"Know the signs. Find the words. Reach out."* This campaign is intended to educate on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources.

The campaign has specifically designed culturally relevant posters to help communities in understanding the message. The posters and marketing materials are available in English, Spanish, Vietnamese, Korean, Hmong, Khmer, Lao, Mandarin, Tagalog, Punjabi and Russian. There are also print ads, TV and radio spots, and online ads available for the public. At the end of each presentation, everyone is encouraged to download the mobile application to help connect at -risk individuals to a supportive network.

Program Objective: Know the Signs has the overarching goal to increase Californians' capacity to prevent suicide by encouraging individuals to know the signs, find the words to talk to someone they are concerned about, and to reach out to resources.

FY 23-24 OVERVIEW

FY 23-24 Know the Signs Training Overview Summary

FY 23-24, there were a total of **17 trainings** and a total of **141 participants** who completed the training. In addition, for the type of audience reached, almost half of the Know the Signs participants identified as the **community at large (40.7%)**.



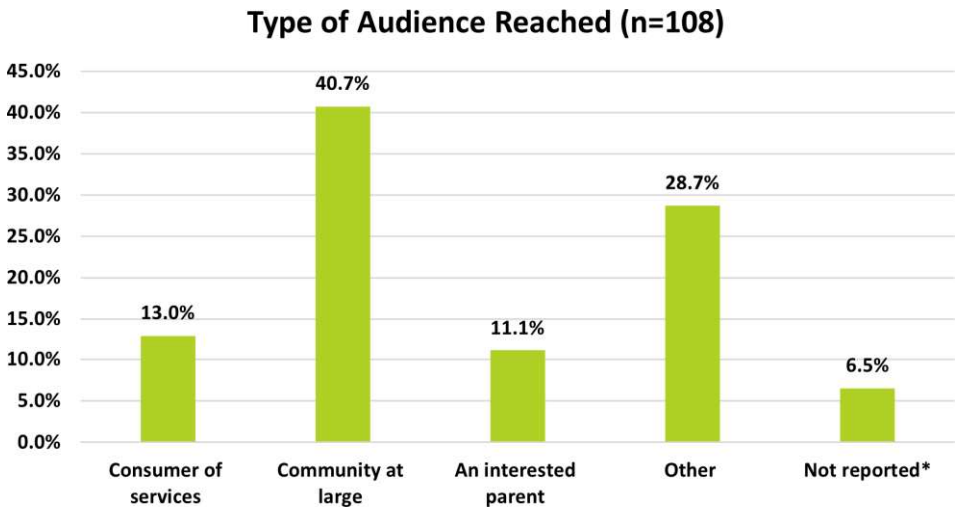
17
Total Number of Trainings



108
Total Number Reached



108
Total Number Completed Training



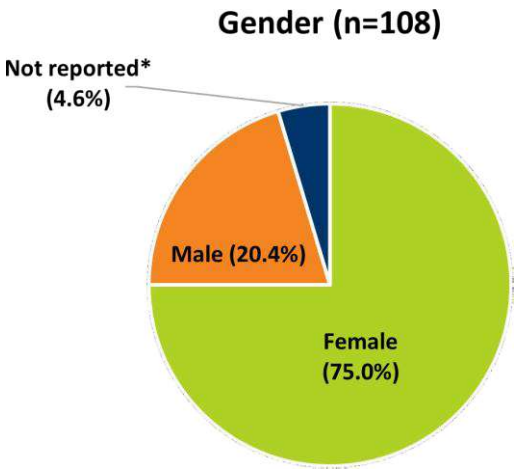
**Note:* "Not reported" includes individuals who chose not to answer.*

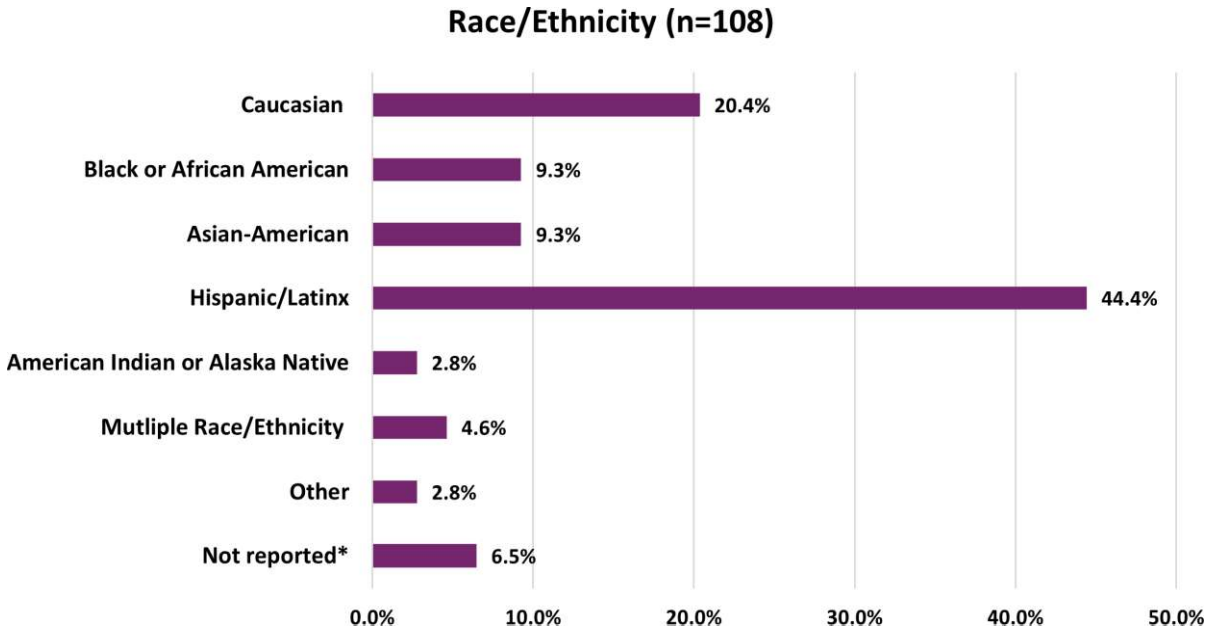
KNOW THE SIGNS

DEMOGRAPHICS

Demographics Summary

All demographic data includes participants from both the English and Spanish-speaking Know the Signs trainings. The majority of participants identified themselves as **female (75.0%)**, followed by males (20.4%). Additionally, most Know the Signs participants identified as **Hispanic/Latinx (44.4%)**, followed by Caucasian (20.4%%), Black or African American (9.3%), Asian-American (9.3%), Multiple Race/Ethnicity (4.6%), and American Indian or Alaska Native (2.8%), and Other (2.8%).





**Note:* "Not reported" includes individuals who chose not to answer.*

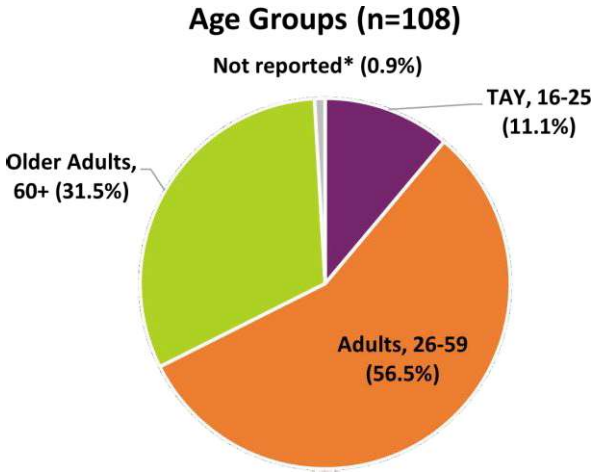
KNOW THE SIGNS

DEMOGRAPHICS (cont.)

Demographics Summary (cont.)

Most participants from the Know the Signs training reported that they were in the **26-59 age group (56.5%)**, followed by the 60+ age group (31.5%), and the 16-25 TAY age group (11.1%). About 0.9% of participants did not report their age resulting in some unknown data.

In addition, a great majority of Know the Signs participants reported **English as their preferred language (89.8%)**. Most Know the Signs participants reported that they **did not have a disability (86.1%) nor did they identify as a veteran (88.9%)**. Lastly, a majority of respondents indicated that they **did not identify as lesbian, gay, bisexual, or queer (LGBQ) (71.3%)** as their sexual orientation status.



Demographic Characteristic	Percentage
Preferred Language (n=108)	
English	89.8%
Spanish	5.6%
*Not reported**	3.7%
Disability (n=108)	
Yes	7.4%
No	86.1%
*Not reported**	6.5%
Veteran Status (n=108)	
Yes	4.6%
No	88.9%
*Not reported**	6.5%
LGBQ Sexual Orientation Status (n=108)	
Yes	11.1%
No	71.3%
*Not reported**	14.8%

**Note:* "Not reported" includes individuals who chose not to answer.*

KNOW THE SIGNS

EVALUATION OUTCOMES

Evaluation Outcomes Summary

At the end of a Know the Signs training, participants are asked to complete a feedback survey via Google Forms to further understand how participants felt and thought about the training. Below are the results of the feedback survey and additional comments that participants may have provided.

As a result of this training, I feel more confident that I can… *(1=Not confident at all, 3=Somewhat confident…5=Very confident; n=108)*

Questions	Responses*				
	1	2	3	4	5
1. Recognize the warning signs of suicide.	**	**	5.7%	22.6%	71.7%
2. Ask someone who was exhibiting the warning signs of suicide if they are thinking about suicide.	**	0.9%	3.7%	25.2%	70.1%
3. Connect or refer someone at-risk for suicide to resources.	**	**	4.7%	21.7%	73.6%

Please circle the number that best describes your response *(1=Strongly Disagree, 3=Neutral... 5=Strongly Agree; n=108)*.

Questions	Responses*				
	1	2	3	4	5
4. Overall, the course goals were clearly communicated.	0.9%	**	1.9%	15.9%	81.3%
5. The presenter demonstrated knowledge of the material presented.	**	0.9%	1.9%	12.1%	85.0%
6. I would recommend this training to someone else.	**	**	1.9%	19.6%	78.5%

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*

***No responses.*

KNOW THE SIGNS ADDITIONAL COMMENTS

"It was very informative and helpful. Great job! Thank you both so much!"

"This training was extremely helpful. The trainers are very knowledgeable, welcoming, and helpful."

"Thank you for sharing this valuable information. I fully support all efforts to stop the stigma of needing mental health support."



APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

Program Description

ASIST is a two-day workshop designed for members of all caregiving groups. Family, friends, and community members may be the first to encounter an at-risk individual, but have little or no training to help. ASIST emphasizes the importance of learning suicide first-aid to keep at-risk individuals safe and to seek further help if needed.

ASIST also helps individuals in formal helping roles with professional development so that they are better prepared to perform suicide first aid help when providing care to others. After completing ASIST, participants will know how to use a suicide intervention model to identify individuals with suicidal thoughts and develop a safety plan with them.

Program Objective: To learn how to prevent suicide by recognizing signs, providing a skilled intervention, and developing a safety plan to keep someone safe.

FY 23-24 OVERVIEW

FY 23-24 ASIST Overview Summary

Overall, for FY 23-24, ASIST had a total of **19 trainings** with **314 participants** who completed the 2-day training. All 19 trainings for ASIST were conducted in collaboration or co-facilitation with **PEI, Helpline, Public Health, Consumer Affairs, WET, school districts,** and **Inland Empire Health Plan (IEHP)**. Additionally, most of the trainings took place at the **Rustin Conference Center** and in the **Western region** of Riverside County.

19
Total Number of Trainings

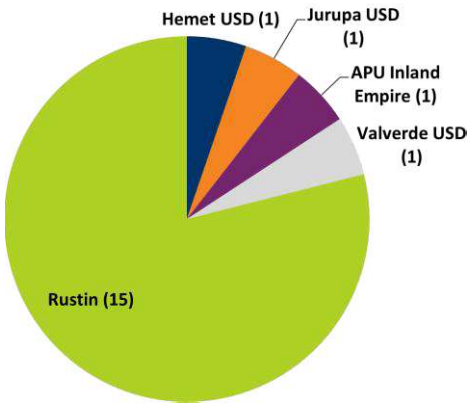
327
Total Number Reached

314
Total Number Completed Training

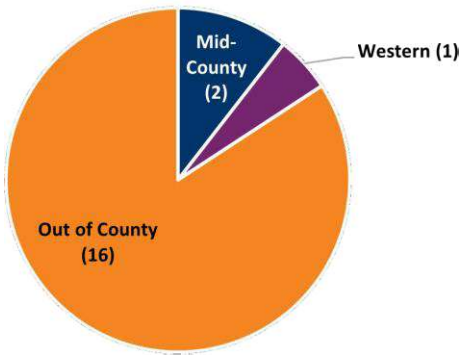
5
Smallest Audience Size

30
Largest Audience Size

Location of Training



Region of Training



**Note:* *"Not reported" includes individuals who chose not to answer.*

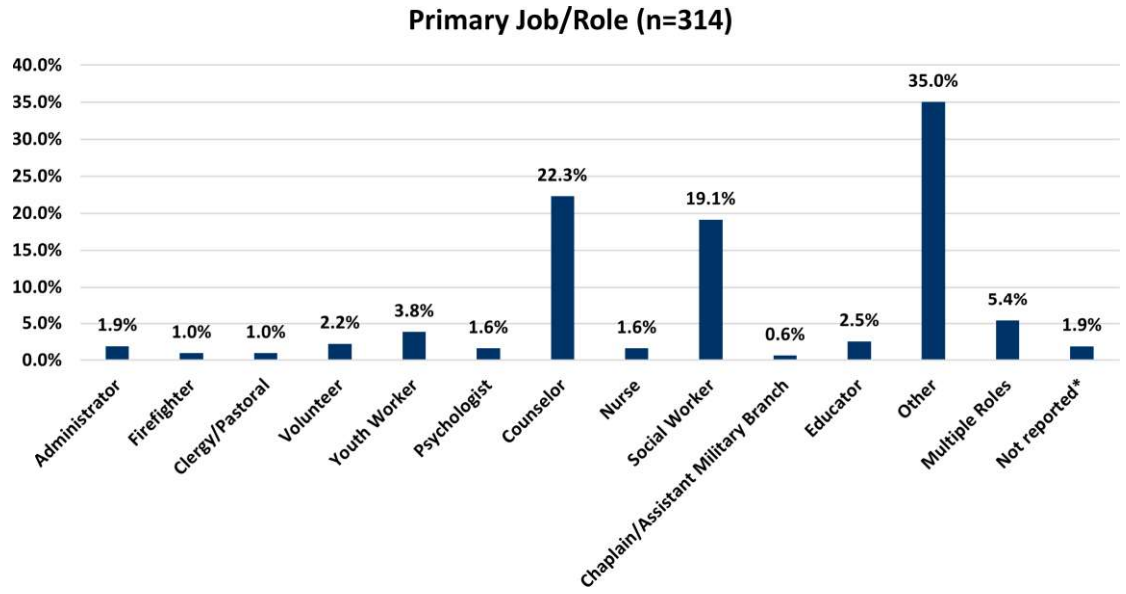
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

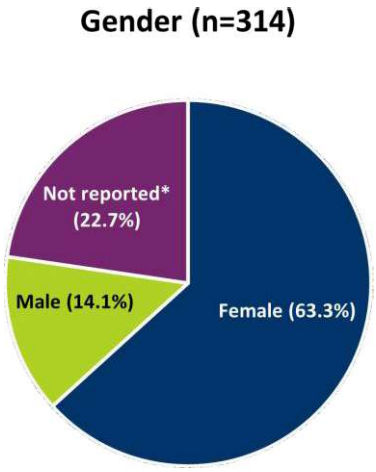
DEMOGRAPHICS

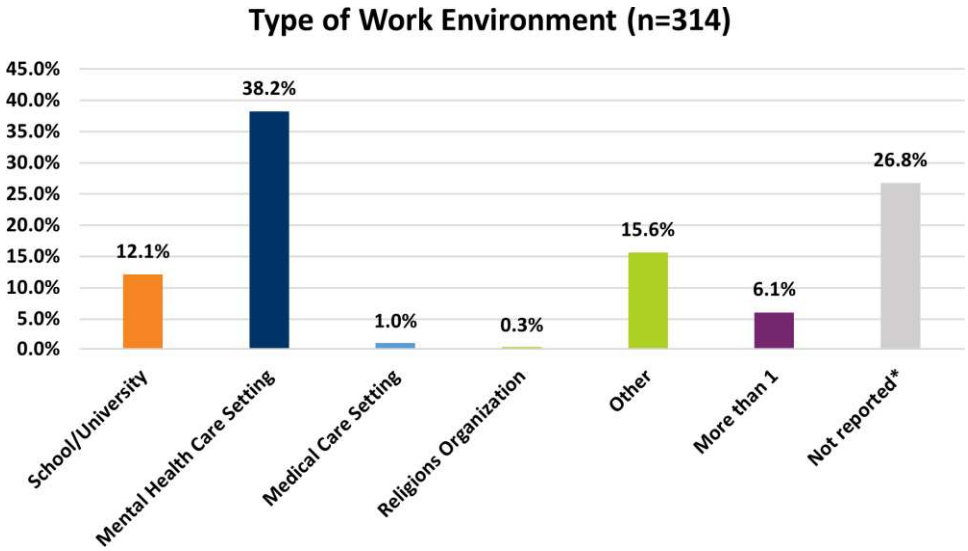
Demographics Summary

Note: There are more "Not reported" counts this fiscal year than there were last fiscal year due to a misunderstanding in providing the demographics section for two trainings for ASIST. Because of this, some demographic information may not be available throughout the demographics section of the report for ASIST.

Many of the ASIST participants come from a diverse range of occupations and primary roles. For example, **35.0% of respondents identified as 'Other'** as their primary job or role. Additionally, the next frequently chosen response was counselor (22.3%), social worker (19.1%), followed by having multiple primary roles (5.4%), youth worker (3.8%), and educator (2.5%). The most frequently chosen type of work environment was **mental health care setting (38.2%)** among ASIST participants. Additionally, the majority of ASIST participants identified themselves **as female (63.3%)**, followed by male (14.1%), and those who did not report on their gender identity (22.7%).







**Note:* "Not reported" includes individuals who chose not to answer.*

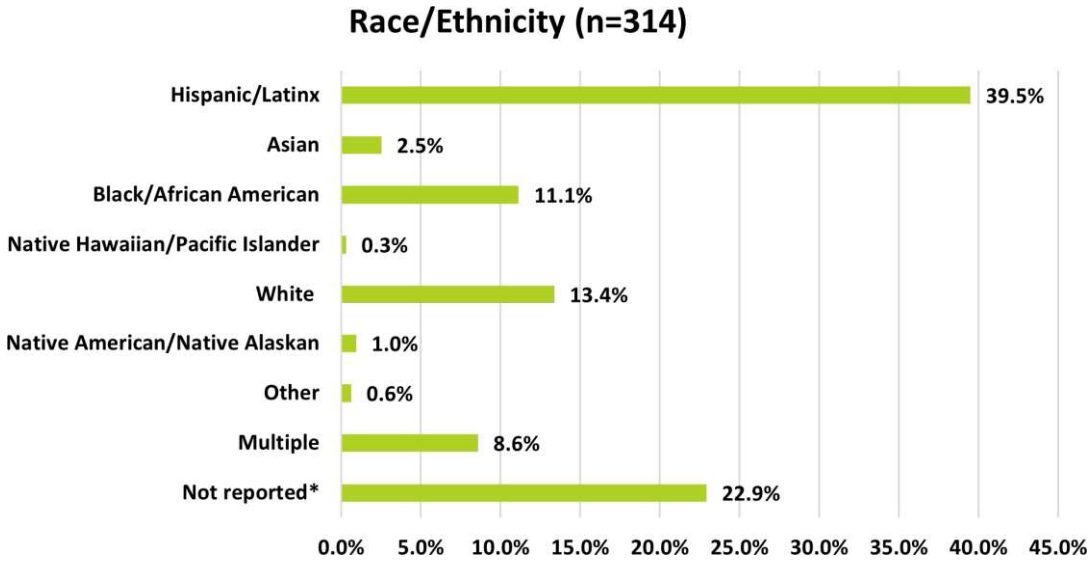
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

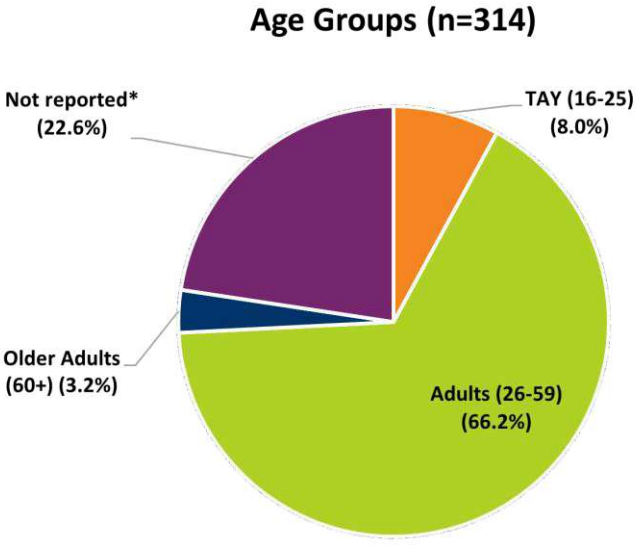
DEMOGRAPHICS (cont.)

Demographics Summary (cont.)

More than half of the ASIST participants identified as **Hispanic/Latinx (39.5%)**, followed by White (13.4%), Black/ African American (11.1%), Multiple (8.6%), Asian (2.5%), Native American/Native Alaskan (1.0%), Other (0.6%), and Native Hawaiian/Pacific Islander (0.3%). Most of the participants reported being in the **26-59 age group (66.2%)**, followed by the Transitional Age Youth (TAY) 16-25 age group (8.0%), and the 60+ age group (3.2%).

In addition, most individuals reported **English as their preferred language (72.3%)**. A great majority of participants reported that they **did not have a disability (70.1%) nor a veteran (76.4%)**. Lastly, most participants did **not identify as LGBTQ+ (64.6%).**





Demographic Characteristic	Percentage
Preferred Language (n=314)	
English	72.3%
Spanish	0.6%
English & Another Language	3.8%
Other	0.6%
Disability (n=314)	
No	70.1%
Veteran Status (n=314)	
No	76.4%
LGBTQ+ Status (n=314)	
Yes	9.2%
No	64.6%

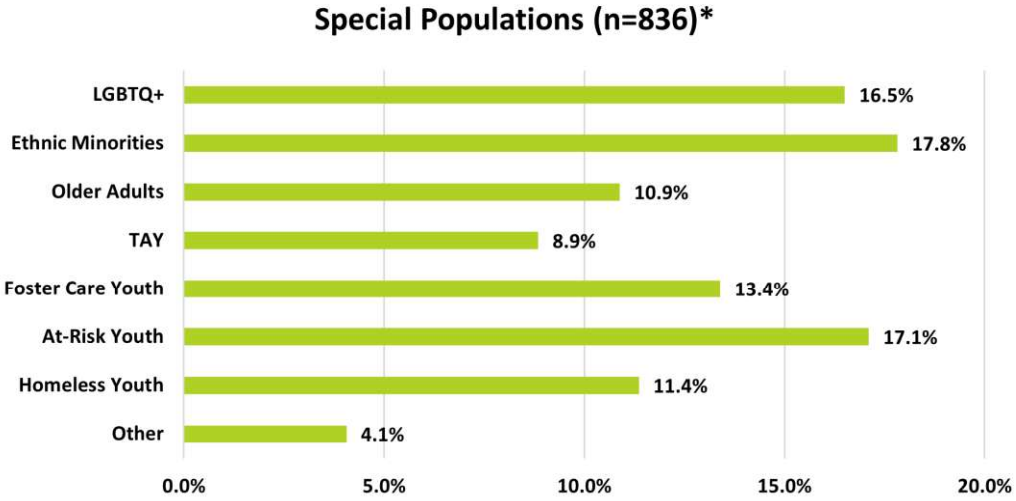
**Note:* *"Not reported" includes individuals who chose not to answer.*

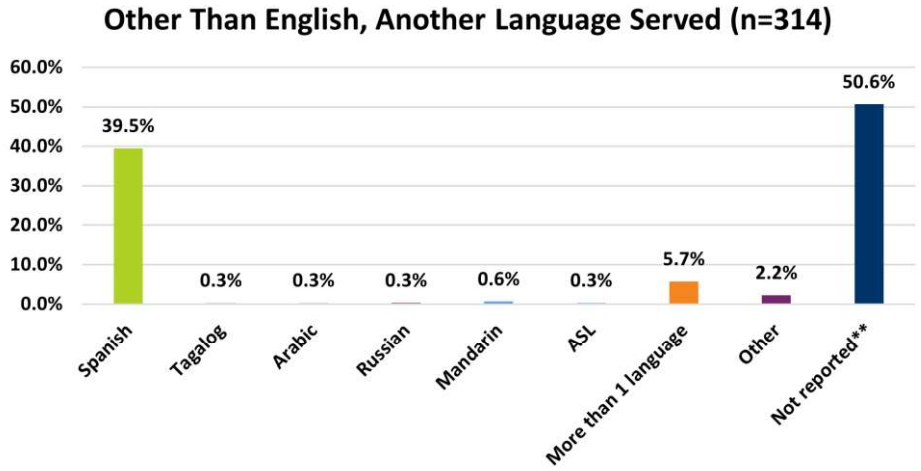
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

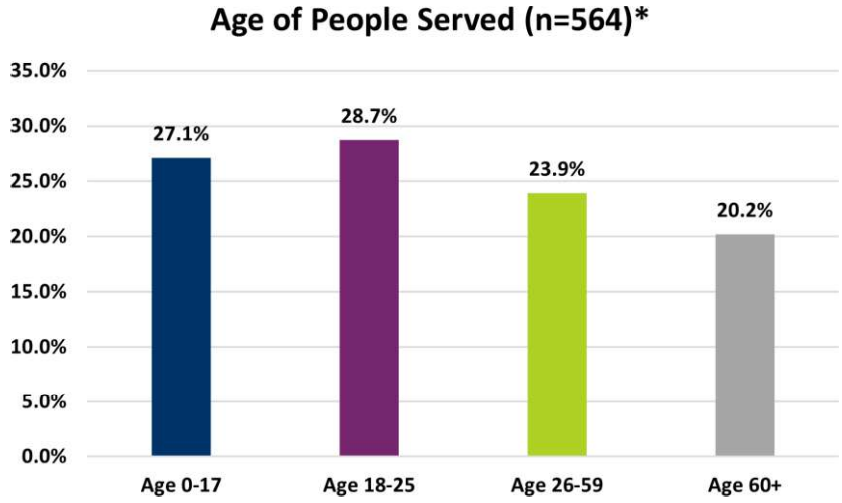
DEMOGRAPHICS—PEOPLE SERVED/WANT TO SERVE (cont.)

Demographics Summary (cont.)

The most frequently reported special population group that ASIST participants serve or want to serve was the **ethnic minorities group (17.8%)**, closely followed by the at-risk youth group (17.1%). Participants were able to choose multiple special population groups for this question. Additionally, participants most frequently chose **Spanish (39.5%) as another language other than English that they serve**. Lastly, participants most frequently responded that they serve or want to serve the **18-25 age group (28.7%)**.







**Note:* Multiple responses are reported here.*

APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

EVALUATION OUTCOMES

Evaluation Outcomes Summary

At the end of ASIST, all participants are encouraged to complete a feedback survey which includes questions about the overall course, how ASIST is helpful to them or others, and a section for additional comments or thoughts about the training.

On a scale of 1 (i.e., did not like at all…) to 10 (i.e., liked a lot), please write the rating that best describes your responses.* (n=314)	Rating (Mean)
1. How would you rate the quality of the ASIST workshop	9.4
2. Would you recommend ASIST to others?	9.6
3. This workshop has practice use in my personal life.	9.2
4. This workshop has practical use in my work life.	9.6

Please circle the number that best describes your response (1=Strongly Disagree… 5=Strongly Agree).* (n=314)					
Questions	Responses				
	1	2	3	4	5
5. If a person's words and/or behaviors suggest the possibility of suicide, I would ask directly if he/she is thinking about suicide.	1.0%	**	0.6%	10.2%	88.2%
6. Before taking the ASIST training, my answer to #5 would have been:	5.7%	12.7%	30.6%	25.2%	25.2%
7. If someone told me he or she were thinking of suicide, I would do a suicide intervention.	1.3%	**	1.3%	14.7%	82.7%
8. Before taking the ASIST training, my answer to #7 would have been:	6.7%	10.5%	23.6%	28.3%	30.9%
9. I feel prepared to help a person at risk of suicide.	60.0%	0.3%	2.2%	23.2%	73.6%
10. Before taking the ASIST training, my answer to #9 would have been:	11.5%	17.2%	24.5%	25.8%	20.7%
11. I feel confident I could help a person at-risk of suicide.	1.0%	0.3%	2.9%	23.6%	72.3%
12. Before taking the ASIST training, my answer to #11 would have been:	13.4%	15.3%	23.6%	28.3%	18.8%

Lastly, a great majority of ASIST participants (n=314) **agreed** with the following statements:

13. I attended two consecutive 8-hour days of training **(100%)**.
14. All trainers were present at the workshop for the full 2 days **(99.3%)**.
15. The "Jack" exercise was done on the afternoon of day 1 **(99.0%)**.

"The training was very smooth and informative. Presenters engaged all and did well. I liked learning the PALS."

"I felt it was very beneficial for my life and future profession."

"ASIST was a fun and helpful training. The guidance and experience obtained is invaluable to me personally and professionally."

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*
***No responses.*

PEI-02 Parent Education and Support

Triple P (Positive Parenting Program)

Program Type: Prevention Program

The Triple P Parenting Program is a multi-level system of parenting and family support strategies for families with children from birth to age 12. Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. In FY23/24 RUHS - BH continued to contract with one well-established provider to deliver the Level 4 parenting program for both parents of children 2-12 as well as parents of teens 12-17 in targeted communities in the West, Mid- County, and Desert regions of Riverside County. The service delivery method of Level 4 Triple P is a series of group parenting classes with active skills training focused on acquiring knowledge and skills. The program is structured to provide four initial group class sessions for parents to learn through observation, discussion, and feedback. Following the initial series of group sessions, parents receive three follow-up telephone sessions to provide additional consultation and support as parents put skills into practice. The group then reconvenes for the eighth and final session where graduation occurs.

For FY23/24 the provider's contract deliverables were doubled (from 360 parents countywide to 720 parents countywide). The program's outreach efforts also expanded to recruit more parents into the service. In total, the provider was able to provide service to 686 parents, coming very close to the goal of 720. Across both programs, parents had an 81.5% program completion rate and parents were overall highly satisfied with both programs (Triple P and Teen Triple P). Program outcomes indicated that participants increased in their positive parenting practices, decreased in inconsistent discipline practices, decreased experiences of depression, anxiety and stress levels, increased the level of involvement with their child/teen, reported decreases in the frequency of disruptive behaviors, and increases in prosocial behaviors.

Positive Parenting Practices Improved

Recruitment into the Spanish and Teen classes remained a significant challenge for FY23/24. Additionally, some school districts had lengthy and complex MOU requirements, delaying approvals and complicating the process with extensive demands to promote and provide services to school parents. With the expansion of contract deliverables, the team needed to increase staffing for the program. This took some time for new team members to be hired and complete the Triple P training and accreditation requirements to be able to facilitate classes. Additionally, staff turnover further impacted program implementation as new staff had to be recruited and trained in the Triple P model. This created delays in being able to start more classes through the County.

Behavior Problems Decreased

With the expansion of contract deliverables, the provider learned new ways to increase outreach and gained valuable insights on how to effectively connect with and relate to diverse communities. They were able to expand outreach efforts by collaborating with new organizations and spaces; for example, creating social media presence in different locations throughout the County (e.g., "Mom Walk" in the mid-county region), partnering with recovery centers for referrals, and focusing on private schools to help with recruitment. The provider learned more about the importance of understanding the unique needs and dynamics of each group they provide services for and worked on tailoring the different classes offered to best meet those needs.

Feedback from participants included:

- "[I learned] better ways to discipline my child based on proper expectations of their age. I learned that my behavior is really a good way to start positivity in our household. Also, learned that slowing down translations in our household for big activities helped us all to stay calm & get ready for morning & bed routine w/ less fights."
- "It was a very safe space and I felt extremely comfortable expressing what I felt like were struggles in my household and the array of solutions and perspective I received were extremely helpful."
- "I liked that there were parents willing to discuss their troubles and offer insight into things that they do or have tried. Also liked doing the scenarios with the breakout sessions."

Riverside University HEALTH SYSTEM Behavioral Health

Triple P and Teen Triple P Positive Parenting Programs

FY 2023/2024

MHSA Prevention and Early Intervention

Program Overview

RUHS-BH with MHSA Prevention and Early Intervention (PEI) funding implemented Triple P Positive Parenting Program and Teen Triple P Program, which are multi-level systems of parenting and family support strategies for families with children aged 2-12, and for families with teens aged 12-16, respectively. Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. Teen Triple P aims to promote positive, caring relationships between parents and their teens, and to help parents develop effective management strategies for dealing with a variety of teen behavior problems and common developmental issues. The service delivery method for this implementation of Level 4 Triple P and Teen Triple P is a series of group parenting classes with active skills training focused on acquiring knowledge and skills. The program is structured to provide four initial group class sessions for parents to learn through observation, discussion, and feedback. Presentations and small group practice are utilized during sessions and parents receive constructive feedback in the supportive environment of the group. Following the initial series of group sessions, parents receive three follow-up telephone sessions to provide additional consultation and support as parents put into practice the skills learned in group. The group then reconvenes for the eighth and final session. The Carolyn Wylie Center, a well established Community-Based Organization (CBO), was contracted to provide Level 4 Triple P throughout Riverside County, and Teen Triple P in the West and Mid-County Regions of Riverside County.

Triple P Outcome Evaluation

Evaluation of Triple P parenting focuses on the development and use of positive parenting practices and decreases in the use of negative parenting practices. Evaluation also includes measuring changes in children's disruptive behavior. The following measures are used in the evaluation of Triple P:

- ***Alabama Parenting Questionnaire (APQ)***
  The APQ is a parent completed questionnaire that measures several dimensions of parenting that have proven to be important for understanding the causes of conduct problems and delinquency in youth. Two of six parenting dimensions are used for analysis including: positive parenting, and inconsistent discipline. Parents completed the Alabama Parenting Questionnaire (APQ) before and after completing the program.

- ***Eyberg Child Behavior Inventory (ECBI)***
  The ECBI is a parent completed measure that focuses on child disruptive behaviors and the parent's perception of whether the behavior is problematic. The ECBI includes an Intensity Scale (frequency of disruptive behaviors) and a Problem Scale (parent's perception of problematic behaviors).

- ***Depression, Anxiety and Stress Scale (DASS-21)***
  The Depression Anxiety and Stress Scale (DASS) is a 21-item questionnaire which includes three self-report scales designed to measure parent's negative emotional states of depression, anxiety, and stress.

Teen Triple P Outcome Evaluation

Similar to Triple P, evaluation of Teen Triple P also focuses on the development and use of positive parenting practices and decreases in the use of negative parenting practices. Evaluation also includes measuring changes in teens conflict behavior. The following measures are used in the evaluation of Teen Triple P:

Strength and Difficulties Questionnaire (SDQ)
Parents completed the SDQ before and after completing the program. The SDQ is a behavioral screening questionnaire designed for children and adolescents aged 4-17 years. Each of the five scales of the SDQ (emotional, conduct, hyperactivity, peer problems, prosocial) are scored from 0-10. Four of these (emotional, conduct, hyperactivity and peer problems) creates a total difficulty score. The emotional and peer items together create an internalizing problems score and the conduct and hyperactivity questions together get an externalizing score.

Alabama Parenting Questionnaire (APQ)
Parents completed the APQ before and after completing the program. For the Teen Triple P program, the involvement scale score (10 items), positive parenting scale score (6 items), and poor monitoring and supervision scale score (10 items) are used. The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale (1—never, 2—almost never, 3—sometimes, 4—often, 5—always).

Conflict Behavior Questionnaire (CBQ)
The Conflict Behavior Questionnaire (CBQ) is a 20 item questionnaire that uses a true false scale to assess general conflict between parents and their children. The responses are then scored (and some items reverse scored) to obtain a total score.

A satisfaction survey is also used for both programs to measure the parent's satisfaction in program logistics, program leaders, and program content.

Executive Summary - Key Findings

Enrollment and Demographics

Countywide, Triple P and Teen Triple P combined served 686 parents in FY 23-24. A total of 261 parents were served in the Western region, 236 parents in the Mid-County Region, and 189 parents in the Desert region. By program, Triple P served 542 parents and Teen Triple P served 144 parents Countywide. Demographics information showed that most of the parents in Triple P spoke English as their preferred language (72.2%), and in Teen Triple P, 62.5% of parents identified English as their primary language. The majority of parents served in Triple P and Teen Triple P were Hispanic/Latinx, 64.6% and 71.5%, respectively. The average age of the child of focus in Triple P was 6.3 years, and 13.5 years for Teen Triple P. The majority of parents/caregivers enrolled in both Triple P and Teen Triple P programs were female.

Service data showed that Countywide 80.8% of parents completed the Triple P Program, and 84% of parents completed the Teen Triple P program. Across both programs, parents had a 81.5% program completion rate. Parents were overall highly satisfied with both programs.

Triple P: Positive Parenting Practices Improved

Analysis of the APQ measure indicated that overall, by the end of the program, participants had shown increases in positive parenting practices, and decreases in inconsistent discipline practices. Analysis of the DASS-21 also showed that parents experienced a decrease in their depression, anxiety, and stress levels.

Triple P: Child Disruptive Behavior Decreased

Outcomes from ECBI measures showed overall decreases in the frequency of children's disruptive behaviors. ECBI Intensity Scale scores decreased significantly from pre to post measure. ECBI Problem Scale scores also decreased significantly indicating that parents reported fewer behaviors as problematic.

Teen Triple P: Teen Problem Scores Decreased, Prosocial Skills Increased

Countywide, outcomes of the SDQ indicated that teen total problems of emotional, conduct, hyperactivity, peer problems decreased significantly upon parent completion of Teen Triple P. Teen prosocial behaviors significantly increased pre to post.

Teen Triple P: Increase in Parent Involvement and Positive Parenting

Analysis of the APQ measure indicated that countywide, parents had a significant increase in involvement with their teen and in positive parenting practices. There was a decrease in poor monitoring practices, however this decrease was not statistically significant.

Teen Triple P: Decrease in General Parent-Teen Discord

Countywide, analysis of the CBQ indicated a statistically significant decrease in parent's report of general conflict between parent and teen.